North East
LOCAL HEALTH INTEGRATION NETWORK

ANNUAL REPORT 2006-07

Health and Wellness for All

Ontario

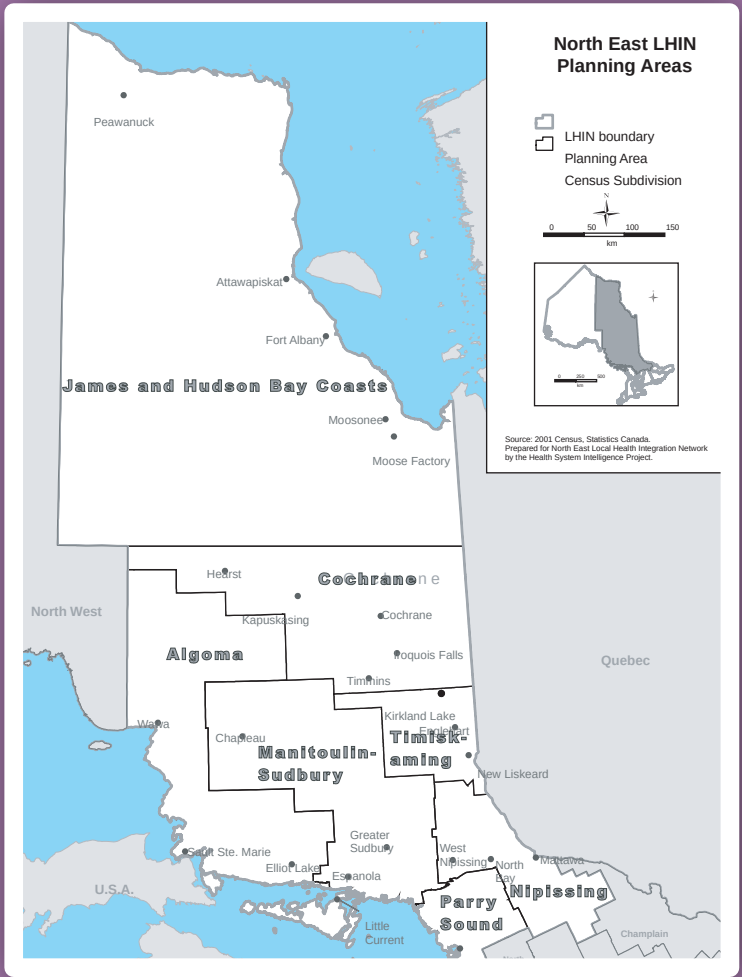
ISSN 1911-2955 Annual Report (North East Local Health Integration Network)

Welcome to the North East LHIN

The North East LHIN is home to close to 550,000 individuals. It is the second largest LHIN geographically in Ontario, covering 400,000 square kilometres or nearly 42 per cent of the province's land mass. About 57 per cent of the population lives in the larger centres of Sudbury, Sault Ste Marie, North Bay and Timmins. The remainder of the residents are spread out in rural and isolated communities, mainly along the Highway 11 and 17 corridors and the James Bay and Hudson Bay Coasts.

The North East LHIN is a culturally and linguistically vibrant and distinct region. It has the largest number of French-speaking communities in the province, with francophones comprising 25 per cent of the region's population. Aboriginal and First Nations communities make up 8 per cent of the North East region.

The North East LHIN has the mandate to locally lead the transformation of the health system. It is responsible for planning, funding and coordination for over 200 health care services in the North East.



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Message from Chair and CEO

There have been some great and exciting accomplishments during this start up year for the North East LHIN.

First, the North East LHIN proceeded in June with the official opening of its office at 555 Oak Street in North Bay. Beginning the year with four staff members we gradually moved towards filling our full staff complement of twenty one under two departments: 1) Planning, Integration and Community Engagement; 2) Performance, Contracts and Allocations. With the full complement of Board members achieved during this current year, Board of Directors meetings were held on a monthly basis in open public settings and in different communities.

Following an extensive and inclusive community stakeholder engagement strategy, the Board of Directors adopted on December 15, 2006, the North East LHIN Health Integration Service Plan (IHSP) which set the following priorities for our health care system:

- First Nations and Aboriginal Health Services;
- Chronic Disease Prevention Management;
- Coordinated Information and Communication Technology System and Information Management;
- French Language Health Services;
- Health Human Resources Needs;
- Primary Care Reform; and
- Reduced Wait Times.

The Board of Directors has set the course for the North East LHIN Corporation to guide the work of Board members and staff by developing clear Vision and Mission statements as follow:

Vision: Health and wellness for all
Mission: To create a system that is innovative, sustainable and accountable

Finally, the North East LHIN has set the strategic directions and operational plan to lead, engage, enable and empower the North East LHIN stakeholders in the delivery of the health care system priorities as identified above.

The North East LHIN Operational Plan integrates the participation of all stakeholders on an ongoing basis in shaping the health care system to answer the health care needs of the North East population.

It will do so through the following structures in each of the seven planning areas as identified in the IHSP:

- Stakeholder Groups constituted of community, health professionals, policy makers, health providers and academic institutions to recommend health care system improvements;
- Governance Forums constituted of trustees representing all health care providers to set the system strategic directions on a yearly basis;
- Health System CEO Round Tables constituted of CEOs representing all health care sectors to implement the system strategic directions and to address operational issues during the fiscal year.

Those strategic accomplishments would not have been possible without the great collaboration, commitment and contributions of North East LHIN stakeholders, Board members and staff. For this, we thank you sincerely.

Mathilde Gravelle Bazinet
Chair

Rémy Beaudoin
CEO

Our Leadership Team

Mathilde Gravelle Bazinet (North Bay)

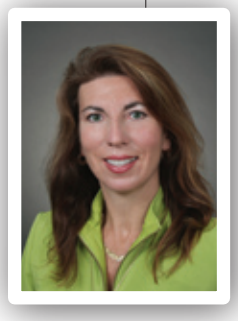
Board Chair
Term: June 8, 2005 to June 7, 2008

Mathilde Gravelle Bazinet, a member of the Law Society of Ontario, entered the law profession after a successful twenty year career in the field of Nursing Education and Health Care Administration at the community college and university level within the Provincial and Federal Public Sector. Ms. Bazinet has served on numerous professional Committees, Boards, and Commissions. Among others are: Ontario Health Review Panel (Evans Commission), Ottawa-Carleton Regional District Health Council, University of Ottawa, Faculty of Medicine – Postgraduate Education Committee, Loeb Medical Research Institute and North Bay's St. Joseph's Hospital Board. In June 2004, she was appointed Commissioner for Ontario Northland Transportation Commission. In June 2005, she was appointed the Founding Chair of the North East Local Health Integration Network. Ms. Bazinet is the author of several publications in the field of Conflict Resolution, Health Care Administration, and Emergency Services.

Margaret Ashcroft (Sudbury) Vice-Chair

Term: May 17, 2006 to May 31, 2008

Margaret Mary Ashcroft was employed for 26 years with the Sudbury Catholic District School Board in the capacity of principal, vice-principal, and teacher. Her community involvement includes past chair and member of the Executive Committee at St. Joseph's Health Centre. From 1993 to 1997, Ashcroft served as a board member with the Sudbury General Hospital. She was also one of the original co-chairs of the Luncheon for Breast Cancer Research. Margaret is currently a member of the Executive Committee of the Board of Regents of the University of Sudbury.



Kim Christianson (Hearst)

Term: May 17, 2006 to June 16, 2007

Kim has worked as a registered dental hygienist in private practice. She is presently enrolled in a PhD in Population Health program with the University of Ottawa. Kim has been involved with the Hearst Hôpital Notre Dame Hospital as a board director and treasurer, as a board director on the Foyer des Pionniers, on the College of Dental Hygienist's of Ontario Quality Assurance and Discipline committees, board director on the Ontario Dental Hygiene Association, chair of the Hearst Breastfeeding Coalition and Constance Lake First Nations Tooth Decay Prevention, member on the Hearst Health Professional Recruitment committee, on the Hearst Community Living Association board, member on the District Health Council Cochrane district board and president of the Pavillon-Notre Dame and St-Louis Catholic Schools parent councils.

Marc Dumont (Temiskaming Shores)

Term: May 17, 2006 to June 16, 2010

Marc Dumont has had a long career in education. He has been a teacher, Vice-Principal and Principal at École Secondaire Ste-Marie in New Liskeard. Marc has worked for the Conseil scolaire catholique des Grandes Rivières as a Strategic Planner, and for the Ministry of Education as an Education Officer in the North Bay/Sudbury areas. Marc was a Teaching Assistant for the Laurentian University Faculty of Education. He has served on the Board of the Temiskaming Hospital and as Regional President of the Foundation at the Collège Boréal. Marc also served as Chairperson of the Board of the Centre de santé communautaire du Témiskaming.

Johanne Labonté (Timmins)

Term: February 5, 2006 to February 4, 2010

Since early 2006, Johanne Labonté has been employed with the Conseil scolaire catholique du district des Grandes Rivières in the capacity of Financial Operations Administrator. From 2000-2006, Johanne worked with the Northeastern Ontario Medical Education Corporation in the

role of Community Development Officer. In 1995, Johanne joined the founding team of the Centre de santé communautaire du Temiskaming. She was appointed Chair of the Northeast Northern Development Council in February 2005. Johanne has served as president of the Porcupine Big Brothers and Big Sisters Association from 2001 – 2005 and is also A Big Sister. She also served as a Director with Collège Boréal Board of Governors and the Centre de counselling familiale de Timmins.

Randy Kapashesit (Moose Factory)

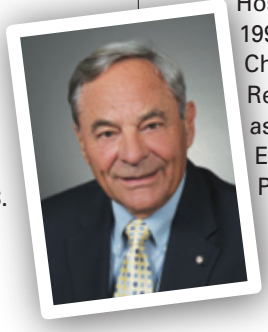
Term: September 20, 2006 to September 19, 2009

Randy Kapashesit has been the Chief of the MoCreebec Council of the Cree Nation since 1987. Mr. Kapashesit has held positions as Coordinator of the Cree Village Ecolodge, Program Coordinator of the Queen's University Weeneebayko Program and Consultant of the Traditional Medicine Study at the Weeneebayko General Hospital. His community involvement includes serving as President of the Weeneebayko Eeyou Association (Charitable Organization), Board Chair of the Cree Village Ecolodge, and Commissioner on the Ontario Northland Transportation Commission.

Claus W. Ott (Elliot Lake)

Term: January 5, 2006 to January 4, 2008

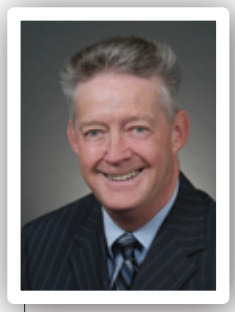
Claus W. Ott has been a Certified Management Accountant since 1968. During his tenure with Dunlop and Uniroyal, Claus has held positions in management and finance until 1969. In 1969, he started an inner tube manufacturing company. As part owner, he served as Vice-President of Finance and Secretary Treasurer for Trent Rubber Group of Companies until 1992. From 1992-2004, he served as Corporate Vice-President overseeing operations with an emphasis on merger and acquisitions. For 10 years, Claus served as Vice-Chair and Treasurer on the Board of Governors at Ross Memorial Hospital in Lindsay, Ontario. Claus is an active Rotarian, past President, who was named Paul Harris Fellow for his support of the organization's educational program.



Dr. Donald Stemp (North Bay)

Term: May 17, 2006 to May 15, 2008

Dr. Donald Stemp received his medical degree from the University of Toronto in 1967. Dr. Stemp practiced medicine in Caledonia, Ontario, 1968-1969 and in Prince George, British Columbia, 1969-1972. Since 1972, he has been in general practice in North Bay, Ontario. Within the North Bay community, Dr. Stemp has served in many capacities at Nipissing University College. Dr. Stemp was Chief of Staff at the North Bay General Hospital from 1996 to1999. From 1996 to the present, he has been Vice-Chair of the Terry McKerrow CT Fund. Recently Dr. Stemp has been involved as an interviewer for the North Eastern Family Practice Residency Program.



Peter Vaudry (Sault Saint Marie)

Term: May 17, 2006 to May 31, 2008

Peter Vaudry is a retired steel worker and was employed at Algoma Steel for 37 years. His past community involvement includes being Chair, Ontario Division Board of Directors at the Canadian Cancer Society, as well as, past board member of Cancer Care Ontario and Sault Area Hospital. He also served two terms as a Councillor (1997-2003) for the City of Sault Ste. Marie. He is currently a member of the Algoma University Foundation Board; chairs the Sault Ste. Marie Youth Opportunities Council and is Treasurer for the Barrier Free in Algoma Association.

Rémy Beaudoin

CEO

Rémy Beaudoin joined the North East LHIN Team on January 9, 2007. Rémy brings over 20 years of experience as a senior manager in the health care field. For the past eight (8) years he led the Community Care Access Centre (CCAC) of Renfrew County as its Executive Director. Prior to that, he served as the Executive Director of the Centre de santé Basse Côte Nord, Blanc Sablon, Québec. This non-profit health care service provider spanned community health, social services, and hospital care and elderly residential facilities in the Lower North Shore region of Québec.

Population, Health Status and Health Service Utilization Highlights

Socioeconomic status (SES) is recognized as an important determinant of health and the link between health status and the utilization of health services. Socioeconomic disadvantage is an important determinant of inequalities in health. People with higher incomes can generally expect to live longer and healthier lives than those earning less; unemployed individuals and their families suffer an increased risk of premature death; and low levels of education are associated with riskier health behaviours. At the individual level, socioeconomic inequalities in health are generally proposed to be related to the prevalence of behavioural risk factors and/or access to material resources.

A population health perspective recognizes the importance of these links, suggesting that the most important determinants of health are the social and economic characteristics of the communities. Population health models suggest that health is influenced by social, economic and physical environments, personal health practices, individual capacity, coping skills, and health services. (North East LHIN Socioeconomic Indicators Atlas, Health System Intelligence Project (HSIP), Spring 2006)

While the total population of Ontario grew by 6.6% between Census 2001 and 2006 to 12.2 million people, the population of Northeastern Ontario was stable at approximately 550,000 people. There are a number of key sociodemographic differences between the population of the province and North East that impact on service planning and delivery.

Overall, relative to the province, the North East has a higher:

- percentage of the population with First Nations and Aboriginal identity;
- percentage of Francophones;
- proportion of older people;
- unemployment and low income rate;
- percentage of daily smokers;
- percentage of adults who are current drinkers reporting heavy drinking; and
- percentage of adults who are obese or overweight.

… and a lower:

- rate of population growth;
- percentage with postsecondary education;
- percentage of immigrants and visible minorities;
- proportion of pre-middle age adults;
- life expectancy for males and females; and
- rate of contact with a medical doctor in last year.

Chronic conditions place a high burden on the health care system and reduce the quality of life for those who suffer from the condition. It is not surprising, based on the information above, that the North East's rates of arthritis/rheumatism, high blood pressure, diabetes, and heart disease are all significantly higher than the province as a whole.

An analysis of age-standardized mortality (2002-2003) and hospitalization rates (2005-2006), as well as potential years of life lost (PYLL, 2002-2003) by ICD-10 chapter indicates that:

- In the North East, 24.0% of deaths occur before the age of 65, and 46.1% of deaths occur by age 75 (the Ontario percentages are 21.6% and 40.5% respectively).
- All cause mortality and hospitalization rates in the North East are significantly higher than provincial rates. This appears to be largely due to higher rates of cancer, circulatory disease, mental and behavioural disorders and injuries, with cancer and circulatory disease being the leading causes of mortality in the North East.
- Examination of PYLL is useful to quantifying the number of years of life lost to premature death (before the age of 75). In the North East, injuries and cancer account for a large proportion of premature deaths.
- The majority of hospitalization rates in the North East by ICD-10 chapter are significantly higher than those for the province, the only exceptions being diseases of the eye, maternal conditions, perinatal conditions, and congenital issues.

Health Status

	NORTH EAST	ONTARIO	LHIN Range
Female life expectancy at birth (years), 2001†	80.5* (±0.5)	82.1 (±0.1)	79.5 - 82.2
Male life expectancy at birth (years), 2001†	75.0* (±0.5)	77.5 (±0.1)	74.7 - 80.6
Low birth weight babies (1999-2001)‡	5.4%	5.6%	3.7 - 6.2%
Infant mortality rate per 1000 livebirths (1999-2001)†‡	5.2 (±1.3)	5.4 (±0.2)	3.9 - 6.1
Population who say their health is Excellent or Very Good, 2003 (age 12+)#	53.7%* (±2.0)	57.4% (±0.7)	51.0 - 61.5%
Population with an activity limitation, 2003 (age 12+)#	28.3%* (±1.7)	24.6% (±0.6)	19.3 - 30.0%

* Significantly different from provincial average based on assessment of 95% confidence intervals.

Data sources: † Ontario Vital Statistics, Mortality Database ‡ Ontario Vital Statistics, Livebirths Database # Canadian Community Health Survey, 2003

The North East Local Health Integration Network: The Year in Review

Integrated Health Service Plan (IHSP)

After careful review of previous planning work undertaken in Northeastern Ontario and with extensive community engagement, the North East LHIN staff has been busy establishing structures and processes necessary for successfully implementing the IHSP priorities and communicating these to key stakeholders in the region.

First Nations and Aboriginal Health Services;
Chronic Disease Prevention and Management;
Coordinated Information and Communication Technology System and Information Management,
French Language Health Services;
Health Human Resources;
Primary Care; and
Reduced Wait Times.

As identified in the IHSP, the North East LHIN will use seven geographic planning areas to focus its planning and implementation efforts to reflect the local needs of Northeastern Ontario residents. The seven planning areas are Algoma, Cochrane, James Bay and Hudson Bay Coasts, Manitoulin and Sudbury, Nipissing, Parry Sound, and Timiskaming.

Community Engagement

The North East LHIN has established a System Planning and Implementing Cycle to ensure that all stakeholders are included in the process of identifying system level priorities and providing opportunities for implementation of the strategic directions.

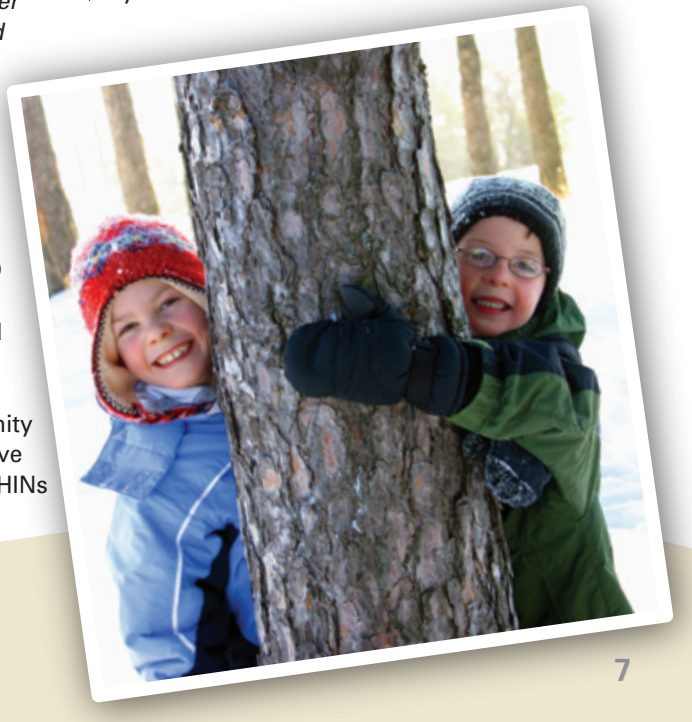
This collaborated community engagement and planning approach will occur utilizing the framework entitled Towards Unity for Health, developed by the World Health Organization. This framework speaks to the importance *"of developing strategies and conditions for unity in purpose and action by key partners/ stakeholders in the health sector, in order to establish a sustainable, people-based health service in line with values of quality, equity, relevance and cost-effectiveness."*

Towards Unity for Health, challenges and opportunities for partnership in health development, World Health Organization, Geneva, Switzerland, 2000.

The five key partners identified by WHO are: policy makers, health professions, academic institutions, communities and health managers.

All aspects of the collaborative community engagement and planning approach have been integrated within the North East LHINs planning and business cycle. This will allow for pertinent information and feedback to be captured in a timely manner. As identified in the diagram, the four key components of this approach include:

The outcome of the community engagement and planning activities, supported by an environmental scan, will provide recommendations to be taken to the Health **System Stakeholder Groups** and Governance Forums to be held in each of the seven planning areas. The result will be system level advice to the North East LHIN Board as it sets the strategic directions for the health care system in Northeastern Ontario.

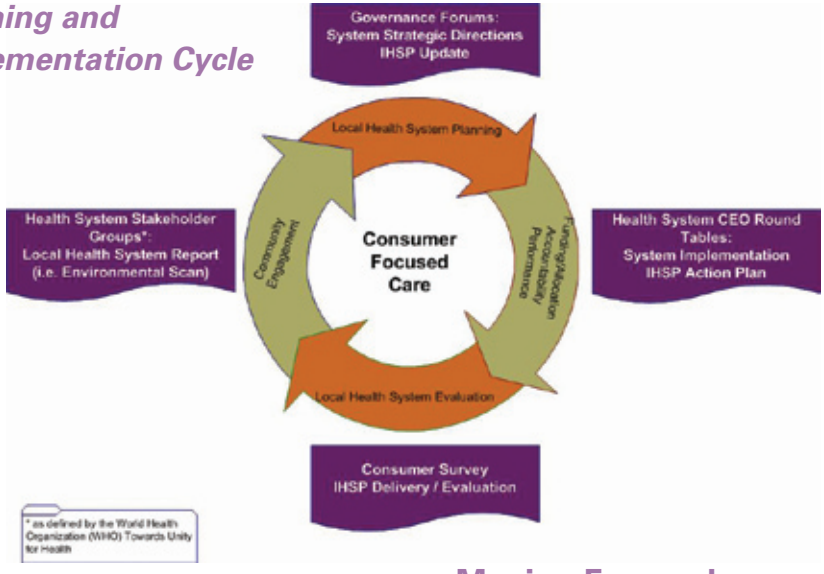


Health System CEO Round Tables are being established in each of the seven planning areas to provide system level advice to the North East LHIN and establish implementation activities to meet the strategic directions of the IHSP. The Round Tables will hold their first meetings in June 2007.

Consumer input is a critical component on the work of the North East LHIN and as a result consumers have an opportunity throughout various components of the planning process to provide input with respect to issues they see as pertinent.

Finally, in order to measure the impact of the strategic directions on the health care system and consumers of health services, the North East LHIN will conduct **Health System Evaluation** work throughout the planning cycle. Established targets will be used to measure system performance and consumer satisfaction (access, quality, etc.).

Planning and Implementation Cycle



Moving Forward

While the North East LHIN's IHSP is a three year strategic plan beginning April 1, 2007, work was already well underway this year to address some key priorities for change in areas such as information and communication technology, alternate level of care patients and the wait times strategy. For example, we saw the completion of Phase 2 of the Northern Ontario Information and Communication Technology Project. This initiative built on the activities of Phase 1, and with the completion of Phase 2, all health sectors have now contributed to an overall North East LHIN system plan. Work is nearing completion on the tactical component of the project which is focusing on the implementation of the development of an electronic health record for Northern Ontario.

The rising numbers of Alternate Level of Care (ALC) patients continues to have a detrimental effect on our system and its ability to respond to our patients needs. The situation reached a critical point this past year in the four larger communities in the region (North Bay, Sault Ste. Marie, Sudbury and Timmins) such that focused attention was required immediately to identify and implement short, mid and long-term solutions.

Through a collaborative approach, the North East LHIN has supported the creation of four community-specific ALC Task Forces that have been charged with the task of identifying strategies to address this challenge and provide advice on the allocation or reallocation of resources to achieve local strategies.

A third priority already being addressed is the reduction of wait times across the region. Staff of the North East LHIN have been working with providers to identify targets and address the challenges to meeting the targets. Going forward, the North East LHIN will be establishing the Regional Wait Times Advisory Panel which will be responsible for monitoring wait times performance statistics and providing advice to the North East LHIN on any necessary programmatic changes.

Through its planning cycle, the North East LHIN will continue to implement activities to address the identified priorities in the IHSP.

Governance

The Board of Directors is responsible for overseeing the affairs of the North East LHIN in order to fulfil its mandate and responsibilities. These are set out in the *"Local Health System Integration Act"*, By-laws, approved business and strategic plans, the relevant government and ministry directives, guidelines and policies and procedures set out in the Memorandum of Agreement. The Board must also adhere to the Accountability Agreement signed with the Minister and any other responsibilities that may be determined and delegated by the Ministry to the North East LHIN.

The Board, through the Chair, is accountable to the Minister for the LHIN's use of public funds and for results in terms of goals, objectives and performance of the local health system.

Board Development and Structure

Further to the enactment of the *"Local Health System Integration Act"* in March 2006, regulations are being developed to determine the mandate of the provincial advisory committees to the Minister of Health, as well as the advisory committees for the individual 14 LHINs.

In the North East LHIN, the Audit Committee as well as the Governance Committee have been established. The Audit Committee oversees the financial and audit mandate of the Board while the Governance Committee advises the Board on the recruitment and nomination of new directors, on the education and development of Board Directors as well as on the evaluation process of Board meetings and of its Directors. There is a component of Board education and development prior to every Board meeting.

The Board is currently planning the terms of reference of the French Language Health Services, the First Nations and Aboriginal Health Services and the Health Professionals Advisory Committees. These three committees will be established as soon as the provincial regulations are finalized by the Ministry of Health and Long-Term Care (MOHLTC).

Orientation Activities

After the North East LHIN Board's nine (9) Directors were nominated in September 2006, a Provincial Orientation Session was attended by all Directors in early November 2006.

In addition, a three (3) day educational program on Governance, offered by the Rotman School of Business, University of Toronto, was attended by all Directors.

Community-Based Recruitment

In order to ensure that the Board represents all of the seven (7) planning areas, i.e., Algoma, Cochrane, James Bay and Hudson Bay Coasts, Nipissing, Parry Sound, Manitoulin-Sudbury and Timiskaming, and that the Directors provide a balance in their qualifications, expertise and experience, the Governance Committee has developed guidelines for the recruitment of new Directors. The Board was successful this past year in recruiting a First Nations Director from Moose Factory. A process is currently underway to recruit a new Director from the Parry Sound District.

Conflict of Interest Guidelines

The Ministry of Health and Long-Term Care has provided LHINs with conflict of interest guidelines. The LHIN Board Chair has the ongoing responsibility for monitoring and ensuring compliance. The purpose of the guidelines is to foster public confidence and trust in the North East LHIN and to promote a standard of conduct that will establish the integrity, objectivity and impartiality of the affairs and decision-making process of the LHIN. The guidelines also enable the LHIN to recognize, to avoid, to mitigate and to manage conflict of interest situations and to ensure that all real, perceived or potential conflicts of interest are resolved for the benefit of the public.

Nine (9) Board Directors of the North East LHIN met with a Conflict of Interest Commissioner in 2006/07 and completed their declarations. The Conflict of Interest Commissioner provided advice in accordance with the LHIN Conflict of Interest Policy.

In the North East LHIN, all Board Directors were found not to have any actual conflict of interest.

Accountability Agreement

The North East LHIN Board, through the Chair, entered into an Accountability Agreement with MOHLTC. The Agreement delineates the mandate of the North East LHIN and the full responsibilities of both the North East LHIN and the MOHLTC in order to ensure the funding and integration of the 239 health care services within the North East LHIN.

CEO Performance Objectives

In order to ensure that our new CEO, who is leading our North East LHIN Management Team and employees, obtains the full support of the Board, performance objectives for the coming year are being developed in cooperation with our CEO.

Finance

The North East LHIN successfully started operations in 2006/07, within the allocated budget provided by the Ministry of Health and Long-Term Care.

Deloitte. Member of Deloitte Touche Tohmatsu

To the Members of the Board of Directors of the
North East Local Health Integration Network

We have audited the statement of financial position of North East Local Health Integration Network (the "LHIN") as at March 31, 2007 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. 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 plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of North East Local Health Integration Network as at March 31, 2007 and the results of its operations, its changes in its net debt and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants

Toronto, Ontario
May 2, 2007

NORTH EAST LOCAL HEALTH INTEGRATION NETWORK

Statement of Financial Position

March 31, 2007

	2007	2006 (Notes 3, 14)
FINANCIAL ASSETS		
Cash	**$ 312,860**	$ 29,037
Accounts receivable	**2,231**	-
	315,091	29,037
LIABILITIES		
Accounts payable and accrued liabilities (Note 4)	**172,537**	-
Due to Ministry of Health and Long-Term Care ("MOHLTC")	**57,803**	29,037
Due to the LHIN Shared Services Office (Note 5)	**84,751**	-
Deferred capital contributions (Note 6)	**423,612**	503,249
	738,703	532,286
NET DEBT	**423,612**	503,249
NON-FINANCIAL ASSETS		
Capital assets (Note 7)	**423,612**	503,249
ACCUMULATED SURPLUS	$ -	$ -

APPROVED BY THE BOARD

Director

Director

Statement of Financial Activities

Year ended March 31, 2007

	2007		2006
	Budget	**Actual**	Actual
	(unaudited) (Note 8)		(Notes 3, 14)
REVENUE			
MOHLTC funding	**$ 3,278,764**	**$ 3,025,083**	$ 180,109
E-Health funding (Note 10)	**181,000**	**181,000**	-
Amortization of deferred capital contributions (Note 6)	-	**142,169**	125,812
	3,459,764	**3,348,252**	305,921
EXPENSES			
General and administrative (Note 9)	**3,278,764**	**3,109,449**	305,921
E-Health (Note 10)	**181,000**	**181,000**	-
	3,459,764	**3,290,449**	305,921
ANNUAL SURPLUS BEFORE REPAYABLE TO MOHLTC	-	**57,803**	-
FUNDING REPAYABLE TO MOHLTC	-	**(57,803)**	-
ANNUAL SURPLUS	-	-	-
OPENING ACCUMULATED SURPLUS	-	-	-
CLOSING ACCUMULATED SURPLUS	**$ -**	**$ -**	$ -

NORTH EAST LOCAL HEALTH INTEGRATION NETWORK

Statement of Changes in Net Debt

Year ended March 31, 2007

	2007	2006 (Notes 3, 14)
ANNUAL SURPLUS	$ -	$ -
ACQUISITION OF TANGIBLE CAPITAL ASSETS	(62,532)	(629,061)
AMORTIZATION OF TANGIBLE CAPITAL ASSETS	142,169	125,812
DECREASE (INCREASE) IN NET DEBT	79,637	(503,249)
OPENING NET DEBT	(503,249)	-
CLOSING NET DEBT	$ (423,612)	$ (503,249)

Statement of Cash Flows

Year ended March 31, 2007

	2007	2006 (Notes 3, 14)
NET INFLOW (OUTFLOW) OF CASH RELATED TO THE FOLLOWING ACTIVITIES		
OPERATING		
Items not affecting cash		
Amortization of capital assets	$ 142,169	$ 125,812
Amortization of deferred capital contributions (Note 6)	(142,169)	(125,812)
	-	-
USES		
Increase in accounts receivable	(2,231)	-
	(2,231)	-
SOURCES		
Increase in accounts payable and accrued liabilities	172,537	
Increase in due to MOHLTC	28,766	29,037
Increase in due to the LHIN Shared Services Office	84,751	-
	286,054	29,037
INVESTING		
Acquisition of capital assets	(62,532)	(629,061)
FINANCING		
Increase in deferred capital contributions (Note 6)	62,532	629,061
NET CHANGE IN CASH	283,823	29,037
CASH, BEGINNING OF YEAR	29,037	-
CASH, END OF YEAR	$ 312,860	$ 29,037

Notes to Financial Statements

1. DESCRIPTION OF BUSINESS

Formation and status
The North East Local Health Integration Network was incorporated by Letters Patent on June 9, 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 North East 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 both the Act and the Memorandum of Understanding between the LHIN and the Ministry of Health and Long-Term Care (the "MOHLTC").

The LHIN has also entered into an annual Accountability Agreement for the 2006/07 fiscal year with the MOHLTC which describes the responsibilities of the LHIN and the performance standards that are required to be maintained and achieved in order to obtain funding from the Province.

As of April 1, 2007, funding payments to providers will flow through the LHIN's financial statements. These transfer payments will be reflected as revenue and expenses in the LHIN's financial statements for the year ended March 31, 2008 and thereafter.

LHIN operations
The objects 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 area of Northeastern Ontario.

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 tangible 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 budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC.

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 contributions
Any amounts received that are used to fund expenditures that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. This amortization revenue recorded is in accordance with the amortization policy applied to the related capital asset recorded.

Tangible capital assets
Tangible capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible 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 tangible 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 tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

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

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.

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. ADOPTION OF PUBLIC SECTOR ACCOUNTING RECOMMENDATIONS

At the direction of the MOHLTC, commencing in 2007, the LHIN has adopted generally accepted accounting principles, applying government accounting standards issued by the Public Sector Accounting Board of the Canadian Institute of Chartered Accountants. The comparative figures included in these financial statements have been restated to conform with accounting standards adopted for the current year.

As a result of this change, during the year the LHIN obtained the fair market value for the donated tangible capital assets received in the prior fiscal period and chose to reflect this more meaningful valuation in the financial statements. This change has been applied retroactively and the prior period has been restated resulting in an increase in deferred capital contributions, net debt and capital assets of $503,249 on the Statement of Financial Position. On the Statement of Financial Activities amortization of deferred capital contributions increased by $125,812 as did general and administrative expenses. On the Statement of Changes in Net Debt acquisition of tangible capital assets increased by $629,061 amortization of tangible capital assets increased by $125,812 and closing net debt increased by $503,249.

4. ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

The MOHLTC has included accounts payable and accrued liabilities totaling $229,089 in its records on behalf of the LHIN as at March 31, 2006. These expenses are included in amounts disclosed in Note 9 related to the prior period.

5. 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. The full costs of providing these services are billed to all the LHINs on an equal basis. Any portions of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable (payable) to the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all the LHINs.

6. DEFERRED CAPITAL CONTRIBUTIONS

	2007	2006
Balance, beginning of year	**$503,249**	$ -
Capital contributions received during the year	**62,532**	629,061
Amortization for the year	**(142,169)**	(125,812)
	$423,612	$ 503,249

7. CAPITAL ASSETS

	2007			2006
	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Furniture and fixtures	$ 70,404	$ 22,763	$ 47,641	$ 34,730
Computer equipment	24,885	8,295	16,590	-
Leasehold improvements	596,304	236,923	359,381	468,519
	$ 691,593	$ 267,981	$ 423,612	$ 503,249

8. BUDGET FIGURES

The budget figures have been approved by the MOHLTC. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles.

9. GENERAL AND ADMINISTRATIVE EXPENSES

For the period ended March 31, 2006, certain operating expenses, other than those disclosed on the Statement of Financial Activities, were approved and paid for on behalf of the LHIN by the MOHLTC. These amounts were not included with the LHIN's financial activities and are disclosed below for information purposes. These expenses are as follows:

Salaries and benefits	$ 68,101
Accommodation/occupancy	1,087,919
Common services	42,126
Information technology	89,859
Other expenditures	332,422
	$ 1,620,427

For the first three months of fiscal 2007, all financial information was processed by the MOHLTC on behalf of the LHIN. Unlike 2006, these amounts are considered expenses of the LHIN directly and are included as part of the financial activities of the LHIN and included in the Statement of Financial Activities.

As part of this transition, additional amounts totalling $180,137 of prior period expenses are included in the current year expenses and are included in the Statement of Financial Activities of the LHIN.

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

	2007	2006
Salaries and benefits	$ 1,364,678	$ 177,179
Accomodation	188,272	-
Amortization	142,169	125,812
Shared services	290,201	-
Conflict of interest commissioner	7,857	-
Directors' per diems	107,420	-
Travel	229,791	-
Consulting	407,219	-
Banking services	907	-
Communications	182,806	-
Community forums	5,666	-
Other	182,463	2,930
	$ 3,109,449	$ 305,921

10. E-HEALTH EXPENSE

The E-Health office of the Ministry of Health and Long-Term Care provided $181,000 to the LHIN. The LHIN had a contract and retained the services of the Group Health Centre (the "GHC") during 2007. The GHC provided services and deliverables as described in the contract. In return, the LHIN

agreed to reimburse the GHC for expenses incurred during the performance of this work. The total amount of expenses reimbursed during the duration of this contract was $181,000.

11. PENSION AGREEMENTS

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of all 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 2007 was $99,935 (2006 - $14,396) for current service costs and is included as an expense in the Statement of Financial Activities.

12. 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 the 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.

13. COMMITMENTS

The LHIN has commitments under various operating leases. Minimum lease payments due in each of the next four years and thereafter are as follows:

2008	$ 163,774
2009	163,774
2010	160,714
2011	77,357
	$ 565,619

14. COMPARATIVE FIGURES

The prior period figures are from the date of incorporation, June 9, 2005 to March 31, 2006.

During the 2007 fiscal year, the LHIN received direction from the MOHLTC in its Memorandum of Understanding to follow PSAB accounting. Presentation changes are a result of the change in presentation format to comply with PSAB.

Staff Members

Rémy Beaudoin
Chief Executive Officer

Martha Auchinleck
Senior Director, Performance, Contract & Allocation

Terry Tilleczek
Senior Director, Planning, Integration & Community Engagement

Lianne Bettiol
Executive Assistant to the CEO

Roch Legros
Administrative Assistant (Board)

Phil Kilbertus
Senior Consultant, Planning, Integration and Community Engagement

Monique Rocheleau
Senior Consultant, Planning Integration and Community Engagement

Frank McGoey
Consultant, Planning Integration and Community Engagement

Michel O'Connor
Consultant, Planning Integration and Community Engagement

Michael Stetch
Senior Consultant, Performance, Contract & Allocation

Carol Philbin Jolette
Senior Consultant, Performance, Contract & Allocation

Jean-Gilles Lemieux
Consultant, Performance, Contract & Allocation

Bruce Villela
Consultant, Performance, Contract & Allocation

Ryan Jeffers
Controller/Business Support Manager

Solange Ethier
Program Assistant

Kathy Murphy
Administrative Assistant

Colette Whitehead
Administrative Assistant

On behalf of the Board of Directors of the North East Local Health Integration Network, we are pleased to submit the approved Annual Report for the period ended March 31, 2007.

Mathilde Gravelle Bazinet
Board Chair

Margaret Ashcroft
Board Vice-Chair

North East
LOCAL HEALTH INTEGRATION NETWORK

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