



# Knowledge Igniting Change

2007 ANNUAL REPORT

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## About ICES—Evidence Guiding Health Care

The **Institute for Clinical Evaluative Sciences (ICES)** is an independent, non-profit organization that produces knowledge to enhance the effectiveness of health care for Ontarians. Internationally recognized for its innovative use of population-based health information, ICES' evidence supports health policy development and guides changes to the organization and delivery of health care services.

Key to our work is our ability to link population-based health information, at the patient-level, in a way that ensures the privacy and confidentiality of personal health information. Linked databases reflecting 12 million of 30 million Canadians allow us to follow patient populations through diagnosis and treatment, and to evaluate outcomes.

ICES brings together the best and the brightest talent under one roof. Many of our scientists are not only internationally recognized leaders in their fields, but are also practicing clinicians who understand the grassroots of health care delivery, making the knowledge produced at ICES clinically-focused and useful in changing practice. Other team members have statistical training, epidemiological backgrounds, project management or communications expertise. The variety of skill sets and educational backgrounds ensures a multi-disciplinary approach to issues and creates a real-world mosaic of perspectives that is vital to shaping Ontario's future health care system.

ICES receives core funding from the Ontario Ministry of Health and Long-Term Care. In addition, our faculty and staff compete for peer-reviewed grants from federal funding agencies, such as the Canadian Institutes of Health Research, and project-specific funds are received from provincial and national organizations. These combined sources enable ICES to have a large number of projects underway, covering a broad range of topics. The knowledge that arises from these efforts is always produced independent of our funding bodies, which is critical to our success as Ontario's objective, credible source of ***Evidence Guiding Health Care***.



### Our goals

**In support of our mission, ICES' key objectives are to:**

- **Carry out population-based health services evaluation** that is relevant to clinical practice and health policy development;
- **Document province-wide patterns and trends** in health care delivery;
- **Develop and share evidence to inform decision-making** by policy makers, managers, clinicians, planners and consumers;
- **Promote linkages** among health services researchers and decision-makers; and,
- **Train researchers** and promote a wider understanding of clinical epidemiology and health services evaluation.



## Message from the Board Chair & CEO (I)

### Knowledge Igniting Change



**Ignition**—the spark that transforms raw fuel into light and energy.

**The Ontario health care system is currently going through an unprecedented transformation that requires timely, credible and accessible knowledge to ignite that change. For 15 years, ICES has harnessed data about the health care system and transformed those data into information and knowledge to help illuminate and energize change.**

The devolution of much of the management of health care delivery to Local Health Integration Networks (LHINs) represents a dramatic change to the Ontario health system. For LHINs to provide health care delivery that is more responsive and integrated, sound evidence is required about local health care needs, delivery and outcomes. At the same time, Ontarians want to know how their local care compares to other regions and to the province as a whole—comparisons that require standardized measures applied uniformly across LHINs. ICES continues to take a leadership role in developing reliable measures of health care delivery and is improving access to those measures through innovative communication strategies. As an example, our recently launched **inTool** provides instant web-based access to a broad range of up-to-date indicators of health status and health care delivery at the provincial, LHIN and sub-LHIN levels.

Timely access to surgical services continues to be a concern for Ontarians. ICES has provided important knowledge to support the provincial government's Wait Time Strategy (WTS), but some have suggested that an intense focus on a small number of high priority services may deflect attention away from other areas of need. To address this concern, ICES recently examined rates of service for a range of surgical procedures not targeted under the WTS and demonstrated that rates for these procedures did not decrease in the face of an intensive investment in WTS procedures.

Specialized surgical services are critically important when needed, but for most Ontarians their encounters with the health care system are typically at the front lines—in family physicians' offices and emergency departments. This year ICES produced its first comprehensive report on **Primary Care in Ontario**, which described regional and temporal trends in patterns of care and the delivery of services to populations.

Urgent needs such as access to advanced surgical services and local primary care can divert attention from the sleeping giants of health care—complex chronic diseases. ICES continues to take a leadership role, both provincially and nationally, in defining the burden of cardiovascular disease, diabetes and asthma, and in tracking these important chronic disease epidemics. The burden of premature morbidity and mortality imposed by these conditions highlights the need for effective chronic disease management and for population-based approaches to chronic disease prevention. In the coming year, ICES will examine how neighbourhood characteristics such as access to health food, recreational facilities and transit options impact the development of diabetes. This work will shed light on practical ways to create healthier environments that support both effective disease management and disease prevention.

Healthy environments, timely access to integrated services and a responsive and sustainable health care system—these are important challenges facing health care in Ontario and around the world. Reliable, accurate and timely information will both illuminate the path forward and energize the changes that are needed to meet growing needs and expectations. ICES will continue to play a central role in providing the knowledge to support that transformation, and will contribute to a more responsive and effective health care system for everyone.



**Dr. Brian Golden**  
Board Chair

**Dr. Jan Hux**  
President and CEO (I) & Senior Scientist

## Board of Directors\*

ICES is governed by a voluntary Board of Directors, whose collective range of experience and expertise guide our strategic direction and research priorities.

### Chair

**Dr. Brian Golden**

SANDRA ROTMAN CHAIR IN HEALTH SECTOR STRATEGY, UNIVERSITY OF TORONTO AND UNIVERSITY HEALTH NETWORK

EXECUTIVE DIRECTOR, COLLABORATIVE FOR HEALTH SYSTEM PERFORMANCE, UNIVERSITY OF TORONTO

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**Dr. Robyn Tamblyn**

SCIENTIFIC DIRECTOR, INTEGRATED HEALTH CARE AND RESEARCH NETWORK OF QUEBEC

**Professor Carolyn Tuohy**

SENIOR FELLOW, SCHOOL OF PUBLIC POLICY AND GOVERNANCE, UNIVERSITY OF TORONTO

**Dr. Ruth Wilson**

FAMILY PHYSICIAN AND CHAIR, ACTION GROUP ON PRIMARY CARE REFORM

**Mr. John Wright**

SENIOR VICE-PRESIDENT, CANADIAN PUBLIC AFFAIRS DIVISION, IPSOS-REID CORPORATION

\* Membership for 2006/07.

## Knowledge Igniting Change



From a public perspective, little is more important than timely access to safe, high-quality health care services. These priorities are coupled with the demand for expensive new drugs and diagnostic tests, and the need for more and better services for an aging population with its increased incidence of chronic diseases. As a result, enumerable challenges are created for those responsible for Ontario's health system and for the provision of health care services.

Managing these challenges with finite resources, in an era of public accountability, requires objective evidence upon which to base decisions about health care delivery.

Over the past year, ICES has made significant contributions in providing the necessary evidence to support decisions on areas of importance to the public and the health care community. The following is a sampling of projects from the past year, as well as some future areas of focus that ICES will engage in, to support policy development and improved health care delivery in Ontario.



### Primary Care

General practitioners and family physicians (GP/FPs) provide more direct service to patients than any other health care providers in Ontario, and are also involved in the provision of several indirect services. Since primary care reform initiatives affect all aspects of the health care system, it is essential that policy and planning decisions are supported by the best available information.

In 2006, ICES released *Primary Care in Ontario* which provided a comprehensive look at the use of primary care services over a decade, from 1992/93 to 2003/04. Over the course of a life span, the report found that:

- Obstetricians and midwives provided more primary care services to pregnant women, and there was an increase in the number of older mothers, as well as multiple and caesarean births.
- Among children, the average number of primary care visits decreased, the proportion with no primary care visits increased, and there was a three-fold variation in visit rates across the province.
- Paediatricians provided an increasing amount of primary care to children.

The report also provided a look at primary care services in special populations:

- Heart failure patients cared for by a GP/FP without specialist consultation had poorer outcomes in terms of mortality, hospital readmission and receipt of some recommended heart failure medications.
- GP/FPs played a key role throughout the continuum of cancer care, and patients had more contact with their GP/FP than with any cancer specialist or other type of physician.
- Among Ontarians who sought mental health care, the most commonly contacted provider was a GP/FP.



- Despite wide variations in health needs and preventive health care, disadvantaged populations (those who have low socioeconomic status, report unmet health needs, live in rural areas, or are immigrants or members of visible minorities) all had similar levels of primary and specialist care.

Finally, the report examined the supply of physicians providing primary care, their practice locations, workloads, services provided, and patient characteristics, as well as the factors which influence preventive, chronic and acute disease management in primary care. This section of the report found that:

- Approximately 140,000 people visit a GP/FP each day in Ontario. Despite Ontario's growing and aging population, there was no change in the overall number of visits to GP/FPs.
- In 2003/04, approximately 30% of Ontario GP/FPs were purely in solo practice, with no formal group affiliations.
- Ontarians who relied on walk-in or after hours clinics for the majority of their primary care were less likely to have had either an annual exam or a flu shot.
- Just under 60% of women between 20 and 39 years of age received at least one Pap test, and only 17% of Ontarians between 50 and 69 years of age underwent colorectal cancer screening. In children, over 70% had received at least five vaccinations by age two. The proportion of adults having high continuity of care was just under 40%.

Overall, this atlas highlighted the need for policy makers to ensure that there will be sufficient numbers of GP/FPs to provide the necessary care for Ontarians in the future. New models and initiatives for primary care reform need to consider and address the trends shown in this report, as there is a need to promote more organized and collaborative efforts between primary care providers and specialists.

## Access to Care

The Ontario government's Wait Time Strategy (WTS) was launched in November 2004 to improve access to services in five key areas—cancer, cataract and cardiac surgeries; hip and knee replacements; and, CT and MRI scans. As of May 2006, \$410 million had been invested in additional procedures. However, at the same time, there had been anecdotal reports of decreased numbers of, and increased waits for, non-priority surgeries. To assess the impact of the WTS on non-priority surgeries, ICES examined the volumes of 30 non-priority surgeries. The results showed that the WTS did not have a negative impact on the rates of these surgical procedures in Ontario, and in fact some non-priority orthopaedic surgery rates may have increased slightly following the introduction of the WTS. Looking to the future, it will be important to monitor the impact of the WTS, particularly for urgent procedures where evidence suggests that delay may compromise outcomes.

Looking at access to care in emergency departments (EDs), ICES found that patients who visit EDs with minor illnesses and injuries do not substantially impact the wait times of ED patients with major illnesses. The results also showed that low-complexity patients do not impact ED crowding. To address the complex issue of ED crowding, the study points to the need for hospitals to focus on other strategies, including increasing the number of inpatient beds and moving patients more efficiently through tests, such as X-rays.





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### Health Care Technologies

While improved health care technology can offer new insights into diagnosis and treatment, the rapid introduction of expensive, and often unproven, technological advancements represents significant challenges for governments who are charged with responding to competing demands for limited resources.

As a case in point, ICES showed that increases in the use of coronary angiography for heart attack patients in Ontario began nearly a year before there was scientific evidence demonstrating improved health outcomes. The study authors noted that poor alignment between technology proliferation and scientific evidence may ultimately undermine a system's resource efficiency by promoting the use of more costly and less effective technologies and interventions, rather than less costly and more effective ones.

Biotechnology is increasingly being used as a treatment option in cardiovascular medicine. As a proactive measure, ICES developed web-based registries to monitor the utilization and outcomes of new, expensive health care technologies, and provide high-quality data to evaluate the effectiveness of these interventions. This past year, two registries were developed to track the use of implantable cardioverter defibrillators (ICDs) as a primary preventive measure, and radiofrequency ablation to treat abnormal heart rhythms. The secure ICD and Ablation databases can be accessed by all Ontario hospitals that offer these procedures. The data that are collected provide real-time information on the utilization of these technologies, and can be linked with the large administrative databases held at ICES to allow for further assessment of patient outcomes. Clinicians who care for these patients were involved in the design of these databases to ensure the utility of collected information in improving patient care.

**...the rapid introduction of expensive, and often unproven, technological advancements represents significant challenges for governments...**



## Drug Safety

New drugs continue to be introduced at a rapid pace, and drug therapy remains an enormous health care cost. However, it is not always clear whether medications are being appropriately and safely prescribed. While some patients may be taking drugs that offer limited benefit, in other cases therapy that is important to recovery, disease management and/or quality of life is stopped or never initiated. Understanding which drugs are beneficial to which patients is critical to improving patient care. During the past year, ICES produced a broad range of studies that explored the safety, prescribing practices and use of various drug therapies.

An important area of focus included the appropriate and safe use of antipsychotic medications in the elderly. ICES examined variation in the use of these drugs across Ontario nursing homes to determine whether prescribing decisions are based on medical need. The study showed that nursing homes with high antipsychotic prescribing rates were three times more likely to dispense drugs to residents who did not need them. This finding provides an impetus for nursing homes to examine their prescribing practices and to determine whether improvements are warranted.

ICES scientists also investigated the drug safety of selective serotonin reuptake inhibitor (SSRI) antidepressants to assess the odds of suicide for people prescribed SSRIs compared to those prescribed a non-SSRI antidepressant. The majority of the 1,142 patients who committed suicide were not treated with an antidepressant. Among those who were, the risk with SSRIs was almost five times higher than with non-SSRIs during the first month of treatment. These results suggest that clinicians should reserve SSRI antidepressants for patients with established uses, monitor them closely after commencing treatment, and inform patients and their families of the possible emergence of suicidal behaviours during the initial weeks of therapy.

A third study showed that patients admitted to the intensive care unit (ICU) may be at higher risk of unintentionally discontinuing medications for chronic conditions, during their hospitalization and after discharge. ICES found that 33% of ICU patients who were prescribed at least one of six medications to treat chronic conditions before hospitalization had one or more of these medications omitted at hospital discharge. Careful review of medication lists at ICU discharge could therefore avoid potential adverse outcomes related to unintentional discontinuation of chronic medications at hospital discharge.



**...it is not always clear whether medications are being appropriately and safely prescribed.**

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### Quality of Care and Patient Outcomes

Efforts to improve quality and processes of care are undertaken with a view to improving outcomes for patients. Quality of care in the emergency department (ED) is an important area of focus, given the high volume of people that visit Ontario EDs each year. In one study, ICES found that EDs that treated a lower volume of heart attack patients had up to twice the risk of missed heart attack diagnosis compared to those EDs that treated a high volume of these patients. Lower volume EDs were also more likely to assign lower urgency triage scores to heart attack patients, less likely to have diagnostic tests available around-the-clock, and less likely to have specialist consultation available in the ED. Since most EDs in Ontario are lower volume sites, improving access to diagnostic tests and specialists, through the use of telemedicine, is critical to improving patient care.

Another ICES study assessed the value of public reporting of outcomes on quality of care. For the past 11 years, Ontario has generated institution-level performance report cards on outcomes of coronary artery bypass graft (CABG) surgery. Ontario CABG mortality outcomes improved sharply after provider results were confidentially disclosed to each institution. No such changes were seen for non-disclosed outcomes or regions outside Ontario, and further public reporting of outcomes had no significant impact on performance. These results indicate that confidential disclosure of outcomes is sufficient to accelerate quality improvement.

Other examples of evidence to improve quality of care included the following:

- Angiotensin-converting enzyme (ACE) inhibitors significantly reduced the risk of someone experiencing a potentially fatal (80–90% mortality rate) ruptured abdominal aortic aneurysm (AAA). Patients who received ACE inhibitors had an 18% lower risk of aortic rupture than patients who did not receive ACE inhibitors. In contrast to ACE inhibitors, this association was not seen for other antihypertensive therapies such as beta blockers, calcium channel blockers, thiazide diuretics, alpha blockers, and angiotensin receptor blockers. The results suggest that patients with established AAAs who are not candidates for repair might benefit from ACE inhibitor therapy.
- Ontario cataract patients treated by ophthalmologists that perform a high volume of the surgeries were less likely to experience post-operative complications. The rate of complications varied between 8/1,000 patients (treated by surgeons who performed 50 to 250 cataract surgeries per year), to 1/1,000 patients (treated by surgeons who performed more than 1,000 cataract surgeries per year). Patients are encouraged to speak with their surgeon or ophthalmologist regarding his/her rate of surgical complications, and professional organizations and policy makers should consider making recommendations regarding the appropriate number of cataract surgeries required for surgeons to maintain a high level of proficiency.

**Quality of care in the emergency department is an important area of focus, given the high volume of people that visit Ontario EDs each year.**

## Chronic Disease Management

Chronic diseases, such as asthma, diabetes and cardiovascular disease, place a heavy burden on patients and their families, while also having a significant impact on health care costs. ICES is well-known for producing knowledge to enhance planning for services and improved care delivery in these areas.

This year ICES released *The Burden of Asthma in Ontario*, which showed that Ontarians have about a 40% risk of developing **asthma** before the age of 40. The report found that family physicians and paediatricians were, most often, the front line providers of care to people with asthma, and therefore are important targets for continuing education initiatives. At the same time, specialist care, associated with decreased emergency department visits and hospitalizations in asthma patients, needs to be optimized.

Another important contribution to the knowledge base on chronic diseases showed that the prevalence of **diabetes** in Ontario rose to nearly nine percent in 2005, surpassing the global rate of 6.4% predicted for the year 2030 by the World Health Organization. The results showed that:

- There was a 31% increase in the number of new cases of diabetes between 1997 and 2003.
- The number of Ontarians with diabetes increased by 69% between 1995 and 2005.

- Although diabetes rates remained higher among people aged 50 years and older, when compared to the 20 to 49 age group, rates increased to a greater extent in the younger population (94% for those aged 20 to 49 years vs. 63% for those aged 50 and older).

These findings are critical for policy makers to plan effectively for the growing burden of diabetes on health care resources.

In the area of **cardiovascular disease**, ICES released a landmark report in 2006. The report examined the influence of geography on the burden, risk factors, treatments and outcomes of heart disease for the more than 1.2 million Canadians suffering from this condition. Cardiovascular disease continues to be the leading cause of death in Canada, responsible for 37% of all deaths in the country. Much of the variation in cardiovascular death rates across Canada was explained by regional variations in traditional cardiovascular risk factors, such as smoking and obesity levels in communities. There was suboptimal treatment of heart attack patients across the country in certain areas of acute hospital care, and also variations in the proportion of people who were treated by a cardiologist. There was also significant variation in the rates of cardiac procedures and cardiac drug spending across Canada that did not appear to reflect differences in clinical need, but rather reflected other factors such as variations in policy, physician practice styles, and possibly patient preferences. The report emphasized the need for a coordinated pan-Canadian approach to measuring and improving the quality of cardiac care.

**Chronic diseases...place a heavy burden on patients and their families, while also having a significant impact on health care costs.**





## Knowledge Igniting Change

### Our Products—Evolving to meet the needs of our users



#### instant•interactive•information

In keeping with our goal to produce useful, accessible information, this year marked the launch of the ICES **inTool**, which was developed to support local, evidence-based decision-making.

The **inTool**, available at [www.ices.on.ca/intool](http://www.ices.on.ca/intool), is a user-friendly, interactive, web-based application that provides information at the provincial, Local Health Integration Network (LHIN) and sub-LHIN levels, in a variety of formats including graphs, tables and maps. All information can be printed and e-mailed, and everything is available in MS PowerPoint so that information can be incorporated into presentations and planning documents.



Currently, the **inTool** contains information on access to health services, diabetes, cancer and primary care. New topics and levels of analyses are being added regularly, so this is a link that is worth bookmarking!

Information derived from ICES studies is also disseminated through ongoing dialogue with stakeholders; presentations at conferences; participation on committees; and, distribution of a variety of product lines, including:

**At A Glance**—a popular monthly e-bulletin, providing highlights of ICES knowledge to stakeholders

**Atlases**—in-depth reports that provide analysis at the provincial, LHIN, census division, and/or hospital levels

**Investigative reports**—narrower in scope than atlases and focused on specific health care issues

**Peer-reviewed journal publications**—cover a wide range of clinical and policy-relevant topics

Knowledge transfer activities are aided by a focused media relations strategy whereby ICES studies are profiled for the public on a regular basis through provincial, national and international coverage.

In addition, all publications are **available free of charge** on the ICES website at [www.ices.on.ca](http://www.ices.on.ca). *If there is a topic that is of particular interest to you, visit our **ICES Alert** and register to receive e-mail notification when new content, matching your specified area(s) of interest, is added to our website.*

### ICES Alert

Be alerted to new information as soon as it's available.

Enter keyword/phrase:

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**ALERT ME!**



**ICES ignites change by providing knowledge to support decision-making.**

# Auditor's Report on Summarized Financial Statements

## To the Board of Directors of the Institute for Clinical Evaluative Sciences

The accompanying summarized statements of financial position, operations and cash flows are derived from the complete financial statements of the Institute for Clinical Evaluative Sciences as at March 31, 2007 and for the year then ended on which we expressed an opinion without reservation in our report dated June 12, 2007. The fair summarization of the complete financial statements is the responsibility of management. Our responsibility, in accordance with the applicable Assurance Guideline of The Canadian Institute of Chartered Accountants, is to report on the summarized financial statements.

In our opinion, the accompanying financial statements fairly summarize, in all material respects, the related complete financial statements in accordance with the criteria described in the Guideline referred to above.

These summarized financial statements do not contain all the disclosures required by Canadian generally accepted accounting principles. Readers are cautioned that these statements may not be appropriate for their purposes. For more information on the entity's financial position, results of operations and cash flows, reference should be made to the related complete financial statements.

*PricewaterhouseCoopers LLP*  
Chartered Accountants

### SUMMARIZED FINANCIAL STATEMENTS

#### Statement of Financial Position

As at March 31, 2007

	Capital and Operating Fund \$	2007 Restricted Fund \$	Total \$	Capital and Operating Fund \$	2006 Restricted Fund \$	Total \$
<b>Assets</b>						
Current Assets						
Cash	474,326	4,253,817	4,728,143	380,817	4,379,796	4,760,613
Other receivables	997,846	-	997,846	494,772	-	494,772
Prepaid expenses	20,449	44,009	64,458	20,971	-	20,971
	1,492,621	4,297,826	5,790,447	896,560	4,379,796	5,276,356
Property, plant and equipment	730,710	-	730,710	927,824	-	927,824
	2,223,331	4,297,826	6,521,157	1,824,384	4,379,796	6,204,180
<b>Liabilities and Deferred Amounts</b>						
Current Liabilities						
Accounts payable and accruals	460,690	-	460,690	323,083	-	323,083
Due to MOHLTC	-	-	-	1,687	-	1,687
Due to Sunnybrook Health Sciences Centre	541,181	-	541,181	554,090	-	554,090
	1,001,871	-	1,001,871	878,860	-	878,860
Post-retirement benefits other than pensions	32,400	-	32,400	17,700	-	17,700
Deferred operating grant	458,350	-	458,350	-	-	-
Deferred capital grant	730,710	-	730,710	927,824	-	927,824
Deferred expense grants	-	4,297,826	4,297,826	-	4,379,796	4,379,796
	2,223,331	4,297,826	6,521,157	1,824,384	4,379,796	6,204,180



## Statement of Operations

For the year ended March 31, 2007

	Capital and Operating Fund		Restricted Fund		Total	
	2007 \$	2006 \$	2007 \$	2006 \$	2007 \$	2006 \$
<b>Revenue</b>						
Grants-operating	5,517,023	5,663,437	-	-	5,517,023	5,663,437
Interest income	57,297	22,041	-	-	57,297	22,041
Other revenue	3,047,799	2,399,647	-	-	3,047,799	2,399,647
Amortization of deferred expense grants	-	-	5,399,025	4,658,150	5,399,025	4,658,150
	8,622,119	8,085,125	5,399,025	4,658,150	14,021,144	12,743,275
<b>Expenditures</b>						
Salaries and benefits	6,339,281	5,672,401	3,585,224	3,111,937	9,924,505	8,784,338
Consultative services	629,752	666,790	1,230,837	1,067,871	1,860,589	1,734,661
Computer supplies and software	186,575	349,521	65,995	167,759	252,570	517,280
Office and general	309,591	305,837	294,279	128,274	603,870	434,111
Travel	42,631	70,727	89,296	85,709	131,927	156,436
Amortization of property, plant and equipment	294,291	242,308	-	-	294,291	242,308
Professional	54,383	52,498	13,306	2,070	67,689	54,568
Administrative	392,183	380,868	78,749	74,478	470,932	455,346
Other	373,432	344,175	41,339	20,052	414,771	364,227
	8,622,119	8,085,125	5,399,025	4,658,150	14,021,144	12,743,275
<b>Excess of revenue over expenditures for the year</b>	-	-	-	-	-	-

## Statement of Cash Flows

For the year ended March 31, 2007

	Capital and Operating Fund		Restricted Fund		Total	
	2007 \$	2006 \$	2007 \$	2006 \$	2007 \$	2006 \$
<b>Cash provided by (used in)</b>						
<b>Operating activities</b>						
Excess of revenue over expenditures for the year	-	-	-	-	-	-
<b>Items not affecting cash</b>						
Increase in post-retirement benefits other than pensions	14,700	600	-	-	14,700	600
Increase (decrease) in deferred operating grant	458,350	(1,054,748)	-	-	458,350	(1,054,748)
Amortization of deferred capital grant	(294,291)	(242,308)	-	-	(294,291)	(242,308)
Amortization of deferred expense grants	-	-	(5,399,025)	(4,658,150)	(5,399,025)	(4,658,150)
Transfer from deferred expense grant	-	-	(86,548)	(5,746)	(86,548)	(5,746)
Amortization of property, plant and equipment	294,291	242,308	-	-	294,291	242,308
Change in non-cash working capital	(379,541)	(176,445)	(44,009)	170,132	(423,550)	(6,313)
	93,509	(1,230,593)	(5,529,582)	(4,493,764)	(5,436,073)	(5,724,357)
<b>Investing activities</b>						
Transfer from operating grant to deferred capital grant	97,177	633,619	-	-	97,177	633,619
Purchase of property, plant and equipment	(97,177)	(633,619)	-	-	(97,177)	(633,619)
	-	-	-	-	-	-
<b>Financing activities</b>						
Deferred grants received plus interest income	-	-	5,403,603	5,059,197	5,403,603	5,059,197
<b>Increase (decrease) in cash for the year</b>	93,509	(1,230,593)	(125,979)	565,433	(32,470)	665,160
<b>Cash—Beginning of year</b>	380,817	1,611,410	4,379,796	3,814,363	4,760,613	5,425,773
<b>Cash—End of year</b>	474,326	380,817	4,253,817	4,379,796	4,728,143	4,760,613

[www.ices.on.ca](http://www.ices.on.ca)



**Institute for Clinical Evaluative Sciences**

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