The Health Roundtable Limited

Annual Report 2005

Promoting Innovation in Patient Care

THE HEALTH ROUNDTABLE LIMITED

ACN 071 387 436
ABN 71 071 387 436

DIRECTORS' REPORT FOR 2005

Your directors submit the financial accounts of the Company for the calendar year ending 31 December 2005

DIRECTORS

The names of directors in office at the date of this report are:

Kaye Challinger
Margot Mains
Jennifer Williams
Deborah Podbury
John Mollett
George Jepson
Kerry Stubbs
John O'Donnell
Michael Szwarcbord

PRINCIPAL ACTIVITIES

The principal activities of the Company during the financial year were:

- to provide opportunities for health executives to learn how to achieve best practice in their organisations
- to collect, analyse and publish information comparing organisations and identifying ways to improve operational practices
- to promote interstate and international collaboration and networking among health organisation executives

The Health Roundtable focuses on sharing innovations in patient care amongst its members so that they can treat additional patients and continue to improve the quality of patient care.

OPERATING RESULTS

The Health Roundtable Limited recorded a small surplus of $2,506 for the financial year ending in December 2005. This represents 0.2% of operating expenses during the year. The accumulated surplus in the Company increased to $110,223 as of the end of the financial year.

It is anticipated that annual member fees and corporate sponsorships will match annual expenditures each year, with any accumulated surplus to be used for special projects as approved by the Board of Directors. There was no provision for income tax, as the company is exempt from income taxation.

Cover photo caption: Working session at the Health Roundtable held in Christchurch, New Zealand, March 2006.

REVIEW OF OPERATIONS

This year marked the tenth anniversary of The Health Roundtable, which held its first meeting in November 1995 with seven public hospitals represented. By the end of 2005, the number of member organisations had grown to 34 public health services which encompassed over 55 separate public hospital facilities. These organisations represent over 40% of public hospital activity in Australia and New Zealand.

The growth in membership required changes to both the governance processes for The Health Roundtable in 2005. In April 2005, the membership voted to reduce the size of the Board of Directors to nine persons. This smaller group provides more strategic oversight to the operations of the organisation, and has also created an Audit and Compliance Committee to ensure that appropriate governance processes and risk management strategies are in place. During the year, the Audit and Compliance Committee and the Board have been engaged in a review of the organisation's constitution, and are recommending that it be updated at the April 2006 Annual General Meeting.

The growth in membership and the desire for wider collaboration across all members have led to major changes in the collaborative concepts used by The Health Roundtable. Previously, members were organised into three Chapters based on their arrival into the organisation. With approximately 10 members in each chapter, it was possible to organise roundtable discussions and networking opportunities for each group. In practice, however, members valued the opportunity to learn new ideas from colleagues in other chapters as much as within their own group. As a result, we have agreed to remove the chapter structure so that all members can interact with any other member. This change has led to major redesign of our data analysis services, which now feature the ability to compare any organisation with any other group of members through interactive queries on our website. The change has also led to major improvements in our collaborative meetings, thanks to the assistance of Rod Anderson & Associates. Rather than limit the number of participants in our Roundtables to 40 people, The Health Roundtable is now able to convene successful meetings that involve our full membership.

We held more Roundtable meetings in 2005 than ever before, with major events in every month from February to December. In addition to follow-up meetings on budget performance, patient journey redesign, and operating theatre utilisation, we held a series of meetings focusing on key aspects of care of the elderly patient with chronic disease:

- Improving ambulatory care for chronic medical patients – March 2005
- Making the chronic care paradigm more proactive – June 2005
- Improving management and measurement of outpatient services – August 2005
- Redesigning work and work practices – September 2005

In total, 482 people from member organisations throughout Australia and New Zealand participated in one or more Roundtable activities during the year.

The Health Roundtable also continued to develop its data benchmarking and analysis activities during the year. In 2005, we analysed over 2.4 million inpatient episodes of care for our member organisations, over 2.2 million allied health interventions, and large amounts of costing, mental health, and key performance indicator data to look for apparent differences in performance. These differences were then discussed with members to identify innovative methodological and clinical practices. Periodic reports are provided to members so that they can identify opportunities for improvement.

In 2005 we began providing customised briefings to each member organisation to summarise the data from various data sources as well as from roundtable meetings. These briefings were provided on request in February and July to update senior executives within each organisation about key issues and opportunities.

Benchmarking activities during 2005 included:

- Inpatient Length of Stay Comparisons (Casemix Reports)
- Clinical Costing Comparisons
- Key Performance Indicators
- Allied Health Activity Comparisons
- Mental Health Key Performance Indicators

In November 2005, The Health Roundtable Board of Directors reviewed its management outsourcing contract with Chappell Dean Pty Limited at the half-way point in the life of the two-year contract period. This contractual approach enables The Health Roundtable to facilitate innovation sharing amongst members at an agreed fixed-price cost per participating organisation for each service in the annual program. Chappell Dean provides a network of consultants, analysts, and administrative staff as well as the services of Dr David Dean, who is seconded to serve as General Manager of The Health Roundtable. Key people providing assistance to Chappell Dean and The Health Roundtable during 2005 include:

- Michael Hart – Data Processing Analyst
- Duncan Stuart – Clinical Consultant
- Bindy Krantis – Report Preparation
- Peter Reeves – Operational Consultant
- Margaret Dean – Accounts Administrator
- Pieter Walker – Operational Consultant
- Nick Smeaton – Website Administrator
- Fabian Chessell – Project Manager
- Rod Anderson – Meeting Facilitator

Key highlights from these Roundtables are included on the following pages. More details may be found at our website (www.healthroundtable.org.au) which has both a publicly-accessible library of key innovations, as well as a members-only library of reports detailing specific innovations in each of the areas covered since The Health Roundtable was founded in 1995.

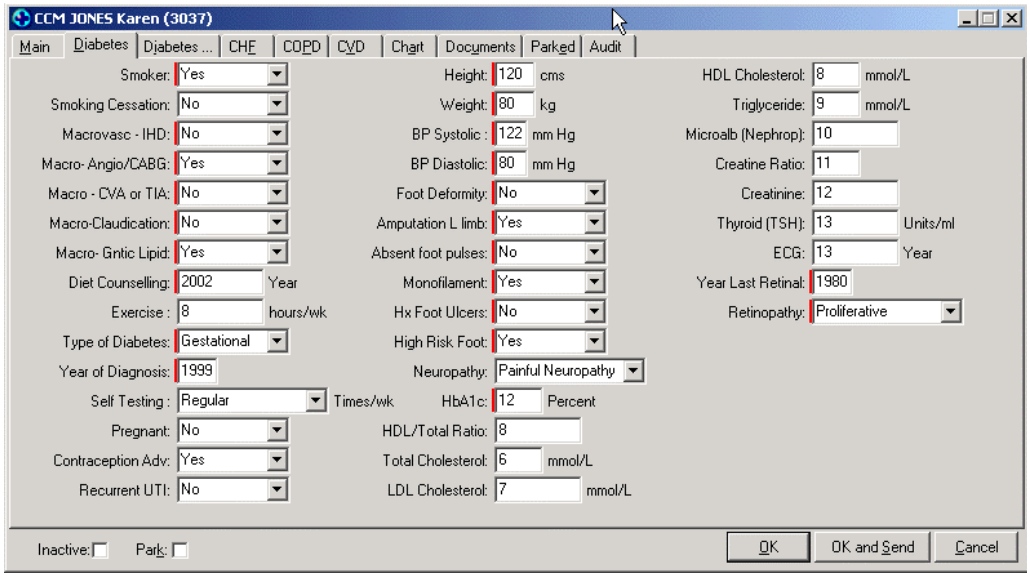
Key Findings and Insights from Roundtable Activities in 2005

February 2005 Improving Budget Performance

	Key Action Ideas Highlighted by Each Organisation													
Nurse Specialling	✓			✓		✓		✓	✓	✓		✓	✓	✓
Consumable Controls	✓			✓	✓	✓								✓
Theatre Review		✓				✓	✓			✓	✓			
Cath Lab Federalisation									✓	✓				✓
Renegotiate with universities					✓						✓	✓		
Clinical trials management					✓							✓	✓	
Right stay project					✓			✓		✓			✓	
Overtime Management	✓	✓		✓			✓	✓			✓			
Frequent Flyer / Case Mgmt		✓	✓				✓							

- Key issues in meeting budget targets included improving controls on the usage of additional staff to provide higher-than-normal levels of patient care ("nurse specials"), better control of consumable supplies, and better management of overtime.
- At least one participating organisation highlighted innovative practices in each of the key areas listed to provide ideas to other members.

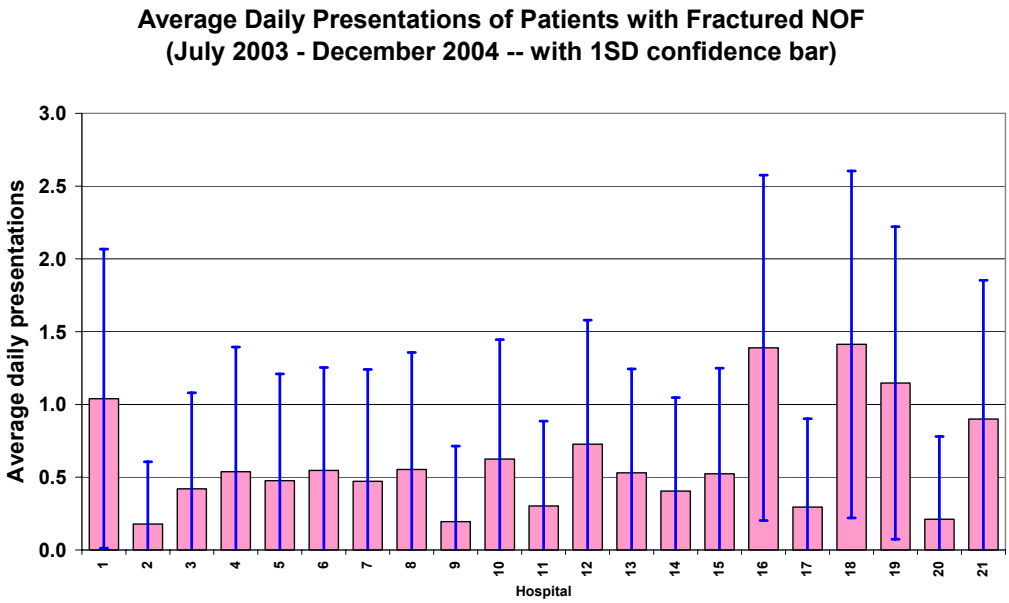
March 2005 Improving Ambulatory Care



- Over half of all hospital admissions do not require an overnight stay in hospital, which challenges existing demarcations of "inpatient," "outpatient," and "ambulatory care."
- Patients with chronic disease are traditionally managed by specialist outpatient clinics at major hospitals, but growth in demand is stretching hospital-based capabilities.
- New Chronic Care Management models, such as at Counties Manukau in New Zealand for diabetes patients, are improving coordination of care between the hospital and primary care providers.

May 2005

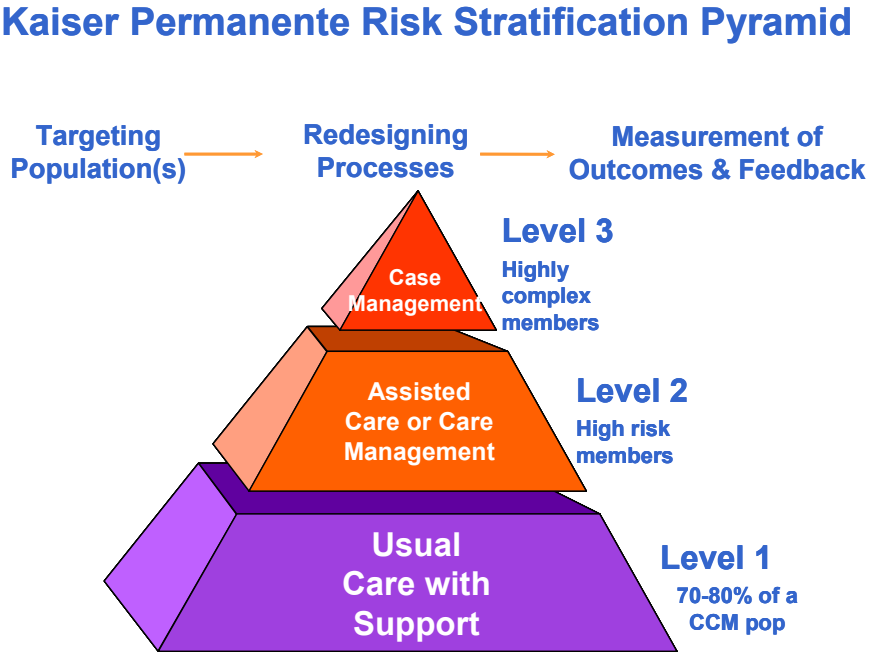
Improving Operating Theatre Utilisation & Production Planning



- Increasing demand for hospital beds by emergency patients is limiting elective surgical capacity at most hospitals. In addition, some hospitals have difficulty obtaining theatre time for routine emergency surgery such as the repair of fractured hips.
- Data collected from the hospitals suggests that the daily volume of sentinel patients (such as fractured hip patients) is highly predictable, and could justify allocation of time on each day's surgical list, rather than as an "extra" case at the end of the day.
- Improved production planning of emergency cases, and extended use of the day-surgery recovery areas were highlighted as key opportunities to improve surgical throughput.

June 2005

Making the Chronic Care Paradigm More Proactive



- Proactive chronic disease management models, such as the Evercare Model and the Kaiser Permanente Model, have been modified for use in Australia (particularly Victoria) and New Zealand.
- Readmission rates and hospital beddays have been reduced for patients with chronic diseases by implementing proactive care management.

August 2005

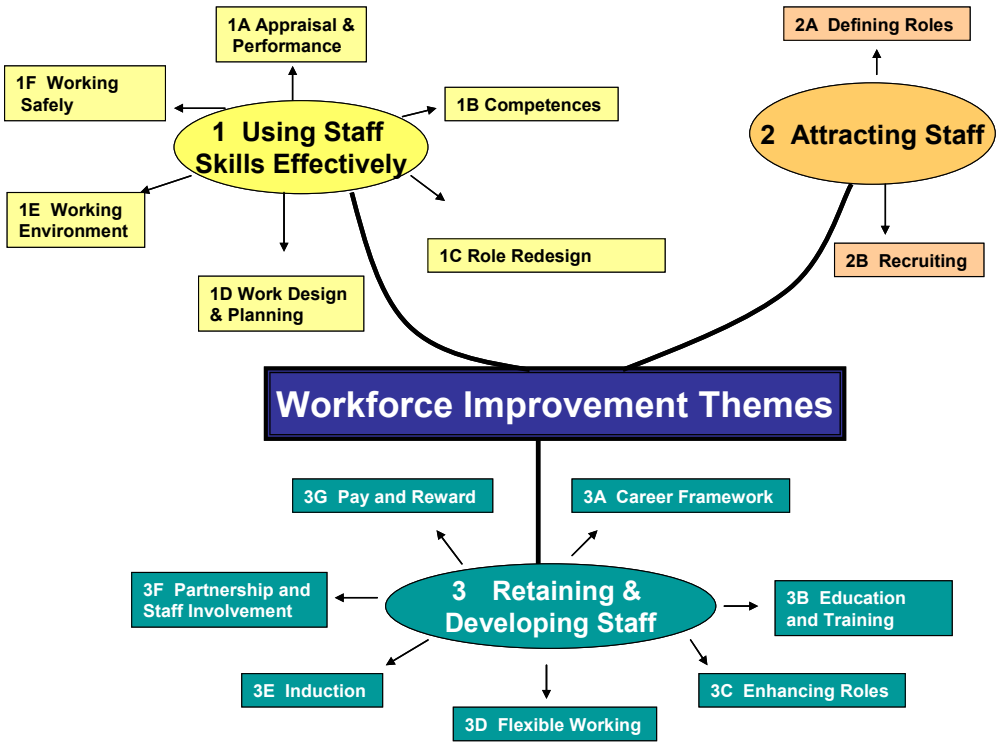
Improving Outpatient Management and Measurement

Key Issues	Solutions Underway
Long waiting lists for new patients	Manage chronic patients in primary care with specialty input
Long delays for complex patients to get coordinated review	Centralised booking of appointments Case managers for complex patients
Senior clinicians missing from scheduled sessions	Centralised scheduling Updated performance contracts Telemedicine appointments
Missing patient records	Patient-held records & self-management On-line protocols & data capture
Missing data and revenue	Capture "in-patient" and "non-inpatient" data together

- Hospitals are actively redesigning their traditional "outpatient clinics" to improve coordination with primary care practitioners.
- However, the lack of consistent measures and funding for ambulatory care makes benchmarking performance very difficult.
- Key treatments such as dialysis, angioplasty, cataract lens procedures, and chemotherapy may be counted as inpatient episodes, outpatient episodes, or not counted at all (privately-referred non-inpatients).

September 2005

How to Redesign the Workforce to Meet Emerging Needs



- Healthcare organisations are facing unprecedented staffing shortages due to the growth of demand, impending retirement of "baby boomer" staff, reduction in hours by newer staff members, and global competition.
- Major improvements are needed in recruitment and retention of staff, as well as redesign of work roles to extend critical skills more widely.
- Work redesign efforts at the hospital facility level face major difficulties due to the heavily-regulated nature of healthcare professions, but some progress is being made using key concepts such as process simplification.

November 2005 Tenth Anniversary Review

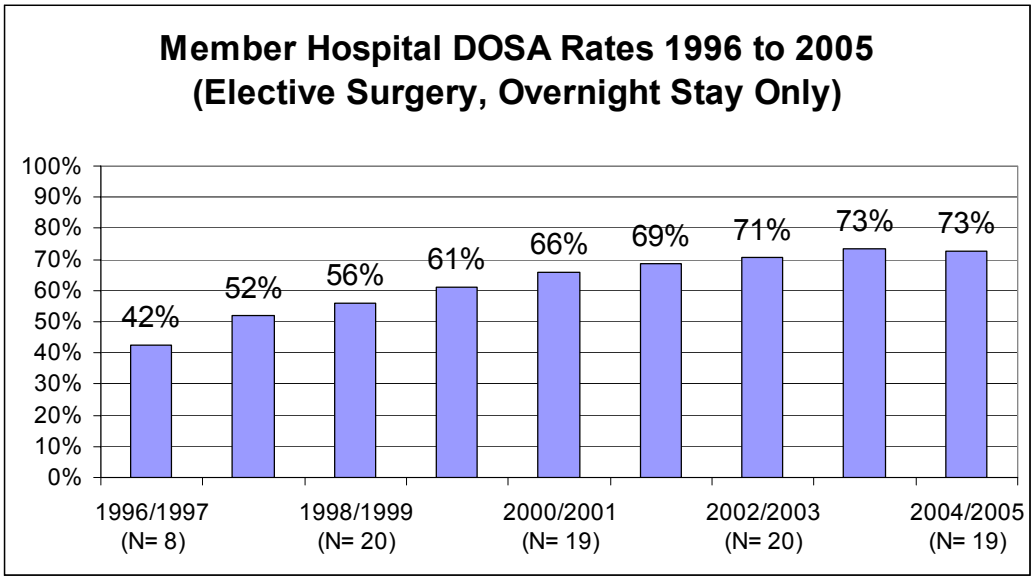
This year marked our 10th anniversary. As part of the November review session we looked back on key goals and progress made in our first ten years of operation.

Participants in the Inaugural Health Roundtable in November 1995 identified ten patient service measures and targets that would represent "good practice" for patient care in major public hospitals. Progress on these goals was highlighted at the November 2005 meeting, with the status shown in the colour coding below.

Legend *Achieved* *Improving* *Struggling*

Patient Service Measure	*Goal*
1. Emergency patients admitted who have an appropriate bed in hospital within 12 hours	***100%***
2. "Urgent" Elective Waiting List patients admitted within 30 days	***100%***
3. Elective patients admitted within 12 months of placement on the waiting list	***100%***
4. Percentage of Elective Waiting List patients who are admitted on the first scheduled date for their admission (i.e. not deferred)	***95%***
5. Percentage of Elective Surgery patients admitted to hospital on the day their surgery is actually performed ***(see below)***	***70%***
6. Elective multi-day patients whose continuity of care planning begins on or before admission	**100%**
7. Emergency multi-day patients whose continuity of care planning begins within 24 hours of admission (i.e. discharge date planned)	**95%**
8. Percentage of patients occupying acute-care hospital beds who clinically require them on any given date	**95%**
9. Percentage of discharges (to home) advised to the patient's GP on or before the discharge date	**100%**
10. Percentage of patients recovering from their hospitalisation without requiring an unplanned readmission to any hospital	**97%**

Day of Surgery Admission Rates (#5 above) have risen to the "good practice" goals at almost all member hospitals, and to well above this level at several locations.

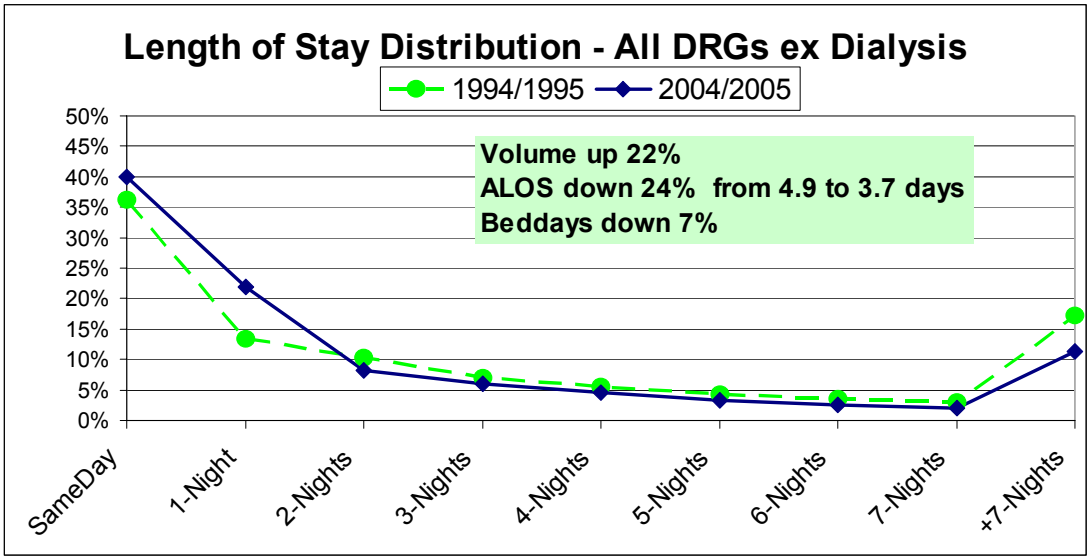


Tenth Anniversary Review (continued)

Other key innovative ideas spread by The Health Roundtable over its first decade include:

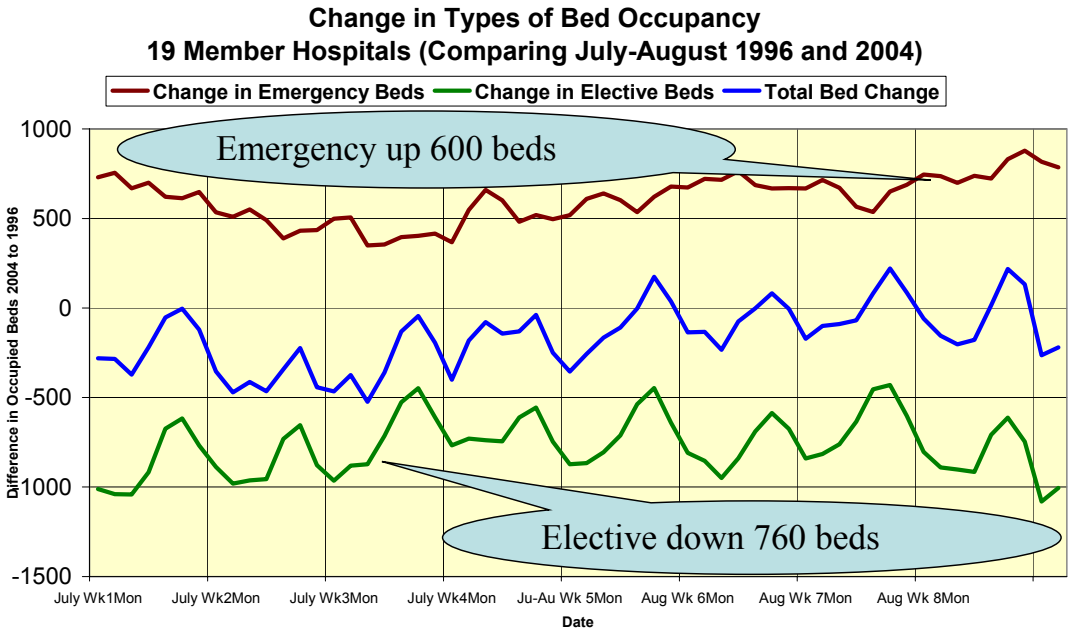
Patient Safety	✓ Medical Emergency Teams (MET) ✓ Death Audits ✓ Focus on Clinical Governance
Efficiency	✓ Day Of Surgery Admissions ✓ Relative Stay Index Length of Stay ✓ Medical Assessment Planning Units
Ageing Population	✓ Hospital in the Nursing Home ✓ "Frequent Flyer" Programs – Chronic Care ✓ Advanced Care Directives
Staffing	✓ Redesigning Care – Patient Journey ✓ Care Substitution – Advanced Practitioners ✓ Extended Hours – "14/7"

Innovation has been essential for hospitals to meet increasing demand for services despite constraints on capacity. Inpatient volume increased by 22% over the decade while bed days dropped by 7%. Average length of stay fell by 24%, with major reductions in the number of patients staying in hospital over 7 days, and major increases in the proportion of patients staying in hospital only one night.

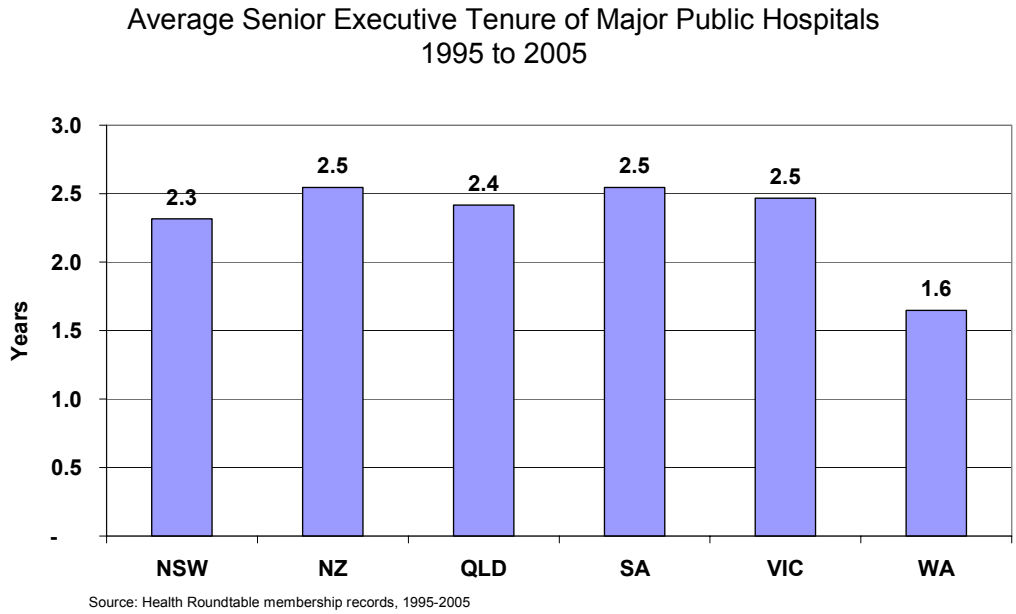


Tenth Anniversary Review (continued)

Overall bed stocks have not grown over the last decade, while emergency demand has increased. As a result, hospitals have been required to allocate an increased proportion of their fixed capacity to emergency patients. Demand is projected to increase more rapidly in coming years due to the combination of population growth and population ageing, which will put even more strain on the public hospital system.



Our healthcare industry's ability to be ready for major demographic changes depends on a clear strategic vision and consistent leadership to translate that vision into reality. Unfortunately, most major healthcare organisations have suffered from a lack of continuity in senior leadership over the last decade, with an average tenure of 2.5 years or less. Hopefully, senior executives will have more time at the helm to implement key initiatives in the decade ahead.



Source: Health Roundtable membership records, 1995-2005

MEMBERSHIP

Both individuals and organisations belong to The Health Roundtable as members. Personal membership in The Health Roundtable is offered to the person with overall management responsibility for a health service, while organisational membership is offered to health services and other collaborative groups.

During 2005, The Health Roundtable approved the applications for membership of two additional organisations – Otago District Health Board in New Zealand, and The Royal Women's Hospital in Melbourne, bringing the total organisational membership to 36. Due to the consolidation of health services in South Australia, however, three of our members (Royal Adelaide, The Queen Elizabeth Hospital, and Lyell McEwin Health Service) were combined into a new entity called the Central Northern Adelaide Health Service, which reduced our membership back to 34 organisational members. One of the organisational members, the Regional Health Improvement Network, is a consortium of smaller regional facilities that conducts its own benchmarking activities as an affiliated group.

Membership of The Health Roundtable (as of March 2006)

John Hunter	NSW	Austin Health	VIC
Prince of Wales	NSW	Barwon Health	VIC
St George	NSW	Bayside Health (3)	VIC
St Vincents (Sydney)	NSW	Eastern Health (3)	VIC
Sydney West (4)	NSW	Melbourne Health	VIC
Auckland City DHB	NZ	Royal Women's (Melbourne)	VIC
Canterbury Health DHB	NZ	Southern Health (3)	VIC
Capital & Coast DHB	NZ	St Vincents Health (Melbourne)	VIC
Counties Manukau DHB	NZ	Fremantle	WA
Otago DHB	NZ	Royal Perth	WA
Health Waikato DHB (4)	NZ	Sir Charles Gairdner	WA
Waitemata DHB	NZ	The Canberra Hospital	ACT
Gold Coast	QLD	Northern Territory Health (3)	NT
Mater Health Brisbane	QLD	Central Northern Adelaide (3)	SA
Princess Alexandra	QLD	Flinders	SA
Royal Brisbane & Womens	QLD	Royal Hobart	TAS
Townsville	QLD	**Regional Health Improvement Network (8)**	

() indicates number of separate facilities reported

Given the recent spate of consolidations, we have developed the capacity to analyse data for our members at both an individual health facility level and at the broader health service level.

Our personal membership as of March 2006 stands at 29 members. Turnover amongst personal members has continued as major teaching hospitals continue to reorganise and/or change chief executives. At present, personal member vacancies exist for ten of the 33 member organisations. Personal members include the General Manager and five life members known as Knights of the Health Roundtable in recognition of their contribution to the organisation.

Cerner Corporation continued its involvement as a "Corporate Partner" of The Health Roundtable during 2005. In addition, Mr Tim Smyth of Phillips Fox provided assistance with constitutional issues on a pro-bono basis during the year. Sponsorship fees are used to support general administrative activities. The Health Roundtable has a corporate sponsorship policy to promote involvement by corporations involved in the health care industry while assuring probity.

The Health Roundtable continued its international affiliate membership in the University Healthsystem Consortium, a collaborative group of over 80 academic medical centres in the USA. This affiliation has provided valuable methodological assistance and insights to the organisation.

The Health Roundtable continued to operate on a sound financial basis in 2005, with income and expenses arising as planned.

AFTER BALANCE DATE EVENTS

No matters or circumstances have arisen since the end of the financial year which may significantly affect the operations of the Company, the results of those operations, or the state of affairs of the Company in subsequent financial years.

DIRECTORS AND AUDITORS INDEMNIFICATION

During the 2005 accounting period, The Health Roundtable paid premiums to insure itself and each of the Directors and Officers of the company against liabilities for costs and expenses incurred by them in defending any actual or alleged breach of duty, breach of trust, neglect, error, misstatement, misleading statement, omission, breach of warranty of authority claimed against them while acting in their individual or collective capacities.

The total amount paid for the insurance in 2005 was $2,184.

MEETINGS OF DIRECTORS

During the 2005 calendar year, the Board of Directors met on 6 April, and on 16 November. At its meeting on 6 April, the Board formed the Audit and Compliance Committee to consider constitutional changes, develop a risk management strategy, and to carry out audit and compliance activities. The Audit Committee held four meetings during the year, on 24 June, 10 August, 21 October, and 16 November. We express our appreciation to Mr Ross Cooke for the insights he is providing as an external member of the Audit & Compliance Committee.

DIRECTORS' BENEFITS

No director has received or become entitled to receive, during or since the financial year, a benefit because of a contract made by the company with: a director, a firm of which a director is a member, or an entity in which a director has a substantial financial interest.

INFORMATION ON OFFICERS AND DIRECTORS SERVING DURING 2005

OFFICERS:

Associate Professor Kaye Challinger, Director and President
(Appointed 16 October 1998, re-elected 6 April 2005, elected President 6 April 2005)

Associate Professor Challinger is the Executive Director, Acute Services, within the Central Northern Adelaide Health Service.

Ms Margot Mains, Director
(Elected 25 November 1999, re-elected 6 April 2005, elected Vice President 6 April 2005)

Ms Mains is Chief Executive Officer of Capital & Coast District Health Board in New Zealand.

Ms Kerry Stubbs, Director and Honorary Treasurer
(Appointed 25 November 2003, re-elected 6 April 2005)

Ms Stubbs is Chief Executive Officer of St Vincent's Public Hospital in Sydney.

Dr Paul Scown, Director and Honorary Secretary (to July 2005)
(Appointed 3 April 2001, re-elected 6 April 2005. Resigned 26 July 2005)

Dr Scown was Chief Executive of Melbourne Health in Victoria. He resigned that position and his membership in The Health Roundtable in July 2005.

Mr John Mollett, Director and Honorary Secretary (from August 2005)
(Elected 4 May 2004, and re-elected 6 April 2005. Appointed Honorary Secretary 15 August 2005)

Mr Mollett is General Manager of The Canberra Hospital.

DIRECTORS

Ms Jennifer Williams, Director
(Elected 27 November 1998; re-elected 6 April 2005)

Ms Williams is Chief Executive of Bayside Health in Victoria.

Ms Deborah Podbury, Director
(Appointed 25 November 2003, re-elected 6 April 2005)

Ms Podbury is District Manager for Princess Alexandra Hospital in Queensland.

Ms Vicki Geytenbeek, Director (to July 2005)
(Appointed 25 November 2003, re-elected 6 April 2005. Resigned on 14 July 2005)

Ms Geytenbeek was General Manager of Royal Darwin Hospital in the Northern Territory. She resigned that position and her membership in The Health Roundtable in July 2005.

Mr Ted Rayment, Director (to November 2005)
(Elected 29 April 2003, re-elected 6 April 2005. Resigned 11 November 2005)

Mr Rayment was Chief Executive of Royal Hobart Hospital in Tasmania. He left that position and resigned his membership in The Health Roundtable in November 2005.

Mr George Jepson, Director (from 16 November 2005)
(Elected 4 May 2004 and served to 6 April 2005. Appointed to fill vacancy on 16 November 2005)

Mr Jepson is the Executive Director of Prince Henry / Prince of Wales Hospital in Sydney.

Mr Michael Szwarcbord, Director (from 16 November 2005)
(Appointed 16 November 2004 and served to 6 April 2005. Appointed to fill vacancy on 16 November 2005)

Mr Szwarcbord is Chief Executive of the Flinders Medical Centre in South Australia.

Dr John O'Donnell, Director (from 16 November 2005)
(Appointed 16 November 2004 and served to 6 April 2005. Appointed to fill vacancy on 16 November 2005)

Dr O'Donnell is Chief Executive of Mater Health Services in Brisbane, Queensland.

The following individuals served as Directors of the Health Roundtable in the period from January 2005 to 6 April 2005, when their terms ended. The organisation reduced the size of the Board to nine members at the April 2005 Annual General Meeting.

Mr Kenneth Whelan

Mr Stephen McKernan

Ms Jean O'Callaghan

Mr Richard Olley

Mr Jeff Hollywood

Dr Nigel Murray

Ms Linda Sorrell

Signed in accordance with a resolution of the Board of Directors.

Kaye Challinger Director	Kerry Stubbs Director

Date: 14 March 2006

THE HEALTH ROUNDTABLE LIMITED

ABN 71 071 387 436

DIRECTORS' DECLARATION

FOR THE YEAR ENDED 31 DECEMBER 2005

The directors have determined that the company is not a reporting entity and that this special purpose financial report should be prepared in accordance with the accounting policies prescribed in Note 1 to the financial statements.

The directors of the company declare that:

1. the financial statements and notes, present fairly the company's financial position as at 31 December 2005 and its performance for the year ended on that date in accordance with the accounting policies described in Note 1 to the financial statements;

2. in the directors' opinion, there are reasonable grounds to believe that the company will be able to pay its debts as and when they become due and payable.

This declaration is made in accordance with a resolution of the Board of Directors.

_____

Kaye Challinger
Director

_____

Kerry Stubbs
Director

Dated: 14 March 2006

The Health Roundtable Limited A.B.N. 71 071 387 436

Financial Statements

For the year ended 31 December 2005

Ronald Smith & Co

Chartered Accountant

Suite 101, 10 Edgeworth David Avenue

Hornsby 2077

Phone: 94771650 Fax: 94776649

The Health Roundtable Limited A.B.N. 71 071 387 436

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Detailed Profit and Loss Statement
For the year ended 31 December 2005

	2005 $	2004 $
Income		
Special project income	38,500	6,000
License & Sponsorship income	32,500	8,565
Subscription fees income	1,167,500	989,912
Membership fees	7,300	7,000
Delegate Rego fees	80,670	92,762
Interest received	26,652	21,192
Total income	1,353,122	1,125,431
Expenses		
Audit fees	2,505	2,543
Bank Fees And Charges	32	17
Filing Fees	40	40
Management & Office expenses	35,492	35,991
Insurance	2,184	2,200
Subscription program expenses	1,163,500	963,978
Hotel and Venue costs	91,580	101,154
UHC Membership costs	16,783	15,909
Special project costs	38,500	6,000
Total expenses	1,350,616	1,127,832
Profit from Ordinary Activities before income tax	**2,506**	**(2,401)**

The accompanying notes form part of these financial statements.

The Health Roundtable Limited A.B.N. 71 071 387 436

Balance Sheet As At 31 December 2005

	Note	2005 $	2004 $
Current Assets			
Cash assets	3	136,899	163,157
Receivables	4	25,936	42,188
Current tax assets		46,553	42,939
Total Current Assets		**209,388**	**248,284**
Non-Current Assets			
Other	5	1,035	1,035
Total Non-Current Assets		**1,035**	**1,035**
Total Assets		**210,423**	**249,319**
Current Liabilities			
Payables	6	28,200	51,102
Other	7	72,000	90,500
Total Current Liabilities		**100,200**	**141,602**
Total Liabilities		**100,200**	**141,602**
Net Assets		**110,223**	**107,717**
Equity			
Retained profits		110,223	107,717
Total Equity		**110,223**	**107,717**

The accompanying notes form part of these financial statements.

The Health Roundtable Limited A.B.N. 71 071 387 436

Statement of Cash Flows
For the year ended 31 December 2005

	2005 $	2004 $
Cash Flow From Operating Activities		
Receipts from customers	1,342,722	1,071,482
Payments to Suppliers and employees	(1,395,632)	(1,100,833)
Interest received	26,652	21,192
Net cash provided by (used in) operating activities (note 2)	(26,258)	(8,159)
Net increase (decrease) in cash held	(26,258)	(8,159)
Cash at the beginning of the year	163,157	171,316
Cash at the end of the year (note 1)	136,899	163,157

The accompanying notes form part of these financial statements.

The Health Roundtable Limited A.B.N. 71 071 387 436

Statement of Cash Flows
For the year ended 31 December 2005

	2005	2004

Note 1. Reconciliation Of Cash

For the purposes of the statement of cash flows, cash includes cash on hand and in banks and investments in money market instruments, net of outstanding bank overdrafts.

Cash at the end of the year as shown in the statement of cash flows is reconciled to the related items in the balance sheet as follows:

Cash At Bank	136,899	163,157
	136,899	163,157

Note 2. Reconciliation Of Net Cash Provided By/Used In Operating Activities To Net Profit

Operating profit (loss) after tax	2,506	(2,401)
Changes in assets and liabilities net of effects of purchases and disposals of controlled entities:		
(Increase) decrease in trade and term debtors	16,252	(32,757)
Increase (decrease) in trade creditors and accruals	(22,902)	6,593
Increase (decrease) in other creditors	(18,500)	31,400
Increase (decrease) in sundry provisions	(3,614)	(10,994)
Net cash provided by (used in) operating activities	**(26,258)**	**(8,159)**

Note 1: Statement of Significant Accounting Policies

This financial report is a special purpose financial report prepared for use by directors and members of the company. The directors have determined that the company is not a reporting entity.

The financial report has been prepared in accordance with the requirements of the following Australian Accounting Standards.

AAS 5:	Materiality
AAS 8:	Events Occurring After Reporting Date

No other Australian Accounting Standards, Urgent Issues Group Consensus Views or other authoritative pronouncements of the Australian Accounting Standards Board have been applied.

The financial report has been prepared on an accruals basis and is based on historic costs and does not take into account changing money values, or except where specifically stated, current valuations of non-current assets.

The following specific accounting policies, which are consistent with the previous period unless otherwise stated, have been adopted in the preparation of this financial report:

(a) Property, Plant and Equipment

Property, plant and equipment are carried at cost, independent or directors' valuation. All assets, excluding freehold land and buildings, are depreciated over their useful lives to the company.

(b) Inventories

Inventories are measured at the lower of cost and net realisable value. Costs are assigned on a first-in first-out basis and include direct materials, direct labour and an appropriate proportion of variable and fixed overhead expenses.

	2005	2004

Note 2: Revenue

Operating Activities:

Other sales revenue	1,326,470	1,104,239
Interest revenue	26,652	21,192
	1,353,122	**1,125,431**

Note 3: Cash assets

Bank accounts:		
- Cash At Bank	136,899	163,157
	136,899	**163,157**

Note 4: Receivables

Current

Trade debtors	25,936	42,188
	25,936	**42,188**

Note 5: Other Assets

Non Current

Preliminary expenses	1,035	1,035
Less: accumulated amortisation		
	1,035	**1,035**

	2005	2004

Note 6: Payables

Unsecured:		
- Trade creditors	28,200	51,102
	28,200	51,102
	28,200	**51,102**

Note 7: Other Liabilities

Current

Advance payments	72,000	90,500
	72,000	**90,500**

Note 8: Auditors' Remuneration

Remuneration of the auditor of the company for:		
Auditing or reviewing the financial report	2,505	2,543
Other services		
	2,505	**2,543**

The Health Roundtable Limited A.B.N. 71 071 387 436

Independent Auditor Report

Scope

We have audited the attached financial report, being a special purpose financial report comprising the Directors' Declaration, Statement of Financial Performance, Statement of Financial Position, Statement of Cash Flows, and Notes to the Financial Statements, for the year ended 31 December 2005 of The Health Roundtable Limited. The company's directors are responsible for the financial report and have determined that the accounting policies used and described in Note 1 to the financial statements which form part of the financial report are consistent with the financial reporting requirements of the company's constitution and are appropriate to meet the needs of the members. We have conducted an independent audit of the financial report in order to express an opinion on it to the members of the company. No opinion is expressed as to whether the accounting policies used, and described in Note 1, are appropriate to the needs of the members.

The financial report has been prepared for distribution to members for the purpose of fulfilling the directors' financial reporting requirements under the Corporations Act 2001. We disclaim any assumption of responsibility for any reliance on this report or on the financial report to which it relates to any person other than the members, or for any purpose other than that for which it was prepared.

Our audit has been conducted in accordance with Australian Auditing Standards. Our procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial statements, and the evaluation of significant accounting estimates. These procedures have been undertaken to form an opinion whether, in all material respects, the financial report is presented fairly in accordance with the accounting policies described in Note 1, so as to present a view which is consistent with our understanding of the company's financial position, and performance as represented by the results of its operations and its cash flows. These policies do not require the application of all Accounting Standards and other mandatory professional reporting requirements to the extent described in Note 1.

The audit opinion expressed in this report has been formed on the above basis.

Audit opinion

In our opinion, the financial report presents fairly, in accordance with the accounting policies described in Note 1 to the financial statements, the financial position of The Health Roundtable Limited as at 31 December 2005 and the results of its operations for the year then ended.

Signed on:

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Ronald Hamilton Smith, Charterred Accountant
Ronald Smith & Co
101/10 Edgeworth David Ave. Hornsby NSW