Contents

1 BACKGROUND .................................................................................................................................................... 10

1.1 INTRODUCTION .............................................................................................................................................. 10
  1.1.1 Purpose..................................................................................................................................................... 10
  1.1.2 Related Documents ................................................................................................................................. 10

1.2 CORPORATE AND FINANCIAL GOVERNANCE .......................................................................................... 11
  1.2.1 Financial Governance and Budget Charter Principles (BCP) .................................................................. 11

1.3 ANNUAL CYCLES ......................................................................................................................................... 15

2 FUNDING FRAMEWORK – BUDGET BUILD 2011-12 ...................................................................................... 18

2.1 SOURCES OF FUNDING .............................................................................................................................. 18

2.2 BUDGET ALLOCATION METHODOLOGY 2011/12 .............................................................................. 18
  2.2.1 The 2011/12 Base Line ............................................................................................................................. 18
  2.2.2 Downward Adjustments to the 2011/2012 Base Line ............................................................................ 18
  2.2.3 Upward Adjustment to the 2011/2012 Base Line .................................................................................. 19
  2.2.4 Facility level Weighted Activity Units (WAU) and Funding Information ............................................ 20
  2.2.5 Grants and Contributions ....................................................................................................................... 22
  2.2.6 Other Funding ....................................................................................................................................... 22

2.3 SOURCES OF FUNDING .............................................................................................................................. 23
  2.3.1 Program Structures and the Activity Based Funding Model ................................................................. 23
  2.3.2 Program Funding Overview .................................................................................................................... 23
  2.3.3 Non-Activity Based Funding .................................................................................................................. 24
  2.3.4 Participation in Clinical Costing ................................................................................................................ 24
  2.3.5 Data Collection Requirements ................................................................................................................ 25
  2.3.6 Activity Based Funding Model Components ......................................................................................... 26
  2.3.7 Funding Policy Incentives and Initiatives ............................................................................................... 26

2.4 REVENUE ....................................................................................................................................................... 29
  2.4.1 Sources of Revenue ................................................................................................................................. 29
  2.4.2 Internal User Charges .............................................................................................................................. 30
  2.4.3 Own Source Revenue ............................................................................................................................... 30
  2.4.4 Revenue Estimates ................................................................................................................................ 31

2.5 OTHER FUNDING CONSIDERATIONS ........................................................................................................ 35
  2.5.1 Expenditure Approved Funds .................................................................................................................. 35
  2.5.2 General Trust Funds and Research Funds ............................................................................................. 35
  2.5.3 Internal Recoveries .................................................................................................................................. 37
  2.5.4 Natural Disaster Claims or Damage to Queensland Health Property .................................................... 37

2.6 BUDGETING ................................................................................................................................................... 40
  2.6.1 Budget Management ............................................................................................................................... 40
  2.6.2 Technical Round ..................................................................................................................................... 41
  2.6.3 Budget Controls ...................................................................................................................................... 42
  2.6.4 Centrally Held Funds ............................................................................................................................... 46
  2.6.5 Corporately Managed Budgets .............................................................................................................. 46

2.7 BUSINESS CASES ....................................................................................................................................... 47
  2.7.1 New Funding for Business Cases ......................................................................................................... 47
  2.7.2 Internal QH Process – Costing Business Cases .................................................................................... 48

2.8 NON OPERATING (EQUITY) ...................................................................................................................... 50
  2.8.1 Capital Funding ....................................................................................................................................... 50
  2.8.2 Minor Acquisitions – Funding ................................................................................................................ 50
  2.8.3 Capital Allocations – Funding ................................................................................................................ 51
  2.8.4 Capital Allocation – Treatments ............................................................................................................... 51
  2.8.5 Capital Swaps Restrictions – Funding .................................................................................................. 51

2.9 DEPRECIATION ............................................................................................................................................. 52
  2.9.1 Depreciation ........................................................................................................................................... 52
  2.9.2 State Depreciation Expenditure ............................................................................................................. 52
  2.9.3 Commonwealth Depreciation Expenditure ........................................................................................... 52

2.10 ROLLOVERS ............................................................................................................................................... 53
  2.10.1 Rollovers and Required Treatments .................................................................................................... 53
3 BUSINESS MANAGEMENT .......................................................................................................................... 56

3.1 COST CENTRE MANAGEMENT ............................................................................................................. 56
  3.1.1 Cost Centres ................................................................................................................................. 56
  3.1.2 Definition of Cost Centres within a Facility Environment .............................................................. 57
  3.1.3 Service Type and Performance Management Framework (PMF) ..................................................... 57
  3.1.4 Fund Type ....................................................................................................................................... 58
  3.1.5 Blocking Cost Centres .................................................................................................................. 58
  3.1.6 Reporting Hierarchies (Standard HLTH, QH_Alt_7 and QH_Alt_2) .................................................. 58
  3.1.7 Cost Centre Maintenance – Contact Person Responsibilities ......................................................... 60
  3.1.8 ABF Percentage Allocations .......................................................................................................... 61
3.2 FULL TIME EQUIVALENTS .................................................................................................................... 63
  3.2.1 Full-Time Equivalents (FTE) ......................................................................................................... 63
  3.2.2 Nursing FTE via the Business Planning Framework ........................................................................ 64
  3.2.3 Minimum FTE Budget Requirements ............................................................................................ 65
  3.2.4 External Budget FTE ..................................................................................................................... 65
  3.2.5 Budget Upload ............................................................................................................................... 65
  3.2.6 FTE Reporting .............................................................................................................................. 67
  3.2.7 Xman Accruals (DSS) .................................................................................................................. 69
3.3 FORECASTING ........................................................................................................................................ 70
  3.3.1 Forecasting ..................................................................................................................................... 70
  3.3.2 Analysis of Forecasting Factors ..................................................................................................... 70
  3.3.3 Forecasting Template and its Inbuilt Features .............................................................................. 71
  3.3.4 Forecasting Process ....................................................................................................................... 71
  3.3.5 Program Owners – Forecasting .................................................................................................... 72
3.4 ACTIVITY BASED FUNDING REPORTING ........................................................................................... 72
  3.4.1 ABF Allocation and Resource Management Reporting ................................................................... 72
  3.4.2 T2 Cost per WAU Reporting for top 25 QH DRGs ........................................................................... 73
3.5 REPORTING .......................................................................................................................................... 73
  3.5.1 Monthly Reporting Requirements .................................................................................................. 73
  3.5.2 PR Fortnightly FTE Reporting ...................................................................................................... 74
  3.5.3 Commonwealth Reporting ........................................................................................................... 74
  3.5.4 Prior Year Expenditure .................................................................................................................... 80
3.6 INCOME STATEMENT – OPERATING – REVENUE / EXPENSE ........................................................... 82
  3.6.1 Revenue (Actual, Budget and Forecast) ......................................................................................... 82
  3.6.2 Income Statement Requirements .................................................................................................. 82
  3.6.3 Actual Revenue, Budget and Forecast Responsibilities ..................................................................... 83
  3.6.4 Expenditure (Accrual, Actual, Budget and Forecast) ..................................................................... 85
  3.6.5 Expenditure – Maintenance Management Obligations .................................................................. 85
  3.6.6 Expenditure – Depreciation Treatment .......................................................................................... 86
3.7 INCOME STATEMENT - NON OPERATING - INFLOWS / OUTFLOWS .................................................. 87
  3.7.1 Non Operating Inflows .................................................................................................................. 87
  3.7.2 Non Operating Outflows ................................................................................................................. 88
3.8 COMPLIANCE AND RECONCILIATIONS ............................................................................................. 90
  3.8.1 Cash Management – Daily Position Reporting ............................................................................. 90
  3.8.2 Reconciliations – FAMMIS to Panorama (DSS) ............................................................................. 90
  3.8.3 Reconciliation of QH Funding to Budget Build ............................................................................. 90

4 ACRONYMS AND GLOSSARY OF TERMS .................................................................................................. 91

4.1 ACRONYMS LISTING ............................................................................................................................. 91
4.2 GLOSSARY OF TERMS .......................................................................................................................... 96
4.3 KEY FINANCE BRANCH CONTACTS ...................................................................................................... 97

5 APPENDIX ................................................................................................................................................. 98

5.1 2011/12 FUNDING MODEL PRICE ....................................................................................................... 98
5.2 CLINICAL EDUCATION .......................................................................................................................... 99
5.3 CATEGORY C WAU TARGETS ................................................................................................................ 102
5.4 DEPRECIATION SCHEDULE 2011/12 .................................................................................................. 103
5.5 STATE BUDGET SUBMISSION DATES 2012-13 ................................................................................. 104
List of Tables

Table 1 Annual Budget Cycle ........................................................................................................................... 16
Table 2 Districts Participating in Patient Level Costing .................................................................................. 25
Table 3 Own Source Revenue Streams 2009-10 (as per the QH Annual Report 2009-10) .................................. 31
Table 4 Key Budget Process Dates and Responsibilities ............................................................................. 41
Table 5 Post Budget Adjustments (Current Year Adjustments) ....................................................................... 41
Table 6 Components of Full Time Equivalents (FTE) ................................................................................... 63
Table 7 Responsibilities for uploading revenue journals for actuals, budgets and forecasts .......................... 83
Table 8 Responsibilities for uploading expenditure budgets and forecasts .................................................... 85

List of Figures

Figure 1 Overall Purchasing Framework ....................................................................................................... 11
Figure 2 Allocation Cycle ................................................................................................................................. 14
Figure 3 Budget by Program 2011-12 ............................................................................................................ 23
Figure 4 ABFM Component Funding 2010-11 ............................................................................................... 26

A) Business Rules Guidelines – Version Control Table

<table>
<thead>
<tr>
<th>Version #</th>
<th>Date</th>
<th>Prepared by:</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>28 October 2011</td>
<td>Anna Daniel</td>
<td>Loaded onto QHEPS for Review/Comment.</td>
</tr>
</tbody>
</table>

Created by: Business Analysis & Management – Financial Reform & Analysis
File Name: Business Rules and Guidelines _11/12_V 1.0
Approved by:
## B) Business Review Guidelines – Change Control Summary

<table>
<thead>
<tr>
<th>Section</th>
<th>Change Type</th>
<th>Change Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2, and 3</td>
<td>Major review</td>
<td>The major change to the document has been due to introduction of Activity Based Funding (ABF). Most of the previous references to ABF have been removed and replaced by links to the ABF Operating Manual and the ABF Peer Group Cost Weights. Previously, the Business Rules and Guidelines Appendices were a separate document. Now, it is included in the Business Rules and Guidelines document. Currently, the ABF related tables of the old appendix are linked to the ABF site.</td>
</tr>
<tr>
<td>1. Background</td>
<td>Major review</td>
<td>Figure 1 on Planning Framework has been removed. Links are provided for various plans under 1.2.1.1 Budget Charter Principle 1 - Planning Drives Resource Allocation.</td>
</tr>
<tr>
<td>2. Funding Framework</td>
<td>Major review with additions, removal and amendments.</td>
<td>Major review of this section was carried out and significant additions were made to Funding Methodology and Sources of Funding. The section on Funding Methodology – Activity Based Funding Model has been removed and incorporated into Budget Allocation Methodology 2011/12. Under Sources of Funding (section 2.3) references to Activity Based Funded Facilities, Measuring Activity with WAU, Activity Price setting Process, ABF Target Setting, Transition Payments for ABF, ABF Model Components (Acute Inpatients, Critical Care, Sub-acute and Post acute care, Mental Health, Interim Funding for Long stay Patients (Activity Accruals), Inpatient funding allocation Summary), Ambulatory (Specialist Outpatients, Allied Health Outpatients, Emergency Department), Tele Health, Home Dialysis, Hospital in the Home, High Cost Home Support Program, Clinical Education and Statewide and Super-speciality Services and the associated tables have been removed. Category C incentives and allocation have been added. Data and Coding, Costing Incentive payments, Clinical Practice Improvement Payment (CPIP), Super Speciality Services and Target Tolerance Initiatives have been discontinued. The section on Internal User Charges has been linked to section 5.8 of FMPM and a segment on intra-departmental accounts has been added. The section on Revenue Estimates has been reviewed and sections on interstate and QComp have been updated. Minor changes were made to the section on General Trust Funds and Research Funds.</td>
</tr>
</tbody>
</table>
### Business Rules & Guidelines - Change Control Summary

<table>
<thead>
<tr>
<th>Section</th>
<th>Change Type</th>
<th>Change Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>A new section on NDRRA Submission Guide has been added.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Under the Budgeting section, the following changes were made:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Key Budget Process, PBA and Income Statement Dates have been changed (tables on Budget Process Dates and Responsibilities and PBA);</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The dates for Technical Rounds have been changed;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It has been noted that, Districts are now responsible for allocating activity targets and loading directly into DSS and not via the ABF website;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Additional links on reporting template and checklist are made to Overseas Travel;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annual Leave Central Scheme has been removed;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Centrally held funds has been discontinued; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A new section on patient transport for Fixed-Wing Aero medical, Queensland Ambulance Service, and Community Helicopter has been added.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Business Cases section has been reviewed and more details have been provided on Category 1-3 Concept briefs. Minor changes have been made to the Internal QH Process – Costing Business Cases and the referenced links have been updated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Non-Operating Equity section’s headings have been reordered and links have been updated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In the Depreciation section, the section on Depreciation – Additional Information has been removed.</td>
</tr>
</tbody>
</table>

### 3. Business Management

**Major review with additions, removal and amendments.**

In the Cost centre section two new fund types have been added and significant changes to ABF/CFM Percentage Allocations has been made. The table on components of Full Time Equivalents has been removed in the Full Time Equivalents section. Added are sections on Non-Standard FTE and Nursing FTE via Business Planning Framework. The Xman Accruals section is reviewed and updated. The Forecasting section is still in draft and will be updated when the new forecasting methodology is finalised. Under the Activity Based Funding Reporting, a new section on T2 Cost per WAU Reporting for top 25 QH DRG’s has been added. Under the Reporting section, references to FTE Statement and
<table>
<thead>
<tr>
<th>Section</th>
<th>Change Type</th>
<th>Change Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAU statement have been removed. Moderate changes have been made to Commonwealth reporting section with the addition of a new policy referring to the NPA on Improving Public Hospital Services (sub-acute) that have activity and dollar acquittals. Added is information on HACC, Transition Care and Aged Care Assessment Program. The Income Statement section has been corrected for GL account code on Depreciation, and offset accounts for non-operating inflows have been added. Revenue Cash Flowing (Phasing) has been changed in 2011/12. Income Statement – Non-Operating – Inflows / Outflows section’s references to sources of funding under Capital Allocation (State Funded), Non Operating Outflows – Capital Acquisitions – Additional Details, Non Operating Outflows Minor Capital Acquisitions and Eco Efficiency Program have been removed Time of notifying Treasury in the Cash Management - Daily Position Reporting section has been added.</td>
<td>Minor Review</td>
<td>Updated acronyms used in the guidelines. Updated contacts list.</td>
</tr>
<tr>
<td>4. Acronyms, Glossary and Contact List</td>
<td>Addition</td>
<td>Added appendix to the Guideline.</td>
</tr>
</tbody>
</table>
Section 1
Background
1 BACKGROUND

1.1 Introduction

These Business Rules and Guidelines describe the reporting and funding arrangements for Queensland Health (QH). This document has been developed by Business Analysis and Management (BAM) in consultation with relevant units within Finance Branch and various Districts and Divisions. These Guidelines are designed to be a practical reference point for Districts and Divisions in the exercising of their day to day financial management responsibilities. The Guidelines include details on the administration and application of various financial inputs and outputs and intends to provide officers with improved explanations and understanding that will assist them in the management of their business.

1.1.1 Purpose

These Business Rules and Guidelines describe the business rules and funding arrangements for QH Districts and Divisions for the 2011-2012 fiscal year. The purpose of the document is to assist the Districts and Divisions in understanding the application and implementation of these financial guidelines in their areas of responsibility and to further develop the link between funding and planned activity.

This document is concerned with:

- General programs and sources of funding;
- Budget Allocation for hospital activity using the 2011-12 Activity Based Funding Model (ABF);
- Budget planning and resource management; and
- Promoting consistent standards for all Districts and Divisions.

QH is obligated to provide a solid governance framework and a dedicated and controlled financial environment. This obligation and framework methodology is applicable to the budget build processes, together with the ongoing development and improvement of all performance reporting and monitoring processes. It will utilise corporate information systems and other associated practices specifically designed to deliver improved efficient and effective outcomes for all Queensland Health resources.

This statement and recognition is applicable to all Districts and Divisions and all other entities that utilise and manage Queensland Health resources. Chief Executive Officers (CEO), Chief Finance Officers (CFO) and Divisional Executive Directors (DED) are to promote and ensure compliance with these obligations and frameworks at all times.

1.1.2 Related Documents

Activity Based Funding Model 2010 – 2011 Technical Paper describes the technical aspects of the funding model construction and can be found at: http://casemix.health.qld.gov.au/CFM/CFMPub.html. This document is currently being reviewed in light of changes to the new funding arrangement that is applied to the delivery of health services.
1.2 Corporate and Financial Governance

QH requires a reporting framework and comprehensive governance process to sustain funding policy at operational levels for the long term. Internal governance arrangements define the roles and responsibilities of individual Districts and Divisions regarding decision making and administration of financial policy and funding model components.

1.2.1 Financial Governance and Budget Charter Principles (BCP)

This section is intended to convey the essential elements of the Budget Charter and its impact on the resource management framework. The key principles of the Charter are as noted below:

- **BCP1 - Planning Drives Resource Allocation (1.2.1.1);**
- **BCP2 - Collective Resource Leadership and Decision Making (1.2.1.2)(Resource Executive Committee);**
- **BCP3 - Devolved Responsibility for Resource Management (1.2.1.3) (Districts and Divisions);**
- **BCP4 - Transparency and Equity (1.2.1.4); and**
- **BCP5 - Financial Management Best Practice (1.2.1.5).**

**1.2.1.1 Budget Charter Principle 1 – Planning Drives Resource Allocation**

The key impact of this principle is that the budget process involves full allocation of resources before the commencement of the financial year. The prioritisation of resources is to be undertaken at the planning stage and not during an annual prioritisation of business cases (as has historically been the case) and include:

- Districts drive Health Services Plans;
- Health Services Plans drive budget allocations;
- Queensland Statewide Health Services Plan 2007-2012, the Strategic Plan and Districts and Divisions Service Plans in turn drive the following plans:
- Integrated Planning/Funding process to be endorsed for future CBRC Budget submissions.

**Figure 1 Overall Purchasing Framework**

This figure will be added when the Overall Purchasing Framework is finalised.
1.2.1.2 Budget Charter Principle 2 – Collective Resource Leadership and Decision Making

The Resource Executive Committee (REC) functions under the authority of the Director-General and reports to the Executive Management Team (EMT), which provides advice and recommendations to the resource Executive Committee Chair. The purpose of the REC is to attend to the following matters:

- Review the financial position and performance of Queensland Health in the current and forward years,
- Provide strategic advice and recommendations to the EMT with regard to the development, implementation and management of Queensland Health’s financial management strategy,
- Ensure that all financial and organisational performance improvement processes are coordinated and effective, and lead to the achievement of Queensland Health’s strategic objectives,
- Oversee progress against critical objectives and ensure appropriate action is taken to support improvements where necessary,
- Promote the development of effective teamwork across Queensland Health, and the most effective division of responsibilities in relation to financial management and organisational performance improvements.

To further contribute to the management and delivery of health services the REC undertakes the following, meeting on a monthly basis to:

- Develop the financial strategy for Queensland Health in accordance with the strategic direction as determined by the Executive;
- Oversee the implementation of the approved financial strategy, including development of an annual budget and funding strategies for Queensland Health for approval by the Executive;
- Oversee the development of an effective organisational performance monitoring and improvement framework to ensure the efficient and effective utilisation of resources;
- Oversee and provide focussed direction in the development of co-ordinated performance and financial information and decision support systems to underpin performance monitoring, analysis and reporting for Queensland Health;
- Monitor variances to the outcomes of the implementation of the financial strategy, including review of significant variances to approved annual budgets and to make decisions to rectify variances to the financial strategy; and
- To analyse any material request for alteration to the approved budget and make decisions on their financial viability.

Another group, the Finance Sub-Committee (FSC) reports to the REC to support its purposes and functions as stated above. The FSC further supports the Resource Executive Committee by providing advice and recommendations in relation to the following:

- The financial position and performance of Queensland Health in the current and forward years;
- The development, implementation and management of Queensland Health’s financial management strategy;
- Decision making on critical objectives and appropriate actions by determining corporate reporting requirements and the supporting of reporting improvements where necessary; and
- Proposed policy changes that have a financial impact on the organisation.
All matters with a financial impact must be referred directly to the Finance Sub-Committee for consideration and approval which will be referred to the Resources Executive Committee for final endorsement. (For further details refer to: http://qheps.health.qld.gov.au/financenetwork/bud_fore_data_ana/docs/bus_ana/procedures/fin_sub_com_to_m.pdf)

1.2.1.3 Budget Charter Principle 3 – Devolved Responsibility for Resource Management

1.2.1.3.1 Management Roles and Responsibilities
Chief Executive Officers / Chief Finance Officers / Divisional Executive Directors and Deputy Directors General are responsible for the total resources allocated to their Districts and Divisions and have the authority to move funding, resources and activity within their Districts or Divisions. They are also expected to take a lead role in the budget process through taking responsibility for the quality and completeness of the process in their Districts and Divisions.

The REC may allocate or re-prioritise any funding, resources and activity between Districts and Divisions as necessary to meet Queensland Health priorities.

Service provision obligations must be met within the resources available and funds allocated should only be utilised for the purpose for which they are allocated. Where funding adjustments occur, activity targets, Budgeted Full Time Equivalent (BFTE) staff and performance indicators must be adjusted accordingly. Similarly, where activity and performance targets are not being achieved, funding may also be adjusted. There should be no expectation that funding supplementation will be received to:

- Meet a balanced budget (see below at: 1.2.1.3.2); and/or
- Fund Districts for exceeding activity targets (without prior approval).

Fund holders are also not to withhold funding. Districts, Program / Fund Holders or other entities with funds that have been pre-identified should release these funds for their intended use at the earliest practical opportunity within the budget build framework (see Section 3 Business Management). This principle is at the centre of full resource allocation, a keystone within the QH budget process.

1.2.1.3.2 Balanced Budget
A balanced budget is defined within the Monthly Performance Report as being Operating Revenue less Operating Expenditure and excludes Trust and Research funds. At the mid-year discussions Districts and Divisions should highlight to the DG their reasons for not meeting their balanced position and their activity targets.

In relation to the balanced budget requirements it should be noted that Commonwealth dollars must be fully utilised in the year that they are received or advice provided to Finance Branch (as early as possible and preferably before 1 June annually) of the inability of Districts or Divisions to fully expend Commonwealth dollars (refer to 3.7.1.2 Rollovers).

1.2.1.3.3 Budget Maintenance and Devolved Responsibility
The Budget loaded in FAMMIS is required to equal the signed Budget Income Statement. Portfolio Managers will review the Budget loaded in FAMMIS and check that it agrees to the budget as reflected in the Income Statement as part of end of month reporting procedures for each of the Districts and Divisions.
Only allocated budgets should be taken into consideration in determining the budget position for Districts and Divisions. The distribution of budgets and the loading of budgets and forecasts should be within the Finance Branch annual timetable requirements.

1.2.1.4 Budget Charter Principle 4 – Transparency and Equity

The figure below depicts the flow of events which will drive the full allocation of resources pre-budget build, consistent with financial best practice. This cycle encapsulates key components of the Budget Charter and supports greater transparency and accountability.

Figure 2 Allocation Cycle

1.2.1.5 Budget Charter Principle 5 – Financial Management Best Practice

Recent years have seen a significant change in financial management best practice, and it is expected that with this experience, budget allocation, budgeting, forecasting and reporting will continue to improve.

Healthcare funding management best practice includes utilising ABF principles. Activity Based Funding (ABF) methodologies are widely recognised throughout the world as the most equitable way to allocate resources and make changes which can increase productivity and improve service delivery while being able to evaluate the outcome of care. ABF is used for clinical benchmarking and is a means to set targets and measure performance.
1.3 Annual Cycles

Budget processes follow a well defined timetable that must be strictly adhered to in order that QH delivers a robust budget to Districts and Divisions. The budget build process begins ten (10) months ahead in August. This process begins with the review of the design and development of costing templates for the Cabinet Budget Review Committee (CBRC); review of State Special line items; base funding with options on growth allocation and available funds; revenue estimates; activity based funding; full time equivalent (FTE) calculation; network or held funds allocation; cash flow; release of Income Statement; and the phasing and upload of both revenue and budgets and forecasts at the start of the financial year in July. (See also Section 2.6 Budgeting).

Requests for alteration or amendment to components of the Queensland Activity Based Funding Model (QABFM) should be made by submission and be compatible with the annual cycle that guides the development of future iterations of the model.

For more information on the governance arrangements and how to request QABFM policy changes, refer to the documents on the Funding Model Governance Arrangements available from the Budget Services intranet site located at: http://casemix.health.qld.gov.au. Table 1 Annual Budget Cycle, over the page shows the annual cycles for Finance and activity based funding and outlines the major tasks and processes over the financial year.
Table 1 Annual Budget Cycle

Please note that this table does not apply to 2011/12 Budget Cycle due to numerous changes associated with preparation for the National Health Reform.

<table>
<thead>
<tr>
<th>Budget Cycle</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>QABFM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation, monitoring &amp; evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QABFM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy Change Requests</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QABFM Policy Review &amp; Analysis processes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy Papers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity Targets Build</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Costing first 6 months complete (SDS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costing Standards Review</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Coding prior year complete (DCU)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Costing prior year figures final</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHCDC Prior year data completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHCDC Data validation process</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHCDC Processed for submission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBRC Submission / Approval</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Budget Papers / Estimates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue Estimates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budget , WAU, FTE, cash flow methodology &amp; phasing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base Budget</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Growth Funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FTE Build</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income Statement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key**

SDS - Service Delivery Statements

TII - Transition II Clinical Costing System

DCU - Data Collections Unit

NHCDC - National Hospital Cost Data Collection

QABFM - Queensland Activity Based Funding Model

CBRC – Cabinet Budget Review Committee

**Legend**

1. Finance
2. State Budget & CBRC
3. NHCDC
4. DCU
5. Patient Costing
6. QABFM
Section 2
Funding Framework
2 FUNDING FRAMEWORK – BUDGET BUILD 2011-12

2.1 Sources of Funding
The QH budget is funded from various sources including:

- Queensland State Government;
- Commonwealth Agreements: National Healthcare Agreements (NHA) (for National Healthcare Specific Purpose Payment (SPP)); National Partnership Agreements (NPA) and other Commonwealth Grants;
- Own Source Revenue – (patient fees and charges, licensing, etc.); and
- Grants and Contributions (various sources).

Policy Strategy and Resourcing Division (PSR) coordinates Commonwealth and State budget processes.

Commonwealth funding includes the National Healthcare SPP. From the 2012-13 financial year this funding will be received through National Health reform funding. In addition, there are a number of National Partnership Agreements and State focused implementation plans.

(Refer to http://www.federalfinancialrelations.gov.au/content/intergovernmental_agreements.aspx website which provides detailed information and copies of the national agreements.)

Refer to the State Funding Unit website at: http://qheps.health.qld.gov.au/policybranch/html/sfu.htm, which coordinates the preparation of State Budget submissions to the CBRC. (Section 2.6.2 Technical Round)

2.2 Budget Allocation Methodology 2011/12

QH has adopted a new budget methodology to allocate the 2011/12 operational budget to Health Service Districts and Divisions. The new methodology was endorsed by the Resource Executive Committee (REC) on 27 June 2011 (Noted by REC agenda item 6.2 – Health Budget Allocation Model 2011-2012). The 2011/12 Income Statements released to Districts and Divisions have been developed using this methodology. The basic elements of the methodology and the information contained in the Income Statements are described below.

2.2.1 The 2011/12 Base Line

The 2011/12 base line is the estimated full year expenditure for 2010/11 based on actual year to date May 2011 expenditure projected to the end of June 2011. **Please Note:** Subsequent adjustments to the District and Divisions’ base line have been made where material differences between the forecasted and actual figures for the full year were detected.

2.2.2 Downward Adjustments to the 2011/2012 Base Line

1. **Additional New Beds Delivered in 2010/11** – Part year non-recurrent funding allocated to Districts that commissioned additional beds was removed from the baseline;

2. **Transition Funding for Additional New Beds Delivered in 2010/11** - Non-recurrent funding allocated in 2010/11 to Districts for commissioning additional beds was removed from the baseline; and

3. **Surgery Connect and Elective Surgery Funding** - Funding allocated by Centre for Health Improvement (CHI) Division to Districts in 2010/11 was removed from the baseline.
Please note: there were other non-recurrent funding items allocated to Districts and Divisions in 2010/11 which were not removed from the baseline because full and detailed information regarding these funding line items was not available. This includes one-off HP back payments and costs incurred in Districts and Divisions during the 2010/11 floods and cyclones. These adjustments may be made pending approval from the REC.

2.2.3 Upward Adjustment to the 2011/2012 Base Line

1. **2011/12 Enterprise Bargaining Funding** - estimated total cost of EB increments to the Districts and Divisions in 2011/12, as determined by the Models & Costings Unit, using actual salary expenditure for the period October to December 2010. Therefore, the Districts and Divisions are fully funded for the impact of EB in 2011/12. In the Income Statement, the EB funding is split into ABF and non-ABF components. The ABF component of EB is included in the overall ABF funding pool, which has been used to derive the 2011/12 WAU price.

2. **Full Year Impact of Additional New Beds delivered in 2010/11** - the recurrent full year funding of new beds delivered in 2010/11 has been added to the 2011/12 base line.

3. **Additional Built Capacity** - Funding has been allocated for the new beds to be commissioned in 2011/12. The funding is determined in the context of total activity being purchased by the Department from the relevant District. In the Income Statement, this appears under the notation “non-recurrent funding for additional built capacity”. **Please Note:** The funding allocation does not represent or equate to individual bed types or planned beds to be delivered within a District.

4. **Indexed Growth** - Refers to additional funding associated with a growth factor applied to non-discretionary DRG’s. Non-discretionary DRG’s refer to those service lines where Districts will be incentivised to do more activity above the allocated targets as well as meet the allocated targets to avoid funding penalties for failure to deliver against targets.


Indexed growth has been applied to the following service types:

- Emergency Surgery;
- Category 1 Elective Surgery;
- Trauma;
- Obstetrics – including neonates;
- Cancer;
- Burns; and
- Stroke.

The level of funding applied will be determined in the context of available funding, existing activity levels being purchased and additional funding being provided through other channels.

5. **Non - Negotiables Funds 2011/12** - These include additional funds for specific purposes and is sourced from Commonwealth Government or State Cabinet / CBRC which have a requirement for acquittal and reporting.

6. **Own Source Revenue** – In the Income Statement the reference to OSR Funding includes:

- User Charges revenue streams from motor vehicle accident insurance commission (MAIC) claims, payments for treating cross border patients, workers compensation (Q-Comp) claims,
Department of Veterans Affairs (DVA) payments, private inpatients and outpatients, and revenues from non-patients activities. For 2011/2012 financial year Districts and Divisions have been allocated the actual 2010/2011 OSR user charge revenue indexed by 3%.

- Other Revenue includes licensing, proceeds from sale of land and equipment, recoveries and revenue interest, which have not been subject to the 3% indexation.
- The Stretch Target is the additional revenue from the public to private patient conversion that is contained in the OSR Private Patient Practice Revenue model. The stretch target that is applied to the OSR User Charge has been negotiated with PANDA in consultation with Districts.

7. **ABF Transition** - The 2011/12 ABF transition was arrived by using the following method.

Districts declared a ‘peered reviewed’ 2009/10 ABF pool based on their cost centre splits. This 2009/10 ABF pool was adjusted for enterprise bargaining, pathology, annual leave on-cost, library journals, ID transfer costs and AFS adjustment to arrive at the 2010/11 ABF pool and adjusted expenditure for each ABF facility.

The ABF pool was divided by the total activity output (Weighted Activity Units – WAUs) from the phase 14 ABF model to determine the QH price (currently $4214). The ABF facility activity output (WAUs) was multiplied by this QH price to determine the ABF funding for each of the ABF facilities. If this ABF funding for 2010/11 for each District is greater than the District’s 2010/11 declared ABF pool submission, the District will be a net beneficiary under the arrangement and no ABF transition allocation will be made to the District. The inference is that the district has been more efficient than the average cost per unit of activity.

Where the District’s 2010/11 ABF funding is lower than the declared ABF pool submission, the District is deemed to be inefficient and an ABF transition is applied to the District. Negative transitions applied to the District are determined by the lesser of the actual calculated negative transition (which is the difference between the 2010/11 ABF funding and District’s 2010/11 declared ABF pool allocation) plus estimated end of year deficit position or 2% of the District’s 2010/11 budget.

There are no positive transition payments in the 2011/12 budget allocations.

Transition appearing in the Income Statement is a contribution to the savings required to be made as a result of relative efficiency against the ABF pool contributions and the end of year deficit position.

2.2.4 **Facility level Weighted Activity Units (WAU) and Funding Information**

From 2011/12 financial year 28 Facilities within Queensland Health will be funded via an activity-based funding (ABF) model. Funding and WAU targets are allocated to service groups in the Emergency Department, Mental Health, Inpatient and Outpatient setting. Adjustments have been made to the WAU within target service group where indexed growth is applicable, or demand management strategies such as potential preventable hospitalisation (PPH) and ambulatory service model (ASM) can be applied.

The ABF Model WAU column on the Income Statement is total WAUs as calculated within the ABF Model (in Phase 14). Indexed Growth is added against the appropriate service type categories. This has been derived from the indexed growth calculation. Potentially Preventable Hospitalisation’s WAUs are then deducted from the surgical service type category, as calculated in the Demand Management calculation. Additionally, Ambulatory Service Model WAUs are deducted from the WAU total as calculated in the Demand Management calculation, however, in the income statement these have been proportionately distributed against Service Type categories based on the ABF Model Outpatient WAUs. This proportionate distribution of Ambulatory Service Model WAUs can be altered at the Districts discretion; however, it is to be fixed in the District plans. The Grand Total WAU is the total WAU the Department will be purchasing from the Health Service District.
The funding allocated via ABF is from the State Output revenue pool.

- **Facility Demand Management**
  
  This is the net decrease in budget as a result of changes to the models of service delivery as negotiated individually with each District. This includes:
  
  o Out of scope activity no longer being purchased (i.e. Appearance Medicine and Aesthetic or cosmetic surgery such as vasectomies and varicose veins);
  
  o Ambulatory Service Model (Outpatient repeat visit ratios) - Managing the demand for outpatient occasions of services by capping the number of times a patient revisits the outpatient clinic. Please Note: the frequency of revisits will be determined on a case by case basis by a clinician;
  
  o Relative utilisation rates (for information only in 2011/12);
  
  o Potentially avoidable admissions - There are certain medical conditions where hospitalisation is believed to be avoidable through provision of timely and adequate non-hospital care. These include vaccine preventable conditions such as influenza, tetanus, diphtheria, whooping cough, measles, mumps, rubella, hepatitis B and polio. PPH can also be applied to certain acute conditions where prompt treatment can reduce morbidity and pain and therefore fewer hospitalisations. These include inflammatory diseases, ear/nose/throat infections and dental conditions. Examples of chronic conditions where PPHs is applicable includes effective monitoring and management of asthma, diabetes complications, iron and nutritional deficiencies and hypertension disorders;
  
  o Modes of treatment; and
  
  o Quality and Safety – treatment injuries & hospital acquired infections.

- **Phase 14**
  
  Phase 14 refers to cost data that has been submitted to the NHCDC to derive the WAU price. The 2009/10 WAU price of $4,190 was derived from the 2004/05 data that was submitted to the NHCDC. The 2011/12 WAU price of $4,214 is derived from the 2009/10 data submitted to the NHCDC.

- **Site specific funding**
  
  Site Specific Grants (SSGs) are intended to fund District products / services where the output cannot be appropriately classified, counted or costed, or where the outputs are only provided by one, or a few hospitals only. In these instances it is not feasible to establish a collective funding mechanism, such as activity based funding (ABF), to accommodate an equitable and viable budget for these outputs.

  There is a Site Specific Grants (SSGs) committee that periodically reviews the SSGs, and Districts that have been allocated SSGs in 2011/12 may not necessarily receive these funding in the outer years.

  The funding allocated via ABF is State Output revenue.

  This is agreed through the site specific approval process. More details can be found in the ABF operating manual at this link: [http://abf.health.qld.gov.au/ABF/Details/118](http://abf.health.qld.gov.au/ABF/Details/118)

  **Please note:** The SSGs process is currently being reviewed by the SSG Review Panel.

- **Clinical Education**
  
  This is as advised by the State Funding Unit and is the value of clinical education, as identified by the CFO and Peer reviews extracted from the ABF pool. Details of Clinical Education budget for 2011/12 can be found in Tables 1 – 3 in appendix section 5.2 Clinical Education.
Clinical education funding is allocated to Health Service Districts to advance the training, development, and education of staff to improve and enhance the delivery of health services.

The funding allocated via ABF is State Output revenue pool.

- **Depreciation**

  Districts and Divisions have been fully funded for Depreciation less clawback.

  This was originally set at the 2010/11 numbers and has been adjusted after the 2011/12 estimated depreciation was run after the financial year end. Section 5.4 of the appendix shows the 2011/12 depreciation.

### 2.2.5 Grants and Contributions

The 2011/12 Grants and Contributions allocation has been adjusted for each District and Division to match the figures published in the Service Delivery Statement (SDS) in February 2011.

The next opportunity to revise and update the SDS will be in Dec/Jan.

### 2.2.6 Other Funding

Other Funding is the combination of State and Commonwealth Output revenues. The 2011/12 Commonwealth output revenue portion is derived from all the agreed Commonwealth Agreements at the close of 2010/2011. The Commonwealth portion of the funding is matched backed to individual Commonwealth Programs and the value as it appears in the pivot.

The State Output revenue is the balancing figure for the purpose of reconciling the details on the Income Statements to the revenue categories loaded at the Department level, and reported to the Queensland Treasury.

**Reconciliation back to the Pivot and Funding Management Template.**

The applied methodology is a departure from previous budget development methodologies and represents a simpler and more “macro” level of budget determination. As such the 2011/12 data contained in the pivot is mainly for planning and information purposes. When all discussions have been concluded and Income Statements finalised, the pivot will be “balanced” back to the model outcomes in order to keep the two aligned. Therefore, specific funding allocations for Commonwealth and State can be tracked for reconciliation purposes.

As the budget methodology assumes 2010/11 expenditure as the starting point, any expenditure incurred in 2010/11, with the exception of Surgery Connect and MB4H, is deemed to be funded in 2011/12. Therefore, funding received from a Division in 2010/11 is deemed to be resident in the District budget for 2011/12. For a Division this means that programs have already been allocated and all that needs to be distributed further is any additional funding that is available. If there is a change in the distribution i.e. if a certain District is not due to receive funding it received in 2010/11 then the withdrawal of that funding and subsequent redistribution will have to be undertaken by the Division responsible for that funding source.

The budget methodology also assumes that QH will continue to perform the 2010/11 recurrent activities in 2011/12 and any new programs/services, unless specifically funded by State or Commonwealth, will have to be internally funded by reprioritising existing funding.
2.3 Sources of Funding

2.3.1 Program Structures and the Activity Based Funding Model

Health Services are categorised on a broad program basis and Figure 3 displays the proportion of funding allocated to the programs across the state (this includes both activity based and non-activity based funding types).

Figure 3 Budget by Program 2011-12

<table>
<thead>
<tr>
<th>Budget by Program 2011-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care 51%</td>
</tr>
<tr>
<td>Integrated Mental Health Services 9%</td>
</tr>
<tr>
<td>Prevention, Promotion and Protection 5%</td>
</tr>
<tr>
<td>Primary Health Care 6%</td>
</tr>
<tr>
<td>Ambulatory Care 20%</td>
</tr>
<tr>
<td>Rehabilitation and Extended Care 9%</td>
</tr>
</tbody>
</table>

Figure 3 Budget by Program 2011 – 12 has been prepared from information available in the Queensland State Budget 11-12 Part 17 Dept. of Health at Page 1-159

2.3.2 Program Funding Overview

Overall funding comprises the funds available from the National Healthcare Agreement (NHA), State funding and own source revenue from activity based funded facilities. Not all of the funds in these facilities form the funding available, as public facilities provide other services that are not included under the ABF model arrangements.
2.3.3 Non-Activity Based Funding

Activity based funding applies to most hospital based activities and is described in detail in the Activity Based Funding Operating Manual located at [http://abf.health.qld.gov.au/ABF/Details/118](http://abf.health.qld.gov.au/ABF/Details/118). Queensland Health Corporate Divisions and capital programs are not currently funded by activity based calculations. Health Services not covered by the ABF model are presently funded on a grant or historical basis from State funding allocations. Some of the items below may be under consideration for a nationally consistent approach to funding in future years from the Commonwealth.

These are:

- **Prevention, Promotion & Protection:**
  - Screening,
  - Immunisation,
  - Statewide Promotional Health.

- **Primary Health Care:**
  - Services in Community Health,
  - Oral Health,
  - Children and Youth.

- **Ambulatory Care:**
  - Community and outreach based services,
  - Alcohol Drug and Tobacco,
  - Sexual Health.

- **Rehabilitation and Extended Care:**
  - Queensland Health Aged Care and Nursing Homes,
  - Home and Community Care (HACC).

- **Integrated Mental Health Services:**
  - Specialised Mental Health facilities,
  - Community based services.

- **Community based services:**
  - National Partnership Programs (NPP) (specific projects),
  - National Healthcare Agreement programs

2.3.4 Participation in Clinical Costing

ABF is supported by patient level detail costing that is maintained by staff in each of the major activity based funded facilities. Sunrise Decision Support Manager (Transition II) is the corporate clinical costing system used and incorporates approximately 80% of the state’s patient volume. Districts are encouraged to ensure that they have adequate capability to handle and provide annual data contributions for the National Hospital Cost Data Collection (NHCDC), coordinated by Finance Branch. Districts are also required to apply the costing standards that facilitate appropriate benchmarking across the state. (This document can be found at: [http://casemix.health.qld.gov.au/CC/CCresources.html](http://casemix.health.qld.gov.au/CC/CCresources.html).)
It is essential that Districts have a facility based cost centre structure that allows for easy separation of activity for patient servicing and other costs. Maintaining consistency with assignment of costs to the appropriate cost centres that link expenditure to outputs is essential to achieving data integrity within the model. Districts are therefore responsible for ensuring that all costs (where possible) are allocated to cost centres where the outputs are produced. It is important that Districts use their Service types or cost centre structures for ABF reporting against allocated ABF budgets. (See also Section 3.1.7 Cost Centre Maintenance – Contact Person Responsibilities.)

2.3.5 Data Collection Requirements

Compliance with corporate standards, timeliness and accuracy of coding has a large impact upon reporting and ABF data quality. Districts are responsible for providing complete and accurate data to the Data Collections Unit of the Health Statistics Centre including the monthly activity collection and the patient administration system extracts information for QH interface (HQI) that are required for Commonwealth reporting. All of this requires close attention to detail at the data entry level to ensure that patients are categorised and coded properly and that staff undertaking data entry understand how the data is used and the consequences of inaccurate work.

Table 2 Districts Participating in Patient Level Costing

<table>
<thead>
<tr>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cairns and Hinterland</td>
</tr>
<tr>
<td>Townsville</td>
</tr>
<tr>
<td>Mackay</td>
</tr>
<tr>
<td>Central Queensland</td>
</tr>
<tr>
<td>Sunshine Coast-Wide Bay</td>
</tr>
<tr>
<td>Children's Health Services</td>
</tr>
<tr>
<td>Metro North</td>
</tr>
<tr>
<td>Metro South</td>
</tr>
<tr>
<td>Darling Downs-West Moreton</td>
</tr>
<tr>
<td>Gold Coast</td>
</tr>
</tbody>
</table>

Table 2 above indicates which Districts currently use Transition II. They are required to provide their annual cost data to Finance Branch for validation and submission to the Department of Health and Ageing for the NHCDC. The smaller hospitals in the Districts feed their data into the District data with the major facilities and in turn this is submitted through to the NHCDC. Additionally, Districts are required to supply patient level detail for outpatients to the Outpatients Performance Reporting Database (known as SATR) which supports State and emerging national reporting requirements and waiting list reporting.

There are significant differences between phase 13 and phase 14 weights for DRG’s, due to phase 13 weights being based on escalation of 05/06 weights data while phase 14 weights based on 09/10 data. The cost base also changed due to the change in the cost of the average admission in QLD. The move from DRG v5.2 to DRG v6.0 groups has brought changes to 549 DRGs. Thus there is little comparability between phase 13 and phase 14 weights.
2.3.6 Activity Based Funding Model Components

2.3.6.1 Funding Components

The graph below shows the proportion of the various components of the ABFM as it would apply to activity estimated for 2010-11. This is the state-wide picture, however, the component splits are often different for each facility, for example, larger Tertiary facilities may have as much as 25% of activity cost belonging to the outpatient component because they specialise more than the smaller facilities. It can be seen that the majority of hospital expenditure (70%) is related to forms of inpatient servicing.

![ABF Model Component Funding 2010-11](image)

2.3.7 Funding Policy Incentives and Initiatives

The following details come from the ongoing reform and development processes for QH and have been formulated to encourage general improvements in organisational performance. These initiatives have impacts on both general funding and activity based funding.

2.3.7.1 New Policy Initiatives

1. District budget allocation will include a ‘New Policy Initiative’ funding schedule which will advise:
   1.1. Policy initiative;
   1.2. Activity and/or other targets associated with the initiative including the policy framework around activity purchased and transitional arrangements; and
   1.3. Allocation for 2011-12.
2. New policy initiative allocations are conditional upon the Chief Executive Officer ensuring that appropriate local consultation about implementation has taken place with staff and unions. This consultation should take into account the impacts upon non-clinical services. An Administrative Impact Statement should be completed where appropriate.

3. The specified allocations in 2011-12 and out years are the maximum amounts available to the Districts and Divisions for the relevant new policy initiatives, subject to achieving the targets specified.

4. In the event that a District or Division does not achieve all the targets specified, actual funding to the District or Division will be adjusted proportionately to achievements, taking into account the start-up provisions in the allocation.

5. Districts must ensure all new policy initiative monitoring reports are completed in a timely manner.

2.3.7.2 Target Tolerance Initiatives
Target Tolerance initiatives were discontinued from 30.06.2011.

2.3.7.3 Super-specialty Services
Super-speciality services incentives were discontinued from 30.06.2011.

2.3.7.4 Category C Incentives
The allocation methodology for Category C revenue (DVA, MAIC, WorkCover and Interstate) has been revised to provide Districts with greater clarity and certainty of funding for the 2011-2012 year. Under the new methodology, these Category C funding streams will have one single base price per Weighted Activity Unit (WAU).

For the Category C funding streams, Districts meeting the target will be paid at Category C base rate of $4,250 per WAU. In addition, an incentive payment will be introduced to reward Districts who exceed their overall revenue WAU target. The WAU revenue targets for 2011-2012 are in section 5.3 of the appendix.

For every additional WAU achieved above the target, the WAU rate will increase by 3% to $4,377.50. Districts failing to achieve the overall Category C WAU targets will be paid only at the casemix rate ($4,214.42) for all Category C WAUs. The process of determining final payments to the Districts will be as follows:

1. During the final week of May 2012, nine months (July 2011-March 2012) total Category C WAUs will be extracted for Districts from the DSS/Panorama Report.

2. Districts, estimated in May 2012 to be meeting above 95% of the full year WAU target, will be considered as meeting the target WAU and will be paid at the Category C base rate of $4,250 per WAU.

3. Districts not meeting the targets (less than 95% of the original target) will be funded at Casemix rate of $4,214.24 per WAU. Districts meeting or exceeding the target will be funded at the Category C base rate of $4,250 per WAU. For the portion above the target, Districts will be paid at an incentive rate greater than $4,250 per WAU depending on the total availability of funds.

4. Category C performance reports being developed by the Funding Arrangements Team will be distributed in November 2011, February 2012 and May 2012 showing how Districts are travelling against the targets and expected final payments.

Activity targets for 2011-2012 are based on 2010-2011 actual activity reported in DSS/Panorama. Furthermore, SOSRU will be developing reports to assist Districts to easily monitor their progress and to assist with full year forecasting. There will be only one budget adjustment which is intended to occur towards the end of the financial year.
2.3.7.5 Patient Safety Officers
Under the new Budget Methodology all costs relating to patient safety officers is fully funded recurrently from 2011-12.

2.3.7.6 Data and Coding
Data and Coding incentives were discontinued from 30.06.2011.

2.3.7.6.1 Costing Incentive Payments, Clinical Costing and National Hospital Cost Data Collection
Costing Incentive Payments discontinued from 30.06.2011.

2.3.7.6.2 Clinical Practice Improvement Payment (CPIP)
Clinical Practice Improvement Payment is managed by CHI.
2.4 Revenue

2.4.1 Sources of Revenue

Districts and Divisions will derive revenues from the Commonwealth and State Governments through the Department as a direct allocation, and also raise and retain revenues from normal operations within their businesses. Below is a summary of key revenue categories which appear on the Income Statement of Districts and Divisions.

2.4.1.1 Output Revenue

2.4.1.1.1 Output Revenue - State

Output Revenue or Controlled Revenue is received from the State Government in the form of payments for agreed service outputs, items and / or programs administered on behalf of the Government, and for the funding of new initiatives as part of an outcome of some election commitments. New funding allocations are quarantined, tracked and monitored in the initial year of allocation, and recurrent allocations are added to the base operating budget of Districts and Divisions in the forward years.

Output Revenue is comprised of ABF, Non-ABF and Depreciation.

- ABF = ABF Facility WAU Target x Price + ED Fixed Component + Fixed Clinical Education Component (for information on the fixed components refer to the Activity Based Funding Model Technical Paper).
- Depreciation and Amortisation Funding (for information on Depreciation refer to Section 2.9).

2.4.1.1.2 Output Revenue - Commonwealth

Commonwealth revenue that is directed to QH via Queensland Treasury, maybe identified for operating and capital purposes. It is beneficial to know the split between operating and capital funds as early as possible.

Commonwealth funds received and reported through Queensland Treasury make up the Output Revenue Commonwealth category. The allocation of the Commonwealth program funds across Districts and Divisions is subject to acquittal and specific terms and conditions as stipulated in the various Commonwealth agreements.

2.4.1.2 Own Source Revenue

Certain revenue categories are generated and retained by Districts and Divisions. These include User Charges and Other Revenue and are regarded as Own Source Revenue (OSR). For additional details refer to Section 2.4.3 Own Source Revenue.

2.4.1.3 Grant Contributions (including Commonwealth)

Commonwealth funding categorised in this section relates to grant revenue received directly from the Commonwealth and maybe subject to acquittal requirements as outlined in the specific terms and conditions of the Commonwealth agreements. Revenue received directly from the Commonwealth can only be treated as operating funds regardless of whether the funds are being utilised for operating or capital purposes.
All grants revenue received are to be accounted for as revenue upon receipt (in the financial year that the funds are received), unless there is an obligation to refund the grant received (e.g. a clause in the agreement that stipulates that any un-expanded funds need to be returned to the fund provider). For example, payments made by the Registration Board in 2010-11 to fund staff salaries in 2011-12 will be accounted as revenue in the financial year 2010-11. There can be no unearned revenue or revenue in advance recognised for these payments.

### 2.4.2 Internal User Charges

An internal user charge is a mechanism whereby business units within QH can recover the cost of providing goods and services to the other business units, with the internal charge intending to encourage efficient consumption of goods and services. This form of charging ensures that the full cost of any goods or services provided are known and recovered without any profit being derived.

Section 5.8 of the FMPM discusses internal User Charges in more detail and can be found at:


The following rules apply to intra-departmental accounts:

- used for internal charges only;
- not to be used for transactions such as invoice and vendor payments with entities external to QH;
- can be used on both debit and credit side of the accounting entry;
- Any disputes in relation to the internal charges should be directed to the charging Districts. The disputed charges should not be transferred to a non-577XXX GL account; and
- No accrual is to be posted to these accounts as this will overstate the Department's expenditure.

These accounts are reconciled by the Financial Accounting Team at the State level.

### 2.4.3 Own Source Revenue

Public health care costs a substantial amount of money to operate, with ninety percent (90%) of all episodes of care are provided at no cost to Medicare eligible patients (i.e. health care is funded by the State or Commonwealth Governments). In most cases, a patient may elect to be treated as either a public or a private patient.

Funding models have been structured to preserve the incentives currently in place for Health Service Districts and Divisions to raise and retain revenue generated at the local level including:

- (i) grant payments;
- (ii) patient fees;
- (iii) user charges;
- (iv) other local revenue; and
- (v) trust funds.

Own Source Revenue (OSR) represents a combination of User Charges and Other Revenue in Panorama (PR_Income). The majority of OSR is related to patient activity with approximately one (1) in ten (10) patients being fee paying. Districts have the capacity through robust systems and processes to increase their revenue
with improved patient identifications processes. The overarching principle of OSR is for this revenue to follow the patient and to be retained by the treating facility.

OSR is an important budget component and remains the responsibility of the Districts to capture the data relating to the following revenue streams:

- Private Inpatients (insured and self funded);
- Private Outpatients (Bulk Billing);
- Department of Veterans Affairs (DVA);
- Department of Defence;
- QComp;
- Motor Accident Insurance Commission (MAIC);
- Other Compensation (e.g. public liability, product liability, Workers’ Compensation and motor vehicle other state);
- Interstate Patients (Cross Border);and
- Ineligible Patients (e.g. overseas visitors, refugees, asylum seekers etc.).

By ensuring the proper identification of these classifications of patients into the above revenue streams, the public health funding pool is able to be reimbursed to provide further services.

In addition to the above, User Charges also includes:

- Medicare Benefits Schedule fees (in-patients and out-patients),
- facility fees,
- pharmacy and
- private imaging and radiology fees.

**Note:** pathology within the hospital is managed and recovered by Clinical and State-wide Services (CaSS), etc.

Other Revenues include: licensing, proceeds and gains from sales of land and equipment, recoveries and revenue interest.

It is imperative that Districts and Divisions continue to be actively involved in the recovery of all sources of revenue. Table 3 illustrates the amount of OSR in QH.

Table 3 Own Source Revenue Streams 2009-10 (as per the QH Annual Report 2009-10)

<table>
<thead>
<tr>
<th>Category</th>
<th>Total ($,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>User Charges</td>
<td>$688,758</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>$27,142</td>
</tr>
<tr>
<td><strong>Total (*)</strong></td>
<td><strong>$715,900</strong></td>
</tr>
</tbody>
</table>

(*) These amounts are Own Source Revenue for QH Districts only and exclude special service provider, salary recovery and C’Wealth grants.

### 2.4.4 Revenue Estimates

QH is required to provide Queensland Treasury (QT) with updated revenue estimates for the current year plus four outer years. This information is maintained in the QT database, TRIDATA. QT actively monitors for any
substantial ‘peaks and troughs’ in revenue. QT requires QH to estimate the expected revenue for the outer years taking into account any escalation (QT usually publishes its minimum expectations re escalation).

Districts and Divisions are required to provide once per year, revenue estimates for Own Source Revenue (i.e. for any revenue directly receipted by them – not corporately receipted). To assist with this process, a template will be provided by the Finance Branch – Internal Allocations Team. In 2011-12, the revenue estimates template will be sent to Districts and Divisions to be reviewed and amended in November for the current year’s estimates plus four outer years. The returned estimates will be assessed by the Statewide OSR Unit for reasonableness before the figures are loaded as the updated revenue budget allocations. These figures are used by QT to update the SDS publications. At year end, the budget will be amended to agree with the amounts actually receipted. Monthly OSR forecasts will assist Districts and Divisions to derive a more reliable and consistent revenue estimate.

For corporately receipted Commonwealth Specific Purpose Grants and Commonwealth Output Revenue, the revenue estimates need to be frequently reviewed by the Program Co-ordinator in accordance with activity being achieved, the Commonwealth Agreement, Commonwealth and State budget estimates and new funding initiatives. It is imperative to update the estimates for these funds in line with the requests by QT to update TRIDATA revenue estimates in September and February of each year (or as requested) and also throughout the year especially in regard to material variations that impact on forecasted revenue.

For the following revenue items (Interstate, DVA, MAIC, Q-Comp and high cost drugs), the estimates are managed corporately with the processes for these revenue types is outlined below:

- **Interstate (Cross Border)**
  
  There are two separate accounting treatments for interstate patient care, Queensland residents treated in other states and territories (cross border expense) and residents from other states and territories being treated in Queensland hospital facilities (cross border revenue).

  Finance Branch accrue the revenue and expense relating to cross border patients and journals monthly the relative portion of estimated revenue earned (account code 443700) and expenses incurred (account code 561030) to the Districts.

  QH enters into bilateral agreements with the other states on a long-term basis. The new round of bilateral agreements has been signed with all jurisdictions except NSW due to ongoing pricing disputes which are expected to be resolved soon. In the current agreements the under-funding situation that prevailed earlier has been minimised. The interstate expense has been calculated using a three year average from prior years and trend analysis. District level allocations of the interstate revenue are governed by the current Category ‘C’ (DVA, MAIC, Interstate and WorkCover) Revenue Allocation Process outlined in section 2.3.7.4.

- **Department of Veterans Affairs (DVA) – (443395)**

  Eligibility for hospital treatment to be funded by the DVA is established by hospitals confirming that patients hold a Gold Card or a valid White repatriation health card.

  A long term funding arrangement titled the Hospital Services Arrangement exists between the DVA and QH which governs the provision of treatment and care, and payment arrangements for ‘entitled persons’ accessing health services at Queensland public hospitals.

  Price reviews on the cost of health services are conducted annually, with QH negotiating payment arrangements with the DVA based on the latest NHCDC results. Funding to Districts is allocated according to the latest WAU as reported in Panorama (DSS) Casemix module. District level allocations of the interstate revenue are governed by the current Category ‘C’ (DVA, MAIC, Interstate and WorkCover) Revenue Allocation Process outlined in section 2.3.7.4.
Motor Accident Insurance Commission (MAIC) – (470050)
Each year during December/January, the MAIC requests QH submit the next financial year’s cost estimates for the treatment of motor accident injury related patients. As per the legislation, MAIC provides only a reasonable portion of the cost. Annual contribution of MAIC is communicated to QH in late March or early April and for 2011-12 MAIC has committed $42M.

In the last three years this contribution has increased per year by an average of twenty percent (20%) as QH introduced a process to estimate the costs, based on secondary data rather than primary data, as there was no incentive for QH facilities to identify the MAIC patients. However, in order to bring the incentive back, the new revenue budget allocation methodology applies the patient identification volumes at the DHS level to apportion the total MAIC budget to Districts which is discussed further in the Revenue Allocation Process outlined in section 2.3.7.4.

Workers’ Compensation (Q-Comp) – (443320 and 443550)
Queensland Health and WorkCover Queensland have entered into an Annual Payment Arrangement for services provided to injured workers (of the employers subscribing WorkCover insurance) by public hospitals being treated as public patients.

The payment amounts are determined on each year’s projected activities and new agreements are drawn up every three years. The next agreement round is due in the 2013/2014 Financial Year.

In 2011/2012 the value of this agreement is $42.0M for hospital services. Funding is allocated to Districts based upon the correct identification and recording of WorkCover patient activity and available funding.

Districts must invoice the insurers directly as per the Q-COMP Table of Cost for QLD injured workers of self-insurers and as per the Queensland Health Fees and Charges Register for injured workers of interstate employers.

High Cost Drugs (450046)
Effective from 1 July 2009, payments for public hospitals under the Highly Specialised Drugs Program became a Commonwealth Own Purpose Expenditure payment, administered by Medicare Australia. QH receives the funds monthly in arrears based on appropriately completed monthly claims, containing details of dispensed medicines identified under the High Cost Drugs category. These funds are banked corporately and will continue until the PBS on-line system for high cost drugs is implemented.

QH hospitals’ monthly claims are consolidated by Medications Services Qld (MSQ). MSQ have set specific timeframes for hospital claims to be submitted. MSQ is QH single point of contact for any queries in relation to Highly Specialised Drugs from Districts, Medicare Australia and the Commonwealth (DoHA).

Due to the payments being made to QH in arrears and the revenue needing to be recognised in the period earned, Finance Branch accrues revenue at a corporate level and allocates revenue to Districts via a monthly journal against general ledger account code 450046. The corporate accruals, District journal transfers and the District budget allocations have been based on an annual estimate provided by MSQ.

Technical adjustments (for both District actual revenue and budget) will be provided at the end of the financial year for the actual revenue received from Medicare. Since only eleven months of revenue will have been received for the respective financial year, the adjustment will be based upon the eleven months paid to date, plus an average paid for the last three months reimbursements (as an estimate of the twelfth month). The June revenue estimate journal will be processed as a reversing entry.
This process is an interim solution until PBS on-line is implemented. When the on-line system is operational, reimbursement and accruals will be District responsibility.
2.5 Other Funding Considerations

2.5.1 Expending Approved Funds

Once a District or Division receives formal notification from a budget holder that funding has been approved for a specific project or business case, the receiving District or Division may expend to that funding limit, adhering to the terms, conditions and reporting requirements of the approval. As budget allocations are processed at key dates during the year (for 2011/12 these dates are to be confirmed), and notification of funding approvals will be sent throughout the year hence. Districts and Divisions should not wait until the funding is physically in their budget before planning to expend the funds. As noted below, recorded surpluses will not be rolled-over for future years and therefore, it is crucial that funding be expended in the year that it is approved.

It is also imperative that the expending of approved funds is included into any Departmental forecasts. This will have the effect of worsening the financial position. However, commenting through the monthly reporting process that the funding will be transferred into the District or Division at the next technical review process as appropriate, will reflect legitimate reasons for variances.

Where material savings strategies are required to balance budget, as agreed by the District or Division, these strategies need to be costed with cash flow projections, so that realisation of any savings can be monitored by the District or Division and by Cost Centre Managers. Corporate financial and reporting systems must also be updated appropriately to accurately reflect the current and full year projected positions to allow for management review as part of the ongoing monthly performance reporting cycle (i.e. the forecast is to reflect the likely revenues, expenses and savings activities throughout for the financial year).

2.5.2 General Trust Funds and Research Funds

Queensland Health General Trust Funds and Research Funds are to be administered in accordance with the General Trust Fund Policy and the Research Management Policy. Details are available through links at:


2.5.2.1 General Trust Funds

QH invests general trust funds (GTF) with the Queensland Treasury Corporation (QTC) in accordance with investment banking arrangement authorities established with them and as agreed by the Treasurer. All supporting documentation and information on any investment transactions must be retained for audit purposes. Interest earned on the funds invested with QTC is remitted monthly in arrears to the QH General Trust Bank Account and dispersed by Finance to Districts and Divisions into their relevant general ledger accounts. The amount of interest earned is to be retained as general trust monies.

For full guidance on managing General Trust funds refer to the relevant documents. Details are available through the following links:


2.5.2.2 Research Funds

Approval and acceptance of all research projects and funding arrangements are subject to review by the Health Service Districts after approval of the project by a Research Ethics Committee. A link providing details of the approval and authorisation process is found at the following site:


- To comply, revenue in relation to research projects (e.g. commercially sponsored trials, NHMRC, ARC, Queensland Cancer Fund, research for higher degrees), which is of a ‘fee-for-service’ nature, must be managed via District operating funds and not GTF. However, funding received as bequests and donations must remain in, and be administered via, General Trust Funds. The policy on General Trust Funds can be found at the following site:

- Funding received for all new research projects that are of a ‘fee-for-service’ nature will be managed by District operating funds from the outset.

- District Finance Units (DFU) will undertake the steps shown at 2.5.2.3 to ensure compliance. However, it is the individual researcher’s responsibility to ensure that all incoming research funds for projects (excluding those from bequests or donations) are identified appropriately and placed into quarantined research cost centres within the District operating funds.

- Regular cost centre reviews must be carried out by Districts to ensure that research cost centres are properly set up with the correct fund code.

- As part of the reporting process the Districts and Divisions are to report on research funds in financial statements.

2.5.2.3 Financial Process

- Determine the nature and source of the research project funds.

- All research project funds acquired through donations and bequests must continue to be administered through cost centres within the General Trust Fund.

- Each research project account is to reference the HREC Reference number.

- DFU should liaise with the researcher to determine the number of cost centres required (i.e. should several research projects be managed through one cost centre with internal order numbers to identify each project, or should each research project be allocated to one cost centre). The availability of these options is District dependent, but with larger projects it is preferable that they have and use their own cost centre.

- For ‘fee-for-service’ research funds, DFU should forward a request to Finance Branch to establish a cost centre in research specific District operating funds for each research project (i.e. excluding those funds identified in point two above).

- Research project revenue must be credited to one of the following account codes (forming part of Category A revenue),
  - 450020 Research Projects — Commercial Organisations (e.g. drug companies) or
  - 450025 Research Projects — Non-Commercial Organisations and or Charitable (e.g. NHMRC, Heart Foundation).

- All revenues raised must be billed via DFU using an official QH tax invoice. (Under no circumstances are researchers to bill or raise invoices directly).

- Reimbursement of costs to QH for study related costs are to be promptly reimbursed from the QH project cost centre.
2.5.3 Internal Recoveries

The processing of valid expenditure of non labour recoveries (through the JMAN part of the Panorama (DSS) suite of software, designed for the processing of internal transfers via general ledger journals) must be settled within ten (10) days of entering the system. All JMAN transactions must be finalised prior to the end of the financial year (i.e. JMAN transactions cannot be carried over into a new financial year and can only be recovered in the financial year in which the expenditure was incurred).

Important Note: The newly introduced SAP HR payroll system will now handle date driven costing adjustments therefore, JMAN is no longer used to correct labour costings for pay run data effective from 8 March 2010.

JMAN non labour transactions should only be initiated where the originator has paid the primary invoice. (All external labour (i.e. contractors) will continue to be processed in XMAN to support FTE calculations.) JMAN entries are to be processed to the same general ledger account where the initial expense was incurred, unless an error is being rectified. All other transactions are construed as funding items and should not be initiated through JMAN, with any transaction (or series of transactions) of less than $50,000 per annum being exempt from this specific requirement.

Note: JMAN journals are not to be used as a mechanism for transferring budgets. Transfers are to be managed through the timelines of PBA processes and budgets transferred to reflect where expenditure has been incurred. Pro-active management is essential in ensuring accuracy and budget certainty, which will help to minimise unnecessary additional processing, resulting in reduced lag times and ensure efficient use of QH resources.

2.5.4 Natural Disaster Claims or Damage to Queensland Health Property

In the event of a natural disaster with damage to public property, the Department of Emergency Services may invite agencies to submit claims for restoration of constructed public assets to their pre-disaster standard, as well as for expenses incurred in relation to counter disaster operations.

All claims must exclude GST and where it relates to staff wages, only expenses over and above normal establishment costs can be claimed. If the claim is accepted, QH is reimbursed seventy-five percent (75%) of expenses relating to the restoration of public assets and hundred percent (100%) for counter disaster operations.

2.5.4.1 Restoration of Public Assets

For all damaged sites a full description (and detailed estimates of eligible works) is required. Damage ‘sites’ are defined as:

- Roads – each damage location along a road (a road name is NOT a ‘site’);
- Buildings – each building;
- Equipment – each building or storage location; or
- Other – each specific damaged location.

Applications are to be submitted using a ‘Form G’ and MUST provide the following details for each damaged site:

- District;
- Local Government Area and the name of Local Government area (i.e. Moreton Bay Regional Council);
- Specific Location (for road damage – road name and specific location on road measured in kilometres (km) from beginning of road (e.g. ‘Problem Road 1.8km to 2.0km; for building etc.’ – Address, Place Name etc.);
- Asset Description (e.g. Road; Bridge; Road culvert; Toilet block; Police Station; Fence);
- Damage Description (*Describe the extent of damage*);
- Cause of Damage (*e.g. Flood Submergence, Landslide, Wind damage*);
- Restoration Works Proposed (*Briefly describe the restoration works proposed* (*e.g. Re-deck bridge and re-gravel approaches; Repair roof and replace broken glass in windows*);
- A dissected and detailed estimate of costs for each ‘damage site’ (*e.g. showing materials, unit rates and quantities*);
- Estimated total cost for each ‘damage site’;
- A summary listing of the total estimated cost for all ‘damage sites’; and
- A summary listing including a total estimated of all costs by Local Government Area.

Digital photographs of damaged sites MUST support the application where the damage cost is significant. The claim must also include copies of tax invoices for expenditure already incurred and quotations for estimated remaining expenditure.  

Please Note: Subsequent increases to quotations greater than ten percent (10%) will require the submission of an amended claim.

Once a claim is approved, Internal Allocations will advise the relevant District and Division and process a budget adjustment up to the limit of expenditure incurred. Further budget adjustments will be made progressively. Supporting documentation must be forwarded when expenditure is completed in order to receive a budget adjustment. The relevant ‘Form G’ must be signed by the Chief Executive Officer.

### 2.5.4.2 Counter Disaster Operations

**Eligible Expenditure Categories:**
- The net cost of emergency food and essential supply drops to stranded individuals or communities.
- Transportation costs for manpower, equipment and materials:
  - Includes aircraft or vessel / vehicle transport / charter and hire costs.
- Non-Capital Expenses:
  - Includes vehicle and helicopter operating costs, food, fuels and other expendable or consumable items necessary for immediate usage,
  - Also includes vehicle or equipment repairs and additional servicing required as a direct consequent of relief operations.
- Overtime, travel expenses / allowances, temporary employment costs,
  - Excludes normal (pre-disaster) administrative commitments (salaries etc), which would otherwise have been incurred.
- The activation, co-ordination and administration of Natural Disaster Relief and Recovery Arrangements (NDRRA) Relief Measures.
  - Excludes pre-disaster salary and other committed costs which would otherwise have been incurred.
  - Emergent expenditure to ensure the safety of life, health and property.
  - Includes the construction of structures / earthworks and movement / hire / use of; buildings, machinery, equipment, specialist skills and personal possessions (e.g. temporary levy banks / sandbagging to divert floodwaters, evacuations and shelters, emergent public health matters, etc.).
2.5.4.3 Expenditure Time Limit

All expenditure on approved restoration works is subject to a time limit of two (2) years after the end of the financial year in which the relevant disaster occurred. For example, should a natural disaster occur in May 2010 claims for relevant expenses can still be made up to 30 June 2012. It is strongly suggested that all entities should strive to finalise approved restoration works within twelve (12) months following the disaster event.

2.5.4.4 NDRRA Monthly Reporting

Monthly reporting requirements for Natural Disaster Relief Arrangements are to be completed using the ‘NDRRA Expenditure & Event Estimates’ reporting spreadsheet to reflect expenditure to date and future estimates relating to work not yet carried out. Completed reports are to be submitted to Internal Allocations with a copy to your Portfolio Manager by the 7th working day of the month.

2.5.4.5 NDRRA Submission Guide (ver.3) August 2011

The Queensland Reconstruction Authority’s (QRA) objective is to ensure that the submissions are processed efficiently and effectively. The submission process is divided into four phases:

- Phase 1: Prepare Submission;
- Phase 2: Detailing planning;
- Phase 3: Undertaking project – monitor and report on project milestones; submit progress claims; and
- Phase 4: Project acquittal – finalise claim.

The NDRRA submission Guide is found at the following site:
2.6 Budgeting

2.6.1 Budget Management

The budget process aims to provide budget certainty for budget holders through the full allocation of known resources in advance of the commencement of the financial year. To support this process all Fund Holders are required to allocate all funds and associated activity targets (where applicable) to Districts and Divisions. This will minimise the level of funds being held and prevent the delayed allocations of these funds.

The 2011/12 budget methodology has been significantly altered to accommodate the gradual introduction of the national health reform agenda. Given the implementation of these changes the historical timelines for delivering budgets to Division & Districts have been delayed and is still continuing.

Despite the changes in the budget methodology and funding adjustments between Districts and Divisions, there will be opportunities within the financial year for further PBA budget adjustments. These will coincide with:

1. The mid year review; and
2. at end of year (EOY).


CBRC approved new funding will be processed at the time of notification. Indicative dates are as outlined in Tables 4 and 5 below. The initial budget allocation will be signed off by the Districts and the Resources Executive Committee as part of the Service Level Agreement for the year.

Allocations that can be expected at each stage are as follows:

- Allocation of all known funds – funding that is held and is intended for service delivery must be allocated to Districts and Divisions.

- Allocation of Estimated Revenue\(^1\) – a reasonable estimate is required for ALL expected receipts, including but not limited to State, Commonwealth and Trust. Physical receipt of funds is not required for allocation, provided Finance Branch (who will inform the Resources Executive Committee) is aware of the risks associated with the allocation.

\(^1\) Allocation of Estimated Revenue based on activity levels or receipts should be for the full financial year and variances to forecast managed through the Post Budget Adjustment (PBA) Process.
2.6.1.1 Key Budget Process, PBA and Income Statement Dates

Please note that the normal budget cycle is not applicable in 2011/12 due to numerous changes associated with preparation for the National Health Reform.

Table 4 Key Budget Process Dates and Responsibilities

<table>
<thead>
<tr>
<th>Item</th>
<th>Responsibility</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commence Outer Year Budget Build</td>
<td>Corporate</td>
<td>September</td>
</tr>
<tr>
<td>Release of Costing Template (for CBRC Submissions)</td>
<td>Corporate</td>
<td>September</td>
</tr>
<tr>
<td>Return of Costing Template (for CBRC Submissions)</td>
<td>Districts and Divisions</td>
<td>Sept / October</td>
</tr>
<tr>
<td>Release of Revenue Estimates Template for review</td>
<td>Corporate</td>
<td>Nov / Dec</td>
</tr>
<tr>
<td>Return of Revenue Estimates Template following review</td>
<td>Districts and Divisions</td>
<td>Dec / Jan</td>
</tr>
<tr>
<td>CBRC Submissions due to Treasury (long form)</td>
<td>Districts and Divisions</td>
<td>January</td>
</tr>
<tr>
<td>Release of budget pivots (relating to outer year base budgets) for review</td>
<td>Corporate</td>
<td>January</td>
</tr>
<tr>
<td>Commence sending outer year budget adjustments to Internal Allocations</td>
<td>Districts and Divisions</td>
<td>March</td>
</tr>
<tr>
<td>Feedback due following review of budget pivots</td>
<td>Districts and Divisions</td>
<td>April</td>
</tr>
<tr>
<td>Release of Income Statements for review</td>
<td>Corporate</td>
<td>April</td>
</tr>
<tr>
<td>CBRC Outcomes</td>
<td>Corporate</td>
<td>May/June</td>
</tr>
<tr>
<td>Release of Final Income Statements</td>
<td>Corporate</td>
<td>August</td>
</tr>
<tr>
<td>Sign off on Final Income Statements</td>
<td>Districts and Divisions</td>
<td>August</td>
</tr>
<tr>
<td>Completion of the Revenue Phasing Template</td>
<td>Districts and Divisions</td>
<td>July</td>
</tr>
</tbody>
</table>

Table 5 Post Budget Adjustments (Current Year Adjustments)

<table>
<thead>
<tr>
<th>Item</th>
<th>Responsibility</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Release of Revenue Estimates Template for review</td>
<td>Corporate</td>
<td>Nov / Dec</td>
</tr>
<tr>
<td>Close off of Technical Round One (1)</td>
<td>Districts and Divisions</td>
<td>Nov / Dec</td>
</tr>
<tr>
<td>Return of Revenue Estimates Template following review</td>
<td>Districts and Divisions</td>
<td>Dec / Jan</td>
</tr>
<tr>
<td>Release of Income Statement</td>
<td>Corporate</td>
<td>Late Jan</td>
</tr>
<tr>
<td>Sign off on Income Statements</td>
<td>Districts and Divisions</td>
<td>Jan / Feb</td>
</tr>
<tr>
<td>Close off of Technical Round Two (2)</td>
<td>Districts and Divisions</td>
<td>End March</td>
</tr>
<tr>
<td>Release of Income Statement</td>
<td>Corporate</td>
<td>End April</td>
</tr>
<tr>
<td>Technical Round Three (3) including rollovers for trust and research</td>
<td>Corporate</td>
<td>June / July / August</td>
</tr>
</tbody>
</table>

2.6.2 Technical Round

Technical Rounds are an opportunity to realign the budget allocations in June. Adjustments processed during Technical Rounds are strictly for those allocations where decisions could not be made previously due to circumstances that were not fully determined at the time.

2.6.2.1 Technical Round One – January

Circumstances that may require a Technical Round One (1) PBA:

- Reallocations determined by the Mid Year Review Panel;
- Performance based adjustments to allocations (activity based allocations only i.e. QABFM, Cancer Screening Services);
- Reallocations due to structural changes;
Exceptional adhoc allocations;
Reallocations due to revised OSR estimates or
Errors from any previous technical round.

2.6.2.2 Technical Round Two – June
Circumstances that may require a Technical Round Three (3) PBA:
Performance based adjustments to allocations (activity based allocations only i.e. ABF, Cancer Screening Services);
Reallocations due to structural changes;
Adjustment for actual receipts;
Depreciation matching less clawback less (see section 2.9 Depreciation); or
Errors from any previous round.

2.6.3 Budget Controls
2.6.3.1 Budget Conditions and Requirements
The budget loaded in FAMMIS (000) must agree to the current Budget Allocation Statement. The budget environment allows for a significant level of freedom for finance managers to make budget changes up to the 5th working day after the end of the month. This level of election is possible to allow for the movement of budgeted amounts to alternate expense areas; however this can only be done for the remaining open months.
Finance Managers must ensure that these budget controls are adhered to and that budgetary processes are completed, being mindful of the applicable timelines. Districts are also responsible for allocating activity targets to their facilities. In 2011/12 this is no longer managed through the ABF website, instead, targets are loaded directly into DSS Panorama by District staff with relevant system access. This process is outlined in the following document:

The following points should be noted to assist with the improved management of financial matters:
Districts and Divisions are to ensure that at all times the overall financial position is balanced (i.e. full year revenue budgets equal full year expenditure budgets).
The monthly period will close on the third (3rd) working day after the last day of the month. The forecast is to be loaded by the fifth (5th) working day after the last day of the month (e.g. the September 2011 ledger closes on Wednesday 5 October 2011 with the forecast to be uploaded on Friday, 7 October 2011 (Note: Public Holidays will effect and extend these dates and timings).
No prior month budget adjustments are allowed. Districts and Divisions are not able to increase labour budgets to match the actuals of a previous month. This also includes FTE budgets which cannot be altered for prior months. All variances are to be explained through the monthly reporting process (see Section 3.2.1 Budgeted Full-Time Equivalents).
Year-to-Date (YTD) impacts of any changes in budgets need to be cash flowed across the remaining open periods. For example, if at the mid year review an additional $120K – 1FTE has been approved, the Districts and Divisions would need to adjust the January budget to $70K and 7 BFTE (reflecting the YTD position) while remaining months will show $10K and 1 BFTE per month.
• Districts and Divisions are responsible for allocating expense budgets. In some circumstances the Director General may approve a certain type of expense budget where Districts and Divisions are required not to transfer any additional funds to top up that budget.

The benefits of maintaining these controls are that:
• QH will be able to report monthly with consistent financial data;
• will result in the ability to view information from previous months and to provide consistent results that were presented in those periods reporting;
• will assist in maintaining the objectives of the budgeting process, ensuring transparency as well as retaining the funding as was allocated at the beginning of the financial year;
• will assist Business Managers in providing reliable, consistence and meaningful budgetary information;
• improve ease of tracking budgets and adjustments, enhance transparency of budgeting processes; and
• assists to ensure that FTE budgets align to labour expenditure budgets.

2.6.3.2 Overseas Travel
There is a stringent requirement in place that all intended overseas travel within QH is to receive prior approval by the Minister for Health with any overseas travel expenditure to be contained within the approved District and Division budgets in any particular year.

Every request from a District or Division for approval of non-award related overseas travel is to be endorsed by the Director-General before submission to the Minister. The submission must include advice indicating and confirming that the relevant funding is contained within the annual budget for that travel (i.e. it is also necessary, when submitting any overseas travel application to the DG, to provide proof of uniquely identified budgeted funds as applicable). All budgeted overseas travel funds must be quarantined and specifically set aside for that expenditure purpose only.

All overseas travel proposals are to have been established as part of the annual District and Division budget process with this measure designed to provide a strong financial management control over any overseas travel.

Overseas travel budgets are to be loaded against the following specified GL account codes:
• 521040 Travel – Airlines and other modes of Travel Overseas – Clinical Staff;
• 521045 Travel – Airlines and other modes of Travel Overseas – Non-Clinical Staff;
• 512050 Travel – Overseas relocation costs – Clinical Staff;
• 520040 Travel – Accommodation and Meals Overseas – Clinical Staff; and
• 520045 Travel – Accommodation and Meals Overseas – Non-Clinical Staff.

With the introduction of a medical component of the Enterprise Bargaining Agreement (EB6), most overseas travel will be non-award related, with eligible medical officers attracting a professional development allowance in exchange for award based travel as was previously funded and facilitated by QH.

There is a mandatory requirement that all overseas travel expenditure is to be reported, whether paid from State funds, Trust or Research Funds or from an external contributor.

There are reporting template and checklists available on the Finance Network website. Links to these are as follows:
Further guidance can be found on the QHEPS website including the Overseas Travel Standard at the following link:


### 2.6.3.3 Patient Travel

Queensland Health uses various means of patient transport including fixed wing aeromedical (via the Royal Flying Doctor Service and on a ad-hoc basis with the Careflight jet), Queensland Health Authorised Transport (QHAT, road ambulance via the Queensland Ambulance Service) and rotary wing aeromedical (via community helicopter providers, a contracted provider and Emergency Management Queensland). The Health Coordination Services Directorate (HCSD), within the Division of the Chief Health Officer (CHO) is coordinating the devolution of patient transport budgets and expenditure for transport provided by fixed wing aeromedical providers and the Queensland Ambulance Services (QAS) to Health Services Districts (HSD). This was a Treasury direction, after Cabinet considered the recommendations from the 2007 QAS Audit stating that all patient transport budgets should be devolved to HSDs in order to better manage demand for these services. Rotary wing budgets will be devolved to HSDs in the future.

Each HSD is required to have at least one cost centre solely dedicated to record transactions for all patient transport (being for either fixed wing aeromedical services provided by RFDS and/or the Careflight Queensland Ltd Lear Jet; and ambulance road transport provided by QAS). The cost centre/s must have the Service Type of “SP” Patient Transport in order to facilitate external reporting.

The following account codes are to be used for the respective patient transport expenditure:

- 519010 MISC-AMBULANCE SERVICE AGREEMENT-RECURR should be used for all QAS expenditure;
- 519005 TRAVEL-AIR CHARTER should be used for all fixed wing patient aeromedical services provided by the Careflight Queensland Ltd Lear Jet (excluding helicopter services); and
- 570025 GRANTS-AEROMEDICAL SERVICE AGREEMENTS. As of 01/07/10, all RFDS Fixed Wing and Community Helicopter Provider (CHP) services must be coded against 570025. RFDS and Helicopters will continue to be coded against the “Grant” account code grouping as the transaction still technically falls under the TRIDATA classification for Grants (Qld Government, under agreement, are subsidising a service provided by a non-profit organisation).

The expenditure and budget responsibilities for QHAT, Fixed Wing and Rotary Wing are as follows:

- **Queensland Health Authorised Transport (QHAT)**
  
The HSD budget allocation for QHAT is based on previous QHAT activity and is as approved by the DDG FPLS. HSDs are to load the QHAT budget against a cost centre with a “SP” Service Type and account code 519010.

  QAS sends monthly invoices and the related QHAT activity reports directly to HSDs, who are to cost invoices against cost centres with “SP” Service Type and account code 519010. Full payment of monthly QHAT invoices is required within 30days of receipt. HSDs should be aware that compliance, under the Financial Management Practice Manual (Version 6 Draft Chapter 6 Expenses Management Section 6.4 Processing and Payment), requires that all QHAT invoices must be paid in full in the first instance. Disputed transport QHAT activity identified by HSDs is provided to the Department of
Community Safety (DCS) CFO who will authorise Credit Notes for disputed transports. The process for dispute resolution is detailed in sections 11.5 to 11.7 of the QHAT Memorandum of Understanding between QH and QAS.

HSDs are to accrue for any outstanding invoices, activity not yet invoiced and items agreed to be credited. FAT is responsible for reviewing the accrued amounts.

- **Fixed Wing aeromedical (Royal Flying Doctor Service and Careflight jet)**

  The HSD budget allocation is based on previous fixed wing aeromedical activity and is approved by DDG FPLS. HSDs are to load the budget against cost centres with “SP” Service Type and account codes 570025 (RFDS) and 519005 (Careflight Queensland Ltd lear jet) for fixed wing transports.

  CSP holds the budget for fixed wing aeromedical transports that can not be allocated to a HSD, such as interstate retrievals to Queensland public hospitals, and loads budget for these transports against a cost centre with “SP” Service Type and account codes 570025 (RFDS) and 519005 (Careflight Queensland Ltd lear jet). NB HSDs will incur the costs for returning patients from a QH facility to an interstate hospital or residence.

  HCSD reviews and reconciles activity against invoices and contracts; prepares vouchers to be paid from a CSP cost centre; and determines the costs to be journalled to HSDs based on the model price of $3,400 per patient per flying hour for RFDS. HCSD also reconcile adhoc invoices for the Careflight Queensland Ltd lear jet and organises payment of invoices. CSP process the journalled cost distribution to HSDs as per HCSD’s advice. Costs are journalled to cost centres with “SP” Service Type and account code 570025 (RFDS) and 519005 (Careflight Queensland Ltd lear jet). CSP will incur the costs for interstate retrievals into Queensland public hospitals, plus will hold the difference between MRT flying hours (amounts charged by RFDS) and the amounts journalled to HSD (under the model price of $3,400). HCSD will provide the HSDs with monthly activity reports to monitor their activity.

  The Health Coordination Services Directorate (HCSD) provides CSP the amounts to be accrued corporately for all unpaid invoices and credit notes by the 1st working day of each month. CSP will process the corporate accrual journal plus the accrual distribution to HSDs. Accrual distribution is calculated on the average of previous months’ activity to HSD.

  The Financial Accounting Team (FAT) reviews the statewide ledger to ensure that amounts accrued appear to be appropriate.

- **Rotary Wing (Helicopters)**

  The budget allocation to CSP is held under cost centre 702586. The Community Helicopter Providers (CHPs) are not activity based and HCSD prepares recipient generated tax invoices each month for funding 1/12th of their full year grant. HCSD processes these invoices. By the 1st working day of the following month, HCSD is to provide to CSP amounts to be accrued corporately for all unpaid invoices and credit notes. CSP processes the corporate accrual journal.

  A commercial contract is in place for Australian Helicopters Pty Ltd (AHPL) to provide emergency helicopter services in the Torres Strait and Northern Peninsula Area HSD. AHPL invoices monthly for standing charges (retainer) and additional invoices for activity per month. HCSD reviews and reconciles activity against invoices and prepares vouchers to be paid from the CSP cost centre. CSP arranges payments of invoices. By the 1st working day of the following month, HCSD to provide to CSP amounts to be accrued corporately for all unpaid invoices and credit notes. CSP processes the corporate accrual journal.
2.6.4.4 Long Service Leave Scheme

Long Service Leave (LSL) is calculated each pay period. Cost Centres are debited with the cost which is the levy together with an additional accrual generated as part of the month end processing methodology. The LSL Levy is remitted by QH on the twelfth (12th) working day of the month following the end of a quarter with any claims being made, received as a remittance back on the fourteenth (14th) working day of the following month.

In December 2009, the State Actuary completed a detailed review of the Long Service Leave Central Scheme (LSLCS) levy rate and concluded that the current levy rate was inadequate to maintain the scheme’s long term solvency and that the rate needed to be increased.

Accordingly, and as part of the Mid Year Review (MYR) the CBRC approved the State Actuary’s recommendation for an increase in the Long Service Levy rate from 1.75% to 2.1%, which will take effect from 1 July 2010. QH will be fully funded for the increase in the levy rate, calculated by multiplying the estimated Long Service Leave expense by twenty percent (20%), with the Districts and Divisions receiving the necessary funding through normal budget processes. All costing templates and any related budget activities will be updated to reflect the changes in the Long Service Leave Levy rate for the 2010-11 financial years.

2.6.4 Centrally Held Funds

This process of retaining budgets centrally on behalf of Divisions has been discontinued from 30.06.2011.

2.6.5 Corporately Managed Budgets

Under the new budget methodology, in general no funds are held in Corporately managed budgets.
2.7 Business Cases

2.7.1 New Funding for Business Cases

The state budget submission process is an avenue where initiatives or proposals that are not funded from existing arrangements can be directed to the Cabinet Budget Review Committee (CBRC) for consideration. The State Funding Unit (SFU) within PSR is responsible for managing and coordinating this process in consultation with Districts and Divisions and Queensland Treasury (QT). Outlined below is the process, undertaken for development of the state budget submission, and a short guide to some matters to be considered when preparing any submissions.

2.7.1.1 Submission Process

While the state budget process can vary from year to year at the discretion of the Treasurer, CBRC often adopts a two-stage budget process – short form and long form funding submissions. However, QH typically implements an initial internal process for prioritising initiatives through development of a Concept Briefs. Templates are distributed by SFU as required. For more information about the state budget process, please visit the SFU website located at: http://qheps.health.qld.gov.au/policybranch/html/sfu.htm

- **Concept Brief** – this is the initial internal QH process for prioritising initiatives to be included in the state budget submission. Concept briefs are usually requested by SFU to PSR in September / October for the following financial year. Prior to requesting concept briefs, PSR will seek endorsement from the Executive Management Team (EMT) on the priorities and parameters for development of the state budget submission for the coming financial year. Concept briefs are requested for initiatives that address these priorities. EMT considers and prioritises concept briefs for inclusion into the short form funding submission. For the 2012-13 State Budget Submission, any Concept Briefs developed must fall within one of the following three categories:

  - **Category 1:** Unavoidable Statewide expenses associated with a commitment or compliance issue that cannot reasonably be funded from existing internal resources. These briefs would be developed under the auspices of the Resource Executive Committee, rather than by individual Districts or Divisions.
  
  - **Category 2:** Key Statewide priorities and commitments (e.g. election commitments or other commitments and priorities identified by the Premier or Minister for Health). Again, these briefs would be developed under the auspices of the various Queensland Health Executive Committees, rather than by individual Districts or Divisions.

  - **Category 3:** Funding submissions from Health Service Districts and Divisions which pose significant risks to the Department (rated as ‘very high’ to ‘extreme’ in accordance with the risk assessment matrix, available at: http://qheps.health.qld.gov.au/policy/docs/imp/qh-imp-070-3.pdf).

- **Short Form Funding Submission** – this stage of the State Budget Process includes the prioritised initiatives arising from the Concept Brief. The short form funding submission is lodged with the Cabinet Secretariat, usually in December, for consideration by CBRC in February. QT and the Department of the Premier and Cabinet also provide advice to CBRC submissions from all Government departments, including QH funding bids.

- **Long Form Funding Submission** – this is usually the final stage of the State Budget Process, and includes initiatives prioritised by CBRC for further consideration during the short form funding submission.
process. The long form submission is usually lodged with the Cabinet Secretariat in early March, and CBRC usually considers the long form funding submissions in March/April.

Outlined above is the ‘standard’ process that is usually followed. However, other events / impacts are taken into consideration (such as a State Election). State Budget Process can also be altered at the discretion of the Treasurer or CBRC.

### 2.7.1.2 Preparing Submissions

Be specific and precise about what the requested funding is to be used for, keeping the audience in mind.

- **Links with Planning** — it is important to detail how the funding proposal will deliver on either Departmental or Whole-of-Government (WoG) priorities. This includes linking with the QH Strategic Plan, the Statewide Health Services Plan, relevant service related plans (e.g. the State-wide Cancer Treatment Services Plan) or Advancing Health Action; as well as WoG plans such as Toward Q2: Tomorrow’s Queensland. If there is a link to any of the health reform agreements and associated targets, this should also be identified in the proposals.

- **Title** — short and concise.

- **Purpose** — clearly explain what the funding will deliver in terms of: an action; a target stating how much of what; and the funding required and a date for when deliverables will be accomplished.

- **Description** — The reader should easily be able to identify what is being proposed to be done, the funding required and why it should be done.

- **Costing Requirements:**
  - It is important to specifically identify ‘Appropriation’ (operational / operating funding) and ‘Equity’ (capital funding) separately;
  - Ensure, where appropriate, that the Finance Branch costing template is used and consulted with the Finance Branch when completing the template as required (Refer to Section 2.7.2 below); and
  - ‘Costing Assumptions’ must be absolutely clear on how the costs were derived (e.g. numbers and levels of new staff and the WAU to be delivered, building or refurbishment required).

New funding for activity approved by the CBRC through the state budget process will be allocated through the Finance Branch based on their current method of funding allocation. Activity estimates used in funding submissions will be used as a guide for the allocation of budgets and corresponding increases to activity targets. Any new funding not linked to activity is to be allocated based upon QH’s planning framework and processes.

### 2.7.2 Internal QH Process – Costing Business Cases

The first step in making a budget submission is to prepare a business case. Costing and the development of business cases are to ensure that ‘yes/no’ decisions on proposed initiatives can be assessed. This is not to be confused with the funding that the initiative will attract under the ABF model. For instance a properly developed business case will demonstrate that the proposed model of care (total initiative cost) can be funded by the proposed activity.

Business cases must be supported by a completed costing template. See Costing Template 2011-12 (V3.2) located at:


A well developed business case will:

- Include performance indicators or targets to measure the effectiveness of the initiative. Business cases for additional funding for urgent and unavoidable issues should be submitted to CEO;
• Identify outputs under the ABF model (i.e. funds are sought based upon a change to the WAU);

• Where a hospital has a ‘clinical costing team’, costings should be calculated by using clinical costing information to ensure that the costing is adequate for the purpose;

• Be fully costed using the Costing Template available from the Finance Branch website (e.g. the labour component assumes the current EB salary rates and conditions including all on-costs such as superannuation, and includes non-labour and capital costs). If the business case commences in a period outside the existing EB agreement a default rate of 2.5% increase has been applied in keeping with the standard increase recommended by government. The funding for the new EB agreement’s impact upon the business case will be sought when the new EB agreement is negotiated;

• Include depreciation in accordance with the Depreciation Policy available from the Finance Management Practice Manual (FMPM) (Refer to FMPM Chapter 7. Asset Management and Section 7.14 Depreciation) in QHEPS via the following link:
  

• Consider the timing of funding requirements. The requested funds will need to be cash flowed across the appropriate financial years. For example, likely delays in commencement, particularly realistic recruitment targets, should be considered in the first year. The receipting of all project resources in the first year of a multi-year proposal is inappropriate.

In the costing template, a FLOWCHART SHEET has been prepared together with instructions on all of the steps necessary to complete the template.

Urgent and unavoidable issues will be considered however the Districts and Divisions are to use discretion regarding the necessity for additional funding. As a general rule individual business cases for less than one tenth of one percent (0.1%) of District and Division base budgets should be dealt with by the District and Division and will not be considered Corporately.

Where a business case is recommended for approval by the District and Division and insufficient funds exist in the District and Division, the business case may be progressed to Finance Branch for discussion at the FSC level and subsequent submission to the REC.
2.8 Non Operating (Equity)

2.8.1 Capital Funding

Capital funding is defined as funding provided for the acquisition, development or enhancement of non-current assets. Non Current Assets are defined as controlled assets which will provide future economic benefit over a period greater than a year and that meet Whole of Government recognition thresholds. Capital funding is only available for capital purposes. Operating revenues are not available to be used as a funding source for capital acquisitions. Additionally, planned acquisitions are not to exceed available funding. The management of capital funding is a core responsibility of the General Manager, Queensland Health (QH).

The current approved Capital Funding Policy and Standards are located at:


QH is required to maintain a Capital Acquisition Plan (CAP). The CAP details planned acquisitions by the Department and available funding sources. The governance arrangements in relation to the CAP are governed through Health Infrastructure and Project Executive Committee (HIPEC), Information and Communication Technology (ICT) and the Resource Executive Committee.

There are only six (6) possible funding sources for the CAP these representing the available resources for all capital acquisitions being:

(i) State Equity – represents a cash investment by the State in QH to fund specific capital acquisitions per a decision made by the Cabinet Budget Review Committee (CBRC). Additional funding requests can be made via submissions to the CBRC as part of the mid-year review (normally only for urgent or unavoidable reasons) and budget process;

(ii) Commonwealth Appropriation Equity – represents capital funding by the Commonwealth with funds provided to QH via Queensland Treasury (QT);

(iii) Depreciation Funding – as depreciation expense is a non-cash expense it results in a build up cash that is used to fund capital acquisitions. It should also be noted that this cash is reduced by partially off-setting equity withdrawals made by QT;

(iv) Borrowings – borrowings occur where funds are provided by a lender but must be repaid. Borrowings in a QH context can only occur with Treasurer’s approval and must be made via the Queensland Treasury Corporation (QTC). Borrowings, as a funding source, will only be considered in exceptional circumstances. No submission to borrow is to proceed without the General Manager’s endorsement;

(v) Proceeds of Sale – are realised funds received from the sale of assets (including land and buildings); and

(vi) Other Funding – represents all other funding sources available to the CAP. This is predominantly Commonwealth Government grants made directly to QH (i.e. the grant is not made via QT) for the specified purpose of a non-current assets acquisition. Any other funding sources can only be included in the CAP with the express approval of the General Manager.

2.8.2 Minor Acquisitions – Funding

QH Minor Acquisitions are represented by one line item on the CAP with a current value of $80M per annum. Minor Acquisitions primarily represent capital allocations made to District and Divisions. It should be noted that a
small number of projects forming part of the minor acquisitions line item are managed through the Investment Module by HPID or ID, including, Eco-Efficiency Projects.

2.8.3 Capital Allocations – Funding

Capital needs are not always met by programs managed by HPID and ID with (i) new services starting from operating funding with no allocation for equipment, (ii) urgent and unplanned acquisition needs (e.g. end of life critical equipment requirements), or (iii) leasehold improvements.

Capital allocations are made to provide areas with the ability to meet unmet needs. It should be noted that at present not all Corporate Divisions have been provided with a capital allocation.

Eco Efficiency Projects for a District or Division are to be funded via a recashflowing of the District or Divisions capital allocation over the proceeding four years. One quarter of the total Eco Efficiency project cost will be allocated from the proceeding four years capital allocation and bought forward.

2.8.4 Capital Allocation – Treatments

Capital allocations cover all capital needs outside of programs managed by HPID and ID. Twenty-five percent (25%) of a District or Division’s capital allocation must remain uncommitted to cover unforeseen and unexpected capital needs. Underspends in capital allocations will not normally be rolled over. Overspends in a District or Division’s capital allocation will be withdrawn from the proceeding year’s allocation.

2.8.5 Capital Swaps Restrictions – Funding

Internal swaps is the term used for approving the swapping of operating revenue to capital. QH has no capacity to swap output funding to capital funding. No PBA is to be processed that results in a swap from operating revenue to capital.

Swaps between operating revenue and capital funding can only occur where submitted to and approved by QT. Any submission to QT requires prior approval of the General Manager with the process to be coordinated by Business Analysis and Management, Finance Branch. No swaps will be considered where the value is less than $2M per project. The timing of any requested swaps must coincide with Forward Estimates updates with submissions limited to the months of both September and March.
2.9 Depreciation

2.9.1 Depreciation

Depreciation is the expense allocation of the cost of a non-current asset to periods throughout its useful life.

Depreciation is calculated as follows:

- Acquisition cost of the asset including all costs incurred in getting it operational;
- Less its estimated residual or salvage value (in most cases nil);
- Divided by its estimated useful life (reflected in straight line depreciation rates).

This forms the planned depreciation schedule of an asset. Other factors that affect planned depreciation are: later enhancements or partial retirements to the asset; revaluation increments/decrements (for buildings and site improvements); or useful life changes.

Historically, Districts and Divisions have been fully funded for depreciation and a negative offset was held Corporately. There exists a recurrent funding shortfall related to depreciation of $40M. Over 5 years, commencing in 2009-2010, this shortfall is being progressively allocated to Districts and Divisions. This shortfall allocation is referred to as the depreciation clawback. The depreciation clawback for 2011- 2012 is $33M. As part of this budget measure Districts and Divisions have been provided with additional capital allocation equivalent to their depreciation clawback.

Districts and Divisions must accommodate the clawback by adjusting their operating expenditure budgets to ensure that the net impact on the Income Statement is nil. At year end the depreciation expenditure budget allocations will be adjusted to reflect final actuals. The revenue actual and budget will also be adjusted to reflect actuals less the agreed depreciation clawback. This will ensure that the District and Division exposure to a depreciation shortfall will be capped to the agreed funding clawback.

The revenue loads for depreciation will continue to be loaded corporately. Districts and Divisions are required to load their own expenditure budget and forecasted expenditure for depreciation. Districts and Divisions can load their depreciation expenditure budgets at individual general ledger account codes (i.e. at the general ledger account code level where the expenditure is incurred, if desired) but the forecasted depreciation expenditure must only be loaded against 590120.

2.9.2 State Depreciation Expenditure

State based depreciation expenditure will be fully funded with an offset equal to the most recent cumulative increase in capital allocation (the clawback). Funding will be allocated at the commencement of the financial year based on planned depreciation costs as extracted from the FAMMIS Asset module. Actual levels of depreciation expenditure may vary to original levels due to such factors as: revaluations, acquisitions, disposals, transfers or changes in useful life. At year end technical adjustments will be made to depreciation funding to ensure it reconciles with the actual recorded levels of depreciation expenditure less the clawback.

District and Divisions are not to report a depreciation funding gap as the reason for a deficit. The expense budget loaded must equal the full year’s depreciation expense. Savings must be found in other areas of the District or Division to offset the depreciation clawback.

2.9.3 Commonwealth Depreciation Expenditure

Depreciation is attributable to Commonwealth Programs as per terms of the agreement (e.g. in some instances, the Commonwealth may provide once only funding for the purchase of an item of equipment but the ongoing expense and replacement of that equipment must be met from the State). The District or Division needs to assess whether depreciation is applicable to the Commonwealth Program.
If overspends occur within a Commonwealth cost centre due to depreciation, further funding may be provided. Firstly, the Program Coordinator will need to assess whether the Commonwealth Program as a whole (state-wide) can absorb the depreciation expense & therefore the funds will be re-allocated to the District or Division from within the Program. For this to occur within the financial year, Districts and Divisions will need to discuss with the Program Coordinator prior to year end so the budgets can be redistributed. If the Commonwealth Program cannot absorb the overspend caused by the depreciation expense, then the District or Division may be provided with additional State funds if an application is made to Internal Allocations by the Program Coordinator prior to the end of the year. In this instance, the District or Division may need to adjust their expenditure so that the Commonwealth Program has a balanced position and/or meets acquittal requirements.

2.10 Rollovers

2.10.1 Rollovers and Required Treatments

Rollovers are non operating inflows and they represent unspent operating revenue from a previous financial year. Rollovers are internal to QH and as such do not have a true source of funding. Rollovers are only provided in strictly limited circumstances. (For more details and information refer to section 3.7.1.2 Rollovers.)

Note: Rollovers are ONLY applicable to Trust and Research Funds.
3 BUSINESS MANAGEMENT

From the maintenance of cost centres and the correct allocation of all costs, to the development of suitable finance and staffing budgets, with the applicable and considered distribution of revenue, through to FTE and forecast reporting and on to the close financial control, reporting and management by all entities, the monitoring of business is detailed and complex – fortunately the tools to effectively perform these tasks are to hand and identified in the following sections.

3.1 Cost Centre Management

3.1.1 Cost Centres

A cost centre should:

- align with service provision (i.e. Service Type),
- reflect an individual ward / unit structure,
- differentiate between funding sources, i.e. (Fund Type: STA – State; C**, SA* and SN*- Commonwealth; STR – Research; T** - Trust and W** - Capital).

Medical and nursing cost centres should reflect individual hospital ward structures - staff working in those areas should be charged to those cost centres. Conversely, when they are not working in their normal cost centres (e.g. outreach services to other hospitals) they need to be charged out to those facilities so that the General Ledger reflects the true cost of services provided at those facilities.

A cost centre is an organisational entity in which costs can be identified in a practical manner and can be controlled by a designated manager. As outlined in the QHFMPM (FMPM), there are several items that need to be considered when setting up a cost centre:

- Does it reflect the organisational or responsibility structure of the hospital?
- Does it occupy its own space or relate to a physical space?
- Does it produce a product or service, either for the rest of the hospital or for its patients?
- Is the product or service unique to this unit? (If not, the unit might not really be suitable to being classed as a cost centre.)
- Can the direct costs associated with this activity be charged to the cost centre in the normal accounting process?
- Does the activity generate statistics that can be used to measure its output?


The number of cost centres should be optimised for management reporting purposes and for compliance with the requirements of Audit and Queensland Treasury. For the National Hospital Cost Data Collection (NHCDC) survey, a hospital cost centre is defined as being: “a productive unit that creates a range of related products which may involve the use of similar mixes of staff and / or equipment, and technically similar production methods”. It is an accounting entity where all costs associated with a particular type of activity can be recorded.

Correctly designated cost centres are critical for accurate reporting. ABF is reliant upon accurately costed data at patient level, as these costs are used to develop prices for the Queensland Activity Based Funding Model (QABFM). To be able to allocate costs at a patient level, cost centres need to be aligned to service delivery areas, such as Operating Rooms, Pharmacy etc. It is also necessary for appropriate costs to be apportioned across cost centres, for example: doctor time should be allocated to ED Departments when time has been
worked in ED, and to OR when working in theatre (it may be necessary for staff costs to be split over several cost centres).

New cost centres, changes to cost centres (including blocking and unblocking) or reporting nodes can be created by submitting a Cost Centre Maintenance Form to: Cost-Centre-Maintenance@health.qld.gov.au. The request is checked, amended if necessary and forwarded to Business and Support Services (BaSS) Team for processing.

Please note that due to payroll processing, the ability to create/amend/block/unblock a cost centre is restricted for a period of time from the Thursday prior to pay day and opening again on Wednesday pay day.

3.1.2 Definition of Cost Centres within a Facility Environment

A hospital is a health care facility that provides health care services that are “hands on” directly affecting the outcome of the patient or client receiving those services (i.e. physical location authorised to provide treatment and care for patients). The hospital’s domain is defined as, ‘the services that are funded through the hospital’s budget and can be directly influenced by the management position responsible for all aspects of the operation of the hospital’. Where the patient treatment and care occurs outside the facility (i.e. in the community) and this health care (i.e. community service) is integral to the operations of the facility, these services form part of the facility for general ledger costing (e.g. Mental Health Unit with integrated mobile and on site health services as part of the facility).

Where other health services such as general practice, community, outreach and other non-acute health care services are located on the same physical location as a public acute hospital facility and their services are not integrated into the services of the public acute facility, where the hospital management team has no direct control or influence over the operations and service provision of these services (e.g. budget, staff appointments, invoice payments etc., are not under the control of the manager of the public acute facility), these services are to be reported separately to the public acute hospital facility with which they are co-located.

In summary, geography and co-location is not the determinant for what services are bundled into the hospital’s cost centre group in the general ledger; rather it is all services that are funded within the hospitals accounts and where the hospital management has direct management and budgetary control over these services.

3.1.3 Service Type and Performance Management Framework (PMF)

A service type is required for each cost centre created.

Each year the Queensland Government publishes information about the performance of the various State Government Departments in the Service Delivery Statements (SDS). In the SDS, QH is required to report on certain service deliverables through the Queensland Performance Management Framework (PMF) – Promotion, Prevention & Protection; Primary Health Care, Ambulatory; Acute Inpatient; Rehabilitation and Extended Care; and Integrated Mental Health. Prior to 2008-09, the cost centre maintenance form had a section for recording a percentage against these 5 service types. In 2008-09, QH was required to report on 6 service types. Instead of making changes in FAMMIS, the REC approved a change in how output reporting was derived. It was endorsed that an output split would be allocated at the service type level rather than at an individual cost centre level. The previous PMF percentages will no longer be recorded against each cost centre in FAMMIS.

When establishing a new cost centre or amending a cost centre, it is critical to chose the correct Service Type so the budget can be properly aligned with service delivery. The Service Type can be determined by considering the budget funding purpose (e.g. if the funding is related to a Population Health Service such as Cervical Cancer Screening, the Service Type would be LV). A cost centre may be classified by either of two different Service
Type codes and it is necessary to select the Service Type that classifies the main type of functionality of the service being delivered. A list of Service Types is available on QHEPS from the following link:


3.1.4 Fund Type

In order to determine the Fund Type for a cost centre, it is necessary to consider the funding source. The funding source can be established by reviewing the budget allocation (refer to the Fund Code in the budget pivot). Once a cost centre has been established and transactions recorded and reported against it, the Fund Type can never be changed.

If an incorrect Funding Type has been chosen and transactions have already been reported against that cost centre, it is necessary to create a new cost centre with the correct Fund Type and to journal the transactions to the new cost centre and block the old cost centre from any future transactions. An old, no longer used cost centre can be reused and renamed but this is only possible where the funding source has remained the same (the budget allocation determines the funding source and the cost centre’s Fund Type that should be used). The name and Service Type of the cost centre can be changed but should not be amended within any one financial year once transactions have been posted and reported against that cost centre. That is, if reactivating closed cost centres for a different purpose, the funding source and Fund Type must be the same for the old and new cost centre. Reactivating Commonwealth cost centres is not permissible as the funding purpose is not likely to be the same. Reactivating a closed cost centre can only be done in a financial period different to when it was closed.

3.1.5 Blocking Cost Centres

Where a cost centre is no longer required, it can be blocked from further processing. Before blocking a cost centre, it is an important responsibility of each District and Division to ensure that:

- there are no assets recorded against the cost centre;
- there are no open purchase orders, receipts or outstanding invoices or credit notes not yet processed;
- all staff have been moved;
- all service levy areas have been advised of an alternative cost centre (e.g. PC levy; remote access; phone; electricity; fuel charges; etc.);
- all journals have been processed.

3.1.6 Reporting Hierarchies (Standard HLTH, QH_Alt_7 and QH_Alt_2)

New cost centres are entered into the ‘Standard HLTH’ reporting hierarchical structure in FAMMIS (refer to report KSH3 – Cost Centre Group - HLTH) by the Business and Support Services (BaSS) Team (formerly known as FAMMIS Operations). The standard HLTH hierarchy reflects the old QH organisational structure based on Business Areas and all cost centres are reported in this hierarchy. There are two ‘alternative’ reporting hierarchies that exist in FAMMIS, ‘QH_Alt_7’ the Corporate based reporting hierarchy and ‘QH_Alt_2’ the facility based reporting hierarchy. Both these alternate hierarchies are used for internal reporting purposes and are adjusted over time to reflect QH’s organisational changes.

Once the cost centre is created in the ‘Standard’ hierarchy, the District or Division is advised of the cost centre creation. It is the District’s or Division’s responsibility to insert the new cost centre into the QH_Alt_7 hierarchy
structure in FAMMIS. It is important that all Districts and Divisions ensure that their QH_Alt_7 hierarchy accurately reflects their current business organisational structure and that it is in line with Panorama (DSS) reporting specifications.

Prescribed levels of the QH_ALT_7 cost centre hierarchy are:
- level 1 is the total for all QH;
- level 2 is the total for all Districts; and
- level 3 is the total for each District.

Prescribed levels of the QH_ALT_2 cost centre hierarchy are:
- level 1 is the total for all QH;
- level 2 is the total for all Districts;
- level 3 is the total for South East Queensland Districts, Rural & Remote Districts and Northern Districts;
- level 4 is the total for each District; and
- level 5 is the total for each facility.

Levels below this (i.e. below level 5 in QH_ALT_2 and below level 3 in QH_ALT_7) can be modified at the District’s discretion subject to not exceeding level 10.

District nodes at level 4 of the QH_ALT_2 cost centre hierarchy must agree with the District nodes at level 3 of the QH_ALT_7 cost centre hierarchy (i.e. District nodes in both hierarchies must have matching cost centres).

The facility nodes at level 5 of the QH_ALT_2 (facility based) cost centre hierarchy will only match nodes in the QH_ALT_7 (local operational based) cost centre hierarchy if Districts operationally managed their costs by facility. For example, the RBWH operational management node in QH_ALT_7 is unlikely to match RBWH facility node in QH_ALT_2 (i.e. they will contain different cost centres as the cost centre groupings have different purposes – local v corporate).

Facilities at level 5 of QH_ALT_2 cost centre hierarchy will be described uniquely:
- as a physical location treating inpatients, outpatients and emergency presentations (e.g. RBWH);
- as a District Office; or
- based on their funding source and / or as a combination of locations if they don’t treat inpatients (e.g. Metro North School Dental Program).

Given that the QH_ALT_2 cost centre hierarchy is aligned to the Standard HLTH cost centre hierarchy, the lower level nodes can only contain cost centres from one Business Area.

Where possible QH_ALT_2 facility descriptions are to align with the corporate definitions used by the Health Statistics Centre as detailed in the Corporate Reference Data Systems (CRDS) website. The link for the CRDS website is:

The nodes in level 5 of QH_ALT_2 cost centre hierarchy must have:
- unique and consistent descriptions that describe the facility / node in level 5 of QH_ALT_2 (so entities at this level of the hierarchy can be easily identified and their costs aligned with their activity such as within Cape York District is a level 5 QH_ALT_2 node called “Islander Medical Services”);
• for all facilities with per annum more than 500 separations, 500 weighted activity units or $3M in expenditure:
  ▪ a unique node at level 5 of QH_ALT_2; and
  ▪ all activity based funding (ABF) expenditure (excluding minor cost reported within District Offices) and revenue associated with these facilities are to be reported against their level 5 node of QH_ALT_2 so that costs (in the ledger) better align with the activity (e.g. data from Monthly Activity Collection (MAC) and Queensland Health Admitted Patient Data Collection); and

• for other facilities and District Offices, currently in or planned by the District Chief Finance Officer to be in level 5 of QH_ALT_2, reasonably accurate and relevant costs and revenues reported against their level 5 node of QH_ALT_2.

On a monthly basis, a person within each of the Districts and Divisions is required to perform a reconciliation between QH_Alt_7 and QH_Alt_2 to ensure that their cost centres sit within both hierarchies where necessary. At all times, all cost centres must remain within these hierarchies.

Before requesting changes to the Standard HLTH reporting node, it is necessary to check with the BaSS Team whether the changes will have any impact on the context of FAMMIS delegations (e.g. requisition release strategies - users can be assigned cost centre groups for requisition release and therefore maintenance of any subsidiary to the group can impact on the requisition authorisations).

3.1.7 Cost Centre Maintenance – Contact Person Responsibilities

There must be a designated person in each District and Division to manage Cost Centre Maintenance and who is registered with the Finance Branch as the contact person for all Cost Centre Maintenance.

The contact person will perform the following functions:

• Request the creation of new structures, including the creation of new reporting nodes and cost centres in FAMMIS which have been previously checked and approved by the respective Business Manager of each:
  ▪ Speciality Group (e.g. Surgery) / Facility or District Office as appropriate within each District; or
  ▪ QH Corporate Division

  prior to being forwarded to the corporate Cost centre Maintenance email address.

• Manage the ‘cleanup’ node and the ‘Division not defined’ node within DSS ensuring that all cost centres are located in the FAMMIS structure correctly for their District or Division.

• Maintain a structure that accurately reports all transactions for their District and Division.

• Ensure movements of Business Areas within the Standard HLTH cost centre Hierarchy are aligned correctly and are NOT moved under another Business Area – e.g. BA65 cannot be moved under BA70. BA65 may sit under the same node name as BA70 but must be in line with BA70 and not underneath it.

• Coordinate the creation, changing, blocking, or unblocking of cost centres and establish new nodes within the structure, processed by way of a Cost Centre Maintenance Form requested through Cost Centre Maintenance e-mail. Ensure all columns are completed on the Cost Centre Maintenance Form.

• Ensure there are no name changes to cost centres within a financial year, however a name change can occur if there has been no change in function. (Refer to 3.1.4 Fund Type.)

• Perform reconciliation between QH_Alt_2 and QH_Alt_7 each time new cost centres and nodes are created and introduced to QH_Alt_7, ensuring newly created cost centre codes are reporting through all structures.
3.1.8 ABF Percentage Allocations

3.1.8.1 Background

Cost per WAU’ is a key Queensland Health (QH) key performance indicator (KPI) reported in the Decision Support System (DSS). ‘Cost per WAU’ is calculated as the cost of all activity-based funded (ABF) related expenditure divided by the WAUs.

Sunrise Decision Support System (i.e. Transition 2 or T2) is not currently used for ‘Cost per WAU’ corporate reporting due to reporting limitations such as timeliness and completeness of data. ‘Cost per WAU’ reported in DSS should correlate closely to data available in T2.

To ensure the above DSS KPI is reported accurately to the QH Resource Executive Committee (REC) and Executive Management Team (EMT), Districts are required to allocate, upload and monitor cost centre percentages which reflect ABF and total District activity costs (i.e. ‘%ABF Facility’ and ‘%District Activity’ respectively). These cost centre percentages should be reviewed at least annually.

The Decision Support System (DSS) is used to upload cost centre percentages for 2011/12 ‘Cost per Weighted Activity Unit (WAU)’ reporting.

3.1.8.1.1 DSS Upload Process for 2011/12

Districts populate the following table at cost centre level via DSS upload:

<table>
<thead>
<tr>
<th>Cost Centre</th>
<th>%ABF Facility</th>
<th>%District Activity</th>
<th>Site Specific</th>
<th>Facility Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. 897881</td>
<td>100%</td>
<td>100%</td>
<td>N</td>
<td>00201</td>
</tr>
</tbody>
</table>

Please note:

- ‘% ABF Facility’ is used:
  - To calculate ABF expenditure at cost centre level for ABF facilities (i.e. the ‘Expenses’ numerator for the DSS indicator ‘Expenses per WAU for ABF Facilities’);
  - As an ABF efficiency indicator for monthly corporate reporting; and
  - To inform the 2012/13 ABF Pool (using state based funding hierarchy in DSS only).

- ‘%District Activity’ is used:
  - To calculate District expenditure at cost centre level (i.e. the ‘Expenses’ numerator for the DSS indicator ‘Expenses per WAU’); and
  - As a District efficiency indicator for monthly corporate reporting.

- For 2011/12 ‘Cost per WAU’ reporting, expenditure attributable to clinical education, site specific grants (SSG), and own source revenue (OSR) revenue sources are to be retained within ‘%ABF Facility’ and ‘%District Activity’ percentages.

- Where costs attributable to a SSG can be completely identified in one or a few cost centres, in this instance the cost centre(s) are to be flagged as ‘Y’ in the ‘Site Specific’ column (i.e. 100% of
cost centre(s) expenditure will be associated with the SSG). SSG expenditure will be included in cost per WAU reporting until more complete state wide exclusion is possible.

- A Facility Code mapping reference table is available in the DSS Activity Based Funding module.

The DSS upload mechanism is available within the ‘Administrator’ folder of the DSS Finance module. Detailed guidelines and users instructions are available on the DSS intranet site (see ‘Phase 14 Funding Percentage Guidelines’ and ‘Phase 14 Funding Percentage Upload Instructions’ under ‘Training Support Guides’ at http://dss.health.qld.gov.au).

Access to the DSS cost centre percentages upload mechanism was removed on 23 August 2011 to enable some consistency for corporate reporting purposes. Districts need to seek permission from the General Manager, Finance, QH to make changes to percentages.

**3.1.8.1.2 Cost Centre Percentages Results**

The results of applying the cost centre percentages to finance dollars and FTEs are visible in the DSS Finance and HR Payroll modules. These figures are used to calculate KPIs in the DSS QH Scorecard module.
3.2 Full Time Equivalents

3.2.1 Full-Time Equivalents (FTE)

Labour expenses account for over seventy percent (70%) of the Queensland Health District budgets and over $7 billion in labour expenditure. Therefore, labour expenses need to be effectively monitored by Districts and Divisions. The monitoring, reporting and analysis of FTE is critical and assists with the management of District and Divisional budgets because of its alignment with labour expenses.

The Standard FTE is the performance reporting FTE for QH and is a Key Performance Indicator (KPI) in the QH Scorecard. Standard FTE are reported against Budgeted FTE (BFTE) with detailed analysis on variations provided by Districts and Divisions in their monthly performance reporting.

Due to the material nature of the costs and the numbers involved, it is a mandatory requirement that all Districts and Divisions with labour budgets, load a corresponding FTE budget. The labour dollar budget is loaded into FAMMIS independently of the FTE budget, which is loaded into Panorama (DSS) and represents the staff budgeted to do the work.

Table 6 Components of Full Time Equivalents (FTE)

<table>
<thead>
<tr>
<th>Components of Standard FTE and Non Standard FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard FTE – Includes:</td>
</tr>
<tr>
<td>QH Employees and External Employment Agencies – Contractors</td>
</tr>
<tr>
<td>Productive Hours (Actual Working Hours)</td>
</tr>
<tr>
<td>Ordinary Hours</td>
</tr>
<tr>
<td>Overtime</td>
</tr>
<tr>
<td>Allowances – Clinical Coders Only</td>
</tr>
<tr>
<td>Non-Productive Hours (Certain types of leave with pay)</td>
</tr>
<tr>
<td>Conference Leave</td>
</tr>
<tr>
<td>Family responsibilities – Maternity and Adoption</td>
</tr>
<tr>
<td>Other Leave – Study Leave, Training and LWOP</td>
</tr>
<tr>
<td>(**) Public Holiday Leave</td>
</tr>
<tr>
<td>(**) Separation Payment – VER and Redundancy</td>
</tr>
<tr>
<td>(**) Sick Leave</td>
</tr>
<tr>
<td>Special Leave</td>
</tr>
<tr>
<td>Work Cover</td>
</tr>
<tr>
<td>Allowances – On Call</td>
</tr>
<tr>
<td>Non Standard FTE</td>
</tr>
<tr>
<td>QH Employees Only</td>
</tr>
<tr>
<td>Levied Leave Paid</td>
</tr>
<tr>
<td>Long Service Leave</td>
</tr>
<tr>
<td>Annual Leave (Recreational)</td>
</tr>
</tbody>
</table>

| (*) Provided for in BFTE and determined if a backfill is required, included in BFTE count. |

3.2.1.1 Standard FTE

The Standard FTE is made up of payroll component types as listed in Table 6. The cost of each of these components must be included in the calculation for determining an accurate BFTE figure that captures all of the relevant FTE related costs. These FTE related costs used to determine the BFTE are not to exceed the labour budget as loaded in FAMMIS. Doing so would require a change in FAMMIS to re-balance the labour budget.

As shown in Table 6 above, a Standard FTE does not include unpaid leave, long service leave and annual leave. In addition, penalties and back pay are not FTE related and therefore are not included in the
calculation of a BFTE and FTE. Standard FTE is used for monthly reporting purposes as it closely aligns to the labour dollars budget in the general ledger.

### 3.2.1.2 Standard FTE Calculation

Standard FTEs are reported in the Panorama (DSS) HR Payroll SAP module and are calculated by subtracting paid annual leave hours and paid long service leave hours from paid. A standard FTE comprises both internal and external FTE employee types.

- **Internal FTE** (as paid through the QH Payroll System) are calculated by taking the hours worked (including ordinary, overtime, sick, special and maternity leave) and dividing this by the standard award hours for all pay streams.

- **External FTE** are calculated by dividing invoice values by the hourly rate (that relate to work performed in the reporting period plus an accrual for unprocessed invoices) by the standard award hours for all pay streams.

### 3.2.1.3 Non-Standard FTE (i.e. Annual Leave and Long Service Leave Taken)

The BFTE for annual and long service leave paid and taken is to be loaded into DSS. This FTE reflects leave taken by staff paid through the QH Payroll System. All Districts and Divisions with labour budgets are to load a FTE budget to reflect a combined or segregated FTE for annual and long service leave taken (i.e. BFTE can be loaded against one FTE type). This BFTE will be loaded mainly in school periods. The loading of this BFTE will also allow reporting of actual verse budget for the Paid FTE. Recently the QH Resource Executive Committee have requested additional reporting against the Paid FTE. The Non-standard BFTE is calculated similar to the Standard FTE being hours to be taken divided by the award hours for all pay streams. The non-standard BFTE is usually based on prior years leave taken adjusted for any savings strategies to reduce the Standard FTE by placing staff on annual or long service leave.

### 3.2.2 Nursing FTE via the Business Planning Framework

The Office of the Chief Nursing Officer has produced a resource manual in the form of the ‘Business Planning Framework’ (BPF). The BPF is a tool designed to manage nursing and midwifery workload. It provides a business planning process to assist nurse and midwives in determining appropriate staffing levels to meet service requirements and evaluate the performance of the health service. The primary aim of the BPF is to achieve a balance between service demand and supply of nursing/midwifery resources. For additional information refer to: [http://qheps.health.qld.gov.au/ocno/content/bus_planning.htm](http://qheps.health.qld.gov.au/ocno/content/bus_planning.htm)

The BPF consists of three stages: developing a service profile, resource allocation and performance evaluation. Each stage of the process should not be considered in isolation, or separate from the desired outcome of developing a business/operational plan. Service aims and analysis of the internal and external environment are necessary steps in completing the process. A generic service profile template is available to assist staff in applying the BPF and should be completed before calculating the staffing requirements and associated labour costs.

All calculations for staffing requirements should include the standard BPF multipliers such as sick leave and mandatory training. The standard multipliers are located in the current BPF manual and should always be incorporated into any locally designed budget tool/spreadsheet.

To allow for accurate workforce planning and budget forecasting, health services should ensure that their cost centre structure precisely reflects actual ward activity. For example, pay information transfers when nurses/midwives from a ‘home’ cost centre work shifts in other cost centres.
3.2.3 Minimum FTE Budget Requirements

To improve the accuracy of BFTE and subsequent variance analysis, minimum requirements for loading BFTE have been developed. BFTE must be loaded by:

1. FTE type (e.g. sick leave FTE (7S00), overtime FTE (6O02), mandatory training FTE (6Z85), professional development leave (7Z35) and annual leave FTE (R00) with the balance as a minimum, loaded as ordinary salary FTE (1B00));
2. Funding type (e.g. split into State based, State Research, Commonwealth etc);
3. Facility (i.e. QH locations with greater than $3M in expenses, 30 Standard FTE or 500 separations per annum are to load their BFTE against a unique and facility identifiable cost centre or group of cost centres);
4. Stream (e.g. nursing, medical, administration, health practitioners, etc.);
5. Employment Type (i.e. Internal and External); and
6. pay point level (i.e. NO1, NO2 etc.) to assist with local FTE management.

Note: The cashflowing of BFTE must take into account monthly impacts, i.e. it must be reflective of seasonal trends such as staff reductions due to Christmas and Easter holidays.

Note: Levels of detail will vary, for instance rural Districts generally do not dissect their profiles down to specific pay points due to the limited need or use for this level of BFTE information.

3.2.4 External Budget FTE

The impact of using external staff must be properly considered when building the Budget FTE (BFTE) budget because of their high cost relative to internal FTE. For instance, locum doctors can cost 1.5 times more than an internal equivalent. Therefore external staff should be engaged as a measure of last resort and only when workflow requirements demand.

As a guide, Districts have historical external FTE data in Panorama (DSS) that can be used to evaluate and budget their agency usage. The external BFTE should be determined based upon what is likely to be required in that year while taking into consideration any planned savings strategies. For example, if the District or Division has planned to reduce external numbers in the latter half of the year, this intention needs to be reflected in the BFTE load. If an external FTE labour dollar budget is allocated, an external BFTE is also required to be loaded as well, as this will assist in performance monitoring. For example, if a District set targets to reduce agency staff levels, an external BFTE will help to monitor the overall FTE budget.

3.2.5 Budget Upload

It remains a mandatory requirement that all Districts and Divisions with labour budgets load a corresponding and appropriate FTE budget that is derived from loaded labour budgets. The BFTE is to be approved by the Resources Executive Committee at the beginning of each year and is ‘locked down’ at that time. All Districts and Divisions are responsible for managing and maintaining the BFTE staff profile in accordance with the Budget Calendar that is published on the Finance Branch website in Budget Services. Updating the FTE budget profile in line with the Budget Calendar enables Districts and Divisions to manage and control their FTE budget as circumstances change throughout the year (e.g. new activity types, new revenues and restructures), upon the issue of a new Income Statement.

The important component of the BFTE is that the staffing profile is affordable (i.e. the costs do not exceed the dollar budget allocated to labour). If a District is likely to employ 110 standards FTE for example, but it can only remain within its labour budget by employing 100 standard FTE, only 100 BFTE must be loaded into Panorama
BFTEs need to be aligned with activity targets as well as labour budgets. The labour budget determines the BFTE staffing profile upon which the activity target is based. BFTEs should be calculated from a 'zero base' or from the expected cost per FTE which is generally the previous year's cost per FTE with an increase for the EBA wage rises, other award changes and staff profile changes, which also affect the labour costs.

### 3.2.5.1 Rules for Loading FTE Budgets

These rules act as a guide to ensure that all relevant matters and information are considered in the development of the BFTE. There are a number of constraints and specific requirements that are applicable and these need to be understood and applied accordingly.

1. BFTE changes are only allowed to occur in accordance with the lockdown business rules of the budget and budget calendar (i.e. in line with the budget build dates – mid year or in a technical round where a new Income Statement is issued).

2. Annual trends are very evident in all District and Divisional data and BFTE need to be phased on a monthly basis to accurately reflect expected usage (e.g. provisions need to be made for increased leave during the Christmas and Easter periods as staff are encouraged to take leave at these times. Recruitment of new medical officers, generally in January, and seasonal graduate intakes should also be incorporated into phasing of FTE and the impacts of the flu season on staff absenteeism should also be a considered). Accurate phasing of the BFTE will greatly assist budget management processes and the reporting of FTE variances.

   A possible trend example would be where a District or Division can afford 100 Standard FTE over the entire financial year and is not planning any service changes or recruitment variations. The annual figure for the financial year (i.e. the average of the twelve (12) months BFTE) needs to equal 100, however, the month to month BFTE needs to reflect increases and decreases in annual leave and long service leave taken (e.g. in the school holiday period usually the BFTE is less than in other months).

3. Retrospective adjustments to BFTE are not to occur. When changes to the BFTE are required to correct errors, or to show the effects of new funding, adjustments must be made to the current period only and not to prior months. This will ensure that the integrity of monthly performance reporting for prior months is maintained.

   For example, in a District funding was received for a BFTE in January. The staff member actually commenced work in July. To adjust the budget at mid year, the previous periods July to December cannot be adjusted. In the current period (January) it is necessary to load the cumulative effect of these FTE. This will ensure that the YTD reporting is consistent with the labour dollar budget allocation. For the previous reporting periods a labour over spend will be evident which can be explained by stating that the FTE was budgeted for but as yet the FTE had not commenced work.

   **Note:** Retrospective BFTE are only permissible where internal restructures occur, when cost centres and department budgets and actuals are transferred between Districts and Divisions or Corporately. BFTE can therefore be adjusted to reflect the current approved structure for previous months assuming that the following conditions are met:

   a. Full year actuals are transferred to the new cost centre; and

   b. Full year funding is transferred through the PBA process to the new cost centre.

4. There can be a reduction in the calculation of the expected cost per FTE value for planned savings, such as reduced agency usage and overtime controls, where planned changes are to be implemented.
3.2.5.2 Upload Process

3.2.5.2.1 Original FTE Budget
Prior to loading the planned BFTE for the financial year, the following processes are be adhered to:

1. Budget holders need to validate budget FTE loads with their portfolio teams for accuracy before authorisation.
2. The planned budgeted FTE load is to be reviewed and verified against the prior years BFTE and should only be varied by any new funded BFTE. This needs to be considered by the respective Business Analysis and Management (BAM) Portfolio Team for reasonableness and any exceptions resolved prior to upload in the Panorama (DSS) Budget Upload section.
3. A key budget officer within each District or Division is to be responsible for uploading the BFTE in Panorama (DSS). This must occur within the timeframe allocated in the budget calendar. Outside this timing, changes cannot be made due to system ‘lock down’.
4. The Resources Executive Committee is to sign off on all BFTE at District and Division level at the beginning of each year; thereafter a ‘lock down’ position is in effect as the numbers are set thereafter.

3.2.5.2.2 Adjustments
When any funding adjustments that have a labour effect occur at a District or Division level, the budgeted FTE are to be adjusted accordingly. Funding adjustments can occur mid year by PBA and are by exception (e.g. transfer of one unit to another department). Any adjustments are to be explained via commentary to the respective portfolio team in the monthly performance reporting.

3.2.6 FTE Reporting
As part of the monthly performance review process, variances between: (a) QH FTE (actual FTE) and BFTE and (b) actual labour cost and labour budget must be understood. This analysis entails a reconciliation of FTE components as identified in Table 6 and is used to identify the drivers leading to the overall labour dollar variance. Generally expenditure should be either over or under budget relative to the FTE.

Some things to consider when preparing an FTE report are highlighted in the following scenarios and include:

1. Labour dollars over budget / FTE under budget. The analysis should include:
   • What payments have been made that don’t reflect FTE?
   • Has there been any back pay or penalties paid?
   • What are the skills mix relative to the budget – The more senior the staff the higher the costs
   • Flow of dollars with the question being: Is the labour dollar budget phased correctly using similar trends to FTE budget?
2. Dollars under budget / FTE over budget will require the following analysis:
   • Unable to recruit at high level, so using base staff?
   • Penalties or Allowances significantly under budget?
   • Flow of dollars – is the labour dollar budget phased using similar trends to FTE budget?

The BFTE does not mean that as soon as the budget is exceeded staff numbers must be reduced. The BFTE is a guide to assist management in the managing of its labour dollar budget. In many circumstances cost centre managers find managing to BFTE easier to deal with than managing a dollar budget or activity targets. Usually
the FTE employed is the key driver for costs and activities as labour is the majority of the cost centre managers’ total costs.

The focus on BFTE is the number of staff at various levels of seniority (reflective of costs) that can be employed to undertake an estimated body of work in a year whilst remaining within the labour dollar allocation. It is expected that when analysing monthly reporting that the percentage variance in labour budgets will be similar to the percentage variance for FTE budget.

Any price variations in BFTE (i.e. cost per FTE variation) should be discussed within the monthly performance reporting and not be masked through budgetary movements (e.g. shifting budgets from non-labour to labour or labour dollar budget not aligning with BFTE). For example, a position that is fully backfilled, with the BFTE cost planned as $100,000 p.a. and the actual cost per FTE transpires to be $200,000 p.a., the:

- BFTE should be noted as being one (1) throughout the year as planned;
- An over BFTE position is to be reported due to an increase in cost per FTE; and
- BFTE profile is to be adjusted to 0.5 in subsequent years budget builds, based on the most recent and accurate data.

### 3.2.6.1 Fortnightly FTE Reporting

Fortnightly FTE reporting assists Districts and Divisions in monitoring the performance of their FTE. A number of automated reports have been set up in Panorama (DSS) allowing Districts and Divisions to produce the suite of fortnightly FTE reports which form the basis of discussions with Queensland Health Senior Executives. The suite of reports can be found in Panorama (DSS) under the Scorecard Module in the folder called, Performance Reports and are located within the HR Payroll module.

To access the monthly performance reports, staff will require the correct security access levels for the Panorama (DSS) Scorecard, HR Payroll, Finance and ABF modules. Access to these modules can be gained via the User Options folder in Panorama (DSS). Access to Panorama (DSS) (i.e. requires user id and a password) can be gained via the register “here” option on the Panorama (DSS) log in screen. The Panorama (DSS) log in screen can be accessed from the Panorama (DSS) QHEPS site.

Some of the reports available from Panorama (DSS) that will facilitate FTE analysis are:

- One Month Table;
- FTE Statement;
- FTE Month Comparison.

In addition, a new fortnightly payroll report has been developed by Finance Branch that incorporates actual payroll costs (including salary and wages, overtime, penalties and allowances) to compare district’s actual payroll costs with projected and targeted performance as outlined in the 2011-12 District’s Financial Performance Plans.

The target FTE represents paid FTE rather than standard FTE. Paid FTE reflect all hours paid whether they are productive or non productive (i.e. leave hours). The paid FTE has been chosen as it better reflects practices around annual leave management and the core critical issue of getting staff on leave without the need to backfill. Backfilling, rather than actual leave, is the main driver for incurring additional cost. Standard FTE can reflect as being stable when in fact they are hiding high level usage of backfill staff.

This report is produced on a fortnightly basis in line with Queensland Treasury requirements and it is tabled at the monthly Finance Sub-Committee and Resource Executive Committee.

It is a requirement by the Districts to review, monitor and provide comments in relation to the fortnightly and year to date payroll performance by the District.
3.2.7 Xman Accruals (DSS)

Xman is a DSS application that attaches an FTE component to payments made to external agencies for labour and accrues for outstanding external FTE related invoices.

There is often a substantial delay between the service provision by an external staff agency, the receipt and subsequent payment of the applicable invoice and the completion of the Xman reconciliation which assigns the costs and FTE to the correct cost centre. The Xman Accrual process allows for a pay run average to be calculated based on previously generated actuals. This can then be used as a basis to generate an accrual which allows the District/Division to reflect their true position in relation to external labour costs.

The Xman accrual functionality was introduced because:

- a material value of external accruals were not previously being recorded by all Districts and Divisions in the general ledger;
- accruals were only being completed for dollars at the end of each month, with no ability to accrue for the FTE component; and
- monthly performance reporting was being distorted by spikes in the external agency FTE related to varying Xman invoice processing timeframes.

For the Xman accrual to be as accurate and as relevant as possible for monthly performance reporting, the pay run dates are to be used when processing the actual Xman transactions. So that the FTE will be recorded against the pay period worked by the external employee rather than the date of the invoice. As the Xman accrual affect the reporting of expenditure against budget it is anticipated that the Xman Accrual user will have some level of responsibility/decision making ability with reference to external agency costs for their District/Division.

To process Xman accruals, the user must first establish a set of parameters that will be used to calculate and then generate the accrual as required. These parameters are determined by the District/Division, based on the local situation i.e. the time taken between service being provided and the invoice being received and processed through Xman.

Xman accruals are actioned by District/Division once a month and can be generated at a District, Division, sub-Division or cost centre level which then can be broken down into pay streams.

If the District believes that the accrual generated by the system has under or overstated their position the figures can be adjusted to reflect what they believe to be their correct external accrual.

For more information please refer to:

3.3 Forecasting

3.3.1 Forecasting

Forecasting is a systematic approach to providing a reliable indication of the future financial position of an organisation using known events and trends to extrapolate and predict a likely outcome. Included in these predictions are both the revenues and the expenses of an organisation, therefore including into the forecast all known factors will subsequently indicate likely impacts upon financial performance. Growing emphasis upon ‘remaining within budget’, with consideration for ‘the level of available funds’, makes forecasting an important business function and decision making tool. Forecasting should utilise known facts such as: seasonal factors, annual events, health service planning impacts, local business knowledge and any other unique factors applicable, when developing reasonable future estimations.

It is essential for business managers and cost centre managers, to know and understand their businesses, and to participate and communicate information that will have an impact upon the forecasted position of their District or Division. This will inform the Finance Branch as to ‘why’ certain figures are changing and how these changes relate to both activity and FTE. Further, it will assist in the identification of any cascading effects from these primary changes that have resulted in movements in overtime costs, increased purchases of clinical supplies and the like. Potential risks will also be highlighted for review and detailed consideration.

*The forecasting process is currently under review and this section of the Business Rules and Guidelines is subject to change accordingly.*

3.3.2 Analysis of Forecasting Factors

In the month end reports Districts and Divisions are required to provide details of their business performance and any potential business related risks. Numerous factors need to be considered when determining key concerns. Adherence to the reporting format of the Monthly Performance Report of Labour and Non Labour Expenses is required and this necessitates the following detailed review processes. Below are some examples of Labour and Non Labour Expenses that can affect the performance of Districts and Divisions:

- **Labour costs affecting performance** – FTE analysis is critical. For example, external nursing labour may increase because of flu outbreaks, additional surgical procedures, changes to quality and care guidelines (such as a change in the required nurse to patient ratio) or there may be an increase in HP (scientific) labour due to some emerging public health risks related to water, foods and air quality – these are just a few examples of the possibilities that need to be considered.

- **Non Labour costs affecting performance** – Any number of possibilities can occur and some possible examples are:
  
  (i) clinical drugs or supplies are effected by movements in the local or international prices;
  
  (ii) increases in pathology usage due to the addition of new medical staff, introduction of new service technologies or a shift in the mix of pathology services requested;
  
  (iii) seasonally varying levels of influenza or a long summer bringing on an increase in mosquito breeding seasons and related viral out-breaks;
  
  (iv) necessary accrual due to delayed consultant tax invoice submissions;
  
  (v) resource changes such as a shortage of nurses resulting in increase over-time costs;
  
  (vi) opening of new facilities; and
(vii) re-negotiation of prices of standing contracts (i.e. clinical supplies, software licenses and necessary hardware upgrades).

There are other factors that also need to be considered such as:

(i) reductions in operational activity;
(ii) a change in the service delivery model;
(iii) introduction of planned saving strategies within a service area;
(iv) use of more external consultancy and training facilities;
(v) changes in freight costs for tissue and organ transportation; and
(vi) general increases in clinical and non-clinical costs.

3.3.3 Forecasting Template and its Inbuilt Features

For the 2011-12 financial year, Business Analysis and Management (BAM) has enhanced the current District and Division specific forecasting template which contains all the relevant financial data for the District and Division to derive an accurate forecast position. Each template contains modelling data that is based upon Districts and Divisions financial performance YTD, modelled for the remaining ‘open’ months and a projected end-of-year position.

3.3.4 Forecasting Process

The actual forecasting process commences when data is download by BAM into the District and Division specific forecasting templates. These downloaded template files will be sent on a monthly basis to all Districts and Divisions. The Districts and Divisions are to review the template information in detail with particular emphasis on the year end position. After a detailed review by the Districts and Divisions, any necessary adjustments need to be included through the completion of the ‘Adjustment Sheet’. Once all necessary amendments have been made and the Districts and Division have arrived at a considered forecast financial position the completed file is to be returned to BAM. The final step in the process is to upload the file into FAMMIS as Finance Branch forecast. The Districts and Divisions have the discretion to load their own forecast for their relevant business areas (950 upload process).

Effectively the template uses methodologies that trend prior year financial data and information by month which allows for an improved level of accuracy in forecasting expenses and revenues for the remaining open months.

- The **revenue section** of the forecast template is calculated by totalling the YTD monthly revenue and subtracting this amount from the total year budget revenue figure. The remaining revenue balance is split proportionally over the remaining months of the current financial year, utilising the prior year’s monthly trend patterns. It is intended that revenue budgets will always balance back to an expected zero balance variance with the exception of user charges, which will be reviewed by Finance Branch on a monthly basis to incorporate Own Source Revenue funding initiatives and achievability of revenue stretch targets. Revenue cash flows will remain unchanged unless a revised Income Statement is released.

- The **expense section** of the template outlines the labour and non-labour expense categories at a high level (labour at account code level; non-labour by account category).
  - The Labour section:
  - The Non-labour section:
• The calculated increase:

• The 'Adjustment' sheet is to be used by Districts and Divisions to amend information in the District and Division forecasting template. The adjustment sheet is used to change the forecast figures as provided by BAM. Following these changes, the completed forecast templates are to be sent back to BAM for review and inclusion into the monthly discussions with District and Division CFO's. The 'Adjustment' sheet provides a means to make changes to the forecasted financial position at the revenue (all categories), labour and non-labour account category level. ‘Adjustment’ sheet changes will be automatically included into the forecast to produce the desired financially forecasted position.

While forecasting is a monthly exercise, the details and information provided in the forecast templates will be updated on a quarterly basis. Any new GL account codes will be automatically included into the forecasting template. It should also be mentioned that forecasted figures must be in alignment with predicted expenditure, revenue and activity that the Districts and Divisions will incur for the entire financial year.

3.3.5 Program Owners – Forecasting

Districts and Divisions can include PBA adjustments for Revenue in the new Forecasting template If a Program Owner is holding funds that it expects are to be released to a District or Division, these funds should be reflected in the District and Division forecast. For example, if a Program Owner is holding $50M for a specific purpose which is expected to transfer out to Districts or Divisions, and it expects to balance its budget the Program Owner needs to be forecasting a balanced position for that month’s reporting in its commentary notes, while it still holds those funds. The District or Division will at the same time be forecasting expenditure for a project (although they may not yet have received the budget), it is a requirement that the expenditure deficit be advised and for the approved PBA ($50M) to be included to balance the budget and for mention to be made in the monthly reporting commentary notes. If the District or Division has an agreed deficit in writing they are allowed to load this deficit into their forecast. However, they will not receive any additional funding for this deficit, this will be held corporately.

It is the responsibility of the Program Owner to advise the District or Division that funding is being held and when the PBA will be processed to transfer those funds to the District or Division. If a District or Division is expecting funds from a Program Owner, it is their responsibility to follow up with them in relation to the release of those funds. It is a requirement that Program Owners maintain a record of all funds held that are to be distributed so that they are able to advise Finance Branch of this information as required.

3.4 Activity Based Funding Reporting

3.4.1 ABF Allocation and Resource Management Reporting

The funding model business rules described in this document applies to corporate data and is available for viewing via the Activity Based Funding (ABF) module of the QH Decision Support System Panorama (DSS) (login or register for access at: http://qhdss.health.qld.gov.au/dss/pages/login.asp ). In general up to five years of historical data is available with two ABF phase pricings applied for comparison (Phase 14 relates to 2011-12 financial year). Both ABF facilities and non-ABF facilities (as if they had been ABF funded) can be viewed in terms of activity weights and budget allocation.

Districts and Divisions should ensure that staff are very familiar with the operation of ABF rules and the DSS ABF module as appropriate. Districts and Divisions should at least monthly:

• evaluate their performance at the facility level;

• use their Divisional / Service line or Institutional structures for internal casemix reporting against allocated casemix budgets;
• evaluate progress to targets at the overall District and Division level in accordance with their District Health Service Plans and Service level Agreements.

The Activity Based Funding and Scorecard (QH key performance indicator (KPI)) modules of DSS are two key reporting modules for monitoring a District's performance. The Queensland Health Scorecard includes the reporting functionality against targets for Tier 1 KPIs for presentation of District Chief Executive Officers (CEOs). QH KPIs can be viewed at: http://qheps.health.qld.gov.au/panda/docs/2011_12_KPIs_List.pdf

3.4.2 T2 Cost per WAU Reporting for top 25 QH DRGs

All ABF facilities (excluding Mt Isa where T2 is yet to be installed) are required to report and analyse T2 ‘Cost per WAU’ for QH’s Top 25 Diagnosis Related Groups (DRGs) measured by WAUs.

The numerator for the above indicator is the T2 Cost. The denominator is the DSS ABF module WAUs, including estimates.

The quarterly reporting schedule is outlined below:

<table>
<thead>
<tr>
<th>Report Date</th>
<th>Data Period Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>5th working day November</td>
<td>YTD September 2011</td>
</tr>
<tr>
<td>5th working day February</td>
<td>YTD December 2011</td>
</tr>
<tr>
<td>5th working day May</td>
<td>YTD March 2012</td>
</tr>
<tr>
<td>5th working day August</td>
<td>YTD June 2012</td>
</tr>
</tbody>
</table>

A DSS ‘Public Report’ will be available to facilitate the above analysis.

3.5 Reporting

Although FAMMIS records all of QH’s financial transactions, the preferred performance reporting tool is the QH Decision Support System (DSS). DSS captures data from key enterprise systems enabling the user to review, analyse and report data at summary down to transactional levels. The corporate based cost centre hierarchy is QH_Alt_2 (Refer to Section 3.1 Cost Centre Management), and the general ledger account hierarchy is called PR_Income. Users are reminded that PR_Income is for internal reporting, and account codes may not roll up under the same summary headings for external reporting. Access to the finance, payroll and activity based funding modules can be found at: http://dss.health.qld.gov.au/index.shtml.

3.5.1 Monthly Reporting Requirements

The ledger closes on the 3rd working day of the month with Districts and Divisions required to analyse the following reports set up in DSS >> Scorecard >> Performance Reports >>

• Income Statement
• FTE (full time equivalents) Statement
• WAU (weighted activity unit) Statement
<table>
<thead>
<tr>
<th>Deadline (working day of month)</th>
<th>Required Action</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>5th</td>
<td>Upload revised forecast information</td>
<td>Districts and Divisions</td>
</tr>
<tr>
<td>6th</td>
<td>Provide reporting template</td>
<td>BAM</td>
</tr>
<tr>
<td>7th</td>
<td>Complete monthly commentary and return to BAM</td>
<td>Districts and Divisions</td>
</tr>
<tr>
<td>8th</td>
<td>Contact Districts and Divisions for a detailed monthly discussion on their year to date performance and forecast position</td>
<td>BAM Portfolio Teams</td>
</tr>
</tbody>
</table>

### 3.5.1.1 Income Statement

The Income Statement that can be viewed in DSS Scorecard is for internal usage only. It separates the operating and non operating (capital) positions for Districts and Divisions and also Administered and Non Administered Funds.

The operating position displays Revenue less Expenditure resulting in the Operating Surplus or Deficit. Where revenue exceeds expenses the operating position is reported in surplus (negative). Conversely, where expenses exceed revenue there is reported an operating deficit position (positive). Revenue is a combination of both District and Corporately receipted funds (refer to the classification as outlined in Section 2.4).

Expenditure is separated into Labour, Non Labour and Depreciation and Amortisation. Non Operating Inflows consist of Capital Allocations; these are identified as Trust Opening Balance and Rollovers (Commonwealth, trust, State research and Capital). Non Operating Outflows consist of Capital Acquisitions and Capital Rollovers – Non State.

A number of Districts and Divisions have Administered transactions that QH administers on behalf of the Queensland government. All revenue from administrated transactions is referred to government (and not to the gain of QH) so that there is always a balanced position in the administered statement.

This Income Statement is used to drive the month end discussions and the anticipated end of year position.

### 3.5.2 PR Fortnightly FTE Reporting

The PR Fortnightly FTE Comparison Report is a fortnightly report based upon fortnightly pay period information for all standard FTE for all pay streams by District. Actual FTE (standard) is compared to the previous year in both crosstab and graphical form to enable trends to be identified. Further data is provided in the DSS performance Reports folded to enable analysis of FTEs by employ type (internal versus external), paystream and facility.

### 3.5.3 Commonwealth Reporting

Commonwealth programs are Commonwealth Government funded initiatives totally or partly undertaken by QH, for example the Immunisation Program (CIM). Most Commonwealth programs are allocated to and are monitored by a designated Commonwealth Program Coordinator. Since 2009, there have been changes to the way that the Commonwealth funds the States.
There are four distinct types of Commonwealth Agreements:

1. Broadbanded Specific Purpose Payments paid to Queensland Treasury (QT) and directed to QH periodically. Unlike the previous Special Purpose Payments for public hospitals (AHCA), Public Health (PHOFA), etc., there are no input controls or financial penalty clauses associated with the Broadbanded Specific Purpose Payment. It is a continuing agreement not subject to re-negotiation every 5 years. The financial terms of the Agreement are the responsibilities of the Commonwealth and State Treasuries. Please note that from 2011-2012, the Commonwealth will be providing National Health and Hospitals Network funding sourced from the existing National Healthcare SPP.

2. National Partnership Agreements are intended to promote reform or to support the delivery of specified outputs or projects. Payments are set for a defined period and consist of an up-front facilitation or a mix of facilitation and reward payments. The majority of these payments are also paid to QT and directed to QH periodically. Budgets allocated to Districts/Divisions at the beginning of the financial year are subject to QH achieving and receiving the estimated reward payments. Budgets will be adjusted to equate to the amount that QH receives from QT.

3. There is still a small group of funding agreements that continue as direct payments from Department of Health and Ageing (DoHA) to QH.

4. National Health and Hospital Network funding, whereby the Commonwealth is established as being: the majority funder of public hospital services; responsible for full funding and policy responsibility for GP and primary health care; and responsible for full funding, policy, management and delivery responsibility for a national aged care system.

Commonwealth Operating Revenue received via QT must be treated as appropriation funding. These funds appear on the Income Statement under Output Revenue Commonwealth. Whereas, revenue received direct from DoHA will appear under Grants and Contributions. It is preferable that all Commonwealth funds are corporately receipted and the budget allocated from a corporately managed cost centre. In order for this revenue to appear on the District and Division Income Statements, the portion of corporately receipted revenue is journalled to Districts and Divisions each month.

From 2009-10 onwards, there is a new classification that has been added to the Income Statement for District receipted Commonwealth revenue. The following Revenue account codes will appear on the Income Statement as Activity Specific Purpose under Grants and Contributions:

- 400030 CWLH-MULTI PURPOSE CENTRE
- 400220 CWLH-REMOTE MEDICAL BENEFIT
- 400225 CWLH-COAG S19(2)EXEMPTION INITIATIVE
- 400380 CWLH-REMOTE INDIGENOUS S100 ARRANGEMENTS
- 400510 CWLH-COM AGED CARE PACKAGING
- 405050 CWLH-RADIATION ONCOLOGY CAPITAL

As the final Post Budget Allocations (PBA) for this group are not usually finalised until after the ledger has closed at the end of the financial year, Districts and Divisions will be able to spend up to the level of correctly receipted funds. Districts and Divisions are to ensure that only correctly receipted funds are posted to the above revenue accounts. If the Finance Branch deems that revenue has been inappropriately receipted to these account codes the District or Division will not be allocated the budget and the District will be required to process the correcting journal or incur a negative rollover in the following year.

Commonwealth cost centres have to be structured in the General Ledger to track revenue and expenditure for acquittal purposes. These majority of Commonwealth Programs are reported in the General Ledger as cost
centres with a three character Fund Type starting with a C** (e.g. CGA Aged Care Assessment Program NP). Generally, Commonwealth Agreements greater than $1 Million will have their own unique Fund Type.

For those less than $1 Million, they are recorded as Minor Programs and are tracked and monitored individually by cost centre numbers. Districts and Divisions need to ensure that the Commonwealth cost centres have the correct Fund Type in regard to the funds that they have been allocated.

Fund Codes under the new National Health and Hospitals Network Agreement, begin with the character of SA* for activity related programs and SN* for non-activity related programs. (These programs are also identified as having a line item reference of 9-*** and a budget group of 9 ‘National Health And Hospitals Network’).

Traditionally, Commonwealth funds were allocated non-recurrently. From 2010-11 onwards, the Commonwealth Broadbanded Specific Purpose Funding has been allocated recurrently. In the future, Program Coordinators will only need to submit a business case to the Finance Sub-committee for any increased funding requirements. For the balance of other Commonwealth funds, they will continue to be allocated non-recurrently.

Commonwealth Programs cannot be overspent (expenditure cannot exceed budget allocation). The only exceptions to this rule are:

- for the small group of District received funds mentioned above - Activity Specific Purpose funds, where the District may not have received the full year’s budget allocation; or
- where a District or Division must meet the financial obligations of an agreement relating to funds received in a prior period (i.e. no rollover approved, the ledger must show funds fully spent for acquittal purposes – the District or Division would need to use State funds to offset Commonwealth expenditure as a balanced budget is required for State and Commonwealth funds.

Programs that have Commonwealth funding must not be charged with a program administration levy by any QH entity, whether administered by Districts or Divisions. It is appropriate that these programs be charged with the full cost of providing the service that has been funded. The costs would include electricity, security, staffing, but not those costs that are simply administrative in nature. The cost should relate to the true cost of doing business, and should be easily justified, and be able to withstand any scrutiny in an audit process.

With the implementation of corporate systems across QH, the focus has been on ensuring that direct costs attributable to responsibility areas are posted directly to those areas, including Commonwealth programs.

Some considerations with respect to the Commonwealth programs are that:

- they do not meet Treasury-imposed savings such as imbedded tax savings,
- they only incur superannuation expense for Go Super,
- they are not funded for State award increases although some receive various escalations from the Commonwealth, while others receive State-matched funding,
- Commonwealth programs are expected to include depreciation and amortisation expenses within the allocated budget and as per the terms of the agreement. For further information regarding depreciation, refer to Section 2.9.3 Commonwealth Depreciation Expenditure.

### 3.5.3.1 Timeframes

Release of Commonwealth funds will be as per budget timeframes as set out in the budget calendar (refer to Tables 4 and 5). As Commonwealth agreements are not always signed when the Income Statements are released, Districts and Divisions need to be in close contact with the Program Co-ordinators to be aware of the funds expected to be released and the financial requirements of the program to be met within the financial year.

For the technical adjustments at the end of the financial year (where Revenue is matched against budget), Finance Branch will only acknowledge Commonwealth funding receipted in terms of the Commonwealth
Agreement. For any other Revenue receipted against a Commonwealth cost centre, the District or Division will not receive a budget allocation and Districts or Divisions should journal any other revenue to a State cost centre.

3.5.3.2 Specific Commonwealth Terms

Most Commonwealth Programs have a QH Program Coordinator (except for some minor programs and District receipted programs). A list of Commonwealth Coordinators is available on QHEPS located at: http://qheps.health.qld.gov.au/financenetwork/bud_fore_data_ana/docs/bus_ana/procedures/cwth_contacts.pdf

Copies of all Commonwealth Agreements or variations must be forwarded to both the Intergovernmental Funding and Policy Unit and Finance Branch so that the budget can be loaded. District CEO’s do not have delegations to sign Commonwealth Funding Agreements.


Guidelines for Australian Government Funding Agreements are administered by Intergovernmental Funding and Policy Coordination Unit. Currently, these guidelines are being updated.

Program Co-ordinators will advise Districts and Divisions of funds held and when a PBA will be processed. (Refer to Section 3.7.2 Non Operating Outflows.)

Funding is to be expended in accordance with the Commonwealth Agreements. The recipient project manager is to ensure adherence to the agreements. Any reporting requirements with respect to funds received are as required by the respective Program Coordinator and will be communicated at the time of the initial allocation. It is the Commonwealth Program Coordinator’s responsibility to ensure that Districts are adhering to the intended purpose of the funding provided by the Commonwealth.

Financial acquittal requirements are outlined in the terms of the Agreement. Districts and Divisions must fulfil the reporting requirements - signed financial reports by District CEO and or General Manager together with supporting ledger reports are to be forwarded to the Program Co-ordinator for consolidation.

The Program Coordinator must forward the consolidated returns together with supporting ledger reports to Finance Branch, Internal Allocations Team for validation and signing by the Department’s General Manager (at least ten (10) working days prior to the reporting deadline). Finance Branch will return the certified financial report to the Program Co-ordinator for despatch to the Commonwealth. A reallocation of funds during the financial year can be undertaken at the discretion of the Program Coordinator in the instance of under or improper expenditure. All financial statements to the Commonwealth Department of Health and Ageing need to agree to QH general ledger and be endorsed by the General Manager as being materially correct.

3.5.3.3 Commonwealth Funded Programs with Activity and Dollar Acquittal Requirements

For Commonwealth funded programs (e.g. National Partnership Agreement on Improving Public Hospital Services), that have requirements for both dollar and activity acquittals against individual approved projects, Districts must meet their agreed activity targets, as the funding for each year is contingent on meeting the previous year’s activity target. The Agreement relating to sub-acute services states, where the agreed performance targets and occupancy rates are not fully met, the subsequent annual payments may be adjusted to reflect the degree of performance achieved in the previous annual period.

In order to meet the Commonwealth reporting requirements of activity and dollars spent, Districts must create specific Commonwealth cost centres with appropriate Fund Types to capture activity. For detailed information on Fund Types refer to section 3.5.4. Commonwealth Reporting. Currently the National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services has dollar and activity acquittal requirement.
3.5.3.3.1 HACC

The Home and Community Care (HACC) program is a jointly funded Australian Government and state/territory government program. It provides funding for basic maintenance and support for people who live at home and whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long term residential care.

These could include:

- older and frail people with moderate, severe or profound disabilities
- younger people with moderate, severe or profound disabilities
- unpaid carers of people assessed as being eligible for the program.

HACC services are offered in the home or local community and may be provided by a HACC agency, community health centre or local council. Funding is administered by Department of Communities (DOCs).

Health Service Districts are funded to provide HACC services under MOUs developed between the Districts and DOCs, and should endeavour to deliver and report according to the terms of those agreements. The onus is on the District to manage the HACC funding, reporting and the acquittal processes.

In the event of HACC underspends revenue is to be returned to DOCs in the same financial year. If funds are returned in the following financial year, it is to be funded from the District’s operational budget rather than HACC funds. As overspends are not funded and are to be absorbed within the District budget.

Guideline on HACC financial and performance reporting is at:

Guidelines, systems and processes in the management of HACC funded assets are found at:

3.5.3.3.2 Aged Care Assessment Program

The Aged Care Assessment Program (ACAP) is an initiative of the Australian Government which provides funds to State and Territory Governments specifically to operate Aged Care Assessment Teams (ACATs). A cooperative working arrangement exists between the Commonwealth and the States and Territories to implement the program.

The primary role of ACATs is to undertake multidisciplinary assessments of the medical, psychological and social care needs of older people (70 years and over) and Aboriginal and Torres Strait Islander people (50 years and older), to assist them and their carers to access available services appropriate to their needs.

ACAT approval is required for people to access Commonwealth funded aged care services. These include:

- high level residential aged care
- low level residential aged care
- Community Aged Care Packages (CACPs)
- Extended Aged Care in the Home (EACH)
- Extended Aged Care in the Home Dementia packages (EACHD); and
- Older people entering the Transition Care Program.
Commonwealth funding is provided on condition that Assessment teams operate in accordance with the current Aged Care Assessment Program Guidelines, the Aged Care Act 1997, the Aged Care Principles, ACAP Funding Agreement and the ACAP Financial Guidelines.


### 3.5.3.3 Transition Care

The Transition Care Program (TCP) is jointly funded by the Commonwealth and the State governments under the provisions of the Aged Care Act 1997. The Department of Health and Ageing (DoHA) allocates places to states and territories based on the target population of older people (aged 70 years and over; and for Aboriginal and Torres Strait Islander people aged 50 years and over).

The TCP provides time limited, and therapy focused support and active management for older people at the interface of the acute/subacute and residential aged care sectors, in a residential or community setting.

Queensland Health has signed a Payment Agreement with DoHA, and is accountable for the funding provided to the Program, and for reporting to the Commonwealth on a statewide basis.

Transition Care is provided by a mix of Queensland Health and non-government service providers. By mid 2012, Queensland will have 733 Transition Care places operating across the State.

The funding contribution ratio is on a 75:25 basis between the Commonwealth and Queensland State respectively. State funding is provided to District Health Services who are responsible for delivering the services at the local level.

Commonwealth funding for TCP is paid retrospectively based on occupied places per day. The Commonwealth reimburses Queensland Health every month based on Medicare claims lodged by each District TCP service.

Queensland Health has implemented a key performance indicator (KPI) for this program, which targets improved occupancy levels across the State in order to maximise the Commonwealth revenue for the Program.

Districts are expected to achieve at least the minimum of 80 per cent occupancy for all approved TCP places. Achievement of this target is reviewed regularly, and occupancy levels are monitored on a monthly basis. If, over a six month period occupancy levels are significantly lower than 80 per cent, Districts will have a proportion of their allocated state funding reduced for the following half of the financial year. Funds recovered in this process are then reallocated to better performing TCP providers.

Queensland Health is required to submit an Annual Accountability Report to the DoHA by 30 September each year as an acquittal for the TCP Commonwealth funding.

### 3.5.3.4 Unspent Commonwealth Funds

It is the Program Coordinator's responsibility to ensure the Commonwealth funds are being fully utilised in the financial year that the funds are received. (Each year there is a substantial amount of unspent funds. Program Coordinators need to review their funding requirements regularly and ensure that the funds are fully spent in the year received).

To assist in this process, Program Coordinators have the following resources available:

1. State-wide access to their respective Commonwealth Program in Panorama (DSS) (access is limited to only one nominated person per Program);
2. Finance Branch provides the Program Coordinators with monthly reports, comparing: budget, revenue and expenditure;

3. Program Coordinators may request ad hoc reports as required or meet with Finance Branch or fund recipients as required.

At the end of April, if Districts and Divisions are forecasting an operational surplus (i.e. for State and Commonwealth funds), the District CEO can apply to the Department’s General Manager to have the unspent Commonwealth funds removed from their current budget and reallocated back to that district or Division in the following financial year. This process can only be endorsed if consultation and approval has been granted between DoHA and the QH Program Coordinator, that the funds can be utilised in the subsequent year. The District CEO will need to advise the quantum of Commonwealth funds requiring rollover, as well as confirmation that the District as a whole will have these funds unspent at the end of the financial year.

For Commonwealth funds paid by DoHA via QT, Finance Branch will apply to QT to have the funds deferred until the new financial year. If approved by QT, the funds would be returned to the District or Division in the following year as Operating Commonwealth Revenue.

For Commonwealth funds paid directly by DoHA to QH, Finance Branch will need to make special arrangements with QT to see if QH can defer State funds to be re-allocated back to QH in the following financial year. If approved, these funds would be returned as State operating funds and allocated as State funds. In the new financial year the Districts and Divisions will need to journal a debit from a State cost centre crediting the Commonwealth cost centre to facilitate the Commonwealth deferral of these funds.

If QH’s overall statewide position is not in surplus, QH’s General Manager may decide in certain circumstances to roll commonwealth balances internally. In these circumstances, the rollover will be reallocated in the new financial year as Non-Operating funds.

If DoHA do not approve for the funds to be rolled from one year to the next, the Program Co-ordinator needs to advise Finance Branch as soon as possible (preferably before 1 June) so that the funds can be removed from the Districts and Divisions and held corporately to cover any refunds to DoHA.

Where Districts and Divisions have an issue with unspent Commonwealth funds not being returned to them in the following financial year and they need to meet the financial commitments of the agreement, they do have the option of applying to the Finance Sub-Committee for additional State funding. If approved, these funds would be allocated as State operating funds. The Districts and Divisions would need to journal a debit from a State cost centre crediting the Commonwealth cost centre to facilitate the ability to expend against a Commonwealth cost centre.

It is critical that Districts and Divisions in consultation with the Program Co-ordinator, endeavour to fully spend Commonwealth funds in the year that they are received (or the Program Coordinator negotiates the deferral of the Commonwealth payments).

3.5.4 Prior Year Expenditure

Every effort must be made to correct financial transactional errors in the same financial year that the error occurred. Payroll errors should always be corrected via the payroll system.

End of financial year processes and timetables are communicated each year via a FAMMIS update and other correspondence from the relevant processing areas. Once the ledger for the financial year has closed, no adjustments to the general ledger can be made. If material errors are identified after the close of the financial year, the Financial Accounting Team must be contacted for advice and to ensure external reporting disclosures (e.g. QH Annual Financial Statements) are complete.
If errors to Commonwealth Programs have been made relating to the closed financial periods, it should be considered whether or not the budget allocations can be amended in the current open period. Journals should not be processed to correct prior year errors.
3.6 Income Statement – Operating – Revenue / Expense

3.6.1 Revenue (Actual, Budget and Forecast)

Income Statements are used to ensure transparency between the internal and external view of QH. Importantly, it will ensure Districts and Divisions will be able to identify how their local financial decisions and performances impact upon the Department's overall financial position. Income Statements must be the primary financial reporting tool for all Districts and Divisions. The Income Statement details Revenues and Expenses as well as the overall operating result (i.e. Surplus or Deficit for a fiscal year) and is prepared in accordance with the Australian Accounting Standard AAS29 'Financial Reporting by Government Departments'. The Income Statement also includes Non Operating Inflows and Outflows and Administered Revenue and Expenses.

Income Statements are intended to be:

- Used as a measure of performance by the Queensland Government.
- A statement in the Service Delivery Statement (SDS) used as the primary source of information for the hearing of the Parliamentary Estimates Committee.
- To ensure transparency and clarity between internal and external financial reports of QH.
- Used as an approval mechanism by Resources Executive Committee to allocate funds and to disseminate this to budget holders as part of their Performance Agreement sign off.

The Panorama (DSS) Income Statement is derived from the PR_Income account hierarchy in FAMMIS. The Actuals, Budgets and Forecasts are derived from information loaded in FAMMIS. The total revenue budget for the Department loaded in FAMMIS must balance to the revenue budget published in SDS. The expectation is that the Districts and Divisions will be operating on the basis of a balanced financial position.

3.6.2 Income Statement Requirements

Under the QT Financial Management Framework, QH along with all other State government agencies, is required to prepare and maintain an Income Statement. Queensland Health’s budget is delivered in the Income Statement format and its performance is also measured by Government on the basis of the Income Statement. The Statements are prepared in accordance with prescribed Accounting Standards and more specifically AAS 29 'Financial Reporting by Government Departments’. Rules for Income Statement format:

- Revenues and inflows are represented as negatives (credits);
- Expenses and capital acquisitions are represented as positives (debits);
- Revenue and inflow budgets are loaded and periodically adjusted by the Finance Branch;
- Expenditure and capital acquisition budgets are loaded by Districts or Divisions;
- Districts and Divisions have the discretion to expend rollover inflows on operating expenses or capital acquisitions. This discretion is governed by the need to comply with the terms of the over arching conditions relating to the funding and the objectives of returning an operating surplus;
- Expenditure plus capital acquisition budgets must equal revenue plus inflows. The overall budgeted position (PR_Income) must always be balanced;
- The overall financial position of a District or Division is represented as a negative (credit) if in surplus and a positive (debit) if in deficit.
3.6.3 Actual Revenue, Budget and Forecast Responsibilities

At the end of each PBA round, Corporate Office load a revenue forecast and budget to match the budget database. Districts and Divisions can adjust the budget and forecast by using offset accounts. Table 7 details the corporate and local responsibilities with respect to the uploading of actual revenue journals, budgets and forecasts and the offset accounts to be used for each type of revenue.

Table 7 Responsibilities for uploading revenue journals for actuals, budgets and forecasts

<table>
<thead>
<tr>
<th>Revenue Type</th>
<th>Receipting Location</th>
<th>GL Account Code</th>
<th>Actual Journal Revenue Loads</th>
<th>Budget</th>
<th>Forecast</th>
<th>Offset Accounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPERATING REVENUE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Output Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AB Funding</td>
<td>Corporate Office</td>
<td>499005</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded and Not Required at District Level</td>
<td>499006 Budget &amp; Actual</td>
</tr>
<tr>
<td>Supplementary Payment (Non-ABF)</td>
<td>Corporate Office</td>
<td>499015</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td>Corporate Office</td>
<td>499020</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded and Not Required at District Level</td>
<td>499036 Budget Only</td>
</tr>
<tr>
<td>Output Revenue – Commonwealth</td>
<td>Corporate Office</td>
<td>499035</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded and Not Required at District Level</td>
<td>499036 Budget Only</td>
</tr>
<tr>
<td><strong>Grants &amp; Contributions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants &amp; Contributions</td>
<td>Corporate Office</td>
<td>405095</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded and Not Required at District Level</td>
<td>405096 Budget Only</td>
</tr>
<tr>
<td>Grants &amp; Contributions</td>
<td>Districts and Divisions</td>
<td>As per ledger</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded but can be adjusted by Districts and Divisions</td>
<td></td>
</tr>
<tr>
<td><strong>Own Source Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>User Charges</td>
<td>Districts and Divisions</td>
<td>443796</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded but can be adjusted by Districts and Divisions</td>
<td>443799 Budget Only</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>Districts and Divisions</td>
<td>443795</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded but can be adjusted by Districts and Divisions</td>
<td>443796 Budget Only</td>
</tr>
<tr>
<td><strong>Internal Appropriation (was Fee For Service)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internally Appropriated</td>
<td>Corporately Managed Budget Division</td>
<td>As per GL</td>
<td>As per GL</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td></td>
</tr>
<tr>
<td><strong>NON OPERATING – INFLOWS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commonwealth Rollovers</td>
<td>499080</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td></td>
<td>499081</td>
</tr>
<tr>
<td>Research Opening Balance</td>
<td>499090</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td></td>
<td>499091</td>
</tr>
<tr>
<td>Trust Opening Balance</td>
<td>499085</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td></td>
<td>499086</td>
</tr>
<tr>
<td>Capital</td>
<td>499070</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td>Corporately Loaded</td>
<td></td>
<td>499071</td>
</tr>
</tbody>
</table>
3.6.3.1 Off-Set Account

Each District and Division is to nominate up to four different cost centres that are to be used for the monthly QH budget upload by Corporate. These nominated cost centres each represent one of the four funding types being: State, Commonwealth, Trust or Research.

Since the Districts and Divisions may want to allocate budget amounts to lower cost centres or accounts, for financial management purposes, an Offset Account structure allows this to happen without there being a duplication of the budget amount appearing in performance reports and at the same time retains the original budget allocation. For the Districts and Divisions to load the allocated budget down to these lower cost centres or accounts the following offset accounts are to be used:

- Output Revenue: 499006 – ‘Output Revenue Offset’ (Budget and Actuals),
- Grants & Contributions: 405096 – ‘Commonwealth-Grants Planning Offset Account’ (Budget Only),
- Other Revenue: 443796 ‘Own Source Revenue – Other Planning Offset Account’ (Budget Only),
- User Charges: 443799 – ‘Own Source Revenue – User Charges Planning Offset Account’ (Budget Only),

For example, if a budget has been loaded against the Grants and Contributions Commonwealth account code 405095, cost centre 111111 for -$100,000, the District and Division can move these funds to any other cost centre or account (within their own District and Division) but they have to ensure that a balanced position is maintained at all times with the entry to be placed against the offset account code 405096.

To move a Grants & Contributions Commonwealth account 405095, cost centre 111111, -$100,000 the journal required would be as follows:

- Debit Grants & Contributions offset account 405096, cost centre 111111 (same cost centre as original budget) +$100,000
- Credit Grants & Contributions Commonwealth account 457000, cost centre 222222, -$60,000 (new account and cost centre)
- Credit Grants & Contributions Commonwealth account 450375, cost centre 333333, -$40,000 (new account and cost centre)

This methodology therefore retains the corporate budget load which can still be seen in account 405095, with the total budget for Grants and Contributions remaining the same. Additionally, the District and Division can now see the budget at a lower account code and cost centre level as required.

Similarly, to reallocate non-operating inflows in Commonwealth, Research, Trust and Capital accounts, the following non-operating offset accounts are to be used:

- Commonwealth: 499081 – ‘Non Operating Rollover – Commonwealth Offset’,
- Research: 499091 – ‘Non Operating Rollover – State Research’,
- Trust: 499086 – ‘Non Operating Rollover – Trust’,
- Capital: 499071 – ‘Non Operating Rollover – Capital’.
3.6.3.2 Revenue Cash Flowing (Phasing)

There has been a change in revenue phasing in 2011/12. The Finance Branch has prepared a revenue phasing profile for each District and Division which is an estimate of 2011/12 monthly expenditure, and is based on upcoming enterprise bargaining agreements (EBA’s), accruals and number of working days. This assists in monitoring and reporting on the traction of budget management strategies and financial plans which were negotiated with, and are currently being implemented by the Districts and Divisions to achieve a balanced operating budget for 2011/12.

3.6.4 Expenditure (Accrual, Actual, Budget and Forecast)

As illustrated in Table 8, from July 2010, Districts and Divisions will be responsible for loading their entire expenditure budgets and forecasts (including depreciation). Districts and Divisions can make their own local decision about loading depreciation to the lower level of cost centre and account code.

Table 8 Responsibilities for uploading expenditure budgets and forecasts

<table>
<thead>
<tr>
<th>Expense Type</th>
<th>Budget</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expense (excluding) Depreciation</td>
<td>Managed Locally</td>
<td>Managed Locally</td>
</tr>
<tr>
<td>Depreciation</td>
<td>Managed Locally</td>
<td>Managed Locally</td>
</tr>
<tr>
<td>Capital</td>
<td>Managed Locally</td>
<td>Managed Locally</td>
</tr>
</tbody>
</table>

3.6.5 Expenditure – Maintenance Management Obligations

QH is required to comply with the Maintenance Management Framework (MMF) which specifies the minimum requirements for the maintenance of Government buildings. The MMF is aligned with and is underpinned by the Financial Accountability Act 2009 (FAA) as well as the Financial and Performance Management Standard 2009 (FPMS).

Districts and Divisions are required to undertake an assessment of maintenance demands through an annual maintenance planning process. This is to ensure that District and Division buildings and site infrastructure are adequately maintained so as to meet their service requirements.

The completed assessment of maintenance demand must be prioritised and an Annual Maintenance Plan (AMP) prepared. The AMP is required to be lodged using the approved template by 30 June annually. To assist with the development of the AMP, a template is provided on the Policy Planning and Assets Services webpage located at: http://qheps.health.qld.gov.au/capital_works/policy_guidelines.htm.

Maintenance budget allocations are based upon the maintenance demand assessment, which is focused on maintenance only (i.e. specific to buildings and infrastructure), excluding expenditure on non-maintenance costs such as:

- energy and water;
- waste management;
- vehicles;
- telecommunications;
- minor / major capital works; and
- health technology maintenance.

To ensure QH sustains its maintenance and life cycle replacement funding needs, maintenance budget allocations will be quarantined for maintenance expenditure only and cannot be used for any other purposes.
Quarterly reports are provided by HPID to HIPEC on year to date maintenance activity against the approved AMP. Districts and Divisions must provide an updated report at February Mid-Year Review (MYR) on AMP progresses. Districts and Divisions must demonstrate improved outcomes against a number of target areas that are detailed under the Building and Infrastructure Maintenance (BIM) Key Performance Indicators (KPI). For the purpose of validating the BIM KPI, data is extracted and used from FAMMIS, Computerised Maintenance Management System (CMMS) and Panorama (DSS).

**3.6.6 Expenditure – Depreciation Treatment**

Depreciation – refer to Section 2.9.1 on page 52.
3.7 Income Statement - Non Operating - Inflows / Outflows

The non operating segment of the internal Income Statement is comprised of two sections being Inflows and Outflows. The difference between Operating and Non Operating relates to the respective funding sources for each segment. The Operating segment of the internal Income Statement is funded by Operating Revenue sources such as State and Commonwealth Output Revenue, Grants and Contributions, Own Source Revenue (User Charges and Other) and Internal Fee-for-Service. The Non Operating segment of the internal Income Statement is funded by Non Operating Inflows either provided as a Capital Allocation or as a Rollover.

3.7.1 Non Operating Inflows

3.7.1.1 Capital Allocation (State Funded)

All capital needs are not met by programs managed by Health Planning and Investment Division (HPID) and the Information Division (ID) with (i) new services starting from operating funding with no allocation for equipment (ii) urgent and unplanned acquisition needs (e.g. end of life critical equipment requirements), or (iii) leasehold improvements.

Capital allocations are made to provide areas with the ability to meet unmet needs. It should be noted that at present not all Corporate Divisions have been provided with a capital allocation.

Capital allocation is a non-operating inflow. Further detail in relation to capital allocations can be found in 2.8.4 Capital Allocations – Treatments.

3.7.1.2 Rollovers

Rollovers are Non Operating Inflows and they represent unspent Operating Revenue from a previous financial year. Rollovers are internal to QH and as such do not have a true source of funding. Rollovers are only provided in strictly limited circumstances and these are detailed as follows:

- Trust Fund Rollovers
  
  This represents trust fund revenues that remain unspent from a previous financial year. Trust funds are governed by the General Trust Fund Policy (GTFP) and from a statutory perspective must be re-provided. There are strict and specific rules governing trusts. Trust funds must be spent in accordance with the purpose for which they were provided. They are monitored closely, and receipting of non trust revenues as trust is strictly prohibited. Trust funds are the only inflow that has an actual posting. Actual inflows are posted as a trust opening balance with budgets being loaded against the rollover trust line item. Both actuals and budgets relating to trust fund inflows are loaded by Finance Branch.

- Commonwealth Rollovers

Since 2009-10 Commonwealth rollovers are no longer automatically re-provided in the subsequent year. As of 2010-11 there will be no Commonwealth rollovers provided for unspent operating Commonwealth funds. (Refer to Section 3.5.4.4 Unspent Commonwealth Funds - regarding the process for unspent Commonwealth funds.) Districts and Divisions need to ensure that Commonwealth Programs are not overspent (refer to the exceptions to this rule, Section 3.5.3 Commonwealth Reporting). If corrections for Commonwealth overspends have not been made prior to the ledger closing at the end of the financial year (i.e. Commonwealth overspends have not been transferred to a State cost centre), negative rollovers will be carried forward into the new financial year to be offset against new funds (or if there are no new funds, a correcting journal against a State cost centre will be required to be completed in the new financial year). For capital Commonwealth rollovers, as long as the DoHA is in agreement with the
rolling of unspent funds and the funds were clearly identified and receipted as capital funds, there are no issues with rolling unspent capital funds from one year to the next as they are recorded in the Capital Allocations Plan (CAP).

- **State Research Rollovers**

  This represents unspent research revenues that relate to commercial and non commercial clinical trials. The significant build up of funds associated with research can reflect issues with attributing research costs against research revenue. Costs associated with research must be monitored closely.

  All budgets associated with inflows are loaded by Corporate Office. State based rollovers, whether they relate to capital allocations or operating, are strictly not provided.

### 3.7.2 Non Operating Outflows

There is only one type of non operating outflow, and that relates to capital acquisitions. In relation to Districts and Divisions this is capital acquisitions funded through the District and Divisions capital allocation. Capital acquisitions are recorded when the asset is receipted or in relation to projects when costs are capitalised (that is when they are transferred to work in progress). Commissioning of work in progress is not recognised as a capital acquisition. Districts and Divisions need to manage acquisitions carefully and ensure a high priority is placed upon asset replacement. Capital funds should not be committed to acquire new assets unless there is certainty that all asset replacement needs have been met, or the acquisition has been specifically funded from Commonwealth, Trust or Research funding sources. Outflow budgets are to be loaded by Districts and Divisions, and there are specific rules which are detailed as follows:

- **Capital Acquisitions - Account 191000 ‘Asset Purchases – Budget Only’**

  Capital acquisition budgets must be loaded by Districts and Divisions and must reconcile to the capital allocation inflow figure. Districts and Divisions must adhere to the capital allocation budget and not exceed it. Capital overspends are no less important than operating overspends and both will be monitored closely.

- **Capital Acquisition Rollovers - Account 577441 ‘Planning – Capital Non-State Rollover Plan’**

  A new account code entitled Capital Rollover Non-State has been created for the purposes of loading outflow budgets. This outflow account relates specifically to rollover inflows (refer Section 3.7.1.2 Rollovers) associated with Research, Commonwealth and Trust funds that are not to be used for operating purposes (e.g. if a District has unspent Commonwealth funds that were provided for FTE these funds cannot be used for capital purposes).

  As defined in Section 3.7.1.2 Rollovers State based capital allocation rollovers are normally not re-provided (e.g. if a District has unspent capital allocation inflows from a previous financial year they will not be re-provided).

  In determining whether rollover inflows are to be loaded as an expense or outflow budget, Districts and Divisions must first determine whether the inflow is to be used for funding operating expenses or non operating outflows (i.e. capital acquisitions). If the purpose of the rollover, for example, was to fund employees, the budget should be loaded as an operating expense. Once a determination regarding the level of operating expenses to be funded has been made, the balance of rollover funding should be loaded as an outflow.

  This account code is used for budgeting purposes only, and has been purposefully kept separate from the regular capital acquisition account codes. It is important to isolate rollover budgets in the non operating segment since, when included within capital acquisition budgets, it potentially distorts the true capital position of a District or Division. (In other words, a District or Division could overspend its State capital allocation however this could be hidden by capital rollovers that are not available to offset this overspend).
A number of Districts have significant rollover balances that can only be used for purchases directly attributable to their purpose. These rollovers cannot be used to offset or conceal regular untied capital acquisitions.

Districts and Divisions can confirm that they have loaded budgets correctly, as the net position of operating and non operating budgets should be zero. Operating revenues plus inflows less operating expenses plus outflows should be equal to zero. If this is not the case, there has been an error in the budget load.
3.8 Compliance and Reconciliations

There are a number of compliance and reconciliation requirements to assist in the effective management of the Districts, Divisions and QH Corporately. The following items have priority:

3.8.1 Cash Management – Daily Position Reporting

Cash balances are managed on a departmental basis and form part of the Whole of Government cash balance (excluding General Trust and Patient Trust balances). The Government cash management administration process requires that forecast dollar inflows and dollar outflows are to be submitted daily, so that the Government can maximise its interest returns on these funds. Penalties are applied departmentally where these forecasts substantially vary to actual positions and those costs may be passed onto the area contributing to the variance where due notice was not provided in relation to outgoings.

It is important therefore that the Districts and Shared Service Providers (SSP) Accounts Receivable or Accounts Payable Officers notify the Cash Management Office (Finance Business Centre, QHSSP) when it is expected that daily transactions for revenue or expenditure are likely to or will exceed $50,000. An email address has been set up at “cash management @health.qld.gov.au” and daily advices should be emailed to that address.

To meet Queensland Treasury timeframes notifications or advices in daily transactions exceeding $50,000 should be submitted to Cash Management by 2:30 pm.

Details of any cheques drawn for large amounts (> $50,000) should also be provided on the day, to the Cash Management Officer.

3.8.2 Reconciliations – FAMMIS to Panorama (DSS)

A reconciliation is performed each month to ensure that the general ledger information as recorded in Panorama (DSS) equates to GL information in FAMMIS. The reconciliation undertaken by the Finance Branch covers only profit and loss accounts as not all balance sheet accounts are recorded in DSS.

To perform the reconciliation, data is exported from both FAMMIS and Panorama (DSS) to an MS Excel spreadsheet template. The data from the two systems is compared to ensure accuracy and completeness.

Any anomalies or mismatches identified are referred to the relevant area for investigation and resolution (e.g. cost centres not reported in the Alt_7 hierarchy, account codes not recorded in PR_Income accounts and account balance differences).

3.8.3 Reconciliation of QH Funding to Budget Build

A reconciliation is performed between the internally allocated budget and the departmental revenue estimates each time an Income Statement is released. The reconciliation compares the budgets allocated via the budget database with the revenue estimates for the revenue categories of Output Revenue, Grants and Contributions, User Charges and Other Revenue. Any variations are investigated and documented. There is also a reconciliation performed at the end of the financial year between actual revenue allocations and the total revenue received by the Districts and Divisions for the twelve (12) month period.
4 ACRONYMS AND GLOSSARY OF TERMS

Acronyms are terms used so often that they begin to be abbreviated and the frequent users becomes familiar with that shortened reference because they are easy to use, but others new to the area, branch or unit, or other stakeholders are not so familiar and need a guide hence the acronyms listing included here.

4.1 Acronyms Listing

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Title in Full</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABF</td>
<td>Activity Based Funding</td>
</tr>
<tr>
<td>ABFM</td>
<td>Activity Based Funding Model</td>
</tr>
<tr>
<td>ADL</td>
<td>Activity of Daily Living</td>
</tr>
<tr>
<td>AHCA</td>
<td>Australian Healthcare Agreement</td>
</tr>
<tr>
<td>AL</td>
<td>Annual Leave</td>
</tr>
<tr>
<td>ALCS</td>
<td>Annual Leave Central Scheme</td>
</tr>
<tr>
<td>ALOS</td>
<td>Average Length of Stay</td>
</tr>
<tr>
<td>AN-SNAP</td>
<td>Australian National Sub and Non-Acute Patient</td>
</tr>
<tr>
<td>AMP</td>
<td>Annual Maintenance Plan</td>
</tr>
<tr>
<td>ARC</td>
<td>Australian Research Centre</td>
</tr>
<tr>
<td>ARDRG</td>
<td>Australian Refined Diagnosis Related Groups</td>
</tr>
<tr>
<td>ASDS</td>
<td>Agent Service Delivery Statements</td>
</tr>
<tr>
<td>BIM</td>
<td>Building Infrastructure Maintenance</td>
</tr>
<tr>
<td>BAM</td>
<td>Business Analysis and Management</td>
</tr>
<tr>
<td>BARA</td>
<td>Beds Availability Reporting Application</td>
</tr>
<tr>
<td>BaSS</td>
<td>Business and Support Services</td>
</tr>
<tr>
<td>BFTE</td>
<td>Budgeted Full Time Equivalent</td>
</tr>
<tr>
<td>BIM</td>
<td>Building and Infrastructure Maintenance</td>
</tr>
<tr>
<td>BP3</td>
<td>Budget Paper Number 3</td>
</tr>
<tr>
<td>BPF</td>
<td>Business Planning Framework</td>
</tr>
<tr>
<td>CaSS</td>
<td>Clinical and State-wide Services</td>
</tr>
<tr>
<td>CAP</td>
<td>Capital Acquisition Plan</td>
</tr>
<tr>
<td>CBRC</td>
<td>Cabinet Budget Review Committee</td>
</tr>
<tr>
<td>Acronym</td>
<td>Title in Full</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>CCU</td>
<td>Coronary Care Unit</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CFM</td>
<td>Casemix Funding Model</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Finance Officer</td>
</tr>
<tr>
<td>CFUA</td>
<td>Commonwealth Funding Unit Agreement</td>
</tr>
<tr>
<td>CHF</td>
<td>Centrally Held Funds</td>
</tr>
<tr>
<td>CMMS</td>
<td>Computerised Maintenance Management System</td>
</tr>
<tr>
<td>CPIP</td>
<td>Clinical Practice Improvement Payment</td>
</tr>
<tr>
<td>CSCF</td>
<td>Clinical Services Capability Framework</td>
</tr>
<tr>
<td>DCU</td>
<td>Data Collection Unit</td>
</tr>
<tr>
<td>DED</td>
<td>Deputy Executive Director</td>
</tr>
<tr>
<td>DFU</td>
<td>District Finance Unit</td>
</tr>
<tr>
<td>DG</td>
<td>Director-General</td>
</tr>
<tr>
<td>DoHA</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnostic Related Groups</td>
</tr>
<tr>
<td>DSMP</td>
<td>District Strategic Maintenance Plan</td>
</tr>
<tr>
<td>DSS</td>
<td>Decision Support System</td>
</tr>
<tr>
<td>DVA</td>
<td>Department of Veterans’ Affairs</td>
</tr>
<tr>
<td>EBA</td>
<td>Enterprise Bargaining Agreement</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EMT</td>
<td>Executive Management Team</td>
</tr>
<tr>
<td>FAA</td>
<td>Financial Accountability Act 2009</td>
</tr>
<tr>
<td>FAT</td>
<td>Financial Accounting Team</td>
</tr>
<tr>
<td>FAMMIS</td>
<td>Finance and Materials Management Information System</td>
</tr>
<tr>
<td>FPMS</td>
<td>Financial and Performance Management Standard</td>
</tr>
<tr>
<td>FMPM</td>
<td>Financial Management Practice Manual</td>
</tr>
<tr>
<td>FPL</td>
<td>Finance, Procurement &amp; Legal Services</td>
</tr>
<tr>
<td>FSC</td>
<td>Finance Sub-Committee</td>
</tr>
<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
</tr>
<tr>
<td>Acronym</td>
<td>Title in Full</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>GTF</td>
<td>General Trust Funds</td>
</tr>
<tr>
<td>GTFP</td>
<td>General Trust Funds Policy</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>HBCIS</td>
<td>Hospital Based Corporate Information System</td>
</tr>
<tr>
<td>HCHSP</td>
<td>High Cost Home Support Program</td>
</tr>
<tr>
<td>HIPEC</td>
<td>Health Infrastructure and Project Executive Committee</td>
</tr>
<tr>
<td>HITH</td>
<td>Hospital in the Home</td>
</tr>
<tr>
<td>HPID</td>
<td>Health Planning and Infrastructure Division</td>
</tr>
<tr>
<td>HQI</td>
<td>HOMER – Health Queensland Interface</td>
</tr>
<tr>
<td>HSD</td>
<td>Health Service District</td>
</tr>
<tr>
<td>HTER</td>
<td>Health Technology and Equipment Replacement</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communication Technology</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>ID</td>
<td>Information Division</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>LOS</td>
<td>Length of Stay</td>
</tr>
<tr>
<td>LSL</td>
<td>Long Service Leave</td>
</tr>
<tr>
<td>LSLCS</td>
<td>Long Service Leave Central Scheme</td>
</tr>
<tr>
<td>LSLS</td>
<td>Long Service Leave Scheme</td>
</tr>
<tr>
<td>MAC</td>
<td>Monthly Activity Collection</td>
</tr>
<tr>
<td>MAIC</td>
<td>Motor Vehicle Accident and Insurance Claims</td>
</tr>
<tr>
<td>MaSS</td>
<td>Medical Aid and Subsidy Scheme</td>
</tr>
<tr>
<td>MCAP</td>
<td>Minor Capital Acquisition Plan</td>
</tr>
<tr>
<td>MFO</td>
<td>Managing For Outcomes</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>MTD</td>
<td>Month to Date</td>
</tr>
<tr>
<td>MMF</td>
<td>Maintenance Management Framework</td>
</tr>
<tr>
<td>MPS</td>
<td>Ministerial Portfolio Statement</td>
</tr>
<tr>
<td>MSQ</td>
<td>Medications Services Queensland</td>
</tr>
<tr>
<td>Acronym</td>
<td>Title in Full</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>MYR</td>
<td>Mid Year Review</td>
</tr>
<tr>
<td>NCAP</td>
<td>Non-Current Capital Asset Program</td>
</tr>
<tr>
<td>NDRRA</td>
<td>Natural Disaster Relief and Recovery Agreement</td>
</tr>
<tr>
<td>NHA</td>
<td>National Healthcare Agreement</td>
</tr>
<tr>
<td>NHCDC</td>
<td>National Hospital Cost Data Collection</td>
</tr>
<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>NPA</td>
<td>National Partnership Agreement</td>
</tr>
<tr>
<td>NPP</td>
<td>National Partnership Program</td>
</tr>
<tr>
<td>NPAHHQR</td>
<td>National Partnership Agreement on Hospital and Health Workforce Reform</td>
</tr>
<tr>
<td>NPFP</td>
<td>Non-Population Funding Pool</td>
</tr>
<tr>
<td>OSR</td>
<td>Own Source Revenue</td>
</tr>
<tr>
<td>PBA</td>
<td>Post Budget Adjustment</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
</tr>
<tr>
<td>PMF</td>
<td>Performance Management Framework</td>
</tr>
<tr>
<td>PSO</td>
<td>Patient Safety Officer</td>
</tr>
<tr>
<td>PPH</td>
<td>Potential Preventable Hospitalisation</td>
</tr>
<tr>
<td>PSQ</td>
<td>Patient Safety and Quality Improvement Service</td>
</tr>
<tr>
<td>PSR</td>
<td>Policy Strategy and Resourcing Division</td>
</tr>
<tr>
<td>QABFC</td>
<td>Queensland Activity Based Funding Committee</td>
</tr>
<tr>
<td>QABFM</td>
<td>Queensland Activity Based Funding Model</td>
</tr>
<tr>
<td>QCMP</td>
<td>Workers’ Compensation</td>
</tr>
<tr>
<td>QGIF</td>
<td>Queensland Government Insurance Fund</td>
</tr>
<tr>
<td>QH</td>
<td>Queensland Health</td>
</tr>
<tr>
<td>QHAPDC</td>
<td>Queensland Hospital Admitted Patient Data Collection</td>
</tr>
<tr>
<td>QHEMT</td>
<td>Queensland Health Executive Management Team</td>
</tr>
<tr>
<td>QHEPS</td>
<td>Queensland Health Electronic Publishing System</td>
</tr>
<tr>
<td>QHSSSP</td>
<td>Queensland Health Share Service Provider</td>
</tr>
<tr>
<td>QT</td>
<td>Queensland Treasury</td>
</tr>
<tr>
<td>QTC</td>
<td>Queensland Treasury Corporation</td>
</tr>
<tr>
<td>Acronym</td>
<td>Title in Full</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>REC</td>
<td>Resource Executive Committee</td>
</tr>
<tr>
<td>SATR</td>
<td>Outpatients Performance Reporting Database</td>
</tr>
<tr>
<td>SDS</td>
<td>Service Delivery Statement</td>
</tr>
<tr>
<td>SNAP</td>
<td>Sub and Non-Acute Patient</td>
</tr>
<tr>
<td>SOSRU</td>
<td>Statewide Own Source Revenue Unit</td>
</tr>
<tr>
<td>SPP</td>
<td>Specific Purpose Payment</td>
</tr>
<tr>
<td>SSP</td>
<td>Shared Service Provider</td>
</tr>
<tr>
<td>SSG</td>
<td>Site Specific Grants</td>
</tr>
<tr>
<td>TII</td>
<td>Transition II (a Sunrise Decision Support System program)</td>
</tr>
<tr>
<td>WAU</td>
<td>Weighted Activity Unit</td>
</tr>
<tr>
<td>WOG</td>
<td>Whole of Government</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>
### 4.2 Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning of Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Node</td>
<td>Node is the name of a structure or line under which a cost centre or series of cost centres sit, which roll up through the structure with all nodes ending up sitting under a main hierarchy name (i.e. Alt 7, Alt 2)</td>
</tr>
<tr>
<td>Per Diem</td>
<td>Per Day</td>
</tr>
<tr>
<td>Phasing</td>
<td>Allocation of Costs over a twelve month period</td>
</tr>
<tr>
<td>PR_Income</td>
<td></td>
</tr>
</tbody>
</table>
## 4.3 Key Finance Branch Contacts

<table>
<thead>
<tr>
<th>Group</th>
<th>Contact</th>
<th>Contact No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Analysis &amp; Management</td>
<td>Senior Director</td>
<td>(07) 3234 0267</td>
</tr>
<tr>
<td>Portfolio Teams</td>
<td>Director</td>
<td>(07) 3234 1881</td>
</tr>
<tr>
<td>Portfolio Green Team</td>
<td></td>
<td>(07) 3237 4853</td>
</tr>
<tr>
<td>Portfolio Purple Team</td>
<td></td>
<td>(07) 3224 8279</td>
</tr>
<tr>
<td>Financial Reform &amp; Analysis</td>
<td>Director</td>
<td>(07) 3224 7856</td>
</tr>
<tr>
<td>Reporting &amp; Analysis</td>
<td>Manager</td>
<td>(07) 3405 6130</td>
</tr>
<tr>
<td>Policy Development and Guidelines</td>
<td>Manager</td>
<td>(07) 3234 1799</td>
</tr>
<tr>
<td>Internal Allocation</td>
<td>Principle Finance Officer</td>
<td>(07) 3006 2876</td>
</tr>
<tr>
<td>Modelling and Costing</td>
<td>Manager</td>
<td>(07) 3895 3173</td>
</tr>
<tr>
<td>Financial Analysis &amp; Strategy</td>
<td>Director</td>
<td>(07) 3234 1876</td>
</tr>
</tbody>
</table>
5 APPENDIX

5.1 2011/12 Funding Model Price

2011/12 Funding Model Price Tables are found at the following link: http://abf.health.qld.gov.au/ABF/Details/118
### 5.2 Clinical Education

#### 5.2.1 Table 1 Clinical Education Funding by District/Facility 2011/12

<table>
<thead>
<tr>
<th>District</th>
<th>Facility</th>
<th>Salaried employees ($)</th>
<th>Clinical academics ($)</th>
<th>Health Practitioner ($)</th>
<th>Dental ($)</th>
<th>Medical ($)</th>
<th>Nursing ($)</th>
<th>Total ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cairns and Hinterland</td>
<td>Atherton Hospital</td>
<td>709,147</td>
<td>18,729</td>
<td>2,690</td>
<td>67,830</td>
<td>26,264</td>
<td></td>
<td>824,661</td>
</tr>
<tr>
<td>Cairns Base Hospital</td>
<td>8,702,680</td>
<td>229,845</td>
<td>31,855</td>
<td>80,228</td>
<td>357,029</td>
<td>70,522</td>
<td></td>
<td>9,472,158</td>
</tr>
<tr>
<td>Innisfail Hospital</td>
<td>224,480</td>
<td>5,929</td>
<td>618</td>
<td>23,717</td>
<td>8,735</td>
<td>263,479</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mareeba Hospital</td>
<td>214,921</td>
<td>5,676</td>
<td>3,469</td>
<td></td>
<td></td>
<td></td>
<td>33,026</td>
<td>257,093</td>
</tr>
<tr>
<td>Cairns and Hinterland Total</td>
<td>9,851,228</td>
<td>260,179</td>
<td>38,633</td>
<td>80,228</td>
<td>448,576</td>
<td>138,547</td>
<td></td>
<td>10,817,391</td>
</tr>
<tr>
<td>Central Qld</td>
<td>Gladstone Hospital</td>
<td>789,442</td>
<td>20,860</td>
<td>309</td>
<td>134,328</td>
<td>944,929</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rockhampton Base Hospital</td>
<td>6,450,691</td>
<td>170,368</td>
<td>3,407</td>
<td>66,188</td>
<td>444,204</td>
<td>279,751</td>
<td>7,414,609</td>
</tr>
<tr>
<td>Central Qld Total</td>
<td>7,240,133</td>
<td>191,218</td>
<td>3,716</td>
<td>66,188</td>
<td>578,532</td>
<td>279,751</td>
<td></td>
<td>8,359,538</td>
</tr>
<tr>
<td>Children's Health Services</td>
<td>Royal Children's Hospital</td>
<td>6,164,303</td>
<td>162,804</td>
<td>24,530</td>
<td>444,204</td>
<td>86,666</td>
<td></td>
<td>6,882,507</td>
</tr>
<tr>
<td>Children's Health Services Total</td>
<td>6,164,303</td>
<td>162,804</td>
<td>24,530</td>
<td>444,204</td>
<td>86,666</td>
<td></td>
<td></td>
<td>6,882,507</td>
</tr>
<tr>
<td>Darling Downs-West Moreton</td>
<td>Ipswich Hospital</td>
<td>6,885,284</td>
<td>181,840</td>
<td>37,476</td>
<td>291,599</td>
<td>293,997</td>
<td></td>
<td>7,656,111</td>
</tr>
<tr>
<td></td>
<td>Toowoomba Hospital</td>
<td>6,680,153</td>
<td>176,425</td>
<td>66,605</td>
<td>672,969</td>
<td>129,361</td>
<td></td>
<td>7,725,516</td>
</tr>
<tr>
<td></td>
<td>Warwick Hospital</td>
<td>324,560</td>
<td>8,572</td>
<td>7,781</td>
<td>206,968</td>
<td>37,969</td>
<td></td>
<td>584,840</td>
</tr>
<tr>
<td>Darling Downs-West Moreton Total</td>
<td>13,899,996</td>
<td>366,846</td>
<td>111,862</td>
<td>1,170,447</td>
<td>427,316</td>
<td></td>
<td>15,966,467</td>
<td></td>
</tr>
<tr>
<td>Gold Coast</td>
<td>Gold Coast Hospital</td>
<td>21,164,874</td>
<td>558,881</td>
<td>59,450</td>
<td>133,880</td>
<td>458,641</td>
<td>240,030</td>
<td>22,615,857</td>
</tr>
<tr>
<td>Gold Coast Total</td>
<td>21,164,874</td>
<td>558,881</td>
<td>59,450</td>
<td>133,880</td>
<td>458,641</td>
<td>240,030</td>
<td></td>
<td>22,615,857</td>
</tr>
<tr>
<td>Mackay</td>
<td>Mackay Base Hospital</td>
<td>4,905,867</td>
<td>129,568</td>
<td>10,732</td>
<td>12,034</td>
<td>13,326</td>
<td>293,134</td>
<td>5,364,861</td>
</tr>
<tr>
<td>Mackay Total</td>
<td>4,905,867</td>
<td>129,568</td>
<td>10,732</td>
<td>12,034</td>
<td>13,326</td>
<td>293,134</td>
<td></td>
<td>5,364,861</td>
</tr>
<tr>
<td>Mater Public Hospitals Total</td>
<td>178,862</td>
<td>1,432,003</td>
<td>142,743</td>
<td></td>
<td></td>
<td></td>
<td>1,753,608</td>
<td></td>
</tr>
</tbody>
</table>

Under-graduate and post-graduate student clinical placements
<table>
<thead>
<tr>
<th>District</th>
<th>Facility</th>
<th>Salaried employees ($)</th>
<th>Clinical academics ($)</th>
<th>Health Practitioner ($)</th>
<th>Dental ($)</th>
<th>Medical ($)</th>
<th>Nursing ($)</th>
<th>Total ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro North</td>
<td>Caboolture Hospital</td>
<td>3,256,648</td>
<td>86,011</td>
<td>7,666</td>
<td>26,575</td>
<td>123,822</td>
<td>80,506</td>
<td>3,581,227</td>
</tr>
<tr>
<td></td>
<td>Redcliffe Hospital</td>
<td>5,196,076</td>
<td>137,233</td>
<td>32,877</td>
<td>26,575</td>
<td>310,943</td>
<td>140,194</td>
<td>5,843,898</td>
</tr>
<tr>
<td></td>
<td>Royal Brisbane and Women's Hospital</td>
<td>29,350,194</td>
<td>775,162</td>
<td>87,886</td>
<td>228,649</td>
<td>2,826,248</td>
<td>935,691</td>
<td>34,203,843</td>
</tr>
<tr>
<td></td>
<td>The Prince Charles Hospital</td>
<td>11,060,433</td>
<td>291,851</td>
<td>127,077</td>
<td>26,575</td>
<td>774,025</td>
<td>290,506</td>
<td>12,542,892</td>
</tr>
<tr>
<td>Metro North Total</td>
<td></td>
<td>48,853,351</td>
<td>1,290,256</td>
<td>255,518</td>
<td>281,800</td>
<td>4,035,038</td>
<td>1,455,897</td>
<td>56,171,860</td>
</tr>
<tr>
<td>Metro South</td>
<td>Logan Hospital</td>
<td>9,203,697</td>
<td>243,077</td>
<td>133,880</td>
<td>346,479</td>
<td>122,351</td>
<td>10,049,485</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Princess Alexandra Hospital</td>
<td>26,724,443</td>
<td>705,814</td>
<td>244,786</td>
<td>1,962,271</td>
<td>525,729</td>
<td>30,163,043</td>
<td></td>
</tr>
<tr>
<td></td>
<td>QEII Hospital</td>
<td>4,041,471</td>
<td>106,738</td>
<td>46,504</td>
<td>378,074</td>
<td>1,142,159</td>
<td>135,946</td>
<td>5,850,803</td>
</tr>
<tr>
<td></td>
<td>Redland Hospital</td>
<td>3,123,197</td>
<td>82,486</td>
<td>27,937</td>
<td>26,575</td>
<td>314,274</td>
<td>57,989</td>
<td>3,632,459</td>
</tr>
<tr>
<td>Metro South Total</td>
<td></td>
<td>43,092,809</td>
<td>1,138,116</td>
<td>319,227</td>
<td>538,530</td>
<td>3,765,184</td>
<td>842,016</td>
<td>49,695,880</td>
</tr>
<tr>
<td>Mt Isa</td>
<td>Mount Isa Hospital</td>
<td>1,632,696</td>
<td>43,121</td>
<td>10,761</td>
<td>202,215</td>
<td>33,330</td>
<td>1,922,123</td>
<td></td>
</tr>
<tr>
<td>Mt Isa Total</td>
<td></td>
<td>1,632,696</td>
<td>43,121</td>
<td>10,761</td>
<td>202,215</td>
<td>33,330</td>
<td>1,922,123</td>
<td></td>
</tr>
<tr>
<td>Sunshine Coast</td>
<td>Caloundra Hospital</td>
<td>541,332</td>
<td>14,297</td>
<td>5,195</td>
<td>51,473</td>
<td>44,776</td>
<td>57,304</td>
<td>714,467</td>
</tr>
<tr>
<td></td>
<td>Gympie Hospital</td>
<td>720,662</td>
<td>19,033</td>
<td>2,726</td>
<td>38,106</td>
<td>56,636</td>
<td>25,490</td>
<td>862,665</td>
</tr>
<tr>
<td></td>
<td>Nambour Hospital</td>
<td>9,088,805</td>
<td>240,043</td>
<td>39,009</td>
<td>76,216</td>
<td>721,831</td>
<td>84,117</td>
<td>10,250,021</td>
</tr>
<tr>
<td>Sunshine Coast Total</td>
<td></td>
<td>10,350,799</td>
<td>273,373</td>
<td>46,929</td>
<td>165,798</td>
<td>823,243</td>
<td>167,000</td>
<td>11,827,143</td>
</tr>
<tr>
<td>Townsville</td>
<td>Townsville Hospital</td>
<td>16,214,261</td>
<td>428,232</td>
<td>125,033</td>
<td>100,285</td>
<td>722,942</td>
<td>413,573</td>
<td>18,004,326</td>
</tr>
<tr>
<td>Townsville Total</td>
<td></td>
<td>16,214,261</td>
<td>428,232</td>
<td>125,033</td>
<td>100,285</td>
<td>722,942</td>
<td>413,573</td>
<td>18,004,326</td>
</tr>
<tr>
<td>Wide Bay</td>
<td>Bundaberg Hospital</td>
<td>2,904,972</td>
<td>76,723</td>
<td>17,375</td>
<td>264,301</td>
<td>83,267</td>
<td>3,346,638</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Harvey Bay Hospital</td>
<td>2,488,805</td>
<td>65,731</td>
<td>3,066</td>
<td>222,102</td>
<td>66,823</td>
<td>2,948,527</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maryborough Hospital</td>
<td>562,374</td>
<td>14,663</td>
<td>9,282</td>
<td>241,799</td>
<td>30,691</td>
<td>858,989</td>
<td></td>
</tr>
<tr>
<td>Wide Bay Total</td>
<td></td>
<td>5,966,151</td>
<td>157,307</td>
<td>29,723</td>
<td>728,194</td>
<td>182,786</td>
<td>7,054,155</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>189,316,470</td>
<td>5,000,000</td>
<td>1,214,975</td>
<td>1,378,743</td>
<td>14,822,545</td>
<td>4,702,784</td>
<td>216,435,517</td>
</tr>
</tbody>
</table>
### 5.2.2 Table 2 Graduate Funding 2011/12

<table>
<thead>
<tr>
<th>Activity</th>
<th>Graduate Posting</th>
<th>Percentage of base salary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Intern (01)</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Medical Junior House Off (01)</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Medical PHO (01)</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>Medical PHO (02)</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td>Medical PHO (03)</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>Medical PHO (04)</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>Medical Registrar PHO (01)</td>
<td>37%</td>
</tr>
<tr>
<td></td>
<td>Medical Registrar PHO (02)</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>Medical Registrar PHO (03)</td>
<td>32%</td>
</tr>
<tr>
<td></td>
<td>Medical Registrar PHO (04)</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>Medical Registrar PHO (05)</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>Medical Registrar PHO (06)</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>House Medical Senior Ho Off (01)s</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Nursing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enrolled Nurse (01)</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Enrolled Nurse (02)</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>Nurse Officer 1 qphs (1)</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Nurse Officer 1 qphs (2)</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>Nurse Officer 1 Re-Entry</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Nurse Officer Level 1 (1)</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Nurse Officer Level 1 (2)</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Health Practitioner/Professional</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Practitioner HP3 Pharmacy Graduate Trainee</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>Health Practitioner 72.5hr HP3 Pre Reg</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Health Practitioner 72.5hr HP3 (1)</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>Health Practitioner HP3 Pre Reg</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Health Practitioner HP3 (1)</td>
<td>30%</td>
</tr>
</tbody>
</table>

### 5.2.3 Table 3 Undergraduate Funding 2011/12

<table>
<thead>
<tr>
<th>Activity</th>
<th>Price per Student Week ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Professional</strong></td>
<td>$50 plus the funding allocated to meet the requirements of s38.4 of the Health Practitioners (Queensland Health) Certified Agreement (No. 1) 2007</td>
</tr>
<tr>
<td></td>
<td>$125.00</td>
</tr>
<tr>
<td><strong>Dentistry</strong></td>
<td>$371.20</td>
</tr>
<tr>
<td><strong>Medical</strong></td>
<td>$369.40</td>
</tr>
<tr>
<td><strong>Nursing</strong></td>
<td>$139.90</td>
</tr>
</tbody>
</table>
## 5.3 Category C WAU Targets

<table>
<thead>
<tr>
<th></th>
<th>2011 - 2012 Targets</th>
<th></th>
<th>Full Year Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DVA</td>
<td>MAIC</td>
<td>WorkCover</td>
</tr>
<tr>
<td>Cairns and Hinterland</td>
<td>1599.58</td>
<td>359.07</td>
<td>395.81</td>
</tr>
<tr>
<td>Cape York</td>
<td>20.97</td>
<td>3.07</td>
<td>2.09</td>
</tr>
<tr>
<td>Central Queensland</td>
<td>739.35</td>
<td>347.05</td>
<td>531.90</td>
</tr>
<tr>
<td>Central West</td>
<td>49.15</td>
<td>0.82</td>
<td>5.55</td>
</tr>
<tr>
<td>Children’s Health Services</td>
<td>0.00</td>
<td>41.16</td>
<td>0.09</td>
</tr>
<tr>
<td>Darling Downs-West Moreton</td>
<td>1680.50</td>
<td>318.78</td>
<td>506.86</td>
</tr>
<tr>
<td>Gold Coast</td>
<td>964.07</td>
<td>1136.82</td>
<td>576.60</td>
</tr>
<tr>
<td>Mackay</td>
<td>618.50</td>
<td>233.47</td>
<td>314.70</td>
</tr>
<tr>
<td>Mater Public Hospitals</td>
<td>69.96</td>
<td>401.70</td>
<td>95.15</td>
</tr>
<tr>
<td>Metro North</td>
<td>5343.94</td>
<td>2599.14</td>
<td>1893.41</td>
</tr>
<tr>
<td>Metro South</td>
<td>1029.87</td>
<td>1851.17</td>
<td>1652.03</td>
</tr>
<tr>
<td>Mt Isa</td>
<td>62.13</td>
<td>26.24</td>
<td>107.12</td>
</tr>
<tr>
<td>South West</td>
<td>166.55</td>
<td>4.80</td>
<td>23.56</td>
</tr>
<tr>
<td>Sunshine Coast</td>
<td>2450.82</td>
<td>506.46</td>
<td>233.67</td>
</tr>
<tr>
<td>Torres Strait</td>
<td>6.01</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Townsville</td>
<td>1965.10</td>
<td>325.04</td>
<td>371.09</td>
</tr>
<tr>
<td>Wide Bay</td>
<td>1464.64</td>
<td>182.70</td>
<td>239.86</td>
</tr>
</tbody>
</table>

**Incentive Rate (3% Higher) for every additional WAU above the Overall Cat C Target**

| WAU Target Rate | $4,250.00 | $4,377.50 |
## 5.4 Depreciation Schedule 2011/12

<table>
<thead>
<tr>
<th>Division/District</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cairns and Hinterland District</td>
<td>16,625,246</td>
</tr>
<tr>
<td>Cape York District</td>
<td>3,828,767</td>
</tr>
<tr>
<td>Central Queensland District</td>
<td>11,166,157</td>
</tr>
<tr>
<td>Central West District</td>
<td>1,647,609</td>
</tr>
<tr>
<td>Centre for Healthcare Improvement</td>
<td>1,241,353</td>
</tr>
<tr>
<td>Chief Health Officer</td>
<td>8,448,053</td>
</tr>
<tr>
<td>Children's Health Services District</td>
<td>5,549,191</td>
</tr>
<tr>
<td>Clinical &amp; Statewide Services</td>
<td>20,127,568</td>
</tr>
<tr>
<td>Community Services Purchasing</td>
<td>2,789</td>
</tr>
<tr>
<td>Corporately Managed Budgets</td>
<td>57,465,476</td>
</tr>
<tr>
<td>Darling Downs District</td>
<td>14,529,900</td>
</tr>
<tr>
<td>West Moreton District</td>
<td>10,003,927</td>
</tr>
<tr>
<td>Finance Procurement and Legal Services Division</td>
<td>555,067</td>
</tr>
<tr>
<td>Gold Coast District</td>
<td>16,844,613</td>
</tr>
<tr>
<td>Health Planning and Infrastructure Division</td>
<td>496,947</td>
</tr>
<tr>
<td>Human Resources Services Division</td>
<td>866,383</td>
</tr>
<tr>
<td>Information Directorate</td>
<td>39,363,370</td>
</tr>
<tr>
<td>Mackay District</td>
<td>7,556,617</td>
</tr>
<tr>
<td>Metro North District</td>
<td>56,117,050</td>
</tr>
<tr>
<td>Metro South District</td>
<td>48,233,498</td>
</tr>
<tr>
<td>Metro South Statewide Services</td>
<td>137,706</td>
</tr>
<tr>
<td>Mt Isa District</td>
<td>2,993,195</td>
</tr>
<tr>
<td>Office of the Director-General</td>
<td>66,733</td>
</tr>
<tr>
<td>Performance and Accountability</td>
<td>206,118</td>
</tr>
<tr>
<td>Policy Strategy and Resourcing</td>
<td>2,577,168</td>
</tr>
<tr>
<td>South West District</td>
<td>4,170,404</td>
</tr>
<tr>
<td>Sunshine Coast District</td>
<td>11,976,868</td>
</tr>
<tr>
<td>Torres Strait-Northern Peninsula District</td>
<td>3,139,156</td>
</tr>
<tr>
<td>Townsville District</td>
<td>19,873,705</td>
</tr>
<tr>
<td>Wide Bay District</td>
<td>11,626,366</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>377,437,000</strong></td>
</tr>
</tbody>
</table>
## 5.5 State Budget Submission Dates 2012-13

<table>
<thead>
<tr>
<th>Actions</th>
<th>Notional timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Development of Concept Briefs</strong></td>
<td></td>
</tr>
<tr>
<td>Memoranda to EMT, Executive Committees and District Chief Executive Officers requesting targeted development of Concept Briefs</td>
<td>20 September 2011</td>
</tr>
<tr>
<td>Executive Committees, Divisions and Districts (in the context of three categories of funding bids) develop and endorse their respective Concept Briefs.</td>
<td>24 October 2011</td>
</tr>
<tr>
<td>Draft Concept Briefs submitted to SFU</td>
<td>25 October 2011</td>
</tr>
<tr>
<td>SFU review of Concept Briefs</td>
<td>From 25 October 2011</td>
</tr>
<tr>
<td>EMT consideration and prioritisation</td>
<td>7 November 2011</td>
</tr>
<tr>
<td><strong>2. Development of Short Form Funding Submission</strong></td>
<td></td>
</tr>
<tr>
<td>SFU request for development of initiatives for inclusion in Short Form Funding Submission, based on prioritised Concept Briefs</td>
<td>11 November 2011</td>
</tr>
<tr>
<td>Initiatives for inclusion in Short Form Funding Submission due to SFU</td>
<td>26 November 2011</td>
</tr>
<tr>
<td>EMT consideration of Short Form Funding Submission</td>
<td>6 December 2011</td>
</tr>
<tr>
<td>Minister for Health consideration and approval of Short Form Funding Submission</td>
<td>13 December 2011</td>
</tr>
<tr>
<td>Lodgement of Short Form Funding Submission with Cabinet Secretariat</td>
<td>Mid December 2011</td>
</tr>
<tr>
<td>Cabinet Budget Review Committee (CBRC) consideration of Short Form Funding Submissions</td>
<td>February 2012</td>
</tr>
<tr>
<td><strong>3. Development of Long Form Funding Submission</strong></td>
<td></td>
</tr>
<tr>
<td>Advice received from CBRC regarding development of Long Form Funding Submissions</td>
<td>February 2012</td>
</tr>
<tr>
<td>SFU request for development of initiatives for inclusion in Long Form Funding Submission</td>
<td>February 2012</td>
</tr>
<tr>
<td>Initiatives for inclusion in Long Form Funding Submission due to SFU</td>
<td>February 2012</td>
</tr>
<tr>
<td>EMT consideration of Long Form Funding Submission</td>
<td>February-March 2012</td>
</tr>
<tr>
<td>Minister for Health consideration and approval of Long Form Funding Submission</td>
<td>February-March 2012</td>
</tr>
<tr>
<td>Lodgement of Long Form Funding Submission with Cabinet Secretariat</td>
<td>February-March 2012</td>
</tr>
<tr>
<td>Cabinet Budget Review Committee (CBRC) consideration of Long Form Funding Submission</td>
<td>March-April 2012</td>
</tr>
</tbody>
</table>