Each year, I report to the Beth Israel Deaconess Medical Center Board of Directors on our progress against operational goals. I was pleased to be able to deliver very positive news in my most recent report. Shared below with the BIDMC community is summary and in-depth information on how we performed based on our FY'05 clinical operating goals.

Michael F. Epstein, M.D.
Executive Vice President and
Chief Operating Officer

Letter to the BIDMC Board of Directors

Summary FY'05 Annual Operating Plan

- Goal 1: Achieve the Highest Level of Health Care Quality and Patient Safety
- Goal 2: Achieve and Sustain the Highest Satisfaction Level and Loyalty Among our Three Core Constituents to Ensure that BIDMC is their Provider or Employer of Choice
- Goal 3: Achieve a 2% operating margin or $19.5 million operating gain

Detail FY'05 Annual Operating Plan

- Goal 1: Achieve the Highest Level of Health Care Quality and Patient Safety
- Goal 2: Achieve and Sustain the Highest Satisfaction Level and Loyalty Among our Three Core Constituents to Ensure that BIDMC is their Provider or Employer of Choice
- Goal 3: Achieve a 2% Operating Margin or $19.5 Million Operating Gain

November 9, 2005

Dear Colleagues:

I am pleased to provide you with this summary of our performance in carrying out the Annual Operating Plan for FY 2005.

This is the third consecutive year that I have had the opportunity to report on the annual performance, and while each year has had its own unique challenges and circumstances, the common element in all three years has been our ability to take pride in a "year well done."

An Annual Operating Plan's value lies in providing two elements to our governing Board, to our medical and administrative leadership, and to the medical staff and employees. First, the AOP provides a framework for keeping the elements of our mission in the appropriate balance and relationship to each other and to the outside world. A Plan that focused exclusively or even primarily on the financial measures would run the risk of neglecting quality, safety, or customer satisfaction. Instead, our three goals weight each of these elements in the proper proportion for achieving our overall mission. Second, the AOP provides a roadmap. The specific objectives and the metrics for measuring performance for each one provide the Board a means to hold leadership accountable and for leadership to organize our daily and weekly work.

This year's summary highlights an exciting and productive year in which innovative health care quality and patient safety initiatives led to approval by outside regulatory bodies such as the JCAHO and ACGME as well as to "best in class" performance on national measures. It was also a year in which patient satisfaction reached new levels enabling us to rank in the top 10% in institutions utilizing the PRC surveys. Finally, it was a year in which we managed the usual series of unpredictable bumps in the road and steered our way to a second consecutive positive bottom line which exceeded the Strategic Plan's target for an operating gain of 2%.

None of this would have been possible without the hard work and dedication demonstrated by the physicians, nurses, other professionals, and employees at the Medical Center. You should all take pride in these accomplishments as well as in the impact you have had on individual patients and their families, on students and trainees, and on future patients, students, and colleagues who will benefit from the new knowledge generated in our laboratories and bedside clinical trials.

My sincerest thanks to all of you.

Sincerely yours,
Michael F. Epstein, MD

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Annual Operating Goals/Fiscal Year 2005
Summary of Performance

Introduction: For FY05, our operating plan focuses on three main levers --- Healthcare Quality and Patient Safety, Customer Satisfaction and Financial Margin. Achieving our specific objectives in these three areas will be necessary to accomplish the goals set out in the strategic plan and enable the Medical Center to successfully carry out its missions in clinical care, research, education, and community service. To that end, we have expanded the traditional scope of our annual plan to include specific objectives that relate to our important education and research missions.

Goal 1: Achieve the highest level of health care quality and patient safety.

In order to accomplish this goal we will:

Objective 1: Promote patient care safety by implementing specific institutional initiatives to create and support a
culture of safety.

Results: Major FY05 initiatives focused on:

1) Designing, piloting, and implementing the Trigger Program for early identification of unstable patients on med/surg units;

2) A multidisciplinary approach to reducing the incidence of bloodstream infections from central venous catheters;

3) Implementation of a new Patient Safety Reporting System to improve the collection of incident reports/patient complaints and analyze them across the Medical Center;

4) Team training for nurses, physicians, and support staff in perioperative services;

5) A focus on transitions in care for communicating between providers in the ED and the perioperative areas;

6) Pathology project that improved the labeling of specimens resulting in a reduction in "incompletely labeled specimens" from 13% to <1%;

7) Implementation of a new badging system and access management to reduce the risk to mothers and babies in postpartum settings; and

8) Establishment of BIDMC as the first "smoke free" hospital in Boston.

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Objective 2: Set and monitor appropriate institutional measures of clinical quality (dashboard) and regularly report on performance to BIDMC physicians, managers, and the governing Board.

Results: Our focus was on developing and coordinating an internal dashboard to include the quality measures listed on public Web sites, e.g. CMS, JCAHO, Leapfrog. We demonstrated substantial improvement in these areas to achieve "top 10%" status in key measures, including

administering antibiotics to patients with pneumonia within four hours of admission to the ED and giving Pneumovax vaccine prior to discharge.

Objective 3: Jointly develop, implement, and monitor evidence-based clinical care guidelines in key clinical areas to reduce variation, improve quality and improve efficiency.

Results: Guidelines were developed and implemented in a variety of disease management settings including prophylactic administration of antibiotics in the perioperative setting, use of intravenous contrast in patients with renal disease, use of Natrecor in congestive heart failure, use of anti-emetics in oncology patients, and the prevention of blood clots in orthopedic patients. In each case, the guidelines resulted in improved performance in the delivery of the right care at the right time and the elimination of unnecessary care and cost.

Objective 4: Ensure ongoing JCAHO and other regulatory/emergency preparedness.

Results: The JCAHO visit in November 2005 was very successful with the Medical Center achieving a perfect score on the National Patient Safety Goals as well as the 500 standards under which we were evaluated. Ongoing efforts to 'hold the gains' are underway with unannounced 'JCAHO-like site visits' to inpatient, ambulatory, and ED sites on a regular basis. Emergency preparedness continued to improve with successful participation in city and state-wide drills as well as updated guidelines for influenza preparation. A computerized maintenance management system was implemented to ensure completion of preventive maintenance work in a timely and thorough manner.

Objective 5: The Center for Education will achieve full accreditation for BIDMC's GME program.

Result: The ACGME granted the Medical Center a full accreditation for the next four years based on a site visit in January,2005. The BIDMC was cited for 13 specific commendations including innovations in mentoring, IS, research opportunities, and administrative support.

Objective 6: Develop a plan and budget for a simulation center for the education and training of doctors, nurses, students, and other healthcare professionals as recommended in the Education Strategic Plan.

Result: The Simulation Center Plan was approved and funded, and construction has begun on this 5,000 square foot space that will house mockups of an OR and an ICU bedspace, as well as a Skills Lab on the ground floor of the Shapiro Building. The Center will open in Spring, 2006.

Objective 7: Develop a research clinical trial database and other tools to register and track patients enrolled in clinical trials.

Results: The software application for enrolling clinical trial patients, tracking their experience, and creating a database for operations improvement has been completed and will be implemented in FY06. Additionally, a budget management database was implemented to enhance Research Administration's ability to track expenses for operations and capital equipment.

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Goal 2: Achieve and sustain the highest satisfaction level and loyalty among our three core constituents to ensure that BIDMC is their provider or employer of choice. Our three core constituents are:

- Patients and their families in the outpatient and inpatient setting,
- Employees, and

- Physicians – including the BIDMC medical staff and referring physicians

To accomplish this goal, we must:

Objective 1: Achieve a high level of "customer" inpatient and outpatient satisfaction for patients and their families as well as in our relationship with our broader urban community.

> *Results:* The PRC telephone survey of discharged inpatients achieved the highest scores since its introduction in 2001, and the survey was expanded in FY05 to include ambulatory and ED patients as well, providing baseline numbers for improvement in FY06. In addition, public and patient care spaces were significantly improved, including the Feldberg Lobby and several Farr inpatient units. A new patient meal service program designed around 'room service' is ready for implementation in early FY06 and should result in a higher level of patient satisfaction. Finally, more patient parking on campus was 'created' by moving employees (including the CEO and COO) to off-campus parking sites.

Objective 2: Expand the service quality training initiative to support achievement of customer satisfaction goals.

> *Results:* Major customer service training programs were implemented for front desk staff in the ED and in the HCA phone bank. Before and after survey results suggest significant improvement in customer satisfaction in these settings.

Objective 3: Recruit, develop and retain exceptional talent with a focus on diversifying our workforce.

> *Results:* There were 2,500 new hires in FY05, including 369 RNs, reducing the RN vacancy rate to 2% by the end of FY05. Retention rates for the first 90 days improved from 83.4% to 90.3%. Among the new hires in management (supervisor, manager, director), 22.8% were from under-represented minority groups.

Objective 4: Develop and implement a referring physician survey to measure awareness of BIDMC's priority clinical areas, utilization of services, and to gauge affinity toward BIDMC.

> *Result:* A referring physicians' satisfaction survey to determine the key drivers for this group was administered to 250 physicians, identifying action items to be addressed in FY06. In addition, referring physicians' needs have been addressed through providing Care Web access (electronic medical record), through enhancing our Faculty Speakers program for community hospital grand rounds, and through adding two staff positions within Network Development who work as physician liaisons focused exclusively on physician relations.

Objective 5: Develop an internal survey tool for our principal investigators to determine their satisfaction with research administration and other important research matters.

> *Result:* Research administration has developed a survey focused on 10 separate research areas, including administrative support, financial reports, purchasing, and HR. The survey will be implemented in FY06 in focus groups and through telephone interviews to identify opportunities for providing better service to our investigators.

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Goal 3: Achieve a 2% operating margin or $19.5 million operating gain.

To accomplish this goal, we will:

Objective 1: Achieve overall budgeted growth in inpatient discharges, outpatient encounters, and case mix index (CMI) by partnering with our physicians to develop and grow strategic clinical programs and through implementation of our Network Development plan.

> *Results:* Inpatient plus 'observation' patient volume grew by 1.4% over the prior year and was within 25 patients of the FY05 budgeted total of 42,983 patients. Changes in insurance company procedures led to a shift from inpatient to observation status, but also resulted in having more inpatient beds available for higher case mix patients. Despite the loss of several key surgeons, surgical discharges grew by 2.3%, with strength in cardiac, thoracic, and vascular surgery. With the growth in surgery as well as in key areas in Medicine, including hematology/oncology and gastroenterology, case mix was 4.1% higher than the prior year. Major growth in Orthopedic surgical volume was a bright spot and reflected the first full year of activity for Dr Gebhardt's newly recruited surgeons. Ambulatory activity was very strong with double digit growth in total outpatient visits as well as the second straight year of growth in ED visits. Strengthening of our network with Milton Hospital, Beverly Hospital's cancer program, Nashoba Valley's cardiology and urology services, and the multi-specialty group BGPMA all contributed to the enhanced volume.

Objective 2: Successfully manage inpatient capacity/ bed utilization on both campuses to ensure timely availability of beds to accommodate volume growth.

> *Results:* Continued investment in our facility enabled us to open 30 additional licensed med/surg beds on Farr 11, and improvements in bed-turnaround times enabled us to reduce the average wait in the ED from 4.5 to 2.5 hours for bed assignment. Elective orthopedic surgical cases were moved from West to East Campus OR enabling a better overall utilization of ORs and beds on the two campuses. The move of more than 100 administrative personnel from 109 Brookline to the Renaissance Center allowed for the planned FY06 move of administrative personnel from the main campus to 109 Brookline which in turn will allow utilization of main campus space for growth in clinical activity.

Objective 3: Achieve appropriate staffing through all patient care and support areas to ensure sufficient resources for volume growth.

> *Results:* While more than 300 new FTE's were approved to manage the clinical growth and improve our service performance, the average FTE/adjusted occupied bed remained relatively unchanged from the prior year (5.4 vs. 5.3) and well below the pre-2002 level of 6.0.

Objective 4: Enhance throughput by focusing on the full range of discharge processes and by exploring all opportunities to appropriately manage length of stay.

> *Result:* Length of stay was on-budget and only 0.1 day longer than the prior year despite significant growth in CMI, a measure of the acuity and complexity of the patient population. Discharge placement of patients needing subacute or rehabilitation care continues to be a challenge.

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Objective 5: Continue focus on tightly managing non-labor expenses through supply chain and clinical resource utilization efforts.

> *Result:* Continuing initiatives to standardize supplies, eliminate waste, utilize clinical practice guidelines and review all new technologies and pharmaceuticals for "need" enabled us to blunt the rapid growth in supply costs. Though these costs grew faster than our targeted strategic goal, there were important savings realized through these initiatives.

Objective 6: For our research efforts, increase the dollar density of IDC/sq ft by 8% over FY04.

> *Result:* IDC in FY05 was $2.6 million higher than the prior year, though $1.5 million below budget. Since no new research space was added, the dollar density increased by 6% over FY04.

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Goal 1: Achieve the highest level of health care quality and patient safety.

FY 05 was an innovative and productive year for the quality/safety programs at BIDMC.

The year began with a successful JCAHO visit following months of preparation. While onerous in some regards, the impending visit allowed major improvements in many areas where change had been difficult to implement in the past. Improvements in medical record legibility, elimination of confusing abbreviations, 100% compliance with utilizing two independent patient identifiers and marking side/site prior to surgery, and observing the write down/read back method for verbal results were adopted across the Medical Center and enabled us to score 100% on the seven National Patient Safety Standards. Similar focus on eliminating outdated supplies and medications and clearing our hallways, stairways, and store rooms enabled us to achieve a perfect score on the overall survey, a rare accomplishment for academic medical centers. The ongoing efforts of Health Care Quality, nursing, support staff, and the medical staff leadership are enabling us to 'hold the gains' through random, unannounced mock surveys and continued focus on 'best practices'.

Ongoing programs like Executive Walk Rounds and expansion of the analysis of adverse events to include the Medical Executive Committee continued to strengthen the culture of safety at the Medical Center. New methodologies for categorizing adverse events at the QI Directors and at the PCAC Sub-Committees enhanced our ability to understand issues and events that crossed departmental lines, and a new software application for incident reports, patient complaints, and adverse events will further enhance our ability to understand and react to quality and safety issues.

Patient safety and health care quality efforts were focused on a number of indicators that have begun to be posted on Web sites by CMS/JCAHO and the Commonwealth, and thus, accessible to the public. While the methodology for determining many of these measures remains controversial, the goal has been to achieve "best in class" status on all of them. To that end, working groups were developed around multidisciplinary measures such as blood stream infections and antibiotic administration to pneumonia patients. By year end, significant progress had been made in key areas. (Figures 1, 2) For example, the rate of administration of pneumococcal vaccine to eligible patients had increased from <10% in Q1 to >80% by Q3. Similarly, the rate of PCI administration within 2 hours of admission had doubled. These measures were added to the 24 measures already being tracked monthly or quarterly on our PCAC Dashboard and will enable the dashboard to be modified for the future to address this rapidly developing 'consumer' involvement in health care quality. (Figure 3)

Team training continued to be expanded to additional areas of the Medical Center including perioperative services and the Department of Medicine, and the Trigger Program was piloted on several inpatient units. The Trigger Program uses defined changes in vital signs and the nurse's impression of the patient's status to "trigger" a call to bring medical and nursing assessment to the bedside and inform the attending physician of a change in a patient's status.
Utilizing the prescribed response to a "trigger" resulted in improved ability to identify unstable patients and intervene in a timely manner to transfer them to an ICU or correct their medical or surgical problem. The Trigger Program has now been implemented throughout the Medical Center as a major patient safety/health care quality initiative.

In another major effort to improve quality of care, construction has begun on a 5000 square foot Simulation Center on the ground floor of the Shapiro Building. This facility which will open in Spring, 2006, will enable medical students, residents, attending physicians, and teams of caregivers to train in simulated settings including an Operating Room and an Intensive Care Unit bedspace as well as to learn surgical techniques in a fully-equipped Skills Lab.

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The American College of Surgery is site-visiting the facility this Fall as part of our effort to become the first ACS simulation-accredited site in New England.

In another accreditation area, the Accreditation Council of Graduate Medical Education site visited BIDMC in January, 2005 and approved a four year accreditation. This institutional approval was significant in that the ACGME gave us 13 commendations and identified several of our approaches as 'best practices', to be communicated nationally to other centers. The institutional approval is a requirement for all of our residency and fellowship programs to be accredited and an important indicator of the strength of our educational offerings.

Progress was made around patient safety in our extensive clinical trails program with the implementation of software that will enroll patients who are in trials and track their experience and outcomes.
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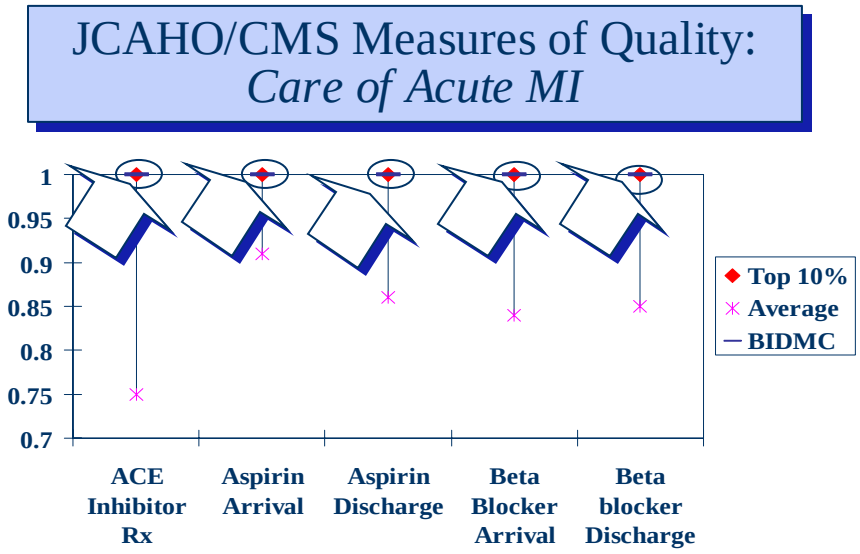
Goal 1: Figure 1



FY'05Q4 to date: All measures reach top 10% performance

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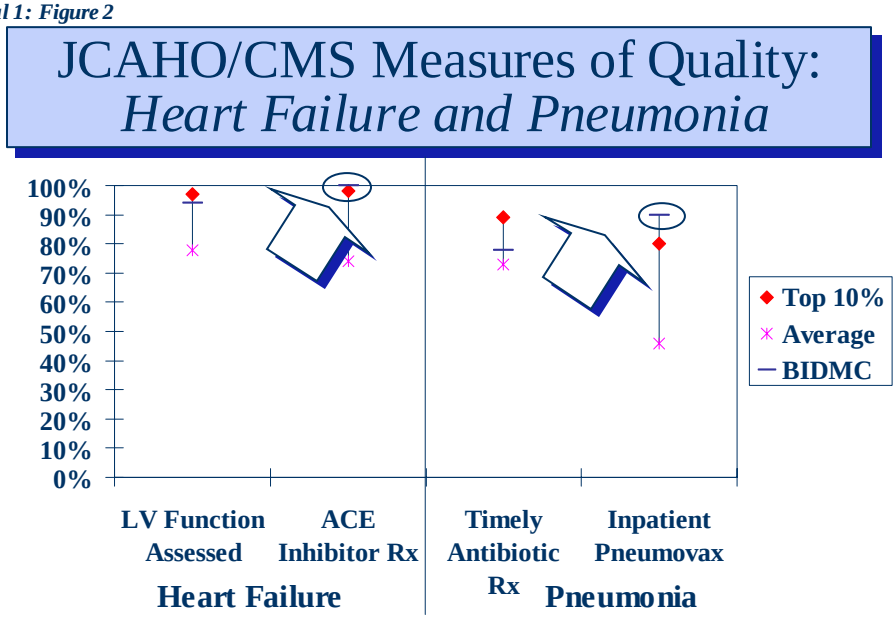
Goal 1: Figure 2



FY'05Q4 to date: 2 measures reach top 10% performance

Goal 1: Figure 3

DEPARTMENT	NEW DATA	MEASURE	Comparison Rate				FY 2005			External Comparison	Prior Quarter Comparison
			External Best Practice	External Comparison	Internal FY03	Internal FY04	1st	2nd	3rd		
Anesthesia	☑	Surgical Inpatients: ASA Class 4 - Any Mortality within 2 Days of Surgery	0.6%	1.4%	2.0%	2.4%	0.3%	1.5%	1.2%		
Surgery		Coronary Artery Bypass Graft Patients - Mortality Rate		2.1%	1.5%	1.0%	0.5%		*		
Neonatology		Neonatal Mortality: Actual vs. Predicted		1.0	1.1	0.60	**	**	**		
Surgery	☑	Unplanned Return to the OR	0.7%	1.5%		1.7%	2.1%	2.3%	3.5%	to be discussed in presentation at PCAC	
Medicine	☑	Heart Failure (CMS/JCAHO Core): ACEI Prescribing Rate for HF Patients w/ Documented EF<= 40%	100%	75%	84%	88%	84%	91%	99%		
Medicine		AMI (JCAHO Core): Door to Ballon % Receiving PCI ≤ 120 minutes		61%			64%		*		
Medicine	☑	AMI (JCAHO Core): Mortality		10.3%			5.1%	6.9%	6.6%		
Emergency Medicine	☑	Community Acquired Pneumonia (CMS/JCAHO Core):Antibiotic Administration Within 4 Hours of Arrival	89%	74%			75%	62%	89%		
Medicine	☑	Community Acquired Pneumonia (CMS/JCAHO Core): Pneumococcal Vaccination	80%	46%			2.7%	77%	82%		
Patient Care Services	☑	Hospital - Acquired Decubitus Ulcers		2.2%	2.1%	1.9%	1.7%	2.4%	2.0%		
Infection Control	☑	Hospital - Acquired Bloodstream Infection Rate (per 1000 Patient Days)		2.25	2.20	2.25	1.33	2.35	2.34		
Risk Management / HCQ	☑	Filed Reports to the Massachusetts Department of Public Health			17	10	2	1	5		
Case Management	☑	Delays: Total			4.9%	4.20%	3.5%	3.7%	3.2%		
	☑	Clinical			2.3%	1.8%	2.2%	1.2%	1.2%		
	☑	Discharge			2.6%	2.4%	1.3%	2.5%	2.0%		
Emergency Medicine	☑	Registered Patient Time in the ED > 6 Hours			35.6%	38.2%	40.0%	42.3%	34.4%		
Patient Care Services	☑	Patient Satisfaction: Likelihood to Recommend (% Excellent)		55%	65%	68%	66.4%	68.1%	71.0%		
Ambulatory Surgery	☑	Patient Satisfaction: Likelihood to Recommend (% Excellent)		63%	71%	75%	76.0%	70.3%	74.0%		

	Favorable Comparison
* *Semi-annual Reporting*	Unfavorable Comparison 0 - 2 SD from mean
** *Data Not Yet Available*	Unfavorable Comparison 2+ SD from

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Goal #2: Achieve and sustain the highest satisfaction level and loyalty among our three core constituents (patients and their families, employees, and physicians) to ensure that BIDMC is their provider or employer of choice.

We continue to utilize extensive surveys to measure "how are we doing?" PRC is a national survey firm whose product is utilized in several hundred hospitals nationally providing a proven technique as well as a data base for comparison. We have used their inpatient survey for six years, and in 2005, we began to use their products for ambulatory and Emergency Department surveys as well.

On the inpatient front, we continued to experience steady improvement in our key measure of patient satisfaction, the percent of discharged inpatients responding "Excellent" when asked about their willingness to recommend BIDMC to friends and family. While hospitals using the PRC survey nationally demonstrate a 90th percentile performance at 66%, BIDMC finished FY 05 with a 68.3% record. We achieved our highest total ever in the third quarter at 71.3%, placing us in the 94th percentile of PRC's hospitals. (Figure 1) The ambulatory and ED surveys while strong,were not quite as positive, providing good baseline data for customer improvement activity in the coming year. (Figure 2)

Multiple initiatives were undertaken to improve our patients' experiences at the Medical Center. Public spaces including the Feldberg Lobby were remodeled and refurnished, and a number of inpatient units in Farr and West Clinical Center were redone as well. A new 'Room Service' program to provide patients with hot meals of their choice within 45 minutes of ordering was piloted successfully and will be implemented hospital wide in early FY 06. Many employees took advantage of new off site parking at Landmark to open more parking for visitors and patients on campus. Finally, a major training program in customer service was launched in key ambulatory areas (ED) and in our HCA phone bank to further enhance patient experience. These initiatives are begin broadened to include all ambulatory areas in 06.

One key to service is to hire and retain an outstanding workforce. In 2005, more than 2500 individuals were hired by the Medical Center, including 369 RN's. This reduced our nurse vacancy rate to 2% by year's end, compared to 6.4% across the Commonwealth.

Another key to workforce adequacy is retention. A new training program for managers in interviewing and hiring skills may have been influential in improving our 90 day retention rate from 83 to 90%. An emphasis on hiring individuals from under-represented minority groups resulted in 23% of new director, supervisor, or manager hires being individuals of color. (Figure 3)

Surveys will be an important part of improving service to and satisfaction of two additional key groups at the Medical Center—physicians and research investigators. A referring physician survey was administered via telephone to 250 referring physicians, and their responses will help us identify barriers to expanding our referrals. In addition, a survey has been finalized and will be administered to our principal research investigators querying them on our performance in 10 key areas (e.g. hiring, financial reports, purchasing, etc) and helping us identify ways to improve their experience at BIDMC.

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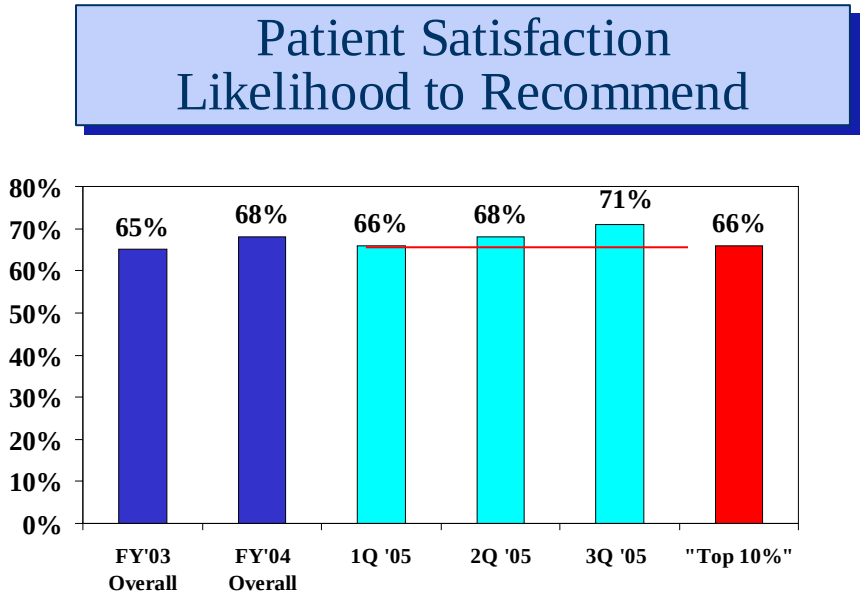
Goal 2: Figure 1



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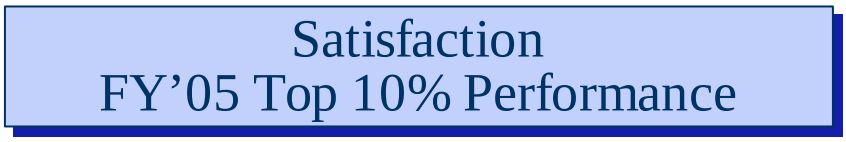
Goal 2: Figure 2



Inpatient Units

- Overall Nursing Care
- Nurses' Instructions
- Overall Safety in Hospital
- Overall Teamwork
- Overall Quality of Care
- Likelihood to Recommend

Ambulatory Surgery

- MD Communication / Understanding
- Nurse's Prompt Response to Calls
- Overall Doctor Care
- Overall Safety in Hospital
- Overall Teamwork
- Overall Quality of Care
- Likelihood to Recommend

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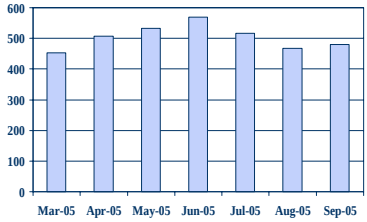
Goal 2: Figure 3

HR Scorecard: Metrics
October, 2005

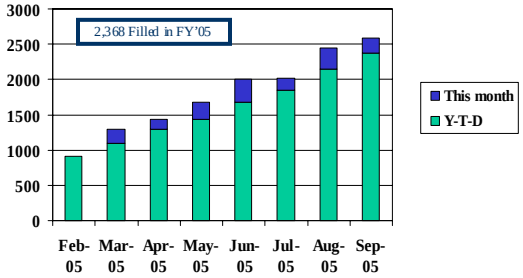
HIRING STATISTICS

Vacancies per month:



NOTE:
>560 vacancies
As of 10/24

Requisitions filled:



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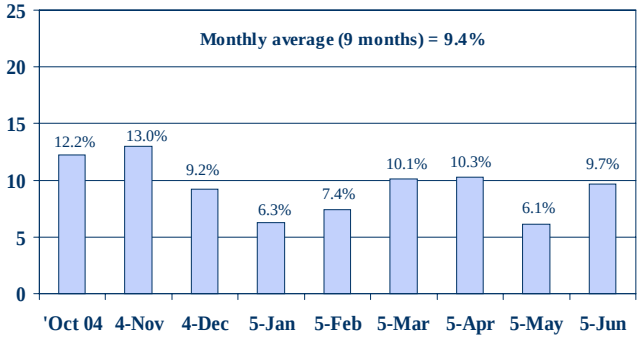
Goal 2: Figure 4

HR Scorecard: Metrics
October, 2005

TURNOVER STATISTICS

90-Day Turnover*:



Total Turnover FY'05 = 15.3%**

Voluntary Turnover = 11.3%

-* Excludes temps, students
-** Excludes temps, students, J.A.s, GME, non-paids

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Goal 3: Achieve a 2% operating margin or $19.5 million operating gain.

The Medical Center's operating margin goal of 2% or $19.5 million for FY05 was set by the Strategic Plan adopted by the Board of Directors in November, 2003. The year-end unaudited consolidated gain from operations totaled $33.7 million, or $14.2 million better than budget. When realized investment gains of $6.7 million are included, the bottom line gain for the year totaled $40.4 million or $20.9 million better than budget. (Table 1)

This performance is the net result of many different components, some of which performed better than budget and some worse. (Table 2, 3) On the Medical Center baseline operations front, the actual Net Patient Services Revenue total was nearly identical to the budgeted $739.5 million before adjustment for outdated accounts. The NPSR total was realized because of a strong performance in ambulatory activity and a better than anticipated growth in our case mix index, the measure of acuity of our inpatient population. These trends were in keeping with the goals of our strategic plan. In contrast, our inpatient discharge total was approximately 1% less than budgeted and only marginally greater than last year. Bright spots were the growth in orthopedic surgery and in the high case mix divisions in Medicine (e.g. hematology/oncology and gastroenterology). While surgery continued to add volume compared to last year, unanticipated departures of personnel in neurosurgery and colo-rectal surgery led to a shortfall from the budgeted target. The double digit growth in ambulatory visits, however, proved to be a major lift to NPSR and continued the multi-year trend of outpatient growth. (Figures 1-7)

In other areas, the revenue from Indirect Cost recovery from research activities showed a 5.1% increase over FY 04, but fell $1.5 million short of the budgeted target. Similarly, donations which were very strong overall, had a $2.9 million shortfall from the budget for unrestricted gifts, the portion of philanthropy that contributes to the Medical Center's operating revenue. On the expense side, fringe benefits costs were below budget while salaries and supplies exceeded budget by less than 1%. A major savings on the expense side was a lower than anticipated depreciation expense due to the preponderance of capital spending coming during the latter part of the year.

An important contributor to the Medical Center's bottom line was the realization of $19.5 million in prior year settlements, approximately $13.9 million more than had been anticipated in the budget. When combined with the baseline operations for the Medical Center, the $800,000 loss at BID-Needham, the $3.6 million loss at APG, and the $6.7 million investment gain, the bottom line totaled $40.4 million, $4.1 million better than last year and well ahead of the 2% operating margin target.

Unrestricted cash and investments increased by $51.0 million during FY05, due both to the positive operating performance as well as to more than $18 million in net proceeds from the sale of property to the developer of the Center for Life Science. As a result, days cash on hand increased from 122.4 days to 133.0 days at September 30, 2005. Unrestricted net assets increased by $57.1 million during the year, to total $285.6 million at year end. As a result, the Medical Center's debt-to-capitalization ratio decreased from 67.9% to 62.5% during the year. Days in accounts receivable decreased slightly to less than 51 days. (Table 4)

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Goal 3: Table 1

Fiscal Year 2005
Results From Operations

$18.6M Gain From Current Hospital Operations
$0.7M better than budget

$33.7M Consolidated Gain From Operations
$14.2M better than budget

$40.4M "Bottom-Line" Gain
$20.9M better than budget

$57.1M Increase in Unrestricted Net Assets

$51.0M Increase in Cash and Investments
(Includes $18.9M net proceeds on sale of land
and $5.0M loan to CareGroup)

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Goal 3: Table 2

Fiscal Year 2005 Results
(Millions)

	Actual	Budget	Variance
Baseline Gain	$ 6.0	$ 3.7	$ 2.3
Prior Year Favorable Settlements	14.5	0.6	13.9
Bad Debt Allowance Reduction	2.0	4.0	(2.0)
Third-party Reserve Reduction	5.0	5.0	-
Amortization of Real Estate Gain	6.2	6.2	-
Consolidated Gain from Operations	$ 33.7	$ 19.5	$ 14.2

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Goal 3: Table 3

Components of Budget Variance Fiscal Year 2005 Results
(Millions)

Net Favorable Variances	
Prior Year Revenue	$ 13.9
Uncompensated Care Costs	9.0
Depreciation	7.1
Investment Income	3.6
APG Operations	0.9
Net Unfavorable Variances	
Net Patient Service Revenue	(7.6)
Research Activity	(3.1)
Unrestricted Contributions	(2.9)
Other Operating Expense	(2.6)
Interest Expense	(1.4)
Other Operating Income	(1.4)
Needham Operations	(1.3)
Year to Date Budget Variance	$ 14.2

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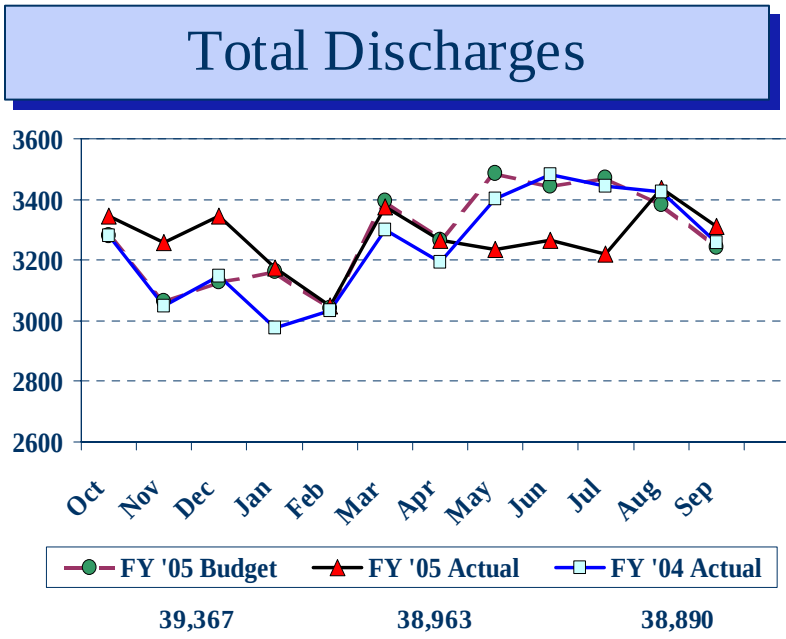
Goal 3: Figure 1



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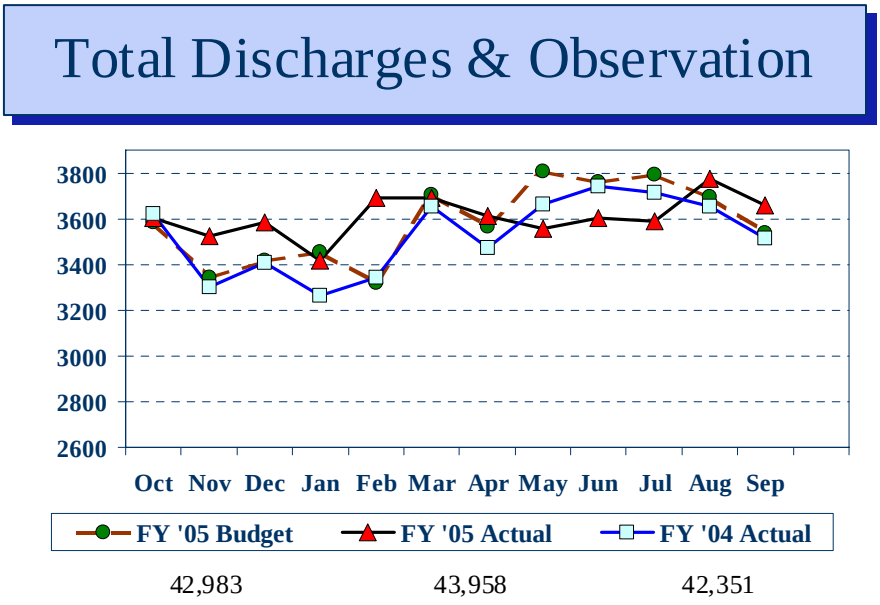
Goal 3: Figure 2



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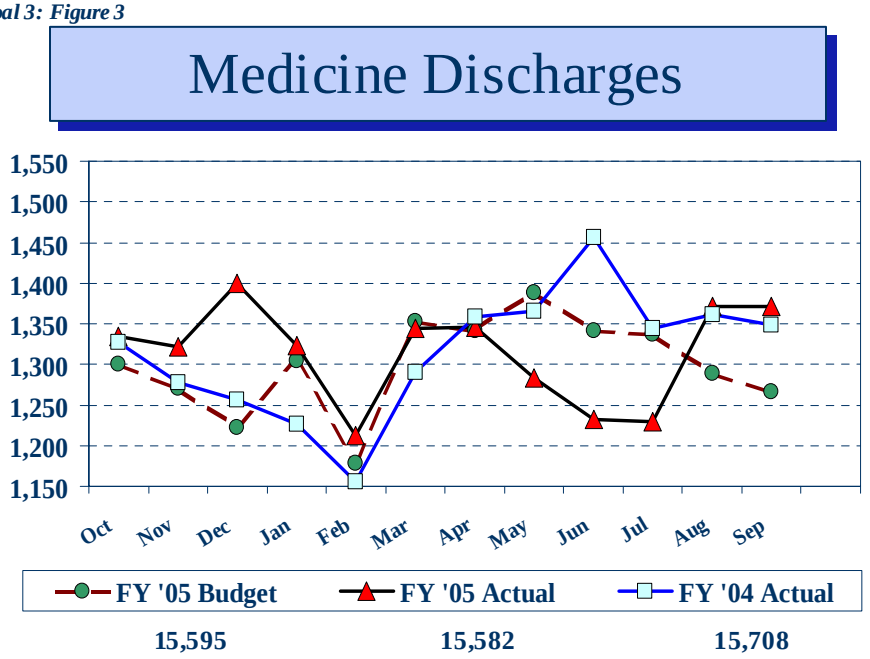
Goal 3: Figure 3



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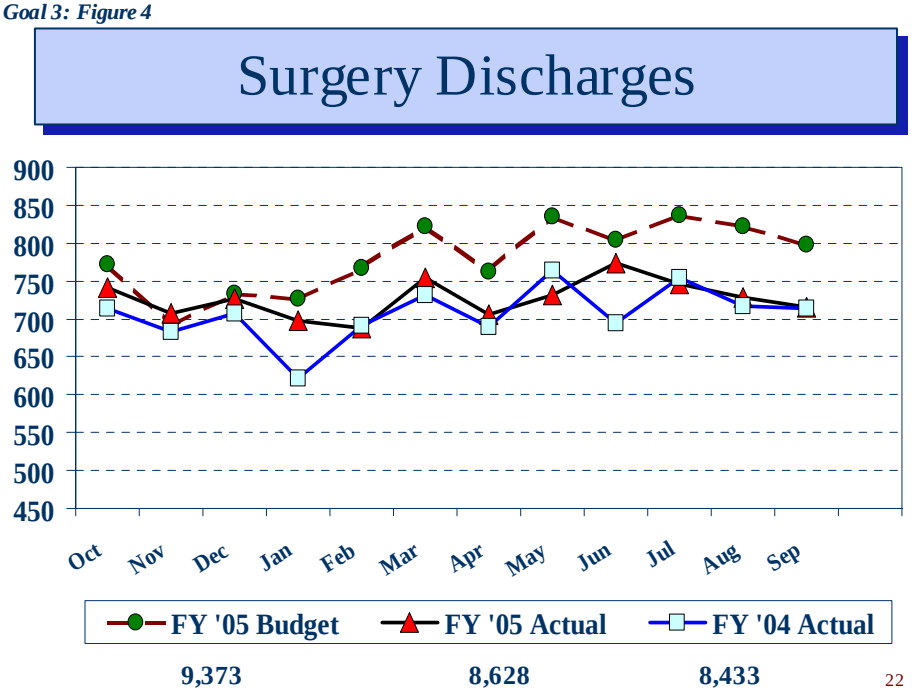
Goal 3: Figure 4



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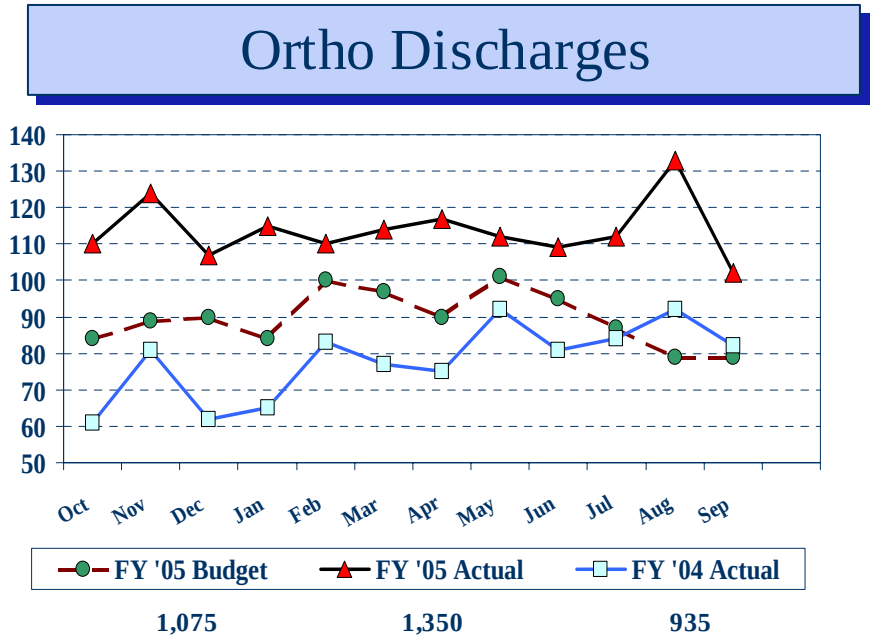
Goal 3: Figure 5



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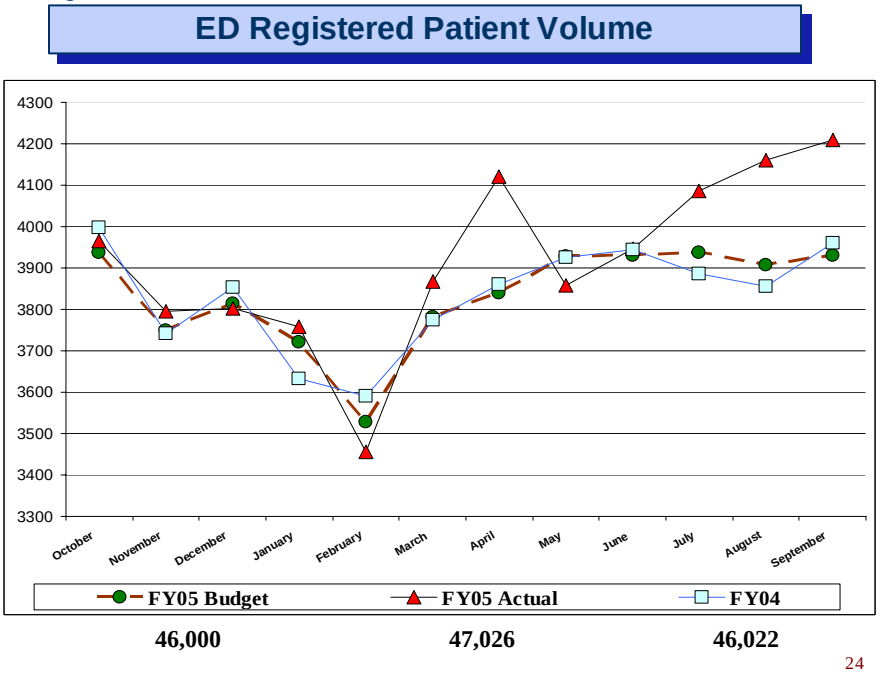
Goal 3: Figure 6



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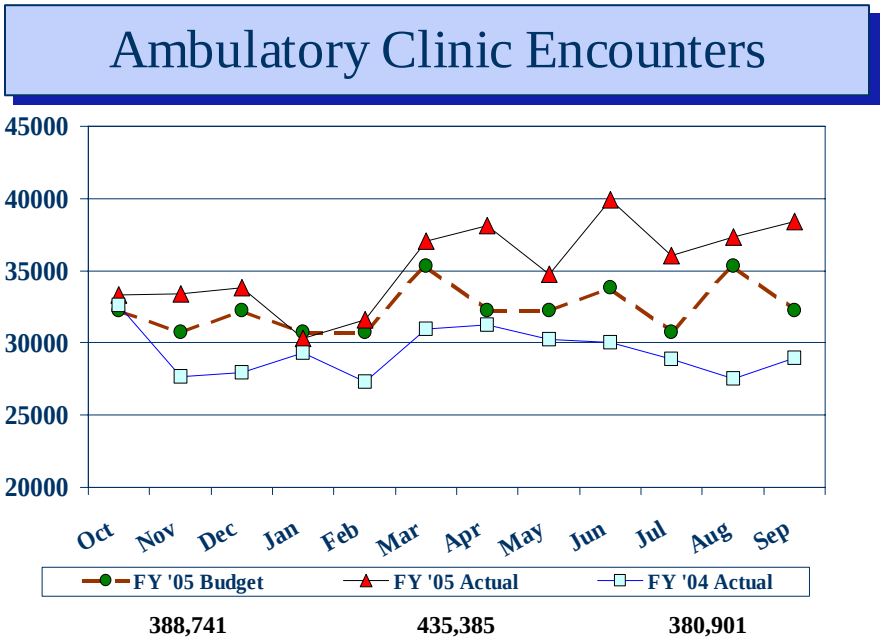
Goal 3: Figure 7



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Goal 3: Table 4

Primary Elements of Cash Flow
Fiscal Year 2005
(Millions)

Increase in Unrestricted Net Assets	$	57.1
Less: Non-cash components		(15.5)
Cash generated by Operations		41.6
Sources of Cash		
Sale of property		18.7
Timing of net capital expenditures		3.6
Release of workers comp bond		3.2
Uses of Cash		
Funding of debt service		(8.2)
Investment in long-term asset		(6.0)
Decrease in accounts payable and accrued expenses		(2.0)
Other factors		0.1
Increase in Cash and Investments	$	51.0

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November 9, 2005

Dear Colleagues:

I am pleased to provide you with this summary of our performance in carrying out the Annual Operating Plan for FY 2005.

This is the third consecutive year that I have had the opportunity to report on the annual performance, and while each year has had its own unique challenges and circumstances, the common element in all three years has been our ability to take pride in a "year well done."

An Annual Operating Plan's value lies in providing two elements to our governing Board, to our medical and administrative leadership, and to the medical staff and employees. First, the AOP provides a framework for keeping the elements of our mission in the appropriate balance and relationship to each other and to the outside world. A Plan that focused exclusively or even primarily on the financial measures would run the risk of neglecting quality, safety, or customer satisfaction. Instead, our three goals weight each of these elements in the proper proportion for achieving our overall mission. Second, the AOP provides a roadmap. The specific objectives and the metrics for measuring performance for each one provide the Board a means to hold leadership accountable and for leadership to organize our daily and weekly work.

This year's summary highlights an exciting and productive year in which innovative health care quality and patient safety initiatives led to approval by outside regulatory bodies such as the JCAHO and ACGME as well as to "best in class" performance on national measures. It was also a year in which patient satisfaction reached new levels enabling us to rank in the top 10% in institutions utilizing the PRC surveys. Finally, it was a year in which we managed the usual series of unpredictable bumps in the road and steered our way to a second consecutive positive bottom line which exceeded the Strategic Plan's target for an operating gain of 2%.

None of this would have been possible without the hard work and dedication demonstrated by the physicians, nurses, other professionals, and employees at the Medical Center. You should all take pride in these accomplishments as well as in the impact you have had on individual patients and their families, on students and trainees, and on future patients, students, and colleagues who will benefit from the new knowledge generated in our laboratories and bedside clinical trials.

My sincerest thanks to all of you.

Sincerely yours,
Michael F. Epstein, MD

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Annual Operating Goals/Fiscal Year 2005
Summary of Performance

Introduction: For FY05, our operating plan focuses on three main levers --- Healthcare Quality and Patient Safety, Customer Satisfaction and Financial Margin. Achieving our specific objectives in these three areas will be necessary to accomplish the goals set out in the strategic plan and enable the Medical Center to successfully carry out its missions in clinical care, research, education, and community service. To that end, we have expanded the traditional scope of our annual plan to include specific objectives that relate to our important education and research missions.

Goal 1: Achieve the highest level of health care quality and patient safety.

In order to accomplish this goal we will:

Objective 1: Promote patient care safety by implementing specific institutional initiatives to create and support a
culture of safety.

Results: Major FY05 initiatives focused on:

1) Designing, piloting, and implementing the Trigger Program for early identification of unstable patients on med/surg units;

2) A multidisciplinary approach to reducing the incidence of bloodstream infections from central venous catheters;

3) Implementation of a new Patient Safety Reporting System to improve the collection of incident reports/patient complaints and analyze them across the Medical Center;

4) Team training for nurses, physicians, and support staff in perioperative services;

5) A focus on transitions in care for communicating between providers in the ED and the perioperative areas;

6) Pathology project that improved the labeling of specimens resulting in a reduction in "incompletely labeled specimens" from 13% to <1%;

7) Implementation of a new badging system and access management to reduce the risk to mothers and babies in postpartum settings; and

8) Establishment of BIDMC as the first "smoke free" hospital in Boston.

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Objective 2: Set and monitor appropriate institutional measures of clinical quality (dashboard) and regularly report on performance to BIDMC physicians, managers, and the governing Board.

Results: Our focus was on developing and coordinating an internal dashboard to include the quality measures listed on public Web sites, e.g. CMS, JCAHO, Leapfrog. We demonstrated substantial improvement in these areas to achieve "top 10%" status in key measures, including

administering antibiotics to patients with pneumonia within four hours of admission to the ED and giving Pneumovax vaccine prior to discharge.

Objective 3: Jointly develop, implement, and monitor evidence-based clinical care guidelines in key clinical areas to reduce variation, improve quality and improve efficiency.

Results: Guidelines were developed and implemented in a variety of disease management settings including prophylactic administration of antibiotics in the perioperative setting, use of intravenous contrast in patients with renal disease, use of Natrecor in congestive heart failure, use of anti-emetics in oncology patients, and the prevention of blood clots in orthopedic patients. In each case, the guidelines resulted in improved performance in the delivery of the right care at the right time and the elimination of unnecessary care and cost.

Objective 4: Ensure ongoing JCAHO and other regulatory/emergency preparedness.

Results: The JCAHO visit in November 2005 was very successful with the Medical Center achieving a perfect score on the National Patient Safety Goals as well as the 500 standards under which we were evaluated. Ongoing efforts to 'hold the gains' are underway with unannounced 'JCAHO-like site visits' to inpatient, ambulatory, and ED sites on a regular basis. Emergency preparedness continued to improve with successful participation in city and state-wide drills as well as updated guidelines for influenza preparation. A computerized maintenance management system was implemented to ensure completion of preventive maintenance work in a timely and thorough manner.

Objective 5: The Center for Education will achieve full accreditation for BIDMC's GME program.

Result: The ACGME granted the Medical Center a full accreditation for the next four years based on a site visit in January,2005. The BIDMC was cited for 13 specific commendations including innovations in mentoring, IS, research opportunities, and administrative support.

Objective 6: Develop a plan and budget for a simulation center for the education and training of doctors, nurses, students, and other healthcare professionals as recommended in the Education Strategic Plan.

Result: The Simulation Center Plan was approved and funded, and construction has begun on this 5,000 square foot space that will house mockups of an OR and an ICU bedspace, as well as a Skills Lab on the ground floor of the Shapiro Building. The Center will open in Spring, 2006.

Objective 7: Develop a research clinical trial database and other tools to register and track patients enrolled in clinical trials.

Results: The software application for enrolling clinical trial patients, tracking their experience, and creating a database for operations improvement has been completed and will be implemented in FY06. Additionally, a budget management database was implemented to enhance Research Administration's ability to track expenses for operations and capital equipment.

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Goal 2: Achieve and sustain the highest satisfaction level and loyalty among our three core constituents to ensure that BIDMC is their provider or employer of choice. Our three core constituents are:

- Patients and their families in the outpatient and inpatient setting,
- Employees, and
- Physicians – including the BIDMC medical staff and referring physicians

To accomplish this goal, we must:

Objective 1: Achieve a high level of "customer" inpatient and outpatient satisfaction for patients and their families as well as in our relationship with our broader urban community.

> *Results:* The PRC telephone survey of discharged inpatients achieved the highest scores since its introduction in 2001, and the survey was expanded in FY05 to include ambulatory and ED patients as well, providing baseline numbers for improvement in FY06. In addition, public and patient care spaces were significantly improved, including the Feldberg Lobby and several Farr inpatient units. A new patient meal service program designed around 'room service' is ready for implementation in early FY06 and should result in a higher level of patient satisfaction. Finally, more patient parking on campus was 'created' by moving employees (including the CEO and COO) to off-campus parking sites.

Objective 2: Expand the service quality training initiative to support achievement of customer satisfaction goals.

> *Results:* Major customer service training programs were implemented for front desk staff in the ED and in the HCA phone bank. Before and after survey results suggest significant improvement in customer satisfaction in these settings.

Objective 3: Recruit, develop and retain exceptional talent with a focus on diversifying our workforce.

> *Results:* There were 2,500 new hires in FY05, including 369 RNs, reducing the RN vacancy rate to 2% by the end of FY05. Retention rates for the first 90 days improved from 83.4% to 90.3%. Among the new hires in management (supervisor, manager, director), 22.8% were from under-represented minority groups.

Objective 4: Develop and implement a referring physician survey to measure awareness of BIDMC's priority clinical areas, utilization of services, and to gauge affinity toward BIDMC.

> *Result:* A referring physicians' satisfaction survey to determine the key drivers for this group was administered to 250 physicians, identifying action items to be addressed in FY06. In addition, referring physicians' needs have been addressed through providing Care Web access (electronic medical record), through enhancing our Faculty Speakers program for community hospital grand rounds, and through adding two staff positions within Network Development who work as physician liaisons focused exclusively on physician relations.

Objective 5: Develop an internal survey tool for our principal investigators to determine their satisfaction with research administration and other important research matters.

> *Result:* Research administration has developed a survey focused on 10 separate research areas, including administrative support, financial reports, purchasing, and HR. The survey will be implemented in FY06 in focus groups and through telephone interviews to identify opportunities for providing better service to our investigators.

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Goal 3: Achieve a 2% operating margin or $19.5 million operating gain.

To accomplish this goal, we will:

Objective 1: Achieve overall budgeted growth in inpatient discharges, outpatient encounters, and case mix index (CMI) by partnering with our physicians to develop and grow strategic clinical programs and through implementation of our Network Development plan.

> *Results:* Inpatient plus 'observation' patient volume grew by 1.4% over the prior year and was within 25 patients of the FY05 budgeted total of 42,983 patients. Changes in insurance company procedures led to a shift from inpatient to observation status, but also resulted in having more inpatient beds available for higher case mix patients. Despite the loss of several key surgeons, surgical discharges grew by 2.3%, with strength in cardiac, thoracic, and vascular surgery. With the growth in surgery as well as in key areas in Medicine, including hematology/oncology and gastroenterology, case mix was 4.1% higher than the prior year. Major growth in Orthopedic surgical volume was a bright spot and reflected the first full year of activity for Dr Gebhardt's newly recruited surgeons. Ambulatory activity was very strong with double digit growth in total outpatient visits as well as the second straight year of growth in ED visits. Strengthening of our network with Milton Hospital, Beverly Hospital's cancer program, Nashoba Valley's cardiology and urology services, and the multi-specialty group BGPMA all contributed to the enhanced volume.

Objective 2: Successfully manage inpatient capacity/ bed utilization on both campuses to ensure timely availability of beds to accommodate volume growth.

> *Results:* Continued investment in our facility enabled us to open 30 additional licensed med/surg beds on Farr 11, and improvements in bed-turnaround times enabled us to reduce the average wait in the ED from 4.5 to 2.5 hours for bed assignment. Elective orthopedic surgical cases were moved from West to East Campus OR enabling a better overall utilization of ORs and beds on the two campuses. The move of more than 100 administrative personnel from 109 Brookline to the Renaissance Center allowed for the planned FY06 move of administrative personnel from the main campus to 109 Brookline which in turn will allow utilization of main campus space for growth in clinical activity.

Objective 3: Achieve appropriate staffing through all patient care and support areas to ensure sufficient resources for volume growth.

> *Results:* While more than 300 new FTE's were approved to manage the clinical growth and improve our service performance, the average FTE/adjusted occupied bed remained relatively unchanged from the prior year (5.4 vs. 5.3) and well below the pre-2002 level of 6.0.

Objective 4: Enhance throughput by focusing on the full range of discharge processes and by exploring all opportunities to appropriately manage length of stay.

> *Result:* Length of stay was on-budget and only 0.1 day longer than the prior year despite significant growth in CMI, a measure of the acuity and complexity of the patient population.

Discharge placement of patients needing subacute or rehabilitation care continues to be a challenge.

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Objective 5: Continue focus on tightly managing non-labor expenses through supply chain and clinical resource utilization efforts.

Result: Continuing initiatives to standardize supplies, eliminate waste, utilize clinical practice guidelines and review all new technologies and pharmaceuticals for "need" enabled us to blunt the rapid growth in supply costs. Though these costs grew faster than our targeted strategic goal, there were important savings realized through these initiatives.

Objective 6: For our research efforts, increase the dollar density of IDC/sq ft by 8% over FY04.

Result: IDC in FY05 was $2.6 million higher than the prior year, though $1.5 million below budget. Since no new research space was added, the dollar density increased by 6% over FY04.

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Goal 1: Achieve the highest level of health care quality and patient safety.

FY 05 was an innovative and productive year for the quality/safety programs at BIDMC.

The year began with a successful JCAHO visit following months of preparation. While onerous in some regards, the impending visit allowed major improvements in many areas where change had been difficult to implement in the past. Improvements in medical record legibility, elimination of confusing abbreviations, 100% compliance with utilizing two independent patient identifiers and marking side/site prior to surgery, and observing the write down/read back method for verbal results were adopted across the Medical Center and enabled us to score 100% on the seven National Patient Safety Standards. Similar focus on eliminating outdated supplies and medications and clearing our hallways, stairways, and store rooms enabled us to achieve a perfect score on the overall survey, a rare accomplishment for academic medical centers. The ongoing efforts of Health Care Quality, nursing, support staff, and the medical staff leadership are enabling us to 'hold the gains' through random, unannounced mock surveys and continued focus on 'best practices'.

Ongoing programs like Executive Walk Rounds and expansion of the analysis of adverse events to include the Medical Executive Committee continued to strengthen the culture of safety at the Medical Center. New methodologies for categorizing adverse events at the QI Directors and at the PCAC Sub-Committees enhanced our ability to understand issues and events that crossed departmental lines, and a new software application for incident reports, patient complaints, and adverse events will further enhance our ability to understand and react to quality and safety issues.

Patient safety and health care quality efforts were focused on a number of indicators that have begun to be posted on Web sites by CMS/JCAHO and the Commonwealth, and thus, accessible to the public. While the methodology for determining many of these measures remains controversial, the goal has been to achieve "best in class" status on all of them. To that end, working groups were developed around multidisciplinary measures such as blood stream infections and antibiotic administration to pneumonia patients. By year end, significant progress had been made in key areas. (Figures 1, 2) For example, the rate of administration of pneumococcal vaccine to eligible patients had increased from <10% in Q1 to >80% by Q3. Similarly, the rate of PCI administration within 2 hours of admission had doubled. These measures were added to the 24 measures already being tracked monthly or quarterly on our PCAC Dashboard and will enable the dashboard to be modified for the future to address this rapidly developing 'consumer' involvement in health care quality. (Figure 3)

Team training continued to be expanded to additional areas of the Medical Center including perioperative services and the Department of Medicine, and the Trigger Program was piloted on several inpatient units. The Trigger Program uses defined changes in vital signs and the nurse's impression of the patient's status to "trigger" a call to bring medical and nursing assessment to the bedside and inform the attending physician of a change in a patient's status.
Utilizing the prescribed response to a "trigger" resulted in improved ability to identify unstable patients and intervene in a timely manner to transfer them to an ICU or correct their medical or surgical problem. The Trigger Program has now been implemented throughout the Medical Center as a major patient safety/health care quality initiative.

In another major effort to improve quality of care, construction has begun on a 5000 square foot Simulation Center on the ground floor of the Shapiro Building. This facility which will open in Spring, 2006, will enable medical students, residents, attending physicians, and teams of caregivers to train in simulated settings including an Operating Room and an Intensive Care Unit bedspace as well as to learn surgical techniques in a fully-equipped Skills Lab.
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The American College of Surgery is site-visiting the facility this Fall as part of our effort to become the first ACS simulation-accredited site in New England.

In another accreditation area, the Accreditation Council of Graduate Medical Education site visited BIDMC in January, 2005 and approved a four year accreditation. This institutional approval was significant in that the ACGME gave us 13 commendations and identified several of our approaches as 'best practices', to be communicated nationally to other centers. The institutional approval is a requirement for all of our residency and fellowship programs to be accredited and an important indicator of the strength of our educational offerings.

Progress was made around patient safety in our extensive clinical trails program with the implementation of software that will enroll patients who are in trials and track their experience and outcomes.

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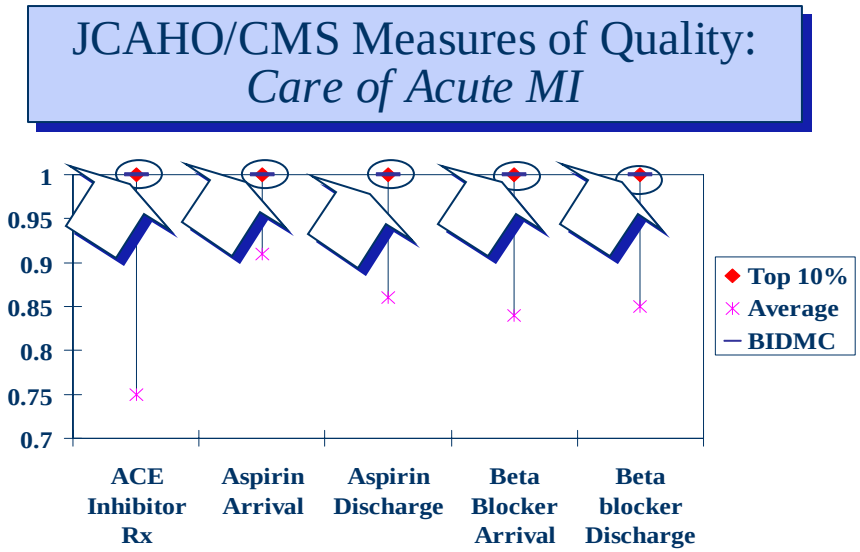
Goal 1: Figure 1



FY'05Q4 to date: All measures reach top 10% performance

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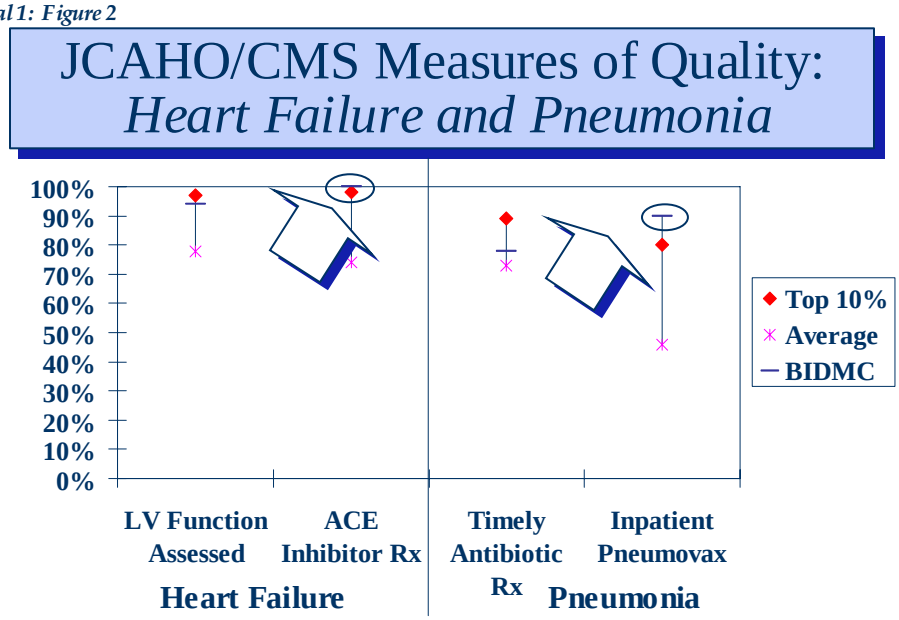
Goal 1: Figure 2



FY'05Q4 to date: 2 measures reach top 10% performance

Goal 1: Figure 3

DEPARTMENT	NEW DATA	MEASURE	Comparison Rate				FY 2005			External Comparison	Prior Quarter Comparison
			External Best Practice	External Comparison	Internal FY03	Internal FY04	1st	2nd	3rd		
Anesthesia	☑	Surgical Inpatients: ASA Class 4 - Any Mortality within 2 Days of Surgery	0.6%	1.4%	2.0%	2.4%	0.3%	1.5%	1.2%		
Surgery		Coronary Artery Bypass Graft Patients - Mortality Rate		2.1%	1.5%	1.0%	0.5%		*		
Neonatology		Neonatal Mortality: Actual vs. Predicted		1.0	1.1	0.60	**	**	**		
Surgery	☑	Unplanned Return to the OR	0.7%	1.5%		1.7%	2.1%	2.3%	3.5%	to be discussed in presentation at PCAC	
Medicine	☑	Heart Failure (CMS/JCAHO Core): ACEI Prescribing Rate for HF Patients w/ Documented EF<= 40%	100%	75%	84%	88%	84%	91%	99%		
Medicine		AMI (JCAHO Core): Door to Ballon % Receiving PCI ≤ 120 minutes		61%			64%		*		
Medicine	☑	AMI (JCAHO Core): Mortality		10.3%			5.1%	6.9%	6.6%		
Emergency Medicine	☑	Community Acquired Pneumonia (CMS/JCAHO Core):Antibiotic Administration Within 4 Hours of Arrival	89%	74%			75%	62%	89%		
Medicine	☑	Community Acquired Pneumonia (CMS/JCAHO Core): Pneumococcal Vaccination	80%	46%			2.7%	77%	82%		
Patient Care Services	☑	Hospital - Acquired Decubitus Ulcers		2.2%	2.1%	1.9%	1.7%	2.4%	2.0%		
Infection Control	☑	Hospital - Acquired Bloodstream Infection Rate (per 1000 Patient Days)		2.25	2.20	2.25	1.33	2.35	2.34		
Risk Management / HCQ	☑	Filed Reports to the Massachusetts Department of Public Health			17	10	2	1	5		
Case Management	☑	Delays: Total			4.9%	4.20%	3.5%	3.7%	3.2%		
	☑	Clinical			2.3%	1.8%	2.2%	1.2%	1.2%		
	☑	Discharge			2.6%	2.4%	1.3%	2.5%	2.0%		
Emergency Medicine	☑	Registered Patient Time in the ED > 6 Hours			35.6%	38.2%	40.0%	42.3%	34.4%		
Patient Care Services	☑	Patient Satisfaction: Likelihood to Recommend (% Excellent)		55%	65%	68%	66.4%	68.1%	71.0%		
Ambulatory Surgery	☑	Patient Satisfaction: Likelihood to Recommend (% Excellent)		63%	71%	75%	76.0%	70.3%	74.0%		

	Favorable Comparison
* *Semi-annual Reporting*	Unfavorable Comparison 0 - 2 SD from mean
** *Data Not Yet Available*	Unfavorable Comparison 2+ SD from

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Goal #2: Achieve and sustain the highest satisfaction level and loyalty among our three core constituents (patients and their families, employees, and physicians) to ensure that BIDMC is their provider or employer of choice.

We continue to utilize extensive surveys to measure "how are we doing?" PRC is a national survey firm whose product is utilized in several hundred hospitals nationally providing a proven technique as well as a data base for comparison. We have used their inpatient survey for six years, and in 2005, we began to use their products for ambulatory and Emergency Department surveys as well.

On the inpatient front, we continued to experience steady improvement in our key measure of patient satisfaction, the percent of discharged inpatients responding "Excellent" when asked about their willingness to recommend BIDMC to friends and family. While hospitals using the PRC survey nationally demonstrate a 90th percentile performance at 66%, BIDMC finished FY 05 with a 68.3% record. We achieved our highest total ever in the third quarter at 71.3%, placing us in the 94th percentile of PRC's hospitals. (Figure 1) The ambulatory and ED surveys while strong, were not quite as positive, providing good baseline data for customer improvement activity in the coming year. (Figure 2)

Multiple initiatives were undertaken to improve our patients' experiences at the Medical Center. Public spaces including the Feldberg Lobby were remodeled and refurnished, and a number of inpatient units in Farr and West Clinical Center were redone as well. A new 'Room Service' program to provide patients with hot meals of their choice within 45 minutes of ordering was piloted successfully and will be implemented hospital wide in early FY 06. Many employees took advantage of new off site parking at Landmark to open more parking for visitors and patients on campus. Finally, a major training program in customer service was launched in key ambulatory areas (ED) and in our HCA phone bank to further enhance patient experience. These initiatives are begin broadened to include all ambulatory areas in 06.

One key to service is to hire and retain an outstanding workforce. In 2005, more than 2500 individuals were hired by the Medical Center, including 369 RN's. This reduced our nurse vacancy rate to 2% by year's end, compared to 6.4% across the Commonwealth.

Another key to workforce adequacy is retention. A new training program for managers in interviewing and hiring skills may have been influential in improving our 90 day retention rate from 83 to 90%. An emphasis on hiring individuals from under-represented minority groups resulted in 23% of new director, supervisor, or manager hires being individuals of color. (Figure 3)

Surveys will be an important part of improving service to and satisfaction of two additional key groups at the Medical Center—physicians and research investigators. A referring physician survey was administered via telephone to 250 referring physicians, and their responses will help us identify barriers to expanding our referrals. In addition, a survey has been finalized and will be administered to our principal research investigators querying them on our performance in 10 key areas (e.g. hiring, financial reports, purchasing, etc) and helping us identify ways to improve their experience at BIDMC.

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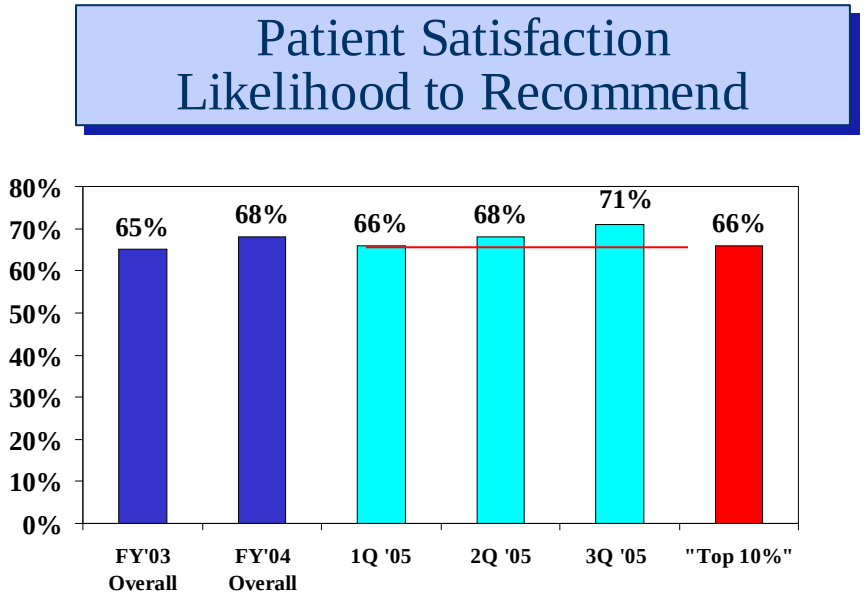
Goal 2: Figure 1



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Goal 2: Figure 2

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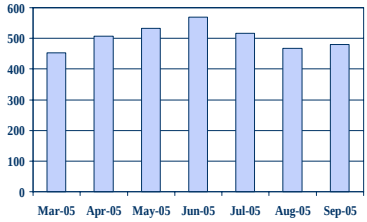
Goal 2: Figure 3

HR Scorecard: Metrics
October, 2005

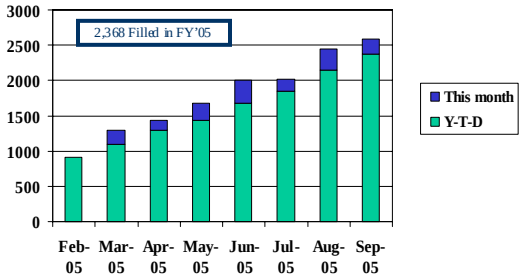
HIRING STATISTICS

Vacancies per month:



NOTE:
>560 vacancies
As of 10/24

Requisitions filled:



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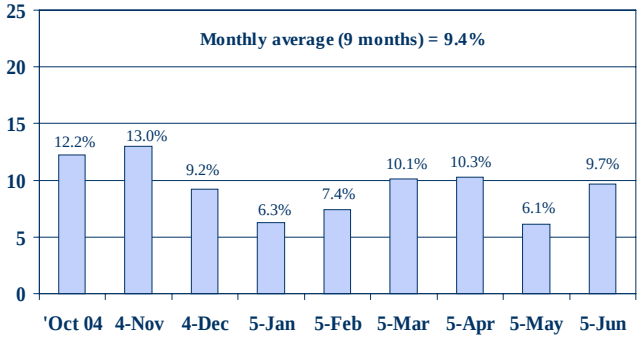
Goal 2: Figure 4

HR Scorecard: Metrics
October, 2005

TURNOVER STATISTICS

90-Day Turnover*:



Total Turnover FY'05 = 15.3%**

Voluntary Turnover = 11.3%

-* Excludes temps, students
-** Excludes temps, students, J.A.s, GME, non-paids

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Goal 3: Achieve a 2% operating margin or $19.5 million operating gain.

The Medical Center's operating margin goal of 2% or $19.5 million for FY05 was set by the Strategic Plan adopted by the Board of Directors in November, 2003. The year-end unaudited consolidated gain from operations totaled $33.7 million, or $14.2 million better than budget. When realized investment gains of $6.7 million are included, the bottom line gain for the year totaled $40.4 million or $20.9 million better than budget. (Table 1)

This performance is the net result of many different components, some of which performed better than budget and some worse. (Table 2, 3) On the Medical Center baseline operations front, the actual Net Patient Services Revenue total was nearly identical to the budgeted $739.5 million before adjustment for outdated accounts. The NPSR total was realized because of a strong performance in ambulatory activity and a better than anticipated growth in our case mix index, the measure of acuity of our inpatient population. These trends were in keeping with the goals of our strategic plan. In contrast, our inpatient discharge total was approximately 1% less than budgeted and only marginally greater than last year. Bright spots were the growth in orthopedic surgery and in the high case mix divisions in Medicine (e.g. hematology/oncology and gastroenterology). While surgery continued to add volume compared to last year, unanticipated departures of personnel in neurosurgery and colo-rectal surgery led to a shortfall from the budgeted target. The double digit growth in ambulatory visits, however, proved to be a major lift to NPSR and continued the multi-year trend of outpatient growth. (Figures 1-7)

In other areas, the revenue from Indirect Cost recovery from research activities showed a 5.1% increase over FY 04, but fell $1.5 million short of the budgeted target. Similarly, donations which were very strong overall, had a $2.9 million shortfall from the budget for unrestricted gifts, the portion of philanthropy that contributes to the Medical Center's operating revenue. On the expense side, fringe benefits costs were below budget while salaries and supplies exceeded budget by less than 1%. A major savings on the expense side was a lower than anticipated depreciation expense due to the preponderance of capital spending coming during the latter part of the year.

An important contributor to the Medical Center's bottom line was the realization of $19.5 million in prior year settlements, approximately $13.9 million more than had been anticipated in the budget. When combined with the baseline operations for the Medical Center, the $800,000 loss at BID-Needham, the $3.6 million loss at APG, and the $6.7 million investment gain, the bottom line totaled $40.4 million, $4.1 million better than last year and well ahead of the 2% operating margin target.

Unrestricted cash and investments increased by $51.0 million during FY05, due both to the positive operating performance as well as to more than $18 million in net proceeds from the sale of property to the developer of the Center for Life Science. As a result, days cash on hand increased from 122.4 days to 133.0 days at September 30, 2005. Unrestricted net assets increased by $57.1 million during the year, to total $285.6 million at year end. As a result, the Medical Center's debt-to-capitalization ratio decreased from 67.9% to 62.5% during the year. Days in accounts receivable decreased slightly to less than 51 days. (Table 4)

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Goal 3: Table 1

Fiscal Year 2005
Results From Operations

$18.6M Gain From Current Hospital Operations
$0.7M better than budget

$33.7M Consolidated Gain From Operations
$14.2M better than budget

$40.4M "Bottom-Line" Gain
$20.9M better than budget

$57.1M Increase in Unrestricted Net Assets

$51.0M Increase in Cash and Investments
(Includes $18.9M net proceeds on sale of land
and $5.0M loan to CareGroup)

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Goal 3: Table 2

Fiscal Year 2005 Results
(Millions)

	Actual	Budget	Variance
Baseline Gain	$ 6.0	$ 3.7	$ 2.3
Prior Year Favorable Settlements	14.5	0.6	13.9
Bad Debt Allowance Reduction	2.0	4.0	(2.0)
Third-party Reserve Reduction	5.0	5.0	-
Amortization of Real Estate Gain	6.2	6.2	-
Consolidated Gain from Operations	$ 33.7	$ 19.5	$ 14.2

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Goal 3: Table 3

Components of Budget Variance Fiscal Year 2005 Results
(Millions)

Net Favorable Variances	
Prior Year Revenue	$ 13.9
Uncompensated Care Costs	9.0
Depreciation	7.1
Investment Income	3.6
APG Operations	0.9
Net Unfavorable Variances	
Net Patient Service Revenue	(7.6)
Research Activity	(3.1)
Unrestricted Contributions	(2.9)
Other Operating Expense	(2.6)
Interest Expense	(1.4)
Other Operating Income	(1.4)
Needham Operations	(1.3)
Year to Date Budget Variance	$ 14.2

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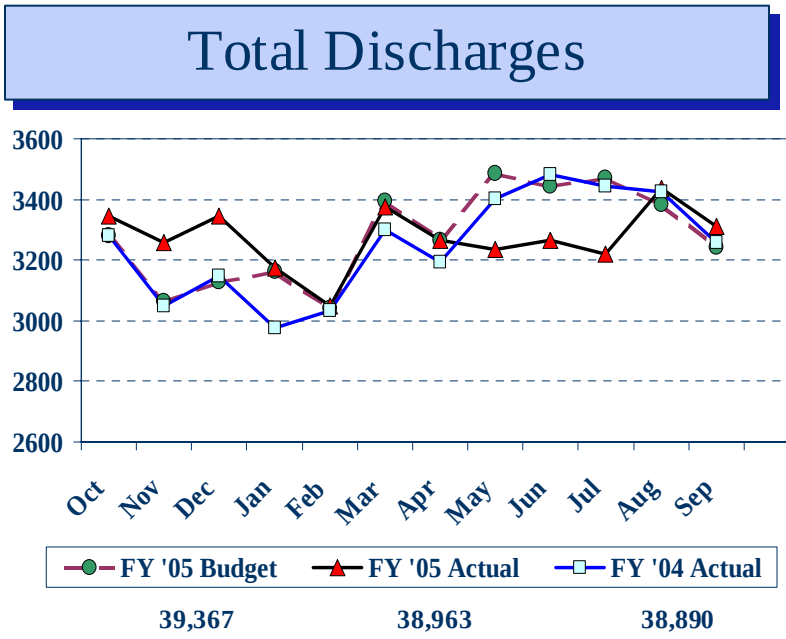
Goal 3: Figure 1



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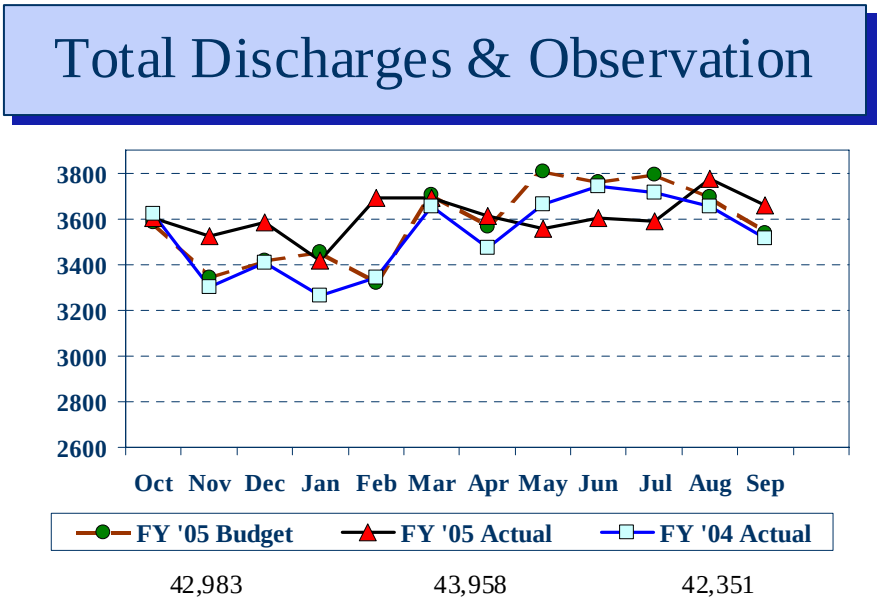
Goal 3: Figure 2



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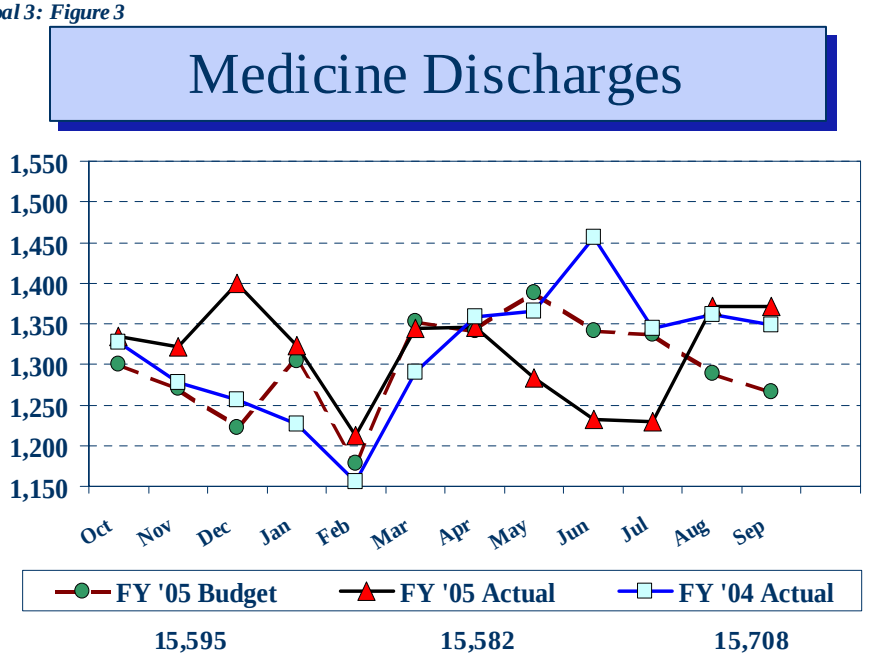
Goal 3: Figure 3



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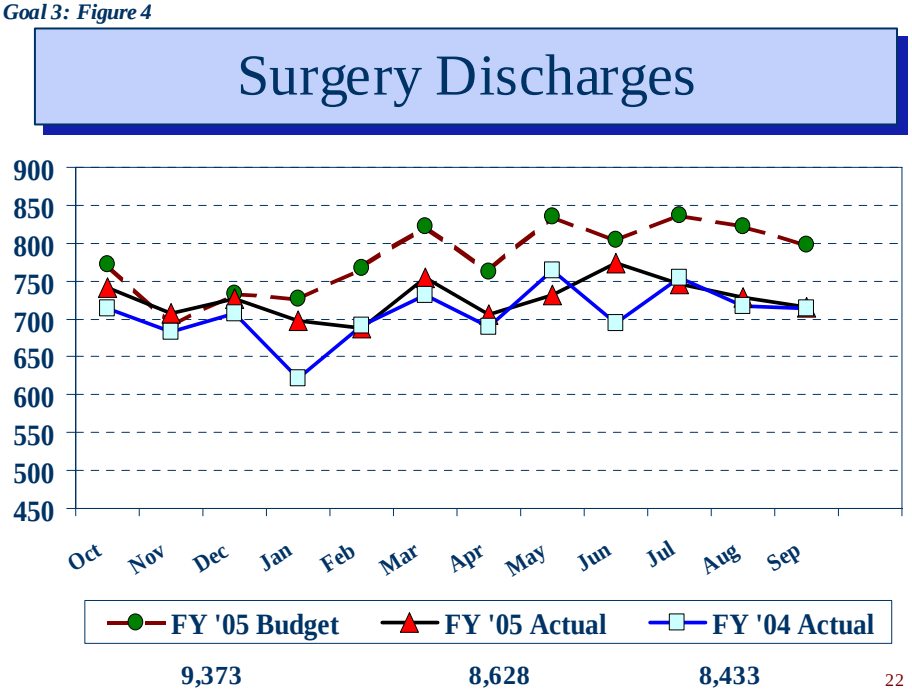
Goal 3: Figure 4



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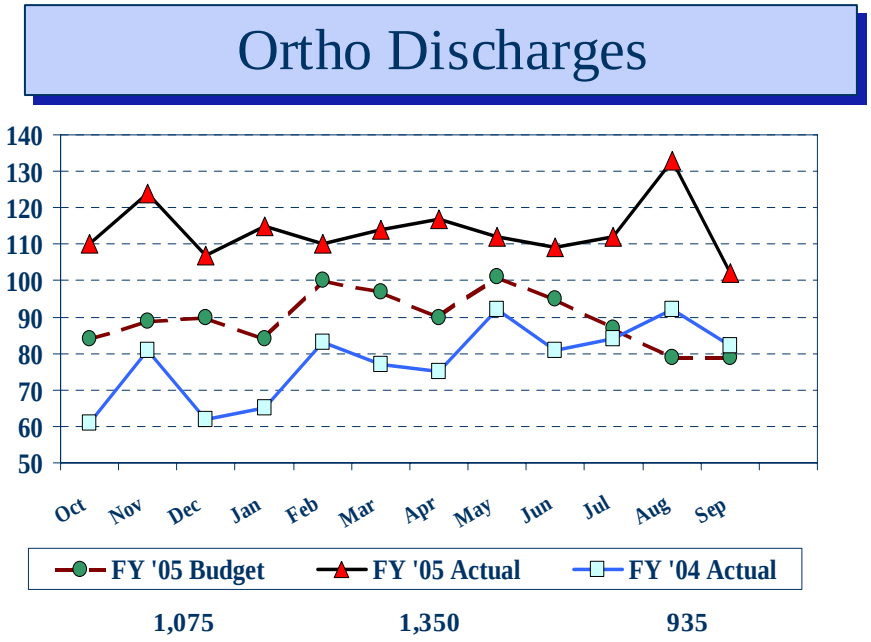
Goal 3: Figure 5



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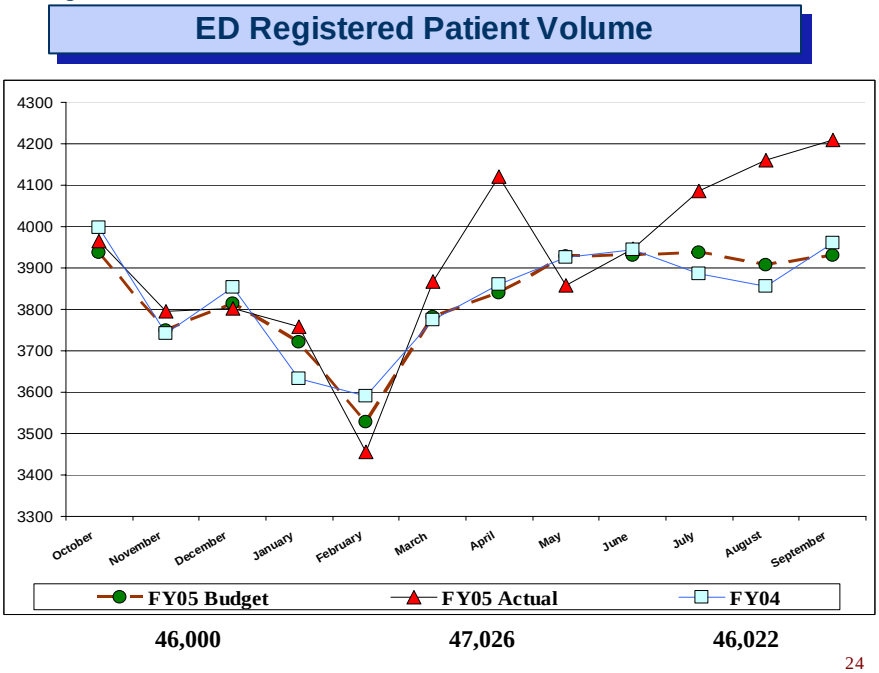
Goal 3: Figure 6



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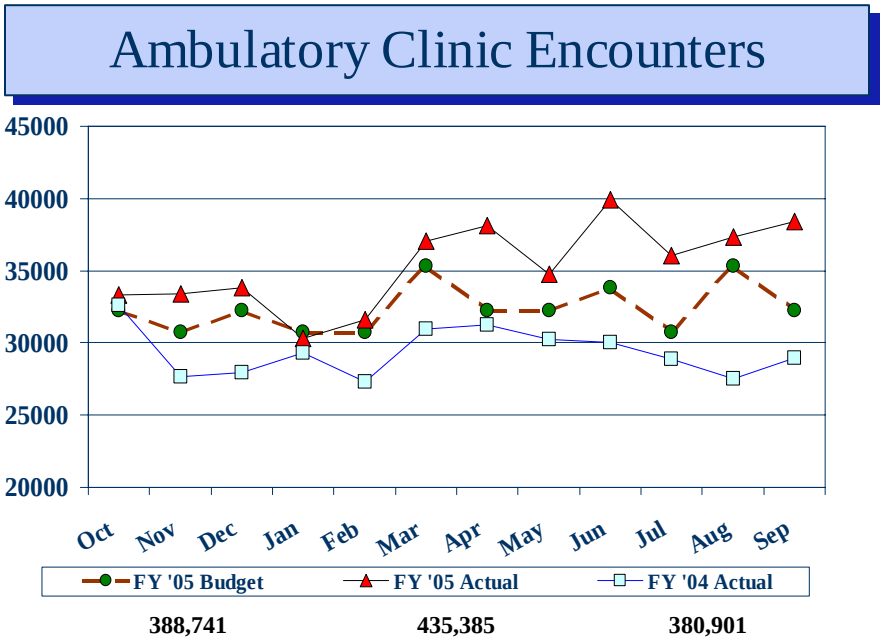
Goal 3: Figure 7



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Goal 3: Table 4

Primary Elements of Cash Flow
Fiscal Year 2005
(Millions)

Increase in Unrestricted Net Assets	$	57.1
Less: Non-cash components		(15.5)
Cash generated by Operations		41.6
Sources of Cash		
Sale of property		18.7
Timing of net capital expenditures		3.6
Release of workers comp bond		3.2
Uses of Cash		
Funding of debt service		(8.2)
Investment in long-term asset		(6.0)
Decrease in accounts payable and accrued expenses		(2.0)
Other factors		0.1
Increase in Cash and Investments	$	51.0

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