

Turanganui Primary Health Organisation

ANNUAL REPORT

2009



Turanganui PHO
Healthy Fit Whanau Ora



HealthRight
Put your future in good hands your own.

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CHAIRMAN'S REPORT

Kia ora - This year has seen the usual highs and lows of an organisation that is concurrently seeking to maintain and foster outstanding service to enrolled patients as well as diligently debating issues and planning for the future. A large amount of time, energy was spent on evaluating and conducting due diligence on the possible acquisition of the Western Rural practice. TDH was keen to divest itself of this entity and looked towards a tender process to assist the task. After a long and tortuous several months the TPHO board decided against accepting the TDH offer as we believed other impending health changes were a greater priority.

During the year our CEO advised that we had achieved 'preferred provider' status with TDH. This was due to the successful delivery and evaluation results of project work over the years along with responsible and accountable use of tax-payer resources by both the CEO and her staff.

During the year our PHO achieved Accreditation from Health & Disability Auditing New Zealand. The result was an unqualified audit which was pleasing to both the Board and staff of the TPHO. Our contracted Communication Adviser 'Redpath Communications' produced a highly innovative and easily explained overview of the Annual Report entitled 'Snack & Go'. This creative publication attracted favourable comments by officials in the Ministry of Health.

Once again the year has seen changes in the Directorate of the Board. Dr David Maplesden resigned as he was appointed a Health & Disability Commissioner's Adviser in Auckland. David made a major contribution to the design and initiation of the HealthRight Programme and we miss his Board involvement. The GP owners decided to reinstate John Macaskill -Smith as their representative, so we were fortunate in having all the wealth of knowledge and experience related to PHOs return to the Board table. We also welcome Ms Diane Cooper to the Board. Diane was successful in seeking and being appointed as a Community Director and we look forward to harnessing her vast accounting and commercial business skills.

Our CEO has now successfully completed 11 of the 12 MPM papers and just has her major research paper to complete. Along with her study and the success of being selected as one of the 2008 Sir Peter Blake Emerging Leaders Award winners Keriana has continued to lead TPHO with intelligence, enthusiasm and commitment. Our Board is extremely fortunate in having one of New Zealand's best health oriented CEO in its employ. On behalf of our Board I would like to thank Keriana and her staff for a very successful year.

David S Scott, Chair, Turanganui Primary Health Organisation LTD



CEO'S REPORT

The 2008 – 2009 financial year has seen another year of maturity and development for Turanganui PHO. Highlights include:

- ✚ Continued focus on communication through the ongoing relationship with Redpath Communications Limited has seen the popularity and value of the PHOnetic continue to rise. Other communication opportunities include the release of the Snack n Go (annual report summary), HealthRight information, public reporting of fees and media releases.
- ✚ The establishment of Cardiac and Pulmonary Rehabilitation services has seen a successful team of staff from three community providers provide education and exercise session to referred patients.
- ✚ The primary mental health programme has gone from strength to strength which both providers and patients identifying the service as being of great value.
- ✚ The continuing strong relationship with both providers and owners Turanga Health and Pinnacle Incorporated, both dynamic and complimentary organisations committed to working to the next level to meet the needs of our enrolled population

The Ministerial Group states 'left unchanged, the model of health delivery is likely to rapidly generate an unsustainable tension between the community's expectations of the public health service and the community's ability to finance those expectations. It will almost certainly fall well short of the desire to lift health system performance over time within a more sustainable slower spending track'.

So for the 2009 – 2010 financial year, TPHO turn our gaze towards the balancing of our local obligations and the expectations of the new Government through the release of their expression of interest "better, sooner, more convenient primary care".

Thank you to the TPHO Board, staff and providers for contributing to our important health services and goals

Keriana Brooking



Organisational structure and governance

OWNERSHIP		
PINNACLE INCORPORATED	TURANGA HEALTH	
GOVERNANCE		
PINNACLE (3) John Macaskill Smith Dr Tom James Dr Ken McFarlane	COMMUNITY (2) David Scott (Chair) Tracey Tangihaere (resigned) Diane Cooper	TURANGA HEALTH (3) Reweti Ropiha Pene Brown Albie Stewart
TURANGANUI PRIMARY HEALTH ORGANISATION		
	KERIANA BROOKING Chief Executive	
MANAGEMENT SUPPORT		
<i>GENERAL PRACTICE</i> PINNACLE GROUP LTD	<i>PRIMARY HEALTH ORGANISATION</i> PINNACLE GROUP LTD	
PROVIDERS		
CITY MEDICAL CENTRE	DESMOND RD MEDICAL CENTRE	ELGIN HEALTHCARE
KAITI MEDICAL CENTRE	MANGAPAPA MEDICAL CENTRE	VILLAGE CLINIC
TURANGA HEALTH	SPORT GISBORNE TAIRAWHITI	



Quality indicators and targets

There are three areas of specific focus in Quality Plan 12; chronic care, maintaining accreditation status and patient safety. Chronic care was selected as:

- it is of understandable interest to health funders,
- it is expensive in terms of health care costs,
- chronic conditions are very debilitating to those patients with them, and
- the outcome of many chronic conditions are strongly influenced by good general practice.

Pinnacle Incorporated's early commitment to supporting general practice teams to achieve CORNERSTONE™ accreditation provided funders and peers with unequivocal evidence of the organisation's ability to play a key role in leading and shaping quality general practice.

During the course of QP12, the great majority of practices will reach the end of their initial three year period of CORNERSTONE™ accreditation. RNZCGP agreed to work with the Pinnacle general practice network to pilot an organisation wide reaccreditation process.

This involved practice teams, supported by Pinnacle's Quality Team, continuing to complete an annual internally facilitated assessment against accreditation standards, and once in a six yearly cycle, undergoing an external assessment to validate that Pinnacle's internal monitoring processes are effective and that practices are maintaining the required quality standard.

The patient safety agenda is finally gaining the significance and recognition that it deserves. A national body (NZ Safety Improvement Programme) has been set up to provide a national framework across all health care providers. The main emphasis of the programme will be the collection and analysis of adverse incidents that occur in health care.

A summary of QP 12 is included in this reporting package.



Performance

The following programmes were developed, implemented, continued or completed 01 July 2007 – 30 June 2008.

Smoking Cessation - continued

The objectives of this project are to provide smoking cessation support to those patients in the contemplative stage of the 'stages of change' model to enable them to give up smoking.

Project Approach:

Smoking Cessation Facilitator based at Turanga Health:

Utilising the national service specification (C-PH8N Tobacco Control), purchasing additional smoking cessation services delivered by Turanga Health. The goal of the service will be to provide smoking cessation programmes that:

- Reduce prevalence and consumption among Maori who smoke; and
- Increase positive changes in smoking behaviour

Status:

Turanga Health:

New Clients Enrolled	63
Referrals from (GP)	30
Referrals from (Self/Whanau)	15
Referrals from (Turanga Health)	5
Referrals from (Other)	13
Number completed initial assessment	81
Number completed individual plans	81
Number completed programme	31
Number smokefree after 12 months	29

Total Programme spend this year: \$80, 547

Diabetes – continued

The Diabetes Get Checked annual report is included in this reporting package.

Oral Health - continued

The Oral Health Facilitator programme aims to decrease the incidence of poor oral health in the children of Gisborne by:

- Improving the level of enrolment in the school dental service and the uptake of the free dental service provided under the Oral Health Service Agreement (OHSA) for adolescents
- Supporting oral health promotion activities e.g. Brush – in programmes in Kohanga reo, pre-schools, schools and like venues and in the community
- Ensuring families have information about how to access free oral health services for children and adolescents under the age of 18 years.
- Promoting oral health and hygiene to young people and their families.

DESCRIPTION OF ACTIVITIES:	<p>Delivery of Oral Health Lift the Lip & Brush In Programmes implemented in local Kohanga.</p> <p>Ongoing networking with Kohanga to maintain relationships and discuss any issues of concern.</p> <p>Involving Tamariki in different oral health physical activities.</p> <p>Establishing report & networks with Kura Kaupapa Maori for oral health education.</p>	
PRESCHOOL ENROLMENTS: <i>Enrolled with the school dental service</i>	No Enrolled: Six	No Accessing: All preschool Tamariki are seen & treated by the Mobile dental service
ADOLESCENT ENROLMENTS:	4	
BRUSH IN PROGRAMMES IMPLEMENTED:	Ngai Tamanuhiri TKR, and Manutuke TKR Lift the lip and Brush In programmes implemented and resources given out	

HEALTH PROMOTION COMPLETED & VENUE:	<p>Turanga Health Tairawhiti Touch module, The Oval Park</p> <ul style="list-style-type: none"> - Static Displays and resources given out. <p>Ante Natal Classes, Turanga Health</p> <ul style="list-style-type: none"> - Lift the lip technique and general Oral Health information taught, with resources given out. <p>ROAR Youth Conference, War Memorial</p> <ul style="list-style-type: none"> - Oral Health messages given with Mau Rakau demonstration
ISSUES:	<p>None to report</p>
TRAINING:	<p>Te Hotu Manawa Maori – Nutrition and Physical activity</p> <p>Safe to go training with Kiri Pardoe</p> <p>Nutrition 5 + Day with Jo Wickham</p> <p>St John – Using AED</p>

1 Number of Brush In programmes involved

- All 9 Rural Kohanga Reo
- 6 Classes at Te Kura o Manutuke
- Junior and Senior classes at Muriwai School
- 1 Class at TKKM o Nga Uri A Maui

18 Brush in programmes total

2 Number of Children involved in Brush in programmes total; and broken down by ethnicity

Waihirere TKR	9
Tangata Rite TKR	13
Parekereke O Te Reo TKR	13
Pakowhai TKR	16
Tapuihikitia TKR	5
Rongowhakaata TKR	13
Te Pahau TKR	12
Manutuke TKR	15
Ngai Tamanuhiri TKR	17

Total preschool 113

All tamariki enrolled in Kohanga Reo come from the Maori ethnic group.

Te Kura o Manutuke

- Rm 1 20 – 1 Samoan, 1 European, 18 Maori
- Rm 3 23 – 3 European, 20 Maori
- Rm 5 23 – all Maori
- Rm 7 28 – all Maori
- Rm 8 26 – all Maori
- Rm 10 26 – all Maori

Muriwai Primary 32 – 5 European, 27 Maori

TKKM O Nga Uri A Maui 17 – All Maori

Total primary school 195

**Number of all children involved
In Brush in programmes 308**

3 Number of Adolescent Dental contacts made total; and broken down by ethnicity

52 students attended the Turanga Health Mau rakau wananga, with 100% coming from the Maori ethnic group.

23 contacts made through (Did not attends). Ethnicity break down for this group below.

Total adolescent contacts made 75

4 Number of Did Not Attends (DNAs) attended to (by age group/ethnicity)

<i>Year of Birth</i>	<i>1991</i>	<i>1992</i>	<i>1993</i>	<i>1994</i>	<i>1995</i>
<i>Number of clients</i>	12	3	2	3	3

<i>Ethnic group</i>	<i>Maori</i>	<i>European</i>	<i>Other</i>
<i>Number of clients</i>	15	5	3

Total number of DNA's 23

Palliative Care - continued

The SIA programme was developed to enable and support the:

- General practice to provide extended consultations to those patients who are in the end stage of terminal disease; or
- General practice team to provide home visits to those patients who are in the end stage of terminal disease and unable to attend the surgery. The home visits will be provided by the patients own GP (or the GP on call – as this service is available in a community where there is a shared roster, close communication could ensure an on-call GP is aware of all terminal patients in the area); or
- Pharmacist to provide pharmaceutical management and advice to those patients and their caregivers; or
- Turanga Health to provide ancillary services to those patients.
- Improve communication and co-ordination between GP's and Gisborne Palliative Care Service

Status:

This programme has been delivered since October 2005. The following information has been prepared by Pinnacle Group Limited on behalf of TPHO:

Number of Palliative Care claims processed in the period

	No. of Claims
City Medical Gisborne Ltd	60
Desmond Road Medical Centre	38
Kaiti Medical Centre	46
Mangapapa Medical Centre	13
Serendipity Health Limited	34
The Village Clinic Ltd	34
Turanganui PHO	225

Demographic Characteristics of Patients enrolled

	Percentage
Maori	25
Non Maori/Pacific	75

Total Programme spend this year: \$26, 000

Sexual Health - continued

AIMS

To improve access to first level GP services in order to facilitate a;

- ♦ Reduction in unwanted pregnancies amongst the target group
- ♦ Reduction in STIs amongst the target group
- ♦ Reduction in infertility amongst target group

Status:

This programme has been delivered since March 2006. The following information has been prepared by Pinnacle Group Limited on behalf of TPHO:

Number of Consults and Patients

	Consultation count	No of patients
Turanganui PHO	1298	736

Type of service provider (GP or Nurse)

	Doctor Consults	Nurse Consults	Total Consults
Turanganui PHO	831	467	1298

By Age

	Consultations
13 – 17 yrs	338
	27%
18 – 21 yrs	601
	46%
22 – 24 yrs	359
	27%

By Ethnic Group

	Consultations
Maori	529
	40%
Pasifika	12
	1%
Others	757
	59%

Total Programme spend this year: \$32, 710

HealthRight - implemented

The following outcomes have been identified:

- Provision of CVRA screening (chance checks and opportunistic screening)
- Provision of Case Management (lifetime lifestyle)
- Nurse Practitioner Services at JNL
- Social Worker Services
- Turanga Health Disease State Management Kaiawhina
- Primary Mental Health
- Cardio and Pulmonary Rehabilitation Programme

Provision of CVRA screening

Numbers of people by age and ethnicity who have had a cardiovascular risk assessment via electronic decision support

	Maori		Pacific Island		Indian Subcont		Other		Total
	M	F	M	F	M	F	M	F	
35-39	20	14	2	-	3	-	23	4	66
40-44	39	20	1	1	2	1	29	17	110
45-49	47	58	3	1	2	5	101	45	262
50-54	80	73	3	4	1	-	130	86	377
55-59	63	63	4	1	-	-	153	132	416
60-64	54	68	1	-	1	1	163	146	434
65-69	46	61	3	1	1	1	158	136	407
70-74	25	32	-	1	-	1	108	96	263
Total	374	389	17	9	10	9	865	662	2335

% of eligible TPHO population who have had a cardiovascular risk assessment

	Maori		Pacific Island		Indian Subcont		Other		Total
	M	F	M	F	M	F	M	F	
35-39	7	-	7	-	30	-	-	-	8
40-44	13	-	3	-	22	-	-	-	13
45-49	16	15	19	7	67	50	13	-	14
50-54	29	25	20	44	25	0	16	-	21
55-59	32	30	40	17	0	-	20	18	22
60-64	39	45	25	0	33	17	27	24	29
65-69	49	50	75	33	-	50	31	26	32
70-74	38	36	0	25	0	100	30	24	28
Total	23	28	16	21	29	36	21	22	23

Number of Patients who have had a Cardiovascular Risk Assessment by risk criteria

	CVD risk > 20%		CVD risk 16-20%		CVD risk 11-15%		CVD risk < 11%		Total
	M	F	M	F	M	F	M	F	
35-39	-	-	-	2	3	3	45	13	66
40-44	-	1	1	3	14	5	56	30	110
45-49	5	1	7	7	36	13	105	88	262
50-54	14	6	23	13	50	34	127	110	377
55-59	34	14	37	22	54	41	95	119	416
60-64	53	19	52	31	41	55	73	110	434
65-69	72	37	40	24	57	50	39	88	407
70-74	67	26	35	19	21	38	10	47	263
Total	245	104	195	121	276	239	550	605	2335

Provision of Lifetime Lifestyle Assessments

Number of Assessments:

Practice	
Kaiti Medical Centre	139
Desmond Road	20
Serendipity Health Limited	126
Mangapapa Medical	5
The Village Clinic Ltd	30
Turanganui PHO	320

Demographics:

	Percentage
Maori	55
Pacific	2
Non Maori/Pacific	43

Nurse Practitioner Services at JNL

Month - 2009	Jul 08	Aug 08	Sept 08	OCT 08	Nov/Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	Total
No. 1st yr assess	50	44	26	43	61	5	2	2	1	5	0	239
No. 2nd yr + assess	3	5	2	2	12	8	19	20	14	20	19	111
No. ref to GP	21	17	10	12	13	2	0	0	2	4	5	86
No. to OPD	0/0	0/0	5/0	4/0	2	2	1	2	1	1	0	18
A&E/2ndry	4 0	5 0	1 1	1 4	3 1	0	0	0	0	1	1	16 6
No. ref to Opt	1	0	1	1	1	2	5	2	0	1	0	15
No. ref to Dental	1	3	2	0	3	2	3	6	2	1	0	23
No. ref to Podiatry	0	0	0	1	0	0	1	1	1	0	0	4

No. pts labs ordered & completed	11 9	8 4	2 2	10 6	10 8	2 5	7 5	7 3	9 4	5 5	6 4	76 55
No. script items written	10	11	8	11	17	8	15	23	20	24	23	160
No. new ACC generated	2	1	2	1	3	0	1	0	2	1	3	16
No. ref to Quitcard	0	0	1	0	1	2	1	2	3	4	0	14
No Cx @ CHC	8	5	6	8	10	8	6	5	3	6	4	69
Fluvacs given	0	0	0	0	0	0	0	36	36	8	0	80
ADTs given	1	0	0	2	0	0	0	2	2	0	0	7
BPAC done	6	7	0	2	6	1	1	3	1	5	7	39

Social Worker Services

Month - 2009	Jul	Aug	Sept	Oct	Nov/Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Referrals in	22	11	5	9	14	4	10	10	8	6	5	104
Referrals out	1	1	1	4	48	42	0	6	10	3	13	129
W&I benefit assess	3	7	0	5	8	0	3	3	3	5	1	38
No. exited	7	9	9	8	14	1	4	11	10	5	8	86

NB. No of referrals out in Dec/Jan is backlog of 2008 letters documented in PMS by SW.

Turanga Health Disease State Management Nurse

Breakdown of DSM Kaiawhina contacts for period 01 January to 30 June 2009

Education – physical activity	10
Education – smoking	5
Education – diabetes	9
Education – nutrition	19
Advocacy	20
Support	158
Transport	100
Total	363

*Breakdown of place of service for DSM Kaiawhina
01 January to 30 June 2009*

Home	25%
Hospital	18%
Other	30%
General Practice	15%
TLab	5%
Marae	7%
Total	100%

Primary Mental Health

Identification, Assessment and Care Planning

Month -	Jul-Sep	Oct-Dec	Jan - Mar	Apr - Jun
Ref to PMH HR (new clients)	48	46	56	65
Total consults	383	369	241	240
No. telephone/other consults	206	154	96	125
No. HVs	6	3	0	0
Ref to Counselling	24	30	22	26
Ref to Psychologist care	15	7	10	19
No. Exited	55	62	40	80

General Practice extended consultations

Quarter -	Sep 08	Dec 08	Mar 09	June 09	Total
Number	64	45	43	46	198

Cardio and Pulmonary Rehabilitation Programme

Month - 2009	Jan	Feb	Mar	Apr	May	Jun	Total
No referred	21	5	21	1	8	14	71
No. started rehab	0	18	0	19	0	14	51
No at. sessions	0	46	76	3	61	35	221
No postponed/ declined prog	5 2	5 0	7 0	2 1	0 2	0 3	19 8
No. Flinders	13	5	4	15	0	4	41
No. completed all rehab 8 sessions	0	0	0	6	0	11#	17
No. exited rehab		2	1	23	4	2	32
No. CRAT forms @ end of semester	0		2	11	0	12	25

Active Whanau Health Initiative (AWHI) - implemented

This Service aims to improve health gain and reduce childhood obesity through delivery a service for children with the aim of helping children and their families make healthier lifestyle choices.

The outcomes sought through this service are:

- Early identification of overweight/obese children;
- Improved access and uptake of physical activity options and nutritional advice

The service users will be children and their families who:

- have developed or are at risk of developing medical conditions related to inactivity and / or poor eating patterns
- are of school age
- have BMI \geq 85th percentile
- have a stable medical condition which would improve with a change in lifestyle
- do less than 30 minutes of moderate physical activity most days of the week
- are ready to make positive changes to their lifestyle

Status:

Reporting information is attached.

**Active Whanau Health Initiative 12-Monthly Report
Sport Gisborne Tairāwhiti**

**Critical Success Factors-
Referrals**

ANNUAL TARGETS

Actual for 12 month reporting period

- 12 families in programme

8.3	Number of <u>children participating</u> in child focused workshop sessions per intake
7.6	Number of <u>parents/ caregivers participating</u> in adult focused workshop sessions per intake
19	Number of <u>families participating</u> in the programme for this reporting period
93	Number of <u>overall family members</u> involved in the programme
2	Number of <u>families</u> withdrawn permanently from the programme before completion
5	Number of <u>families</u> who have completed the programme

Comments:

- Two families requested individual workshops for all family members in the home. The issues had been identified as areas where further assistance would be beneficial to achieve goals with full family input. These numbers have also been included in the statistics regarding participation in workshops
- A family from intake 1 were going through changes within the home and in personal circumstances and chose to withdraw 9 months after commencement of the AWHI initiative. However the family indicated they would endeavour to maintain the healthy options and family based skills that were developed while on the program.
- Another family from intake 3 withdrew after 4 months on the program. The Mother of the family stated she was not in a clear head space where health was her main concern at this time. Both families left the program with the understanding that they were able to return to Green Prescription Active Families in the future if they required support and encouragement to make healthy lifestyle changes.
- Two families from intake 1 completed the 12 month program at the end of February 2009. They were given the option of graduating from AWHI or remaining on the program for an additional 12 months of tapering support.

The optional 12 months consist of:

- Phone call 1x/month for 12 months
- Access to activity sessions, group gatherings and current information regarding community activity initiatives
- Client visits at the their request with a maximum 3 visits for the year
- Fitness testing and Evaluation forms at 18 and 24 months
- Discharge at 24 months
- Referral to Green Prescription and Green Prescription Active Families is support still required
- Both families who were due to graduate from AWHI have chosen to continue with the extended support for a further 12 months. Within these families there have been great success and improvements with many of the choices that have been made in regards to nutrition, activity and parenting. The extended support will assist with the continuation of achieving the family set goals benefiting all Whanau involved.
- The two families that completed the 12 month program in February 2009 and the three families that completed the program at the end of the second school term had chosen to remain on AWHI for an extended period. The support for this period was planned to be minimal which included monthly phone support and family access to activity sessions and workshops. A common goal for all families in the extended support was to work towards autonomy with their healthy lifestyles in specific areas that had been identified by each family.

**Critical Success Factors-
Demographics**

ANNUAL TARGETS

Actual for first reporting period

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> Engagement of those groups identified as high risk populations within our community | <ul style="list-style-type: none"> 60% Maori 35% Non-Maori 5% Pacific Island peoples | <ul style="list-style-type: none"> 68% Maori 32% Non-Maori 0% Pacific Island peoples |
|---|--|---|

Ethnicity of children participating

Gender of children participating

NZ Euro	Maori	Pacific Island Maori	Samoaan	Tongan	Other
8	15				

Male	Female
13	10

Age of children participating at time of registration

5 yrs	6 yrs	7 yrs	8 yrs	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs
1	3	5	2	4	4	2	2		

Referred by

Paediatrician	GP	Ward RN	Practice Nurse	Community Nurse	Dietician/ Nutritionist	Other
2	16	2	1	2		



Fee Levels

Practice	0-5 years	6-17 years	18-24 years	25-44 years	45-64 years	65 plus
City Medical	Free	\$11	\$16.50	\$16.50	\$16.50	\$16.50
Desmond Road	Free	\$11	\$16.50	\$16.50	\$16.50	\$16.50
Kaiti Medical Centre	Free	\$11	\$16.50	\$16.50	\$16.50	\$16.50
Mangapapa Medical Centre	Free	\$11	\$16.50	\$16.50	\$16.50	\$16.50
Serendipity Health Ltd	Free	\$11	\$16.50	\$16.50	\$16.50	\$16.50
The Village Clinic	Free	\$11	\$16.50	\$16.50	\$16.50	\$16.50



Audited Financial Reports

The information for the financial year relating to this report is attached.