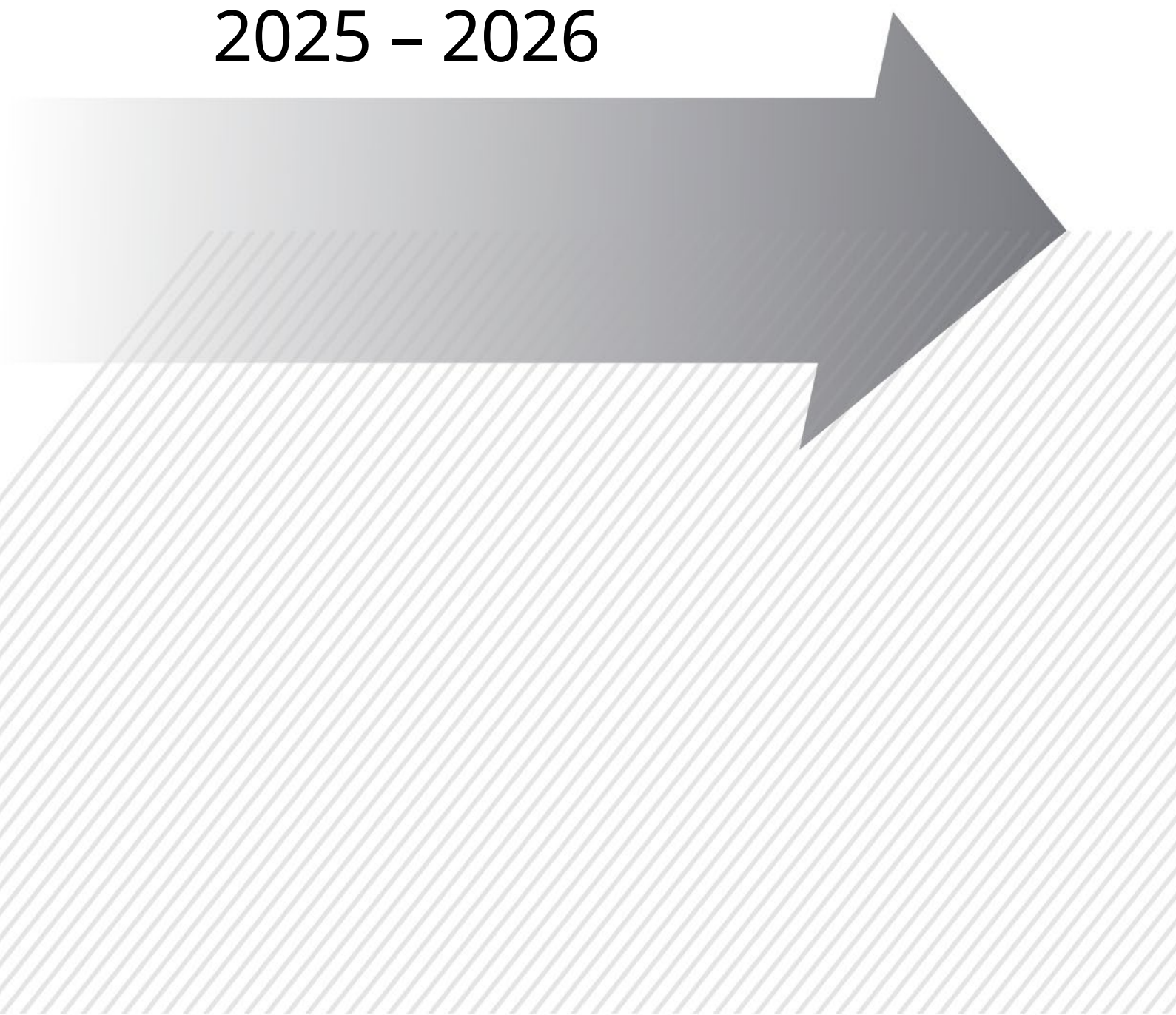


Townsville Hospital and Health Service

Annual Report

2025 – 2026



Information about consultancies, overseas travel, the Queensland Language Services Policy and the Charter of Victims' Rights is available at the Queensland Government Open Data website <https://www.data.qld.gov.au>

An electronic copy of this report is available at www.townsville.health.qld.gov.au and www.townsville.health.qld.gov.au/about-us/strategies-and-publications/



The Queensland Government is committed to providing accessible information and service to Queenslanders from all cultural and linguistic backgrounds. To talk to someone about the Townsville Hospital and Health Service Annual Report in your preferred language call 4433 1111 and ask to speak with the Interpreter Services team.

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Acknowledgement of Country

We acknowledge the Traditional and Cultural Custodians of the lands, waters and seas on which our health facilities are placed.

We pay our respects to Elders past and present and recognise the role of current and emerging leaders in shaping a better health system. We acknowledge First Nations peoples in north Queensland are both Aboriginal peoples and Torres Strait Islander peoples, and support the cultural knowledge, determination and commitment of Aboriginal and Torres Strait Islander communities in caring for the health and wellbeing of First Nations peoples for millennia.

The Townsville Hospital and Health Service is committed to honouring Aboriginal and Torres Strait Islander peoples' unique cultural and spiritual relationships to the land, waters, and seas and their rich contribution to society.

The Townsville Hospital and Health Service is proud to recognise and celebrate the cultural diversity of our communities and workforce at the following locations:

Location - Traditional Custodians

Townsville - Bindal (Birri Gubba) and Gurrumbilbarra Wulgurukaba

Palm Island - Manbarra and Bwgcolman (historical)

Ayr / Home Hill - Bindal/Juru (Birri Gubba)

Charters Towers - Gudjal

Ingham - Nywaigi Warrgamay Bandjin

Cardwell - Girramay

Richmond - Wanamara / Woolgar Valley

Hughenden - Yerunthully

Health Equity

The Townsville Hospital and Health Service is committed to delivering equitable access to high-quality healthcare for all.

We are actively working to build respectful, inclusive relationships with Aboriginal and Torres Strait Islander peoples and their communities. The Townsville Hospital and Health Service remains steadfast in its commitment to achieving health equity and life-expectancy parity for Aboriginal and Torres Strait Islander peoples by 2031, in alignment with national Closing the Gap targets.

Recognition of Australian South Sea Islanders

The Townsville Hospital and Health Service recognises Australian South Sea Islanders as a distinct cultural group within our geographical boundaries. The Townsville Hospital and Health Service is committed to fulfilling the Queensland Government Recognition Statement to ensure that present and future generations of Australian South Sea Islanders have equality of opportunity to participate in, and contribute to, the economic, social, political and cultural life of the state.

1 September 2026

The Honourable Timothy Nicholls MP
Minister for Health and Ambulance Services
GPO Box 48
Brisbane QLD 4001

Dear Minister

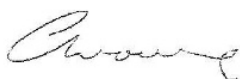
I am pleased to submit for presentation to the Parliament the Annual Report 2025-2026 and financial statements for the Townsville Hospital and Health Service.

I certify that this annual report complies with:

- the prescribed requirements of the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2019*; and
- the detailed requirements set out in the *Annual report requirements for Queensland Government agencies*.

A checklist outlining the annual reporting requirements is provided at page 100 of this annual report.

Yours sincerely



Tony Mooney AM FAICD
Chair
Townsville Hospital and Health Board

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Queensland Government objectives for the community

The *Townsville Hospital and Health Service Strategic Plan 2022-2026 (2025 review)* contributes, and is continuing to contribute, to the Queensland Government objectives for the community:

- Safety where you live
- Health services when you need them
- A better lifestyle through a stronger economy
- A plan for Queensland's future.

Restoring health services when Queenslanders need them most through:

- Transparent and targeted investment with real-time data
- Boosting frontline health services
- Driving resources where they're needed most
- Improving our EDs
- Reopening regional maternity wards
- Fast-tracking access to elective surgeries helping patients to be seen faster.

Message from the Board Chair

It is my pleasure and privilege to contribute this message to the Townsville Hospital and Health Service (HHS) Annual Report 2025-2026. This report acknowledges and celebrates the outstanding care the health service has delivered to hundreds of thousands of people and highlights our performance, innovation, service growth, and continuous improvement.

The capital expansion of Townsville University Hospital (TUH) has moved up several gears, following the Queensland Government's announcement of \$1.17 billion for the first stage of the Masterplan, enabling us to reach significant planning milestones that will deliver more beds and emergency capacity by 2029. The sod was turned on the new multi-storey car park, a transformative piece of infrastructure for patients, staff, and families which will contemporise our hospital, further positioning it as the tertiary facility for northern Australia.

Progress on the \$45 million Kirwan Health Campus over the past year will deliver a greater clinical footprint for ante-natal, post-natal, and dental care when the new build opens later this year. This project represents modern community healthcare at its finest with the new environment capturing the best in design, wayfinding, and aesthetic elements, codesigned with staff and consumers. My thanks to the project teams and consumers who have worked diligently together over many months to shape and deliver this project.

I'm very proud of what the health service achieved for individuals, families, and communities this year. The North Queensland Kidney Transplant Service performed its first transplant last October, the first transplant in Queensland outside the south-east corner and the first in a regional area. The Charters Towers CT service opened this year and is expected to perform around 2,000 scans annually while good progress continues toward the CT scanner for Ingham. Access to life-saving healthcare closer to home is a cornerstone of our service delivery.

We were delighted to welcome the Minister for Health, the Honourable Tim Nicholls, to our health service this year where he joined us to officially launch the North Queensland Pelvic Pain and Endometriosis Service. This service is funded under the Queensland Women and Girls Health Strategy to improve access to advanced, multidisciplinary pelvic pain and endometriosis services for women and girls across the state. It was a pleasure to meet 17-year-old Emily Walker who has lived with debilitating pelvic pain since she was 11. Emily described the service as a 'game changer' for our community. The Minister also announced the Midwifery Clinical Facilitator Program, an initiative to grow, strengthen, and maintain Queensland's midwifery workforce. This program gives experienced midwives the opportunity to harness their extensive skills and step into high-level clinical facilitator roles and mentor the next generation of midwives in their own communities.

This year we welcomed four new faces to the Board; Gerry Wyvill, Dr Craig Costello, Dallas Leon, and Kari Arbouin who bring a breadth of experience across emergency services, medicine, corporate healthcare management, and First Nations healthcare.

I would especially like to thank our three outgoing members Michelle Morton, Dr Erin Waters and Professor Kunwarjit Sangla. As a GP and director of the Townsville Aboriginal and Islander Health service, Dr Waters' expertise in, and advocacy for, health equity and primary care helped shaped several major policy and governance decisions. Professor Sangla's acumen and advice on patient safety and clinical matters was exceptional, and I was delighted to see him appointed as our next Chief Medical Officer. Appointed the inaugural Deputy Board Chair in 2012, Ms Morton's expertise in workplace relations, financial management, regulatory compliance, and public-sector governance contributed substantially to both the Board and the wider health service operations. I offer my sincere thanks to them all.

It would be impossible for me to do my job without the support of Health Service Chief Executive Kieran Keyes. I thank Kieran for his leadership and stewardship of our large and complex organisation over the past year.

Finally, a sincere thank you to our staff. Healthcare is not easy. It takes a special type of person to take responsibility for the health and wellbeing of others. It takes humanity and compassion to share the worst possible news with someone and then step up, unflinchingly, as that journey continues. My heartfelt thanks to all of you.

Tony Mooney AM FAICD

Chair

Townsville Hospital and Health Board

Message from the Health Service Chief Executive

It's a pleasure to once again contribute a foreword to the annual report as we publish our performance, successes, and challenges of 2025-2026.

Last year, we treated more patients than ever before on a background of growing demand, increased burdens of chronic disease, as our population grows and ages, and high numbers of long-stay patients awaiting placement in residential aged care.

This annual review is an opportunity to reflect on what our health service has achieved for the people of the region through innovation, research, and invention. Achievements like our paediatric surgeons performing keyhole surgery on a four-month-old baby girl with a congenital diaphragmatic hernia, setting a new standard for care in north Queensland. Successes like keeping patients closer to home by offering elective surgeries in rural hospitals and reducing the need for disruptive travel.

We continued to pursue excellence and innovation through initiatives such as a specialist ultrasound machine that provides rapid assessments for patients like Ty, who has lived with Crohn's disease for 14 years and can now receive a diagnosis of a flare-up within minutes and treatment within half an hour. We broke the record for the most pre-term baby ever to survive in Australia, sending baby Stevie back home to Perth in the arms of her grateful parents Bree and Jake. Melia, aged 23, is now cancer-free after six rounds of intensive chemotherapy and a 12-hour operation to treat her osteosarcoma. Fifteen-year-old Sam is back home after being almost fatally mauled by a shark while swimming off a beach in the Torres Strait Islands. Sam spent five months in Townsville University Hospital and had almost 20 surgeries performed by our paediatric surgeons to reconstruct his abdomen. Sam's now at home on Thursday Island, back at school and, incredibly, in dance troupe.

The billion-dollar capital expansion of TUH took hold this year with several milestones, including the start of enabling works for Stage 1A which will deliver 165 new overnight beds, expanded emergency services, and a new multi-storey car park. The tender closed on the transit lounge in April at TUH with construction now underway. The lounges are part of the Queensland Government's Hospital Rescue Plan and are the first tranche of an \$80 million investment through the Easier Access to Health Services Plan. This expansion is the most ambitious in our history, and it is a privilege to be part of something that will benefit future generations of north Queenslanders for many years to come.

We know to support this growth, we must grow our clinical workforce. Efforts started this year on shoring up the health service as an employer of choice through the development of a new employee value proposition, investment in new staff accommodation, and the expansion of specialist medical training opportunities. Our Aboriginal and Torres Strait Islander workforce participation increased to 4.35 per cent as progress continues toward Closing the Gap in health outcomes for First Nations peoples.

I am fortunate to have great support in my role as Chief Executive. My sincere thanks to Board Chair Tony Mooney, and the Board, and to my own executive and leadership teams for their commitment to delivering the best public healthcare to our communities. I especially wanted to thank outgoing Chief Medical Officer and former Emergency Department Director Dr Niall Small. Dr Small was the clinical architect of TUH's modern-day emergency department and he also spearheaded the region's first aeromedical retrieval service, pioneering a model for consultant-led rapid access retrieval has been picked up around the country. The scope and breadth of emergency and medical care provided by this health service would rival any hospital and health service in Australasia and much of that is due to Niall's vision and leadership.

My greatest thanks are reserved, as ever, for our 8,000 staff. In my travels around our facilities, I am so impressed and grateful for your dedication to delivering skilled and compassionate care to patients and consumers whatever the hour, circumstance, or illness. You are in a league of your own.

Professor Kieran Keyes

Health Service Chief Executive

Townsville Hospital and Health Service

About us

The Townsville HHS is the public healthcare provider for more than 250,000 people living in northern Queensland. The catchment extends north from Townsville to Cardwell, west to Richmond, south to Home Hill, and east to Magnetic and Palm Islands.

The HHS operates 19 facilities, and provides a comprehensive range of healthcare services, from primary care in remote locations, to highly specialised services at Townsville University Hospital. TUH is the tertiary referral hospital for north Queensland and has the added role of providing specialist care to more than 700,000 people in a broader catchment extending from Mackay in the south, north to the Torres Strait Islands, and west to the Northern Territory border.

The Townsville HHS is an independent statutory body established under the *Hospital and Health Boards Act 2011*.

Strategic direction

The *Townsville Hospital and Health Service Strategic Plan 2022-2026 (2025 review)* outlines the strategic direction of the organisation, including its vision, purpose, values, strategic priorities, and success measures.

Vision, purpose and values

Vision

World-class healthcare for northern Queensland

Purpose

Great care every day

Values

The Townsville HHS's values of integrity, compassion, accountability, respect and engagement, which make up the acronym ICARE, underpin, and are consistent with, the Queensland public service values of customers first, ideas into action, unleash potential, be courageous and empower people.

Priorities

The strategic plan's priorities are:

- improving patient experience
- enhancing patient outcomes
- better value care
- improving staff experience.

A new strategic plan will take effect from 1 July 2026.

Aboriginal and Torres Strait Islander health

The Townsville HHS is committed to achieving health equity and creating a healthcare system that is culturally safe, equitable and free from racism and discrimination. Guided by the Health Equity Strategy 2026-2029 and the National Agreement on Closing the Gap, we continued to progress our commitment to partnering with Aboriginal and Torres Strait Islander peoples, communities and organisations to transform how healthcare is designed, delivered and governed.

During 2025-2026, the HHS focused on embedding organisational reforms and practices that support self-determination, strengthen accountability, and improve experiences and outcomes for Aboriginal and Torres Strait Islander peoples. We recognise that achieving health equity requires more than improving access to services; it requires actively identifying, addressing and dismantling systemic barriers, discriminatory practices and institutional racism that contribute to inequitable experiences and outcomes. Through genuine partnerships, shared decision-making and transparent governance, we are working alongside Aboriginal and Torres Strait Islander communities to create a health system that is culturally safe, culturally strong and responsive to community aspirations, and reflects, respects and celebrates the diversity, strengths and leadership of First Nations peoples.

Key achievements for 2025-2026 include:

Governance and strategic oversight:

- development of governance and reporting arrangements to support the implementation of the Health Equity Strategy 2026-2029, including monitoring and reporting frameworks for the Palm Island Health Action Plan 2018-2028
- continued implementation and refinement of the Indigenous Health Service Division governance framework, including clearer delineation of strategic, operational, and cultural governance functions
- completion of a review and redesign of the Indigenous Health Service Division and development of a Business Case for Change to strengthen role clarity, optimise resources, support workforce sustainability, and better align services with patient and community need
- strengthened Aboriginal and Torres Strait Islander cultural governance mechanisms through regular reporting to Executive and Board committees, integration of health equity performance measures, and improved transparency regarding progress and outcomes
- regular Aboriginal and Torres Strait Islander workforce forums embedded as an ongoing mechanism for cultural governance and peer support and leadership development
- advocacy to strengthen Aboriginal and Torres Strait Islander workforce role classification, embed anti-racism initiatives, and support sustainable culturally safe models of care in regional and rural health services.

Service access and clinical integration:

- establishment of Journey Connect, a culturally responsive patient transport initiative designed to improve access to care, reduce barriers associated with travel, and strengthen coordination between hospital and community services
- Journey Way Home Team implemented daily follow-up of Aboriginal and Torres Strait Islander patients who discharged against medical advice, supporting patients to understand drivers of discharge, reconnect with primary healthcare providers, and re-present to hospital where clinically indicated
- standardised follow-up processes and documentation pathways were implemented to strengthen monitoring along with reporting and continuity of care for patients at increased risk of inequitable experiences and outcomes

- Expansion and strengthening of the First Nations Patient Journey Hub to support Aboriginal and Torres Strait Islander patients who self-discharged, did not wait, or experienced barriers navigating the health system with ongoing improvements in re-engagement with primary healthcare and community services
- Indigenous Health Liaison Officer support expanded across outpatient, allied health, mental health and specialist services, contributing to reduced missed opportunities to treat, and supporting culturally safe care planning
- Development and implementation of practical tools to support culturally responsive care including patient information packs, clinical decision-making pocket guides and culturally informed discharge resources, patient information packs and clinical quick reference guides.

Workforce development and inclusion:

- Aboriginal and Torres Strait Islander workforce participation increased to 4.35 per cent, continuing progress towards achieving workforce parity reflective of the population served by the Townsville HHS
- implementation and expansion of Journey Learn, a culturally safe training and employment pathway supporting Aboriginal and Torres Strait Islander trainees through structured on-the-job learning, peer support and tailored mentoring
- recruitment and support of eight local Aboriginal and Torres Strait Islander Health Worker trainees through a localised traineeship model developed in partnership with TAFE North Queensland
- recruitment of two Aboriginal and Torres Strait Islander Health Worker trainees at the Charters Towers Health Service
- continued implementation of Deadly Starts, cadetships, school-based traineeships and graduate pathways, with expansion of these programs to rural and remote sites
- strengthened governance arrangements for identified positions and culturally responsive recruitment practices, including alternative application processes, best-fit assessment approaches, and implementation of guidance to support recruitment to identified positions
- strengthened trainee and supervision models, including structured handover processes with rural-site health workers, to improve continuity of care and support culturally safe workforce development.

Cultural capability and health equity action:

- completion of the draft Health Equity Strategy 2026-2029 and commencement of prescribed stakeholder, community and workforce consultation to inform finalisation and implementation
- Cultural Capability Program participation continued to increase across the HHS, with delivery expanded into Health Service Orientation, rural and remote facilities and through partnerships with other agencies, including Queensland Ambulance Service, Retrieval Services Queensland and Mater Hospital
- launch of Humans in Health, an organisational storytelling initiative that celebrates the lived experiences, strengths, and contributions of Aboriginal and Torres Strait Islander staff and consumers while fostering understanding, encouraging speaking-up behaviours, and supporting anti-racism and culturally safe care across the workforce
- launch of Deadly Decisions and the Cultural Accountability Requires Everyone (CARE) Framework to influence the way we lead, speak, and support one another, ensuring cultural safety is embedded not only in training, but in everyday actions, policies and decision-making
- development of a culturally informed performance and development framework and Yarning resources to support meaningful conversations, leadership development and culturally safe supervision practices.

Community engagement and cultural recognition:

- more than 12,500 community members engaged through 128 activities undertaken between 2022 and 2026, with the majority occurring in community settings and through partnership approaches
- delivery of the inaugural Health Equity Showcase (October 2025), bringing together community organisations, consumers and health services to celebrate achievements and co-design future priorities
- delivery of Reconciliation Week activities that encouraged reflection and dialogue on how initiatives such as ICARE, Humans in Health, and Deadly Decisions are being embedded into leadership practice and service delivery through culturally informed approaches, including Yarning Circles
- continued support for significant events, NAIDOC Week celebrations, and local cultural initiatives across Townsville HHS sites
- development of a Significant Events Guideline to support culturally responsive recognition and acknowledgement of events impacting Aboriginal and Torres Strait Islander peoples, communities, and staff
- strengthened partnerships with Aboriginal Community Controlled Health Organisations, Traditional Custodians, Elders and community representatives to inform service redesign and implementation of the Health Equity Strategy
- embedding cultural considerations into infrastructure planning, building design, and place-making initiatives associated with the TUH Master Plan and broader Queensland Health projects.
- Over the coming year, the Townsville HHS will continue to embed health equity across all aspects of the organisation through the implementation of the Health Equity Strategy 2026-2029 and by partnering with Aboriginal and Torres Strait Islander peoples to co-design and deliver services that respond to community priorities.

We remain committed to creating a healthcare system that actively eliminates racism and discrimination, upholds cultural rights, values lived experience, and ensures Aboriginal and Torres Strait Islander peoples, families and staff feel respected, connected and empowered.

Our Facilities

Ayr Health Service
Cambridge Street Facility
Cardwell Community Health Centre
Charters Towers Health Service
Charters Towers Community Care Unit
Eventide Residential Aged Care
Home Hill Health Service
Hughenden Multipurpose Health Service
Ingham Health Service
Joyce Palmer Health Service
Josephine Sailor Adolescent Inpatient Unit and Day Service
Kirwan Health Campus
Magnetic Island Health Service
North Ward Health Campus
Palmerston Street Facility
Parklands Residential Aged Care
Richmond Multipurpose Health Service
Townsville Community Care and Acquired Brain Injury Unit
Townsville University Hospital Campus

Our community-based and hospital-based services

The Townsville HHS delivers acute, community, public health, multipurpose, and residential aged care to the people of the region.

Car parking concessions

The Townsville HHS offers car parking concessions to eligible patients, carers, immediate family members, and volunteers at TUH.

In 2025-2026, 2,448 concessional car parking applications valued at \$117,534.50 were approved.

Ingham Health Service

Ingham Health Service provides emergency care, inpatient, outpatient, obstetric, renal dialysis and general surgical services.

Joyce Palmer Health Service

The Joyce Palmer Health Service provides emergency and acute care to the Palm Island community.

Magnetic Island Health Service

Magnetic Island Primary Health Community Clinic operates during normal business hours and offers a 24-hour on-call service for a range of community and emergency care.

Townsville University Hospital

Townsville University Hospital is the only tertiary referral hospital in north Queensland and provides cardiac, obstetric, gynaecological, paediatric, neurosurgical, orthopaedic, cancer care, mental health, neonatal, allied health, and intensive care services.

Home Hill Health Service

Home Hill Health Service provides aged care, rehabilitation and renal dialysis services to the local community.

Ayr Health Service

Ayr Health Service provides emergency, general medical, surgical and obstetric services to Ayr, Home Hill and the broader Burdekin region.

Richmond Multipurpose Health Service

Richmond Health Service provides emergency care, inpatient and general medical services.

Hughenden Multipurpose Health Service

Hughenden Multipurpose Health Service provides emergency care, inpatient and general medical services.

Charters Towers Health Service

Charters Towers Health Service provides emergency care, renal dialysis, inpatient and outreach services.

Challenges and opportunities

Key challenges experienced by the HHS include:

Increasing demand

- Like health services across the country, the Townsville HHS is experiencing continued demand growth. This is being driven by a range of factors including population growth, ageing, disease prevalence, and private market limitations.

Rising complexity

- The increasing age and disease burden of patients, coupled with continued advancements in treatment options, is making patient care more complex and fundamentally changing how care needs to be delivered.

Diminishing aged care capacity

- Residential aged care capacity, relative to the number of people aged over 65, has been decreasing for several years. This has occurred at a time when more people require aged care places.

Workforce attraction

- Global workforce shortages, coupled with the challenge of attracting people to regional and remote areas, is making recruitment extremely difficult.

Workforce retention

- The combined effect of global workforce shortages, changing workforce expectations, burnout, workplace culture, and the innate challenge of retaining people in regional and remote locations, is driving a high turnover of staff.

Major opportunities include:

Capital expansion

- Significant government funding to expand several health facilities over the coming years will greatly improve the ability of the organisation to meet demand. This includes 165 additional overnight beds by 2029 through the Hospital Rescue Plan.

Service redesign

- The HHS will continue to modernise its service delivery by focussing on earlier intervention, providing more care outside the hospital, and leveraging virtual care.

Cultural transformation

- The HHS is beginning a multi-year, whole-of-organisation cultural transformation program to build a values-driven, high-performing, constructive culture where people and teams feel safe, supported and empowered to do their best work for our patients and community.

Streamlined recruitment

- The HHS has a major opportunity to shift from a passive recruitment model reliant on traditional job advertisements, which often means positions take several months to fill, to a proactive model that seeks out candidates and assists them through a streamlined process.

Leading efforts to achieve health equity for First Nations peoples

- In the Townsville HHS, 9.3 per cent of people are Aboriginal and/or Torres Strait Islander which is more than double the Queensland average. The HHS, therefore, has a major responsibility to take meaningful steps to achieve health equity.

Governance

Our people

Board membership

Anthony (Tony) Mooney AM

Chair

BEd-BA (Hons), FAICD

Appointed: 18 May 2016

Current Term: 1 April 2024 to 31 March 2028

Tony Mooney AM has served as Chair of the Townsville Hospital and Health Board since May 2016. He is also Chair of the Board Executive Committee and member of the Audit and Risk, Finance, Safety and Quality, and Stakeholder Engagement Committees. Tony holds director roles with the Tropical Australian Academic Health Centre, Townsville Hospital Foundation (Brighter Lives) and NQ Spark.

A former Mayor of Townsville (1989–2008), Tony was appointed a Member of the Order of Australia in 2011 for his service to local government and the community. He is a Fellow of the Australian Institute of Company Directors and a life member of Townsville Enterprise. His previous board roles include North Queensland Bulk Ports, Ergon Energy, LG Super, and the Great Barrier Reef Marine Park Authority.

Tony is committed to strengthening public health governance and ensuring high-quality healthcare services for North Queensland communities.

Michelle Morton

Deputy Chair

LLB (Hons), Solicitor (Qld & Australia), FAICD

Appointed: 29 June 2012

Term: 1 April 2024 to 31 March 2026

Michelle Morton was Deputy Chair of the Townsville Hospital and Health Board and Chair of the Finance Committee until the end of March 2026. She is Managing Partner of a regional legal practice and a Fellow of the Australian Institute of Company Directors. Michelle holds specialist accreditations in Workplace Relations and Personal Injuries Law.

Her governance experience includes roles with the National Injury Insurance Scheme Queensland and Chair of the Townsville Fire Ltd. Michelle contributed expertise in legal compliance, financial oversight, and organisational risk management throughout her 14-year tenure on the Board.

Michelle was appointed to the Queensland Government's Racing Queensland Board in March 2026.

The organisation remains indebted to Michelle for her contribution to the Board since 2012.

Gerard (Gerry) Wyvill

Deputy Chair

BBus (Acct), CPA, GAICD

Appointed: 1 April 2026

Current Term: 1 April 2026 to 31 March 2030

Gerard Wyvill is the Deputy Chair of the Townsville Hospital and Health Board and Chair of the Finance Committee. He is an experienced non-executive director with more than 30 years' senior executive and governance experience across complex healthcare organisations in both the public and private sectors. He brings deep expertise in corporate governance, financial stewardship, risk management and strategic planning.

Gerard has held executive leadership roles including Chief Executive Officer and Executive Director within major hospital organisations and has served on numerous health-related boards and committees. He is currently a non-executive director and chairs audit and risk committees within the health sector, and has extensive experience overseeing clinical governance, accreditation, performance improvement and large-scale organisational change.

A Certified Practising Accountant and graduate of the Australian Institute of Company Directors, Gerard brings strong financial and governance capability to the Board, with a particular focus on sustainability, quality and safety, and regional workforce development.

Kari Arbouin
Board Member

GCert (Legal), GCert (Mid), MPHTM, MBA, BN, RN

Appointed: 1 April 2026

Current Term: 1 April 2026 to 31 March 2030

Kari Arbouin is a senior health and public-sector leader with extensive experience across nursing, executive management, emergency services, higher education and regional development. She currently holds a senior leadership role within Queensland Ambulance Service having operational oversight of the northern part of Queensland with portfolio responsibilities for rural and remote communities across the state.

Kari has previously held executive roles within Queensland Health and has served as a member and chair of hospital and health service boards and subcommittees, with a strong focus on workforce, quality and safety, and system improvement. She has also contributed to regional economic development and innovation initiatives, including governance roles supporting health and social innovation.

With qualifications spanning nursing, business administration, public health and governance, Kari brings a strong understanding of rural and remote health systems, workforce sustainability and effective governance to support high-quality health services for regional communities.

Debra Burden
Board Member

BBus (Acc & Bus Mng), FAICD, FIML

Appointed: 18 May 2016

Current Term: 1 April 2024 to 31 March 2028

Debra Burden is the Chair of the Townsville Hospital and Health Board Audit and Risk Committee. She is Chief Executive Officer of selectability and an award-winning executive with a background in health, finance, and community services. She is a Fellow of both the Australian Institute of Company Directors and the Institute of Managers and Leaders.

Debra has held chief executive officer roles at Queensland Country Credit Union and Health Fund and 1300SMILES. She currently chairs Regional Development Australia Townsville and North West Queensland and serves on the Ageing Australia National/Queensland State Membership Council.

Debra is dedicated to improving the wellbeing of people in regional, rural, and remote Queensland, particularly in aged care and mental health.

Dr Craig Costello**Board Member**

MBBS, FRACP, BApSc., Consultant Neurologist

Appointed: 1 April 2026

Current Term: 1 April 2026 to 31 March 2030

Craig is a consultant neurologist with extensive experience across public and private health services in Townsville and north Queensland. He has practised as a neurologist for more than a decade and is actively involved in clinical leadership, medical education, and workforce development.

Craig has served as Co-Director of Physician Training at Townsville University Hospital, where he led the development of the Physician Training Unit, a Queensland-first model that has delivered strong training and examination outcomes and informed practice across other health services. He has held leadership roles within regional and national medical committees and is a strong advocate for expanding high-quality specialist services in regional settings.

Craig brings to the Board a clinician's perspective, a commitment to education and innovation, and a strong focus on delivering safe, high-quality care close to home for north Queensland communities.

Luke Guazzo**Board Member**

BCom, CPA, GAICD

Appointed: 1 April 2022

Current Term: 1 April 2026 to 31 March 2030

Luke Guazzo is a Certified Practising Accountant with extensive experience in health and property sectors. He has held executive roles including Chief Executive Officer of Northern Australia Primary Health Ltd and Chief Finance Officer at Cootharinga North Queensland and Lancini Property Group.

Luke serves on risk, audit and finance committees for the CRC for Developing Northern Australia and Townsville Enterprise.

A north Queensland local, Luke is passionate about health equity and community wellbeing, and also supports local enterprise through his family-run coffee roasting business.

Nicole Hayes**Board Member**

BEd, MBA, FAICD

Appointed: 18 May 2019

Current Term: 1 April 2024 to 31 March 2028

Nicole Hayes is the Chair of the Townsville Hospital and Health Board Stakeholder Engagement Committee. She is the Chief Executive Officer of Northern Queensland Legacy and has a strong background in education, stakeholder engagement, and project management. She holds an MBA, a Bachelor of Education, and is a Fellow of the Australian Institute of Company Directors.

Nicole serves on the Queensland Veterans' Council and co-chairs the Queensland Veterans' Reference Group. Her previous roles span education, infrastructure, and health sectors.

Nicole is committed to delivering patient-centred care and ensuring Townsville Hospital and Health Service facilities are inclusive, respectful, and responsive to community needs.

Dallas Leon**Board Member**

MAE, BAppHlthSc

Appointed: 1 October 2025

Current Term: 1 April 2026 to 31 March 2030

A Kalkadoon and Waanyi man, Dallas Leon is an experienced health executive and non-executive director with more than 25 years' experience working in the Aboriginal and Torres Strait Islander health arena. He currently serves as Director, Commercial Operations at the Institute for Urban Indigenous Health, where he leads national program delivery for the Deadly Choices program.

Dallas has held senior executive roles within Queensland Health and the community-controlled health sector, including Executive Director Aboriginal and Torres Strait Islander Health at Townsville Hospital and Health Service, and Chief Executive Officer of the Mount Isa Aboriginal and Torres Strait Islander Community Controlled Health Service. He has extensive board experience, including as Chair of the Western Queensland Primary Health Network, Director of the Lowitja Institute, and former Director of the North West Hospital and Health Service. Dallas is currently a Director of the Ngarnal Aboriginal Community Controlled Health Service.

With formal qualifications in Primary Health Care (Indigenous Health), Applied Epidemiology (Indigenous Health) and Governance, Dallas brings strong expertise in Indigenous health, strategic leadership and healthy system knowledge to the Board.

Professor Kunwarjit Sangla AM**Board Member**

MBBS, MD, FRACP, GAICD, SOMANZ Certificate

Appointed: 1 April 2024

Current Term: 1 April 2026 to 31 March 2030 (resignation effective 30 June 2026)

Professor Kunwarjit Singh Sangla is a Medical Director for Medical Service Group (Townsville HHS), Pre-eminent Staff specialist, surveyor for Australian Council for Healthcare Standards and Professor (adjunct) of Medicine at James Cook University.

Kunwarjit has also been the Medical Director of Rural Hospitals and Deputy Executive Director of Medical Services. Professor Sangla is a Senior Examiner for the Royal Australasian College of Physicians (RACP).

He received the Rural Services Medal from RACP in 2015 and Townsville HHS NAIDOC day award in 2019. He was recognised as member of the Order of Australia in January 2026.

Kunwarjit has credentials as an internal medicine physician, endocrinologist and obstetric medicine physician. He has provided face to face specialist clinics in many rural and remote areas of Queensland for more than two decades. He has an active research portfolio and is a reviewer for national and international journals and research grants.

Dr Erin Waters
Board Member

MBBS, FRACGP, BSc, MMed, DCH, GAICD

Appointed: 1 April 2024

Term: 1 April 2024 to 31 March 2026

Dr Erin Waters is the Clinical Director of the Institute of Urban Indigenous Health, Chair of the Queensland Medical Board of Australia, the previous Director of Medical Services at the Townsville Aboriginal and Islander Health Service (2023-2025) and specialist general practitioner with 23 years' experience as a clinician.

She is a fellow of the Royal Australian College of General Practitioners, graduate member of the Australian Institute of Company Directors, and Associate Professor with the JCU College of Medicine.

Erin is a strong advocate for health equity and accessible, safe, and future-ready public health services that meet the diverse needs of local communities. In early 2026, Erin and her family relocated to her hometown in Brisbane.

Georgina Whelan
Board Member

BN, RN, MBA, GAICD

Appointed: 18 May 2020

Current Term: 1 April 2024 to 31 March 2028

Georgina Whelan is the Chair of the Townsville Hospital and Health Board Safety and Quality Committee. She is the Site Manager at Icon Cancer Centre Townsville and a registered nurse with over 30 years clinical and leadership experience. Georgina holds an MBA and is a Graduate of the Australian Institute of Company Directors.

Georgina has served in advisory roles with the Townsville Local Disaster Management Group and Varian Medical Systems.

Georgina is a passionate advocate for equitable cancer care and is committed to improving access to services for patients in regional, rural, and remote Queensland.

Non-Board members of committees

During 2025-2026, the Board was expertly assisted by non-Board Members as follows:

- Board Audit and Risk Committee: Mrs Jan Pool
- Board Safety and Quality Committee: Ms Virginia Bendall Harris, Mrs Kandy McAuliffe, and Mr Andrew Paton
- Board Finance Committee: Mr Sean Rooney and Ms Alicia Fowles.

The table over page shows the attendance record and number of meetings Board members were eligible to attend. The Finance, Audit and Risk, Executive, and Safety and Quality committees are prescribed committees.

Townsville Hospital and Health Board – 1 July 2025 to 30 June 2026					
Act or instrument	Hospital and Health Boards Act 2011 (Qld)				
Functions	Reported throughout the Annual Report				
Achievements	Reported throughout the Annual Report				
Financial reporting	Refer to financial statements section of the Annual Report				
Remuneration					
Position	Name	Meetings/sessions attendance	Approved annual fees	Approved sub-committee fees	Actual fees received
Chair	Tony Mooney AM	13/13 – Board* 9/11 – Finance 5/6 – Audit and Risk 8/9 – Executive* 2/4 – Stakeholder Engagement 5/6 – Safety and Quality	\$85,714	\$4,000 (as chair) \$3,000 (as member)	\$102,000
Deputy Chair (Until 31 March 2026)	Michelle Morton	10/11 – Board 8/8 – Finance* 5/5 – Audit and Risk 6/6 – Executive	\$44,503	\$4,000 (as chair) \$3,000 (as member)	\$42,000
Deputy Chair (From 1 April 2026)	Gerard Wyvill	2/2 – Board 3/3 – Finance* 1/1 – Audit and Risk 3/3 – Executive	\$44,503	\$4,000 (as chair) \$3,000 (as member)	\$14,000
Member (From 1 April 2026)	Kari Arbouin	2/2 – Board 1/1 – Audit and Risk 0/1 – Stakeholder Engagement	\$44,503	\$3,000 (as member)	\$13,000
Member	Debra Burden	12/13 – Board 9/11 – Finance 6/6 – Audit and Risk* 7/9 – Executive	\$44,503	\$4,000 (as chair) \$3,000 (as member)	\$55,000
Member (From 1 April 2026)	Dr Craig Costello	2/2 – Board 1/1 – Audit and Risk 0/1 – Safety and Quality	\$44,503	\$3,000 (as member)	\$13,000
Member	Luke Guazzo	12/13 – Board 11/11 – Finance 4/4 – Stakeholder Engagement	\$44,503	\$3,000 (as member)	\$51,000
Member	Nicole Hayes	12/13 – Board 5/5 – Audit and Risk 7/9 – Executive 4/4 – Stakeholder Engagement*	\$44,503	\$4,000 (as chair) \$3,000 (as member)	\$54,000
Member (From 1 October 2025)	Dallas Leon	8/8 – Board 3/3 – Stakeholder Engagement 3/5 – Safety and Quality	\$44,503	\$3,000 (as member)	\$38,000
Member	Professor Kunwarjit Sangla	11/13 – Board 1/3 – Executive 3/3 – Stakeholder Engagement 4/6 – Safety and Quality	\$44,503	\$3,000 (as member)	\$51,000
Member (Until 31 March 2026)	Dr Erin Waters	8/11 – Board 5/5 – Audit and Risk 4/4 – Safety and Quality	\$44,503	\$3,000 (as member)	\$39,000
Member	Georgina Whelan	13/13 – Board 11/11 – Finance 8/9 – Executive 6/6 – Safety and Quality*	\$44,503	\$4,000 (as chair) \$3,000 (as member)	\$55,000
No. scheduled meetings/sessions	49				
Total out of pocket expenses	\$3,438.50				

Notes:

1. * Indicates Chair roles
2. One occurrence of Board, Audit and Risk, and Finance was delivered jointly, and reflects on the tally of Board meetings only.
3. In addition to the monthly meetings, the Board held 10 extraordinary meetings.

Board committees

Four of the Board committees are prescribed, while the Board Stakeholder Engagement Committee is a non-prescribed committee.

Executive

The Executive Committee (the Committee) assists the HSCE in advancing the strategic plan and progressing key strategic priorities, including those referred by the Board.

The Committee also enhances the working relationship between the Board and the HSCE by reinforcing accountability for service delivery across the Townsville HHS and supporting timely and effective responses to critical and emerging matters.

The Committee oversaw the review of the Townsville HHS 2026-2030 Strategic Plan in 2026.

Safety and Quality

The Safety and Quality Committee (the Committee) delivers strategic clinical governance guidance, supporting the Board in its oversight of safe and high-quality care across the Townsville HHS.

The Committee is responsible for monitoring the effectiveness of safety and quality governance frameworks, ensuring alignment with relevant plans and strategic priorities, and assessing the standard of care delivered within the Townsville HHS. It also works in partnership with other safety and quality forums to drive continuous improvement and foster innovation.

Throughout the year, the Committee maintained critical oversight of clinical review processes arising from both internal and external findings ensuring opportunities to strengthen the safety and quality of care were appropriately addressed.

Audit and Risk

The Audit and Risk Committee (the Committee) provides independent oversight and advice to the Board on risk management, compliance management, internal controls, significant accounting policies, and the internal and external audit functions.

The Committee delivers its function in alignment with internal risk and compliance frameworks, and external responsibilities as outlined in the *Financial Accountability Act 2009*, *Auditor-General Act 2009*, *Financial Accountability Regulation 2019*, *Financial and Performance Management Standard 2019* and Queensland Treasury's Audit Committee Guidelines.

The Committee maintained effective oversight of the internal audit function, ensuring alignment with the internal audit plan, monitoring the implementation of audit recommendations, and supporting the continuous improvement of governance, risk management, and control processes.

The Committee considers reports and insights provided by the Queensland Audit Office (QAO) and oversees management's responses to QAO observations and recommendations.

Finance

The Finance Committee (the Committee) is responsible for overseeing the financial management, performance, systems, and associated risks of the Townsville HHS.

The Committee provides advice to the Board on financial matters, including performance monitoring, financial systems and frameworks, strategy and policy settings, capital investment, cash flow, revenue management, and budget development, ensuring these align with strategic priorities and organisational objectives.

The Committee also maintains oversight of the Townsville HHS Capital Expansion Program and supports the Executive in addressing financial risks, including those arising from fiscal constraint measures required to achieve a balanced budget.

Stakeholder Engagement

The Stakeholder Engagement Committee (the Committee) is a non-prescribed committee established in 2016 to support and enhance the reputation of the Townsville HHS through effective, transparent, and meaningful engagement with staff, the community, and key stakeholders.

The Committee monitors and guides the implementation of two core engagement frameworks - Clinician Engagement Strategy and Consumer and Community Engagement Strategy. It also serves as the formal conduit to the Board for three Advisory Councils: clinical, consumer, and First Nations community.

Following a review of its role and purpose, the Committee has refined its focus with an increased emphasis on organisational culture while continuing to strengthen partnerships with key industry stakeholders.

Executive management

The Townsville HHS executive was led in 2025-2026 by Health Service Chief Executive Kieran Keyes.

The HSCE is responsible and accountable for the day-to-day management of the HHS and for operationalising the Board's strategic vision and direction. The HSCE is appointed by, and reports to, the Board.

The HSCE was supported by an executive team comprised of:

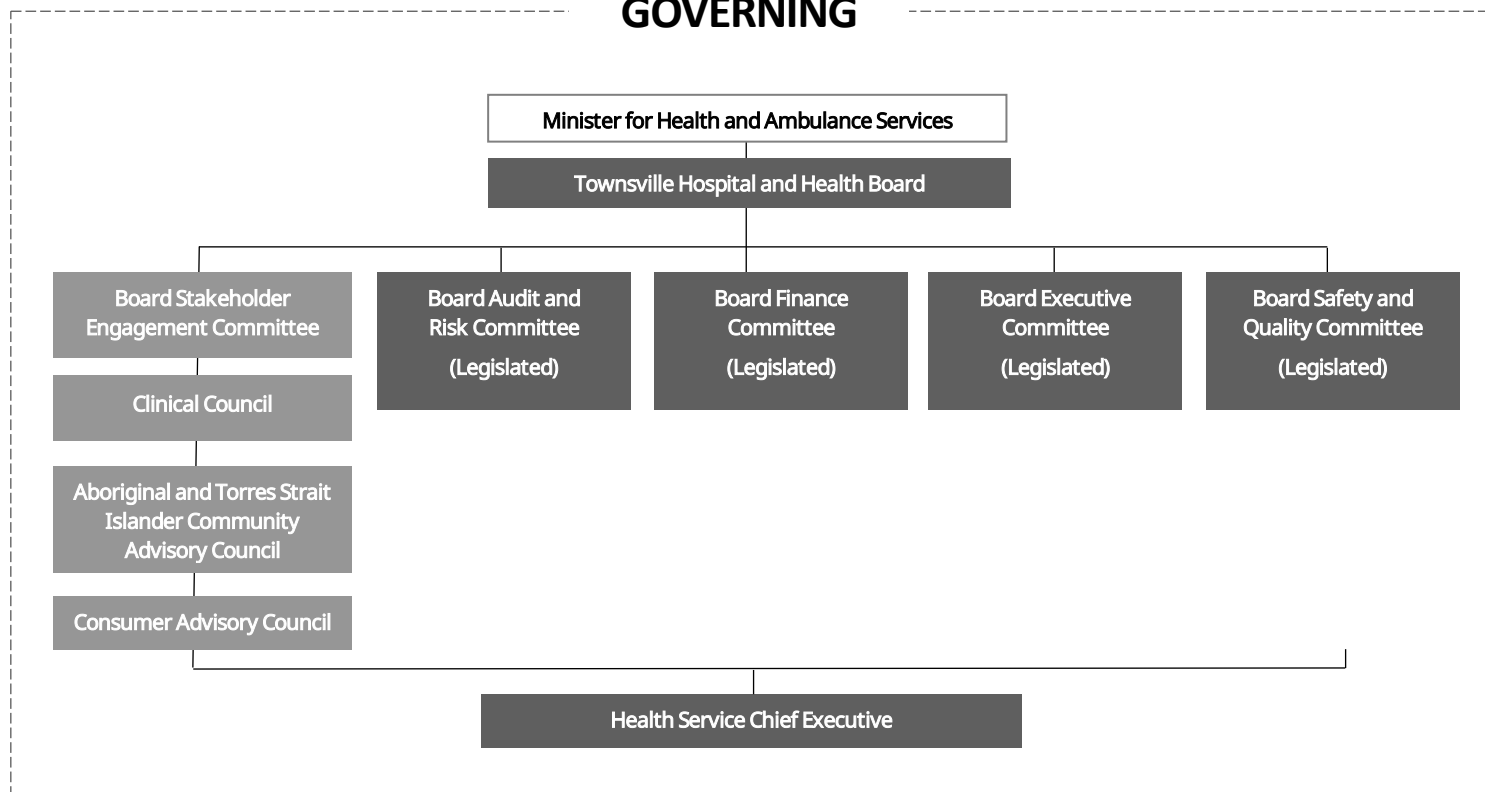
- Chief Operating Officer - Susan Freiberg
- Chief Medical Officer - Dr Niall Small
- Chief Finance Officer - Michelle Warrington
- Executive Director Nursing and Midwifery Services - Judy Morton
- Executive Director Clinical Governance - Marina Daly
- Executive Director People, Strategy and Governance - Shellee Chapman
- Executive Director Aboriginal and Torres Strait Islander Health - Amanda Cooms
- Executive Director Digital Health and Knowledge - Louise Hayes
- Executive Director Allied Health - Danielle Hornsby
- Executive Director Infrastructure Program Delivery - Thomas Hegarty

The business of the HHS is operationalised through five service groups: Medical, Mental Health, Rural Hospitals, Surgical and Women's and Children's, two divisions, Allied Health and Indigenous Health, and one directorate, Facilities and Integrated Support Services.

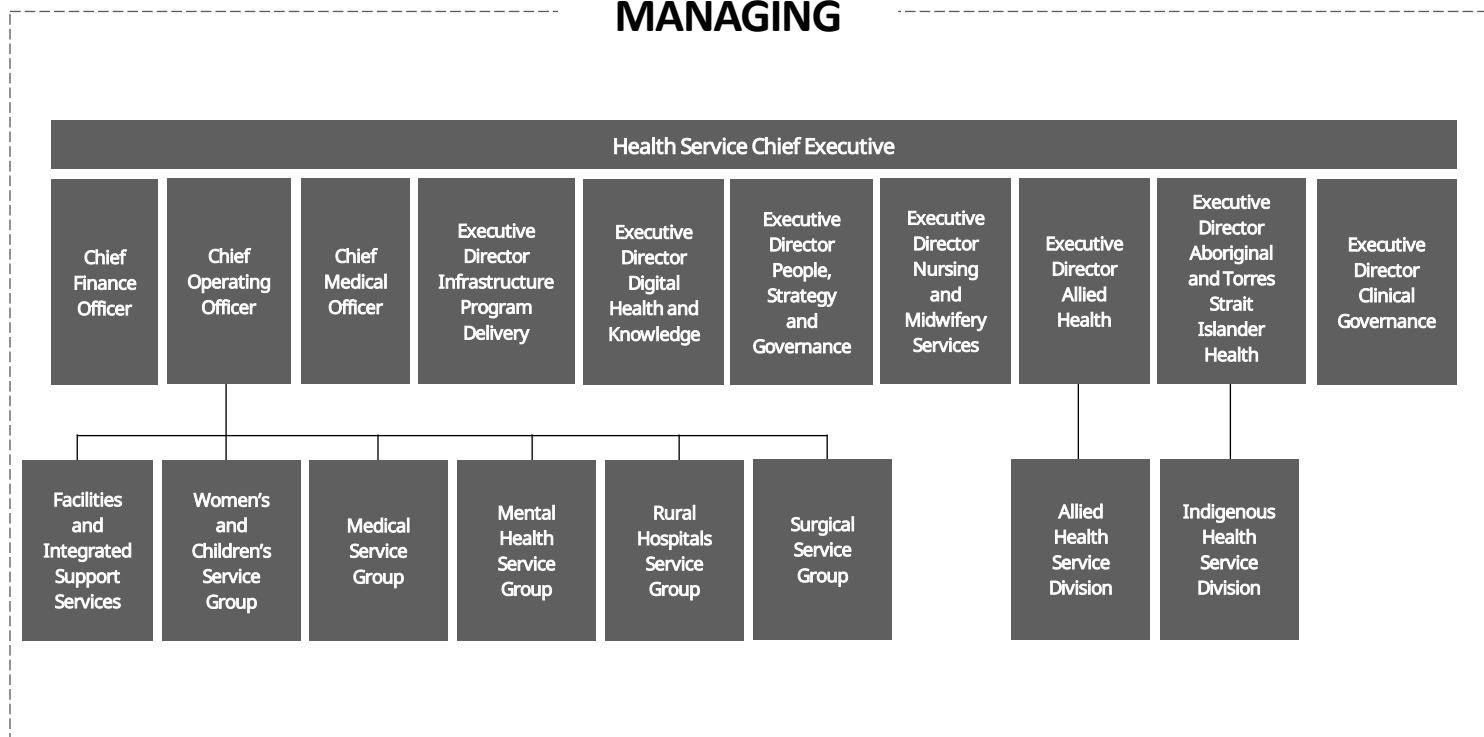
The service groups, directorates and divisions are supported by a corporate services function. The Townsville Public Health Unit is responsible for population health, disease prevention, and health promotion.

Organisational structure and workforce profile

GOVERNING



MANAGING



Minimum Obligatory Human Resource Information (MOHRI) Data
June Quarter 2026
Active/Paid Employees only

Total Staffing	#	Occupation Types by FTE	%
Headcount	8,121	Corporate	6.93%
Paid FTE	6,653.76	Frontline and Frontline Support	93.07%
Appointment Type by FTE	%	Employment Status by Headcount	%
Permanent	80.17%	Full-time	50.22%
Temporary	15.75%	Part-time	42.74%
Casual	3.89%	Casual	7.04%
Contract	0.20%		

Figure 1: Gender

Gender*	Headcount	%
Woman	6,248	76.94%
Man	1,863	22.94%
Non-binary	10	0.12%
Another term	0	0.00%
Not disclosed	0	0.00%

* Where data available

Figure 2: Diversity target group data*

Diversity Groups*	Headcount	%
Women	6,248	76.94%
Aboriginal Peoples and Torres Strait Islander Peoples	353	4.35%
People with disability	194	2.39%
Culturally and Linguistically Diverse – Speak a language at home other than English ^	1,164	14.33%

* To ensure privacy, in tables where there are less than 5 respondents in a category, specific numbers must be replaced by <5.

^ This includes Aboriginal and Torres Strait Islander languages or Australian South Sea Islander languages spoken at home

Figure 3: Target group data for Women in Leadership Roles*

Group	Headcount	%
Senior Officers (Classified, s122 and s155 combined)	7	63.64%
Senior Executive Service, High-level senior executives and Chief Executives (Classified, s122 and s155 combined)	9	64.29%

* Women in leadership are defined as those in classified roles or on s122 or s155 contracts. This data must not include salary equivalency.

Data caveats

* Workforce is measured in Minimum Obligatory Human Resource Information (MOHRI) Full-Time Equivalent (FTE). This MOHRI data supplied by the Public Sector Commission is not an exact match with data in the Financial Statements, which is drawn from the Decision Support System (DSS).

* Beginning the 2023 financial year end, the Public Sector Commission advised all workforce annual report data needs to be based on the PSC MOHRI data. This is submitted quarterly to the PSC through the HR Branch.

* The difference between the PSC MOHRI data and QH Reporting FTE (MOHRI Occupied FTE) from DSS exists due to different counting rules. The total FTE for both DSS MOHRI occupied FTE data and PSC MOHRI submission data are the same at a whole of Queensland Health level, however, minor variances can appear at an HHS level and will also be noticeable at a pay stream level. In PSC reporting, the FTE for an employee is counted against their primary role. For example, if employee works 0.5FTE in a health practitioner role and 0.3FTE in a nursing role, this employee would be reported 0.8FTE health practitioner. In Qld health reports, FTE is split across both roles.

* Women in Leadership roles include the following Queensland Health position classifications:

- Senior Officers: HSO, DSO and ASO (Ambulance only).
- Senior Executive Service, High-level senior executives and Chief Executives: HES, CEO, SES, Senior Officer Public Service, and AES (Ambulance only).

* Employee status: Where appointed FTE (0-100) is equal or greater than 95, employees are reported as full-time. Where appointed FTE is less than 95, employees are reported as part-time. Employees are reported as casual, if their appointment type is identified as casual.

* Norfolk Island Taskforce is excluded from summary and sub-measures.

* In alignment with PSC reporting guidelines, only one employment record per employee is reported. For employees with concurrent employment, the arrangement with the highest percentage of work is reported. This may result in a minor variance where staff work across multiple Hospital and Health Services

Strategic workforce planning and performance

Workforce Planning

The HHS developed its inaugural Workforce Strategy in 2025-2026. This document, developed with the input of more than 650 staff, identifies how the organisation will invest in its workforce for the next four years. The strategy has four key priorities: care for our people, support and retain existing staff, build and attract new talent, and transform how we work. These streams of work build on deliverables achieved in 2025-2026, which included:

- implementing the Staff Welfare Initial Support program
- establishing several early career support roles for clinical staff
- implementing a leadership program for registered nurses
- embedding the International Medical Graduate workforce support model
- expanding the suite of First Nations traineeships
- establishing the Rural and Remote Connect workforce initiative
- implementing the flexible and hybrid working framework
- rolling out of an employee engagement survey (3,017 respondents).

Focus areas for 2026-2027 will include preventing and responding to occupational violence; embedding a culture of respect, accountability and performance; enhancing leadership capability, and streamlining recruitment.

Diverse Workforce

From 1 March 2023, the *Public Sector Act 2022* introduced an obligation for Chief Executives to progress equity, diversity, respect and inclusion in their organisation, as well as a requirement to conduct an annual equity and diversity review.

The Equity and Diversity Audit for 2026 was completed and submitted to the Public Service Commission in June 2026. The audit identified that representation of each of the target diversity cohorts increased from the previous year. This follows the roll out of several initiatives across the organisation, including:

- International Women's Day events
- two-day First Nations Leadership program
- Humans in Health campaign
- NAIDOC Week celebrations
- Disability Action Week events
- Multicultural Day celebrations
- establishment of a Pride Network for LGBTIQ+ staff
- expansion of flexible work options.

Looking ahead, the HHS will continue to develop a workforce that reflects the diversity of the community it serves. Of particular focus will be increasing the representation of First Nations peoples in the workforce, who are currently 4.35 per cent of total headcount, compared to a target of 6.47 per cent.

Union Engagement

The HHS fosters union engagement as part of its commitment to consult with employees within an effective industrial relations framework. This begins with the Townsville HHS staff orientation, where unions have the opportunity to meet with new employees. The HHS then participates in several local consultative forums and the overarching HHS Consultative Forum on a regular basis.

Early retirement, redundancy and retrenchment

No redundancy, early retirement or retrenchment packages were paid during the reporting period.

Our risk management

The *Hospital and Health Boards Act 2011* requires annual reports to state each direction given by the Minister to the HHS during the financial year and the action taken by the HHS because of the direction. In 2025-2026 the HHS received two Ministerial Directions.

In response to Ministerial Direction QH-MD-002, Treatment of gender dysphoria in children and adolescents with hormone therapy, the HHS complied with the directive in full by no longer offering the commencement of stage one and stage two treatments to new diagnoses of gender dysphoria since the issuing of the directive.

In response to Ministerial Direction QH-MD-003, Mandatory reporting to the Queensland Police Service where a person is unsuitable to possess a firearm, the HHS developed a local procedure to support compliance with the Direction and associated legislative requirements. The procedure establishes a consistent process for clinicians to assess, document and report concerns regarding firearm possession where required under the Direction and section 151 of the *Weapons Act 1990*. The procedure was considered through Townsville HHS governance processes and endorsed for implementation across relevant clinical services.

Enterprise Risk Management

The Townsville HHS adopts an enterprise-wide approach to risk management, considering risk from a strategic, whole-of-service perspective. This approach identifies and assesses potential threats and opportunities that may impact the delivery of safe, effective, and high-value care.

Risk management is integrated into strategic planning and operational decision-making, supporting the achievement of organisational objectives. It enhances the HHS's capacity to anticipate and respond to change while maintaining a focus on improving patient outcomes, experience, and value across the health system. A structured approach to risk also reduces reactive issue management, enabling more efficient allocation of resources and supporting continuous improvement.

Risks are managed in accordance with the Townsville HHS Risk Management Framework and in accordance with the Board-approved Risk Appetite Statement. Risks are recorded and managed in the enterprise risk register, and bi-monthly risk reporting occurs to the Executive and Board Audit and Risk and Safety and Quality Committees.

A network of risk champions supports the consistent application of risk management practices and facilitates integration across clinical and corporate areas.

Internal audit

Internal audit is a key component of the governance and assurance framework of the Townsville HHS, supporting the effective management of risk and strengthening organisational performance. The HHS's internal audit function was established in accordance with the *Finance and Performance Management Standard 2019* and operates under a Board-approved charter.

Its primary objective is to support the HHS in achieving its strategic objectives by providing independent and objective assurance and advisory services on governance, risk management, and internal control processes.

The Townsville HHS's internal audit services are provided through a co-source service delivery model, led and managed by the Director Internal Audit, Risk and Compliance who is responsible for the effective, efficient, and economical operation of the internal audit function and who reports key audit results and program deliverables to the Board Audit and Risk Committee bi-monthly. Overall strategy, performance, and effectiveness of the function is reviewed in consultation with the Board Audit and Risk Committee and reported annually to the Board.

The internal audit function conducts all audits in line with the Institute of Internal Auditor's International Professional Practices Framework, including the Global Internal Audit Standards.

The internal audit function operates under a risk-based annual plan, which outlines the scope and focus of audit activities. The plan is developed through a structured consultation process and remains flexible to respond to emerging risks and changes in the organisation's risk profile. During 2025-2026, seven internal audit reviews were completed, identifying opportunities for business improvement and strengthening internal controls across key areas, including:

- operating theatre efficiency
- health service governance on Palm Island
- activity-based funding
- HR establishment management
- contract management
- information security management system
- outpatient follow-up management

Management actions in response to audit findings are tracked to completion to ensure sustained improvement.

External scrutiny

National Aged Care Quality Standards

Within the Townsville HHS, there are two residential aged care facilities (RACFs) – Eventide RACF located in Charters Towers and Parklands RACF in Townsville. Both facilities were assessed in 2023 by the Australian Aged Care Quality Agency for compliance with the National Aged Care Quality Standards. Eventide RACF was accredited to June 2026 and Parklands RACF to March 2026. Both facilities are expected to undergo reassessment against the new standards this year.

National Safety and Quality Health Service Standards

The Townsville HHS had its first Short-Notice Assessment conducted by the Australian Council on Healthcare Standards against the requirements of the National Safety and Quality Health Service Standards. The Townsville HHS was awarded accreditation for three years from 27 March 2025 until 26 March 2028.

Coroner and Health Ombudsman

The Coroner did not identify any significant findings of deficiency requiring remedial actions for the health service in this reporting period.

The Office of the Health Ombudsman finalised a systemic investigation into the Townsville University Hospital Secure Mental Health Rehabilitation Unit on 13 January 2026. A decision was reached to take no further action; however, recommendations were made regarding improvements in the unit and these are monitored by the Office of the Health Ombudsman.

Crime and Corruption Commission

The HHS was not under scrutiny by the Commission during the reporting period.

Parliamentary reporting

In 2025–2026, Auditor-General reports tabled in Parliament that considered or evaluated the performance of Townsville HHS included:

- Managing funding from the mental health levy Report 14: 2025-26
- 2025 status of Auditor-General's recommendations Report 3: 2025-26
- Health 2025 Report 9: 2025-26

The HHS considered the findings and recommendations contained in these reports and, where required, has taken action to implement the recommendations or address issues raised. The HHS also considers recommendations made to the broader public sector by the Auditor-General in other audit reports, including:

- Managing the ethical risks of artificial intelligence Report 2: 2025-26
- Managing third-party cyber security risks Report 13: 2025-26

Implementation of Auditor-General recommendations is monitored by the Board Audit and Risk Committee.

Queensland Health Service Audits

Under the *Hospital and Health Boards Act 2011*, health service auditors may be appointed to examine the performance of HHSs across the Queensland health system.

In 2025–2026, the HHS participated in the following reviews conducted by the Queensland Health Internal Audit Unit in its capacity as health system auditors:

- First Nations workforce recruitment and retention
- Queensland Clinical Guidelines Governance

The outcomes of these audits are considered by management and, where required, action plans are implemented. Health service audits are reported to, and overseen, by the Board Audit and Risk Committee.

Information systems and records management

The Townsville HHS continued to strengthen its information systems and records management practices during 2025–2026, in line with the *Public Records Act 2023* and standards issued by the State Archivist.

The HHS maintained a whole-of-organisation records management program to ensure public records accurately document decisions, actions, and their context. Records governance arrangements remained in place, with roles and responsibilities clearly defined and supported through ongoing staff awareness and capability development.

The HHS continued to progress its transition to a digital-first environment, with the Integrated electronic Medical Record (ieMR) supporting real-time, secure access to patient information across TUH and rural facilities. Improvement activities during the year focused on strengthening system use and data quality and consistency of digital clinical workflows alongside enhanced controls over access to electronic medical records.

Physical records continued to be securely managed in accordance with approved retention and disposal schedules, with disposal undertaken using current authorisations. Appropriate controls remained in place to support the safe keeping and accessibility and preservation of records across their lifecycle.

During the year, targeted initiatives were delivered to enhance the reliability and security and resilience of information systems, including improvements to network infrastructure, strengthened credential management practices, and the introduction of emerging digital capabilities.

Information Security Attestation

During 2025-2026, the HSCE attested to the appropriateness of the HHS's information security risk management to the Queensland Government Cyber Security Unit as part of the mandatory Information Security Annual Return.

This attestation was informed by assurance activities undertaken during the year, including internal audit and control uplift initiatives, confirming that information security risks were actively managed in alignment with the Queensland Government Enterprise Architecture (QGEA) Information and Cyber Security Policy (IS18) and the HHS's risk appetite.

Public sector ethics

The HHS complies with the requirements established under the *Public Sector Ethics Act 1994* (PSEA) to implement the Code of Conduct (the Code). This occurs through a range of mechanisms, including:

- embedding the Code within the orientation program for new staff
- requiring all staff to complete an annual Working Ethically training module
- having proper regard to the Code in administrative practices and procedures.

Human rights

As a public entity, the Townsville HHS must act in accordance with the 23 human rights protected under the *Human Rights Act 2019 (Qld)* (the Act). When reviewing existing or creating new policies and procedures, the document custodian reviews the document content for compatibility with human rights identifying the considerations made when assessing the policy or procedure for its impact on human rights.

The HHS displays posters around waiting and ward areas advising of the rights of individuals under the Act with further information available on the organisation's website. Staff orientation includes information for staff about human rights. Consumer feedback, including human rights complaints, are continuously monitored by the Patient Feedback Service through a well-embedded complaints management process.

During 2025-2026, the health service received 55 human rights complaints. Each complaint has been thoroughly investigated, with 37 complaints fully resolved, and 18 still undergoing review or finalisation of the process. When necessary, the HHS adapts and improves practices to ensure the actions and decisions of staff are compatible with human rights.

Queensland Public Service values

The HHS's values of integrity, compassion, accountability, respect and engagement, which make up the acronym ICARE, align with the Queensland public services values.

The HHS embeds its values through several mechanisms including staff orientation, signage in work areas, inclusion of the values within the performance and development framework, and the annual staff excellence awards with categories for each of the individual values.

A priority of the HHS is creating a values-driven, high-performing, constructive culture where people and teams feel safe, supported, and empowered to do their best. A cultural transformation program has been developed with staff during 2025-2026 to support this. It will be rolled out in 2026-2027.

Confidential information

The *Hospital and Health Boards Act 2011* requires annual reports to state the nature and purpose of any confidential information disclosed in the public interest during the financial year. The Health Service Chief Executive did not authorise the disclosure of confidential information during the 2025-2026 reporting period.

Performance

HHS performance is monitored and reported against key areas including strategic plan measures, service standards and financial performance.

Non-financial performance

The HHS monitors and reports on progress against its strategic plan each year. The results for 2025-2026 are below.

Improve patient experience

Objectives	Measures
Put patients first in all that we do	The proportion of patients who rated the overall quality of their care as "Very Good" increased from 71.1 per cent to 84 per cent.
Ensure our services are culturally appropriate	The proportion of staff who have completed the cultural practice program increased from 68.1 per cent to 74.3 per cent.
Maximise the use of virtual care models	- The proportion of outpatient appointments provided via telehealth remained consistent at 2.4 per cent. - The proportion of overnight separations delivered via Hospital in the Home decreased slightly from 2.7 to 2.4 per cent.
Develop care closer to home for rural patients	The proportion of rural patients treated at their local hospitals increased slightly to 44.9 per cent, up from 43.7 per cent the year prior.
Develop future-focused tertiary services	The proportion of public patients treated within the HHS without needing to travel to Brisbane for care was consistent at 96.4 per cent.

Enhance patient outcomes

Objectives	Measures
Ensure the highest standards of safety and quality	The Hospital Standardised Mortality Ratio has decreased compared to previous years as at March 2026.
Focus on early intervention and hospital avoidance	The proportion of hospitalisations that were potentially preventable remained stable at 36.5 per 1,000 population in the 12 months to March 2026.
Treat all patients within recommended timeframes	The proportion of emergency presentations, specialist outpatient appointments, elective surgeries, and gastrointestinal endoscopies delivered within clinically recommended timeframes was 77 per cent, 70 per cent, 61 per cent and 44 per cent.
Improve health equity for First Nations people	The proportion of First Nations patients who accessed care without missing an appointment or leaving before their care was completed remained consistent at 87.4 per cent.
Research, innovate and pursue excellence	- The number of research publications by HHS staff, which is measured in calendar years, increased to 282 up to December 2025. - The number of active registered clinical trials, which is also measured in calendar years, was 89, down slightly from 96 in 2024.

Better value care

Objectives	Measures
Eliminate low-value care	The number of avoidable hospital readmissions remained consistent, at 847 up to May 2026.
Continuously optimise our productivity	The cost per weighted activity unit was \$6,405 compared to a target of \$6,149.
Strengthen partnerships with other providers	Relative stay index remained consistent at 1.07 as at May 2026, slightly above the target of 1.00.
Deliver new infrastructure to meet future needs	Capital expenditure performance was 97.88%
Allocate resources in a responsible manner	The end-of-year budget position was a \$0.9M deficit.

Improve staff experience

Objectives	Measures
Ensure all staff are safe at work	The number of worker incidents per 1,000 headcount was 342.97, an increase compared to 302.9 in 2024-2025.
Embed a culture that reflects our ICARE values	The number of conduct and performance matters as a percentage of headcount remained steady at 1.8 per cent as of March 2026.
Develop each person and build high-performing teams	The proportion of staff with a current performance assessment and development plan increased to 63.7 per cent.
Cut red tape to empower people at every level	The HHS rolled out a new staff engagement survey in 2025-2026, with the mean engagement score 3.60 out of 5. This will act as the baseline measure for this objective moving forward.
Attract and retain staff as an employer of choice	The turnover rate for permanent employees remained stable at 8.7 per cent.

Service standards

In 2025-2026, the HHS continued to deliver a broad range of healthcare services across its catchment, supporting the healthcare needs of the north Queensland community.

Performance across the year reflected ongoing commitment to providing safe, high-quality and patient-centred care while responding to increasing demand and the complexities of a large and diverse health service. Strong results were achieved in a number of quality and safety indicators, including infection prevention and mental health outcomes, while significant volumes of inpatient, outpatient, emergency, sub-acute and community-based services were delivered throughout the year.

Like health services across Queensland and Australia, the HHS experienced sustained pressures associated with growing demand, workforce challenges and increasing service complexity. These factors contributed to performance variation across some access measures, including emergency department flow, elective surgery and specialist outpatient waiting times.

Despite these challenges, the health service maintained a strong focus on improving access to care, enhancing patient outcomes, expanding service delivery through initiatives such as telehealth, and delivering activity broadly in line with service delivery expectations.

Townsville Hospital and Health Service	2025-2026 Target	2025-2026 Actual
Effectiveness measures		
Percentage of emergency department patients seen within recommended timeframes		
- Category 1 (within 2 minutes) - Category 2 (within 10 minutes) - Category 3 (within 30 minutes) - Category 4 (within 60 minutes) - Category 5 (within 120 minutes)	100% 80% 75% 70% 70%	100% 78% 71% 80% 96%
Percentage of emergency department attendances who depart within 4 hours of their arrival in the department	>80%	61%
Percentage of elective surgery patients treated within the clinically recommended times		
- Category 1 (30 days) - Category 2 (90 days) - Category 3 (365 days)	>98% >95% >95%	71% 49% 55%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days ¹	≤1.0	0.8
Rate of community mental health follow up within 1-7 days following discharge from an acute mental health inpatient unit ²	>65%	73.5%
Proportion of re-admissions to acute psychiatric care within 28 days of discharge ³	<12%	10.4%
Percentage of specialist outpatients waiting within clinically recommended times ⁴		
- Category 1 (30 days) - Category 2 (90 days)⁵ - Category 3 (365 days)⁵	98%	66% 32% 74%

Townsville Hospital and Health Service	2025-2026 Target	2025-2026 Actual
Percentage of specialist outpatients seen within clinically recommended times		
• Category 1 (30 days)	98%	81%
• Category 2 (90 days) ⁵	..	50%
• Category 3 (365 days) ⁵	..	75%
Median wait time for treatment in emergency departments (minutes) ⁶	..	15
Median wait time for elective surgery treatment (days) ⁷	..	42
Efficiency measure		
Average cost per weighted activity unit for Activity Based Funding facilities ⁸	\$6,149	\$6,405
Other measures		
Number of elective surgery patients treated within clinically recommended times ⁹		
• Category 1 (30 days)	3,885	3,135
• Category 2 (90 days)	2,763	1,597
• Category 3 (365 days)	1,184	686
Number of Telehealth outpatients service events ¹⁰	16,966	18,584
Total weighted activity units (WAU) ¹¹		
• Acute Inpatients	113,989	115,634
• Outpatients	33,872	33,815
• Sub-acute	16,109	18,436
• Emergency Department	22,394	22,131
• Mental Health	18,144	17,754
• Prevention and Primary Care	2,021	2,498
Ambulatory mental health service contact duration (hours) ¹²	>68,647	48,238
Staffing ¹³	6,378	6,654

Notes:

1. Staphylococcus aureus (including MRSA) bloodstream (SAB) infections Actual rate is based on data reported between 1 July 2025 and 31 March 2026 as at 7 August 2026.
2. Mental Health rate of community follow up 2025-2026 Actuals are as at 19 August 2026.
3. Mental Health readmissions 2025-2026 Actuals are as at 19 August 2026.
4. Waiting within clinically recommended time is a point in time performance measure. 2025-2026 Actual is as at 1 July 2026.
5. Given the System's focus on reducing the volume of patients waiting longer than clinically recommended for specialist outpatients, it is expected that higher proportions of patients seen from the waitlist will be long wait patients and the seen within clinically recommended time percentage will be lower. To maintain the focus on long wait reduction, the 2025-2026 Targets for category 2 and 3 patients are not applicable.
6. There is no nationally agreed target for this measure, and the median wait time varies depending on the proportion of patients in each urgency category.
7. There are no targets for median wait times as performance is determined through the percentage of elective surgery patients treated within the clinically recommended time for their respective category.
8. All measures are reported in QWAU Phase Q28. 2025-2026 Actual is based on data as at 18 August 2026. The 2025-2026 Target does not include funding adjustments made during the year, including those for Enterprise Bargaining or reproductive leave, which impact the actual results.
9. Elective surgery performed in public hospitals.
10. The Telehealth 2025-2026 Actual is as at 20 August 2026.
11. All measures are reported in Queensland WAU Phase Q28. The 2025-2026 Actuals are as at 18 August 2026. As the Hospital and Health Services have operational discretion to respond to service demands and deliver activity across services streams to meet the needs of the community, variation to the Target can occur. Variances in the Mental Health stream are the result of ongoing refinement and maturing of the new national Mental Health classification.
12. Ambulatory Mental Health service contact duration 2025-2026 Actual is as at 19 August 2026.
13. In alignment with PSC reporting guidelines, only one employment record per employee is reported. For employees with concurrent employment, the arrangement with the highest percentage of work is reported. This may result in a minor variance where staff work across multiple Hospital and Health Services.

Financial summary

For the year ended 30 June 2026

Townsville HHS planning and governance processes have ensured that the Townsville HHS continues to provide a comprehensive range of services and improved health outcomes to the local government areas of Townsville, Burdekin, Charters Towers, Flinders, Richmond, Hinchinbrook, and Palm Island within the funding allocation and that funds are spent efficiently and effectively.

In 2025-2026 financial year, the Townsville HHS delivered Service Agreement activity, measured by Weighted Activity Units (WAU), to meet the significant demand for integrated patient-centred hospital and health care services of our north Queensland communities driven by demographic factors including a growing and ageing population, growing demand for emergency services and increasing chronic health conditions. The Townsville HHS managed the demand for services in an environment of declining private health insurance coverage along with decreasing bulk billed primary health care services and increasing input costs. The Townsville HHS funded the additional service delivery from retained earnings.

The following financial summary provides an overview of the Townsville HHS financial performance for the year ending 30 June 2026. A more detailed view of the HHS' financial performance is provided in the 2025-2026 financial statements.

Financial Overview	2026	2025
Income	\$1.681 billion	\$1.572 billion
Expenses	\$1.682 billion	\$1.572 billion
Operating Result	(\$0.935) million	\$0.608 million
Capital Acquisitions	\$52.060 million	\$55.784 million
Total Assets	\$1.167 billion	\$1.089 billion
Equity	\$0.986 billion	\$0.942 billion

Where the funds come from

	2026	2025
Income	\$'000	\$'000
Activity based funding	1,138,467	1,013,071
User charges	126,466	120,716
Other funding for public health services	357,658	379,325
Other revenue and Grants and contributions	58,532	58,997
Total Income	1,681,123	1,572,109

The Townsville HHS is responsible for the delivery of public hospital and health services including medical, surgical, emergency, obstetrics, paediatrics, specialist outpatient clinics, mental health, critical care and clinical support services.

The Service Agreement between Townsville HHS and the Queensland Department of Health for the delivery of the above services, uses WAU to quantify the activity delivered and funded based on a detailed classification system and the cost of the activity based on the Queensland Efficient Price.

User charges principally include public patients electing to use private health insurance, self-funded private patients, bulk billed outpatients (Medicare) and reimbursements of pharmaceutical benefits and the sale of goods and services.

Other revenue relates principally to block funding provided for Townsville HHS services delivered at Home Hill, Charters Towers, Richmond, Hughenden and Palm Island, tertiary training and system management.

How the funds are spent

	2026	2025
Expenses	\$'000	\$'000
Employee expenses	212,438	196,691
Health Service employee expenses	947,505	876,269
Supplies and Services	411,857	391,717
Depreciation and amortisation	87,549	86,782
Other expenses	22,709	20,042
Total Expenses	1,682,058	1,571,501

The above table shows the resources consumed in 2025-2026 for the delivery of services across the HHS including Townsville, Ingham, Ayr, Home Hill, Charters Towers, Richmond, Hughenden and Palm Island. Total expenses for 2025-2026 were \$1.682 billion or an average of \$4.6 million per day.

Total expenses increased principally due to an overall increase in the volume of services delivered, increased employee expenses pursuant to enterprise bargaining outcomes and increased cost of goods and services in line with consumer price index movements.

The largest percentage of the spend was against employee expenses including clinicians and support staff at 69.0 per cent. Non-labour expenses such as outsourced services, locum/agency labour, clinical supplies, pharmaceuticals, prosthetics, pathology, catering, repairs and maintenance, communications, computers and energy accounted for 24.5 per cent of expenditure; 5.2 per cent of expenditure was related to depreciation and amortisation of the asset base.

Financial outlook

In 2026-2027, the Board and HHS management team will continue to undertake careful planning for, and monitoring of, demand and alignment of operational resources / capacity to ensure the Townsville HHS continues to:

- optimise the delivery of safe, appropriate and timely hospital care
- strengthen access to care in the community and closer to home
- improve the health and wellbeing of our communities and North Queenslanders to minimise their interface with the acute healthcare system.

Asset maintenance and renewal

All Queensland Health entities comply with the Queensland Government Building Policy Framework which requires the reporting of overdue asset maintenance liabilities. Delaying maintenance is a commonly used asset management strategy which can optimise value while managing resources and asset risks.

Queensland Health entities report overdue maintenance using the terms 'deferred maintenance' and 'postponed capital renewal'.

Deferred maintenance refers to maintenance of an operational nature (OPEX) that has been identified as required but has been delayed.

Postponed capital renewal refers to capital works required to restore an asset's service potential (CAPEX) that have been delayed.

Neither deferred maintenance nor postponed capital renewal includes forecast maintenance; that is work that was planned but found not to be required during the reporting period (e.g. planned repainting where no deterioration occurred).

All overdue asset expenditure is risk assessed to identify any potential impact on users and services and is closely managed to ensure all facilities remain safe.

Both operational and capital quantities are reported. As of 30 June 2026, the Townsville HHS reported:

- \$7.18 million in deferred maintenance, and
- \$96.7 million in postponed capital renewal.

The Townsville HHS has the following strategies in place to mitigate any risks associated with these items:

- developed a five-year program of forecast capital renewal investment initiatives (life-cycle replacement, renewals, and refurbishments) with indicative value of \$720 million across 32 projects
- coordinated health service and Department of Health-funded capital redevelopment projects to include applicable anticipated remediation works where possible
- prioritised state health infrastructure planning for replacement of facilities that have exceeded service life
- prioritised Timely Investment in Infrastructure Maintenance Program funding submissions for applicable capital renewal projects based on the impact on service delivery and risk of failure
- prioritised funding of all identified deferred maintenance and postponed capital renewal assessed as very high risk and emergent condition-based maintenance activity that cannot be deferred or postponed
- regular preventative maintenance inspections and minor repairs where necessary
- management of critical spare stock holdings where appropriate.

Forecast lifecycle costs are planned future asset replacements, renewals, and refurbishments. They may be planned as capital or operational expenditure but are reported as a single figure. Forecasts are based on asset lifecycle models, expected asset deterioration, and required asset condition standards.

As at 30 June 2026, the Townsville HHS expected forecast lifecycle replacements, renewals, and refurbishments of \$720 million. This includes \$40 million planned to be delivered over the 2026-2027 financial year, and \$680 million forecast for the period 2027-2028 to 2030-2031.

Capital works

Throughout 2025–2026, the Townsville HHS progressed a significant capital works program focused on delivering modern, sustainable, infrastructure to meet the growing healthcare needs of our communities, now and into the future.

Capital works projects delivered included:

- The refreshed TUH Master Plan was successfully completed during the 2025–2026 financial year, establishing a clear long-term vision for future infrastructure investment and healthcare service growth
- \$53.2 million Kirwan Health Campus Expansion Project - a new build two-storey clinical services building that will facilitate the delivery of improved maternity and oral health services to the community
- \$8.64 million Charters Towers Health Service Computed Tomography (CT) Scanner - construction of a medical imaging suite incorporating CT and X-ray adjacent to the emergency department. This will introduce CT scanning capability at the Charters Towers Health Service
- \$5 million TUH Ward Midlife Renewal Emergent Works Program (Stage 3) - refurbishment works and services upgrades to three TUH surgical inpatient wards with works now completed on two wards, numbers two and three.

- \$4.5 million TUH Hospital Rescue Plan Enabling Works - construction and upgrades to Angus Smith Drive and significant stormwater diversion works at the TUH Campus
- \$3.03 million Central Sterilisation Department upgrades including equipment at Charters Towers Health Service
- \$3 million Central Sterilisation Department upgrades including equipment at Ingham Health Service
- \$3 million North Queensland Kidney Transplant Service - fit-out of level three space at TUH to accommodate the staff required to operationalise the service
- \$1.96 million Electric Vehicle Transition Infrastructure Project - procurement and installation of 172 EV chargers across 16 HHS sites, for both Queensland Government fleet and public charging use, consisting of both 7 kw and 22 kw chargers to satisfy both local vehicle charging and fast charging vehicles from different sites
- \$1 million Emissions Reduction Program supporting the installation of Light Emitting Diode (LED) lighting across the Townsville HHS sites.

Capital works projects under construction included:

- Eight-storey multi-storey car park project - to deliver a minimum of 1,000 additional parking spaces at the TUH site enhancing parking capacity and accessibility for patients, visitors, and staff
- \$49.8 million TUH heating, ventilation and air-conditioning (HVAC) Midlife Renewal Project - refurbishment of identified HVAC plant in TUH acute buildings, central energy facilities and critical equipment in other TUH areas as required to achieve an additional 15 years of operation. Building management system controls end-of-life replacement and renewal of end-of-life engineering network critical hardware will support HVAC operation
- \$14 million Joyce Palmer Health Service Staff Accommodation Project (delivered under the Building Rural Remote Health Program) - modular construction and onsite installation of 13 new staff accommodation bedrooms
- \$12 million e-Health Queensland and Townsville HHS Infrastructure Maintenance Program - a project aimed at implementing robust and resilient information communication technologies to lower significant risks associated with ageing infrastructure
- \$10.18 million Ingham Health Service CT Scanner Project - construction of a medical imaging suite incorporating CT. This will provide 24/7 access to a publicly operated CT scanning service at the Ingham Health Service
- \$10 million Ingham Staff Accommodation Project (delivered under the Building Rural and Remote Health Program) - construction and installation of three modular accommodation buildings, delivering 12 contemporary staff bedrooms (a net increase of nine beds) to support workforce attraction and retention at the Ingham Health Service
- \$6 million Charters Towers Staff Accommodation Project (delivered under the Building Rural Remote Health Program) - modular construction and onsite installation of 10 new (additional) beds at the Eventide site (10 bedrooms delivered across four modular units)
- \$6.9 million TUH Transit Lounge, delivering a dedicated transit lounge to improve patient flow, enhance patient experience, support timely discharge and optimise inpatient bed capacity across the hospital
- \$9.98 million TUH Lift Modernisation Project - refurbishment of the existing TUH lifts one to 10, replacement of existing control equipment for TUH lifts 11 to 13, construction of a new single steel frame glass lift located in the TUH western atrium, and the upgrade of five additional lifts across the TUH floor plate to serve as compliant emergency lifts
- \$2.2 million TUH Ward Midlife Renewal Emergent Works Program (Stage 3) - refurbishment works and services upgrades to three TUH surgical inpatient wards, with works to surgical ward number one underway and expected to be completed September 2026.
- \$5.5 million construction of a 328-space extension to car park 17, increasing parking capacity to support staff and future growth across the TUH campus
- \$4.4 million TUH HVAC upgrades to support pandemic management improvements
- \$4.5 million Stage 2 of car park expansion road works, to link the extension of car park 17 to Discovery Drive

- \$0.8 million Building, Engineering and Maintenance Services (BEMS) workshop - relocation of the existing BEMS mechanical workshop onsite to the previous medical records shed to facilitate commencement of the Central Energy Facility- three onsite at TUH (deliverable scope as part of the TUH Expansion Project)
- \$1.5 million TUH Make Good Works including upgrades to the internal ring road network and car park five, together with aviation compliance works following completion of the Civil Aviation Safety Authority (CASA) upgrades of the helipad.

Capital works projects under design included:

- Townsville University Hospital as part of the Hospital Rescue Plan (Stage 1) - a multi-building, multi-stage clinical services project that when fully realised will deliver more than 165 additional beds. Works include:
 - the clustering related sub-acute services in a new Eastern Campus expansion, and to promote operational efficiencies
 - an expansion to the intensive care unit and the emergency department by expanding North Block, and
 - an interim surgical services solution to deliver additional beds and theatre capacity.
- Hughenden Multipurpose Health Service - plan and design for new health facilities to replace the existing facilities which have been identified as aged and end of life. The project is part of the Building Rural and Remote Health Program
- Richmond Multipurpose Health Service - plan and design for new health facilities to replace the existing facilities which have been identified as aged and end of life. The project is part of the Building Rural and Remote Health Program
- Home Hill Health Service - plan and design to refurbish part of the health facility to replace the existing aged facilities and adjust the layout to suit future service demand. The project is part of the Building Rural and Remote Health Program
- \$2.83 million Joyce Palmer Health Service HVAC upgrades to support pandemic management improvements
- TUH Ward Midlife Renewal Works Program (Stage 4) - refurbishment works and services upgrade to medical wards one, two and three (project budget TBC pending finalisation of design and quantity survey cost estimation)
- Ayr CT Expansion part of Statewide MRI and CT Expansion (SMACE)
- \$19.3 million Youth Step Up / Step Down project to aid in Youth Mental Health outcomes, six living units along with clinical capacity to be delivered on the HHS's Vincent Campus and proposed to be operated by non-government organisations.

Townsville Hospital and Health Service

FINANCIAL STATEMENTS

For the year ending 30 June 2026

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Statement of comprehensive income

For the year ended 30 June 2026

		2026	2025
	Notes	\$'000	\$'000
Income			
User charges	B1-1	126,466	120,716
Funding for public health services	B1-2	1,496,125	1,392,396
Grants and other contributions	B1-3	50,136	48,397
Other revenue	B1-4	8,396	10,600
Total Income		1,681,123	1,572,109
Expenses			
Employee expenses	B2-1	(212,438)	(196,691)
Health Service employee expenses	B2-2	(947,505)	(876,269)
Supplies and services	B2-3	(411,857)	(391,717)
Grants and subsidies		(1,722)	(532)
Interest on lease liabilities		(196)	(187)
Depreciation and amortisation	B2-4	(87,549)	(86,782)
Impairment losses on financial assets		(3,043)	(3,385)
Other expenses	B2-5	(17,748)	(15,938)
Total Expenses		(1,682,058)	(1,571,501)
Operating result for the year		(935)	608
Other comprehensive income			
<i>Items that will not be reclassified subsequently to profit or loss</i>			
Increase in asset revaluation surplus		65,703	85,193
Other comprehensive income for the year		65,703	85,193
Total comprehensive income for the year		64,768	85,801

The accompanying notes form part of these financial statements.

Statement of financial position

As at 30 June 2026

	Notes	2026 \$'000	2025 \$'000
Assets			
Current assets			
Cash and cash equivalents	B3	114,094	81,029
Trade and other receivables	B4	38,364	39,393
Inventories	B5	12,135	13,014
Other assets	B6	3,970	3,584
Total current assets		168,563	137,020
Non-current assets			
Property, plant and equipment	B7	990,490	944,623
Right-of-use assets	B11-1	4,457	5,159
Intangibles	B7-4	3,893	2,633
Total non-current assets		998,840	952,415
Total assets		1,167,403	1,089,435
Liabilities			
Current liabilities			
Trade and other payables	B8	166,903	136,596
Lease liabilities	B11-1	1,128	1,111
Accrued employee benefits		5,802	4,103
Other liabilities	B9	3,370	1,523
Total current liabilities		177,203	143,333
Non-current liabilities			
Trade and other payables	B8	687	-
Lease liabilities	B11-1	3,560	4,259
Total non-current liabilities		4,247	4,259
Total liabilities		181,450	147,592
Net assets		985,953	941,843
Equity			
Contributed equity	B10-1	379,065	399,723
Asset revaluation surplus	B10-2	529,025	463,322
Accumulated surpluses		77,863	78,798
Total equity		985,953	941,843

The accompanying notes form part of these financial statements.

Statement of changes in equity

For the year ended 30 June 2026

B10	Contributed equity \$'000	Asset revaluation surplus \$'000	Accumulated surpluses \$'000	Total equity \$'000
Balance at 1 July 2024	440,070	378,129	78,190	896,389
Operating result for the year	-	-	608	608
<i>Other comprehensive income for the year</i>	-	85,193	-	85,193
<i>Transactions with members in their capacity as members:</i>				
Non-appropriated equity asset transfers	684	-	-	684
Non-appropriated equity injections	45,751	-	-	45,751
Non-appropriated equity withdrawals	(86,782)	-	-	(86,782)
<i>Net transactions with members in their capacity as members</i>	(40,347)	-	-	(40,347)
Balance at 30 June 2025	399,723	463,322	78,798	941,843
	Contributed equity \$'000	Asset revaluation surplus \$'000	Accumulated surpluses \$'000	Total equity \$'000
Balance at 1 July 2025	399,723	463,322	78,798	941,843
Operating result for the year	-	-	(935)	(935)
<i>Other comprehensive income for the year</i>	-	65,703	-	65,703
<i>Transactions with members in their capacity as members:</i>				
Non-appropriated equity asset transfers	13,618	-	-	13,618
Non-appropriated equity injections	53,273	-	-	53,273
Non-appropriated equity withdrawals	(87,549)	-	-	(87,549)
<i>Net transactions with members in their capacity as members</i>	(20,658)	-	-	(20,658)
Balance at 30 June 2026	379,065	529,025	77,863	985,953

The accompanying notes form part of these financial statements.

Statement of cash flows

For the year ended 30 June 2026

	Notes	2026 \$'000	2025 \$'000
Cash flows from operating activities			
<i>Inflows</i>			
User charges		135,304	126,368
Funding for public health services		1,402,370	1,302,512
Grants and other contributions		50,136	48,373
Interest received		987	1,090
GST input tax credits from ATO		25,464	27,812
GST collected from customers		3,880	3,314
Other revenue		7,370	9,217
<i>Outflows</i>			
Employee expenses		(202,368)	(195,861)
Health service employee expense		(869,504)	(872,846)
Supplies and services		(469,752)	(372,140)
Grants and subsidies		(1,722)	(532)
Interest payments on lease liabilities		(196)	(187)
GST paid to suppliers		(26,811)	(25,403)
GST remitted to ATO		(3,029)	(2,933)
Other expenses		(17,000)	(19,690)
Net cash provided by operating activities	CF-1	35,129	29,094
Cash flows from investing activities			
<i>Outflows</i>			
Payments for property, plant, equipment and intangibles		(53,974)	(56,828)
Net cash used in investing activities		(53,974)	(56,828)
Cash flows from financing activities			
<i>Inflows</i>			
Proceeds from equity injections		53,273	45,751
<i>Outflows</i>			
Lease payments		(1,363)	(584)
Net cash provided by financing activities		51,910	45,167
Net increase in cash held		33,065	17,433
Cash and cash equivalents at the beginning of the financial year		81,029	63,596
Cash and cash equivalents at the end of the financial year	B3	114,094	81,029

The accompanying notes form part of these financial statements.

Statement of cash flows

For the year ended 30 June 2026

CF1 NOTES TO THE STATEMENT OF CASH FLOWS

CF-1 Reconciliation of operating result to net cash provided by operating activities

	2026 \$'000	2025 \$'000
Operating result for the year	(935)	608
Adjustments for:		
Depreciation and amortisation	87,549	86,782
Impairment losses on receivables	3,043	3,385
Equity funding for depreciation and amortisation	(87,549)	(86,781)
Assets donated revenue – non-cash	-	(24)
Net loss/(gain) on sale of non-current assets	(39)	(293)
Change in operating assets and liabilities:		
(Increase)/decrease in receivables	873	(381)
(Increase)/decrease in inventories	879	(936)
(Increase)/decrease in contract assets	(2,260)	(5,687)
(Increase)/decrease in other receivables	2,416	9,301
(Increase)/decrease in prepayments	(386)	(618)
Increase/(decrease) in trade and other payables	29,863	22,595
Increase/(decrease) in contract liabilities and unearned revenue	(24)	86
Increase/(decrease) in employee benefits	1,699	1,057
Net cash provided by operating activities	35,129	29,094

CF-2 Changes in liabilities arising from financing activities

2026

	Opening balance	New leases acquired	Cash repayments	Closing balance
	\$'000	\$'000	\$'000	\$'000
Lease liabilities	5,370	681	(1,363)	4,688
Total	5,370	681	(1,363)	4,688

2025

	Opening balance	New leases acquired	Cash payments	Closing balance
	\$'000	\$'000	\$'000	\$'000
Lease liabilities	3,262	2,692	(584)	5,370
Total	3,262	2,692	(584)	5,370



Basis of financial statement preparation

General information

The Townsville HHS is an individual entity and is controlled by the State of Queensland, the ultimate parent entity.

The head office and principal place of business of the Townsville HHS is:

100 Angus Smith Drive
Townsville Queensland 4810

Compliance with prescribed requirements

The financial statements have been prepared in compliance with section 62(1) of the *Financial Accountability Act 2009* and section 39 of the *Financial and Performance Management Standard 2019*. The financial statements comply with Queensland Treasury's Minimum Reporting Requirement for reporting periods beginning on or after 1 July 2025.

The Townsville HHS is a not-for-profit entity and these general-purpose financial statements are prepared on an accrual basis (except for the statement of cash flows which is prepared on a cash basis) in accordance with Australian Accounting Standards and Interpretations applicable to not-for-profit entities.

New accounting standards early adopted and/or applied for the first time in these financial statements are outlined in Note F4.

Presentation

Currency and rounding

The financial statements are presented in Australian dollars, which is the Townsville HHS' functional and presentation currency. Amounts included in the financial statements have been rounded to the nearest thousand dollars, or in certain cases, the nearest dollar.

Comparatives

Comparatives have been reclassified where appropriate for consistency with current year classification.

Current/non-current classification

Assets and liabilities are classified as either 'current' or 'non-current' in the statement of financial position and associated notes.

Assets are classified as 'current' where their carrying amount is expected to be realised within 12 months after the reporting date. Liabilities are classified as 'current' when they are due to be settled within 12 months after the reporting date, or the Townsville HHS does not have the right at the end of the reporting period to defer settlement to beyond 12 months after the reporting date.

All other assets and liabilities are classified as non-current.

Authorisation of financial statements for issue

The general-purpose financial statements are authorised for issue by the Board Chair, Health Service Chief Executive and the Chief Finance Officer, at the date of signing the Management Certificate.

Basis of measurement

These financial statements are general purpose financial statements and have been prepared on both a historical cost and fair value basis in accordance with all applicable new and amended Australian Accounting Standards and Interpretations, applicable to not-for-profit entities, except where stated otherwise.

Further information

For information in relation to the Townsville HHS's financial statements:

- Email tsv-public-affairs@health.qld.gov.au or
- Visit the Townsville HHS website at: www.townsville.health.qld.gov.au

How we operate – Townsville HHS objectives and activities

A1 OBJECTIVES OF THE TOWNSVILLE HHS

The Townsville HHS is an independent statutory body established on 1 July 2012 under the *Hospital and Health Boards Act 2011* (The Act). The Townsville HHS is governed by the Townsville Hospital and Health Board (the Board), which is accountable to the local community and the Minister for Health and Ambulance Services.

The Townsville HHS is responsible for providing primary health, community health and hospital services in the area assigned under the *Hospital and Health Boards Regulation 2023*. The Townsville HHS covers an area of more than 148,000 square kilometres, around 8.5 per cent of Queensland, and serves a population of approximately 250,000. The Townsville HHS also provides tertiary services to 670,000 people throughout northern Queensland from Mackay to the Torres Strait and out to the Northern Territory border.

Funding is obtained predominantly through the purchase of health services by the Department of Health (DOH/the Department) on behalf of both the State and Australian Governments. In addition, health services are provided on a fee-for-service basis mainly for private patient care.

Please refer to the Townsville HHS Annual Report 2025-2026 for more information.

NON-WHOLLY OWNED ENTITIES

Investment in Northern Queensland Primary Health Network

The Northern Queensland Primary Health Network (NQPHN) was established as a public company limited by guarantee on 22 May 2015. Townsville HHS is one of 13 members, with each member holding one vote in the company.

The principal place of business of the NQPHN is Level 5, 111 Grafton Street, Cairns, Queensland. The company's principal purpose is to work with general practitioners, other primary health care providers, community health services, pharmacists and hospitals in Queensland to improve and coordinate primary health care across the local health system for patients requiring care from multiple providers.

As each member has the same voting entitlement, it is considered that no member has controlling power or significant influence over NQPHN (as defined by AASB 10 *Consolidated Financial Statements*). While Townsville HHS currently has 7.69 per cent of the voting power of the NQPHN and the fact that every other member also has 7.69 per cent voting power, it limits the extent of any influence that the Townsville HHS may have over the NQPHN.

Each member's liability to NQPHN is limited to \$10. The NQPHN is legally prevented from paying dividends to its members and its constitution also prevents any income or property of the company being transferred directly or indirectly to or amongst the members.

As the NQPHN is not controlled by the Townsville HHS and is not considered a joint operation or an associate of the Townsville HHS, the financial results of the NQPHN are not required to be disclosed in these statements.

Tropical Australian Academic Health Centre Limited

Tropical Australian Academic Health Centre Limited (TAAHC) registered as a public company limited by guarantee on 3 June 2019. The Townsville HHS is one of eight founding members along with Cairns and Hinterland Hospital and Health Service, Mackay Hospital and Health Service, North West Hospital and Health Service, Torres and Cape Hospital and Health Service, Northern Queensland Primary Health Network, James Cook University and Queensland Aboriginal and Islander Health Council. Each founding member holds two voting rights in the company and is entitled to appoint two directors.

The principal place of business of TAAHC is Townsville, Queensland. The company's principal purpose is the advancement of health through the promotion of the study and research topics of special importance to people living in the tropics.

As each member has the same voting entitlement (12.5%), it is considered that none of the individual members has power or significant influence over TAAHC (as defined by AASB 10 *Consolidated Financial Statements* and AASB 128 *Investments in Associates and Joint Ventures*). Each members' liability to TAAHC is limited to \$10. TAAHC's constitution prevents any income or property of the company being transferred directly or indirectly to or amongst the members. Each member must pay annual membership fees as determined by the Board of TAAHC.

As TAAHC is not controlled by Townsville HHS and is not considered a joint operation or an associate of Townsville HHS, financial results of TAAHC are not required to be disclosed in these statements.

Notes about financial performance

This section considers the income and expenses of the Townsville HHS

B1 INCOME

Note B1-1: User charges

	2026 \$'000	2025 \$'000
Revenue from contracts with customers		
Service income and recoveries	9,982	14,189
Pharmaceutical Benefits Scheme	54,977	50,359
Public patient income	19,680	21,364
Private hospital bed income	17,132	15,702
Other hospital services	24,695	19,102
Total	126,466	120,716

User charges

Revenue from contracts with customers is recognised when the service is rendered and can be measured reliably with a sufficient degree of certainty. This involves either invoicing for related goods/services and/or the recognition of accrued revenue. Revenue in this category primarily consists of hospital fees (private patients), reimbursement of pharmaceutical expense and the sale of goods and services.

Note B1-2: Funding for public health services

	2026 \$'000	2025 \$'000
Revenue from contracts with customers		
Department of Health		
Activity based funding	750,842	628,649
Australian Government		
Activity based funding	387,625	384,422
Other funding for public health services		
Department of Health		
Block funding	67,325	80,253
Tertiary training	29,159	27,177
System funding	138,000	133,345
Depreciation funding	87,549	86,782
Australian Government		
Block funding	25,188	40,286
Tertiary training	10,437	11,482
Total	1,496,125	1,392,396

Funding for public health services

Funding is provided predominantly from the Department of Health for specific public health services purchased by the Department in accordance with a service agreement. The Australian Government pays its share of national health funding directly to the Department of Health, for onforwarding to the Hospital and Health Service. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by Townsville HHS. Cash funding from the Department of Health is received fortnightly for state payments and monthly for commonwealth payments and is recognised as revenue as the performance obligations under the service level agreement are discharged.

At the end of the financial year, an agreed technical adjustment between the Department of Health and Townsville HHS may be required for the level of services performed above or below the agreed levels, which may result in a receivable or unearned revenue. This technical adjustment process is undertaken annually according to the provisions of the service level agreement and ensures that the revenue recognised in each financial year correctly reflects Townsville HHS' delivery of health services.

Activity Based Funding (ABF) funding is recognised where the specific conditions and activity targets have been met or funding is renegotiated with the Department and may result in a deferral or return of revenue recognised as a liability in the statement of financial position.

Block funding is not based on levels of public health care activity. Non-activity-based funding (block, etc.) is received for other services the Townsville HHS has agreed to provide as per the service agreement. This funding has conditions attached which are not related to activity covered by ABF. Non-activity-based funding is recognised upon receipt of funds and accords with the requirements of AASB 1058.

Tertiary training funding supports teaching, training and research in public hospitals, and public health programs.

System manager funds are funds paid directly to the HHS from the Department's operating account and consists of funding for various programmes for public health services. This funding does not form part of the National Health Reform Agreement.

The service agreement between the Department of Health and the Townsville HHS specifies that the Department of Health funds the Townsville HHS's depreciation and amortisation charges via non-cash revenue. The Department of Health retains the cash to fund future major capital replacements. This transaction is shown in the Statement of Changes in Equity as a non-appropriated equity withdrawal. Depreciation Funding is recognised under AASB 1058.

Note B1-3: Grants and other contributions

	2026	2025
	\$'000	\$'000
Revenue from contracts with customers		
Australian Government - Specific purpose recurrent grants	31,664	31,596
Other grants	7,112	6,135
Other grants and contributions		
Donations other	42	283
Donations non-current physical assets	341	52
Services received below fair value	10,977	10,331
Total	50,136	48,397

Grants and other contributions

Grants, contributions, and donations revenue arise from non-exchange transactions where the Townsville HHS does not directly give approximately equal value to the grantor.

Where the grant agreement is enforceable and contains sufficiently specific performance obligations for the Townsville HHS to transfer goods or services to a third-party on the grantor's behalf, the transaction is accounted for under AASB 15 *Revenue from Contracts with Customers*. In this case, revenue is initially deferred (as a contract liability) and recognised as or when the performance obligations are satisfied.

Otherwise, the grant is accounted for under AASB 1058 *Income of Not-for-Profit Entities*, whereby revenue is recognised upon receipt of the grant funding, except for special purpose capital grants received to construct non-financial assets to be controlled by the Townsville HHS. Special purpose capital grants are recognised as unearned revenue when received, and subsequently recognised progressively as revenue as the Townsville HHS satisfies its obligations under the grant through construction of the asset.

Grants included from revenue from contracts with customers consist of Commonwealth funding agreements and other grants. Grant revenue is determined by the level of care and the nature of the service provided. Revenue is recognised and measured in compliance with AASB 15 upon provision of services.

Specific purpose recurrent grants have Commonwealth funding agreements in place and have specific requirements for the funding to be provided. Funding is determined by the level of care or service provided. As such, these funds are recognised under AASB 15 and recognised upon provision of service.

The Townsville HHS will retain ownership of the final asset. Revenue will be recognised under AASB 1058 and recognised over time.

Other grants, have formal agreements in place and funding is based on levels of service and/or activities performed. Revenue is recognised under AASB 15 upon provision of service or activity performed.

Donations other, are donations of cash or equipment that is provided unconditionally. The Townsville HHS will retain donated funds for general use. The Townsville HHS does not provide an equivalent value or service in return for the donation. These funds are recognised under AASB 1058 and recognised upon receipt.

Services received below fair value represents services received by the Townsville HHS below fair value, from the Department of Health \$10.977M (2025: \$10.331M). The Townsville HHS has brought the income and corresponding expense into account at 30 June 2026 and is included in other grants and contributions and classified under AASB 1058 *Income for Not-for-Profit Entities*.

Note B1-4: Other revenue

	2026	2025
	\$'000	\$'000
Interest	987	1,090
Rental income	669	632
Sale proceeds of non-capitalised assets	7	1
Fees, charges and recoveries	6,694	8,584
Gain on sale of property plant and equipment	39	293
Total other revenue	8,396	10,600

Other revenue

Other revenue is recognised when the right to receive the revenue has been established. Revenue is measured at the fair value of the consideration received, or receivable.

B2 EXPENSES

Note B2-1: Employee expenses

	2026	2025
	\$'000	\$'000
Employee benefits		
Wages and salaries	156,970	145,223
Annual leave levy	20,806	18,934
Long service leave levy	4,280	3,972
Employer super contribution	17,814	16,360
Termination expenses	99	807
Employee-related expenses		
WorkCover expenses	1,451	1,541
Other employee related expenses	11,018	9,854
Total employee expenses	212,438	196,691

Note B2-2: Health service employee expenses

	2026	2025
	\$'000	\$'000
Employee benefits		
Health service employee expenses	938,824	867,065
WorkCover expenses	8,681	9,204
Total health service employee expenses	947,505	876,269

Employee benefits

Board members, executives and senior medical officers are directly engaged by the Townsville HHS. The number of full-time equivalent staff employed in this capacity was 366 (2025: 316).

(i) Wages, Salaries and Sick Leave

Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at current salary rates. As the Townsville HHS expects such liabilities to be wholly settled within 12 months of the reporting date, the liabilities are recognised at undiscounted amounts.

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

(ii) Annual and Long Service Leave

The Townsville HHS participates in the Annual Leave Central Scheme and the Long Service Leave Scheme.

Under the Queensland Government's Annual Leave Central Scheme and the Long Service Leave Central Scheme, levies are payable by the Townsville HHS to cover the cost of employee and Department of Health contract staff's annual leave (including leave loading and on-costs) and long service leave. These levies are expensed in the period in which they are payable. Amounts paid to staff for annual leave and long service leave are claimed from the schemes quarterly in arrears which is currently facilitated by the Department of Health. The leave balances are

restated to include the wage increase in the relevant Enterprise Bargaining Agreements (EBA) approved in the year.

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

(iii) *Superannuation*

Post-employment benefits for superannuation are provided through defined contribution (accumulation) plans or the Queensland Government's defined benefit plan (the former QSuper defined benefit categories now administered by the Government Division of the Australian Retirement Trust) as determined by the employee's conditions of employment.

Defined contribution plans – Contributions are made to the eligible complying superannuation funds based on the rates specified in the relevant EBA or other conditions of employment. Contributions are expensed when they are paid or become payable following completion of the employee's service each pay period.

Defined benefit plan – The liability for defined benefits is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting*. The amount of contributions for defined benefit plan obligations is based upon the rates determined on the advice of the State Actuary. Contributions are paid by the Townsville HHS at the specified rate following completion of employee's service each pay period. The Townsville HHS's obligations are limited to those contributions paid.

(iv) *Other employee related expenses*

Other employee related expenses include professional development, salary recoveries and other payments made to staff.

Employee related expenses

The Townsville HHS pays premiums to WorkCover Queensland in respect of its obligations for employee compensation related to workplace injuries, health, and safety.

Workers' compensation insurance is a consequence of employing employees but is not counted in an employee's total remuneration package. It is not an employee benefit and is recognised separately as employee-related expenses.

Health service employee expenses

The Townsville HHS through service arrangements with the Department of Health has engaged 6,289 (2025: 6,027) full-time equivalent persons at 30 June 2026.

In accordance with the *Hospital and Health Boards Act 2011* section 67, the employees of the Department of Health are referred to as health service employees. Under this arrangement the Department provides employees to perform work for Townsville HHS and acknowledges and accepts its obligations as the employer of these employees. Townsville HHS is responsible for the day-to-day management of these departmental employees and reimburses the department for the salaries and on-costs of these employees.

The health service employee-related expenses include a pro-rata of the Townsville HHS's workers' compensation insurance premium of \$8.681M (2025: \$9.204M). Recoveries of salaries and wages costs for health service employees working for other agencies are recorded as revenue. Refer to note B1-4.

Note B2-3: Supplies and services

	2026	2025
	\$'000	\$'000
Consultants and contractors	27,821	30,299
Electricity and other energy	9,568	8,505
Patient travel	16,359	16,215
Other travel	5,381	5,533
Building services	3,930	3,437
Computer services	13,986	12,862
Motor vehicles	581	579
Communications	23,697	21,470
Repairs and maintenance	22,071	19,375
Expenses relating to capital works	4,757	2,567
Rental expenses	260	386
Lease expenses	5,352	4,963
Drugs	75,505	70,560
Clinical supplies and services	133,652	118,978
Catering and domestic supplies	16,964	16,106
Other supplies and services	51,973	59,882
Total supplies and services	411,857	391,717

Supplies and services

For a transaction to be recognised as supplies and services, the value of goods or services received by the Townsville HHS must be of approximately equal value to the value of the consideration exchanged for these goods and services. Where this is not the substance of the arrangement, the transaction is classified as a grant.

The Townsville HHS also receives corporate services support from the Department of Health for no cost. Corporate services received include payroll services, accounts payable services, finance transactional services and taxation services. The cost of services received by the Townsville HHS below fair value is \$10.977M (2025: \$10.331M), as determined by the Department of Health. The Townsville HHS has brought the income and corresponding expense to account at 30 June 2026 and is included in other supplies and services.

Lease expenses

Lease expenses include lease rentals for short-term leases and office accommodation payments for non-specialised commercial office accommodation under the Queensland Government Accommodation Office (QGAO) framework. Refer to Note B11 for breakdown of lease expenses and other lease disclosures.

Payments for QFleet leasing arrangements are expensed as incurred and categorised in lease expenses.

Note B2-4: Depreciation and amortisation

	2026	2025
	\$'000	\$'000
Depreciation		
Buildings and Land Improvements	67,564	68,954
Plant and equipment	17,948	15,891
ROU Depreciation		
Buildings	1,383	1,298
Amortisation		
Software purchased	77	63
Software developed	577	576
Total depreciation and amortisation	87,549	86,782

Depreciation and amortisation

Depreciation and amortisation expenses include depreciation on property plant and equipment (Note B7-1), right-of-use assets (Note B11-1) and amortisation of intangibles (Note B7-4).

Note B2-5: Other expenses

	2026	2025
	\$'000	\$'000
Audit fees*	614	861
Bank fees	96	48
Insurance**	12,433	12,263
Inventory written off	344	230
Special payments - ex gratia payments	110	158
Other legal costs	1,321	681
Journals and subscriptions	306	303
Advertising	575	428
Interpreter fees	471	392
Fees, fines and other charges	1,478	574
Total other expenses	17,748	15,938

* During the 2026 financial year \$260,500 fees were quoted for supply of services provided by Queensland Audit Office, the auditor of the Townsville HHS (2025: \$258,500). The Townsville HHS paid \$409,343 to other service providers for internal audit services (2025: \$388,708). Some of these services will not be finalised in the 2025-2026 financial year and as such are not included in the above Audit fees

** Includes Queensland Government Insurance Fund (QGIF)

Special payments

Special payments include ex-gratia expenditure and other expenditure that the Townsville HHS is not contractually or legally obligated to make to other parties. In compliance with the *Financial and Performance Management Standard 2019*, the Townsville HHS maintains a register setting out details of all special payments exceeding \$5,000.

Special payments during 2025-2026 include payments over \$5,000 for compensation for damages.

Special payments:

- Patient and other \$6K
- Out-of-court settlement \$55K
- Compensation claims \$49K

Patient and other payments generally relate to payments made for items lost or damaged whilst the patient is in attendance at a Townsville HHS facility.

Insurance

Queensland Health annually purchases insurance cover for hospital and health services and the Department of Health through the Queensland Government Treasury managed self-insurance scheme, QGIF. For the 2025-2026 policy year, the premium was allocated to each hospital and health service according to the underlying risk of an individual insured party.

Property and general losses above a \$10,000 threshold are insured through QGIF. Health litigation payments above a \$20,000 threshold and associated legal fees are also insured through QGIF. Premiums are calculated by QGIF on a risk-assessed basis.

Notes about our financial position

This section provides information on the assets used in the operation of the Townsville HHS's service and the liabilities incurred as a result.

B3 CASH AND CASH EQUIVALENTS

	2026	2025
	\$'000	\$'000
Cash at bank and on hand	92,674	58,522
Restricted cash*	21,420	22,507
Total cash and cash equivalents	114,094	81,029

*Refer to Note E2

Cash and cash equivalents

Cash and cash equivalents include all cash and cheques receipted at 30 June 2026 as well as deposits with financial institutions.

General trust funds are managed on an accrual basis and are included within cash and cash equivalents. This money is controlled by the Townsville HHS and forms part of the cash and cash equivalents balance; however, it is restricted as it can only be used for specific purposes. The restricted cash balances are invested under the whole-of-government banking arrangements with Queensland Treasury Corporation.

B4 RECEIVABLES

	2026	2025
	\$'000	\$'000
Trade receivables	16,547	17,545
Less: Loss allowance	(2,008)	(2,377)
	14,539	15,168
GST input tax credits receivable	2,886	3,080
GST payable	(342)	(292)
	2,544	2,788
Contract Assets	18,747	16,487
Other	2,534	4,950
Total receivables	38,364	39,393

Receivables

Receivables are measured at amortised cost which approximates their fair value at reporting date.

Trade debtors are recognised at the amounts due at the time of sale or service delivery i.e. the agreed purchase/contract price. Settlement of these amounts is required within 30 days from invoice date.

Other debtors generally arise from transactions outside the usual operating activities of the Townsville HHS and are recognised at their assessed values. Terms are a maximum of three months, no interest is charged and no security is obtained.

Contract assets arise from contracts with customers and are transferred to receivables when the Townsville HHS's right to payment becomes unconditional. This usually occurs when the invoice is issued to the customer. Accrued revenue that does not arise from contracts with customers are reported as part of Other.

Contract assets were not impaired as they relate primarily to Government contracts and carry minimal risk of non-payment.

B4-1 IMPAIRMENT OF RECEIVABLES

Accounting policy – Impairment of receivables

The loss allowance for trade and other receivables reflects lifetime expected credit losses and incorporates reasonable and supportable forward-looking information. Economic changes impacting the Townsville HHS's debtors, and relevant industry data form part of the Townsville HHS's impairment assessment.

The Townsville HHS's contract asset receivables are from Queensland Government agencies or Australian Government agencies. No loss allowance is recorded for these receivables. Refer to Note C2 for the Townsville HHS credit risk management policies.

Where the Townsville HHS has no reasonable expectation of recovering an amount owed by a debtor, the debt is written-off by directly reducing the receivable against the loss allowance. This occurs when the Townsville HHS has ceased enforcement activity.

Disclosure – Credit risk exposure of receivables

The maximum exposure to credit risk at balance date for receivables is the gross carrying amount of those assets. No collateral is held as security and there are no other credit enhancements relating to Townsville HHS's receivables.

The Townsville HHS uses a provision matrix to measure the expected credit losses on trade and other debtors. Loss rates are calculated separately for groupings of customers with similar loss patterns by debt type. The Townsville HHS has measured expected credit losses based on the sale of services reflecting the different customer profiles and debt categories for these revenue streams. Debt categories include Medicare ineligible, inpatient, outpatient, pharmacy, other debt (inter-entity and corporate) and recoverability rates are based on historical loss patterns.

The calculations reflect historical observed default rates calculated using credit losses experienced on past transactions during the last five years preceding 30 June 2026. The Townsville HHS has not adjusted the credit loss calculation for any forward-looking indicators as national or local macroeconomic factors would not cause a significant change in overall loss value.

Set out below is the credit risk exposure on the Townsville HHS's trade and other debtors broken down by debtor types.

Debt Type	2026			2025		
	Gross	Loss rate	Expected	Gross	Loss rate	Expected
	receivables		credit	receivables		credit
	\$'000	%	\$'000	\$'000	%	\$'000
Ineligible - inpatient	2,434	40%	975	2,561	46%	1,190
Ineligible - outpatient	678	28%	192	455	25%	113
Inpatient	8,504	7%	618	8,881	4%	366
Outpatient	2,472	5%	115	3,873	13%	498
Other - pharmacy	34	2%	1	41	7%	3
Other	2,425	4%	107	1,734	12%	207
	16,547		2,008	17,545		2,377

B5 INVENTORIES

Inventories consist mainly of pharmaceutical and clinical supplies held for distribution. Inventories are measured at cost following periodic assessments for obsolescence. Where damaged or expired items have been identified, provisions are made for impairment.

B6 OTHER ASSETS

	2026 \$'000	2025 \$'000
Current		
Prepayments	3,970	3,584
Total other current assets	3,970	3,584

B7 PROPERTY, PLANT AND EQUIPMENT

Note B7-1

	2026 \$'000	2025 \$'000
Land - at fair value	71,353	68,424
Buildings - at fair value	2,229,805	1,931,700
Less: Accumulated depreciation	(1,432,659)	(1,176,801)
	797,146	754,899
Plant and equipment - at cost	217,456	210,951
Less: Accumulated depreciation	(136,562)	(140,233)
	80,894	70,718
Heritage, artworks and cultural assets – at fair value	428	428
Heritage, artworks and cultural assets – at cost	115	115
Capital works in progress - at cost	40,554	50,039
	990,490	944,623

	Land \$'000	Buildings \$'000	Plant and equipment \$'000	Heritage, artworks and cultural assets \$'000	Capital works in progress \$'000	Total \$'000
Balance at 30 June 2024	64,558	717,477	65,958	543	39,271	887,807
Additions	-	10,671	16,810	-	28,303	55,784
Revaluation increments	3,866	81,327	-	-	-	85,193
Transfers in	-	-	684	-	-	684
Transfers between classes	-	14,378	3,157	-	(17,535)	-
Depreciation expense	-	(68,954)	(15,891)	-	-	(84,845)
Balance at 30 June 2025	68,424	754,899	70,718	543	50,039	944,623
Additions	-	1,030	9,442	-	41,590	52,062
Disposals	-	-	(4)	-	-	(4)
Revaluation increments	2,929	62,774	-	-	-	65,703
Transfers in	-	13,554	64	-	-	13,618
Transfers between classes	-	32,453	18,622	-	(51,075)	-
Depreciation expense	-	(67,564)	(17,948)	-	-	(85,512)
Balance at 30 June 2026	71,353	797,146	80,894	543	40,554	990,490

Note B7-2: Accounting policies

Property, plant and equipment

Recognition threshold for property, plant and equipment

Items of property, plant, and equipment with a cost or other value equal to more than the following thresholds, and with a useful life of more than one year, are recognised at acquisition. Items below these values are expensed on acquisition.

Class	Threshold
Land	\$1
Buildings	\$10,000
Plant and Equipment	\$5,000
Heritage, artworks and cultural assets	\$5,000

Key judgement: Expenditure is only capitalised if it increases the service potential or useful life of the existing asset. Maintenance expenditure that merely restores original service potential (arising from ordinary wear and tear, for example) is expensed.

Acquisition of Assets

Actual cost is used for the initial recording of all non-current asset acquisitions. Cost is determined as the value given as consideration plus costs incidental to the acquisition, including all other costs incurred in getting the assets ready for use.

Capital works in progress are at cost until they are ready for use. The construction of major health infrastructure assets is managed by the Department of Health on behalf of the Townsville HHS. These assets are assessed at fair value upon practical completion by an independent valuer. They are then transferred from the Department of Health to the Townsville HHS via an equity adjustment.

Where assets are received free of charge from another Queensland Government entity (whether because of a machinery-of-government change or other involuntary transfer), the acquisition cost is recognised at the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation.

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

Subsequent measurement of property, plant and equipment

Land and buildings are subsequently measured at fair value as required by Queensland Treasury's Non-Current Asset Policies for the Queensland Public Sector. These assets are reported at their revalued amounts, being the fair value at the date of valuation, less any subsequent accumulated depreciation and subsequent accumulated impairment losses where applicable. The cost of items acquired during the financial year has been judged by management to materially represent their fair value at the end of the reporting period.

Plant and equipment are measured at cost net of accumulated depreciation and any impairment in accordance with Queensland Treasury's Non-Current Asset Policies for the Queensland Public Sector. The carrying amounts for such plant and equipment at cost are not materially different from their fair value.

Heritage, artworks and cultural assets are measured at both cost and fair value. The cost at the date of acquisition was equivalent to fair value.

Depreciation

Land is not depreciated as it has an unlimited useful life.

Buildings, plant, and equipment are depreciated on a straight-line basis to allocate the revalued amount or net cost of each asset (respectively), less its estimated residual value, progressively over its estimated useful life to the Townsville HHS.

Heritage, artworks and cultural assets are not depreciated as the assets have an unlimited useful life.

Capital works in progress are not depreciated until ready for use. These assets are then reclassified to the relevant class within property, plant, and equipment.

Any expenditure that increases the capacity or service potential of an asset is capitalised and depreciated over the remaining useful life of the asset to the Townsville HHS.

Key estimate: The depreciation rate is determined by application of appropriate useful life to relevant non-current asset classes. The useful lives could change significantly because of a change in use of the asset, technical obsolescence or some other economic event. The impact on depreciation can be significant and could result in a write-off of the asset.

For each class of depreciable assets, the following depreciation rates are used:

Class	Rate
Buildings	2.5% to 3.3%
Plant and equipment	5% to 33.33%

Accounting policy

Indicators of impairment and determining the recoverable amount

All property, plant and equipment assets are assessed for indicators of impairment on an annual basis or, where the asset is measured at fair value, for indicators of a change in fair value/service potential since the last valuation arise, the asset is revalued at the reporting date under AASB 13 *Fair value Measurement*. If an indicator of possible impairment exists, the HHS determines the asset's recoverable amount under AASB 136 *Impairment of Assets*. Recoverable amount is equal to the higher of the fair value less costs of disposal and the asset's value in use subject to the following:

- As a not-for-profit entity, certain property, plant, and equipment of the HHS is held for the continuing use of its service capacity and not for the generation of cash flows. Such assets are typically specialised in nature. In accordance with AASB 136, where such assets measured at fair value under AASB 13, that fair value (with no adjustment for disposal costs) is effectively deemed to be a recoverable amount. Consequently, AASB 136 does not apply to such assets unless they are measured at cost.
- For other non-specialised property, plant and equipment measured at fair value, where indicators of impairment exist, the only difference between the asset's fair value and its fair value less costs of disposal, is the incremental costs attributable to the disposal of the asset. Consequently, the fair value of the asset determined under AASB 13 will materially approximate its recoverable amount where the disposal costs attributable to the asset are negligible. After the revaluation requirements of AASB 13 are first applied to these assets, applicable disposal costs are assessed and, in the circumstances where such costs are not negligible, further adjustments to the recoverable amount are made in accordance with AASB 136.

For all other remaining assets measured at cost, recoverable amount is equal to the higher of the fair value less costs of disposal and the asset's value in use.

Value in use is equal to the present value of the future cashflows expected to be derived from the asset, or where the department no longer uses an asset and has made a formal decision not to reuse or replace the asset, the value in use is the present value of net disposal proceeds.

Revaluation of land and buildings at fair value

Property, plant, and equipment classes measured at fair value are revalued on an annual basis by an independent professional valuer, or by the use of appropriate and relevant indices. Where an asset is revalued using a market valuation approach, any accumulated impairment losses at that date are eliminated against the gross amount of the asset prior to restating for the revaluation.

Revaluations using an independent professional valuer are undertaken using a rolling revaluation plan over three years. However, if an asset class experiences significant and volatile changes in fair value, that class is subject to specific appraisal in the reporting period, where practicable, regardless of the timing of the last specific appraisal.

Where assets have not been specifically appraised in the reporting period, their previous valuations are materially kept up to date via the application of relevant indices. The Townsville HHS ensures that the application of such indices results in a valid estimation of the assets' fair values at reporting date.

The valuer supplies the indices used for the various types of assets. Such indices are either publicly available or are derived from market information available to the valuer. The valuer provides assurance of their robustness, validity and appropriateness for application to the relevant assets.

Accounting for changes in fair value

Any revaluation increment arising on the revaluation of an asset is credited to the asset revaluation surplus of the appropriate class, except to the extent it reverses a revaluation decrement for the class previously recognised as an expense. A decrease in the carrying amount on revaluation is charged as an expense, to the extent it exceeds the balance, if any, in the revaluation surplus relating to that asset class.

The Townsville HHS has adopted the cost valuation approach (e.g. current replacement cost) – accumulated depreciation is adjusted to equal the difference between the gross amount and the carrying amount, after taking into account accumulated impairment losses. This is generally referred to as the 'gross method'.

Valuation

Key judgement: The fair values reported by the Townsville HHS are based on appropriate valuation techniques that maximise the use of available and relevant observable inputs and minimise the use of unobservable inputs.

Land

For financial reporting purposes, the land and building revaluation process is overseen by the Board and coordinated by senior management and support staff.

Land is measured at fair value using indexation or asset-specific independent revaluations, being provided by an independent quantity surveyor, Jacobs Group (Australia) Pty Ltd. Independent asset specific revaluations are performed with sufficient regularity to ensure land assets are carried at fair value.

Land indices are based on actual market movements for the relevant locations and asset category and are applied to the fair value of land assets on hand. Independent land revaluations were conducted utilising comparative market analysis data as at April 2026, with an effective date as at 30 June 2026. Land resulted in a net revaluation increment of \$2.929M (2025: Increment of \$3.866M).

Buildings

Valuation approach (key judgement): Current replacement cost (due to no active market for such facilities) - Reflecting the specialised nature of health service buildings, fair value is determined by applying replacement cost methodology or an index which approximates movement in market prices for construction labour and other key resource inputs, as well as changes in design standards as at the reporting date. Both methodologies are executed on behalf of the Townsville HHS by an independent quantity surveyor and valuer Jacobs Group (Australia) Pty Ltd. The Townsville HHS undertakes a three-year rolling revaluation plan for valuation of assets. Assets not revalued in a financial year are adjusted through the application of indices.

Inputs (key estimates): The valuation methodology for the independent valuation uses historical and current construction costs. The replacement cost of each building at date of valuation is determined by considering Townsville location factors and comparing against current construction costs. The valuation is provided for a replacement building of the same size, shape and functionality that meets current design standards, and is based on estimates of gross floor area, number of floors, building girth and height and existing lifts and staircases.

This method makes an adjustment to the replacement cost of the modern-day equivalent building for any utility embodied in the modern substitute that is not present in the existing asset (e.g. mobility support) to give a gross replacement cost that is of comparable utility (the modern equivalent asset). The methodology makes further adjustment to total estimated life taking into consideration physical obsolescence impacting on the remaining useful life to arrive to the current replacement cost via straight-line depreciation.

For residential buildings held by the Townsville HHS on separate land titles, fair value is determined by reference to independent market revaluations.

On revaluation, accumulated depreciation is restated proportionately with the change in the carrying amount of the asset and the change in the estimate of remaining useful life.

Assets under construction are not revalued until they are ready for use.

The impact of the valuation exercise conducted in April 2026, with an effective date as at 30 June 2026, resulted in a building increment of \$62.774M (2025 increment of \$81.327M). The valuation increment was primarily due to a 6% increase (2025: 6% increase) in indexation valuation in 2025-2026 due to rising construction costs and an increase in estimated remaining useful lives on some buildings.

Note B7-3: Intangibles and amortisation expense

Recognition and measurement

Intangible assets of the Townsville HHS with a historical cost or other value equal to or greater than \$100,000 are recognised in the financial statements.

Items with a lesser value are expensed. Any training costs are expensed as incurred.

There is no active market for any of the Townsville HHS's intangible assets. As such, the assets are recognised and carried at historical cost less accumulated amortisation and accumulated impairment losses.

Expenditure on research activities relating to internally generated intangible assets is recognised as an expense in the period in which it is incurred.

Costs associated with the internally generated intangible assets are capitalised and amortised under the amortisation policy below. No intangible assets have been classified as held for sale or form part of a disposal group held for sale.

Amortisation expense

Accounting policy

All intangible assets of the Townsville HHS have finite useful lives and are amortised on a straight-line basis over their estimated useful life to the Townsville HHS. Straight line amortisation is used reflecting the expected consumption of economic benefits on a progressive basis over the intangible's useful life. The residual value of all the Townsville HHS's intangible assets is zero.

Useful life

Key estimate: For each class of intangible asset the following amortisation rates are used:

Intangible Asset	Rate
Software Purchased	20%
Internally Generated Intangible Asset	20%

Impairment

Accounting policy

All intangible assets are assessed for indicators of impairment on an annual basis. If an indicator of possible impairment exists, the Townsville HHS determines the asset's recoverable amount. Any amount by which the asset's carrying amount exceeds the recoverable amount is recorded as an impairment loss.

Intangible assets are principally assessed for impairment by reference to the actual and expected continuing use of the asset by the Townsville HHS, including discontinuing the use of the intangible asset. Recoverable amount is determined as the higher of the asset's fair value less costs to sell and its value-in-use.

Note B7-4: Intangibles

	2026	2025
	\$'000	\$'000
Total intangibles		
Software work in progress	1,188	297
Software purchased	5,731	5,429
Software purchased - accumulated amortisation	(5,474)	(5,397)
Internally generated intangible asset	3,601	2,880
Software generated - accumulated amortisation	(1,153)	(576)
Total intangibles	3,893	2,633

2026

	Software purchased \$'000	Internally generated intangible asset \$'000	Software work in progress \$'000	Total \$'000
Cost	5,731	3,601	1,188	10,520
Less: Accumulated amortisation	(5,474)	(1,153)	-	(6,627)
Carrying amount at end of year	257	2,448	1,188	3,893

Movement

Carrying amount at start of period	32	2,304	297	2,633
Additions	302	721	891	1,914
Amortisation expense	(77)	(577)	-	(654)
Carrying amount at end of year	257	2,448	1,188	3,893

2025

	Software purchased \$'000	Internally generated intangible asset \$'000	Software work in progress \$'000	Total \$'000
Cost	5,429	2,880	297	8,606
Less: Accumulated depreciation	(5,397)	(576)	-	(5,973)
Carrying amount at end of year	32	2,304	297	2,633

Movement

Carrying amount at start of period	95	2,133	-	2,228
Additions	-	747	297	1,044
Amortisation expense	(63)	(576)	-	(639)
Carrying amount at end of year	32	2,304	297	2,633

B8 TRADE AND OTHER PAYABLES

	2026 \$'000	2025 \$'000
Current		
Trade creditors	79,493	80,237
Accrued expenses	83,753	55,298
Payable funding expenses	2,691	107
Other payables	966	954
Total other current payables	166,903	136,596
Non-current		
Other payables	687	-
Total non-current payables	687	-
Total payables	167,590	136,596

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

Other payables are recognised as a result of a financing arrangement entered into with respect to the purchase of two linear accelerator plant and equipment assets.

All payables are presented as current liabilities unless payment is not due within 12 months from the reporting date.

B9 OTHER LIABILITIES

	2026 \$'000	2025 \$'000
Current		
Contract liabilities	3,254	1,383
Unearned other revenue	166	140
Total other current liabilities	3,370	1,523

Disclosure – contract liabilities

Contract liabilities arise from contracts with customers while other unearned revenue arise from transactions that are not contracts with customers.

The opening balance of contract liabilities from the beginning of the period has been fully recognised as revenue from contracts with customers in year.

B10 EQUITY

Note B10-1: Equity - contributed

	2026 \$'000	2025 \$'000
Opening balance at beginning of year	399,723	440,070
<i>Non-appropriated equity injections</i>		
Minor capital funding	53,273	45,751
<i>Non-appropriated equity withdrawals</i>		
Non-cash depreciation funding returned to Department of Health as a contribution towards capital works program	(87,549)	(86,782)
<i>Non-appropriated equity</i>	13,618	684
Asset transfers		
Net equity injections and equity withdrawals for the period	379,065	399,723

Equity contributions consist of cash funds provided for sustaining minor capital works \$53.273M during 2026 (\$45.751M during 2025) and assets transferred to the Townsville HHS \$13.618M during 2026 (\$684K transferred during 2025). Equity withdrawals represent the contribution towards the capital works program undertaken by the Department of Health on behalf of the Townsville HHS.

Capital acquisitions for the Townsville HHS are funded through accumulated surpluses and contributed equity. When managing capital, management's objective is to ensure the entity continues as a going concern as well as to meet service delivery outcomes.

Note B10-2: Asset revaluation surplus

	2026 \$'000	2025 \$'000
Land		
Balance at the beginning of the financial year	38,930	35,064
Revaluation increments/(decrements)	2,929	3,866
	41,859	38,930
Buildings		
Balance at the beginning of the financial year	424,392	343,065
Revaluation increments/(decrements)	62,774	81,327
	487,166	424,392
Balance at the end of the financial year	529,025	463,322

The asset revaluation surplus represents the net effect of revaluation movements in assets since inception.

B11 LEASES

Note B11-1: Leases as a lessee

Right-of-use assets

	Buildings \$'000
Balance at 30 June 2025	5,159
Additions	681
Depreciation expense	(1,383)
Balance at 30 June 2026	4,457

	Buildings \$'000
Balance at 30 June 2024	3,063
Additions	3,394
Depreciation expense	(1,298)
Balance at 30 June 2025	5,159

Lease liabilities

	2026 \$'000	2025 \$'000
Current		
Lease liabilities	1,128	1,111
Non-current		
Lease liabilities	3,560	4,259
Total	4,688	5,370

Right-of-use assets

Right-of-use assets are initially recognised at cost comprising the following:

- the amount of the initial measurement of the lease liability
- lease payments made at or before the commencement date, less any lease incentives received
- initial direct costs incurred, and
- the initial estimate of restoration costs

Right-of-use assets are subsequently depreciated over the lease term and be subject to impairment testing on an annual basis.

The carrying amount of right-of-use assets are adjusted for any remeasurement of the lease liability in the financial year following a change in discount rate, a reduction in lease payments payable, changes in variable lease payments that depend upon variable indexes/rates or a change in lease term.

The Townsville HHS measures right-of-use assets from concessionary leases at cost on initial recognition, and measures all right-of-use assets at cost subsequent to initial recognition.

The Townsville HHS has elected not to recognise right-of-use assets and lease liabilities arising from short-term leases and leases of low value assets. The lease payments are recognised as expenses on a straight-line basis over the lease term. An asset is considered low value where it is expected to cost less than \$10,000 when new.

Lease liabilities

Lease liabilities are initially recognised at the present value of lease payments over the lease term that are not yet paid. The lease term includes any extension or renewal options that the Department is reasonably certain to exercise. The future lease payments included in the calculation of the lease liability comprise the following:

- fixed payments (including in-substance fixed payments), less any lease incentives receivable
- variable lease payments that depend on an index or rate, initially measured using the index or rate as at the commencement date
- amounts expected to be payable by the department under residual value guarantees
- the exercise price of a purchase option that the department is reasonably certain to exercise
- payments for termination penalties if the lease term reflects the early termination

When measuring the lease liability, the Townsville HHS uses its incremental borrowing rate as the discount rate where the interest rate implicit in the lease cannot be readily determined, which is the case for all of the Townsville HHS's leases. To determine the incremental borrowing rate, the Townsville HHS uses loan rates provided by Queensland Treasury Corporation that correspond to the commencement date and term of the lease.

Subsequent to initial recognition, the lease liabilities are increased by the interest charge and reduced by the amount of lease payments. Lease liabilities are also remeasured in certain situations such as a change in the lease arrangement.

Disclosures – Leases as a lessee

(i) Details of leasing arrangements as lessee

Category/Class of Lease Arrangement	Description of Arrangement
Building leases	Townsville HHS routinely enters into leases for housing and commercial space. Lease payments are subject to market rent reviews and/or CPI adjustments.

(ii) Office accommodation, employee housing and motor vehicles

The Department of Housing and Public Works (including QFleet) provides the Townsville HHS with access to office accommodation, employee housing and motor vehicle leases under government-wide frameworks. These arrangements are categorised as procurement of services rather than as leases because these Departments have substantive substitution rights over the assets. The related service expenses are included in Note B2-3.

(iii) Amounts recognised in profit or loss

	2026 \$'000	2025 \$'000
Interest expense on lease liabilities	197	187
Breakdown of 'Lease expenses' included in Note [B2-3]		
Expenses relating to short-term leases	3,175	2,935
Expenses relating to QFleet	2,177	2,028
Income from subleasing included in 'Rental income' in Note [B1-4]	(669)	(632)

Notes about risks and other accounting uncertainties

C1 FAIR VALUE MEASUREMENT

Fair value is the price that would be received to sell an asset in an orderly transaction between market participants at the measurement date under current market conditions (an exit price) regardless of whether the price is directly derived from observable inputs or estimated using another valuation technique.

Observable inputs are publicly available data that are relevant to the characteristics of the assets/liabilities being valued, and include, but are not limited to, published sales data for land.

Unobservable inputs are data, assumptions and judgements that are not available publicly, but are relevant to the characteristics of the assets/liabilities being valued. Significant unobservable inputs used by the Townsville HHS include, but are not limited to, subjective adjustments made to observable data to take account of the specialised nature of health service buildings and on hospital-site residential facilities, including historical and current construction contracts (and/or estimates of such costs), and assessments of physical condition and remaining useful life. Unobservable inputs are used to the extent that sufficient relevant and reliable observable inputs are not available for similar assets/liabilities.

A fair-value measurement of a non-financial asset considers a market participant's ability to generate economic benefit by using the asset in its highest and best use, which is its current use unless the asset is classified as held-for-sale under AASB 5 or it becomes highly probable that the asset will be used for an alternative purpose.

All assets and liabilities of the Townsville HHS for which fair value is measured or disclosed in the financial statements are categorised within the following fair value hierarchy, based on the data and assumptions used in the most recent specific appraisals:

- Level 1: represents fair value measurements that reflect unadjusted quoted market prices in active markets for identical assets and liabilities;
- Level 2: represents fair value measurements that are substantially derived from inputs (other than quoted prices included in level 1) that are observable, either directly or indirectly; and
- Level 3: represents fair value measurements that are substantially derived from unobservable inputs. There were no transfers of assets between fair value hierarchy levels during the period.

2026	Level 1 \$'000	Level 2 \$'000	Level 3 \$'000	Total \$'000
<i>Assets</i>				
Land	-	71,353	-	71,353
Buildings	-	1,493	795,653	797,146
Heritage, artworks and cultural assets	-	-	428	428
Total assets	-	72,846	796,081	868,927
2025	Level 1 \$'000	Level 2 \$'000	Level 3 \$'000	Total \$'000
<i>Assets</i>				
Land	-	68,424	-	68,424
Buildings	-	2,167	752,732	754,899
Heritage, artworks and cultural assets	-	-	428	428
Total assets	-	70,591	753,160	823,751

Refer to B7-2 for valuation of land and buildings.

C2 FINANCIAL RISK MANAGEMENT

A financial instrument is any contract that gives rise to both a financial asset of one entity and a financial liability or equity instrument of another entity. The Townsville HHS holds financial instruments in the form of cash, receivables and payables.

Recognition

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

Classification

Financial instruments are classified and measured as follows:

- Cash and cash equivalents – held at fair-value
- Receivables – held at amortised cost
- Payables – held at amortised cost

The Townsville HHS does not enter into transactions for speculative purposes, or for hedging. Apart from cash and cash equivalents, the Townsville HHS holds no financial assets classified at fair-value through profit or loss.

The Townsville HHS is exposed to a variety of financial risks – credit risk, liquidity risk and market risk. The Townsville HHS holds the following financial instruments by category:

	2026 \$'000	2025 \$'000
Financial assets		
Cash and cash equivalents	114,094	81,029
Financial assets at amortised cost:		
Trade and other receivables	14,539	15,168
Net GST input tax credits receivable	2,544	2,788
Total financial assets	131,177	98,985
	2026 \$'000	2025 \$'000
Financial liabilities		
Financial liabilities at amortised cost - comprising:		
Trade and other payables	166,903	136,596
Lease liabilities	4,688	5,370
Total financial liabilities	171,591	141,966

No financial assets and liabilities have been offset and presented net in the statement of financial position.

Risk management is carried out by senior finance executives under policies approved by the Board. These policies include identification and analysis of the risk exposure of the Townsville HHS and appropriate procedures, controls and risk limits. Finance reports to the Board monthly.

Risk Exposure	Measurement method
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Credit risk	Ageing analysis, cash inflows at risk
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Liquidity risk	Monitoring of cash flows by management for short term obligations
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Market risk	Interest rate sensitivity analysis
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(a) Credit risk

Credit risk is the potential for financial loss arising from a counterparty defaulting on its obligations. The maximum exposure to credit risk at balance date is equal to the gross carrying value of receivables, inclusive of any allowance for impairment.

The carrying value of receivables represents the maximum exposure to credit risk.

Credit risk on cash deposits is considered minimal given all Townsville HHS deposits are held by the State through Queensland Treasury Corporation and the Commonwealth Bank of Australia and, as such, any reasonable change to trading terms has been assessed not to have a material impact on the Townsville HHS.

The Townsville HHS considers Medicare ineligible debtors to have a significantly increased credit risk and measures the loss allowance of such assets at lifetime expected credit losses by debt type.

Past due but not impaired as well as impaired financial assets are disclosed in Note B4-1.

(b) Liquidity risk

Liquidity risk is the risk that the Townsville HHS will not have the resources required at a time to meet its obligations to settle its financial liabilities.

The Townsville HHS is exposed to liquidity risk through its trading in the normal course of business. The Townsville HHS aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations as they fall due.

The Townsville HHS has an approved overdraft facility of \$13.5 million under whole-of-government banking arrangements to manage any short-term cash shortfall. As at 30 June 2026, the Townsville HHS had not drawn down on this facility.

(c) Market risk

The Townsville HHS is not exposed to fluctuations in market prices; market-risk exposure is limited to interest-rate risk.

Townsville HHS's only interest-rate risk exposure is on its 24-hour call deposits, which are limited to the balance as disclosed in Note B3. The impact of a reasonably possible change in interest rates has been assessed not to have a material impact on the Townsville HHS.

C3 CONTINGENCIES

(a) Litigation in progress

As at 30 June 2026, the following cases were filed in the courts naming the State of Queensland acting through the Townsville Hospital and Health Service as defendant:

Court	2026 No. of cases	New Cases	Completed Cases	2025 No. of cases
Health Litigation	63	33	39	69
General Liability	5	5	9	9
Property	8	3	-	5
Business Interruption	-	-	-	-
	76	41	48	83

Health litigation is underwritten by the Queensland Government Insurance Fund. The Townsville HHS's liability in this area is limited to an excess per insurance event of \$20,000 for health litigation claims and \$10,000 for General Liability, Property and Business interruption claims.

The Townsville HHS's legal advisers and management believe it would be misleading to estimate the final amounts payable (if any) in respect of the litigation before the courts at this time, but do not anticipate that the amount would exceed \$1.390M (2025: \$1.520M), being the upmost deductible amount being payable, based on the claims reflected above.

(b) Financial guarantees

Townsville HHS holds a register of unconditional undertakings in the form of contract performance guarantees as defined in the *Financial and Performance Management Standard 2019*.

The fair value of the performance guarantees at 30 June 2026 is \$7.455M (2025: \$4.121M) and is not considered to be material and is not recognised in the statement of financial position.

The HHS does not expect that the contract guarantees will be called upon. Consequently, the probability of contract performance default is considered remote, and any provisions would also not be material.

C4 COMMITMENTS

Commitments for capital expenditure at reporting date (inclusive of non-recoverable GST input tax credits) are payable:

	2026 \$'000	2025 \$'000
<i>Capital expenditure commitments</i>		
Committed at reporting date but not recognised as liabilities, payable:		
Property, plant and equipment		
Not later than 1 year	10,691	2,708
Later than 1 year and not later than 5 years	9,640	19,504
	20,331	22,212

Budgetary reporting disclosures

D1 BUDGETARY REPORTING DISCLOSURES

In accordance with Accounting Standard AASB 1055, explanations of major variances between actual amounts presented in the financial statements against the 2025-2026 budgets are disclosed below.

Materiality for Notes commentary is based on the calculation of the line item's actual value percentage of the group total. If the percentage is greater than 5 per cent and movement greater than \$1 million, the line-item variance from budget to actual is deemed material.

a) Statement of comprehensive income

Statement of comprehensive income

	Budget 2026 \$'000	Actual 2026 \$'000	Variance \$'000	Variance %	
Income					
User charges	122,131	126,466	4,335	3.55%	
Funding for public health services	1,437,824	1,496,125	58,301	4.05%	
Grants and other contributions	45,877	50,136	4,259	9.28%	(a)
Other revenue	4,342	8,396	4,054	93.37%	(b)
Total revenue	1,610,174	1,681,123	70,949		
Expenses					
Employee expenses	(199,798)	(212,438)	(12,640)	6.33%	(c)
Health Service employee expenses	(939,369)	(947,505)	(8,136)	0.87%	(c)
Supplies and services	(359,232)	(411,857)	(52,625)	14.65%	(d)
Grants and subsidies	-	(1,722)	(1,722)	0.00%	
Interest on lease liabilities	(73)	(196)	(123)	168.49%	
Depreciation and amortisation	(87,772)	(87,549)	223	-0.25%	
Impairment losses on financial assets	(1,100)	(3,043)	(1,943)	176.64%	(e)
Other expenses	(22,830)	(17,748)	5,082	-22.26%	(f)
Total expenses	(1,610,174)	(1,682,058)	(71,876)		
Operating result for the year	-	(935)	(935)		
Other comprehensive income					
Items that will not be reclassified subsequently to profit or loss					
Increase in asset revaluation surplus	-	65,703	65,703		
Other comprehensive income for the year	-	65,703	65,703		
Total comprehensive income for the year	-	64,768	64,768		

Major variances between 2025-2026 budget and 2025-2026 actual amounts include:

- a. Grants and other contributions were favourable to budget due to receipt of additional funding of Australian Government-Specific purpose recurrent grants, increases in Commonwealth Nursing Home grants and increases research and other general grant funding received by the Townsville HHS. This is inclusive of alignments for Aged Care service configurations.
- b. Other revenue budget variance was a result of salary recoveries and interest receipts greater than anticipated.
- c. The increase in Employee Expenses is primarily due to additional workforce funding received through in-year amendments to the Service Agreement, supporting increased staffing levels to meet service delivery requirements. The variance also reflects the impact of enterprise bargaining agreement (EBA) outcomes, wage escalation, agency and overtime costs to support activity growth and workforce sustainability initiatives across the Hospital and Health Service.
- d. Supplies and services expense relates to increased delivery of public hospital and health services including blood and clotting, clinical supplies, drug costs, other supplies and services, prosthetics charges, repairs and maintenance and the increased cost of goods and services consumed due to cost increases associated with consumer price index price movements. Costs are inclusive of outsourced delivery expenses across several patient related programs, including MiTH and other outsourced arrangements to reflect current service delivery profiles and patient volumes.
- e. Impairment losses on financial assets were greater than expected due to bad and doubtful debts written off, predominantly related to Medicare ineligible inpatients.
- f. The variance in Other Expenses is due to end of year technical adjustments for activity and program related funding in accordance with AASB1058, offset by an increase in legal expenses associated with the Townsville Hospital Part 9 Urology investigation.

Statement of financial position

	Budget 2026 \$'000	Actual 2026 \$'000	Variance \$'000	Variance %	
Assets					
Current assets					
Cash and cash equivalents	72,885	114,094	41,209	56.54%	(a)
Trade and other receivables	42,741	38,364	(4,377)	-10.24%	(b)
Inventories	12,078	12,135	57	0.47%	
Other assets	3,085	3,970	885	28.69%	
Total current assets	130,789	168,563	37,774		
Non-current assets					
Property, plant and equipment	901,529	990,490	88,961	9.87%	(c)
Right-of-use assets	3,544	4,457	913	25.76%	
Intangibles	2,134	3,893	1,759	82.43%	(d)
Total non-current assets	907,207	998,840	91,633		
Total assets	1,037,996	1,167,403	129,407		
Liabilities					
Current liabilities					
Trade and other payables	120,935	166,903	45,968	38.01%	(e)
Lease liability	2,303	1,128	(1,175)	-51.02%	(f)
Accrued employee benefits	3,043	5,802	2,759	90.67%	(g)
Other liabilities	3,171	3,370	199	6.28%	
Total current liabilities	129,452	177,203	47,751		
Non-Current liabilities					
Trade and other payables	267	687	420	157.30%	(e)
Lease liabilities	3,054	3,560	506	16.57%	(f)
Total non-current liabilities	3,321	4,247	926		
Total liabilities	132,773	181,450	48,677		
Net assets	905,223	985,953	80,730		
Equity					
Contributed	415,857	379,065	(36,792)	-8.85%	(h)
Asset revaluation surplus	416,275	529,025	112,750	27.09%	(i)
Accumulated surpluses	73,091	77,863	4,772	6.53%	(j)
Total equity	905,223	985,953	80,730		

Major variances between 2025-2026 budget and 2025-2026 actual amounts include:

- a. The cash increase is due to timing of payroll payments made across reporting periods. Additionally, there has been an increase to trade and other payables due to timing of payments made at year end.
- b. Trade and other receivables did not exceed budget as a result of an unanticipated decrease in contract assets classified under AASB1058 and AASB15.
- c. Property, plant and equipment variance is due to the actual 2025-2026 land and building valuation being higher than anticipated in addition to increased capital acquisitions in year.
- d. The variance in intangible assets is due to the capitalisation of internally generated intangible assets not budgeted for.
- e. Trade and other payables balances (current and non-current) is reflective of increased service delivery and increased costs and adjustments to service over-delivery activity and unpaid at year end due to timing.
- f. Current and non-current lease liabilities variance is a result of lower than anticipated corresponding right of use assets being recognised in year.
- g. Accrued employee benefits budget variance is due to the timing of the payroll payment run and increase in leave accrual by days.
- h. The contributed equity accumulation reflects the timing of the expected capital program completion and actual associated funding.
- i. The asset revaluation surplus variance to budget reflects accumulated increase in asset revaluations as per the annual revaluation of land and buildings at fair value.
- j. The variance of accumulated surplus' against budget is due principally to the 2025-2026 operating result.

Statement of cash flows

	Budget 2026 \$'000	Actual 2026 \$'000	Variance \$'000	Variance %	
Cash flows from operating activities					
<i>Inflows</i>					
User charges	121,104	135,304	14,200	11.73%	(a)
Funding for public health services	1,437,824	1,402,370	(35,454)	-2.47%	(b)
Grants and other contributions	36,545	50,136	13,591	37.19%	(c)
Interest received	550	987	437	79.45%	
GST input tax credits from ATO	15,951	25,464	9,513	59.64%	(d)
GST collected from customers	-	3,880	3,880	0.00%	(d)
Other revenue	3,772	7,370	3,598	95.39%	(e)
<i>Outflows</i>					
Employee expenses	(199,798)	(202,368)	(2,570)	1.29%	
Health service employee expenses	(939,369)	(869,504)	69,865	-7.44%	(f)
Supplies and services	(352,954)	(469,752)	(116,798)	33.09%	(g)
Grants and subsidies	-	(1,722)	(1,722)	0.00%	
Interest payments on lease liabilities	(73)	(196)	(123)	168.49%	
GST paid to suppliers	(15,962)	(26,811)	(10,849)	67.97%	(d)
GST remitted to ATO	-	(3,029)	(3,029)	0.00%	(d)
Other expenses	(13,498)	(17,000)	(3,502)	25.94%	(h)
Net cash from/(used by) operating activities	94,092	35,129	(58,963)		
Cash flows from investing activities					
<i>Outflows</i>					
Payments for property, plant and equipment	20	(53,974)	(53,994)	- 269970.00%	(i)
<i>Inflows</i>					
Net cash from/(used by) investing activities	20	(53,974)	(53,994)		
Cash flows from financing activities					
<i>Inflows</i>					
Proceeds from equity injections	1,073	53,273	52,200	4864.86%	(j)
<i>Outflows</i>					
Lease payments	(214)	(1,363)	(1,149)	536.92%	(k)
Proceeds from equity withdrawals	(87,772)	-	87,772	-100.00%	(l)
Net cash from/(used by) financing activities	(86,913)	51,910	138,823		
Net increase/(decrease) in cash held	7,199	33,065	25,866		
Cash and cash equivalents at the beginning of the financial year	65,686	81,029	15,343		
Cash and cash equivalents at the end of the	72,885	114,094	41,209		

financial year

Major variances between 2025–2026 budget and 2025-2026 actual amounts include:

- a. User charges variance relates to increased receipts from inpatients, outpatients, non-patient income inclusive of Pharmaceutical Benefits Scheme (PBS) cost recovery revenue and inter-entity sales recoveries.
- b. Funding for public health services variance relates to post-budget funding being provided through in-year amendments to the Service Agreement for the delivery of increased public hospital and health services and the provision of funding to support Enterprise Bargaining Agreements negotiated and payable in year.
- c. Grants and Contributions is over budget as a result of increased receipts from Commonwealth Specific-Purpose recurrent grants, Commonwealth Nursing Home grants and research and other general grant funding received by the Townsville HHS.
- d. GST collected and paid variance is due to the higher than budgeted payments and receipts of GST related supplies and services.
- e. The budget overstates the expected cash flow from other revenue as it incorporates the rolled over opening trust balances relating to Trust and Research, which do not generate a cash flow in year.
- f. Employee expenses variance reflects post-budget additional employee costs attributable to in-year amendments to the Service Agreement for the delivery of increased public hospital and health services and increases arising from Enterprise Bargaining agreements. Additionally, the timing of cash payments for pay periods at year end affects reported amounts.
- g. Supplies and Services variance principally relates to increased costs associated with increased public hospital and health services and the increased cost of goods and services consumed in the delivery of these services with above budgeted consumer price index price movements.
- h. Other expenses budget variance is due to increase in QGIF premiums, legal fees and other expenses generally.
- i. The variance in Payments for Property, Plant and Equipment relates to the Department holding the budget for Department-funded capital acquisitions and projects. Townsville HHS pays for all capital acquisitions and projects and is reimbursed by the Department on a cost recovery basis in arrears. Expenditure was incurred on major capital works and infrastructure projects, health technology equipment replacement programs, digital and clinical system enhancements, sustaining capital works, and upgrades across Townsville University Hospital and regional health facilities within the Hospital and Health Service.
- j. The Proceeds from equity injections variance relates to the Department holding the budget for Department funded acquisitions/projects. The Townsville HHS pays for the capital acquisitions/projects and is reimbursed on a cost recovery basis by the Department in arrears.
- k. The variance in lease payments is due to the higher than expected payment for associated lease liabilities.
- l. The Proceeds from equity withdrawals variance relates to depreciation and amortisation funding being treated as a cash item (equity withdrawal) in the budget, however depreciation and amortisation funding is a non-cash adjustment.

What we look after on behalf of whole of government and third parties

E1 PATIENT TRUST FUNDS

	2026 \$'000	2025 \$'000
Patient Trust receipts and payments		
<i>Receipts</i>		
Amounts receipted on behalf of patients	15,869	10,604
Total receipts	15,869	10,604
<i>Payments</i>		
Amounts paid to or on behalf of patients	(16,455)	(8,869)
Total payments	(16,455)	(8,869)
Trust assets and liabilities		
<i>Assets</i>		
Current asset beginning of year	10,920	9,185
Total assets	10,334	10,920

Patient trust

The Townsville HHS is responsible for the efficient, effective and accountable administration of patients' monies. Patients' monies/ properties are held in a fiduciary capacity for the benefit of the patient to whom the duty is owed.

Patients' monies do not represent resources controlled by the Townsville HHS. These monies are received and held on behalf of patients and, as such, do not form part of the assets recognised by the Townsville HHS. The Townsville HHS acts in a trust capacity in relation to patient trust accounts. Although patient funds are not controlled by the Townsville HHS, trust activities are included in the audit performed annually by the Auditor-General of Queensland.

Patient Trust funds include refundable accommodation deposits (RADs) and represent amounts received from residents in aged care facilities for their accommodation. These amounts are permitted to be used for the purposes specified in section 52N-1(2) of the *Aged Care Act 2024* including investments and facilitating ongoing capital investment in aged care infrastructure. Refundable accommodation deposits are refundable to residents when they leave a residential aged care facility. These funds are retained in the Queensland Treasury Corporation Cash Fund.

Interest earned from RADs is offset against operating and capital costs of the aged care facilities concerned.

E2 RESTRICTED ASSETS

	2026 \$'000	2025 \$'000
Study education and research trust		
Revenue	2,661	1,952
Education and professional development	(45)	(39)
Travel	(14)	(13)
Equipment	(52)	(47)
Research grants and expenses	(3,117)	(2,655)
Total Payments	(3,228)	(2,754)
Surplus/(Deficit) for the year	(567)	(802)
Current asset beginning of year	8,029	8,831
Property, plant and equipment purchases	(517)	(384)
Current asset end of year	6,945	7,645
Plus: Amounts held in other trusts	14,475	14,862
Total general trust funds	21,420	22,507

Restricted assets

General Trust transactions incorporate monies received through fundraising activities, donations, and bequests which are held by the Townsville HHS for a stipulated purpose as well as cash contributions arising from the Right of Private Practice arrangements that are specified for study, education and research activities.

The General Trust fund includes Study Education and Research Trust Account (SERTA) as disclosed in this table. Under the MOCA 7 Granted Private Practice Revenue Retention arrangement, service-retention amounts generated by doctors after reaching the threshold allowable under the retention arrangement are held in trust for specific purposes of study, education and research activities.

General Trust Funds are managed on an accrual basis and form part of cash and cash equivalents at 30 June 2026. This money is controlled by the Townsville HHS and forms part of the cash and cash equivalents balance (refer to Note B3); however, it is restricted as it can only be used for specific purposes. At 30 June 2026 amounts of \$21.420M (2025: \$22.507M) are set aside for the specified purpose of the underlying contribution.

Given that funds generated from private practice arrangements are reflected in the Statement of Comprehensive Income when the services are rendered, the timing of SERTA expenditure can impact on the overall Townsville HHS operating result. For instance, a positive financial impact will result when SERTA revenue exceeds SERTA expenditure during any given financial year. Conversely, a negative financial impact will result when SERTA expenditure exceeds SERTA revenue during any given financial year.

E3 ARRANGEMENTS FOR THE PROVISION OF PUBLIC INFRASTRUCTURE BY OTHER ENTITIES

The Department of Health, prior to the establishment of the Townsville HHS, had entered into several contractual arrangements with private sector entities for the construction and operation of public infrastructure facilities for a period of time on land now controlled by the Townsville HHS (Public Private Partnership (PPP) arrangements).

Although the land on which the facilities have been constructed remains an asset of the Townsville HHS, the Townsville HHS does not control the facilities with these arrangements. Therefore, these facilities are not recorded as assets. The Townsville HHS received rights and incurs obligations under these arrangements including:

- a. rights and obligations to receive and pay cash flows in accordance with the respective contractual arrangements; and
- b. rights to receive the facilities at the end of the contractual term.

The arrangements have been structured to minimise risk exposure for the Townsville HHS. The Townsville HHS has not recognised any rights or obligations that may attach to those arrangements.

Public Private Partnership arrangements operating during the financial year are as follows:

	2026 \$'000	2025 \$'000
Revenue and expenses		
<i>Revenue</i>		
Medilink	53	50
Goodstart Early Learning	20	19
Total revenue	73	69

Medilink

The developer has constructed an administrative and retail complex on the site at Townsville University Hospital. Land rental of \$36,000 per annum, escalated for CPI annually will be received from the facility owner up to January 2042. The facility owner operates and maintains the facility at its sole cost and risk. Estimated net rent receivable to 2042 is \$0.967M (2025: \$1.020M)

Goodstart Early Learning Centre

The developer has constructed a childcare facility on the site at Townsville University Hospital. Land rental of \$14,000 per annum, escalated for CPI annually will be received from the facility owner up to February 2044. The facility owner operates and maintains the facility at its sole cost and risk. Estimated net rent receivable to 2042 is \$0.393M (2025: \$0.413M).

In accordance with the relevant provisions of the contractual arrangements, the ownership of the building's transfers to Townsville HHS at no cost to the Townsville HHS at the expiry of the contractual arrangements.

Other information

F1 KEY MANAGEMENT PERSONNEL AND REMUNERATION

Key management personnel (KMP) are those persons having authority and responsibility for planning, directing, and controlling the activities of the Townsville HHS, directly or indirectly, including any director of the Townsville HHS. The following persons were considered key management personnel of the Townsville HHS during the current financial year.

Key management personnel and remuneration disclosures are made in accordance with Section 5 of the Financial Reporting Requirements for Queensland Government Agencies issued by Queensland Treasury. The Townsville HHS's responsible Minister, the Hon Timothy Nicholls MP, is identified as part of the Townsville HHS's KMP.

Position	Name	Contract classification and appointment authority	Initial Appointment date
Chair of Townsville Hospital and Health Board (Townsville HHB) Chair of Board Executive Committee	Tony Mooney AM	<i>Hospital and Health Boards Act 2011</i> Tenure: 01/04/2024 - 31/03/2028	18/05/2016
Deputy Chair Townsville HHB Chair of Board Finance Committee	Michelle Morton	<i>Hospital and Health Boards Act 2011</i> Tenure: 01/04/2024 - 31/03/2026	29/06/2012
Board Member Townsville HHB Chair of Board Audit and Risk Committee	Debra Burden	<i>Hospital and Health Boards Act 2011</i> Tenure: 01/04/2024 - 31/03/2028	18/05/2016
Board Member Townsville HHB Chair of Board Stakeholder Engagement Committee	Nicole Hayes	<i>Hospital and Health Board Act 2011</i> Tenure: 01/04/2024 – 31/03/2028	18/05/2019
Board Member Townsville HHB	Craig Costello	<i>Hospital and Health Boards Act 2011</i> Tenure: 01/04/2026 - 31/03/2030	01/04/2026
Deputy Chair Townsville HHB Chair of Board Finance Committee	Gerard Wyvill	<i>Hospital and Health Boards Act 2011</i> Tenure: 01/04/2026 - 31/03/2030	01/04/2026
Board Member Townsville HHB	Kari Arbouin	<i>Hospital and Health Boards Act 2011</i> Tenure: 01/04/2026 - 31/03/2030	01/04/2026
Board Member Townsville HHB	Luke Guazzo	<i>Hospital and Health Board Act 2011</i> Tenure: 01/04/2026 - 31/03/2030	1/04/2022
Board Member Townsville HHB	Dallas Leon	<i>Hospital and Health Boards Act 2011</i> Tenure: 01/04/2026 – 31/03/2030	1/10/2025

Position	Name	Contract classification and appointment authority	Initial Appointment date
Board Member Townsville HHB	Professor Kunwarjit Sangla	<i>Hospital and Health Boards Act 2011</i> Tenure: 01/04/2026 – 30/06/2026	1/04/2024
Board Member Townsville HHB	Dr Erin Waters	<i>Hospital and Health Boards Act 2011</i> Tenure: 01/04/2024 - 31/03/2026	1/04/2024
Board Member Townsville HHB Chair of Board Safety and Quality Committee	Georgina Whelan	<i>Hospital and Health Boards Act 2011</i> Tenure: 01/04/2024 - 31/03/2028	18/05/2020
Health Service Chief Executive - responsible for the strategic direction and the efficient, effective and economic administration of the health service.	Kieran Keyes	S24/S70 01 <i>Hospital and Health Boards Act 2011</i> Tenure: 13/11/2017 – 14/08/2026	13/11/2017
Chief Operating Officer – responsible for the efficient operation of the health service providing strategic leadership and direction for the Townsville HHS service delivery.	Susan Freiberg	HES3-4 01 <i>Hospital and Health Boards Act 2011</i>	17/02/2025
Chief Finance Officer – responsible for strategic leadership and direction over the efficient, effective and economic financial administration of the Townsville HHS	Michelle Warrington	HES3-1 01 <i>Hospital and Health Boards Act 2011</i>	18/11/2024
Executive Director People Strategy and Governance - provides direct advice to the HSCE and Townsville HHB Chair. The purpose of the role is to drive the strategic workforce agenda for the Townsville HHS in relation to the ongoing attraction, development, and retention of a highly skilled and motivated workforce and leading the strategic and corporate governance functions of the organisation.	Shellee Chapman	HES3-1 01 <i>Hospital and Health Boards Act 2011</i>	25/10/2023

Position	Name	Contract classification and appointment authority	Initial Appointment date
Executive Director Aboriginal and Torres Strait Islander Health - provides strategic oversight and operational leadership for indigenous liaison, workforce management and cultural practices.	Amanda Cooms	HWF9NQ 00 <i>Hospital and Health Boards Act 2011</i>	15/05/2023
Executive Director Clinical Governance - provides strategic oversight of the safety and quality functions across the Townsville HHS.	Marina Daly	HES2-5 01 <i>Hospital and Health Boards Act 2011</i>	12/11/2019
Executive Director Infrastructure Program Delivery - responsible for providing strategic direction and leadership to health infrastructure of the Townsville HHS.	Thomas Hegarty	HES2-3 01 <i>Hospital and Health Boards Act 2011</i>	24/03/2025
Executive Director Digital Health and Knowledge - responsible for providing strategic and operational leadership of health and knowledge resources for Townsville HHS.	Louise Hayes	HES2-4 01 <i>Hospital and Health Boards Act 2011</i>	11/03/2019
Executive Director Allied Health - provides professional leadership for all allied health practitioners, including professional governance, credentialing, education and research for Townsville HHS.	Danielle Hornsby	HP8-4 01 <i>Health Practitioners and Dental Officers (Queensland Health) Award - State 2015</i>	27/11/2017
Executive Director Nursing and Midwifery Services - responsible for providing strategic and operational leadership of nursing and midwifery services of the Townsville HHS. Executive COVID-19 Lead.	Judith Morton	NRG13-2 01 <i>Hospital and Health Boards Act 2011</i>	1/12/2014
Chief Medical Officer – responsible for providing strategic and operational leadership of medical service delivery of the Townsville HHS.	Dr Niall Small	MMO14 01 <i>Hospital and Health Boards Act 2011</i>	17/02/2020

Ministerial remuneration entitlements are outlined in the Legislative Assembly of Queensland's Members' Remuneration Handbook. The Townsville HHS does not bear any cost of remuneration of Ministers. Most Ministerial entitlements are paid by the Legislative Assembly, with the remaining entitlements being provided by Ministerial Services Branch within the Department of the Premier and Cabinet. As all Ministers are reported as KMP of the Queensland Government, aggregate remuneration expenses for all Ministers is disclosed in the Queensland General Government and Whole-of-Government Consolidated Financial Statements, which are published as part of Queensland Treasury's Report on State Finances.

The Townsville HHS is independently and locally controlled by the Board. The Board appoints the Health Service Chief Executive and exercises significant responsibilities at a local level, including controlling the financial management of the Townsville HHS and the management of the Townsville HHS land and buildings (section 7 *Hospital and Health Board Act 2011*). Remuneration arrangements for the Townsville HHS Board are approved by the Governor in Council and the chair, deputy chair and members are paid an annual fee consistent with the government procedures titled 'Remuneration procedures for part-time chairs and members of Queensland Government bodies'.

Remuneration policy for the Townsville HHS's other KMP is set by the Queensland Public Service Commission as provided for under the *Public Sector Act 2022* and the *Industrial Relations Act 2016*. Individual remuneration and other terms of employment (including motor vehicle entitlements and performance payments if applicable) are specified in employment contracts.

Remuneration expenses for those KMP comprise the following components:

Short-term employee expenses, including:

- salary, allowances and leave entitlements earned and expensed for the entire year, or for that part of the year during which the employee occupied a KMP position;
- performance payments recognised as an expense during the year; and
- non-monetary benefits – consisting of provision of vehicle together with fringe benefits tax applicable to these benefits

Long-term employee expenses include amounts expensed in respect of long service leave entitlements earned.

Post-employment expenses include amounts expensed in respect of employer superannuation obligations.

Termination benefits include payments in lieu of notice on termination and other lump sum separation entitlements (excluding annual and long service leave entitlements) payable on termination of employment or acceptance of an offer of termination of employment.

Short-term benefits

2026

Name	Monetary \$'000	Non- monetary \$'000	Post- employment benefits \$'000	Long-term benefits \$'000	Termination benefits \$'000	Total \$'000
Tony Mooney AM	102	9	13	-	-	124
Michelle Morton	42	9	5	-	-	56
Debra Burden	55	9	7	-	-	71
Luke Guazzo	51	9	6	-	-	66
Nicole Hayes	54	-	7	-	-	61
Dallas Leon	38	-	5	-	-	43
Professor Kunwarjit Sangla	51	8	6	-	-	65
Dr Erin Waters	39	9	5	-	-	53
Georgina Whelan	55	9	7	-	-	71
Craig Costello	13	9	2	-	-	24
Gerard Wyvill	14	-	2	-	-	16
Kari Arbouin	13	-	2	-	-	15
Kieran Keyes	418	9	50	10	-	487
Susan Freiberg	298	9	34	7	-	348
Michelle Warrington	254	9	29	6	-	298
Shellee Chapman	260	6	30	6	-	302
Amanda Cooms	288	-	-	-	-	288
Marina Daly	268	3	31	6	-	308
Thomas Hegarty	232	-	27	5	-	264
Louise Hayes	248	9	29	6	-	292
Danielle Hornsby	246	8	28	6	-	288
Judith Morton	302	9	34	7	-	352
Dr Niall Small	674	10	71	15	-	770

Short-term benefits

2025

Name	Monetary \$'000	Non- monetary \$'000	Post- employment benefits \$'000	Long-term benefits \$'000	Termination benefits \$'000	Total \$'000
Tony Mooney AM	102	10	13	-	-	125
Michelle Morton	55	9	7	-	-	71
Debra Burden	55	9	7	-	-	71
Luke Guazzo	51	9	6	-	-	66
Nicole Hayes	55	-	7	-	-	62
Mr Graham Pattel	18	-	2	-	-	20
Professor Kunwarjit Sangla	51	8	6	-	-	65
Dr Erin Waters	51	8	6	-	-	65
Georgina Whelan	55	9	7	-	-	71
Kieran Keyes	413	9	48	10	-	480
Stephen Eaton	159	-	17	4	-	180
Susan Freiberg	87	-	10	2	-	99
Anthony Mathas	117	9	6	1	284	417
Michelle Warrington	180	9	19	4	-	212
Shellee Chapman	250	8	29	6	-	293
Amanda Cooms	263	1	14	3	-	281
Marina Daly	237	8	27	5	-	277
Stuart Garantziotis	179	9	20	4	-	212
Thomas Hegarty	64	-	7	1	-	72
Louise Hayes	240	9	28	5	-	282
Danielle Hornsby	225	4	26	5	-	260
Judith Morton	296	9	33	7	-	345
Dr Niall Small	709	8	74	17	-	808

F2 RELATED PARTY TRANSACTIONS

Transactions with people/entities related to KMP

Any transactions in the year ended 30 June 2026 between the Townsville HHS and key management personnel, including the people/entities related to key management personnel were on normal commercial terms and conditions and were immaterial in nature.

Transactions with other Queensland Government-controlled entities

The Townsville HHS is controlled by its ultimate parent entity, the State of Queensland. All State of Queensland controlled entities meet the definition of a related party in AASB 124 *Related Party Disclosures*. The following table summarises significant transactions with Queensland Government controlled entities.

	2026 \$'000	2025 \$'000
Entity – Department of Health		
Revenue	1,072,875	956,206
Expenditure	139,553	136,786
Asset	9,469	14,423
Liability	64,835	60,864
Entity – Department of Housing and Public Works (including Qfleet)		
Expenditure	5,411	4,940

Department of Health

The Townsville HHS's primary source of funding is provided by the Department of Health, with payments made in accordance with a service agreement. The signed service agreements are published on the Queensland Government website and are publicly available. For further details on the purchase of health services by the Department refer to Note B1-2.

The Department of Health centrally manages, on behalf of hospital and health services, a range of services including pathology testing, pharmaceutical drugs, clinical supplies, patient transport, telecommunications and technology services. In addition, the Townsville HHS receives corporate services support from the Department at no cost. Corporate services received include payroll services, financial transactions services (including accounts payable and banking services), administrative services and information technology services. For further details on these services received by the Department refer to Note B1-3.

Any associated receivables or payables owing to the Department of Health at 30 June 2026 are included in the balances within Note B4, Note B8 and Note B9 and separately disclosed in the table above.

The Department of Health also provides funding from the State as equity injections to purchase property, plant and equipment. All construction of major health infrastructure is managed and funded by the Department of Health. Upon practical completion of a project, assets are transferred from the Department to the Townsville HHS. Throughout the year, funding received to cover the cost of depreciation is offset by a withdrawal of equity by the State for the same amount. For further details on equity transactions with the Department refer to the Statement of Changes in Equity.

Entity – Department of Housing and Public Works (including Qfleet)

Department of Housing and Public Works - Townsville HHS pays rent to the Department of Housing and Public Works for several properties. In addition, the Townsville HHS pays the Department of Housing and Public Works for vehicle fleet management services.

There are no material transactions with other Queensland Government controlled entities.

Queensland Treasury Corporation

The Townsville HHS holds cash investments with Queensland Treasury Corporation (QTC) in relation to trust monies which are outlined in Note E1 and Note E2.

F3 TAXATION

The Townsville HHS is exempted from income tax under the *Income Tax Assessment Act 1936* and is exempted from other forms of Commonwealth taxation except for Fringe Benefits Tax (FBT) and Goods and Service Tax (GST).

All FBT and GST reporting to the Commonwealth is managed centrally by the Department of Health, with payments/receipts made on behalf of Townsville HHS reimbursed to/from the Department monthly. GST credits receivable from, and GST payable to the ATO, are recognised on this basis.

Both the Townsville HHS and the Department of Health satisfy section 149-25(e) of the *A New Tax System (Goods and Services) Act 1999 (Cth)* (the GST Act). Consequently, they were able with other hospital and health services, to form a “group” for GST purposes under Division 149 of the GST Act. Any transactions between the members of the “group” do not attract GST.

Revenues and expenses are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the ATO. In these circumstances, the GST is recognised as part of the cost of acquisition of the asset or as part of an item of expense. Receivables and payables in the Statement of Financial Position are shown inclusive of GST.

F4 FIRST-YEAR APPLICATION OF NEW STANDARDS OR CHANGE IN POLICY

Accounting standards applied for the first time

No new accounting standards or interpretations that apply to the department for the first time in 2025-2026 had any material impact on the financial statements.

Accounting standards early adopted

No Australian Accounting Standards have been early adopted for 2025-2026.

Future impact of accounting standards not yet effective

At the date of authorisation of the financial report, the expected impacts of new or amended Australian Accounting Standards issued but with future effective dates are set out below:

AASB 18 Presentation and Disclosure in Financial Statements

AASB 18 applies to not-for-profit public sector entities for annual reporting periods beginning on or after 1 January 2028, which will be the 2028-29 financial year for the Townsville HHS.

This standard sets out new requirements for the presentation of the Statement of Comprehensive Income, requires new disclosures about management-defined performance measures and removes existing options in the classification of dividends and interest received and interest paid in the Statement of Cash Flows.

The AASB is aware that there are issues that need to be clarified in applying AASB 18's new requirements to not-for-profit entities. The AASB expects to conduct outreach with not-for-profit and public sector entities to address these issues and expects that modifications to AASB 18 for application by these entities could take the form of guidance, exemptions and alternative requirements.

The Townsville HHS will make an assessment of the expected impacts of AASB 18 after the AASB has decided on the modifications applicable to not-for-profit public sector entities. AASB 18's changes will only affect presentation and disclosure; it will not affect the recognition or measurement of any reported amounts.

F5 SUBSEQUENT EVENTS

No matter or circumstance has arisen since 30 June 2026 that has significantly affected, or may significantly affect the Townsville HHS's operations, the results of those operations, or the Townsville HHS's future in financial years.

F6 CLIMATE RISK

The State of Queensland, as the ultimate parent of the Townsville HHS, provides information and resources on climate related strategies and actions accessible at <https://www.treasury.qld.gov.au/energy-and-climate/>

The Queensland Sustainability Report (QSR) outlines how the Queensland Government measures, monitors and manages sustainability risks and opportunities, including governance structures supporting policy oversight and implementation. To demonstrate progress, the QSR also provides time series data on key sustainability policy responses. The QSR is available via Queensland Treasury's website at <https://www.treasury.qld.gov.au/programs-and-policies/queensland-sustainability-report>

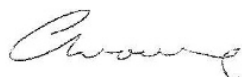
No adjustments to the carrying value of assets were recognised during the financial year as a result of climate-related risks impacting current accounting estimates and judgements. No other transactions have been recognised during the financial year specifically due to climate-related risks impacting the Townsville HHS.

MANAGEMENT CERTIFICATE

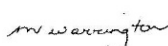
These general-purpose financial statements have been prepared pursuant to Section 62(1) of the *Financial Accountability Act 2009* (the Act), Section 39 of the *Financial and Performance Management Standard 2019* and other prescribed requirements. In accordance with Section 62(1)(b) of the Act we certify that in our opinion:

- a) the prescribed requirements for establishing and keeping the accounts have been complied with in all material respects; and
- b) the financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Townsville Hospital and Health Service for the financial year ended 30 June 2026 and of the financial position of the Townsville Hospital and Health Service at the end of the year.

We acknowledge responsibility under Section 7 and Section 11 of the *Financial and Performance Management Standard 2019* for the establishment and maintenance, in all material respects, of an appropriate and effective system of internal controls and risk management processes with respect to financial reporting throughout the reporting period.



Tony Mooney AM
Board Chair
Townsville Hospital and Health Service
Date: 17/08/2026



Digitally signed by
Michelle
Warrington, Chief
Finance Officer
Date: 2026.08.19
16:16:47 +10'00'

Michelle Warrington
Chief Finance Officer
Townsville Hospital and Health Service
Date: 17/08/2026



Digitally signed
by Shellee
Chapman, Acting
Health Service
Chief Executive
Date: 2026.08.19
15:59:16 +10'00'

Shellee Chapman
A/Health Service Chief Executive
Townsville Hospital and Health Service
Date: 17/08/2026

Independent auditor's report

To the Board of Townsville Hospital and Health Service

Report on the audit of the financial report

Opinion

I have audited the accompanying financial report of Townsville Hospital and Health Service.

The financial report comprises the statement of financial position as at 30 June 2026, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including material accounting policy information, and the management certificate.

In accordance with s. 40 of the *Auditor-General Act 2009*, for the year ended 30 June 2026:

- a) I received all the information and explanations I required.
- b) I consider that, the prescribed requirements in relation to the establishment and keeping of accounts were complied with in all material respects.
- c) In my opinion, the financial report:
 - i. gives a true and fair view of the entity's financial position as at 30 June 2026, and its financial performance and cash flows for the year then ended
 - ii. complies with the *Financial Accountability Act 2009*, the Financial and Performance Management Standard 2019 and Australian Accounting Standards.

Basis for opinion

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

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

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

Key audit matters

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

Valuation of specialised buildings \$797 million

Refer to Note B7 in the financial report

Key audit matter	How my audit addressed the key audit matter
Buildings were material to Townsville Hospital and Health Service at balance date and were measured at fair value using the current replacement cost method. Townsville Hospital and Health Service performed a comprehensive revaluation of a portion of their building portfolio this year as part of the rolling revaluation program. All other buildings were assessed using relevant indices. The current replacement cost method comprises: - gross replacement cost, less - accumulated depreciation. Townsville Hospital and Health Service derived the gross replacement cost of its buildings at balance date using unit prices that required significant judgements for: - identifying the components of buildings with separately identifiable replacement costs - developing a unit rate for each of these components, including: - estimating the current cost for a modern substitute (including locality factors and oncosts), expressed as a rate per unit (e.g. \$/square metre) - identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference. The measurement of accumulated depreciation involved significant judgements for determining condition and forecasting the remaining useful lives of building components. The significant judgements required for gross replacement cost and useful lives are also significant judgements for calculating annual depreciation expense. Using indexation required: - significant judgement in determining changes in cost and design factors for each asset type since the previous revaluation - reviewing previous assumptions and judgements used in the last comprehensive valuation to ensure ongoing validity of assumptions and judgements used.	My procedures included, but were not limited to: - assessing the adequacy of management's review of the valuation process and results - reviewing the scope and instructions provided to the valuer as management's specialist - assessing the appropriateness of the valuation methodology and the underlying assumptions with reference to common industry practices - assessing the appropriateness of the components of buildings used for measuring gross replacement cost with reference to common industry practices - assessing the competence, capabilities and objectivity of the experts used to develop the models - for unit rates, on a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate of the: - modern substitute (including locality factors and oncosts) - adjustments for excess quality or obsolescence - evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices - evaluating useful life estimates for reasonableness by: - reviewing management's annual assessment of useful lives - at an aggregated level, reviewing asset management plans for consistency between renewal budgets and the gross replacement cost of assets - testing that no material building asset still in use has reached or exceeded its useful life - enquiring of management about their plans for assets that are nearing the end of their useful life - reviewing assets with an inconsistent relationship between condition and remaining useful life - where changes in useful lives were identified, evaluating whether the effective dates of the changes applied for depreciation expenses were supported by appropriate evidence.

Responsibilities of the Board for the financial report

The Board is responsible for:

- the preparation of the financial report that gives a true and fair view in accordance with the *Financial Accountability Act 2009*, the Financial and Performance Management Standard 2019 and Australian Accounting Standards, and such internal control as they determine is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error
- the establishment and keeping of accounts in accordance with prescribed requirements
- assessing the entity's ability to continue as a going concern, disclosing, as applicable, matters relating to going concern and using the going concern basis of accounting unless it is intended to abolish the entity or to otherwise cease operations.

Auditor's responsibilities for the audit of the financial report

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

A further description of my responsibilities for the audit of the financial report is located at the Auditing and Assurance Standards Board website at: www.auasb.gov.au/auditors_responsibilities/ar6.pdf

A further description of my responsibilities under the *Auditor-General Act 2009* and *Auditor-General Auditing Standards* is located at the Queensland Audit Office website at: www.qao.qld.gov.au/audit-program/audit-standards These descriptions form part of my auditor's report.



B Deoji
as delegate of the Auditor-General

20 August 2026
Queensland Audit Office
Brisbane

Glossary

AASB	Australian Accounting Standards Board
ABF	Activity Based Funding
AM	Member of the Order of Australia
ATO	Australian Taxation Office
BEMS	Building, Engineering and Maintenance Services
CPI	Consumer Price Index
CT	Computed Tomography
DOH	Department of Health
DSS	Decision Support System
EBA	Enterprise Bargaining Agreements
EV	Electric Vehicle
FAICD	Fellow of the Australian Institute of Company Directors
FBT	Fringe Benefits Tax
FTE	Full-time Equivalent
GST	Goods and Services Tax
HHS	Hospital and Health Service
HSCE	Health Service Chief Executive
HVAC	Heating, Ventilation and Air-Conditioning
ICARE	Integrity, Compassion, Accountability, Respect and Engagement
ieMR	Integrated electronic Medical Record
KMP	Key Management Personnel
LED	Light Emitting Diode
MBA	Master of Business Administration
MOCA	Medical Officers' Certified Agreement

MOHRI	Minimum Obligatory Human Resource Information is a whole-of-government methodology for reporting and monitoring the workforce
MP	Member of Parliament
MRSA	Methicillin-Resistant Staphylococcus Aureus
NAIDOC	National Aborigines and Islanders Day Observance Committee
NQPHN	Northern Queensland Primary Health Network
PBS	Pharmaceutical Benefits Scheme
PPP	Public Private Partnership
PSEA	Public Service Ethics Act
QAO	Queensland Audit Office
QGAO	Queensland Government Accommodation Office
QGEA	Queensland Government Enterprise Architecture
QGIF	Queensland Government Insurance Fund
QLD	Queensland
QSR	Queensland Sustainability Report
QTC	Queensland Treasury Corporation
QWAU	Queensland Weighted Activity Units
RACF	Residential Aged Care Facilities
RACP	Royal Australasian College of Physicians
RAD	Refundable Accommodation Deposit
SAB	Staphylococcus Aureus Bloodstream
SERTA	Study Education and Research Trust Account
SMACE	Statewide MRI and CT Expansion
TAAHC	Tropical Australian Academic Health Centre
TUH	Townsville University Hospital
WAU	Weighted Activity Units

Compliance Checklist

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	A letter of compliance from the accountable officer or statutory body to the relevant Minister/s	ARRs – section 7	Page 4
Accessibility	- Table of contents - Glossary	ARRs – section 9.1	Page 5 Page 99
	Public availability	ARRs – section 9.2	Page 2
	Interpreter service statement	<i>Queensland Government Language Services Policy</i> ARRs – section 9.3	Page 2
	Copyright notice	<i>Copyright Act 1968</i> ARRs – section 9.4	Page 2
	Information Licensing	<i>QGEA – Information Licensing</i> ARRs – section 9.5	Page 2
General information	Introductory Information	ARRs – section 10	Page 7-10, 14-15
Non-financial performance	Government's Objectives for the Community and whole-of-government plans/specific initiatives	ARRs – section 11.1	Page 6, 11-13
	Agency objectives and performance indicators	ARRs – section 11.2	Page 31-32
	Agency service areas and service standards	ARRs – section 11.3	Page 33-34
Financial performance	Summary of financial performance	ARRs – section 12.1	Page 35-39
Governance – management and structure	Organisational structure	ARRs – section 13.1	Page 16-20, 22-24
	Executive management	ARRs – section 13.2	Page 23
	Government bodies (statutory bodies and other entities)	ARRs – section 13.3	Page 21
	Public Sector Ethics	<i>Public Sector Ethics Act 1994</i> ARRs – section 13.4	Page 30
	Human Rights	<i>Human Rights Act 2019</i> ARRs – section 13.5	Page 30
	Queensland public service values	ARRs – section 13.6	Page 30
Governance – risk management and accountability	Risk management	ARRs – section 14.1	Page 27
	Audit committee	ARRs – section 14.2	Page 22
	Internal audit	ARRs – section 14.3	Page 27-28
	External scrutiny	ARRs – section 14.4	Page 28-29
	Information systems and records management	ARRs – section 14.5	Page 29
	Information security attestation	ARRs – section 14.6	Page 30
Governance – human resources	Strategic workforce planning and performance	ARRs – section 15.1	Page 25-27
	Early retirement, redundancy and retrenchment	<i>Directive No.04/18 Early Retirement, Redundancy and Retrenchment</i> ARRs – section 15.2	Page 27
Open Data	Statement advising publication of information	ARRs – section 16	Page 2

	• Consultancies	ARRs – section 31.1	https://data.qld.gov.au
	• Overseas travel	ARRs – section 31.2	https://data.qld.gov.au
	• Queensland Language Services Policy	ARRs – section 31.3	https://data.qld.gov.au
	• Charter of Victims' Rights	VCSVRB Act 2024 ARRs – section 31.4	https://data.qld.gov.au
Financial statements	• Certification of financial statements	FAA – section 62 FPMS – sections 38, 39 and 46 ARRs – section 17.1	Page 40-95
	• Independent Auditor's Report	FAA – section 62 FPMS – section 46 ARRs – section 17.2	Page 96-98

FAA *Financial Accountability Act 2009*

FPMS *Financial and Performance Management Standard 2019*

ARRs *Annual report requirements for Queensland Government agencies*

QGEA *Queensland Government Enterprise Architecture*

VCSVRB *Victims' Commissioner and Sexual Violence Review Board Act 2024*

