M O V I N G  F O R W A R D


# UK HealthCare

## *Growing to Serve Kentucky*

Annual Report 2005

UK HealthCare

An Equal Opportunity University

## Financial Highlights

| *Dollars in thousands* | 2004 | 2005 |
|---|---|---|
| Discharges | 19,664 | 22,269 |
| Average Daily Census | 308 | 336 |
| Average Length of Stay | 5.72 | 5.51 |
| Patient Days | 112,575 | 122,704 |
| Outpatient Visits | 286,866 | 309,154 |
| Operating Revenue | $ 371,982 | $ 441,935 |
| Operating Income | $ 30,659 | $ 37,158 |
| Increase in Net Assets | $ 18,087 | $ 28,315 |
| Cash and Cash Equivalents (unrestricted) | $ 230,075 | $ 264,634 |

During fiscal year 2004, we established a governance structure that engaged and empowered faculty at all levels of decision making. We also initiated a comprehensive and coordinated strategic, financial and facilities planning process in order to develop a vision for UK HealthCare and a road map that would lead us to our goals. During 2005, while we continued to refine the vision for UK HealthCare, the clinical enterprise at the University of Kentucky, we also started implementation of many strategies to help us achieve that vision. To date, we have enjoyed a number of early successes. Many clinical programs have shown substantial growth and our combined inpatient and outpatient volumes are at levels projected for fiscal year 2008.

The architectural team we have assembled to accomplish our ambitious physical changes is truly world class. Working with them we have sited and sized the new patient care facility and the new parking garage is literally rising out of the ground.

Fiscal planning has been conservative and responsible. Our operating margins have been better than budgeted and our balance sheet is stronger than anticipated.

In this annual report we update our progress and anticipate the challenges for the coming year. I hope all of you are as enthusiastic about our progress as I am. UK HealthCare continues to make great strides in its quest to become a top 20 public academic health center, in order to better serve Kentuckians.

Sincerely,

Michael Karpf, MD
Executive Vice President for Health Affairs
University of Kentucky

# UK HealthCare—Growing to Serve Kentucky

## Introduction

Fiscal year 2004 was consumed with defining both the governance structure for UK HealthCare and a vision for UK HealthCare supported by a comprehensive and coordinated strategic, facilities and financial plan. During fiscal year 2005, we refined that vision and began implementing many of the tactics of our plan.

To date, we have achieved many early successes—some of which we will describe in this report. Our fiscal performance in 2005 was much better than anticipated. Our facilities planning efforts are on schedule and moving forward. Significant strides have been taken on quality, safety and patient throughput activities. Our strategic initiatives have progressed well and academic growth in the College of Medicine continues to advance.

We remain committed to the goal of making the University of Kentucky Chandler Medical Center one of the top 20 public academic medical centers in the country. Achieving this ambitious vision will ensure our service to Kentuckians continues to expand and improve.

*The UK HealthCare Executive Committee was established beneath the Advisory Board and meets weekly to empower and engage the faculty in decision making.*

## Governance

During 2004, the governance structure for UK HealthCare was defined and established to support the goal of becoming a top 20 public academic medical center (Figure 1). In 2005, the governmental structure of UK HealthCare was organized, bringing together the disparate entities within the clinical enterprise—UK Hospital, the academic health science colleges and the physician practices. Ultimate responsibility for the academic medical center lies with the University of Kentucky Board of Trustees with delegated oversight to the President and Executive Vice President for Health Affairs for day-to-day management. The UK HealthCare Advisory Board was established and includes the deans of all six health science colleges, senior clinical and basic science faculty and administrators. This board reviews the activities of the clinical enterprise and meets on a quarterly basis.

The UK HealthCare Executive Committee was established beneath the Advisory Board and meets weekly to empower and engage the faculty in decision making. This committee has now met weekly for nearly two years and has taken on a number of important issues. Committee members have been educated on the finances of the hospital, College of Medicine, the physician practice organization and Kentucky Medical Services Foundation. The committee now monitors the financial performance of these entities on a regular basis. This group has been involved in the review and approval of the financing plan for the new patient care facility as well as the investments in the strategic initiatives and capital budgets. No financial data within the enterprise has been protected from disclosure. The committee has been deeply engaged in understanding and monitoring the finances of the enterprise. They have closely monitored the progress of the strategic clinical initiatives as well as all operational initiatives including those focused on surgical services and the Emergency Department.

**FIGURE 1: UK HealthCare Governance Structure**

# Strategic Plan

Our comprehensive strategic plan was defined in 2004 in coordination with our facilities and financial plan. During fiscal year 2005 we began implementing many of the tactics outlined in the strategic plan. Our plan recognized the need to immediately focus our efforts on:

- patient safety and quality
- patient throughput
- strategic clinical initiatives
- market development

## PATIENT SAFETY AND QUALITY

- √ Designated a Primary Stroke Center and opened dedicated inpatient Stroke Unit
- √ Sixty-three faculty recognized as *America's Best Doctors*[1]
- √ Initiated and completed quality work groups related to CMS/JCAHO core measures
- √ Significantly reduced:
  - errors related to improper patient labeling
  - the use of banned abbreviations
  - MRSA infections in the NICU
- √ Received *American Association of Hospital Pharmacists Best Practices Award* for ongoing antimicrobial management program
- √ Developed and implemented a surgical infection prophylaxis program
- √ Completed a national collaborative CMS project to develop surgical indicators
- √ Sustained universal protocol (time-out) requirements in all procedure locations
- √ Completed implementation of computerized physician order entry system

## Patient Safety and Quality

At UK HealthCare we are committed to provide the highest quality of care utilizing nationally accepted standards for best practices that promote optimal patient outcomes in the safest possible environment. It starts with our faculty and staff. Sixty-three faculty were recently recognized as America's Best Doctors[1]—more than any other institution in Kentucky.

UK Hospital pharmacy was recognized nationally for its antimicrobial management program. Along with the Department of Infectious Diseases, this program has been successful in managing the appropriate use of antibiotics and in reducing the number of organisms that are resistant to antibiotics in our patients. Our rates are among the lowest in the nation. We were one of the first hospitals to be awarded the prestigious Magnet designation for our outstanding nursing services, and in 2005, during our recent application for renewal, we received no recommendations for improvement.

A dedicated specialized inpatient Stroke Unit was opened in 2004-05, receiving designation as a certified center by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Ours is one of only two certified stroke centers in Kentucky.

[1] *Best Doctors® is a registered trademark of Best Doctors Inc. in the United States and other countries*

We regularly monitor, compare and analyze our results in 318 measures of performance identified by government and private organizations as indicators of quality and safety. We compare our outcomes with many other teaching hospitals through the University HealthSystem Consortium. Our results are generally equal to and frequently superior to those of other academic facilities.

In 2005, we successfully developed and implemented a number of new programs to improve the quality of care. We developed systems to ensure that all eligible patients are offered pneumococcal and influenza vaccines prior to discharge from the hospital. All patients who smoke are being educated and counseled about strategies to quit. A number of programs designed to prevent infections have been implemented, and as a result of these efforts we have been able to dramatically reduce the number of methicillin-resistant staph (MRSA) infections in our neonatal intensive care unit. With our surgical infection prophylaxis program, nearly 100 percent of eligible patients receive antibiotics within two hours prior to surgery. All individuals (physicians, nurses and resident physicians) involved in the placement and care of central IV lines participate in a novel standardized computer-based learning module. A Rapid Response Team was launched in February to assist the bedside nurse to quickly recognize and care for patients who deteriorate acutely. Our return rate to the ICU and the number of cardiopulmonary arrests has decreased since the program was implemented.

*The Rapid Response Team has helped reduce the return to the ICU by recognizing and caring for patients who deteriorate acutely.*

*Charles G. Sargent, MD*
*Sue McFarlan, RN*
*Dee Dee Robinson, RN*

Over the past year there have been a number of initiatives designed to improve the safety of our patient care areas. Studies have shown that when care providers enter orders into computers, there are fewer errors. The deployment of a computerized provider order entry system on all of our inpatient care units has been completed. To avoid potentially dangerous miscommunication between providers, we also implemented strategies that have essentially eliminated the use of banned abbreviations that can be confusing or misread. We have taken steps to eliminate errors related to improper patient labeling. We have been able to sustain our outstanding performance in using the universal protocol (time-out) requirement prior to all procedures to ensure we have the correct patient, the correct side and the correct procedure.

*Improving the quality, safety and efficiency of our systems of care is our top priority.*

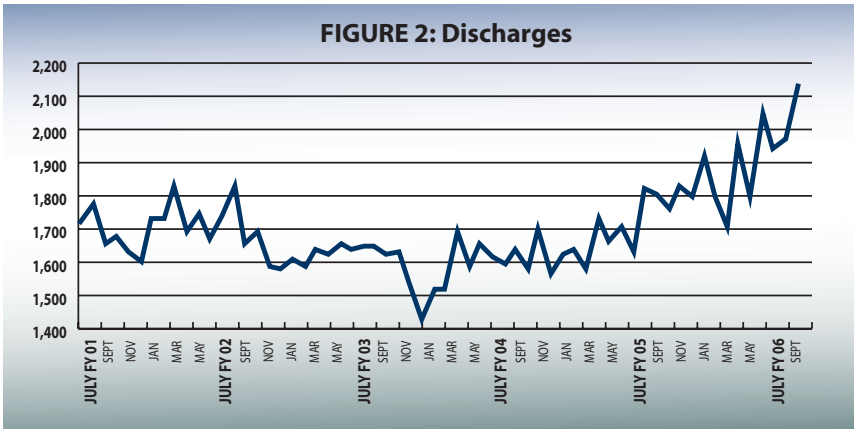
Improving the quality, safety and efficiency of our systems of care is our top priority. It is essential that everyone throughout the organization understands and participates in this commitment. We have created multidisciplinary work groups to address our internal as well as national quality and safety goals to help guarantee our future success in this critical area.

## Patient Throughput

With increasing pressure to be cost conscious and efficient in today's medical marketplace, over the past year we have focused our attention and put the appropriate emphasis on initiatives that will improve our operations and the services we provide. Under the leadership of the Chief Medical Officer and involving the physician and nursing staffs of UK HealthCare, we have taken significant steps forward in this arena.

*The demand for our unique and advanced specialty services continues to expand. Inpatient hospital discharges have experienced growth of more than 13 percent over the past year.*

**FIGURE 2: Discharges**




The demand for our unique and advanced specialty services continues to expand. Inpatient hospital discharges have experienced growth of more than 13 percent over the past year. From a low period in 2002, our discharges have increased dramatically, with each quarter better than the last for the past six quarters (Figure 2). With volumes increasing rapidly it became critical that we manage one of our most valuable resources, patient beds, as effectively as possible. We employed several strategies to accomplish this.

One mechanism for accommodating those increased volumes was the expansion of our bed capacity with the addition of 34 inpatient beds. The opening of the new 11-bed Critical Decision Unit and Observation Area and an Admission, Discharge and Transfer Unit with 12 beds and four reclining chairs also allowed us to group patients, freeing up additional inpatient bed capacity. We have added about 500 additional staff in nearly every area (e.g., nursing, pharmacy, technicians and laboratory) and recruited over 100 new physicians. The creation of the new Capacity Center, which monitors all bed availability and patient flow throughout the hospital, provides better coordination of this resource, improving patient flow through the hospital. The Capacity Center includes an electronic bed board that tracks the availability of beds in real time, houses the hospital operational administrators and transport services and coordinates the activities of housekeeping and the patient and physician phone access lines. We proactively assess and forecast the future needs and availability of resources to better serve our referring physicians.

*We have added about 500 additional staff in nearly every area (e.g., nursing, pharmacy, technicians and laboratory) and recruited over 100 new physicians.*

Surgical services provided another significant opportunity for the improvement of patient throughput. A complete review and redesign of patient flow in the operating rooms and post-anesthesia care units has improved efficiency in the operating rooms. We have experienced a 50 percent reduction in the time of first case delays and more than a 25 percent decrease in case cancellation. A plan has also been developed to decompress the Emergency Department, a primary entry point to the hospital, which is seeing ever-increasing volumes. The Emergency Department has accommodated this significant increase in demand while decreasing the frequency and time on diversion. Renovation to decompress this area and provide more privacy for our patients will be complete in the upcoming year.

## PATIENT THROUGHPUT

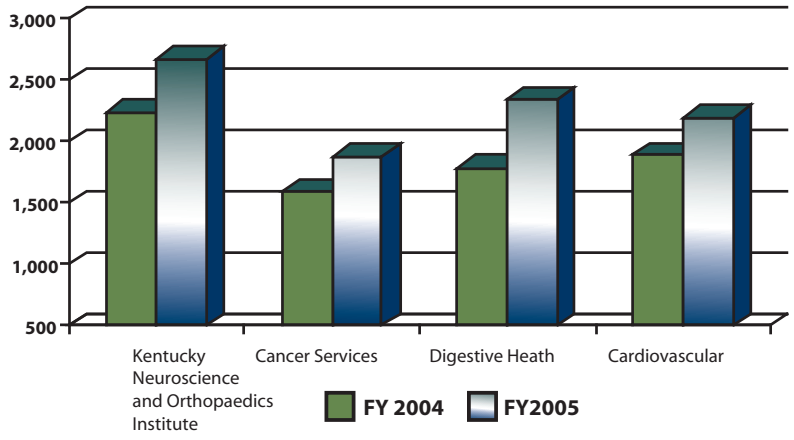
- √ **Created the new Capacity Center, including a bed board and human resources focused on bed availability and patient flow**
- √ **Opened 34 additional inpatient beds**
- √ **Opened a new 11-bed Critical Decision Unit /Observation Area**
- √ **Completed the review and redesign of patient flow in the OR and PACU**
- √ **Optimized staffing models and expanded personnel pools**
- √ **Planned the renovation to decompress the Emergency Department**
- √ **Expanded chemotherapy capacity and operating hours**
- √ **Implemented a centralized transport service**
- √ **Developed a plan for expansion of outpatient imaging**

The addition of a number of chemotherapy suites in the Markey Cancer Center as well as the expansion of operating hours has offered tremendous opportunity to meet increasing patient demand and improve accessibility to our services. Similarly, we have developed a plan for the expansion of outpatient imaging.

## Strategic Clinical Initiatives

The strategic planning process, which successfully concluded in the fall of 2004, focuses on a number of important strategic initiatives including cardiology and cardiovascular surgery, neurology and neurosciences, orthopaedics, digestive disorders, and oncology and oncological surgery. The plan for each strategic initiative was developed by a team of clinical faculty and staff. In total, the plans call for nearly $60 million to be invested in our strategic clinical initiatives through fiscal year 2010 for faculty, staff and other capital. During 2005 we began the implementation of specific tactics within each plan and have already begun to realize a number of important benefits including significant growth in inpatient discharges for each of the strategic initiatives (Figure 3).

**FIGURE 3: Inpatient Discharges for Strategic Clinical Initiatives**



The cardiology and cardiovascular surgery initiative, lead by David Moliterno, MD, has put significant effort into improving the flow of patients through their service as well as improving the patient experience. Great strides have also been taken in making their service more efficient through standardization of care where appropriate, improving overall outcomes for patients. Recruitment in cardiology has been strong as well, with the addition of five new faculty, and efforts have expanded to partner with community providers to enhance care available at the local level.

*Cardiology and Cardiovascular Surgery:*
*John Gurley, MD (cardiology), David Moliterno, MD (cardiology),*
*Chand Ramaiah, MD (cardiovascular surgery),*
*Steven Steinhubl, MD (cardiology)*

The formation of the Kentucky Neuroscience and Orthopaedics Institute (KNOI), lead by Byron Young, MD, Joseph Berger, MD, and Darren Johnson, MD, brings together the disciplines of neurosurgery, neurology and orthopaedics and was instrumental in our recent designation as a primary stroke center. KNOI staff have also worked to expand our adult epilepsy inpatient EEG monitoring capability. Recruitments to the Institute have included the addition of two neurologists, one neurosurgeon and one primary care/sports medicine physician. New outreach clinics have also been established.

*Kentucky Neuroscience and Orthopaedics Institute:*
*Darren Johnson, MD (orthopaedics),*
*A. Byron Young, MD (neurosurgery), Joseph Berger, MD (neurology)*

*Oncology and Oncological Surgery:*
*Kevin McDonagh, MD (hematology/oncology),*
*Patrick McGrath, MD (surgical oncology), Suzanne Arnold, MD (hematology/oncology),*
*Alfred Cohen, MD (surgical oncology), Paul DePriest, MD (gynecologic oncology),*
*Timothy Mullet, MD (surgical oncology), Jeffrey Moscow, MD (pediatric hematology/oncology), William St Clair, MD (radiation medicine)*

Leading the oncology and oncological surgery strategic initiative within the Markey Cancer Center are Kevin McDonagh, MD, and Alfred Cohen, MD. Current demand for cancer care has grown at such a pace we have begun a significant expansion of our outpatient chemotherapy clinic. Significant recruitment, including the addition of four medical oncologists and one surgical oncologist, and the development of a new disease-focused staffing model in the outpatient cancer clinics will help to better serve our patients and meet the anticipated growth in this area. The development and implementation of the Markey Cancer Network serves to strengthen our partnerships with local providers, enhancing care to cancer patients in their home communities.

*Digestive Health:*
*Bernard Boulanger, MD (surgery),*
*Willem de Villiers, MD, PhD (gastroenterology),*
*Harohalli Shashidhar, MD (pediatric gastroenterology)*

The digestive health initiative combines the medical and surgical leadership of Willem de Villiers, MD, PhD, and Bernard Boulanger, MD. This initiative takes a comprehensive disease-focused approach and has recently led to a significant renovation within Kentucky Clinic to establish an integrated gastroenterology clinic. Two new gastroenterologists have been recruited, and they have also established new outreach sites.

Given the significant amount of investment in our strategic initiatives, it is critical to monitor the implementation of these plans and their related investments. Each strategic initiative now has a senior-level executive management team focused on monitoring the work plan implementation. These teams monitor quality, volume and financial metrics established for each initiative; track physician recruitment plans; assess market trends; develop and implement clinical outreach strategies; and ensure that efforts are focused on care optimization and patient outcomes.

## Market Development

Integral to our mission, being the primary academic medical center in Kentucky, is the support of the delivery of health care throughout the Commonwealth, particularly Central, Southern and Eastern Kentucky. Toward that end, we have pursued the development of clinical outreach initiatives with community providers. These outreach activities allow patients to receive care at local facilities for as long as possible with only those needing the complex care offered at an academic medical center coming to our campus.

In many cases, such as at Harrison Memorial Hospital in Cynthiana, Kentucky, our physicians function as members of the local hospital's staff, enabling patients to receive treatment conveniently in their communities (Figure 4).

These outreach activities enhance the health care delivery at the local level via professional development and improved exchange of patient information. Opening doors to new research and education opportunities, they also enhance our desire to be a health care resource to the communities of the Commonwealth.

The strategic plan will be a continuously evolving process. The planning that concluded last year is really just the beginning. The second phase of planning, currently underway, focuses on refining and adjusting the existing plan as well as undertaking new planning efforts to support:

- ambulatory programs
- transplantation
- primary care
- Kentucky Children's Hospital
- care of the aging Kentucky population
- key geographic strategies

Figure 4: PARTNERING WITH COMMUNITY PROVIDERS

*In a joint marketing effort, Harrison Memorial Hospital introduces a member of our faculty, Antonio Bosch, MD, to its local community.*


*These outreach activities allow patients to receive care at local facilities for as long as possible with only those needing the complex care offered at an academic medical center coming to our campus.*


Figure 5: MASTER PLAN ZONING DIAGRAM

## Facilities

As we began planning for the revitalization of our facilities, we felt it important to plan, in a broader context, not just a new hospital facility, but for the health care delivery systems of the future. We recognize that we must provide care in the most appropriate setting. Therefore, the siting of the new hospital had to take into consideration inpatient and outpatient systems of care. Thus as we began planning for the future, we started with the new patient care facility.

The project has progressed substantially over the recent past. During the 2005 Kentucky General Assembly, the University obtained authorization for the use of $100 million in cash and $100 million in bonds for the construction of this new facility. The remainder of the $450 million authority is anticipated in the 2006 session of the state legislature.

A world-class team of architects, engineers and consultants has been selected and planning has begun. The partnership of architectural firms GBBN and AM Kinney is coordinating the project at the local level, while the project draws on the design talents of national health care architects Ellerbe Becket.

As a first step, the team confirmed the long-range master plan established last year during an intensive facilities planning process. The master plan establishes the future campus facility zones for education, clinical and research activities as well as the location, shape and size of the new patient care facility (Figure 5).

The educational and research activities will primarily be located west of Limestone and the clinical activities will remain essentially in their current location. The new patient care facility will be sited at the south end of the existing hospital on property currently occupied by the hospital parking garage. The location of this new facility affords the opportunity to create a new circular drive entrance to the UK HealthCare campus, making it easy for patients and visitors to recognize the entrance and navigate our facilities. A lobby will link the new building, the Critical Care Tower and the Gill Heart Building.

Phase 1, split into two separate implementation stages 1A and 1B, will allow for the step-by-step replacement of the existing UK Hospital building (Figure 6). Phase 1A will expand our capacity, allowing us to operate our full licensed complement of 473 beds, creating a majority, if not all, of private rooms. It will expand our emergency services and increase surgery capacity. It will create patient rooms that are flexible, with the ability to accommodate higher acuity patients and will replace our most critically outdated patient units. It will significantly improve the patient, family and visitor experience, providing an environment that meets the needs of staff.

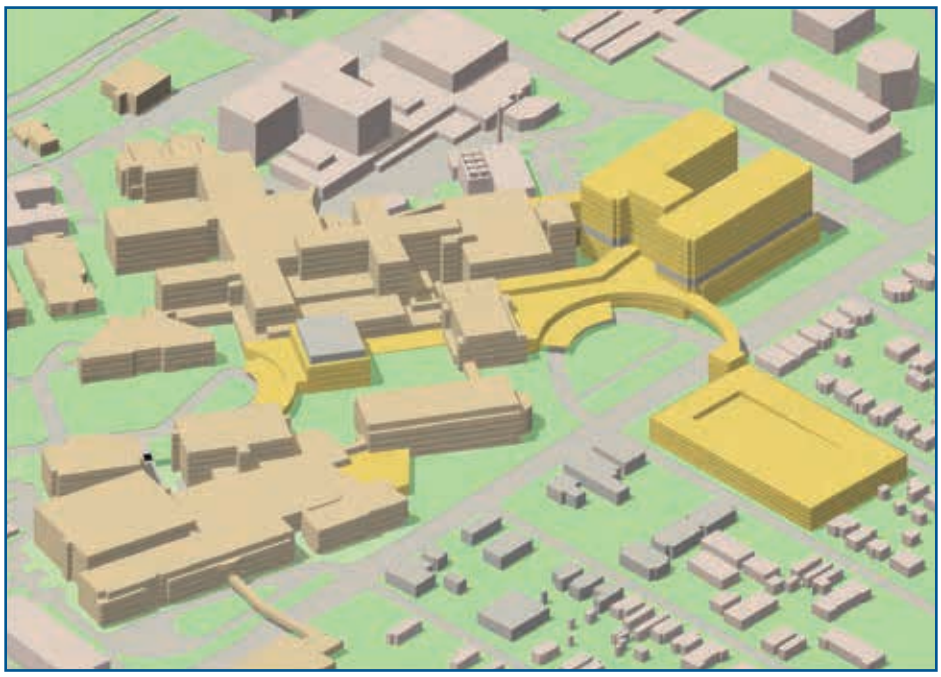
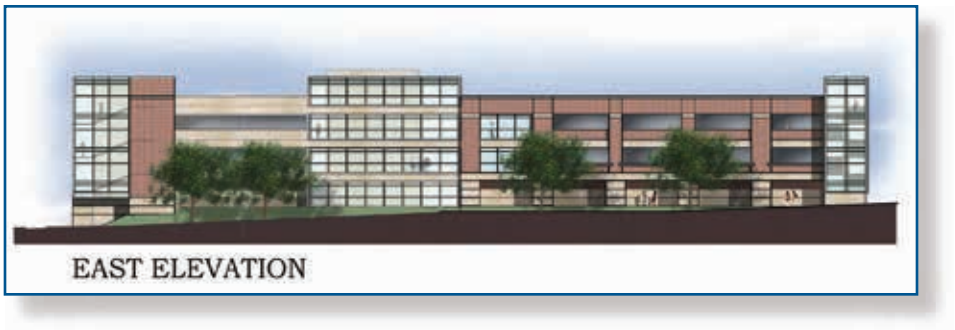


Figure 6: PHASE 1

*Phase 1, split into two separate implementation stages 1A and 1B, will allow for the step-by-step replacement of the existing UK Hospital building.*

Figure 7: HOSPITAL PARKING GARAGE

*The new hospital parking garage west of Limestone is now under construction and will be complete early in 2007.*




The new hospital parking garage west of Limestone is now under construction and will be complete early in 2007 (Figure 7). It will be connected to the lobby of the new patient care facility by a concourse crossing over Limestone providing easy access for patients and their families to our medical center.

After the completion of Phase 1, all activities in the existing hospital building will be moved into new facilities, and the vacated building will be razed. Consequently, the Colleges of Medicine and Dentistry must move to new facilities. Jay Perman, Dean of the College of Medicine, recently initiated a planning effort with the deans of all six health science colleges and the Dean of Libraries resulting in a proposal to create a shared academic and research facility. This facility, to be located west of Limestone, will cement the already strong programmatic integration of educational and research activities among the colleges. Ellerbe Becket and our entire team are now engaged with these colleges in the planning of this leading-edge facility.

Planning is also underway to assess our ambulatory facility needs and to organize the services provided within to better meet the needs of our patients and their families. The ambulatory care facilities are inadequate to provide the quality and capacity of care needed to meet demands of the future. New outpatient facilities and the opportunity to improve utilization and efficiency of our current operations will allow UK HealthCare to continue to accommodate the anticipated growth of outpatient activity and improve the level of service provided.

## FACILITIES

- √ Confirmed future campus facility zones
- √ Selected and contracted with a world-class team of architects, engineers and consultants
- √ Completed a traffic study confirming the location of the new garage
- √ Obtained state legislature approval to use $100 million of cash and $100 million bonding authority for new facility construction
- √ Obtained city approval for the rerouting of Rose Street
- √ Nearly completed the acquisition of property for new garage site
- √ Planned tactical renovations of the operating rooms, post-anesthesia care unit, emergency department and chemotherapy infusion suites
- √ Confirmed the bed tower location and building shape
- √ Began planning to assess ambulatory and academic facility needs

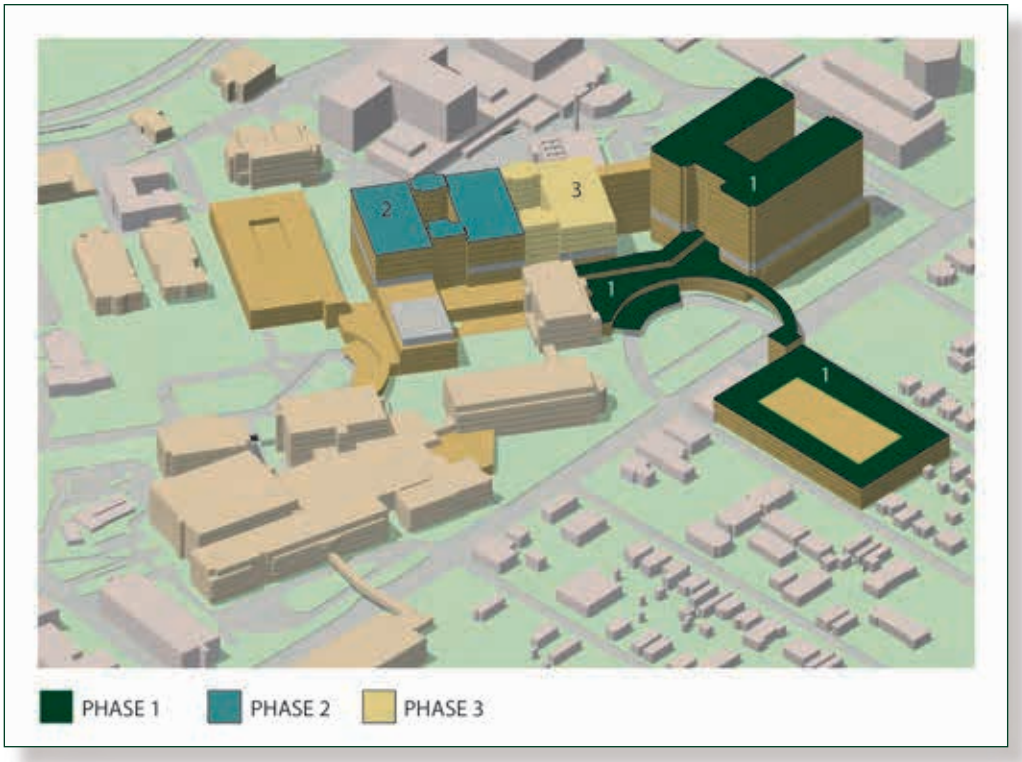



Figure 8: PHASE 2 AND 3

*In the final phases of our master plan, Phase 2 and Phase 3, we will build a facility on the site of the existing hospital, that will support coordinated and organized complex outpatient services linked with the inpatient services in the new patient care facility.*

While these long-term efforts are progressing, there remain a number of immediate facilities needs being addressed throughout the medical center. Surgical services are critically important to the advanced subspecialty care we provide. Hence, renovations of the operating rooms and post-anesthesia care units are in the planning stages. These renovations will increase the capacity of these areas, improve privacy for all patients and expand family waiting space. The Emergency Department will also be renovated, increasing its capacity from 21 to approximately 35 rooms or bays. Twelve additional chemotherapy suites are being added to increase capacity in the Markey Cancer Center. The significant growth in ophthalmology has called for the doubling of its space in Kentucky Clinic. Options for accommodating this need are being reviewed. Imaging capacity in the Kentucky Clinic is also being improved with the replacement of two general radiology rooms and the addition of a new modular MRI.

*Planning is also under way to assess our ambulatory facility needs and to organize the services provided within to better meet the needs of our patients and their families.*

These renovations and planning efforts, in addition to the construction of the new hospital patient care facility, will move us through the initial phase of the implementation of our master plan. While working on the new patient care facility we will begin to focus on improving our outpatient facilities. In the final phases of our master plan, Phase 2 and Phase 3, we will build a facility on the site of the existing hospital that will support coordinated and organized complex outpatient services linked with the inpatient services in the new patient care facility (Figure 8).

*While these long-term efforts are progressing, there remain a number of immediate facilities needs being addressed throughout the medical center.*

## Academic Growth

Part of the support for the strategic plan of UK HealthCare involves a significant investment in people, particularly the faculty. During fiscal year 2005, the College of Medicine enjoyed substantial recruitment success with the appointment of 73 new faculty members, comprised of 53 physician and 20 doctorate faculty. These new faculty members include nine associate professors and eight professors, demonstrating our increasing ability to recruit senior faculty. Our recruits throughout the year were drawn from many highly regarded institutions including:

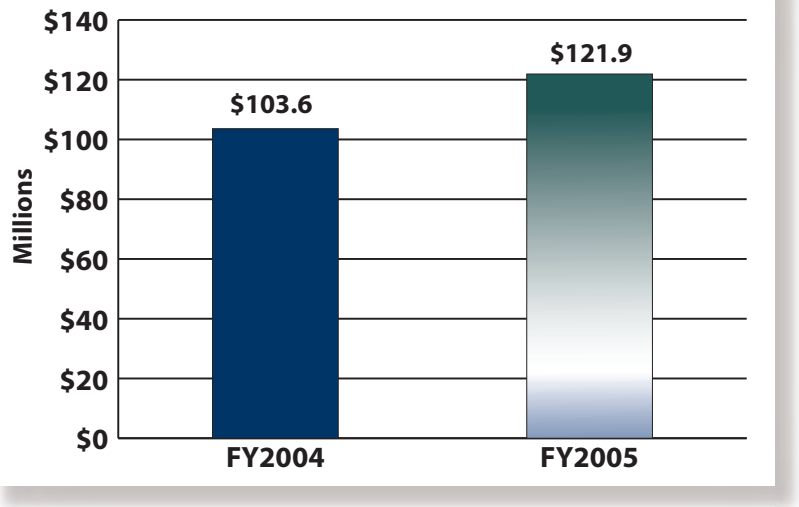
Harvard (5)
University of Michigan (4)
Case Western Reserve (3)
Medical College of Wisconsin (3)
University of Maryland (3)
Cedars-Sinai (2)
Cincinnati Children's (2)
University of Alabama Birmingham (1)
Baylor University (1)
Cleveland Clinic (1)
Sloan Kettering (1)
University of Pennsylvania (1)
Yale University (1)

*During fiscal year 2005 the total grants and contracts for the College of Medicine grew from $103.6 million to $121.9 million, representing a 17.6 percent increase in funding.*

Not only are we attracting talent from prestigious institutions across the country, we are also preparing people from within for academic positions, by hiring 15 faculty who graduated from our own training programs. While 73 faculty were hired, 41 faculty resigned or retired, equating to a relatively low turnover rate of 6.5 percent.

The College of Medicine has continued to focus on the development of its research programs under the 1997 House Bill 1 mandate that UK become a nationally recognized public research university by 2020. During fiscal year 2005 the total grants and contracts for the College of Medicine grew from $103.6 million to $121.9 million, representing a 17.6 percent increase in funding (Figure 9). In addition, NIH funding increased from approximately $61 million to $63 million. Research funds generated by the college over the past several years has also grown as a percentage among the University's total research funding from 40.55 percent to 44.47 percent of the total UK grant funding. The College of Medicine recognizes that for the University to reach the goal of top 20, it must play an integral and substantial role in that achievement.

**FIGURE 9: College of Medicine Research Awards**



In addition to growth in absolute dollars, the college moved upward to 31st of 73 public medical schools in the country as measured by fiscal year 2004 National Institutes of Health (NIH) research awards. This represented significant progress from 35th in fiscal year 2003. Five basic science departments ranked in the top 20 in public medical school NIH rankings in 2004: Behavioral Science (1st), Molecular & Biomedical Pharmacology (10th), Anatomy & Neurobiology (14th), Molecular & Cellular Biochemistry (14th) and Microbiology, Immunology and Molecular Genetics (17th). At the same time, four clinical science departments ranked in the top 20: Physical Medicine and Rehabilitation (8th), Neurology (13th), OB/GYN (15th) and Pathology (20th). The basic sciences departments have consistently performed well in receiving research funding, however the clinical departments may have the most potential for growth.

Apart from college and departmental rankings, there has been considerable individual success in the research arena.

**Mark B. Dignan, PhD,** received a $6.0 million U01 Cooperative Agreement to develop an Appalachia Community Cancer Network and a $2.4 million R01 to study colorectal cancer screening in rural Kentucky.

**Edward D. Hall, PhD,** was awarded the $3.0 million SCoBIRC Core Grant to further research in spinal cord and brain injury.

**Don M. Gash, PhD,** and **Greg Gerhardt, PhD**, successfully competed to renew the $6.0 million program project for the Morris K. Udall Parkinson's Center of Excellence.

**James E. Ferguson, MD,** and colleagues successfully renewed their $2.5 million BIRCWH award, a career development program for scientists focused on women's health.

**Louis B. Hersh, PhD**, received a five-year $10 million COBRE grant to study the molecular basis of human disease and provide mentoring of assistant professors in cancer, diabetes and Alzheimer's disease research.

**Edward J. Kasarskis, MD, PhD**, received a two-year $3.34 million grant to set the standard of care for patients with ALS. This 11-site multicenter trial is lead by Dr. Kasarskis and UK.

Despite this wonderful success, the College of Medicine faces considerable challenges in the development of research programs, primarily adequacy of contemporary research space. An examination of research space shows that approximately 217,000 net assignable square feet is currently occupied by the College of Medicine research programs, much of which is

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**Five basic science departments ranked in the top 20 in public medical school NIH rankings in 2004.**

**At the same time, four clinical science departments ranked in the top 20.**

*By almost any measure, FY 2005 has been an excellent year for UK HealthCare. Progress made during this past year put us much farther along towards achieving our goals than originally projected. In nearly every key utilization statistic, FY 2005 actual results exceeded the budget, and our positive momentum accelerated near the end of the year.*

*Adjusted patient discharges, up nearly 16 percent, are already in the range projected for FY 2007, and inpatient discharges are up over 13 percent.*

outdated and inadequate for today's research programs. In addition, it is estimated the current research space will need to be doubled to accommodate the research growth required to achieve the goal of a top 20 NIH ranking. This is the greatest limiting factor to the college's ability to make its contribution to the overall research goals of the University. In the meantime, we are carefully scrutinizing all current space to ensure it is being used to the maximum extent possible.

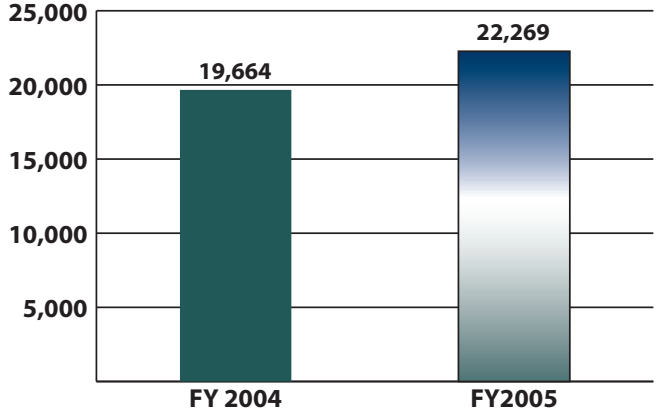
## Finances

During 2004 we established a financial plan that incorporated all aspects of our facilities and strategic planning efforts. We also spent significant time educating the organization on the financial position of the clinical enterprise at every level and integrating financial planning among the various entities within the clinical enterprise. The financial plan approach seeks to maximize the investment in strategic initiatives and capital and maintain the strength of the balance sheet.

By almost any measure, FY 2005 has been an excellent year for UK HealthCare. Progress made during this past year put us much farther along towards achieving our goals than originally projected. In nearly every key utilization statistic, FY 2005 actual results exceeded the budget, and our positive momentum accelerated near the end of the year.

The financial proformas developed during the planning process define the targets required to achieve our goals and support the construction of the new patient care facility. Fiscal year 2005 activity has already met or exceeded many of the original out-year projections of our financial proformas. For example, the number of outpatient visits, up 8 percent over last year and 8.7 percent over budget, already exceeds the FY 2007 projections of our original financial proformas. Adjusted patient discharges, up nearly 16 percent, are already in the range projected for FY 2007, and inpatient discharges are up over 13 percent (Figure 10). These examples and the excellent performance depicted by other statistics have impacted in a substantial way the growth in the operating margin and unrestricted cash balance and make our plans for renewing our physical plant all the more realistic as we move forward in that process.

**FIGURE 10: Inpatient Discharges**

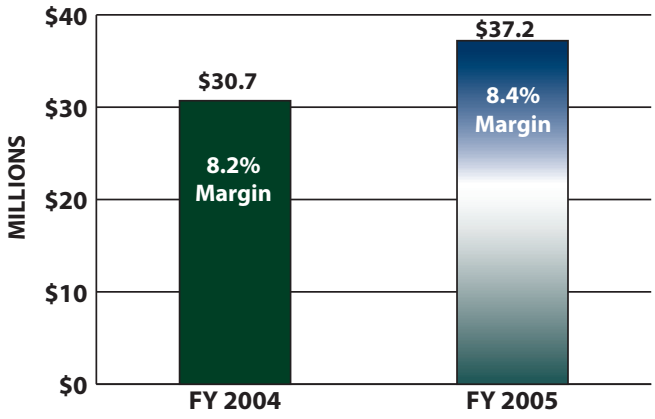


With this level of growth, the hospital's overall financial position, already strong when the year began, improved significantly. The year saw operating revenue grow from $372 million in 2004 to $442 million in 2005. The $70 million growth came across almost all services due to the improved recruitment and retention of faculty and the increase in available beds. Net revenue by funding source or sponsor increased for all payors with no one growing less than 10 percent. Commercial insurance business grew by more than $34 million and Medicare by more than $17 million.

The increased volume and associated revenue led to a corresponding increase in expenses with salaries and benefits increasing by over $19 million due in part to the addition of 242 full-time equivalent jobs. The net result for the year was an improved financial result over the prior year with operating income increasing from $30.7 million to $37.2 million (Figure 11) and the change in net assets increasing from $18.1 million to $28.3 million.

The growth in revenue and positive operating results yielded significant cash flow. The efforts in the revenue cycle led to days in accounts receivable dropping to 42 days and unrestricted cash balances at year end of $264.6 million, an increase of $34.6 million over the prior year. This improved liquidity position better prepares us to meet our strategic goals.

**FIGURE 11: Operating Income**




A record $43 million capital budget was approved. This represents a level of investment in capital that we have not seen before and hope to repeat for several years. It has been the significant growth in volumes and financial performance of the hospital, driven by the commitment of the faculty and staff throughout the enterprise that has allowed us to make a larger investment than the $35 million initially planned. These investments focused on patient safety, increased capacity and patient throughput, information technology, strategic initiatives and facility renovations.

As we move forward, we will continually monitor our performance and adjust our financial projections accordingly. For fiscal year 2006 we have planned on a continuation of the large growth in volumes. Capacity constraints within the system are a significant challenge we will face in meeting this target. The initiatives focusing on patient throughput and alternative strategies for managing specific patient cohorts will be critical in supporting this growth.

## FINANCES

- √ FY 2005 actual performance exceeded budget in every key utilization statistic, with the exception of inpatient days.
- √ Outpatient visits exceeded FY 2007 projections.
- √ FY 2005 adjusted patient discharges and adjusted patient days are in the range projected for FY 2007.
- √ FY 2005 activity has already met or exceeded many of the original out-year projections that were based upon FY 2004 Actual and FY 2005 Budget.
- √ A record $43 million capital budget was approved.
- √ Income from operations increased to $37.2 million.
- √ Unrestricted cash and cash equivalents increased to $264 million.

*Overcoming these challenges allows us to move closer to achieving our goal of becoming a top 20 public academic medical center and affords us the opportunity to improve and expand our service to Kentuckians.*

# Challenges for the Future

With a vision of becoming a top 20 academic medical center, we must continue to build on the successes we have achieved. As we enjoy these successes, we recognize there will be substantial challenges in the future.

The first of these challenges centers on our most important asset—our people. We must continue the recruitment of physicians and faculty who will strengthen our programs and enhance the services we provide to Kentuckians. With the impending shortfall of medical manpower we must also remain focused on the recruitment and availability of nurses, X-ray technicians, pharmacists and other health care providers.

Health care funding challenges also persist. There is uncertainty on both the federal and state levels that we must continually monitor. And we must also continue the maturation of our relationships with community and regional providers as we establish ourselves as the purveyor of advanced subspecialty care for their patients. We must be true to our word that we will work with our community partners to strengthen and support the health care capabilities at their facilities so that patients can stay at their local hospital as much as possible when appropriate.

The new patient care facility is a very complex project and presents an exciting challenge. We will continually monitor our financial position to ensure we construct a facility that serves our patients well and leaves us in a position where we can move forward with future phases of construction. In the interim period, before the new facility is complete, we must also find ways to meet the growing demands for our services within the capacity of our current facilities.

We will continue to plan and to take steps daily to meet each of these challenges in a positive way. Overcoming these challenges allows us to move closer to achieving our goal of becoming a top 20 public academic medical center and affords us the opportunity to improve and expand our service to Kentuckians.

# Financial Statements

**Operating revenue grew nearly 19 percent in FY2005**

## Statistics

| | 2004 | 2005 |
|---|---|---|
| **Discharges** | | |
| Medicare | 4,591 | 5,574 |
| Medicaid | 5,942 | 6,544 |
| Commercial/Blue Cross | 7,095 | 7,933 |
| Patient/charity | 2,036 | 2,218 |
| Total Discharges | 19,664 | 22,269 |
| Average Daily Census | 308 | 336 |
| Average Length of Stay | 5.72 | 5.51 |
| **Patient Days** | | |
| Medicare | 27,971 | 32,871 |
| Medicaid | 40,507 | 41,084 |
| Commercial/Blue Cross | 32,170 | 36,099 |
| Patient/charity | 11,927 | 12,650 |
| Total Patient Days | 112,575 | 122,704 |
| Operative Cases | 17,246 | 19,338 |
| Outpatient Visits | 286,866 | 309,154 |

*The financial information presented in these tables is based on the June 30, 2005 audited financial statements.*

## Condensed Statement of Revenues and Expenses *($ in thousands)*

| | 2004 | 2005 |
|---|---|---|
| Operating Revenue | $371,982 | $441,935 |
| Operating Expenses | 341,323 | 404,777 |
| Operating Income | 30,659 | 37,158 |
| Nonoperating revenue (expenses) | (2,985) | 8,502 |
| Income before transfers to UK | 27,674 | 45,660 |
| Transfers to UK/other | (9,587) | (17,345) |
| Total increase in net assets | $ 18,087 | $ 28,315 |
| Operating margin | 8.2% | 8.4% |
| Total margin | 4.9% | 6.4% |

## Condensed Statement of Net Assets *($ in thousands)*

| | 2004 | 2005 |
|---|---|---|
| **Assets** | | |
| Current Assets | $283,907 | $322,867 |
| Capital assets, net of depreciation | 138,277 | 133,279 |
| Other noncurrent assets | 51,765 | 53,183 |
| Total assets | 473,949 | 509,329 |
| **Liabilities** | | |
| Current liabilities | 33,743 | 42,165 |
| Noncurrent liabilities | 11,844 | 10,487 |
| Total liabilities | 45,587 | 52, 652 |
| **Net Assets** | | |
| Invested in capital assets, net of related debt | 133,078 | 130,986 |
| Restricted expendable | 569 | 687 |
| Unrestricted | 294,715 | 325,004 |
| Total net assets | $428,362 | $456,677 |

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