Toronto Central **LHIN**

2010/11
Annual
Report

Improving access to care for healthier people and communities

Ontario
Local Health Integration Network

Contact Information

Toronto Central **LHIN**

Telephone:

416.921.7453
1.866.383.5446

Address:

425 Bloor Street East, Suite 201
Toronto, ON M4W 3R4

E-mail:

torontocentral@lhins.on.ca

Website:

www.torontocentrallhin.on.ca
www.lhins.on.ca
www.health.gov.on.ca/transformation/lhin/lhin_mn.html

ISSN 1911-3641 (Print) Annual Report (Toronto Central Local Health Integration Network)
ISSN 1911-365X (Online) Annual Report (Toronto Central Local Health Integration Network)
ISSN 1911-3668 (Imprimé) Rapport annuel (Réseau local d'intégration des services de santé du Centre-Toronto)
ISSN 1911-3676 (En ligne) Rapport annuel (Réseau local d'intégration des services de santé du Centre-Toronto)

2010/11
Annual
Report

Table of Contents

Executive Summary

What is the LHIN?

The Local Health Integration Network's (LHIN) job is to plan, fund and organize local health services so that they respond to community needs.

No single organization or health service provider can change the health care system on its own. It takes all parts of the system working together. The LHINs are the only organizations whose role is to bring all providers to the table with one set of goals and one plan for patients and communities.

Toronto Central LHIN is home to approximately 1.15 million people. We fund 174 health service providers including hospitals, the Toronto Central Community care access centre, community support services, community health centres, mental health and addictions agencies and long-term care homes.

Results

In 2010/11 the LHIN made measureable improvements in two particular areas: better access to services and greater efficiency.

In March 2010, the LHIN began implementing the 2010-2013 Integrated Health Service Plan. The Plan has four areas of focus to improve access to health care services for residents and patients:

1. Lowering emergency room (ER) wait times and reducing alternate level of care (ALC) days by providing more patients with the right care at right time
2. Mental health and addictions
3. Diabetes
4. Value and affordability of health services

›› Lower Emergency Room Wait Times

Last year, **more people were in and out of the ER sooner. At year-end 79 per cent or more than three out of four patients were seen within the province's ER wait time targets.** Nine out of 10 people visiting Toronto Central LHIN ERs received treatment 36 per cent faster than they would have three years ago. The greatest improvements are for patients with minor conditions and those with more complex conditions who do not need to be admitted to hospital.

This achievement is particularly significant considering that the number of visits to Toronto Central LHIN ERs has increased by 23 per cent since April 2008.

Wait times for seriously injured or ill people who need to be admitted remains the greatest challenge. In March 2011, 33 per cent of these ER patients were treated and admitted within the province's eight hour target. In 2011/12, the Toronto Central LHIN will emphasize strategies to reduce the time it takes to get people from the ER into an inpatient bed.

›› Right Care, Right Place, Right Time – Reducing Alternate Level of Care

ALC data tell us how many patients are waiting in a hospital bed unnecessarily because they cannot get access to appropriate care at home or another setting.

Last year, some 22 per cent fewer patients were waiting in a hospital bed to be discharged than the year before.

The main reason for this achievement is that significantly more seniors in Toronto Central LHIN hospitals who were waiting for a long-term care home were able to return home to wait for long-term care. In many cases, these seniors were able to remain in the comfort of their own homes and communities.

The LHIN together with hospitals and community agencies are successfully transitioning patients who have been hospitalized a long time (40 days or more) to another level of care that better meets their needs.

Along with the Toronto Central Community Care Access Centre, the Toronto Central LHIN brought together care providers, patients' families and home care workers to tackle each patient's situation one at a time. So far, 37 of these patients have been able to leave hospital. **The team saved those patients from spending another 18,500 days in hospital and helped Toronto hospitals avoid about $27 million dollars in spending.** Hospitals can now redirect that money — and those 37 beds — to care for other patients.

›› Improving Mental Health and Addictions Services

This past year, community agencies and hospitals worked together to make services more accessible and effective for people with mental illness and addictions.

The LHIN and health service providers made it easier for people to find and access the services they need. All 29 supportive housing agencies have one wait list and system for clients to access supportive housing in the city. With an investment from the LHIN, the Inner City Health Associates launched the Coordinated Access to Care for the Homeless program, a single phone number and way to connect homeless people with primary and psychiatric care.

The Toronto Community Addictions Team helps people with addictions find a place to live and the right treatment options. The program is working. There has been a 56 per cent reduction in ER visits for clients who previously used to visit ERs 40 times a year on average.

There are more housing options for these individuals as a result of the first-ever addictions supportive housing units this past year. Two-hundred units have been created for people with serious addictions in the LHIN.

Improving Diabetes Care

Toronto's ethnocultural communities have more services to prevent and treat diabetes. The Toronto Diabetes Regional Coordinating Centre, launched in 2010/11 and hosted by the South Riverdale Community Health Centre, will make it easier for people living with diabetes to access diabetes services.

Six new diabetes education teams have also opened in high-needs neighbourhoods along with three screening and outreach teams targeting South Asian, Aboriginal, and Caribbean and Latin American seniors.

Increasing Value Through Integration

Last year, the Toronto Central LHIN began leading and investing in initiatives to integrate services across sectors to improve care for specific populations. These models improve quality of care for seniors, children and others, and they make more efficient use of health care resources.

The Integrated Client Care Project for Seniors with Complex Needs links together a range of services for seniors with complex needs, helping seniors at every step from hospital back to the community. The Hospital for Sick Children is working with other organizations to better integrate services for vulnerable and high-needs children. The Centre for Addictions and Mental Health is leading an initiative to integrate care for people with mental illness and addictions, including those with behavioural issues who are hard to place.

A number of providers are voluntarily integrating their services to improve efficiency while delivering the same or better services to patients and clients. New Heights Community Health Centre and York Community Services merged to create Unison Health and Community Services. Providence Healthcare and Toronto East General Hospital are sharing pharmacy services.

Also Last year, the Toronto Central LHIN Laboratory Collaborative continued to make progress towards one integrated shared clinical lab service in the LHIN, starting with University Avenue hospitals. Once fully implemented, this initiative is estimated to save $15 to $16 million a year.

The Road Ahead

The accomplishments over the last year are the result of the combined efforts of health care organizations and agencies within the Toronto Central LHIN.

While tremendous improvements have been achieved, there remain many challenges to tackle and areas where we can do better.

Two particular challenges will continue to demand our attention in the year ahead.

Currently 54 per cent of patients who receive care in Toronto Central LHIN hospitals reside in other LHINs. Existing funding methodologies are largely based on the assumption that people get care in their home region and do not fully account for the fact that many patients and clients in Toronto Central LHIN live in other areas. At the same time, some long-term care organizations are deciding to leave or not build homes in Toronto because high cost, availability of land, and other factors. The Toronto Central LHIN is working with the Ministry of Health and Long-Term Care, providers and other stakeholders to address these issues.

The local health care system at a glance shows both the rich diversity and the troubling inequities in Toronto. In the year ahead, the LHIN has updated its Strategic Plan with initiatives designed to raise the quality of care for *all* people and reduce access and health outcome disparities in the city.

Letter from the Board Chair and CEO

Angela Ferrante
Board Chair

Camille Orridge
CEO

We are pleased and proud to provide you with the LHIN's 2010/11 Annual Report.

We would like to recognize our community partners, health service providers, staff and the Board for a year of significant progress.

This Annual Report reflects the key developments and accomplishments of the Toronto Central LHIN health care system made up of health service providers, front-line health professionals, community members, partner agencies, and the Toronto Central LHIN team.

By any number of metrics, people have better access to key services than a year ago. And health care organizations are becoming increasingly innovative in working as a system to deliver better value for the investment in health care. We would like to highlight two particular accomplishments.

First, the Toronto Central LHIN has made major improvements in two of the top issues concerning Ontarians: reducing the time people wait in emergency rooms for treatment and reducing alternate level of care days or, in other words, allowing more people to transition to the right level of care and avoid hospitals and institutions when they can.

People prefer to receive care in the familiarity of their homes and communities with the right supports in place. As a result of investments such as Aging at Home, more seniors have the option of living in their own communities.

Secondly, the improvements are the result of collaboration and integration across organizations and sectors.

From working together to develop a coordinated Emergency Management Plan for the health system last summer, to the Integrated Client Care Project that supports seniors at every step from hospital back to the community, to the continued drop in emergency room wait times – all these initiatives resulted from the combined efforts of organizations from across the city.

We confront considerable and pressing challenges. The fact that some groups in our community do not receive the best standard of care and have significantly less access to services than others is an issue we will be addressing vigorously in the years ahead.

Sustainability is one of the most pressing issues we must continue to address together. We have the opportunity to make the necessary fundamental changes in how we fund, organize and deliver health

Letter from the Board Chair and CEO

care. We are able to choose locally what kind of care we need. We have a chance to truly organize the system around people rather than providers and services. We have made some critical progress together in the Toronto Central LHIN and can learn from innovations underway in other parts of the province.

The Toronto Central LHIN Board and staff look forward to another great year, taking on these challenges with you. There is a lot of hard work ahead and we are well on our way!

Angela Ferrante
Board Chair

Camille Orridge
CEO

Local Health System at a Glance

Toronto's Unique Urban Population

Toronto Central LHIN is home to approximately 1.15 million people, or 8.6 per cent of Ontario's population. It is the most densely populated and the only completely urban LHIN.

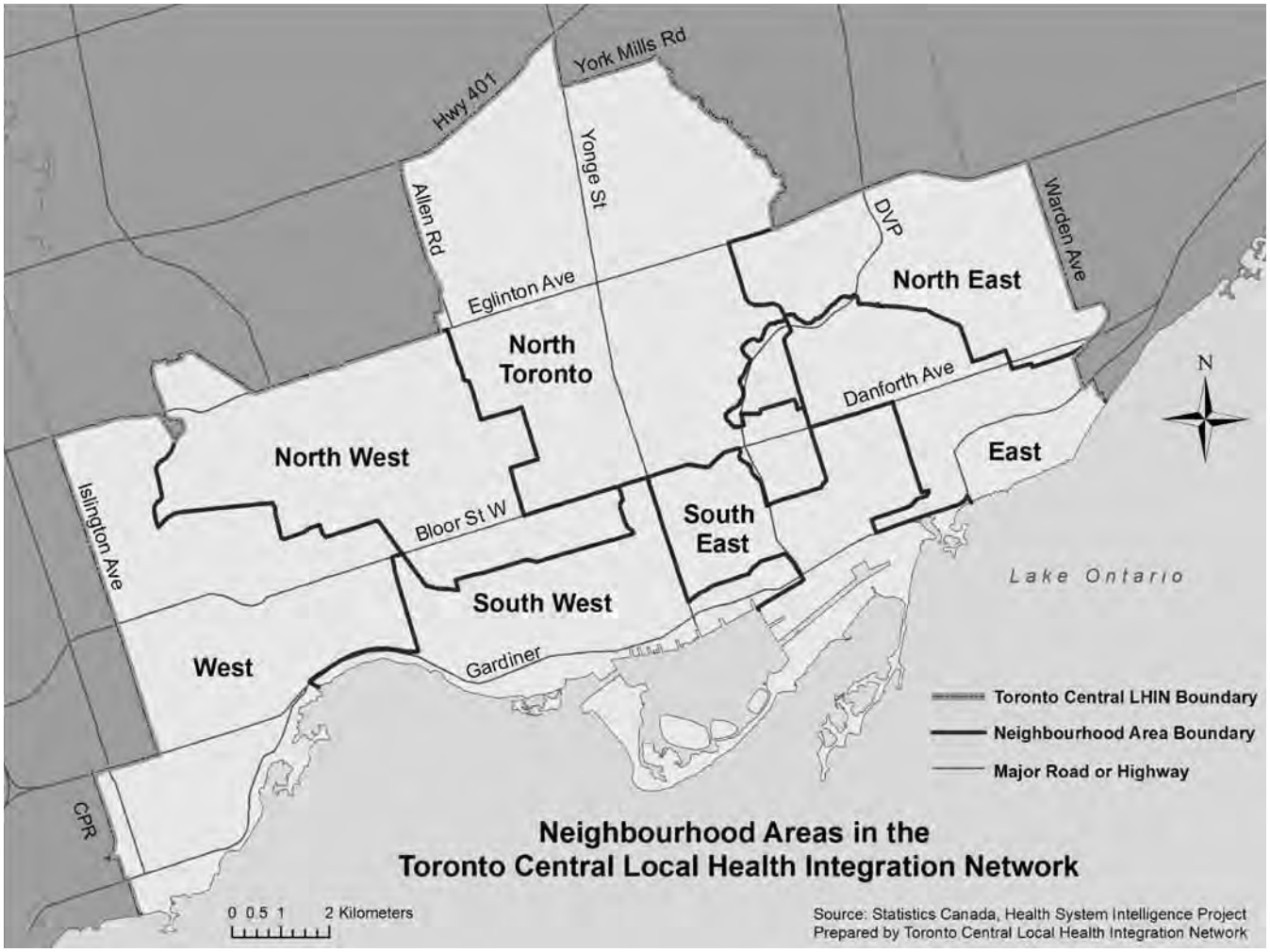
Immigrants make up 41 per cent of the population and more than 160 languages and dialects are spoken here.

The City of Toronto has a French-speaking population of about 53,370. According to the 2006 Census, 7.4 per cent of Francophones in the city are recent immigrants and 20.6 per cent are part of a visible minority group.

In the City of Toronto, there are approximately 25,000 Aboriginal peoples (2006 Census) comprising about 0.5 per cent of the population. This is thought to under-represent the actual numbers as the Census data does not capture the large number of Aboriginal people who are homeless or those who migrate between the city and their home communities during the year. There are an estimated 16,200 residents of Aboriginal ancestry (1.5 per cent) in the Toronto Central LHIN.

The Toronto Central LHIN has the largest lesbian, gay, bisexual, and transgendered community in Canada.

There are also vast differences in incomes and educational levels in Toronto, ranging from some of the most affluent neighbourhoods in Canada to some of the poorest. Twenty-four per cent of the population is low income and there are over 5000 homeless people in the LHIN.



City of Young and Old

Compared to the rest of the province, a higher proportion of young adults 25 to 44 years of age live in the Toronto Central LHIN, representing 32 per cent of the LHIN's population.

Seniors 65 years and older accounted for 14 per cent of the population in 2010. The population over the age of 85 is growing faster than all other age groups in the LHIN, with a projected increase of 15 per cent between 2010 and 2015.

Who Comes to Toronto Central LHIN for Care

Toronto Central LHIN health care organizations provide services to people from across Ontario.

Some 54 per cent of patients in Toronto Central LHIN hospitals and 41 per cent of alternate level of care patients discharged from Toronto Central LHIN acute care hospitals live in other LHINs.

Health Needs of the Population

Mental illness and addictions are also serious local health issues, affecting 20 per cent of residents in their lifetime.

More than one in three residents has at least one chronic condition. As the population ages, the prevalence of chronic disease is expected to grow.

Almost 10 per cent of LHIN residents aged 20 and over suffer from diabetes.

Compared with the rest of the province, the Toronto Central LHIN has a high concentration of infectious diseases, including HIV.

Disparities

Toronto's diversity is a source of vitality. There are also great challenges when differences in ethnicity, race, culture and means lead to different levels of access and different health outcomes.

Consider some of the facts.

- Low income people access the ER more often than those with high income.
- Diabetes incidence is twice as high in low income neighbourhoods. Immigrant populations have higher rates of diabetes than the rest of the population.
- People with low income have a lower life expectancy.
- Aboriginal communities have poorer health outcomes than the rest of the population, including lower life expectancy; higher infant mortality; and higher rates of diabetes, mental health and addictions, and new HIV infections.

Local Health Care Services

Toronto Central LHIN had a budget of $4.378 billion in 2010/11, $4.36 billion of which was provided to health service providers for day-to-day operations. Toronto Central LHIN funds 174 health service providers, including 18 hospitals, 17 community health centres, 37 long-term care homes, one Community Care Access Centre, 67 community support agencies, and 68 mental health and addictions organizations (some health service provider organizations deliver more than one service, e.g., community support services and addictions services).

The health service providers in the Toronto Central LHIN are also very diverse. The LHIN includes a range of small to medium-sized community-based agencies that serve specific populations and neighbourhoods. Toronto Central LHIN is also home to 44% of Ontario's teaching hospitals. A number of hospitals in the Toronto Central LHIN provide specialized services not offered anywhere else in Ontario.

Community Engagement

Community engagement is a part of everything that the LHINs do.

The reason for this is simple. Since most health care is delivered locally, local health care organizations, patients and community members need to be involved in identifying the problems and the solutions.

No single health service provider can change the health care system on its own. It takes all parts of the system working together. The LHINs are the only organizations that are responsible for bringing all providers to the table with one set of goals and one plan for patients and communities.

To fulfill its role, the Toronto Central LHIN consults with and involves community members and stakeholders in local health planning and decision-making.

In 2010/11, the Toronto Central LHIN engaged the public; health service providers; health professionals/ workers; strategic partners; government, elected officials and interest groups; and priority communities.

Highlights of community engagement in 2010/11

›› Engaging Health Professionals

The Toronto Central LHIN's Health Professionals Advisory Committee (HPAC) is made up of 14 leaders representing a spectrum of professions and experiences.

In 2010/11, HPAC members began the Toronto Central LHIN's Quality Indicator Task Group. The group is advising the LHIN on the selection of indicators the LHIN should adopt to measure and promote quality health care across the system.

The LHIN also continued to strengthen its partnerships with health professional associations, including the Ontario Medical Association's (OMA) District 11 which represents Toronto physicians. In January 2011, the LHIN and OMA District 11 held Transitions in Care, a symposium with primary care physicians and specialists which focused on improving patient transitions within the health care system.

> "The Health Professionals Advisory Committee has thrived in the Toronto Central LHIN for the following reasons: the LHIN leadership has honoured the group's stated intention to provide a respected voice to aid policy development and decision-making, and HPAC itself has expended some effort to monitor its impact on LHIN activities. Consequently, HPAC meetings are dynamic, synergistic forums that are routinely highly rated by HPAC members and there is competition among health care providers, including physicians, for available HPAC positions."
>
> – Dr. Pauline Pariser
> *Chair, Health Professionals Advisory Committee*

Engaging Health Service Providers

In 2010/11 the LHIN engaged health service providers through the following advisory and task groups.

Health Service Provider Leadership Forum
These are bi-annual meetings with executives from across sectors to address shared health system issues, planning and integration. Starting in 2010, the format was changed to focus on advancing opportunities for health service providers to work across sectors to share and streamline business processes. The goal is to reduce time and costs while improving efficiency and service delivery to patients and clients.

Sector Tables
Sector tables are quarterly meetings with CEOs and executive directors of each LHIN-funded sector regarding performance, integration and system planning. These forums have become an extremely important mechanism for advancing initiatives to improve the access, quality and equity of local health services.

Toronto Central LHIN Advisory Committees on Integrated Health Service Plan Priorities

- Mental Health and Addictions Steering Committee (and working groups)
- Aging At Home Steering Committee (and working groups)
- ER Pay-For-Results Working Group
- Resource Matching and Referral Steering Committee

Time-Limited Task Groups
In 2010/11 the Toronto Central LHIN convened a Task Group of provider organizations across all sectors to develop a community engagement strategy for the LHIN.

The group's first step was to create a Community Engagement Toolkit for Health Service Providers and the Toronto Central LHIN that outlines the roles, accountabilities and expectations regarding community engagement, and provides tools to support effective community engagement.

Engaging Consumers

Over the years, the Toronto Central LHIN has increasingly used peer-to-peer and community-led processes to engage local residents, patients, clients, families and other community members.

Over the past year and a half, the Toronto Central LHIN has worked with its Mental Health and Addictions Consumer and Family Advisory Panels to develop a peer-led approach to community engagement that provides opportunities for people with lived experiences to contribute their knowledge about how to improve mental health and addictions services. This approach was piloted through focus groups in 10 community-based organizations.

Most recently, peer-led focus groups were used to seek input from clients and families about the referral process for mental health and addictions, and justice supportive housing.

In addition to seeking ongoing advice from the Seniors Advisory Panel, the LHIN had a number of targeted processes to seek input on seniors' issues. This includes the Aging at Home Working Group chaired by the Alzheimer's Society to identify initiatives to support informal caregivers.

Francophone Engagement

The report *French Language Services in Toronto Central LHIN: Environmental Scan and Future Directions*, provides an overview of French health services in the LHIN and proposes steps that will lead to more equitable access for the Francophone community.

In early 2011, a French Language Services Coordinator joined the LHIN's staff to support community engagement and health service planning with the LHIN's Francophone communities.

Toronto Central LHIN French Language Services Coordinator, Tharcisse Ntakibirora, speaking to Francophone stakeholders about the LHIN's strategic plan.

Also last year, the province created six French language health services planning entities to provide expert advice to the LHINs about the health care needs and priorities of local Francophones. At the end of March 2011, the Toronto Central, Central West and Mississauga Halton LHINs signed a funding and accountability agreement with the entity for our three regions called Entité de planification pour les services de santé en français de Toronto Centre, Centre Ouest et Mississauga Halton. The Toronto Central LHIN is the lead LHIN responsible for managing the agreement with the new entity.

Over the next year, the LHINs and the entity will work together to engage the multi-cultural and multi-ethnic Francophone communities served by the three LHINs.

›› Aboriginal Engagement

According to the latest Census, 62 per cent of Aboriginal peoples in Ontario live in urban areas. Toronto has one of the largest and most diverse Aboriginal populations in Canada.

This past year, the LHIN was involved in a number of partnerships with Aboriginal groups to develop culturally relevant, community-based strategies to address the health care needs of Aboriginal communities in and around Toronto.

Toronto Central LHIN-specific initiatives

Noojimawin Aboriginal Health Equity Project
The Toronto Central LHIN is addressing Aboriginal health equity issues by supporting an initiative led by Noojimawin Health Authority in partnership with the Greater Toronto Area (GTA) LHINs and the Toronto Central LHIN Hospital Collaborative on Marginalized Populations. Noojimawin used culturally-based community approaches (e.g., sharing circles) to seek input from Aboriginal community members, including some of the most marginalized populations (e.g., homeless and people living with mental health and addictions issues) about unmet needs and barriers.

Interim Advisory Circle on Aboriginal Health in Toronto
The Toronto Central LHIN in partnership with Toronto Public Health, Anishnawbe Health Toronto and non-Aboriginal agencies created an Interim Advisory Circle on Aboriginal Health to guide Aboriginal community engagement and provide advice on urban Aboriginal health strategies in Toronto. The goal is to promote more coordinated Aboriginal health service planning in Toronto.

In 2010/11, the 14 LHINs established an Aboriginal Health Charter and an Aboriginal Provincial Network. Chaired by the Toronto Central LHIN, the Network will address Aboriginal issues that cut across geographic areas.

The Toronto Central LHIN was also involved in the Aboriginal Health Transition Fund (AHTF) initiative in a number of ways. The LHIN was a member of the provincial committee evaluating AHTF projects, and contributed to multiple initiatives including: an Aboriginal-specific residential men's treatment cycle through the Centre for Addiction and Mental Health; and an urban Aboriginal healing circle for members of The Meeting Place to address addictions and diabetes in homeless Aboriginals.

Also in 2011, the Toronto Central LHIN participated in the AHTF Aboriginal Knowledge Translation Forum which involved stakeholders from across Ontario.

2010/11 – A Year of Progress and Results

In 2010/11, the Toronto Central LHIN together with health service providers and stakeholders made measurable progress in two particular areas: better access to services and greater efficiency.

Toronto Central LHIN Vision Statement

A health care system that helps people stay healthy, delivers good care when people need it, and will be there for our children and grandchildren.

In March 2010, the LHIN began implementing the 2010-2013 Integrated Health Service Plan. The Plan has four areas of focus to improve access to health care services for residents and patients:

1. Lowering ER wait times and reducing ALC days by providing more patients with the right care at right time
2. Mental health and addictions
3. Diabetes
4. Value and affordability of health services

Emergency Room Wait Times and Alternate Level of Care

When people wait too long in the ER or remain in the hospital well after they are ready to leave, the health system is not working the way it should.

The Toronto Central LHIN's strategies target the following root causes of ER gridlock and ALC.

1. Preventing the need for emergency care
2. Treating patients more quickly in ER and transitioning them to right services; and
3. Supporting people in their homes and communities.

Emergency Room Wait Times

Last year, more people were in and out of the ER sooner, with 79 per cent of patients being seen within the province's targets. That means that as of March 2011, nine out of 10 people visiting a Toronto Central LHIN ER were treated 36% more quickly than they would have been three years ago.

This improvement is particularly significant considering that the number of visits to Toronto Central LHIN ERs has climbed 23 per cent since April 2008.

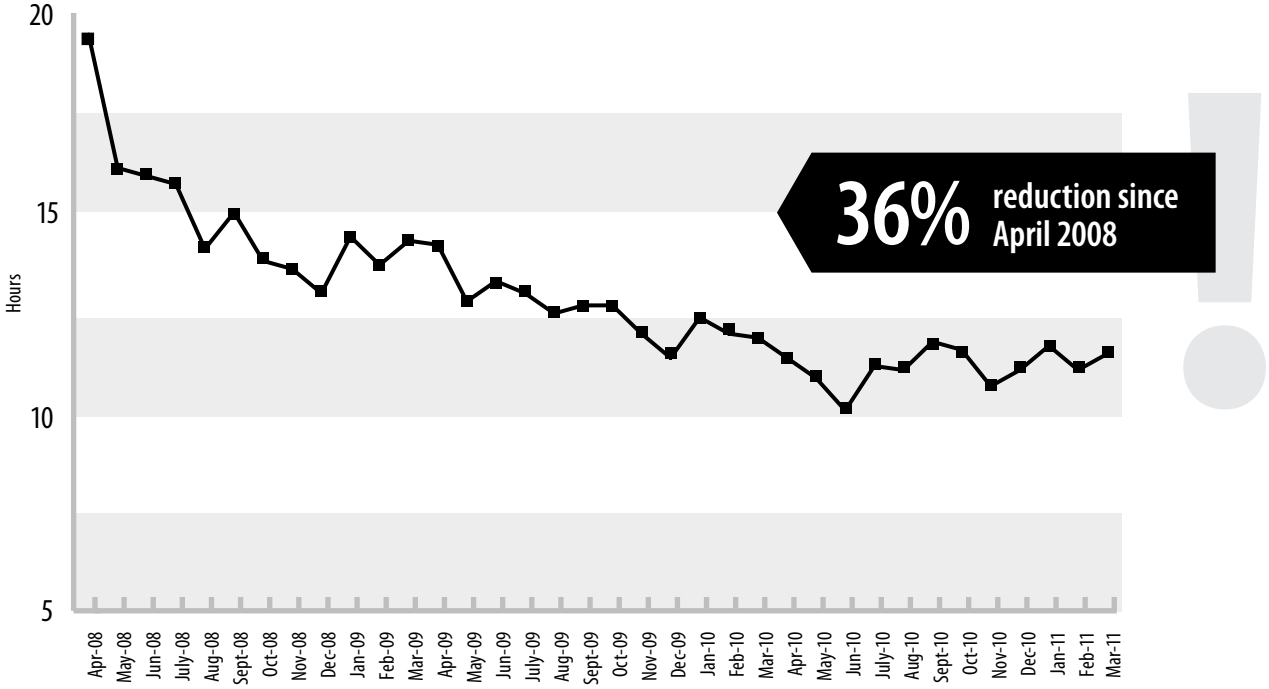
An ever-increasing number of people from across the province come into the Toronto Central LHIN for care. Currently, 54 per cent of patients in Toronto Central LHIN hospitals reside in other LHINs. In the case of the Hospital for Sick Children, only 18 per cent of inpatient and 22 per cent of ambulatory patients live in Toronto Central LHIN.

ER wait times for complex patients that need to be admitted to hospital remain a significant challenge. In March 2011, 33 per cent of these patients were treated in the ER and admitted to hospital within the province's eight hour target.

Continuing in the year ahead, the Toronto Central LHIN and local health service providers are targeting the top causes of ER wait times, including the time it takes to admit patients from the ER to a hospital bed.

> "I used to see patients waiting on stretchers, crowding our ER daily. Our hospital transformation has now led to patients admitted and receiving care sooner. Patients and staff are happier. Some nurses who left have returned after hearing about our progress."
>
> – Mark Joithe, RN
> *ER Team Leader, St. Michael's*

90th Percentile ER Length of Stay – All Patients
(April 2008 to March 2011)



Right Care, Right Place, Right Time – Reducing Alternate Level of Care

When someone uses the term 'ALC patient', they are referring to people who are waiting in hospital beds to be discharged to another, more appropriate level of care.

This situation is changing in the Toronto Central LHIN. Those who previously would have had no other option but to remain in hospital are now able to return to their homes and communities for ongoing care.

This year, the LHIN targeted investments at the following strategies that have a proven impact on ALC and people's access to appropriate care.

- Allowing more patients to wait for long-term care (LTC) at home or in the community instead of in hospital.
- Supporting long-stay ALC patients (those who have been in hospital 40 days or more) to transition to a place of care that best meets their needs, while preventing future patients from becoming ALC.
- Integrating and organizing services around different populations, including seniors, children and people with mental health and addictions issues.

Last year, **22 per cent fewer patients were waiting in a hospital bed to be discharged than the year before**.

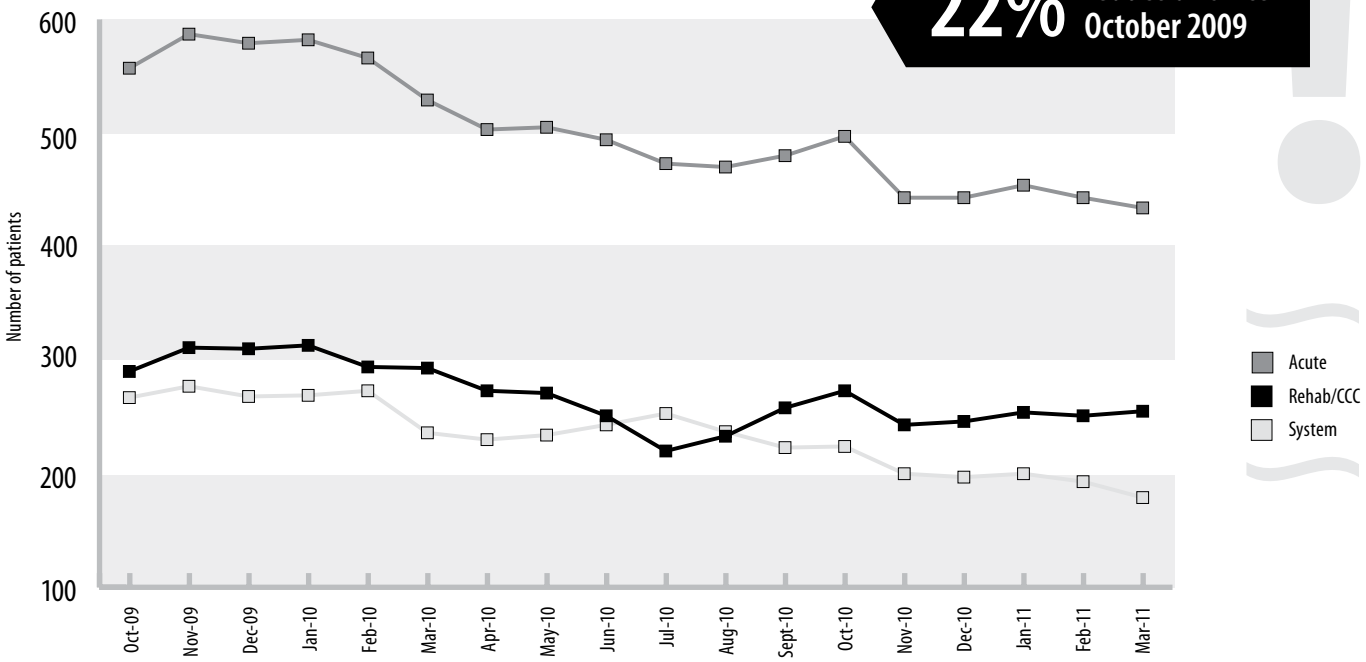
Largely as a result of the LHIN's Home First strategy, the number of seniors waiting in hospital for a LTC home dropped by 44% since October 2009.

In July 2010, the Toronto Central LHIN tasked the Community Care Access Centre (CCAC) to work with hospitals and community providers to identify the barriers preventing long-stay ALC patients from moving to the next care destination. Some of these patients have spent up to a decade in hospital.

The LHIN designated hospital CEOs to lead cross-sector teams focused on target populations. West Park Healthcare Centre is leading the task group for ventilator-dependent patients; the Centre for Addiction and Mental Health (CAMH) is leading the task group for mental health and addictions clients; and Bridgepoint Health and Toronto Rehabilitation Institute are leading the task group for hard-to-place patients in rehabilitation and complex continuing care. These teams review each patient's needs, remove barriers and help them get to the right place of care.

A fourth task group, co-chaired by St Joseph's Health Centre and St. Michael's, is focusing on improving the discharge planning process for patients.

Average Monthly ALC Patients
(October 2009 to March 2011)



So far, 37 of these long-stay ALC patients have been able to leave hospital. The teams have saved those patients from spending another 18,500 days in hospital and helped Toronto hospitals avoid about **$27 million dollars in spending. Hospitals can now redirect that money** – and those 37 beds – to care for other patients.

These efforts are enhancing the quality of life of these individuals and improving the system for future patients. The Toronto Central CCAC is leading an effort to prevent patients in these populations from becoming ALC down the road.

Carlos' story

Twenty-four-year-old Carlos is one of many clients that a Toronto Central CCAC care coordinator has been able to support through the project on long-stay ALC patients.

In July 2005, at the age of 18, Carlos suffered a traumatic injury. For six weeks he clung to life after suffering the loss of parts of both his legs and some of his fingers.

Carlos was transitioned to rehabilitation in 2006 and once his rehabilitation was complete he was designated ALC waiting for long-term care - the only destination his care team thought appropriate for him. His situation was one of 148 that were reviewed by an ALC Review Team assembled by the Toronto Central CCAC. The team included representatives from all areas in the continuum of care and their job was to exhaust all opportunities to get clients who had been living in hospital as an ALC patient to the right place of care. For Carlos, the team identified a need to find him a place of care in his community that would support his youth and growing independence.

Tracey Raymore, a Toronto Central CCAC care coordinator, worked with Carlos for two months to transition him to the right place of care – a boarding home close to his family that allowed him to be independent with some support.

After spending five years in hospital, Carlos is thriving in his home community close to his family and friends and is planning to go back to school.

The Integrated Client Care Project for Seniors with Complex Needs

In 2010/11 the Toronto Central LHIN began leading and investing in cross-sector integration initiatives to improve care for specific populations. Hospitals, the CCAC, community and mental health and addictions agencies, LTC and community health centres are coming to the table with one plan and one set of goals for populations including seniors, children and mental health and addictions clients.

The Integrated Client Care Project (ICCP) for Seniors with Complex Needs is the most well developed of these cross-sector client-based integrations.

ICCP knits together programs geared to the needs of seniors, including Virtual Ward, the Toronto Community Addictions Team, Home First, and House Calls.

The Hospital for Sick Children is working with other organizations in the LHIN to better integrate services for vulnerable and high-needs children. CAMH is leading an initiative to integrate care for people with mental illness and addictions, including long-stay clients with behavioural issues.

New health system capacity to reduce ALC

New beds opening at Runnymede Healthcare Centre's complex continuing care (CCC) facility provide a new option for long-stay ALC patients with complex health needs.

In September 2009, regulations came into effect enhancing the CCAC's role in helping clients access adult day programs, CCC beds, rehabilitation beds and supportive housing. More recently, this role was extended to assisted living. This enhanced role is already being implemented in the Toronto Central LHIN with the CCAC placing long-stay ALC patients at Runnymede Healthcare Centre and leading new Aging at Home initiatives to link seniors with assisted living and adult day programs.

In 2010/11, the Toronto Central LHIN launched the Senior Friendly Hospital Strategy, an initiative to prevent seniors' physical and mental decline in hospital. Toronto Central LHIN hospitals completed the first step: a self-assessment to identify successful initiatives and action steps to improve health outcomes of seniors in hospital.

The Senior Friendly Hospital Strategy, along with Home First and the CCAC's enhanced role, are part of a group of strategies being implemented by all LHINs to lower ALC and enhance seniors' care.

Home First – Helping Seniors Safely Return Home from Hospital

At 95 years of age, Lillian lives in a retirement home with daily visits from her daughter-in law, Alena, and regular visits by her grandsons. She was first admitted to hospital after a fall and, a short time later, was again admitted to the ER as a result of overmedication.

When her acute care was complete, Lillian was admitted to Virtual Ward, a program supported by the Toronto Central LHIN that provides short-term 'transitional care' to high-risk, complex patients who have recently been discharged from hospital so that they can safely return home or to their communities.

At that point, Lillian was connected with Home First. A community care coordinator with the Toronto Central CCAC's Seniors Enhanced Care Team screened Lillian and found that she was able to receive intensive support in her home. The care coordinator then developed a service plan to best meet Lillian's needs.

Lillian is now happily living in her own home, supported by a multidisciplinary team that includes a care coordinator, a physician, a pharmacist to assist with her medications, and personal support to assist with bathing, dressing, and meals.

"This is exactly what we wanted for Lillian," said Alena. "She's settled and happy and our family continues to spend time together as we always have."

Lillian

Mental Health and Addictions

This past year, community agencies and hospitals worked together to make services more accessible and effective for people with mental illness and addictions. Here are some of the highlights:

- Launched in early 2010, the Toronto Community Addictions Team (TCAT) provides clients with housing and addiction treatment options that work for them. Many of these clients have a concurrent mental illness and are homeless. Clients who used to visit ERs on average 40 times a year are making 56 per cent fewer visits as a result of TCAT. There has also been a 45 per cent reduction in the use of withdrawal management services by TCAT clients nine months after enrolment in the program.
- All 29 supportive housing agencies in the LHIN have one wait list and system to help clients access supportive housing. In addition, a single access point for primary and psychiatric care was created last year through the Inner City Health Associates Clinics, and agencies began working together to coordinate access to case management services.
- Over the course of the year, people with addictions will have access to 200 supportive housing units designed to meet their unique health care needs. These are among the first supportive housing units for people with addictions in Ontario.
- Sixty-eight per cent of eligible organizations are implementing a common client assessment tool – Ontario Common Assessment of Need (OCAN) – which is designed by consumers, for consumers.
- The LHIN held a Homelessness and Mental Health and Addictions Think Tank which generated three pilots now underway: Peer Outreach Worker Pilot; Concurrent Disorders Crisis Response; and Coordinated Access to Primary Care Clinics for the Homeless.

> The LHIN funded an innovative community-based research project titled **Lemme tell you how it works: A consumer/survivor and user-led gap analysis of mental health and addiction services in the Toronto Central LHIN.**
>
> Consumers described their experiences, how they access services and the kinds of services they need. This research will help shape how mental health and addictions services are planned and evaluated in 2011/12.

The Toronto Community Addictions Team (TCAT)

Jim's story

Jim* was a very regular user of withdrawal management services and ERs for a number of years. In addition to a long history of intense drug use, Jim had serious mental health, trauma, physical health and neurological challenges. As a result of an accident, Jim ended up in intensive care in hospital.

Jim was worried about returning to the neighbourhoods in which he used substances after his hospital stay. TCAT arranged for him to go to a withdrawal management site in a different neighbourhood while the TCAT team sorted out his treatment. It also arranged for Jim to have an extended stay at withdrawal management services so that a CCAC nurse could come in to assist him with wound care and pain management until his injuries finished healing. TCAT staff then enrolled Jim in a transitional treatment program while he awaited longer term treatment, and helped Jim resolve outstanding legal issues.

TCAT staff supported Jim throughout this process, helping him both to succeed in his residential transitional treatment program and in dealing with the distress he felt about the barriers to accessing longer term treatment. During his time in the TCAT program, Jim's quality of life improved dramatically as his physical health improved significantly and he was able to access appropriate treatment for his psychiatric and neurological challenges. He stayed drug free after his accident and did not need withdrawal management services or visits to the ER in his last six months in the program. Jim successfully completed the transitional treatment program and achieved his goal of moving back to stable, safe housing in his home town where he has remained.

**not client's real name*

Diabetes

Last year there were more services in place to prevent and treat diabetes in Toronto's ethnocultural communities.

The Toronto Diabetes Regional Coordinating Centre at South Riverdale Community Health Centre will make it easier for people with diabetes to access culturally relevant services.

Six new diabetes education teams also opened in high-needs neighbourhoods identified by the LHIN. In addition, the LHIN has implemented three culturally-specific screening and outreach teams for South Asian, Aboriginal, Caribbean and Latin American seniors. In 2010/11, these programs screened 1,775 individuals at risk of diabetes.

Live Free…Prevent Diabetes team hosting an open screening clinic in Lawrence Square Mall

The Anishnawbe Health Diabetes Program

The Anishnawbe Health Diabetes Program enhances diabetes prevention services for the Aboriginal community in Toronto and offers culturally relevant services to detect diabetes earlier. The program reaches out to Aboriginal peoples in venues where community members congregate such as the Native Canadian Centre of Toronto. The Anishnawbe Diabetes Team consists of a chiropodist, a diabetic nurse educator and a dietician.

MJT, a senior at Wigwamen Terrace, recounted his experience with the Anishnawbe Health Diabetes Program:

I am a senior at Wigwamen Terrace and on behalf of the seniors we need foot care badly. Chiropody services are much needed for seniors in our building. We are able to come down and have our feet looked after by the chiropodist on the diabetes team from Anishnawbe Health. The team also provides us with monitoring of our blood sugar levels. It is important for us to monitor our blood sugars. We also have our blood pressure taken. I have my blood pressure taken and when I go to my doctor I show him the results.

The team also has a dietician that comes to our building and talks to seniors about eating proper food and the amount we should be eating – servings and portion sizes. Eating five meals a day helps me with my diabetes. When I eat right my sugar test is stable and I am very happy about that.

Participants at Drumming for Diabetes, an annual event of the Anishnawbe Health Diabetes Program. The culturally sensitive event raises awareness about diabetes and educates the Aboriginal community about preventing the complications of diabetes.

Value and Affordability, and Integration

The Toronto Central LHIN's initiatives in 2010/11 are contributing to better outcomes for patients and communities and better use of health care resources.

Over the past year, the LHIN and health service providers undertook a number of specific initiatives to improve efficiencies and reduce costs by integrating back office and support services. While these initiatives are in the early stages, some important results have been achieved.

- The Toronto Central LHIN Laboratory Collaborative continued to work towards creating one integrated, high-quality and efficient shared clinical lab service. The laboratories at University Health Network, the Hospital for Sick Children and Mount Sinai Hospital are beginning to integrate as a first step towards a LHIN-wide hospital lab integration. Once fully implemented, it is estimated that this integrated lab will yield annual savings of $15 to $16 million.
- The Toronto Central LHIN and the GTA Rehab Network Musculoskeletal Flow Group developed recommendations to reduce the time hip and knee surgery patients stay in hospital by providing safe, effective outpatient and community rehabilitation options. The target is to have 80 per cent of patients discharged home without inpatient rehabilitation hospitalization, up from 66 per cent.
- Providence Healthcare and Toronto East General Hospital (TEGH) integrated their pharmacy services to increase efficiencies and cut costs. Pharmacy-based preparation of intravenous medications, previously outsourced by Providence Healthcare to private manufacturers, is now being provided by TEGH's pharmacy department at a lower cost. This is the first step towards a larger pharmacy integration across the LHIN.

In addition to the Providence Healthcare and TEGH integration, there were two other voluntary integrations this past year:

- New Heights Community Health Centres merged with York Community Services to create Unison Health and Community Services. The goals are to:
  - Increase the proportion of clients receiving interdisciplinary care from 35% to 50% over the next three years;
  - Improve the services to clients with mental health conditions by more than 130% over the next three years;
  - Decrease wait times for clients; and
  - Reinvest savings from efficiencies into client care.
- CAMH partnered with Pilot Place Society and Homes First Society to create 35 to 40 high-support housing units for clients with schizophrenia. Living in the community not only contributes to the recovery of these clients, it is less expensive than institutional care.

Health Equity

The Toronto Central LHIN brings a health equity lens to everything we do. The LHIN's Integrated Health Service Plan priorities are designed to reduce gaps and disparities in care for specific populations.

The LHIN has undertaken a number of initiatives to improve health equity in the city.

- The Toronto Central LHIN's 18 hospitals updated their Health Equity Plans in 2010. Hospitals described how they are incorporating health equity into their organizations and the actions they will take to decrease disparities in their hospitals and communities.
- Last year, the community health centres opted to develop a collective health equity plan for the sector. The LHIN and community health centres have been working together this past year to understand and address the challenges of providing services to non-insured populations.
- In March 2011, the Ministry of Health and Long-Term Care launched the Health Equity Impact Assessment (HEIA) tool across the province. Developed in partnership with the Toronto Central LHIN, this tool assesses the impact of decisions and investments on different populations. Last year, the LHIN used the HEIA tool to assess proposals for Aging at Home and mental health and addictions supportive housing. The LHIN also included the tool in the last Hospital Service Accountability Agreements.
- In 2010, the LHIN asked the Hospital for Sick Children to lead the development of a Centralized Interpretation Model. This proposal is the first step towards a LHIN-wide interpretation system to increase the availability of language and interpretation services to non-English-speaking patients/clients in the LHIN.

eHealth

Over the past year, the Toronto Central LHIN made significant progress in harnessing the power of information technology to improve the local health care system.

Using the Toronto Central LHIN's **Resource Matching and Referral** (RM&R) system, hospitals, LTC homes and the CCAC are all using one centralized system to match people to the services that best meet their needs.

> "The system is a great improvement and saves me much time as a Director of Care in managing our bed vacancies. I am sure that all around this system will free up many professionals to use their expertise in providing improved care coordination for people moving into long-term care homes."
>
> – Martin Griffey, Director of Care
> *Maynard Nursing Home*

Benefits include a faster referral process, better access to appropriate care, and the ability to improve health equity by pinpointing those who are waiting and being denied access. RM&R is an answer to a number of the Auditor General's recent recommendations regarding improvements to the discharge planning process.

Recognizing its potential to improve patient transitions, the Ministry of Health and Long-Term Care has designated the Toronto Central LHIN to lead the implementation of RM&R province-wide.

In February 2011, LTC bed-level matching functionality was added to the RM&R system. This means that people waiting for LTC will be matched directly to vacant beds based on their personal profiles. In addition, in March 2011, RM&R began its expansion to community support services. The Toronto Central CCAC is now able to refer people more seamlessly to the 33 community support service agencies that make up the Community Navigation and Access Program (CNAP) network.

ConnectingGTA (cGTA) is a joint initiative of the five GTA LHINs to connect the disparate clinical information systems of organizations within the GTA.

A number of foundational activities began in 2010/11 which will produce clinical benefits in 2011/12. ConnectingGTA will allow 700 service providers to securely share patient health information across the five GTA LHINs, improving decision-making and patient care.

> "The ConnectingGTA project will benefit patients, clinicians, health care organizations and the health care system more broadly. It will allow clinicians to make decisions in real-time and enable collaboration amongst the whole health care team – from family physician to acute care specialist – resulting in better patient care."
>
> – Dr. Bob Bell, President and CEO
> *University Health Network*

G20 Summit

The Toronto Central LHIN led the health system planning and response for the G20 Summit for Toronto and the GTA. This involved:

- Creating a G20 health system planning team involving hospitals, the CCAC, community health centres, primary care, the Ministry of Health and Long-Term Care and leading clinicians. The team worked in partnership with GTA LHIN providers, the City of Toronto, the Toronto Police Service and others.
- Creating plans for various scenarios and running a system-wide simulation.
- Working with hospitals and the CCAC to create additional capacity to respond to emergency situations.
- Creating a groundbreaking online dashboard that provided stakeholders with real-time information as events unfolded during the G20. The British government has reviewed the Toronto Central LHIN's G20 dashboard as part of its planning for the upcoming Olympic Games.

Health System Performance and Accountability

In 2010/11, the Toronto Central LHIN met or performed better than our LHIN targets for cancer surgery, hip replacement, diagnostic CT scans and ER length of stay for non-admitted complex patients.

Innovations That Contributed to Successes

›› Cancer surgery

Despite an ever-increasing number of cancer patients being treated in Toronto Central LHIN hospitals, LHIN hospitals performed better than the wait time target for cancer surgery. This result is due to a collaborative effort spearheaded by Cancer Care Ontario, and hospitals and surgeons within the LHIN to improve processes and efficiencies and to ensure that surgeries are performed in the most appropriate place.

›› ER wait times for complex patients not admitted to hospital

Last year, the LHIN performed better than its ER wait time target for patients who have complex conditions

but are not admitted to hospital. The LHIN's ER Pay-for-Results working group brings together hospitals and community agencies to address the systemic causes of ER wait times. Health service providers are employing strategies including improving discharge planning, providing intensive case management to high-needs patients and improving the efficiency of the ER.

Areas for Improvement

In 2010/11, the Toronto Central LHIN did not meet its targets for a number of indicators.

›› Cataract Surgery

Patient demand for both routine and specialized cataract surgery continue to grow at a higher rate than the capacity within the LHIN. While the LHIN and stakeholders work on longer term solutions to this issue, we will pursue strategies to continually improve cataract surgery wait lists.

›› Knee Replacement Surgery

The Toronto Central LHIN is fortunate to have some of the best academic health care centres in the country with highly skilled specialists. However, one of the consequences of this is that our specialists and surgeons are often in high demand. The primary contributor to longer wait times for knee replacements within the Toronto Central LHIN is patient preference for specific surgeons as well as for highly specialized surgeries. If patients who elect to wait for a specific surgeon or surgical technique are removed from the data, the Toronto Central LHIN would be well within its target wait time for knee replacement surgeries.

Toronto Central LHIN Performance Indicators

* A negative percentage means the LHIN has met its target
** FY 2010/11 is based on only 2 quarters of data (Q1-Q2 2010/11) due to availability
*** FY 2010/11 is based on only 3 quarters of data (Q1-Q3 2010/11) due to availability

Performance Indicator	LHIN 10/11 Starting Point	LHIN 10/11 Performance Target	Most Recent Quarter 2010/11 LHIN Performance	Percent from Target for Most Recent Quarter Result*	FY 2010/11 LHIN Annual Result
90th Percentile Wait Times for Cancer Surgery	66	66	64	-3.0%	65
90th Percentile Wait Times for Cardiac By-Pass Procedures	44	44	59	34.1%	48
90th Percentile Wait Times for Cataract Surgery	100	100	114	14.0%	106
90th Percentile Wait Times for Hip Replacement	123	135	129	-4.4%	124
90th Percentile Wait Times for Knee Replacement	129	140	150	7.1%	125
90th Percentile Wait Times for Diagnostic MRI Scan	122	115	122	6.1%	132
90th Percentile Wait Times for Diagnostic CT Scan	38	35	35	0.0%	33
Percentage of Alternate Level of Care (ALC) Days – By LHIN of Institution***	11.20%	8.40%	10.49%	24.9%	10.78%
90th Percentile ER Length of Stay for Admitted Patients	30.20	25.00	29.38	17.5%	27.72
90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	9.50	8.30	8.13	-2.0%	8.20
90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	5.80	5.00	5.32	6.3%	5.12
Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions**	25.80%	23.22%	25.58%	10.2%	26.19%
Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions**	35.00%	32.00%	39.49%	23.4%	38.72%
Readmission within 30 Days for Selected CMGs**	16.20%	15.20%	19.60%	28.9%	18.67%

The LHIN is undertaking a number of strategies to address this challenge including having sought-after surgeons refer patients who do not require their type of surgery to other surgeons.

MRI Scans

The demand for MRI scans continues to grow faster than funding for this test. The Institute for Clinical Evaluative Sciences is undertaking a study on the appropriate use of MRIs that will support improved utilization of this technology and help reduce unnecessary scans.

Percentage of ALC Days

While the LHIN did not meet its target for percentage of ALC days, it has made great strides in reducing the number of ALC patients. Various actions to reduce ALC are outlined in this report.

ER Wait Times for Admitted Patients and Minor, Uncomplicated Patients

While the LHIN did not meet its wait time targets for ER visits by patients with complex conditions that need to be admitted to hospital and patients with minor or uncomplicated conditions, it did make steady improvements throughout the year.

In the year ahead, the Toronto Central LHIN and local health service providers will build on their successes so far and target the top causes of ER wait times through initiatives described earlier in this report.

Three new indicators:

- ER Visits Within 30 Days for Mental Health Conditions
- ER Visits Within 30 Days for Substance Abuse Conditions
- Readmission Within 30 Days for Elected CMGs or Case Mix Groups (specific groups of patients including congestive heart failure)

Performance on repeat unplanned ER visits within 30 days for selected mental health conditions and for substance abuse conditions are both slightly worse than the target. This is likely related to an overall increase in patient visits to Toronto Central LHIN ERs. The LHIN is investigating the specific cause of readmission rates for some groups of patients.

Looking Ahead

The accomplishments over the last year are the result of the combined efforts of health care organizations and agencies within the Toronto Central LHIN.

While tremendous improvements have been achieved, there remain many challenges to tackle and areas where we can do better.

In the year ahead, the LHIN will build on this success with an updated Strategic Plan designed to continually improve the quality of care provided in the Toronto Central LHIN.

The Ontario government's *Excellent Care for All* strategy makes quality improvement the central goal in the health care system. This is extremely important because higher quality and better value are what everyone wants in their health care system.

The LHIN is going to put a particular emphasis on the words "for all" in Excellent Care for All with initiatives designed to ensure that everyone benefits from a high standard of care.

Better quality and equitable health services are also more cost effective in the long run.

In the year ahead, we will further promote health system sustainability through focused strategies to improve the efficiency of the LHIN and the health care system.

In 2011/12, the LHIN looks forward to continuing our partnership with community members, health service providers, other LHINs and the Ministry of Health and Long-Term Care to ensure high quality and sustainable services in the Toronto Central LHIN for all residents and people who come here for care.

Our Board of Directors

Name	Position	Appointed	End of Term	Length of Term
Blickstead, Richard	Director	November 3, 2010	November 2, 2013	3 years
Coyles, Stephanie	Director	October 29, 2008	October 28, 2011	3 years
Everett, Babara	Director	May 17, 2006 June 16, 2007	June 16, 2007 June 15, 2010	13 months 3 years
Kennedy, Tom	Director	June 27, 2007 June 27, 2008	June 26, 2008 June 26, 2011	1 year 3 years
Ferrante, Angela	Chair	November 3, 2010	November 2, 2013	3 years
Komori, Lloyd	Director	August 21, 2008	August 20, 2011	3 years
Magill, Dennis	Director	March 7, 2007 March 7, 2010	March 6, 2010 March 6, 2013	3 years 3 years
Nott, Harley	Director	June 2, 2005 June 2, 2008	June 1, 2008 June 1, 2011	3 years 3 years
Virmani Kumar, Anju	Director	May 14, 2008 May 14, 2011	May 13, 2011 May 13, 2012	3 years 1 year

Richard Blickstead
Director

Stephanie Coyles
Director

Barbara Everett
Director

Tom Kennedy
Director

Angela Ferrante
Chair

Lloyd Komori
Director

Dennis Magill
Director

Harley Nott
Director

Anju Virmani Kumar
Director

Deloitte

Deloitte & Touche LLP
5140 Yonge Street
Suite 1700
Toronto ON M2N 6L7
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

Independent Auditor's Report

To the Members of the Board of Directors of the
Toronto Central Local Health Integration Network

We have audited the accompanying financial statements of the Toronto Central Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2011, and the statements of financial activities, changes in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2011, and the results of its financial activities, changes in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 30, 2011

Toronto Central Local Health Integration Network

Statement of financial position
as at March 31, 2011

	2011	2010
	$	$
Financial assets		
Cash	**1,618,218**	2,117,680
Due from Local Health Integration Networks ("LHINs") (Note 3)	**190,390**	33,172
Due from Ministry of Health and Long-Term Care ("MOHLTC") regarding HSP transfer payments	**59,651,414**	2,333,699
HST receivable	**322,081**	-
	61,782,103	4,484,551
Liabilities		
Accounts payable and accrued liabilities	**2,192,348**	2,089,583
Due to HSPs	**59,651,414**	2,333,699
Due to MOHLTC (Note 4b)	**30,837**	46,070
Deferred revenue	**-**	66,700
Deferred capital contributions (Note 5)	**465,091**	783,608
	62,339,690	5,319,660
Net debt	**557,587**	835,109
Non-financial assets		
Prepaid expenses	**92,496**	51,501
Capital assets (Note 6)	**465,091**	783,608
	557,587	835,109
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

Toronto Central Local Health Integration Network

Statement of financial activities
year ended March 31, 2011

	Budget (Unaudited) (Note 7)	2011 Actual	2010 Actual
	$	$	$
Revenue			
Ministry of Health and Long-Term Care ("MOHLTC") funding	**5,818,921**	**5,773,491**	5,732,821
MOHLTC Funding to LHIN Collaborative (LHINC) (Note 20)	**670,000**	**670,000**	670,000
Health Service Provider ("HSP") transfer payments (Note 8)	**4,210,305,000**	**4,364,963,326**	4,200,566,501
E-Health (Note 9)	**600,000**	**710,000**	600,000
Emergency Department ("ED") Leads (Note 10)	**75,000**	**75,000**	75,000
Diabetes Strategy (Note 11)	**-**	**-**	95,000
Aboriginal Health Transition Planning (Note 12)	**49,600**	**49,600**	63,500
Emergency Room and Alternate Level of Care (ER/ALC) (Note 13)	**100,000**	**100,000**	100,000
Critical Care (Note 14)	**-**	**75,000**	-
Resources Matching Referrals (Note 15)	**-**	**200,000**	-
French Language Health Services (Note 16)	**-**	**141,400**	-
French Planning Entities (Note 17)	**-**	**192,178**	-
Amortization of deferred capital contributions (Note 5)	**-**	**363,948**	781,191
Amounts recovered/recoverable from the LHINs for LHINC (Note 20)	**700,000**	**683,000**	159,714
Amounts recovered/recoverable from the LHINs for LSSO	**5,032,924**	**4,823,435**	4,161,756
	4,223,351,445	**4,378,820,378**	4,213,005,483
Expenses			
Transfer payments to HSPs (Note 8)	**4,210,305,000**	**4,364,963,326**	4,200,566,501
General and administrative (Note 18)	**5,818,921**	**5,785,344**	6,102,387
LHIN Shared Services Office expense (Note 19)	**5,032,924**	**5,174,815**	4,572,366
LHIN Collaborative (Note 20)	**1,370,000**	**1,353,000**	829,714
E-Health (Note 9)	**600,000**	**710,000**	600,000
Emergency Department ("ED") Leads (Note 10)	**75,000**	**75,000**	75,000
Diabetes Strategy and Diabetes Registry (Note 11)	**-**	**-**	95,000
Aboriginal Health Transition Planning (Note 12)	**49,600**	**49,600**	63,500
Emergency Room and Alternate Level of Care (ER/ALC) (Note 13)	**100,000**	**100,000**	100,000
Critical Care (Note 14)	**-**	**75,000**	-
Resources Matching Referrals (Note 15)	**-**	**200,000**	-
French Language Health Services (Note 16)	**-**	**111,278**	-
French Planning Entities (Note 17)	**-**	**192,178**	-
	4,223,351,445	**4,378,789,541**	4,213,004,468
Annual surplus before funding repayable to the MOHLTC	**-**	**30,837**	1,015
Funding repayable to the MOHLTC (Note 4a)	**-**	**(30,837)**	(1,015)
Annual surplus	**-**	**-**	-
Opening accumulated surplus	**-**	**-**	-
Closing accumulated surplus	**-**	**-**	-

Toronto Central Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2011

	Budget (Unaudited) (Note 7)	2011	2010
	$	$	$
Annual surplus	-	-	-
Acquisition of capital assets	-	**(45,431)**	(579,480)
Amortization of capital assets	-	**363,948**	781,191
Change in other non-financial assets	-	**(40,995)**	(23,275)
Increase in net debt	-	**277,522**	178,436
Opening net debt	-	**(835,109)**	(1,013,545)
Closing net debt	-	**(557,587)**	(835,109)

Toronto Central Local Health Integration Network

Statement of cash flows
year ended March 31, 2011

	2011	2010
	$	$
Operating transactions		
Annual surplus	-	-
Less: items not affecting cash		
Amortization of capital assets	**363,948**	781,191
Amortization of deferred capital contributions (Note 5)	**(363,948)**	(781,191)
	-	-
Changes in non-cash operating items		
(Increase) decrease in due from LHINs	**(157,218)**	239,725
(Increase) in accounts receivable	**(322,080)**	-
(Increase) decrease in due from MOHLTC regarding transfer payments	**(57,317,715)**	8,522,284
Increase (decrease) in accounts payable and accrued liabilities	**102,764**	(42,972)
Increase (decrease) in due to HSPs	**57,317,715**	(8,522,284)
(Decrease) increase in due to MOHLTC	**(15,233)**	45,520
(Decrease) increase in deferred revenue	**(66,700)**	40,750
(Increase) in prepaid expenses	**(40,995)**	(23,275)
	(499,462)	259,748
Capital transactions		
Acquisition of capital assets	**(45,431)**	(579,480)
Financing transactions		
Increase in deferred capital contributions (Note 5)	**45,431**	579,480
Net change in cash	**(499,462)**	259,748
Cash, beginning of year	**2,117,680**	1,857,932
Cash, end of year	**1,618,218**	2,117,680

Toronto Central Local Health Integration Network

Notes to the financial statements
March 31, 2011

1. Description of business

The Toronto Central Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Toronto Central Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2011.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the City of Toronto. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital assets and losses in the value of assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN financial statements do not include any MOHLTC managed programs.

2. **Significant accounting policies (continued)**

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are initially recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Office furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

For assets acquired or brought into use during the year, amortization is calculated for a full year.

Segmented financial reporting

The financial statements of the LHIN include the accounts of its LSSO and LHINC divisions. Separate schedules of LSSO and LHINC financial position and financial activities are presented in the attached schedules to the financial statements.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) to (from) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

The LHIN Collaborative (the "LHINC") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LHINC is responsible for providing advice to all LHINs in the areas of planning integration and community engagement, allocation methodologies, accountability performance and system alignment and co-ordination. Any portion of the LHINC operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) to (from) the LHINC. This is all done pursuant to the LHINC Agreement the LHINC has with all the LHINs.

4. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a. The amount repayable to the MOHLTC related to the current activities is made up of the following components:

	Revenue	Expenses	2011 Surplus	2010 Surplus
	$	$	$	
Transfer payments to HSPs	4,364,963,326	4,364,963,326	-	-
LHIN operations	5,786,059	5,785,344	715	1,015
LHINC	670,000	670,000	-	-
E-Health	710,000	710,000	-	-
ED Leads	75,000	75,000	-	-
Diabetes strategy	-	-	-	-
Aboriginal Health Transition Planning	49,600	49,600	-	-
ER/ALC	100,000	100,000	-	-
Critical Care Leads	75,000	75,000	-	-
ALC Resources Matching	200,000	200,000	-	-
FLHS	141,400	111,278	30,122	-
French Planning Entities	192,178	192,178	-	-
	4,372,962,563	4,372,931,726	30,837	1,015

b. The amount due to the MOHLTC at March 31 is made up as follows:

	2011	2010
	$	$
Due to MOHLTC, beginning of year	(46,070)	(550)
MOHLTC payment	46,070	-
Funding repayable to the MOHLTC		(44,505)
Funding repayable to the MOHLTC related to current year activities (Note 4a)	(30,837)	(1,015)
Due to MOHLTC, end of year	(30,837)	(46,070)

5. Deferred capital contributions

	2011	2010
	$	$
Balance, beginning of year	**783,608**	985,319
Capital contributions received during the year	**45,431**	579,480
Amortization for the year	**(363,948)**	(781,191)
Balance, end of year	**465,091**	783,608

6. Capital assets

			2011	2010
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office furniture and fixtures	**251,685**	**251,685**	**-**	12,568
Computer equipment	**2,060,966**	**1,600,573**	**460,393**	765,168
Leasehold improvements	**1,261,883**	**1,257,185**	**4,698**	5,872
	3,574,534	**3,109,443**	**465,091**	783,608

7. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the Statement of Financial Activities reflect the initial budget at April 1, 2010. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approves budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $4,364,963,326 is made up of the following:

	$
Initial HSP Funding budget	4,210,305,000
Adjustment due to announcements made during the year	154,658,326
Total HSP Funding budget	4,364,963,326

The total operating budget excluding HSP Funding of $6,643,521 and French Planning entities is made up of the following:

	$
Initial budget	5,818,921
Additional funding received during the year for:	
E-Health	600,000
Emergency Department Leads	75,000
Aboriginal Health Transition Planning	49,600
Emergency Room and Alternative Level of Care (ER/ALC) (Note 13)	100,000
Total budget	6,643,521

8. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $4,364,963,326 (2010 - $4,200,566,501) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in fiscal 2011 as follows:

	2011	2010
	$	$
Operation of hospitals	**3,402,000,919**	3,284,060,297
Grants to compensate for municipal taxation - public hospitals	**743,250**	736,800
Long-term care homes	**237,332,764**	233,431,076
Community care access centres	**205,621,957**	184,791,680
Community support services	**44,287,376**	43,192,053
Assisted living services in supportive housing	**43,964,652**	42,116,912
Community health centres	**77,213,192**	72,497,865
Community mental health addictions program	**93,891,490**	89,763,672
Addictions program	**24,420,104**	22,553,652
Specialty psychiatric hospitals	**235,443,072**	227,377,944
Grants to compensate for municipal taxation - psychiatric hospitals	**44,550**	44,550
	4,364,963,326	4,200,566,501

9. E-Health

The LHIN received funding of $710,000 (2010 - $600,000) related to the E-Health project. E-Health expenses incurred during the year are as follows:

	2011	2010
	$	$
Salaries and benefits	**512,047**	588,575
Translation services	**1,463**	1,055
Consulting services	**92,750**	-
Other	**103,740**	10,370
	710,000	600,000

10. Emergency Department ("ED") Leads

The LHIN received funding of $75,000 (2010 - $75,000) related to the ED Leads project. ED Leads expenses incurred during the year are as follows:

	2011	2010
	$	$
Salaries and benefits	**1,400**	15,000
Consulting services	**69,000**	60,000
Other	**4,600**	-
	75,000	75,000

11. Diabetes Strategy and Diabetes Registry

In the prior year, the LHIN was provided with funding from the MOHLTC for Diabetes Strategy and Diabetes Registry Program for the amount of $95,000.

12. Aboriginal Health Transition Planning

The LHIN received funding of $49,600 (2010 - $63,500) related to the Aboriginal Health Transition Planning Project. Aboriginal Health Transition Planning expenses incurred during the year are as follows:

	2011	2010
	$	$
Salaries and benefits	**44,146**	59,285
Consulting services	**-**	2,265
Other	**5,454**	1,950
	49,600	63,500

13. Emergency Room and Alternate Level of Care (ER/ALC)

During the year, the LHIN was provided funding of $100,000 (2010 - $100,000) from the MOHLTC for the ER/ALC program. The LHIN incurred $100,000 (2010 - $100,000) ER/ALC expenses related to salaries and benefits.

14. Critical Care (CC) Leads

During the year, the LHIN received funding of $75,000 (2010 - Nil) related to the Critical Care Leads project. CC Leads expenses incurred during the year are as follows,

	2011	2010
	$	$
Salaries and benefits	**1,869**	-
Consulting services	**72,750**	-
Other	**381**	-
	75,000	-

15. Alternate Level of Care (ALC) Resources Matching Referrals Leads (ALC RMR)

During the year, the LHIN was provided funding of $200,000 (2010 - Nil) from the MOHLTC for the ALC RMR project. ALC RMR expenses incurred during the year are as follows:

	2011	2010
	$	$
Salaries and benefits	**199,985**	-
Other	**15**	-
	200,000	-

16. French Language Health Services (FLHS)

During the year, the LHIN was provided funding of $141,400 (2010 - Nil) from the MOHLTC for the French Language Health Services program. FLHS expenses incurred during the year as follows:

	2011	2010
	$	$
Salaries and benefits	46,369	-
Translation services	29,554	-
Consulting services	5,750	-
Other	29,605	-
	111,278	-

17. French Panning Entities

During the year, the LHIN was provided funding of $192,178 (2010 - Nil) from the MOHLTC for the French Planning Entities which include $50,000 one–time funding for start up cost related to establishing the "Entité de planification pour les services de santé en français de Toronto Centre". The fund flowed directly to "Entité de planification pour les services de santé en français de Toronto Centre".

18. General and administrative expenses

The Statement of Financial Activities presents the expenses by function, the following classifies general and administrative expenses by object:

	2011	2010
	$	$
Salaries and benefits	4,519,036	4,430,938
Occupancy	258,548	265,333
Amortization	12,568	370,580
Shared services	305,695	362,714
LHINC	50,000	12,286
Public affairs and communications	9,256	44,494
Consulting services	220,914	72,522
Translation services	9,393	33,890
Professional services	23,645	39,624
Supplies	83,266	102,557
Governance	55,866	104,554
Mail, courier and telecommunications	48,697	63,586
Other	188,460	199,309
	5,785,344	6,102,387

The following lists the Board Chair and Directors per diem costs as well as their travel which are included in governance expense in the general and administrative expenses above.

		2011	2010
	Budget	Actual	Actual
	$	$	$
Board Chair per diem cost	54,600	22,475	34,225
Directors per diem cost	103,500	32,100	66,325
Board travel	6,900	1,291	4,004
	165,000	55,866	104,554

19. Common LHIN services expenses

The Statement of Financial Activities presents the common LHIN services expenses by function, the following classifies the same expenses by object:

	2011	2010
	$	$
Salaries	1,556,568	1,093,259
Benefits	222,066	137,687
Supplies	29,620	31,489
Telecommunications	17,312	22,000
Recruitment and staff development	10,294	60,417
Computer expense	508,995	663,941
Consulting fees	606	262,800
Professional services	15,099	34,904
Meeting expenses	4,806	2,444
Amortization	351,380	410,610
Occupancy	180,770	103,490
Other	59,673	34,106
Shared services	2,577,121	2,077,933
Total common LHIN services expenses	5,534,310	4,935,080
Less: inter-entity transactions eliminated on combination	(359,495)	(362,714)
	5,174,815	4,572,366

20. Collaborative LHIN services expenses

The Statement of Financial Activities presents the collaborative LHIN services expenses by function; the following classifies the same expenses by object:

LHINC receives $670,000 funding from MOHLTC and the balance of the revenue from all the LHINs. Costs allocation is based on the percentage proportionate on the funding received.

			2011	2010
	LHINs	MOHLTC	Total	Total
	$	$	$	$
Salaries	517,094	472,651	989,745	325,387
Benefits	126,654	115,768	242,422	82,394
Supplies	1,188	1,086	2,274	6,337
Telecommunications	20,207	18,470	38,677	35,785
Recruitment and staff development	1,998	1,827	3,825	48,634
Computer expense	3,519	3,215	6,734	83,692
Consulting fees	8,645	7,902	16,547	206,815
Meeting expenses	13,287	12,145	25,432	7,584
Occupancy	36,906	33,734	70,640	40,299
Other	3,502	3,202	6,704	5,073
	733,000	670,000	1,403,000	842,000
Less: inter-entity transactions eliminated on combination	(50,000)	-	(50,000)	(12,286)
	683,000	670,000	1,353,000	829,714

21. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 62 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2011 was $ 467,710 (2010 - $379,969) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan as of December 31, 2009. At that time, the plan was fully funded.

22. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

23. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due over the next five fiscal years are as follows:

	$
2012	601,462
2013	615,932
2014	633,985
2015	653,012
2016	334,090

The LHIN also has funding commitments to some HSPs associated with accountability agreements for fiscal 2012 and 2013.

Toronto Central Local Health Integration Network

Combined statement of financial position and financial activities by division - Schedule 1
year ended March 31, 2011

	2011	2010	2011	2010	2011	2010	2011	2010
	Toronto Central		Shared Services Office		Collaborative		Total	Total
	$	$	$	$	$	$	$	$
Financial assets								
Cash	**936,490**	650,198	**457,810**	1,364,852	**223,918**	102,630	**1,618,218**	2,117,680
Due from the LHIN Shared Services Office*	**98,762**	187,628	**-**	-	**-**	-	**98,762**	187,628
Due from Local Health Integration Network ("LHIN")	**-**	-	**157,390**	33,172	**33,000**	-	**190,390**	33,172
Due from the LHIN Collaborative*	**12,744**	67,805	**-**	-	**-**	-	**12,744**	67,805
Due from Ministry of Health and Long-Term Care ("MOHLTC")	**-**	-	**-**	-	**-**	-	**-**	-
Due from MOHLTC regarding HSP transfer payments	**59,651,414**	2,333,699	**-**	-	**-**	-	**59,651,414**	2,333,699
HST receivable	**90,033**	-	**226,367**	-	**5,681**	-	**322,081**	-
	60,789,443	3,239,330	**841,567**	1,398,024	**262,599**	102,630	**61,893,609**	4,739,984
Liabilities								
Accounts payable and accrued liabilities	**1,160,887**	796,181	**695,426**	1,258,577	**336,034**	34,825	**2,192,348**	2,089,583
Due to TC LHIN*	**-**	-	**98,762**	187,628	**12,744**	67,805	**111,506**	255,433
Due to LHINC*	**-**	-	**85,736**	-	**(85,736)**	-	**-**	-
Due to HSPs	**59,651,414**	2,333,699	**-**	-	**-**	-	**59,651,414**	2,333,699
Deferred revenue	**-**	66,700	**-**	-	**-**	-	**-**	66,700
Deferred capital contributions	**45,430**	12,568	**419,661**	771,040	**-**	-	**465,091**	783,608
Due to Ministry of Health and Long-Term Care ("MOHLTC")	**30,837**	46,070	**-**	-	**-**	-	**30,837**	46,070
	60,888,568	3,255,218	**1,299,585**	2,217,245	**263,042**	102,630	**62,451,196**	5,575,093
Net debt	**(99,125)**	(15,888)	**(458,018)**	(819,221)	**(444)**	-	**(557,587)**	(835,109)
Non-financial assets								
Prepaid expenses	**53,695**	3,320	**38,357**	48,181	**444**	-	**92,496**	51,501
Capital assets	**45,430**	12,568	**419,661**	771,040	**-**	-	**465,091**	783,608
Accumulated surplus	**-**	-	**-**	-	**-**	-	**-**	-

* Amounts due from the LHIN Shared Services Office, due from the LHINC and due to TC LHIN are eliminated upon combination.

Toronto Central Local Health Integration Network

Combined statement of financial position and financial activities by division - Schedule I (continued) year ended March 31, 2011

	2011		2010	2011		2010	2011		2010	2011	2010
	Toronto Central Operations			Shared Services Office			Collaborative				
	Budget	Actual	Actual	Budget	Actual	Actual	Budget	Actual	Actual	Total	Total
	$	$	$	$	$	$	$	$	$	$	$
Revenue											
Amounts recovered/recoverable from the LHINs*	-	-	-	5,032,924	5,182,930	4,524,470	700,000	733,000	172,000	5,915,930	4,696,470
MOHLTC funding	5,818,921	5,773,491	5,732,821	-	-	-	670,000	670,000	670,000	6,443,491	6,402,821
HSP transfer payments (Note 8)	4,210,305,000	4,364,963,326	4,200,566,501	-	-	-	-	-	-	4,364,963,326	4,200,566,501
E-Health funding (Note 9)	600,000	710,000	600,000	-	-	-	-	-	-	710,000	600,000
Emergency Department ("ED") Leads (Note 10)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Diabetes Strategy (Note 11)	-	-	95,000	-	-	-	-	-	-	-	95,000
Aboriginal Health Transition Planning (Note 12)	49,600	49,600	63,500	-	-	-	-	-	-	49,600	63,500
Emergency Room and Alternate Level of Care (ER/ALC) (Note 13)	-	100,000	100,000	-	-	-	-	-	-	100,000	100,000
Critical Care (Note 14)	100,000	75,000	-	-	-	-	-	-	-	75,000	-
Resources Matching Referrals (Note 15)	-	200,000	-	-	-	-	-	-	-	200,000	-
French Language Health Services (Note 16)	-	141,400	-	-	-	-	-	-	-	141,400	-
French Planning Entities (Note 17)	-	192,178	-	-	-	-	-	-	-	192,178	-
Amortization of deferred capital contributions (Note 5)	-	12,568	370,581	-	351,380	410,610	-	-	-	363,948	781,191
	4,216,948,521	4,372,292,563	4,207,603,403	5,032,924	5,534,310	4,935,080	1,370,000	1,403,000	842,000	4,379,229,873	4,213,380,483
Expenses											
General and administrative (Note 18)	5,818,921	5,785,344	6,102,387	-	-	-	-	-	-	5,785,344	6,102,387
Common LHIN Services*	-	-	-	5,032,924	5,534,310	4,935,080	-	-	842,000	5,534,310	5,777,080
LHIN Collaborative (Note 20)	-	-	-	-	-	-	1,370,000	1,403,000	-	1,403,000	-
Transfer payments to HSPs (Note 8)	4,210,305,000	4,364,963,326	4,200,566,501	-	-	-	-	-	-	4,364,963,326	4,200,566,501
E-Health (Note 9)	600,000	710,000	600,000	-	-	-	-	-	-	710,000	600,000
Emergency Department ("ED") Leads (Note 10)	75,000	75,000	75,000	-	-	-	-	-	-	75,000	75,000
Diabetes Strategy and Diabetes Registry (Note 11)	-	-	95,000	-	-	-	-	-	-	-	95,000
Aboriginal Health Transition Planning (Note 12)	49,600	49,600	63,500	-	-	-	-	-	-	49,600	63,500
Emergency Room and Alternate Level of Care (ER/ALC) (Note 13)	100,000	100,000	100,000	-	-	-	-	-	-	100,000	100,000
Critical Care (Note 14)	-	75,000	-	-	-	-	-	-	-	75,000	-
Resources Matching Referrals (Note 15)	-	200,000	-	-	-	-	-	-	-	200,000	-
French Language Health Services (Note 16)	-	111,278	-	-	-	-	-	-	-	111,278	-
French Planning Entities (Note 17)	-	192,178	-	-	-	-	-	-	-	192,178	-
	4,216,948,521	4,372,261,726	4,207,602,388	5,032,924	5,534,310	4,935,080	1,370,000	1,403,000	842,000	4,379,199,036	4,213,379,468
Annual surplus before funding surplus repayable	-	30,837	1,015	-	-	-	-	-	-	30,837	1,015
Funding surplus repayable to the MOHLTC (Note 4(a))	-	(30,837)	(1,015)	-	-	-	-	-	-	(30,837)	(1,015)
Opening accumulated surplus	-	-	-	-	-	-	-	-	-	-	-
Closing accumulated surplus	-	-	-	-	-	-	-	-	-	-	-

* These amounts have been adjusted by $359,495 related to Toronto Central LHIN transactions. These numbers reflect LSSO operations on behalf of all 14 LHINs (Note 19
* These amounts have been adjusted by $50,000 related to Toronto Central LHIN transactions. These numbers reflect LHINC operations on behalf of all 14 LHINs (Note 20

Local Health Integration Network
Local Shared Services Office

Schedule of financial position and financial activities - Schedule II
year ended March 31, 2011

	2011	2010
	$	$
Financial assets		
Cash	**457,810**	1,364,852
Due from LHINs	**157,390**	33,172
HST receivable	**226,367**	-
	841,567	1,398,024
Liabilities		
Accounts payable and accrued liabilities	**695,426**	1,258,577
Due to TC LHIN*	**98,762**	187,628
Due to LHINC*	**85,736**	-
Deferred capital contribution	**419,661**	771,040
	1,299,585	2,217,245
Net debt	**(458,018)**	(819,221)
Non-financial assets		
Prepaid expenses	**38,357**	48,181
Capital assets	**419,661**	771,040
Accumulated surplus	**-**	-

		2011	2010
	Budget (Unaudited)		
	$	$	$
Revenue			
Amounts recovered/recoverable from the LHINs	**5,032,924**	**5,182,930**	4,524,470
Amortization of deferred capital contributions	**-**	**351,380**	410,610
	5,032,924	**5,534,310**	4,935,080
Expenses			
Common LHIN Services	**5,032,924**	**5,534,310**	4,935,080
Annual surplus	**-**	**-**	-

* Amounts due to TCLHIN and LHINC are eliminated upon consolidation.

Local Health Integration Network
LHIN Collaborative (LHINC)

Schedule of financial position and financial activities - Schedule III
year ended March 31, 2011

	2011	2010
	$	$
Financial assets		
Cash	**223,918**	102,630
Due from Local Health Integration Network ("LHIN")	**33,000**	-
HST receivable	**5,681**	-
Due from LSSO*	**85,736**	-
	348,335	102,630
Liabilities		
Accounts payable and accrued liabilities	**336,035**	34,825
Due to TC LHIN*	**12,744**	67,805
	348,779	102,630
Net debt	**(444)**	-
Non-financial assets		
Prepaid expenses	**444**	-
Accumulated surplus	**-**	-

		2011	2010
	Budget (Unaudited)	Actual	Actual
	$	$	$
Revenue			
Amounts recovered/recoverable from the LHINs	**700,000**	**733,000**	172,000
MOHLTC funding	**670,000**	**670,000**	670,000
	1,370,000	**1,403,000**	842,000
Expenses			
Collaborative LHIN expenses	**1,370,000**	**1,403,000**	842,000
Annual surplus	**-**	**-**	-

* Amounts due from the LHIN Shared Services office and due to TC LHIN are eliminated upon consolidation.