THIS AMENDMENT AGREEMENT effective as of the 1st day of August, 2011.

BETWEEN:

Her Majesty the Queen in right of Ontario, as represented by the Minister of Health and Long-Term Care ("MOHLTC")

- and -

Central Local Health Integration Network ("LHIN")

WHEREAS the parties entered into an accountability agreement for fiscal years 2010—2012 made pursuant to section 18 of the *Local Health System Integration Act, 2006* (the "Agreement");

AND WHEREAS the parties wish to amend the Agreement on the terms and conditions set out herein.

NOW THEREFORE in consideration of the mutual covenants and agreements contained in this amending agreement and other good and valuable consideration (the receipt and sufficiency of which are hereby acknowledged by each of the parties), the parties agree as follows:

1.0 Amendments

1.1 The Agreement is amended in accordance with the amendments contained in the attached documents:

Schedule 0: The Agreement
Schedule 1: General
Schedule 2: Local Health System Program Specific Management
Schedule 3: Funding and Allocations
Schedule 4: Local Health System Performance
Schedule 5: Integrated Reporting

2.0 General

2.1 Except as specifically provided in this amendment agreement, all other terms and conditions of the Agreement shall remain the same and continue in full force and effect.

IN WITNESS WHEREOF the parties have executed this agreement.

Her Majesty the Queen in right of Ontario, as represented by the Minister of Health and Long-Term Care:

Deb Matthews

The Honorable Deb Matthews
Minister of Health and Long-Term Care

Central Local Health Integration Network

By:

Mr. John Langs
Chair

SCHEDULE 0: THE AGREEMENT

Introduction

1. **The ninth paragraph of the Introduction to the Agreement is amended by adding the following sentence to the end of the paragraph:**

> It also includes the Excellent Care for All Act (ECFAA) which aims to put Ontario patients first by strengthening the health care sector's organizational focus and accountability to deliver high quality patient care. The goal of ECFAA is to blend quality and value in such a way that Ontarians will be able to count on the health care system for generations to come.

Section 2 - Principles

2. **Paragraph 2.1(i) of the Agreement is deleted and replaced with the following:**

> (i) Quality Care
> (j) Person-Centred Care.

SCHEDULE 1: GENERAL

3. **Section 2 of Schedule 1: General is amended by adding the following paragraph after paragraph 2(b):**

   (c) Work with Health Quality Ontario in supporting hospitals' quality improvement requirements under ECFAA.

4. **Paragraph 6(b) of Schedule 1: General is deleted and replaced with the following:**

   (b) Engage with French language health planning entities selected by the Minister under Ontario Regulation 515/09 made under LHSIA about the matters prescribed in the regulation, and comply with any obligations set out in the agreement with the French language health planning entities required under the regulation; and

5. **The word** "Informatics" **in the second line of paragraph 9(a) of Schedule 1: General is deleted and replaced with** "Information"**.**

6. **Section 10 of Schedule 1: General is amended by adding the following paragraph after paragraph 10(a):**

   (b) Continue to work collaboratively to identify and discuss data, propose strategies to address data and information gaps, information management requirements, decision support requirements, standards, data quality issues, and other pertinent information management topics.

7. **The acronyms** "HSP" **and** "HSPs" **in the following provisions of Schedule 1: General are deleted and replaced with the words** "health service provider" **or** "health service providers" **respectively, as the case may be:**

   (a) paragraph 11(b) definition;
   (b) paragraph 12(d) in line 4 and line 6;
   (c) paragraph 13(b);
   (d) paragraph 13(c);
   (e) paragraph 13(e).

8. **Paragraph 31(a) of Schedule 1: General is deleted and replaced with the following:**

   (a) Provide the LHIN with, and develop as appropriate, those provincial standards (such as operational, financial or service standards and policies, operating manuals and program eligibility), directives and guidelines that apply to health service providers, including providing the LHIN with relevant program manuals.

9. **Paragraphs 32(a) and (b) of Schedule 1: General are deleted and replaced with the following:**

   (a) Provide a Certificate of Compliance to the MOHLTC in form and substance as required by the MOHLTC;

(b) Require health service providers to provide services funded by the LHIN in accordance with applicable legislation as well as those provincial standards, directives and guidelines provided pursuant to paragraph 31(a) above;

10. The following two new sections are added to Schedule 1: General after section 32:

32.1 The LHIN will reduce its executive office costs by 10 per cent over fiscal years 2011/12 and 2012/13, with a minimum of 5 per cent reduction to be made in fiscal year 2011/12. Executive offices consist of the office of the chief executive officer of the LHIN and the office of every member of senior management at the LHIN that reports directly to the chief executive officer. The costs of executive offices includes all costs for those offices, including office space, supplies, salaries and wages of the officers and staff of the offices, conferences held for or by those offices and travel expenses of the officers and staff of the offices. The LHIN will report to the MOHLTC annually about the reduction in executive office costs as required by the MOHLTC. The MOHLTC and the LHIN will work together to identify the executive offices and the costs of the executive offices of the LHIN that are included for the purposes of this section.

32.2 The LHIN will also require hospitals and its CCAC to reduce their executive office costs by 10 per cent over fiscal years 2011/12 and 2012/13 by amending their service accountability agreements with hospitals and its CCAC to include this requirement. Executive offices of hospitals and the CCAC consist of the office of the chief executive officer, chief operating officer or executive director, and the office of every member of senior management of hospitals or CCAC that reports directly to the chief executive officer, chief operating officer or executive director. The costs of executive offices includes all costs for those offices, including office space, supplies, salaries and wages of the officers and staff of the offices, conferences held for or by those offices and travel expenses of the officers and staff of the offices. The LHIN will report to the MOHLTC annually about the reduction in hospital and CCAC executive office costs as required by the MOHLTC.

SCHEDULE 2: LOCAL HEALTH SYSTEM PROGRAM SPECIFIC MANAGEMENT

11. The word "decision-making" **in Part A, Purpose of Schedule 2: Local Health System Program Specific Management is deleted and replaced with** "accountability".

12. Schedule 2: Local Health System Program Specific Management is amended by adding the following new sections after section 3:

Other Programs

3.1.1 There may be other programs for which the LHINs are accountable where the MOHLTC will want to establish certain expectations and requirements for the programs; if the MOHLTC does establish such expectations and requirements, it will advise the LHIN of these expectations and requirements for the specific program.

3.1.2 If the MOHLTC advises the LHIN of expectations and requirements for a specific program, the LHIN will require health service providers that provide the specific program to provide services in accordance with the expectations and requirements established by the MOHLTC.

Devolution of Ministry Programs

3.2.1 Definitions. For the purposes of Schedule 2 the following terms shall have the following meanings.

"**Lead LHIN**" means the LHIN selected by the MOHLTC to administer a province-wide program following its devolution.

"**Lead LHIN model**" means a funding and administration model that enables a single LHIN to assume accountability for a province-wide program;

"**province-wide program**" means a province-wide program that the MOHLTC funds through a single health service provider;

3.2.2 Where the MOHLTC chooses to devolve a province-wide program to the LHINs, the MOHLTC will identify a Lead LHIN, and the particular terms and conditions applicable to the funding and administration of the province-wide program after its devolution, and provide this information to all LHINs. When the MOHLTC is advised by the LHINs that the devolution of the province-wide program has been accepted, the MOHLTC will add the accountability for the devolved province-wide program to its accountability agreement with the Lead LHIN.

3.2.3 The LHIN will

(i) Consider and respond to any request by the MOHLTC to devolve a province-wide program to the LHINs in accordance with the terms of the "Agreement Concerning the Devolution of Provincial Programs" effective April 1, 2011, also known as the Lead LHIN Model Agreement;
(ii) Abide by any program specific terms and conditions identified by the

MOHLTC in respect of the devolved province-wide program;
(iii) Administer the devolved province-wide program in accordance with the terms and conditions of the Lead LHIN Model Agreement;
(iv) Post a copy of the Lead LHIN Model Agreement on its website; and
(v) Confirm any proposed changes to the Lead LHIN Model Agreement with the MOHLTC prior to implementation.

3.2.4 The governance and administration of each devolved provincial program may be reviewed by the LHINs and the MOHLTC as required.

13. Sections 4 through 26 of Schedule 2: Local Health System Program Specific Management are deleted and replaced with the following sections:

Long-Term Care Homes

4. Definitions in this section on Long-Term Care Homes:

(a) "Acknowledgement and Consent Agreement" means an agreement entered into between the MOHLTC, the operator of a LTCH, and one or more lenders or secured parties, by which the MOHLTC consented to, or agreed to request a consent to, any of the following: (a) a mortgage of real property associated with the LTCH, (b) an assignment of a Development Agreement with the MOHLTC, and/or (c) an assignment of a service agreement. Acknowledgement and Consent Agreements are generally not entered into by the Ministry since July 1, 2010.

(b) "CFS per diem" means any per diem funding paid pursuant to a Development Agreement;

(c) Development Agreement" means an agreement between the MOHLTC and a LTC health service provider to develop, upgrade, retrofit or redevelop LTCH beds;

(d) "Funding Policies" means the funding and financial management policies determined by the MOHLTC for LTCHs. Funding Policies establish the rates, amounts and envelopes of all funding provided to LTC health service providers by the MOHLTC or the LHIN, including the per diem rate and the per diem envelopes, the Registered Practical Nurses in Long-Term Care Homes Initiative funding, and Other Funding. Funding Policies also establish the applicable conditions for funding, the funding reconciliation rules, and the form, manner and content and date for submission of reports;

(e) "LTCH" means long-term care home;

(f) "LTCH Protocol" means the document titled "Long-Term Care Homes Protocol" as prepared and amended by the MOHLTC;

(g) "LTCHA" means the *Long-Term Care Homes Act, 2007* and regulations thereunder;

(h) LTC health service provider" means a health service provider that is a licensee within the meaning of s. 2(1) of the LTCHA;

(i) "Other Funding" means funding for LTCH beds paid in accordance with the Funding Policies, other than the funding paid in accordance with paragraphs 6 and 8, and includes but is not limited to:
- Accreditation Premium
- High Intensity Need Fund (HINF)
- Laboratory Services Funding
- Municipal Tax Funding
- Equalization Adjustment Funding
- RAI-MDS Funding
- Physician On-Call Funding;

(j) "service agreement" means the agreement pursuant to which funding is provided to a LTC health service provider and includes a service accountability agreement; and

(k) "service accountability agreement" means the service accountability agreement between a LHIN and a LTC health service provider required by s. 20 of LHSIA.

LTCHs - Total Funding per Diem

5. The **MOHLTC** will:

(a) Determine the Funding Policies and the amount of funding that a LTC health service provider may receive from MOHLTC and LHINs under the Funding Policies;

(b) Provide to the LHIN the Funding Policies and the amount of funding to be provided by the LHIN to the LTC health service providers.

(c) Determine any net projected unused funding for all LHINs that, as of September 30 in each fiscal year, has not or is projected not to be used by LTC health service providers as reported by LTC health service providers through the revenue occupancy reports;

(d) Reallocate a share of the net projected unused funding referred to in subparagraph (b) to the LHIN if the LHIN is projected to be overspent on its funding for the LTCH per diem rate; and

(e) If there is net projected unused funding remaining after the reallocation referred to in subparagraph (c), allocate to the LHIN by December 31 of each year a share of the unused funding in proportion to the number of LTCH beds that are licensed or approved and in operation in the LHIN's geographic area compared to the provincial total number of LTCH beds that are licensed or approved.

6. The **LHIN** will distribute the funding provided under paragraph 5 to LTC health service providers in accordance with the Funding Policies and pursuant to the terms of a service accountability agreement that is consistent with and requires adherence to the Funding Policies.

LTCHs - Construction Funding Subsidy (CFS)

7. The **MOHLTC** will

   (a) determine the CFS per diem and the LTC health service providers in the geographic area of the LHIN that will receive the per diem, including any conditions on the funding and the number of beds for which the LTC health service provider will receive the CFS per diem; and

   (b) provide the CFS per diem to the LHIN.

8. The **LHIN** will provide the CFS per diem to LTC health service providers for each approved or licensed bed that is identified in paragraph 7 and operated in accordance with the MOHLTC's conditions of funding, applicable legislation or Development Agreement.

9. Every service accountability agreement entered into between the LHIN and the LTC health service provider during the term of this Agreement and in the future will contain an obligation on the LHIN to provide the CFS per diem to the LTC health service provider for the length of time set out in the particular Development Agreement for the particular beds.

LTCHs – Assignment of LTC Service Agreement

10. Where the **MOHLTC** has entered into an Acknowledgement and Consent Agreement with a LTC health service provider and one or more lenders of the LTC health service provider (Lender) prior to the proclamation of the LTCHA, the **LHIN** will treat the MOHLTC's consent to assign the service agreement under the Acknowledgement and Consent Agreement as if MOHLTC had provided the consent on behalf of the LHIN.

11. Where an Acknowledgement and Consent Agreement or a Development Agreement between the MOHLTC and the LTC health service provider provides that the MOHLTC will request the LHIN to consent to an assignment of the service agreement, to the Lender or person designated by the Lender, the **LHIN** will consent to the assignment of the service agreement to that person where the MOHLTC so requests, and the consent shall be subject to terms and conditions similar to those of the Acknowledgement and Consent Agreement or the Development Agreement as the case may be.

12. In addition, the LHIN will not unreasonably withhold consent requested from a Lender, or from a receiver or receiver and manager appointed by a Lender or by a court order, to assign its or the LTC health service provider's right, title and

interest in the service agreement or any part thereof or interest therein to another party, subject to all applicable legislative requirements.

13. Where the **MOHLTC**

(a) has entered into a Development Agreement with a LTCH health service provider or a proposed LTCH health service provider (an "Operator");
(b) has consented to the grant of a security interest to a Lender under the Development Agreement; and
(c) has directed the LHIN to consent to the assignment of the Operator's rights under a service accountability agreement,

then the **LHIN**,

(i) Shall deliver to the Lender a commitment, in the MOHLTC's standard form, to provide the LHIN's consent to the assignment of the Operator's rights under the service accountability agreement between the Operator and the LHIN;
(ii) Upon the grant of a licence to the Operator in respect of the Home, and for so long as a CFS is to be paid in respect of the Home, shall consent to the grant of a security interest in the service accountability agreement between the LHIN and the Operator in respect of the Home, provided that:

1) the security interest in the service accountability agreement may only be exercised together with the exercise of a security interest in the licence for the beds; and

2) the security interest is subject to all applicable statutory requirements and restrictions, including section 107 of the LTCHA and sections 2(2), 19 and 20 of LHSIA; and

(iii) Shall amend section 15.8 of the service accountability agreement in respect of the Home to remove the following sentence: "No assignment or subcontract shall relieve the HSP from its obligations under this Agreement or impose any liability upon the LHIN to any assignee or subcontractor."

LTCHs - Beds in Abeyance

14. In paragraphs 15 and 16 the term "Beds in Abeyance" are LTCH beds licensed or approved by the MOHLTC, for which the LTC health service provider has obtained written permission from the Director, PICB, in accordance with the LTCHA for the beds not to be available for occupancy.

15. The **MOHLTC** will review and may approve Beds in Abeyance applications with LHIN recommendation as set out in the Beds in Abeyance policy and LTCH Protocol.

16. The **LHIN** may request approval from the MOHLTC to temporarily use the amount of funding available as a result of any approved Beds in Abeyance under

paragraph 15, and if the MOHLTC approves the amount under paragraph 17 the LHIN will use the funding in accordance with the approval, including any conditions that may attach to the approval.

17. The **MOHLTC** will review the request described in paragraph 16 and may approve the LHIN to temporarily use this funding subject to any conditions that may attach to the approval.

LTCHs - Short-Stay Program Beds

18. Definitions in paragraphs 18.1 and 19

(a) "Convalescent Care Beds" means those short-stay beds, licensed or approved under the LTCHA, that are part of a short-stay convalescent care program for which residents may be eligible for admission in accordance with regulations under the LTCHA.

(b) "Dedicated Funding Envelope for Convalescent Care Beds" means the Dedicated Funding Envelope for Convalescent Care Beds funded through that envelope on or before March 31, 2008 as determined by the MOHLTC and adjusted by the MOHLTC from time to time.

(c) "Dedicated Funding Envelope for Interim Beds" means the Dedicated Funding Envelope for Interim Beds funded through that envelope on or before March 31, 2008 as determined by the MOHLTC and adjusted by the MOHLTC from time to time.

(d) "Interim Beds" means those licensed or approved beds under the LTCHA that would fall within the definition of "interim bed" in accordance with regulations under the LTCHA.

(e) "Short-Stay Respite Beds" means those short-stay beds, licensed or approved under the LTCHA, that are part of a short-stay respite care program for which residents may be eligible for admission in accordance with regulations under the LTCHA.

18.1. The **MOHLTC** will:

(a) Determine the minimum threshold for occupancy for Short-Stay Respite Beds;

(b) Determine and provide the Dedicated Funding Envelope for Convalescent Care Beds and the Dedicated Funding Envelope for Interim Beds;

(c) In consultation with the LHIN, determine the LTC health service providers that will provide the Convalescent Care Beds and the Interim Beds and the number of those beds to be funded by the Dedicated Funding Envelope for Convalescent Care Beds and the Dedicated Funding Envelope for Interim Beds respectively; and

(d) Set other conditions of funding related to beds funded with the Dedicated Funding Envelope for Convalescent Care Beds and the Dedicated Funding Envelope for Interim Beds.

19. The **LHIN** will:

(a) Take action as appropriate to improve the utilization of Short-Stay Respite Beds;

(b) Have the ability to set, in its discretion, a threshold for occupancy of Short-Stay Respite Beds that is higher than the minimum set by the MOHLTC;

(c) Determine which LTC health service providers will provide Short-Stay Respite Beds within the existing licensed or approved beds of each home and the number of such beds;

(d) Advise MOHLTC about matters referred to in subparagraph 18.1 (c);

(e) Use the Dedicated Funding Envelope for Interim Beds and the Dedicated Funding Envelope for Convalescent Care Beds to fund the LTC health service providers referred to in subparagraph 18.1 (c);

(f) Incorporate any conditions of funding referred to in subparagraph 18.1 (d) in service accountability agreements;

(g) At its discretion, request that the MOHLTC approve the conversion of existing licensed beds in the long-stay program to Convalescent Care Beds in accordance with the LTCH Protocol; and

(h) Provide from its allocation all additional funding for the MOHLTC approved converted Convalescent Care Beds to LTC health service providers in accordance with the Funding Policies, including the additional subsidy for Convalescent Care Beds and the resident co-payment portion of the base level-of-care per diem funding.

LTCHs – LHIN Requested LTCH Beds

20. In paragraphs 21 and 22 "LHIN Requested LTCH Beds" means a LTCH bed funded by the LHIN out of its allocation, other than its allocation for LTCHs:

(i) that would increase the bed capacity of an existing LTCH licence issued under s.99, or an approval granted under s. 130 of the LTCHA; or
(ii) in the case of a development or redevelopment, that is over and above the number of LTCH beds that the MOHLTC has approved a LTC health service provider for development or redevelopment.

21. The **LHIN** will:

(a) At its discretion, request LHIN Requested LTCH Beds;

(b) In its request identify the number of LHIN Requested LTCH Beds requested, the estimated amount of funding required to support the beds in accordance with the Funding Policies, including Other Funding and funding that would be paid in accordance with paragraphs 6 and 8 in this Schedule, and where the funding will be found within the LHIN's allocation, other than its allocation for LTCHs; and

(c) Fund the LHIN Requested LTCH Beds in accordance with the Funding Policies and paragraphs 6 and 8 of this Schedule if the LHIN's request for LHIN Requested LTCH Beds is granted by the MOHLTC.

22. The **MOHLTC** will:

(a) Consider the LHIN's request for LHIN Requested LTCH Beds and decide whether to grant the request.

(b) Confirm the amount of the funding required to support the beds in accordance with the Funding Policies, including Other Funding and funding that would be calculated pursuant to paragraphs 5 and 7 in this Schedule; and

(c) Reallocate the confirmed funding from the sources identified by the LHIN to (i) the LHIN's allocation for LTCH beds for all funding to be paid in accordance with paragraphs 6 and 8 of this Schedule; and (ii) the MOHLTC's allocation for Other Funding when the LHIN Requested LTCH Beds are available for occupancy.

LTCHs – LHIN Requested Temporary LTCH Beds

23. In paragraphs 24 and 25, "LHIN Requested Temporary LTCH Beds" means a LTCH bed for which the MOHLTC would issue a temporary licence in accordance with s. 111 of the LTCHA or increase the bed capacity of a temporary licence in accordance with the LTCHA, on the condition that the LTCH bed will be funded by the LHIN out of the LHIN's allocation.

24. The **LHIN** will:

(a) At its discretion, make a request for LHIN Requested Temporary LTCH Beds for a term of no longer than 5 years;

(b) In its request identify the number of LHIN Requested Temporary LTCH Beds requested, the estimated amount of funding required to support the beds in accordance with the Funding Policies, including Other Funding and funding that would be paid in accordance with paragraph 6 and where the funding will be found within the LHIN's allocation; and

(c) Provide all Other Funding and all funding in accordance with paragraph 6 of this Schedule for the LHIN Requested Temporary LTCH Beds in accordance with the Funding Policies for the term of the temporary licence issued by the

MOHLTC, including any increases in this funding and Other Funding after the date the temporary licence is issued by the MOHLTC for these beds, if the LHIN's request for LHIN Requested Temporary LTCH Beds is granted by the MOHLTC.

25. The **MOHLTC** will:

(a) Consider the LHIN's request for LHIN Requested Temporary LTCH Beds and decide whether to grant the request;

(b) Confirm the amount of funding required to support the beds in accordance with the Funding Policies, including Other Funding and the funding paid in accordance with paragraph 6 of this Schedule.

LTCHs – MOHLTC Direct Funding

26. The **MOHLTC** will manage and fund LTC health service providers directly for certain LTC programs in accordance with the Funding Policies and pursuant to a Direct Funding Agreement, a RAI-MDS Funding Agreement, and any other agreement between the MOHLTC and a LTC health service provider.

LTCHs – LHIN Direct Funding

26.1 For greater certainty, the LHIN may not fund LTC health service providers for the provision of LTCH services except as provided in the Funding Policies and this Schedule.

14. In paragraphs 27(a) and 28(a) of Schedule 2: Local Health System Program Specific Management the word "persons" **is deleted in both paragraphs and replaced with the word** "clients" **in both paragraphs.**

15. Paragraph 29 (e) of Schedule 2: Local Health System Program Specific Management is amended by adding the following after the words "Eating Disorders" **in line 5 of the paragraph:** "the Psychiatric Outpatient Medical Salaries,".

16. Paragraph 30(a) of Schedule 2: Local Health System Program Specific Management is amended as follows:

(a) by adding the word "psychiatric" **in front of the words** "sessional services" **in clauses (vi) and (vii) of paragraph 30(a).**

(b) by adding the following new clause at the end of the paragraph:

(x) The Psychiatric Outpatient Medical Salaries.

17. Paragraph 30(b) of Schedule 2: Local Health System Program Specific Management is amended by adding the following at the beginning of line 3 of the

section after the words "forensic mental health service"**:** "and of the required service delivery capacity and/or service levels"**.**

18. **Paragraph 31(e) of Schedule 2: Local Health System Program Specific Management is deleted and replaced with the following:**

    (e) Maintain the Supportive Housing – Support Services that are funded by the LHIN at a ratio of 1 case manager for no greater than 10 clients, and at a ratio of 1 case manager for no greater than 8 clients for the supportive housing funded under the Service Enhancement Initiative for individuals with serious mental illness who have come into contact with the criminal justice system;

19. **Paragraph 34(b) of Schedule 2: Local Health System Program Specific Management is deleted and replaced with the following paragraph (b) and the following new paragraph (c) is added:**

    (b) Use the Dedicated Funding Envelopes to fund the specific purpose for which it is funded; and

    (c) Maintain the Supportive Housing – Support Services that are funded by the LHIN for individuals with problematic substance use issues at a ratio of 1 case manager for no greater than 8 clients.

20. **Paragraph 35(a) of Schedule 2: Local Health System Program Specific Management is deleted and replaced with the following:**

    (a) All School Health Professional Services and School Health Personal Support Services.

21. **Paragraph 36(b) of Schedule 2: Local Health System Program Specific Management is deleted.**

SCHEDULE 3: FUNDING and ALLOCATIONS

22. The first bullet of Part A. Purpose of Schedule 3. is amended by deleting "2010/11" **in the first line and replacing it with** "2011/12".

23. Paragraph 2(a) of Schedule 3: Funding and Allocations is deleted and replaced with the following:

(a) By August 15, 2011, provide the LHIN with the 2011-12 funding allocation as of July 31st, 2011 Table 1 – Statement of Total LHIN 2011-12 Funding Allocation, Table 2 – Statement of each LHIN 2011-12 Funding Allocation for all 14 LHINs, Table 3 – Statement of Total 2011-12 Dedicated Funding by Sector, and Table 4 – Dedicated Funding by Sector for each LHIN of this Schedule;

24. The occurrences of "2010/11" **in the following provisions of Schedule 3: Funding and Allocations are deleted and replaced with** "2011/12":

(c) paragraph 2(b) in two places;
(d) paragraph 3(a).

25. Tables 1 through 4 of Schedule 3: Funding and Allocations are updated and replaced with the Tables 1 through 4 attached to this Amending Agreement as Appendix A.

SCHEDULE 4: LOCAL HEALTH SYSTEM PERFORMANCE

26. **Paragraphs 3(a)(v) and (vi) of Schedule 4: Local Health System Performance are amended by deleting the word** "Unplanned" **in both paragraphs and replacing it with the word** "Unscheduled" **in both paragraphs.**

27. **Table A of Schedule 4: Local Health System Performance is updated and replaced with the Table A attached to this Amending Agreement as Appendix B.**

SCHEDULE 5: INTEGRATED REPORTING

28. The table referred to in section 1 of Schedule 5: Integrated Reporting and set out in Schedule 5: Integrated Reporting is updated and replaced with the Reporting Table attached to this Amending Agreement as Appendix C.

APPENDIX A

Table 1: Statement of Total LHIN 2011/2012 Funding Allocation

	2011\12 Funding Allocation (000's)	2012\13 Funding Target (000's)	2013\14 Funding Target (000's)
Total LHIN Budget	**23,328,428.9**	**TBD**	**TBD**
Total Capital Budget (see table 1b)	.0	TBD	TBD
Total Operating Budget (see table 1a)	23,328,428.9	TBD	TBD

1 The 2011/12 funding allocation are updated as of July 31, 2011 from the approved 2011/12 multi-year Results Based Plan and the 2011/12 Printed Estimates. The update is based on realignments within and between the LHIN programs vote 1411 and the Ministry programs vote 1412 which correspond with decisions about programs and services that will remain with the Ministry or transfer to the LHINs, as it relates to the LHINs. They include base and one-time realignments for 2011/12. The realignment occurs within the Ministry's total approved appropriation.

2 The 2011/12 funding allocation includes additional funding (base and one-time only). If further additional funding is designated throughout 2011/12, the table and schedule may be amended or updated allocation letters appended to the agreement to reflect the LHIN allocation. Any additional funding provided would be within the Ministry's total approved appropriation.

Table 1a: Statement of Total LHIN 2011/2012 Funding Allocation - Operating Budget

		2011\12 Funding Allocation (000's)	2012\13 Funding Target (000's)	2013\14 Funding Target (000's)
Total LHIN Operating Budget		**23,328,428.9**	**TBD**	**TBD**
Total Health Service Provider (HSP) Transfer Payments by Sector		23,251,999.7	TBD	TBD
Operation of LHIN		67,284.4	TBD	TBD
Initiatives	(3)	9,144.8	TBD	TBD
E-Health	(4)	.0	TBD	TBD
Total Health Service Provider (HSP) Transfer Payments by Sector				
Operations of Hospitals		15,611,759.5	TBD	TBD
Grants to compensate for Municipal Taxation - public hospitals		3,741.9	TBD	TBD
Long Term Care Homes	(5)	3,240,847.3	TBD	TBD
Community Care Access Centres		2,016,592.9	TBD	TBD
Community Support Services		401,088.6	TBD	TBD
Acquired Brain Injury		44,707.0	TBD	TBD
Assisted Living Services in Supportive Housing		212,805.8	TBD	TBD
Community Health Centres		314,728.7	TBD	TBD
Community Mental Health		631,420.7	TBD	TBD
Addictions Program		154,490.7	TBD	TBD
Specialty Psych Hospitals		596,677.8	TBD	TBD
Grants to compensate for Municipal Taxation - psychiatric hospitals		121.0	TBD	TBD
Initiatives	(6)	23,017.8	TBD	TBD

1 The 2011/12 funding allocation are updated as of July 31, 2011 from the approved 2011/12 multi-year Results Based Plan and the 2011/12 Printed Estimates. The update is based on realignments within and between the LHIN programs vote 1411 and the Ministry programs vote 1412 which correspond with decisions about programs and services that will remain with the Ministry or transfer to the LHINs, as it relates to the LHINs. They include base and one-time realignments for 2011/12. The realignment occurs within the Ministry's total approved appropriation.

2 The 2011/12 funding allocation includes additional funding (base and one-time only). If further additional funding is designated throughout 2011/12, the table and schedule may be amended or updated allocation letters appended to the agreement to reflect the LHIN allocation. Any additional funding provided would be within the Ministry's total approved appropriation.

3 LHIN Operations initiatives include Aboriginal Community Engagement, French Language Health Services, French Planning Entities, ER/ALC Performance Leads, ED LHIN Leads, and LHIN Collaborative.

4 The funding for E-Health Project Management Office will be flowed by E-Health Ontario to the LHINs starting from 2011/12.

5 The LTC Homes funding allocation is an estimate only, and is subject to change, as the Ministry adjusts the funding allocation for the LTC Homes based on changes in CMI, bed numbers, resident revenue and construction cost funding.

6 Transfer payment initiatives by LHIN will be allocated by sector by the LHIN at a later date. Initiatives include Aging at Home, Urgent Priorities Funds, and Aging At Home Supplementary ER/ALC Funding that are unallocated. It should be noted that as the LHIN allocates by sector, the allocation will be distributed at the sector level

Table 1b: Statement of Total LHIN 2011/2012 Funding Allocation - Capital Budget

		2011\12 Funding Allocation (000's)	2012\13 Funding Target (000's)	2013\14 Funding Target (000's)
Total Capital Budget		.0	TBD	TBD
Total Health Service Provider (HSP) Transfer Payments by Sector		.0	TBD	TBD
LHIN-Specific Capital Initiatives		.0	TBD	TBD
Total Health Service Provider (HSP) Transfer Payments by Sector				
Hospitals	(1)	.0	TBD	TBD
Long Term Care Homes		.0	TBD	TBD
Acquired Brain Injury		.0	TBD	TBD
Assisted Living Services in Supportive Housing		.0	TBD	TBD
Community Health Centres		.0	TBD	TBD
Community Mental Health		.0	TBD	TBD
Addictions Program		.0	TBD	TBD

1 The allocation under "Hospitals" represents the approved LHIN allocation to support grants for public and specialty psychiatric hospitals in 2011/12 under the 2011/12 Health Infrastructure Renewal Fund (HIRF), and in accordance with 2011/12 HIRF Guidelines which the ministry has provided to LHINs. The allocation approved for LHINs for this purpose is available in 2011/12 only.

Table 2: Statement of LHIN 2011/2012 Funding Allocation

	2011\12 Funding Allocation (000's)	2012\13 Funding Target (000's)	2013\14 Funding Target (000's)
Total LHIN Budget	**1,803,740.2**	**TBD**	**TBD**
Total Capital Budget (see table 1b)	.0	TBD	TBD
Total Operating Budget (see table 1a)	1,803,740.2	TBD	TBD

1 The 2011/12 funding allocation are updated as of July 31, 2011 from the approved 2011/12 multi-year Results Based Plan and the 2011/12 Printed Estimates. The update is based on realignments within and between the LHIN programs vote 1411 and the Ministry programs vote 1412 which correspond with decisions about programs and services that will remain with the Ministry or transfer to the LHINs, as it relates to the LHINs. They include base and one-time realignments for 2011/12. The realignment occurs within the Ministry's total approved appropriation.

2 The 2011/12 funding allocation includes additional funding (base and one-time only). If further additional funding is designated throughout 2011/12, the table and schedule may be amended or updated allocation letters appended to the agreement to reflect the LHIN allocation. Any additional funding provided would be within the Ministry's total approved appropriation.

Table 2a: Statement of LHIN 2011/2012 Funding Allocation - Operating Budget

		2011\12 Funding Allocation (000's)	2012\13 Funding Target (000's)	2013\14 Funding Target (000's)
Total LHIN Operating Budget		**1,803,740.2**	**TBD**	**TBD**
Total Health Service Provider (HSP) Transfer Payments by Sector		1,799,039.6	TBD	TBD
Operation of LHIN		4,409.6	TBD	TBD
Initiatives	(3)	291.0	TBD	TBD
E-Health	(4)		TBD	TBD
Total Health Service Provider (HSP) Transfer Payments by Sector				
Operations of Hospitals		1,116,237.0	TBD	TBD
Grants to compensate for Municipal Taxation - public hospitals		252.3	TBD	TBD
Long Term Care Homes	(5)	311,124.3	TBD	TBD
Community Care Access Centres		222,900.8	TBD	TBD
Community Support Services		41,104.4	TBD	TBD
Acquired Brain Injury		9,576.1	TBD	TBD
Assisted Living Services in Supportive Housing		21,306.7	TBD	TBD
Community Health Centres		8,375.8	TBD	TBD
Community Mental Health		63,397.2	TBD	TBD
Addictions Program		4,764.9	TBD	TBD
Specialty Psych Hospitals			TBD	TBD
Grants to compensate for Municipal Taxation - psychiatric hospitals			TBD	TBD
Initiatives	(6)	.1	TBD	TBD

1 The 2011/12 funding allocation are updated as of July 31, 2011 from the approved 2011/12 multi-year Results Based Plan and the 2011/12 Printed Estimates. The update is based on realignments within and between the LHIN programs vote 1411 and the Ministry programs vote 1412 which correspond with decisions about programs and services that will remain with the Ministry or transfer to the LHINs, as it relates to the LHINs. They include base and one-time realignments for 2011/12. The realignment occurs within the Ministry's total approved appropriation.

2 The 2011/12 funding allocation includes additional funding (base and one-time only). If further additional funding is designated throughout 2011/12, the table and schedule may be amended or updated allocation letters appended to the agreement to reflect the LHIN allocation. Any additional funding provided would be within the Ministry's total approved appropriation.

3 LHIN Operations initiatives include Aboriginal Community Engagement, French Language Health Services, French Planning Entities, ER/ALC Performance Leads, ED LHIN Leads, and LHIN Collaborative.

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5 The LTC Homes funding allocation is an estimate only, and is subject to change, as the Ministry adjusts the funding allocation for the LTC Homes based on changes in CMI, bed numbers, resident revenue and construction cost funding.

6 Transfer payment initiatives by LHIN will be allocated by sector by the LHIN at a later date. Initiatives include Aging at Home, Urgent Priorities Funds, and Aging At Home Supplementary ER/ALC Funding that are unallocated. It should be noted that as the LHIN allocates by sector, the allocation will be distributed at the sector level.

Table 2b: Statement of LHIN 2011/2012 Funding Allocation - Capital Budget

		2011\12 Funding Allocation (000's)	2012\13 Funding Target (000's)	2013\14 Funding Target (000's)
Total Capital Budget		.0	TBD	TBD
Total Health Service Provider (HSP) Transfer Payments by Sector		.0	TBD	TBD
LHIN-Specific Capital Initiatives		.0	TBD	TBD
Total Health Service Provider (HSP) Transfer Payments by Sector				
Hospitals	(1)	.0	TBD	TBD
Long Term Care Homes			TBD	TBD
Acquired Brain Injury			TBD	TBD
Assisted Living Services in Supportive Housing			TBD	TBD
Community Health Centres			TBD	TBD
Community Mental Health			TBD	TBD
Addictions Program			TBD	TBD

1 The allocation under "Hospitals" represents the approved LHIN allocation to support grants for public and specialty psychiatric hospitals in 2011/12 under the 2011/12 Health Infrastructure Renewal Fund (HIRF), and in accordance with 2011/12 HIRF Guidelines which the ministry has provided to LHINs. The allocation approved for LHINs for this purpose is available in 2011/12 only.

Table 3: Statement of Total 2011/12 Dedicated Funding by Sector

	2011/12 Dedicated Funding Envelope [1]
Hospitals	
Cardiac Services	$31,469,700
Chronic Kidney Disease	$0
Critical Care	$86,318,486
Wait Times Strategy	$269,575,200
Health Infrastructure Renewal Fund	TBD
Post Construction Operating Plan	$219,634,400
Long Term Care Homes	
Convalescent Care Beds [2]	$25,752,327
Interim Beds [3]	$18,897,828
Community Health Centres	
Uninsured Persons Services	$2,886,782
Community Mental Health	
Crisis Intervention programs and services (funded through Health Accord and Service Enhancement)	$43,817,593
Short-Term Residential Crisis Beds (Safe Beds)	$11,297,893
Assertive Community Treatment Teams (ACTT)	$34,541,300
Intensive Case Management (funded through Health Accord and Service Enhancement)	$29,672,466
Court Diversion / Supports	$4,606,000
Supportive Housing Supports	$10,387,000
Early Intervention in Psychosis programs (funded through Health Accord)	$22,202,188
Forensic Case Management Initiatives	$2,040,000
Sessional services in hospitals (Psychiatric Out-Patient Medical Salaries)	$13,967,953
Sessional services provided by community-based agencies	$15,881,658
Eating Disorder Services	$15,460,113
Consumer Survivor Initiatives	$12,000,355
Addictions	
Problem Gambling Treatment Services	$10,108,400
Programs for pregnant women with addictions (funded through federal Early Childhood Development initiative)	$3,200,000
Methadone Case Management Services	$740,680
Sessional services provided by community-based agencies	$748,358
Community Care Access Centres	
School Health Professional and Personal Support Services	$84,091,615
Chronic Kidney Disease	$1,562,300
Other	
Direct Funding Self-Managed Attendant Services (Centre for Independent Living Toronto)	$24,117,702
Compensation Under Specified Initiatives / Agreements	TBD

Notes

(1) Actual Dollar Amounts

(2) Convalescent care funding is based on levels of care per diem and convalescent care top-up.
As per March 2011 Payment Notice, there are 337 convalescent care beds.
Excludes convalescent care beds funded by the Urgent Priority Fund and Aging at Home.

(3) Interim Bed funding is based on 100 CMI and 85% of collection rate for the resident revenue.
As per March 2011 Payment Notice, there are 505 interim beds.
Excludes Interim beds funded by the Urgent Priority Fund and Aging at Home.

Table 4: Dedicated Funding by Sector for Central LHIN

	2011/12 Dedicated Funding Envelope [1]
Hospitals	
Cardiac Services	$2,634,800
Chronic Kidney Disease	$0
Critical Care	$4,074,600
Wait Times Strategy	$25,874,000
Health Infrastructure Renewal Fund	TBD
Post Construction Operating Plan	$9,405,500
Long Term Care Homes	
Convalescent Care Beds [2]	$2,368,908
Interim Beds [3]	NA
Community Health Centres	
Uninsured Persons Services	$275,000
Community Mental Health	
Crisis Intervention programs and services (funded through Health Accord and Service Enhancement)	$2,720,760
Short-Term Residential Crisis Beds (Safe Beds)	$2,114,598
Assertive Community Treatment Teams (ACTT)	$4,738,500
Intensive Case Management (funded through Health Accord and Service Enhancemen	$2,784,200
Court Diversion / Supports	$588,000
Supportive Housing Supports	$3,024,000
Early Intervention in Psychosis programs (funded through Health Accord)	$2,808,000
Forensic Case Management Initiatives	N/A
Sessional services in hospitals (Psychiatric Out-Patient Medical Salaries)	$2,277,733
Sessional services provided by community-based agencies	$1,451,344
Eating Disorder Services	$1,134,047
Consumer Survivor Initiatives	$733,125
Addictions	
Problem Gambling Treatment Services	$204,700
Programs for pregnant women with addictions (funded through federal Early Childhood Development initiative)	$115,824
Methadone Case Management Services	NA
Sessional services provided by community-based agencies	$136,537
Community Care Access Centres	
School Health Professional and Personal Support Services	$9,703,522
Chronic Kidney Disease	$118,000
Other	
Direct Funding Self-Managed Attendant Services (Centre for Independent Living Toronto)	N/A
Compensation Under Specified Initiatives / Agreements	TBD

Notes

(1) Actual Dollar Amounts

(2) Based on levels of care per diem and convalescent care top-up.
Excludes convalescent care beds funded by the Urgent Priority Fund and Aging at Home.

(3) Based on 100 CMI and 85% of collection rate for the resident revenue.
Excludes Interim beds funded by the Urgent Priority Fund and Aging at Home.

APPENDIX B

Table A: Performance Indicators

- Objective: To improve persons' access and outcomes as they move through the continuum of healthcare services.
- Expected Outcome: Persons will experience improved access and outcomes related to the health care services identified below.
- Other indicators may be considered as a measure of this expected outcome.

INDICATOR	Provincial target	LHIN Baseline 2011-12	LHIN Target 2011-12	Data Provided to LHINs
90th Percentile Emergency Room (ER) Length of Stay for Admitted Patients	8 hours	44.28 hours	36 hours	May 13, 2011 August 12, 2011 November 14, 2011 and February 10, 2012
90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	8 hours	7.83 hours	7.83 hours	
90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	4 hours	3.9 hours	3.9 hours	
Percentage of Alternate Level of Care (ALC) Days	9.46%	16.10%	13.01%	
Repeat Unscheduled Emergency Visits within 30 days for Mental Health Conditions*	TBD	17.90%	17.00%	
Repeat Unscheduled Emergency Visits within 30 days for Substance Abuse Conditions*	TBD	20.70%	19.70%	
90th Percentile Wait Time from Community or CCAC In-Home Services – Application from Community Setting to First CCAC Service (excluding case management)**	TBD	39 days	37.1 days	
Readmission within 30 Days for Selected CMGs	TBD	15.19%	14.40%	
90th Percentile Wait Times for Cancer Surgery	Provincial Priority IV Target: 84 days	46 days	47 days	
90th Percentile Wait Times for Cardiac By-Pass Procedures	Provincial Priority IV Target: 182 days	64 days	63 days	

Table A: Performance Indicators				
▪ Objective: To improve persons' access and outcomes as they move through the continuum of healthcare services. ▪ Expected Outcome: Persons will experience improved access and outcomes related to the health care services identified below. ▪ Other indicators may be considered as a measure of this expected outcome.				
INDICATOR	**Provincial target**	**LHIN Baseline 2011-12**	**LHIN Target 2011-12**	**Data Provided to LHINs**
90th Percentile Wait Times for Cataract Surgery	Provincial Priority IV Target: 182 days	102 days	102 days	
90th Percentile Wait Times for Hip Replacement	Provincial Priority IV Target: 182 days	150 days	139 days	
90th Percentile Wait Times for Knee Replacement	Provincial Priority IV Target: 182 days	162 days	154 days	
90th Percentile Wait Times for Diagnostic MRI Scan	Provincial Priority IV Target: 28 days	147 days	112 days	
90th Percentile Wait Times for Diagnostic CT Scan	Provincial Priority IV Target: 28 days	37 days	34 days	

* New indicators for 2010/11. The MOHLTC and the LHINs will monitor performance in 2010/11 and work together to refine quality and consistency of data. The methodology for these indicators has been revised to include planned and unplanned ER visits. Therefore, targets for 11/12 may be higher than those established for 2010/11.

** New indicator methodology to be confirmed for 2010/11. The MOHLTC and the LHINs will monitor results and work together to improve data collection and coding. Targets will be established for 2011/12.

APPENDIX C

Due Date	Description of Item
2011/2012	
APRIL	
April 18, 2011	MOHLTC will provide to the LHIN a Report confirming interim actual expenditures, recoverables and payables related to its transfer payments as of March 31 of the preceding fiscal year
April 30, 2011	MOHLTC will provide to the LHIN the forms for the Year-end Consolidation Report
By April 30, 2011	The LHIN will submit to the MOHLTC a Declaration of Compliance (Attestation)
MAY	
May 13, 2011	MOHLTC will provide the LHIN with the most recent quarter of data for indicators in Schedule 4: Local Health System Performance
May 16, 2011	MOHLTC will provide to the LHIN a Report with updated interim actual expenditures, recoverables and payables related to its transfer payments as of March 31 of the preceding fiscal year
May 17, 2011	The MOHLTC will provide to the LHIN for planning and reporting purposes the initial preliminary allocation for 2011-12
May 27, 2011	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
May 31, 2011	The LHIN will submit to the MOHLTC the year-end consolidation report using forms provided by the MOHLTC and the draft Audited Financial Statement if the signed statements are not ready by May 31 of each fiscal year to which this agreement applies
JUNE	
On or about the 7th working day (date may depending on the IFIS GL close)	MOHLTC will provide to the LHIN a Q1 Report confirming year-to-date expenditures, recoverables and payables related to LHIN transfer payments
June 30, 2011	The LHIN will submit to the MOHLTC an Annual Report for the previous fiscal year in accordance with MOHLTC requirements
June 30, 2011	The LHIN will submit to the MOHLTC Q1 Regular and Consolidation Report using the forms provided by the MOHLTC
JULY	
By July 29,2011	The LHIN will submit to the MOHLTC a Declaration of Compliance (Attestation)
AUGUST	
August 2, 2011	The LHINs will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
August 12, 2011	The MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 4: Local Health System Management
August 15, 2011	The MOHLTC will provide the preliminary approved allocation for the current fiscal year, as of July 31, 2011, and the funding targets for the next year, if available.
August 26, 2011	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
August 30, 2011	MOHLTC will provide to the LHIN the forms and information requirements for the 2012/13 Annual Business Plan

Due Date	Description of Item
August 31, 2011	MOHLTC will provide to the LHIN the forms and information requirements for the Multi-year Consolidation Report
SEPTEMBER	
On or about the 7th working day (date may vary on IFIS GL close)	MOHLTC will provide to the LHIN a Q2 Report confirming year-to-date expenditures, recoverables and payables related to LHIN transfer payments
September 30, 2011	The LHIN will submit to the MOHLTC Q2 Regular and Consolidation Report using the forms provided by the MOHLTC
OCTOBER	
October 31, 2011 (or date necessary to meet central agency reporting requirements)	The LHIN will submit to the MOHLTC a Multi-year Consolidation Report using the form provided by the MOHLTC
By October 31, 2011	The LHIN will submit to the MOHLTC a Declaration of Compliance (Attestation)
October 31, 2011	The LHINs will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
NOVEMBER	
November 14, 2011	MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 4: Local Health System Management
November 25, 2011	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
DECEMBER	
On or about the 7th working day (date may vary depending on the IFIS GL close)	MOHLTC will provide to the LHIN a Report confirming year-to-date expenditures, recoverables and payables related to LHIN transfer payments
December 30, 2011	LHIN will submit to the MOHLTC Q3 Regular and Consolidation Report including final year-end forecast using the forms provided by the MOHLTC
JANUARY	
January 31, 2012	The LHIN will submit to the MOHLTC a Draft 2012/13 Annual Business Plan using the forms provided by the MOHLTC
January 31, 2012	MOHLTC will provide the LHIN with year end instructions (including templates)
By January 31, 2012	The LHIN will submit to the MOHLTC a Declaration of Compliance (Attestation)
January 31, 2012	The LHINs will submit to the MOHLTC a Quarterly Expense Report using the forms provided by the MOHLTC
FEBRUARY	
February 10, 2012	MOHLTC will provide the LHIN with most recent quarter of performance data for indicators in Schedule 4: Local Health System Performance
February 15, 2012	MOHLTC will provide to the LHIN the forms and requirements for the Annual Report (non-financial content)
February 24, 2012	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
February 24, 2012	The LHIN will submit to the MOHLTC Year-End Reallocation Report on planned vs. actual expenditures related to in-year reallocations
MARCH	

Due Date	Description of Item
March 30, 2012	MOHLTC will provide to the LHIN the forms for the Annual Report (financial content)
2012/2013	
APRIL	
April 16, 2012	MOHLTC will provide to the LHIN a Report confirming interim actual expenditures, recoverables and payables related to its transfer payments as of March 31 of the preceding fiscal year
April 30, 2012	MOHLTC will provide to the LHIN the forms for the Year-end Consolidation Report
By April 30, 2012	The LHIN will submit to the MOHLTC a Declaration of Compliance (Attestation)
April 30, 2012	The LHINs will submit to the MOHLTC a Expense Report using the forms provided by the MOHLTC
MAY	
May 14, 2012	The MOHLTC will provide to the LHIN the most recent quarter of performance data for indicators in Schedule 4: Local Health System Performance
May 14, 2012	MOHLTC will provide to the LHIN a Report with updated interim actual expenditures, recoverables and payables related to its transfer payments as of March 31, of the preceding fiscal year
May 18, 2012	The MOHLTC will provide to the LHIN for planning and reporting purposes the initial preliminary allocation for 2010-11
May 28, 2012	The LHIN will submit to the MOHLTC a report on performance indicators using the forms provided by the MOHLTC
May 31, 2012	The LHIN will submit to the MOHLTC the year-end consolidation report using forms provided by the MOHLTC and the draft Audited Financial Statement if the signed statements are not ready by May 31 of each fiscal year to which this agreement applies