

2012/13 ANNUAL REPORT

# DATA DISCOVERY IMPACT



# About ICES

## Population-based health research that makes a difference

Since 1992, ICES has been leading cutting-edge research to study and evaluate health care delivery and outcomes in Ontario. ICES researchers link data from many sources, including population-based health surveys, anonymous patient records, as well as clinical and administrative databases. ICES goes to great lengths to protect privacy and is recognized as an international leader in maintaining the security of health information.

## Scientists and clinicians leading world-class research teams

Many ICES scientists are internationally recognized and a number of them are practicing clinicians who understand the everyday challenges of health care delivery. They lead multidisciplinary teams consisting of statisticians and epidemiologists, as well as specialists in knowledge translation and information security, privacy and technology. The diverse expertise presented within these specialized teams is the foundation of the innovative approach to research at ICES.

## Evidence-based research that informs decisions

To obtain a comprehensive picture of health care issues, ICES researchers take a unique approach to studying the continuum of care. Their research results in an evidence base that is published as atlases, investigative reports and peer-reviewed papers, and is used to guide

decision-making and inform changes in health care policy and delivery. Highly regarded in Canada and abroad, ICES research is utilized by clinicians, governments and health care planners.

## Independence from funders

ICES receives core funding from the Ontario Ministry of Health and Long-Term Care. ICES faculty and staff have successful track records competing for peer-reviewed grants from federal agencies, such as the Canadian Institutes of Health Research, and from provincial as well as international organizations. However, ICES is independent from these funding sources and takes pride in its international reputation as a trusted and credible source of high quality health and health services research and evidence.

## A growing network across Ontario

ICES is located on the campus of Sunnybrook Health Sciences Centre in Toronto. It has physical satellite sites at Queen's University in Kingston (ICES Queen's), at the University of Ottawa (ICES uOttawa), at the University of Toronto (ICES UofT) and at Western University in London (ICES Western). Additional sites are in development at McMaster University in Hamilton and Laurentian University in Sudbury.

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## From David Henry, president and CEO

This year marked the 20th anniversary of ICES. If I had to distill two decades of remarkable effort down to a single word, it would be impact. Our accomplishments in 2012/13 are no exception, as we enhanced our capacity and increased our productivity to broaden our impact in Ontario and beyond.

Among our many achievements in 2012/13, we:

- Prepared 153 grant submissions (up 22% over 2011/12), initiated 285 new research projects (up 18%) and had 360 papers published in peer-reviewed journals (up 10%).
- Opened satellite offices at the University of Toronto and Western University. Expanded our research capacity with the addition of 12 adjunct scientists across six research programs. Introduced the new Kidney, Dialysis and Transplantation Program at ICES Western, which is the first pan-provincial program located outside of ICES Central.
- Marked our 20th anniversary by chronicling the ICES story in *Twenty* and hosting a day-long symposium to celebrate our successes.
- Welcomed Catherine Zahn, president and CEO of CAMH, and Don Drummond, former chair of the Commission on the Reform of Ontario's Public Services, to the ICES board of directors. Supported the Scientific Advisory Committee of the board, led by Colleen Flood, in its work to develop a framework and metrics to evaluate ICES' science performance.
- Integrated new key datasets such as the Ministry of Government Services Vital Statistics Death Register (including cause of death), Citizenship and Immigration Canada data, the Ontario HIV Treatment Network cohort study and the initiation of a child and youth-focused de-identified and linkable data repository.

- Signed a data sharing agreement with Aboriginal Affairs and Northern Development Canada to transfer a copy of the Indian Registry System file to ICES.
- Launched a new corporate identity including a new logo for ICES.
- Garnered an average of 240 media hits per month and expanded our social media presence to attract over 1,800 Twitter followers and 100 Facebook subscribers.

In countless ways, ICES research has changed how, where and why health services are delivered in Ontario and well beyond its borders. This collective achievement would not have been possible without the hard work and dedication of our staff and scientists. I deeply appreciate their commitment to our vision and direction.

I am also very grateful to the members of the ICES board of directors for their guidance, and to the Ministry of Health and Long-Term Care, in particular Alison Paprica and Vasanthi Srinivasan, for their strategic thinking and support.

This year marks the end of my term as president and CEO of ICES. It has been an honour to lead this great institute, and I enjoyed the privilege of working with staff and scientists over the past six years. I look forward to continuing my involvement with ICES and watching how this unique organization continues to evolve.

My most sincere and heartfelt thanks to all,

Dr. David Henry



# Ontario-wide research network

LAKE HURON

LAKE ONTARIO

ICES

North  
In development

ICES

uOttawa  
Opened in 2010

ICES

Queen's  
Opened in 2007

ICES

Central  
Opened in 1992

ICES

UofT  
Opened in 2012

ICES

McMaster  
In development

ICES

Western  
Opened in 2012

# Board of directors

The ICES board of directors brings together experts in health, law, business, academe and other sectors to act as a sounding board and to provide valued counsel on all aspects of ICES policy and strategy.

## **Dr. Michael Baker, Chair**

Professor, Faculty of Medicine, University of Toronto

## **Mr. Donald Drummond**

Matthews Fellow on Global Public Policy and Adjunct Professor, School of Policy Studies, Queen's University  
Former Chair, Commission on the Reform of Ontario Public Services

## **Dr. Colleen M. Flood**

Professor and Canada Research Chair in Health Law and Policy, Faculty of Law, University of Toronto

## **Mr. Murray Glendining**

Executive Vice-President, Corporate Affairs, London Health Sciences

## **Mr. Bruce MacLellan**

President and CEO, Environics Communications

## **Dr. Harriet MacMillan**

Professor, Departments of Psychiatry and Behavioural Neurosciences and of Pediatrics, and David R. (Dan) Offord Chair in Child Studies, McMaster University and McMaster Children's Hospital

## **Mr. Mark Rudowski**

Chair, ICES Finance, Audit and Risk Committee

## **Dr. Catherine Zahn**

President and CEO, Centre for Addiction and Mental Health

## **Ms. Helen Cromarty**

Special Advisor for First Nations Health

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The Scientific Advisory Committee (SAC), led by Dr. Colleen Flood, was established in 2012 with a mandate to advise the board on the quality, direction, scope, salience and focus of ICES' work and to review the Institute's achievements in light of its stated mission. At its first meeting in April 2012, the SAC undertook the development of a scientific performance review of ICES. Many of the results of that review are presented throughout this annual report.



## ICES welcomes a new CEO... Dr. Michael Schull

On behalf of the board of directors, I am pleased to announce the appointment of Dr. Michael Schull as president and chief executive officer of ICES, effective September 1, 2013. This announcement follows an intensive recruitment process in which highly-qualified individuals were sought in both domestic and international forums to fill this significant role in health research in Ontario.

Dr. Schull is well known at ICES, both as a senior scientist and most recently, as deputy CEO. He comes to the CEO role with a diverse background, and brings with him an understanding and appreciation of its complex nature.

Dr. Schull trained as an emergency medicine specialist at the University of Toronto, and completed graduate training in epidemiology and biostatistics at McGill University. He is a full professor of medicine and the director of the Division of Emergency Medicine in the Department of Medicine at the University of Toronto. He is a CIHR Applied Chair in Health Services and Policy Research for work that brings together clinicians, scientists and policy makers. His research focuses on health service utilization, quality of care and patient outcomes as they relate to emergency care, and the study of interventions designed to reduce emergency department wait times.

As a world-renowned scientist, clinician and innovative thinker, Dr. Schull is uniquely positioned to lead ICES as it expands to meet the demand for evidence to support decision making, policy development and improved care delivery. He brings a wealth of knowledge and experience to his new appointment at ICES, including an international perspective on health care issues that will benefit Ontario and Canada as a whole.

Please join me in congratulating Dr. Schull and welcoming him to his new role.

Dr. Michael A. Baker, CM OOnt  
Chair, Board of Directors

# ICES data

ICES is privileged to act as a steward of one of the world's largest holdings of individual-level, de-identified and linkable health and health-related data — encompassing 13.5 million Ontarians in 2012/13. This represents an invaluable resource for researchers from across Ontario, Canada and internationally.

The range of data holdings supports research across many content areas and disciplines. Data holdings can be grouped into the following 10 categories, with some examples provided for each:

## 1. Health services datasets

Home Care Database, National Ambulatory Care Reporting System

## 2. Population and demographics

Census area profiles, Citizen and Immigration Canada

## 3. Acquired cohorts and registries

Cardiac Care Network data, Ontario Cancer Registry

## 4. Surveys

Canadian Community Health Survey, Ontario Health Survey

## 5. Care providers

Corporate Provider Database, individual medical practitioners

## 6. Facilities

Institution numbers, nursing home institution numbers

## 7. Financial

Management information system

## 8. Geography

Postal code to sub-LHIN lookup table

## 9. Coding tables

Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures, OHIP fee codes

## 10. ICES-derived cohorts

Chart-validated cohorts of individuals with specific diseases and conditions, such as asthma, congestive heart failure and diabetes

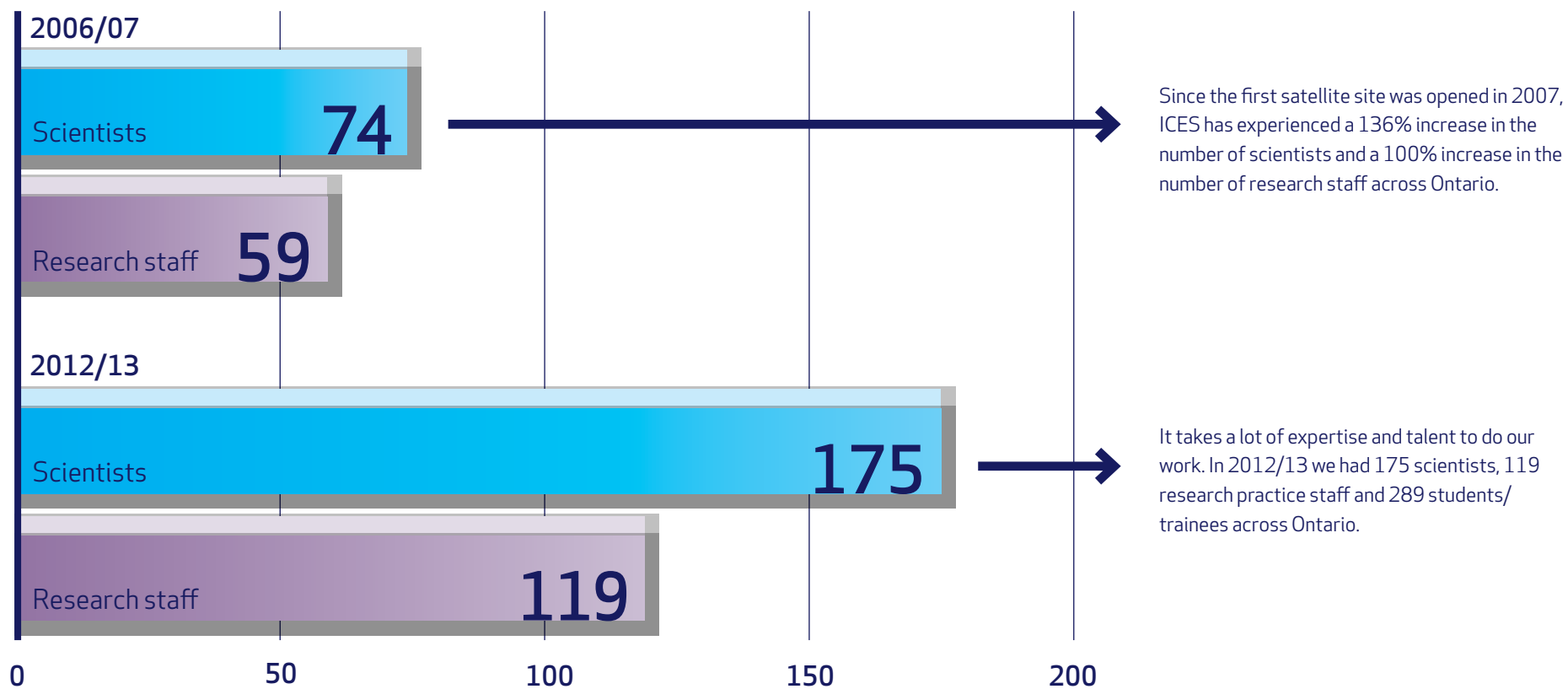
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ICES is a prescribed entity under Ontario's *Personal Health Information Protection Act*. This designation, conferred on organizations with strong privacy practices by Ontario's Information and Privacy Commissioner, allows hospitals and others across Ontario's health system to share personal health information with ICES for research.



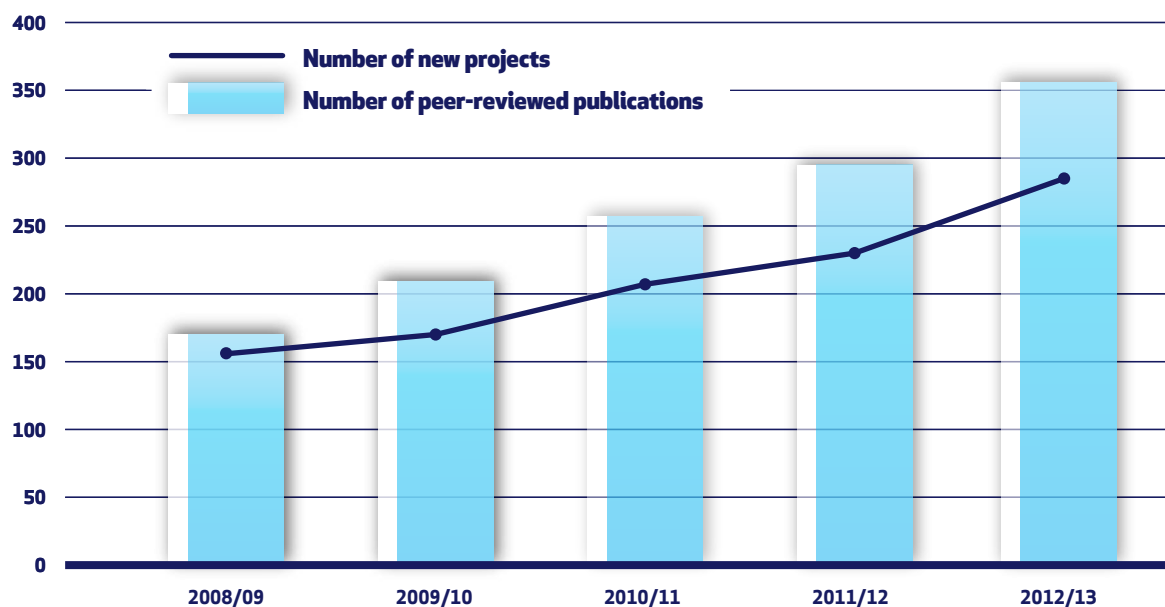
# Staff and scientists

Critical to ICES' success are the scientists and staff who are experts in different aspects of health services research, including data quality, biostatistics, medical geography and project management. The majority of ICES scientists are clinician researchers who are committed to the process of evidence guiding policy from the conceptual phase through to the knowledge translation and policy implementation phases of research.



# Research and collaborations

In addition to considerable support from the Ontario Ministry of Health and Long-Term Care, peer-reviewed research grants underpin both the quantity and quality of ICES research, as demonstrated in the number and quality of research projects, publications and grants. From 2008/09 to 2012/13, ICES researchers co-authored peer-reviewed publications using ICES data with over 3,000 scientists from around the world.



Over 500 active research projects using ICES data  
 285 new research projects  
 360 peer-reviewed publications using ICES data,  
 or nearly one publication every day!

## Active research partnerships in 2012/13 included:

### Provincial

- Ontario Ministries: Children and Youth Services, Community and Social Services, Education, Environment, Health and Long-Term Care, Transportation
- Trillium Gift of Life Network
- Ontario HIV Treatment Network

### National

- Canadian Network for Observational Drug Effect Studies
- Canadian Primary Health Care Research and Innovation Network
- Schizophrenia Society of Canada
- Canadian Medical Association

### International

- American Heart Association, US
- Brigham and Women's Hospital, Boston, US
- Centre for Health Equity Studies, Sweden
- Korean Stroke Registry, South Korea
- University of Auckland, New Zealand

ICES researchers collaborate with a diverse group of stakeholders at the provincial, national and international levels. Over the years, ICES has strengthened many long-term relationships and established new relationships to support emerging areas of research.

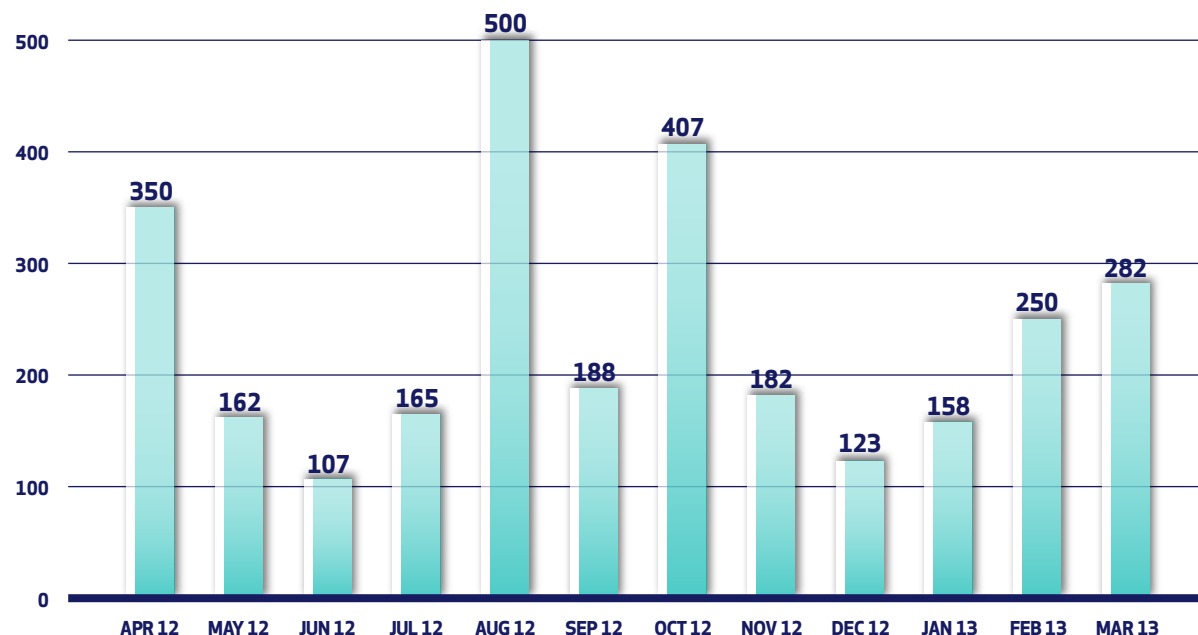
# Knowledge translation and communications

The ability to synthesize, disseminate and effectively communicate our findings is a key component of ICES' success. ICES knowledge translation and communications staff are actively engaged in media outreach that spans from traditional media sources (TV, newspapers) to social media platforms (Facebook, Twitter, YouTube).

## In 2012/13, ICES:

- garnered 2,874 total media hits.
- issued 50 news releases with 90% media uptake.
- received media coverage that consisted of 46% Canadian outlets and 54% international outlets.
- attracted 110,950 visitors to our website.

## ICES media hits in 2012/13



Publications with the most media impact:

**Seven more years: The impact of smoking, alcohol, diet, physical activity and stress on health and life expectancy in Ontario (April 2012)** Manuel DG, Perez R, Bennett C, Rosella L, Taljaard M, Roberts M, Sanderson R, Meltem T, Tanuseputro P, Manson H. An ICES/PHO Report. Toronto: Institute for Clinical Evaluative Sciences and Public Health Ontario 2012.

**Universal drug coverage and socioeconomic disparities in major diabetes outcomes (August 2012)** Booth GL, Bishara P, Lipscombe LL, Shah BR, Feig DS, Bhattacharyya O, Bierman AS. Diabetes Care. 2012; 35 (11): 2257-64

**Trends in the incidence and outcomes of heart failure in Ontario, Canada: 1997-2007 (August 2012)** Yeung DF, Boom NK, Guo H, Lee DS, Schultz SE, Tu JV. CMAJ. 2012;184 (14): E765-73.

**Opening eyes, opening minds: the Ontario burden of mental illness and addictions report (October 2012)** Ratnasingham S, Cairney J, Rehm J, Manson H, Kurdyak PA. An ICES/PHO Report. Toronto: Institute for Clinical Evaluative Sciences and Public Health Ontario; 2012

**High mortality and low access to care following incident acute myocardial infarction in individuals with schizophrenia (October 2012)** Kurdyak P, Vigod S, Calzavara A, Wodchis WP. Schizophr Res. 2012;142 (1-3):52-7.

# Five high-impact studies

## that demonstrate how ICES research makes a difference

The scientific performance review conducted over the past year by the Scientific Advisory Committee of the ICES Board of Directors reports on the effectiveness of ICES research across policy and practice domains. The five studies that follow were published in 2012/13 and illustrate the range and depth of research impact and the levels of influence of ICES' work.

# Researchers find basic infrastructure already in place to build a better health care system in Ontario

Chronic disease, including heart failure, diabetes, respiratory disease and depression, affects more than one in three Canadians. However, Canada's health system is designed to cope with short-term, acute conditions such as heart attacks and broken bones. Large multispecialty physician group practices, with a central role for primary care practitioners, have been shown to achieve high-quality, low-cost care for patients with chronic disease. ICES researchers assessed the extent to which informal multispecialty physician networks in Ontario could be identified by using health billing records to assess existing linkages among patients, physicians and hospitals.

## Findings

- The study identified 78 informal multispecialty physician networks serving over 1.2 million people.
- The networks developed naturally through patient travel patterns, longstanding referral practices, information sharing and admission of patients to local hospitals.
- Virtually all eligible residents were linked to a usual provider of primary care and to a network, and most specialists and primary care physicians were linked to a hospital.
- Networks were reasonably self-contained in that most residents received most of their care from providers within their network.
- Formalizing these multispecialty physician networks would foster accountability for efficient, integrated care through care management tools and quality improvement.

## Impact

- The Ontario Ministry of Health and Long-Term Care call for pilot formalized networks, or Health Links, was based in part on the concepts of the multispecialty physician networks. There are currently 19 pilot Health Links, and the Ministry anticipates they will spread to the entire province. ICES researchers continue to be consulted on their implementation.
- Further research is underway with the University of Toronto's Institute of Health Policy, Management and Evaluation, the Ministry of Health and Long-Term Care and legal counsel on governance structures and legal requirements for integrating financial and quality incentives for physicians and hospitals.
- The study has attracted new research funding and created new collaborations, including one with The Dartmouth Institute for Health Policy and Clinical Practice to compare performance across the US and Canada, and another with l'Institut de recherche et documentation en économie de la santé in Paris to create formal networks in France.



"The current health care structure and payment system in Ontario is focused on acute care and is poorly aligned with the needs of patients with chronic disease. Serious quality gaps in providing chronic disease care are attributed to poor coordination among health care providers and fragmentation of care." – Dr. Thérèse Stukel, lead author and ICES senior scientist

Stukel TA, Glazier RH, Schultz SE, Guan J, Zagorski BM, Gozdyra P, Henry DA. Multispecialty physician networks in Ontario. *Open Med*. 2013; 7(2):e40–55.



# Physicians' warnings to patients judged unfit to drive reduces risk of crashes

Chronic medical diseases, including dementia, stroke, alcoholism and diabetes, contribute to about a third of all road crashes. To prevent these accidents, physicians in Ontario provide medical warnings to patients who suffer from a condition that may make it dangerous to operate a motor vehicle. Since 2006, physicians in Ontario have received a fee of \$36.25 per patient for performing this service. ICES researchers examined more than 100,000 patients who received medical warnings from physicians between 2006 and 2010.

## Findings

- Medical warnings led to a 45% decrease in serious trauma from motor vehicle crashes.
- The decrease was apparent for drivers with diverse diagnoses, including alcoholism, epilepsy, sleep disorders or multiple conditions.
- Medical warnings were associated with worsening depression in some patients and a decrease in return visits to the responsible physician in some cases.
- The evaluation of this intervention shows that medical warnings reduced injuries and saved Ontario about \$7 million each year by avoiding economic losses associated with motor vehicle crashes.

## Impact

- This research has led to new collaborations with investigators at Stanford University.
- The study was cited in the Canadian Medical Association's *Driver's Guide: Determining Medical Fitness to Operate Motor Vehicles*.
- This study informed discussions of the American Medical Association's Fitness to Drive Guidelines Committee.



Photo by Doug Nicholson/MediaSource

"The reduction in risk is immediate, profound and sustained. An effect of this magnitude is about two times larger than the combined effects of modern trauma hospitals on saving people's lives. The results also caution that judgment is needed to prevent an effective program being carried to excess." – Dr. Donald Redelmeier, lead investigator and ICES senior scientist

Redelmeier DA, Yarnell CJ, Thiruchelvam D, Tibshirani RJ. Physicians' warnings for unfit drivers and the risk of trauma from road crashes. *N Engl J Med*. 2012; 367(13):1228–36.

# OxyContin prescribing increases dramatically near Ontario border after US introduces tamper-resistant formulation

OxyContin is a powerful painkiller made to slowly release the potent opioid oxycodone to treat patients requiring round-the-clock pain management. Opioid addicts break down the coating of the tablets, then mix them with water to inject or inhale for an instant high. In August 2010, a tamper-resistant formulation of oxycodone (OxyContin-OP) was introduced in the United States but not in Canada. ICES researchers examined dispensing rates of OxyContin at retail pharmacies in the three Ontario cities with the highest volume of US–Canada border crossings in 2011.

## Findings

- Pharmacies close to the Detroit-Windsor Tunnel experienced a 390% increase in OxyContin dispensing.
- Almost 250,000 excess OxyContin tablets were dispensed in Windsor neighbourhoods close to the Detroit-Windsor Tunnel between August 2010 and October 2011.
- OxyContin dispensing near border crossings in Niagara Falls and Sarnia remained stable.
- Following warnings to prescribers and pharmacies regarding drug-seeking behaviour in April 2011, dispensing declined and by November 2011 had returned to levels observed in early 2010.

## Impact

- This study highlights the effect that differing availability of opioids may have on trafficking across borders, and also suggests that timely notification of prescribers and dispensers of this drug-seeking behavior may help to mitigate the problem.
- Information from this paper was circulated widely to provincial and federal governments dealing with the impact of differential availability of generic long-acting oxycodone across borders.
- Together with prior research from this investigative team, this study helped to build the case for 2012 amendments to the *Ontario Drug Benefit Act* and the *Drug Interchangeability and Dispensing Fee Act* that would prevent the dispensing of generic OxyContin to beneficiaries of the Ontario Drug Benefit Program.



“These results are a testament to the abuse potential of OxyContin, and they have immediate implications for government policy and public safety. If the generic formulation of the original product is allowed on the Canadian market, I predict we will see a flood of the product back onto the streets, not just in Canada but also in the US.” – Tara Gomes, lead author and ICES scientist

Gomes T, Paterson JM, Juurlink DN, Dhalla IA, Mamdani MM. Reformulation of controlled-release oxycodone and pharmacy dispensing patterns near the US–Canada border. *Open Med.* 2012; 6(4).

# Unhealthy behaviours are costing Ontarians more than seven years of life

A joint study undertaken by researchers at ICES and Public Health Ontario expands our understanding of healthy living by quantifying the impact of five behavioural health risks on Ontarians' overall health and life expectancy. The health risks studied were smoking, unhealthy alcohol consumption, poor diet, physical inactivity and high stress.

## Findings

- Sixty percent of Ontario deaths in 2007 were attributable to the five health risks.
- Nearly all Ontarians reported at least one of the five health risks; only 1.4% had none.
- People with the unhealthiest behaviour for all five risks had much shorter life expectancy than people with none of the risks: respectively, 68.5 years versus 88.6 years for men and 71.5 years versus 92.5 years for women.
- Smoking, physical inactivity and unhealthy eating had the greatest impact on reduced life expectancy at 2.5, 2.4 and 2.0 years, respectively.
- Ontarians lost 9.8 years of "health-adjusted life expectancy" due to the five unhealthy behaviours. By avoiding these behaviours, Ontarians would not only live longer, but they would also increase the number of years spent in good health.

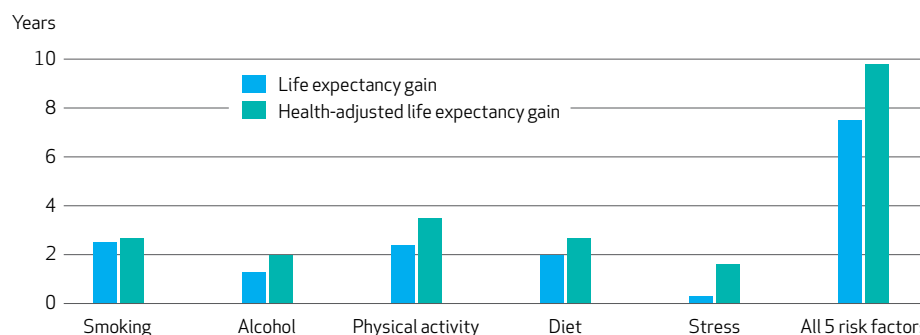
- Ontarians in the most deprived neighbourhoods had a life expectancy that was nearly 4.5 years lower than those living in the most affluent conditions. This gap would be reduced by almost half if behavioural risks were the same across socioeconomic levels.
- Ontarians would gain 7.5 years of life expectancy and have a better quality of life if everyone were in the healthiest category for all five health risks.

To become a healthier province, Ontario needs to build on its success in achieving a reduction in smoking and focus similar attention on reducing other risk factors.

## Impact

- This study has had a major influence on people's understanding of health risks and how to modify them.
- There have been numerous requests to extend the research to examine additional outcomes, such as disease-specific outcomes, health care use outcomes, and social risks.
- The study has led to the development of new research collaborations and attracted new student trainees.
- The software code developed for the study will allow health planners to replicate the study approach in their target population.

Impact of eliminating unhealthy behaviours on life expectancy for Ontario adults aged 20 and older, 2007



Individuals can calculate their own life expectancy with a new [Life Expectancy Calculator](#) based on smoking, alcohol, food, exercise and stress level. This tool is also accessible from the [ICES](#) and [PHO](#) websites.

# The risk of developing diabetes is higher in less walkable neighbourhoods

Building on a 2007 ICES study on the role Toronto's neighbourhoods play in the diabetes epidemic, ICES researchers set out to determine whether people living in neighborhoods that were less conducive to walking or other physical activities were more likely to develop diabetes and, if so, whether recent immigrants were particularly susceptible to such effects.

## Findings

- Neighborhood walkability was a strong predictor of diabetes incidence, particularly among recent immigrants living in low-income areas.
- A new immigrant living in a less walkable neighbourhood — one with fewer retail and service destinations within a 10-minute walk, low population density and poorly connected streets — was about twice as likely to develop diabetes than a long-term resident living in the most walkable neighbourhood, regardless of resident age or area income.
- The least walkable neighbourhoods were often the most recently developed, with an emphasis on large blocks, low-density housing, and zoning that restricted mixed land use.

## Impact

- This study has provided support to policies that promote walking and cycling infrastructure to reduce obesity-related diseases. Toronto Public Health, the Toronto Planning Department and the Ontario Ministry of Health and Long-Term Care are working together to move this agenda forward. Earlier related ICES research was cited in Toronto Public Health's 2012 report, *The Road to Health: Improving Walking and Cycling in Toronto*.
- This research has provided additional evidence to inform discussions about healthy urban design and public policy, particularly with respect to vulnerable populations, such as people living on low incomes and recent immigrants.
- It has led to an ongoing collaboration with Public Health Ontario for continued exploration of ways to influence policy on healthy urban design.
- The extensive media coverage this study received has led to an increased public profile for the impact of the built environment on health.



"Previous studies have looked at how walkable neighbourhoods affect health behaviour, but this is the first to look at the risk of developing a disease. The results emphasize the importance of neighbourhood design in influencing the health of urban populations." – Dr. Gillian Booth, an endocrinologist and researcher at St. Michael's Hospital and lead author of the study

Booth GL, Creatore MI, Moineddin R, Gozdyra P, Weyman JT, Matheson FI, Glazier RH. Unwalkable neighborhoods, poverty, and the risk of diabetes among recent immigrants to Canada compared with long-term residents. *Diabetes Care*. 2013; 36(2):302-8.

# Report of the independent auditor on the summary financial statements

## **To the board of directors of the Institute for Clinical Evaluative Sciences**

The accompanying summary financial statements, which comprise the summary statement of financial position as at March 31, 2013 and the summary statements of operations and cash flows for the year then ended are derived from the audited financial statements of the Institute for Clinical Evaluative Sciences for the year ended March 31, 2013. We expressed an unmodified audit opinion on those financial statements in our report dated June 28, 2013. Those financial statements, and the summary financial statements, do not reflect the effects of events that occurred subsequent to the date of our report on these financial statements.

The summary financial statements do not contain all the disclosures required by Canadian accounting standards for not-for-profit organisations. Reading the summary financial statements, therefore, is not a substitute for reading the audited financial statements of the Institute for Clinical Evaluative Sciences.

## **Management's responsibility**

Management is responsible for the preparation of a summary of the audited financial statements in accordance with Canadian accounting standards for not-for-profit organizations.

## **Auditor's responsibility**

Our responsibility is to express an opinion on the summary financial statements based on our procedures, which were conducted in accordance with Canadian Auditing Standard (CAS) 810, "Engagements to Report on Summary Financial Statements."

## **Opinion**

In our opinion, the summary financial statements derived from the audited financial statements of the Institute for Clinical Evaluative Sciences for the year end March 31, 2013 are a fair summary of those financial statements, in accordance with Canadian accounting standards for not-for-profit organisations.

*PricewaterhouseCoopers LLP*

Chartered Accountants, Licenced Public Accountants  
February 5, 2014  
Toronto, Ontario



## Statement of financial position

(in thousands of dollars)

	GENERAL FUND			RESTRICTED FUND			TOTAL		
	March 31, 2013	March 31, 2012	April 1, 2011	March 31, 2013	March 31, 2012	April 1, 2011	March 31, 2013	March 31, 2012	April 1, 2011
	\$	\$	\$	\$	\$	\$	\$	\$	\$
		(Unaudited)	(Unaudited)		(Unaudited)	(Unaudited)		(Unaudited)	(Unaudited)
<b>ASSETS</b>									
<b>Current assets</b>									
Cash	737	784	399	8,088	9,869	8,032	8,825	10,653	8,431
Accounts receivable	2,128	1,596	1,820	417	285	118	2,545	1,881	1,938
Due from Ministry of Health and Long-Term Care	—	—	—	—	—	1,408	—	—	1,408
Due from Sunnybrook Health Sciences Centre	356	—	—	—	—	—	356	—	—
Prepaid expenses	215	252	184	31	—	19	246	252	203
	3,436	2,632	2,403	8,536	10,154	9,577	11,972	12,786	11,980
Tangible capital assets	1,141	688	722	—	—	—	1,141	688	722
	<b>4,577</b>	<b>3,320</b>	<b>3,125</b>	<b>8,536</b>	<b>10,154</b>	<b>9,577</b>	<b>13,113</b>	<b>13,474</b>	<b>12,702</b>
<b>LIABILITIES</b>									
<b>Current liabilities</b>									
Accounts payable and accrued liabilities	2,998	1,269	1,921	31	—	—	3,029	1,269	1,921
Due to Ministry of Health and Long-Term Care	—	—	—	1,483	1,757	829	1,483	1,757	829
Due to Sunnybrook Health Sciences Centre	—	996	198	—	—	—	—	996	198
	<b>2,998</b>	<b>2,265</b>	<b>2,119</b>	<b>1,514</b>	<b>1,757</b>	<b>829</b>	<b>4,512</b>	<b>4,022</b>	<b>2,948</b>
<b>Post-employment benefits other than pensions</b>	415	367	284	—	—	—	415	367	284
<b>Deferred capital grant</b>	1,141	688	722	—	—	—	1,141	688	722
<b>Deferred operating grants</b>	23	—	—	7,022	8,397	8,748	7,045	8,397	8,748
	<b>4,577</b>	<b>3,320</b>	<b>3,125</b>	<b>8,536</b>	<b>10,154</b>	<b>9,577</b>	<b>13,113</b>	<b>13,474</b>	<b>12,702</b>

Full audited statements are available upon request.

## Statement of operations

For the year ended March 31, 2013

(in thousands of dollars)

	GENERAL FUND		RESTRICTED FUND		TOTAL	
	2013	2012	2013	2012	2013	2012
	\$	\$	\$	\$	\$	\$
		(Unaudited)		(Unaudited)		(Unaudited)
<b>REVENUE</b>						
Grants — Ministry of Health and Long-Term Care	4,824	4,816	—	—	4,824	4,816
Interest income	13	16	—	—	13	16
Other revenue	6,659	5,497	—	—	6,659	5,497
Amortization of deferred capital grant	285	279	—	—	285	279
Amortization of deferred operating grants	10	—	7,489	6,369	7,499	6,369
	<b>11,791</b>	<b>10,608</b>	<b>7,489</b>	<b>6,369</b>	<b>19,280</b>	<b>16,977</b>
<b>EXPENDITURES</b>						
Employee costs	11,080	9,061	5,745	5,502	16,825	14,563
Contracted services	749	228	263	116	1,012	344
Information, technology and security	404	478	853	322	1,257	800
Office and general	696	363	108	163	804	526
Amortization of tangible capital assets	285	279	—	—	285	279
Professional	383	339	520	266	903	605
Premises	796	754	—	—	796	754
	<b>14,393</b>	<b>11,502</b>	<b>7,489</b>	<b>6,369</b>	<b>21,882</b>	<b>17,871</b>
<b>Deficiency of revenue over expenditures for the year</b>	(2,602)	(894)	—	—	(2,602)	(894)
<b>Indirect Cost Fund recognition</b>	2,602	894	—	—	2,602	894
<b>Excess of revenue over expenditures for the year</b>	<b>—</b>	<b>—</b>	<b>—</b>	<b>—</b>	<b>—</b>	<b>—</b>

Full audited statements are available upon request.

## Statement of cash flows

For the year ended March 31, 2013

(in thousands of dollars)

	GENERAL FUND		RESTRICTED FUND		TOTAL	
	2013	2012	2013	2012	2013	2012
	\$	\$	\$	\$	\$	\$
		(Unaudited)		(Unaudited)		(Unaudited)
<b>Cash provided by (used in)</b>						
<b>OPERATING ACTIVITIES</b>						
Items not affecting cash						
Increase in post-employment benefits other than pensions	48	83	—	—	48	83
Amortization of deferred capital grant	(285)	(279)	—	—	(285)	(279)
Amortization of deferred operating grants	(10)	—	(7,489)	(6,369)	(7,499)	(6,369)
Transfer from deferred operating grant	33	—	(2,523)	(2,523)	(2,490)	(2,523)
Amortization of tangible capital assets	285	279	—	—	285	279
Change in non-cash working capital	(118)	302	(406)	2,188	(524)	2,490
	<b>(47)</b>	<b>385</b>	<b>(10,418)</b>	<b>(6,704)</b>	<b>(10,465)</b>	<b>(6,319)</b>
<b>INVESTING ACTIVITIES</b>						
Transfer to deferred capital grant	738	245	—	—	738	245
Purchase of tangible capital assets	(738)	(245)	—	—	(738)	(245)
	<b>—</b>	<b>—</b>	<b>—</b>	<b>—</b>	<b>—</b>	<b>—</b>
<b>FINANCING ACTIVITIES</b>						
Deferred operating grants received plus interest and other income	—	—	8,872	8,541	8,872	8,541
Deferred operating grants to Ministry of Health and Long-Term Care	—	—	(235)	—	(235)	—
	<b>—</b>	<b>—</b>	<b>8,637</b>	<b>8,541</b>	<b>8,637</b>	<b>8,541</b>
<b>Increase (decrease) in cash during the year</b>	<b>(47)</b>	<b>385</b>	<b>(1,781)</b>	<b>1,837</b>	<b>(1,828)</b>	<b>2,222</b>
<b>Cash — Beginning of year</b>	<b>784</b>	<b>399</b>	<b>9,869</b>	<b>8,032</b>	<b>10,653</b>	<b>8,431</b>
<b>Cash — End of year</b>	<b>737</b>	<b>784</b>	<b>8,088</b>	<b>9,869</b>	<b>8,825</b>	<b>10,653</b>

Full audited statements are available upon request.

The background features a series of concentric circles in shades of gray and white, creating a ripple effect. A solid blue horizontal bar is positioned at the top of the image.

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