HAMILTON NIAGARA HALDIMAND BRANT
LOCAL HEALTH INTEGRATION NETWORK

(the “LHIN”)

and

BRANT COMMUNITY HEALTHCARE SYSTEM

(the “Hospital”)

Hospital Service Accountability Agreement for 2008-10

TABLE OF CONTENTS

1.0 BACKGROUND 7

1.1. GOAL 7
1.2. ROLES 7
1.3. GOVERNANCE 7
1.4. RELATIONSHIP PRINCIPLES 7
1.5. LEGAL CONTEXT 8
1.6. HEALTH SYSTEM TRANSFORMATION 8

2.0 DEFINITIONS 8

2.1. DEFINITIONS 8

3.0 APPLICATION AND TERM OF AGREEMENT 12

3.1. A SERVICE ACCOUNTABILITY AGREEMENT 12
3.2. TERM 12
3.3. SCHEDULES 12
3.4. APPLICATION 12

4.0 OBLIGATIONS OF THE PARTIES 12

4.1. THE LHIN 12
4.2. THE HOSPITAL 12

5.0 FUNDING 12

5.1. ANNUAL FUNDING 12
5.2. PLANNING ALLOCATIONS 12
5.3. REVISIONS 12
5.4. ADJUSTMENTS 13
5.5. FUNDING INCREASES 13
5.6. FUNDING RECOVERY 13
5.7. CONSIDERATION OF WEIGHTED CASES 15
5.8. LHIN DISCRETION REGARDING CASE LOAD VOLUMES 15
5.9. SETTLEMENT AND RECOVERY OF FUNDING FOR PRIOR YEARS 15
5.10. DEBT OWING TO THE CROWN 15

6.0 HOSPITAL SERVICES 15

6.1. FUNDING CONDITIONS 15
6.2. HOSPITAL SERVICES 16
6.3. E-HEALTH; INTEROPERABILITY OF ONTARIO'S HEALTH SYSTEM 17

7.0 PLANNING 17

7.1. PLANNING CYCLE 17
7.2. COMMUNITY ENGAGEMENT 17
7.3. SYSTEM PLANNING 17
7.4. PROCESS FOR SYSTEM PLANNING. 17
7.5. CAPITAL PROJECTS 17
7.6. REVIEWS AND APPROVALS 18

TABLE OF CONTENTS

8.0 REPORTING AND DOCUMENT RETENTION 19

8.1. General Reporting Obligations 19
8.2. Specific Reporting Obligations 19
8.3. Confidential Information 19
8.4. Disclosure of Information 19
8.5. Document Retention 19

9.0 PERFORMANCE MANAGEMENT AND IMPROVEMENT 19

9.1. General Approach 19
9.2. Notice of a Performance Factor 19
9.3. Performance Meetings 20
9.4. Performance Meeting Purpose 20
9.5. Performance Improvement Process 20
9.6. Factors Beyond the Hospital's Control 20
9.7. Hospital Improvement Plan 20

10.0 ISSUE RESOLUTION 22

10.1. Principles to be Applied 22
10.2. Informal Resolution 22
10.3. Formal Resolution 22
10.4. CFMA Resolution 22

11.0 INSURANCE AND INDEMNITY 22

11.1. Insurance. 22
11.2. Indemnity 22

12.0 REMEDIES FOR NON-COMPLIANCE 23

12.1. Planning Cycle 23

13.0 DENOMINATIONAL HOSPITALS 24

14.0 NOTICE 24

14.1. Notice 24
14.2. Effective Date 25
14.3. LHIN Representative 25

15.0 ADDITIONAL PROVISIONS 25

15.1. Interpretation 25
15.2. Transparency 25
15.3. Amendment 25
15.4. Severability 25
15.5. Assignment and Assumption 25
15.6. LHIN is an Agent of the Crown 25
15.7. Relationship of the Parties 25
15.8. Survival 26
15.9. Waiver 26
15.10. Counterparts 26
15.11. Further Assurances 26
15.12. Governing Law 26
15.13. Entire Agreement 26

SCHEDULES

Schedule A: Planning and Funding Timetable
Schedule B: Performance Obligations
Schedule C: Hospital Multi-Year Funding Allocation
Schedule D: Global Volumes and Performance Indicators
Schedule E: Critical Care Funding
Schedule F: Post-Construction Operating Plan Funding and Volume
Schedule G: Protected Services
Schedule H: Wait Time Services

1.0 BACKGROUND

1.1. Goal.

The LHIN seeks to enter into a Hospital Service Accountability Agreement ("H-SAA") with the Hospital. The H-SAA reflects that to the extent one party succeeds, the other party will also succeed as the parties share a common interest in supporting "… a health care system that keeps people healthy, gets them good care when they are sick and will be there for our children and grandchildren".

1.2. Roles.

1.2.1 MOHLTC's Role. The MOHLTC provides strategic leadership, planning and central oversight as steward of the health system in Ontario. The MOHLTC is an active partner in supporting the health system and establishes strategic direction, multi-year plans, provincial standards and priorities. The MOHLTC also monitors, evaluates and reports on the performance of the health system and the health of Ontarians and establishes funding models and funding levels for the health system.

1.2.2 LHIN and Hospital Shared Roles. The parties will collaborate and cooperate to facilitate the achievement of this Agreement. The parties will work together to enhance the efficiency and effectiveness of Hospital Services using a continuous improvement framework.

1.2.3 LHIN's Role. The LHIN will lead, plan, coordinate, integrate and fund the local health system. The LHIN will also monitor, evaluate, report on and address the performance of health service providers and the local health system.

1.2.4 Hospital's Role. The Hospital provides Hospital Services and organizational leadership supporting systems integration and improved health outcomes. The Hospital also plans, monitors, evaluates and reports on the performance of Hospital Services delivered by the Hospital.

1.3. Governance.

The LHIN acknowledges and supports the role of local independent hospital boards contributing to an effective and efficient local health system. The Hospital's Board of Directors remains fully responsible for using its authority to govern the Hospital under Applicable Law and Applicable Provincial Policies.

1.4. Relationship Principles.

Recognizing their interdependence, the parties will adopt and follow a proactive, collaborative and responsive approach to:

(i) establish clear lines of communication and responsibility;
(ii) develop clear and achievable performance obligations;
(iii) focus on ongoing performance improvement and risk management; and
(iv) resolve issues in a diligent, proactive and timely manner,

all based on the practice of early notice.

1.5. Legal Context.

1.5.1 Background. Under the Local Health System Integration Act (the "Act"), the LHIN is required to enter into a service accountability agreement with each of the health service providers that it funds. This Agreement is the first public hospital H-SAA and it succeeds the 07/08 HAA that was assigned by the MOHLTC to the LHIN in April 2007.

1.5.2 The Act. The purpose of the Act is to provide for an integrated health system to 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 (ii) effective and efficient management of the health system at the local level by LHINs.

1.5.3 The Act and an H-SAA. The Act requires the terms and conditions of an H-SAA to be in accordance with: (i) the funding that the LHIN receives from the MOHLTC; and (ii) the LHIN's accountability agreement with the MOHLTC. The H-SAA is a service accountability agreement under, and subject to, the provisions of the *Commitment to the Future of Medicare Act, 2004* (the "CFMA").

1.6. Health System Transformation.

Health system transformation will be an evolutionary process. The H-SAA and processes contained within it reflect this transitional state. Through the term of the H-SAA, it is intended that LHINs and hospitals will work collaboratively to further define and refine the processes necessary to fulfill their respective funding, planning, integration and performance obligations. The H-SAA template reflects, in part, the LHINs' intention over the next few years to move to the use of standardized terms and common formats as appropriate in their service accountability agreements with all health service providers. The use of standard terms and common formats will support equitable treatment of health service providers across the province, facilitate the administration of Service Accountability Agreements (SAAs) and ensure that the focus is on outcomes and the quality of care and treatment of individuals.

2.0 DEFINITIONS

2.1. Definitions. The following definitions are applicable to terms used in this Agreement:

Act means the *Local Health System Integration Act, 2006* as it may be amended from time to time;

Agreement means this agreement and includes the Schedules, as amended from time to time;

Applicable Law; when used in reference to the Hospital means legislation affecting the operations of the Hospital, and when used in reference to the LHIN, means legislation affecting the operations of the LHIN;

Applicable Policies means provincial policies, standards and operating manuals that are identified by the parties and where there is agreement that they apply;

Base Funding means the funding set out in ***Schedule C*** on the lines labeled "Opening Base Funding" and "Incremental Base Funding";

Balanced Budget means that in a given Fiscal Year the total corporate revenues (excluding interdepartmental recoveries and facility-related deferred revenues) of the Hospital are greater than or equal to the total corporate expenses (excluding interdepartmental expenses and facility-related amortization expenses) of the Hospital when using the consolidated corporate income statements (all fund types and sector codes) (see subsection 6.1.3);

Capital Initiatives means any initiative of the Hospital related to the construction, renewal or renovation of a facility or site, funded in whole or in part by the Government of Ontario, that is not an Own-Funds Capital Project or part of the HIRF;

CEO means Chief Executive Officer;

CFMA means the *Commitment to the Future of Medicare Act, 2004* as it may be amended from time to time;

Days means calendar days*;*

Factors Beyond the Hospital's Control include occurrences that are, in whole or in part, caused by persons, organizations or events beyond the Hospital's control. Examples may include, but are not limited to, the following:

(i) significant costs associated with complying with new or amended Government of Ontario technical standards, guidelines, policies or legislation;

(ii) the availability of health care in the community (long-term care, home care, and primary care);

(iii) the availability of health human resources;

(iv) arbitration decisions that affect Hospital employee compensation packages, including wage, benefit and pension compensation, which exceed reasonable Hospital planned compensation settlement increases and in certain cases non-monetary arbitration awards that significantly impact upon Hospital operational flexibility; and

(v) catastrophic events, such as natural disasters and infectious disease outbreaks;

Fiscal Year means a period of 12 consecutive months beginning on April 1 and ending the following March 31;

Funding means the funding provided by the LHIN to the Hospital under this Agreement;

HAA means the hospital accountability agreement previously executed between a

hospital and the MOHLTC;

HAPS means the Board-approved hospital annual planning submission provided by the Hospital to the LHIN for the Fiscal Years 2008-2009 and 2009-2010;

HIRF means the health infrastructure renewal fund established to provide capital funding grants of usually less than $1 million for the renewal or renovation of a public hospital;

Hospital Services means the clinical services provided by the Hospital, and the operational activities that support those clinical services;

H-SAA means a hospital service accountability agreement, i.e. a SAA between a LHIN and a hospital;

Improvement Plan means a plan that the Hospital may be required to develop under subsection 9.7 of this Agreement;

LHINs mean one or more of the local health integration networks continued or established under the Act;

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

Own-Funds Capital Project means a capital project funded by the Hospital without capital funding from the Government of Ontario, including the MOHLTC and the LHIN;

Performance Corridor means the acceptable range of results around a Performance Target;

Performance Factor means any matter that significantly affects a party's ability to fulfill its obligations under this Agreement;

Performance Indicator means a measure of Hospital performance for which a Performance Target is set;

Performance Standard means the acceptable range of performance for a Performance Indicator or Service Volume that results when a Performance Corridor is applied to a Performance Target (as described in the Schedules);

Performance Target means the planned level of performance expected of the Hospital in respect of Performance Indicators or Service Volumes;

person or entity includes any individual, corporation, partnership, firm, joint venture or other single or collective form of organization under which business may be conducted;

SAA means a service accountability agreement as that term is defined in the Act;

Schedule means any one of, and "Schedules" mean any two or more, as the context requires, of the schedules appended to this Agreement including the following:

Schedule A: Planning and Funding Timetable;
Schedule B: Performance Obligations;
Schedule C: Hospital Multi-Year Funding Allocation;
Schedule D: Global Volumes and Performance Indicators;
Schedule E: Critical Care Funding;
Schedule F: Post-Construction Operating Plan Funding and Volume;
Schedule G: Protected Services; and
Schedule H: Wait Time Services.

Service Volume means a measure of Hospital Services for which a Performance Target has been set.

3.0 APPLICATION AND TERM OF AGREEMENT

3.1. **A Service Accountability Agreement.** This Agreement is a SAA for the purposes of subsection 20(1) of the Act and Part III of the CFMA. This Agreement sets out the parties' respective obligations as set out in *section 4.0*.

3.2. **Term.** This Agreement will commence on April 1, 2008 and will terminate on March 31, 2010.

3.3. **Schedules.** Each Schedule will clearly specify the fiscal period or periods to which it applies.

3.4. **Application.** This Agreement does not apply to or supersede other funding or contractual arrangements that the Hospital may have with the provincial Crown, Cancer Care Ontario or the federal Crown.

4.0 OBLIGATIONS OF THE PARTIES

4.1. **The LHIN.** The LHIN will fulfill its obligations under this Agreement in accordance with the terms of this Agreement, Applicable Law and Applicable Provincial Policies.

4.2. **The Hospital.** The Hospital will fulfill its obligations under this Agreement in accordance with the terms of this Agreement, Applicable Law and Applicable Provincial Policies.

5.0 FUNDING

5.1. **Annual Funding.** The LHIN will provide the Hospital with the Funding specified in ***Schedule C*** in equal installments twice monthly unless otherwise agreed. The LHIN is not responsible for any commitment or expenditure by the Hospital in excess of the Funding that the Hospital makes in order to meet its commitments under this Agreement nor does this Agreement commit the LHIN to provide additional funds during or beyond the term of this Agreement.

5.2. **Planning Allocations.** The Hospital acknowledges that the planning allocations specified in ***Schedule C*** are targets only, provided solely for the purposes of planning and is subject to confirmation. Funding and the confirmation of ***Schedule C*** is conditional upon an appropriation of moneys by the Legislature of Ontario to the MOHLTC and funding of the LHIN by the MOHLTC under the Act.

5.3. **Revisions.** If actual Funding is different than what is specified in ***Schedule C***, the parties will negotiate and revise the requirements for Performance Indicators, Performance Standards or Service Volumes, as necessary.

5.4. Adjustments. The LHIN may make in-year, year end and after year end settlement adjustments to the Funding. Increases in Funding specified in ***Schedule C*** will be carried out in accordance with the provisions of *subsection 5.5*. Any recovery of Funding specified in ***Schedule C*** will be carried out in accordance with the provisions of *subsection 5.6*.

5.5. Funding Increases. Before the LHIN can make an allocation of additional funds to the Hospital, the parties will: (i) agree on the amount of the increase; (ii) agree on any terms and conditions that will apply to the increase; and (iii) execute an amendment to this Agreement that reflects the agreement reached.

5.6. Funding Recovery.

5.6.1 Recovery of Funding.

(a) Generally. Recovery of Funding specified in ***Schedule C*** may occur for the following reasons:

(i) the LHIN makes an overpayment to the Hospital that results in the Hospital receiving more Funding than specified in ***Schedule C***;

(ii) an assessment of financial reductions under *subsection 12.1*;

(iii) as a result of a system planning process under *section 7.4*;

(iv) as a result of an integration decision made under section 26 of the Act; and

(v) as provided for in ***Schedule B***.

(b) Recovery of Errors, Penalties and under ***Schedule B***. The LHIN may recover Funding subject to *subsection 5.6.1(a)(i), (ii) or (v)* in accordance with the process outlined in *subsection 5.6.2*.

(c) Recovery of Funding as a Result of System Planning or Integration. If Hospital Services are reduced as a result of a system planning process under *subsection 7.4* or an integration decision made under section 26 of the Act, the LHIN may recover Funding as agreed in the process in *subsection 7.4* or as set out in the decision.

5.6.2 Process of Recovery. If the LHIN, acting reasonably, determines that a recovery of Funding is required under *subsection 5.6.1 (a)(i), (ii) or (v)*, then:

(i) the LHIN will give 30 Days' notice to the Hospital.

(ii) The notice will describe:

(a) the amount of the proposed recovery;

(b) the term of the recovery if not permanent;

(c) the proposed timing of the recovery;

(d) the reasons for the recovery; and

(e) the amendments, if any, that the LHIN proposes be made to the Hospital's obligations under this Agreement.

(iii) Where a Hospital disputes any matter set out in the notice, the parties will discuss the circumstances that resulted in the notice and the Hospital may make representations to the LHIN about the matters set out in the notice within 14 Days of receiving the notice.

(iv) The LHIN will consider the representations made by the Hospital and will advise the Hospital of its decision. Funding recoveries, if any, will occur in accordance with the timing set out in the LHIN's decision. No recovery of Funding will be implemented earlier than 30 Days after the delivery of the notice.

5.6.3 Full Consideration. In making a determination under *subsection 5.6.2*, the LHIN will act reasonably and will consider the impact, if any, that a recovery of Funding will have on the Hospital's ability to meet its obligations under this Agreement.

5.6.4 Hospital's Retention of Operating Surplus. In accordance with the MOHLTC's 1982 (revised 1999) Business Oriented New Development Policy (BOND), the Hospital will retain any net income or operating surplus of income over expenses earned in a Fiscal Year, subject to any in-year or year-end adjustments to Funding in accordance with *subsection 5.6.1*. Any net income or operating surplus retained by the Hospital under the BOND policy must be used in accordance with the BOND policy. If using operating surplus to start or expand the provision of clinical services, the Hospital will comply with *subsection 7.3*.

5.7. Consideration of Weighted Cases. Where a settlement and recovery is primarily based on volumes of cases performed by the Hospital, the LHIN may consider the Hospital's actual total weighted cases.

5.8. LHIN Discretion Regarding Case Load Volumes. The LHIN may consider, where appropriate, accepting case load volumes that are less than a Service Volume or Performance Standard, and the LHIN may decide not to settle and recover from the Hospital if such variations in volumes are: (i) only a small percentage of volumes; or (ii) due to a fluctuation in demand for the services.

5.9. Settlement and Recovery of Funding for Prior Years. The Hospital acknowledges that settlement and recovery of Funding can occur up to seven years after the provision of Funding. Recognizing the transition of responsibilities from the MOHLTC to the LHIN, the Hospital agrees that if the parties are directed in writing to do so by the MOHLTC, the LHIN will settle and recover on behalf of the MOHLTC, and the Hospital will enable the recovery of, Funding provided to the Hospital by the MOHLTC in fiscal 2000/01 and every subsequent Fiscal Year up to and including 2006/07. All such settlements and recoveries will be subject to the terms applicable to the original provision of funding.

5.10. Debt Owing to the Crown. Where the Hospital is required to repay the LHIN any amount of the Funding, the amount is a debt owing to the Crown and the LHIN may:

(i) set-off the amount owing against any further payment under this Agreement or under any other agreement with the LHIN; or

(ii) require the Hospital to immediately pay the amount to the MOHLTC.

6.0 HOSPITAL SERVICES

6.1. Funding Conditions.

6.1.1 Funding. The Hospital will ensure that the Funding is:

(i) used to provide Hospital Services in accordance with *subsection 6.2*;

(ii) used in accordance with ***Schedules B - H***; and

(iii) not used for major building renovation or construction, or for direct expenses relating to research projects.

6.1.2 Provision for the Recovery of Funding. The Hospital will make reasonable and prudent provision for the recovery by the LHIN of any Funding that the LHIN may recover under this Agreement and will hold this Funding in an interest bearing account until such time as reconciliation and settlement has occurred with the LHIN. Interest earned on Funding will be recoverable by the LHIN or be used for the provision of Hospital Services in accordance with this Agreement.

6.1.3 Balanced Budget.

(a) **Basic Requirement.** The Hospital will achieve and maintain a Balanced Budget.

(b) **Facilitating a Balanced Budget.** The parties will work together to identify budgetary flexibility and manage in-year risks and pressures to facilitate the achievement of a Balanced Budget for the Hospital and a balanced budget for the LHIN.

(c) **Waiver.** The obligation to achieve a Balanced Budget may be waived by the LHIN as follows:

(i) Where the Hospital has the capacity to fund a negative margin, it can request a different target. The LHIN may consider the request based upon the overall financial health of the Hospital (as measured by its Current Ratio), the Hospital's commitment to use its working capital to fund its deficit and the Hospital's plan to achieve a Balanced Budget within an agreed upon timeframe; or

(ii) The LHIN may consider accepting a proposed deficit where the LHIN has determined that achievement of a Balanced Budget position is not feasible in such cases the LHIN may agree to a reasonable deficit in the first Fiscal Year of the H-SAA as long as a Balanced Budget will be achieved within a timeframe acceptable to the LHIN.

Prior to considering a waiver of the Balanced Budget requirement, the LHIN must first work with the Hospital under *subsection 6.1.3(b)* determine whether a waiver is necessary and/or appropriate. Any waiver granted under this *subsection 6.1.3(c)* at the discretion of the LHIN and will be subject to conditions, including, but not limited to: (i) a requirement that the Hospital comply with a plan approved by the LHIN to achieve a Balanced Budget within a defined period of time; and (ii) monitoring requirements. The conditions of any waiver of *subsection 6.1.3(a)* that may be granted by the LHIN will be set out in ***Schedule B***.

Where such a waiver is granted, it and the conditions attached to it will form part of this Agreement.

6.2. Hospital Services. The Hospital will:

(i) achieve the Performance Standards described in the Schedules;

(ii) not reduce, stop, start, expand, cease to provide or transfer the provision of Hospital Services to another hospital or to another site of the Hospital if such action would result in the Hospital being unable to achieve the Performance Standards described in the Schedules; and

(iii) not restrict or refuse the provision of Hospital Services to an individual based on the geographic area in which the person resides in Ontario.

6.3. E-health; Interoperability of Ontario's Health System. The MOHLTC has agreed to set, in consultation with the LHIN and others, as appropriate, technical standards related to e-Health and the interoperability of Ontario's health system. It is expected that the LHINs will consult the hospital sector when setting these standards. The Hospital agrees to comply with any standards set by Ontario Health Informatics Standards Council that are approved for use.

7.0 PLANNING

7.1. Planning Cycle. The parties will use, and meet the due dates in, the planning cycle in Part II of ***Schedule A*** ("Planning Cycle") for Fiscal Years 2010/11 and 2011/12.

7.2. Community Engagement. The Hospital acknowledges that it is required by subsection 16(6) of the Act to engage the community of diverse persons and entities in the area where it provides health services when developing plans and setting priorities for the delivery of health services. The Hospital agrees to communicate with the LHIN on its efforts and activities in community engagement.

7.3. System Planning. The parties will collaborate and cooperate in matters that affect them concerning health system improvement. If the Hospital is planning to significantly reduce, stop, start, expand, cease to provide or transfer the provision of Hospital Services to another hospital or to another site of the Hospital, it will inform the LHIN.

7.4. Process for System Planning.

If:

(i) the Hospital has identified an opportunity to integrate its Hospital Services with that of one or more other health service providers;

(ii) the health service provider or providers, as the case may be, has or have agreed to the proposed integration with the Hospital;

(iii) the Hospital and the health service providers have agreed on the amount of funds needed to be transferred from the Hospital to one or more other health service providers to effect the integration as planned between them;

(iv) the Hospital has complied with its obligations under section 27 of the Act;

then the LHIN may recover from the Hospital, Funding specified in ***Schedule C*** and agreed by the Hospital as needed to facilitate the integration.

7.5. Capital Projects.

7.5.1 Capital Initiatives. The Hospital acknowledges that the LHIN will provide advice to the MOHLTC about the consistency of a Hospital's Capital Initiative with local health system needs during the MOHLTC's review and approval processes, including at the pre-proposal, business case or functional program stages and that

the MOHLTC will continue to be responsible for the approval and funding of approved Capital Initiatives.

7.5.2 Own-Funds Capital Projects. The Hospital acknowledges that until such time as the MOHLTC devolves the review and approval process for Own-Funds Capital Projects to the LHIN, the LHIN will provide advice to the MOHLTC about the consistency of the Hospital's Own-Funds Capital Project with local health system needs during the MOHLTC's review and approval processes, including at the pre-proposal, business case or functional program stages.

7.5.3 HIRF. The Hospital acknowledges that starting in Fall 2007, the LHIN will approve eligible HIRF projects in accordance with the MOHLTC's guidelines. The MOHLTC will continue to be responsible for the funding of approved HIRF projects.

7.6. Reviews and Approvals.

7.6.1 Timely Response. Subject to *subsection 7.6.2*, and except as expressly provided by the terms of this Agreement, the LHIN will respond to Hospital submissions requiring a response from the LHIN in a timely manner and in any event, within the time period set out in ***Schedule B***. If the LHIN has not responded to the Hospital within the time period set out in ***Schedule B***, following consultation with the Hospital, the LHIN will provide the Hospital with written notice of the reasons for the delay and a new expected date of response. If a delayed response from the LHIN could reasonably be expected to have a prejudicial effect on the Hospital, the Hospital may refer the matter for issue resolution under *section 10.0*.

7.6.2 Exceptions. *Subsection 7.6.1* does not apply to: (i) any notice provided to the LHIN under section 27 of the Act, which shall be subject to the timelines of the Act; and (ii) any report required to be submitted to the MOHTC by the LHIN for which the MOHLTC response is required before the LHIN can respond.

8.0 REPORTING AND DOCUMENT RETENTION

8.1. General Reporting Obligations. The Hospital will provide to the LHIN, or to such other entity as the parties may reasonably agree, in the form and within the time specified by the LHIN, the plans, reports, financial statements or other information ("Information"), other than personal health information as defined in subsection 31(5) of the CFMA, that: (i) the LHIN requires for the purposes of exercising its powers and duties under this Agreement, the Act or for the purposes that are prescribed under the Act; or (ii) that may be requested under the CFMA.

8.2. Specific Reporting Obligations. Without limiting the foregoing, the Hospital will fulfill the specific reporting requirements set out in ***Schedule B***. The Hospital will ensure that all reports are in a form satisfactory to the LHIN, are complete, accurate, signed on behalf of the Hospital by a person authorized to sign them and provided to the LHIN in a timely manner.

8.3. Confidential Information. If any Information submitted by the Hospital under this Agreement contains information that is of a confidential nature, then the LHIN will treat that Information as confidential and will not disclose the Information except with the consent of the Hospital or under the *Freedom of Information and Protection of Privacy Act*, which the Hospital acknowledges applies to the LHIN.

8.4. Disclosure of Information. The LHIN may disclose information that it collects under this Agreement in accordance with the Act, the CFMA, the *Freedom of Information and Protection of Privacy Act*, court order or subpoena.

8.5. Document Retention. The Hospital will retain all records (as that term is defined in the *Freedom of Information and the Protection of Privacy Act*) related to the Hospital's performance of its obligations under this Agreement for seven years after the expiration of the term of this Agreement.

9.0 PERFORMANCE MANAGEMENT AND IMPROVEMENT

9.1. General Approach. The parties will follow a proactive, collaborative and responsive approach to performance management and improvement. Either party may request a meeting at any time. The parties will use their best efforts to meet as soon as possible following a request.

9.2. Notice of a Performance Factor. Each party will notify the other party, as soon as reasonably possible, of any Performance Factor. The notice will:

(i) describe the Performance Factor and its actual or anticipated impact;

(ii) include a description of any action the party is undertaking, or plans to undertake, to remedy or mitigate the Performance Factor;

(iii) indicate whether the party is requesting a meeting to discuss the Performance Factor; and

(iv) address any other issue or matter the party wishes to raise with the other party, including whether the Performance Factor may be a Factor Beyond the Hospital's Control.

The recipient party will acknowledge in writing receipt of the notice within five Days of the date on which the notice was received ("Date of the Notice").

9.3. Performance Meetings. Where a meeting has been requested under *subsection 9.2(iii)*, the parties will meet to discuss the Performance Factor within 14 Days of the Date of the Notice. A LHIN can require a meeting to discuss the Hospital's performance of its obligations under this Agreement, including but not limited to a result for a Performance Indicator or a Service Volume that falls outside the applicable Performance Standard.

9.4. Performance Meeting Purpose. During a performance meeting, the parties will:

(i) discuss the causes of the Performance Factor;

(ii) discuss the impact of the Performance Factor and the relative risk of non-performance; and

(iii) determine the steps in the performance improvement process to be taken to remedy or mitigate the impact of the Performance Factor.

9.5. Performance Improvement Process. The purpose of the performance improvement process is to remedy or mitigate the impact of a Performance Factor. The performance improvement process may include:

(i) a requirement that the Hospital develop an Improvement Plan; or

(ii) an amendment of the Hospital's obligations as mutually agreed by the parties.

9.6. Factors Beyond the Hospital's Control. If the LHIN, acting reasonably, determines that the Performance Factor is, in whole or in part, a Factor Beyond the Hospital's Control:

(i) the LHIN will collaborate with the Hospital to develop and implement a mutually agreed upon joint response plan which may include an amendment of the Hospital's obligations under this Agreement;

(ii) the LHIN will not require the Hospital to prepare an Improvement Plan; and

(iii) the failure to meet an obligation under this Agreement will not be considered a breach of the Agreement for the purposes of paragraph 5 of subsection 24(1) of the CFMA, to the extent that failure is caused by a Factor Beyond the Hospital's Control.

9.7. Hospital Improvement Plan.

9.7.1 Development of an Improvement Plan. If, as part of a performance improvement process, the LHIN requires the Hospital to develop an Improvement

Plan, the process for the development and management of the Improvement Plan is as follows:

(i) The Hospital will submit the Improvement Plan to the LHIN within 30 Days of receiving the LHIN's request. In the Improvement Plan, the Hospital will identify remedial actions and milestones for monitoring performance improvement and the date by which the Hospital expects to meet its obligations.

(ii) Within 15 business Days of its receipt of the Improvement Plan, the LHIN will advise the Hospital which, if any, remedial actions the Hospital should implement immediately. If the LHIN is unable to approve the Improvement Plan as presented by the Hospital, subsequent approvals will be provided as the Improvement Plan is revised to the satisfaction of the LHIN.

(iii) The Hospital will implement all aspects of the Improvement Plan for which it has received written approval from the LHIN, upon receipt of such approval.

(iv) The Hospital will report quarterly on progress under the Improvement Plan, unless the LHIN advises the Hospital to report on a more frequent basis. If Hospital performance under the Improvement Plan does not improve by the timelines in the Improvement Plan, the LHIN may agree to revisions to the Improvement Plan.

The LHIN may require, and the Hospital will permit and assist the LHIN in conducting, an operational and/or financial audit of the Hospital to assist the LHIN in its consideration and approval of the Improvement Plan. The Hospital will pay the costs of these audits.

9.7.2 Peer/LHIN Review of Improvement Plan. If Hospital performance under the Improvement Plan does not improve in accordance with the Improvement Plan, or if the Hospital is unable to develop an Improvement Plan satisfactory to the LHIN, the LHIN may appoint an independent team to assist the Hospital to develop an Improvement Plan or revise an existing Improvement Plan. The independent team will include a representative from another hospital selected with input from the OHA. The independent team will work closely with the representatives from the Hospital and the LHIN. The Hospital will submit a new Improvement Plan or revisions to an existing Improvement Plan within 60 Days of the appointment of the independent team.

9.7.3 Costs. The Hospital will pay for costs incurred by the Hospital in developing an Improvement Plan and costs incurred by an independent team assisting the Hospital to either develop or revise an Improvement Plan.

10.0 ISSUE RESOLUTION

10.1. Principles to be Applied. The parties will use their best efforts to resolve issues and disputes in a collaborative manner. This includes avoiding disputes by clearly articulating expectations, establishing clear lines of communication, and respecting each party's interests.

10.2. Informal Resolution. The parties will use their best efforts to resolve all issues and disputes through informal discussion and resolution. To facilitate and encourage this informal resolution process, the parties will use their best efforts to jointly develop a written issues statement. The issues statement will describe the facts and events leading to the issue or dispute and will list potential options for its resolution. If the issue or dispute cannot be resolved at the level at which it first arose, either party may refer it to the Senior Director of Performance Contracts and Allocations of the LHIN and to his or her counterpart in the senior management of the Hospital. If senior management is unable to resolve the issue or dispute, each party will refer it to its respective CEO. The CEOs will meet within 14 Days of this referral and will use their best efforts to resolve the issue or dispute.

10.3. Formal Resolution. If the issue or dispute remains unresolved 30 Days after the first meeting of the CEOs, then the LHIN will either: (a) provide the Hospital with its decision to resolve the issue or dispute; or (b) provide the Hospital with notice under subsection 24(1) of the CFMA. The parties agree that before invoking the provisions of *subsection 10.3 or 10.4*, the parties' respective Boards Chairs (or Board member designate) will be engaged in the attempt to resolve the issue or dispute.

10.4. CFMA Resolution. If the LHIN provides notice under subsection 24(1) of the CFMA, then the resolution of the issue or dispute will thereafter be governed by the dispute resolution provisions of the CFMA.

11.0 INSURANCE AND INDEMNITY

11.1. Insurance. The Hospital shall maintain Comprehensive Professional and General Liability insurance against claims for bodily injury, death or property damage or loss arising out of the performance of the Hospital's obligations under this Agreement , including the provision of Hospital Services, indemnifying and protecting the LHIN and her Majesty the Queen as represented by the Minister of Health and Long Term Care ("HMQ") but only with respect to liability arising from this Agreement, to an amount of not less then the maximum limit of liability maintained under the Hospital's Comprehensive Professional and General Liability Insurance coverage, in respect of any one accident or occurrence. Any and all such policies of such insurance shall be for the mutual benefit of the Hospital, the LHIN and HMQ and shall include coverage providing for cross liability and severability of interest. The Hospital agrees to include the LHIN and HMQ as additional insureds.

11.2. Indemnity. The Hospital will indemnify and save harmless the LHIN and its officers, employees, directors, independent contractors, subcontractors, agents, and assigns and HMQ and her Ministers, employees, directors, independent contractors, subcontractors, agents and assigns (together the "Indemnified Persons"), from all

costs, losses, damages, judgments, claims, demands, suits, actions, causes of action or other proceedings of any kind or nature (a "Claim"), based on, occasioned by, or attributable to anything done or omitted to be done by the Hospital or the Hospital's directors, agents, employees and/or students related to or arising out of this Agreement, including all legal expenses and costs incurred by an Indemnified Person in defending any legal action pertaining to the Claim, except to the extent that the Claim arose as a direct result of the gross negligence or willful misconduct of the LHIN or HMQ.

12.0 REMEDIES FOR NON-COMPLIANCE

12.1. Planning Cycle. The success of the Planning Cycle depends on the timely performance of each party. To ensure delays do not have a material adverse effect on Hospital Services or LHIN operations, the following provisions apply:

(i) If the LHIN fails to meet an obligation or due date in ***Schedule A***, the LHIN may do one or all of the following:

(a) adjust funding for Fiscal Year 2009/10 to offset a material adverse effect on Hospital Services resulting from the delay; and/or

(b) work with the Hospital in developing a plan to offset any material adverse effect on Hospital Services resulting from the delay, including providing LHIN approvals for any necessary changes in Hospital Services.

(ii) At the discretion of the LHIN, the Hospital may be subject to a financial reduction if the Hospital's:

(a) HAPS is received by the LHIN after the due date in Schedule A without prior LHIN approval of such delay;

(b) HAPS is incomplete;

(c) quarterly performance reports are not provided when due; or

(d) financial and/or clinical data requirements are late, incomplete or inaccurate.

If assessed, the financial reduction will be as follows:

(i) if received within seven Days after the due date, incomplete or inaccurate, the financial penalty will be the greater of: (i) a reduction of 0.03% of the Hospital's Base Funding; or (ii) $2,000; and

(ii) for every full or partial week of non-compliance thereafter, the rate will be one half of the initial financial reduction.

13.0 DENOMINATIONAL HOSPITALS

13.1. For the purpose of interpreting this Agreement, nothing in this Agreement is intended to, and this Agreement will not be interpreted to, unjustifiably, as determined under section 1 of the *Canadian Charter of Rights and Freedoms*, require a Hospital with a denominational mission to provide a service or to perform a service in a manner that is contrary to the denominational mission of the Hospital**.**

14.0 NOTICE

14.1. **Notice.** Any notice required to be given under this Agreement must be in writing. Notice will be sufficiently given if a party delivers it personally, by courier or by fax to the other party at the address set out below.

Name of LHIN: Hamilton Niagara Haldimand Brant Local Health Integration Network	Name of Hospital: Brant Community Healthcare System
Title and Name of LHIN Contact: Alan P. Iskiw, Senior Director, Performance, Contract and Allocation	Title and Name of Hospital Contact: Mr. Richard B. Woodcock, President and CEO
Address: 270 Main Street East Units 1-6 Grimsby ON L3M 1P8 Facsimile: 905-945-1992	Address: 200 Terrace Hill Street Brantford ON N3R 1G9 Facsimile: 519-752-0098

14.2. Effective Date. All notices will be effective at the time the delivery is made when the notice is delivered personally, by courier or by fax provided that the sender of the notice has a written confirmation that the notice was received during the recipient's ordinary business hours. If delivered outside ordinary business hours, the notice will be effective at 9 a.m. at the start of the next business Day.

14.3. LHIN Representative. The LHIN's representative for the purposes of implementing any adjustments to Funding may be a person other than the person named in this section.

15.0 ADDITIONAL PROVISIONS

15.1. Interpretation. In the event of a conflict or inconsistency in any provision of this Agreement, the main body of this Agreement will govern over the Schedules.

15.2. Transparency. As required by the CFMA, the Hospital will post a copy of this Agreement in a conspicuous public place at its sites of operations to which this Agreement applies and on its public website.

15.3. Amendment. The parties may amend this Agreement (including any amendment that adds additional Schedules or amends existing Schedules) and amendments will be in writing and executed by duly authorized representatives of each party.

15.4. Severability. The invalidity or unenforceability of any provision of this Agreement will not affect the validity or enforceability of any other provision of this Agreement and any invalid or unenforceable provision will be deemed to be severed.

15.5. Assignment and Assumption. The Hospital requires the prior written consent of the LHIN to assign this Agreement or the Funding in whole or in part. The LHIN may assign this Agreement or any of its rights and obligations under this Agreement to any one or more of the LHINs or to the Minister.

15.6. LHIN is an Agent of the Crown. The parties acknowledge that the LHIN is an agent of the Crown and may only act as an agent of the Crown in accordance with the provisions of the Act. Notwithstanding anything else in this Agreement, any express or implied reference to the LHIN providing an indemnity or any other form of indebtedness or contingent liability that would directly or indirectly increase the indebtedness or contingent liabilities of the LHIN or Ontario, whether at the time of execution of the Agreement or at any time during the term of the Agreement, will be void and of no legal effect.

15.7. Relationship of the Parties. The Hospital will have no power or authority to bind the LHIN or to assume or create any obligation or responsibility, express or implied, on behalf of the LHIN. The Hospital will not hold itself out as an agent, partner or employee of the LHIN. Nothing in the Agreement will have the effect of creating an employment, partnership or agency relationship between the LHIN and the Hospital (or any of the Hospital's directors, officers, employees, agents, partners, affiliates, volunteers or subcontractors).

15.8. Survival. The provisions in *sections 2.1, 5.1, 5.4, 5.6, 5.9, 6.1.1, 6.1.2, 6.1.3(c), 6.2(i), 7.4, 8.3, 8.4, 8.5, 9.5, 9.6, 9.7, 10.0, 11.2, 12.1, 13.1, 14.0, 15.1, 15.6 and 15.12* will survive the termination or expiry of this Agreement.

15.9. Waiver. The LHIN or the Hospital may waive in writing any of the other party's obligations under this Agreement. A waiver of any failure to comply with any term of this Agreement will not have the effect of waiving any subsequent failures to comply.

15.10. Counterparts. This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument.

15.11. Further Assurances. The parties agree to do or cause to be done all acts or things necessary to implement and carry into effect this Agreement to its full extent.

15.12. Governing Law. This Agreement and the rights, obligations and relations of the parties hereto will be governed by and construed in accordance with the laws of the Province of Ontario and the federal laws of Canada applicable therein.

15.13. Entire Agreement. This Agreement constitutes the entire agreement between the parties with respect to the subject matter contained in the Agreement and supersedes all prior oral or written representations and agreements.

IN WITNESS WHEREOF the parties have executed this Agreement made effective as of April 1, 2008.

BRANT COMMUNITY HEALTHCARE SYSTEM

By:

Name: Gordon Stratford
Chair

April 16/08
Date

I sign as a representative of the Hospital, not in my personal capacity, and I represent that I have authority to bind the Hospital.

And By:

Name: Richard B. Woodcock
CEO

April 1, 2008
Date

I sign as a representative of the Hospital, not in my personal capacity, and I represent that I have authority to bind the Hospital.

HAMILTON NIAGARA HALDIMAND BRANT LOCAL HEALTH INTEGRATION NETWORK

By:

Name: Juanita G. Gledhill
Chair

April 3/08
Date

And By:

Name: Pat Mandy
CEO

April 3, 2008
Date

Facility No. 970

Schedule A
Planning and Funding Timetable

OBLIGATIONS

Part I - Funding Obligations	Party	Timing
Announcement of multi-year funding allocation (confirmation of 2008/09 Schedule C funding, reinforcement of 2009/10 Schedule C funding)	LHIN	The later of June 30, 2008 or 14 days after confirmation from the Ministry of Health and Long Term Care
Announcement of multi-year funding allocation (confirmation of 2009/10 Schedule C funding)	LHIN	The later of June 30, 2009 or 14 days after confirmation from the Ministry of Health and Long Term Care

Part II - Planning Obligations	Party	Timing
Announcement of 2010/11 planning target for hospital planning purposes	LHIN	The later of June 30, 2008 or 14 days after confirmation from the Ministry of Health and Long Term Care
Publication of the Hospital Annual Planning Submission Guidelines for 2010-12	LHIN	No later than June 30, 2009
Announcement of multi-year funding allocation (reaffirm 2010/11 and announce 2011/12 planning targets for 2010-12 HSAA negotiations)	LHIN	The later of June 30, 2009 or 14 days after confirmation from the Ministry of Health and Long Term Care
Submission of Hospital Annual Planning Submission for 2010-12	Hospital	No later than October 31, 2009
Indicator Refresh (including detailed hospital calculations)	LHIN (in conjunction with MOHLTC)	No later than November 30, 2009
Refresh the Hospital Annual Planning Submission for 2010-12 and related Schedules	Hospital/LHIN	No later than January 31, 2010
Sign 2010-12 Hospital Service Accountability Agreement	Hospital/LHIN	No later than February 28, 2010

Obligation Timeline Diagram

Definitions:

Planning Target = For negotiations

Confirm = Confirm signed agreement amounts after appropriation of monies by the Legislature of Ontario

	Funding Year						
	06/07	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**	**12/13**
Announce		**2007/08 HAA**	**2008-10 H-SAA**		**2010-12 H-SAA**		**2012 - 2014**
June 06	Confirm Schedule C Funding	Planning Target	Planning Target				
June 07		Confirm Schedule C Funding	Planning Target (Oct)	Planning Target (Oct)			
Feb. 08			Negotiated Schedule C Funding	Negotiated Schedule C Funding			
June 08			Confirm Schedule C Funding	Reaffirm Schedule C Funding	Planning Target		
June 09				Confirm Schedule C Funding	Planning Target	Planning Target	
Feb. 10					Negotiated Schedule C Funding	Negotiated Schedule C Funding	
June 10					Confirm Schedule C Funding	Reaffirm Schedule C Funding	Planning Target

Funding Obligations are shaded
Planning Obligations are not shaded

Schedule B
Performance Obligations

LIST OF CONTENTS

1.0 PERFORMANCE CORRIDORS FOR SERVICE VOLUMES IDENTIFIED IN SCHEDULE D
- 1.1 Application
- 1.2 Total Acute Activity, including Inpatient and Day Surgery Weighted Cases
- 1.3 Mental Health Inpatient Days
- 1.4 Elderly Capital Assistance Program (ELDCAP) Inpatient Days
- 1.5 Rehabilitation Inpatient Days
- 1.6 Complex Continuing Care Resource Utilization Group (RUG) Weighted Patient Days
- 1.7 Ambulatory Care Visits
- 1.8 Emergency Department Visits

2.0 PERFORMANCE CORRIDORS FOR PERFORMANCE INDICATORS IDENTIFIED IN SCHEDULE D
- 2.1 Application
- 2.2 Readmissions to Own Facility for Selected CMGs
- 2.3 Percentage of Chronic Patients with New Stage 2 or Greater Skins Ulcers (Chronic Care Designated Activity Only)
- 2.4 Current Ratio
- 2.5 Total Margin
- 2.6 Percentage of Full Time Nurses

3.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO NURSING ENHANCEMENT/CONVERSION
- 3.1 Measurement of Full-Time Nursing Performance Indicators
- 3.2 Reporting and Annual Nursing Staff Plans

4.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO CRITICAL CARE – SCHEDULE E
- 4.1 Application
- 4.2 Critical Care Beds
- 4.3 Critical Care Funding
- 4.4 Financial Settlement and Recovery

5.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO POST CONSTRUCTION OPERATING PLAN FUNDING AND VOLUME – SCHEDULE F
- 5.1 Post Construction Operating Plan (PCOP) Funding
- 5.2 Financial Settlement and Recovery for Post-Construction and Operating Plan

6.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO PROTECTED SERVICES – SCHEDULE G
- 6.1 Definitions
- 6.2 Performance Obligations for Protected Services
- 6.3 Financial Settlement and Recovery for Protected Services

7.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO WAIT TIME SERVICES – SCHEDULE H
- 7.1 Performance Obligations with respect to Wait Time Services
- 7.2 Wait Time Reporting Obligations
- 7.3 Financial Settlement and Recovery for Wait Time Services

8.0 REPORTING OBLIGATIONS

9.0 LHIN SPECIFIC PERFORMANCE OBLIGATIONS

APPENDIX 1 HOSPITAL AND LHIN REPORTING OBLIGATIONS

APPENDIX 1 HOSPITAL AND LHIN REPORTING OBLIGATIONS

1.0 PERFORMANCE CORRIDORS FOR SERVICE VOLUMES IDENTIFIED IN SCHEDULE D

1.1 APPLICATION

The following Performance Corridors are to be applied to the Service Volumes set out in ***Schedule D***. Performance Corridors have been stratified by Hospital size.

1.2 TOTAL ACUTE ACTIVITY, INCLUDING INPATIENT AND DAY SURGERY WEIGHTED CASES

The table below shows the Performance Corridor boundaries by Hospital size for inpatient and day surgery activity as measured by weighted cases.

Hospital Weighted Cases	Corridor Floor	Corridor Ceiling
≤ 500	75%	125%
501 – 1,000	85%	115%
1,001 – 5,000	90%	110%
5,001 – 10,000	92%	108%
10,001 – 15,000	94%	106%
15, 001 – 25,000	95%	105%
25,001 – 40, 000	96%	104%
> 40,000	97%	103%

Day Surgery Activity: Hospital day surgery cases are reported in the National Ambulatory Care Reporting System (NACRS) maintained by the Canadian Institute for Health Information (CIHI). The total number of cases is aggregated under the following functional centres:

Account	Description
71260*	Operating Rooms (OR)
71262*	Combined OR/ Post Anesthetic Recovery Rooms (PARR)
71265*	Post Anesthetic Recovery Rooms (PARR)
7134020	Day/Night Surgical/Procedural (OR/PARR Excluded)
7134025*	Day/Night Surgical/Procedural
7134055*	Endoscopy Day/Night

Inpatient surgery volumes reported under the 712* functional centres *and* in the Discharge Abstract Database (DAD), are excluded.

1.3 MENTAL HEALTH INPATIENT DAYS

Mental Health Inpatient Days for designated mental health beds are reported in the Ontario Health Reporting System (OHRS) Management Information System (MIS) Standard under the following account codes:

Primary Account	Secondary Account	Description
7127625*	403*	Acute Mental Health
7127645*		Addiction Inpatient
7127650*		Child/Adolescent
7127655*		Forensic
7127690*		Psychiatric Crisis Unit
7127695*		Longer Term Psychiatry

Below are Performance Corridors for this indicator:

Mental Health Inpatient Days	Corridor Floor
≤ 5,000	85%
> 5,000 to ≤10,000	90%
> 10,000	94%

1.4 ELDERLY CAPITAL ASSISTANCE PROGRAM (ELDCAP) INPATIENT DAYS

ELDCAP Inpatient Days for designated ELDCAP beds are reported in the OHRS under the following account codes:

Primary Account	Secondary Account	Description
7129560	403*	ELDCAP

The Performance Corridor is between 98% and 102% for all hospitals.

1.5 REHABILITATION INPATIENT DAYS

Rehabilitation Inpatient Days for designated rehabilitation beds are reported in the OHRS under the following account codes:.

Primary Account	Secondary Account	Description
71281*	403*	Rehabilitation Inpatient Days

Below are the Performance Corridors for this indicator.

Hospital Rehabilitation Inpatient Days	Corridor Floor
< 10,000	85%
10,001 – 20,000	90%
> 20,000	94%

1.6 COMPLEX CONTINUING CARE RESOURCE UTILIZATION GROUP (RUG) WEIGHTED PATIENT DAYS

This indicator is based upon the CIHI Chronic Care Reporting System (CCRS)/Resource Utilization Group (RUG-III) weighted patient days (RWPD).

Below are the Performance Corridors for CCC RUG Weighted Patient Days.

Hospital Complex Continuing Care RWPD	Corridor Floor
≤ 20,000	85%
20,001 – 40,000	90%
40,001 – 100,000	92%
> 100,000	94%

1.7 AMBULATORY CARE VISITS

Ambulatory Care Visits are reported in the OHRS as Total Ambulatory Visits minus Emergency Department Visits (all scheduled, non-scheduled, inpatient (IP) and outpatient (OP) clinic visits, and visits in non- surgical Day / Night functional centres) under the following account codes:

Primary Account	Secondary Account	Description
7134* (excluding 7134025, 7134055), 712*, 7135*, 715*	450*, 5*, (excluding 50*, 511*, 512*, 513*, 514*, 518*, 519*, 521*)	Ambulatory Care Visits

Below are the Performance Corridors for this indicator.

Hospital Ambulatory Visits (excluding Emergency Department Visits)	Corridor Floor
≤ 30,000	75%
30,001 – 100,000	80%
100,001 – 200,000	85%
200,001 – 300,000	90%
300,001 – 400,000	92%
> 400,000	94%

1.8 EMERGENCY DEPARTMENT VISITS

Emergency Department visits are reported in the OHRS as Emergency Visits (all scheduled, non-scheduled, IP and OP visits in Emergency functional centres).

Primary Account	Secondary Account	Description
71310*	450*, 5*, (excluding 50*, 511*, 512*, 513*, 514*, 518*, 519*, 521*)	Emergency Visits

Below are the Performance Corridors for this indicator:

Hospital Emergency Visits	Corridor Floor
≤ 30,000	85%
30,001 – 50,000	90%
50,001 – 100,000	93%
> 100,000	96%

2.0 PERFORMANCE CORRIDORS FOR PERFORMANCE INDICATORS IDENTIFIED IN SCHEDULE D

2.1 APPLICATION

The following Performance Corridors are to be applied to the Performance Indicators set out in ***Schedule D***.

2.2 READMISSIONS TO OWN FACILITY FOR SELECTED CMGS

(a) Definition: The number of patients readmitted to own facility for unplanned inpatient care. This is compared to the number of expected unplanned readmissions using data from all Ontario facilities and accounting for the likelihood of return to the same facility (varies by facility).

Readmissions to Own Facility for Selected CMGs = **Observed number** of patients discharged with specified CMGs, readmitted to own acute care facility for any unplanned inpatient care, within 30 days of discharge for the index hospitalization.

The following CMGs were identified for inclusion in this Performance Indicator:

Eligible Conditions & CMGs for Calculation of Readmission Indicator*	
CMG	CMG Description
Stroke: Age: >=45	
13	Specific Cerebrovascular Disorders Except Transient Ischemic Attacks
COPD: Age>=45	
140	Chronic Obstructive Pulmonary Disease (COPD)
142	Chronic Bronchitis
Pneumonia: All ages	
143	Simple Pneumonia and Pleurisy
AMI: Age >=45	
205	AMI without Cardiac Cath with Congestive Heart Failure
206	AMI without Cardiac Cath with Ventricular Tachycardia
207	AMI without Cardiac Cath with Angina
208	AMI without Cardiac cath without Specified Cardiac Conditions
CHF: Age>=45	
222	Heart Failure
Diabetes: All ages	
483	Diabetes
GI: All ages	
281	GI Hemorrhage
285	Complicated Ulcer
286	Uncomplicated Ulcer
289	Inflammatory Bowel Disease

APPENDIX 1 HOSPITAL AND LHIN REPORTING OBLIGATIONS

Eligible Conditions & CMGs for Calculation of Readmission Indicator*	
CMG	CMG Description
290	GI Obstruction
294	Esophagitis, Gastroenteritis and Misc. Digestive Disease
297	Other GI Diagnoses
323	Cirrhosis and Alcoholic Hepatitis
325	Pancreas Disease (except Malignancy)
326	Liver Diseases (except Cirrhosis or Cancer)
329	Biliary Tract Diseases
Cardiac CMGs	
Cardiac: Age	
212	Unstable Angina without Cardiac Cath with Specific Cardiac Conditions
213	Unstable Angina without Cardiac Cath without Specific Cardiac Conditions
237	Arrhythmia
235	Angina Pectoris
242	Chest Pain

*Specified CMGs are subject to change if CMG+ is implemented in Ontario.

Readmissions are limited to unplanned readmissions to own hospital within thirty (30) days of index hospitalization discharge date (excluding deaths, patient sign-outs against medical advice and transfers). Discharge date of index hospitalization should occur within the calendar year.

(b) LHIN Target: **Expected number** of readmissions *times* historical "own hospital" readmission proportion The Expected Number Readmissions equals the sum of all predicted probabilities for unplanned readmission to any Ontario acute care hospital *times* the proportion of readmissions that return to the same facility (differs for different facilities). It is adjusted for patient factors such as CMG, age, sex and prior hospitalizations. Look-up tables are provided in WERS to assist in the calculation of this indicator.

(c) Performance Corridor: The Performance Corridor is the upper control limit on the amount by which the Hospital's readmission rate exceeds the expected rate. The width of this corridor is related to the Hospital's annual number eligible cases. The width is three times the standard deviation of the Hospital's expected readmission rate divided by the square root of the Hospital's number of eligible cases.

Hospital-specific corridors are available on the Web Enabled Reporting System (WERS).

2.3 PERCENTAGE OF CHRONIC PATIENTS WITH NEW STAGE 2 OR GREATER SKIN ULCERS (CHRONIC CARE DESIGNATED ACTIVITY ONLY)

(a) Definition: Percentage of Patients with New Stage 2 or Greater Skin Ulcers can be interpreted as an estimate of the percentage of ulcer-free CCC patients who developed stage 2 or greater skin ulcers (of any kind) over a typical 90-day period. Lower values are expected to reflect better performance. This indicator is risk adjusted.

% Chronic Patients with New Stage 2 or > Skin Ulcers = $\frac{\text{Count of target assessments, across all quarters of a fiscal year that meet both the numerator and denominator criteria. An RAI-MDS target assessment is counted if patient is recorded as having one or more skin ulcers at stage 2 or higher [any of the following MDS items have a value greater than 0: M1b “Number of Stage 2 skin Ulcers;” M1c “Number of Stage 3 Skin Ulcers; M1d “Number of Stage 4 Skin Ulcers.}{\text{All RAI-MDS target assessments in the fiscal year that do not meet the exclusion criteria.}}$

Exclusions:
Target assessments that meet any of the following conditions are excluded: 1. Patient who already had one or more skin ulcers of stage 2 or greater on the most recent prior MDS assessment; 2. Missing data for MDS items M1b, M1c or M1d on the target assessment or on the most recent prior one.

(b) LHIN Target: The indicator target is the weighted average of the risk adjusted rate (most recently 6.1%).

(c) Performance Corridor: The corridor is the upper control limit for this rate. This is three times the standard deviation associated with the average risk-adjusted rate divided by the square root of the Hospital’s eligible number of cases. The indicator should not exceed the target by more than this upper control limit.

Hospital-specific corridors available on the Web-Enabled Reporting System.

2.4 CURRENT RATIO

(a) Definition: The number of times a Hospital's short-term obligations can be paid using the Hospital's short-term assets.

$$\textbf{Current Ratio} = \frac{\text{Current Assets}}{\text{Current Liabilities}} = \frac{\text{Current Assets - credits in current asset accounts excluding bad debt + debits in current liability accounts}}{\text{Current Liabilities, excluding deferred contributions - debits in current liability accounts+ credits in current asset accounts (excluding bad debt)}}$$

This performance indicator should be calculated using consolidated corporate balance sheet (all fund types and sector codes). Treatment of credits and debits for assets and liabilities is applied at the HAPS account roll-up level.

(b) LHIN Target: 0.8 – 2.0

(c) Performance Corridor: If outside LHIN Target, a Performance Corridor of plus or minus 10% of the Negotiated Target would be applied. For example, if the Negotiated Target is 0.7, the Performance Corridor would have a lower limit of 0.63 (0.7 * 90%) and an upper limit of 0.77 (0.7 * 110%).

(d) Calculating the Current Ratio

(i) Account Contents of Numerator: i.e. current assets - credits in current asset accounts excluding bad debt + debits in current liability accounts:

Primary Accounts	Secondary Accounts
1* (excluding credit balances in all 1* accounts except for bad debt [1*355]) + debit balances in 4* accounts	Not applicable

Clarification of treatment of Bad Debt: Balances in Bad Debt accounts 1*355 are kept in numerator whether negative or positive.

(ii) Account Contents of Denominator: i.e. Current Liabilities, excluding deferred contributions - debits in current liability accounts + credits in current asset accounts (excluding bad debt):

Primary Accounts	Secondary Accounts
4* (excluding 4*8 and excluding debit balances in 4* accounts) + credit balances in 1* accounts (excluding bad debts 1*355)	Not applicable

Excluded Deferred Contributions	
Account	Description
4* 8 00	Deferred Contributions - Current Detailed accounts required
4* 8 40	Deferred Donations - Current New Reporting Level
4* 8 42	Def. Donations - Current - Land, Building & Building Service Equipment
4* 8 44	Def. Donations - Current – Equipment
4* 8 46	Def. Donations – Current – Operations
4* 8 50	Deferred Provincial Grants - Current New Reporting Level
4* 8 52	Def. Provincial Grants - Current - Land, Building & Building Service Equipment
4* 8 54	Def. Provincial Grants - Current – Equipment
4* 8 56	Def. Provincial Grants - Current - Operations
4* 8 60	Deferred Research Grant - Current New Reporting Level
4* 8 62	Def. Research Grants - Current - Land, Building & Building Service Equipment
4* 8 64	Def. Research Grants - Current – Equipment
4* 8 66	Def. Research Grants - Current - Operations
4* 8 70	Def. Donation Contributed – Current
4* 8 72	Def. Donation Contributed - Current - Land, Building & Building Service Equipment
4* 8 74	Def. Donation Contributed - Current - Equipment
4* 8 76	Def. Donation Contributed - Current - Operations

2.5 TOTAL MARGIN

(a) Definition: The percent by which total revenues exceed or fall short of total expenses, excluding the impact of facility amortization, in a given year.

$$\textbf{Total Margin} = \frac{\text{Total Surplus / Deficit}}{\text{Total Revenues}} \quad \frac{\text{Total Corporate Revenues (excluding Interdepartmental Recoveries and Facility-related Deferred Revenues) minus Total Corporate Expenses (excluding Interdepartmental Expenses and Facility-related Amortization Expenses}}{\text{Total Corporate Revenues (excluding interdepartmental Recoveries and Facility-related Deferred Revenues)}}$$

Total margin is calculated before facility-related amortized expenses and revenues. Inter-departmental recoveries and expenses are also excluded. The Total Margin indicator should be calculated using the consolidated corporate income statements (all fund types and sector codes)

(b) LHIN Target: : 0% unless the LHIN has granted a waiver. The LHIN waiver will form part of the Agreement pursuant to section 6.1.3. (c). The negotiated Performance Target as agreed in the waiver will be included in Schedule D and the conditions that may be granted by the LHIN are to be included in this section of Schedule B.

(c) Performance Corridor: No negative variance is acceptable from the Negotiated Target.

(d) Calculating the Total Margin

(i) Account Contents of Numerator (i.e. Total Corporate Revenues (excluding Interdepartmental Recoveries and Facility-related Deferred Revenues) – Total Corporate Expenses (excluding Interdepartmental Expenses and Facility-related Amortization Expenses)

Primary Accounts	Secondary Accounts
7* + 8*	1* to 9* (excluding 12171, 12195, 12196, 12197, 122*, 13002, 13102, 14102, 15102, 15103, 45100, 62800, 69571, 69700, 72000, 95020, 95040, 95060, 95065, 955*)

Note: Because revenues are reported as credits (negative values) and expenses as debits (positive values) in the MIS Trial Balance, the straight sum of the above revenue and expense accounts will net to the surplus/deficit.

(ii) Account Contents of Denominator (i.e. Total Corporate Revenues (excluding Interdepartmental Recoveries and Facility-related Deferred Revenues)

Primary Accounts	Secondary Accounts
7* + 8*	1* (excluding 12171, 12195, 12196, 12197, 122*, 13002, 13102, 14102, 15102, 15103)

2.6 PERCENTAGE OF FULL-TIME NURSES

(a) Definition: The percentage of Management and Operational Support (MOS), Unit Producing Personnel (UPP) and Nurse Practitioner (NP) earned hours (including worked and benefit hours) provided by full-time nurses of all employment status for provincial sector code 1*.

.

$$\textbf{\% Full-Time Nurses} = \frac{\text{MOS, UPP and NP Earned Hours for Professional \& Regulated Full-Time RNs, RPNs, Nurse Managers, CNS, Nurse Educators and Nurse Practitioners}}{\text{MOS, UPP and NP Earned Hours for Professional and Regulated RNs, RPNs, Nurse Managers, CNS, Nurse Educators and Nurse Practitioners of all Employment Status}}$$

(b) LHIN Target: Minimum of 70%

(c) Performance Corridors:

(i) For Academic and Community Hospitals the Performance Corridor is the Performance Target minus 1% (lower limit only).

(ii) For Small Hospitals, as defined by the JPPC, the Performance Corridor is the Performance Target minus 3% (lower limit only).

(d) Calculating the Percentage of Full-time Nurses:

(i) Account contents of Numerator (i.e. MOS, UPP and NP Earned Hours for Full-Time Nurses)

Primary Accounts	Secondary Accounts
711*, 712*, 713*, 714*, 715*, 717*, 718*, 719*	See table below

Nursing Account Codes	Description
631 11 1*	Earned Hours Details MOS RN Full-Time
631 11 3*	Earned Hours Details MOS RN Part-Time - Temporary Full-Time
631 11 4*	Earned Hours Details MOS RN Part-Time - Job Share
631 11 6*	Earned Hours Details MOS RN Casual - Temporary Full-Time
631 12 1*	Earned Hours Details MOS RPN Full-Time
631 12 3*	Earned Hours Details MOS RPN Part-Time - Temporary Full-Time
631 12 4*	Earned Hours Details MOS RPN Part-Time - Job Share
631 12 6*	Earned Hours Details MOS RPN Casual -Temporary Full-Time
631 13 1*	Earned Hours Details MOS Nurse Manager Full-Time
631 13 3*	Earned Hours Details MOS Nurse Manager Part Time - Temporary Full-Time
631 13 4*	Earned Hours Details MOS Nurse Manager Part Time - Job Share
631 13 6*	Earned Hours Details MOS Nurse Manager Casual - Temporary Full time
631 14 1*	Earned Hours Details MOS Clinical Nurse Specialist Full-Time
631 14 3*	Earned Hours Details MOS Clinical Nurse Specialist Part-Time - Temporary Full-Time
631 14 4*	Earned Hours Details MOS Clinical Nurse Specialist Part-Time - Job Share
631 14 6*	Earned Hours Details MOS Clinical Nurse Specialist Casual - Temporary Full-Time
631 15 1*	Earned Hours Details MOS Nurse Educator Full-Time
631 15 3*	Earned Hours Details MOS Nurse Educator Part-Time - Temporary Full-Time
631 15 4*	Earned Hours Details MOS Nurse Educator Part-Time - Job Share
631 15 6*	Earned Hours Details MOS Nurse Educator Casual - Temporary Full-Time
631 16 1*	Earned Hours Details MOS Nurse Practitioner Full-Time
631 16 3*	Earned Hours Details MOS Nurse Practitioner Part-Time - Temporary Full-Time
631 16 4*	Earned Hours Details MOS Nurse Practitioner Part-Time - Job Share
631 16 6*	Earned Hours Details MOS Nurse Practitioner Casual - Temporary Full-Time
635 11 1*	Earned Hours Details UPP RN Full-Time
635 11 3*	Earned Hours Details UPP RN Part-Time - Temporary Full-Time
635 11 4*	Earned Hours Details UPP RN Part-Time - Job Share
635 11 6*	Earned Hours Details UPP RN Casual - Temporary Full-Time
635 12 1*	Earned Hours Details UPP RPN Full Time
635 12 3*	Earned Hours Details UPP RPN Part Time - Temporary Full Time
635 12 4*	Earned Hours Details UPP RPN Part-Time - Job Share
635 12 6*	Earned Hours Details UPP RPN Casual - Temporary Full-Time
635 13 1*	Earned Hours Details UPP Nurse Manager Full-Time
635 13 3*	Earned Hours Details UPP Nurse Manager Part Time - Temporary Full-

Nursing Account Codes	Description
	Time
635 13 4*	Earned Hours Details UPP Nurse Manager Part Time - Job Share
635 13 6*	Earned Hours Details UPP Nurse Manager Casual - Temporary Full-Time
635 14 1*	Earned Hours Details UPP Clinical Nurse Specialist Full-Time
635 14 3*	Earned Hours Details UPP Clinical Nurse Specialist Part Time - Temporary Full-Time
635 14 4*	Earned Hours Details UPP Clinical Nurse Specialist Part Time - Job Share
635 14 6*	Earned Hours Details UPP Clinical Nurse Specialist Casual Temporary Full-Time
635 15 1*	Earned Hours Details UPP Nurse Educator Full-Time
635 15 3*	Earned Hours Details UPP Nurse Educator Part-Time - Temporary Full-Time
635 15 4*	Earned Hours Details UPP Nurse Educator Part-Time Job Share
635 15 6*	Earned Hours Details UPP Nurse Educator Casual Temporary Full-Time
635 16 1*	Earned Hours Details UPP Nurse Practitioner Full-Time
635 16 3*	Earned Hours Details UPP Nurse Practitioner Part-Time - Temporary Full-Time
635 16 4*	Earned Hours Details UPP Nurse Practitioner Part-Time Job Share
635 16 6*	Earned Hours Details UPP Nurse Practitioner Casual Temporary Full-Time
638 11 1*	Earned Hours Details NP RN Full-Time
638 11 3*	Earned Hours Details NP RN Part-Time - Temporary Full-Time
638 11 4*	Earned Hours Details NP RN Part-Time - Job Share
638 11 6*	Earned Hours Details NP RN Casual - Temporary Full-Time
638 16 1*	Earned Hours Details NP Nurse Practitioner Full-Time
638 16 3*	Earned Hours Details NP Nurse Practitioner Part-Time - Temporary Full-Time
638 16 4*	Earned Hours Details NP Nurse Practitioner Part-Time - Job Share
638 16 6*	Earned Hours Details NP Nurse Practitioner Casual - Temporary Full-Time

(ii) Account Contents of Denominator (i.e. MOS, UPP and NP Earned Hours for Nurses of all Employment Status)

Primary Accounts	Secondary Accounts
711*, 712*, 713*, 714*, 715*, 717*, 718* and 719*	See table below

Account	Description
631 ** **	Earned Hours Details MOS
635 ** **	Earned Hours Details UPP
638 ** **	Earned Hours Details NP

Where ** the 4th and 5th position is equal to all nursing occupational class codes, with a value of:

4th and 5th digits	Occupational Class
11	RN
12	RPN
13	Nurse Manager
14	Clinical Nurse Specialist
15	Nurse Educator
16	Nurse Practitioner

APPENDIX 1 HOSPITAL AND LHIN REPORTING OBLIGATIONS

Where ** the 6th and 7th position is equal to employment status, type of earned hrs (worked + benefit) with a value of :

6th digit	Employment status
1	Full-Time
2	Part-Time Regular
3	Part-Time Temporary Full-Time
4	Part-Time Job Share
5	Casual Regular
6	Casual-Temporary Full-Time
9	Purchased Service

7th digit	Type of Earned hours
1	wkd-overtime
2	wkd-other
3	ben-sick
4	ben-vacation
5	ben-education
6	ben-orientation
7	ben-other

APPENDIX 1 HOSPITAL AND LHIN REPORTING OBLIGATIONS

3.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO NURSING ENHANCEMENT/CONVERSION

3.1 MEASUREMENT OF FULL-TIME NURSING PERFORMANCE INDICATOR

For the purposes of measuring the Performance Indicator respecting full-time employed nurses set out in Schedule D, the percentage of nursing staff working on a full-time basis shall be calculated as described above under "Percent Full-Time Nurses."

The term "nursing staff" means registered nurses/nurse practitioners and registered practical nurses working at the Hospital who are registered with the College of Nurses of Ontario.

3.2 REPORTING AND ANNUAL NURSING STAFF PLANS

(a) The Hospital shall report to the LHIN at the end of each fiscal year to confirm that the hiring of the nursing staff positions set out on the Hospital's report entitled "Reporting for Full-Time Nursing Fund" has been achieved;

(b) The Hospital Annual Planning Submission (HAPS), will include a plan to achieve the Performance Target respecting full-time nursing staff (the "Nursing Plan"). The Nursing Plan may include staff reductions if:

(i) such reductions are achieved through voluntary attritions or management of vacancies; or

(ii) the Hospital demonstrates that:

(a) It has considered measures to maintain the employment of nursing staff and to improve efficiency in administrative and clinical areas; and

(a) It has discussed any reductions proposed in the HAPS with its chief nursing executive and has engaged its nursing staff in its decisions about such matters, such as discussions with its nursing council, all with a view to maintaining the stability of nursing employment.

(c) The Hospital shall implement the Nursing Plan approved by the LHIN.

(d) The percentage of full-time nurses in the Nursing Plan approved by the LHIN shall be the Performance Target for the % Full-Time Performance Indicator as outlined in Schedule D of this Agreement.

APPENDIX 1 HOSPITAL AND LHIN REPORTING OBLIGATIONS

4.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO CRTICAL CARE SCHEDULE E

The following are the Performance Obligations regarding critical care as set out in Schedule E:

4.1 APPLICATION

The following accountability conditions apply to all hospitals that provide Level 3 or Level 2 critical care services:

(a) Submission of accurate and timely data to the Critical Care Information System and participating in data accuracy audits as requested by MOHLTC or the LHIN.

(b) Submission of a change request form to the MOHLTC and LHIN within 30 days of any changes to the hospital's critical care capacity (as defined through Ontario's Critical Care Strategy).

(c) Ensure hospital senior leadership and ICU leaders review and assess CCIS data and implications with the Critical Care LHIN Leader on a quarterly basis as part of on gong efforts to improve patient access and patient safety.

(d) Cooperate with MOHLTC, LHIN and the Critical Care LHIN Leader to identify and implement at least one performance improvement initiative for critical care within the year.

(e) Coordinate/report all inter-hospitals transfer of critically ill patients through CritiCall.

(f) Cooperate with LHIN hospitals and CritiCall to establish a CritiCall on-call schedule for medical/surgical critical care patients and track adherence to this on-call schedule.

(g) Cooperate with CritiCall, LHIN hospitals and other hospitals to support the establishment of CritiCall on-call schedules for other ICU-related specialty services (e.g. neurosurgical critical care, cardiac care, trauma and paediatrics).

4.2 CRITICAL CARE BEDS

Accountability conditions associated with funding for critical care beds in 2008/09 and 2009/10 will be provided to the Hospital if funding is provided.

4.3 CRITICAL CARE FUNDING

The following additional conditions apply to critical care, if critical care funding was received in 2007/08:

(a) The ICU beds put into operation since 2004/05 as a result of critical care funding should continue to be allocated in addition to pre-existing Medical-Surgical ICU capacity;

(b) These beds shall generally serve the needs of patients with multi-system organ failure and critically ill patients from the emergency room and presenting through CritiCall shall receive priority for these beds;

(c) In respect to CritiCall, the Hospital shall follow the ICU bed availability rotation plan as established by the teaching Hospital ICU leadership, namely, Mount Sinai Hospital, St. Michael's Hospital, University Health Network, and Sunnybrook Health Sciences Centre; and

(d) The Hospital shall alter its internal priorities on such occasions as necessary in order to maintain access to CritiCall and to keep its emergency department open.

4.4 FINANCIAL SETTLEMENT AND RECOVERY FOR CRITICAL CARE

If the Performance Obligations set out above are not met, the LHIN will adjust the Critical Care Funding following the submission of in-year and year-end data.

APPENDIX 1 HOSPITAL AND LHIN REPORTING OBLIGATIONS

5.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO POST CONSTRUCTION OPERATING PLAN FUNDING AND VOLUME SCHEDULE F

5.1 POST CONSTRUCTION OPERATING PLAN (PCOP) FUNDING

PCOP funding is additional operating funding provided to support service expansions and other costs occurring in conjunction with completion of an approved capital project. The LHIN is providing operating funding in 2008/09 and 2009/10 to support the expansion of services that occurred in conjunction with the completion of capital projects detailed in Schedule F. Funding for either of 2008/09 and 2009/10 will be based on LHIN review of expected services increases expressed in Hospital's PCOP. Schedule F provides the expected service volumes for funding provided. All funding should be considered as annualized for those meeting volume expectations subject to section 5.2. Additionally, service expansion volumes have been adjusted from the PCOP in line with LHIN funding available.

5.2 FINANCIAL SETTLEMENT AND RECOVERY FOR POST-CONSTRUCTION OPERATING PLANS

If the Hospital does not meet a Performance Obligation or Service Volume under its post-construction operating plan, as detailed in Schedule F, the LHIN may do the following:

(a) adjust the applicable Post-Construction Operating Plan Funding to reflect reported actual results and projected year-end activity; and

(b) perform final settlements following the submission of year-end data of Post-Construction Operating Plan Funding.

APPENDIX 1 HOSPITAL AND LHIN REPORTING OBLIGATIONS

6.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO PROTECTED SERVICES SCHEDULE G

6.1 DEFINITIONS:

For the purposes of this Agreement, *Protected Services* refers to the following services:

Stable Priority Services. Priority Services refers to services designated for life-threatening conditions that typically require highly skilled human resources, specialized infrastructure, that are not yet fully diffused, are rapidly growing, and for which access to the services by residents in different regions of the province is at issue. Priority Services are detailed in Schedule G. Priority Services are a time-limited designation.

Specialized Hospital Services. Specialized Hospital Services are services that were funded on the basis of volumes in 2004-2005 or earlier and are now funded through the Hospitals' base allocation. The Specialized Hospital Services are detailed in Schedule G.

Provincial Strategies/Projects. The Provincial Strategies/Projects are detailed in Schedule G.

In addition to the Performance Obligations for Protected Services set out below, the Hospital will meet the Service Volumes set out in Schedule G or D for each Protected Service program for which the Hospital receives funding.

6.2 PERFORMANCE OBLIGATIONS FOR PROTECTED SERVICES

(a) Where the Hospital provided any of the Protected Services in the 2007/08 fiscal year, and where these services will continue to be protected in 2008/09 and 09/10 the Hospital will provide, in the 2008/09 and 09/10 fiscal year, at least the service level that the Hospital provided in the 2007/08 fiscal year. This excludes additional volumes that may have been allocated in-year on a one-time basis or services that may have been transferred to another Hospital.

(b) Changes to Protected Services are acceptable as long as the needs of patients are addressed, established service levels are maintained, and any planned program changes are discussed with, and approved in advance by the LHIN.

(c) Hospitals shall maintain the established regional or provincial service catchment area to ensure continued access where local provision of Protected Services are not otherwise available.

(d) In respect of those Protected Services that are not measured with an activity level or unit of service as set out in Schedule G, the Hospital shall use the funding for those Protected Services for their intended purpose.

(e) The Hospital shall plan for Specialized Hospital Services as part of its Base Funding and provide the volumes as detailed in Schedule G.

6.3 FINANCIAL SETTLEMENT AND RECOVERY FOR PROTECTED SERVICES

If the Hospital does not meet a Performance Obligation or Service Volume as detailed in Schedule G for a Protected Service, the LHIN may do the following:

(a) Adjust the respective Protected Services Funding to reflect reported actuals and projected year-end activity; and,

(b) Perform in-year reallocations and final settlements following the submission of year-end data of Protected Services Funding.

APPENDIX 1 HOSPITAL AND LHIN REPORTING OBLIGATIONS

7.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO WAIT TIME SERVICES SCHEDULE H

7.1 PERFORMANCE OBLIGATIONS WITH RESPECT TO WAIT TIME SERVICES

(a) *Cardiac Revascularization:* For the purposes of monitoring volumes performed, all selected Cardiac procedures will be performed in accordance with the terms and conditions of Section 6, and monitored as set out in Schedule G.

(b) *Cancer Surgery*: Where the Hospital receives funding from Cancer Care Ontario, the Hospital will enter into a Cancer Surgery and/or Chemotherapy Agreement with Cancer Care Ontario.

(c) *Cataract Surgery, Total Hip and Knee Joint Replacements, Magnetic Resonance Imaging (MRI) and Computed Tomography (CT):* If the Hospital receives Wait Time Funding, the Hospital agrees to provide the surgical volume levels and/or MRI hours as indicated in Schedule H and comply with the following conditions:

(i) The Hospital will complete all base volumes/hours as detailed in Schedule H by the end of each fiscal year;

(ii) Incremental surgery volumes for cataracts, total hip and knee joint replacements, MRI and/or CT hours of operation will be completed by the end of each fiscal year;

(iii) The Hospital will report the base and incremental volumes/hours via the LHIN's quarterly performance reports;

(iv) For greater clarity, the Hospital agrees that the delivery of these additional volumes/hours will not impede on its performance in delivering other Hospital services under the Agreement;

(v) The Hospital will begin to develop surgical access management processes by creating a centralized wait list within the Hospital for those services funded as part of the Wait Time Strategy by the end of the fiscal year.

(vi) For MRI and/or CT, the Hospital agrees to report the number of MRI and/or CT inpatients via the LHIN's regular reporting system.

(vii) The Hospital will demonstrate compliance with the funding conditions outlined in appendix A of the funding agreement.

APPENDIX 1 HOSPITAL AND LHIN REPORTING OBLIGATIONS

7.2 WAIT TIME REPORTING PERFORMANCE OBLIGATIONS

(a) The Hospital will participate in a province-wide Wait Time Information System.

(b) Pursuant to LHIN Administrative Letters respecting Wait Time funding, the Hospital will provide the minimum wait time data requirements for the Wait Time services (cardiac, cancer, cataract, total hip and knee joint replacements, MRI and CT) to the Wait Time Information Office on a monthly basis.

7.3 FINANCIAL SETTLEMENT AND RECOVERY FOR WAIT TIME SERVICES

If the Hospital does not meet a Performance Obligation or Service Volume as detailed in Schedule H for a Wait Time Service, the LHIN may do the following:

(a) Adjust the respective Wait Time Funding to reflect reported actuals and projected year-end activity; and

(b) Perform in-year reallocations and final settlements following the submission of year-end data.

8. REPORTING OBLIGATIONS

8.1 REPORTING

A table consolidating the Hospital's and LHIN reporting obligations are attached as Appendix 1 to this ***Schedule B***.

8.2 REPORTING TIMELINES

In accordance with *section 7.6.1* of this Agreement, where no timeline is set out in this ***Schedule B*** or elsewhere in this Agreement, the LHIN will respond to a report or submission from the Hospital not later than 30 days after the report or submission has been received.

9. LHIN SPECIFIC PERFORMANCE OBLIGATIONS

9.1 ALTERNATIVE LEVEL OF CARE (ALC)

Definition:
Percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed was well enough to have been cared for in a non-acute setting.

Hospitals are required to report on these indicators quarterly using the Quarterly Report on WERS

LHIN Target:
- Reduction in ALC days and beds

(a) *ALC PERFORMANCE INDICATORS*

Average # of ALC Days
Average # of ALC Beds
% of Total Beds

(b) *ALC MONITORING INDICATORS*

ALC monitoring indicators are explanatory to the performance indicators and will not be used to determine performance

Hospitals are expected to review practice if there is a rise in monitoring indicators.

ALOS for ALC Patients
# of Patients waiting for LTC
# of Patients waiting for additional home supports

9.2 HOSPITAL STANDARDIZED MORTALITY RATIO (HSMR) MONITORING INDICATOR

Definition:
The ratio of the actual number of acute in-hospital deaths to the expected number of in-hospital deaths for conditions accounting for 80% of in-patient mortality as reported by the Canadian Institute for Health Information (CIHI).

Hospitals are required to report on these indicators quarterly using the Quarterly Report on WERS. Reports are sent to hospitals by CIHI quarterly.

LHIN Target:
HSMR will be lower than reported previously or in line with the provincial average. Hospitals are expected to review practice if there is a rise in monitoring indicators.

Multi-site hospitals must report by site

CIHI Reported HSMR
HSMR
HSMR with Palliative
Medical HSMR
Surgical HSMR
ICU-Related HSMR
HSMR excl transfers

APPENDIX 1 HOSPITAL AND LHIN REPORTING OBLIGATIONS

HOSPITAL CALENDARIZED REPORTING CHART 2008 - 10				
Due Date	**Description of Item**	**From**	**To**	**Submission Process/Tool**
MAY				
May 31	Hospitals' year end trial balance, year end consolidation reports, and audited financial statements (if available) or draft financial statements.	Hospital	LHIN	MIS Trial Balance, WERS, Electronic File Transfer to Ministry
May 31	All Clinical Submissions (Q4 2007/08; 2008/09)	Hospital	CIHI	Electronic File Transfer to CIHI
JUNE				
June - within first 5 working days	Exception Reporting: Hospitals provide LHINs with a statement indicating if they are not on target to achieve a balanced budget or to meet performance targets. It may include an action plan to address any in-year pressures. This report supports LHIN Q1 reporting. Year end Supplementary Form reports.	Hospital	LHIN	Format to be provided by LHIN, WERS
June 15	Hospitals to provide information to support LHIN's Annual Service Plan submission to Ministry. The information identifies opportunities and risks to transform the health delivery system.	Hospital	LHIN	Format to be provided by LHIN
June 30	Board approved Audited Financial statements.	Hospital	LHIN	e-mail or hard copy
June 30	Hospital Annual Planning Submission Guide to Hospitals	LHIN	Hospital	Guide distributed by LHIN
JULY				
July 31	Hospitals submit Q1 report (Note: This is a new requirement. In past, Hospital did not submit a Q1 Report)	Hospital	LHIN	MIS Trial balance
AUGUST				
August – within first 5 working days	Q1 Supplementary Form reports.	Hospital	LHIN	WERS
SEPTEMBER				
September – within first 5 working days	Exception Reporting: Hospitals provide LHINs with a statement indicating if they are not on target to achieve a balanced budget or to meet performance targets. It may include an action plan to address any in-year pressures. This will support LHIN Q2 reporting.	Hospital	LHIN	Format to be provided by LHIN
September 30	All Clinical Submissions (Q1 2008/09; 2009/10)	Hospital	CIHI	Electronic File Transfer to CIHI
OCTOBER				
October 31	Hospitals submit Q2 reports (Note: It is important for the hospital to accurately predict year-end volumes for cataracts, total hips and knee joint replacements, MRI and/or CT hours of operations to facilitate in-year reallocation of cases.)	Hospitals	LHIN	WERS, MIS Trial balance

APPENDIX 1 HOSPITAL AND LHIN REPORTING OBLIGATIONS

HOSPITAL CALENDARIZED REPORTING CHART 2008 - 10				
Due Date	**Description of Item**	**From**	**To**	**Submission Process/Tool**
NOVEMBER				
November – within first 5 working days	Q2 Supplementary Form reports.	Hospital	LHIN	WERS
November 30	All clinical Submissions (Q2 2008/09, 2009/10)	Hospital	CIHI	Electronic File Transfer to CIHI
DECEMBER				
December – within first 5 working days	Exception Reporting: Hospitals provide LHINs with a statement indicating if they are not on target to achieve a balanced budget or to meet performance targets. It may include an action plan to address any in-year pressures This information supports LHIN Q3 reporting. The LHIN Q3 will be the most detailed to enable LHINs to reallocate funds within HSPs and to outline plans to meet performance targets.	Hospital	LHIN	Format to be provided by LHIN
JANUARY				
January 31	Hospitals submit Q3 reports	Hospital	LHIN	WERS, MIS Trial balance
FEBRUARY				
February – within first 5 working days	Q3 Supplementary Form reports.	Hospital	LHIN	WERS
February 28	All Clinical Submissions (Q3 2008/09; 2009/10)	Hospital	CIHI	Electronic File Transfer to CIHI
MARCH				
March – within first 5 working days	Exception Reporting: Hospitals provide LHINs with a statement indicating if they are not on target to achieve a balanced budget and performance targets. This report supports LHIN Q4 – LHINs are required to confirm year end financial position and achievement of non-financial targets.	Hospital	LHIN	Format to be provided by LHIN

Hospital Multi-Year Funding Allocation

Schedule C 2008-10

Hospital Brant Community Healthcare System

Fac # 970

	2008/09 Planning Allocation		2009/10 Planning Allocation	
	Base	One-Time	Base	One-Time
Opening Base Funding	$103,461,600		$106,389,900	
Multi-Year Funding Incremental Adjustment	$2,595,000		$2,087,000	
Other Funding				
Annualization MRI	$333,300		$0	
Funding adjustment 2		$0		$0
Funding adjustment 3		$0		$0
Funding adjustment 4		$0		$0
Funding adjustment 5		$0		$0
Funding adjustment 6		$0		$0
Other Items		$0		$0
Prior Years' Payments				
Critical care Strategies Schedule E	$0		$0	
PCOP: Schedule F				
PCOP	$0		$0	
Stable Priority Services: Schedule G				
Chronic Kidney Disease		N/A		
Cardiac Catherization		N/A		
Cardiac Surgery		N/A		
Provincial Strategies: Schedule G				
Organ Transplantation		N/A		
Endovascular aortic aneurysm repair				
Electrophysiology studies EPS/ablation		N/A		
Percutaneous coronary intervention (PCI)		N/A		
Implantable cardiac defibrillators (ICD)		N/A		
Daily nocturnal home hemodialysis				
Provincial peritoneal dialysis initiative				
Newborn screening program				
Specialized Hospital Services: Schedule G				
Cardiac Rehabilitation				
Visudyne Therapy				
Total Hip and Knee Joint Replacements (Non-WTS)				
Magnetic Resonance Imaging				
Regional Trauma				
Regional & District Stroke Centres				
Sexual Assault/Domestic Violence Treatment Centres				
Provincial Regional Genetic Services				
HIV Outpatient Clinics				
Hemophiliac Ambulatory Clinics				
Permanent Cardiac Pacemaker Services				
Provincial Resources				
Bone Marrow Transplant				
Adult Interventional Cardiology for Congenital Heart Defects				
Cardiac Laser Lead Removals				
Pulmonary Thromboendarterectomy Services				
Thoracoabdominal Aortic Aneurysm Repairs (TAA)				
Health Results (Wait Time Strategy): Schedule H				
Selected Cardiac Services				
Total Hip and Knee Joint Replacements		$1,665,500		$1,665,500
Cataract Surgeries		$687,800		$687,800
Magnetic Resonance Imaging (MRI)		$215,500		$215,500
Computed Tomography (CT)		$51,300		$51,300
Total Additional Base and One Time Funding	$2,928,300	$2,620,100	$2,087,000	$2,620,100
Total Allocation	$109,010,000		$111,097,000	

Allocations not provided in this schedule for 2008/09 and 2009/10, will be provided to hospitals in subsequent planning cycles. Hospitals should assume, for planning purposes, funding for similar volumes for Priority Services in out-years.

Global Volumes

Schedule D 2008/10

Hospital Brant Community Healthcare System

Fac # 970

Global Volumes	Units of Service*	2008/09 Budget	2008/09 Performance Standard**	2009/10 Budget	2009/10 Performance Standard**
Total Acute Activity, including inpatient and Day Surgery	Weighted Cases	14,500	13630-15370	14,500	13630-15370
Other					
Complex Continuing Care	RUG Weighted Patient Days	16,256	> 13817.6	16,256	> 13817.6
Mental Health	Inpatient Days	5,300	> 4770	5,300	> 4770
ELDCAP	Inpatient Days	0	0.00 - 0.00	0	0.00 - 0.00
Inpatient Rehabilitation	Inpatient Days	9,100	> 7735	9,100	> 7735
Emergency Visits	Visits	55,705	> 51805.65	55,705	> 51805.65
Ambulatory Care***	Visits	93,800	> 75040	94,800	> 75840

* Global volumes based on CIHI Case mix Group (CMG)/Plx methodology and MOHLTC PAC-10 weights.
** Volume Performance Indicators under Global Volumes vary in application based on hospital type.
***Ambulatory Care includes Account Codes 7134* (excluding 7134025, 7134055), 712*, 7135*, 7136*, 7137*, 715*.

Performance Indicators

Hospital Brant Community Healthcare System

Fac # 970

Performance Indicators	2008/09 Budget	2008/09 Performance Standard**	2009/10 Budget	2009/10 Performance Standard**
HSAA Performance Indicators				
Designated Acute Care Activity only				
Readmission to Own Facility for Selected CMGs	332.00	422.48	332.00	422.48
Designated Chronic Care Activity Only				
Percentage of Patients with new Stage 2 or Greater Skin Ulcers	15.00	15.25	15.00	15.25
Perfomance Indicators For All Hospitals				
Current Ratio	0.89	0.8 - 2.0	0.85	0.8 - 2.0
Percent Full-time Nurses	65.37%	64.37%	65.37%	64.37%
Year End Total Margin	0.00%	0	0.00%	0

*Readmissions Performance Indicator based on CIHI Case Mix Group (CMG)/Plx methodology.
**Volume Performance Indicators under Global Volumes vary in application based on hospital type.

Critical Care Funding

Schedule E 2008/10

Hospital

This section has been intentionally left blank

Once negotiated, an amendment will be made under section 15.3 of the Agreement to include these targets and any additional conditions not otherwise set out in Schedule B. This funding would be an additional in-year allocation contemplated by section 5.3 of the Agreement

Post-Construction Operating Plan Funding and Volume

Schedule F 2008/10

Hospital

This section has been intentionally left blank

Once negotiated, an amendment will be made under section 15.3 of the Agreement to include these targets and any additional conditions not otherwise set out in Schedule B. This funding would be an additional in-year allocation contemplated by section 5.3 of the Agreement

Protected Services

Schedule G 2008/10

Hospital Brant Community Healthcare System

Fac # 970

	Units of Service	2008/09 LHIN Target	2008/09 Performance Standard	2009/10 LHIN Plan
Stable Priority Services				
Chronic Kidney Disease	Weighted Units	12,845	12,845	12,845
Cardiac Catherization	Procedures	N/A	N/A	N/A
Cardiac Surgery	Weighted Units	N/A	N/A	N/A
Provincial Strategies				
Organ Transplantation*	Cases	N/A	N/A	N/A
Endovascular aortic aneurysm repair				
Electrophysiology studies EPS/ablation				
Percutaneous coronary intervention (PCI)				
Implantable cardiac defibrillators (ICD)				
Daily nocturnal home hemodialysis				
Provincial peritoneal dialysis initiative				
Newborn screening program				
Specialized Hospital Services				
Cardiac Rehabilitation	Number of patients treated	N/A	N/A	N/A
Visudyne Therapy	Number of insured Visudyne vials	N/A	N/A	N/A
Total Hip and Knee Joint Replacements (Non-WTS)	Number of Implant Devices	275	275	275
Magnetic Resonance Imaging	Hours of operation	2,080	2,080	2,080
Regional Trauma	Cases	N/A	N/A	N/A
Regional & District Stroke Centres				
Sexual Assault/Domestic Violence Treatment Centres				
Provincial Regional Genetic Services				
HIV Outpatient Clinics				
Hemophiliac Ambulatory Clinics				
Permanent Cardiac Pacemaker Services				
Provincial Resources				
Bone Marrow Transplant				
Adult Interventional Cardiology for Congenital Heart Defects				
Cardiac Laser Lead Removals				
Pulmonary Thromboendarterectomy Services				
Thoracoabdominal Aortic Aneurysm Repairs (TAA)				

* Organ Transplantation - Funding for living donation (kidney & liver) included as part of organ transplantation funding. Hospitals are funded retrospectively for deceased donor management activity, reported and validated by the Trillium Gift of Life Network.

Note: Additional accountabilities assigned in Schedule B

Funding and volumes for these services should be planned for based on 2007/08 approved allocations. Amendments, pursuant to section 5.2 of this Agreement, may be made during the quarterly submission process.

Wait Time Services

Schedule H 2008/10

Hospital Brant Community Healthcare System

Fac # 970

	2007/08 Funded Incremental Volumes *	Base Volumes	2008/09 Funded Incremental Volumes **	2009/10 Funded Incremental Volumes **
Selected Cardiac Services	Refer to Schedule G for Cardiac Service Volumes and Targets			
Total Hip and Knee Joint Replacements (Total Implantations)	212	275	237	237
Cataract Surgeries (Total Procedures)	841	1,600	917	917
Magnetic Resonance Imaging (MRI) (Total Hours)	128	2,080	829	829
Computed Tomography (CT) (Total Hours)	292	2,210	205	205

* The 2007/08 Funded volumes are as a reference only

** Once negotiated, an amendment will be made under section 15.3 of the Agreement to include these targets and any additional conditions not otherwise set out in Schedule B. This funding would be an additional in-year allocation contemplated by section 5.3 of the Agreement.

This schedule will change to reflect the implementation of a new MRI funding model currently under review. The change to the schedule is anticipated in Q1, subject to the completion of consultations and confirmation to proceed with the model. A refresh of this schedule is anticipated in spring 2009, or earlier.