



Consolidated Local Health Integration Network Annual Report 2020/21

Table of Contents

Table of Contents	2
Message from the Local Health Integration Networks' Board Chair	3
Introduction	4
Supporting Pandemic Response	4
Maintaining Continuity of Care	4
Supporting Better Connected Care	5
Population Profile	6
Description of Activities over the Year	7
Supporting Provincial Pandemic Response	7
Reducing Hospital Overcrowding	12
Improving Long-Term Care	17
Improving the Delivery of Home Care	21
Capacity Planning	25
Health System Transformation	26
Community Engagement	29
Engagement with Francophone Communities	30
Engagement with Indigenous Communities	31
Engagement with Other Communities and Populations	32
Health System Performance	34
Challenges	37
Appointees	37
Financial Analysis	39
Audited Financial Statements	42
Appendix One – LHIN Populations Profiles	218
Appendix Two- LHIN Performance Data	224

Message from the Local Health Integration Networks' Board Chair

On behalf of the Board of Directors, I am very pleased to share the Consolidated Local Health Integration Network Annual Report for 2020/21.

The 2020/21 year began with the COVID-19 pandemic which created an unprecedented challenge for our health care system and Ontarians. Together with partnership from Ontario Health, the Local Health Integration Networks (LHINs) played an integral role in activating the system's response, including an early and critical rapid response through frontline care delivery, as well as capacity planning and stabilization supports for health system partners to meet the urgent, complex and growing health needs of Ontarians.

Over the last year, the LHINs collaborated with the Ministry of Health, Ministry of Long-Term Care and Ontario Health, as well as home and community care and other health system partners to increase service levels and ensure continuity of care during the COVID-19 pandemic response. They consistently demonstrated strong community relationships and local health system expertise by working together and with health service providers, contracted service providers, patients, families and caregivers to deliver uninterrupted, high-quality care and to support Ontarians throughout their care journey.

While supporting the provincial response to the pandemic was front and centre, the LHINs worked diligently to carry out their mandate to plan, integrate and fund local health care, and to deliver, and provide access to, home and community care.

It was anticipated that LHIN non-patient care functions would transfer into Ontario Health in early 2020 and as previously announced by the Minister of Health, that after the transfer, the LHINs would be carrying out a narrowed mandate of home and community care and long-term care home placement functions would become known as Home and Community Care Support Services. This transition was paused due to the COVID-19 pandemic in order to maintain health system stability, and to ensure resources focused on addressing the pandemic and protecting the health and well-being of Ontarians.

Later in 2020, planning resumed for this important piece of the government's plan to modernize home and community care and build an integrated, connected health care system centred around the needs of patients. The Ministry of Health, Ontario Health and the LHINs worked together to ensure a smooth transfer of the non-patient care functions and staff on April 1, 2021 and LHINs began operating under a new business name, Home and Community Care Support Services, to reflect a singular mandate to deliver patient care.

Integral to their success in 2020/21 was collaboration; the LHINs worked to break down silos, geographic lines and other barriers to work together as a united team. Despite the unprecedented demands put onto the LHINs and their staff this last year, the pages of this report detail the LHINs' continued leadership in providing innovative and collaborative solutions to support and coordinate the health care system in their regions and across the province.

The Board of Directors would like to extend our deep appreciation to the tremendously hard working and dedicated professionals throughout the LHINs, as well as to the heroic health care providers and community partners they serve.

Bill Hatanaka
Board Chair, Local Health Integration Networks

Introduction

In 2020/21 the province's 14 Local Health Integration Networks (LHINs) continued to build strong local health care systems, centred around the patient and in collaboration with health care and community partners. This work was guided by the health care system's Quadruple Aim, an invaluable compass for informing decisions and optimizing health care performance, which calls for improving population health outcomes, improving patient experience, improving frontline and provider experience, and achieving better value.

Throughout the year, LHINs supported the planning, implementation and ongoing operation of countless initiatives across the province in sectors including (but not limited to) home and community care, long-term care, hospitals, primary care, mental health and addictions, rehabilitation, occupational therapy and palliative care. Much of this work was guided by three key priorities: maintaining continuity of care while improving access and quality, supporting better connected care and supporting and stabilizing the health system and their regional communities through the first, second and third waves of the COVID-19 pandemic.

Supporting Pandemic Response

Throughout the fiscal year 2020/21 LHINs continued to find themselves in the midst of an unprecedented era in health care, supporting the provincial response to COVID-19. Through their regions, LHINs played an early and important role in supporting many health care sectors. This included work in capacity planning, obtaining and allocating personal protective equipment, stabilizing long-term care homes and other congregate care settings and supporting health human resources efforts through recruitment and staff redeployment, to name a few.

And through it all, home and community care continued to be delivered to Ontarians who needed it most through a robust delivery model that included in-home nursing and personal supports, while further leveraging virtual care platforms.

Through well-established relationships with system partners, LHINs supported increased testing capacity, ongoing personal protective equipment procurement and distribution planning with local supply chain organizations, capacity planning to reduce the risk of hospital overcrowding and added health human resources and expertise for long-term care to protect those most vulnerable to COVID-19.

Maintaining Continuity of Care

Despite the unprecedented pressures of the pandemic on human resources and maintaining continuity of care under capacity pressures and public health restrictions, the LHINs continued to plan, fund and integrate local health care and to manage and deliver high-quality home and community care, under the *Local Health System Integration Act, 2006* (LHSIA).

In order to maintain continuity of care during the COVID-19 pandemic and support health system partners in dire need, all LHINs worked to develop and establish regional COVID-19 response structures

in collaboration with local leadership from hospitals, community and public health agencies, and various multi-sector stakeholders.

The implementation of these response structures catalyzed development of strong inter-sectoral relationships and a much more integrated approach to delivering care. They enabled effective planning and implementation underpinning all key functions of the COVID-19 response including testing, capacity planning, support for congregate care settings and long-term care homes, infection prevention and control, access to equipment, and vaccination.

Supporting Better Connected Care

The *Connecting Care Act, 2019* laid the foundation for the continued implementation of Ontario's phased strategy to build an integrated, connected health care system centred around the needs of patients.

The LHINs supported health system transformation by planning and preparing for the transfer of non-patient care functions and staff into Ontario Health leading up to the official transfer as of April 1, 2021.

The LHINs worked closely in advance of the transfer day to plan and implement communications tactics and strategies that supported staff and ensured adherence to ministry branding and name change guidelines.

The government announced in March 2020 that following the transfer, LHINs will begin operating under a new business name, Home and community Care Support Services to reflect a singular mandate to deliver patient care.

With the previous establishment of the Ontario Health's Regions, in the 2020/21 year, LHINs were able to pool resources and expertise to apply a regional approach to their initiatives. This involved more coordination between individual LHINs and also at the regional level, resulting in better connected care for Ontarians and efficiencies within the health care system.

Population Profile

Below is a population profile of Ontario, which includes information on the number and type of health service providers across the province. Individual LHIN population profiles can be found in Appendix One.

Area (km2)	908,699 km2	Health Service Providers: • 146 Hospitals • 626 Long-Term Care Homes • 573 Community Services • 370 Mental Health Agencies • 61 Residential Hospices • 77 Community Health Centres
Total Population	13,448,494	
Population Age 65+	16.7%	
Population Growth Rate	4.6%	
Population Density	14.8/km2	
Rural Population	17.2%	
Indigenous Population	2.8%	
Francophone Population	4.7%	
Low Income Population	14.4%	

Sources:

- Statistics Canada. Canada, Provinces, Territories, Census Divisions, Census Subdivisions and Dissemination Areas tables. Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001.
- Land area and population density: 2016 Census Geographic Attribute File. Statistics Canada.
- Special Tabulations: Statistics Canada. 2016 Census. Detailed age and sex; Inclusive Definition of Francophone; Seniors living alone. Prepared by Health Analytics and Insight Branch (HAIB), March 2019.
- Population Health/Select Highlights from the LHINs' 2019-22 IHSPs and the 2019-22 Integrated Health Service Plan (IHSP) Environmental Scan document.

Description of Activities over the Year

In 2020/21, LHINs focused on advancing government priorities such as:

- Supporting provincial pandemic response
- Reducing hospital overcrowding
- Mental health and addictions
- Long-term care
- Home care
- Capacity planning
- Health system transformation

While work on the above priorities continued, the lens of what that work looked like in 2020/21 changed significantly with the unprecedented challenges of the COVID-19 pandemic. The LHINs quickly pivoted to be able to support the provincial response efforts and address the new and evolving challenges at the provincial and local levels, including access to personal protective equipment, staffing redeployments, COVID-19 testing, capacity planning, support for congregate care settings and long-term care homes, infection prevention and control, and vaccination efforts.

The strain on the health care system was tremendous in 2020/21, and the LHINs continued to support Ministry of Health priorities and the communities they serve, all while looking for ways to deliver their services effectively and efficiently, with the ultimate goal of improving health outcomes for Ontarians.

Supporting Provincial Pandemic Response

The emergence of COVID-19 refocused the attention and efforts of the health system across Ontario. The LHINs actively and tirelessly worked together and in collaboration with health system partners in their regions to support the provincial pandemic response in several priority areas.

Specifically, home and community care played an important leadership role in the pandemic response through regional Incident Management Structures (IMS). Dedicated leadership and additional Infection Prevention and Control (IPAC) resources were provided for outbreak management across a number of settings (home care, retirement homes and long-term care).

Personal Protective Equipment

Early in the pandemic, for many LHINs, a key priority was to secure a stable and steady supply of personal protective equipment (PPE).

To address these new challenges in PPE acquisition and distribution, in March 2020, Mississauga Halton LHIN, Central LHIN, Central West LHIN, and North Simcoe Muskoka LHIN established the Central Region PPE and Critical Supplies Team, responsible for supplying eligible health care organizations with PPE inventory from the provincial stockpile. The team supplied over 49,577,410 PPE and testing items, including 3,140,711 PCR swabs and 1,643,819 rapid tests between April 22, 2020 and March 31, 2021. Through outreach and education, including a dedicated PPE web page, bulletins and the creation of the PPE Knowledge Exchange webinar series, health system partners were kept informed on vital PPE and critical supplies updates, guidance and directives. PPE Knowledge Exchanges brought together thousands of health system partners to learn from experts, collaborate to address challenges in PPE supply chain management and build resilient supply chains within Central region, garnering interest and recognition across the province, after four successful regional PPE Knowledge Exchanges, they were

expanded provincially.

Erie St. Clair LHIN, Hamilton Niagara Haldimand Brant LHIN, South West LHIN and Waterloo Wellington LHIN mobilized with local supply chain partners to create a centralized warehouse of supplies and distribution hubs that allowed for good inventory management and stewardship and timely delivery of PPE for organizations experiencing urgent shortages. The South West LHIN specifically led the development of the COVID-19 Regional Allocation Committee (RAC) to promote fair decision-making when setting priorities for scarce resources, especially personal protective equipment. This included the development of a regional portal and regular alerts to the West region stakeholders about PPE supplies and directives.

Champlain LHIN and South East LHIN convened a multi-sectoral Critical PPE and Supplies Table to gather, manage and equitably distribute PPE and critical supplies to health service providers in the region. A regional team was formed to monitor regional PPE and critical supply issues, fulfill urgent requests for PPE from local inventories where possible, and escalate requests to Ontario Health and/or the Ministry of Health when PPE and critical supplies were required from provincial inventories.

Testing

LHINs across the province worked collaboratively with hospitals, Ontario Health Teams (OHTs), paramedics, Public Health and municipalities to respond to local COVID-19 testing needs using a variety of approaches.

As part of the province's High Priority Communities Strategy, in December 2020, 15 priority communities were identified as the province's hardest-hit neighbourhoods, 10 of which resided in Central Region. The Central LHINs (Central LHIN, Central West LHIN, Mississauga Halton LHIN, North Simcoe Muskoka LHIN) identified 10 lead agencies to implement and execute tailored community outreach and engagement and increase access to testing. Between January and March 2021, these lead agencies partnered with 500 health or social service agencies; contacted 179,413 individuals through community outreach activities; distributed 70,326 PPE kits, provided 4,749 individuals with case management support; referred 328 to isolation centres; and delivered 27,127 meals.

The creation of a Regional Testing Advisory Committee engaged physicians, clinicians, public health and laboratory scientists to recommend a testing and assessment approach across the West Region aligned with provincial guidance and informed by emerging science regarding COVID-19. This resulted in the establishment of 50 Testing and Assessment Centres across the four LHINs in the West Region (Erie St. Clair LHIN, Hamilton Niagara Haldimand Brant LHIN, South West LHIN and Waterloo Wellington LHIN).

To ensure equitable access to testing for all, the Champlain LHIN supported community health centres in Ottawa to engage with and reduce barriers to testing for marginalized and high-priority communities through outreach and education.

Using a health equity lens, Toronto Central LHIN identified neighbourhoods that would benefit from additional localized testing and wrap-around supports and engaged a cross-sector of partners to operationalize the targeted strategy. Toronto Central LHIN ensured strategic alignment between city and health partners and monitored and evaluated neighbourhood-level data and testing uptake on an ongoing basis to ensure the strategy was responsive to needs.

Human Resourcing and Staff Redeployments

In March 2020, the Ontario government made an emergency order under subsection 7.0.2 (4) of the Emergency Management and Civil Protection Act to better support Ontario's long-term care homes. The orders allowed for the redeployment of staff to work where they were needed most during the COVID-19 pandemic. Across the province, the LHINs worked to plan, coordinate and facilitate staffing redeployments.

LHIN staff have shown their dedication and commitment to the important work they do without hesitation, and have expanded and redefined their roles in order to fill gaps in response to COVID-19, demonstrating flexibility and adaptability, finding workable solutions to virtual visits with patients, and assisting with an 'all hands on deck' approach.

For example, Mississauga Halton LHIN, Central LHIN, Central West LHIN, and North Simcoe Muskoka LHIN redeployed 456 staff to Telehealth, IPAC extenders, assessment centres, vaccinations, long-term care and other congregate settings.

Staff from Erie St. Clair LHIN, Hamilton Niagara Haldimand Brant LHIN, South West LHIN, and Waterloo Wellington LHIN were also redeployed in conjunction with hospital teams to support residents in long-term care and retirement home facilities in outbreak.

Hundreds of Ontario Health East team members put their hands up to be reassigned to support the efforts to fight COVID-19 over these last several months. During Wave 1:

- 276 regional staff were deployed to front-line positions in hospitals, long-term care and other care facilities
- 31 people supported public health contact tracing
- 18 human resources staff supported assessment and recruitment

The Human Resources team in the East region also navigated a variety of challenges presented by the pandemic, while also focusing on a number of transition priorities. In the Ontario Health East Region, the HR Team worked as one integrated entity to support the Central East, Champlain and South East LHINs. This included managing an environment of constant change to accommodate staff, the LHIN organizations and the health care system overall. They worked to:

- Ensure safe workplaces in accordance with COVID-19 regulations and subsequent adjustments required
- Work with health system partners to redeploy staff to LTCHs, retirement homes and hospitals
- Provide timely and accurate information to staff
- Administer and implement new employment legislation, ensuring compliance and applying necessary measures
- Administer pandemic pay

The expertise afforded by the HR team played a direct role in helping alleviate additional stress, support staff in their work and personal lives, and displayed the true value the Human Resource function adds as strong foundation to organizational effectiveness.

Vulnerable and Underserved Communities

The COVID-19 pandemic exposed inequities and disparities in health care across the province, and many LHINs developed programs and initiatives to serve their most vulnerable communities.

For example, the Erie St. Clair LHIN in partnership with Ontario Health supported multi-sectoral pandemic planning and response in regard to temporary foreign workers and COVID-19. This included mobile testing, health checks, stakeholder engagement, shelter and isolation sites and being integral members of the Incident Management System. Further, collaborative work continued in planning for improved access to primary care for temporary foreign workers.

The South West LHIN and Carrefour Communautaire francophone de London (CCFL) initiated work to mobilize stakeholders and Francophone organizations to develop the Info Fran COVID-19 web page. The web page is intended to act as a resource guide/directory of services and supports available in French in response to the COVID-19 pandemic. The main web page includes a phone number offering direct access to a system navigator offered through the Accès Franco-Santé London. The navigator is able to provide support and information on any health-related matters.

The Central East LHIN increased supports for the deaf community in Durham Region during COVID-19. Durham Deaf Services (DDS) is a non-profit organization offering services and educational programs that promote self-reliance within the deaf, deafened and hard of hearing community. DDS is the only centre between Toronto and Belleville where deaf individuals can find support services and social opportunities with their peers. Since March 2020, DDS received numerous calls for intervention for deaf individuals where distance visits were conducted to ensure individuals were safe and short-term supports put in place. However, there remained a group of deaf seniors at high risk who live alone and lack supports. Realizing this need, DDS proposed increased programming to support the deaf community during COVID-19. Funded by the Central East LHIN, DDS temporarily expanded their supports to include:

- Safe home visits and reassurance checks using American Sign Language (ASL)
- Translation of English COVID-19 content into ASL
- Technology options to allow deaf seniors to remain informed at home
- Education for providers on how to support the deaf community during COVID-19
- Support and referrals for mental health counseling using ASL
- Support accessing food banks and booking medical appointments using ASL
- Development of ASL videos to educate on the COVID-19 impact for the deaf community
- Information in ASL on elder abuse prevention education, and more

The Toronto Central LHIN established a comprehensive COVID-19 testing strategy to ensure testing and supports were accessible for Torontonians, particularly residents who were more vulnerable to impacts of COVID-19. The strategy included:

- **Schools:** In partnership with school boards, testing partners and Toronto Public Health, the school testing strategy ensured a coordinated and timely response for case and outbreak investigations while offering flexible testing approaches (e.g., onsite testing, take away testing kits, allocated time at assessment centres) that supported the unique needs of each school population
- **Child care:** In response to a growing number of outbreaks in child care centres, a coordinated testing response was developed (in partnership with Toronto Public Health and testing partners) to respond to case and outbreak investigations with a family-centred and child-friendly approach (including drive-thru testing, take-home kits and infant testing supports).
- **Indigenous:** Led by Toronto's Indigenous community partners, testing approaches were developed to be culturally safe and reach the Indigenous community that may not have otherwise accessed traditional testing venues. Anishnawbe Health Toronto used a mobile testing RV to provide testing, medical and social support directly to Indigenous communities. An Indigenous specific assessment centre was developed by Native Men's Residence, Seventh Generation Mid-Wives and Well Living House to provide a culturally safe location for Toronto's Indigenous community.
- **Shelters:** Toronto Central LHIN established a Toronto Region Shelter and Congregate Coordination Table with partners (hospital, community health centres/primary care teams, the city's Shelter Support Housing and Administration Division and Toronto Public Health) to support the development of a mobile testing strategy that enabled coordinated case and outbreak management within shelters. The strategy included infection prevention and control supports and coordinated surveillance testing, as well as the establishment of a COVID-19 Recovery Site for people who are homeless to have a place to safely isolate with clinical, peer and harm reduction supports.

Crisis Management & Capacity Building

Responding to the urgent capacity issues and evolving needs within their communities, all LHINs worked to develop and establish regional COVID-19 response structures in collaboration with local leadership from hospitals, community and public health agencies and various multi-sector stakeholders. Some examples include:

In the North West LHIN, to ensure timely effective crisis management, the LHIN's Emergency Response Team met frequently to review system issues and provincial directions and guidance and align operational policies and communications appropriately, including direct and virtual patient care, screening and risk assessments, PPE, staff and provider testing supports and work space use/design.

Throughout the pandemic, the South East LHIN decision support (DS) team collected, analyzed and distributed weekly reports to assist COVID-19 related monitoring and decision-making by key stakeholders in the South East LHIN and across the South East system of health service providers as well as broader system stakeholders. A weekly acute care surveillance report was designed to answer key questions focused on specific domains of interest that were vetted and modified to meet the needs of the decision makers. In addition, South East LHIN DS staff worked in their region to design,

create and distribute a weekly provincial report. Using data from the Acute Care Enhanced Surveillance (ACES) system, this report provided a syndromic-based overview of the impact of COVID-19 on acute care institutions across the province. This report was also distributed to key provincial contacts including the Chief Medical Officer of Health to assist monitoring and decision-making.

Many LHINs also directly increased capacity within their hospital networks by adding beds for patients with COVID-19, or establishing emergency department avoidance strategies. Examples include:

In the South West LHIN, the hospital sector mobilized and created approximately 1,200 new bed spaces to ensure care was available for patients with COVID-19 and those requiring urgent access to hospital-based care for other reasons.

The Erie St. Clair LHIN prioritized Care in Place and an Emergency Department avoidance strategy in congregate living settings. The LHIN also supported multi-partner response teams to assist congregate settings in outbreak, including long term care with clinical and non-clinical supports. Additionally, the Erie St. Clair LHIN supported load-balancing patients from across Ontario and their region to transfer patients into available ICU and acute medicine capacity as needed in an effort to maintain access and flow (starting March 5, 2021, the LHIN received 180 transfers; 123 of those from outside of their region).

Due to the escalating COVID-19 patient volumes in the GTA, the Central East, South East, and Champlain LHINs supported the transfer of 66 patients to or between our regional facilities, with strong support from the hospital patient-flow leads and emergency medical services. The transferred patient populations included acute COVID-19 positive, acute COVID-19 negative, alternative level of care and mental health.

Reducing Hospital Overcrowding

Increasing capacity in acute care and hospitals is one of the highest health priorities in the province. To address the many factors contributing to hospital overcrowding, LHINs across Ontario worked in collaboration with health service providers to support improved patient transitions across the health care system, enabling better access to acute care.

Alternate Level of Care

Alternate Level of Care (ALC) is a designation assigned to a hospitalized patient who no longer requires acute medical services, however remains in hospital. All LHINs continued to work to address the existing barriers for the ALC patient population, build local capacity and support care delivery in the appropriate care setting as close to home as possible. Across the LHINs, strategies for ALC avoidance and management continued to be coordinated and optimized across all hospital and home and community care partners. The approaches involved strong collaborative partnerships to develop and implement solution-focused initiatives.

The North East LHIN, for example, supported the creation of two Alternative Health Facilities (AHFs) in Timmins and North Bay. Creating a combined additional 45 beds (29 in Timmins and 16 in North Bay), these facilities alleviated ALC and other pressures on the North Bay Regional Health Centre and Timmins District Hospital and allowed for continued quality care and patient flow during the peak periods of the COVID-19 pandemic. Prior to opening these AHF beds, both hospitals had experienced an increase in ALC patients; however, the AHFs provided much needed flow, supporting additional patient pressures due to COVID-19, including reduced capacity in long-term care and community care.

Several programs across the LHINs helped create capacity in acute care, and for the potential surge of COVID-19 patients by transitioning patients out of hospitals and into community settings. These included the following:

Short-Term Transitional Care

In response to health system ALC pressures, the Ministry of Health invested in increasing hospital capacity and enhancing patient flow by implementing short-term transitional care models (STTCM). These initiatives provided appropriate care for patients outside of hospitals, supported patients and care providers through transitions in care, and assisted in maintaining overall system capacity. Many LHINs were able to open additional care beds in a variety of settings and using varied models of care at the local level. For example, Waterloo Wellington LHIN opened an additional 48 transitional care beds across multiple settings, and the LHIN supported the development of Greystone Manor, a 120-bed transitional care facility which supports transitions from hospital or community to long-term care, rehabilitation or other destinations.

Other LHINs, like the South East LHIN worked to expand existing short-term care units. The South East LHIN expanded their short-term unit from 30 to 70 patients, supporting Kingston Health Sciences Centre (KHSC) and KHSC@Home program to assist with ALC pressures during COVID-19.

High Intensity Supports at Home Programs

On December 2, 2020, the Government of Ontario announced one-time special funding for a new High Intensity Supports at Home (HISH) program to help address capacity challenges, including overcrowding in hospitals and long-term care homes as the health care system continued to respond to the COVID-19 pandemic and potential winter flu surge. The HISH program enabled patients who were designated alternate level of care in hospital or awaiting long-term care placement in community and at risk of hospitalization to receive enhanced care during the COVID-19 pandemic.

Mississauga Halton LHIN, Central LHIN, Central West LHIN, and North Simcoe Muskoka LHIN Long-Term Care at Home and Rehab at Home models were offered. Enhanced Intensive Home and Community Care 2.0 offered a unique approach to supporting hospital discharges.

This program leveraged the Community Support Services sector, which proved critical in responding to hospital decanting directives, served patients at a lower cost, and provided a more flexible model of personal support worker care.

As a result of this program, at the local level in the Mississauga Halton LHIN, 345 home care patients received enhanced care from December 1, 2020, to March 31, 2021, which included over 131,000 hours and 4,200 visits during the 16-week funding period. Feedback from patients and caregivers showed 86% (LTC at Home) to 94% (Rehab at Home) are satisfied with the care they are receiving.

Remote Patient Monitoring

Many LHINs worked with their system partners to leverage existing or create new remote patient monitoring models to be able to assist and access patients virtually from their homes or long-term care. These initiatives not only helped to support hospital, but also increased system capacity during the pandemic, and supported infection prevention control efforts for both COVID-19 positive and non-COVID-19 patients.

The collaboration between the Central East LHIN, Lakeridge Health, and Ontario Health is an example of an initiative that leveraged the structure of the COVID-19 Remote Monitoring Program. Through the new Central East Telehomecare Remote Surgical Monitoring Program, patients communicate their symptoms

through an app with a home and community care nurse seven days a week. The Remote Surgical Monitoring program was launched in collaboration with Lakeridge Health in July 2020 with thoracic surgery, then in August for orthopedic surgery, and finally for gynecologic-oncology surgeries in early 2021. More than 230 patients were enrolled in the Remote Surgical Monitoring program since the launch in July 2020. Since launching their remote surgical monitoring streams, Lakeridge Health has reported a drop in 30-day ED utilization by 10% across all three surgical cohorts compared to prior year data without remote monitoring. Scarborough Health Network joined with the surgical orthopedic pathway in February 2021 with 40 patients enrolled in the program at the end of fiscal 2021.

In the Hamilton Niagara Haldimand Brant LHIN, Remote Patient Monitoring programs were implemented to support COVID-19 positive patients recovering in their homes.

The South East LHIN facilitated the implementation of remote care technology at four hospital sites, various primary care, community and paramedic organizations. This supported virtual urgent care and monitoring for selected chronic conditions, including COPD, congestive heart failure and diabetes, benefiting more than 300 patients.

Intensive Home Care

Many ALC patients also benefited from hospital-to-home programs that offered short-term intensive home care and community support services. These targeted programs leveraged capacity within the community support sector to assist patients with customized care who would otherwise be unable to transition out of hospital. Effective examples include how Waterloo Wellington LHIN reinstated their Rapid Recovery program, a high intensity rehab program in the home setting to support discharge to home rather than waiting in hospital for a rehab bed, and how the North West LHIN implemented targeted expansion of two Wait-At-Home programs, which have been instrumental in reducing ALC-LTC patient populations in acute care settings.

Improving Mental Health & Addictions (MHA) Services

The demand for mental health and addictions (MHA) services increased significantly in the 2020/21 fiscal year due to the COVID-19 pandemic, and the LHINs continued to expand mental health and addictions services to ensure easier access to higher quality care and support in communities across the province. Through collaborations with the health system, justice system and municipal partners, as well as with patients, families and caregivers and other Ontarians, LHINs aimed to effectively respond to community needs through projects and investments, including:

Mobile Crisis Response Teams

Mobile Crisis Response Teams help connect people to the mental health services they need when they need them. Integrated with safe beds programs, and working in partnership with police and first responders, Mobile Crisis Response Teams engage individuals in crisis, de-escalate the situation, and help connect people with appropriate services in the community. The goal of Mobile Crisis Response Teams is to divert individuals experiencing a mental health or addictions crisis from incarceration, the justice system and/or unnecessary hospitalization. Many LHINs created or expanded on their mobile crisis response programs and teams in the 2020/21 fiscal year.

Central West LHIN continued to expand their Mobile Crisis Rapid Response Team. In 2020/21 Mobile Crisis Rapid Response Team operations, 2,355 calls for service were placed, 448 apprehensions (19%), 153 individuals were under the age of 16 (6%), with 1,137 referrals made to 24/7 crisis programs (48%).

Additional support was provided to nearly 50% of clients in crisis, offering support and connection to services, and reducing the risk of future crises.

The South East LHIN provided support and funding to Addictions and Mental Health Services - Hastings Prince Edward for the development of the Integrated Mobile Police and Co-Response Team (IMPACT) program to assist individuals where and when most needed, while supporting police managing calls for individuals experiencing MHA-related concerns. This collaborative, integrated model assigns a MHA worker at each of the local police services, improving police response, decreasing hospitalization and facilitating immediate intervention.

The Central LHIN expanded the operations of their Mobile Crisis Team, ensuring 321 individuals received services at a time of greatest need, and in the Hamilton Niagara Haldimand Brant LHIN, their Mobile Crisis Rapid Response Team (MCRRT) capacity was expanded to the Niagara region by hiring a team of mobile mental health crisis workers to provide primary crisis response together with police 12 hours per day, 7 days per week.

Withdrawal Management

Many LHINs made investments into Withdrawal Management services and programs. These programs function as stabilization services to support people who want to detox from a substance they've been using. Many of these programs also support averting or reducing presentations at the emergency department for withdrawal treatment, and were therefore expanded to help support the pandemic response.

Erie St. Clair LHIN added interim withdrawal management beds to increase capacity and reduce pressures on their local hospitals. In North Halton, considered to be among the fastest growing region in Ontario, Mississauga Halton LHIN invested in expanding on an integrated addiction medicine service, helping to avert opioid-related presentations to the emergency department and inpatient admissions for medical withdrawal or medical complications of opioid misuse which have continued to rise annually in this community.

The North Simcoe Muskoka LHIN established an in-home/mobile withdrawal management service. This service is a mobile withdrawal management and stabilization service that supports people living in the community who want to detox from a substance they are using. Developed near the end of 2020/21 this program will pave the way to support 36 unique individuals and will deliver 800 service provider interactions annually.

Hamilton Niagara Haldimand Brant LHIN supported the development of a clinical pathway for children and youth presenting to McMaster Children's Hospital in withdrawal or at risk of withdrawal. The LHIN also enhanced capacity of the community residential withdrawal management programs in Brant, Hamilton, and Niagara through the addition of a nurse practitioner in each program to improve the medical management of clients who are withdrawing from substances and need access to primary care and/or medications to manage the symptoms of withdrawal.

Support for Health Services Providers

Supporting those who provide health care services took on many forms across the LHINs, but many LHINs made providing funding, resources and supports for this group a priority in the 2020/21 fiscal year, but also as part of their pandemic response.

Waterloo Wellington LHIN co-led the development of a framework and resources for system-level partners' staff suffering from mental health issues, particularly but not limited to, in the area of bereavement and trauma. Targeted areas included staff working in highly destabilized congregate care settings, where significant outbreaks, illness and loss of life occurred.

South West LHIN identified and allocated three tranches of COVID-19 MHA emergency funds to health service providers to ensure robust resources were in place to allow health service providers to pivot services to virtual platforms and/or adopt infection prevention and control strategies. This work supported the safe and seamless transition of services across the MHA sector.

Toronto Central LHIN provided MHA health services providers support and access to Community Health Centre partners should they require support with navigating challenges related to COVID-19. These resource partners volunteered to share their knowledge, experience and resource materials to support MHA health services providers with questions related to Infection Prevention and Control (IPAC) training, accessing PPE supply chains, health and safety guidance, staff resilience, isolation capacity and operational approach to contract tracing.

In the North West LHIN, in collaboration with the Mental Health and Addictions Centre of Excellence within Ontario Health, COVID-19 emergency funding was allocated to both mainstream and Indigenous providers of mental health and addictions services. These funds enabled virtual care delivery, safe re-opening of in-person services, as well as supporting critical one-time staffing related needs. For example, funding was provided for mobile devices to be used by clients staying within the Isolation Shelter to virtually connect with family or clinical supports during their stay. The Isolation Shelter was established for the vulnerable population increased the availability and accessibility of safe, voluntary isolation spaces for vulnerable persons who are precariously housed or experiencing homelessness, where an individualized assessment of needs related to substance use, mental health and other health conditions were completed. The mobile devices supported adherence to isolation requirements.

Enhanced Programming for Priority Populations

A critical focus for 2020/21 was providing short-term strategies and resources to help children and youth, as well as their parents, guardians and family members, recognize and address additional stresses related to the COVID-19 pandemic.

In the Central LHIN, mental health and addictions nurses engaged with local school boards and community partners to support school-aged children struggling with depression, addiction or other mental health issues. In 2020/21, the team provided over 3,500 video, telephone and in-person visits to 493 youth between the ages of four to 21 still attending secondary school. The nurses provide short-term support and therapy to help young patients stay well and remain in school while they await more intensive treatment. The team also provided health teaching to youth about eating disorders. The Waterloo Wellington LHIN supported four CAIP (Child and Adolescent Inpatient Mental health) beds to remain open in hospital and the community aimed at reducing length-of-stay in ED for highly at-risk youth presenting to the hospital with significant issues.

The Erie St. Clair LHIN implemented Urgent Care Centre in Windsor/Essex to support crisis mental health needs and support hospital capacity and reduce overcrowding, and the Champlain LHIN participated in the integration initiative to bring the Ontario Structured Psychotherapy Program to all residents in the

East Region. Partner organizations provided 19,409 therapy sessions to more than 2,000 clients. The program demonstrated its effectiveness with 57% of clients showing reliable improvement.

Improving Long-Term Care

Long-term care (LTC) homes were impacted by COVID-19 during the first and second waves of the pandemic, with outbreaks due to poor infection prevention and control (IPAC) measures, overcrowding and health human resources issues. While the LHINs supported the LTC sector and continued to collaborate with administrators, operators, health service providers and community stakeholders to support planning for future capacity across the province, the primary focus in 2020/21 was preventing and addressing COVID-19-related concerns in long-term care homes.

Pandemic Response and Staffing

Due to the severity of the impact the COVID-19 pandemic has had on long-term care across the province, many LHINs worked quickly in 2020/21 to develop and implement staffing redeployment plans as well as strategies to communicate to stakeholders and partners more clearly and effectively, and to collaborate more efficiently.

In the North East LHIN, a North Region Community and Long-Term Care Working Group was formed to bring providers together from long-term care, retirement homes, home care, community support services (including independent living services) and emergency medical services from across the North. The group focused on sharing COVID-19 information, identifying pandemic preparedness gaps and seeking cross-sectoral resolutions wherever possible. For example, early in the pandemic, the group produced a paper on the consequences of the absence of family caregivers in LTC due to visitor restriction and limiting rituals, especially for Indigenous people. The paper formed the basis of discussion among the community and home care sectors to achieving a balanced system response to necessary public health measures.

Central West LHIN worked closely with long-term care operators and leaders across the LHIN to support stability and flow across the system. With a large number of long-term care homes in outbreak within the LHIN, teams supported high-risk homes to manage through outbreaks and to recover to a state where patients could safely transition to the preferred home of their choice. This support included deploying frontline staff to work in long-term care homes to help stabilize staffing needs. In addition, teams and other system partners served as coaches and mentors and, in several instances, identified opportunities to strengthen long-term care home staffing resilience and used their system navigation experience to build temporary partnerships in areas such as mental health for several homes.

Waterloo Wellington LHIN acted as the lead partner responsible for assisting homes in a staffing crisis, through redeployment and procurement of appropriate agency staff. Staff were redeployed into destabilized LTC homes to do laundry, provide personal support level services, nursing support, management level support, support with patient cohorting and staff scheduling.

South East LHIN hosted regular calls with LTC homes ensuring concerns were identified; established a common understanding of new directives, operating procedures and public health measures to avoid a crisis.

In Hamilton Niagara Haldimand Brand LHIN, staff were deployed into LTC to supplement staffing in caring for COVID-19 patients during a COVID-19 outbreak. This support also included working with LTC homes to

secure agency staff to meet the homes staffing needs in caring for patients during outbreak situations. With HISH funding, Hamilton Niagara Haldimand Brand LHIN also supported long-term care with the additional nursing and PSW staffing needed to rapidly admit and isolate patients to their many vacant beds. This partnership between HCC, Service Provider Organizations (SPOs) and LTC was a successful health human resource initiative enabling rapid admission of greater numbers of patients from hospital and community into long-term care.

The Champlain LHIN invested \$2,875,100 to hire additional IPAC personnel for long-term care homes and support the training of new and existing support staff to enhance their understanding of and skills related to IPAC practices and protocols. This initiative also ensured long-term care homes from across the region could participate in the IPAC community of practice support by the IPAC Hub. During the pandemic's second wave, the Champlain LHIN worked closely with public health units, hospital partners, long-term care and others to support the pandemic response and, ultimately, safely increase long-term care homes admissions.

IPAC Hubs

As part of the province's comprehensive Keeping Ontarians Safe: Preparing for Future Waves of COVID-19 plan, local networks of IPAC expertise (IPAC Hubs) were developed across the province to enhance IPAC practices in community-based, congregate living settings. Ontario Health identified organizations including hospitals, public health units and others from across the province to lead local IPAC Hubs, and many the LHINs were directly involved in this work.

The Champlain LHIN invested \$950,000 to establish an IPAC Hub to support LTC and other congregate living organizations across the region. The IPAC Hub was led by The Ottawa Hospital, in partnership with local public health units, Champlain LHIN Home and Community Care, Public Health Ontario and others. Through the IPAC hub, LTC homes access expertise, education and training, best-practice recommendations and coaching. The IPAC Hub has also been instrumental in establishing a community of practice in the region to support system coordination and knowledge transfer.

In the North West LHIN, by advancing the IPAC Hub and Spoke model across the North and responding to all long-term care homes with COVID-19 concerns and challenges, including participation in outbreak meetings, LTC functions and care were protected and enabled a supportive community environment.

The South East LHIN ensured equitable distribution of IPAC funding to LTC to support staffing and training, and in the Toronto Central LHIN, the use of an IPAC Hub and Spoke model and IPAC extenders as well as mobile enhancement support teams decreased the level of risk in LTC and increased their ability to manage outbreaks when they occurred.

Improving Access to Long-Term Care and Planning for Future Capacity

The Ministry of Long-Term Care announced a transformational strategy government's current commitment is to create 30,000 new long-term care spaces over the next decade and redevelopment of older existing spaces to modern standards. In support of this strategy, LHINs conducted reviews of local long-term care sector needs in order to help inform the development of future long-term care capacity. For example:

A new 160-bed long-term care home under construction, Glen Hill Terrace in the Central East LHIN, is projected to be completed by May 2021, and in the South East LHIN, there were an additional 954 new beds allocated, and 1,871 beds are expected to be redeveloped.

Toronto Central LHIN developed a Toronto Region Long-Term Care Home Recovery Plan which supported the Ministry of Long-Term Care's request for all long-term care homes to work with the regions to develop and implement an admissions plan. This plan enabled homes to implement a local framework to optimize capacity while managing risks.

In the South West LHIN, a long-term care home capacity plan was developed to understand the current and future priority needs of the overall region and geographic areas. Phase I (completed) focused on the current state in each of the geographic areas of the Ontario Health West region, and Phase II (in progress) focuses on the future state of long-term care.

The North West LHIN focused activities on preparation work for potential severe staffing shortage situations due to the COVID-19 pandemic by linking each long-term care home in the region with a hospital and bringing together a Mobile Enhancement and Support team (MEST) across the North West. This included working with partners such as regional public health units, EMS, supply chains and public health Ontario labs.

Behavioural Support Services in Long-Term Care Homes

Behavioural Supports Ontario (BSO) provides enhanced services for individuals with complex responsive behaviours associated with dementia, mental health, addictions and other neurological disorders, as well as supports for families and caregivers. Staff are specially trained to identify and reduce triggers, provide non-pharmacological interventions and improve engagement and quality of life for these individuals.

The pandemic increased stress for patients awaiting long-term care admissions and their families. The Central West LHIN's BSO program was instrumental in supporting these patients and families during the pandemic by offering more support and strategies to at-risk patients living with behavioural health and social issues, and their families. BSO nurses supported complex discharges and transfers of hospital patients in and out of region. Caregiver support was extended to families to provide emotional respite in the absence of traditional adult day programming. Additionally, they prevented escalation of personal expressions by diverting emergency department presentations and hospital admissions in partnership with primary care and geriatric outpatient services.

In collaboration and partnership with Behavioural Supports Ontario, and the three Alzheimer's Societies across the region, North East LHIN completed a regional High Intensity Needs Collaborative Pilot Project. Approximately 55 clients living with dementia with responsive behaviours were successfully transitioned to LTC from the acute care setting during the pandemic and were supported through the Infection Prevention and Control (IPAC) isolation requirements under public health measures. A quadruple aim evaluation is being finalized to measure the success of the project, which includes improving access to long-term care for people with dementia and demonstrating safe practices for serving this population. The pilot is continuing through the first quarter of 2021/22.

Long-Term Care Behavioural Specialized Units

In November 2019, the Ministry of Long-Term Care announced funding for specialized long-term care support for residents with complex needs through its Behavioural Specialized Unit pilot program. The pilot program was developed with the goal of helping relieve hospital capacity pressures by assisting patients with complex behaviours move from hospitals to long-term care homes more quickly.

The South West LHIN's Behavioural Support Transition Unit in Grey Gables, Markdale (20 bed unit) has provided time-limited, specialized supports for individuals who have responsive behaviours. This unit offers a safe living environment that enhances a person's quality of life and identifies triggers and

interventions to responsive behaviours. The program helps residents to improve coping skills and reduce responsive behaviours so that they can move on to other living arrangements.

Nurse Practitioners Supporting Teams Averting Transfers & Nurse-Led Outreach Teams

Two teams supported residents in long-term care by responding to acute health concerns that might otherwise result in an emergency transfer to hospital: Nurse Practitioners Supporting Teams Averting Transfers and Nurse-Led Outreach Teams.

Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) is an outreach program where NPs travel to LTC homes to assess, diagnose and treat acute and episodic conditions and injuries to help prevent avoidable transfers of residents to emergency departments.

Nurse-Led Outreach Teams (NLOTs) are teams of specialized nurses who provide emergency mobile nursing services to residents of long-term care homes to build capacity and avoid emergency department visits.

As part of the Mississauga Halton LHIN's COVID-19 response in long-term care homes, the Nurse Practitioners Supporting Team Averting Transfers continued to support the residents and staff of all 28 long-term care homes in the Mississauga Halton LHIN with on-site acute episodic care, risk assessment, system navigation, emergency department and hospital flow.

The Mississauga Halton LHIN NPSTAT averted unnecessary admissions from ED to inpatient units (82 inpatient days saved), reduced the risk of unnecessary 30-day readmission to acute care after discharge and improved the satisfaction of healthcare received across the care team, family and resident.

The Central West LHIN NLOT supported the successful repatriation of over 1,000 LTC residents from hospital to LTC homes and contributed to a 49% reduction of LTC residents admitted to the ED during the pandemic.

Nurse Practitioners Supporting Team Averting Transfers worked closely with long-term care staff, medical team and other allied staff to support resident needs during COVID-19 outbreaks and contributed to the implementation of the provincial six point plan to stop the spread of COVID-19 variants, announced in January 2021. These teams assisted with COVID-19 testing and provided dedicated nurse practitioner resources to homes most impacted by COVID-19.

In the South East, a Nurse-Led Outreach Team played an important role in the delivery of care stabilization and assistances throughout the pandemic and particularly in assisting with the delivery of vaccines to LTC residents and staff.

Improving On-site Care for Long-Term Care Residents

The Champlain LHIN contributed to the rapid development of a provincial decision tool to guide patients and families considering taking their loved ones out of long-term care and facilitated daily reporting on risks and mitigation strategies across key system partners. The LHIN worked to ensure the flow of accurate information from long-term care homes to inform admissions planning, and deployed numerous home care staff to help with staffing shortages. Through base funding for Behavioural Supports Ontario in Champlain, 1,149 long-term care staff received funded virtual education on behaviour supports.

Two initiatives taken on by the LHINs highlight the benefits of expanding on virtual care in long-term care. In the South West LHIN, 13 long-term care homes participated in Think Research to extend virtual consultations to enhance primary care capacity to support integrated digital strategy for long-term care homes inclusive of specialist and team-based care. The Mississauga Halton LHIN Nurse Practitioner Supporting Team Averting Transfers team was instrumental in supporting long-term care homes to develop and implement virtual care options to support resident care early in the pandemic response.

The Erie St Clair LHIN ensured Digital Lab Access 24/7 for all long-term care homes in Erie St. Clair and South West regions to support prompt lab results for patients to enable better care.

Palliative Care in Long-Term Care

The Central LHIN developed a Palliative Care Resource Package which offers resources to optimize staff capacity, (including physicians, nursing staff, personal support workers, social workers, recreation therapists and registered dietitians) was introduced to all 46 long-term care homes in the region. This expansion was implemented after a pilot project in seven long-term care homes the previous year earned very high satisfaction responses from staff, patients and family members. The purpose of this electronic toolkit is to enable standardized, sustainable palliative/end-of-life care for residents of long-term care homes, support resident requests and reduce transfers to hospital. The electronic toolkit includes gap analysis tools to support decision-making along with resources to distinguish between palliative and end-of-life care. With the introduction of the Palliative Care Resource Package, long-term care homes in Central LHIN demonstrated improvement in avoidable emergency department visits with plans to continue this work to further reduce avoidable emergency department visits. The Palliative Care Resource Package was developed collaboratively by the Central LHIN Long-Term Care Working Group, with oversight provided by the Regional Palliative Care Network. The toolkit also supports the implementation of Quality Improvement Plans.

The Mississauga Halton Palliative Care Network Palliative Care Response Team in the Mississauga Halton LHIN has partnered with long-term care and retirement homes as they manage residents with a progressive, life-threatening illness and/or experiencing symptom burden at end of life. Support is offered through consultative assessment visits and focus on palliative care needs including symptom management, goals of care, end of life management, palliative care education and psychosocial and bereavement counselling for residents, families and staff. Since October 2020, they have supported eight long-term care homes and seven retirement homes, performing 226 clinical consults, seven virtual psychosocial consults and two virtual educational consults.

In the South East LHIN, South East Regional Palliative Care Network and Home and Community Care initiated a pilot program in two long-term care homes to ensure patients receive high-quality palliative care and die in their place of choice. Palliative Pain and Symptom Management Consultants were embedded part-time in the homes over a two-month period, providing bedside mentoring and customized curriculum based on identified needs. Results indicate the partnership improved long-term care home staff capacity and comfort in providing palliative care and promoted an interdisciplinary approach to care. The success of this pilot will assist the expansion of this model into other long-term care homes.

Improving the Delivery of Home Care

LHINs delivered home and community care services to more than 700,000 people across the province in 2020/21. This work involved partnerships among care coordinators, physicians, nursing professionals, physiotherapists, occupational therapists, speech language pathologists, rehabilitation assistants, social workers, dietitians and others. As a result, LHINs continued to develop innovative and collaborative initiatives to safely transition patients along their care journey

Addressing Personal Support Service Human Resource Challenges and Advancing Home Care Capacity and Consistency

In order to address previously identified challenges related to recruiting and retaining personal support workers (PSWs) in their regions, LHINs, in collaboration with local partners, have implemented a range

of strategies and initiatives to support PSW job satisfaction and retention, and improved consistency in service delivery and patient satisfaction.

North Simcoe Muskoka LHIN implemented a new personal support services model designed to enhance the safety and wellness of both residents and staff in area retirement homes. The new 'shift-based' model saw PSWs adopt a shift approach, replacing multiple PSWs providing 30-minute service visits to clients at the retirement home. This new model also enhanced the safety of retirement home residents during the pandemic by limiting the number of care workers visiting the home. In addition, the model provides increased continuity of care for residents and more consistent work for PSWs.

To reduce their footprint, and enhance flexibility in care provision, Erie St. Clair LHIN implemented shift service delivery for PSW and occasional nursing in congregate settings.

Client-partnered scheduling was implemented in North East LHIN to increase provider flexibility scheduling PSWs, minimize missed care and foster improved relationships with patients. With this model, visit times are flexible and may change depending on the patient's needs and the needs of other patients. The provider contacts patients or their caregivers directly to arrange a visit schedule. Patients can contact the provider directly to discuss needs or concerns they might have about the timing of visits. When the care tasks are completed, the PSW proceeds to the next client, making better use of their time. This model is helping service providers make better use of the PSWs' time through improvements to scheduling, helping to reach more patients and retain more PSWs. During the pandemic, all nursing and PSW providers were aligned to individual retirement homes in order to minimize risk of COVID-19 transmission, improve efficiency for providers and build partnering relationships with retirement homes staff.

Care Coordination Initiatives

Recognizing the value of operating as an integrated team to support patients as they move through their care journey, Central West LHIN Home and Community Care staff in Dufferin/Caledon were cross-trained to mobilize resources, which enabled care coordinators to provide patient-focused care for patients in the community and during hospitalization. This integrated care coordination model has resulted in fewer hand-offs, an improved ability to advocate for the patient's needs, an increased awareness of the patient's story, and improved communication with stakeholders. In addition to a 29% increase in referrals following implementation, this new model has resulted in the following outcomes:

- reduced length of time to process long-term care applications
- fewer inappropriate service plans and home care referrals
- a streamlined opportunity for care coordinators to contribute knowledge directly to the hospital teams when complex patients are admitted to hospital and during the discharge planning process

Toronto Central LHIN implemented centralized hospital intake to facilitate community-based home care delivered at the neighbourhood level that improves transitions across the continuum of care and collaborative care planning for complex and chronic patients. The concept of a shared team with hospital, local community providers and primary care was optimized by use of e-notifications and team-based model of care to address urgent client issues, with the goal of minimizing risk of readmissions for complex clients.

The initial implementation of Champlain LHIN's High Intensity Support at Home program supported 85 patients in several geographic clusters using a team-based model to provide wrap-around care.

Innovative models of care were implemented in order to enhance quality and safety of patient care and

utilize scarce resources through neighborhood and shift approaches. Earlier hospital discharges and hospital avoidance were facilitated through the implementation of nursing tele-monitoring models. Care coordinators work with partners to do “whatever it takes” to meet the needs of complex patients. Dementia support is also provided, including installation of wandering detection and diversion technology in the home.

The Community Stroke Rehabilitation Program shifted to virtual care in March 2020 and obtained a supply of iPads for patient use. The program supported earlier hospital discharges and a higher number of referrals compared to previous years. The program expanded to provide Champlain-wide care. This involved a novel collaboration with Bruyere Hospital to develop an integrated community/outpatient partnership. The project has ensured better access to specialized interdisciplinary stroke care for patients while maintaining a high standard of patient centered outcomes. The CSRP had a hospital Length of Stay (LOS) savings of 3.48 days on average in an area where no specialized stroke outpatient care existed.

Palliative Care Initiatives

During the 2020/21 fiscal year, North Simcoe Muskoka saw a sharp increase in the care provided at home in the last weeks of life and record high medical assistance in dying numbers (MAiD), with at-home deaths increasing from 41.7 percent to 59 percent. As a result, Ontarians had better access to palliative care in their homes and in their communities.

Despite a pandemic and health and human resources challenges, caregivers responding to North Simcoe Muskoka LHIN’s annual Caregiver VOICES survey reported an improvement in nearly all areas of support measured, and 99.3 percent believed their family member died in the right place. To preserve much-needed end-of-life medications and increase accountability with narcotics in the home, the team adjusted the contents of symptom relief kits to align with Ontario Palliative Care Network guidelines, strengthened accountability, and added an additional layer of review by nurse practitioners to ensure these vital medications went where they were most needed. The work done this year on safety, tracking and accountability will be further strengthened to ensure the ongoing safe usage of end-of-life medications in the home.

In April of 2020, partners including Heart House Hospice, Acclaim Health, Dorothy Ley Hospice and Mississauga Halton Palliative Care Network worked with the Mississauga Halton LHIN to develop a 24/7 Hospice Palliative Care Helpline. The regional Helpline provides patients, caregivers, long-term care home, retirement home partners, primary care physicians, service provider organization staff, etc. with palliative care information, education, counselling, emotional supports, and palliative care clinical support managed by Mississauga Halton Palliative Care Nurse Practitioners. Over 125 calls have been received with 40% deemed as urgent and have resulted in referrals to community palliative care providers. Beginning January 2021, palliative care nurse practitioner hours were extended to be available 24 hours a day, seven days a week. Over 290 calls were received between January and the end of April 2021 averaging 72 calls per month with 85% received on the weekends.

The South East Regional Palliative Care Network, in partnership with South East LHIN and other community stakeholders developed a COVID-19 specific Symptom Response Kit to improve access to pain and symptom management for individuals at end-of-life, which also included strategies for managing potential shortages in palliative care medications during COVID-19. This also led to the development of a Goals of Care Guide for Talking About Wishes and Goals with COVID-19.

Using Digital Health Technology to Deliver High Quality, Innovative and Accessible Health Care

As a result of the COVID-19 pandemic, there was an increase virtual home care to support provincial public health self-isolation and social distancing efforts in a way that minimizes disruption to patient care. Such home and community virtual solutions support intake assessments, monitoring and treatment of patients presumed or confirmed with COVID-19, and virtual care for palliative care by using existing virtual care technologies, including videoconferencing tools provided through the Ontario Telemedicine Network (OTN) to support care.

Digital health technology is changing the way health care is delivered. Across the province, LHINs have worked with patients, caregivers, clinicians and other organizations to implement new tools to enhance connectivity between providers and patients.

Aligned with Ontario's Digital First for Health Strategy, and expedited to respond to evolving patient needs during the COVID-19 pandemic, Central LHIN expanded virtual care services significantly to home and community care patients in 2020/21. Within just a few weeks, over 200 registered health care professionals were trained to provide virtual care over a provincially approved secure video interface platform. This team – comprised of community care coordinators, including specialty caseloads, as well as direct care nurses – completed nearly 82,000 virtual care visits or phone assessments in 2020/21. In providing this critical patient care support, the team applied internationally recognized interRAI tools, which provide reliable, person-centred assessments for medical complexity, physical and cognitive ability, mental health, caregiver distress and more. These factors inform and guide comprehensive service planning and care. Patient feedback on virtual care services received was very positive, with 100% of surveyed patients and caregivers indicating they received adequate information about the virtual care process and felt comfortable exchanging information virtually. In addition to providing virtual care in 2020/21, Central LHIN Home and Community Care completed 10,000 face-to-face in- home visits with complex or at-risk patients.

Erie St. Clair LHIN implemented a digital triage tool across Erie St. Clair hospitals for utilization by care coordinators to decrease wait times, enable virtual referral flow from hospital to intake for support when needed.

In Hamilton Niagara Haldimand Brant LHIN, home care frontline staff were supported with technology and policies which enabled them to remain connected with patients and support them during COVID-19 in both community and hospitals for discharge planning. Virtual care tools in the hand of care coordinators as well as service provider staff ensured no patients were left without support.

Waterloo Wellington LHIN rolled out InterRAI CheckUp, which is a new tool validated for virtual assessment of home care patients, and participated in the Safety Net program for COVID-19 positive patients convalescing at home and requiring remote monitoring.

Remote patient monitoring programs were also impended in Hamilton Niagara Haldimand Brant LHIN to support COVID-19 positive patients in their homes through home care teams and paramedicine partnership programs, and care coordination supports were established to support high-intensity patients in the community while they waited for a long-term care bed.

Community Access Points

To further development and integration of community access points, Toronto Central LHIN launched an integrated work flow and call flow between Information and Referral and Toronto Seniors Helpline (TSH) to support system navigation and community service referrals. The LHIN streamlined access to the Community Behavioural Support Outreach team through TSH, leveraging live counselling and access to Crisis Outreach Services for Seniors. Toronto Central LHIN also piloted rapid access to the Community Behavioural Support Outreach team from the emergency department at Toronto Western Hospital and planned for expansion to other emergency departments. Referrals from ED to date are highly complex and patients have been successfully maintained at home with the benefit of a behavioural care plan and clinical assessment by a nurse practitioner

Capacity Planning

Capacity planning efforts involved the alignment of health system resources to meet the current and future needs of patients and families. LHINs worked with the Ministry of Health, Ministry of Long-Term Care and broader system partners to anticipate and respond to impending needs, such as those of a rapidly growing senior population.

Surge Planning

LHINs participated with acute care and community partners to plan and respond to higher than normal service demands, throughout the pandemic. These plans included solutions to expand beyond normal services to meet the increased demand for qualified personnel, medical care and public health to support surge planning.

With the decrease in the availability of long-term care beds, South West LHIN funded and opened 188 transitional beds in retirement homes across the region. Through partnerships with home care, patients and caregivers, hospitals and retirement homes, the LHIN was focused on ensuring patients received care in a safe environment while awaiting their next care destination, rather than staying in alternate level of care in hospital.

Waterloo Wellington LHIN moved to an informed triage and wait list system which ensured capacity as it was challenged in the system, and that the most vulnerable and complex patients did not go without care.

Capacity planning efforts in Central West LHIN focused on the expansion of acute, post-acute and critical care beds between April 2020 and March 2021, with the opening of 87 total beds at William Osler Health System and six total beds at Headwaters Health Care Centre, providing relief for the surge in critical and acute care volumes brought on by the pandemic.

Toronto Central LHIN spearheaded the GTA COVID-19 Hospital Incident Management Structure (IMS) to:

- Monitor hospital critical capacity needs in real time
- Respond in a timely manner to the pace of capacity issues, while targeting upstream engagement with hospitals and focusing on early warning signs
- Move patients to and from hospitals
- Engage the system to redirect resources as needed to preserve system integrity

The GTA Hospital IMS has been successful in ensuring the health care system can withstand the increased capacity pressures felt by the pandemic.

Wait at Home Initiatives

To improve the health system's capacity to respond to the COVID-19 pandemic, North West LHIN Home and Community Care implemented targeted expansion of two Wait At Home programs, which have been instrumental in reducing alternate level of care and long-term care patient populations in acute care settings. Through the Active at Home Program, 85 frail, complex patients with multiple comorbidities were supported, resulting in improved mobility, greater community independence, reduced hospital admissions and long-term care placement.

Community Paramedicine

In 2020/21, in response to COVID-19, the Ministry of Health provided funding to enhance system capacity in the community so that high-needs patients continued to receive timely, high-quality care in their home. Mississauga Halton LHIN expanded community paramedicine programs in Halton, Peel and Toronto to develop and implement a Home Visit Wellness Check program to support seniors and other vulnerable patient populations during COVID-19. Between December 1, 2020, and March 31, 2021, the three community paramedicine programs completed 759 home visits to 127 high-needs clients across Mississauga Halton LHIN, and the expanded community paramedicine services supported the COVID-19 response by administering COVID-19 tests and vaccinations to over 450 individuals living in Oakville, Milton, Halton Hills, Mississauga and South Etobicoke.

North East LHIN established partnerships with multiple community paramedicine programs across the region, leveraging the use of a Health Partner Gateway platform for the bilateral referral of patients between the community paramedicine programs and home care.

Erie St Clair LHIN partnered with their community paramedicine program which resulted in increased opportunities to leverage emergency medical services and mobile teams to support testing, isolation, mobile health assessments and vaccinations.

Health System Transformation

Ontario is continuing to build an integrated, connected health care system centred around the needs of patients. Under the *Connecting Care Act, 2019*, Ontario Health Teams were introduced to provide a new way of organizing and delivering services in local communities. This new model of care brings together health care providers to work as one coordinated team that better connects patients and providers in their communities to improve patient outcomes.

Supporting the Development and Expansion of Ontario Health Teams

Starting in 2019, the Ontario government approved the establishment of Ontario Health Teams (OHTs) to begin implementing a new model for organizing and delivering health care. Under Ontario Health Teams, a varied group of health care providers – including primary care, hospitals, long-term care home, emergency service providers, home and community care, and other providers from across the continuum of care – work together as one coordinated team.

The implementation of OHTs remains a key priority within the government's plan to modernize the health care system. In July 2020, five new Ontario Health Teams were announced, and in November 2020, an additional 13 OHTs were announced with a total of 42 OHTs in the province.

Through OHTs, patients will receive 24/7 access to seamless navigation and care coordination.

Despite the pressures of COVID-19 in 2020/21, significant progress was made in establishing additional OHTs, and also exploring and expanding services offered by the initial cohort of approved OHTs.

In the Central LHIN, with the announcement of the Western York Region OHT on July 23, 2020, there are now five OHTs approved to operate in Central LHIN in 2020/21. These teams introduced several new initiatives. Examples include:

The North Western Toronto OHT introduced Seamless Care Optimizing the Patient Experience (SCOPE+). This initiative provided a single telephone number for primary care physicians to call for an array of services – from setting up diagnostic imaging to arranging home and community care services for their patients and securing counselling on general medicine queries. A Central LHIN Care Manager served as the point person for this interdisciplinary care program. The North Western Toronto OHT also designed and implemented a new pilot program for patients with chronic obstructive pulmonary disease (COPD). The same Central LHIN Care Coordinator for SCOPE+ also supported multiple providers to ensure their COPD patients received consistent and streamlined care coordination, navigation and service levels using a consistently applied pathway. In 2020/21, the team also began preparations to expand this intensive case management model of care for patients with congestive heart failure.

Another OHT in Central LHIN, North York Toronto Health Partners, developed a new program called North York Community Access to Resources Enabling Support (North York CARES). Through the collaboration of 14 care providers, the focus of this program is to help transition patients from hospital to home with an integrated care program, which, depending on the patient's individual needs, could include home and community care services.

Toronto Central LHIN supported OHTs in the region to develop a coordinated flu vaccination plan for Fall 2020. OHT partners were able to implement a number of creative flu vaccine delivery models and modalities including: community pop-up flu clinics to increase access to vulnerable populations and less mobile clients; targeted mobile outreach to congregate and high density settings (including shelters, group homes and seniors housing buildings); shared clinics where cross-sector partners collaborated to share physical spaces and staffing to set up flu clinics; and establishing websites to provide a centralized point of access to information for providers, partners and community members, enabling consistency in messaging across OHT partners related to flu planning.

South East LHIN continued supporting regional OHTs, with two OHTs approved at time of writing and one that has submitted a full application (Hastings Prince Edward), which will ensure that the entire South East region will be covered.

North East LHIN planning staff provided key support to the Algoma Ontario Health Team in developing its readiness to become an approved team. Algoma OHT IS one of two OHTs across the North East Region (Nipissing Wellness Team, North Bay, 2019). The Algoma Ontario Health Team brings together health care providers to improve coordination of care for Algoma communities and build a more integrated system of care for people living in Algoma. Their work is focused on frail, elderly and patients with conditions that are best managed in the community. As part of their commitment to meaningfully engage citizens in system design, the OHT convened a Citizens' Reference Panel to hear from a representative group of citizens that broadly reflect the diversity found within the community. Working together, this diverse group of randomly selected citizens provides the OHT with recommendations that help to shape the

future of health in their region through a process known as “deliberative engagement”.

Health Service Provider Integrations

Integrations in health care offer efficiencies in the system to support improved quality of care, patient and provider satisfaction and further sustainability.

In alignment with the province's focus on integrated care, the South West LHIN Community Support Services Bundled Care program integrates community support services, home care and community paramedicine support, providing discharge for hospital patients or patients in the emergency department. This integrated bundle of care lasts four weeks post-discharge, can be accessed through Community Support Services Central Intake, and includes: transportation home; medication pick up; two weeks of Meals on Wheels; two homemaking visits; two transportation rides to medical appointments; and caregiver supports.

Champlain LHIN provided project support to the Neighbourhood Integrated Care Model Project steering committee, core teams and allied partners who are implementing the project. The model is an innovative approach to planning, funding and delivering place-based supports in communities whose populations frequently use health services. In the 2020/21 year fiscal year, 13 housing, health and social service providers signed a letter of cooperation to implement interdisciplinary neighbourhood teams in three communities. The LHIN brought partners together to develop core team guides to respond consistently to ongoing and emergent mental and physical health needs, and transitions. Increased collaboration through this project led to a range of successful initiatives during the pandemic. Partners conducted wellness checks and addressed emerging needs (e.g., food baskets, face masks, cell phones to access virtual care and social programs). In the mixed-age dwelling, new members of the team were quickly integrated. The teams had early success in supporting transitions home from hospital, and for personal support and homemaking, the teams improved referral processes and coordination.

Integrating team-based care, Central West LHIN Home and Community Care team partnered to create a new COVID-19 monitoring program. Launched in April 2020, and led by the Dufferin County Paramedic Service, the LHIN and the Dufferin Area Family Health Team, the remote program provides monitoring by respiratory therapists 7 days a week, while actively involving primary care and specialist collaboration, and Hospice Dufferin. Patients and the clinical team received support through a centralized intake team coordination and monitoring, with effective transition from home and community care teams serving as the foundation to support the program.

COVID-19 Response

North Simcoe Muskoka LHIN collaborated with local health units and local providers to deliver COVID-19 vaccines to patients who were not able to leave their homes to get a vaccine. This Homebound Vaccination Program was unique to the North Simcoe Muskoka region and the South Simcoe area of Central Region. A significant volume of preparation work done in late 2020/21, including screening, identification and service authorization.

Implementing Wound Care Standards

Working to help ensure continuity and accessibility of care for wound patients in the home and community and supported by Central East LHIN, a consortium of leading Canadian organizations has come together to launch Telewound Care Canada, a virtual care initiative designed to help patients connect with their care teams while reducing unnecessary travel and in-person care. Telewound Care Canada aims to implement, evaluate and scale integrated, virtually enabled models of wound care that will impact over 1,000 wound patients in Ontario and Quebec by summer 2021.

North West LHIN established a Regional Wound Care Lead to help reduce the impact of wounds, amputation rates and pressure injuries. This was achieved through the development of pathways, chairing the Regional Wound Care Advisory and the provision of education in evidence informed best practices including Health Quality Ontario Standards.

Virtual Care and Digital Solutions

Leveraging virtual care platforms and digital solutions to ensure delivery of care in home and community by many LHINs was a key component of serving their populations during the pandemic.

Through the application of enabling technology, Waterloo Wellington LHIN implemented a strengthened, intelligent and patient-informed approach to virtual care. During 2020/21, virtual care delivery in home and community care was successfully expanded with over 1,300 unique patients served this past year in Central West LHIN. Home and community care teams and patients across the Central region have seen an increase in access and confidence using appropriate virtual models of care. Well received interventions include seniors-based exercise and falls prevention classes, reassessments and a variety of clinical intervention.

Working closely with their Digital Health Advisory Committee and Ontario Health Teams, Mississauga Halton LHIN successfully undertook new digital tools for improving the delivery of care with an emphasis on multi-partner integration and commitment to access and continuity of care. Over 21 different programs are in progress, including virtual home care, urgent care, surgical transitions, remote home care monitoring and the more recent central wait list management.

In an effort to help contain the spread of COVID-19 in the north region, North West LHIN used funding provided by the Ontario Health Virtual Health Secretariat to provide virtual care services through remote care monitoring, surgical transitions and virtual urgent care. In 2020/21, 1,600 patients in the North region accessed these virtual supports.

Other virtual care projects launched by North West LHIN include:

- Virtual critical care
- COVID-19 remote care monitoring
- Surgical transitions
- Virtual urgent care
- Virtual care in home and community care

Community Engagement

Community engagement is built into every part of the planning, delivery and evaluation of LHIN work. Serving communities across the province responsibly and responsively relies on ongoing dialogue with those who use health services and those who deliver them. LHINs actively engaged with communities, residents, health service providers, provincial associations, local government leaders and many other organizations and individuals on how to improve and enhance Ontario's public health system.

In this last year, LHINs continued to engage with priority populations, including Francophone and Indigenous communities and other health system partners to identify potential risks and implement targeted interventions to improve access to appropriate and culturally sensitive care. As might be expected, many engagements in 2020/21 focused on ensuring support for these populations through the pandemic.

Engagement with Francophone Communities

Access to quality French language health services directly impacts the health of Franco-Ontarians. LHINs are committed to engaging with the Francophone community to inform planning and integration of these services in accordance with the *French Language Services Act*. Strong working partnerships have been established with French Language Health Planning Entities (les Entités) across the province to support engagement with Francophone stakeholders, as the following examples demonstrate.

Champlain LHIN, in collaboration with Le Réseau des services de santé de l'Est de l'Ontario (Le Réseau), continued to support health service providers seeking their official designation under the French Language Services Act, including the Foyer St-Jacques and Renfrew Victoria Hospital. Champlain LHIN also worked with Le Réseau to increase Francophone capacity in long-term care in the region.

In collaboration with Entité 4, North Simcoe Muskoka LHIN developed a comprehensive webinar module on active offering of French language services, which was adopted by area hospitals.

The Francophones and Cultural and Linguistic Sensitive Care online training was launched to home and community care and staff in Erie St. Clair and South West LHINs. This training encouraged participants to reflect on how their own beliefs, biases and assumptions about the Francophone community shape their behaviours.

Toronto Central LHIN and Entité 3 worked in partnership to provide advice and support for the final steps of the designation process for Women's College Hospital. This resulted in the official designation of Women's College Hospital in May 2021.

South West LHIN had a total of 17 community engagements sessions for the francophone community, which were organized and held in collaboration with the French Language Health Planning Entity.

North West LHIN, in partnership with the Réseau, worked with health service providers to increase awareness and provide support to implement active offer within their practices. The Réseau participated in various committees to provide the Francophone perspective on issues such as senior care, palliative care and rehab care.

North East LHIN worked closely with the Réseau to enhance care coordination, improve the patient experience, increase access to services in French, reduce inequities, and strengthen the sustainability of French Language Services across the North. During this pandemic year, engagement was focused primarily with health service providers.

South East LHIN, in collaboration with the Réseau, continued working towards establishing French Language Services designation, with Ontario Health East approval, for Kingston Community Health Centres.

Engagement with Indigenous Communities

In 2020/21, LHINs continued to focus on establishing trust and strengthening relationships with Indigenous partners and communities to better understand and address the needs of Indigenous populations. Continuing to build mutually respectful relationships and engage with Indigenous communities, leadership and health service partners, LHINs were better equipped to facilitate new partnerships, particularly in response to the pandemic, to ensure culturally safe care, access to testing, PPE supplies, and Indigenous-specific messaging.

The Hamilton Niagara Haldimand Brant Indigenous Health Network, in partnership with the Hamilton Niagara Haldimand Brant LHIN, facilitated a unified vision for pandemic care that supported Indigenous people through creating space to identify and respond to the needs of the Indigenous community and embracing wellness. This included redeploying staff to support Indigenous members of the community, distributing essential items such as food reserves and PPE, and developing and implementing strategies to address vaccine hesitancy and support culturally safe and trauma-informed approaches to vaccination.

Waterloo Wellington LHIN continued to work in partnership with local Indigenous communities to improve access to culturally safe care, COVID-19 testing and vaccination clinics. More than 200 LHIN staff (including front-line staff), providers and community members participated in an online Indigenous Cultural Safety Training course.

Central LHIN staff continued to work with Georgina Island Health Services Office, Barrie Area Native Advisory Circle, Canadian Mental Health Association York Region, as well as other Indigenous and non-Indigenous partners by participating in the 11th Annual Indigenous Health Forum hosted by the Simcoe Muskoka York Indigenous Health Circle. The event built on prior year co-design planning to identify needs, considerations and culturally appropriate programs and services.

Toronto Central LHIN worked with Anishnawbe Health Toronto to convene the Toronto Region Indigenous Table to help better understand and meet the needs of Toronto's Urban Indigenous population. The LHIN also engaged with a number of Indigenous community leaders on a virtual event discussing real First Nations, Inuit, Métis and urban Indigenous experiences in the health care system which advised on a number of ways to address anti-Indigenous racism.

Mississauga Halton LHIN, Central LHIN, Central West LHIN, and North Simcoe Muskoka LHIN quickly mobilized a Central Region Indigenous Specific Response in partnership with the Indigenous Health Circle of North Simcoe Muskoka. Indigenous representation was at the Emergency Operations Command table. The development of a Central Region Indigenous Specific Strategy for COVID-19 was the main priority and led to activities which included frequently connecting with stakeholders so all First Nations and urban Indigenous communities felt supported during the pandemic. To align with regional integration, the NSM Indigenous Health Circle extended an invitation to Central LHIN's First Nation Community Chippewas of Georgina Island and The Indigenous Network to participate in critical discussions focusing on the pandemic. As a result, the Indigenous Health Circle established an Indigenous Leadership COVID-19 Response Table where the five First Nations and Indigenous providers strategize, share information and support on COVID-19 response and recovery with topics including PPE allocation and supplies, testing, contact tracing and communication.

In an effort to keep communication lines open, the South West LHIN maintained regular contact with one-on-one meetings with Indigenous partners to address needs and offer ongoing support. The LHIN

facilitated discussions between the Western Ontario Health Team and the Indigenous Health Committee (IHC) to discuss how Indigenous communities/agencies may wish to participate and support Ontario Health Team developments to ensure planning and provision of services is influenced by Indigenous voices.

Central East LHIN held weekly touch-base meetings with First Nation, Métis, Inuit and urban Indigenous agencies during the pandemic. This enabled local response to PPE needs, provision of advice on overcoming challenges related to testing, assessment and vaccine access for urban Indigenous peoples. Central East Health Advisory Circles worked with the touch-base group to invest their annual Indigenous community engagement budget to directly support COVID-19 response, including cultural supports and essential supplies for those in need.

North East and North West LHINs engaged extensively with Northern Indigenous partners and people this pandemic year. In April 2020, North East LHIN created a COVID-19 Response Indigenous Working Group, which includes Northern First Nation Health Directors (109 First Nations in the North), Tribal Councils, health authorities, and federal and provincial partners. The working group focused on mental health and addictions, PPE and critical supplies, communications and engagement, connectivity and testing.

North East LHIN supported the provincial roll out of rapid access testing to First Nations communities, Indigenous health service providers, and health partners across the North. All 109 First Nations communities were engaged either directly or through Tribal Councils or Indigenous health partners.

Engagement with Other Communities and Populations

Throughout the year, engagement activities with Patient and Family Advisory Committees (PFACs) across the LHINs continued, albeit it virtually due to restrictions on in-person meetings. Many PFACs pivoted their meetings to focus on pandemic issues. Membership of these committees is diverse and encompasses Ontarians with a broad range of lived experiences, including home care patients', caregivers, palliative caregivers and those with mental health and addiction issues.

Engaging with underserved populations supports the LHINs' efforts to inform strategies that improve the quality of care and the patient experience. Through community engagement, LHINs are able to address care needs through a more local lens, which was vital in supporting these populations through the pandemic.

Toronto Central LHIN launched the Toronto Region Anti-Racism Steering Committee, composed of leaders from Black and Indigenous communities, alongside other health system leaders and allies, in response to the heightened sense of urgency to address anti-Black and anti-Indigenous racism. A critical step was to engage with Black communities to understand how a truly anti-racist health system would look, feel and be experienced. To address health inequities for Black communities that were amplified by COVID-19, Toronto Central LHIN led the High Priority Community Testing strategy, partnered with other system allies to support the Black Health Strategy, and through our partners, supported the COVID-19 Vaccine Sprint Strategy which took an equity lens to vaccine provision and rollout.

North Simcoe Muskoka hosted a meeting in which Ontario's late Patient Ombudsman, Cathy Fooks, spoke about "Honoring the Voices and Experiences of Long-Term Care Home Residents, Caregivers and Staff During the First Wave of COVID-19 in Ontario." Participants included members of LHIN Patient and Family Advisory Committees, advisors for area hospitals and regional Ontario Health Teams, as well as

patient experience and relations staff from LHINs and area hospitals.

Erie St. Clair LHIN engaged with Southwestern Ontario Local Immigration Partnership to help bring the We Speak interpretation strategy to health care providers within their memberships. This tool was used at COVID-19 testing centres, in mobile units as well as in vaccine clinics. The LHIN worked with the international agricultural workers community to help connect system-level and community-level COVID-19 initiatives, and general health and wellness resources, including language supports via We Speak.

Waterloo Wellington LHIN came alongside the shelter system when they began to experience multiple travel outbreaks and partnered to provide additional nursing resources to homeless patients in isolation units, including palliative care, and increased the number of isolation units overall.

Champlain LHIN worked to increase access to gender-affirming care for transgender, two-spirit, intersex, non-binary and gender-diverse communities. The LHIN provided base funding to support the ongoing work of the Regional Planning Table on Trans, Two-Spirit, Intersex, Non-Binary and Gender Diverse Health, whose work plan focused on the development of strategies to increase primary care capacity and strengthen care pathways between primary care providers and transition-related mental health supports.

Health System Performance

In 2020/21 LHINs defined their ability to adapt and innovate during the COVID-19 pandemic while driving system integration, supporting the needs of home and community care patients in their region.

Throughout the year, LHINs were at the frontline of the province's pandemic response whether it be providing care in patients' home, being redeployed into long-term care homes or developing new services and supports for patients when hospital or community care was halted due to ensuring the health and safety of staff and Ontarians, and the ramp down of non-urgent or emergent care.

The pressures across the entire health care system because of the pandemic resulted in several provincial performance indicators not being met. Based on provincial averages, LHINs met or achieved the provincial target for one performance indicator: *Percentage of home care clients who received their nursing visit within five (5) days of the date they were authorized for nursing services*. Individually, the majority of LHINs exceeded the provincial target for at least one indicator.

Indicator	Provincial target	Provincial						
		2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result (Year to Date)
1. Performance Indicators								
Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	85.36%	89.86%	87.80%	86.69%	85.63%	86.12%
Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	94.00%	96.07%	96.25%	95.87%	95.66%	94.43%
90th Percentile Wait Time from community for Home Care Services -	21 days	29.00	29.00	30.00	29.00	28.00	27.00	24.00

Application from Community Setting to first Home Care Service (excluding case management)*								
90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	7.00	7.00	7.00	8.00	9.00
90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	9.97	10.38	10.75	10.87	10.87	10.88
90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.07	4.15	4.38	4.62	4.95	4.43
Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.97%	78.47%	77.99%	79.58%	80.20%	64.00%
Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	79.14%	75.02%	73.72%	75.12%	76.67%	60.00%
Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.50%	15.69%	15.70%	16.62%	19.50%	17.83%
ALC rate	12.70%	13.70%	13.98%	15.19%	15.68%	15.35%	16.30%	16.76%
Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.19%	20.67%	21.60%	21.91%	21.62%	23.18%
Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.01%	32.50%	32.80%	33.75%	34.38%	34.81%

Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.65%	16.74%	16.57%	16.63%	16.40%	16.96%
2. Monitoring Indicators								
Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	88.09%	85.01%	83.95%	85.56%	85.44%	71.00%
Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	59.47%	62.58%	67.57%	69.77%	70.58%	65.91%	70.00%
Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	78.25%	78.18%	82.11%	84.73%	84.20%	80.40%	80.00%
Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	13.00	13.00	13.00	12.00	13.00
Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	7.00	7.00	7.00	7.00	7.00
Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	18.47	17.12	16.82	14.26	12.51	4.31
Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	320.13	321.18	335.22	332.68	325.89	179.64
Percentage of acute care patients who had a follow-up with	NA	46.09%	46.61%	47.43%	46.71%	46.17%	44.76%	29.69%

a physician within 7 days of discharge**								
--	--	--	--	--	--	--	--	--

Challenges

The pandemic placed an unprecedented pressure on the health care service resulting in the ramp down of elective or non-emergent care, and redeployment of health care staff to support COVID-19 patients or critical care services over the 12 months. As a result of service closures, the redirection of human resources, and multiple waves of the pandemic, several provincial indicators were not met despite the tremendous work undertaken by the LHINs.

It is anticipated that focus for 2021/22 will be health system recovery, and the LHINs have identified several pressures and opportunities to increase activities levels so that outcomes are more closely aligned to provincial indicators and targets in subsequent years.

ALC Rate

As a result of COVID-19, there was a need for a system-wide approach to improve flow of ALC patients out of acute and post-acute care settings. The Ministry of Health, Ministry of Long Term Care and Ontario Health supported broad system changes with directives that eliminated barriers to flow and enabled collaboration to drive fast-acting processes to improve patient flow. The health care system shifted to prioritize placement for those in greater need and to optimize all available LTC beds and increase admissions of ALC patients to long-term care.

Toronto Central LHIN, one of the hardest hit LHINs, leveraged a series of existing models and ALC initiatives to continue to drive flow of ALC patients to the next appropriate place of care. (i.e., integrated transitional services, service resolution tables, short-term transitional models).

Hospitalization rate for ambulatory care sensitive conditions.

Historically, in the North Simcoe Muskoka LHIN the outcomes for this indicator have been significantly higher than provincial performance, indicating a reliance on hospital-based services to provide regular and routine care. Over the past year, this indicator declined substantially. This was in part due to COVID-19 restrictions, but also relates to increased usage of virtual platforms and e-health initiatives that ensured a degree of continued access to primary care. Historical investments in e-health and virtual care are beginning to demonstrate outcomes, as the COVID-19 situation encouraged the population to engage with virtual health options rather than relying on hospitals.

Appointees

Board Members for Ontario	Initial Appointment Date	Current Term Expired or Will Expire
Bill Hatanaka (Chair)	March 7, 2019	June 30, 2021

Elyse Allan (Vice Chair)	March 7, 2019	June 30, 2021
Jay Aspin	March 7, 2019	June 30, 2021
Andrea Barrack	March 7, 2019	June 30, 2021
Alexander Barron	March 7, 2019	June 30, 2021
Adalsteinn Brown	March 7, 2019	June 30, 2021
Robert Devitt *	March 7, 2019	February 11, 2021
Garry Foster	March 7, 2019	June 30, 2021
Shelly Jamieson	March 7, 2019	June 30, 2021
Jacqueline Moss	March 7, 2019	June 30, 2021
Paul Tsaparis	March 7, 2019	June 30, 2021
Anju Virmani	March 7, 2019	June 30, 2021
Kenneth Joseph Parker	March 5, 2021	December 31, 2021

*Robert Devitt resigned on January 9, 2021. His appointment was revoked on February 11, 2021

Total remuneration paid to members of the Board of Directors by Ontario Health during the 2020/21 period amounted to \$150,000.

Financial Analysis

Local Health Integration Networks (LHINs) were established as Crown Agencies under the *Local Health System Integration Act, 2006*. LHINs are funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement (MLAA), which describes budgetary arrangements established by the Ministry of Health and the approved funding arrangements reflected in the Financial Statements.

In accordance with the MLAA, LHINs are required to be in a balanced position at year end. Funding directed toward home and community care may be reallocated from one LHIN to another for shared programming and resources, and to help address in-year funding pressures, pending ministry approval. Any funding received in excess of expenses incurred is required to be returned to the Ministry of Health. Detailed finances can be found in the attached Audited Financial Statements.

Central LHIN

Central LHIN delivered on its objective within the Ministry of Health funding allotment of \$2.97 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, \$2.58 billion represented transfer payments to health service providers, while \$394 million was related to LHIN operations including the delivery of home and community care.

Central East LHIN

Central East LHIN delivered on its objective within the Ministry of Health funding allotment of \$2.88 billion (based on ministry funding schedules) for the full fiscal year 2020-21. Of that amount, \$2.51 billion represented transfer payments to health service providers, while \$368.8 million was related to LHIN operations including the delivery of home and community care. During the year, Central East LHIN reallocated \$5.7 million to other LHINs and Ontario Health to assist with in-year funding pressures.

Central West LHIN

Central West LHIN delivered on its objective within the Ministry of Health funding allotment of \$1.28 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, \$1.12 billion represented transfer payments to health service providers, while \$163 million was related to LHIN operations including the delivery of home and community care.

Champlain LHIN

Champlain LHIN delivered on its objective within the Ministry of Health funding allotment of \$3.47 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, \$3.18 billion represented transfer payments to health service providers, while \$291.6 million was related to LHIN operations including the delivery of home and community care. During the year, Champlain LHIN reallocated \$9.3 million to other LHINs and Ontario Health to assist with in-year funding pressures.

Erie St Clair LHIN

Erie St. Clair LHIN delivered on its objective within the Ministry of Health funding allotment of \$1.48 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, \$1.31 billion represented transfer payments to health service providers, while \$169 million was related to LHIN operations including the delivery of home and community care.

Hamilton Niagara Haldimand Brant LHIN

Hamilton Niagara Haldimand Brant LHIN delivered on its objective within the Ministry of Health funding allotment of \$3.89 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, \$3.5 billion represented transfer payments to health service providers, while \$394 million was related to LHIN operations including the delivery of home and community care.

Mississauga Halton LHIN

Mississauga Halton LHIN delivered on its objective within the Ministry of Health funding allotment of \$2.12 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, \$1.89 billion represented transfer payments to health service providers, while \$229 million was related to LHIN operations including the delivery of home and community care.

North East LHIN

The North East LHIN delivered on its objective within the Ministry of Health funding allotment of \$1.91 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, \$1.75 billion represented transfer payments to health service providers, while \$166 million was related to LHIN operations including the delivery of home and community care.

North Simcoe Muskoka LHIN

North Simcoe Muskoka LHIN delivered on its objective within the Ministry of Health funding allotment of \$1.19 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, \$1.07 billion represented transfer payments to health service providers, while \$125.7 million was related to LHIN operations including the delivery of home and community care.

North West LHIN

North West LHIN delivered on its objective within the Ministry of Health funding allotment of \$875 million (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, \$812 million represented transfer payments to health service providers, while \$63 million was related to LHIN operations including the delivery of home and community care.

South East LHIN

South East LHIN delivered on its objective within the Ministry of Health funding allotment of \$1.43 billion (based on ministry funding schedules) for the full fiscal year 2020-21. Of that amount, \$1.30 billion represented transfer payments to health service providers, while \$136.7 million was related to LHIN operations including the delivery of home and community care. During the year, South East LHIN reallocated \$12.0 million to other LHINs and Ontario Health to assist with in-year funding pressures.

South West LHIN

South West LHIN delivered on its objective within the Ministry of Health funding allotment of \$2.8 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, \$2.57 billion represented transfer payments to health service providers, while \$239 million was related to LHIN operations including the delivery of home and community care.

Toronto Central

Toronto Central LHIN delivered on its objective within the Ministry of Health funding allotment of \$7.76 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, \$7.48 billion represented transfer payments to health service providers, while \$278 million was related to LHIN

operations including the delivery of home and community care.

Waterloo Wellington LHIN

Waterloo Wellington LHIN delivered on its objective within the Ministry of Health funding allotment of \$1.47 billion (based on ministry funding schedules) for the full fiscal year 2020/21. Of that amount, \$1.3 billion represented transfer payments to health service providers, while \$172 million was related to LHIN operations including the delivery of home and community care.

Audited Financial Statements

Financial statements of Central Local Health Integration Network

March 31, 2021

Independent Auditor's Report	1-2
Statement of financial position	3
Statement of operations and changes in net assets	4
Statement of cash flows	5
Notes to the financial statements	6-11

Independent Auditor's Report

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

Audit Opinion

We have audited the accompanying financial statements of Central Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2021 and the statements of operations and changes in net assets, and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies (collectively referred to as the "financial statements"). We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2021, and the results of its operations, changes in net assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards ("Canadian GAAS"). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the LHIN in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the LHIN's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the LHIN or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the LHIN's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian GAAS will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian GAAS, we exercised professional judgment and maintained professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 LHIN's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the LHIN's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the LHIN to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 23, 2021

Central Local Health Integration Network**Statement of financial position**

As at March 31, 2021

	Notes	2021 \$	2020 \$
Assets			
Current assets			
Cash		26,159,973	32,266,080
Due from Ministry of Health ("MOH")	11	194,825,989	13,195,721
Accounts receivable	4	17,787,945	1,948,129
Prepaid expenses		949,227	1,287,442
		239,723,134	48,697,372
Capital assets	5	2,216,500	2,783,410
		241,939,634	51,480,782
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities	3 and 4	32,650,229	30,773,133
Due to Health Service Providers ("HSPs")	11	194,825,989	13,195,721
Due to MOH	3	12,246,916	4,728,518
		239,723,134	48,697,372
Deferred capital contributions	6	2,216,500	2,783,410
		241,939,634	51,480,782
Commitments and contingencies	7 and 8		
Net assets		—	—
		241,939,634	51,480,782

The accompanying notes are an integral part of the financial statements.

Approved by the Board



William Hatanaka, Board Chair



Garry Foster, Audit Committee Chair

Central Local Health Integration Network
Statement of operations and changes in net assets
Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Revenue			
MOH funding – transfer payments	11	2,582,708,129	2,078,771,855
MOH funding – operations and initiatives		390,803,342	381,773,452
Ontario Health Cancer Care Division	4	1,938,694	2,122,782
Amortization of deferred capital contributions	6	566,910	567,328
Other revenue	4	287,448	484,482
		393,596,394	384,948,044
Total revenue		2,976,304,523	2,463,719,899
Expenses			
HSP transfer payments	11	2,582,708,129	2,078,771,855
Operations and Initiatives			
Contracted out			
In-home/clinic services		286,750,529	281,501,255
School services		2,753,138	5,944,158
Hospice services		2,831,926	2,694,901
Salaries and benefits		72,455,143	73,189,673
Medical supplies		19,355,661	12,772,632
Medical equipment rental		2,630,044	2,245,537
Supplies and sundry		6,253,043	6,032,560
Amortization		566,910	567,328
		393,596,394	384,948,044
Total expenses		2,976,304,523	2,463,719,899
Excess of revenue over expenses		—	—
Net assets, beginning of year		—	—
Net assets, end of year		—	—

The accompanying notes are an integral part of the financial statements.

Central Local Health Integration Network

Statement of cash flows

Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Operating activities			
Excess of revenue over expenses		—	—
Less amounts not affecting cash			
Amortization of capital assets		566,910	567,328
Amortization of deferred capital contributions	6	(566,910)	(567,328)
		—	—
Changes in non-cash working capital items	9	(6,106,107)	2,409,969
		(6,106,107)	2,409,969
Investing activity			
Purchase of capital assets		—	(19,960)
Financing activity			
Increase in deferred capital contributions	6	—	19,960
Net increase (decrease) in cash		(6,106,107)	2,409,969
Cash, beginning of year		32,266,080	29,856,111
Cash, end of year		26,159,973	32,266,080

The accompanying notes are an integral part of the financial statements.

1. Description of business

The 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 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 mandate of the LHIN is as follows:

- (a) 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 most of North York, York Region and South Simcoe. The LHIN enters into service accountability agreements with health service providers.

The LHIN has also entered into an accountability agreement with the Ministry of Health ("MOH"), which provides the framework for LHIN accountabilities and activities.

All funding payments to LHIN managed Health Service Providers are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to Health Service Providers, are recorded in the LHIN's Financial Statements as revenue from the MOH and as transfer payment expenses to Health Service Providers.

- (b) Provision of community services. The LHIN has the responsibility to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the Home Care and Community Services Act, 1994 and to provide information to the public about, and make referrals to, health and social services.

On March 17, 2021 in accordance with subsection 40(1) of the Continuing Care Act, 2019 the Ontario Minister of Health issued a transfer order to the LHIN which transferred certain assets, liabilities, rights and obligations of the LHIN, primarily those related to the activities related to planning, funding and integration as described in (a) above to Ontario Health. In addition certain staff positions of the LHIN were also transferred to Ontario Health. The transfer became effective April 1, 2021.

Operating as Home and Community Care Support Services Central the LHIN will continue to be responsible for the provision of home and community services within its geographic area. The Board of Directors of Ontario Health ("OH") were appointed to constitute the Board of Directors of the LHIN on March 8, 2018. The OH board will continue in this capacity until such time as a new Board is appointed.

A memorandum of understanding between the LHIN and OH outlining the process to be followed with respect to the transfer of certain assets and liabilities between the LHIN and OH under the transfer order is currently being developed. It is anticipated that the amounts involved will primarily related to liabilities associated with employees transferred to OH and reassigned back to the LHIN as part of the transfer. The amounts of assets and liabilities transferred are not expected to be material. (see note 4)

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards for government not-for-profit organizations including the 4200 series standards, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOH represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOH are set up as repayable to the MOH at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Ministry of Health Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOH. The Financial Statements reflect funding approved by the MOH to support LHIN managed Health Services Providers and the operations of the LHIN. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOH in the MLAA. Due to the nature of the Accountability Agreement, the LHIN is economically dependent on the MOH.

Transfer payment amounts to Health Service Providers are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the Health Service Providers. The cash associated with the transfer payment flows directly from the MOH to the Health Service Provider and does not flow through the LHIN bank account.

LHIN Financial Statements includes only transfer payment funds and LHIN operating funds included in the Ministry-LHIN Accountability Agreement.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of an asset, are capitalized

Capital assets are amortized on a straight-line basis based on their estimated useful life as follows:

Furniture and equipment	5 years
Computer equipment and software	3 years
Leasehold improvements	Over the term of the lease

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and are amortized to income at the same rate as the corresponding capital asset.

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery.

2. Significant accounting policies (continued)

Financial instruments (continued)

Financial assets are then written down to net recoverable value with the write-down being recognized in the Statement of operations and changes in net assets.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Funding repayable to the MOH

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 MOH.

The amount due to the MOH at March 31 is made up as follows:

	2021	2020
	\$	\$
Due to MOH, beginning of year	4,728,518	4,424,642
Funding repaid to MOH	—	(2,247,687)
Funding repayable to the MOH related to current year activities	7,518,398	2,551,563
Due to MOH, end of year	12,246,916	4,728,518

4. Related party transactions

Ontario Health

On May 30, 2019, the Continuing Care Act (the "CCA") was proclaimed with key sections of the Act, including the creation of a new Crown Agency called Ontario Health, effective June 6, 2019. Ontario Health is a related party to the LHIN through the common control of the Province of Ontario. On December 2, 2019, the LHIN signed a Memorandum of Understanding ("MOU") with Ontario Health and 10 non-home and community care employees of the LHIN were transferred to Ontario Health. Under the MOU, the LHIN continued to provide compensation and benefits to transferred employees.

During the year, the LHIN incurred \$1,221,488 (\$570,184 in 2020) for the period from April 1, 2020 to March 31, 2021) in salaries and benefits expense for the 10 transferred employees, of which \$79,286 (\$94,865 in 2020) remained in accounts payable and accrued liabilities as at year-end. All amounts were recorded at cost in the Statement of operations and changes in net assets and the Statement of financial position.

Due to a change in the scope of the transfer, effective April 1, 2021 10 employees previously transferred to OH on December 2, 2019 were assigned back to the LHIN.

During the year, the LHIN recognized revenue of \$1,938,694 (\$2,122,782 in 2020) from OH (Cancer Care Division) which is reported as Ontario Health Cancer Care Division in the statement of operations. In addition, the LHIN received \$426,096 (\$430,400 in 2020) of Business Technology Infrastructure (BTI) funding from OH which is included as other revenue on the statement of operations.

5. Capital assets

	Cost	Accumulated amortization	2021 Net book value	2020 Net book value
	\$	\$	\$	\$
Computer equipment	1,132,749	1,089,258	43,491	93,505
Computer software	1,206,269	1,206,269	—	35,400
Leasehold improvements	3,325,848	1,740,574	1,585,274	1,819,530
Furniture and equipment	3,078,742	2,491,007	587,735	834,975
	8,743,608	6,527,108	2,216,500	2,783,410

6. Deferred capital contributions

The changes in the deferred capital contributions balance are as follows:

	2021	2020
	\$	\$
Balance, beginning of year	2,783,410	3,330,778
Capital contributions received during the year	—	19,960
Amortization for the year	(566,910)	(567,328)
Balance, end of year	2,216,500	2,783,410

7. Commitments

The LHIN has commitments under various operating leases as follows:

	\$
2022	1,640,281
2023	1,544,582
2024	1,591,659
2025	1,571,061
2026	1,571,061
Thereafter	2,242,722
	<u>10,161,366</u>

8. Contingencies

The LHIN has been named as defendants in various claims. Management believes any liability resulting from these actions would be adequately covered by existing liability insurance.

9. Change in non-cash working capital items

	2021	2020
	\$	\$
Due from MOH	(181,630,268)	(8,726,423)
Accounts receivable	(15,839,816)	7,796,509
Prepaid expenses	338,215	(114,718)
Accounts payable and accrued liabilities	1,877,096	(5,575,698)
Due to HSP's	181,630,268	8,726,423
Due to MOH	7,518,398	303,876
Total change in non-cash working capital items	(6,106,107)	2,409,969

10. Pension plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 760 members of its staff. The plan is 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 2021 was \$5,144,531 (\$5,306,350 in 2020) for current service costs and is included as an expense in the Statement of Operations and changes in net assets. The last actuarial valuation was completed for the plan as of December 31, 2020. At that time, the plan was fully funded.

11. Transfer payment to HSPs

The LHIN has authorization to allocate funding of \$2,582,708,129 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2021 as follows:

	2021	2020
	\$	\$
Operations of hospitals	1,942,455,785	1,478,668,461
Grants to compensate for municipal taxation – public hospitals	263,250	275,250
Long-Term Care Homes	393,065,340	378,736,941
Home and Community Care	18,263,941	—
Community support services	108,425,746	110,824,218
Community health centres	19,866,305	17,450,610
Community mental health addictions program	100,367,762	92,816,375
	2,582,708,129	2,078,771,855

The LHIN receives funding from the MOH and in turn allocates it to the HSPs. As at March 31, 2021, an amount of \$194,825,989 (\$13,195,721 in 2020) was receivable from the MOH, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and are included in the table above.

12. Financial risk

The LHIN through its exposure to financial assets and liabilities, has exposure to credit risk and liquidity risk as follows:

Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.

Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

13. 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 favor 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.

Financial statements of Central East Local Health Integration Network

March 31, 2021

Independent Auditor's Report	1-2
Statement of financial position	3
Statement of operations and changes in net assets	4
Statement of cash flows	5
Notes to the financial statements	6-11

Independent Auditor's Report

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

Audit Opinion

We have audited the accompanying financial statements of Central East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2021 and the statements of operations and changes in net assets, and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies (collectively referred to as the "financial statements"). We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2021, and the results of its operations, changes in net assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards ("Canadian GAAS"). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the LHIN in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the LHIN's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the LHIN or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the LHIN's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian GAAS will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 LHIN's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the LHIN's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the LHIN to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 23, 2021

Central East Local Health Integration Network**Statement of financial position**

As at March 31, 2021

	Notes	2021 \$	2020 \$
Assets			
Current assets			
Cash		67,477,501	40,116,213
Due from the Ministry of Health("MOH")	11	125,130,360	6,049,330
Accounts receivable	4	1,843,275	2,327,211
Prepaid expenses		1,043,151	1,046,090
		195,494,287	49,538,844
Capital assets			
	5	701,799	954,062
		196,196,086	50,492,906
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities	3 and 4	50,891,131	41,206,211
Due to Health Service Providers ("HSPs")	11	125,130,360	3,820,055
Due to MOH	3	18,429,968	3,942,996
Deferred operating contributions		1,042,828	569,582
		195,494,287	49,538,844
Deferred capital contributions			
	6	701,799	954,062
		196,196,086	50,492,906
Commitments and contingencies			
	7 and 8		
Net assets			
		—	
		196,196,086	50,492,906

The accompanying notes are an integral part of the financial statements.

Approved by the Board



William Hatanaka, Board Chair



Garry Foster, Audit Committee Chair

Central East Local Health Integration Network
Statement of operations and changes in net assets
Year ended March 31, 2021

	Notes	2021 Actual \$	2020 Actual \$
Revenue			
MOH funding – transfer payments	11	2,511,125,943	2,161,734,186
MOH funding – operations and initiatives		365,174,376	357,110,160
Ontario Health Cancer Care Division	4	1,608,959	1,494,177
Amortization of deferred capital contributions	6	292,556	461,505
Other revenue	4	1,719,286	1,625,217
		368,795,177	360,691,059
Total revenue		2,879,921,120	2,522,425,245
Expenses			
HSP transfer payments	11	2,511,125,943	2,161,734,186
Operations and initiatives			
Contracted out			
In-home/clinic services		237,678,242	231,868,365
School services		2,015,521	5,476,673
Hospice services		2,960,152	1,985,323
Salaries and benefits		92,995,378	93,226,792
Medical supplies		20,629,097	14,904,274
Medical equipment rental		3,762,140	3,333,613
Supplies and sundry		2,264,500	3,185,364
Building and ground		4,512,087	4,621,617
Amortization		292,556	461,505
Repairs and maintenance		1,685,504	1,627,533
		368,795,177	360,691,059
Total expenses		2,879,921,120	2,522,425,245
Excess of revenue over expenses		—	—
Net assets, beginning of year		—	—
Net assets, end of year		—	—

The accompanying notes are an integral part of the financial statements.

Central East Local Health Integration Network

Statement of cash flows

Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Operating activities			
Excess of revenue over expenses		—	—
Less amounts not affecting cash			
Amortization of deferred capital contributions		(292,559)	(461,505)
Amortization of capital assets	6	292,559	461,505
		—	—
Changes in non-cash working capital items	9	27,361,288	(7,974,940)
		27,361,288	(7,974,940)
Investing activity			
Purchase of capital assets		(40,296)	(98,131)
Financing activity			
Increase in deferred capital contributions	6	40,296	98,131
Net change in cash		27,361,288	(7,974,940)
Cash, beginning of year		40,116,213	48,091,153
Cash, end of year		67,477,501	40,116,213

The accompanying notes are an integral part of the financial statements.

1. Description of business

The Central East 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 Central 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 the Act.

The mandate of the LHIN is as follows:

(a) 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 Durham North East, Durham West, Haliburton County and the City of Kawartha Lakes, Northumberland County, Peterborough City and County, Scarborough North and Scarborough South. The LHIN enters into service accountability agreements with health service providers.

The LHIN has also entered into an accountability agreements with the Ministry of Health ("MOH"), which provide the framework for LHIN accountabilities and activities.

All funding payments to LHIN managed Health Service Providers are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to Health Service Providers, are recorded in the LHIN's Financial Statements as revenue from the MOH as transfer payment expenses to Health Service Providers.

(b) Provision of community services

These services include health and related social services, medical supplies and equipment for the care of persons in home and community settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and to provide information to the public about, and make referrals to, health and social services.

On March 17, 2021 in accordance with subsection 40(1) of the Connecting Care Act, 2019 the Ontario Minister of Health issued a transfer order to the LHIN which transferred certain assets, liabilities, rights and obligations of the LHIN, primarily those related to the activities related to planning, funding and integration as described in (a) above to Ontario Health in addition certain staff positions of the LHIN were also transferred to Ontario Health.

Operating as Home and Community Care Support Services Central East the LHIN will continue to be responsible for the provision of home and community services within its geographic area. The Board of Directors of Ontario Health ("OH") were appointed to constitute the Board of Directors of the LHIN on March 8, 2018. The OH board will continue in this capacity until such time as a new Board is appointed.

A memorandum of understanding between the LHIN and OH outlining the process to be followed with respect to the transfer of certain assets and liabilities between the LHIN and OH under the transfer order is currently being developed. It is anticipated that the amounts involved will primarily be liabilities associated with employees transferred to OH and reassigned back to the LHIN as part of the transfer. The amounts of assets and liabilities transferred are not expected to be material (see note 4).

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards including the 4200 series standards for government not-for-profit organizations, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOH represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOH are set up as repayable to the MOH at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Ministry of Health Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOH. The Financial Statements reflect funding approved by the MOH to support LHIN managed Health Services Providers and the operations of the LHIN. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOH in the MLAA. Due to the nature of the Accountability Agreement, the LHIN is economically dependent on the MOH.

Transfer payment amounts to Health Service Providers are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the Health Service Providers. The cash associated with the transfer payment flows directly from the MOH to the Health Service Provider and does not flow through the LHIN bank account.

LHIN Financial Statements includes only transfer payment funds and LHIN operating funds included in the Ministry-LHIN Accountability Agreement.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of a capital asset, are capitalized.

Capital assets are amortized on a straight-line basis based on their estimated useful life as follows:

Computer equipment and software	3 years
Furniture and equipment	10 years
Leasehold improvements	Over the term of the lease
Medical equipment	10 years

For capital assets acquired or brought into use, during the year, amortization is provided for one half of a year.

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and are amortized to income at the same rate as the corresponding capital asset.

2. Significant accounting policies (continued)

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the Statement of operations and changes in net assets.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Funding repayable to the MOH

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 MOH.

The amount due to the MOH at March 31 is made up as follows:

	2021	2020
	\$	\$
Due to MOH, beginning of year	3,942,996	4,778,781
Funding repaid to MOH		(2,122,789)
Funding repayable to MOH related to current year activities	14,486,972	1,287,004
Due to MOH, end of year	18,429,968	3,942,996

4. Related party transactions

Ontario Health

On May 30, 2019, the Connecting Care Act (the "CCA") was proclaimed with key sections of the Act, including the creation of a new Crown Agency called Ontario Health, effective June 6, 2019. Ontario Health is a related party to the LHIN through the common control of the Province of Ontario. On December 2, 2019, the LHIN signed a Memorandum of Understanding ("MOU") with Ontario Health and 15 non-home and community care employees of the LHIN were transferred to Ontario Health. Under the MOU, the LHIN continued to provide compensation and benefits to transferred employees.

During the year, the LHIN incurred \$2,534,380 (\$939,860 in 2020 for the period from December 2, 2019 to March 31, 2020) in salaries and benefits expense for the 15 transferred employees, of which \$25,412 (\$21,620 in 2020) remained in accounts payable and accrued liabilities as at year-end. All amounts were recorded at cost in the Statement of operations and changes in net assets and the Statement of financial position.

4. Related party transactions (continued)

Ontario Health (continued)

Due to a change in the scope of the transfer, effective April 1, 2021 6 employees previously transferred to OH on December 2, 2019 were assigned back to the LHIN.

During the year, the LHIN recognized revenue of \$1,608,959 (\$1,494,177 in 2020) from OH (Cancer Care Division) which is reported as Ontario Health Cancer Care Division in the statement of operations. In addition, the LHIN recognized \$412,632 (\$536,611 in 2020) of Business Technology Infrastructure (BTI) funding from OH which is included as other revenue in the statement of operations and incurred various miscellaneous costs from OH totaling \$406,078 (\$262,444 in 2020) which are reported as expenses in the statement of operations. At year-end a total of \$18,360 (nil in 2020) due to OH is included in accounts payable and accrued liabilities.

Other LHINs

During year the LHIN recognized \$232,536 (\$116,893 in 2020) of revenue from Champlain LHIN in respect of funding for enabling technologies and eReferral programs which is included as other income in the statement of operations and of which \$232,536 remains due from Champlain LHIN and is included in accounts receivable at March 31, 2021. Additionally, during the year, the LHIN incurred \$7,500 (\$15,000 in 2020) of expense related to translation services from the Champlain LHIN of which nil (\$15,000 in 2020) is included in accounts payable and accrued charges at year-end.

5. Capital assets

	Cost	Accumulated amortization	2021 Net book value	2020 Net book value
	\$	\$	\$	\$
Computer equipment and software	3,949,205	3,938,393	10,812	21,623
Leasehold improvements	5,012,678	4,607,550	405,128	536,313
Furniture and equipment	4,779,244	4,592,714	186,530	139,233
Medical equipment	1,562,600	1,463,271	99,329	184,567
Construction-in-progress	—	—	—	72,326
	15,303,727	14,601,928	701,799	954,062

6. Deferred capital contributions

The changes in the deferred capital contributions balance are as follows:

	2021	2020
	\$	\$
Balance, beginning of year	954,062	1,317,436
Capital contributions received during the year	40,296	98,131
Amortization for the year	(292,559)	(461,505)
Balance, end of year	701,799	954,062

7. Commitments

The LHIN has commitments under various operating leases extending to 2023 as follows:

(a) Property leases

	\$
2022	1,156,831
2023	576,660
	<u>1,733,491</u>

(b) Computer and office equipment leases

	\$
2022	<u>146,281</u>

The LHIN enters into accountability agreements with the HSP's which include planned funding targets. The actual funding provided by the LHIN is contingent on the MOH providing the funding.

8. Contingencies

The LHIN has been named as defendants in various claims. Management believes any liability resulting from these actions would be adequately covered by existing liability insurance.

9. Change in non-cash working capital items

	2021 \$	2020 \$
Due from MOH	(119,081,030)	(738,477)
Accounts receivable	483,936	(867,470)
Prepaid expenses	2,939	(263,283)
Accounts payable and accrued liabilities	9,684,920	(7,484,302)
Due to HSPs	121,310,305	2,430,602
Due to MOH	14,486,972	(835,785)
Deferred operating contributions	473,246	(213,225)
Total change in non-cash working capital items	<u>27,361,288</u>	<u>(7,971,940)</u>

10. Pension plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 1,020 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 2021 was \$ 6,683,789 (\$6,941,824 in 2020) for current service costs and is included as an expense in the 2021 Statement of operations and changes in net assets. The last actuarial valuation was completed for the plan as of December 31, 2020. At that time, the plan was fully funded.

11. Transfer payments to HSPs

The LHIN has authorization to allocate funding of \$2,511,125,943 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2021 as follows:

	2021	2020
	\$	\$
Operations of hospitals	1,634,191,126	1,335,737,148
Grants to compensate for municipal taxation – public hospitals	282,000	280,350
Long-Term Care Homes	509,251,616	492,081,533
Lakeridge Health HCC	4,950,600	4,185,900
Community support services	66,645,258	62,301,456
Assisted living services in supportive housing	17,863,979	15,929,844
Community health centres	42,432,153	39,125,631
Community mental health addictions program	80,468,542	75,410,089
Specialty psychiatric hospitals	152,374,466	134,430,942
Acquired brain injury	2,639,878	2,224,968
Grants to compensate for municipal taxation – psychiatric hospitals	26,325	26,325
	2,511,125,943	2,161,734,186

The LHIN receives funding from the MOH and in turn allocates it to the HSPs. As at March 31, 2021, an amount of \$125,130,360 (\$3,820,055 in 2020) was receivable from the MOH and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and changes in net assets and are included in the table above.

12. Financial risk

The LHIN through its exposure to financial assets and liabilities, has exposure to credit risk and liquidity risk as follows:

- (i) Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.
- (ii) Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

13. 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 favor 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.

Financial statements of Central West Local Health Integration Network

March 31, 2021

Independent Auditor's Report	1-2
Statement of financial position	3
Statement of operations and changes in net assets	4
Statement of cash flows	5
Notes to the financial statements	6-12

Independent Auditor's Report

To the Board of Directors of
Central West Local Health Integration Network

Audit Opinion

We have audited the accompanying financial statements of Central West Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2021 and the statements of operations and changes in net assets, and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies (collectively referred to as the "financial statements"). We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2021, and the results of its operations, changes in net assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards ("Canadian GAAS"). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are independent of the LHIN in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the LHIN's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the LHIN or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the LHIN's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian GAAS will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 LHIN's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the LHIN's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the LHIN to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 23, 2021

Central West Local Health Integration Network**Statement of financial position**

As at March 31, 2021

	Notes	2021 \$	2020 \$
Assets			
Current assets			
Cash		19,354,506	15,326,662
Due from Ministry of Health ("MOH")	13	70,335,848	1,780,511
Accounts receivable		838,599	846,573
Prepaid expenses		386,892	674,381
		90,915,845	18,628,127
Capital assets	5	354,039	510,140
		91,269,884	19,138,267
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities		16,700,913	12,458,938
Due to Health Service Providers ("HSPs")	13	70,335,848	1,780,511
Due to MOH	3	3,821,857	4,301,985
Deferred operating contributions	6	57,227	86,693
		90,915,845	18,628,127
Deferred capital contributions	7	354,039	510,140
		91,269,884	19,138,267
Commitments and contingencies	8 and 9		
Net assets		—	—
		91,269,884	19,138,267

The accompanying notes are an integral part of the financial statements.

Approved by the Board



William Hatanaka, Board Chair



Garry Foster, Audit Committee Chair

Central West Local Health Integration Network
Statement of operations and changes in net assets
Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Revenue			
MOH funding – transfer payments	13	1,117,819,591	918,348,766
MOH funding – operations and initiatives		161,779,273	156,622,884
Ontario Health Cancer Care Division	5	668,797	540,283
Amortization of deferred capital contributions		176,514	285,472
Other revenue		443,930	585,230
		163,068,514	158,033,869
Total revenue		1,280,888,105	1,076,382,635
Expenses			
HSP transfer payments	13	1,117,819,591	918,348,766
Operations and Initiatives			
Contracted out			
In-home/clinic services		111,625,232	102,700,838
School services		798,367	2,951,824
Hospice services		1,206,434	1,150,612
Salaries and benefits		36,466,562	38,769,994
Medical supplies		8,088,658	6,614,310
Medical equipment rental		1,671,906	1,474,997
Supplies and sundry		1,577,859	2,319,009
Building and grounds		1,317,548	1,649,446
Amortization		176,514	285,472
Repairs and maintenance		139,434	117,367
		163,068,514	158,033,869
Total expenses		1,280,888,105	1,076,382,635
Excess of revenue over expenses		—	—
Net assets, beginning of year		—	—
Net assets, end of year		—	—

The accompanying notes are an integral part of the financial statements.

Central West Local Health Integration Network

Statement of cash flows

Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Operating activities			
Excess of revenue over expenses			
Less amounts not affecting cash			
Amortization of capital assets		176,514	285,472
Amortization of deferred capital contributions	8	(176,514)	(285,472)
		—	—
Changes in non-cash working capital items	11	4,027,844	1,801,528
		4,027,844	1,801,528
Investing activities			
Purchase of capital assets		20,413	(30,398)
Disposal of capital assets		—	19,276
		20,413	(11,122)
Financing activities			
Increase in deferred capital contributions		(20,413)	30,398
Disposal of deferred capital contributions	8	—	(19,276)
		(20,413)	11,122
Net change in cash		4,027,844	1,801,528
Cash, beginning of year		15,326,662	13,525,134
Cash, end of year		19,354,506	15,326,662

The accompanying notes are an integral part of the financial statements.

Central West Local Health Integration Network

Notes to the financial statements

March 31, 2021

1. Description of business

The Central West 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 Central West 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 spans the defined geographical areas of Dufferin County, the northern portion of Peel Region, part of York Region, and a small part of the City of Toronto.

The mandate of the LHIN is as follows:

(a) Plan, fund and integrate the local health system within its geographic area

The LHIN 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 enters into service accountability agreements with health service providers.

The LHIN has also entered into an accountability agreement with the Ministry of Health ("MOH"), which provides the framework for LHIN accountabilities and activities.

All funding payments to LHIN managed Health Service Providers are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to Health Service Providers, are recorded in the LHIN's Financial Statements as revenue from the MOH and as transfer payment expenses to Health Service Providers.

(b) The delivery of home and community care services within its geographic area

These services include health and related social services, medical supplies and equipment for the care of persons in home and community settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and to provide information to the public about, and make referrals to, health and social services.

On March 17, 2021 in accordance with subsection 40(1) of the Connecting Care Act, 2019 the Ontario Minister of Health issued a transfer order to the LHIN which transferred, on April 1, 2021, certain assets, liabilities, rights and obligations of the LHIN, primarily those related to the activities related to planning, funding and integration as described in (a) above to Ontario Health. In addition certain staff positions of the LHIN were also transferred to Ontario Health.

Operating as Home and Community Care Support Services Central West the LHIN will continue to be responsible for the provision of home and community services within its geographic area. The Board of Directors of Ontario Health ("OH") were appointed to constitute the Board of Directors of the LHIN on March 8, 2018. The OH board will continue in this capacity until such time as a new Board is appointed.

A memorandum of understanding between the LHIN and OH outlining the process to be followed with respect to the transfer of certain assets and liabilities between the LHIN and OH under the transfer order is currently being developed. It is anticipated that the amounts involved will primarily be liabilities associated with employees transferred to OH and reassigned back to the LHIN as part of the transfer. The amounts of assets and liabilities transferred are not expected to be material (see note 4).

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards including the 4200 series for government not-for-profit organizations, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOH represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOH are set up as repayable to the MOH at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Ministry of Health Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOH. The Financial Statements reflect funding approved by the MOH to support LHIN managed Health Services Providers and the operations of the LHIN. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOH in the MLAA. Due to the nature of the Accountability Agreement, the LHIN is economically dependent on the MOH.

Transfer payment amounts to Health Service Providers are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the Health Service Providers. The cash associated with the transfer payment flows directly from the MOH to the Health Service Provider and does not flow through the LHIN bank account.

LHIN Financial Statements includes only transfer payment funds and LHIN operating funds included in the Ministry-LHIN Accountability Agreement.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of an asset, are capitalized

Capital assets are amortized on a straight-line basis based on their estimated useful life as follows:

Furniture and equipment	3-10 years
Computer and communications equipment	3 years
Medical equipment	4 years
Leasehold improvements	Over the term of the lease

For assets acquired or brought into use, during the year, amortization is provided for one half of a year.

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and are amortized to income at the same rate as the corresponding capital asset.

2. Significant accounting policies (continued)

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the Statement of operations and changes in net assets.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Amounts Due to the MOH

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end and funding received from the MOH in excess of expenses incurred, is required to be returned to the MOH. All interest income earned by the LHIN is payable to the MOH.

The amount due to the MOH at March 31 is made up as follows:

	2021	2020
	\$	\$
Due to MOHLTC, beginning of year	4,301,985	2,679,738
Funding repaid to MOHLTC	(1,833,009)	—
Interest Income earned and payable to MOHLTC	170,219	311,433
Funding repayable to MOHLTC related to current year activities	1,182,662	1,310,814
Due to MOHLTC, end of year	3,821,857	4,301,985

4. Related party transactions

Ontario Health

On May 30, 2019, the Connecting Care Act (the "CCA") was proclaimed with key sections of the Act, including the creation of a new Crown Agency called Ontario Health, effective June 6, 2019. Ontario Health is a related party to the LHIN through the common control of the Province of Ontario. On December 2, 2019, the LHIN signed a Memorandum of Understanding ("MOU") with Ontario Health and 11 non-home and community care employees of the LHIN were transferred to Ontario Health. Under the MOU, the LHIN continued to provide compensation and benefits to transferred employees.

4. Related party transactions (continued)

Ontario Health (continued)

During the year, the LHIN incurred \$1,622,492 (\$628,285 in 2020 for the period from December 2, 2019 to March 31, 2020) in salaries and benefits expense for the 11 transferred employees. All amounts were recorded at cost in the Statement of operations and changes in net assets and the Statement of financial position.

Due to a change in the scope of the transfer, effective April 1, 2021 5 employees previously transferred to OH on December 2, 2019 were assigned back to the LHIN.

During the year the LHIN recongnized \$668,797 (\$540,283 in 2020) from OH (Cancer Care Division) which is reported as Ontario Health Cancer Care Division in the statement of operations. In addition the LHIN recognized \$186,296 (\$190,110 in 2020) of Business Technology Infrastructure ("BTI") funding from OH and recovered \$121,659 for miscellaneous expenses incurred on behalf of OH which are included as other revenue on the statement of operations. At year-end at total of \$6,749 (\$968 in 2020) due from OH is included in accounts receivable.

During the year, due to staff secondments from the Hamilton Niagara Haldimand Brant LHIN, the LHIN incurred \$353,744 (nil in 2020) in salaries and benefit expense. At year-end, a total of \$29,739 (nil in 2020) due to f Hamilton Niagara Haldimand Brant LHIN is included in accounts payable and accrued liabilities in the statement of financial position.

5. Capital assets

	Cost	Accumulated depreciation	2021 Net book value	2020 Net book value
	\$	\$	\$	\$
Furniture and equipment	2,638,645	(2,389,488)	249,157	310,794
Computer equipment	300,302	(291,478)	8,824	14,707
Medical equipment	354,322	(258,264)	96,058	184,639
Leasehold improvements	2,397,984	(2,397,984)	—	—
	5,691,253	(5,337,214)	354,039	510,140

6. Deferred operating contributions

Deferred operating contributions represent the unamortized amount of grants and other contributions received to fund expenditures of future periods BTI equipment leases represent the unamortized amount of grants received from Health shared Services Ontario for the payment of computer leases under the Base Technology Infrastructure Project.

	2021	2020
	\$	\$
Balance, beginning of year	86,693	112,002
Operating contributions received during the year	156,830	164,801
Amount recognized as revenue in the year	(186,296)	(190,110)
Balance, end of year	57,227	86,693

7. Deferred capital contributions

The changes in the deferred capital contributions balance are as follows:

	2021	2020
	\$	\$
Balance, beginning of year	510,140	784,490
Capital contributions received during the year	20,413	30,398
Amortization for the year	(176,514)	(285,472)
Disposals	—	(19,276)
Balance, end of year	354,039	510,140

8. Commitments

The LHIN has commitments under various operating leases as follows extending to 2025 as follows:

	\$
2022	1,135,374
2023	1,089,092
2024	1,073,266
2025	1,068,475
2026	—

9. Contingencies

The LHIN has been named as defendants in various claims. Management believes any liability resulting from these actions would be adequately covered by existing liability insurance.

10. Change in non-cash working capital items

	2021	2020
	\$	\$
Due from MOH	(68,555,337)	1,062,733
Accounts receivable	7,974	536,388
Prepaid expenses	287,489	(183,454)
Accounts payable and accrued liabilities	4,241,975	(2,681,455)
Due to Health Services Providers ("HSPs")	68,555,337	1,699,180
Due to other LHINs	—	(228,802)
Due to MOH	(480,128)	1,622,247
Deferred operating contributions	(29,466)	(25,309)
	4,027,844	1,801,528

11. Pension plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 380 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 2021 was \$2,528,123 (\$2,697,062 in 2020) for current service costs and is included as an expense in the 2021 Statement of operations and changes in net assets. The last actuarial valuation was completed for the plan as of December 31, 2020. At that time, the plan was fully funded.

12. Transfer payment to HSPs

The LHIN has authorization to allocate funding of \$1,117,819,591 in 2021 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors as follows:

	2021	2020
	\$	\$
Operations of hospitals	825,417,341	645,075,787
Grants to compensate for municipal taxation - public hospitals	100,275	96,975
Long-term care homes	187,201,488	180,544,914
Community support services	21,857,584	18,100,361
Assisted living services in supportive housing	12,628,481	11,959,405
Community health centres	17,505,887	14,367,170
Community mental health and addictions programs	53,108,535	48,204,154
	1,117,819,591	918,348,766

The LHIN receives funding from the MOH and in turn allocates it to the HSPs. As at March 31, 2021, an amount of \$70,335,848 (\$1,780,511 in 2020) was receivable from the MOH, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and changes in net assets and are included in the table above.

13. Financial risk

The LHIN through its exposure to financial assets and liabilities, has exposure to credit risk and liquidity risk as follows:

- (i) Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.
- (ii) Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

14. 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 favor 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.

Financial statements of Champlain Local Health Integration Network

March 31, 2021

Independent Auditor's Report	1-2
Statement of financial position	3
Statement of operations and changes in net assets	4
Statement of cash flows	5
Notes to the financial statements	6-12

Independent Auditor's Report

To the Members of the Board of Directors of the
Champlain Local Health Integration Network

Opinion

We have audited the financial statements of the Champlain Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2021, and the statements of operations and changes in net assets, and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2021, and the results of its operations, changes in net assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards ("Canadian GAAS"). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the LHIN in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the LHIN's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the LHIN or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the LHIN's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian GAAS will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 LHIN's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the LHIN's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the LHIN to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 23, 2021

Champlain Local Health Integration Network**Statement of financial position**

As at March 31, 2021

	Notes	2021 \$	2020 \$
Assets			
Current assets			
Cash		36,590,027	18,142,470
Due from Ministry of Health ("MOH")	10	290,254,559	13,173,378
Accounts receivable		1,917,746	2,159,784
Prepaid expenses		171,966	46,079
		328,934,298	33,521,711
Capital assets	5	1,076,423	1,281,024
		330,010,721	34,802,735
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities	4	19,707,936	13,764,493
Due to Health Service Providers ("HSPs")	10	288,446,559	13,173,378
Due to MOH	3	20,779,803	6,583,840
		328,934,298	33,521,711
Deferred capital contributions	6	1,076,423	1,281,024
		330,010,721	34,802,735
Commitments and contingencies	7 and 13		
Net assets		—	—
		330,010,721	34,802,735

The accompanying notes are an integral part of the financial statements.

Approved by the Board



William Hatanaka, Board Chair



Garry Foster, Audit Committee Chair

Champlain Local Health Integration Network
Statement of operations and changes in net assets
Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Revenue			
MOH funding - transfer payments	10	3,176,821,474	2,584,037,896
MOH funding - operations and initiatives		290,719,802	292,526,272
Ontario Health Cancer Care Division		6,070	170,039
Amortization of deferred capital contributions	6	304,835	349,126
Other revenue	4	546,357	1,730,285
		291,577,064	294,775,722
Total revenue		3,468,398,538	2,878,813,618
Expenses			
HSP transfer payments	10	3,176,821,474	2,584,037,896
Operations and initiatives			
Contracted out			
In-home/clinic services		183,069,371	183,525,354
School services		2,022,551	3,611,515
Hospice services		6,893,823	6,888,657
Salaries and benefits	4	72,080,755	79,825,430
Medical supplies		18,613,752	10,871,293
Medical equipment rental		3,084,564	3,023,767
Supplies and sundries		3,061,586	3,815,311
Building and ground		2,445,827	2,865,269
Amortization	6	304,835	349,126
		291,577,064	294,775,722
Total expenses		3,468,398,538	2,878,813,618
Excess of revenue over expenses		—	—
Net assets, beginning of year		—	—
Net assets, end of year		—	—

The accompanying notes are an integral part of the financial statements.

Champlain Local Health Integration Network**Statement of cash flows**

Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Operating activities			
Excess of revenue over expenses		—	—
Less amounts not affecting cash			
Amortization of capital assets		304,835	349,126
Amortization of deferred capital contributions		(304,835)	(349,126)
		—	—
Changes in non-cash operating working capital item	8	18,447,557	(1,245,188)
Investing activity			
Purchase of capital assets		(100,234)	(47,199)
Financing activity			
Increase in deferred capital contributions		100,234	47,199
Net change in cash		18,447,557	(1,245,188)
Cash, beginning of year		18,142,470	19,387,658
Cash, end of year		36,590,027	18,142,470

The accompanying notes are an integral part of the financial statements.

1. Description of business

The Champlain 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 Champlain 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 mandate of the LHIN is as follows:

- (a) 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 Renfrew County, the City of Ottawa, Prescott & Russell, Stormont, Dundas & Glengarry, North Grenville and four parts of North Lanark. Most people live in the Ottawa area. Cornwall, Clarence-Rockland and Pembroke/Petawawa are also large communities. The LHIN enters into service accountability agreements with Health Service Providers (HSP).

The LHIN has also entered into an accountability agreement with the Ministry of Health (MOH), which provides the framework for LHIN accountabilities and activities.

All funding payments to LHIN managed HSP are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to HSP are recorded in the LHIN's financial statements as revenue from the MOH and as transfer payment expenses to HSP.

- (b) Effective May 24, 2017, the LHIN assumed the responsibility to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the *Home Care and Community Services Act, 1994*, and to provide information to the public about, and make referrals to, health and social services.

On March 17, 2021, in accordance with subsection 40(1) of the *Connecting Care Act, 2019* the Ontario Minister of Health issued a transfer order to the LHIN which transferred certain assets, liabilities, rights and obligations of the LHIN, primarily those related to the activities related to planning, funding and integration as described in (a) above to Ontario Health. In addition, certain staff positions of the LHIN were also transferred to Ontario Health.

Operating as Home and Community Care Support Services Central East, the LHIN will continue to be responsible for the provision of home and community services within its geographic area. The Board of Directors of Ontario Health ("OH") were appointed to constitute the Board of Directors of the LHIN on March 8, 2018. The OH board will continue in this capacity until such time as a new Board is appointed.

A memorandum of understanding between the LHIN and OH outlining the process to be followed with respect to the transfer of certain assets and liabilities between the LHIN and OH under the transfer order is currently being developed. It is anticipated that the amounts involved will primarily be liabilities associated with employees transferred to OH and reassigned back to the LHIN as part of the transfer. The amounts of assets and liabilities transferred are not expected to be material (see Note 4).

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards including the 4200 series standards, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOH represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOH are set up as repayable to the MOH at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Ministry of Health funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement (MLAA), which describes budgetary arrangements established by the MOH. The financial statements reflect funding approved by the MOH to support LHIN managed HSP and the operations of the LHIN. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOH in the MLAA. Due to the nature of the MLAA, the LHIN is economically dependent on the MOH.

Transfer payment amounts to HSP are based on the terms of the Health Service Provider MLAA with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the HSP. The cash associated with the transfer payment flows directly from the MOH to the HSP and does not flow through the LHIN bank account.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of an asset, are capitalized.

Capital assets are amortized on a straight-line basis based on their estimated useful life on the following terms:

Furniture and equipment	10 years
Computer and communication equipment	3 years
Leasehold improvements	5 years

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

Deferred capital contributions

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

2. Significant accounting policies (continued)

Financial instruments

Financial assets and financial liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the statement of operations and changes in net assets.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3 Funding repayable to the MOH

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 MOH.

The amount due to the MOH as at March 31 is made up as follows:

	2021	2020
	\$	\$
Due to MOH, beginning of year	6,583,840	5,236,829
Funding repaid to MOH	(1,271,203)	(1,191,127)
Funding repayable to MOH related to current year activities	15,467,166	2,482,579
Funding repayable to MOH related to current year ETI PMO Cluster activities (note 4)	—	55,559
Due to MOH, end of year	20,779,803	6,583,840

4. Related party transactions

Ontario Health

On May 30, 2019, the *Connecting Care Act* (the "CCA") was proclaimed with key sections of the Act, including the creation of a new Crown Agency called Ontario Health, effective June 6, 2019. Ontario Health is a related party to the LHIN through the common control of the Province of Ontario. On December 2, 2019, the LHIN signed a Memorandum of Understanding ("MOU") with Ontario Health and 10 non-home and community care employees of the LHIN were transferred to Ontario Health. Under the MOU, the LHIN continued to provide compensation and benefits to transferred employees.

Champlain Local Health Integration Network

Notes to the financial statements

March 31, 2021

4. Related party transactions (continued)

Ontario Health (continued)

During the year, the LHIN incurred \$1,304,625 (\$555,379 in 2020 for the period from December 2, 2019 to March 31, 2020) in salaries and benefits expense for the 10 transferred employees, of which \$43,378 (\$49,212 in 2020) remained in accounts payable and accrued liabilities as at year-end. All amounts were recorded at cost in the statement of operations and changes in net assets and the statement of financial position.

Due to a change in the scope of the transfer, effective April 1, 2021, 4 employees previously transferred to OH on December 2, 2019, were assigned back to the LHIN.

During the year the LHIN recognized \$6,070 (\$170,039 in 2020) of funding from OH (Cancer Care Division) which is reported as Ontario Health Cancer Care Division in the statement of operations. In addition the LHIN recognized \$370,418 (\$374,160 in 2020) of Business Technology Infrastructure ("BTI") funding from OH which is included as other revenue on the statement of operations, and incurred miscellaneous costs from OH of \$60,745 (\$4,566 in 2020) which are reported as supplies and sundry in the statement of operations. At year-end at total of \$41,359 (nil in 2020) due to OH is included in accounts receivable.

Other LHINs

During the year the LHIN allocated \$1,232,595 to South East LHIN and \$232,536 to Central East LHIN in respect of Enabling Technologies and eReferral programs which is recorded as an offset to other income in the statement of operations, these amounts remain due to the respective LHINs and is included in accounts payable and accrued liabilities at March 31, 2021. Additionally during the year the LHIN received \$126,342 (\$170,250 in 2020) of translation services revenue from various LHINs of which \$82,500 (nil in 2020) is included in accounts receivable at year-end.

5. Capital assets

	Cost	Accumulated amortization	2021 Net book value	2020 Net book value
	\$	\$	\$	\$
Furniture and equipment	3,953,938	3,061,692	892,246	1,070,539
Computer and communication equipment	5,008,892	4,870,522	138,370	186,442
Leasehold improvements	4,787,651	4,741,844	45,807	24,043
	13,750,481	12,674,058	1,076,423	1,281,024

6. Deferred capital contributions

The changes in the deferred capital contributions balance are as follows:

	2021	2020
	\$	\$
Balance, beginning of year	1,281,024	1,582,951
Capital contributions received during the year	100,234	47,199
Amortization for the year	(304,835)	(349,126)
Balance, end of year	1,076,423	1,281,024

Champlain Local Health Integration Network

Notes to the financial statements

March 31, 2021

7. Commitments

Facilities

The LHIN has entered into lease agreements for multiple facilities. Annual lease payments for the next five years at their current rates are as follows:

	\$
2022	2,594,045
2023	2,047,735
2024	1,653,729
2025	1,653,729
2026	1,653,729

Operations

The LHIN has entered into operating lease commitments for equipment rental with varied conditions. Annual lease payments for the next year are as follows:

	\$
2022	66,407

8. Changes in non-working capital items

	2021 \$	2020 \$
Due from MOH	(277,081,181)	4,967,259
Accounts receivable	1,707,169	(251,151)
Prepaid expenses	(125,887)	(38,061)
Accounts payable and accrued liabilities	4,478,312	(5,605,707)
Due to HSPs	275,273,181	(1,664,539)
Due to MOH	14,195,963	1,347,011
	18,447,557	(1,245,188)

9. Pension plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 758 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 2021 was \$5,073,043 (\$5,184,517 in 2020) for current service costs and is included in salaries and benefits expense in the statement of operations and changes in net assets. The last actuarial valuation was completed for the plan as of December 31, 2020. At that time, the plan was fully funded.

Champlain Local Health Integration Network

Notes to the financial statements

March 31, 2021

10. Transfer payments to HSP

The LHIN has authorization to allocate funding of \$3,176,821,474 (\$2,584,037,896 in 2020) to various HSP in its geographic area. The LHIN approved transfer payments to various sectors as follows:

	2021 \$	2020 \$
Operations of Hospitals	2,354,385,373	1,812,122,759
Grants to compensate for Municipal Taxation – Public Hospitals	355,650	355,650
Long-Term Care Homes	402,768,861	390,478,424
Community Support Services and Acquired Brain Injury	61,497,561	58,378,742
Assisted Living Services in Supportive Housing	29,355,965	26,686,035
Community Health Centres	79,978,861	73,539,761
Community Mental Health and Addictions Programs	120,340,210	111,768,387
Specialty Psychiatric Hospitals	128,111,018	110,680,163
Grants to compensate for Municipal Taxation – Psychiatric Hospitals	27,975	27,975
	3,176,821,474	2,584,037,896

The LHIN receives funding from the MOH and in turn allocates it to the HSP. As at March 31, 2021, an amount of \$288,446,559 (\$13,173,378 as at March 31, 2020) was included in due from MOH, and due to HSP. In addition, the due from MOH also includes \$1,808,000 (nil as at March 31, 2020) related to Digital Health and SCA, thus bringing the total due from MOH to \$290,254,559. These amounts have been reflected as revenue and expenses in the statement of operations and changes in net assets and are included in the table above.

11. Financial risk

The LHIN through its exposure to financial assets and liabilities has exposure to credit risk and liquidity risk as follows:

Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.

Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

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 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. Contingencies

Operations

Due to the nature of its operations, the LHIN is susceptible to claims from clients, employees, suppliers and past service provider agencies. Management has recorded its best estimate of the outcome of these claims in these financial statements.

The LHIN enters into accountability agreements with HSP which include planned funding targets. The actual funding provided by the LHIN is contingent on the MOH providing the funding.

The LHIN is a member of the Healthcare Insurance Reciprocal of Canada (HIROC), which is a pooling of the liability insurance risks of its members. Members of the pool pay annual premiums that are actuarially determined. HIROC members are subject to reassessment for losses, if any, experienced by the pool for the years in which they are members, and these losses could be material. No reassessments have been made to March 31, 2021.

Should these result in additional revenues or costs, the difference will be recorded in the year of settlement.

GST/HST on Personal Support Services

The 2014 federal budget proposed to formally expand the tax exemption for homemaker services to include personal support services. This treatment is in line with current provincial and territorial practices. Starting March 22, 2013, personal support services are HST exempt. However, services provided before this date remain taxable. It is unclear at this time if the Canada Revenue Agency will proceed with the audit and reassessment of personal support service providers. While the LHIN believes this course of action is unlikely, such exposure could represent a significant financial liability for the LHIN. The LHIN has not recorded any liabilities with respect to this matter.

14. Corresponding figures

Certain corresponding figures have been reclassified to conform to the current year's presentation.

Financial statements of Erie St. Clair Local Health Integration Network

March 31, 2021

Independent Auditor's Report	1-2
Statement of financial position	3
Statement of operations	4
Statement of changes in net financial assets	5
Statement of cash flows	6
Notes to the financial statements	7-16

Independent Auditor's Report

To the Board of Directors of the
Erie St. Clair Local Health Integration Network

Audit Opinion

We have audited the accompanying financial statements of Erie St. Clair Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2021 and the statements of operations and changes in net financial assets and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies (collectively referred to as the "financial statements"). We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2021, and the results of its operations, changes in net financial assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards ("Canadian GAAS"). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are independent of the LHIN in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the LHIN's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the LHIN or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the LHIN's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian GAAS will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 LHIN's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the LHIN's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the LHIN to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

The image shows a handwritten signature in black ink that reads "Deloitte LLP". The signature is written in a cursive, flowing style.

Chartered Professional Accountants
Licensed Public Accountants
June 23, 2021

Erie St. Clair Local Health Integration Network
Statement of financial position
As at March 31, 2021

	Notes	2021 \$	2020 \$
Assets			
Current assets			
Cash		23,282,053	20,114,443
Due from Ministry of Health ("MOH")	11	112,257,208	877,881
Accounts receivable	4	700,446	510,554
Prepaid expenses		1,435,988	1,230,111
		137,675,695	22,732,989
Capital assets	5	638,447	950,266
		138,314,142	23,683,255
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities	4	17,715,210	14,523,605
Due to Health Service Providers ("HSPs")	11	112,257,208	877,881
Due to MOH	3	7,667,598	7,678,489
Deferred revenue		151,692	117,267
		137,791,708	23,197,242
Employee future benefits	6	2,543,800	2,163,900
Deferred capital contributions	7	638,447	950,266
		140,973,955	26,311,408
Commitments and contingencies	8 and 9		
Net assets		(2,659,813)	(2,628,153)
		138,314,142	23,683,255

The accompanying notes are an integral part of the financial statements.

Approved by the Board



_____, Director



_____, Director

Erie St. Clair Local Health Integration Network
Statement of operations
Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Revenue			
MOH funding - transfer payments	11	1,313,212,981	1,106,658,271
MOH funding - operations and initiatives		167,165,623	162,642,311
Ontario Health Cancer Care Division	4	634,800	458,342
Amortization of deferred capital contributions	7	315,486	433,757
Other revenue	4	559,569	797,803
		168,675,478	164,332,213
Total revenue		1,481,888,459	1,270,990,484
Expenses			
HSP transfer payments	11	1,313,212,981	1,106,658,271
Operations and Initiatives			
Contracted out			
In-home/clinic services		95,492,377	92,940,000
School services		1,308,974	3,352,391
Hospice services		4,472,830	4,276,544
Salaries and benefits		51,372,770	49,331,911
Medical supplies		8,352,378	6,109,692
Medical equipment rental		1,691,071	1,573,269
Supplies and sundry	4	3,170,686	4,103,600
Equipment repairs, rental and minor equipment		602,873	649,779
Building and grounds		1,927,693	2,013,010
Amortization		315,486	433,757
		168,707,138	164,783,953
Total expenses		1,481,920,119	1,271,442,224
Excess of expenses over revenue		(31,660)	(451,740)

The accompanying notes are an integral part of the financial statements.

Erie St. Clair Local Health Integration Network
Statement of changes in net financial assets
Year ended March 31, 2021

	Unrestricted	Employee	2021	2020
	\$	benefits	Total	Total
		\$	\$	\$
Net assets,				
beginning of year	(371,566)	(2,256,587)	(2,628,153)	(2,176,413)
Excess of expenses				
over revenue	371,566	(403,226)	(31,660)	(451,740)
Net assets, end of year	—	(2,659,813)	(2,659,813)	(2,628,153)

The accompanying notes are an integral part of the financial statements.

Erie St. Clair Local Health Integration Network
Statement of cash flows
Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Operating activities			
Excess of expenses over revenue		(31,660)	(451,740)
Less amounts not affecting cash			
Amortization of capital assets		315,486	433,757
Amortization of deferred capital contributions	7	(315,486)	(433,757)
		(31,660)	(451,740)
Changes in non-cash working capital items	10	3,199,270	2,234,354
		3,167,610	1,782,614
Investing activity			
Purchase of capital assets		(3,667)	(12,965)
Financing activity			
Increase in deferred contributions	7	3,667	12,965
Net change in cash		3,167,610	1,782,614
Cash, beginning of year		20,114,443	18,331,829
Cash, end of year		23,282,053	20,114,443

The accompanying notes are an integral part of the financial statements.

1. Description of business

The Erie St. Clair 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 Erie St. Clair 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 mandate of the LHIN is as follows:

- (a) 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 Municipalities of Essex, Lambton and Chatham-Kent. The LHIN enters into service accountability agreements with Health Service Providers ("HSPs").

The LHIN has also entered into an accountability agreement with the Ministry of Health ("MOH"), which provides the framework for LHIN accountabilities and activities.

All funding payments to LHIN managed HSPs are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to HSPs, are recorded in the LHIN's Financial Statements as revenue from the MOH and as transfer payment expenses to HSPs.

- (b) Provide health and related social services, medical supplies and equipment for the care of persons in home and community settings and to provide goods and services to assist caregivers in the provision of care for such persons. The LHIN manages the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals. The LHIN provides information to the public about, and make referrals to, health and social services.

On March 17, 2021 in accordance with subsection 40(1) of the Connecting Care Act, 2019 the Ontario Minister of Health issued a transfer order to the LHIN which transferred certain assets, liabilities, rights and obligations of the LHIN, primarily those related to the activities related to planning, funding and integration as described in (a) above to Ontario Health. In addition certain staff positions of the LHIN were also transferred to Ontario Health. The transfer became effective April 1, 2021.

Operating as Home and Community Care Support Services Erie St. Clair the LHIN will continue to be responsible for the provision of home and community services within its geographic area. The Board of Directors of Ontario Health ("OH") were appointed to constitute the Board of Directors of the LHIN on March 8, 2018. The OH board will continue in this capacity until such time as a new Board is appointed.

A memorandum of understanding between the LHIN and OH outlining the process to be followed with respect to the transfer of certain assets and liabilities between the LHIN and OH under the transfer order is currently being developed. It is anticipated that the amounts involved will primarily be liabilities associated with employees transferred to OH and reassigned back to the LHIN as part of the transfer. The amounts of assets and liabilities transferred are not expected to be material (see note 4).

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards for government not-for-profit organizations including the 4200 series standards, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOH represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOH are set up as repayable to the MOH at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Ministry of Health Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOH. The Financial Statements reflect funding arrangements approved by the MOH. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOH. Due to the nature of the Accountability Agreement, the LHIN is economically dependent on the MOH.

Transfer payment amounts to HSPs are based on the terms of the HSPs Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the HSPs. The cash associated with the transfer payment flows directly from the MOH and does not flow through the LHIN bank account.

LHIN Financial Statements include only transfer payment funds and LHIN operating funds included in the MLAA.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of an asset, are capitalized.

Capital assets are amortized on a straight-line basis based on their estimated useful life as follows:

Furniture and equipment	5, 10 and 20 years
Computer and communications equipment	3 and 5 years
Leasehold improvements	5 and 10 years

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

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and are amortized to income at the same rate as the corresponding capital asset.

2. Significant accounting policies (continued)

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the Statement of Operations.

Employee future benefits

The LHIN accrues its obligations relating to the defined benefit pension plan administered by the LHIN, other post-employment benefits and sick leave as the employees render services necessary to earn benefits. The LHIN has adopted the following policies:

- (i) The cost of benefits earned by employees is actuarially determined using the projected benefit method prorated on service and management's best estimate of expected plan investment performance, salary escalation, mortality and termination rates, and retirement ages of employees;
- (ii) For the purpose of calculating expected return on plan assets related to the defined benefit pension plan, these assets are valued at fair value;
- (iii) The excess of the net actuarial gain /loss is amortized over the average remaining service period of the employees;
- (iv) Differences arising from changes in assumptions and experience gains and losses are amortized on a straight line basis over the average remaining service period of the employees;
- (v) Past service costs arising from plan amendments are recognized immediately in the period the plan amendments occur.

A majority of the employees of the LHIN are eligible to be members of the Health Care of Ontario Pension Plan ("HOOPP"), which is a multi-employer, defined benefit, final average earnings and contributory pension plan. Defined contribution plan accounting is applied to HOOPP as LHIN has insufficient information to apply defined benefit accounting.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Funding repayable to the MOH

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 MOH. In fiscal year ended March 31, 2020 the LHIN incurred a deficit of \$371,566. In consultation with the Ministry of Health, the LHIN received permission to implement a plan that would return the LHIN back to a balance position in the next year. As a result of this agreement, the LHIN has a surplus of \$371,566 before accrued employee future benefits.

The amount due to the MOH at March 31 is made up as follows:

	2021	2020
	\$	\$
Due to MOH, beginning of year	7,678,489	7,047,485
Funding repaid to MOH	(3,361,379)	—
Funding repayable to the MOH related to current year activities	3,438,246	487,570
Write-off of prior year repayable not recovered	(87,758)	—
Funding repayable to the MOH related to current year ETI PMO Cluster activities	—	143,434
Due to MOH, end of year	7,667,598	7,678,489

4. Related party transactions

Ontario Health

On May 30, 2019, the Connecting Care Act (the "CCA") was proclaimed with key sections of the Act, including the creation of a new Crown Agency called Ontario Health, effective June 6, 2019. OH is a related party to the LHIN through the common control of the Province of Ontario. On December 2, 2019, the LHIN signed a Memorandum of Understanding ("MOU") with OH and 10 non-home and community care employees of the LHIN were transferred to OH. Under the MOU, the LHIN continued to provide compensation and benefits to transferred employees.

During the year, the LHIN incurred \$1,600,857 (\$866,351 in 2020 for the period from December 2, 2019 to March 31, 2020) in salaries and benefits expense for the transferred employees, of which \$359,286 (\$324,779 in 2020) remained in accounts payable and accrued liabilities at year-end. All amounts were recorded at cost in the Statement of operations and changes in net assets and the Statement of financial position.

Due to a change in the scope of the transfer, effective April 1, 2021 5 positions previously transferred to OH on December 2, 2019 were assigned back to the LHIN.

During the year the LHIN recognized \$634,800 (\$458,342 in 2020) from OH (Cancer Care Division) which is reported as Ontario Health Cancer Care Division in the statement of operations, \$196,350 (\$271,801 in 2020) of Business Technology Infrastructure ("BTI") funding which is included as other revenue on the statement of operations, \$74,764 (\$30,304 in 2020) cost recovery which is included in the statement of operations as a reduction of miscellaneous costs and incurred miscellaneous costs of \$225,684 (\$30,080 in 2020) which are reported as supplies and sundry in the statement of operations. At year-end a total of \$16,149 (nil in 2020) due from OH related to BTI is included in accounts receivable and \$20,785 (\$4,080 in 2020) due to OH is included in accounts payable and accrued liabilities.

4. Related party transactions (continued)

Other LHINs

During year the LHIN recognized \$109,350 (nil in 2020) of revenue from Waterloo Wellington LHIN in respect of funding for enabling technologies and referral programs which is included as other revenue on the statement of operations and which remains due from Waterloo Wellington LHIN at year-end and is included in accounts receivable in the statement of financial position. During the year the LHIN recognized \$39,572 (nil in 2020) from South West LHIN in respect of remote patient monitoring which is included as other income in the statement of operations and which remains due from South West LHIN at year-end and is included in accounts receivable on the statement of financial position. During the year the LHIN incurred \$15,000 (\$15,000 in 2020) of expenses related to translation services from the Champlain LHIN and \$11,899 (\$11,000 in 2020) of miscellaneous expenses from South West LHIN which are included in supplies and sundry in the statement of operations of which \$7,500 (nil in 2020) is included in accounts payable and accrued liabilities in the statement of financial position at year-end.

5. Capital assets

	Cost	Accumulated amortization	2021 Net book value	2020 Net book value
	\$	\$	\$	\$
Leasehold improvements	4,347,660	3,986,863	360,797	533,535
Furniture and equipment	2,605,290	2,417,680	187,610	225,286
Computer equipment	2,351,110	2,261,070	90,040	191,445
	9,304,060	8,665,613	638,447	950,266

6. Employee future benefits

The net employee future benefits liability consists of:

	2021	2020
	\$	\$
(a) Pension plan – accrued future benefit asset	(38,000)	(172,300)
(b) Other benefits – accrued future benefit liability	2,456,200	2,247,500
(c) Accumulated sick leave liability	125,600	88,700
Net employee future benefits	2,543,800	2,163,900

(a) Pension plans

The LHIN has a defined benefit pension plan administered by the LHIN and managed by The Manufacturers Life Insurance Company, which provides pension benefits based on years of service prior to January 1, 1999 for some unionized employees and prior to January 1, 2002 for some non-unionized employees. Subsequent to the above mentioned dates, some of the respective employees became members of Healthcare of Ontario Pension Plan ("HOOPP"), a multi-employer final average pay contributory pension plan.

The LHIN uses actuarial reports prepared by independent actuaries for funding and accounting purposes. The most recent actuarial valuation of the pension plans for funding purposes was as of November 30, 2017. The measurement date is March 31, 2021.

6. Employee future benefits (continued)

(a) Pension plans (continued)

The following significant actuarial assumptions were employed to determine the periodic pension expense and the accrued benefit obligations:

	2021 %	2020 %
Assumptions		
Accrued benefit obligation as of March 31		
Discount rate	3.21	3.29
Rate of compensation increase	1.50	1.50
Benefit costs for period ended March 31		
Expected long-term rate of return on plan assets	5.00	5.00
Rate of compensation increase	1.50	1.50

Information about the LHINs defined benefit pension plan is as follows:

	2021 \$	2020 \$
Accrued benefit obligation		
Accrued benefit obligation, beginning of year	487,200	693,000
Interest cost	15,300	18,900
Benefits paid	(44,800)	(198,200)
Actuarial loss (gain)	6,200	(26,500)
	463,900	487,200

	2021 \$	2020 \$
Plan assets		
Fair value of plan assets, beginning of year	530,500	733,100
Actual return on plan assets	24,900	32,100
Contributions	12,200	17,500
Benefit payments	(44,800)	(198,200)
Actuarial gain (loss)	92,900	(54,000)
Adjustment to assets	(16,200)	—
	599,500	530,500

Funded status

	2021 \$	2020 \$
Funded status		
Unamortized net actuarial (gain) loss	(97,600)	129,000
Funded status surplus	135,600	43,300
	38,000	172,300

6. Employee future benefits (continued)

(a) Pension plans (continued)

Funded status (continued)

Most employees are also members of HOOPP, which is a multi-employer plan, on behalf of approximately 510 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 2021 was \$3,676,892 (\$3,745,892 in 2020) for current service costs and is included as an expense in the 2021 Statement of operations. The last actuarial valuation was completed for the plan as of December 31, 2020. At that time, the plan was fully funded.

(b) Other benefits

The LHIN provides for the continuation of medical benefits to most employees upon retirement. Information about the plan is as follows:

Accrued benefit liability is determined as follows:

	2021 \$	2020 \$
Accrued benefit obligation	1,944,900	2,084,300
Unamortized actuarial gain	511,300	163,200
	2,456,200	2,247,500

Continuity of benefit liability is as follows:

	2021 \$	2020 \$
Balance, beginning of year	2,247,500	2,002,600
Current service cost	189,200	195,700
Interest cost	74,200	72,700
Benefits paid	(36,800)	(35,100)
Amortization of net actuarial (gains) loss	(17,900)	11,600
Balance, end of year	2,456,200	2,247,500

The following significant actuarial assumptions were employed to determine the periodic benefit expense and the accrued benefit obligation:

	2021 %	2020 %
Assumptions		
Accrued benefit obligation as of March 31		
Discount rate	3.21%	3.29%
Health care trend rate	6% trending down by 1% to 5%	6% trending down by 1% to 5%

6. Employee future benefits (continued)

(c) Sick leave benefits

Under the sick leave benefit plan, unused sick leave for most employees can accumulate. Information about the plan is as follows:

Compensated absence liability is determined as follows:

	2021	2020
	\$	\$
Accrued benefit obligation	2,283,800	2,170,500
Unamortized actuarial losses	(2,158,200)	(2,081,800)
	125,600	88,700

Continuity of benefit liability is as follows:

	2021	2020
	\$	\$
Balance, beginning of year	88,700	344,000
Interest cost	68,500	58,800
Benefits paid	(175,200)	(433,800)
Amortization of net actuarial gains	143,600	119,700
Balance, end of year	125,600	88,700

The following significant actuarial assumptions were employed to determine the periodic benefit expense and the accrued benefit obligation:

	2021	2020
	%	%
Assumptions		
Accrued benefit obligation as of March 31		
Discount rate	3.21	3.29
Rate of compensation increase	1.50	1.50

7. Deferred capital contributions

Deferred capital contributions represent the unamortized amount of contributions received for the purchase of capital assets. The changes in the deferred capital contributions balance are as follows:

	2021	2020
	\$	\$
Balance, beginning of year	950,266	1,371,058
Capital contributions received during the year	3,667	12,965
Amortization for the year	(315,486)	(433,757)
Balance, end of year	638,447	950,266

8. Commitments

The LHIN has commitments under various operating leases extending to 2025 as follows:

	\$
2022	2,267,421
2023	1,524,134
2024	382,774
2025	23,569

9. Contingencies

The LHIN has been named as a defendant in various claims. Management believes any liability resulting from these actions would be adequately covered by existing liability insurance.

10. Changes in non-cash working capital items

	2021 \$	2020 \$
Due from MOH	(111,379,327)	11,276,319
Accounts receivable	(189,892)	900,006
Prepaid expenses	(205,877)	199,244
Accounts payable and accrued liabilities	3,191,605	(1,242,856)
Due to HSPs	111,379,327	(9,603,119)
Due to MOH	(10,891)	631,004
Deferred revenue	34,425	6,156
Employee future benefits	379,900	67,600
Total change in non-cash working capital items	3,199,270	2,234,354

11. Transfer payments to HSPs

The LHIN has authorization to allocate funding of \$1,313,212,981 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2021 as follows:

	2021 \$	2020 \$
Operations of hospitals	918,106,175	728,348,037
Grants to compensate for municipal taxation – public hospitals	156,975	156,975
Long-Term Care Homes	245,729,158	238,195,771
Community support services	28,061,896	27,253,972
Assisted living services in supportive housing	14,632,231	12,373,706
Community health centres	39,747,322	39,657,970
Community mental health addictions program	18,199,387	14,548,542
Community mental health program	48,579,837	46,123,298
	1,313,212,981	1,106,658,271

11. Transfer payments to HSPs (continued)

The LHIN receives funding from the MOH/MLTC and in turn allocates it to the HSPs. As at March 31, 2021, an amount of \$112,257,208 (\$877,881 in 2020) was receivable from the MOH/MLTC, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and are included in the table above.

12. Financial risk

The LHIN through its exposure to financial assets and liabilities, has exposure to credit risk and liquidity risk as follows:

- (i) Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.
- (ii) Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

13. 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 favor 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.

14. Corresponding figures

Certain corresponding figures have been reclassified to conform to the current year's presentation.

Financial statements of
Hamilton Niagara Haldimand Brant
Local Health Integration Network

March 31, 2021

Independent Auditors' Report	1-2
Statement of financial position	3
Statement of operations	4
Statement of changes in net financial assets	5
Statement of cash flows	6
Notes to the financial statements	7-14

Independent Auditor's Report

To the Members of the Board of Directors of the
Hamilton Niagara Haldimand Brant Local Health Integration Network

Audit Opinion

We have audited the accompanying financial statements of Hamilton Niagara Haldimand Brant Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2021 and the statements of operations and changes in net financial assets, and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies (collectively referred to as the "financial statements"). We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2021, and the results of its operations, changes in net assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards ("Canadian GAAS"). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the LHIN in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the LHIN's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the LHIN or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the LHIN's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian GAAS will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 LHIN's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the LHIN's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the LHIN to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 23, 2021

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of financial position

As at March 31, 2021

	Notes	2021 \$	2020 \$
Assets			
Current assets			
Cash		28,545,162	24,580,967
Due from Ministry of Health ("MOH")		248,937,160	21,041,840
Accounts receivable		2,812,402	1,935,017
Prepaid expenses		2,966,759	2,433,884
		283,261,483	49,991,708
Capital assets	5	764,088	1,010,182
		284,025,571	51,001,890
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities		27,564,408	23,083,676
Due to Health Service Providers ("HSPs")	12	248,937,160	21,041,840
Due to MOH	3	6,688,562	5,535,471
Deferred operating contributions		71,353	330,721
		283,261,483	49,991,708
Deferred capital contributions	6	764,088	1,010,182
Employee future benefits	7	3,766,237	3,704,366
		287,791,808	54,706,256
Commitments and contingencies	8 and 9		
Net assets		(3,766,237)	(3,704,366)
		284,025,571	51,001,890

The accompanying notes are an integral part of the financial statements.

Approved by the Board



William Hatanaka, Board Chair



Garry Foster, Audit Committee Chair

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of operations

Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Revenue			
MOH funding – transfer payments	12	3,465,035,113	2,941,982,544
MOH funding – operations and initiatives		393,450,123	373,402,412
Ontario Health - Cancer Care Division	4	183,530	569,929
Amortization of deferred capital contributions	6	246,094	260,407
Other revenue	4	(6,169)	499,825
		393,873,578	374,732,573
		3,858,908,691	3,316,715,117
Expenses			
HSP transfer payments	12	3,465,035,113	2,941,982,544
Operations and initiatives			
Contracted out			
In-home/clinic services		258,064,489	239,077,750
School services		4,622,818	9,620,642
Hospice services		5,752,863	4,785,587
Salaries and benefits		91,339,940	92,053,124
Medical supplies		22,525,364	17,147,916
Medical equipment rental		3,484,862	3,184,617
Supplies and sundry		4,839,871	5,685,427
Building and ground		2,997,277	2,917,103
Amortization		246,094	260,407
		393,873,578	374,732,573
		3,858,908,691	3,316,715,117
Excess of revenue over expenses before the undernoted		—	—
Accrued non vested sick benefits		(61,871)	(46,102)
		(61,871)	(46,102)

The accompanying notes are an integral part of the financial statements.

Hamilton Niagara Haldimand Brant Local Health Integration Network**Statement of changes in net financial assets**Year ended March 31, 2021

	Unrestricted	Employee	2021	2020
	\$	benefits	Total	Actual
	\$	\$	\$	\$
Net assets, beginning of year	—	(3,704,366)	(3,704,366)	(3,658,264)
Excess of revenue over expenses before the undernoted	—	(61,871)	(61,871)	(46,102)
Net assets, end of year	—	(3,766,237)	(3,766,237)	(3,704,366)

The accompanying notes are an integral part of the financial statements.

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of cash flows

Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Operating activities			
Excess of expenses over revenue		(61,871)	(46,102)
Less: amounts not affecting cash			
Amortization of capital assets		246,094	260,407
Amortization of deferred capital contributions	6	(246,094)	(260,407)
		(61,871)	(46,102)
Changes in non-cash working capital items	10	4,026,066	4,411,002
Net increase in cash		3,964,195	4,364,900
Cash, beginning of year		24,580,967	20,216,067
Cash, end of year		28,545,162	24,580,967

The accompanying notes are an integral part of the financial statements.

1. Description of business

The Hamilton Niagara Haldimand Brant 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 Hamilton Niagara Haldimand Brant 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 mandate of the LHIN is as follows:

- (a) 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 Counties of Hamilton, Niagara, Haldimand, Brant, most of the County of Norfolk and the City of Burlington. The LHIN enters into service accountability agreements with Health Service Providers ("HSPs").

The LHIN has also entered into an accountability agreement with the Ministry of Health ("MOH"), which provides the framework for LHIN accountabilities and activities.

All funding payments to LHIN managed HSPs are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to HSPs, are recorded in the LHIN's Financial Statements as revenue from the MOH and as transfer payment expenses to HSPs.

- (b) Provision of community services. These services include providing health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided and to provide information to the public about, and make referrals to, health and social services.

On March 17, 2021 in accordance with subsection 40(1) of the Connecting Care Act, 2019 the Ontario Minister of Health issued a transfer order to the LHIN which transferred certain assets, liabilities, rights and obligations of the LHIN, primarily those related to the activities related to planning, funding and integration as described in (a) above to Ontario Health. In addition certain staff positions of the LHIN were also transferred to Ontario Health. The transfer became effective April 1, 2021.

Operating as Home and Community Care Support Services Hamilton, Niagara, Haldimand, Brant the LHIN will continue to be responsible for the provision of home and community services within its geographic area. The Board of Directors of Ontario Health ("OH") were appointed to constitute the Board of Directors of the LHIN on March 8, 2018. The OH board will continue in this capacity until such time as a new Board is appointed.

A memorandum of understanding between the LHIN and OH outlining the process to be followed with respect to the transfer of certain assets and liabilities between the LHIN and OH under the transfer order is currently being developed. It is anticipated that the amounts involved will primarily be liabilities associated with employees transferred to OH and reassigned back to the LHIN as part of the transfer. The amounts of assets and liabilities transferred are not expected to be material (see Note 4).

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards for government not-for-profit organizations including the 4200 series standards, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOH represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOH are set up as repayable to the MOH at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Ministry of Health Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOH. The Financial Statements reflect funding arrangements approved by the MOH. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOH. Due to the nature of the Accountability Agreement, the LHIN is economically dependent on the MOH.

Transfer payment amounts to HSPs are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the HSPs. The cash associated with the transfer payment flows directly from the MOH and does not flow through the LHIN bank account.

LHIN Financial Statements do not include transfer payment funds not included in the MLAA.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of an asset, are capitalized.

Capital assets are amortized on a straight-line basis based on their estimated useful life as follows:

Furniture and equipment	5 to 10 years
Computer equipment and software	3 years
Leasehold improvements	Over the remaining lease term

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and are amortized to income at the same rate as the corresponding capital asset.

Accrued non-vested sick benefits

The LHIN provides a sick leave benefit plan to all permanent employees and accrues it obligations as the employees render the service necessary to earn the benefits. The actuarial determination of the accrued benefit obligation uses the projected benefit method prorated on service (which incorporates management's best estimate of future salary levels, retirement ages of employees and other actuarial factors). Under this method, the benefit costs are recognized over the expected average service life of the employee group.

2. Significant accounting policies (continued)

Accrued non-vested sick benefits (continued)

The accrued benefit obligation is equal to the present value of the cost of sick leave credits accumulated to date that are expected to be used in the future in excess of the current yearly allotment of 18 days (pro-rated accordingly for part-time employees).

The current service costs for a particular period is equal to the actuarial present value of the cost of sick leave credits earned in the year that are expected to be used in the future in excess of the yearly allotment.

Actuarial gains and losses on the accrued benefit obligation arise from the differences between actual and expected experience and from changes in the actuarial assumptions used to determine the accrued benefit obligation. Any gains or losses are amortized over the estimated average remaining service life of the employees. The most recent actuarial evaluation of the sick leave plan was as of March 31, 2021.

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the Statement of Operations.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Funding repayable to the MOH

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 MOH.

The amount due to the MOH at March 31 is made up as follows:

	2021	2020
	\$	\$
Due to MOH, beginning of year	5,535,471	4,478,805
Funding repaid during year	(2,973,663)	—
Funding repayable to the MOH related to current year activities	4,126,754	1,056,666
Due to MOH, end of year	6,688,562	5,535,471

4. Related party transactions

Ontario Health

On May 30, 2019, the Connecting Care Act (the "CCA") was proclaimed with key sections of the Act, including the creation of a new Crown Agency called Ontario Health, effective June 6, 2019. Ontario Health is a related party to the LHIN through the common control of the Province of Ontario. On December 2, 2019, the LHIN signed a Memorandum of Understanding ("MOU") with Ontario Health and 13 non-home and community care employees of the LHIN were transferred to Ontario Health. Under the MOU, the LHIN continued to provide compensation and benefits to transferred employees.

During the year, the LHIN incurred \$2,489,157 (\$891,974 in 2020 for the period from December 2, 2019 to March 31, 2020) in salaries and benefit expense for the 13 transferred employees, of which \$28,868 (nil in 2020) remained in accounts payable and accrued liabilities as at year-end. All amounts were recorded at cost in the Statement of operations and the Statement of financial position.

Due to a change in the scope of the transfer, effective April 1, 2021, 6 employees previously transferred to OH on December 2, 2019 were assigned back to the LHIN.

During the year, the LHIN incurred \$65,743 (nil in 2020) for staff secondments to OH which was reported under salaries and benefit expense. The LHIN recognized \$65,743 in revenue from OH in respect of funding for staff secondments reported under other revenue. At year-end, a total of \$51,868 due from OH is included in accounts receivable in the statement of financial position.

During the year, the LHIN recognized \$183,530 (\$569,929 in 2020) of funding from OH (Cancer Care Division) which is reported as Ontario Health Cancer Care Division in the statement of operations, \$422,928 (\$427,200 in 2020) of Business Technology Infrastructure (BTI) which is included as other revenue on the statement of operations and incurred miscellaneous costs of \$57,523 (nil in 2020) which are reported as supplies and sundry in the Statement of operations.

Other LHINs

During the year, the LHIN incurred \$15,000 (\$15,000 in 2020) of expenses related to translation services from Champlain LHIN. During the year, the LHIN incurred \$321,359 (nil in 2020) for staff secondment to the Central West LHIN which was reported under salaries and benefit expense. The LHIN recognized \$321,359 in revenue from Central West LHIN in respect of funding for staff secondment reported under other revenue. At year-end, a total of \$31,176 (nil in 2020) due from Central West LHIN is included in accounts receivable in the statement of financial position.

5. Capital assets

	Cost	Accumulated amortization	2021 Net book value	2020 Net book value
	\$	\$	\$	\$
Computer equipment and software	633,809	633,809	—	5,255
Leasehold improvements	5,836,582	5,098,879	737,703	969,750
Furniture and equipment	6,471,421	6,445,036	26,385	35,177
	12,941,812	12,177,724	764,088	1,010,182

6. Deferred capital contributions

The changes in the deferred capital contributions balance are as follows:

	2021	2020
	\$	\$
Balance, beginning of year	1,010,182	1,270,589
Capital contributions received during the year	—	—
Amortization for the year	(246,094)	(260,407)
Balance, end of year	764,088	1,010,182

7. Employee future benefits

All full-time and part-time employees are credited with 1.5 days per month (pro-rated accordingly for part-time employees) for use as paid absences in the year, due to illness or injury. Employees are allowed to accumulate unused sick day credits each year, up to a maximum of 130 days for unionized employees and 120 days for non-union employees. Accumulated credits may be used in future years if the employee's illness or injury exceeds the annual allocation of credits. Employees are not entitled to any cash payment upon retirement.

The significant assumptions used are as follows:

	2021	2020
	%	%
Discount rate	3.21%	3.29%
Rate of compensation/inflation increases	2.00%	2.00%

Accrued benefit liability is determined as follows:

	2021	2020
	\$	\$
Accrued benefit obligation	3,473,498	3,265,600
Unamortized actuarial gain	292,739	438,766
Accrued benefit liability	3,766,237	3,704,366

Continuity of the accrued benefit liability is as follows:

	2021	2020
	\$	\$
Change in liability	3,704,366	3,658,264
Benefit expense	564,852	547,875
Less: benefits paid	(502,981)	(501,773)
Accrued benefit liability, end of year	3,766,237	3,704,366

7. Employee future benefits (continued)

The accrued non-vested sick benefit expense is as follows:

	2021	2020
	\$	\$
Benefit cost	478,778	466,327
Interest on accrued benefit obligation	114,916	108,953
Amortization of actuarial losses	(28,842)	(27,405)
Accrued non-vested sick benefits expense	564,852	547,875

The current year expense in excess of actual benefits paid of \$61,871 is recorded through the employee benefits fund.

8. Commitments

The LHIN is committed to the following operating lease payments extending to 2025 as follows:

	\$
2021	1,840,055
2022	1,612,610
2023	1,159,391
2024	1,119,141
2025	798,259

9. Contingencies

The LHIN has been named as defendants in various claims. Management believes any liability resulting from these actions would be adequately covered by existing liability insurance.

10. Change in non-cash working capital items

	2021	2020
	\$	\$
Due from MOH	(227,895,320)	5,156,430
Accounts receivable	(877,385)	6,174,796
Prepaid expenses	(532,875)	(1,244,849)
Accounts payable and accrued liabilities	4,480,732	(1,583,933)
Due to HSPs	227,895,320	(5,156,430)
Due to MOH	1,153,091	1,056,666
Deferred operating contributions	(259,368)	(37,780)
Employee future benefits	61,871	46,102
Total change in non-cash working capital items	4,026,066	4,411,002

Hamilton Niagara Haldimand Brant Local Health Integration Network

Notes to the financial statements

March 31, 2021

11. Pension Plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 1,024 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 2021 was \$6,440,395 (\$6,673,800 in 2020). The last actuarial valuation was completed for the plan as of December 31, 2020. At that time, the plan was fully funded.

12. Transfer payments to HSPs

The LHIN has authorization to allocate funding of \$3,465,035,113 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2020 as follows:

	2021	2020
	\$	\$
Operations of hospitals	2,631,100,565	2,152,887,700
Grants to compensate for municipal taxation – public hospitals	452,250	459,750
Long-Term Care Homes	561,480,026	543,199,892
Community support services	67,012,873	60,858,003
Acquired brain injury	12,291,007	10,729,789
Assisted living services in supportive housing	47,326,708	39,789,313
Community health centres	35,437,435	33,240,262
Community mental health addictions program	109,934,249	100,817,835
	3,465,035,113	2,941,982,544

The LHIN receives funding from the MOH and in turn allocates it to the HSPs. As at March 31, 2021, an amount of \$248,937,160 (\$21,041,840 in 2020) was receivable from the MOH, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and are included in the table above.

13. Financial risk

The LHIN through its exposure to financial assets and liabilities, has exposure to credit risk and liquidity risk as follows:

Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.

Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

14. 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 favor 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.

Financial statements of
Mississauga Halton Local Health
Integration Network

March 31, 2021

Independent Auditor's Report	1-2
Statement of financial position	3
Statement of operations and changes in net assets	4
Statement of cash flows	5
Notes to the financial statements	6-11

Independent Auditor's Report

To the Members of the Board of Directors of the
Mississauga Halton Local Health Integration Network

Audit Opinion

We have audited the accompanying financial statements of Mississauga Halton Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2021 and the statements of operations and changes in net assets, and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies (collectively referred to as the "financial statements"). We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2021, and the results of its operations, changes in net assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards ("Canadian GAAS"). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the LHIN in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the LHIN's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the LHIN or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the LHIN's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian GAAS will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 LHIN's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the LHIN's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the LHIN to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 23, 2021

Mississauga Halton Local Health Integration Network**Statement of financial position**

As at March 31, 2021

	Notes	2021 \$	2020 \$
Assets			
Current assets			
Cash		37,037,948	19,511,890
Due from Ministry of Health ("MOH")		1,127,100	—
MOH transfer payments to Health Service Providers ("HSPs")	11	116,466,189	3,903,544
Accounts receivable		1,336,540	616,624
Prepaid expenses		1,229,912	1,405,785
		157,197,689	25,437,843
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities		19,500,508	12,890,745
Deferred revenue		50,118	72,671
Due to HSPs	11	116,466,189	3,903,544
Due to MOH	3	21,180,874	8,570,883
		157,197,689	25,437,843
Commitments and contingencies	7 and 8		
Net assets		—	—
		157,197,689	25,437,843

The accompanying notes are an integral part of the financial statements.

Approved by the Board



William Hatanaka, Board Chair



Garry Foster, Audit Committee Chair

Mississauga Halton Local Health Integration Network
Statement of operations and changes in net assets
Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Revenue			
MOH funding – transfer payments	11	1,889,925,361	1,558,848,778
MOH funding – operations and initiatives		227,691,615	218,239,696
Ontario Health – Cancer Care Division	4	489,946	442,910
Amortization of deferred capital contributions	6	—	2,793
Other revenue	4	394,319	781,251
		228,575,880	219,466,650
Total revenue		2,118,501,241	1,778,315,428
Expenses			
HSP transfer payments	11	1,889,925,361	1,558,848,778
Operations and initiatives			
Contracted out			
In-home/clinic services		151,403,819	143,247,370
School services		1,760,595	3,850,665
Hospice services		1,897,614	1,901,369
Salaries and benefits		54,701,248	54,905,650
Medical supplies		9,608,998	6,467,276
Medical equipment rental		4,198,254	3,466,082
Supplies and sundry		1,947,411	2,189,452
Building and ground		2,364,985	2,659,529
Amortization		—	2,793
Equipment repairs and maintenance		692,956	776,464
		228,575,880	219,466,650
Total expenses		2,118,501,241	1,778,315,428
Excess of revenue over expenses		—	—
Net assets, beginning of year		—	—
Net assets, end of year		—	—

The accompanying notes are an integral part of the financial statements.

Mississauga Halton Local Health Integration Network

Statement of cash flows

Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Operating activities			
Excess of revenue over expenses		—	—
Less: amounts not affecting cash			
Amortization of capital assets		—	2,793
Amortization of deferred capital contributions	6	—	(2,793)
		—	—
Net changes in non-cash working capital items	9	17,526,058	6,742,483
Net increase in cash		17,526,058	6,742,483
Cash, beginning of year		19,511,890	12,769,407
Cash, end of year		37,037,948	19,511,890

The accompanying notes are an integral part of the financial statements.

Mississauga Halton Local Health Integration Network

Notes to the financial statements

March 31, 2021

1. Description of business

The Mississauga Halton 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 Mississauga Halton 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 mandate of the LHIN is as follows:

- (a) 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 a south-west portion of the City of Toronto, the south part of Peel Region and all of Halton Region except for Burlington. The LHIN enters into service accountability agreements with Health Service Providers ("HSPs").

The LHIN has also entered into an accountability agreement with the Ministry of Health ("MOH"), which provides the framework for LHIN accountabilities and activities.

All funding payments to LHIN managed HSPs are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to HSPs, are recorded in the LHIN's Financial Statements as revenue from the MOH and as transfer payment expenses to HSPs.

- (b) The LHIN is responsible to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places and to provide information to the public about, and make referrals to, health and social services.

On March 17, 2021 in accordance with subsection 40(1) of the Connecting Care Act, 2019 the Ontario Minister of Health issued a transfer order to the LHIN which transferred certain assets, liabilities, rights and obligations of the LHIN, primarily those related to the activities related to planning, funding and integration as described in (a) above to Ontario Health. In addition certain staff positions of the LHIN were also transferred to Ontario Health. The transfer became effective April 1, 2021.

Operating as Home and Community Care Support Services Mississauga Halton the LHIN will continue to be responsible for the provision of home and community services within its geographic area. The Board of Directors of Ontario Health ("OH") were appointed to constitute the Board of Directors of the LHIN on March 8, 2018. The OH board will continue in this capacity until such time as a new Board is appointed.

A memorandum of understanding between the LHIN and OH outlining the process to be followed with respect to the transfer of certain assets and liabilities between the LHIN and OH under the transfer order is currently being developed. It is anticipated that the amounts involved will primarily be liabilities associated with employees transferred to OH and reassigned back to the LHIN as part of the transfer. The amounts of assets and liabilities transferred are not expected to be material (see note 4).

Mississauga Halton Local Health Integration Network

Notes to the financial statements

March 31, 2021

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards for government not-for-profit organizations including the 4200 series standards, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOH represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOH are set up as repayable to the MOH at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Ministry of Health

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOH. The Financial Statements reflect funding arrangements approved by the MOH. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOH. Due to the nature of the Accountability Agreement, the LHIN is economically dependent on the MOH.

Transfer payment amounts to HSPs are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the HSPs. The cash associated with the transfer payment flows directly from the MOH and does not flow through the LHIN bank account. Funding allocations for transfer payment from the MOH are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2021.

LHIN Financial Statements do not include transfer payment funds not included in the MLAA.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of an asset, are capitalized

Capital assets are amortized on a straight-line basis based on their estimated useful life as follows:

Furniture and equipment	5 years
Computer equipment	3 years
Leasehold improvements	Over the remaining lease term

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

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and are amortized to income at the same rate as the corresponding capital asset.

2. Significant accounting policies (continued)

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the Statement of Operations and changes in net assets.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Funding repayable to the MOH

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 MOH.

The amount due to the MOH at March 31 is made up as follows:

	2021	2020
	\$	\$
Due to MOH, beginning of year	8,570,883	2,618,801
Funding repaid to MOH	(700,254)	—
Funding repayable to the MOH related to current year activities	13,310,245	5,952,082
Due to MOH, end of year	21,180,874	8,570,883

4. Related party transactions

Ontario Health

On May 30, 2019, the Connecting Care Act (the "CCA") was proclaimed with key sections of the Act, including the creation of a new Crown Agency called Ontario Health, effective June 6, 2019. Ontario Health is a related party to the LHIN through the common control of the Province of Ontario. On December 2, 2019, the LHIN signed a Memorandum of Understanding ("MOU") with Ontario Health and 17 non-home and community care employees of the LHIN were transferred to Ontario Health. Under the MOU, the LHIN continued to provide compensation and benefits to transferred employees.

Mississauga Halton Local Health Integration Network

Notes to the financial statements

March 31, 2021

4. Related party transactions (continued)

Ontario Health (continued)

During the year, the LHIN incurred \$2,695,082 (\$1,123,816 in 2020 for the period from December 2, 2019 to March 31, 2020) in salaries and benefits expense for the 17 transferred employees, of which \$107,032 (\$21,753 at March 31, 2020) remained in accounts payable and accrued liabilities as at year-end. All amounts were recorded at cost in the Statement of operations and changes in net assets and the Statement of financial position.

Due to a change in the scope of the transfer, effective April 1, 2021 9 employees previously transferred to OH on December 2, 2019 were assigned back to the LHIN.

During the year the LHIN recognized \$489,946 (\$442,910 in 2020) of funding from OH (Cancer Care Division) which is reported as Ontario Health Cancer Care Division in the statement of operations. In addition, the LHIN recognized \$234,234 (\$238,400 in 2020) of Business Technology Infrastructure ("BTI") funding which is included as other revenue on the statement of operations.

5. Capital assets

	Cost	Accumulated amortization	2021 Net book value	2020 Net book value
	\$	\$	\$	\$
Computer equipment	1,360,742	1,360,742	—	—
Leasehold improvements	6,422,929	6,422,929	—	—
Furniture and equipment	1,278,304	1,278,304	—	—
	9,061,975	9,061,975	—	—

6. Deferred capital contributions

The changes in the deferred capital contributions balance are as follows:

	2021 \$	2020 \$
Balance, beginning of year	—	2,793
Capital contributions acquired	—	—
Amortization for the year	—	(2,793)
Balance, end of year	—	—

7. Commitments

The LHIN has commitments under various operating leases related to building and equipment extending to 2024 as follows:

	\$
2022	2,096,283
2023	1,878,377
2024	137,284

8. Contingencies

The LHIN has been named as defendants in various claims. Management believes any liability resulting from these actions would be adequately covered by existing liability insurance.

9. Change in non-cash working capital items

	2021 \$	2020 \$
Due from MOH	(113,689,745)	6,132,489
Due from other LHINs	—	122,213
Accounts receivable	(719,916)	207,367
Prepaid expenses	175,873	(50,080)
Accounts payable and accrued liabilities	6,609,763	(1,850,419)
Deferred revenue	(22,553)	9,220
Due to HSPs	112,562,645	(3,780,389)
Due to MOH	12,609,991	5,952,082
Total change in non-cash working capital items	17,526,058	6,742,483

10. Pension plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 600 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 2021 was \$3,914,135 (\$4,001,912 in 2020). The last actuarial valuation was completed for the plan as of December 31, 2020. At that time, the plan was fully funded.

11. Transfer payment to HSPs

The LHIN has authorization to allocate funding of \$1,889,925,361 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2020 as follows:

	2021 \$	2020 \$
Operations of hospitals	1,478,329,809	1,172,027,990
Grants to compensate for municipal taxation – public hospitals	168,675	168,675
Long-term care homes	229,958,026	221,886,747
Community support services	69,872,356	59,380,067
Assisted living services in supportive housing	47,066,782	42,001,910
Community mental health	39,700,291	39,308,857
Addictions program	10,312,238	9,672,403
Acquired brain injury	6,446,581	6,415,617
Community health centres	8,070,603	7,986,512
	1,889,925,361	1,558,848,778

The LHIN receives funding from the MOH and in turn allocates it to the HSPs. As at March 31, 2021, an amount of \$116,466,189 (\$3,903,544 in 2020) was receivable from the MOH and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and changes in net assets and are included in the table above.

12. Financial risk

The LHIN through its exposure to financial assets and liabilities has exposure to credit risk and liquidity risk as follows:

Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.

Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

13. 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 favor 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.

Financial statements of North East Local Health Integration Network

March 31, 2021

Independent Auditor's Report	1-2
Statement of financial position	3
Statement of operations	4
Statement of changes in net financial assets	5
Statement of cash flows	6
Notes to the financial statements	7-14

Independent Auditor's Report

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

Audit Opinion

We have audited the accompanying financial statements of North East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2021 and the statements of operations, changes in net financial assets, and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies (collectively referred to as the "financial statements"). We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2021, and the results of its operations, changes in net assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards ("Canadian GAAS"). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the LHIN in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the LHIN's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the LHIN or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the LHIN's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian GAAS will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 LHIN's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the LHIN's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the LHIN to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 23, 2021

North East Local Health Integration Network

Statement of financial position

As at March 31, 2021

	Notes	2021 \$	2020 \$
Assets			
Current assets			
Cash		21,769,187	19,829,822
Due from Ministry of Health ("MOH")	12	166,325,360	2,618,520
Accounts receivable		1,371,039	841,066
Prepaid expenses		1,491,152	222,502
		190,956,738	23,511,910
Capital assets	5	309,199	541,525
		191,265,937	24,053,435
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities		14,269,733	17,409,790
Due to Health Service Providers ("HSPs")	12	166,325,360	2,618,520
Due to MOH	3	10,345,467	3,467,422
		190,940,560	23,495,732
Employee future benefits	6	4,549,479	4,546,762
Deferred capital contributions	7	309,199	541,525
		195,799,238	28,584,019
Commitments and contingencies	8 and 9		
Net liabilities		(4,533,301)	(4,530,584)
		191,265,937	24,053,435

The accompanying notes are an integral part of the financial statements.

Approved by the Board



William Hatanaka, Board Chair



Garry Foster, Audit Committee Chair

North East Local Health Integration Network
Statement of operations
Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Revenue			
MOH funding - transfer payments	12	1,752,190,662	1,470,244,941
MOH funding - operations and initiatives		164,346,022	156,768,657
Ontario Health Cancer Care Division	4	445,555	211,493
Amortization of deferred capital contributions	7	256,170	429,271
Other revenue	4	1,364,740	1,787,077
		166,412,487	159,196,498
		1,918,603,149	1,629,441,439
Expenses			
HSP transfer payments	12	1,752,190,662	1,470,244,941
Operations and Initiatives			
Contracted out			
In-home/clinic services		73,259,813	68,606,337
School services		374,264	1,012,703
Hospice services		6,289,992	5,214,313
Salaries and benefits		65,429,616	66,229,254
Medical supplies		10,782,992	6,729,467
Medical equipment rental		3,756,422	2,969,690
Supplies and sundry	4	4,110,263	5,504,076
Building and ground		2,155,672	2,486,135
Amortization	5	256,170	429,271
		166,415,204	159,181,246
		1,918,605,866	1,629,426,187
(Deficiency) excess of revenue over expenses		(2,717)	15,252

The accompanying notes are an integral part of the financial statements.

North East Local Health Integration Network**Statement of changes in net financial assets**

Year ended March 31, 2021

	Unrestricted	Employee	Internally	2021	2020
	\$	benefits	restricted	Total	Total
		\$	\$	\$	\$
Net assets, beginning of year	—	(4,546,762)	16,178	(4,530,584)	(4,545,836)
(Deficiency) excess of					
revenue over expenses	—	(2,717)	—	(2,717)	15,252
Net assets, end of year	—	(4,549,479)	16,178	(4,533,301)	(4,530,584)

The accompanying notes are an integral part of the financial statements.

North East Local Health Integration Network

Statement of cash flows

Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Operating activities			
(Deficiency) excess of revenue over expenses		(2,717)	15,252
Less: amounts not affecting cash			
Amortization of capital assets	5	256,170	429,271
Amortization of deferred capital contributions	7	(256,170)	(429,271)
		(2,717)	15,252
Change in non-cash working capital items	10	1,942,082	(92,332)
		1,939,365	(77,080)
Investing activities			
Purchase of capital assets	5	(23,844)	(15,597)
Disposal of capital assets	5	—	3,640
		(23,844)	(11,957)
Financing activity			
Increase in deferred capital contributions	7	23,844	11,957
Net change in cash		1,939,365	(77,080)
Cash, beginning of year		19,829,822	19,906,902
Cash, end of year		21,769,187	19,829,822

The accompanying notes are an integral part of the financial statements.

North East Local Health Integration Network

Notes to the financial statements

March 31, 2021

1. Description of Business

The North East 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 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 the Act.

The mandate of the LHIN is as follows:

(a) 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 most of the North East. The LHIN enters into service accountability agreements with Health Service Providers ("HSPs").

The LHIN has also entered into an accountability agreement with the Ministry of Health ("MOH"), which provides the framework for LHIN accountabilities and activities.

All funding payments to LHIN managed HSPs are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to HSPs, are recorded in the LHIN's financial statements as revenue from the MOH and as transfer payment expenses to HSPs.

(b) The delivery of home and community care services

These services include health and related social services, medical supplies and equipment for the care of persons in home and community settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and to provide information to the public about, and make referrals to, health and social services.

On March 17, 2021 in accordance with subsection 40(1) of the Connecting Care Act, 2019 the Ontario Minister of Health issued a transfer order to the LHIN which transferred certain assets, liabilities, rights and obligations of the LHIN, primarily those related to the activities related to planning, funding and integration as described in (a) above to Ontario Health. In addition certain staff positions of the LHIN were also transferred to Ontario Health. The transfer became effective April 1, 2021.

Operating as Home and Community Care Support Services North East the LHIN will continue to be responsible for the provision of home and community services within its geographic area. The Board of Directors of Ontario Health ("OH") were appointed to constitute the Board of Directors of the LHIN on March 8, 2018. The OH board will continue in this capacity until such time as a new Board is appointed.

A memorandum of understanding between the LHIN and OH outlining the process to be followed with respect to the transfer of certain assets and liabilities between the LHIN and OH under the transfer order is currently being developed. It is anticipated that the amounts involved will primarily be liabilities associated with employees transferred to OH and reassigned back to the LHIN as part of the transfer. The amounts of assets and liabilities transferred are not expected to be material (see note 4).

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards including the 4200 series for government not-for-profit organizations, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOH represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOH are set up as repayable to the MOH at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collected is reasonably assured.

Ministry of Health Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOH. The Financial Statements reflect funding arrangements approved by the MOH. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOH. Due to the nature of the MLAA, the LHIN is economically dependent on the MOH.

Transfer payment amounts to HSPs are based on the terms of the Accountability Agreements between the HSPs and the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the HSPs. The cash associated with the transfer payment flows directly from the MOH and does not flow through the LHIN bank account.

LHIN Financial Statements do not include transfer payment funds not included in the Ministry-LHIN Accountability Agreement.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of an asset, are capitalized.

Capital assets are amortized on a straight-line basis based on their estimated useful life as follows:

Furniture and equipment	5 years
Computer equipment	3 years
Leasehold improvement	Over the lease term

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

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and amortized to income at the same rate as the corresponding capital asset.

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

North East Local Health Integration Network

Notes to the financial statements

March 31, 2021

2. Significant accounting policies (continued)

Financial instruments (continued)

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the Statement of operations.

Employee future benefits

The LHIN accrues its obligations for sick leave and post-employment benefit plans as the employees render the services necessary to earn the benefits. The actuarial determination of the accrued benefit obligations uses the projected benefit method prorated on service (which incorporates management's best estimate of future salary levels, other cost escalation, retirement ages of employees and other actuarial factors). Under this method, the benefit costs are recognized over the expected average service life of the employee group.

Actuarial gains and losses on the accrued benefit obligation arise from differences between actual and expected experience and from changes in the actuarial assumptions used to determine the accrued benefit obligation. The excess of the future actuarial gains and losses will be amortized over the estimated average remaining service life of the employees (7.4 to 11.6 years). The most recent actuarial valuation of the sick leave plan and the benefit plan was as of March 31, 2021.

Substantially all of the employees of the LHIN are eligible to be members of the Health Care of Ontario Pension Plan ("HOOPP"), which is a multi-employer, defined benefit, final average earnings and contributory pension plan. Defined contribution plan accounting is applied to HOOPP as the LHIN has insufficient information to apply defined benefit accounting.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Funding repayable to the MOH

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 MOH.

The amount due to the MOH at March 31 is made up as follows:

	2021 \$	2020 \$
Due from MOH, beginning of year	3,467,422	757,473
Funding received from MOH	208,590	1,465,846
Funding repaid to MOH	—	(10,260)
Funding repayable to the MOH related to current year activities	6,669,455	1,254,363
Due to MOH, end of year	10,345,467	3,467,422

North East Local Health Integration Network

Notes to the financial statements

March 31, 2021

4. Related party transactions

Ontario Health

On May 30, 2019, the Connecting Care Act (the "CCA") was proclaimed with key sections of the Act, including the creation of a new Crown Agency called Ontario Health, effective June 6, 2019. Ontario Health is a related party to the LHIN through the common control of the Province of Ontario. On December 2, 2019, the LHIN signed a Memorandum of Understanding ("MOU") with Ontario Health and 19 non-home and community care employees of the LHIN were transferred to Ontario Health. Under the MOU, the LHIN continued to provide compensation and benefits to transferred employees.

During the year, the LHIN incurred \$3,530,771 (\$1,305,983 in 2020) in salaries and benefits expense for the 19 transferred employees, of which \$338,390 (\$356,389 in 2020) remained in accounts payable and accrued liabilities as at year-end. All amounts were recorded at cost in the Statement of operations and changes in net assets and the Statement of financial position.

Due to a change in the scope of the transfer, effective April 1, 2021 5 employees previously transferred to OH on December 2, 2019 were assigned back to the LHIN.

During the year the LHIN recognized \$445,555 (\$211,493 in 2020) of funding from OH (Cancer Care Division) which is reported as Ontario Health Cancer Care Division in the statement of operations, \$229,407 (\$238,510 in 2020) of Business Technology Infrastructure ("BTI") funding which is included as other revenue on the statement of operations, and incurred miscellaneous costs of \$52,931 (\$1,995 in 2020) which are reported as supplies and sundry in the statement of operations. At year-end at total of \$65,905 (nil in 2020) due to OH is included in accounts payable and accrued liabilities.

Other LHINs

During year the LHIN recognized \$474,180 (nil in 2020) of revenue from North West LHIN in respect of funding for enabling technologies and eReferral programs which is included as other income in the statement of operations and of which \$474,180 remains due from North West LHIN and is included in accounts receivable at March 31, 2021. Additionally, during the year, the LHIN incurred \$30,000 (\$22,500 in 2020) of expense related to translation services from the Champlain LHIN of which nil (\$15,000 in 2020) is included in accounts payable and accrued liabilities at year-end.

5. Capital assets

	Cost	Accumulated amortization	2021 Net book value	2020 Net book value
	\$	\$	\$	\$
Furniture and equipment	878,229	829,015	49,214	55,102
Computer equipment	1,228,576	1,156,712	71,864	95,065
Leasehold improvements	3,393,737	3,205,616	188,121	391,358
	5,500,542	5,191,343	309,199	541,525

North East Local Health Integration Network

Notes to the financial statements

March 31, 2021

6. Employee future benefits

The North East Local Health Integration Network provides for the reimbursement of medical and some life insurance expenses to certain retired employees provided that specified conditions are met. The LHIN provides 50% of accumulated sick leave entitlement not taken by certain employees, on their departure, provided certain conditions are met. The LHIN provided for a non-vesting benefit where it accrues to employees. An actuarial calculation of the future liabilities thereof has been made and forms the basis for the liability reported in these financial statements.

The significant assumptions used are as follows (weighted-average):

	Vested and non-vested sick leave	Post-employment benefit obligation
Discount rate	3.21%	3.21%
Rate of compensation increases	3%	3%
Health care costs trend rate		6% trending to 4.5% over a 8 year period

Information about the LHIN's benefit plans in aggregate is as follows:

	Vested and non-vested sick leave	Other employee future benefits	Total
	\$	\$	\$
Balance, beginning of year	2,698,839	1,847,923	4,546,762
Benefit cost	157,747	63,644	221,391
Interest paid	83,229	43,828	127,057
Benefits paid	(192,780)	(38,220)	(231,000)
Amortization of actuarial gains	(15,745)	(98,986)	(114,731)
Employee future benefit liability March 31, 2021	2,731,290	1,818,189	4,549,479
Obligation	2,541,685	1,027,381	3,569,066
Unamortized net actuarial gains	189,605	790,808	980,413
Employee future benefit liability March 31, 2021	2,731,290	1,818,189	4,549,479

6. Employee future benefits (continued)

Employee future benefits expense

	Vested and non-vested sick leave	Other employee future benefits	Total
	\$	\$	\$
Benefit cost	157,747	63,644	221,391
Interest on accrued benefit obligation	83,229	43,828	127,057
Amortization charges	(15,745)	(98,986)	(114,731)
Employee future benefits expense	225,231	8,486	233,717

A total loss of \$2,717 is included in the statement of operations. The Ministry does not fund the full actuarial expense, but rather the actual payments made during the year. The funded portion of the overall expense is reported through the unrestricted fund, the overfunded portion is reported in the employment benefit fund as follows:

	Vested and non-vested sick leave	Other future benefits	Total
	\$	\$	\$
Benefit expense	225,231	8,486	233,717
Funded portion of expense	(192,780)	(38,220)	(231,000)
Underfunded (overfunded) portion of expense	32,451	(29,734)	2,717

7. Deferred capital contributions

Deferred capital contributions represent the unamortized amount of contributions received for the purchase of capital assets. Deferred capital contributions are amortized to income at the same rate as the corresponding capital asset. The changes in the deferred capital contributions balance are as follows:

	2021	2020
	\$	\$
Balance, beginning of year	541,525	958,839
Capital contributions received during the year	23,844	11,957
Amortization for the year	(256,170)	(429,271)
Balance, end of year	309,199	541,525

8. Commitments

The LHIN has commitments under various operating leases extending to 2024 as follows:

	\$
2022	1,600,175
2023	1,125,776
2024	313,803

9. Contingencies

The LHIN has been named as defendants in various claims. Management believes any liability resulting from these actions would be adequately covered by existing liability insurance.

10. Change in non-cash working capital items

	2021	2020
	\$	\$
Due from MOH	(163,706,840)	57,441
Accounts receivable	(529,973)	79,779
Prepaid expenses	(1,268,650)	(3,910)
Accounts payable and accrued liabilities	(3,140,057)	(2,860,184)
Due to HSPs	163,706,840	(57,441)
Due to MOH	6,878,045	2,709,950
Deferred revenue		(2,715)
Employee future benefits	2,717	(15,252)
Change in non-cash working capital items	1,942,082	(92,332)

11. Pension plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 738 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 2021 was \$4,753,976 (\$4,858,422 in 2020) for current service costs and is included as an expense in the 2021 Statement of financial operations. The last actuarial valuation was completed for the plan as of December 31, 2020. At that time, the plan was fully funded.

12. Transfer payments to HSPs

The LHIN has authorization to allocate funding of \$1,752,190,662 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2021 as follows:

	2021	2020
	\$	\$
Operations of hospitals	1,288,739,294	1,023,421,118
Grants to Compensate for		
Municipal Taxation – Public Hospitals	199,575	211,500
Long-Term Care Homes	250,760,295	243,329,862
Community Support Services	47,460,906	47,058,953
Acquired Brain Injury	5,314,154	4,303,283
Assisted Living Services in Supportive Housing	27,897,624	25,334,831
Community Health Centers	26,477,401	25,084,434
Community Mental Health	75,759,397	73,802,537
Substance Abuse and Gambling Problem	29,582,016	27,698,423
	1,752,190,662	1,470,244,941

12. Transfer payments to HSPs (continued)

The LHIN receives funding from the MOH and in turn allocates it to the HSPs. As at March 31, 2021, an amount of \$166,325,360 (\$2,618,520 in 2020) was receivable from the MOH, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and are included in the table above.

13. Financial risk

The LHIN through its exposure to financial assets and liabilities, has exposure to credit risk and liquidity risk as follows:

Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.

Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

14. Accumulated non-vesting sick pay

The accumulated non-vesting sick pay comprises the sick pay benefits that accumulated but do not vest. These adjustments are not funded by the MOH.

15. 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 favor 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.

Financial statements of South East Local Health Integration Network

March 31, 2021

Independent Auditor's Report	1-2
Statement of financial position	3
Statement of operations and changes in net assets	4
Statement of cash flows	5
Notes to the financial statements	6-12

Independent Auditor's Report

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

Opinion

We have audited the accompanying financial statements of South East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2021, and the statements of operations and changes in net assets, and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2021, and the results of its operations, changes in net assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards ("Canadian GAAS"). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the LHIN in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the LHIN's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the LHIN or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the LHIN's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with Canadian GAAS will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 LHIN's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the LHIN's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the LHIN to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 23, 2021

South East Local Health Integration Network**Statement of financial position**

As at March 31, 2021

	Notes	2021 \$	2020 \$
Assets			
Current assets			
Cash		24,171,643	23,002,360
Due from Ministry of Health ("MOH")	12	74,370,972	1,939,804
Accounts receivable	4	1,938,849	1,313,503
Prepaid expenses		323,070	422,217
		100,804,534	26,677,884
Capital assets	5	8,577	40,221
		100,813,111	26,718,105
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities	4	17,611,419	15,293,295
Due to Health Service Providers ("HSPs")	12	74,370,972	1,939,804
Due to MOH	3	8,556,582	9,112,500
Deferred revenue		265,561	296,111
Current portion of obligations under capital leases	6	—	36,174
		100,804,534	26,677,884
Deferred capital contributions	7	8,577	40,221
		100,813,111	26,718,105
Contingencies and commitments	8 and 9		
Net assets		—	—
		100,813,111	26,718,105

The accompanying notes are an integral part of the financial statements.

Approved by the Board



William Hatanaka, Board Chair



Garry Foster, Audit Committee Chair

South East Local Health Integration Network
Statement of operations and changes in net assets
Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Revenue			
MOH funding – transfer payments	12	1,298,185,935	1,113,941,853
MOH funding – operations and initiatives		134,723,886	133,201,646
Ontario Health Cancer Care Division	4	238,535	342,186
Amortization of deferred capital contributions	7	31,644	96,024
Other revenue	4	1,685,075	1,732,783
		136,679,140	135,372,639
Total revenue		1,434,865,075	1,249,314,492
Expenses			
HSP transfer payments	12	1,298,185,935	1,113,941,853
Operations and initiatives			
Contracted out			
In-home/clinic services		84,711,715	80,923,588
School services		359,123	1,793,682
Hospice services		610,849	691,091
Salaries and benefits	4 and 11	37,023,073	39,552,945
Medical supplies		8,826,619	6,776,088
Medical equipment rental		1,240,358	1,139,976
Supplies and sundry		2,333,057	2,853,138
Buildings and grounds		1,542,702	1,546,107
Amortization	7	31,644	96,024
		136,679,140	135,372,639
Total expenses		1,434,865,075	1,249,314,492
Excess of revenue over expenses		—	—
Net assets, beginning of year		—	—
Net assets, end of year		—	—

The accompanying notes are an integral part of the financial statements.

South East Local Health Integration Network

Statement of cash flows

Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Operating activities			
Excess of revenue over expenses		—	—
Less amounts not affecting cash			
Amortization of capital assets		31,644	96,024
Amortization of deferred capital contributions		(31,644)	(96,024)
		—	—
Changes in non-cash working capital items	10	1,205,457	2,656,669
Investing activity			
Purchase of capital assets		—	(21,881)
Financing activities			
Increase in deferred capital contributions		—	21,881
Repayment of capital lease obligations		(36,174)	(37,621)
		(36,174)	(15,740)
Net increase in cash		1,169,283	2,619,048
Cash, beginning of year		23,002,360	20,383,312
Cash, end of year		24,171,643	23,002,360

The accompanying notes are an integral part of the financial statements.

South East Local Health Integration Network

Notes to the financial statements

March 31, 2021

1. Description of the business

The South East 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 South 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 the Act.

The mandate of the LHIN is as follows:

- (a) 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 most of the areas of Hastings, Prince Edward, Lennox and Addington, Frontenac, Leeds and Grenville Counties, the cities of Kingston, Belleville and Brockville, the towns of Smith Falls and Prescott, and part of Lanark and Northumberland Counties. The LHIN enters into service accountability agreements with Health Service Providers (HSP).

The LHIN has also entered into an accountability agreement with the Ministry of Health (MOH), which provides the framework for LHIN accountabilities and activities.

All funding payments to LHIN managed HSP are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to HSP are recorded in the LHIN's financial statements as revenue from the MOH and as transfer payment expenses to HSP.

- (b) Provision of community services: These services include health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and to provide information to the public about, and make referrals to, health and social services.

On March 17, 2021, in accordance with subsection 40(1) of the *Connecting Care Act, 2019* the Ontario Minister of Health issued a transfer order to the LHIN which transferred certain assets, liabilities, rights and obligations of the LHIN, primarily those related to the activities related to planning, funding and integration as described in (a) above to Ontario Health. In addition, certain staff positions of the LHIN were also transferred to Ontario Health.

Operating as Home and Community Care Support Services Central East, the LHIN will continue to be responsible for the provision of home and community services within its geographic area. The Board of Directors of Ontario Health ("OH") were appointed to constitute the Board of Directors of the LHIN on March 8, 2018. The OH board will continue in this capacity until such time as a new Board is appointed.

A memorandum of understanding between the LHIN and OH outlining the process to be followed with respect to the transfer of certain assets and liabilities between the LHIN and OH under the transfer order is currently being developed. It is anticipated that the amounts involved will primarily be liabilities associated with employees transferred to OH and reassigned back to the LHIN as part of the transfer. The amounts of assets and liabilities transferred are not expected to be material (see note 4).

2. Accounting policies

The financial statements of the LHIN are the representations of management and are prepared in accordance with Canadian public sector accounting standards for government not-for-profit organizations including the 4200 series standards, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOH represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOH are set up as repayable to the MOH at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collected is reasonably assured.

Ministry of Health Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement (MLAA), which describes budgetary arrangements established by the MOH. The financial statements reflect funding arrangements approved by the MOH. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOH. Due to the nature of the MLAA, the LHIN is economically dependent on the MOH.

Transfer payment amounts to HSP are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the HSP. The cash associated with the transfer payment flows directly from the MOH and does not flow through the LHIN bank account.

LHIN financial statements do not include transfer payment funds not included in the MLAA.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of an asset, are capitalized.

Capital assets are amortized on a straight-line basis based on their estimated useful life as follows:

Furniture and equipment	5 years
Computer equipment	3 years
Leasehold improvements	Over the lease term

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

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and amortized to income at the same rate as the corresponding capital asset.

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

2. Accounting policies (continued)

Financial instruments (continued)

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the statement of operations and changes in net assets.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Funding repayable to the MOH

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 MOH.

The amount due to the MOH at March 31, 2021 and 2020 is made up as follows:

	2021	2020
	\$	\$
Due to MOH, beginning of year	9,112,500	6,484,668
Funding repayable to the MOH related to prior year activities	(3,639,110)	—
current year activities	3,083,192	2,627,832
Due to MOH, end of year	8,556,582	9,112,500

4. Related party transactions

Ontario Health

On May 30, 2019, the *Connecting Care Act* (the "CCA") was proclaimed with key sections of the Act, including the creation of a new Crown Agency called Ontario Health, effective June 6, 2019. Ontario Health is a related party to the LHIN through the common control of the Province of Ontario. On December 2, 2019, the LHIN signed a Memorandum of Understanding ("MOU") with Ontario Health and 10 non-home and community care employees of the LHIN were transferred to Ontario Health. Under the MOU, the LHIN continued to provide compensation and benefits to transferred employees.

During the year, the LHIN incurred \$1,532,241 (\$598,421 in 2020 for the period from December 2, 2019 to March 31, 2020) in salaries and benefits expense for the 10 transferred employees, of which \$17,731 (\$13,206 in 2020) remained in accounts payable and accrued liabilities as at year-end. March 31, 2021. All amounts were recorded at cost in the statement of operations and changes in net assets and the statement of financial position.

Due to a change in the scope of the transfer, effective April 1, 2021 2 employees previously transferred to Ontario Health on December 2, 2019 were assigned back to the LHIN.

4. Related party transactions (continued)

Ontario Health (continued)

During the year the LHIN recognized \$238,535 (\$342,186 in 2020) of funding from OH (Cancer Care Division) which is reported as Onatrio Health Cancer Care Division in the statement of operations and changes in net assets. In addition the LHIN recognized \$171,853 (\$196,800 in 2020) of Business Technology Infrastructure ("BTI") funding from OH which is included as other revenue on the statement of operations and changes in net assets, and incurred miscellaneous costs from OH of \$32,224 (\$15,848 in 2020) which are reported as supplies and sundry in the statement of operations and changes in net assets. At year-end at total of \$65,905 (nil in 2020) due to OH is included in accounts payable and accrued liabilities.

Other LHINs

During year the LHIN recognized \$1,228,845 (nil in 2020) of revenue from Champlain LHIN in respect of funding for enabling technologies and eReferral programs which is included as other income in the statement of operations and changes in net assets and the full amount remains due from Champlain LHIN and is included in accounts receivable at March 31, 2021. Additionally, during the year, the LHIN incurred \$1,875 (\$6,703 in 2020) of expense related to translation services from the Champlain LHIN of which \$3,750 (\$7,500 in 2020) is included in accounts payable and accrued liabilities at year-end.

5. Capital assets

	Cost	Accumulated amortization	2021 Net book value	2020 Net book value
	\$	\$	\$	\$
Furniture and equipment	2,346,393	2,345,256	1,137	2,275
Computer equipment	872,335	864,895	7,440	34,393
Leasehold improvements	1,676,439	1,676,439	—	3,553
	4,895,167	4,886,590	8,577	40,221

6. Obligations under capital lease

The LHIN had a lease under the provision of capital lease of leasehold improvements. The cost of this lease was included in capital assets and the related liabilities were included in liabilities to reflect the effective acquisition and financing of these items. The lease on the building expired during the year.

The present value of future minimum payments were as follows:

	2021	2020
	\$	\$
2021	—	36,174
Less: current portion	—	36,174
Long-term portion of capital lease obligation	—	—

Pledged as security for the above borrowings were the leasehold improvements under capital lease.

South East Local Health Integration Network

Notes to the financial statements

March 31, 2021

7. Deferred capital contributions

Deferred capital contributions represent the unamortized amount of contributions received for the purchase of capital assets. Deferred capital contributions are amortized to income at the same rate as the corresponding capital asset. The changes in the deferred capital contributions balance are as follows:

	2021 \$	2020 \$
Balance, beginning of year	40,221	114,364
Capital contributions received during the year	—	21,881
Amortization for the year	(31,644)	(96,024)
Balance, end of year	8,577	40,221

8. Commitments

The LHIN has commitments under various operating leases extending to 2025 as follows:

	\$
2022	670,891
2023	182,894
2024	45,285
2025	5,906
	904,976

9. Contingencies

Due to the nature of its operations, the LHIN is susceptible to claims from clients, employees, suppliers and past service provider agencies. Management has recorded its best estimate of the outcome of these claims in these financial statements.

The LHIN is a member of the Healthcare Insurance Reciprocal of Canada (HIROC), which is a pooling of the liability insurance risks of its members. Members of the pool pay annual premiums that are actuarially determined. HIROC members are subject to reassessment for losses, if any, experienced by the pool for the years in which they are members, and these losses could be material. No reassessments have been made to March 31, 2021.

Should these result in additional revenues or costs, the difference will be recorded in the year of settlement.

10. Changes in non-working capital items

	2021 \$	2020 \$
Due from MOH	(72,431,168)	1,215,896
Accounts receivable	(625,346)	154,129
Prepaid expenses	99,147	17,130
Accounts payable and accrued liabilities	2,318,124	(2,670,251)
Due to HSPs	72,431,168	403,404
Due to MOH	(555,918)	3,579,095
Deferred revenue	(30,550)	(42,734)
	1,205,457	2,656,669

South East Local Health Integration Network

Notes to the financial statements

March 31, 2021

11. Pension Plan

The LHIN contributes to the Healthcare of Ontario Pension Plan (HOOPP), which is a multi-employer plan, on behalf of approximately 424 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 2021 was \$2,715,218 (\$2,877,762 in 2020) for current service costs and is included in salaries and benefits expense in the 2021 statement of operations. The last actuarial valuation was completed for the plan as of December 31, 2020. At that time, the plan was fully funded.

12. Transfer payments to HSPs

The LHIN has authorization to allocate funding of \$1,298,185,935 (\$1,113,941,853 in 2020) to various HSP in its geographic area. The LHIN approved transfer payments to various sectors as follows:

	2021 \$	2020 \$
Operations of hospitals	907,973,667	739,239,279
Grants to compensate for municipal taxation – public hospitals	177,375	177,375
Long-Term care homes	213,509,179	206,872,139
Community support services	46,273,327	43,699,523
Assisted living services in supportive housing	2,500,995	2,299,255
Community health centers	37,090,175	37,092,826
Community mental health	90,661,217	84,561,456
	1,298,185,935	1,113,941,853

The LHIN receives funding from the MOH and in turn allocates it to the HSP. As at March 31, 2021, an amount of \$74,370,972 (\$1,939,804 in 2020) was receivable from the MOH and was payable to HSPs. These amounts have been reflected as revenue and expenses in the statement of operations and changes in net assets and are included in the table above.

13. Financial risks

The LHIN through its exposure to financial assets and liabilities has exposure to credit risk and liquidity risk as follows:

Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.

Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

South East Local Health Integration Network

Notes to the financial statements

March 31, 2021

14. 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 favor 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 chapter 28 of the *Financial Administration Act*.

15. Corresponding figures

Certain corresponding figures have been reclassified to conform to the current year's presentation.

Financial statements of South West Local Health Integration Network

March 31, 2021

Independent Auditor's Report	1-2
Statement of financial position	3
Statement of operations	4
Statement of changes in net financial assets	5
Statement of cash flows	6
Notes to the financial statements	7-13

Independent Auditor's Report

To the Board of Directors of
South West Local Health Integration Network

Audit Opinion

We have audited the accompanying financial statements of South West Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2021 and the statements of operations and changes in net financial assets and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies (collectively referred to as the "financial statements"). We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2021, and the results of its operations, changes in net assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards ("Canadian GAAS"). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the LHIN in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the LHIN's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the LHIN or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the LHIN's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian GAAS will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 LHIN's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the LHIN's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the LHIN to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 23, 2021

South West Local Health Integration Network

Statement of financial position

As at March 31, 2021

	Notes	2021 \$	2020 \$
Assets			
Current assets			
Cash		36,163,348	31,387,080
Due from Ministry of Health ("MOH")	11	108,140,692	9,911,586
Accounts receivable	4	1,003,911	1,052,154
Prepaid expenses		771,497	994,672
		146,079,448	43,345,492
Capital assets	5	315,152	818,250
		146,394,600	44,163,742
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities	4	25,822,058	27,584,689
Due to Health Service Providers ("HSPs")	11	108,140,692	9,911,586
Due to MOH	3	12,851,866	6,506,553
Current portion of obligations under capital leases		—	74,867
		146,814,616	44,077,695
Deferred capital contributions	6	315,152	818,250
		147,129,768	44,895,945
Commitments and contingencies	7 and 8		
Net assets		(735,168)	(732,203)
		146,394,600	44,163,742

The accompanying notes are an integral part of the financial statements.

Approved by the Board



William Hatanaka, Board Chair



Garry Foster, Audit Committee Chair

South West Local Health Integration Network

Statement of operations

Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Revenue			
MOH funding – transfer payments	11	2,568,335,998	2,268,768,270
MOH funding – operations and initiatives		233,810,669	231,048,594
Ontario Health Cancer Care Division	4	329,728	251,351
Amortization of deferred capital contributions	6	503,098	1,085,001
Other revenue	4	1,200,236	916,956
		235,843,731	233,301,902
Total revenue		2,804,179,729	2,502,070,172
Expenses			
HSP transfer payments	11	2,568,335,998	2,268,768,270
Operations and initiatives			
Contracted out			
In-home/clinic services		129,431,698	124,798,330
School services		3,306,000	7,180,164
Hospice services		4,620,000	4,375,000
Salaries and benefits		71,751,723	72,215,477
Medical supplies		14,217,888	10,928,374
Medical equipment rental		2,097,895	1,409,242
Supplies and sundry	4	7,770,918	9,124,967
Building and ground		2,147,476	2,275,306
Amortization		503,098	1,085,001
		235,846,696	233,391,861
Total expenses		2,804,182,694	2,502,160,131
Excess of expenses over revenue		(2,965)	(89,959)

The accompanying notes are an integral part of the financial statements.

South West Local Health Integration Network**Statement of changes in net financial assets**Year ended March 31, 2021

	Unrestricted	Employee	2021	2020
	\$	benefits	Total	Total
		\$	\$	\$
Net assets, beginning of year	—	(732,203)	(732,203)	(642,244)
Excess of expenses over revenue	—	(2,965)	(2,965)	(89,959)
Net assets, end of year	—	(735,168)	(735,168)	(732,203)

The accompanying notes are an integral part of the financial statements.

South West Local Health Integration Network

Statement of cash flows

Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Operating activities			
Excess of expenses over revenue		(2,965)	(89,959)
Less amounts not affecting cash			
Amortization of capital assets		503,098	1,085,001
Amortization of deferred capital contributions	6	(503,098)	(1,085,001)
		(2,965)	(89,959)
Changes in non-cash working capital items	9	4,854,100	(15,720,826)
		4,851,135	(15,810,785)
Financing activities			
Repayment of capital lease obligations		(74,867)	(306,553)
Increase in deferred capital contributions	6	—	317,949
		(74,867)	11,396
Net change in cash		4,776,268	(15,799,389)
Cash, beginning of year		31,387,080	47,186,469
Cash, end of year		36,163,348	31,387,080

The accompanying notes are an integral part of the financial statements.

South West Local Health Integration Network

Notes to the financial statements

March 31, 2021

1. Description of business

The South West 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 South West 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 mandate of the LHIN is as follows:

- (a) 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 approximately 22,000 square kilometers from Tobermory in the north to Long Point in the south. The LHIN enters into service accountability agreements with Health Service Providers ("HSPs").

The LHIN has also entered into an accountability agreement with the Ministry of Health ("MOH"), which provides the framework for the LHIN accountabilities and activities.

All funding payments to LHIN managed HSPs are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to HSPs, are recorded in the LHIN's Financial Statements as revenue from the MOH and as transfer payment expenses to the HSPs.

- (b) Provision of community services. These services include health and related social services, medical supplies and equipment for the care of persons in home and community settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and to provide information to the public about, and make referrals to, health and social services.

On March 17, 2021 in accordance with subsection 40(1) of the Connecting Care Act, 2019 the Ontario Minister of Health issued a transfer order to the LHIN which transferred certain assets, liabilities, rights and obligations of the LHIN, primarily those related to the activities related to planning, funding and integration as described in (a) above to Ontario Health. In addition certain staff positions of the LHIN were also transferred to Ontario Health. The transfer became effective April 1, 2021.

Operating as Home and Community Care Support Services South West the LHIN will continue to be responsible for the provision of home and community services within its geographic area. The Board of Directors of Ontario Health ("OH") were appointed to constitute the Board of Directors of the LHIN on March 8, 2018. The OH board will continue in this capacity until such time as a new Board is appointed.

A memorandum of understanding between the LHIN and OH outlining the process to be followed with respect to the transfer of certain assets and liabilities between the LHIN and OH under the transfer order is currently being developed. It is anticipated that the amounts involved will primarily be liabilities associated with employees transferred to OH and reassigned back to the LHIN as part of the transfer. The amounts of assets and liabilities transferred are not expected to be material (see Note 4).

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards for government not-for-profit organizations including the 4200 series standards, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOH represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOH are set up as repayable to the MOH at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Ministry of Health and Long-Term Care Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOH. The Financial Statements reflect funding approved by the MOH to support LHIN managed HSPs and the operations of the LHIN. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOH in the MLAA. Due to the nature of the Accountability Agreement, the LHIN is economically dependent on the MOH.

Transfer payment amounts to HSPs are based on the terms of the HSPs Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the HSPs. The cash associated with the transfer payment flows directly from the MOH to the HSPs and does not flow through the LHIN bank account.

LHIN Financial Statements includes only transfer payment funds and LHIN operating funds included in the MLAA.

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the Statement of Operations.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital revenue 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 operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

2. Significant Accounting Policies (continued)

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of an asset, are capitalized.

Capital assets are amortized on a straight-line basis based on their estimated useful life as follows:

Computer equipment	3 years
Computer software	3 years
Equipment capital lease	Life of lease
Leasehold improvements	Life of lease
Furniture and equipment	10 years
Phone system	5 years

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

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Funding repayable to the MOH

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 MOH.

The amount due to the MOH at March 31 is made up as follows:

	2021	2020
	\$	\$
Due from MOH, beginning of year	6,506,553	22,031,229
Funding repaid to MOH	—	(20,464,445)
Funding repayable to the MOH related to current year activities	6,345,313	4,939,769
Due to MOH, end of year	12,851,866	6,506,553

4. Related party transactions

Ontario Health

On May 30, 2019, the Connecting Care Act (the "CCA") was proclaimed with key sections of the Act, including the creation of a new Crown Agency called Ontario Health, effective June 6, 2019. Ontario Health is a related party to the LHIN through the common control of the Province of Ontario. On December 2, 2019, the LHIN signed a Memorandum of Understanding ("MOU") with OH and 15 non-home and community care employees of the LHIN were transferred to OH. Under the MOU, the LHIN continued to provide compensation and benefits to transferred employees.

South West Local Health Integration Network

Notes to the financial statements

March 31, 2021

4. Related party transactions (continued)

Ontario Health (continued)

During the year, the LHIN incurred \$2,384,191 (\$843,475 in 2020 for the period from December 2, 2019 to March 31, 2020) in salaries and benefits expense for 15 transferred employees, of which \$67,664 (\$62,397 at March 31, 2020) remained in accounts payable and accrued liabilities as at year-end. All amounts were recorded at cost in the Statement of operations and changes in net assets and the Statement of financial position.

Due to a change in the scope of the transfer, effective April 1, 2021 7 employees previously transferred to OH on December 2, 2019 were assigned back to the LHIN.

During the year the LHIN recognized \$329,728 (\$251,351 in 2020) of funding from OH (Cancer Care Division) which is reported as Ontario Health Cancer Care Division in the statement of operations. In addition the LHIN recognized \$289,936 (\$328,992 in 2020) of Business Technology Infrastructure ("BTI") funding which is included as other revenue on the statement of operations, and incurred miscellaneous costs of \$430,826 (nil in 2020) and \$58,624 (nil in 2020) which are reported as medical equipment and supplies and sundry respectively in the statement of operations.

Other LHINs

During year the LHIN recognized \$394,873 (nil in 2020) of revenue from Waterloo Wellington LHIN in respect of funding for enabling technologies and eReferral programs and \$6,700 (nil in 2020) for miscellaneous revenue which is included as other income in the statement of operations and which \$401,573 remains due from Waterloo Wellington LHIN and is included in accounts receivable at March 31, 2021. The LHIN also recognized miscellaneous revenue \$11,899 (nil in 2020) from the Erie St. Clair LHIN and \$6,700 from HNHB LHIN which is included as other revenue in the statement of operations. Additionally, during the year, the LHIN incurred \$15,000 (nil in 2020) of expense related to translation services from the Champlain LHIN which is reported in supplies and sundry in the statement of operations and \$39,572 (nil in 2020) from Erie St Clair LHIN for remote patient monitoring and is included in salaries and benefits, medical equipment and supplies and sundry in the statement of operations.

5. Capital assets

	Cost	Accumulated depreciation	2021 Net book value	2020 Net book value
	\$	\$	\$	\$
Computer equipment	4,941,537	4,941,537	—	157,145
Computer software	2,231,898	2,231,898	—	3,667
Equipment capital lease	2,631,713	2,631,713	—	94,491
Leasehold improvements	5,145,820	4,905,435	240,385	387,338
Furniture and equipment	5,067,139	4,992,372	74,767	160,277
Phone system	1,342,568	1,342,568	—	15,332
	21,360,675	21,045,523	315,152	818,250

6. Deferred capital contributions

The changes in deferred capital contributions balance are as follows:

	2021	2020
	\$	\$
Balance, beginning of year	818,250	1,585,302
Capital contributions received during the year	—	317,949
Amortization of deferred capital contributions	(503,098)	(1,085,001)
Balance, end of year	315,152	818,250

7. Commitments

The LHIN has commitments under various operating leases expiring in 2023 as follows:

	\$
2021	1,384,316
2022	1,040,072
2023	<u>268,650</u>

8. Contingencies

The LHIN has been named as defendants in various claims. Management believes any liability resulting from these actions would be adequately covered by existing liability insurance.

9. Change in non-cash working capital items

	2021	2020
	\$	\$
Due from MOH	(98,229,106)	712,759
Accounts receivable	48,243	208,085
Prepaid expenses	223,175	273,502
Accounts payable and accrued liabilities	(1,762,631)	(2,341,996)
Due to HSPs	98,229,106	1,304,634
Due to MOH	6,345,313	(15,524,676)
Due to other LHINs	—	(353,134)
Total change in non-cash working capital items	4,854,100	(15,720,826)

10. Pension plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 880 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 2021 was \$5,078,448 (\$5,093,630 in 2020) for current service costs and is included as an expense in the statement of operations. The last actuarial valuation was completed for the plan as of December 31, 2020. At that time, the plan was fully funded.

11. Transfer payments to HSPs

The LHIN has authorization to allocate funding of \$2,568,335,998 (\$2,268,768,270 in 2020) to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2021 as follows:

	2021	2020
	\$	\$
Operations of hospitals	1,960,500,254	1,694,684,273
Grants to compensate for municipal taxation – public hospitals	381,225	381,225
Long-Term care homes	389,846,819	374,736,534
Community support services	51,727,598	49,429,224
Assisted living services in supportive housing	33,096,759	29,891,911
Community health centres	27,934,207	26,434,900
Acquired brain injury	10,396,867	9,646,023
Community mental health addictions program	94,452,269	83,564,180
	2,568,335,998	2,268,768,270

The LHIN receives funding from the MOH and in turn allocates it to the HSPs. As at March 31, 2021, an amount of \$108,140,692 (\$9,911,586 in 2020) was receivable from the MOH, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the statement of operations and are included in the table above.

12. Financial risk

The LHIN through its exposure to financial assets and liabilities, has exposure to credit risk and liquidity risk as follows:

- (i) Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.
- (ii) Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

13. Accumulated non-vesting sick pay

Accumulated non-vesting sick pay of \$735,168 (\$732,203 in 2020) is included in accounts payable and accrued liabilities. The amounts are not funded by the Ontario Ministry of Health until they are paid.

14. 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 favor 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.

South West Local Health Integration Network

Notes to the financial statements

March 31, 2021

15. Comparative figures

Certain of prior year's comparative figures have been reclassified to conform with current years presentation.

Financial statements of Toronto Central Local Health Integration Network

March 31, 2021

Independent Auditor's Report	1-2
Statement of financial position	3
Statement of operations and changes in net assets	4
Statement of cash flows	5
Notes to the financial statements	6-12

Independent Auditor's Report

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

Audit Opinion

We have audited the accompanying financial statements of Toronto Central Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2021 and the statements of operations and changes in net assets, and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies (collectively referred to as the "financial statements"). We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2021, and the results of its operations, changes in net assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards ("Canadian GAAS"). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are independent of the LHIN in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the LHIN's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the LHIN or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the LHIN's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian GAAS will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian GAAS, we exercised professional judgment and maintained professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 LHIN's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the LHIN's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the LHIN to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

The signature "Deloitte LLP" is written in a cursive, handwritten style.

Chartered Professional Accountants
Licensed Public Accountants
June 23, 2021

Toronto Central Local Health Integration Network

Statement of financial position

As at March 31, 2021

	Notes	2021 \$	2020 \$
Assets			
Current assets			
Cash		20,498,265	22,436,674
Due from Ministry of Health ("MOH")		649,361,743	22,314,487
Accounts receivable	4	1,741,125	1,238,434
Prepaid expenses		231,255	375,837
		671,832,388	46,365,432
Deposits		107,501	107,501
Capital assets	5	294,801	386,354
		672,234,690	46,859,287
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities		21,783,996	22,420,392
Due to Health Service Providers ("HSPs")	10	647,910,943	22,097,187
Due to MOH		2,244,950	1,955,354
		671,939,889	46,472,933
Deferred capital contributions	6	294,801	386,354
		672,234,690	46,859,287
Commitments and contingencies	8 and 14		
Net assets		—	—
		672,234,690	46,859,287

The accompanying notes are an integral part of the financial statements.

Approved by the Board



William Hatanaka, Board Chair



Garry Foster, Audit Committee Chair

Toronto Central Local Health Integration Network
Statement of operations and changes in net assets
Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Revenue			
MOH - transfer payments	10	7,482,990,884	5,036,511,020
MOH funding - operations and initiatives		277,488,422	274,576,617
Ontario Health Cancer Care Division	4	786,572	793,417
Amortization of deferred capital contributions	6	91,553	91,553
Other revenues		340,359	360,197
		278,706,906	275,821,784
eHealth-Enabling Technologies for Integration allocated to Central LHIN		—	(159,040)
Total revenue		7,761,697,790	5,312,173,764
Expenses			
HSP transfer payments	10	7,482,990,884	5,036,511,020
Operations and initiatives			
Contracted out			
In-home/clinic services		188,071,156	185,056,270
School services		1,459,758	3,658,732
Hospice services		4,259,407	3,414,111
Salaries and benefits		62,778,794	63,582,290
Medical supplies		13,414,000	10,016,466
Medical equipment rental		2,801,058	2,748,029
Supplies and sundry	4	3,764,117	4,550,679
Building and ground		2,008,248	2,279,269
Amortization		91,553	91,553
Repairs and maintenance		58,815	265,345
		278,706,906	275,662,744
Total expenses		7,761,697,790	5,312,173,764
Excess of revenue over expenses		—	—
Net assets, beginning of year		—	—
Net assets, end of year		—	—

The accompanying notes are an integral part of the financial statements.

Toronto Central Local Health Integration Network

Statement of cash flows

Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Operating activities			
Excess of revenues over expenses		—	—
Less amounts not affecting cash			
Amortization of capital assets		91,553	91,553
Amortization of deferred capital contributions	6	(91,553)	(91,553)
		—	—
Changes in non-cash working capital items	8	(1,938,409)	(2,643,997)
		(1,938,409)	(2,643,997)
Net (decrease) in cash		(1,938,409)	(2,643,997)
Cash, beginning of year		22,436,674	25,080,671
Cash, end of year		20,498,265	22,436,674

The accompanying notes are an integral part of the financial statements.

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 ("MOH"), which provides the framework for LHIN accountabilities and activities.

The mandate of the LHIN is as follows:

- (a) 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 most of City of Toronto. The LHIN enters into service accountability agreements with health service providers.

All funding payments to LHIN managed Health Service Providers are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to Health Service Providers, are recorded in the LHIN's Financial Statements as revenue from the MOH and as transfer payment expenses to Health Service Providers.

- (b) Provision of community services. The LHIN has the responsibility to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the Home Care and Community Services Act, 1994 and to provide information to the public about, and make referrals to, health and social services.

On March 17, 2021 in accordance with subsection 40(1) of the Connecting Care Act, 2019 the Ontario Minister of Health issued a transfer order to the LHIN which transferred certain assets, liabilities, rights and obligations of the LHIN, primarily those related to the activities related to planning, funding and integration as described in (a) above to Ontario Health. In addition, certain staff positions of the LHIN were also transferred to Ontario Health.

Operating as Home and Community Care Support Services Toronto Central, the LHIN will continue to be responsible for the provision of home and community services within its geographic area. The Board of Directors of Ontario Health ("OH") was appointed to constitute the Board of Directors of the LHIN on March 8, 2018. The OH board will continue in this capacity until such time as a new Board is appointed.

A memorandum of understanding between the LHIN and OH outlining the process to be followed with respect to the transfer of certain assets and liabilities between the LHIN and OH under the transfer order is currently being developed. It is anticipated that the amounts involved will primarily be liabilities associated with employees transferred to OH and reassigned back to the LHIN as part of the transfer. The amounts of assets and liabilities transferred are not expected to be material (see note 4).

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards for government not-for-profit organizations including the 4200 series standards, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOH represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOH are set up as repayable to the MOH at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Ministry of Health funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOH. The Financial Statements reflect funding arrangements approved by the MOH. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOH. Due to the nature of the Accountability Agreement, the LHIN is economically dependent on the MOH.

Transfer payment amounts to Health Service Providers are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the Health Service Providers. The cash associated with the transfer payment flows directly from the MOH and does not flow through the LHIN bank account.

LHIN Financial Statements do not include transfer payment funds not included in the Ministry-LHIN Accountability Agreement.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated lives of an asset, are capitalized.

Capital assets are amortized on a straight-line basis based on their estimated useful lives as follows:

Furniture and equipment	5 years
Computer and communications equipment	3 years
Client serving equipment	5 years
Leasehold improvements	Life of lease

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

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and are amortized to income at the same rate as the corresponding capital asset.

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

2. Significant accounting policies (continued)

Financial instruments (continued)

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the Statement of operations and changes in net assets.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, 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. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Due to MOH

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 MOH.

The amount due to the MOH at March 31 is made up as follows:

	2021	2020
	\$	\$
Due to MOH, beginning of year	1,955,354	1,011,865
Funding repayable to the MOH related to current year activities	289,596	943,489
Due to MOH, end of year	2,244,950	1,955,354

4. Related party transactions

Ontario Health

On May 30, 2019, the Connecting Care Act (the "CCA") was proclaimed with key sections of the Act, including the creation of a new Crown Agency called Ontario Health, effective June 6, 2019. Ontario Health is a related party to the LHIN through the common control of the Province of Ontario. On December 2, 2019, the LHIN signed a Memorandum of Understanding ("MOU") with Ontario Health and 16 non-home and community care employees of the LHIN were transferred to Ontario Health. Under the MOU, the LHIN continued to provide compensation and benefits to transferred employees.

During the year, the LHIN incurred \$ 2,793,649 (\$ 928,118 in 2020 for the period from December 2, 2019 to March 31, 2020) in salaries and benefits expense for the 16 transferred employees, of which \$ 121,943 (\$ 20,481 in 2020) remained in accounts payable and accrued liabilities as at year-end. All amounts were recorded at cost in the Statement of operations and changes in net assets and the Statement of financial position.

Due to a change in the scope of the transfer, effective April 1, 2021 2 employees previously transferred to OH on December 2, 2019 were assigned back to the LHIN.

4. Related party transactions (continued)

Ontario Health (continued)

During the year the LHIN recognized revenue of \$786,572 (\$793,417 in 2020) from OH (Cancer Care Division) which is reported as Ontario Health Cancer Care Division in the statement of operations. In addition the LHIN recognized \$336,235 (\$353,600 in 2020) of Business Technology Infrastructure ("BTI") funding from OH which is included as other revenue on the statement of operations, and incurred miscellaneous costs from OH of \$94,724 (\$9,669 in 2020) which are reported as supplies and sundry in the statement of operations. At year-end, a total of \$691,848 (\$652,157 in 2020) due from OH is included in accounts receivable.

5. Capital assets

	Cost	Accumulated depreciation	2021 Net book value	2020 Net book value
	\$	\$	\$	\$
Computer and communication equipment	13,802,756	(13,802,756)	—	—
Leasehold improvements	4,304,402	(4,009,601)	294,801	339,580
Furniture and equipment	2,160,107	(2,160,107)	—	—
Client serving equipment	233,866	(233,866)	—	46,774
	20,501,131	(20,206,330)	294,801	386,354

6. Deferred capital contributions

Deferred capital contributions represent the unamortized amount of contributions received for the purchase of capital assets. Deferred capital contributions are amortized to income at the same rate as the corresponding capital asset. The changes in the deferred capital contributions balance are as follows:

	2021 \$	2020 \$
Balance, beginning of year	386,354	477,907
Amortization for the year	(91,553)	(91,553)
Balance, end of year	294,801	386,354

7. Commitments

The LHIN has commitments under various operating leases as follows:

	\$
2022	1,826,631
2023	1,836,448
2024	1,713,872
2025	1,688,067
2026	1,706,120
Thereafter	2,738,691
	<u>11,509,829</u>

8. Change in non-cash working capital items

	2021 \$	2020 \$
Due from MOH	(627,047,256)	(11,079,215)
Accounts receivable	(502,691)	(531,644)
Prepaid expenses	144,582	(57,091)
Accounts payable and accrued liabilities	(636,396)	(6,453,351)
Due to HSPs	625,813,756	14,533,815
Due to MOH	289,596	943,489
Total change in non-cash working capital items	<u>(1,938,409)</u>	<u>(2,643,997)</u>

9. Pension Plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 647 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 2021 was \$ 5,248,085 (\$4,743,558 in 2020) for current service costs and is included as an expense in the statement of operations and changes in net assets. The last actuarial valuation was completed for the plan as of December 31, 2020. At that time, the plan was fully funded.

10. Transfer payment to HSPs

The LHIN has authorization to allocate funding of \$7,482,990,884 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors as follows:

	2021	2020
	\$	\$
Operations of hospitals	6,210,079,619	3,925,224,856
Grants to compensate for municipal taxation – public hospitals	715,275	715,275
Long-term care homes	314,540,487	302,565,432
Community support services	183,948,622	140,723,257
Assisted living services in supportive housing	72,636,745	61,731,825
Community health centres	123,273,627	111,028,436
Community mental health	182,341,728	161,452,508
Addictions program	46,726,472	42,752,179
Acquired brain injury	3,176,530	3,109,709
Specialty psychiatric hospital	345,502,729	287,158,493
Grants to compensate for municipal taxation – psychiatric hospital	49,050	49,050
	7,482,990,884	5,036,511,020

The LHIN receives funding from the MOH and in turn allocates it to the HSPs. As at March 31, 2021, an amount of \$ 647,910,943 (\$22,097,187 in 2020) was receivable from the MOH, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the statement of operations and changes in net assets and are included in the table above.

11. Financial risk

The LHIN through its exposure to financial assets and liabilities, has exposure to credit risk and liquidity risk as follows:

- (i) Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.
- (ii) Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

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 favor 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. Contingencies

The LHIN has been named as defendants in various claims. Management believes any liability resulting from these actions would be adequately covered by existing liability insurance.

14. Corresponding figures

Certain of prior year's comparative figures have been reclassified to conform with current years presentation.

Financial statements of Waterloo Wellington Local Health Integration Network

March 31, 2021

Independent Auditor's Report	1-2
Statement of financial position	3
Statement of operations	4
Statement of changes in net assets (liabilities)	5
Statement of cash flows	6
Notes to the financial statements	7-13

Independent Auditor's Report

To the Members of the Board of Directors of the
Waterloo Wellington Local Health Integration Network

Audit Opinion

We have audited the accompanying financial statements of the Waterloo Wellington Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2021 and the statements of operations, changes in net assets (liabilities) and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies (collectively referred to as the "financial statements"). We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2021, and the results of its operations, changes in net assets (liabilities), and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards ("Canadian GAAS"). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the LHIN in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the LHIN's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the LHIN or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the LHIN's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian GAAS will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian GAAS, we exercised professional judgment and maintained professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 LHIN's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the LHIN's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the LHIN to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 23, 2021

Waterloo Wellington Local Health Integration Network

Statement of financial position

As at March 31, 2021

	Notes	2021 \$	2020 \$
Assets			
Current assets			
Cash		22,919,504	20,269,083
Due from Ministry of Health ("MOH")	12	99,059,276	3,281,194
Accounts receivable		2,121,437	2,303,957
Prepaid expenses		967,678	1,830,389
		125,067,895	27,684,623
Deposits		47,061	48,001
Capital assets	5	160,558	323,053
		125,275,514	28,055,677
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities	4	18,371,149	15,574,661
Due to Health Service Providers ("HSPs")	12	96,219,976	3,213,227
Due to MOH	3	10,523,831	8,925,837
Deferred revenue		—	4,001
		125,114,956	27,717,726
Employee future benefits	6	1,908,056	1,742,007
Deferred capital contributions	7	160,558	323,053
		127,183,570	29,782,786
Commitments and contingencies	8 and 9		
Net liabilities		(1,908,056)	(1,727,109)
		125,275,514	28,055,677

The accompanying notes are an integral part of the financial statements.

Approved by the Board



William Hatanaka, Board Chair



Garry Foster, Audit Committee Chair

Waterloo Wellington Local Health Integration Network

Statement of operations

Year ended March 31, 2021

	Notes	2021 Actual \$	2020 Actual \$
Revenue			
MOH funding - transfer payments	12	1,300,879,988	1,041,639,281
MOH funding - operations and initiatives		169,769,792	163,686,041
Ontario Health Cancer Care Division	4	312,991	507,760
Amortization of deferred capital contributions	8	162,495	141,153
Other revenue	4	1,926,581	2,860,925
		172,171,859	167,195,879
Total revenue		1,473,051,847	1,208,835,160
Expenses			
HSP transfer payments	12	1,300,879,988	1,041,639,281
Operations and initiatives			
Contracted out			
In-home/clinic services		107,044,144	96,483,807
School services		1,931,056	4,034,422
Hospice services		3,594,310	3,001,235
Salaries and benefits		42,497,331	43,743,698
eReferral and System Coordinated Access	4	1,665,650	7,480,092
Medical supplies		7,964,126	5,420,877
Medical equipment rental		1,860,939	1,790,531
Supplies and sundry	4	3,587,958	3,123,566
Building and ground		1,863,850	1,976,497
Amortization		162,495	141,153
		172,171,859	167,195,878
Total expenses		1,473,051,847	1,208,835,159
Excess of revenue over expenses before the undernoted		—	—
Employee future benefits expense		(166,049)	(201,287)
Expenditures from donations fund		(14,898)	(95)
Excess of expenses over revenue		(180,947)	(201,382)

The accompanying notes are an integral part of the financial statements.

Waterloo Wellington Local Health Integration Network**Statement of changes in net assets (liabilities)**

Year ended March 31, 2021

	Donations Fund	Employee benefits	2021 Total	2020 Total
	\$	\$	\$	\$
Net assets (liabilities), beginning of year	14,898	(1,742,007)	(1,727,109)	(1,525,727)
Excess of expenses over revenue	(14,898)	(166,049)	(180,947)	(201,382)
Net liabilities, end of year	—	(1,908,056)	(1,908,056)	(1,727,109)

The accompanying notes are an integral part of the financial statements.

Waterloo Wellington Local Health Integration Network

Statement of cash flows

Year ended March 31, 2021

	Notes	2021 \$	2020 \$
Operating activities			
Excess of expenses over revenue		(180,947)	(201,382)
Add amounts not affecting cash			
Amortization of capital assets		162,495	141,153
Amortization of deferred capital contributions	7	(162,495)	(141,153)
		(180,947)	(201,382)
Changes in non-cash working capital items	10	2,831,368	(1,604,815)
		2,650,421	(1,806,197)
Investing activity			
Purchase of capital assets		—	(17,105)
Financing activity			
Increase in deferred capital contributions	7	—	17,105
Net increase (decrease) in cash		2,650,421	(1,806,197)
Cash, beginning of year		20,269,083	22,075,280
Cash, end of year		22,919,504	20,269,083

The accompanying notes are an integral part of the financial statements.

Waterloo Wellington Local Health Integration Network

Notes to the financial statements

March 31, 2021

1. Description of business

The Waterloo Wellington 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 Waterloo Wellington 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 mandate of the LHIN is as follows:

- (a) 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 most of Regions of Waterloo Wellington. The LHIN enters into service accountability agreements with Health Service Providers ("HSPs").

The LHIN has also entered into an accountability agreement with the Ministry of Health ("MOH"), which provides the framework for LHIN accountabilities and activities.

All funding payments to LHIN managed HSPs are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to HSPs, are recorded in the LHIN's Financial Statements as revenue from the MOH and as transfer payment expenses to HSPs.

- (b) Provision of home and community services include health and related social services, medical supplies and equipment for the care of persons in home and community settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and to provide information to the public about, and make referrals to, health and social services.

On March 17, 2021 in accordance with subsection 40(1) of the Connecting Care Act, 2019 the Ontario Minister of Health issued a transfer order to the LHIN which transferred certain assets, liabilities, rights and obligations of the LHIN, primarily those related to the activities related to planning, funding and integration as described in (a) above to Ontario Health. In addition certain staff positions of the LHIN were also transferred to Ontario Health. The transfer became effective April 1, 2021.

Operating as Home and Community Care Support Services Waterloo Wellington the LHIN will continue to be responsible for the provision of home and community services within its geographic area. The Board of Directors of Ontario Health ("OH") were appointed to constitute the Board of Directors of the LHIN on March 8, 2018. The OH board will continue in this capacity until such time as a new Board is appointed.

A memorandum of understanding between the LHIN and OH outlining the process to be followed with respect to the transfer of certain assets and liabilities between the LHIN and OH under the transfer order is currently being developed. It is anticipated that the amounts involved will primarily be liabilities associated with employees transferred to OH and reassigned back to the LHIN as part of the transfer. The amounts of assets and liabilities transferred are not expected to be material (see Note 4).

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards for government not-for-profit organizations including the 4200 series standards, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOH represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOH are set up as repayable to the MOH at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Ministry of Health Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOH. The Financial Statements reflect funding arrangements approved by the MOH. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOH. Due to the nature of the MLAA, the LHIN is economically dependent on the MOH.

Ministry of Health Funding

Transfer payment amounts to HSPs are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the HSPs. The cash associated with the transfer payment flows directly from the MOH and does not flow through the LHIN bank account.

LHIN Financial Statements do not include transfer payment funds not included in the MLAA.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of an asset, are capitalized.

Capital assets are amortized on a straight-line basis based on their estimated useful life as follows:

Computer and communications equipment	3 years
Computer software	3 years
Leasehold improvements	Term of the lease
Furniture and equipment	10 years

For assets acquired or brought into use, during the year, amortization is provided for at one half of the annual rate.

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and are amortized to income at the same rate as the corresponding capital asset.

2. Significant accounting policies (continued)

Employee future benefits

The LHIN accrues its obligations for sick leave and post-employment benefit plans as the employees render the services necessary to earn the benefits. The actuarial determination of the accrued benefit obligations uses the projected benefit method prorated on service (which incorporates management's best estimate of future salary levels, other cost escalation, and other actuarial factors). Under this method, the benefit costs are recognized over the expected average service life of the employee group.

Actuarial gains and losses on the accrued benefit obligation arise from differences between actual and expected experience and from changes in the actuarial assumptions used to determine the accrued benefit obligation. The excess of the future actuarial gains and losses will be amortized over the estimated average remaining service life of the employees. The most recent actuarial valuation of the sick leave plan and the benefit plan was as of March 31, 2021.

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the statement of operations.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Funding repayable to the MOH

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 MOH.

The amount due to the MOH at March 31 is made up as follows:

	2021	2020
	\$	\$
Due to MOH, beginning of year	8,925,837	5,938,689
Funding repaid to MOH	(1,348,163)	—
Funding repayable to the MOH related to current year activities	2,946,157	2,987,148
Due to MOH, end of year	10,523,831	8,925,837

Waterloo Wellington Local Health Integration Network

Notes to the financial statements

March 31, 2021

4. Related party transactions

Ontario Health

On May 30, 2019, the Connecting Care Act (the "CCA") was proclaimed with key sections of the Act, including the creation of a new Crown Agency called Ontario Health, effective June 6, 2019. Ontario Health is a related party to the LHIN through the common control of the Province of Ontario. On December 2, 2019, the LHIN signed a Memorandum of Understanding ("MOU") with Ontario Health and 14 non-home and community care employees of the LHIN were transferred to Ontario Health. Under the MOU, the LHIN continued to provide compensation and benefits to transferred employees.

During the year, the LHIN incurred \$2,428,828 (\$1,069,491 in 2020 for the period from December 2, 2019 to March 31, 2020) in salaries and benefits expense for the 14 transferred employees, of which \$77,204 (\$252,497 in 2020) remained in accounts payable and accrued liabilities as at March 31, 2021. All amounts were recorded at cost in the Statement of operations and changes in net assets (liabilities) and the Statement of financial position.

Due to a change in the scope of the transfer, effective April 1, 2021, 2 employees previously transferred to OH on December 2, 2019 were reassigned back to the LHIN.

During the year the LHIN recognized \$312,991 (\$507,760 in 2020) of funding from OH (Cancer Care Division) which is reported as Ontario Health Cancer Care Division in the statement of operations. In addition the LHIN recognized \$183,057 (\$196,000 in 2020) of Business Technology Infrastructure ("BTI") funding from OH which is included as other revenue on the statement of operations, and incurred miscellaneous costs from OH of \$31,710 (\$5,506 in 2020) which are reported as supplies and sundry in the statement of operations.

Other LHINs

During year the LHIN allocated \$394,873 to the South West LHIN and \$109,350 (\$500,000 received from in 2020) to the Erie St. Clair LHIN in respect of enabling technologies and referral programs which is included as supplies and sundry and eReferral and System Coordinated Access, respectively, in the statement of operations.

At March 31, 2021 \$394,873 allocated to the South West LHIN and \$109,350 allocated to the Erie St. Clair LHIN remains due to the respective LHINs and is included in accounts payable and accrued liabilities. Additionally during the year the LHIN incurred \$30,000 (nil in 2020) of expense related to translation services from the Champlain LHIN which is included in supplies and sundry in the statement of operations.

5. Capital assets

	Cost	Accumulated depreciation	2021 Net book value	2020 Net book value
	\$	\$	\$	\$
Computer equipment	45,088	36,536	8,552	20,058
Computer software	21,678	18,065	3,613	10,839
Leasehold improvements	716,747	574,724	142,023	284,793
Furniture and equipment	263,144	256,774	6,370	7,363
	1,046,657	886,099	160,558	323,053

6. Employee future benefits

The LHIN has a defined early retirement benefit plan that provides benefits to employees who are 55 years of age, have retired and are withdrawing funds from the pension plan. The early retirement benefits cease when the individual reaches 65 years of age.

Waterloo Wellington Local Health Integration Network

Notes to the financial statements

March 31, 2021

6. Employee future benefits (continued)

The accrued benefit obligation for early retirement benefits as at March 31, 2021 is based on an actuarial valuation for accounting purposes using the projected benefit method pro-rated on service. The most recent actuarial valuation of the early retirement benefits obligation was completed March 31, 2021.

This valuation was based on assumptions about future events. The economic assumptions used in these valuations are management's best estimates of expected rates of:

	2021 %
Inflation	2.00
Discount on accrued benefit obligation	3.21
Compensation increase	3.00
Dental cost trends	4.00
Health care cost trends	6.00

Information about the employee future benefit plan is as follows:

	2021 \$	2020 \$
Accrued benefit liability, beginning of year	1,742,007	1,540,720
Current service cost	227,099	223,209
Interest on obligation	76,352	70,967
Amortization of actuarial losses	77,461	79,411
Benefits paid	(214,863)	(172,300)
Accrued benefit liability, end of year	1,908,056	1,742,007
Accrued benefit obligation	2,473,232	2,332,163
Unamortized actuarial losses	(565,176)	(590,156)
Accrued benefit liability, end of year	1,908,056	1,742,007

7. Deferred capital contributions

Deferred capital contributions represent the unamortized amount of contributions received for the purchase of capital assets. Deferred capital contributions are amortized to income at the same rate as the corresponding capital asset. The changes in the deferred capital contributions balance are as follows:

	2021 \$	2020 \$
Balance, beginning of year	323,053	447,101
Capital contributions received during the year	—	17,105
Amortization for the year	(162,495)	(141,153)
Balance, end of year	160,558	323,053

Waterloo Wellington Local Health Integration Network

Notes to the financial statements

March 31, 2021

8. Commitments

The LHIN has commitments under various operating leases extending to 2023 as follows:

	\$
2021	1,193,945
2022	702,382
2023	114,831

9. Contingencies

The LHIN has been named as defendants in various claims. Management believes any liability resulting from these actions would be adequately covered by existing liability insurance.

10. Changes in non-cash working capital items

	2021 \$	2020 \$
Due from MOH	(95,778,082)	4,334,406
Accounts receivable	182,520	(460,399)
Prepaid expenses	862,711	(1,310,376)
Deposits	940	798
Accounts payable and accrued liabilities	2,796,488	(4,723,830)
Due to HSP	93,006,749	(2,577,773)
Due to MOH	1,597,994	2,931,172
Deferred revenue	(4,001)	(100)
Employee future benefits	166,049	201,287
	2,831,368	(1,604,815)

11. Pension plan

The LHIN contributes to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 459 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 2021 was \$2,988,766 (\$3,084,827 in 2020) for current service costs and is included as an expense in the 2021 statement of operations. The last actuarial valuation was completed for the plan as of December 31, 2020. At that time, the plan was fully funded.

Waterloo Wellington Local Health Integration Network

Notes to the financial statements

March 31, 2021

12. Transfer payments to HSPs

The LHIN has authorization to allocate funding of \$1,300,879,988 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2021 as follows:

	2021 \$	2020 \$
Operations of hospitals	902,042,039	662,622,856
Grants to compensate for municipal taxation – public hospitals	170,100	159,225
Long-term care homes	224,586,041	217,626,076
Community care access centres	—	—
Community support services	33,230,233	32,597,161
Assisted living services in supportive housing	6,736,939	6,471,004
Community health centres	28,599,110	26,581,111
Community mental health addictions program	105,515,526	95,581,848
	1,300,879,988	1,041,639,281

The LHIN receives funding from the MOH and in turn allocates it to the HSPs.

As at March 31, 2021, an amount of \$96,219,976 (\$3,213,227 in 2020) was receivable from the MOH, and was payable to HSPs, and included as due from the MOH and due to HSPs in the statement of financial position, respectively. Amounts have been reflected as revenue and expenses in the statement of operations and are included in the table above.

13. Financial risk

The LHIN through its exposure to financial assets and liabilities, has exposure to credit risk and liquidity risk as follows:

- (i) Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.
- (ii) Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

14. Accumulated non-vesting sick pay

The accumulated non-vesting sick pay comprises the sick pay benefits that accumulated but do not vest. These adjustments are not funded by the MOH.

15. 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 favor 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.

Appendix One – LHIN Populations Profiles

LHIN	Population Profile		Health Service Providers*
Erie St. Clair	Area (km ²):	7,324	5 Hospitals 36 Long-Term Care Homes 29 Community Services 20 Mental Health Agencies 4 Residential Hospices 5 Community Health Centres
	Total Population:	666,890	
	% of Ontario Population:	4.58%	
	Population Age 65+:	19.69%	
	Population Growth Rate:	1.16%	
	Population Density:	85.7	
	Rural Population:	22.50%	
	Indigenous Population:	3.40%	
	Francophone Population:	3.30%	
	Low Income Population	3.30%	
South West	Area (km ²):	1,886,389	19 Hospitals 78 Long-Term Care Homes 53 Community Services 31 Mental Health Agencies 5 Residential Hospices 5 Community Health Centres
	Total Population:	1,038,957	
	% of Ontario Population:	7.13%	
	Population Age 65+:	19.38%	
	Population Growth Rate:	1.87%	
	Population Density	45.6	
	Rural Population	39.80%	
	Indigenous Population	2.40%	
	Francophone Population	1.40%	
	Low Income Population	15.00%	

Waterloo Wellington	Area (km ²):	4,751	8 Hospitals 36 Long-Term Care Homes 24 Community Services 13 Mental Health Agencies 4 Residential Hospices 4 Community Health Centres
	Total Population:	845,582	
	% of Ontario Population:	5.80%	
	Population Age 65+:	15.21%	
	Population Growth Rate:	2.40%	
	Population Density:	161.2	
	Rural Population:	14.00%	
	Indigenous Population:	1.70%	
	Francophone Population:	1.60%	
	Low Income Population:	11.60%	
Hamilton Niagara Haldimand Brant	Area (km ²):	6,474	9 Hospitals 86 Long-Term Care Homes 59 Community Services 38 Mental Health Agencies 7 Residential Hospices 7 Community Health Centres
	Total Population:	1,499,117	
	% of Ontario Population:	10.29%	
	Population Age 65+:	19.58%	
	Population Growth Rate:	1.25%	
	Population Density:	216.1	
	Rural Population:	13.80%	
	Indigenous Population:	2.70%	
	Francophone Population:	2.30%	
	Low Income Population:	13.50%	
Central West	Area (km ²):	2,591	2 Hospitals 23 Long-Term Care Homes 19 Community Services 8 Mental Health Agencies 1 Residential Hospices 2 Community Health Centres
	Total Population:	1,056,893	
	% of Ontario Population:	7.26%	
	Population Age 65+:	12.78%	

	Population Growth Rate:	3.74%	
	Population Density	355.9	
	Rural Population	6.10%	
	Indigenous Population	0.80%	
	Francophone Population	1.50%	
	Low Income Population	12.40%	
Mississauga Halton	Area (km ²):	1,054	2 Hospitals 28 Long-Term Care Homes 31 Community Services 9 Mental Health Agencies 3 Residential Hospices 0 Community Health Centres
	Total Population:	1,260,695	
	% of Ontario Population:	8.65%	
	Population Age 65+:	14.31%	
	Population Growth Rate:	1.84%	
	Population Density	1104.6	
	Rural Population	1.60%	
	Indigenous Population	0.70%	
	Francophone Population	2.30%	
	Low Income Population	12.40%	
Toronto Central	Area (km ²):	192	16 Hospitals 36 Long-Term Care Homes 65 Community Services 82 Mental Health Agencies 3 Residential Hospices 16 Community Health Centres
	Total Population:	1,337,884	
	% of Ontario Population:	9.18%	
	Population Age 65+:	15.61%	
	Population Growth Rate:	1.57%	
	Population Density	6412.6	
	Rural Population	0.00%	
	Indigenous Population	1.10%	

	Francophone Population	2.90%	
	Low Income Population	19.00%	
Central	Area (km ²):	2,731	8 Hospitals 46 Long-Term Care Homes 33 Community Services 24 Mental Health Agencies 3 Residential Hospices 2 Community Health Centres
	Total Population:	1,954,258	
	% of Ontario Population:	13.42%	
	Population Age 65+:	15.78%	
	Population Growth Rate:	1.68%	
	Population Density	663.9	
	Rural Population	3.70%	
	Indigenous Population	0.60%	
	Francophone Population	1.70%	
	Low Income Population	15.80%	
Central East	Area (km ²):	15,395	8 Hospitals 68 Long-Term Care Homes 43 Community Services 24 Mental Health Agencies 2 Residential Hospices 6 Community Health Centres
	Total Population:	1,672,971	
	% of Ontario Population:	11.49%	
	Population Age 65+:	17.35%	
	Population Growth Rate:	1.47%	
	Population Density	100.7	
	Rural Population	14.60%	
	Indigenous Population	1.80%	
	Francophone Population	1.80%	
	Low Income Population	15.00%	
South East	Area (km ²):	18,253	6 Hospitals 37 Long-Term Care Homes 20 Community Services
	Total Population:	511,938	

	% of Ontario Population:	3.51%	11 Mental Health Agencies 5 Residential Hospices 5 Community Health Centres
	Population Age 65+:	23.30%	
	Population Growth Rate:	1.10%	
	Population Density	26.4	
	Rural Population	55.80%	
	Indigenous Population	4.70%	
	Francophone Population	3.10%	
	Low Income Population	14.60%	
Champlain	Area (km ²):	17,723	20 Hospitals 60 Long-Term Care Homes 46 Community Services 34 Mental Health Agencies 7 Residential Hospices 11 Community Health Centres
	Total Population:	1,406,174	
	% of Ontario Population:	9.65%	
	Population Age 65+:	17.24%	
	Population Growth Rate:	1.96%	
	Population Density	72.9	
	Rural Population	21.50%	
	Indigenous Population	3.20%	
	Francophone Population	19.80%	
	Low Income Population	12.80%	
North Simcoe Muskoka	Area (km ²):	8,449	6 Hospitals 26 Long-Term Care Homes 29 Community Services 14 Mental Health Agencies 5 Residential Hospices 3 Community Health Centres
	Total Population:	503,783	
	% of Ontario Population:	3.46%	
	Population Age 65+:	20.27%	
	Population Growth Rate:	1.87%	
	Population Density	54.9	

	Rural Population	41.50%	
	Indigenous Population	5.00%	
	Francophone Population	2.70%	
	Low Income Population	12.20%	
North East	Area (km ²):	395,920	24 Hospitals 45 Long-Term Care Homes 70 Community Services 44 Mental Health Agencies 3 Residential Hospices 7 Community Health Centres
	Total Population:	571,768	
	% of Ontario Population:	3.93%	
	Population Age 65+:	21.56%	
	Population Growth Rate:	0.38%	
	Population Density	1.4	
	Rural Population	47.30%	
	Indigenous Population	13.40%	
	Francophone Population	22.50%	
	Low Income Population	14.90%	
North West	Area (km ²):	406,926	12 Hospitals 12 Long-Term Care Homes 59 Community Services 33 Mental Health Agencies 6 Residential Hospices 2 Community Health Centres
	Total Population:	239,637	
	% of Ontario Population:	1.65%	
	Population Age 65+:	18.87%	
	Population Growth Rate:	0.40%	
	Population Density	0.6	
	Rural Population	54.20%	
	Indigenous Population	24.80%	
	Francophone Population	3.10%	
	Low Income Population	13.20%	

Appendix Two- LHIN Performance Data

ONTARIO MLAA INDICATORS 2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	Provincial						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result (Year to Date)
1. Performance Indicators									
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	85.36%	89.86%	87.80%	86.69%	85.63%	86.12%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	94.00%	96.07%	96.25%	95.87%	95.66%	94.43%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	29.00	29.00	30.00	29.00	28.00	27.00	24.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	7.00	7.00	7.00	8.00	9.00
5	90th percentile emergency department (ED) length of stay for	8 hours	10.13	9.97	10.38	10.75	10.87	10.87	10.88

	complex patients								
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.07	4.15	4.38	4.62	4.95	4.43
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.97%	78.47%	77.99%	79.58%	80.20%	64.00%
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	79.14%	75.02%	73.72%	75.12%	76.67%	60.00%
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.50%	15.69%	15.70%	16.62%	19.50%	17.83%
10	ALC rate	12.70%	13.70%	13.98%	15.19%	15.68%	15.35%	16.30%	16.76%
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.19%	20.67%	21.60%	21.91%	21.62%	23.18%
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.01%	32.50%	32.80%	33.75%	34.38%	34.81%
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.65%	16.74%	16.57%	16.63%	16.40%	16.96%
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	88.09%	85.01%	83.95%	85.56%	85.44%	71.00%
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	59.47%	62.58%	67.57%	69.77%	70.58%	65.91%	70.00%
16	Percent of priority 2 and 3 cases completed within access target for CT	90.00%	78.25%	78.18%	82.11%	84.73%	84.20%	80.40%	80.00%

	scans								
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	13.00	13.00	13.00	12.00	13.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	7.00	7.00	7.00	7.00	7.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	18.47	17.12	16.82	14.26	12.51	4.31
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	320.13	321.18	335.22	332.68	325.89	179.64
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	46.61%	47.43%	46.71%	46.17%	44.76%	29.69%

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

**ERIE ST CLAIR LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA**

No.	Indicator	Provincia l target	LHIN						
			2014/1 5 Fiscal Year Result	2015/1 6 Fiscal Year Result	2016/1 7 Fiscal Year Result	2017/1 8 Fiscal Year Result	2018/1 9 Fiscal Year Result	2019/2 0 Fiscal Year Result	2020/2 1 Fiscal Year Result (Year to Date)
1.	Performanc e Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	92.45%	90.54%	93.46%	95.51%	92.35%	88.52%	89.99%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	95.04%	95.03%	95.88%	96.46%	96.01%	95.10%	95.42%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	18.00	19.00	26.00	27.00	28.00	21.00	23.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	5.00	5.00	6.00	6.00	6.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	8.87	9.67	9.55	9.78	9.92	10.13	9.83
6	90th percentile emergency department (ED)	4 hours	4.00	3.98	4.22	4.45	4.85	5.10	4.67

	length of stay for minor/uncomplicated patients								
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	83.85%	80.24%	87.90%	88.22%	84.09%	80.71%	59.00%
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	75.26%	75.94%	72.62%	67.56%	72.51%	71.54%	49.00%
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	18.07%	15.97%	14.96%	10.46%	11.56%	6.74%	9.30%
10	ALC rate	12.70%	19.58%	19.50%	15.24%	13.28%	12.36%	10.62%	9.73%
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	17.05%	17.80%	19.10%	18.00%	18.68%	19.04%	19.89%
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	25.04%	23.99%	30.92%	32.70%	30.59%	34.45%	33.16%
13	Readmission within 30 days for selected HIG conditions**	15.50%	15.51%	14.66%	15.57%	16.02%	15.00%	15.72%	15.12%
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	94.40%	84.60%	90.62%	85.61%	85.33%	82.81%	82.00%
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	0.00%	0.00%	88.50%	84.85%	84.03%	70.29%	77.00%
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	0.00%	0.00%	94.22%	94.40%	94.18%	89.06%	88.00%
17 (a)	Wait times from application to eligibility determination for	NA	10.00	10.00	11.00	9.00	11.00	9.00	14.00

	long-term care home placements: from community setting**								
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	7.00	5.00	4.00	3.00	3.00	2.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	30.57	28.04	22.49	18.38	14.38	12.08	3.66
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	384.49	404.45	389.65	417.71	395.71	450.61	228.47
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	44.12%	44.30%	45.41%	45.85%	45.66%	42.77%	26.29%

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

SOUTH WEST LHIN MLAA INDICATORS

2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/ 15 Fiscal Year Result	2015/ 16 Fiscal Year Result	2016/ 17 Fiscal Year Result	2017/ 18 Fiscal Year Result	2018/ 19 Fiscal Year Result	2019/ 20 Fiscal Year Result	2020/ 21 Fiscal Year Result (Year to Date)
1.	Performance Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00 %	90.87 %	88.95 %	91.99 %	88.90 %	84.74 %	79.87 %	83.89 %
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00 %	92.59 %	93.10 %	93.69 %	94.01 %	93.16 %	92.79 %	90.42 %
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	21.00	21.00	22.00	30.00	25.00	26.00	25.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	8.00	9.00	10.00	12.00	15.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	8.37	7.73	7.73	8.45	8.40	8.23	8.05
6	90th percentile emergency department (ED) length of	4 hours	3.62	3.62	3.60	3.90	4.03	4.28	3.80

	stay for minor/uncomplicated patients								
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00 %	76.53 %	68.39 %	50.35 %	47.44 %	52.30 %	52.86 %	37.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00 %	76.83 %	68.86 %	47.56 %	44.16 %	51.83 %	50.52 %	35.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	8.39 %	9.24 %	10.46 %	9.66 %	10.48 %	14.68 %	12.44 %
10	ALC rate	12.70 %	9.65 %	11.05 %	11.68 %	11.64 %	11.98 %	13.38 %	14.74 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30 %	17.64 %	18.00 %	18.37 %	18.40 %	20.42 %	0.00 %	20.83 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40 %	21.08 %	23.06 %	24.52 %	27.00 %	26.87 %	27.90 %	27.95 %
13	Readmission within 30 days for selected HIG conditions**	15.50 %	17.34 %	17.19 %	17.12 %	17.17 %	17.11 %	16.82 %	17.14 %
2. Monito ring Indicator s									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00 %	88.52 %	91.27 %	83.57 %	81.47 %	84.71 %	87.29 %	77.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00 %	0.00 %	0.00 %	66.49 %	65.75 %	69.49 %	58.83 %	60.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00 %	0.00 %	0.00 %	84.57 %	82.41 %	81.82 %	82.16 %	82.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	8.00	9.00	7.00	8.00	8.00	7.00	18.00
17 (b)	Wait times from application to eligibility determination for long-term care home	NA	4.00	4.00	3.00	3.00	3.00	3.00	4.00

	placements: from acute-care setting**								
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	46.03	42.56	41.76	42.79	37.55	27.97	8.94
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	389.3 2	397.7 9	414.6 7	423.3 6	405.2 4	396.2 1	230.8 3
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	40.80 %	42.37 %	42.61 %	41.51 %	40.27 %	40.46 %	27.39 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

**WATERLOO WELLINGTON LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA**

No.	Indicator	Provinc ial target	LHIN						
			2014/ 15 Fiscal Year Result	2015/ 16 Fiscal Year Result	2016/ 17 Fiscal Year Result	2017/ 18 Fiscal Year Result	2018/ 19 Fiscal Year Result	2019/ 20 Fiscal Year Result	2020/ 21 Fiscal Year Result (Year to Date)
1.	Performance Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	84.50 %	85.66 %	92.90 %	95.32 %	97.21 %	95.57 %	89.13 %
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	94.77 %	93.97 %	95.98 %	97.00 %	96.11 %	96.57 %	94.71 %
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	12.00	13.00	13.00	14.00	14.00	15.00	19.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	5.00	5.00	6.00	6.00	8.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	7.62	7.73	7.48	8.63	9.17	9.32	7.78
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.23	4.42	4.32	5.10	5.30	5.40	4.28
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	84.88 %	63.44 %	43.62 %	58.79 %	62.34 %	57.95 %	51.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	81.80 %	61.75 %	41.72 %	52.74 %	54.34 %	51.45 %	39.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	13.20 %	11.94 %	12.00 %	14.92 %	14.95 %	19.19 %	14.81 %

10	ALC rate	12.70%	9.96%	9.33%	9.44%	12.88 %	13.19 %	14.66 %	17.06 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	15.20 %	17.08 %	17.98 %	18.90 %	18.93 %	17.95 %	19.42 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	24.36 %	24.01 %	27.42 %	26.50 %	26.99 %	27.33 %	30.73 %
13	Readmission within 30 days for selected HIG conditions**	15.50%	15.84 %	14.95 %	15.72 %	15.52 %	15.60 %	15.41 %	15.59 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	95.13 %	73.77 %	70.05 %	68.36 %	67.51 %	67.47 %	37.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	0.00%	0.00%	72.97 %	93.27 %	81.06 %	63.37 %	68.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	0.00%	0.00%	86.52 %	91.52 %	92.49 %	79.91 %	77.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	12.00	11.00	9.00	10.00	11.00	9.00	11.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	4.00	5.00	5.00	5.00	5.00	6.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	13.24	12.44	11.13	11.28	11.06	9.99	3.45
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	299.64	293.40	302.40	324.61	315.65	302.17	167.87
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	44.14 %	44.51 %	46.44 %	45.56 %	44.62 %	41.99 %	25.93 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

HAMILTON NIAGARA HALDIMAND BRANT LHIN MLAA INDICATORS **2020/21 ANNUAL REPORT DATA**

No.	Indicator	Provinci al target	LHIN						
			2014/1 5 Fiscal Year Result	2015/1 6 Fiscal Year Result	2016/1 7 Fiscal Year Result	2017/1 8 Fiscal Year Result	2018/1 9 Fiscal Year Result	2019/2 0 Fiscal Year Result	2020/2 1 Fiscal Year Result (Year to Date)
1.	Performan ce Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	89.37%	90.28%	89.92%	88.63%	85.05%	86.03%	87.84%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	92.67%	93.69%	95.97%	95.89%	95.79%	95.32%	94.14%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	23.00	25.00	28.00	28.00	28.00	34.00	33.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	6.00	6.00	6.00	7.00	8.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	13.28	12.83	14.53	15.97	16.02	15.12	14.87
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.50	4.55	4.57	5.08	5.43	5.37	4.85
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	75.06%	79.22%	73.88%	66.32%	70.10%	73.32%	58.00%

8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	72.25%	75.32%	66.34%	63.41%	65.05%	68.20%	50.00%
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	18.23%	16.21%	16.27%	16.51%	17.48%	17.13%	17.03%
10	ALC rate	12.70%	15.78%	13.61%	14.31%	15.91%	14.90%	16.14%	15.60%
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	18.59%	18.78%	20.40%	20.80%	21.28%	21.54%	24.27%
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	27.11%	30.10%	29.57%	30.90%	30.10%	31.89%	32.60%
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.50%	16.60%	16.97%	16.31%	16.52%	16.17%	17.72%
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	84.78%	85.21%	84.90%	88.76%	93.81%	96.20%	77.00%
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	0.00%	0.00%	61.45%	70.24%	66.40%	64.84%	66.00%
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	0.00%	0.00%	71.75%	78.18%	78.03%	76.46%	75.00%
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	9.00	8.00	8.00	9.00	10.00	10.00	13.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	5.00	6.00	8.00	8.00	8.00	8.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	22.27	20.06	19.61	18.36	13.99	12.81	4.55
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	389.33	397.01	411.62	415.92	426.03	413.97	224.16
20	Percentage of acute care patients who had a follow-up with a physician within 7	NA	47.71%	48.07%	48.25%	47.93%	46.03%	45.03%	28.70%

	days of discharge**								
--	---------------------	--	--	--	--	--	--	--	--

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

CENTRAL WEST LHIN MLAA INDICATORS

2020/21 ANNUAL REPORT DATA

No.	Indicator	Provinci al target	LHIN						
			2014/1 5 Fiscal Year Result	2015/1 6 Fiscal Year Result	2016/1 7 Fiscal Year Result	2017/1 8 Fiscal Year Result	2018/1 9 Fiscal Year Result	2019/2 0 Fiscal Year Result	2020/2 1 Fiscal Year Result (Year to Date)
1. Performanc e Indicators									
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	92.23%	88.97%	85.31%	82.61%	85.93%	82.73%	88.15%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	96.52%	95.43%	95.17%	95.69%	96.48%	96.05%	95.81%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	19.00	21.00	24.00	30.00	29.00	36.00	21.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	8.00	8.00	9.00	9.00	8.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.85	10.57	11.23	9.72	9.10	9.23	11.12
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	3.50	3.68	3.85	3.63	3.83	3.73	3.25

7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	47.47%	67.50%	75.90%	68.81%	71.75%	63.24%	47.00%
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	47.88%	72.19%	64.65%	53.70%	54.70%	51.92%	54.00%
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	7.14%	6.38%	8.12%	9.35%	9.43%	16.35%	12.72%
10	ALC rate	12.70%	6.26%	5.53%	6.44%	8.11%	7.27%	8.94%	10.54%
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	24.74%	24.84%	24.37%	26.90%	26.29%	26.29%	25.83%
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	27.59%	31.89%	33.78%	36.10%	38.81%	33.41%	35.16%
13	Readmission within 30 days for selected HIG conditions**	15.50%	15.90%	15.91%	16.20%	16.76%	16.08%	14.85%	16.01%
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	89.21%	87.08%	92.63%	96.74%	96.68%	94.62%	81.00%
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	0.00%	0.00%	NA***	NA***	NA***	NA***	80.00%
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	0.00%	0.00%	95.41%	97.53%	94.83%	92.50%	88.00%
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	21.00	18.00	20.00	21.00	19.00	18.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	12.00	13.00	11.00	14.00	14.00	13.00	13.00
18	Rate of emergency visits for conditions best managed elsewhere per	NA	5.25	4.93	4.17	5.60	5.51	5.53	3.16

	1,000 population*								
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	279.11	273.16	272.23	280.86	251.58	256.68	132.22
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	55.41%	56.52%	56.65%	56.34%	56.84%	55.53%	38.25%

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

MISSISSAUGA HALTON LHIN MLAA INDICATORS

2020/21 ANNUAL REPORT DATA

No.	Indicator	Provinci al target	LHIN						
			2014/1 5 Fiscal Year Result	2015/1 6 Fiscal Year Result	2016/1 7 Fiscal Year Result	2017/1 8 Fiscal Year Result	2018/1 9 Fiscal Year Result	2019/2 0 Fiscal Year Result	2020/2 1 Fiscal Year Result (Year to Date)
1. Performanc e Indicators									
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	92.07%	91.48%	92.63%	90.81%	90.99%	90.91%	91.59%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	95.22%	95.58%	96.69%	96.60%	95.99%	95.61%	94.50%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	27.00	28.00	34.00	27.00	24.00	23.00	24.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	0.00	0.00	11.00	9.00	10.00	11.00	14.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	9.15	9.62	10.47	10.82	11.18	11.13	12.57
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	3.58	3.70	3.72	3.82	4.05	4.30	4.43

7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	89.36%	69.10%	57.02%	49.42%	53.74%	59.55%	58.00%
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	76.51%	53.48%	46.16%	42.06%	43.49%	53.33%	46.00%
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	12.62%	14.05%	15.18%	17.29%	16.19%	16.26%	14.30%
10	ALC rate	12.70%	9.60%	11.35%	14.05%	14.70%	13.38%	11.86%	10.83%
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	17.23%	17.30%	16.69%	17.40%	17.79%	17.71%	18.83%
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	25.50%	25.48%	27.21%	27.20%	30.22%	28.80%	27.61%
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.09%	15.52%	15.80%	15.60%	14.81%	15.18%	16.31%
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	95.74%	77.31%	73.06%	64.05%	68.75%	65.71%	71.00%
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	0.00%	0.00%	79.68%	83.44%	83.21%	81.16%	81.00%
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	0.00%	0.00%	79.58%	81.01%	81.24%	77.73%	78.00%
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	15.00	12.00	12.00	15.00	16.00	11.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	17.00	11.00	12.00	15.00	10.50	12.00	13.00

18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	6.36	6.00	5.17	5.39	4.92	4.30	1.41
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	205.67	192.44	199.39	202.72	219.79	192.19	107.39
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	52.99%	53.46%	54.28%	54.75%	54.02%	53.21%	34.56%

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

TORONTO CENTRAL LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA

No.	Indicator	Provinci al target	LHIN						
			2014/1 5 Fiscal Year Result	2015/1 6 Fiscal Year Result	2016/1 7 Fiscal Year Result	2017/1 8 Fiscal Year Result	2018/1 9 Fiscal Year Result	2019/2 0 Fiscal Year Result	2020/2 1 Fiscal Year Result (Year to Date)
1.	Performanc e Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.47%	85.03%	93.95%	95.57%	95.54%	96.40%	96.41%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.64%	93.50%	96.19%	96.06%	96.46%	95.77%	95.91%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	25.00	26.00	26.00	26.00	28.00	27.00	20.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	8.00	9.00	10.00	10.00	12.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	12.17	12.18	12.85	13.08	13.62	13.47	14.70
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.47	4.50	4.58	4.65	4.82	5.05	4.80
7	Percent of priority 2, 3 and 4 cases completed	90.00%	85.53%	80.19%	90.28%	91.75%	94.57%	91.97%	81.00%

	within access target for hip replacement								
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	85.61%	84.05%	90.89%	91.85%	93.46%	92.62%	76.00%
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	9.79%	10.46%	12.86%	11.25%	11.70%	13.27%	13.16%
10	ALC rate	12.70%	10.33%	11.97%	12.58%	11.49%	11.75%	12.92%	12.73%
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	26.59%	28.54%	27.90%	28.40%	28.69%	26.49%	28.84%
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	40.84%	43.17%	41.95%	39.00%	41.15%	41.50%	42.88%
13	Readmission within 30 days for selected HIG conditions**	15.50%	17.89%	18.13%	17.72%	17.99%	18.19%	18.24%	18.35%
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	88.43%	86.55%	80.12%	79.36%	79.47%	74.11%	69.00%
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	52.48%	50.43%	47.95%	55.23%	59.82%	54.55%	60.00%
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	65.24%	67.68%	69.15%	75.61%	72.79%	67.31%	73.00%
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	3.00	N/R***	N/R***	N/R***	N/R***	N/R***	N/R***
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	11.00	N/R***	N/R***	N/R***	N/R***	N/R***	N/R***
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	6.90	6.73	6.32	5.70	4.12	4.10	1.71

19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	259.37	244.27	250.57	272.35	268.57	261.79	148.05
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	49.89%	50.52%	51.59%	50.26%	49.27%	48.59%	29.80%

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

**CENTRAL LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA**

No.	Indicator	Provinc ial target	LHIN						
			2014/ 15 Fiscal Year Result	2015/ 16 Fiscal Year Result	2016/ 17 Fiscal Year Result	2017/ 18 Fiscal Year Result	2018/ 19 Fiscal Year Result	2019/ 20 Fiscal Year Result	2020/ 21 Fiscal Year Result (Year to Date)
1.	Performance Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	84.35 %	83.68 %	92.39 %	93.03 %	94.12 %	93.81 %	94.54 %
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	94.13 %	94.23 %	96.65 %	96.41 %	95.93 %	96.09 %	96.04 %
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	31.00	33.00	33.00	22.00	22.00	20.00	17.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	6.00	6.00	5.00	6.00	5.00	6.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.28	9.80	10.20	10.35	10.67	10.05	10.42
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	3.43	3.33	3.50	3.80	4.18	4.28	3.73
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	95.63 %	97.46 %	97.90 %	97.40 %	94.94 %	93.31 %	72.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	93.88 %	96.20 %	96.41 %	95.31 %	93.36 %	89.75 %	71.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.34 %	14.36 %	15.95 %	16.65 %	18.24 %	23.06 %	20.11 %

10	ALC rate	12.70%	13.23 %	13.87 %	15.72 %	15.14 %	12.32 %	11.47 %	11.77 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	18.25 %	18.99 %	19.28 %	20.70 %	20.64 %	19.75 %	20.61 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	23.68 %	26.02 %	25.12 %	25.70 %	27.59 %	27.33 %	29.12 %
13	Readmission within 30 days for selected HIG conditions**	15.50%	15.90 %	15.92 %	15.94 %	15.52 %	16.37 %	15.72 %	16.43 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	99.71 %	98.46 %	96.69 %	99.68 %	99.41 %	97.77 %	73.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	62.78 %	67.66 %	69.42 %	67.87 %	79.99 %	78.74 %	78.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	84.92 %	83.75 %	82.66 %	83.87 %	87.63 %	86.18 %	83.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	17.00	22.00	19.00	21.00	21.00	20.00	22.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	6.00	6.00	4.00	5.00	4.00	3.00	4.50
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	6.53	6.87	6.41	6.07	5.33	5.06	1.91
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	190.85	177.72	177.24	198.25	207.16	197.32	108.72
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	53.32 %	54.31 %	54.83 %	53.80 %	53.43 %	52.19 %	36.24 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

**CENTRAL EAST LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA**

No.	Indicator	Provinc ial target	LHIN						
			2014/ 15 Fiscal Year Result	2015/ 16 Fiscal Year Result	2016/ 17 Fiscal Year Result	2017/ 18 Fiscal Year Result	2018/ 19 Fiscal Year Result	2019/ 20 Fiscal Year Result	2020/ 21 Fiscal Year Result (Year to Date)
1.	Performance Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	87.88 %	88.69 %	90.64 %	90.10 %	87.75 %	88.48 %	89.13 %
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	95.67 %	95.84 %	96.83 %	96.51 %	95.99 %	96.27 %	94.71 %
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	23.00	30.00	49.00	41.00	39.00	31.00	23.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	13.00	10.00	9.00	9.00	10.00	12.00	13.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	9.62	9.47	10.33	11.00	11.28	10.75	11.07
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.02	3.92	4.08	4.33	4.70	4.75	4.28
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	95.63 %	94.27 %	91.86 %	91.97 %	92.71 %	94.47 %	83.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	94.03 %	90.70 %	88.67 %	86.52 %	88.43 %	93.82 %	81.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	16.84 %	15.22 %	18.40 %	20.83 %	20.78 %	24.94 %	24.42 %

10	ALC rate	12.70%	18.13 %	17.79 %	23.62 %	23.96 %	21.51 %	24.14 %	22.68 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.63 %	19.58 %	21.45 %	23.80 %	22.39 %	23.09 %	24.06 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	25.18 %	26.03 %	27.30 %	29.20 %	27.83 %	28.94 %	30.99 %
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.69 %	17.33 %	16.95 %	16.78 %	17.25 %	16.43 %	16.88 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	98.03 %	95.10 %	95.53 %	96.71 %	98.60 %	97.96 %	86.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	67.95 %	74.31 %	80.98 %	84.67 %	92.81 %	92.07 %	92.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	84.62 %	88.04 %	95.10 %	97.78 %	98.79 %	98.03 %	95.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	21.00	20.00	17.00	20.00	20.00	16.00	24.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	10.00	10.00	8.00	8.00	9.00	8.00	12.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	14.85	14.52	12.82	12.19	9.50	8.37	3.02
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	322.50	317.86	308.07	317.42	314.57	300.93	167.74
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	47.54 %	47.32 %	48.17 %	47.94 %	47.57 %	46.64 %	31.17 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

**SOUTH EAST LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA**

No.	Indicator	Provinci al target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result (Year to Date)
1. Performan ce Indicators									
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	86.84%	84.62%	90.72%	88.12%	87.37%	80.26%	72.78%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	92.70%	91.90%	96.14%	96.28%	95.04%	93.64%	90.04%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	23.00	21.00	22.00	21.00	20.00	22.00	21.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	7.00	7.00	7.00	7.00	7.00	7.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	9.47	8.90	9.18	8.87	8.98	9.18	9.05
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.28	4.35	4.48	4.43	4.58	4.67	4.45

7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	55.82%	60.17%	66.78%	80.63%	77.31%	85.29%	76.00%
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	61.35%	66.27%	74.55%	78.17%	76.42%	86.40%	70.00%
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	15.40%	15.24%	17.21%	17.74%	16.80%	20.47%	18.93%
10	ALC rate	12.70%	17.11%	19.19%	17.74%	19.30%	20.66%	21.32%	18.78%
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	21.94%	21.79%	20.12%	22.40%	22.28%	20.81%	25.23%
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	24.86%	28.14%	22.84%	25.80%	26.46%	26.37%	28.75%
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.23%	17.01%	17.64%	17.34%	17.59%	17.02%	17.86%
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	90.95%	84.43%	65.34%	67.53%	66.01%	75.78%	53.00%
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	60.94%	67.79%	67.55%	64.70%	76.61%	77.75%	79.00%
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	84.87%	78.20%	78.63%	83.82%	80.37%	81.71%	80.00%
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	13.00	15.00	14.00	13.00	13.00	13.00	7.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	7.00	7.00	6.50	8.00	11.00	11.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	41.11	39.92	37.54	38.21	31.62	27.85	9.71

19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	460.80	506.16	498.43	549.67	542.45	539.66	293.52
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	42.72%	42.50%	43.04%	41.00%	40.30%	38.34%	26.72%

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

**CHAMPLAIN LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA**

No.	Indicator	Provinci al target	LHIN						
			2014/1 5 Fiscal Year Result	2015/1 6 Fiscal Year Result	2016/1 7 Fiscal Year Result	2017/1 8 Fiscal Year Result	2018/1 9 Fiscal Year Result	2019/2 0 Fiscal Year Result	2020/2 1 Fiscal Year Result (Year to Date)
1.	Performan ce Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	78.86%	77.03%	77.33%	71.39%	68.16%	66.12%	63.24%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	91.70%	93.48%	96.04%	96.08%	95.29%	95.25%	93.35%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	62.00	55.00	34.00	50.00	45.00	40.00	40.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	7.00	7.00	7.00	8.00	11.00	9.50	9.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.68	10.38	11.22	11.68	11.53	13.03	12.02
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.52	4.58	4.77	5.03	5.42	6.53	5.47

7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.96%	85.27%	90.84%	89.76%	90.25%	91.55%	59.00%
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	85.02%	88.02%	86.19%	89.16%	93.14%	95.66%	63.00%
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	12.10%	12.70%	14.20%	14.32%	15.40%	19.90%	16.63%
10	ALC rate	12.70%	12.13%	12.64%	13.94%	14.47%	14.65%	16.73%	21.25%
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	18.02%	17.72%	18.19%	18.50%	19.60%	19.32%	19.85%
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	27.02%	27.41%	25.02%	25.70%	26.29%	28.47%	28.41%
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.11%	16.84%	16.35%	15.59%	16.10%	16.00%	16.38%
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	89.84%	88.91%	85.86%	81.70%	84.00%	81.75%	65.00%
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	52.32%	56.84%	77.55%	73.60%	67.06%	60.61%	68.00%
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	81.30%	75.52%	83.28%	83.18%	84.13%	76.99%	79.00%
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	20.00	21.00	24.00	24.00	23.00	13.00	20.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	11.00	10.00	9.00	13.00	16.00	N/R***	N/R***
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	21.94	20.23	18.66	19.25	17.01	15.22	5.11

19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	297.25	305.79	303.84	304.59	305.52	319.34	173.27
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	42.31%	42.08%	43.03%	41.59%	41.37%	38.84%	24.78%

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

NORTH SIMCOE MUSKOKA LHIN MLAA INDICATORS

2020/21 ANNUAL REPORT DATA

No.	Indicator	Provincial target	LHIN						
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	2016/17 Fiscal Year Result	2017/18 Fiscal Year Result	2018/19 Fiscal Year Result	2019/20 Fiscal Year Result	2020/21 Fiscal Year Result (Year to Date)
1.	Performance Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	69.53%	77.19%	89.20%	87.03%	86.56%	86.89%	87.68%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	91.52%	93.08%	95.79%	97.62%	98.13%	97.75%	97.17%
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	69.00	67.00	51.00	41.00	32.00	27.00	27.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	6.00	7.00	8.00	6.00	8.00	9.00	12.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	8.95	9.03	9.10	10.38	10.23	9.52	9.48
6	90th percentile emergency department (ED) length of stay for	4 hours	3.95	4.37	4.25	4.37	4.35	4.62	4.32

	minor/uncomplicated patients								
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	90.62%	81.32%	77.26%	83.08%	73.05%	71.01%	54.00%
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	88.66%	84.52%	75.69%	77.35%	69.44%	69.20%	52.00%
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	21.02%	23.83%	21.13%	20.24%	22.69%	26.83%	23.50%
10	ALC rate	12.70%	15.04%	15.81%	14.47%	17.03%	18.67%	19.37%	18.78%
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	16.08%	17.18%	17.01%	17.00%	17.58%	18.48%	18.22%
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	25.00%	21.12%	23.96%	22.30%	22.11%	25.59%	25.04%
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.17%	16.81%	16.60%	17.25%	16.40%	17.54%	17.67%
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	94.39%	81.36%	68.41%	50.82%	62.92%	78.39%	69.00%
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	51.19%	52.98%	57.35%	63.96%	59.92%	54.64%	60.00%
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	87.85%	82.11%	81.97%	85.20%	83.28%	85.56%	76.00%
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	19.50	15.00	15.00	14.00	13.00	14.00	4.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	13.00	15.00	24.00	28.00	34.00	29.00	19.00
18	Rate of emergency visits for conditions best	NA	31.64	28.48	26.46	26.38	22.50	18.22	6.35

	managed elsewhere per 1,000 population*								
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	392.71	401.63	389.40	403.15	449.36	432.00	238.71
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	40.80%	42.83%	43.65%	41.13%	42.39%	39.53%	27.11%

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

**NORTH EAST LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA**

No.	Indicator	Provinc ial target	LHIN						
			2014/ 15 Fiscal Year Result	2015/ 16 Fiscal Year Result	2016/ 17 Fiscal Year Result	2017/ 18 Fiscal Year Result	2018/ 19 Fiscal Year Result	2019/ 20 Fiscal Year Result	2020/ 21 Fiscal Year Result (Year to Date)
1.	Performa nce Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	86.06 %	83.70 %	96.05 %	87.65 %	85.99 %	83.10 %	80.96 %
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.61 %	94.09 %	98.20 %	98.49 %	98.25 %	98.50 %	96.41 %
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	70.00	48.00	39.00	31.00	28.00	24.00	23.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	11.00	9.00	7.00	7.00	8.00	7.00	8.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	8.20	8.47	8.60	8.43	8.62	8.93	8.55
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	3.95	3.92	4.05	4.10	4.25	4.57	4.33
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	72.26 %	87.08 %	82.28 %	76.67 %	81.78 %	88.60 %	78.00 %

8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	71.13 %	84.16 %	81.84 %	74.45 %	70.07 %	82.92 %	72.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	23.17 %	27.64 %	26.31 %	25.05 %	29.33 %	33.65 %	30.69 %
10	ALC rate	12.70%	21.03 %	19.45 %	22.47 %	24.95 %	24.77 %	26.20 %	27.90 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	17.56 %	17.95 %	18.84 %	18.60 %	18.96 %	20.58 %	21.88 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.29 %	32.76 %	27.34 %	28.90 %	32.68 %	30.40 %	32.86 %
13	Readmission within 30 days for selected HIG conditions**	15.50%	17.84 %	17.32 %	17.47 %	17.09 %	17.10 %	16.62 %	16.56 %
2. Monitorin g Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	90.52 %	91.90 %	93.72 %	93.61 %	86.89 %	86.87 %	70.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	68.71 %	69.40 %	71.21 %	71.99 %	69.36 %	63.68 %	69.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	83.66 %	84.77 %	85.90 %	83.25 %	85.09 %	81.84 %	80.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	8.00	8.00	7.00	7.00	7.00	7.00	13.50
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	7.00	9.00	11.00	9.00	9.00	8.00	7.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	55.29	54.49	52.87	55.03	46.11	46.24	14.28
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	626.00	627.01	598.97	632.37	607.54	582.59	324.81
20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	36.41 %	37.03 %	38.99 %	37.50 %	37.55 %	34.82 %	24.95 %

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)

**NORTH WEST LHIN MLAA INDICATORS
2020/21 ANNUAL REPORT DATA**

No.	Indicator	Provinci al target	LHIN						
			2014/ 15 Fiscal Year Result	2015/ 16 Fiscal Year Result	2016/ 17 Fiscal Year Result	2017/ 18 Fiscal Year Result	2018/ 19 Fiscal Year Result	2019/ 20 Fiscal Year Result	2020/ 21 Fiscal Year Result (Year to Date)
1.	Performan ce Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	76.43 %	78.52 %	83.92 %	83.46 %	85.23 %	93.59 %	94.44 %
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	89.31 %	88.32 %	95.86 %	96.09 %	95.73 %	97.38 %	98.20 %
3	90th Percentile Wait Time from community for Home Care Services - Application from Community Setting to first Home Care Service (excluding case management)*	21 days	35.00	28.00	30.00	26.00	23.00	22.00	18.00
4	90th Percentile Wait Time from Hospital Discharge to Service Initiation for Home and Community Care*	TBD	5.00	5.00	5.00	5.00	5.00	6.00	6.00
5	90th percentile emergency department (ED) length of stay for complex patients	8 hours	9.73	9.33	9.58	10.30	10.38	10.93	10.57
6	90th percentile emergency department (ED) length of stay for minor/uncomplicated	4 hours	3.88	3.93	4.18	4.67	4.98	5.32	4.87

	patients								
7	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	73.04 %	83.08 %	78.65 %	76.65 %	88.47 %	82.62 %	71.00 %
8	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	64.66 %	71.85 %	76.61 %	74.49 %	78.27 %	73.56 %	77.00 %
9	Percentage of Alternate Level of Care (ALC) Days*	9.46%	21.72 %	21.27 %	26.07 %	24.00 %	27.09 %	33.26 %	31.03 %
10	ALC rate	12.70%	27.60 %	27.76 %	30.58 %	33.98 %	33.99 %	33.59 %	35.69 %
11	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	16.32 %	16.98 %	18.12 %	20.70 %	22.43 %	22.55 %	24.30 %
12	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	43.22 %	46.24 %	43.76 %	43.00 %	46.76 %	47.54 %	47.23 %
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.64 %	16.45 %	17.75 %	17.27 %	17.40 %	17.04 %	18.35 %
2. Monitoring Indicators									
14	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	93.87 %	91.51 %	89.21 %	82.73 %	93.32 %	87.09 %	74.00 %
15	Percent of priority 2 and 3 cases completed within access target for MRI scans	90.00%	89.65 %	88.88 %	83.38 %	77.61 %	64.41 %	64.99 %	80.00 %
16	Percent of priority 2 and 3 cases completed within access target for CT scans	90.00%	80.58 %	59.46 %	89.42 %	88.29 %	82.85 %	68.93 %	69.00 %
17 (a)	Wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	35.00	34.50	32.00	27.00	36.00	16.00	8.00
17 (b)	Wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	15.00	12.00	14.00	11.00	12.00	10.00	8.00
18	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	42.67	42.62	39.71	35.19	32.37	34.38	10.87
19	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	519.59	564.67	600.65	619.81	559.38	608.50	388.27

20	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	36.98 %	36.89 %	38.65 %	39.72 %	36.97 %	36.49 %	28.63 %
----	---	----	---------	---------	---------	---------	---------	---------	---------

*FY 2020/21 is based on the available data from the fiscal year (Q1-Q3, 2020/21)

**FY 2020/21 is based on the available data from the fiscal year (Q1-Q2, 2020/21)