

Long-Term Care Home Accountability Planning Submission
(LAPS) Guidelines
2010-13



Ontario
Local Health Integration
Network

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1. Introduction

The introduction of 14 Local Health Integration Networks (LHINs) was a key component of the provincial government's plan to transform the delivery of health care in Ontario. On April 1, 2007, LHINs assumed full responsibility for planning, funding and integrating health services in their geographic areas, pursuant to the terms of the *Local Health System Integration Act, 2006* (LHSIA).

With the enactment of the LHSIA, the LHINs began the negotiation of service accountability agreements (SAAs) between the LHINs and health service providers (HSPs) funded by the LHINs in accordance with the timetable set out in O.Reg. 279/07. Hospital SAAs (H-SAAs) were negotiated for 2008-10. Multi-sector SAAs (M-SAAs) were negotiated with community support services, community care access centres, community health centres and community mental health and addictions agencies for 2009-11. Long-Term Care Home SAAs (L-SAA) will be negotiated and signed by March 31, 2010. To support the negotiation of the L-SAAs, each long-term care home (LTCH) will be required to submit a planning document known as the Long-Term Care Home Accountability Planning Submission (LAPS). Both the LAPS and the L-SAA will cover a three-year period.

The L-SAAs and LAPS are important changes for the long-term care (LTC) sector and for the LHINs. These documents emphasize the important role the sector must play in the transformation of the Ontario health system. It is recognized, however, that significant change is already underway in LTC. For example, the proclamation of the new *Long-Term Care Homes Act 2007* will have an impact for LTCHs in that it will replace existing legislation and regulations governing LTCHs.

The purpose of producing these LAPS Guidelines is to assist LTCHs in completing the 2010-13 LAPS. Central themes of the LAPS are service planning, measurement and evaluation of health services, and organizational performance. The LAPS together with the L-SAA form the basis of a multi-year funding and planning framework. This framework supports the province's efforts to enhance stability and accountability of the health system by providing a more sustainable financial footing and facilitating alignment of the provision of health services across health sectors and in line with MOHLTC and LHIN priorities.

The LTC sector is facing a number of changes over the next three years, not the least of which is the anticipated proclamation of the *Long-term Care Homes Act, 2007*. Other important changes include the implementation of interRAI MDS, the piloting of the Ontario Healthcare Reporting Standards (OHRS)/Management Information System (MIS), compliance transformation, the Ontario Health Quality Council (OHQC) public reporting initiative, the implementation of recommendations from the People Caring for People report¹, and the LTCH Renewal Strategy and other development projects. Given these changes, the LAPS and the L-SAA emphasize the use of planning, funding and performance processes that already exist in the sector.

The LHINs and the LTCH associations each developed principles that have helped to shape the development of these guidelines and of the draft L-SAA. In addition, the LTC sector provided direct input to the guidelines and to the indicators in section 4.5.

¹ People Caring for People. Impacting the Quality of Life and Care of Residents of Long-Term Care Homes. A report of the independent review of staffing and care standards for long-term care homes in Ontario. May 2008.

1.1. LHSIA 2006

LHSIA was created to support the achievement of an integrated health system that will improve the health of Ontarians through (i) better access to high quality health services; (ii) coordinated health care in local health systems and across the province; and (iii) effective and efficient management of the health system at the local level.

LHSIA provides the LHINs with a number of tools to achieve integration in the system. One of these tools is funding. LHSIA requires that the accountability for the funding provided by the Ministry of Health and Long-Term Care (MOHLTC) to the LHINs be closely aligned with the accountability for the funding provided by the LHINs to the HSPs.

You can see the MOHLTC-LHIN Accountability Agreement (ML-AA) on the LHIN's website. It sets out the funding that the LHIN will receive over the term of the ML-AA, restrictions on the LHIN's use of the funding it receives from the MOHLTC and the system performance objectives that the LHIN must achieve. Specifically, the ML-AA identifies:

- a. Performance goals and objectives for each LHIN and the local health system;
- b. Performance standards, targets and measures for each LHIN and the local health system;
- c. Planning and reporting requirements; and
- d. A progressive performance management process.

Your agreement with the LHIN is the L-SAA. The terms and conditions of the L-SAA are aligned with the terms and conditions of the ML-AA and are designed to enable and facilitate the achievement of system goals. The guidelines set out the process by which you prepare a LAPS for discussion with the LHIN. The LAPS is then used to finalize the L-SAA and the objectives that you will strive to achieve over the term of the L-SAA.

Link to *Local Health System Integration Act, 2006*:

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_06l04_e.htm

If you have any questions about how to complete the LAPS, or how it fits within health system transformation, contact your local LHIN. Please refer to Appendix D to contact your local LHIN.

1.2. The 2004 Transformation Agenda

The Government of Ontario's 2004 Transformation Agenda aims to transform health care through four key priority transformation projects:

1. Access to Services/Wait Times: A strategy focused on improving wait times in five key areas associated with a high degree of disease and disability (hip and knee replacements, cataract surgeries, MRI and CT scans, and certain cardiac and cancer treatments). LTCHs can contribute to improved hospital access and wait times when they are seen as part of a connected health care system. The LAPS is your LTCH's opportunity to describe how it can contribute to improving overall health system performance.
2. Primary Care: A target was set in 2004 to increase access to primary care by adding 150 new family health teams by 2007-08. With increased access to family physicians and more preventive care, fewer people will use hospital services for non-emergency visits and more space and hospital beds will be available for those who really need them. Increasing access to hospitals through primary care reform improves wait times if needed hospital beds are more appropriately used.
3. System Integration: System integration means creating a health care system that truly works like a system—one that is integrated and where the various parts work together

to deliver better health care. The creation of the LHINs is a key component of the transformation agenda as they are the organizations responsible for achieving system integration through the planning, funding and integration tools provided by LHSIA.

4. **Information Management:** The vision for transformation is to turn an array of isolated, stand alone services into a coherent system of connected services tied together by modern information and communications technology. Currently there is a mix of different reporting and information systems across different sectors—hospitals have a different reporting system than does the community sector, or LTCHs, and there is no single patient record. For the LHINs to be system managers, current, consistent, high quality data, and the systems to collect them, need to be in place.

The 2004 Transformation Agenda set in motion many of the changes needed to achieve an improved health care system. All HSPs are part of this transformation process. Most likely, your organization has already been involved in some LHIN planning activities and has received funding and other correspondence from your local LHIN. The L-SAA is one of the tools that will facilitate and enhance the transformation process. Among other provisions it will include requirements to consult with your LHIN, to track and report performance information, to identify integration opportunities, and to work cooperatively and collaboratively with the LHIN and other HSPs in the system. These requirements will enable the LHIN and you to create a health care system that truly works like a system—one that is integrated and where the various parts work together to deliver better health care.

1.3. Integrated Health Service Plan (IHSP) 2010-11 to 2012-13

IHSPs for 2010-13 will be released on November 30, 2009. All LHIN IHSPs will have the following four priorities:

1. ER service improvement;
2. ALC reduction;
3. Diabetes services improvement; and
4. Mental health and addictions services improvement.

Each LHIN may also have additional local priorities. Enabling strategies (such as Health Human Resources, eHealth, back office integration, etc.) may also be included to support the priorities. Your LHIN will inform you of any additional local priorities. All LHIN priorities should be addressed in the LAPS.

The principles of each IHSP are:

Community Engagement

Health needs and priorities are best addressed when the community providers, HSPs and the people they serve have input that informs the making of decisions.

Cooperation, Coordination and Integration

Community providers, HSPs, LHINs and the government must work together to reduce duplication and better coordinate health service delivery.

Equity and Diversity

Communities are made up of individuals with differing cultures, ethnicities, beliefs and lifestyle choices. The LHINs are committed to equity and respect for diversity in communities. LHINs respect the requirements of the *French Language Services Act* and requirements under the LHSIA in planning for and serving Ontario's French speaking community. The LHSIA also sets out requirements for LHINs regarding relationships with and recognition of Aboriginal and First

Nation peoples. Access to health services, except where permitted by the LHSIA, is not to be limited to the geographic area of the LHIN in which an Ontarian lives.

Accountability and Transparency

The health system is governed and managed in a way that reflects the public interest and that promotes efficient delivery of high quality health services to Ontarians.

Sustainability

An integrated health system will deliver health services that people need now and in the future. These principles are also to be considered and reflected in the development of the LAPS. LTCHs may contact the LHIN for release of available technical documentation relating to the 2010-13 IHSP to help inform their LAPS submission.

2. Roles and Responsibilities

2.1. Key Roles and Responsibilities of the MOHLTC

The key role and function of the MOHLTC is stewardship: to create the direction for the health care system. The MOHLTC is responsible for:

- Establishing strategic directions and provincial priorities for the health system;
- Developing legislation, regulations, standards, policies and directives to support those strategic directions;
- Monitoring and reporting on the performance of the health system; and
- Planning for and establishing funding models and levels of funding for the health care system.

For LTCHs, the MOHLTC retains responsibility for:

- Compliance, inspection and enforcement of LTCHs under legislation/regulation;
- Setting MOHLTC program and LTCH policy;
- Licensing and approval of LTC beds;
- Determining the total per diem funding per bed funding;
- Determining the construction cost funding per diem and LTCHs that will receive the per diem;
- Setting of fees for licensing;
- Approving changes of ownership, sale of businesses and amalgamations of providers for purposes of licensing;
- Approving management contracts;
- Selected funding programs; and
- Among other responsibilities, approving the selection of a third-party management company in the event of a bankruptcy.

Compliance Management

Responsibility for compliance management remains with the MOHLTC. The LTCHs Compliance Management Program resides within the Performance Improvement and Compliance Branch (PICB) and protects the over 75,000 residents in Ontario's 640 LTCHs, safeguarding their rights, safety, security and quality of life by ensuring that LTCHs comply with legislation and regulations as well as standards and criteria set out in policy, service agreements and licenses.

The PICB's mandate is to provide leadership and direction to accelerate sustainable health system performance improvement in areas of provincial priority or identified need. It is also responsible for the evaluation, design and delivery of programs to provide assurance that health facilities are in compliance with legislation and regulations.

Funding

The MOHLTC retains responsibility for reviewing the Audited Annual Report, Revenue Occupancy Report, and administering the Subsidy Calculation Worksheet, on behalf of the LHINs.

The following are examples of MOHLTC funded programs:

- High Intensity Needs Funding;
- High Wage Transition Funding;
- Municipal Tax Allowance Funding;
- Pay Equity Funding;
- Physician On-call Funding;
- Structural Compliance Premium;
- Laboratory Services Funding;
- MDS Early Adopter Funding; and
- Peritoneal Dialysis (PD) Funding.

Development / Renewal

The MOHLTC will continue to administer programs related to the development of new LTCHs and the renewal of existing ones. This includes the development of funding models and processes as well as the ongoing monitoring of development.

For the purpose of selecting projects under the LTCH Renewal Strategy LHINs will make recommendations based on LHIN specific priorities through an application process administered by the MOHLTC.

2.2. Key Roles and Responsibilities of LHINs

LHINs are responsible for planning, integrating and funding the provision of health services within the geographic boundaries of their LHIN.

System and LTCH Performance: LHINs are responsible for performance management. LHINs will monitor the achievement of specific performance goals under the L-SAA. Where these goals are not being achieved, the LHIN will work with the LTCH to address system and LTCH performance issues.

Without limiting the foregoing, LHINs also review and monitor:

- Placement refusal trends;
- Transfer request trends;
- Wait list profiles; and
- Occupancy.

LTCH Funding

LHINs provide and administer the following types of LTCH funding:

- Levels of care (*per diem*) funding;
- Non-levels of care funding such as:
 - Registered Practical Nurse Funding;
 - Construction Cost Funding; and
 - Convalescent Care Bed Funding.

The LHINs also:

- Participate, as appropriate, in the preparation and submission of funding requests related to LTCHs through the MOHLTC annual planning cycle;
- Monitor the utilization of LTCH beds, LTCH performance and related funding;
- Recover LHIN operating funds identified through the Revenue Occupancy Report and annual reconciliation process;
- Re-allocate operating funds recovered through the Revenue Occupancy Report;
- Recommend projects through the application process for the LTCH Renewal Strategy;
- Approve the designation of existing long-stay beds as short-stay beds; and
- Monitor the utilization of short stay beds.

The LHINs do not have the authority to establish LTCH resident care standards. This responsibility remains within the domain of the MOHLTC. However, LHINs may set performance targets for LTCH indicators within the context of a provincial health system framework.

3. Key Planning Consideration for the LAPS and L-SAA

3.1. Changes between the Service Agreement and the L-SAA

The table below sets out the major changes between previous funding agreements and the L-SAA.

MOHLTC Funding Agreement	L-SAA
Focus on operational oversight.	Focus on performance and accountability.
Focus on organizational activities.	Focus on the system and deliverables with an emphasis on collaboration, cooperation and integration activities within the LHIN.
Agreements linked to activity measures.	Agreements linked to performance/outcome measures.
Agreements not aligned with provincial program and priorities.	Agreements aligned with provincial planning and priorities, the MLAA, and LHIN Integrated Health Service Plans (IHSP).
Annual agreement (currently 'evergreen').	Three-year agreement.
No operational change proposals.	No operational change proposals, however, requirement to notify and discuss with LHIN changes affecting your description of services as described in Section 4.1.
Different terms and conditions for each health care sector.	Consistent approach for all health care sectors.

3.2. Principles Guiding the Process

LTCHs should consider the following principles when preparing their LAPS and engaging their local and regional partners.

a. Accountability

- The LAPS is prepared by and owned by the LTCH.
- The LAPS will inform the discussions of the L-SAA between the LHIN and the LTCH.
- The LHINs will provide guidance, approve and monitor the performance obligations of the L-SAA.

- LTCHs will be accountable to the LHINs for the achievement of the LTCHs performance obligations in the L-SAA.

b. Funding and Allocation

- LTCHs are expected to achieve a non-deficit operating position for the LTCH for each year of the L-SAA. For example, a LTCH with expenditures higher than its approved funding has to show another revenue source to offset its higher costs.
- LTCH funding provided by the LHINs can only be used in accordance with the terms of the L-SAA.

c. Local Health System Planning

- LTCH planning must be in alignment with the LHIN Integrated Health Service Plan (IHSP), the government's health care priorities, and reflect best practices, evidence-informed decisions, and the pursuit of efficiency opportunities within the LTCH and in collaboration with hospitals, community partners and other HSPs.
- LTCH planning must engage the community of diverse persons and entities in the area where the LTCH provides health services and it should identify opportunities to integrate the services of the local health system to provide appropriate, coordinated, effective and efficient services.

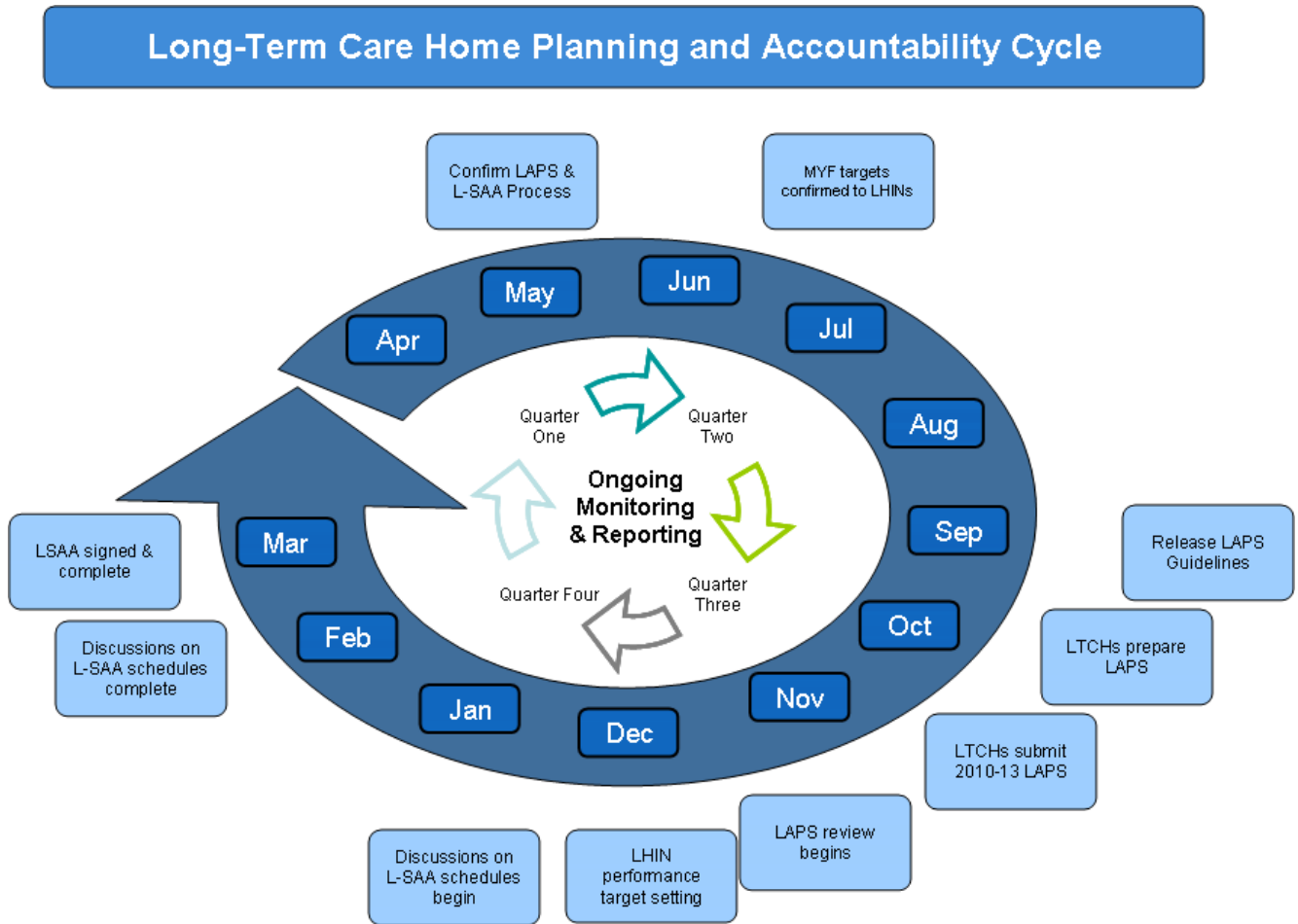
3.3. Multi-Year Funding Targets

Multi-year funding (MYF) targets provide stability and increased capacity to effectively plan and manage operations. Under the current funding approach LTCHs are not eligible to receive MYF targets from the LHINs. In the future, LHINs plan to introduce multi-year funding targets for the LTC sector. Currently, the MOHLTC is undertaking a funding review to re-evaluate the funding approach for the sector. Once the funding review is completed the LHINs will re-evaluate the feasibility of introducing MYF targets to LTCHs. In the meantime, status quo will be maintained and LTCHs will continue to be funded according to the existing funding approach.

3.4. The 2010-13 Monitoring Process

Although there has been periodic reporting of financial and some performance data for the community and hospital sectors, reporting for LTCHs has been limited to annual reconciliation, staffing, revenue/occupancy, critical incidents and other reports. There has been no regular quarterly reporting of indicators for the sector that align with or 'cascade' from the LHINs' own performance obligations under the ML-AA and that support the objectives of a transformed health care system. With the L-SAA, your LTCH will have a direct and regular reporting relationship with your LHIN. These reports will be submitted to the LHIN on a quarterly basis, as outlined in the L-SAA. The LHIN will review your performance results and compare them to your established performance target. This process of monitoring and responding to performance reports is part of the LTCH planning and accountability cycle.

3.5. Overview of the 2010-13 LTCH Planning and Accountability Cycle



The LTCH Planning and Accountability Cycle diagram outlines two major interrelated processes and timelines of your relationship with your local LHIN. The outer cycle shows the process to completing your LAPS planning submission which occurs before the three year L-SAA is finalized, and the inner cycle shows the annual reporting that occurs in each year of the L-SAA.

These LAPS guidelines will assist you in completing the outer cycle process. The inner cycle of quarterly reporting is new to the LTCH sector, and is tied to the goals of health system transformation and the accountability framework that were outlined above. Your L-SAA with the LHIN will have schedules that clearly outline your reporting requirements, and a schedule of performance indicators. These indicators and their monitoring support the goals of health system transformation by linking LTCH performance to LHIN system level outcomes, and to the MOHLTC's own strategic priorities.

These new reporting requirements have been built on existing processes in the LTC sector and these processes will continue to evolve to ensure they are easy to use and offer value to LTCHs, the LHINs, and to the MOHLTC. Performance data will be made available to LTCHs and will provide valuable input into the LAPS and other planning processes. LTCH financial reporting will remain on a calendar year while performance reporting will mirror the term of the L-SAA on a fiscal year basis.

3.6. Other Services (French Language Services)

If the LTCH is required to provide services to the public in French under the provisions of the *French Language Services Act* (FLSA), the LTCH will be required to submit a French language implementation report to the LHIN.

The list of identified/designated agencies can be found at:

http://www.health.gov.on.ca/english/public/program/flhs/identified_mn.html

If the LTCH is not required to provide services to the public in French under the provisions of the *French Language Service Act*, it will be required to provide a report to the LHIN that outlines how the LTCH addresses the needs of its local Francophone community.

4. LAPS Components

A LAPS is required from each Ontario LTCH. Upon notification from the LHIN, templates for completing the LAPS will be made available through the <http://www.fimdata.com/LTCHome> website.

Examples of the forms used to complete the Description of Services and the Service Plan can be found in Appendix B.

4.1. Description of Services

The Description of Services provides an overview of the LTCH including:

- General identifying information;
- Bed types and numbers offered within the LTCH;
- Structural classification;
- A listing of additional services provided to residents;
- Additional service conditions related to new bed awards for the period 1987 to 1998
- Community linkages; and
- Services provided by the LTCH or operated out of the LTCH to support community needs (i.e. Meals on Wheels).

The description of services will include services offered by the LTCH, including those funded by the MOHLTC/LHIN and those funded by other sources designed to meet the unique needs of the local community.

The information to be provided is unique to each LTCH and must be completed separately for each location. This information will guide discussions with the LHIN and facilitate preparation of schedules to be included in L-SAA.

4.2. Service Plan

The LAPS service plan narrative should be no more than four (4) pages in length on letter size paper using Arial 11pt font. Do not include attachments or any other additional documents with the LAPS.

The narrative service plan is an opportunity for the LTCH to describe for the LHIN the role that it plays within the local community and how it will support the sustainability of the local health care system. The information will describe the programs and services provided by the LTCH, to meet the unique needs of the local community. This section may include information related to

the parent corporation in relation to corporate service improvement initiatives but must be provided in a local context.

The Service Plan narrative is comprised of two sections. The Service Plan Part A will allow the LTCH to provide information that describes services that the home operates or plans to operate within the 2010-11 year. Service Plan Part B will allow the LTCH to provide information related to services that the home operates or plans to operate in 2011-12 and 2012-13.

Service Plan - Part A: 2010-11

The service plan part A must include the following components:

i. Strategic Goals and Priorities

This may include:

- Key messages for the LHIN such as:
 - Services or programs the LTCH operates or plans to operate in 2010-11 that meet the unique needs of the resident population and/or the local community. These would include unique clinical programs or programs meeting the needs of local cultural, linguistic or religious groups. Describe the characteristics of the specific population(s) served and the needs the services are intended to address. The narrative should address all services described in 4.1 Part A above.
 - Describe how the LTCH's initiatives address the health needs of the local Francophone community if the LTCH is required to provide services to the public in French under the *French Language Services Act*.
 - Communication strategies planned or underway with other HSPs or the local community.
 - Plans for structural redevelopment within the MOHLTC's Long-Term Care Home Renewal Strategy.
 - Any other activity of which the LHIN should be aware.

iii. Advancement of the IHSP

- How the LTCH's strategic and operating plans contribute to the LHIN IHSP and improve service capacity, delivery and coordination of care/services within the local health system. For example, outline any partnerships/alliances with other HSPs or other service providers such as linkages with mental health services or hospitals for residents with complex medical needs, etc.
- How the LTCH plans to meet its obligations within the LHSIA that include:
 - Community engagement obligations under sections 16(6);
 - Identify integration opportunities under section 24.
- The results of any community engagement and integration activities. Specifically, the impact these results have on the community and the LTCH's ability to enhance service capacity and improve service delivery to meet identified community needs.

ii. Situation Analysis

- Prudent business assumptions and rationale regarding bed occupancy, service delivery and overall expenses and revenues, including collection of resident co-payment revenue.
- A description of significant budgetary and operational risks (no more than three (3)), if any, that may affect the LTCH's ability to meet compliance standards, resident care needs, operational objectives and financial objectives. This should include the identification of any operational issues that may impact their ability to meet compliance standards.

- An outline of the realistic strategies to mitigate or manage the identified risk(s).
- iii. Evaluation of Prior Year Performance (optional)
- A critical and objective evaluation of the prior year's operational performance:
 - Challenges encountered;
 - Strategies undertaken to address these challenges.
- iv. Changes to Operations Summary (optional)
- Highlight changes to operations that are being considered for the duration of the L-SAA (Changes that require pre-approval from the LHINs cannot be included unless the change has already been approved.).

Service Plan – Part B: 2011-12 and 2012-13

The information to be provided within this section is for LHIN planning purposes only and will not be included within the agreement.

The service plan part B must include the following components

i. Strategic Goals and Priorities

This may include:

- Key messages for the LHIN such as:
 - Services or programs the LTCH plans to operate or is interested in operating in 2011-12 and 2012-13 that meet the unique needs of the resident population and/or the local community. These would include unique clinical programs or programs planned to meet the needs of local cultural, linguistic or religious groups. Describe the characteristics of the specific population(s) served and the needs the services are intended to address.
 - Describe how the LTCH's initiatives address the health needs of the local Francophone community if the HSP is required to provide services to the public in French under the *French Language Services Act*.
 - Communication strategies planned or underway with other HSPs or the local community.
 - Plans for structural redevelopment within the MOHLTC's Long-Term Care Home Renewal Strategy.
 - Any other activity of which the LHIN should be aware.

ii. Advancement of the IHSP

- How the LTCH's strategic and operating plans contribute to the LHIN IHSP and improve service capacity, delivery and coordination of care/services within the local health system. For example, outline any partnerships/alliances with other HSPs or other service providers such as linkages with mental health services or hospitals for residents with complex medical needs, etc.
- How the LTCH plans to meet its obligations within the LHSIA that include:
 - Community engagement obligations under sections 16(6);
 - Identify integration opportunities under section 24.
- The results of any community engagement and integration activities. Specifically, the impact these results have on the community and the LTCH's ability to enhance service capacity and improve service delivery to meet identified community needs.

4.3. Financial Summary (Total LTCH Funding)

The Financial Summary Template (Appendix C) consists of four tables collectively intended to capture all revenues and expenses as it applies to the operation of the LTCH only (exclude revenues and expenses for attached retirement homes, assisted living units, etc. (if any)). Wherever possible the information in the tables will be pre-populated. Upon notification from the LHIN, the financial template will be made available through the <http://www.fimdata.com/LTCHome> website.

Note that although all revenues and expenditures will be reported on the LAPS Financial Summary, the financial schedule attached to the L-SAA will only include Tables A and B.

Table A: Pre-populated information reflecting the number of beds and classification, per diems by envelope, applicable Case Mix Index (CMI) and maximum resident days.

Table B: Estimate of LHIN subsidy by envelope for 2010, 2011 and 2012 – Pre-populated information with per diem funding, RPN funding, construction cost funding and resident revenue calculated based on the data in Table A.

Table C: Estimate of MOHLTC subsidy by envelope for 2010, 2011 and 2012. This information is mostly pre-populated. LTCHs will need to enter their Nursing Initiative Funding.

Table D: Estimate of total LTCH Revenue/Expenses for 2010, 2011 and 2012 – the Total Funding section is pre-populated from information in Tables B and C. LTCHs will need to enter total expenses by envelope and total revenue. LTCHs are expected to achieve a non-deficit/balanced budget.

NOTE: For LTCHs that also operate convalescent care beds, the budget line does not separately identify the revenue and expenses allocated to convalescent care beds; instead, it combines revenues and expenses with non-convalescent care beds to provide a total picture of the LTCH's position.

The expenses and revenues relating to the operation of convalescent care beds are reconciled separately from the expenses and revenues relating to the operation of non-convalescent care beds. LTCHs must not use any projected surplus identified in the recoverable envelopes (i.e. Nursing and Personal Care, Program and Support Services, and Raw Food) from the operation of convalescent care beds to offset any projected deficit in the recoverable envelopes from the operation of non-convalescent care beds, and vice versa.

4.4. Reporting

A reporting schedule will be set out in the L-SAA which will apply to financial and performance reporting during the term of the L-SAA beginning April 1, 2010.

4.5. Performance Framework

The Indicator Development Process

In the summer of 2007, the LHINS and MOHLTC began the development of an indicator framework for the SAAs, together with an inventory of indicators to support health system transformation and accountability.

Following development of the framework, work began on indicators for each sector as they were transferred to LHIN authority under the LHSIA timetable. In some cases, the chosen indicators were included in the planning guidelines because of earlier development work. For example, the hospital sector's planning guidelines included indicators because of previous development work

that had been underway prior to the transfer of funding responsibilities to the LHINS. For some other sectors, additional time was needed to develop indicators and they were released after a period of development and consultation.

These guidelines include indicators and the strategy to implement over the term of the L-SAA, according to the indicator framework developed for the sector.

Indicator Framework

The indicator framework builds on the Kaplan and Norton Balanced Scorecard² approach with a dimension added to reflect the LTCH's role as an integral part of the local health system.

The LTCH performance domains are:

1. Financial/Fiscal Health
 - The LTCH demonstrates sound business practices and efficiency in service delivery.
2. Organizational Capacity/Health
 - The LTCH has the capacity / demonstrates the ability to deliver the services for which it receives LHIN funding.
3. High Quality Health Services
 - The LTCH delivers the services specified in its service plan that are accessible, appropriate, integrated with appropriate health system partners, effective (evidence-based), outcome focused, and safe.
4. System Perspective/Integration
 - The LTCH contributes to system performance and local population health outcomes as part of the local LHIN.

Each of these domains will be developed to include different types (*classes*) of indicators, implemented over time as more data becomes available.

Indicator Classes:

Indicators will be classed as either “performance”, “pilot”, or “developmental”.

A *performance indicator* has satisfied the criteria for its selection, has a target and a performance standard by which the LTCH can be measured. LTCHs are held accountable under the L-SAA for performance in these indicators. **Example:** in the community sector, Balanced Budget is a performance indicator (total revenues minus total expenses/total revenue * 100).

A *pilot indicator* may have a target, but does not have a performance standard. A performance standard is required to hold an LTCH accountable under the L-SAA. Pilot indicators will be included to track important data, and to identify collection and data quality issues that need correction before a standard can be included in the L-SAA. **Example:** an indicator based on data that are not fully collected in the sector cannot be used as a performance indicator

A *developmental indicator* is an indicator for which work is required in order to develop it as a performance measure. For example, work may be needed in terms of the technical specification of the indicator, data capture or data quality. A developmental indicator is not included in the L-SAA, and does not have a target or standard. These indicators continue to be researched and assessed before they are considered as pilot or performance indicators in the L-SAA.

2 Kaplan R S and Norton D P (1992) "The balanced scorecard: measures that drive performance", Harvard Business Review Jan – Feb pp. 71-80.

Indicator Phases:

Indicators will be implemented in three different phases:

- Phase I: Available in the first year of the L-SAA (2010-11);
- Phase II: Implemented during the term of the L-SAA before becoming a performance measure either within the term of the 2010-13 L-SAA or in a subsequent L-SAA; and
- Phase III: Implemented after the term of the L-SAA.

Indicator Targets, Corridors and Standards

A performance indicator is a measure of performance related to some attribute of an operation or system. The balanced budget indicator in the above example is a number that measures that financial attribute of a LTCH's finances. Every performance indicator has a target value (a value of 0 for balanced budget) - established through research, expert opinion, by a preexisting standard or policy, and by sector knowledge - that is considered a reasonable and appropriate standard of performance.

The measure of performance is related to the target value of an indicator. An indicator may have a target of 10%, for example, and a performance range of +/- 2%. The LTCH's acceptable performance range, therefore, is between 8%-12%. If the LTCH's actual performance is outside this range, then the LTCH and its LHIN will discuss the indicator and possible performance improvement steps that could be taken. In the above example, the 2% value is called the 'performance corridor', and the range is called the 'performance standard'. Every SAA refers to a provider's performance standard, so the connection between the L-SAA and performance is defined by the standard. If an L-SAA does not have standards defined in its performance schedule, then there is no performance obligation or consequences for the provider. There are many examples of indicators in SAAs in other sectors where there are no defined performance standards. The indicator is listed in the schedule because it shows the indicators that will have defined standards within the term of the L-SAA, for data collection purposes, and to show all the indicators that will be used in the L-SAA over time. Appendix A includes definitions of performance targets, corridors and standards.

Indicator Strategy

Based on the above indicator framework, and a review of the available data, a strategy was adopted for the LTC sector to gradually add performance indicators over the term of the L-SAA. Generally, the LTC sector does not currently have existing validated sources of data that could be used in a SAA because the necessary performance targets, corridors, and standards have not been determined. As noted above, a performance standard is needed to create a performance obligation in the L-SAA. For the most part these have not been developed yet with the exception of one indicator. Compliance Status has been added to the L-SAA as a performance indicator in each year of the agreement. All chosen indicators are listed below, showing their status (class and phase of indicator).

Domains and Indicators	Long Term Care Homes		
	2010-11	2011-12	2012-13
Financial/Fiscal Health			
Current Ratio (Site or Consolidated)	Pilot-NT	Pilot-NT	Performance
Debt Service Coverage Ratio (Site or Consolidated)	Pilot-NT	Pilot-NT	Performance
Organizational Capacity / Health			
Injury Frequency and Severity		Pilot-NT	Pilot-T
Refusal Rates per 100 Beds	Pilot-NT	Pilot-T	Performance
High Quality Health Services			
Compliance Status	Performance	Performance	Performance
Prevalence of Worsening Pressure Ulcers (Stage 2 to 4)	Pilot-NT	Performance	Performance
Incidence of New Pressure Ulcers (Stage 2 to 4)	Pilot-NT	Pilot-T	Performance
Prevalence of Daily Physical Restraint	Pilot-NT	Performance	Performance
Incidence of worsening bladder incontinence	Pilot-NT	Pilot-T	Performance
Incidence of New Fractures	Pilot-NT	Pilot-T	Performance
Incidence of Falls	Pilot-NT	Pilot-T	Performance
Systems Perspective/Integration			
Potentially avoidable ED visits by Facility		Pilot-T	Performance
Immunization Rates	Pilot-NT	Pilot-T	Performance

How to Interpret the Table

It can be seen from the above table that Compliance Status is the only performance indicator in the first year of the L-SAA (2010-11). The remaining indicators in year one will be developed by determining their targets and standards. The Injury Frequency and Severity indicator will continue as a pilot indicator in the last year of the L-SAA with a target calculated, but no standard.

The two financial ratio indicators will require each LTCH to provide some financial data to start the process of determining appropriate targets and standards for these ratios. A user input form will be developed as part of the <http://www.fimdata.com/LTCHome> website to capture these data. There are no other data required from the LTCH for this strategy. All other indicator data will be obtained from sources such as interRAI MDS and the Workplace Safety and Insurance Board (WSIB). Training will be provided to LTCHs on how to provide data, and overall on the indicator strategy.

The above indicator strategy represents a three-year plan to establish the performance targets and standards for inclusion in the performance schedule within the term of the L-SAA. The collection and analysis of these data, and the determination of performance targets, corridors and standards, will be completed in partnership with the LTCH provider associations, MOHLTC staff, research experts and other stakeholders.

5. LHIN Evaluation of LAPS

5.1. Evaluative Process

The following evaluative processes will be used by the LHINs to review and evaluate the LAPS. While each LAPS is submitted by individual LTCHs, the review process will consider each submission in relation to the local health system.

5.2. LHIN LAPS Review Process

As appropriate, the LAPS review will:

- Ensure the submission is complete;
- Identify any performance measure concerns;
- Ensure the LTCH is maintaining required services;
- For consistency, compare the narrative component with other information provided;
- Review assumptions for consistency and reasonableness;
- Identify inconsistencies or anomalies in submissions;
- Generate a list of questions for the LTCH that requires clarification; and
- Prepare a summary document for each LTCH.

Once the review of the final submission is completed, LHIN staff will contact each LTCH to obtain answers for any questions that the LHIN has as a result of its review. Further discussion and meetings may occur to confirm information to be in L-SAA schedules. The intensity and frequency of meetings will depend on the circumstances of an individual LTCH.

6. Linking the LAPS to the L-SAA

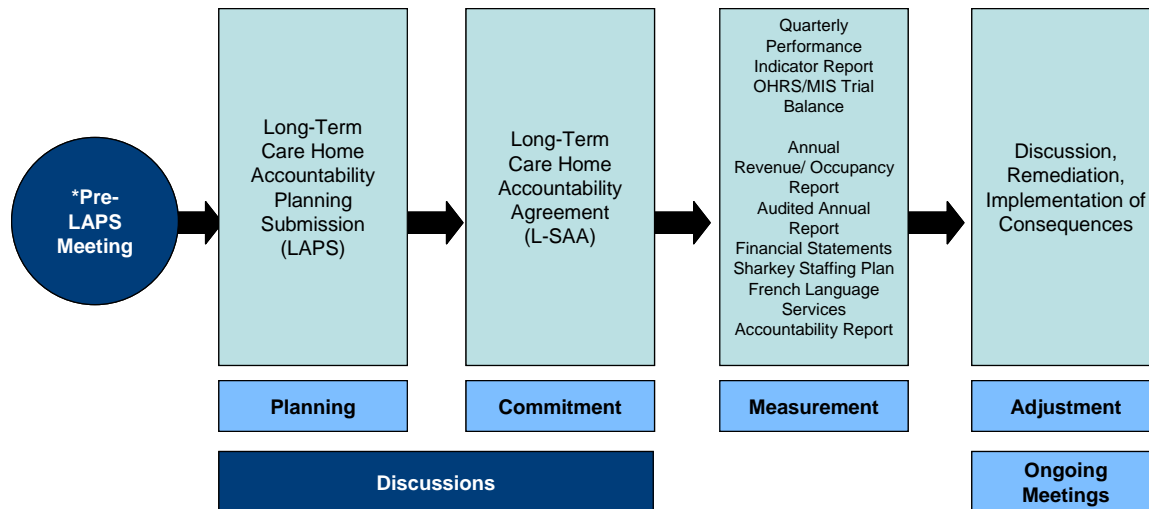
6.1. Overview

The LAPS is a LTCH-owned document that focuses on service planning and organizational performance. Data submitted by LTCHs in the LAPS will be used to develop targets, corridors and performance standards over the term of the L-SAA, including:

- Financial/Fiscal Health;
- Organizational Capacity/Health;
- High Quality Health Services; and
- System perspective/Integration

The L-SAA, a public document, is the multi-year legal agreement between the LTCHs and the LHINs pursuant to which the LTCH provides services and the LHIN provides funding. LHINs are committed to achieving balanced, innovative and realistic L-SAAs that rely on regular discussion and collaboration to the greatest extent possible.

The process from development of a LAPS through to the term of the L-SAA is depicted below:



**Pre-LAPS meetings between LTCHs and the LHIN are recommended to: discuss, clarify and align expectations of and roles in the process; to agree and discuss principles, values and assumptions; and to share and discuss possible options and levers that both sides could draw on during the proceedings.*

7. Directives, Guidelines and Policies

A listing of all mandatory guidelines, directives and policies will be set out in the L-SAA.

8. Changes Needing LHIN Review/Approval

8.1. Bed Types / New Regulations

This information will be available upon release of the draft new regulations and this document will be updated immediately following.

8.2. Adding New Services, Service Enhancement, Service Reduction, Transfer or Elimination Proposal

Any proposed reduction, transfer or elimination of a service should be consistent with the overall goal of an integrated health system that provides access to high quality health services and coordinated health care in an effective and efficient manner. A LTCH's plans for these types of changes should be included in the Service Plan of the LAPS, however, the LAPS is not a vehicle to request funding.

Service reductions, transfers or elimination proposal should include:

- The specific nature of the proposed change;
- Rationale for the service change and alternative measures considered during the decision-making process;
- Anticipated funding adjustments;

- The group(s) to be impacted by the proposed change;
- Strategy for mitigating any anticipated client impacts from the service change;
- Consultation process and outcomes with health care partners and the community; and
- Communications plan to communicate to both internal and external audiences.

Changes proposed to services that are currently funded by the LHIN through Aging at Home (AAH), Urgent Priority Fund (UPF) or other dedicated funds must comply with conditions and requirements as set out in the current funding agreement.

Where changes are proposed to services that do not receive dedicated funding, but play an important role in meeting the needs of the community, the LTCH is required to notify the LHIN of these changes. This notification is essential for the LHINs to fulfill their obligation as systems manager to understand the impacts these changes may have and future service options. LHIN staff may wish to meet and discuss with the LTCH the proposed changes and their local system impact.

Appendix A: Glossary

Terms used throughout these guidelines are defined below. Terms that appear in a single section or part are defined there for ease of reference.

Additional beds is defined as a non-licensed bed in the LTCH that has no current designation or specific use.

Ageing at Home (AAH) strategy is a \$1.1 billion investment over four years to expand community services for seniors and their caregivers and relieve pressures on hospitals and long-term care homes. It is one of the key strategies supporting the government's platform commitment to decrease ER wait times and associated alternative level of care (ALC) days.

Balanced Budget means that, in a given year, the total expenses of an entity are less than or equal the total revenue, from all sources, for the entity.

Annual Reconciliation Report (ARR) is also referred to as the Long-Term Care Home Annual Report, the format is developed and prepared by the Ministry. The report is completed by each LTC home and captures resident revenue and expenditure by funding envelope on a calendar year basis. Unutilized funding in the NPC, PSS and RF envelopes are recovered by the Ministry. Actual resident revenues that are greater than or less than estimated resident revenue respectively, are recovered or paid to the LTC home.

Beds in Abeyance are beds previously licensed or approved by the MOHLTC that are unoccupied and not currently available for occupancy. They have been approved by the Director for temporary withdrawal from the LTCH funding system but must be returned to the system within a specified period, or surrendered.

Case Mix Index (CMI) is used to express the Level-of-Care requirements of each LTC home, and represents the basis upon which Nursing and Personal Care funding at a home level is determined.

Convalescent Care Bed is a licensed bed that supports additional care to be provided for individuals in acute care facilities who need to recover strength and functioning to return home.

Elderly Capital Assistance Program (ELDCAP) provides services to long-term care residents in units that are collocated within hospitals in small northern communities. ELDCAP beds are subject to the long-term care program requirements but are funded through a hospital's global budget. ELDCAP beds are also used to classify interim long-term care beds opened temporarily in hospitals.

ELDCAP Beds means any beds at a LTCH that are listed in Schedule 1 of Regulation 832 under the Nursing Home Act.

FLS means French Language Services.

FLSA means *French Language Services Act*. Link to Act:
http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90f32_e.htm

HSP means health service provider as that term is defined in the LHSIA.

IHSP means the Integrated Health Service Plan developed and published by each LHIN pursuant to s.15 of the LHSIA. A copy of a LHIN's IHSP is available through the LHIN's office or on its web-site

Interim Beds are licensed beds that are designed to help facilitate the discharge of hospital patients to long-term care homes. The purpose of the Interim LTC beds is to ensure that hospital patients, who are currently awaiting transfer to permanent long-term care homes, are cared for in a home- like environment that includes programming and services.

interRAI MDS is a comprehensive, standardized instrument for evaluating the needs, strengths, and preferences of those in complex continuing care and nursing home settings.

LAPS means Long-Term Care Home Accountability Planning Submission, a document used to negotiate a three-year service accountability agreement between the LHIN and HSP.

LHIN means one and LHINs means more than one Local Health Integration Network. The LHINs are 14 networks established by the LHSIA across the province. Specific information about geographic parameters and contact information can be found at www.lhins.on.ca.

LHSIA means the *Local Health System Integration Act, 2006*. This is the legislation that established the LHINs, and sets out the terms by which the LHINs may exercise the powers devolved from the Minister in respect of planning, funding and integration of their local health system. Link to the Act:

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_06l04_e.htm

Long-Term Care Home (LTCH) is a home that provides long-term care on a 24-hour basis to individuals whose needs can no longer be met in the community. Long-term care homes include all existing nursing homes and homes for the aged.

Minister means the Minister of Health and Long-Term Care.

ML-AA or MOHLTC-LHIN Accountability Agreement means the accountability agreement that must be signed between the LHINs and the Minister of Health and Long-Term Care pursuant to the terms of the LHSIA.

MIS (Management Information System) is the term used to identify and report data organized in a format consistent with Ontario Healthcare Reporting Standards.

MOHLTC means the Ministry of Health and Long-Term Care.

Multi-year Funding Targets means an allocation for the first year of the agreement and funding targets for up to three additional years, consistent with the term of the agreement. Funding targets are to be used for planning purposes only and may be revised upward or downward at the discretion of the LHIN.

Nursing and Personal Care Envelope is that part of per diem funding designated for Nursing and Personal Care. It is calculated by multiplying the Base Nursing and Personal Care Per Diem by the LTCH's CMI.

OHRS (Ontario Healthcare Reporting Standards) is a set of reporting standards and chart of accounts consistent with national health care reporting standards.

Other Accommodation Envelope is that part of per diem funding designated for expenditures on housekeeping, dietary services, building and property operations and maintenance, laundry and linen, general and administrative expenses and facility use costs. This is a fixed rate and does not vary with the CMI.

Performance Corridor: means the acceptable range of results around a performance target.

Performance Standard: means the acceptable range of performance for a performance indicator that results when a performance corridor is applied to a performance target.

Performance Target means the planned level of performance expected of the LTCH in respect of performance indicators.

Program and Support Services Envelope is that portion of per diem funding designated for program and support service expenditures as specified in the regulations. This is a fixed rate and does not vary with the CMI.

Raw Food Envelope is that portion of per diem funding that must be spent on raw food as defined in the regulations. This is a fixed rate that does not vary with the CMI.

Resident Days is the total number of resident days calculated annually. The number of resident days is important in the calculation of the Provincial Subsidy amounts because each component of the Subsidy Calculation Worksheet is expressed as a per diem. The maximum resident days for a home is calculated by multiplying the number of beds in operation (operating capacity) by the number of days in the period under consideration.

Resource Utilization Groups (RUGs) is the case mix measurement algorithm that will be used to calculate CMI and adjust the NPC envelope for LTCHs that are part of the LTCH Common Assessment Project (CAP).

SAA or “Service Accountability Agreement” means the agreement that the LHINs must enter into with health service providers funded by the LHIN, pursuant to the terms of LHSIA.

Short-Stay (Respite) bed is a licensed bed in a LTCH for an individual who may require or benefit from a short stay in the LTCH or for the benefit of the caregivers by providing relief. The short-stay beds must be available at all times and should not be used for long-term placement.

Urgent Priorities Fund (UPF) provides the Local Health Integration Networks (LHINs) with funding to address local priorities based on their Integrated Health Service Plans (IHSPs) and consistent with objectives, criteria and parameters defined by the Ministry. The UPF provides LHINs with levers of system change to assist them in ensuring health system transformation.

Veterans Priority Access Beds are beds in a LTCH for which priority is given to veterans for access and for which funding is provided under an agreement between the Government of Ontario and the Government of Canada relating to veterans.

Appendix B: Description of Services and Service Plan Narrative

Description of Services						
Page 1						
General Information						
LTCH Legal Name:						
LTCH Common Name:						
LTCH Facility ID Number:						
Address:						
City:					Postal Code:	
Geography served (catchment area):						
Accreditation organization						
Date of Last Accreditation:				Year(s) Awarded:		
LTCH Classification						
Licensed / Approved Beds	Total # of Beds	A	B	C	D	Other
Total Licensed / Approved Beds						
Bed Types:						
	Total # of Beds	Comments/Additional Information				
Convalescent Care Beds						
Respite Beds						
Beds in Abeyance						
ELDCAP Beds						
Interim Beds						
Veterans' Priority Access Beds						
Other beds available for over-bedding						
Structural Information						
Type of Room						
<i>(this refers to structural layout rather than what charged in accommodations)</i>						
Number of rooms with 1 bed		Number of rooms with 2 beds				
Number of rooms with 3 beds		Number of rooms with 4 beds				
Other						
Separate Infirmary (Y/N)		Number of Rooms				
Year of Construction		Year(s) of renovations				
Opening Date		Number of Floors				
Number of Units and Beds						
<i>Unit</i>				<i>Number of Beds</i>		

Description of Services					
Page 2					
General Information					
LTCH Legal Name:					
LTCH Common Name:					
LTCH Facility ID Number:					
Additional Information					
Additional Services Provided					
	Service Provided		Contract for Service		Explanation if applicable
	Yes	No	Yes	No	
Nurse Practitioner					
Physiotherapy					
Occupational therapy					
Ophthalmology/ Optometry					
Audiology					
Dental					
Respiratory Technology					
Denturist					
IV Therapy (antibiotics or hydration)					
Peritoneal Dialysis (PD)					
Support for hemodialysis (HD)					
French Language Services					
Secure residential home area(s)					
Specialized Demential Care unit(s)					
Designated smoking room(s)					
Specialized unit for younger physically disabled adults					
Support for Feeding Tubes					
Specialized Behavioural treatment unit(s)					
Additional service commitments for new bed awards (1987-1998)					
Other - please specify					
Other - please specify					
Other - please specify					

Description of Services			
Page 3			
General Information			
LTCH Legal Name:			
LTCH Common Name:			
LTCH Facility ID Number:			
Community Linkages			
	Service Provided		Comments
	Yes	No	
Volunteer program			
Service groups			
Language interpreters			
Cultural interpreters			
Advisory council			
Community board			
Faith communities			
Other (specify)			
Service Provided to the Community			
	Service Provided		Comments
	Yes	No	
Meal Services			
Social Congregate Dining			
Supportive Housing/SDL			
Adult Day Program			
Retirement Living			
Hospital			
Other			
Other			
Specialized Designations			
	Designated		Comments
	Yes	No	
Religious			
Ethnic			
Linguistic			
French Language Services			
Other			
Other			

Service Plan Narrative – Part A: 2010-11
Strategic Goals and Priorities
Advancement of the IHSP
Situation Analysis
Evaluation of Prior Year Performance (optional)
Changes to Operations Summary (optional)

Service Plan Narrative – Part B: 2011-12 and 2012-13
<u>Strategic Goals and Priorities</u>
Advancement of the IHSP

Appendix C: Financial Summary

Long-Term Care Home Name:

Recipient number:

Facility Number:

Table A Level of Care Per Diem and Beds/Resident days as at January 1, 2010													
Bed Class	Nursing and Personal Care base	Adjusted Case Mix Index	Nursing and Personal care after applying CMI/100	Program and Support Services	Raw Food	Other Accommodation (excludes Raw Food)	Total LOC Per Diem	Basic Resident Revenue per diem	Beds/Maximum Resident Days				
									Approved	Interim	Total Beds	Maximum Resident Days	
1 Classified							-					-	-
2 Unclassified							-					-	-
3 Convalescent Care							-					-	-

Table B January 1, 2010 to December 31, 2010 Estimated LHIN Subsidy					
	Nursing and Personal Care	Program and Support Services	Raw Food	Other Accommodation	Total
4 Classified and Unclassified: Levels of Care Funding	\$ -	\$ -	\$ -	\$ -	\$ -
5 Convalescent Care: Levels of Care Funding and Additional Per Diem	-	-	-	-	\$ -
6 RPN Funding					\$ -
7 Construction Costs Funding					\$ -
8 Estimated LOC, RPN & Construction Subsidy	\$ -	\$ -	\$ -	\$ -	\$ -
9 Less: Estimate of Basic Resident Revenue excluding preferred portion					\$ -
10 Estimated LHIN Subsidy					\$ -

Table C January 1, 2010 to December 31, 2010. Estimated Ministry Subsidy						
	Nursing and Personal Care	Program and Support Services	Raw Food	Other Accommodation	Claims /Other	Total
11 Pay Equity						\$ -
12 Equalization Adjustment						\$ -
13 Transition Fund - High Wage						\$ -
14 On-Call Physician						\$ -
15 Nursing Initiative						\$ -
16 Accreditation Differential						\$ -
17 Municipal and Capital Tax Allowance						\$ -
18 Debt Service Allowance						\$ -
19 Structural Compliance Premium						\$ -
20 Transition Support Funding						\$ -
21 Claims for High Intensity Needs						\$ -
22 Claims for Lab Costs						\$ -
23 MDS - RAI Funding						\$ -
24 Estimated Ministry Subsidy	\$ -	\$ -		\$ -	\$ -	\$ -

Table D January 1, 2010 to December 31, 2010 Total Estimated LTC Home Revenues/Expenses								
		Nursing and Personal Care	Program and Support Services	Raw Food	Other Accommodation	Claims/Other	Total	
25	Estimated LOC, RPN & Construction Subsidy (from line 8)	\$ -	\$ -	\$ -	\$ -		\$ -	
26	Estimated Ministry Subsidy (from line 24)	-	-		-	-	\$ -	
27	Estimated Subsidy (includes estimated basic resident revenue)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
28	Total Estimated Expenses						\$ -	
29	Estimated Subsidy less Total Estimated Expenses (before Other Revenue)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Other Revenue:								
30	Preferred Revenue (i.e. max. of \$18 per day for private accommodation and \$8 per day for semi-private accommodation)							\$ -
31	Municipal Contribution							\$ -
32	Donations and Fundraising							\$ -
33	Interest Income							\$ -
34	Other (Provide Description):							\$ -
35	Other (Provide Description):							\$ -
36	Other Revenue Sub-total							\$ -
37	Non-deficit/Balanced Budget after Other Revenue							\$ -

Pre-populated information	No input required	LTC Home to enter data
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Appendix D: LHIN Contact Information

Readers are directed to each LHIN's website for contact information. Each LHIN will have a "LAPS/L-SAA" page on the website to provide updates, FAQs, etc.

Listed below is the home page for each LHIN's website and a link to a page devoted to LAPS/L-SAA information including contact information, forms, and FAQ's.

LHIN	Website Home Page	LAPS/L-SAA Primary Contact	LAPS/L-SAA Secondary Contact
Central	http://centrallhin.on.ca/	Naj Hassam	Hyder Yusufzai
Central East	http://www.centraleasthin.on.ca/	John Lohrenz	Lindsay Wyers
Central West	http://www.centralwesthin.on.ca/	Neil McIntosh	Jasdeep Sahota
Champlain	http://www.champlainhin.on.ca/	Eric Partington	Mike Sawyer
Erie St. Clair	http://www.eriestclairhin.on.ca/	Stephanie Harper	Brad Keeler
Hamilton Niagara Haldimand Brant	http://www.hnhblhin.on.ca/	Rosalind Tarrant	Jim Borysko
Mississauga Halton	http://www.mississaugahaltonhin.on.ca/	Rob Low	Monita O'Connor
North Simcoe Muskoka	http://www.nsmlhin.on.ca/	Jill Tettmann	Ann-Marie Kungl-Baker
North East	http://www.nelhin.on.ca/	Barry Lajeunesse	Bruce Villella
North West	http://www.northwesthin.on.ca/	Liisa Simi	Kevin Holder
South East	http://www.southeasthin.on.ca/	Rick Giajnorio	Mike McClelland
South West	http://www.southwesthin.on.ca/	Scott Chambers	Devi Pandya
Toronto Central	http://www.torontocentrallhin.on.ca/	Nello Del Rizzo	Tessie Pajaro
Waterloo Wellington	http://www.waterloowellingtonhin.on.ca/	Blair Philippi	Rebecca Webb