SOUTH WEST
LOCAL HEALTH INTEGRATION NETWORK

(the "LHIN")

and

London Health Sciences Centre

(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.

South West LHIN
Tony Woolgar, CEO
Suite 700
201 Queens Avenue
London ON N6A 1J1
Fax (519) 672-6562

London Health Sciences Centre
Cliff Nordal, F09360
800 Commissioners Road E

London ON N6A 5W9
Fax (519)685-8225

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.

London Health Sciences Centre

By:

Original Copy Signed

Doug Alexander — Date 21/4/2008
Chair
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:

Original Copy Signed

Cliff Nordal — Date 15 April 08
CEO
I sign as a representative of the Hospital, not in my personal capacity, and I represent that I have authority to bind the Hospital.

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK

By:

Original Copy Signed

Norm Gamble
Chair

Date May 7/2008

And By:

Original Copy Signed

Tony Woolgar
CEO

Date May 7 2008

Facility No.8654

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

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:

<table>
<tr><th>Primary Account</th><th>Secondary Account</th><th>Description</th></tr>
<tr><td>7127625*</td><td rowspan="6">403*</td><td>Acute Mental Health</td></tr>
<tr><td>7127645*</td><td>Addiction Inpatient</td></tr>
<tr><td>7127650*</td><td>Child/Adolescent</td></tr>
<tr><td>7127655*</td><td>Forensic</td></tr>
<tr><td>7127690*</td><td>Psychiatric Crisis Unit</td></tr>
<tr><td>7127695*</td><td>Longer Term Psychiatry</td></tr>
</table>

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

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 =

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.

divided by

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.

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

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.

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

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*.

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

(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-

Schedule B
Performance Obligations

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

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

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.

4.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO CRITICAL 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.

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.

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.

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.

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 Notwithstanding anything in this Agreement or the Schedules thereto to the contrary, the South West LHIN and London Health Sciences Centre agree to the following. In the Peer Review Funding Conditions letter signed by the Ministry of Health and Long-Term Care and London Health Sciences Centre (LHSC) in February 2007, LHSC is to receive a one-time operating grant of $7.4 million in 2006/07, 2007/08, and 2008/09 to address outstanding operational issues. This funding is noted in Schedule C for 2008/09.

Based on the fact that restructuring costs associated with program transfers between LHSC sites and between St. Joseph's Health Care London and LHSC will continue through 2009/10, and no operating grant was provided in 2009/10, LHSC is looking to secure an additional operating grant in 2009/10 to off-set expenses associated with this restructuring.

Although an operating grant has not been secured for 2009/10, the South West LHIN will permit LHSC to project a negative total margin of -0.39% for the fiscal year 2009/10 as listed in Schedule D to allow LHSC and the South West LHIN additional time to work together to secure funding for restructuring costs in 2009/10. If an operating grant for fiscal year 2009/10 is not secured prior to the Hospital Annual Planning Submission (HAPS) refresh process (to be scheduled prior to the start of the 2009/10 fiscal year), the hospital will resubmit its HAPS for 2009/10 and produce a zero or positive total margin in 2009/10.

9.2 The Southwestern Ontario Stroke Strategy is an important model in our health care system and as a LHIN-wide resource has a key role in coordinating and providing the education, programs and services for improved stroke care. As a Regional Stroke Centre (RSC) and recipient of annualized stroke strategy funding, London Health Sciences Centre has an important role in ensuring RSC responsibilities are met, effective linkages with District Stroke Centres continue and overall accountability for these funds is maintained. It is expected that the RSC report to the South West LHIN by March 31st each fiscal year of this Agreement key performance metrics that demonstrate the RSC's effectiveness towards the goals and objectives of the LHIN-wide strategy.

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	Hospitals provide LHINs with a statement indicating they are on target to achieve a balanced budget and 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	Hospitals provide LHINs with a statement indicating they are on target to achieve a balanced budget and 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	Hospitals provide LHINs with a statement indicating they are on target to achieve a balanced budget and 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	Hospitals provide LHINs with a statement indicating they are 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: LONDON Health Sciences Fac#: 936	[illegible]		[illegible]	
	[illegible]	[illegible]	[illegible]	[illegible]
Opening Base Funding	$622,185,900		$639,621,900	
Multi-Year Funding Incremental Adjustment	$17,438,000		$15,582,000	
Other Funding				
Funding adjustment 1	$0		$0	
WT Anaesthesia Care Team		$432,000		$324,000
Peer Review		$7,400,000		$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		$1,920,014		
Cardiac Catherization		N/A		
Cardiac Surgery		N/A		
Provincial Strategies: Schedule G				
Organ Transplantation		$2,202,524		
Endovascular aortic aneurysm repair				
Electrophysiology studies EPS/ablation		$0		
Percutaneous coronary intervention (PCI)		$1,052,100		
Implantable cardiac defibrillators (ICD)		$2,838,700		
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		$3,316,200		
Cataract Surgeries		$0		$0
Magnetic Resonance Imaging (MRI)		$2,067,600		
Computed Tomography (CT)		$133,500		
Total Additional Base and One Time Funding	$17,438,000	$21,162,836	$15,582,000	$324,000
Total Allocation	$660,784,736		$655,527,900	

llocations not provided in this schedule for 2008/09 and 2009/10, will be provided to hospitals in subsequent planning cycles. Hospitals

Global Volumes

Schedule D 2008/10

Hospital LONDON Health Sciences

Fac# 936

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	68,195	66,149 -70,241	68,219	66,149 -70,241
Other					
Complex Continuing Care	RUG Weighted Patient Days	0	> 0.00	0	> 0.00
Mental Health	Inpatient Days	19,700	> 18,518	19,700	> 18,013
ELDCAP	Inpatient Days	0	0.00 - 0.00	0	0.00 - 0.00
Inpatient Rehabilitation	Inpatient Days	0	> 0.00	0	> 0.00
Emergency Visits	Visits	146,250	>140,400	146,250	> 137,333
Ambulatory Care***	Visits	675,638	> 635,100	677,262	> 635,100

* Global volumes based on [illegible] (CMG) methodology and [illegible] weights

** Volume performance standard [illegible] by hospital type.

*** Ambulatory Care includes Account Codes [illegible] (excluding [illegible]) [illegible]

Performance Indicators

Hospital LONDON Health Sciences

Fac# 936

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	779.00	798.00	TBD	TBD
Designated Chronic Care Activity Only				
Percentage of Patients with new Stage 2 or Greater Skin Ulcers	0.00	N/A	0.00	N/A
Perfomance Indicators For All Hospitals				
Current Ratio	0.39	0.8 - 2.0	0.37	0.37 - 2.0
Percent Full-time Nurses	79.70%	78.70%	79.70%	78.70%
Year End Total Margin	0.42%	0	-0.39%	0

* Readmission [illegible] (CMG) methodology

** Volume Performance [illegible] Global Volumes vary [illegible] by 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 LONDON Health Sciences

Fac # 936

	Units of Service	2008/09 LHIN Target	2008/09 Performance Standard	2009/10 LHIN Plan
Stable Priority Services				
Chronic Kidney Disease	Weighted Units	132,814	132,814	132,814
Cardiac Catherization	Procedures	4,400	4,400	4,400
Cardiac Surgery	Weighted Units	1,400	1,400	1,400
Provincial Strategies				
Organ Transplantation*	Cases	230	230	230
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	800	800	800
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	968	968	968
Magnetic Resonance Imaging	Hours of operation	8,320	8,320	8,320
Regional Trauma	Cases	430	430	430
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 15.2 of this Agreement, may be made during the quarterly submission process.

Wait Time Services

Schedule H 2008/10

Hospital LONDON Health Sciences

Fac # 936

	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)	300	968	360	360
Cataract Surgeries (Total Procedures)	0	N/A	N/A	N/A
Magnetic Resonance Imaging (MRI) (Total Hours)	6,036	8,320	7,953	7,953
Computed Tomography (CT) (Total Hours)	482	11,634	534	534

* 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 effective April 2009 pending further consultation regarding the newly proposed MRI funding model. This will be confirmed during the schedule refresh in Winter/Spring 2009.

2008-2012 H-SAA AMENDING AGREEMENT # 2

THIS AMENDING AGREEMENT (the "Agreement") is made as of the 1st day of April, 2011

B E T W E E N:

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

London Health Sciences Centre (the "Hospital")

WHEREAS the LHIN and the Hospital entered into a hospital service accountability agreement that took effect April 1, 2008 and has been amended by agreements made as of April 1, 2010 and April 1, 2011 (the "H-SAA");

AND WHEREAS the Parties acknowledged, in the amending agreement made as of April 1, 2011, that further amendments would be required to the Schedules following the announcement of funding allocations by the Ministry of Health and Long Term Care.

NOW THEREFORE in consideration of mutual promises and agreements contained in this Agreement and other good and valuable consideration, the parties agree as follows:
1.0 Definitions. Except as otherwise defined in this Agreement, all terms shall have the meaning ascribed to them in the H-SAA.

2.0 Amendments.

2.1 Agreed Amendments. The Parties agree that the H-SAA shall be amended as set out in this Article 2.

2.2 Schedules.

(a) Schedule A-1 shall be deleted and replaced with Schedule A-1 attached to this Agreement.

(b) Schedule B-2 shall be deleted and replaced with Schedule B-2 attached to this Agreement.

(c) Schedules C-2 shall be deleted and replaced with Schedule C-2 attached to this Agreement.

(d) Schedules D-2 shall be deleted and replaced with Schedule D-2 attached to this Agreement.

(e) Schedules E-2 shall be deleted and replaced with Schedule E-2 attached to this Agreement.

(f) Schedules F-2 shall be deleted and replaced with Schedule F-2 attached to this Agreement.

(g) Schedules G-2 shall be deleted and replaced with Schedule G-2 attached to this Agreement.

(h) Schedules H-2 shall be deleted and replaced with Schedule H-2 attached to this Agreement.

3.0 **Effective Date.** The Parties agree that the amendments set out in Article 2 shall take effect on April 1, 2011. All other terms of the H-SAA, those provisions in the Schedules not amended by s. 2.2, above, shall remain in full force and effect.

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

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

6.0 **Entire Agreement**. This Agreement together with Schedules A-1, B-2, C-2, D-2, E-2, F-2, G-2 and H-2, constitutes the entire agreement between the Parties with respect to the subject matter contained in this Agreement and supersedes all prior oral or written representations and agreements.

IN WITNESS WHEREOF the Parties have executed this Agreement on the dates set out below.

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK

By:

Jeff Low, Chair	Date

And by:

Michael Barrett, CEO	Date

London Health Sciences Centre

Original Copy Signed

	Nov. 30/11
Peter Johnson, Chair	Date

And by:

Original Copy Signed

	Nov. 22 2011
Bonnie Adamson, CEO	Date

Schedule A1
Planning and Funding Timetable

OBLIGATIONS

Part I - Funding Obligations	Party	Timing
Announcement of hospital-specific 2011-12 base funding allocation	LHIN	The later of June 30, 2011or 21 Days after confirmation from the MOHLTC

Part II - Planning Obligations	Party	Timing
Sign 1 year extension to the 2008-11 Hospital Service Accountability Agreement	Hospital/LHIN	No later than March 31, 2011
Announcement of multi-year planning targets for 2012-15 Hospital Service Accountability Agreement negotiations*	LHIN	Contingent upon MOHLTC announcement and direction
Publication of the Hospital Accountability Planning Submission Guidelines for 2012-15*	LHIN	Fiscal quarter following MOHLTC direction regarding new multi-year agreements
Indicator Refresh (including detailed hospital calculations)*	LHIN (in conjunction with MOHLTC)	Contingent upon announcement and timing of multi-year planning targets
Submission of Hospital Accountability Planning Submission for 2012-15 *	Hospital	Contingent upon announcement and timing of multi-year planning targets and provincial 2012-15 HAPS /Hospital Service Accountability Agreement process
Sign 2012-15 Hospital Service Accountability Agreement *	Hospital/LHIN	No later than March 31, 2012

* Intended process based on timely announcement of multi-year planning targets from the MOHLTC. Actual process may change to adapt to timing and duration of the planning targets actually announced by the MOHLTC.

Schedule B2
Performance Obligations for 11/12

1.0 PERFORMANCE CORRIDORS FOR SERVICE VOLUMES AND ACCOUNTABILITY INDICATORS

1.1 The provisions of Article 1 of Schedule B apply in Fiscal Year 11/12 with all references to Schedule D being read as ref erring to Schedule D2.

2.0 PERFORMANCE CORRIDORS FOR ACCOUNTABILITY INDICATORS

2.1 The provisions of Article 2 of Schedule B, as amended by B1, apply in Fiscal Year 11/12 subject to the following amendments:

(a) new sub articles 2.7, 2.8 and 2.9 shall be added as set out below;

2.7 90th Percentile Emergency Room (ER) Length of Stay for Admitted Patients

a) Definition. The total emergency room (ER) length of stay (LOS) where 9 out of 10 admitted patients completed their visits. ER LOS is defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ER.

Steps:
1: Calculate ER LOS in hours for each patient.
2: Apply inclusion and exclusion criteria.
3: Sort the cases by ER LOS from shortest to highest.
4: The 90th percentile is the case where 9 out of 10 admitted patients have completed their visits.

Excludes:
1. ER visits where Registration Date/Time and Triage Date/Time are both missing;
2. ER visits where Left ER Date/Time and Disposition Date/Time are both missing;
3. ER visits where patients are over the age of 125 on earlier of triage or registration date;
4. Negative ER LOS (earlier of registration or triage after date/time patient left ER);
5. Duplicate records within the same functional centre where all data elements have the same values, except Abstract ID number;
6. Non-Admitted Patients (Disposition Codes 01 – 05 and 08 – 15); and
7. Admitted Patients (Disposition Codes 06 and 07) with missing patient left ER Date/Time.

b) LHIN Target

(i) For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Target: maintain or improve current performance

(ii) For hospitals performing above the LHIN's Accountability Agreement target:
Performance Target: To be negotiated locally taking into consideration contribution to the M LPA target

c) Performance Corridor

(i) For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor: equal to or less than the LHIN' s Accountability Agreement target

(ii) For hospitals performing above the LHIN's Accountability Agreement target:
Performance Corridor: 10%

2.8 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients

a) Definition. The total emergency room (ER) length of stay (LOS) where 9 out of 10 non-admitted complex (Canadian Triage and Acuity Scale (CTAS) levels I, II and III) patients completed their visits. ER LOS is defined as the time from triage or registration, whichever comes first, to the time the patient leaves ER.

Steps
1. Calculate ER LOS in hours for each patient.
2. Apply inclusion and exclusion criteria.
3. Sort the cases by ER LOS from shortest to highest.
4. The 90th percentile is the case where 9 out of 10 non-admitted patients have completed their visits.

Excludes:
1. ER visits where Registration Date/Time and Triage Date/Time are both missing;
2. ER visits where Left ER Date/Time and Disposition Date/Time are both missing;
3. ER visits where patients are over the age of 125 on earlier of triage or registration date;
4. Negative ER LOS (earlier of registration or triage after date/time patient left ER);
5. Duplicate records within the same functional centre where all data elements have the same values;
6. ER visits identified as the patient has left ER without being seen (Disposition Codes 02 and 03);
7. Admitted Patients (Disposition Codes 06 and 07);

8. Non-Admitted Patients (Disposition Codes 01, 04 – 05 and 08 – 15) with assigned CTAS IV and V;
9. Non-Admitted Patients (Disposition Codes 01, 04 – 05 and 08 – 15) with missing CTAS; and
10. Transferred Patients (Disposition Codes 08 and 09) with missing patient left ER Date/Time.

b) LHIN Targets

(i) For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Target: maintain or improve current performance

(ii) For hospitals performing above the LHIN's Accountability Agreement target with Pay for Results Funding:
Performance Target: To be negotiated locally taking into consideration contribution to the LHIN's Accountability Agreement target

c) Performance Corridors

(i) For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor: equal to or less than the LHIN's Accountability Agreement target

(ii) For hospitals performing above the LHIN's Accountability Agreement target:
Performance Corridor: 10%

2.9 90th Percentile ER Length of Stay for Non-admitted Minor Uncomplicated (CTAS IV-V) Patients

a) Definition. The total emergency room (ER) length of stay (LOS) where 9 out of 10 non-admitted minor/uncomplicated (Canadian Triage and Acuity Scale (CTAS) levels IV and V) patients completed their visits. ER LOS is defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ER.

Steps

1. Calculate ER LOS in hours for each patient.
2. Apply inclusion and exclusion criteria.
3. Sort the cases by ER LOS from shortest to highest.
4. The 90th percentile is the case where 9 out of 10 non-admitted patients have completed their visits.

Excludes:

1. ER visits where Registration Date/Time and Triage Date/Time are both missing;
2. ER visits where Left ER Date/Time and Disposition Date/Time are both missing;

3. ER visits where patients are over the age of 125 on earlier of triage or registration date;
4. Negative ER LOS (earlier of registration or triage after date/time patient left ER);
5. Duplicate records within the same functional centre where all data elements have the same values;
6. ER visits identified as the patient has left ER without being seen (Disposition Codes 02 and 03);
7. Admitted Patients (Disposition Codes 06 and 07);
8. Non-Admitted Patients (Disposition Codes 01, 04 – 05 and 0 8 – 15) with assigned CTAS I, II and III;
9. Non-Admitted Patients (Disposition Codes 01, 04 – 05 and 08 – 15) with missing CTAS; and
10. Transferred Patients (Disposition Codes 08 and 09) with missing patient left ER Date/Time.

b) LHIN Target

(i) For hospitals performing at the LHIN's Accountability Agreement target or better:
PerformanceTarget: maintain or improve current performance

(ii) For hospitals performing above the LHIN's Accountability Agreement target:
Performance Target: To be negotiated locally taking into consideration contribution to the LHIN' s Accountability Agreement target

c) Performance Corridor

(i) For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor: less than or equal to the LHIN's Accountability Agreement target

(ii) For hospitals performing above the LHIN's Accountability Agreement target with Pay for Results Funding:
Performance Corridor: 10%

and

(b) All references to Schedule D1 shall be read as referring to Schedule D2.

3.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO NURSING ENHANCEMENT/CONVERSION

3.1 The provisions of Article 3 of Schedule B, as amended by B1 apply in Fiscal Year 11/12 subject to the following amendments:

(a) subsection 3.1 and 3.2(b) shall be deleted; and
(b) all references to Schedule D1 shall be read as referring to Schedule D2.

4.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO CRITICAL CARE

4.1 The provisions of Article 4 of Schedule B, as amended by B1, apply in Fiscal Year 11/12

subject to the following amendments:

(a) references to "2010/11" shall be read as referring to "2011/12"; and
(b) all references to Schedule E1 shall be read as referring to Schedule E2.

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

5.1 The provisions of Article 5 of Schedule B, as amended by B1, apply in Fiscal Year 11/12, subject to the following amendments:

(a) references to Schedule F1 shall be read as referring to Schedule F2; and
(b) references to "2010/11" shall be read as referring to 2011/12.

6.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO PROTECTED SERVICES

6.1 The Performance Obligations set out in Article 6 of Schedule B, as amended by B1, apply in Fiscal Year 11/12, subject to the following amendments:

(a) All references to Schedule D1 or Schedule G1 shall be read as referring to Schedules D2 and G2 respectively; and
(b) All references to "2010/11" shall be read as referring to "2011/12"

7.0 PERFORMANCE OBLIGATIONS WITH RESPECT TO WAIT TIME SERVICES

7.1 The Performance Obligations set out in Article 7 of Schedule B, as amended by B1 apply to Fiscal Year 11/12 subject to the following amendments.

(a) Sub article 7.2 shall be amended with the addition of the following eight new sub paragraphs (c)-(i):

(c) **90th Percentile Wait Times for Cancer Surgery**

(i) Definition. This indicator measures the time between a patient's and surgeon's decision to proceed with surgery, and the time the procedure is conducted. The 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th percentile wait time is an actual wait time of a patient and is not estimated.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).
3. Count the total number of cases and multiply by 0.90 to get the "90th percentile patient". If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the "90th percentile patient" is the indicator value

Excludes:

1. Procedures no longer required;
2. Diagnostic, palliative and reconstructive cancer procedures;
3. Procedures on skin - carcinoma, skin-melanoma, and lymphomas;
4. Procedures assigned as priority level 1;
5. Wait list entries identified by hospitals as data entry errors; and
6. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors.

(ii) LHIN Targets

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Target: maintain or improve current performance

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Target: Accountability Agreement target or better

(iii) Performance Corridors

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor: less than or equal to the LHIN's Accountability Agreement target

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Corridor: 10%

(d) **90th Percentile Wait Times for Cardiac Bypass Surgery**

(i) Definition. 90th percentile wait times for cardiac bypass surgery. This indicator measures the time between a patients' acceptance for bypass surgery, and the time the procedure is conducted. The 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th percentile wait time is an actual wait time of a patient and is not estimated. Waiting periods are counted from the date a patient was accepted for bypass surgery by the cardiac service or cardiac surgeon.

Includes: Elective patients who have been accepted for bypass surgery who are Ontario residents.

Excludes: Time spent investigating heart disease before a patient is accepted for a procedure. For example, the time it takes for a patient to have a heart catheterization procedure before being referred to a heart surgeon is not part of the waiting time shown for heart surgery.

(ii) LHIN Target

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Target: maintain or improve current performance

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding
Performance Target: the LHIN's Accountability Agreement target or better

(iii) Performance Corridor

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor: less than or equal to the LHIN's Accountability Agreement target

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Corridor: 10%

(e) 90th Percentile Wait Times for Cataract Surgery

(i) Definition. This indicator measures the time between a patient's and surgeon's decision to proceed with surgery, and the time the procedure is conducted. The 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th percentile wait time is an actual wait time of a patient and is not estimated.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).
3. Count the total number of cases and multiply by 0.90 to get the "90th percentile patient". If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).

4. The number of wait days for the "90th percentile patient" is the indicator value.

Excludes:
1. Procedures no longer required;
2. Procedures assigned as priority level 1;
3. Wait list entries identified by hospitals as data entry errors; and
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors.

(ii) LHIN Target

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Target: maintain or improve current performance

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Target: The LHIN's Accountability Agreement target or better

(iii) Performance Corridor

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor: less than or equal to the LHIN's Accountability Agreement target

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Corridor: 10%

(f) 90th Percentile Wait Times for Joint Replacement (Hip)

(i) Definition. This indicator measures the time between a patient's and surgeon's decision to proceed with surgery, and the time the procedure is conducted. The 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th percentile wait time is an actual wait time of a patient and is not estimated.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom.)
3. Count the total number of cases and multiply by 0.90 to get the "90th percentile patient". If this value has a decimal digit

greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).

4. The number of wait days for the "90th percentile patient" is the indicator value.

Excludes:

1. Procedures no longer required;
2. Procedures assigned as priority level 1;
3. Wait list entries identified by hospitals as data entry errors; and
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors.

(ii) LHIN Target.

1. For hospitals performing at the LHIN's Accountability Agreement target or better: *Performance Target*: maintain or improve current performance
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding: *Performance Target*: the LHIN's Accountability Agreement target or better

(iii) Performance Corridor

1. For hospitals performing at the LHIN's Accountability Agreement target or better: *Performance Corridor*: less than or equal to Accountability Agreement target
2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding: *Performance Corridor*: 10%

(g) 90th Percentile Wait Times for Joint Replacement (Knee)

(i) Definition. This indicator measures the time between a patient's and surgeon's decision to proceed with surgery, and the time the procedure is conducted. The 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer. The 90th percentile wait t time is an actual wait time of a patient and is not estimated.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).

3. Count the total number of cases and multiply by 0.90 to get the "90th percentile patient". If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the "90th percentile patient" is the indicator value

Excludes:

1. Procedures no longer required;
2. Procedures assigned as priority level 1;
3. Wait list entries identified by hospitals as data entry errors; and
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors.

(ii) LHIN Target

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
PerformanceTarget: maintain or improve current performance

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Target: the LHIN's Accountability Agreement target or better

(iii) Performance Corridor

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor: less than or equal to the LHIN's Accountability Agreement target

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding
Performance Corridor: 10%

(h) 90th Percentile Wait Times for Diagnostic Magnetic Resonance Imaging (MRI) Scan

(i) Definition. This indicator measures the wait time from when a diagnostic scan is ordered, until the time the actual exam is conducted. This interval is typically referred to as 'intent to treat'. The 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.

2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).
3. Count the total number of cases and multiply by 0.90 to get the "90th percentile patient". If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the "90th percentile patient" is the indicator value

Excludes:

1. Procedures no longer required;
2. Procedures assigned as priority level 1;
3. Wait list entries identified by hospitals as data entry errors;
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors; and
5. As of January 1, 2008, diagnostic imaging cases classified as specified date procedures (timed procedures).

(ii) LHIN Target

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Target: maintain or improve current performance

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Target: the LHIN's Accountability Agreement target or better

(iii) Performance Corridor

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
Performance Corridor: less than or equal to the LHIN's Accountability Agreement target

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
Performance Corridor: 10%

(i) 90th Percentile Wait Times for Diagnostic Computed Tomography (CT) Scan

(i)) Definition. This indicator measures the wait time from when a diagnostic scan is ordered, until the time the actual exam is conducted. This interval is typically referred to as 'intent to treat'. The 90th percentile is the point at which 90% of the patients received their treatment while the other 10% waited longer.

Steps:

1. Wait Days = Procedure Date – Decision to Treat Date – Patient Unavailable Days.
2. Sort the records in ascending order (i.e. patients with short wait days on top and patients with long wait days at the bottom).
3. Count the total number of cases and multiply by 0.90 to get the "90th percentile patient". If this value has a decimal digit greater than zero, then round up (ex. 6.6 ~ 7, 6.0 ~ 6, 17.01 ~ 18).
4. The number of wait days for the "90th percentile patient" is the indicator value

Excludes:

1. Procedures no longer required;
2. Procedures assigned as priority level 1;
3. Wait list entries identified by hospitals as data entry errors;
4. If unavailable days fall outside the decision to treat date up to procedure date, unavailable days are not deducted from patients' wait days. These are considered data entry errors; and
5. As of January 1, 2008, diagnostic imaging cases classified as specified date procedures (timed procedures).

ii) <u>LHIN Target</u>

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
   Performance Target: maintain or improve current performance

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
   Performance Target: the LHIN's Accountability Agreement target or better

(iii) <u>Performance Corridor</u>

1. For hospitals performing at the LHIN's Accountability Agreement target or better:
   Performance Corridor: less than or equal to the LHIN's Accountability Agreement target

2. For hospitals performing above the LHIN's Accountability Agreement target with incremental wait time funding:
   Performance Corridor: 10%

and

(b) All references to Schedules A, G, or H being read as referring to Schedules A1, G2 or H2 respectively.

8.0 REPORTING OBLIGATIONS

8.1 The reporting obligations set out in Article 8 of Schedule B, as amended by B1, apply to Fiscal Year 11/12.

8.2 The following reporting obligations are added to Article 8 of Schedule B:

(a) n/a

9.0 LHIN SPECIFIC PERFORMANCE OBLIGATIONS

9.1 Except where specifically limited to a given year, the obligations set out in Article 9 of Schedule B, as amended by B1, apply to Fiscal Year 11/12. Without limiting the foregoing, waivers or conditional waivers for 08/09, 09/10 and 10/11 do not apply to 11/12.

9.2 The following provisions are added to Article 9 of Schedule B

(a) Hospitals will participate in and advance the LHIN's 2010-13 Integrated Health Service Plan (IHSP) specifically for the strategic direction of enhancing access and sustainability of hospital-based treatment and care consistent with the priorities established through the Hospital/CCAC Leadership Group.
-Hospitals will focus on Emergency Department access, cancer surgery and hip fractures.

(b) Hospitals will participate in performance improvement initiatives through the LHIN's Quality Improvement Program and/or Excellent Care for All Act implementation and align their enterprise performance management solutions to the drivers (service utilization and cost) of the Health Based Allocation Model (HBAM), through:

- Completion of the HBAM Template for *each* clinical module (as applicable) to your hospital to be submitted to the South West LHIN by March 31, 2012.

(c) The South West LHIN, CCAC and Hospital partners will work together in 2011/12 to determine indicator(s) related to appropriate placement of patient/client discharge and patient flow, including percentage of patients designated ALC and number of long term care home applications conducted in hospital including by not limited to:

a. Reduction in the % ALC Days at source hospital and at SW LHIN

b. Reduction in the total number of clients designated ALC

c. Reduction in ALC to LTC designation in hospitals

d. Reduction in ALC to TBD designation in hospitals

e. Reduction in the number of ALC LTC applications completed in hospital

Hospital Multi-Year Funding Allocation

Schedule C2 2011/12

Hospital: London Health Sciences Centre
Fac #: 936

	2011/12 Allocation	
	Base	One Time
Operating Base Funding	745,321,885	
Multi-Year Funding Incremental Adjustment		
Other Funding		
Funding adjustment 1 (Cochlear Implants)		736,000
Funding adjustment 2 (Urgent Priorities)		362,500
Funding adjustment 3 (ER Kiosks)		2,600
Funding adjustment 4 (ER Pay for Results)		4,849,700
Funding Adjustment 8 (WTS General Surgery)		66,400
Funding Adjustment 9 (WTS Paediatric)		219,000
Funding Adjustment 9 (MRI)	400,000	
Critical Care Stategies Schedule E		
PCOP: Schedule F		
PCOP	21,971,100	
Stable Priority Services: Schedule G		
Chronic Kidney Disease		
Cardiac catherization		1,109,300
Cardiac surgery		
Neurosciences		330,000
Provincial Strategies: Schedule G		
Organ Transplantation		(873,700)
Wireless Endocopy Cameras		70,000
Emergency Neurological Services		400,000
Percutaneous coronary intervention (PCI)		
Implantable cardiac defibrillators (ICD)		
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		2,697,900
Cataract Surgeries		
Magnetic Resonance Imaging (MRI)		1,950,000
Computed Tomography (CT)		218,800
Total Additional Base and One Time Funding	767,692,985	11,938,500
Total Allocation	779,631,485	

Allocations not provided in this schedule for 2011/12 will be provided to hospitals in subsequent planning cycles.

Performance Indicators

Schedule D2 2011/12

Hospital: London Health Sciences Centre

Fac #: 936

	Measurement Unit	2011/12 Performance Target	2011/12 Performance Standard**
PERSON EXPERIENCE: Access, Safe, Effective, Person-Centred			
Accountability Indicators			
90th Percentile ER LOS for Admitted Patients	Hours	29.00	<=32
90th Percentile ER LOS for Non-admitted Complex Patients	Hours	7.80	<=8.2
90th Percentile ER LOS for Non-admitted Minor / Uncomplicated Patients	Hours	5.50	<=6.6
Explanatory Indicators			
Emergency Department Activity	Weighted Cases		
Emergency Department Visits	Visits		
30-day readmission of patients with stroke or transient ischemic attack (TIA) to acute care for all diagnoses	Percentage		
Percent of stroke patients discharged to rehabilitation	Percentage		
Percent of stroke patients managed on a designated stroke unit	Percentage		
Wait Time Volumes (Per Schedule H2)	Cases		
Rehabilitation Separations	Separations		
ORGANIZATIONAL HEALTH: Efficient, Appropriately Resourced, Employee Experience, Governance			
Accountability Indicators			
Current Ratio (consolidated)	Ratio	1.00	.90 - .1.10
Total Margin (Consolidated)	Percentage	0.71%	>0
Explanatory Indicators			
Total Margin (Hospital Sector Only)	Percentage		
Percentage Full Time Nurses	Percentage		
Percentage Paid Sick Time	Percentage		
Percentage Paid Overtime	Percentage		
SYSTEM INTEGRATION: Integration, Community Engagement, eHealth			
Explanatory Indicators			
Percentage ALC Days	Days		
Repeat Unplanned Emergency Visits within 30 days for Mental Health Conditions	Visits		
Repeat Unplanned Emergency Visits within 30 days for Substance Abuse Conditions	Visits		
GLOBAL VOLUMES			
Accountability Indicators			
Total Acute Activity, incl. Inpatient and Day Surgery*	Weighted Cases	80,061	>77,659
Complex Continuing Care	RUG Weighted Patient Days	n/a	n/a
Mental Health	Inpatient Days	28,786	> 25,160
ELDCAP	Inpatient Days	n/a	n/a
Rehabilitation	Inpatient Days	n/a	n/a
Ambulatory Care***	Visits	757,240	>711,806

* Global volumes based on CIHI Case mix Group (CMG)+ methodology and RIW weights

**Volume Performance Indicators under Global Volumes vary in application based on hospital type.

***Ambulatory Care includes OHRS Primary account codes 7134* (excluding 7134055), 712*, 7135*, 715*, OHRS secondary statistical account codes 447*, 450*, 5* (excluding 50*, 511*, 512*, 513*, 514*, 518*, 519*, 521*)

Critical Care Funding

Schedule E2 2011/12

Hospital London Health Sciences Centre

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, B1 or B2. 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 F2 2011/12

Hospital London Health Sciences Centre

TBD. This section has been intentionally left blank

Once negotiated, an amendment (Sch F2.1) 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, B1 or B2. This funding would be an additional in-year allocation contemplated by section 5.3 of the Agreement

Protected Services

Schedule G2 2011/12

Hospital London Health Sciences Centre

Fac #: 936

	Units of Service	2011/12 Interim Performance Target	2011/12 Performance Standard
Stable Priority Services			
Chronic Kidney Disease	Weighted Units	140,978	140,978
Cardiac catherization	Procedures	4,000	4,000
Cardiac surgery	Cases	1,426	1,426
Provincial Strategies			
Organ Transplantation*	Cases	160	160
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	800	800
Visudyne Therapy	Number of insured Visudyne vials administered	N/A	N/A
Total Hip and Knee Joint Replacements (Non-WTS)	Number of Implant Devices	968	968
Magnetic Resonance Imaging	Hours of operation	9,360	9,360
Regional Trauma	Cases	430	430
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, B1, B2

Funding and volumes for these services should be planned for based on 2010/11 approved allocations. Amendments, pursuant to section 5.2 of this Agreement, may be made during the quarterly submission process.

Wait Time Services

Schedule H2 2011/12

Hospital London Health Sciences Centre

Fac # 936

	2010/11 Funded		2011/12 Funded	
	Base Volumes	Incremental Volumes*	Base Volumes	Incremental Volumes**
Selected Cardiac Services	Refer to Schedule G for Cardiac Service Volumes and Targets			
Total Hip and Knee Joint Replacements (Total Implantations)	968	185	968	300
Cataract Surgeries (Total Procedures)	n/a	n/a	n/a	n/a
Magnetic Resonance Imaging (MRI) (Total Hours)	8,320	7,158	9,360	7,500
Computed Tomography (CT) (Total Hours)	17,199	767	20,349	877

	Measurement Unit	2011/12 Performance Target	2011/12 Performance Standard**
90th Percentile Wait Times for Cancer Surgery	Days	95.00	86 - 105
90th Percentile Wait Times for Cardiac Surgery	Days	45.00	<=55
90th Percentile Wait Times for Cataract Surgery	Days	n/a	n/a
90th Percentile Wait Times for Hip Replacement Surgery	Days	178.00	160 - 200
90th Percentile Wait Times for Knee Replacement Surgery	Days	182.00	164 - 200
90th Percentile Wait Times for MRI Scan	Days	62.00	<=62
90th Percentile Wait Times for CT Scan	Days	35.00	32 - 38

* The 2010/11 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,B1, B2. This funding would be an additional in-year allocation contemplated by section 5.3 of the Agreement.

H-SAA AMENDING AGREEMENT

THIS AMENDING AGREEMENT (the "Agreement") is made as of the 30th day of June, 2012

BETWEEN:

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

London Health Sciences Centre (the "Hospital")

WHEREAS the LHIN and the Hospital (together the "Parties") entered into a hospital service accountability agreement that took effect April 1, 2008 and was initially due to expire on March 31, 2011 (the "H-SAA");

AND WHEREAS the LHIN and the Hospital have extended the H-SAA, most recently to June 30, 2012 pending the MOHLTC's announcement of funding allocations;

AND WHEREAS the LHIN and the Hospital are in the process of negotiating further amendments to the H-SAA following the release of the funding allocations, such further amendments to include an extension of the H-SAA to March 31, 2013 and amendments to the Schedules to reflect the funding allocations;

NOW THEREFORE in consideration of mutual promises and agreements contained in this Agreement and other good and valuable consideration, the parties agree as follows:

1.0 Definitions. Except as otherwise defined in this Agreement, all terms shall have the meaning ascribed to them in the H-SAA.

2.0 Amendments.

2.1 Agreed Amendments. The Parties agree that the H-SAA shall be amended as set out in this Article 2.

2.2 Term. The Parties agree that Section 3.2 (Term) of the H-SAA shall be deleted and replaced by the following: "**Term.** This Agreement is will commence on April 1, 2008 and will terminate on September 30, 2012.

3.0 Effective Date. The Parties agree that the amendments set out in Article 2 shall take effect on June 30, 2012. All other terms of the H-SAA, shall remain in full force and effect.

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

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

6.0 **Entire Agreement.** This Agreement constitutes the entire agreement between the Parties with respect to the extension of the H-SAA and supersedes all prior oral or written representations and agreements.

IN WITNESS WHEREOF the Parties have executed this Agreement on the dates set out below.

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK

By:

Jeff Low, Board Chair　　　　Date

And by:

Michael Barrett, Chief Executive Officer　　　　Date

London Health Sciences Centre

By:
Original Copy Signed

Ruthe Anne Conyngham, Board Chair　　　　June 29 2012
Date

And by:

Original Copy Signed
Bonnie Adamson, President & Chief Executive Officer　　　　June 29 2012.
Date

REÇU / RECEIVED
- 1 -10- 2012

H-SAA AMENDING AGREEMENT

THIS AMENDING AGREEMENT (the "Agreement") is made as of the 1st day of October, 2012

BETWEEN:

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

London Health Sciences Centre (the "Hospital")

WHEREAS the LHIN and the Hospital (together the "Parties") entered into a hospital service accountability agreement that took effect April 1, 2008 and was initially due to expire on March 31, 2011 (the "H-SAA");

AND WHEREAS the LHIN and the Hospital have extended the H-SAA, most recently to September 30, 2012;

AND WHEREAS the LHIN and the Hospital are in the process of negotiating further amendments to the H-SAA following the release of the funding allocations, such further amendments to include an extension of the H-SAA to March 31, 2013 and amendments to the Schedules to reflect the funding allocations;

NOW THEREFORE in consideration of mutual promises and agreements contained in this Agreement and other good and valuable consideration, the parties agree as follows:

1.0 Definitions. Except as otherwise defined in this Agreement, all terms shall have the meaning ascribed to them in the H-SAA.

2.0 Amendments.

2.1 Agreed Amendments. The Parties agree that the H-SAA shall be amended as set out in this Article 2.

2.2 Term. The Parties agree that Section 3.2 (Term) of the H-SAA shall be deleted and replaced by the following: "**Term.** This Agreement is will commence on April 1, 2008 and will terminate on October 31, 2012."

3.0 Effective Date. The Parties agree that the amendments set out in Article 2 shall take effect on October 1, 2012. All other terms of the H-SAA, shall remain in full force and effect.

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

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

6.0 **Entire Agreement.** This Agreement constitutes the entire agreement between the Parties with respect to the extension of the H-SAA and supersedes all prior oral or written representations and agreements.

IN WITNESS WHEREOF the Parties have executed this Agreement on the dates set out below.

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK

Original Copy Signed
Jeff Low, Chair

JAN 2 3 2012
Date

Original Copy Signed
Michael Barrett, CEO

JAN 2 3 2012
Date

London Health Sciences Centre

Original Copy Signed
Ruthe Anne Conyngham, Board Chair

September 26 2012
Date

Original Copy Signed
Bonnie Adamson, President & Chief Executive Officer

September 26 2012
Date

REÇU / RECEIVED
27 -11- 2012

2008-13 H-SAA AMENDING AGREEMENT

THIS AMENDING AGREEMENT (this "Agreement") is made as of April 1, 2012.

BETWEEN:

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

LONDON HEALTH SCIENCES CENTRE (the "Hospital")

WHEREAS the LHIN and the Hospital (together the "Parties") entered into a hospital service accountability agreement that took effect April 1, 2008 and has been amended by agreements made as of April 1, 2010 and April 1, 2011 (the "H-SAA");

AND WHEREAS the Parties have extended the H-SAA by agreement effective April 1, 2012;

AND WHEREAS the Parties wish to further amend the H-SAA;

NOW THEREFORE in consideration of mutual promises and agreements contained in this Agreement and other good and valuable consideration, the Parties agree that the H-SAA shall be amended as follows:

1.0 Definitions. Except as otherwise defined in this Agreement below, all terms shall have the meaning ascribed to them in the H-SAA.

2.0 Amendments.

2.1 Agreed Amendments. The Parties agree that the H-SAA shall be amended as set out in this Article 2.

2.2 Amended Definitions. Effective April 1, 2012, the following terms shall have the following meanings:

"**Base Funding**" means the Base funding set out in Schedule C (as defined below).

"**Costs**" for the purposes of Section 2.13 below, means all costs for the Executive Office (as defined below) including office space, supplies, salaries and wages of the officers and staff of the Executive Office, conferences held for or by the Executive Office and travel expenses of the officers and staff of the Executive Office.

"**Executive Office**" means the office of the chief executive officer or equivalent, and the office of every member of senior management of the Hospital that reports directly to the chief executive officer or equivalent.

"**Explanatory Indicator**" means an indicator of Hospital performance that is complementary to one or more Accountability Indicators and used to support planning, negotiation or problem solving, but for which no Performance Target has been set.

"**HAPS**" means the Board-approved hospital annual planning submission provided by the Hospital to the LHIN for the Fiscal Years 2012-2013;

"**Indicator Technical Specifications**" and "**2012 -13 H-SAA Indicator Technical Specifications**" means the document entitled "Hospital Service Accountability Agreement 2012-13: Indicator Technical Specifications March 2012" as it may be amended or replaced from time to time.

The definition of "**Performance Standard**" is amended by adding the words "and the Indicator Technical Specifications" after the last word "Schedules". As a result, "**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 and the Indicator Technical Specifications).

"**Post-Construction Operating Plan (PCOP) Funding**" and "**PCOP Funding**" means annualized operating funding provided to support service expansions and other costs occurring in conjunction with completion of an approved capital project, as set out in Schedule C (2012 – 2013) (Hospital One-Year Funding Allocation) and further detailed in Schedule F (2012 – 2013) (Post-Construction Operating Plan Funding and Volume).

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

Schedule A (2012 – 2013) (Planning and Reporting);
Schedule C (2012 – 2013) (Hospital One-Year Funding Allocation)
Schedule D (2012 – 2013) (Service Volumes)
Schedule E (2012 – 2013) (Indicators)
Schedule E1 (2012 – 2013) (LHIN Specific Indicators and Targets) and
Schedule F (2012 – 2013) (Post-Construction Operating Plan Funding and Volume)

"**Schedule A**" means Schedule A (2012 – 2013) (Planning and Reporting).

"**Schedule C**" means Schedule C (2012 – 2013) (Hospital One-Year Funding Allocation).

2.3 Interpretation. This Agreement and the H-SAA shall be interpreted with reference to the Indicator Technical Specifications.

2.4 Term. This Agreement and the H-SAA will terminate on March 31, 2013.

2.5 Recovery of Funding. Section 5.6.1 (Recovery of Funding) (a) (Generally) of the H-SAA is amended by deleting (v) and adding the following as Section 5.6.1(Recovery of Funding) (a.1) (Specific Programs):

(i) if the Performance Obligations set out in Schedule E (2012 – 2013) (Indicators) in respect of Critical Care Funding are not met, the LHIN will adjust the Critical Care Funding following the submission of in-year and year-end data;

(ii) if the Hospital does not meet a performance Obligation or Service Volume under its post-construction operating plan, as detailed in Schedule F or Schedule F (2012 – 2013), the LHIN may: adjust the applicable Post-Construction Operating Plan Funding to reflect reported actual results and projected year-end activity; and perform final settlements following the submission of year-end data of Post Construction Operating Plan Funding;

(iii) if the Hospital does not meet a Performance Obligation or Service Volume set out in Schedule D for a service within Part III - Services and Strategies, the LHIN may: adjust the Funding for that service to reflect reported actuals and projected year-end activity; and, perform in-year reallocations and final settlements following the submission of year-end data of service; and,

(iv) if the Hospital does not meet a Performance Obligation or Service Volume as detailed in Schedule D for a Wait Time Service, the LHIN may: adjust the respective Wait Time Funding to reflect reported actuals and projected year-end activity; and perform in-year reallocations and final settlements following the submission of year-end data.

2.6 Funding. Section 6.1.1 (Funding) of the H-SAA is amended by deleting (ii) and replacing it with:

"(ii) used in accordance with the Schedules".

2.7 Balanced Budget. Section 6.1.3 (Balanced Budget) of the H-SAA is amended by deleting "Schedule B" at the end of the Section and replacing it with "Schedule E1 (2012 – 2013) LHIN Specific Indicators and Targets".

2.8 Hospital Services. Section 6.2 (Hospital Services) of the H-SAA is amended by adding the words "and the Indicator Technical Specifications" after the word "Schedule" in (i) and (ii).

2.9 Planning Cycle. Section 7.1 (Planning Cycle) of the H-SAA is amended by replacing the words "the planning cycle in Part II of *Schedule A* ("Planning Cycle") for Fiscal Years 2010/11 and 2011/12" with the words "the timing requirements of Schedule A (2012 – 2013) Planning and Reporting".

2.10 Timely Response. Section 7.6.1 (Timely Response) of the H-SAA is amended by deleting both occurrences of "Schedule B" and replacing these with "Schedule A (2012 – 2013) Planning and Reporting".

2.11 Specific Reporting Obligations. Section 8.2 (Specific Reporting Obligations) of the H-SAA is amended by deleting "Schedule B" and replacing it with "Schedule A (2012 – 2013) Planning and Reporting".

2.12 Planning Cycle. Section 12.1 (Planning Cycle) of the H-SAA is amended by replacing "Schedule A" in (i) with "Schedule A (2012 – 2013) Planning and Reporting".

2.13 Executive Office Reduction. The Hospital shall reduce the Costs of its Executive Office by ten percent (10%) over fiscal years 2011/12 and 2012/13. Entities that have a year end of March 31 should use their 2010/2011 budget as a baseline, and entities that have a year end of December 31 should use their 2010 budget as a baseline.

3.0 Effective Date. The Parties agree that the amendments set out in Article 2 shall take effect on April 1, 2012. All other terms of the H-SAA shall remain in full force and effect.

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

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

6.0 Entire Agreement. This Agreement together with Schedules A (2012 – 2013) (Planning and Reporting), C (2012 – 2013) (Hospital One-Year Funding Allocation), D (2012 – 2013) (Service Volumes), E (2012 – 2013) (Indicators), Schedule E1 (LHIN Specific Indicators and Targets) and F (2012 – 2013) (Post-Construction Operating Plan Funding and Volume) constitute the entire agreement between the Parties with respect to the subject matter contained in this Agreement and supersedes all prior oral or written representations and agreements.

IN WITNESS WHEREOF the Parties have executed this Agreement on the dates set out below.

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK

Original Copy Signed

Jeff Low, Board Chair

And by:

Original Copy Signed

Michael Barrett, Chief Executive Officer

LONDON HEALTH SCIENCES CENTRE

Original Copy Signed

Ruthe Anne Conyngham, Board Chair

I have authority to bind the Hospital.

And by:

Original Copy Signed

Bonnie Adamson, President and Chief Executive Officer

I have authority to bind the Hospital.

Planning and Reporting

Schedule A (2012-2013)

Part I – Planning
Since the MOHLTC was unable to release the amount of Hospital funding for the 2012 – 2013 fiscal year before March 31, 2012, it was not possible for the LHIN and the Hospital to enter into an H-SAA for the 2012 – 2013 fiscal year by March 31, 2012. In the circumstances, the following steps were taken at the following times: ▪ The 2008-12 H-SAA was extended to September 30, 2012. ▪ The HAPS Submission process was launched on April 17th, 2012, with the HAPS due May 29th. ▪ On execution of an amending agreement, the 2008-12 H-SAA will be amended and extended for a one year term, effective April 1, 2012 through March 31, 2013.

Part II – Reporting	Party	Timing
Hospitals submit MIS trial balance and supplemental reporting as necessary	Hospital	30 days after the end of each quarter beginning with the 2nd quarter
Year end MIS trial balance and supplemental report	Hospital	60 days following the end of the fiscal year
Audited Financial Statements	Hospital	60 days following the end of the fiscal year
French Language Services Report as applicable	Hospital	60 days following the end of the fiscal year
Attestation of compliance with tasks required by CritiCall as per the Agreement between the assigned CritiCall Transfer Payment Agency and the MOHLTC	Hospital	60 days following the end of the fiscal year
Hospital to provide compliance attestations as required by Applicable Law	Hospital	In accordance with obligations
Such other reporting as may be required by the LHIN from time to time (Note 1)	Hospital	As directed by the LHIN

Note 1: Request for reporting as per LHIN authority as set out in the Local Health System Integration Act

Hospital One-Year Funding Allocation

Schedule C (2012-2013)

Hospital London Health Sciences Centre Fac # 123	2012/13 Allocation	
	Base	One-Time
Operating Base Funding		
Base Funding (Note 1)	468,515,698	
PCOP (Reference Schedule F)	7,290,200	
Incremental Funding Adjustment		
Other Funding		
Funding adjustment 1 (HBAM)	261,352,600	
Funding Adjustment 1 (Reallocation for BSS)	(124,562)	
Funding Adjustment 2 (Indirect WTS Costs)		227,300
Funding Adjustment 3 (BSS)	78,685	
Funding Adjustment 4 (Starch Volumes)	594,000	
Funding Adjustment 5 (BSS Start Up)		83,882
Funding Adjustment 6 (WTS General Surgery)		31,700
Funding Adjustment 7 (WTS Paediatric)		149,400
Funding Adjustment 8 (Trsf to CCAC LTCH Act)	(104,902)	
Funding Adjustment 9 (PP Wireless Capsules)		70,000
Funding Adjustment 10 (JRR clawback)	(1,908,023)	
Services: Schedule D		
Cardiac catherization	TBD	TBD
Cardiac surgery	TBD	TBD
Organ Transplantation	TBD	TBD
Strategies: Schedule D		
Organ Transplantation		
Endovascular aortic aneurysm repair		
Electrophysiology studies EPS/ablation		
Percutaneous coronary intervention (PCI)		
Implantable cardiac defibrillators (ICD)		
Newborn screening program		
Specialized Hospital Services: Schedule D		
Magnetic Resonance Imaging		
Provincial Regional Genetic Services2		
Permanent Cardiac Pacemaker Services	TBD	TBD
Provincial Resources		
Stem Cell Transplant		
Adult Interventional Cardiology for Congenital Heart Defects		
Cardiac Laser Lead Removals		
Pulmonary Thromboendarterectomy Services		
Thoracoabdominal Aortic Aneurysm Repairs (TAA)		
Other Results (Wait Time Strategy):		
Selected Cardiac Services		
Hip Replacements - Revisions		107,800
Knee Replacements - Revisions		
Magnetic Resonance Imaging (MRI)		1,581,840
Computed Tomography (CT)		197,250
Quality-Based Procedures: Schedule D Planning Allocation Assumption (rate x volume)		
Primary Hips QBP Recalculation		4,117,573
Primary Hips Additional		452,544
Primary Hips Additional - Indirect Funding		78,430
Primary Knees QBP Recalculation		5,062,997
Primary Knees Additional		487,812
Primary Knee Additional - Indirect Funding		134,469
Cataract		10,211
Inpatient rehab for primary hip		
Inpatient rehab for primary knee		
Chronic Kidney Disease -as per Ontario Renal Network Funding Allocation		38,244,792
TOTAL	$	788,728,694

Note 1 - Includes lines previously in Schedules G and H (Cardiac Rehabilitation, Visudyne Therapy, Regional Trauma, Regional and district Stroke Centres, Sexual Assault/Domestic Violence Treatment Centres, HIV Outpatient clinics). See 2012-13 HAPS Guideline for additional information.

Reference to Schedules D and F means (2012 - 2013) unless otherwise stated

* Note - Hip/Knees program transfer from St. Joseph's Health Care, London still to be confirmed.
[illegible]

Service Volumes

Schedule D (2012 - 2013)

Hospital: London Health Sciences Centre

Facility #: 123

Part I - GLOBAL VOLUMES Refer to 2012-13 H-SAA Indicator Technical Specification Document for further details	Measurement Unit	2012/13 Performance Target	2012/13 Performance Standard
Emergency Department	Weighted Cases	7,734.00	>=7115 and <=8363
Complex Continuing Care	Weighted Patient Days	0.00	0.00
Total Inpatient Acute	Weighted Cases	87,471	>= 84,846 and <= 90,095
Day Surgery	Weighted Visits	2,943	>= 2649 and <=3237
Inpatient Mental Health	Weighted Patient Days		
Inpatient Rehabilitation	Weighted Cases		
Elderly Capital Assistance Program (ELDCAP)	Inpatient Days		
Ambulatory Care	Visits	773,800	> =727,200

Part II - WAIT TIME VOLUMES (Formerly Schedule H) (Note 1)	Measurement Unit	2012/13 Base	2012/13 Incremental
Cardiac Surgery -CABG	Cases	TBD	TBD
Cardiac Surgery -Other Open Heart	Cases	TBD	TBD
Cardiac Surgery -Valve	Cases	TBD	TBD
Cardiac Surgery -Valve/CABG	Cases	TBD	TBD
Paediatric Surgery	Cases	945.00	101.00
General Surgery	Cases	1,320.00	10.00
Hip Replacement - Revisions	Cases	153.00	10.00
Knee Replacements - Revisions	Cases		
Magnetic Resonance Imaging (MRI)	Total Hours	10,400.00	6084.00
Computed Tomography (CT)	Total Hours	20,349.00	789.00

Part III - Services & Strategies (Formerly Schedule G)	Measurement Unit	2012/13 Performance Target	2012/13 Performance Standard
Catherization	Cases	TBD	
Angioplasty	Cases	TBD	
Other Cardiac (Note 2)	Cases	TBD	
Organ Transplantation (Note 3)	Cases	TBD	
Neurosurgery (Note 4)	Cases	TBD	
Bariatric Surgery	TBD		

Part IV - Quality Based Procedures (Formerly in Wait Times program Schedule H) (Note 5)	Measurement Unit	2012/13 Volume
Primary hip	Volumes	609.00
Primary knee	Volumes	838.00
Cataract	Volumes	6.00
Inpatient rehab for primary hip	Volumes	
Inpatient rehab for primary knee	Volumes	
Chronic Kidney Disease (as per Ontario Renal Network Allocation Schedule)	Volumes	See Schedule

Note 1 - Reflect wait time procedure volumes, both base and incremental at 2011/2012 levels unless otherwise directed by your LHIN

Note 2 -Cardiac Services are LHIN managed (Protected Services) including: Implantable Cardic Defibrilators (ICD), electrophysiology studies (EPS), Ablations, Ablations with advance mapping, Pacemakers, Drug Eluting Stents (DES), Cardiac surgery (CABG, valve, other open heart, valve+CABG), Angioplasty, and Cardiac Cathethorization.

Note3- Organ Transplantation - Funding for living donation (kidney & liver) is 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.

Note4 - Includes neuromodulation, coil embolization, and emergency neurosurgery cases.

Note 5- Under Health system Funding Reform (H&FR), for each quality-based procedure, the volumes are determined as a single figure for the year. Previously, under Wait Time program they were identified as base and incremental

Indicators*

Schedule E (2012 - 2013)

Hospital: London Health Sciences Centre

Facility #: 123

Accountability Indicators

	Measurement Unit	2012/13 Performance Target	2012/13 Performance Standard
Part I - PERSON EXPERIENCE: Access, Effective, Safe, Person-Centered			
90th Percentile ER LOS for Admitted Patients	Hours	29.00	> 31.9
90th Percentile ER LOS for Non-admitted Complex (CTAS I-III) Patients	Hours	7.80	> 8.58
90th Percentile ER LOS for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	Hours	5.50	> 6.05
90th Percentile Wait Times for Cancer Surgery	Days	84.00	>= 84
90th Percentile Wait Times for Cardiac Bypass Surgery	Days	45.00	> 49
90th Percentile Wait Times for Cataract Surgery	Days		
90th Percentile Wait Times for Joint Replacement (Hip)	Days	182.00	>= 182
90th Percentile Wait Times for Joint Replacement (Knee)	Days	253.00	>= 253
90th Percentile Wait Times for Diagnostic MRI Scan	Days	78.00	>= 78
90th Percentile Wait Times for Diagnostic CT Scan	Days	28.00	> 30.8
Rate of Ventilator-Associated Pneumonia	Cases/Days	0.00	0 to .99
Central Line Infection Rate	Cases/Days	0.00	0 to 0.7
Rate of Hospital Acquired Cases of Clostridium Difficile Infections	Cases/Days	0.00	0 to 0.27
Rate of Hospital Acquired Cases of Vancomycin Resistant Enterococcus Bacteremia	Cases/Days	0.00	0 to 0.58
Rate of Hospital Acquired Cases of Methicillin Resistant Staphylococcus Aureus Bacteremia	Cases/Days	0.00	0 to 0.04
Part II - ORGANIZATIONAL HEALTH: Efficient, Appropriately Resourced, Employee Experience, Governance			
Current Ratio (Consolidated)	Ratio	1.44	0.8 to 2.0
Total Margin (Consolidated)	Percentage	0.86%	> 0
Part III - SYSTEM PERSPECTIVE: Integration, Community Engagement, eHealth			
Percentage ALC Days (closed cases)	Days	9.15	< 9.46

Explanatory Indicators

	Measurement Unit
Part I - PERSON EXPERIENCE: Access, Effective, Safe, Person-Centered	
30-day Readmission of Patients with Stroke or Transient Ischemic Attack (TIA) to Acute Care for All Diagnoses	Percentage
Percent of Stroke Patients Discharged to Inpatient Rehabilitation Following an Acute Stroke Hospitalization	Percentage
Percent of Stroke Patients Admitted to a Stroke Unit During Their Inpatient Stay	Percentage
Hospital Standardized Mortality Ratio	Percentage
Readmissions Within 30 Days for Selected CMGs	Ratio
Part II - ORGANIZATIONAL HEALTH: Efficient, Appropriately Resourced, Employee Experience, Governance	
Total Margin (Hospital Sector Only)	Percentage
Percentage of Full-Time Nurses	Percentage
Percentage of Paid Sick Time (Full-Time)	Percentage
Percentage of Paid Overtime	Percentage
Part III - SYSTEM PERSPECTIVE: Integration, Community Engagement, eHealth	
Repeat Unscheduled Emergency Visits Within 30 Days for Mental Health Conditions	Visits
Repeat Unscheduled Emergency Visits Within 30 Days for Substance Abuse Conditions	Visits

Part IV - LHIN Specific Indicators and Performance targets, see Schedule E1 (2012-2013)

*Refer to 2012-13 H-SAA Indicator Technical Specification for further details.

LHIN Specific Indicators and Targets

Schedule E1 (2012-2013)

All Hospitals

All South West LHIN hospitals agree to re-engage in an integrated supply chain process with the intent of improving efficiencies and achieving resource savings with the goal of having a business proposal in place by the end of 2012/13.

All South West LHIN hospitals agree to proactively participate in ongoing planning discussions with respect to health system funding reform and the South West LHIN's Integrated Health Service Plan 2013-16.

All South West LHIN hospitals agree to annually review and update site specific programs and services information, as represented within the Healthline.ca website.

Performance Management Teams

Cancer: LHSC, GBHS, SGH, STEGH, WGH, SMGH, HDH, TDMH

H&K: LHSC, GBHS, SGH, STEGH, WGH, SMGH

As related to the performance improvement work occurring in the South West LHIN, your hospital will continue to participate in established groups such as the Cancer and Hip and Knee Performance Management Teams (PMT). 90th percentile performance (closed cases), open case performance and other metrics, as established between the LHIN and hospital partners will be monitored. Improvement expectations will be established through on-going dialogue and action plans articulated through performance improvement plans or other means of communication.

For Hips and Knees PMT, a weighted scoring methodology will be utilized to rank hospital performance with the opportunity for additional investment, if available.

Post-Construction Operating Plan Funding and Volume

Schedule F (2012/13)

Hospital: London Health Sciences Centre

See LHIN13-81A letter for volume and funding details	Total Approved Volume	2012/13 Received from LHIN % Funding Received			2012/13 Hospital Plan		
		Funding Rate	2012/13 Additional Volumes	Funding (Note 1)	Additional Volumes	New Beds	Funding
Inpatient Acute - Medicine/Surgery	6,524	$ 5,302	$ 4,263,860	804	323		$ 1,712,543
Inpatient Acute -Pediatics - cases	445	$ 5,302	$ 199,885	38	0		
Inpatient Acute - NICU -beds	4	$ 375,000	$ 375,000	1	1		$ 375,000
Inpatient Acute -Obstetrics							
Inpatient Acute - ICU							
Inpatient Rehabilitation General							
Inpatient Complex Continuing Care							
Inpatient Acute - Mental Health	3,638	$ 881	$ 475,197	540	3059		$ 2,694,398
Day Surgery							
Endoscopy (cases)	7,719	$ 526	$ 361,396	687	687		$ 361,396
Emergency			$ -				
Amb Care - Acute Mental Health	10,052		$ -				
Other - Medicine Day Night	5089	$ 288	$ 238,202	828	-		$ -
Other - Mental Health Day Night Adult	551		$ -				
Other - Mental Health Day Night Child &	226						
Other - ENT	2338	$ 141	$ 18,591	132	-		$ -
Other - Combined OBS / Gynecology	4345	$ 101	$ 83,859	834	-		$ -
Other - Gynecology	4583	$ 81	$ 82,851	1,025	-		$ -
Other - Infertility	855	$ 471	$ 113,566	241	-		$ -
Other - Paeds	12332	$ 210	$ 655,341	3,118	-		$ -
Other - Ortho	14733	$ 75	$ -		4,188		$ 314,268
Other - Adult Mental Health	7025	$ 169	$ 65,739	388	10,291		$ 1,743,804
Other - Child & Adolescent Mental Healt	3028	$ 172	$ 10,661	62	1,114		$ 191,552
Facility Costs							
Amortization			$ 346,000				$ 346,000
Total Funding			$ 7,290,248	(Note2)			$ 7,738,761

Funding provided in this Schedule is an additional in-year allocation contemplated by section 5.3 of the Agreement

Note 1 - *Terms and conditions of PCOP funding are determined by the Ministry of Health and Long Term care (MOHLTC). Incremental volumes required to be achieved by the Hospital as set out above are in addition to PCOP volumes provided in previous years. The MOHLTC may adjust funded volumes upon reconciliation.*

Note 2 - *This amount must be the same as PCOP (Operating Base Funding) on Schedule C (2012 - 2013).*

Once negotiated, an amendment (Schedule F1 (2012 - 2013) will be made under section 15.3 of the Agreement to include these targets and any additional conditions not otherwise set out in any other Schedule.

H-SAA AMENDING AGREEMENT

THIS AMENDING AGREEMENT (the "Agreement") is made as of the 31st day of March, 2013

B E T W E E N:

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

London Health Sciences Centre (the "Hospital")

WHEREAS the LHIN and the Hospital (together the "Parties") entered into a hospital service accountability agreement that took effect April 1, 2008 (the "H-SAA");

AND WHEREAS pursuant to various amending agreements the term of the H-SAA has been extended to March 31, 2013;

AND WHEREAS the LHIN and the Hospital have agreed to extend the H-SAA for a further six-month period to permit the LHIN and the Hospital to execute an H-SAA for the period April 1, 2013 – March 31, 2016;

NOW THEREFORE in consideration of mutual promises and agreements contained in this Agreement and other good and valuable consideration, the parties agree as follows:

1.0 Definitions. Except as otherwise defined in this Agreement, all terms shall have the meaning ascribed to them in the H-SAA. References in this Agreement to the H-SAA mean the H-SAA as amended and extended.

2.0 Amendments.

2.1 Agreed Amendments. The H-SAA is amended as set out in this Article 2.

2.4 Term. The reference to "March 31, 2013" in Article 3.2 is deleted and replaced with "September 30, 2013".

3.0 Effective Date. The amendments set out in Article 2 shall take effect on April 1, 2013. All other terms of the H-SAA shall remain in full force and effect.

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

5.0 Counterparts. This Agreement may be executed in any number of counterparts, each of which will be deemed an original, but all of which together will constitute

one and the same instrument.

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

IN WITNESS WHEREOF the Parties have executed this Agreement on the dates set out below.

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK

By:

______________________________ ______________________________

Jeff Low, Board Chair Date

And By:

______________________________ ______________________________

Michael Barrett, Chief Executive Officer Date

London Health Sciences Centre

Original Copy Signed April 2, 2013

Ruthe Anne Conyngham, Board Chair Date

I have authority to bind the HSP

Original Copy Signed March 28, 2013

For Bonnie Adamson, President & Chief Executive Officer Date

I have authority to bind the HSP

CU/RECEIVED
05-11-2013

THIS AMENDING AGREEMENT (the "Agreement") is made as of the 1st day of October, 2013

BETWEEN:

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

London Health Sciences Centre (the "Hospital")

WHEREAS the LHIN and the Hospital (together the "Parties") entered into a hospital service accountability agreement that took effect April 1, 2008 (the "H-SAA");

AND WHEREAS pursuant to various amending agreements the term of the H-SAA has been extended to September 30, 2013;

AND WHEREAS the LHIN and the Hospital have agreed to extend the H-SAA for a further six-month period with the joint intention of finalizing and executing an H-SAA for the period April 1, 2014 – March 31, 2017;

NOW THEREFORE in consideration of mutual promises and agreements contained in this Agreement and other good and valuable consideration, the parties agree as follows:

1.0 **Definitions.** Except as otherwise defined in this Agreement, all terms shall have the meaning ascribed to them in the H-SAA. References in this Agreement to the H-SAA mean the H-SAA as amended and extended.

2.0 **Amendments.**

2.1 Agreed Amendments. The H-SAA is amended as set out in this Article 2.

2.2 Term. The reference to "September 30, 2013" in Article 3.2 is deleted and replaced with "March 31, 2014".

3.0 **Effective Date.** The amendments set out in Article 2 shall take effect on October 1, 2013. All other terms of the H-SAA shall remain in full force and effect.

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

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

6.0 **Entire Agreement.** This Agreement constitutes the entire agreement between the Parties with respect to the subject matter contained in this Agreement and

supersedes all prior oral or written representations and agreements.

IN WITNESS WHEREOF the Parties have executed this Agreement on the dates set out below.

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK

By:

Original Copy Signed

Jeff Low, Board Chair

OCT 31, 2013
Date

And by:

Original Copy Signed

Michael Barrett, CEO

OCT 31, 2013
Date

London Health Sciences Centre

By:

Original Copy Signed

Ruthe Anne Conyngham, Board Chair

October 30 2013
Date

And by:

Original Copy Signed

~~Bonnie Adamson~~ Murray Glendining
President & Chief Executive Officer Acting

October 31 2013
Date

2008-14 H-SAA AMENDING AGREEMENT

THIS AMENDING AGREEMENT (the "Agreement") is made as of the 31st day of March, 2014

B E T W E E N:

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

London Health Sciences Centre (the "Hospital")

WHEREAS the LHIN and the Hospital (together the "Parties") entered into a hospital service accountability agreement that took effect April 1, 2008 (the "H-SAA");

AND WHEREAS pursuant to various amending agreements the term of the H-SAA has been extended to March 31, 2014;

AND WHEREAS the LHIN and the Hospital have agreed to extend the H-SAA for a further three month period to permit the LHIN and the Hospital to continue to work toward a multi-year H-SAA;

NOW THEREFORE in consideration of mutual promises and agreements contained in this Agreement and other good and valuable consideration, the parties agree as follows:

1.0 **Definitions.** Except as otherwise defined in this Agreement, all terms shall have the meaning ascribed to them in the H-SAA. References in this Agreement to the H-SAA mean the H-SAA as amended and extended.

2.0 **Amendments.**

2.1 Agreed Amendments. The H-SAA is amended as set out in this Article 2.

2.2 Term. The reference to "March 31, 2014" in Article 3.2 is deleted and replaced with "June 30, 2014".

3.0 **Effective Date.** The amendments set out in Article 2 shall take effect on April 1, 2014. All other terms of the H-SAA shall remain in full force and effect.

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

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

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

IN WITNESS WHEREOF the Parties have executed this Agreement on the dates set out below.

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK

Original Copy Signed — JUN 1 2 2014

Jeff Low, Chair — Date

And by:

Original Copy Signed — JUN 1 2 2014

Michael Barrett, Chief Executive Officer — Date

London Health Sciences Centre

By:

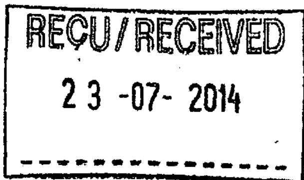
Original Copy Signed — April 30 2014

Ruthe Anne Conyngham, Board Chair — Date
I have authority to bind the HSP

And by:

Original Copy Signed — April 22 2014

Murray Glendining, Acting President and Chief Executive Officer — Date
I have authority to bind the HSP



2008-15 H-SAA AMENDING AGREEMENT

THIS AMENDING AGREEMENT (the "Agreement") is made as of the 1st day of July, 2014

BETWEEN:

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK (the "LHIN")

AND

London Health Sciences Centre (the "Hospital")

WHEREAS the LHIN and the Hospital (together the "Parties") entered into a hospital service accountability agreement that took effect April 1, 2008 (the "H-SAA");

AND WHEREAS pursuant to various amending agreements the term of the H-SAA has been extended to June 30, 2014;

AND WHEREAS the LHIN and the Hospital have agreed to extend the H-SAA for a further nine month period to permit the LHIN and the Hospital to continue to work toward a multi-year H-SAA;

NOW THEREFORE in consideration of mutual promises and agreements contained in this Agreement and other good and valuable consideration, the parties agree as follows:

1.0 Definitions. Except as otherwise defined in this Agreement, all terms shall have the meaning ascribed to them in the H-SAA. References in this Agreement to the H-SAA mean the H-SAA as amended and extended.

2.0 Amendments.

2.1 Agreed Amendments. The H-SAA is amended as set out in this Article 2.

2.2 Amended Definitions.

(a) The following terms have the following meanings.

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

Schedule A: Funding Allocation
Schedule B: Reporting
Schedule C: Indicators and Volumes
C.1. Performance Indicators
C.2. Service Volumes
C.3. LHIN Indicators and Volumes

2.3 Term. This Agreement and the H-SAA will terminate on March 31, 2015.

3.0 **Effective Date.** The amendments set out in Article 2 shall take effect on April 1, 2014. All other terms of the H-SAA shall remain in full force and effect.

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

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

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

IN WITNESS WHEREOF the Parties have executed this Agreement on the dates set out below.

SOUTH WEST LOCAL HEALTH INTEGRATION NETWORK

By:

Original Copy Signed

Jeff Low, Board Chair

Date 7/28/14

And by:

Original Copy Signed

Michael Barrett, CEO

OCT 15 2014

Date

London Health Sciences Centre

By:

Original Copy Signed

Ruthe Anne Conyngham, Board Chair

Date July 17 2014

And by:

Original Copy Signed

Murray Glendining
President and Chief Executive Officer

July 17, 2014
Date

Hospital Sector 2014-2015

Facility #: 936

Hospital Name: London Health Sciences Centre

Hospital Legal Name: London Health Sciences Centre

2014-2015 Schedule A1: Funding Allocation

Intended Purpose or Use of Funding	2014-2015 Target Estimated[1] Funding Allocation	
[1] FUNDING SUMMARY	Base[2]	Allocation[3]/One-Time[2]
Other LHIN Allocations- Global Funding	$387,336,000	
Health System Funding Reform (HSFR) HBAM Funding (Includes Mitigation)	$270,538,000	
Health System Funding Reform (HSFR) QBP Funding (Section 1 below)	$33,214,000	
Wait Time Strategy Services ("WTS") (Section 2 below)	$0	$2,042,000
Provincial Program Services ("PPS") (Section 3 below)	$0	$0
Other Non-HSFR LHIN & MOHLTC Funding (Section 4 below)	$7,674,000	$12,751,000
Post Construction Operating Plan (PCOP)	$53,768,000	
Total 14/15 Estimated Funding Allocation	$752,530,000	$14,793,000

[4] Section 1: Health System Funding Reform - Quality-Based Procedures	Rate	Allocation[4]
Cancer- Surgery	$0	$0
Cancer- Colposcopy	$0	$0
Cardiac- Aortic Valve Replacement	$0	$0
Cardiac- Coronary Artery Disease	$0	$0
Cataracts- Bilateral	$0	$0
Cataracts- Unilateral	$1,765	$10,590
Chemotherapy Systemic Treatment	$0	$0
Chronic Obstructive Pulmonary Disease	$7,661	$5,270,768
Congestive Heart Failure	$9,265	$6,300,200
Endoscopy	$0	$0
Hip Replacement- Inpatient Rehabilitation for Unilateral Primary	$0	$0
Hip Replacement- Unilateral Primary	$8,997	$4,786,404
Knee Replacement- Inpatient Rehabilitation for Unilateral Primary	$0	$0
Knee Replacement- Unilateral Primary	$7,895	$6,592,325
Non-Cardiac Vascular- Aortic Aneurysm (AA)	$18,438	$3,669,162
Non-Cardiac Vascular Lower Extremity Occlusive Disease (LEOD)	$9,963	$1,424,709
Orthopaedics- Hip Fracture	$0	$0
Orthopaedics- Knee Arthroscopy	$0	$0
Paediatric- Neonatal Jaundice (Hyperbilirubinemia)	$0	$0
Paediatric- Tonsillectomy	$0	$0
Respriatory- Pneumonia	$0	$0
Sroke- Transient Ischemic Attack (TIA)	$3,408	$218,112
Stroke- Hemorrahage	$14,533	$988,244
Stroke- Ischemic or Unspecified	$11,068	$4,637,492
Vision Care- Retinal Disease	$0	$0

Hospital Sector 2014-2017

Facility #: 936

Hospital Name: London Health Sciences Centre

Hospital Legal Name: London Health Sciences Centre

2014-2015 Schedule A: Funding Allocation

Section 2: Wait Time Strategy Services ("WTS")	Base[2]	One-Time[2]
General Surgery	$0	$92,000
Pediatric Surgery	$0	$218,000
Hip & Knee Replacement - Revisions	$0	$108,000
Magnetic Resonance Imaging (MRI)	$0	$1,318,000
Ontario Breast Screening Magnetic Resonance Imaging (OBSP MRI)	$0	$0
Computed Tomography (CT)	$0	$185,000
Other WTS Funding	$0	$121,000

Section 3: Provincial Program Services ("PPS")	Base[2]	One-Time[2]
Cardiac Surgery	$0	$0
Other Cardiac Services	$0	$0
Organ Transplantation	$0	$0
Neurosciences	$0	$0
Bariatric Services	$0	$0
Regional Trauma	$0	$0

Section 4: Other Non-HSFR Funding	Base[2]	One-Time[2]
LHIN One-time payments		$1,857,000
MOH One-time payments		$12,936,000
LHIN/MOH Recoveries	$0	
Other Revenue from MOHLTC	$9,028,000	
Paymaster	($1,354,000)	
Other Funding adjustment 1 ( )	$0	$0
Other Funding adjustment 2 ( )	$0	$0
Other Funding adjustment 3 ( )	$0	$0
Other Funding adjustment 4 ( )	$0	$0

Other Funding (Not included in the Summary above)	Base[2]	One-Time[2]
Grant in Lieu of Taxes	$0	$0
Cancer Care Ontario[3]	$0	$0
Ontario Renal Funding[3]	$0	$0
Funding adjustment 1 (MOH Drugs)	$0	$11,366,000
Funding adjustment 2 (Oral & Maxillofacial Rehab Prog)	$0	$878,000
Funding adjustment 3 (Net Transplant, Aortic Valve, Critical Care Nurse Training F	$0	$627,000

[1] Estimated funding allocations are subject to appropriation and written confirmation by the LHIN.

[2] Funding allocations are subject to change year over year.

[3] Funding provided by Cancer Care Ontario, not the LHIN.

[4] All QBP Funding is fully recoverable in accordance with Section 5.6 of the H-SAA. QBP Funding is not base funding for the purposes of the BOND policy. The Quality Based Procedures allocations above include assumed mitigation funding for 2014-2015. Funding is listed for Year One and Year Two QBPs only; Year Three QBP funding is listed within the Global funding line.

Hospital Sector 2014-2015

Facility #: 936
Hospital Name: London Health Sciences Centre
Hospital Legal Name: London Health Sciences Centre

2014-2015 Schedule B - Reporting Requirements

1. MIS Trial Balance	Due Date 2014-2015	Due Date 2015-2016	Due Date 2016-2017
Q2 – Apr 01 to Sept 30	31-Oct-2014	31-Oct-2015	31-Oct-2016
Q3 – Oct 01- to Dec 31	31-Jan-2015	31-Jan-2016	31-Jan-2017
Q4 – Jan 01 to March 31	31-May-2015	31-May-2016	31-May-2017

2. Hospital Quarterly SRI Reports and Supplemental Reporting as Necessary	Due Date 2014-2015	Due Date 2015-2016	Due Date 2016-2017
Q2 – Apr 01 to Sept 30	07-Nov-2014	07-Nov-2015	07-Nov-2016
Q3 – Oct 01- to Dec 31	07-Feb-2015	07-Feb-2016	07-Feb-2017
Q4 – Jan 01 to March 31	30-Jun-2015	30-Jun-2016	30-Jun-2017
Year End 2014-2015	30-Jun-2015	30-Jun-2016	30-Jun-2017

3. Audited Financial Statements

Fiscal Year	Due Date
2014-15	30-Jun-2015
2015-16	30-Jun-2016
2016-17	30-Jun-2017

4. French Language Services Report

Fiscal Year	Due Date
2014-15	30-Apr-2015
2015-16	30-Apr-2016
2016-17	30-Apr-2017

Hospital Sector 2014-2015

Facility #:	936
Hospital Name:	London Health Sciences Centre
Hospital Legal Name:	London Health Sciences Centre
Site Name:	TOTAL ENTITY

2014-2015 Schedule C1: TOTAL ENTITY Performance Indicators

Part I - PATIENT EXPERIENCE: Access, Effective, Safe, Person-Centered

Performance Indicators	Measurement Unit	2014-2015 Performance Target	**2014-2015 Performance Standard
90th Percentile Emergency Room (ER) Length of Stay for Admitted Patients	Hours	25.0	<= 27.5
90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	Hours	7.02	<= 7.7
90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	Hours	5.2	<= 5.7
Cancer Surgery: % Priority 4 cases completed within Target	Percent	≥ 90%	≥ 90%
Cardiac Bypass Surgery: % Priority 4 cases completed within Target	Percent	≥ 90%	≥ 90%
Cataract Surgery: % Priority 4 cases completed within Target	Percent	N/A	
Joint Replacement (Hip): % Priority 4 cases completed within Target	Percent	≥ 90%	≥ 90%
Joint Replacement (Knee): % Priority 4 cases completed within Target	Percent	90.0%	≥ 90%
Diagnostic Magnetic Resonance Imaging (MRI) Scan: % Priority 4 cases completed within Target	Percent	70.0%	≥ 70%
Diagnostic Computed Tomography (CT) Scan: % Priority 4 cases completed within Target	Percent	90.0%	≥ 90%
Rate of Ventilator-Associated Pneumonia	Rate	0.00	≤ 0.35
Central Line Infection Rate	Rate	0.00	≤ 0.56
Rate of Hospital Acquired Clostridium Difficile Infections	Rate	0.00	≤ 0.40
Rate of Hospital Acquired Vancomycin Resistant Enterococcus Bacteremia	Rate	0.00	≤ 0.01
Rate of Hospital Acquired Methicillin Resistant Staphylococcus Aureus Bacteremia	Rate	0.00	≤ 0.02

Explanatory Indicators	Measurement Unit
30-Day Readmission Of Patients With Stroke Or Transient Ischemic Attack (TIA) To Acute Care For All Diagnoses.	Percentage
Percent Of Stroke Patients Discharged To Inpatient Rehabilitation Following An Acute Stroke Hospitalization.	Percentage
Percent Of Stroke Patients Admitted To A Stroke Unit During Their Inpatient Stay.	Percentage
Hospital Standardized Mortality Ratio (HSMR)	Ratio
Readmissions Within 30 Days For Selected Case Mix Groups (CMGS)	Percentage

Part II - ORGANIZATIONAL HEALTH Efficient, Appropriately Resourced, Employee Experience, Governance

Performance Indicators	Measurement Unit	2014-2015 Performance Target	**2014-2015 Performance Standard
Current Ratio (Consolidated – all sector codes and fund types)	Ratio	1.64	1.5 to 1.8
Total Margin (Consolidated – all sector codes and fund types)	Percentage	0.00%	>=0

Explanatory Indicators	Measurement Unit
Total Margin (Hospital Sector Only)	Percentage
Adjusted Working Funds	Amount
Adjusted Working Funds / Total Revenue %	Percentage

Hospital Sector 2014-2017

Facility #:	936
Hospital Name:	London Health Sciences Centre
Hospital Legal Name:	London Health Sciences Centre
Site Name:	TOTAL ENTITY

2014-2015 Schedule C1: TOTAL ENTITY Performance Indicators

Part III - SYSTEM PERSPECTIVE: Integration, Community Engagement, eHealth

Performance Indicators	Measurement Unit	2014-2015 Performance Target	**2014-2015 Performance Standard
Percentage of Acute Alternate Level of Care (ALC) Days (closed cases)	Percentage	8.28%	<=9.11%

Explanatory Indicators	Measurement Unit
Repeat Unscheduled Emergency Visits Within 30 Days For Mental Health Conditions (Methodology Updated)	Percentage
Repeat Unscheduled Emergency Visits Within 30 Days For Substance Abuse Conditions (Methodology Updated)	Percentage

Part IV - LHIN Specific Indicators and Performance targets, see Schedule C3 2014-2015

**Refer to 2014-17 H-SAA Indicator Technical Specification for further details.

Hospital Sector 2014-2015

Facility #: 936
Hospital Name: London Health Sciences Centre
Hospital Legal Name: London Health Sciences Centre

2014-2015 Schedule C2 Service Volumes

Part I - Global Volumes

	Measurement Unit	2014-2015 Performance Target	2014-2015 Performance Standard
Ambulatory Care	Visits	776,047	>= 729,484.2
Complex Continuing Care	Weighted Patient Days	0	-
Day Surgery	Weighted Visits	7,241	>= 6661.7 and <= 7820.3
Elderly Capital Assistance Program (ELDCAP)	Inpatient Days	0	-
Emergency Department	Weighted Cases	8,324	>= 7658.1 and <= 8989.9
Emergency Department and Urgent Care	Visits	154,109	>= 130,992.7
Inpatient Mental Health	Weighted Patient Days	33,587	>= 30228.3 and <= 36945.7
Inpatient Mental Health	Days	31,487	>=29,597.8
Inpatient Rehabilitation	Days	0	-
Rehabilitation Separations	Days	0	-
Total Inpatient Acute	Weighted Cases	87,808	>= 85173.8 and <= 90442.2

Part II - Hospital Specialized Services

	Measurement Unit	2014-2015 Primary	2014-2015 Revision
Cochlear Implants	Cases	48	0

	Measurement Unit	2014-2015 Base	2014-2015 Incremental
Cleft Palate	Cases	0	0
HIV Outpatient Clinics	Visits	0	
Sexual Assault/Domestic Violence Treatment Clinics	# of Patients	0	

Hospital Sector 2014-2015

Facility #: 936
Hospital Name: London Health Sciences Centre
Hospital Legal Name: London Health Sciences Centre

2014-2015 Schedule C2: Service Volumes

Part III - Wait Time Volumes

	Measurement Unit	2014-2015 Base	2014-2015 Incremental
General Surgery	Cases	1,320	73
Paediatric Surgery	Cases	1,169	117
Hip & Knee Replacement - Revisions	Cases	153	0
Magnetic Resonance Imaging (MRI)	Total Hours	11,046	5,070
Ontario Breast Screening Magnetic Resonance Imaging (OBSP MRI)	Total Hours	0	0
Computed Tomography (CT)	Total Hours	20,349	739

Part IV - Provincial Programs

	Measurement Unit	2014-2015 Base	2014-2015 Incremental
Cardiac Surgery	Cases	1,361	0
Cardiac Services - Catheterization	Cases	3,773	
Cardiac Services- Interventional Cardiology	Cases	4,074	
Cardiac Services- Permanent Pacemakers	Procedures	35	
Automatic Implantable Cardiac Defib's (AICDs)- New Implants	# of New Implants	187	
Automatic Implantable Cardiac Defib's (AICDs)- Replacements	# of Replacements	124	
Automatic Implantable Cardiac Defib's (AICDs)- Replacements done at Supplier's request	# of Replacements	0	
Automatic Implantable Cardiac Defib's (AICDs)- Manufacturer Requested ICD Replacement Procedure	Procedures	0	
Organ Transplantation	Cases	180	2014-2015 Revision
Neurosciences	Procedures	117	29
Regional Trauma	Cases	430	
Number of Forensic Beds- General	Beds	0	
Number of Forensic Beds- Secure	Beds	0	
Number of Forensic Beds- Assessment	Beds	0	
Bariatric Surgery	Procedures	0	
Medical and Behavioural Treatment	Cases	0	

Hospital Sector 2014-2017

Facility #: 936
Hospital Name: London Health Sciences Centre
Hospital Legal Name: London Health Sciences Centre

2014-2015 Schedule C2 Service Volumes

Part V - Quality Based Procedures*

	Measurement Unit	2014-2015 Volume
Cancer- Surgery	Volume	0
Cancer- Colposcopy	Volume	0
Cardiac- Aortic Valve Replacement	Volume	0
Cardiac- Coronary Artery Disease	Volume	0
Cataracts- Bilateral	Volume	0
Cataracts- Unilateral	Volume	6
Chemotherapy Systemic Treatment	Volume	21500
Chronic Obstructive Pulmonary Disease	Volume	888
Congestive Heart Failure	Volume	680
Endoscopy	Volume	15480
Hip Replacement- Inpatient Rehabilitation for Unilateral Primary	Volume	0
Hip Replacement- Unilateral Primary	Volume	532
Knee Replacement- Inpatient Rehabilitation for Unilateral Primary	Volume	0
Knee Replacement- Unilateral Primary	Volume	835
Non-Cardiac Vascular- Aortic Aneurysm (AA)	Volume	199
Non-Cardiac Vascular Lower Extremity Occlusive Disease (LEOD)	Volume	143
Orthopaedics- Hip Fracture	Volume	0
Orthopaedics- Knee Arthroscopy	Volume	0
Paediatric- Neonatal Jaundice (Hyperbilirubinemia)	Volume	0
Paediatric- Tonsillectomy	Volume	0
Respriatory- Pneumonia	Volume	0
Sroke- Transient Ischemic Attack (TIA)	Volume	64
Stroke- Hemorrahage	Volume	68
Stroke- Ischemic or Unspecified	Volume	419
Vision Care- Retinal Disease	Volume	0

*Estimated volumes for Year Three 2014/15 QBPs not listed.

Hospital Sector 2014-2015

Facility #: 936
Hospital Name: London Health Sciences Centre
Hospital Legal Name: London Health Sciences Centre

2014-2015 Schedule C3: Local Indicators and Obligations

Clinical Services Planning
Hospitals will participate in Clinical Services Planning initiatives, as required, specifically: Outpatient/Ambulatory Realignment & Best Practice Implementation – Endoscopy, Cataracts, and Stroke.

Healthline.ca
Hospitals agree to annually review and update site specific programs and services information, as represented within the Healthline.ca website.

Improving % of discharge summaries sent from hospital to primary care in 48 hours
Hospitals will report on the % of discharge summaries sent from hospital to primary care within 48 hours.

Behavioral Supports Ontario (BSO) program
Hospitals shall participate in the Behavioral Supports Ontario (BSO) program with other health service providers and regularly report their progress to St. Joseph's Health Care, London who performs the LHIN-wide coordination role.

Senior Friendly Hospitals
Hospitals shall participate in and contribute to the support of Senior Friendly hospital strategies.

Identified French Language Services (FLS) Organizations
Utilizing the tools and resources in the FLS Toolkit, hospitals will meet their obligations contained within their French Language Services Implementation plan. Hospitals will actively participate in activities designed to support their French Lanuage Services Plan, including working collaboratively with the South West LHIN. Reporting to the South West LHIN will be completed annually.

Repeat Unscheduled Emergency Visits within 30 Days for Subtance Abuse Conditions
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions indicator, as defined in the 2014/15 H-SAA Indicator Technical specifications, will be an accountability indicator for the duration of this agreement and will work with the South West LHIN to make improvements. TARGET: 34.6

Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions
Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions indicator, as defined in the 2014/15 H-SAA Indicator Technical specifications, will be an accountability indicator for the duration of this agreement and will work with the South West LHIN to make improvements. TARGET: 14.00