Toronto Central **LHIN**

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April 5, 2012

Dr. William Reichman
President and Chief Executive Officer
Baycrest Centre for Geriatric Care
3560 Bathurst Street
Toronto, ON M6A 2E1

Dear Dr. Reichman:

This is notice from Toronto Central Local Health Integration Network (the "LHIN") pursuant to Section 3.4 of the Long-Term Care Home Service Accountability Agreement (the "LSAA") between the LHIN and The Jewish Home for the Aged (the "HSP"), that Schedule F of the L-SAA is amended as follows.

1. The current versions of the policies listed below (each a "Policy"), is replaced with the attached updated versions of those policies (collectively the "Updated Policies"). Each of the Updated Policies is effective on the corresponding "Effective Date" listed below.

   With regard to the updated Occupancy Targets Policy, please note that in addition to other conditions set out in that policy, LHIN endorsement of a long-term care home is required in order for that home to receive the available interim relief.

Policy	Effective Date
LTCH Level-of-Care Per Diem Funding Policy	April 1, 2011
LTCH Cash Flow Policy	April 1, 2011
Registered Practical Nurses in Long-Term Care Homes Initiative Funding Policy	April 1, 2011
LTCH Reconciliation and Recovery Policy	April 1, 2011
LTCH Occupancy Targets Policy	January 1, 2012

2. The attached "LTCH Convalescent Care Additional Subsidy Funding Summary" is added to Schedule F of the L-SAA and is as of effective April 1, 2011. It indicates the specific amount of funding that constitutes Additional Subsidy at a specific point in time and the allocation of the subsidy between Nursing and Personal Care (NPC), Program Support Services (PS) and Other Accommodations (OA). The Additional Subsidy amounts are set and will be updated by the Ministry of Health and Long-Term Care.

Please acknowledge the HSP's receipt of this notice that Schedule F of the L-SAA has been amended as described above, by signing below and returning one copy of this letter to Ryan Joyce (the "LHIN Contact") within two weeks of receipt of this letter.

If you have any questions or concerns please contact Nello Del Rizzo at Nello.DelRizzo@lhins.on.ca or (416) 969-3318.

Sincerely,

Camille Orridge
Chief Executive Officer

c: Garry Foster, Board Chair, Baycrest Centre for Geriatric Care
Bill Manson, Senior Director, Performance Management, TC LHIN
Nello Del Rizzo, Senior Director, Performance Management, TC LHIN

Amendment to Schedule F of the L-SAA acknowledged by:

The Jewish Home for the Aged

By: _____
Chair, I have the authority to bind Baycrest Centre for Geriatric Care

By: _____
CEO, I have the authority to bind Baycrest Centre for Geriatric Care

DR. WILLIAM E. REICHMAN
PRESIDENT AND CHIEF EXECUTIVE OFFICER

Policy: LTCH Occupancy Targets Policy	Date: July 1, 2010 as amended on January 1, 2011 and January 1, 2012

1.1 Introduction

The *LTCH Level of Care Per Diem Funding Policy* outlines the funding approach, including rules and conditions, for the Level of Care (LOC) per diem paid to the licensee for each Long-Term Care (LTC) home. Whether a licensee receives the LOC per diem funding based on a number of licensed or approved beds in the home[1] will depend on what portion of those beds will be occupied during the year. The occupancy targets that need to be achieved in order to receive the LOC per diem funding based on the number of licensed or approved beds in the home will vary by bed type. If a licensee fails to achieve the occupancy target, the LOC per diem funding, in most cases, will be paid based on actual resident days, or the days that the resident actually occupied the beds in the home, in accordance with the rules and conditions set out in this policy.

2.1 Overview

Resident occupancy targets for the purpose of LOC per diem funding are set differently for long-stay and short-stay types of beds, and are subject to details set out in this policy. Briefly,

- Long-stay beds must achieve 97% occupancy to receive 100% of the LOC per diem funding;
- Short-stay respite beds will receive 100% of the LOC per diem funding regardless of the actual occupancy achieved;
- Convalescent care beds will receive 100% of the base (as defined in 4.1 below) LOC per diem funding regardless of the actual occupancy achieved but they must achieve a minimum occupancy rate of 80% to receive 100% of the Additional Subsidy (as defined in 4.1 below); and
- Interim short-stay beds must achieve 90% occupancy to receive 100% of the LOC per diem funding.

The sections below outline the detailed approach for calculating occupancy targets for the different types of beds in LTC homes. Specifically, there are three separate calculations to determine occupancy targets for the purpose of funding. In the first calculation long-stay beds and short-stay respite beds are grouped together to set a single target referred to as *'target long-stay resident days'*. The second calculation sets the occupancy target for convalescent care beds only and it is referred to as *'target convalescent care resident days'*. The third calculation sets the occupancy targets for the interim short-stay beds and it is referred to as *'target interim short-stay resident days.'*

Target calculations will be provided in the Subsidy Calculation Worksheet.

3.1 Funding Based on Target Long-Stay Resident Days

To receive the LOC per diem funding based on full occupancy, the actual occupancy of a home must not be less than the home's Target Long-Stay Resident Days.

To determine a home's Target Long-Stay Resident Days the following calculation is applied, using the terms as defined further below:

Maximum Resident Days – (Allowable Long-Stay Vacancy Days + Allowable Short-Stay Respite Resident Days) = Target Long-Stay Resident Days

[1] Please note this will exclude beds in abeyance as they are not in operation.

The terms set out in the above calculation are defined as follows:

Maximum Resident Days: The maximum resident days for a home are calculated by multiplying the number of beds in operation[2] (operating capacity) by the number of days in the period under consideration. This calculation includes all beds in operation, (including long-stay beds and short-stay respite beds, except for convalescent care beds and interim beds), provided they are part of the regular or temporary licensed/approved capacity of the home.

- There will be cases where the number of beds in operation in the home will vary during the year, e.g. when renovations, expansions or downsizing of the home are taking place.
- If two or more residents occupy a bed on the same day it is counted as one resident day.

Allowable Long-Stay Vacancy Days: The number of long-stay bed-days that the Ministry/LHIN will allow as vacancies for which funding is provided. The current allowable long-stay vacancy days are set at 3% of the home's Maximum Resident Days, as applicable.
(i.e., Allowable Long-Stay Vacancy Days = 0.03 x Maximum Resident Days).

Allowable Short-Stay Respite Resident Days: The number of short-stay respite bed-days that the Ministry/LHIN will fund at the home.

Target Long-Stay Resident Days: The minimum number of resident days the licensee must provide service for long-stay residents to receive LOC per diem funding based on maximum resident days in the home. The target long-stay resident days are commonly referred to as the 'occupancy target'.

The total number of maximum resident days, allowable long-stay resident days, allowable short-stay respite resident days and target long-stay resident days are calculated for each home annually by the Ministry or LHIN.

3.2 Funding Based on Actual Resident Days

Long-Stay Beds:
A LTC home that does not achieve the home's Target Long-Stay Resident Days, or occupancy target, will be funded based on its actual long-stay resident days.

Despite the rule that a LTC home that does not achieve the home's Target Long-Stay Resident Days will be funded based on actual long-stay resident days, for the interim period of January 1, 2011 to December 31, 2011 (Interim Period), the home will be funded based on its actual long-stay resident days + 3% of Maximum Resident Days (Interim Rate) if the following conditions are met:

(a) the LTC home's Long-Stay Vacancy Days are greater than 3% and less than or equal to 15% of Maximum Resident Days; and
(b) the LTC home is:
    i. 'substantially compliant' with the Compliance Status Indicator in Schedule E of the Long-Term Care Home Service Accountability Agreement (L-SAA);
    ii. not subject to a Suspension of Admissions directed by the Director under the *Long-Term Care Homes Act, 2007*;
    iii. not subject to a Mandatory Management Order, unless:
        (a) there is already a management company in place; and
        (b) the Licensee has complied with every order issued by either an inspector or the Director in respect of the home; and
    iv. not subject to an Order Revoking a licence

If paragraph 6.1.1 or paragraph 6.1.5 applies to the LTC home, then Maximum Resident Days excludes Orientation and Fill-Rate Days and Occupancy Reduction Protection Days for the calculation of the Interim Rate during the Interim Period.

[2] Please note the maximum resident days exclude beds in abeyance as these beds are not in operation.

For the Interim Period where a LTC home is funded at the Interim Rate, every reference in a funding and financial management policy listed in Schedule F of the L-SAA to funding based on Actual Resident Days or actual occupancy will be read as actual resident days + 3% of Maximum Resident Days excluding Orientation and Fill-Rate days and Occupancy Reduction Protection days provided the LTC home licensee meets the conditions in 3.2 in respect of the LTC home. Note: The following L-SAA policies may be impacted:

LTCH Level-of-Care Per Diem Funding Policy
LTCH Reconciliation and Recovery Policy
Funding Policy for Suspension of Admission Due to Outbreaks

For the Interim Period where a LTC home is funded at the Interim Rate, the funding will not exceed funding based on Maximum Resident Days.

For 2012:
Despite the rule that a LTC home that does not achieve the home's Target Long-Stay Resident Days will be funded based on actual long-stay resident days, for the interim period of January 1, 2012 to December 31, 2012 (Interim Period 2012), the home will be funded based on its actual long-stay resident days plus 1% or 2% of Maximum Resident Days (Interim Rate 2012) if the following conditions are met:

(a) The home will be funded based on its actual resident days plus 2% of its Maximum Resident Days if the LTC home's Long-Stay Vacancy Days are greater than 3% and less than or equal to 6% of Maximum Resident Days; or
(b) The LTC home will be funded based on its actual resident days plus 1% of its Maximum Resident Days if the LTC home's Long-Stay Vacancy Days are greater than 6% and less than or equal to 10% of Maximum Resident Days;

and

(c) The LTC home is:
    i. 'substantially compliant' with the Compliance Status Indicator in Schedule E of the Long-Term Care Home Service Accountability Agreement (L-SAA);
    ii. not subject to a Suspension of Admissions directed by the Director under the *Long-Term Care Homes Act, 2007*;
    iii. not subject to a Mandatory Management Order, unless:
        (a) there is already a management company in place; and
        (b) the Licensee has complied with every order issued by either an inspector or the Director in respect of the home; and
    iv. not subject to an Order Revoking a licence

and

(d) The home receives endorsement from the LHIN. To receive the LHIN's endorsement, the licensee of the home must engage with the LHIN in 2012 to discuss the home's occupancy challenges and explore best practices and home-specific solutions. The LHIN's endorsement will be guided by, but not limited to, the following considerations related to the home's activities during the 2012 calendar year:
    i. The long-term care home licensee's openness to work collaboratively with its LHIN to address occupancy challenges in the home;
    ii. The long-term care home licensee's ability to reach an agreement with its LHIN as to the most likely reasons for the occupancy challenges in the home; and
    iii. The long-term care home licensee's willingness to implement reasonable suggestions from the LHIN to improve occupancy in the home.

    The LHIN must provide its endorsement to the Ministry by June 29, 2013. The ministry will not take into consideration any LHIN endorsement provided after June 29, 2013.

If paragraph 6.1.1 or paragraph 6.1.5 applies to the LTC home, then Maximum Resident Days excludes Orientation and Fill-Rate Days and Occupancy Reduction Protection Days for the calculation of the Interim Rate 2012 during the Interim Period 2012.

For the Interim Period 2012 where a LTC home is funded at the Interim Rate 2012, every reference in a funding and financial management policy listed in Schedule F of the L-SAA to funding based on Actual Resident Days or actual occupancy will be read as actual resident days plus 1% or 2% of Maximum Resident Days, as applicable, excluding Orientation and Fill-Rate days and Occupancy Reduction Protection days provided the LTC home licensee meets the conditions in 3.2 for 2012 in respect of the LTC home. Note: The following L-SAA policies may be impacted:

LTCH Level-of-Care Per Diem Funding Policy
LTCH Reconciliation and Recovery Policy
Funding Policy for Suspension of Admission Due to Outbreaks

For the Interim Period 2012 where a LTC home is funded at the Interim Rate 2012, the funding will not exceed funding based on Maximum Resident Days.

Short-Stay Respite Beds:
As outlined in the section above, the allowable short-stay respite resident days are subtracted in the calculation of the home's target long-stay resident days. Specifically, where a short-stay respite program exists, the number of resident days approved for the short-stay respite program is separate from the allowable 3% vacancy rate.

Short-stay respite beds receive LOC per diem funding based on allowable short-stay respite resident days regardless of the actual occupancy achieved. This means that short-stay respite beds are not required to meet a specific target for resident days to receive full funding.

However, occupancy levels for short-stay respite beds are monitored to inform approval of these beds for the following year. This means that if a home does not achieve the set target occupancy days these beds may not be approved the following year. The number of short-stay respite beds in a LHIN may be adjusted based on the demonstrated need that has been determined in the LHIN planning process. The current minimum occupancy threshold has been set by the Ministry at 50%. LHINs may increase the threshold for occupancy higher than the minimum set by the Ministry.

4.1 Funding Based on Target Convalescent Care Resident Days

The maximum resident days and occupancy targets for convalescent care beds are calculated and monitored separately from other beds in a home.

Funding for convalescent care beds has two parts: 1) Base LOC per diem; and 2) Additional Subsidy. A licensee will be permitted to retain 100% of the base LOC per diem funding regardless of the actual occupancy of the convalescent care beds in the home. The Additional Subsidy varies according to occupancy in the convalescent care beds in the home.

- To receive the Additional Subsidy based on maximum convalescent care resident days the home must meet its target convalescent care resident days, which are set at 80% of the maximum convalescent care resident days.

To determine a home's Target Convalescent Care Resident Days the following calculation is applied,

Maximum Convalescent Care Resident Days – Allowable Convalescent Care Vacancy Days = Target Convalescent Care Resident Days

The terms set out in the above calculation are defined as follows:

Maximum Convalescent Care Resident Days: The maximum convalescent care resident days for a home are calculated by multiplying the number of convalescent care beds in operation (operating capacity) in the home by the number of days in the period under consideration.

- The operating capacity is based on the number of convalescent care beds in operation for each period. The number is not to exceed the number of licensed or approved beds in a home. There will be cases where the number of beds in operation in the home will vary during the year, e.g., when renovations, expansions or downsizing of the home are taking place.

- If two or more residents occupy a bed on the same day it is counted as one resident day.

Allowable Convalescent Care Vacancy Days: The number of convalescent care bed-days that the Ministry/LHIN will allow as vacancies for which funding (for the additional subsidy) is provided. The current allowable convalescent care vacancy days are set at 20% of the home's maximum convalescent care resident days. (i.e., Allowable Convalescent Care Vacancy Days = 0.20 x (Maximum Convalescent Care Resident Days).

Target Convalescent Care Resident Days: The minimum number of resident days the licensee must provide service to convalescent care residents to receive the Additional Subsidy based on maximum convalescent care resident days in the home. The target convalescent care resident days are commonly referred to as the 'convalescent care occupancy target'.

Base Level of Care Per Diem: means the total per diem subsidy as determined by the Ministry in effect for the period under consideration, and is comprised of the four funding components of the current funding model (Nursing and Personal Care (NPC) envelope, Program and Support Services (PSS) envelope, Raw Food (RF) envelope and Other Accommodation (OA) envelope). The Base Level of Care Per Diem represents the per diem amount that has not been modified by a Case Mix Index (CMI) adjustment.

Additional Subsidy: means the Additional Subsidy paid for designated Convalescent Care beds conditional on the home achieving the occupancy target for their designated Convalescent Care beds.

Please refer to the *LTCH Convalescent Care Additional Subsidy Funding Summary* for the specific amount of funding that constitutes the Additional Subsidy at a specific point in time and the allocation of the subsidy to NPC, PSS and OA envelopes. The Additional Subsidy amounts are set by the Ministry and are updated by the Ministry from time to time.

The total number of maximum convalescent resident days, allowable convalescent care resident days and target convalescent care resident days are calculated for each home annually by the Ministry or LHIN.

4.2 Funding Based on Actual Convalescent Care Resident Days

If a LTC home does not achieve its target convalescent care resident days, the additional subsidy funding will be based on the actual convalescent care resident days. For example, if a home achieves 40% occupancy in its convalescent care beds it will receive LOC funding based on the maximum convalescent care resident days but the additional subsidy funding will be based on 40% of the maximum convalescent care resident days.

In addition, if the overall convalescent care bed occupancy is below 50%, or such other level as the LHIN may determine, the licensee and the LHIN will meet to discuss reasons and next steps, which could include an assessment of the community's need for these convalescent care beds and a possible reduction of bed number in the convalescent care program, with a corresponding reduction in funding.

5.1 Funding Based on Target Interim Short-Stay Resident Days

The maximum resident days and occupancy targets for interim short-stay beds are calculated and monitored separately from other beds in a home. To receive the LOC per diem funding based on full occupancy, the actual occupancy for interim short-stay beds must not be less than the home's Target Interim Short-Stay Resident Days.

To determine a home's Target Interim Short-Stay Resident Days the following calculation is applied:

Maximum Interim Short-Stay Resident Days – Allowable Interim Short-Stay Vacancy Days = Target Interim Short-Stay Resident Days

The terms set out in the above calculation are defined as follows:

Maximum Interim Short-Stay Resident Days: The maximum interim short-stay resident days for a home are calculated by multiplying the number of interim short-stay beds in operation (operating capacity) in the home by the number of days in the period under consideration.

- The operating capacity is based on the number of interim short-stay beds in operation for each period. The number is not to exceed the number of licensed or approved interim beds in a home. There will be cases where the number of interim beds in operation in the home will vary during the year. e.g., when renovations, expansions or downsizing of the home are taking place.
- If two or more residents occupy a bed on the same day it is counted as one resident day.

Allowable Interim Short-Stay Vacancy Days: The number of interim short-stay bed-days that the Ministry/LHIN will allow as vacancies for which funding is provided. The current allowable interim short-stay vacancy days are set at 10% of the home's maximum interim short-stay resident days. (i.e., Allowable Interim Short-Stay Vacancy Days = 0.10 x (Maximum Interim Short-Stay Resident Days).

Target Interim Short-Stay Resident Days: The minimum number of resident days the licensee must provide service to interim short-stay residents to receive funding based on maximum interim short-stay resident days in the home. The target interim short-stay resident days are commonly referred to as the 'interim short-stay occupancy target'.

The total number of maximum interim short-stay resident days, allowable interim short-stay resident days and target interim short-stay resident days are calculated for each home annually by the Ministry or LHIN.

5.2 Funding Based on Actual Interim Short-Stay Resident Days

If a LTC home does not achieve its target interim short-stay resident days, funding will be based on the actual interim short-stay resident days.

6.1 Adjustments of Occupancy Targets

6.1.1 New and Redeveloped Beds Orientation and Fill Rate Period

Just before and after new or redeveloped beds begin operations, they may be provided with a period of orientation days (before the beds begin to operate) and fill rate days (after the beds begin to operate) when the beds are funded based on full capacity without regard to actual occupancy. Please refer to the Ministry's *Fill Rate Guidelines for New and Redeveloped/Retrofitted 'D' Long-Term Care Facilities* document for further details and other guidelines, as they are issued by the Ministry, on when these days apply. The Ministry/LHIN may adjust the home's occupancy targets to reflect the orientation and fill rate period for new and redeveloped beds, excluding convalescent care beds.

In the event that the orientation and fill rate period applies the calculation of occupancy targets for the home changes. Specifically, orientation and fill rate days are subtracted from the maximum resident days to calculate the Target Long-Stay Resident days. In addition, orientation and fill rate days are excluded from the maximum resident days to calculate the Allowable Long-Stay Vacancy Days. Under this scenario the definition of allowable long-stay vacancy days is adjusted as follows:

> Allowable Long-Stay Vacancy Days means the number of long-stay bed-days that the Ministry/LHIN will allow as vacancies for which funding is provided. The current allowable long-stay vacancy days are set at 3% of the home's Maximum Resident Days, less orientation and fill rate days i.e., Allowable Long-Stay Vacancy Days = 0.03 x (Maximum Resident Days – Orientation and Fill Rate Days).

To determine the Target Long-Stay Resident Days for the home with orientation and fill rate days the following calculation is applied:

Maximum Resident Days – (Allowable Long-Stay Vacancy Days + Allowable Short-Stay Respite Resident Days excluding any such Days within Orientation and Fill Rate Period + Orientation and Fill Rate Days) =

Target Long-Stay Resident Days

The orientation and fill rate days are applied only for the allowable period. This means that they cannot be assigned to any other period. To achieve this, the calculation of actual long-stay resident days used to determine if the occupancy target has been met will exclude all such resident days during the orientation and fill rate period.

6.1.2 Interim Beds Orientation and Fill Rate Period

Similarly to section 6.1.1, just before and after interim beds begin operations, they may be provided with a period of orientation (before the beds begin to operate) and fill rate days (after the beds begin to operate) when the beds are funded based on full capacity without regard to actual occupancy. Please refer to the *LTCH Fill Rate Guidelines for New Interim LTC Beds* document for further details and other guidelines on when these days apply. The Ministry/LHIN may adjust the home's occupancy targets to reflect the orientation and fill rate period for new interim beds, excluding convalescent care beds.

In the event that the orientation and fill rate period applies the calculation of occupancy targets for the home changes. Specifically, orientation and fill rate days are subtracted from the maximum interim short-stay resident days to calculate the Target Interim Short-Stay Resident days. In addition, orientation and fill rate days are excluded from the maximum interim short-stay resident days to calculate the Allowable Interim Short-Stay Vacancy Days. Under this scenario the definition of allowable Interim Short-Stay Vacancy Days is adjusted as follows:

> Allowable Interim Short-Stay Vacancy Days means the number of interim short-stay bed-days that the Ministry/LHIN will allow as vacancies for which funding is provided. The current allowable interim short-stay vacancy days are set at 10% of the home's Maximum Interim Short-Stay Resident Days, less orientation and fill rate days, i.e., Allowable Interim Short-Stay Vacancy Days = 0.10 x (Maximum Interim Short-Stay Resident Days – Orientation and Fill Rate Days).

To determine the Target Interim Short-Stay Resident Days for the home with orientation and fill rate days the following calculation is applied:

Maximum Interim Short-Stay Resident Days – (Allowable Interim Short-Stay Vacancy + Orientation and Fill Rate Days) = Target Interim Short-Stay Resident Days

The orientation and fill rate days are applied only for the allowable period. This means that they cannot be assigned to any other period. To achieve this, the calculation of actual interim short-stay resident days used to determine if the occupancy targets has been met will exclude all such resident days during the orientation and fill rate period.

6.1.3 Convalescent Care Beds Orientation Period

The first 90 days of the operation of the new convalescent care program is considered an orientation period and the occupancy rate during this time period is excluded from the calculation of the target convalescent care resident days. The licensee will therefore be entitled to retain the Additional Subsidy for this 90-day period, subject to reconciliation.

In the event that the orientation period applies the calculation of convalescent care occupancy targets for the home changes. Specifically, the orientation days are subtracted from the maximum convalescent care resident days to calculate the target convalescent care resident days. In addition, the orientation days are excluded in the calculation of the allowable convalescent care vacancy day. (See formula below for precise detail).

Where orientation days apply the definition of allowable convalescent care vacancy days is adjusted as follows:

> Allowable Convalescent Care Vacancy Days means the number of convalescent care bed-days that the Ministry/LHIN will allow as vacancies for which funding is provided. The current allowable convalescent care vacancy days are set at 20% of the home's Maximum Resident Days, less orientation days.

(i.e., Allowable Convalescent Care Vacancy Days = 0.20 x (Maximum Resident Days – Orientation Days).

To determine the Target Convalescent Care Resident Days for the home with orientation days the following calculation is applied:

Maximum Convalescent Care Resident Days – (Allowable Convalescent Care Vacancy Days + Orientation Period Days) = Target Convalescent Care Resident Days

The orientation days are applied only for the allowable period. This means that that they cannot be assigned to any other period. To achieve this, the calculation of actual convalescent care resident days used to determine if the occupancy target has been met will exclude all such resident days during the orientation period.

6.1.4 Suspension of Admissions due to Outbreaks

In the event of suspension of admission due to an outbreak in the home the occupancy targets for a home may be adjusted. Please refer to the *LTCH Funding Policy for Suspension of Admissions Due to Outbreaks* document for further details.

6.1.5 Occupancy Reduction Protection (ORP) Period

Under certain circumstance the LHIN/Ministry may approve an occupancy reduction protection period during which time modified occupancy and funding rules apply. Please see the *LTCH Non-Capital Occupancy Reduction Protection Guidelines* for further details on these rules. For the purpose of calculating the occupancy targets for the home, the bed days to which occupancy reduction protection applies will be subtracted from the calculation of the home's occupancy target. In addition, allowable vacancy days will also exclude occupancy reduction protection days in calculating the target resident days for homes with occupancy reduction protection period (please see below the amended definition of the allowable vacancy days for each calculation, as applicable).

To determine the Target Long-Stay Resident Days for the home with occupancy reduction protection period the following calculation is applied:

Maximum Resident Days – (Allowable Long-Stay Vacancy Days + Allowable Short-Stay Respite Resident Days + Occupancy Reduction Protection Days) = Target Long-Stay Resident Days

Where Allowable Long-Stay Vacancy Days = 0.03 x (Maximum Resident Days – Occupancy Reduction Protection Days)

To determine the Target Convalescent Care Resident Days for the home with occupancy reduction protection period the following calculation is applied:

Maximum Convalescent Care Resident Days – (Allowable Convalescent Care Vacancy Days + Occupancy Reduction Protection Days) = Target Convalescent Care Resident Days

Where Allowable Convalescent Care Vacancy Days = 0.20 x (Maximum Convalescent Care Resident Days – Occupancy Reduction Protection Days)

To determine the Target Interim Short-Stay Resident Days for the home with occupancy reduction protection period the following calculation is applied:

Maximum Interim Short-Stay Resident Days – (Allowable Interim Short-Stay Vacancy Days + Occupancy Reduction Protection Days) = Target Interim Short-Stay Resident Days

Where Allowable Interim Short-Stay Vacancy Days = 0.10 x (Maximum Interim Short-Stay Resident Days – Occupancy Reduction Protection Days)

7.1 Reconciliation Rules

This policy must be read in conjunction with the *LTCH Level of Care Per Diem Funding Policy*, *Eligible Expenditures for LTCHs*, and the *LTCH Reconciliation and Recovery Policy*, among others. As in addition to occupancy targets rules the funding is also subject to other conditions of funding, i.e., reconciliation rules.

8.1 Examples: Calculation of Occupancy Targets for the Purpose of Funding

Example 1:

Occupancy targets for a LTC home with 100 long-stay beds

The target resident days for a home with 100 long-stay beds would be 35,405

Maximum Resident Days – (Allowable Long-Stay Vacancy Days + Allowable Short-Stay Respite Resident Days) = Long-Stay Target Resident Days

36,500 – (1,095 + 0) = 35,405

Maximum long-stay resident days are 36,500 (100 beds x 365 days)

Allowable long-stay vacancy is 3% of maximum long-stay resident days = 1,095 (36,500 x 0.03)

Allowable short-stay respite resident days is 0 (the home has no short-stay respite beds)

Target long-stay days is 36,500 – 1,095 = 35,405

Example 2:

Occupancy targets for a LTC home with 98 long-stay beds and 2 short-stay respite beds

The target resident days for a home with 98 long-stay beds and 2 short-stay respite beds is 34,675

Maximum Resident Days – (Allowable Long-Stay Vacancy Days + Allowable Shot-Stay Respite Resident Days) = Long-Stay Target Resident Days

36,500 – (1,095 + 730) = 34,675

Maximum long-stay resident days are 36,500 (100 beds x 365 days)

Allowable long-stay vacancy is 3% of maximum long stay resident days = 1,095 (36,500 x 0.03)

Allowable short-stay respite resident days is 730 (2 x 365)

Target long-stay days is 36,500 – (1,095 + 730) = 34,675

9.1 Cash Flow Management for Low Occupancy

Purpose

Low Occupancy Funding policy provides additional rules for cash flow management for licensees with homes that have low occupancy.

Objective

The objective of Low Occupancy Funding is to allow the continuation of the delivery of quality care and service levels to resident in LTC homes with low occupancy rates while improving the licensee's cash management strategy for the home.

Applicability

For the purpose of initial cash flow, and subject to subsequent reconciliation, homes that achieve an average occupancy level of greater than 80% are paid LOC funding at a rate equal to 100%. Homes with reported average occupancy level of 80% or below, as measured by the most recent Revenue Occupancy Report, will receive monthly funding based on their actual occupancy level plus 10%. This applies to cash flow long-stay bed only. Convalescent care and interim short-stay beds will continue to receive cash flow at 100%.

However, in the event that occupancy increases by more than 5% and that increased occupancy is maintained for more than one month, homes are advised to consult with their LHIN regarding an increase in monthly payments.

Please refer to the *LTCH Cash Flow Policy* for further information on the cash flow approach.

Recovery Standards

Please refer to the *LTCH Reconciliation and Recovery Policy* on the current process and standards for recoveries of surplus funds.

Policy: LTCH Level-of-Care Per Diem Funding Policy	As Amended and Effective	**April 1, 2011**	Released March 2012
	As Amended and Effective	**April 1, 2011**	Released July 2011
	Original Publish Date	**July 1, 2010**	Released July 2010

1.1 Introduction

The policy outlines the funding approach for the Level-of-Care (LOC) per diem paid to a licensee for each Long-Term Care (LTC) home.

1.2 Overview of the Funding Approach for the LOC Per Diem Funding

The LHINs fund the licensee of a LTC home the LOC per diem for every licensed or approved bed in the home[1], subject to the conditions set out in this policy, other funding and financial management policies, applicable law, and the service accountability agreement between the LHIN and the licensee. The LOC per diem is calculated for each bed using the following formula:

(NPC + PSS + RF + OA) – Resident Co-Payment Revenue = LOC Per Diem Funding

Please note: the NPC envelope in the above formula may be adjusted for acuity, as appropriate. Please see section 4 of this policy for further information on acuity adjustment of the NPC envelope. Also, please see section 5 of this policy and the *LTCH Cash Flow* policy for more information on the Resident Co-Payment Revenue.

Please see the ***Level-of-Care Per Diem Funding Summary*** for the specific funding amount under each envelope for the applicable period. The per diem amounts are set by the Ministry and are updated by the Ministry from time to time.

2.1 Base Level-of-Care Per Diem Funding Components

The LOC per diem funding consists of four funding components, referred to as envelopes. Specifically,

- Nursing and Personal Care (NPC)
- Program and Support Services (PSS)
- Raw Food (RF)
- Other Accommodation (OA)

The envelopes are defined[2] as follows:

Nursing and Personal Care

To be an NPC Expenditure, expenditures must fall into one of the following elements:

1. Expenditures on salaries, wages, benefits and purchased services for active direct care staff (e.g., registered nurses, registered practical nurses, personal support workers, and other persons hired to provide personal support services) and for nursing and personal care administrators (e.g., director of nursing and personal care, nurse managers, unit clerks, MDS RAI Coordinator, and, shared clinical nursing consultants[3]) who assess, plan, provide, assist, evaluate, and

[1] Please note beds in abeyance are excluded as these beds are not in operation.
[2] For further information please see *Eligible Expenditures for LTC Homes* policy.
[3] See definition in Appendix A of the *Eligible Expenditures for LTC Homes* policy.

document the direct care required to meet the residents' assessed nursing and personal care requirements if and only if:

a) Staff provides nursing and personal care directly to the resident to meet the nursing and personal care requirements assessed in a care plan or plan of care.
b) Direct nursing and personal care includes the following activities: assistance with the activities of daily living, including personal hygiene services, administration of medication, and nursing care.

2. Expenditures for Nursing and Personal Care training, including attendance costs, if and only if:
   a) The training or education enhances the NPC staff's ability to fulfill their primary job function.[4]
   b) Attendance costs included are limited to reasonable charges for food, accommodation, and travel.

3. Expenditures on nursing and personal care equipment, supplies, and devices (excluding furnishings) used by NPC staff in the provision of direct nursing and personal care as outlined in residents' care plans or plans of care if, and only if:
   a) NPC equipment, supplies, and devices purchased meet the residents' nursing and personal care requirements in accordance with section 44 of O. Reg. 79/10 under the *Long-Term Care Homes Act, 2007*.
   b) Computers and computing devices (that is, hardware and software) exclusively used for the creation and maintenance of resident records and used by NPC staff in the assessment, planning, providing, assisting, evaluation, and/or documentation of the medical, nursing and personal care needs of residents are eligible. Only computer and computing devices that are solely used for clinical purposes (e.g., shared by direct care staff recognized under NPC and PSS) may be prorated between the NPC and PSS envelopes.
   c) The cost of NPC equipment maintenance and repair (e.g., lift maintenance) performed by internal or external service providers is limited to hours of labour and parts necessary for the required repair and/or maintenance. Labour costs associated with the job should be allocated as a purchased service whether completed by an internal or external service provider.

<u>Program and Support Services</u>

To be a PSS Expenditure, expenditures must fall into one of the following elements:

1. Expenditures on the salaries and benefits and purchased services for active staff (e.g., physiotherapists, speech-language therapists, occupational therapists, OT/PT aides, recreational staff, volunteer co-ordinators, social workers, registered dietician time (in accordance with section 2.2 of the *LTCH Level-of-Care Per Diem Funding Policy*), and others) that provide support services directly to residents or conduct programs for the residents if, and only if:
   a) Support services and programs are required under the *Long-Term Care Homes Act, 2007,* are in the schedule of recreation and social activities, or are assessed in a care plan or plan of care to benefit the maintenance or improvement of the level of functioning of residents with regard to the activities of daily living and/or improve the quality of life of residents.
   b) The time spent by PSS staff to assess, plan, provide, evaluate, and document the support services and programs being provided are included.

2. Expenditures on Program and Support Services training and education if and only if:
   a) The training or education enhances the Program and Support Services staff's ability to fulfill their primary job function.[5]
   b) Attendance costs included are limited to reasonable charges for food, accommodation, and travel costs.

[4] For NPC staff whose primary job function includes leadership of other staff, education and training related to management and leadership skills is eligible under NPC.
[5] For PSS staff whose primary job function includes leadership of other staff, education and training relating to management and leadership skills is eligible under PSS.

3. Expenditures on equipment, supplies, and devices used by staff that are irreplaceable in the provision of support services and planned and structured programs to meet the requirements of the *Long-Term Care Homes Act, 2007* or the assessed needs of residents as determined by medical and nursing staff if, and only if:
    a) The PSS equipment, supplies, and devices purchased must meet the majority of residents' needs or must be assessed as necessary as part of a resident's care plan or plan of care.
    b) Computers and computing devices (that is, hardware and software) exclusively used for the creation and maintenance of resident records and used by PSS staff in the assessment, planning, providing, assisting, evaluation, and/or documentation of the program and support services needs of residents are eligible. Only computer and computing devices that are solely used for clinical purposes (i.e., shared by direct care staff recognized under NPC and PSS) may be prorated between the NPC and PSS envelopes.
    c) The cost of PSS equipment maintenance and repair (e.g., repair of a projector used solely for PSS activities) performed by internal or external service providers is limited to hours of labour and parts necessary for the required repair and/or maintenance. Labour costs associated with the job should be allocated as a purchased service whether completed by an internal or external service provider.

Raw Food

1. Expenditures for the purchase of raw food including food materials used to sustain life including supplementary substances such as condiments and prepared therapeutic food supplements ordered by a physician, nurse practitioner, registered dietitian, and/or registered nurse, as appropriate, for a resident. Alcohol and food for non-residents are not included in this envelope. This envelope includes food for special events including seasonal, cultural, religious and ethnic celebrations.

    Food used in resident programs: If the licensee can demonstrate that food used in a scheduled recreation or social activity that meets the interests of the residents does not replace all or part of a meal, resident food costs can be charged to PSS.

Other Accommodation

1. Expenditures for salaries, employee benefits[6], education, training, reasonable attendance costs, purchased services, and supplies, equipment and devices related to housekeeping services, buildings and property operations and maintenance, dietary services (nutrition/hydration services), laundry and linen, general and administrative services, and facility costs that will maintain or improve the care environment of the LTC home. These costs are defined in Appendix A of the *Eligible Expenditures for LTC Homes* policy and the Annual Report and the Annual Report Technical Instructions and Guidelines in effect for the period under consideration.

Please see the ***Eligible Expenditures for LTC Homes*** policy for additional information on envelope definitions and eligibility criteria.

2.2 Additional Conditions, Rules and Restrictions on the Level-of-Care Per Diem Funding

Nursing and Personal Care Envelope

Incontinence Supplies

A licensee may expense a maximum of $1.20 per resident per day under the NPC envelope for incontinence supplies. If the licensee achieves its target resident days, then the licensee may expense the $1.20 per resident per day up to the maximum resident days for the home. If the licensee does not achieve its target resident days then the licensee may expense the $1.20 per resident per day based on the actual resident days in the home. This funding is subject to reconciliation.

[6] WSIB rebates may be deposited to the OA envelope to create an incentive for licensees to improve their workplace safety performance.

Any amount over $1.20 per resident per day must be expensed under the Other Accommodations envelope.

Medical Director Fees

All licensees are expected to pay Medical Directors fees of at least $0.30 per resident per day. Licensees may expense the Medical Director fees of $0.30 per resident per day under the NPC envelope. If the licensee achieves its target resident days for the home then the licensee may expense the $0.30 per resident per day up to the maximum resident days for the home. If the licensee does not achieve its target resident days then the licensee may expense the $0.30 per resident per day based on the actual resident days in the home. This funding is subject to reconciliation.

Any amount over $0.30 per resident per day must be expensed under the Other Accommodations envelope.

Personal Support Workers (PSW) Funding

Licensees receive $3.12[7] per resident per day as part of the NPC envelope to increase the number of provincially-funded, through LHINs,[8] PSW hours and PSW FTE positions. Funding is based on actual resident days if a licensee does not meet its target long-stay resident days, or maximum resident days if a licensee meets its target long-stay resident days for the home. For further information on occupancy targets please see the *LTCH Occupancy Targets Policy.* Licensees are required to apply the funding to increase the number of provincially-funded PSW hours and PSW FTE positions. The licensee must maintain detailed records, in the form required by the Ministry substantiating the use of the PSW funding for the home and provide information as directed about the increase in the number of net new provincially-funded PSW FTEs and PSW hours in the annual staffing survey, and otherwise as may be directed. Note that the additional amount in the per diem for this purpose effective April 1, 2011 may only be allocated to PSW hours and FTE positions created on or after that date.

Base Funding Increase for Staff Training

Licensees receive $0.18 for implementation of *LTCHA* mandatory staff training provisions. This funding will support compliance with the Act and improve quality of care for residents as identified in quality of care indicators of the L-SAA regime and Health Quality Ontario indicators. A primary focus for training is on unregulated staff, to ensure improvement of resident care is achieved. The licensee must apply the funding to staff training activities, including development and delivery of training modules and backfilling of staff attending training.

Program and Support Services Envelope

Dietician Time

The licensee may expense in the PSS envelope expenditures related to the provision of 30 minutes per resident per month of Registered Dietician time to carry out clinical and nutritional care duties consistent with s. 74(2) of O. Reg. 79/10. The expenditure of the 30 minutes must be related to registered dietician salary and benefits only. Expenditures beyond the 30 minutes are to be expensed to the OA envelope.

Base Funding Increase for Staff Training

Licensees receive $0.02 for implementation of LTCHA mandatory staff training provisions. This funding will support compliance with the Act and improve quality of care for residents as identified in quality of care indicators of the L-SAA regime and Health Quality Ontario indicators. The licensee must apply the funding to staff training activities, including development and delivery of training modules and backfilling of staff attending training. The licensee must maintain records relating to the use of the funding for the home.

Other Accommodation Envelope

Nutrition Managers and Food Service Workers

Minimum Staffing Requirements

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[7] Rates current as of 2011-12

[8] 'Provincially funded' refers to those positions funded by the LHINs and identified in the LTC Homes Staffing Report as 'Ministry funded'. This is intended to differentiate such positions from those funded through licensees' voluntary contributions.

1. The licensee must comply with requirements set out in section 75 of Ontario Regulation 79/10 under the *Long-Term Care Homes Act, 2007* (LTCHA) (the Regulation).

1.1. Consistent with section 75 (6) of the Regulation,

(a) prior to January 1, 2011, the licensee must comply with the requirements set out in ss. 75 (6) (a), (b) and (c) of the Regulation and, therefore, paragraph 1.2 below does not apply prior to January 1, 2011; and

(b) on and after January 1, 2011, the licensee must comply with ss. 75 (3) of the Regulation.

1.2. Consistent with subsection 75 (3) of the Regulation,, the licensee must ensure that the nutritional manager(s) is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under the Regulation, without including any hours spent fulfilling other responsibilities. The minimum number of hours is determined by the following formula:

$M = A \times 8 \div 25$, where

"M" is the minimum number of hours per week,

"A" is

(a) if the occupancy of the home is 97 per cent or more, the licensed bed capacity of the home for the week, or

(b) if the occupancy of the home is less than 97 per cent, the number of residents residing in the home for the week, including absent residents.

2. The licensee must comply with requirements set out in section 77 of Ontario Regulation 79/10 under the *Long-Term Care Homes Act, 2007* (LTCHA) (the Regulation).

2.1. Consistent with section 77 (4) of the Regulation,

(a) prior to January 1, 2011, the licensee must comply with the requirements set out in ss. 77 (4) (a), (b) and (c) of the Regulation and, therefore, paragraph 2.2 below does not apply prior to January 1, 2011; and;

(b) on and after January 1, 2011, the licensee must comply with ss. 77 (1) of the Regulation.

2.2. Consistent with the subsection 77 (1) of the Regulation, the licensee must ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under the Regulation. The minimum number of hours is determined by the following formula:

$M = A \times 7 \times 0.45$, where

"M" is the minimum number of hours of staffing hours per week,

"A" is

(a) if the occupancy of the home is 97 per cent or more, the licensed bed capacity of the home for the week, or

(b) if the occupancy of the home is less than 97 per cent, the number of residents residing in the home for the week, including absent residents.

Verification of Minimum Staffing Requirements

3. An inspector under the LTCHA will verify if the licensee meets the minimum requirements set out in paragraphs 1.2 and 2.2 above.

4. The Ministry may take into consideration the hours in a week, if any, devoted to producing meals and other food and beverages for non-residents (e.g. staff, visitors) for the sole purpose of determining whether the licensee is in compliance with the requirements set out in paragraphs 1.2 and 2.2 above. An inspector under the LTCHA may apply the formulas set out under paragraph 4.1 and 4.2 below to confirm whether the licensee is meeting the minimum requirements set out in paragraphs 1.2 and 2.2 above.

4.1. An inspector under the LTCHA may apply the following formula to confirm whether the licensee is meeting the minimum requirement set out in paragraph 1 for the Nutritional Manager(s):

$M_{Total} = [A + (B \div 3 \div 7) + (C \div 3 \div 7)] \times 8 \div 25$

$= 0.32 \left\lfloor A + {}^{B}\!/_{21} + {}^{C}\!/_{21} \right\rfloor$, where

"M_{Total}" is the minimum number of hours of service per week for the management of all resident and non-resident nutritional care and dietary service programs.

"A" is,

(a) if the occupancy of the home is 97 per cent or more, the licensed bed capacity of the home for the week, or

(b) if the occupancy of the home is less than 97 per cent, the number of residents residing in the home for the week, including absent residents.

"B" is the total number of meals prepared in the home for the week for persons who are not residents of the home where one or both of the following two conditions are met:

(i) staff are involved in activities in addition to food preparation including but not limited to the following:

(a) distribution of meals;
(b) receiving, storing and managing of the inventory of food and food service supplies;
(c) daily cleaning and sanitizing of dishes, utensils and equipment used for meal preparation, delivery or service.

(ii) the menus for residents and persons who are not residents are not the same.

In all cases, the following meals are included under "B": visitors, staff, day care, cafeteria, and catering.

"B" is the sum of meals prepared for each of its components, e.g., meals for visitors, staff, day care, and cafeteria. As such, "B" is calculated using the following formula:

$$B = \sum_{n=i} b_i \ .$$

Where possible each component, i.e., b_i , should be measured using the number of meals prepared. For all operations that generate revenue, such as a cafeteria, the following formula should be applied to calculate b_i :

$$b_i = \frac{\text{Average weekly revenue}}{\text{Average cost per meal}}, \text{ where}$$

$$\text{Average cost per meal} = \frac{\text{Raw food per diem}}{3}$$

"C" is the total number of meals prepared in the home for other operations where both of the following two conditions are met:

i) LTC staff is only involved in food preparation and not other activities that may include but are not limited to the following:

(a) distribution of meals;
(b) receiving, storing and managing of the inventory of food and food service supplies;
(c) daily cleaning and sanitizing of dishes, utensils and equipment used for meal preparation, delivery or service.

ii) the menus for residents and for persons who are not residents are the same.

4.2. An inspector under the LTCHA may apply the following formula to verify that the licensee is meeting the minimum standard defined under paragraph 2 for Food Service Workers:

M_{Total} = [A × 7 × 0.45] + [(B ÷ 3) × 0.45] + [(C ÷ 3) x 0.22]

$= 0.45\left\lfloor 7A + B/3 \right\rfloor + 0.22\left\lfloor C/3 \right\rfloor$, where

"M_{Total}" is the minimum number of hours per week for the activities outlined under subsection 77 (1) of the Regulation and the same or other activities related to meals for persons who are not residents defined under B and for the preparation of meals under C

"A" is,

(a) if the occupancy of the home is 97 per cent or more, the licensed bed capacity of the home for the week, or

(b) if the occupancy of the home is less than 97 per cent, the number of residents residing in the home for the week, including absent residents.

"B" is the total number of meals prepared in the home for the week for persons who are not residents of the home where one or both of the following two conditions are met:

(i) staff are involved in activities in addition to food preparation including but not limited to the following:

(a) distribution of meals;
(b) receiving, storing and managing of the inventory of food and food service supplies;
(c) daily cleaning and sanitizing of dishes, utensils and equipment used for meal preparation, delivery or service.

(ii) the menus for residents and persons who are not residents are not the same.

In all cases, the following meals are included under "B": visitors, staff, day care, cafeteria, and catering.

"B" is the sum of meals prepared for each of its components, e.g., meals for visitors, staff, day care, and cafeteria. As such, "B" is calculated using the following formula:

$$B = \sum_{n=i} b_i \ .$$

Where possible each component, i.e., b_i , should be measured using the number of meals prepared. For all operations that generate revenue, such as a cafeteria, the following formula should be applied to calculate b_i :

$$b_i = \frac{\text{Average weekly revenue}}{\text{Average cost per meal}}, \text{ where}$$

$$\text{Average cost per meal} = \frac{\text{Raw food per diem}}{3}$$

"C" is the total number of meals prepared in the home for other operations where both of the following two conditions are met:

i) LTC staff is only involved in food preparation and not other activities that may include but are not limited to the following:

(a) distribution of meals;
(b) receiving, storing and managing of the inventory of food and food service supplies;
(c) daily cleaning and sanitizing of dishes, utensils and equipment used for meal preparation, delivery or service.

ii) the menus for residents and for persons who are not residents are the same.

All meals prepared for retirement home operations are included under "C" unless the two conditions defined above are not met. The inspector under the LTCHA will determine if there is non-compliance with the LTCHA and the Regulation.

Base Funding Increase for Staff Training
Licensees receive $0.06 for implementation of LTCHA mandatory staff training provisions. This funding will support compliance with the Act and improve quality of care for residents as identified in quality of care indicators of the L-SAA regime and Health Quality Ontario indicators. The licensee must apply the funding to staff training activities, including development and delivery of training modules and backfilling of staff attending training. The licensee must maintain records relating to the use of the funding for the home.

Base Funding Increase related to *LTCHA* Provisions
The $0.52 base increase provided in 2011/12 is intended to support requirements under the Act related to dietary services and mandatory training. Licensees should also consider using this funding toward professional development, recruitment and retention activities, to improve supply of qualified, unregulated direct care staff (e.g. through such initiatives as 'Grow Your Own PSW').

3.1 Applicability by Bed Type

All beds in LTC homes receive the same base LOC per diem funding for the PSS, RF and OA envelopes in affect for that period as defined in the *Level-of-Care Per Diem Funding Summary*. The level of care per diem funding amount for the NPC envelope may vary among beds as the amount may be adjusted based on resident acuity; specifically the base amount is adjusted by the home's Case Mix Index (CMI). The beds that have their NPC level of care per diem funding adjusted for resident acuity are referred to as classified beds. Section 4 provides an overview of the resident acuity adjustment process.

However, not all beds in LTC homes may have their NPC LOC per diem funding adjusted for resident acuity. New licensed or approved LTC beds where, for the purposes of case mix adjustment, the care needs of new residents have not been calculated are referred to as unclassified beds. This means that the unclassified beds are funded at the base level of care per diem in effect for that period as defined in the *Level-of-Care Per Diem Funding Summary.* The base LOC per diem funding is set at a CMI of 1.0.

Convalescent Care Beds
The NPC LOC per diem funding for convalescent care beds is not adjusted based on CMI. Convalescent care beds receive the base LOC per diem funding, as set in the *Level- of- Care Per Diem Funding Summary* for the applicable period. Convalescent care beds also receive an additional subsidy. The additional subsidy is provided in addition to the base LOC per diem funding because a resident in a convalescent care bed requires a period of time in which to recover strength, endurance and functioning and it is anticipated that the resident will return to his or her residence within 90 days after admission to

the home and as such they require more nursing care and therapies than other LTCH residents. The additional subsidy is allocated between the NPC, PSS and OA envelopes.

Please refer to the *LTCH Convalescent Care Additional Subsidy Funding Summary* for the specific amount of funding that constitutes the additional subsidy at a specific point in time and the allocation of the subsidy between NPC, PSS and OA envelopes. The additional subsidy amounts are set by the Ministry and are updated by the Ministry from time to time.

Short-Stay Respite Beds
NPC LOC per diem funding for short-stay respite beds is adjusted based on the average CMI of the home.

Interim Beds
In instances where interim beds are being implemented and resident care needs have not been calculated for the purpose of case mix adjustment, CMI is deemed to be 1.0 and the bed receives the base LOC per diem funding as set in the *Level-of-Care Per Diem Funding Summary* for the applicable period.

In instances where interim beds are being added to a LTC home where, for the purpose of case mix adjustment, the resident care needs have been estimated, the CMI applicable to the home may be assigned to the interim bed.

4.1 Acuity Adjustment

The NPC LOC per diem funding component for LTC beds may be adjusted for resident acuity. Until April 2010, the Ministry applied the Alberta Resident Classification System (ARCS) to determine resident acuity and adjust funding accordingly. As of April 2010, the Ministry moved to adopt a new classification system called Resource Utilization Groups (RUGs) for the purposes of adjusting the base per diem of the NPC envelope.

The sections below describe how funding is adjusted under the new system during the transition to RUGs and going forward thereafter.

Resource Utilization Groups
The calculation of CMI using RUGs is a result of the move to RAI-MDS across the LTC sector. The RAI-MDS data is collected on a quarterly basis, rather than annually under ARCS, and a RUGs score is assigned for each assessment period. As a result it is possible to calculate a resident-level CMI, and ultimately a home-level CMI that reflects changes in resident acuity throughout the year.

Under RAI-MDS, for the purpose of case mix grouping, the Ministry has adopted the RUG-III 34-group model. The 34-group model uses over 100 MDS items to determine the appropriate RUG III category. Membership in a RUG category is based on how much care a resident needs, types of treatments received, and whether or not the resident has certain conditions or diagnoses.

The method used to calculate a CMI under RUG-III (34) is called RUG Weighted Patient Days (RWPD). This method is also used in Complex Continuing Care to calculate home-level CMI in that sector. Calculation of RWPD involves the following steps:

1. RUG-III (34) classification of each MDS assessment over a 12-month period.
2. Calculation of number of days associated with the RUG-III (34) classification for each MDS assessment over a 12-month period.
3. Weighting of days (i.e. resident days in an assessment period multiplied by the case mix weight associated with the RUG-III (34) group for that assessment).
4. Sum weighted days within a home (RWPD).
5. Sum un-weighted days within a home (total resident days).
6. Calculate the home-level CMI by dividing total home RWPD by total home resident days.

Please see Appendix B for an example of how to calculate home-level CMI.

The CMI will be calculated once annually by the Ministry during the winter and then applied to funding the

following April based on the formula below:

Base NPC x Home CMI = NPC adjusted for CMI

By definition, a CMI of 1.0 represents the resource use of the average LTC resident. Therefore, every year the provincial average CMI will be set to 1.0. In order to ensure this average, the RUG case mix weights will be rescaled by the Ministry on an annual basis. This process will take into account the distribution of resident days in the year as well as applicable changes in wage rates. This practice is in line with that in place in other sectors including acute care and Complex Continuing Care.

Note: During transition from ARCS to RUGs, the method for calculating CMI for the purposes of funding includes assessed days only. Following transition, assessed and unassessed days will be included in the calculation of CMI. For a full description of the RWPD methodology, including assessed and unassessed days, please go: www.cihi.ca.

Transition from ARCS to RUGs

During the implementation of RAI-MDS, homes have been subject to a case mix freeze for funding purposes. As of April 2010 homes in Phase 1 through 5 will come off the freeze and be funded based on a RUGs CMI. Homes in Phase 6 through 8 remain on a CMI freeze. The CMI freeze methodology applied to homes in Phases 6 through 8 as of April 2010 was as follows:

The higher of:
(1) The home's 2008 ARCS CMI;
(2) The average of the home's 2006, 2007, 2008 ARCS CMIs;

If the value of both of the above was less than 100, than the higher of (1) or (2) was toped up by 3 to a maximum of 100.

For those homes that went through the Audit & Appeal process, the average of the 2006, 2007, 2008 ARC CMIs was the protected (frozen) CMI. If the value is less than 100, the average was toped up by 3 to a maximum of 100.

Homes will come off the CMI freeze in two groups as set out in the following table with the first group of homes transitioning to the new RUGs CMI effective April 1, 2010.

		Apr-09	Apr-10	Apr-11	Apr-12	Apr-13	Apr-14	Apr-15
Phase I - V	Transition Status	Base Year	Year 1	Year 2	Year3	Off	Off	Off
	CMI	Frozen ARCS	RUG-III 08/09	RUG-III 09/10	RUG-III 10/11	RUG-III 11/12	RUG-III 12/13	RUG-III 13/14
	Corridor		± 5%	± 5%	± 5%			
Phase VI - VIII	Transition Status			Base Year	Year 1	Year 2	Year 3	Off
	CMI	2008 ARCS	Frozen ARCS	Frozen ARCS	RUG-III 10/11	RUG-III 11/12	RUG-III 12/13	RUG-III 13/14
	Corridor				± 5%	± 5%	± 5%	

During the transition period the following provisions will apply:

- A corridor will be applied to limit year-to-year changes in CMI for funding purposes. This corridor has been set at a + or – 5% change in CMI from the previous year, although may be subject to change by the Ministry depending on increases to the NPC envelope in any given year in order to prevent a significant number of homes being significantly off-side as a result of the transition.

- Each home transitioning effective April 1, 2010 will be funded based on an adjusted transition CMI equal to the product of 1.0231 and the home's transition CMI.

- Homes in Phases 6 through 8 will be transitioned no earlier than April 2012, subject to availability of data for the purposes of calculating CMI.

Following transition, annual CMI notices will be provided to the licensee for each home based on the ongoing assessment of residents using the RAI-MDS assessment tool.

5.1 Resident Accommodation Charge

Each resident is responsible for paying the charge for accommodation in accordance with the *Long-Term Care Homes Act (LTCHA) 2007,* and regulations thereunder. This is often referred to as resident co-payment. A resident who is unable to pay the full charge for accommodation may be eligible for a rate reduction in accordance with Ontario Regulation 79/10 under the LTCHA. Please see the *Rate Reduction Summary Guide* for further details.

In the calculation of the LOC per diem funding, the revenue generated from resident accommodation charges is subtracted from the total of the four funding envelopes as follows:

(NPC + PSS + RF + OA) – Resident Co-payment Revenue = LOC Per Diem Funding

Please note: the NPC envelope in the above formula may be adjusted for resident acuity, as appropriate.

Generally speaking the resident co-payment revenue is referring to resident accommodation charge but please refer to the *LTCH Cash Flow Policy* for further details on resident co-payment revenue estimation and cash flow.

A LHIN may not fund any portion of the resident co-payment unless permitted by the Ministry in policy or in an accountability agreement between the Ministry and the LHIN.

Appendix A: Introduction to RUGs-III (34)

Case mix groupers are a way to categorize long-term care residents into groups that are similar with respect to cost or resident acuity. Since 1993, one hundred per cent of the NPC envelope has been adjusted for resident acuity using the Alberta Resident Classification System (ARCS). Over time, ARCS has been seen to have a number of limitations. For example, stakeholders have criticized the fact that it does not contribute to resident care planning and provides only a "snapshot" of resident needs.

RAI-MDS 2.0 will be in place across the Ontario LTC sector and all homes submitting data by the summer of 2010. Please see RAI-MDS 2.0 LTC Homes – Practice Requirements for details.

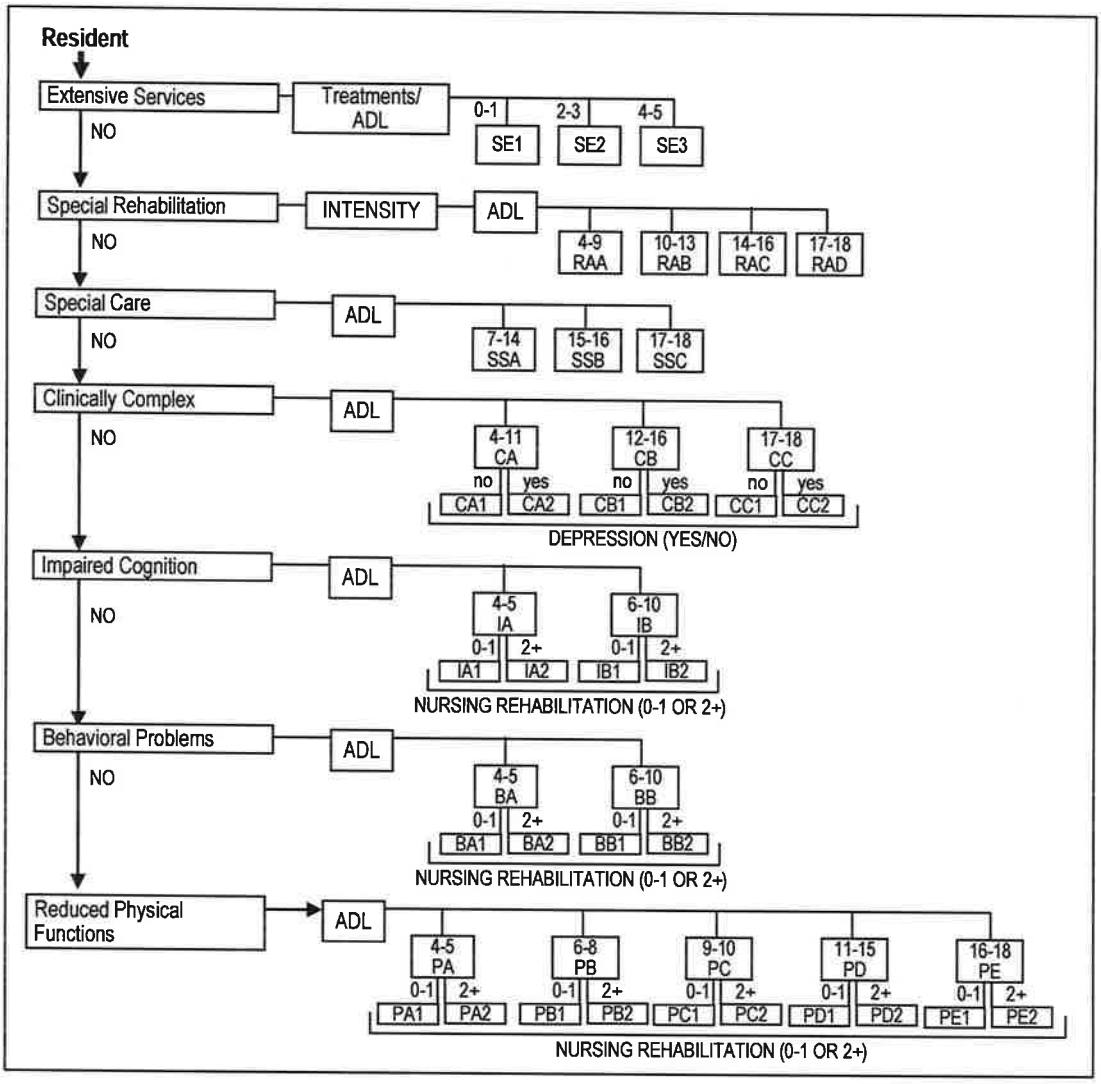
Resource Utilization Groups (RUGs) is a case mix grouping methodology that can be calculated using data from the RAI-MDS. Compared to ARCS, RUGs provides a more comprehensive view of residents based on diagnosis and informs which services residents receive with a focus on activities of daily living and measurable outcomes.

In partnership with the LTC sector, the MOHLTC adopted the RUG III 34 group model as the case mix grouping methodology to adjust the NPC envelope for LTC homes in Ontario. The 34-group model includes 4 groups for residents that receive rehabilitation services. The 34-group model is more suitable for long-term care programs where nursing care is the primary cost driver. The 34-group model is used in the prospective payment model for Medicaid long-term care programs in the United States.

The algorithm for the 34-group model is shown below in Figure #1. The 34-group model uses over 100 MDS items to determine the appropriate RUG category. Membership in a RUG category is based on how much care a resident needs, types of treatments received, and whether or not the resident has certain conditions or diagnoses. These could include:

- Assistance with Activities of Daily Living (ADLs) - bed mobility, transferring from one position to another, eating, and toilet use. A total ADL score of 4 – 18 is possible. The ADL score is a main part of determining your case mix classification. The more assistance you need, the higher your ADL score will be;
- Treatments such as intravenous (IV) medication, fluids, or nutrition;
- Depression or behavioral symptoms;
- Decreased ability to communicate or make decisions;
- Therapy needs (Speech, Occupational, and/or Physical therapy).

Figure #1: RUG-III 34 Groups



NOTE: Licensees do NOT need to determine a resident's membership in a RUG. Vendor software packages automatically calculate RUG membership for each relevant assessment. Reports on RUG distribution at the home and provincial level are provided by CIHI. In addition, education on RUG-III (34) is provided by CIHI (www.cihi.ca).

Appendix B: Calculating Home-Level CMI under RUGs

Apr 1, 2010 Tra
Group (Z15 h

Home Name : ABC LTC Home
Assessment Period : 2008/2009 Fiscal Year commencing April 1

	RUG III (34 Group)	Reference	Assessed Days (A)	%	Weight (2009) (B)	RUG Weighted Patient Days (RWPD) A * B	Assessed Days
1	SE3		112	0.2%	1.9422	217.5264	8,739
2	SE2		92	0.2%	1.5910	146.3720	45,381
3	SE1		0	0.0%	1.4460	0.0000	2,862
4	RAD		25	0.1%	1.6125	40.3125	164,841
5	RAC		292	0.6%	1.3492	393.9664	172,612
6	RAB		0	0.0%	1.1973	0.0000	132,057
7	RAA		0	0.0%	1.0167	0.0000	135,667
8	SSC		496	1.1%	1.4020	695.3920	347,259
9	SSB		1,610	3.5%	1.3189	2,123.4290	230,639
10	SSA		610	1.3%	1.2135	740.2350	230,154
11	CC2		270	0.6%	1.3794	372.4380	192,286
12	CC1		586	1.3%	1.2770	748.3220	206,509
13	CB2		788	1.7%	1.1905	938.1140	318,639
14	CB1		1,325	2.9%	1.1161	1,478.6325	250,812
15	CA2		266	0.4%	1.0683	219.0015	319,687
16	CA1		2,168	4.7%	0.9413	2,040.7384	363,950
17	IB2		81	0.2%	0.9729	78.8049	98,740
18	IB1		3,124	6.8%	0.9469	2,958.1156	882,097
19	IA2		92	0.2%	0.7561	69.5612	34,429
20	IA1		2,327	5.1%	0.7177	1,670.0879	296,591
21	BB2		0	0.0%	0.9388	0.0000	9,920
22	BB1		262	0.6%	0.8917	233.6254	111,273
23	BA2		0	0.0%	0.7036	0.0000	8,028
24	BA1		1,359	3.0%	0.6327	859.8393	496,252
25	PE2		645	1.4%	1.1291	728.2695	230,358
26	PE1		8,492	18.4%	1.1063	9,394.6996	1,878,700
27	PD2		89	0.2%	0.9959	87.6392	225,286
28	PD1		7,382	16.0%	0.9718	7,173.8276	1,654,421
29	PC2		0	0.0%	0.9095	0.0000	17,882
30	PC1		1,316	2.9%	0.8429	1,109.2564	190,082
31	PB2		0	0.0%	0.7116	0.0000	26,356
32	PB1		3,603	7.8%	0.7016	2,527.6848	374,136
33	PA2		184	0.4%	0.6452	118.7168	40,739
34	PA1		8,509	18.5%	0.6308	5,367.4772	1,194,823
	Total Assessed Days	**A**	**46,043**	**100.0%**			**10,892,707**
	Total RUG Weighted Patient Days	**B**				**42,532.4651**	

Home Assessed Days Case Mix Index (RUG-III (34) C = B/A = 42,532/46,043 = 0.9238

Policy: LTCH Cash Flow Policy	As Amended and Effective	**April 1, 2011**	Released March 2012
	Original Publish Date	**July 1, 2010**	Released July 2010

1.1 Introduction

The Cash Flow Policy outlines the basis for calculating payment of the Estimated Total Subsidy to long-term care homes, as well as the manner in which payment of funding is provided to licensees. The Estimated Total Subsidy is comprised of the Estimated Provincial Subsidy from a Local Health Integration Network (LHIN) and, as applicable, Non-Level of Care Funding from the Ministry of Health and Long-Term Care (Ministry) by way of a direct funding agreement between the Ministry and a licensee. Notwithstanding the payment of funding distributed between LHINs and Ministry, funding to Long-Term Care Homes, as outlined in this policy document, continues to follow established processes utilizing the same reports and notifications as in prior years.

1.2 Background

The majority of funding paid by a LHIN to a licensee for a Long-Term Care home is provided through the Level of Care Per Diem. The Level of Care Per Diem is funded from two sources: 1) revenue for accommodation charges from residents as co-payment fees, and 2) payments made by a LHIN to a licensee for the difference between the Level of Care Per Diem and the sum of the Resident Co-payment Revenue. In addition, licensees may be eligible for other Non-Level of Care Funding paid by a LHIN through the Long-Term Care Home/LHIN Service Accountability Agreement (L-SAA) or paid by the Ministry through a direct funding agreement. For the purpose of providing cash flow, funding is advanced to licensees in monthly payments based on estimates of funding.

1.3 Definitions

Additional Subsidy - means the Additional Subsidy paid for designated Convalescent Care beds conditional on the home achieving the occupancy target for their designated Convalescent Care beds. See the *LTCH Occupancy Targets Policy* Section 4.1 for information on occupancy targets for Convalescent Care beds.

Base Level of Care Per Diem – means the total per diem subsidy as determined by the Ministry in effect for the period under consideration, and is comprised of the four funding components of the current funding model (Nursing and Personal Care (NPC) envelope, Program and Support Services (PSS) envelope, Raw Food (RF) envelope and Other Accommodation (OA) envelope). The Base Level of Care Per Diem represents the per diem amount that has not been modified by a Case Mix Index (CMI) adjustment.

Basic Accommodation – in relation to a long-term care home, means lodging in a standard room in the home, housekeeping services, maintenance and use of the home, dietary services, laundry and linen services, administrative services and raw food.

Bed Class – means one of the bed categories Classified, Unclassified or Convalescent Care as identified on the licensee's Monthly Payment Calculation Notice.

Case Mix Index (CMI) – is a numeric value assigned to a long-term care home and is used as a measure of the average care requirements of residents in the long-term care home. The Case Mix Index is multiplied by the Base Level of Care Per Diem for the Nursing and Personal Care envelope only, and is

applied to a home's Classified Beds. For further information on resident care assessment and CMI calculations, please refer to the *LTCH Level of Care Per Diem Funding Policy*.

Classified Beds – refers to long-stay beds that are licensed or approved under the *Long-Term Care Homes Act, 2007* where the care needs of the residents occupying those beds have been assessed and a CMI has been assigned for the bed.

Convalescent Care Beds – refers to the beds that are licensed or approved under the *Long-Term Care Homes Act, 2007* and are designated for the Convalescent Care Program as short-stay supportive care beds and identified as Convalescent Care Beds in Schedule B of a licensee's Long-Term Care Home Service Accountability Agreement. Convalescent care beds receive the Level of Care Per Diem funding, as set in the *LTCH Level-of-Care Per Diem Funding Summary* for the applicable period. Convalescent care beds also receive an additional subsidy. Please refer to the *LTCH Convalescent Care Additional Subsidy Funding Summary* for the specific amount of funding that constitutes the Additional Subsidy at a specific point in time and the allocation of the subsidy between NPC, PSS and OA envelopes. The Additional Subsidy amounts are set by the Ministry and are updated by the Ministry from time to time.

Estimated Provincial Subsidy – means an estimate of the monies payable to a licensee based on their Licensed Bed Capacity subject to the terms and conditions of funding and funding methodologies as outlined in the Long-Term Care Home/LHIN Service Accountability Agreement (L-SAA) and/or applicable Policy and calculated in accordance with Section 2.1 (i) through (iv) of the *LTCH Cash Flow Policy*. The Estimated Provincial Subsidy includes Level of Care Per Diem Funding net of the sum of estimated Resident Co-payment Revenue, Registered Practical Nurse Funding, Construction Funding Subsidy and, where applicable, any other Non-Level of Care Funding paid by a LHIN[1]. In addition, beds that are not available for occupancy under a written permission of the Director under subsection 104 (3) of the *Long-Term Care Homes Act, 2007* will continue to receive Construction Funding Subsidy in accordance with the *Beds in Abeyance Policy*. The Estimated Provincial Subsidy for a licensee is stated on the Monthly Payment Calculation Notice and annual Fac05C Report available at www.fimdata.com/LTCHome.

Estimated Total Subsidy – means the Estimated Provincial Subsidy plus an estimate of the monies payable by the Ministry to a qualifying licensee under a direct funding agreement for Non-Level of Care Funding, subject to the terms and conditions of funding and/or funding methodologies as outlined in the direct funding agreement and/or applicable Policy, and calculated in accordance with Section 2.1 of this policy. The Estimated Total Subsidy for a licensee is stated on the Monthly Payment Calculation Notice and annual Fac05C Report available at www.fimdata.com/LTCHome.

Interim Short-Stay Bed – means a bed in a long-term care home under the interim bed short-stay program.

Level of Care (LOC) Per Diem – means the total per diem subsidy in effect for the period under consideration and is comprised of the four funding envelope components (Nursing and Personal Care (NPC), Program and Support Services (PSS), Raw Food (RF) and Other Accommodation (OA)) of the current funding model. Of the four envelopes, only the Base Level of Care Per Diem in the Nursing and Personal Care envelope is subject to adjustment by the CMI. Please refer to the *LTCH Level of Care Per Diem Funding Policy* for further information.

Licensed Bed Capacity – means the total licensed or approved beds under the *Long-Term Care Homes Act, 2007* excluding beds that are not available for occupancy under a written permission of the Director under subsection 104 (3) of the *Long-Term Care Homes Act, 2007*.

Licensee - means the holder of a licence issued under the *Long-Term Care Homes Act, 2007*, and includes the municipality or municipalities or board of management that maintains a municipal home, joint home or First Nations home.

L-SAA (Long-Term Care Home/LHIN Service Accountability Agreement) – means the service accountability agreement between a licensee of a long-term care home and a LHIN required by section 20 of the *Local Health System Integration Act, 2006*.

[1] Please refer to Section 2.1 (i) though (iv) of this policy for the calculation of Estimated Provincial Subsidy.

Low Occupancy Homes – means long-term care homes where the actual occupancy, excluding Convalescent Care Beds and Interim Short Stay Beds, for the period January 1 to September 30, as reported on the home's most recent submission of the In-Year Revenue/Occupancy Report, is 80% or less. Low Occupancy Homes are subject to an Occupancy Factor adjustment to their Level of Care Per Diem funding. Please refer to the *LTCH Occupancy Targets Policy* and Section 2.2.4 of the *LTCH Reconciliation and Recovery Policy* for further information.

Maximum Resident Days – means the sum of the Licensed Bed Capacity (operating capacity) multiplied by the number of days in operation for each funding period. The operating capacity is based on the number of beds in operation for each period, as agreed to by the licensee and the LHIN and/or Ministry. See the *LTCH Occupancy Targets Policy* and the "Technical Instructions and Guidelines for the Long-Term Care Home Subsidy Calculation Worksheet" for further details on calculating Maximum Resident Days for Long-Stay, Short-Say Respite, Convalescent Care and Interim Short-Stay beds.

Non-Level of Care Funding - means supplementary funding streams, each with distinct terms and conditions provided to qualifying licensees, and excludes the Level of Care Per Diems. Although some supplementary funding may be distributed among the envelopes as set out in the terms and conditions of funding, it does not form part of the Level of Care Per Diems. Non-Level of Care funding may be paid to a licensee by a LHIN through the L-SAA or by the Ministry through a direct funding agreement. Non-Level of Care Funding includes, but is not limited to, Construction Funding Subsidy and Registered Practical Nurse Initiative, which are paid by a LHIN, and High Wage Transition Funding, Pay Equity Funding and/or Equalization Adjustment, Municipal Tax Allowance Funding, Accreditation Funding, Physician On-Call Funding, Structural Compliance Premium, MDS Early Adopter Funding, High Intensity Needs Funding, and Laboratory Services Funding, which are paid by the Ministry, except where paid by a LHIN and calculated as part of the Estimated Provincial Subsidy in accordance with the L-SAA. Non-Level of Care Funding initiatives may be amended, terminated and/or initiated from time to time as the result of changes to policy that provides the specific rules in respect of each form of funding.

Occupancy Factor – means the percentage applied to adjust the bed count, excluding Convalescent Care Beds and Interim Short Stay Beds, to approximate the actual occupancy plus 10% of the home, and thereby affecting the Level of Care Per Diem funding payment. The Occupancy Factor applies only to those Low Occupancy homes where the actual occupancy (excluding Convalescent Care Beds and Interim Short Stay Beds) for the period January 1 to September 30, as reported on the most recent In-Year Revenue/Occupancy Report, is 80% or less. The Occupancy Factor is calculated as the home's actual occupancy (excluding Convalescent Care Beds and Interim Short Stay Beds) from the most recent In-Year Revenue/Occupancy Report plus 10%. For homes that achieve average occupancy of greater than 80% on their most recent In-Year Revenue/Occupancy Report, the Occupancy Factor is not applicable and licensees will be cash-flowed their estimated Level of Care Per Diem funding based on an occupancy level equal to 100%. Please refer to the *LTCH Occupancy Targets Policy* for further information on Low Occupancy homes.

Occupancy Targets – means the minimum number of resident days a licensee must provide service for residents based on the bed type identified in Schedule B of the licensee's L-SAA as either Long-Stay, Short-Stay Respite, Interim Short-Stay or Convalescent Care to receive their Level of Care Per Diem funding, and Additional Subsidy as applicable, based on Maximum Resident Days. Please refer to the *LTCH Occupancy Targets Policy* and the "Technical Instructions and Guidelines for the Long-Term Care Home Subsidy Calculation Worksheet" for further details on calculating Occupancy Targets.

Preferred Accommodation – in relation to a long-term care home, means lodging in private accommodation in the home, or semi-private accommodation in the home, housekeeping services, maintenance and use of the home, dietary services, laundry and linen services, administrative services and raw food.

Replacement "D" Beds - means long-term care beds that have been rebuilt to the new mandatory design standards as set out in the 1998 "Long-Term Care Home Design Manual" to replace a home's outdated long-term care beds that were identified by the Ministry as in need of replacement and classified as Category "D" beds.

Resident Co-payment Revenue – means the sum of basic accommodation fees a licensee may charge residents for a bed, subject to the maximum rates outlined in the *Long-Term Care Homes Act, 2007* for

the type of accommodation the resident occupies and subject to the following rules. Reductions in basic accommodation charges are only permitted for residents residing in basic accommodation for whom the Director has provided a reduced rate in accordance with Ontario Regulation 79/10 under the *Long-Term Care Homes Act, 2007.*[2] For residents in preferred accommodation, including Veterans' Priority Access Long-Term Care (VLTC) residents, Resident Co-payment Revenue is the amount calculated using the maximum rate outlined in the *Long-Term Care Homes Act, 2007* for basic accommodation. For residents in basic accommodation who have not applied for a rate reduction in accordance with O. Reg. 79/10 under the *Long-Term Care Homes Act, 2007*, including residents occupying Interim Short-Stay Basic beds, Resident Co-payment Revenue is the amount calculated using the maximum rate in the *Long-Term Care Homes Act, 2007* for basic accommodation. For residents in basic accommodation who have applied for a rate reduction in accordance with O. Reg. 79/10 under the *Long-Term Care Homes Act, 2007*, including residents occupying Interim Short-Stay Basic beds, Resident Co-payment Revenue is the amount calculated using the rate determined by the Director in accordance with Regulation 79/10 under the *Long-Term Care Homes Act, 2007,* pursuant to the rate reduction application process in accordance with the *Long-Term Care Homes Act, 2007* and the *Guide for Rate Reductions.* Where a rate reduction has been calculated using the rate determined by the Director in accordance with O. Reg. 79/10, a LHIN will provide the difference in funding to a licensee between the Level of Care Per Diem funding and the Resident Co-payment rate as determined by the Director. For Short-Stay Respite residents, Resident Co-payment Revenue is the amount calculated using the maximum rate for short-stay accommodation in the *Long-Term Care Homes Act, 2007.* For Long-stay residents who occupy designated Convalescent Care Beds during the Orientation Period only, the co-payment and preferred accommodation fees charged by licensees shall be considered as basic accommodation revenue during reconciliation.

Resident Co-payment Revenue Per Diem Rate Estimate – means an estimate of the average daily Resident Co-payment Revenue (basic portion only) based on the actual Resident Co-payment Revenue as reported on the licensee's most recent submission of the In-Year Revenue/Occupancy Report. Please refer to Sec. 2.2.4 (iv) and (v) of the *LTCH Reconciliation and Recovery Policy* document for further details.

Short-Stay Respite Care Beds – means a bed that is licensed or approved under the *Long-Term Care Homes Act, 2007,* and designated as a bed in the short-stay respite care program. The purpose of the short-stay respite care program in a long-term care home is to provide temporary care for individuals whose caregivers require temporary relief from their care-giving duties. Level of Care Per Diem Funding for Short-Stay Respite Care Beds is provided at Maximum Resident Days regardless of actual occupancy rates achieved. However, actual occupancy rates are monitored and continued participation in the Short-Stay Respite Program may depend on actual occupancy rates achieved for the period under consideration.[3] To determine the actual occupancy rate for Short-Stay Respite Care Beds, the day of admission may be included in the count of Actual Resident Days, but the day of discharge may not in accordance with O. Reg. 79/10 Sec. 256 (3) whereby a resident is required to pay a charge for accommodation on the day of admission and is not required to pay a charge for accommodation on the day of discharge.

Target Long-Stay Resident Days – means the minimum number of resident days a licensee must provide service for long stay residents to receive their Level of Care Per Diem funding based on Maximum Resident Days. Please refer to the *LTCH Occupancy Targets Policy* and the "Technical Instructions and Guidelines for the Long-Term Care Home Subsidy Calculation Worksheet" for further details on calculating Target Long-Stay Resident Days.

Unclassified Beds – are new licensed or approved long-term care beds under the *Long-Term Care Homes Act, 2007*, where, for the purposes of case mix adjustment, the care needs of the new residents have not been calculated. Unclassified beds are funded at the base Level of Care Per Diem in effect for that period as set in the *LTCH Level-of-Care Per Diem Funding Summary*. The Level of Care Per Diem funding is set at a CMI of 1.0.

Veterans' Priority Access Long-Term Care (VLTC) Bed – means a long-term care bed that is a) occupied by a Veteran[4]; b) now vacant and being held for a Veteran[5] who is eligible for a Veterans

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[2] For further information on reductions to basic accommodation charges, please refer to the *Guide for Rate Reductions.*

[3] Please refer to the *LTCH Occupancy Targets Policy* for further information on Short -Stay Respite Care Beds.

[4] Veteran has the same meaning as defined in Section 7 of O. Reg. 79/10 of the *Long-Term Care Homes Act, 2007.*

Priority Access Long-Term Care (VLTC) Bed, for a period of 5 days under subparagraph 185 (1) (f) (i) of O. Reg 79/10 of the *Long-Term Care Homes Act, 2007,* provided a Veteran is on the waiting list for a bed; or c) being held for a Veteran for allowable absences in accordance with O. Reg. 79/10 under the *Long-Term Care Homes Act, 2007.*

2.1 Annual Estimated Total Subsidy

The annual Estimated Total Subsidy for cash flow purposes is the sum of the Estimated Provincial Subsidy paid by a LHIN plus the Non-Level of Care Funding provided by the Ministry through direct funding agreements. The Estimated Total Subsidy is calculated by deducting the estimated Resident Co-payment Revenue from the Level of Care Per Diem funding, the result of which is added to the Non-Level of Care funding, as applicable to each licensee. For the purpose of determining this calculation, the following methodology will be applied:

(i) The estimated Resident Co-payment Revenue is determined by multiplying the licensee's Resident Co-payment Revenue Per Diem Rate Estimate by the Licensed Bed Capacity (excluding Convalescent Care Beds) multiplied by 365 days.[6] The Resident Co-payment Revenue Per Diem Rate Estimate for each licensee is based on their most recent In-Year Revenue/Occupancy Report submission and may be adjusted within the 12 month period. Please refer to the *LTCH Reconciliation and Recovery Policy* section 2.2.4 (iv) and (v) for further details on calculating Resident Revenue Per Diem Estimates.

Estimated Resident Co-payment Revenue Calculation:

Resident Revenue Per Diem Rate Estimate x (Licensed Classified + Unclassified Beds) x 365 Days

(ii) To determine the Level of Care Per Diem funding,

a. Licensed beds will be divided into the bed categories Classified, Unclassified or Convalescent Care.
   - For Classified beds, the Level of Care Per Diem is determined by multiplying the Base Level of Care Per Diem for the NPC envelope by the home's Case Mix Index (CMI). The product is added to the PSS per diem, the RF per diem and the OA per diem.
   - For Unclassified beds, the Level of Care Per Diem is equal to the Base Level of Care Per Diem.
   - For Convalescent Care beds, the Base Level of Care Per Diem is added to the Additional Subsidy.

b. the total Level of Care Per Diem by bed category calculated in accordance with Section 2.1 (ii) (a) is multiplied by the Licensed Bed Capacity for each bed category,

c. the Occupancy Factor, applicable only to Low Occupancy homes, is then applied to the funding formula. Low Occupancy homes will have their Level of Care Per Diem funding adjusted based on their most recent In-Year Revenue/Occupancy Report's actual occupancy plus 10% (Occupancy Factor).[7] See the *LTCH Occupancy Target*

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[5] Ibid.

[6] Revenue from residents for accommodation charges may not exceed the maximum monthly rates in accordance with the *Long-Term Care Homes Act, 2007* regardless of the number of days in a month. As such, the estimated Resident Co-payment Revenue is calculated by multiplying the maximum daily rate times 365 days, regardless of the number of days in a year, which is the same as multiplying the maximum monthly rate times 12 months.

[7] Although licensees may receive their Level of Care Per Diem funding at estimated occupancy rates that are greater than the actual occupancy rate achieved by the home, licensees that fail to achieve their Occupancy Target may be subject to adjustments to their Level of Care Per Diem funding through the In-Year Revenue/Occupancy Report and

Policy for further details on calculating Target Long-Stay Resident Days and Occupancy Targets.

d. the result of the calculations in accordance with Section 2.1 (ii) (a) through (c) is multiplied by 365 days, or 366 days in the case of a leap year. Where the Level of Care Per Diem rates change within the calendar year, the year may be divided into periods that represent the interval of time for which the Level of Care Per Diem rate remains the same. Steps (a) through (c) of Section 2.1 (ii) are calculated for each period for which the Level of Care Per Diem rates change. The sum of the periods will equal 365 days, or in the case of a leap year, 366 days.

e. the sum of the Level of Care Per Diem funding for each bed category is used to determine the licensee's Total Estimated Level of Care Per Diem Funding.

Classified Beds Level of Care Funding Subtotal Calculation:

(NPC Per Diem x Home's CMI) + PSS Per Diem + RF Per Diem + OA Per Diem = Total LOC Per Diem for Classified Beds Total LOC Per Diem for Classified Beds x # Licensed Classified Beds x Occupancy Factor * x # Days = Classified Beds Level of Care Subtotal

Unclassified Beds Level of Care Funding Subtotal Calculation:

NPC Per Diem + PSS Per Diem + RF Per Diem + OA Per Diem = Total LOC Per Diem for Unclassified Beds Total LOC Per Diem for Unclassified Beds x # Licensed Unclassified Beds x Occupancy Factor * x # Days = Unclassified Beds Level of Care Subtotal

* applicable only on Low Occupancy Homes

Convalescent Care Beds Level of Care Funding Subtotal Calculation:

NPC Per Diem + PSS Per Diem + RF Per Diem + OA Per Diem + Additional Subsidy = Total LOC Per Diem for Convalescent Care Beds Total LOC Per Diem for Convalescent Care Beds x # of Licensed Convalescent Care Beds x # Days = Convalescent Care Beds Level of Care Subtotal

Total Estimated Level of Care Per Diem Funding:

Classified Beds Level of Care Subtotal + Unclassified Beds Level of Care Subtotal + Convalescent Care Beds Level of Care Subtotal = Total Estimated Level of Care Funding

(iii) The Registered Practical Nurse and/or, as applicable, Construction Funding Subsidy, will be based on the applicable funding formula as outlined in the L-SAA and/or applicable Policy. Each applicable component of the Registered Practical Nurse funding and/or Construction Funding Subsidy received by a qualifying licensee from a LHIN will be specified on the licensee's Monthly Payment Calculation Notice. Registered Practical Nurse funding and/or Construction Funding Subsidy is not considered to form part of the

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Long-Term Care Home Annual Report reconciliation process. See the *LTCH Reconciliation and Recovery Policy* for further details.

Level of Care Per Diem. It may, however, be allocated among the envelopes as outlined in the terms and conditions of funding.

(iv) Where agreed to by a LHIN, Non-Level of Care Funding, other than the funding referred to in (iii) above, may be paid by a LHIN in accordance with applicable Ministry policy specific to that type of Non-Level of Care Funding The calculation of Section 2.1 (i) through (iv) of this policy document equals the Estimated Provincial Subsidy.

Estimated Provincial Subsidy:

Total Estimated Level of Care Per Diem Funding – Resident Co-Payment Revenue Estimate + Registered Practical Nurse Funding + Construction Funding Subsidy + Other Non-Level of Care Funding paid by a LHIN = Total Estimated Provincial Subsidy

(v) Other Non-Level of Care funding provided by the Ministry through a direct funding agreement will be calculated in accordance with the applicable funding formula as outlined in the direct funding agreement and/or applicable Policy. Each applicable component of the Non-Level of Care funding received by a qualifying licensee will be specified on the licensee's Monthly Payment Calculation Notice. Non-Level of Care Funding is not considered to form part of the Level of Care Per Diem. It may, however, be allocated among the envelopes as outlined in the terms and conditions of funding.

Estimated Total Subsidy:

Estimated Provincial Subsidy + Non-Level of Care Funding = Estimated Total Subsidy

2.2 Monthly Cash Flow Calculation

For the purpose of continuity, each monthly operating cash flow is based on approximately one-twelfth of the Estimated Total Subsidy, unless otherwise stipulated. The monthly payment may be subject to adjustments in accordance with Section 2.4.

Each month, the Monthly Payment Calculation Notice will be made available on or about the 15th of the month and posted at www.fimdata.com/LTCHome. Licensees may access their Monthly Payment Calculation Notice using their user name and pass code.

2.3 Estimated Total Subsidy and Cash Flow Calculation for Beds Opened During the Calendar Year

For each bed that is opened during the calendar year, the Estimated Provincial Subsidy paid by a LHIN to a licensee is determined to be equal to the difference between the estimated Resident Co-payment Revenue and the Level of Care Per Diem funding in effect for the period as applicable to each bed category, multiplied by the applicable Maximum Resident Days as determined by the start date of the funding. The result is added to the Registered Practical Nursing funding and, if applicable, Construction Funding Subsidy. In addition, where agreed to by a LHIN, other Non-Level of Care Funding may be paid by a LHIN in accordance with Ministry's policy applicable to that type of Non-Level of Care Funding

To determine the Estimated Total Subsidy, the Estimated Provincial Subsidy is added to the Non-Level of Care funding paid by the Ministry through a direct funding agreement, as applicable, subject to the terms

and conditions of funding and/or direct funding agreements between the Minister and a licensee and/or applicable policy.

The start date of the funding will be the day following the successful pre-occupancy review and occupancy approval by the Ministry, together with a confirmation of the admission date of the first resident.[8] Commencing the admission date of the first resident,[9] licensees will be funded their Estimated Provincial Subsidy plus the applicable number of approved orientation days[10]. In the case of category "D" facility beds that have been redeveloped/retrofitted, the start date of funding will commence 14 days prior to the successful pre-occupancy review and occupancy approval by the Ministry.[11]

To calculate the first monthly payment, the funding for the first month will be prorated based on the number of days between the start date of funding and the last day of the month, as follows:

(i) The Resident Co-payment Revenue Per Diem Rate Estimate[12] multiplied by the number of days between the start date of the funding and the last day of the month.

(ii) To determine the Level of Care funding,

a. Licensed beds will be divided into the bed categories Classified, Unclassified or Convalescent Care.
   - For Classified beds, the Level of Care Per Diem is determined by multiplying the Base Level of Care Per Diem for the NPC envelope by the home's Case Mix Index (CMI). The product is added to the PSS per diem, the RF per diem and the OA per diem.
   - For Unclassified beds, the Level of Care Per Diem is equal to the Base Level of Care Per Diem.
   - For Convalescent Care beds, the Base Level of Care Per Diem is added to the Additional Subsidy.

b. the total Level of Care Per Diem calculated in accordance with Section 2.3 (ii) (a) is multiplied by the Licensed Bed Capacity for each bed category,

c. the result of the calculations in accordance with Section 2.3 (ii) (a) and (b) are multiplied by the number of days between the start date of funding and the last day of the month,

d. the sum of the Level of Care Per Diem funding for each bed category is used to determine the licensee's Total Estimated Level of Care Per Diem Funding.

(iii) The Registered Practical Nurse and/or, as applicable, Construction Funding Subsidy, will be based on the applicable funding formula as outlined in the L-SAA and/or applicable Policy. Each applicable component of the Registered Practical Nurse funding or Construction Funding Subsidy received by a qualifying licensee from a LHIN will be calculated based on the number of days between the start date of the funding and the last day of the month.

(iv) Where agreed to by a LHIN, any other Non-Level of Care Funding may be paid by the LHIN in accordance with the Ministry's policy applicable to that type of Non-Level of Care

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[8] Please refer to the "Manual for Awardees/Operators in the Preparation for Occupancy" for further information on the pre-occupancy review and occupancy approval process. The Manual also provides the required template for 'Confirmation of Admission of First Resident'.

[9] If the admission date of the first resident is not the day immediately following the Pre Occupancy Review and occupancy approval by the Ministry, the confirmation date of the admission of the first resident shall be the start date of the funding.

[10] Please refer to the "Fill Rate Guidelines for New and Redeveloped/Retrofitted "D" Long-Term Care Facilities", the *LTCH Occupancy Targets Policy* and the *LTCH Fill Rate Guidelines for New Interim LTC Beds* for further information on orientation days and fill rate periods.

[11] Please refer to the "Fill Rate Guidelines for New and Redeveloped/Retrofitted "D" Long-Term Care Facilities" document for further details.

[12] For new homes, the Ministry, on behalf of the LHINs, will determine the applicable Resident Co-payment Revenue Per Diem Rate Estimate.

Funding. Each applicable component of any other Non-Level of Care Funding received by a qualifying licensee from a LHIN will be calculated based on the number of days between the start date of the funding and the last day of the month.

(v) Other Non-Level of Care funding provided by the Ministry through a direct funding agreement will be calculated in accordance with the applicable funding formula as outlined in the direct funding agreement and/or applicable Policy and will be calculated based on the number of days between the start date of funding and the last day of the month.

Following the first month, the Estimated Total Subsidy will be paid using the formula in accordance with Section 2.3 above. However, each monthly instalment will represent the full month's subsidy for each of the months remaining between the first day of the month following the start date of funding and December 31 of that year, subject to adjustments in accordance with section 2.4 as they may apply.

2.4 In-Year Adjustments to Monthly Cash Flow

Periodically, adjustments may be made to the monthly cash flow during a year in accordance with the L-SAA and/or any other direct funding agreement between the Minister and a licensee and/or as a result of terms and conditions stipulated by the Minister on payment of funding.

Licensees will be advised of adjustments to their cash flow on their Monthly Payment Calculation Notice or by other means as specified in the applicable Policy and/or report submission instructions.

3.1 Direct Deposit of Monthly Payments

All licensees will receive their monthly cash payment in Canadian funds by direct deposit to an account in the name of the licensee at a Canadian Financial Institution in accordance with the L-SAA.

4.1 References to Other Policy Documents and Technical Instructions and Guidelines

For further information, please refer to:

Policy –
Beds in Abeyance Policy
Convalescent Care Program
Eligible Expenditures for LTC Homes Policy
Fill Rate Guidelines for New and Redeveloped/Retrofitted "D" Long-Term Care Facilities
Guide for Rate Reductions
LTCH Bad Debt Reimbursement Policy
LTCH Fill Rate Guidelines for New Interim LTC Beds
LTCH Funding Policy for Suspension of Admissions due to Outbreaks
LTCH Furnishings and Equipment Management Policy
LTCH Level of Care Per Diem Funding Policy
LTCH Level of Care Per Diem Funding Summary
LTCH Municipal Tax Allowance Policy
LTCH Non-Capital Occupancy Reduction Protection Guidelines
LTCH Occupancy Targets Policy
LTCH Reconciliation and Recovery Policy
Policy for Funding Construction Costs of Long-Term Care Homes
Registered Practical Nurses in Long-Term Care Homes Initiative Funding Policy

Technical Instructions and Guidelines[13] -
Manual for Awardees/Operators in the Preparation for Occupancy
Municipal Tax Allowance Application Instructions

[13] Report submission instructions and technical instructions and guidelines are issued annually. Consult the applicable document in effect for the period for which the report data is being submitted and reconciled.

In-Year Revenue/Occupancy Report Submission Instructions
Long-Term Care Home Annual Report Technical Instructions and Guidelines
Long-Term Care Home Subsidy Calculation Worksheet Technical Instructions and Guidelines

Ontario

Ministry of Health and Long-Term Care

Long-Term Care Home Financial Policy

Policy:	**Registered Practical Nurses in Long-Term Care Homes Initiative Funding Policy**	As Amended and Effective	**April 1, 2011**	Released March 2012
		Original Publish Date	**July 1, 2010**	Released July 2010

1.1 Introduction

The purpose of this policy is to provide the rules and processes by which Local Health Integration Networks (LHINs) will provide funding to licensees of Long-Term Care (LTC) homes related to the Registered Practical Nurses (RPN) in LTC Homes Initiative.

2.1 Overview

The LHIN will provide funding to licensees in support of RPN positions. Funding is calculated using a formula that includes the number of eligible bed days for a home and the home's case mix index (CMI). All licensees receive at least a minimum amount of funding for each LTC home, based on average RPN salary that ensures each home has enough funding to create and sustain at least one new RPN full-time equivalent (FTE) position.

3.1 Definitions

Classified Beds – refers to long-stay beds that are licensed or approved under the *Long-Term Care Homes Act*, 2007 where the care needs of the residents occupying those beds have been assessed and a CMI has been assigned for the bed.

Convalescent Care Beds – refers to the beds that are licensed or approved under the *Long-Term Care Homes Act, 2007* and are designated for the Convalescent Care Program as short-stay supportive care beds and identified as Convalescent Care Beds in Schedule B of a licensee's Long-Term Care Home Service Accountability Agreement (L-SAA). Convalescent care beds receive the base LTC level-of-care (LOC) *per diem* funding, as set in the *Level-of-Care Per Diem Funding Summary* for the applicable period. Convalescent care beds also receive an additional subsidy. Please refer to the *LTCH Convalescent Care Additional Subsidy Funding Summary* for the specific amount of funding that constitutes the additional subsidy at a specific point in time and the allocation of the subsidy between NPC, PSS and OA envelopes. The Additional Subsidy amounts are set by the Ministry and are updated by the Ministry from time to time.

Licensee – has the same meaning as in section 2(1) of the *Long-Term Care Homes Act, 2007*.

Unclassified Beds – are new licensed or approved LTC beds under the *Long-Term Care Homes Act*, 2007, where, for the purposes of case mix adjustment, the care needs of the new residents have not been calculated. Unclassified beds are funded at the base LOC *per diem* in effect for that period as set in the *Level-of-Care Per Diem Funding Summary*. The base LOC *per diem* funding is set at a CMI of 1.0.

4.1 Scope

This policy is in relation to funding for 1,200 RPN positions in LTC homes announced on May 9th, 2007. $57.4M was provided to licensees for the initiative in 2008/09, the first full year of funding. This initiative is intended to establish new full-time RPN positions in LTC homes. Funding is expected to contribute to a net increase in full-time RPN positions, effective January 1, 2008.

5.1 Funding Approach

Minimum funding has been provided to ensure that the licensee for each home was, with the establishment of the funding initiative in 2008, able to add at least one new full-time RPN position in the home; this minimum amount is based on the average cost to a home of employing a full-time RPN. In 2009/10, minimum funding per home was $48,790 annually. The funding amount will be adjusted annually, subject to additional funding availability. Minimum funding is provided to homes with capacity of 66 beds or less (including unclassified and convalescent care beds); however, if the home's CMI is such that the home would be eligible to receive an amount greater than the minimum, the licensee for the LTC home will receive the greater amount. Each licensee's funding for the LTC home will be calculated and compared accordingly, to determine the greater amount.

Funding will be based on a set *per diem* rate (in 2009/10, the rate was $2.03 per resident per day); in the case of classified beds, the per diem will be adjusted according to the home's CMI. Unclassified and convalescent care beds will not be adjusted for CMI. Funding under this policy does not apply to Beds in Abeyance.

For 2009/10, each LTC home licensee's funding has been calculated as follows:
($2.03 x CMI x maximum eligible classified bed days) + ($2.03 x maximum eligible convalescent care days) + ($2.03 x maximum eligible unclassified bed days).

This funding methodology will continue until further notice, with adjustments made to the *per diem* rate, bed days and CMI, as appropriate.

RPN Funding is defined as non-Levels of Care funding and is subject to adjustment, as per the *LTCH Reconciliation and Recovery Policy*, based on changes to CMI and bed count.

6.1 Accountability

Funding provided under this policy is part of non-levels of care funding provided in the Nursing and Personal Care envelope and is subject to the conditions and definitions of that envelope (as per *Guidelines for Eligible Expenditures for LTCH*). A licensee must use the funding to create and maintain RPN FTE positions for the home, including the creation of at least one full-time equivalent RPN position This funding may be used only as intended; such use may also include top-up of existing part-time RPN positions to full-time status. With this funding, licensees are expected to increase direct care to residents in every home.

For any new funding provided during the term of the L-SAA, a licensee may be required to provide sign-back indicating acceptance of the terms and conditions of funding and amending its existing service accountability agreement and/or Schedules with the LHIN to reflect the new funding.

Use of funds must be reported in the Long-Term Care Home Annual Report. In the event that funding is not applied as required, the licensee shall return to the LHIN, upon request, any amounts not required or that such amounts may be set off against amounts payable by the LHIN to the licensee, as per the *LTCH Reconciliation and Recovery Policy.*

Ontario

Ministry of Health and Long-Term Care

Long-Term Care Home Financial Policy

Policy:	LTCH Reconciliation and Recovery Policy	As Amended and Effective	**April 1, 2011**	Released March 2012
		Original Published Date	**July 1, 2010**	Released July 2010

1.1 Purpose

This policy will outline the process by which the Local Health Integration Network (LHIN) and Ministry of Health and Long-Term Care (Ministry) will adjust funding estimates and cash flow to licensees on an in-year basis, and reconcile and recover funding on a year-end basis.

While a LHIN is required to reconcile funding they have paid to a licensee, and where applicable, provide additional funding to a licensee or recover over-funding from a licensee as a result of that reconciliation, and the Ministry is required to reconcile funding they have paid to a licensee, and where applicable, provide additional funding to a licensee or recover over-funding from a licensee as a result of that reconciliation, the reconciliation and recovery of funding provided to licensees, as outlined in this policy document, continues to follow established processes utilizing the same reports and notifications as in prior years, and, further, in order to avoid duplicative reporting, the Ministry, on behalf of a LHIN, may reconcile and recover LHIN and Ministry funding together where stated.

1.2 Background

For the purpose of providing cash flow, funding is advanced to licensees in monthly payments based on estimates of funding.[1] At the beginning of each year, the LHIN and the Ministry estimate the funding for the licensee and determine the cash flow based on this estimate.

The funding advanced to licensees in monthly installments is approximately one-twelfth of the estimated annual funding. The LHINs and Ministry must reconcile the estimated funding they pay on an in-year and year-end basis, subject to the terms and conditions of funding. Overpayments of funding are recovered and, in the case of underpayment, additional funding is provided.

As such, the in-year and year-end reconciliation and recovery process allows the LHIN and Ministry to determine the adjustments to funding estimates and identify payments to or recoveries from a licensee where applicable.

1.3 Definitions

Accommodation Type – means the type of accommodation occupied by a resident in a long-term care home. Currently, the Accommodation Types are Long-Stay Private, Long-Stay Semi Private, Long-Stay Basic, Homes for Special Care, Status Indian, Short-Stay Respite, Convalescent Care, Veterans' Priority Access, Veterans' Priority Access – Private Pay Preferred, Interim Short-Stay Private, Interim Short-Stay Semi Private and Interim Short-Stay Basic.

Actual Resident Days – resident days are defined as a unit of service that represents one resident in the home for a period of one day. For the purposes of determining resident days, a day is a 24-hour period starting at 12 midnight for long-stay residents and interim short-stay residents, and a 24-hour period starting at the time of admission for short-stay respite and convalescent care residents. Both the day of

[1] Please refer to the *LTCH Cash Flow Policy* for further details.

admission and the day of discharge are included in the count of resident days.[2] If a bed is occupied, only one resident day may be counted per bed in a 24-hour period. Where the placement co-ordinator has authorized the resident's admission to the home as a long-stay resident or an interim bed short-stay resident, but the resident has not yet moved into the home, the 5 days contemplated by subparagraph 185 (1) (f) (ii) of O.Reg 79/10 under the *Long-Term Care Homes Act 2007,* are included in the count of Actual Resident Days. Further, where applicable, bed retention days are included in the count of Actual Resident Days where a resident is absent from the home only as permitted for absences as defined in section 138 of O. Reg 79/10. Total Actual Resident Days are calculated by taking the sum of the resident days as defined above, in the period under consideration.

Allowable Expenditures – means the sum of admissible expenditures for each of the four funding envelopes (Nursing and Personal Care (NPC), Program and Support Services (PSS), Raw Food (RF) and Other Accommodation (OA)), as submitted on the audited Long-Term Care Home Annual Report and as determined in the Overall Reconciliation Report, for a specified twelve-month period. The expenditures submitted on the Long-Term Care Home Annual Report are subject to adjustment for reasonability, eligibility or admissibility by the LHINs and/or Ministry in accordance with the Eligible Expenditures Guidelines and the Envelope Definitions of the *Eligible Expenditures for LTC Homes Policy,* the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" in effect for the period under consideration, and the *LTCH Level of Care Per Diem Funding Policy*. The sum of the Allowable Expenditures of the four funding envelopes represents the Total Allowable Expenditures.

Approved Expenditures – means the sum of funding for each of the four funding envelopes (Nursing and Personal Care (NPC), Program and Support Services (PSS), Raw Food (RF) and Other Accommodation (OA)), as determined in the Overall Reconciliation Report, for a specified twelve-month period. The sum of funding includes the Level of Care Per Diem funding plus all other applicable Non-Level of Care Funding allocated by envelope, subject to the terms and conditions of funding as outlined in the Long-Term Care Homes Service Accountability Agreement (L-SAA) and/or direct funding agreement between the Minister and a licensee and/or applicable Policy. The sum of the Approved Expenditures of the four funding envelopes represents the Total Approved Expenditures.

Allowable Subsidy – means the funding for which a licensee is eligible to receive for the twelve-month period specified in the "Long-Term Care Home Annual Report Technical Instructions and Guidelines", taking into consideration the actual occupancy, actual resident co-payment revenue and allowable expenditures, as determined by the year-end reconciliation process and as stated in the Overall Reconciliation Report. Also referred to as 'Approved Funding'.

Base Level of Care Per Diem – means the total per diem subsidy as determined by the Ministry in effect for the period under consideration, and is comprised of the four funding components of the current funding model (Nursing and Personal Care (NPC) envelope, Program and Support Services (PSS) envelope, Raw Food (RF) envelope and Other Accommodation (OA) envelope). The Base Level of Care Per Diem represents the per diem amount that has not been modified by a Case Mix Index (CMI) adjustment.

Basic Accommodation – in relation to a long-term care home, means lodging in a standard room in the home, housekeeping services, maintenance and use of the home, dietary services, laundry and linen services, administrative services and raw food.

Bed Class – means one of the bed categories Classified, Unclassified or Convalescent Care as identified on the licensee's Monthly Payment Calculation Notice.

Cash Flow – means the Estimated Total Funding advanced each month by the LHIN and/or Ministry to a licensee pursuant to the *LTCH Cash Flow Policy*. Monthly cash flow is determined by taking the estimated funding for a year and dividing by twelve. Monthly cash flows may be subject to revised funding adjustments that apply to that same twelve-month period but which may have occurred before or after the same twelve-month period as warranted.

Eligible Expenditures – means the lesser of the Approved Expenditures or the Allowable Expenditures for each of the three recoverable envelopes, which are Nursing and Personal Care, Program and Support

[2] The following exceptions apply in accordance with O.Reg. 79/10 Sec. 256 (2) and (3): in the case of a long-stay resident , the day of discharge is not counted as a resident if the resident is transferred to another long-term care home, and in the case of a short-stay resident, the day of discharge is not counted as a resident day.

Services and Raw Food. The Eligible Expenditures for the Other Accommodation envelope will equal the Approved Expenditures[3]. The sum of the Eligible Expenditures of the four funding envelopes represents the Total Eligible Expenditures.

Estimated Provincial Subsidy – means an estimate of the monies payable to a licensee based on their Licensed Bed Capacity subject to the terms and conditions of funding and funding methodologies as outlined in the Long-Term Care Home/LHIN Service Accountability Agreement (L-SAA) and/or applicable Policy and calculated in accordance with Section 2.1 (i) through (iv) of the *LTCH Cash Flow Policy*. The Estimated Provincial Subsidy includes Level of Care Per Diem Funding net of the sum of estimated Resident Co-payment Revenue, Registered Practical Nurse Funding, Construction Funding Subsidy and, where applicable, any other Non-Level of Care Funding paid by a LHIN[4]. In addition, beds that are not available for occupancy under a written permission of the Director under subsection 104 (3) of the *Long-Term Care Homes Act, 2007* will continue to receive Construction Funding Subsidy in accordance with the *Beds in Abeyance Policy*. The Estimated Provincial Subsidy for a licensee is stated on the Monthly Payment Calculation Notice and annual Fac05C Report available at www.fimdata.com/LTCHome.

Estimated Total Subsidy – means the Estimated Provincial Subsidy plus an estimate of the monies payable by the Ministry to a qualifying licensee under a direct funding agreement for Non-Level of Care Funding, subject to the terms and conditions of funding and/or funding methodologies as outlined in the direct funding agreement and/or applicable Policy, and calculated in accordance with Section 2.1 of the *LTCH Cash Flow Policy*. The Estimated Total Subsidy for a licensee is stated on the Monthly Payment Calculation Notice and annual Fac05C Report available at www.fimdata.com/LTCHome.

Final Settlement Amount – means the amount of monies either recoverable from or payable to a licensee by the LHINs and/or Ministry at the end of a calendar year. The Final Settlement Amount is equal to the difference between the Allowable Subsidy and the sum of the Estimated Total Subsidy advanced as monthly cash flows for the same twelve-month period, plus or minus any adjustments that apply to that same twelve-month period, but which may have occurred before or after the same twelve-month period. The Final Settlement Amount is the amount calculated in the Overall Reconciliation Report as "Recovery / (Owing)".

Interim Short-Stay Beds – means a bed in a long-term care home under the interim bed short-stay program.

Level of Care (LOC) Per Diem – means the total per diem subsidy as determined by the Ministry in effect for the period under consideration and is comprised of the four funding envelope components (Nursing and Personal Care (NPC), Program and Support Services (PSS), Raw Food (RF) and Other Accommodation (OA)) of the current funding model. Of the four envelopes, only the Base Level of Care Per Diem in the Nursing and Personal Care envelope is subject to adjustment by the CMI. Please refer to the *LTCH Level of Care Per Diem Funding Policy* for further information.

Licensed Bed Capacity – means the total licensed or approved beds under the *Long-Term Care Homes Act, 2007* excluding beds that are not available for occupancy under a written permission of the Director under subsection 104 (3) of the *Long-Term Care Homes Act, 2007*.

Licensee - means the holder of a licence issued under the *Long-Term Care Homes Act, 2007*, and includes the municipality or municipalities or board of management that maintains a municipal home, joint home or First Nations home.

L-SAA (Long-Term Care Home/LHIN Service Accountability Agreement) – means the service accountability agreement between a licensee of a long-term care home and a LHIN required by section 20 of the *Local Health System Integration Act, 2006*.

Low Occupancy Homes – means long-term care homes where the actual occupancy, excluding Convalescent Care Beds and Interim Short Stay Beds, for the period January 1 to September 30, as reported on the home's most recent submission of the In-Year Revenue/Occupancy Report, is 80% or less. Low Occupancy Homes are subject to an Occupancy Factor adjustment to their Level of Care Per

[3] Special conditions apply to licensees in receipt of Red Circle funding. Please refer to the *Appendix to the Recovery and Reconciliation Policy* for further information.
[4] Please refer to Section 2.1 (i) though (iv) of the *LTCH Cash Flow Policy* for the calculation of Estimated Provincial Subsidy.

Diem funding. Please refer to the *LTCH Occupancy Targets Policy* and Section 2.2.4 of this policy for further information.

Maximum Resident Days – means the sum of the Licensed Bed Capacity (operating capacity) multiplied by the number of days in operation for each funding period. The operating capacity is based on the number of beds in operation for each period, as agreed to by the licensee and the LHIN and/or Ministry. See the *LTCH Occupancy Targets Policy* and the "Technical Instructions and Guidelines for the Long-Term Care Home Subsidy Calculation Worksheet" for further details on calculating Maximum Resident Days for Long-Stay, Short-Say Respite, Convalescent Care and Interim Short-Stay beds.

Non-Level of Care Funding - means supplementary funding streams, each with distinct terms and conditions provided to qualifying licensees, and excludes the Level of Care Per Diems. Although some supplementary funding may be distributed among the envelopes as set out in the terms and conditions of funding, it does not form part of the Level of Care Per Diems. Non-Level of Care funding may be paid to a licensee by a LHIN through the L-SAA or by the Ministry through a direct funding agreement. Non-Level of Care Funding includes, but is not limited to, Construction Funding Subsidy and Registered Practical Nurse Initiative, which are paid by a LHIN, and High Wage Transition Funding, Pay Equity Funding and/or Equalization Adjustment, Municipal Tax Allowance Funding, Accreditation Funding, Physician On-Call Funding, Structural Compliance Premium, MDS Early Adopter Funding, High Intensity Needs Funding, and Laboratory Services Funding, which are paid by the Ministry, except where paid by a LHIN and calculated as part of the Estimated Provincial Subsidy in accordance with the L-SAA. Non-Level of Care Funding initiatives may be amended, terminated and/or initiated from time to time as the result of changes to policy that provides the specific rules in respect of each form of funding.

Occupancy Targets – means the minimum number of resident days a licensee must provide service for residents based on the bed type identified in Schedule B of the licensee's L-SAA as either Long-Stay, Short-Stay Respite, Interim Short-Stay or Convalescent Care to receive their Level of Care Per Diem funding, and Additional Subsidy as applicable, based on Maximum Resident Days. Please refer to the *LTCH Occupancy Targets Policy* and the "Technical Instructions and Guidelines for the Long-Term Care Home Subsidy Calculation Worksheet" for further details on calculating Occupancy Targets.

Other Recoverable Revenue – means revenues generated using Ministry-funded and/or LHIN-funded resources that are non-retainable by the licensee. Ministry-funded and/or LHIN-funded resources include any real or personal, tangible or intangible asset or human resource to which a LHIN or the Ministry, either directly or indirectly, has provided financial assistance through either capital investment, project funding or operating subsidy. Examples of Other Recoverable Revenues include interest earned on advance payments of LHIN and/or Ministry operating subsidies and/or project funding, recoveries of previously written-off bad debts[5] and disposal of LHIN and/or Ministry funded assets[6]. The licensee's share of preferred accommodation revenue, resident charges for optional services, and revenues related to operations that are not part of the funded home are examples of items not to be included as Other Recoverable Revenue.[7]

Preferred Accommodation – in relation to a long-term care home, means lodging in private accommodation in the home, or semi-private accommodation in the home, housekeeping services, maintenance and use of the home, dietary services, laundry and linen services, administrative services and raw food.

Prior Period Revenue – means Resident Co-payment Revenues collected during the current reporting period that were reported as not collected in previous audited Long-Term Care Home Annual Report submissions.[8]

Reconciliation – for the purpose of identifying variances and adjusting cash flow to licensees where appropriate, Reconciliation means a process by which the Estimated Total Subsidy is compared to actual

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[5] For further information, please refer to the *LTCH Bad Debt Reimbursement Policy*.
[6] Please refer to the *LTCH Furnishings and Equipment Management Policy* for further information.
[7] For further information on the types of revenues to be reported as and/or excluded from Other Recoverable Revenue, please refer to the *LTCH Furnishings and Equipment Management Policy*, the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" in effect for the period under review, the L-SAA and the direct funding agreements between the Minister and a licensee.
[8] Please refer to the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" for further information on reporting Prior Period Revenues.

admission and the day of discharge are included in the count of resident days.[2] If a bed is occupied, only one resident day may be counted per bed in a 24-hour period. Where the placement co-ordinator has authorized the resident's admission to the home as a long-stay resident or an interim bed short-stay resident, but the resident has not yet moved into the home, the 5 days contemplated by subparagraph 185 (1) (f) (ii) of O.Reg 79/10 under the *Long-Term Care Homes Act 2007,* are included in the count of Actual Resident Days. Further, where applicable, bed retention days are included in the count of Actual Resident Days where a resident is absent from the home only as permitted for absences as defined in section 138 of O. Reg 79/10. Total Actual Resident Days are calculated by taking the sum of the resident days as defined above, in the period under consideration.

Allowable Expenditures – means the sum of admissible expenditures for each of the four funding envelopes (Nursing and Personal Care (NPC), Program and Support Services (PSS), Raw Food (RF) and Other Accommodation (OA)), as submitted on the audited Long-Term Care Home Annual Report and as determined in the Overall Reconciliation Report, for a specified twelve-month period. The expenditures submitted on the Long-Term Care Home Annual Report are subject to adjustment for reasonability, eligibility or admissibility by the LHINs and/or Ministry in accordance with the Eligible Expenditures Guidelines and the Envelope Definitions of the *Eligible Expenditures for LTC Homes Policy,* the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" in effect for the period under consideration, and the *LTCH Level of Care Per Diem Funding Policy*. The sum of the Allowable Expenditures of the four funding envelopes represents the Total Allowable Expenditures.

Approved Expenditures – means the sum of funding for each of the four funding envelopes (Nursing and Personal Care (NPC), Program and Support Services (PSS), Raw Food (RF) and Other Accommodation (OA)), as determined in the Overall Reconciliation Report, for a specified twelve-month period. The sum of funding includes the Level of Care Per Diem funding plus all other applicable Non-Level of Care Funding allocated by envelope, subject to the terms and conditions of funding as outlined in the Long-Term Care Homes Service Accountability Agreement (L-SAA) and/or direct funding agreement between the Minister and a licensee and/or applicable Policy. The sum of the Approved Expenditures of the four funding envelopes represents the Total Approved Expenditures.

Allowable Subsidy – means the funding for which a licensee is eligible to receive for the twelve-month period specified in the "Long-Term Care Home Annual Report Technical Instructions and Guidelines", taking into consideration the actual occupancy, actual resident co-payment revenue and allowable expenditures, as determined by the year-end reconciliation process and as stated in the Overall Reconciliation Report. Also referred to as 'Approved Funding'.

Base Level of Care Per Diem – means the total per diem subsidy as determined by the Ministry in effect for the period under consideration, and is comprised of the four funding components of the current funding model (Nursing and Personal Care (NPC) envelope, Program and Support Services (PSS) envelope, Raw Food (RF) envelope and Other Accommodation (OA) envelope). The Base Level of Care Per Diem represents the per diem amount that has not been modified by a Case Mix Index (CMI) adjustment.

Basic Accommodation – in relation to a long-term care home, means lodging in a standard room in the home, housekeeping services, maintenance and use of the home, dietary services, laundry and linen services, administrative services and raw food.

Bed Class – means one of the bed categories Classified, Unclassified or Convalescent Care as identified on the licensee's Monthly Payment Calculation Notice.

Cash Flow – means the Estimated Total Funding advanced each month by the LHIN and/or Ministry to a licensee pursuant to the *LTCH Cash Flow Policy*. Monthly cash flow is determined by taking the estimated funding for a year and dividing by twelve. Monthly cash flows may be subject to revised funding adjustments that apply to that same twelve-month period but which may have occurred before or after the same twelve-month period as warranted.

Eligible Expenditures – means the lesser of the Approved Expenditures or the Allowable Expenditures for each of the three recoverable envelopes, which are Nursing and Personal Care, Program and Support

[2] The following exceptions apply in accordance with O.Reg. 79/10 Sec. 256 (2) and (3): in the case of a long-stay resident , the day of discharge is not counted as a resident if the resident is transferred to another long-term care home, and in the case of a short-stay resident, the day of discharge is not counted as a resident day.

Diem funding. Please refer to the *LTCH Occupancy Targets Policy* and Section 2.2.4 of this policy for further information.

Maximum Resident Days – means the sum of the Licensed Bed Capacity (operating capacity) multiplied by the number of days in operation for each funding period. The operating capacity is based on the number of beds in operation for each period, as agreed to by the licensee and the LHIN and/or Ministry. See the *LTCH Occupancy Targets Policy* and the "Technical Instructions and Guidelines for the Long-Term Care Home Subsidy Calculation Worksheet" for further details on calculating Maximum Resident Days for Long-Stay, Short-Say Respite, Convalescent Care and Interim Short-Stay beds.

Non-Level of Care Funding - means supplementary funding streams, each with distinct terms and conditions provided to qualifying licensees, and excludes the Level of Care Per Diems. Although some supplementary funding may be distributed among the envelopes as set out in the terms and conditions of funding, it does not form part of the Level of Care Per Diems. Non-Level of Care funding may be paid to a licensee by a LHIN through the L-SAA or by the Ministry through a direct funding agreement. Non-Level of Care Funding includes, but is not limited to, Construction Funding Subsidy and Registered Practical Nurse Initiative, which are paid by a LHIN, and High Wage Transition Funding, Pay Equity Funding and/or Equalization Adjustment, Municipal Tax Allowance Funding, Accreditation Funding, Physician On-Call Funding, Structural Compliance Premium, MDS Early Adopter Funding, High Intensity Needs Funding, and Laboratory Services Funding, which are paid by the Ministry, except where paid by a LHIN and calculated as part of the Estimated Provincial Subsidy in accordance with the L-SAA. Non-Level of Care Funding initiatives may be amended, terminated and/or initiated from time to time as the result of changes to policy that provides the specific rules in respect of each form of funding.

Occupancy Targets – means the minimum number of resident days a licensee must provide service for residents based on the bed type identified in Schedule B of the licensee's L-SAA as either Long-Stay, Short-Stay Respite, Interim Short-Stay or Convalescent Care to receive their Level of Care Per Diem funding, and Additional Subsidy as applicable, based on Maximum Resident Days. Please refer to the *LTCH Occupancy Targets Policy* and the "Technical Instructions and Guidelines for the Long-Term Care Home Subsidy Calculation Worksheet" for further details on calculating Occupancy Targets.

Other Recoverable Revenue – means revenues generated using Ministry-funded and/or LHIN-funded resources that are non-retainable by the licensee. Ministry-funded and/or LHIN-funded resources include any real or personal, tangible or intangible asset or human resource to which a LHIN or the Ministry, either directly or indirectly, has provided financial assistance through either capital investment, project funding or operating subsidy. Examples of Other Recoverable Revenues include interest earned on advance payments of LHIN and/or Ministry operating subsidies and/or project funding, recoveries of previously written-off bad debts[5] and disposal of LHIN and/or Ministry funded assets[6]. The licensee's share of preferred accommodation revenue, resident charges for optional services, and revenues related to operations that are not part of the funded home are examples of items not to be included as Other Recoverable Revenue.[7]

Preferred Accommodation – in relation to a long-term care home, means lodging in private accommodation in the home, or semi-private accommodation in the home, housekeeping services, maintenance and use of the home, dietary services, laundry and linen services, administrative services and raw food.

Prior Period Revenue – means Resident Co-payment Revenues collected during the current reporting period that were reported as not collected in previous audited Long-Term Care Home Annual Report submissions.[8]

Reconciliation – for the purpose of identifying variances and adjusting cash flow to licensees where appropriate, Reconciliation means a process by which the Estimated Total Subsidy is compared to actual

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[5] For further information, please refer to the *LTCH Bad Debt Reimbursement Policy*.
[6] Please refer to the *LTCH Furnishings and Equipment Management Policy* for further information.
[7] For further information on the types of revenues to be reported as and/or excluded from Other Recoverable Revenue, please refer to the *LTCH Furnishings and Equipment Management Policy*, the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" in effect for the period under review, the L-SAA and the direct funding agreements between the Minister and a licensee.
[8] Please refer to the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" for further information on reporting Prior Period Revenues.

results, which are subject to adjustment to comply with the terms and conditions of funding for the period under consideration. With respect to the Long-Term Care Home Annual Report reconciliation process, the Allowable Subsidy is determined based on the audited Long-Term Care Home Annual Report submission, subject to adjustments where appropriate to comply with the terms and conditions of funding as set out in the applicable policies and governing documents. The Allowable Subsidy is compared to actual cash flowed during the same period, plus or minus any adjustments as they apply to that same twelve-month period but which may have occurred before or after the same twelve-month period, to determine the Final Settlement Amount in the form of a recovery from or payment to a licensee.

Recovery – means the process by which the LHINs and Ministry recover monies from a licensee as a result of a variance between the Allowable Subsidy and the Estimated Total Subsidy whereby future funding payments to a licensee are reduced based on established recovery standards in accordance with Section 2.4, or by a lump-sum repayment by way of bank draft payable to the Minister of Finance, or by any other means necessary.

Resident Co-payment Revenue – means the sum of basic accommodation fees a licensee may charge residents for a bed, subject to the maximum rates outlined in the *Long-Term Care Homes Act, 2007* for the type of accommodation the resident occupies and subject to the following rules. Reductions in basic accommodation charges are only permitted for residents residing in basic accommodation for whom the Director has provided a reduced rate in accordance with Ontario Regulation 79/10 under the *Long-Term Care Homes Act, 2007.*[9] For residents in preferred accommodation, including Veterans' Priority Access Long-Term Care (VLTC) residents, Resident Co-payment Revenue is the amount calculated using the maximum rate outlined in the *Long-Term Care Homes Act, 2007* for basic accommodation. For residents in basic accommodation who have not applied for a rate reduction in accordance with O. Reg. 79/10 under the *Long-Term Care Homes Act, 2007*, including residents occupying Interim Short-Stay Basic beds, Resident Co-payment Revenue is the amount calculated using the maximum rate in the *Long-Term Care Homes Act, 2007* for basic accommodation. For residents in basic accommodation who have applied for a rate reduction in accordance with O. Reg. 79/10 under the *Long-Term Care Homes Act, 2007*, including residents occupying Interim Short-Stay Basic beds, Resident Co-payment Revenue is the amount calculated using the rate determined by the Director in accordance with Regulation 79/10 under the *Long-Term Care Homes Act, 2007,* pursuant to the rate reduction application process in accordance with the *Long-Term Care Homes Act, 2007* and the *Guide for Rate Reductions.* Where a rate reduction has been calculated using the rate determined by the Director in accordance with O. Reg. 79/10, a LHIN will provide the difference in funding to a licensee between the Level of Care Per Diem funding and the Resident Co-payment rate as determined by the Director. For Short-Stay Respite residents, Resident Co-payment Revenue is the amount calculated using the maximum rate for short-stay accommodation in the *Long-Term Care Homes Act, 2007.* For Long-stay residents who occupy designated Convalescent Care Beds during the Orientation Period only, the co-payment and preferred accommodation fees charged by licensees shall be considered as basic accommodation revenue during reconciliation.

Resident Co-payment Revenue Per Diem Rate Estimate – means an estimate of the average daily Resident Co-payment Revenue (basic portion only) based on the actual Resident Co-payment Revenue as reported on the licensee's most recent submission of the In-Year Revenue/Occupancy Report. Please refer to Sec. 2.2.4 (iv) and (v) of this Policy document for further information.

Short-Stay Respite Care Beds – means a bed that is licensed or approved under the *Long-Term Care Homes Act, 2007,* and designated as a bed in the short-stay respite care program. The purpose of the short-stay respite care program in a long-term care home is to provide temporary care for individuals whose caregivers require temporary relief from their care-giving duties. Level of Care Per Diem Funding for Short-Stay Respite Care Beds is provided at Maximum Resident Days regardless of actual occupancy rates achieved. However, actual occupancy rates are monitored and continued participation in the Short-Stay Respite Program may depend on actual occupancy rates achieved for the period under consideration.[10] To determine the actual occupancy rate for Short-Stay Respite Care Beds, the day of admission may be included in the count of Actual Resident Days, but the day of discharge may not in accordance with O. Reg. 79/10 Sec. 256 (3) whereby a resident is required to pay a charge for accommodation on the day of admission and is not required to pay a charge for accommodation on the day of discharge

[9] For further information on reductions to basic accommodation charges, please refer to the *Guide for Rate Reductions.*

[10] Please refer to the *LTCH Occupancy Targets Policy* for further information on Short -Stay Respite Care Beds.

Target Convalescent Care Resident Days – means the minimum number of resident days a licensee must provide service for convalescent care residents to receive their Additional Subsidy based on Maximum Convalescent Care Resident Days. Please refer to the *LTCH Occupancy Targets Policy* and the "Technical Instructions and Guidelines for the Long-Term Care Home Subsidy Calculation Worksheet" for further details on calculating Target Convalescent Care Resident Days.

Target Interim Short-Stay Resident Days – means the minimum number of resident days a licensee must provide service for interim short-stay residents to receive their Level of Care Per Diem funding based on Maximum Interim Short-Stay Resident Days. Please refer to the *LTCH Occupancy Targets Policy* and the "Technical Instructions and Guidelines for the Long-Term Care Home Subsidy Calculation Worksheet" for further details on calculating Target Interim Short-Stay Resident Days.

Target Long-Stay Resident Days – means the minimum number of resident days a licensee must provide service for long stay residents to receive their Level of Care Per Diem funding based on Maximum Long-Stay Resident Days. Please refer to the *LTCH Occupancy Targets Policy* and the "Technical Instructions and Guidelines for the Long-Term Care Home Subsidy Calculation Worksheet" for further details on calculating Target Long-Stay Resident Days.

Veterans' Priority Access Long-Term Care (VLTC) Bed – means a long-term care bed that is a) occupied by a Veteran[11]; b) now vacant and being held for a Veteran[12] who is eligible for a Veterans Priority Access Long-Term Care (VLTC) Bed, for a period of 5 days under subparagraph 185 (1) (f) (i) of O. Reg 79/10 of the *Long-Term Care Homes Act, 2007,* provided a Veteran is on the waiting list for a bed; or c) being held for a Veteran for allowable absences in accordance with O. Reg. 79/10 under the *Long-Term Care Homes Act, 2007.*

2.1 Submission of Reports

As a term and condition of funding, licensees will be required to submit reports by the specified due dates in the form and manner in accordance with the L-SAA, a direct funding agreement with the Ministry, applicable policy documents and report submission instructions in effect for the period being submitted. Requested reports include those that are in-year and year-end.

Both the LHINs and Ministry may only reconcile funding they provide to a licensee. However, in order to avoid cumbersome or duplicative reporting processes, the Ministry may reconcile LHIN and Ministry funding together. To this end, the Ministry continues to reconcile funding and process recoveries on behalf of the LHIN unless otherwise stated.

2.2 In-Year Reconciliation

In-year reconciliation reports include Municipal Tax Allowance, In-Year Revenue/Occupancy Reports and ad hoc Report requests. The report submission and/or application instructions will be provided to all licensees.

2.2.1 In-Year Reconciliation of Funding for Municipal Tax Allowance

The Ministry recognizes that some Long-Term Care Homes are required to pay municipal taxes while others are exempt. Each year, the Ministry requests the submission of applications in order to subsidize the costs incurred by eligible licensees that pay these taxes.

The Municipal Tax Allowance funding paid to licensees is based on the sum of the licensee's eligible final municipal taxes assessed and paid, plus capital tax estimates for the year. The sum is multiplied by the reimbursement rate set for the current year to determine the annualized estimated funding. The Municipal Tax Allowance submission allows the Ministry to adjust this estimated funding for each home once the final Municipal Property Tax invoices for the current year are available. Where a LHIN has agreed to fund the Municipal Tax Allowance funding for a home, the Ministry on behalf of a LHIN, will request the submission of the Municipal Tax Allowance application and, following a review of the

[11] Veteran has the same meaning as defined in Section 7 of O. Reg 79/10 of the *Long-Term Care Homes Act, 2007.*
[12] Ibid.

application, advise each LHIN of the estimated Municipal Tax Allowance funding for each home for which the LHIN has agreed to provide the funding.

Annual Process

i. In January of each year, the Ministry or the Ministry on behalf of a LHIN, where a LHIN has agreed to fund the Municipal Tax Allowance, will estimate funding for the Municipal Tax Allowance for eligible licensees based on the previous year's Municipal Tax Allowance Application. Licensees will receive monthly cash advances against their future eligible municipal taxes and capital taxes based on the applicable reimbursement rate multiplied by the previous year's actual municipal tax assessed and paid plus their estimated capital taxes. Eligible new licensees will be cash-flowed an estimated per diem[13] which is subject to adjustment upon submission of the current year's Municipal Tax Allowance Application.

ii. At a time specified by the Ministry during each calendar year, licensees will be required to submit an application for the Municipal Tax Allowance together with documentation to support their claim as outlined in the *LTCH Municipal Tax Allowance Policy* and Municipal Tax Allowance application instructions.

iii. Ministry staff, on behalf of the Ministry or a LHIN, will review the application and required documentation, and calculate the eligible allowance for the twelve-month period for each home based on the reimbursement rate in accordance with the report submission instructions for the period under consideration. During the review of the Municipal Tax Allowance submission, licensees may receive requests for additional information or clarification to ensure funding is provided at appropriate levels.

iv. Ministry staff, on behalf of the Ministry or a LHIN, will compare the eligible amount of the Municipal Tax Allowance with the amount cash flowed for the same twelve-month period from the Monthly Payment Calculation Notice to determine any adjustment to cash flow. If a licensee received an amount exceeding the amount determined in accordance with (iii), the difference will be recovered from the licensee by the Ministry, or by a LHIN, if a LHIN has agreed to provide funding for the Municipal Tax Allowance for a home. If a licensee received less than the amount determined in accordance with (iii), the difference will be paid to the licensee by the Ministry, or by a LHIN, if a LHIN has agreed to provide funding for the Municipal Tax Allowance for a home. Unless otherwise specified in the application instructions, adjustments to cash flow will be made in December of the current year.

v. The final verification of the Municipal Tax Allowance funding will take place at the time of the Long-Term Care Home Annual Report reconciliation. The final Municipal Tax Allowance funding will equal the applicable reimbursement rate multiplied by the lesser of: the sum of the actual eligible Municipal Tax and Capital Tax assessed and paid as reported on the audited Long-Term Care Home Annual Report, or the eligible Municipal Tax and Capital Tax amounts reported on the Municipal Tax Allowance application submission.

2.2.2 In-Year Reconciliation of Funding for Revenue and Occupancy

As outlined in the *LTCH Cash Flow Policy*, the Level of Care Per Diem funding provided by a LHIN each month is an estimate that may be adjusted for occupancy rates[14], and an estimated Resident Co-Payment Revenue component.

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[13] The Ministry will determine the applicable estimated per diem for the Municipal Tax Allowance for eligible new licensees.

[14] Licensees are cash-flowed 100% of their estimated Level of Care Per Diem funding if the licensee achieved greater than 80% occupancy (excluding Convalescent Care Beds and Interim Short Stay Beds) on the most recent In-Year Revenue/Occupancy report, or actual occupancy plus 10% if the licensee achieved 80% or less actual occupancy (excluding Convalescent Care Beds and Interim Short Stay Beds) based on the most recent Revenue/Occupancy report. Please see the *LTCH Cash Flow Policy* and *LTCH Occupancy Targets Policy* for further information.

The In-Year Revenue/Occupancy Report allows the LHINs to determine if an adjustment to cash flow is required based on revised estimated funding for a licensee as it relates to actual resident revenue charged and actual occupancy rates achieved for the period January to September of each calendar year.

Annual Process

i. At a time specified in Schedule D of the L-SAA during each calendar year and in accordance with the report submission instructions, licensees are required to report the Actual Resident Days by Accommodation Type and the actual Resident Co-Payment Revenue charged by Accommodation Type for the periods defined in the In-Year Revenue/Occupancy Report submission instructions.

ii. The actual Resident Co-Payment Revenue reported will be compared to the sum of the estimated Resident Co-Payment Revenue as stated on the Monthly Payment Calculation Notices for the same period. If the actual Resident Co-Payment Revenue exceeds the estimated Resident Co-Payment Revenue, the difference is recovered from the licensee by a LHIN. If the actual Resident Co-Payment Revenue is less than the estimated Resident Co-Payment Revenue, the difference is paid to the licensee by a LHIN.

iii. The monthly Resident Co-payment Revenue Per Diem Rate Estimate as stated on the Monthly Payment Calculation Notices will be adjusted either up or down to more accurately reflect the licensee's current resident revenue per diem. Assuming no further adjustments to the Level of Care Per Diem, if the Resident Co-payment Revenue Per Diem Rate Estimate is adjusted upward, the payments made by a LHIN to a licensee for the difference between the Level of Care Per Diem and the sum of the Resident Co-payment Revenue are reduced. Conversely, if the Resident Co-payment Revenue Per Diem Rate Estimate is adjusted downward, the payments made by a LHIN to a licensee for the difference between the Level of Care Per Diem and the sum of the Resident Co-payment Revenue are increased.

iv. For those licensees that may achieve the Occupancy Target by December 31 of that same year, based on the reported resident days for the period January 1 through September 30, the new Resident Co-payment Revenue Per Diem Rate Estimate will be calculated as follows:[15]

Actual Resident Co-Payment Revenue (basic portion only) / Maximum Resident Days

v. For those licensees that will not achieve the Occupancy Target by December 31 of that same year, based on the reported resident days for the period January 1 through September 30, the new Resident Co-payment Revenue Per Diem Rate Estimate will be calculated as follows:[16]

Actual Resident Co-Payment Revenue (basic portion only) / Actual Resident Days

vi. For those licensees that will not achieve their Target Long-Stay Resident Days, an adjustment to estimated funding will also be determined based on occupancy. The adjustment will reflect the difference between the Level of Care Per Diem funding cash flowed on the Monthly Payment Calculation Notices and the Level of Care Per Diem funding based on the Actual Resident Days

[15] In order to determine the most current Resident Co-Payment Revenue Per Diem Rate Estimate, the calculation uses the most recent period for which the co-payment rates have been set. For example, if the co-payment rate changed in July, the formula would be Actual Resident Co-payment Revenue (Jul – Sep) / Maximum Resident Days (Jul – Sep).

[16] In order to determine the most current Resident Co-Payment Revenue Per Diem Rate Estimate, the calculation uses the most recent period for which the co-payment rates have been set. For example, if the co-payment rate changed in July, the formula would be Actual Resident Co-payment Revenue (Jul – Sep) / Actual Resident Days (Jul – Sep).

as reported on the In-Year Revenue/Occupancy report, plus, where applicable, Maximum Short-Stay Respite Care Days plus approved credited days due to outbreak[17]]

vii. Low Occupancy Homes that achieved an average occupancy of 80% or below their Target Long-Stay Resident Days based on the most recent In-Year Revenue/Occupancy Report will have their future monthly Level of Care Per Diem funding adjusted by an Occupancy Factor. The Occupancy Factor will be the home's actual occupancy, excluding Convalescent Care Beds and Interim Short Stay Beds, plus 10%. Please refer to the *LTCH Cash Flow Policy* for further details.

viii. If licensees fail to submit the requested In-Year Revenue/Occupancy Report by the required deadline, adjustments will be made based on estimates from other sources. In addition, penalties for late filing or failure to file the requested report may also apply.

ix. During the review of the In-Year Revenue/Occupancy Report, licensees may receive requests for additional information or clarification to ensure funding is provided at appropriate levels.

x. If it is determined that a variance exists between the estimated funding based on the In-Year Revenue/Occupancy Report and the funding paid to a licensee for the same period, the LHIN will initiate recoveries or payments in accordance with Section 2.4.

xi. As determined by the Ministry on behalf of a LHIN, only those licensees who will fail to achieve their Target Long-Stay Resident Days, based on the year-to-date information provided in the In-Year Revenue/Occupancy Report, will be notified in writing of their respective recovery and/or payment schedules and adjustments to future cash flow payments.

2.2.3 In-Year Reconciliation of Funding Based on ad hoc Information and Reports

The LHIN and Ministry may reconcile funding they provide in-year based on other available information. To this end, the LHIN and Ministry may request ad hoc reports and/or additional information from a licensee in order to ensure funding is provided at appropriate levels as provided for in the L-SAA and/or a direct funding agreement between the Minister and a licensee.

Ad hoc reports may take the form of surveys, studies, financial reports or other types of information depending on the need. Licensees will be provided with instructions and due dates for providing the requested information.

2.3 Year-End Reconciliation

The year-end reconciliation report referred to in section 2.3 of this policy document is the audited Long-Term Care Home Annual Report submission, as in previous years. The "Long-Term Care Home Annual Report Technical Instructions and Guidelines" identifying the period covered by the report and report submission instructions will be provided to all licensees prior to the report due date.

2.3.1 Year-End Reconciliation of Funding - Long-Term Care Home Annual Report

All licensees will be required to submit audited Long-Term Care Home Annual Reports as required by Schedule D of the L-SAA and by direct funding agreements between the Minister and a licensee. This is the Report contemplated by clause 3(1)(a) of O. Reg 79/10 under the *Long-Term Care Homes Act 2007* when it comes into force on July 1, 2010..

Whereas the LHIN must reconcile funding they have paid to a licensee, and the Ministry must reconcile funding they have paid to a licensee, in order to avoid duplicative processes for reconciling the calendar-year funding, the Ministry on behalf of the LHINs, will reconcile the LHIN and Ministry funding together through the Long-Term Care Home Annual Report reconciliation. The Long-Term Care Annual Report reconciliation process, as outlined below, will allow the LHINs and Ministry to determine the Final

[17] For further information on Short-Stay Respite Care Beds, please refer to the *LTCH Occupancy Targets Policy*. For information on reporting requirements for outbreak days, please refer to the *LTCH Funding Policy for Suspension of Admissions due to Outbreaks.*

Settlement Amount for each licensee's home for the twelve-month period specified in the "Long-Term Care Home Annual Report Technical Instructions and Guidelines". The Final Settlement Amount will take into consideration the actual occupancy, the actual resident co-payment revenue charged, and the actual eligible expenditures as reported in the audited Long-Term Care Home Annual Report, subject to adjustments as provided for in this Policy document, to determine the Allowable Subsidy. The Allowable Subsidy is compared to the sum of the Estimated Total Subsidy advanced as monthly cash flows for the same twelve-month period, plus or minus any adjustments that apply to that same twelve-month period but which may have occurred before or after the same twelve-month period, to determine the Final Settlement Amount.

For the purpose of determining the licensee's Occupancy Targets on which the Level of Care Per Diem funding component will be calculated and reconciled, licensees will be provided a Subsidy Calculation Worksheet prior to the request for submission of the licensee's audited Long-Term Care Home Annual Report. The Subsidy Calculation Worksheet will confirm the licensee's Maximum Resident Days (operating capacity) and Target Resident Days (occupancy target), taking into consideration the Occupancy Targets applicable for Long-Stay, Short-Stay Respite, Convalescent Care and Interim Short-Stay beds, for the 12-month period on which the Level of Care Per Diem funding calculations, and, if applicable, Additional Subsidy, will be based and reconciled.[18]

Annual Process

i. Licensees will be required to submit an audited Long-Term Care Home Annual Report for a defined twelve-month period in accordance with the form and manner set out in the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" in effect for the period being submitted, together with the required auditor's statements and Resident Trust Account Audit by the requested due date.

ii. Special reconciliation rules in addition to those set out in this policy document may apply. For further information consult the funding policy as it applies to each of the Non-Level of Care Funding[19] as outlined in the licensee's L-SAA and/or a direct funding agreement between the Minister and a licensee and the *LTCH Level of Care Per Diem Funding.*

iii. Prior to submission, licensees will be required to:
   a) assess the eligibility of expenditures submitted on their Long-Term Care Home Annual Report in accordance with the Eligible Expenditures Framework in effect for the period under consideration together with the Envelope Definitions outlined in the *Eligible Expenditures for LTC Homes Policy* and *LTCH Level of Care Per Diem Funding Policy*,
   b) demonstrate that the conditions of funding and use of funding requirements as outlined in the L-SAA, a direct funding agreement between the Minister and a licensee, the applicable Policies and report submission instructions have been met,
   c) ensure that revenues and expenditures reported in the Long-Term Care Home Annual Report relate only to the operation of the licensee's licensed beds, and exclude any revenues or expenditures for funded programs that are expressly excluded from the Long-Term Care Home Annual Report in accordance with the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" in effect for the period being submitted,
   d) ensure that Inadmissible Expenditures as specified in the *Eligible Expenditures for LTC Homes Policy* and the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" have not been included in the Long-Term Care Home Annual Report submission,
   e) have a Licensed Public Accountant conduct an audit of the Long-Term Care Home Annual Report. The scope of the audit shall be in accordance with the requirements as set out in the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" in effect for the period being submitted. In addition, the auditor will be required to attest that the audit was conducted in accordance with generally accepted

[18] For further information on occupancy target calculations, please refer to the *LTCH Occupancy Targets Policy*, the *Convalescent Care Program* and the "Long-Term Care Home Subsidy Calculation Worksheet Technical Instructions and Guidelines".

[19] For a comprehensive list of Non-Level of Care Funding policies, please refer to section 3.1 of this policy document. In addition, licensees may refer to their L-SAA and/or direct funding agreements between the Minister and a licensee for further information.

auditing standards, and set out an opinion as to the revenues, expenditures and accrual information contained in the Long-Term Care Home Annual Report. Auditors are required to certify that expenditures that relate to funded programs that are expressly excluded from the Long-Term Care Home Annual Report in accordance with Section 2.3.1 (iii) c) and (iv) have not been included in the Long-Term Care Home Annual Report. The Long-Term Care Home Annual Report must be signed and dated by the auditor in the designated "Auditor's Report" section of the Long-Term Care Home Annual Report in accordance with the "Long-Term Care Home Annual Report Technical Instructions and Guidelines",

f) have a Licensed Public Accountant conduct an annual audit of the home's Trust Account. A copy of the auditor's statement must be provided with the Long-Term Care Home Annual Report submission in "Appendix A" of the "Auditor's Report". If no Trust Account exists for the home, that information must also be included with the submission; and

g) A person who has the authority to bind the licensee must sign and date the "Operator's Statement and Approval" contained in the Long-Term Care Home Annual Report to attest that the information contained in the Long-Term Care Home Annual Report was completed in accordance with the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" in effect for the period being submitted, that acceptable systems of internal accounting control are in place for the licensee and that the information contained in the report is in accordance with the L-SAA, any direct funding agreement between the Minister and the licensee and/or the applicable policies as they relate to the funding provided to the home for the period being submitted. In addition, the licensee must attest that the Long-Term Care Home Annual Report was prepared in accordance with the basis or bases of accounting described in the "Notes to the Report".

iv. Licensees who are awarded new long-term care beds or who are redeveloping their Category "D" homes shall maintain a separate set of accounting records for revenues and expenditures associated with the development of each capital project. The review and reconciliation of expenditures relating to funding for Construction Costs for these projects will be done in a separate exercise.

v. Licensees with licensed Convalescent Care Beds will be required to report expenditures relating to their licensed Convalescent Care Beds separate from their other licensed beds on the audited Long-Term Care Home Annual Report submission.

vi. The Long-Term Care Home Annual Report submission will be reviewed by Ministry staff on behalf of the LHINs and the Ministry for the period under consideration, and may be subject to applicable adjustments, including:

a) adjustments based on actual basic Resident Co-payment Revenue charged as compared to estimated basic Resident Co-payment Revenue as stated on the licensee's Monthly Payment Calculation Notices;

b) reallocations of preferred revenue to basic revenue where licensees fail to report an amount that approximates the maximum basic per diem revenue on preferred accommodation beds;

c) reallocation of preferred revenue to basic revenue where licensees charge in excess of the legislated preferred rates for preferred accommodation beds;

d) adjustments based on actual occupancy levels;

e) adjustments based on actual expenditures;

f) adjustments based on the lesser of the eligible amounts reported on the Municipal Tax Allowance application or the actual eligible amounts of Municipal and Capital taxes assessed and paid as reported on the Long-Term Care Home Annual Report;

g) adjustments based on the total new or replacement equipment purchases from the Nursing and Personal Care and/or Program and Support Services envelopes if they exceed the $400 per bed limit;[20]

h) adjustments based on expenditures reported as Medical Director Fees where licensees that meet their Occupancy Targets may pay and expense up to an amount equal to $0.30 per resident day based on their Maximum Resident Days in the NPC envelope. Licensees that fail to achieve their Occupancy Targets may pay and expense up to an amount equal to $0.30 per Actual Resident Day in their NPC envelope. Separate

[20] For further information, please refer to the *LTCH Furnishings and Equipment Management Policy*.

calculations apply to Convalescent Care beds where licensees must achieve their Target Convalescent Care Resident Days to pay and expense an amount equal to $.30 per resident day based on Maximum Resident Days for Convalescent Care beds in the NPC envelope. If the licensee does not achieve their Target Convalescent Care Resident Days, the maximum expenditure for Medical Director Fees in the NPC envelope for Convalescent Care beds is limited to an amount equal to $.30 per actual Convalescent Care Resident Day. Under-expenditures of Medical Director Fees in the NPC envelope will be recovered based on the difference between the maximum allowable expense and the actual expense. Costs incurred and expensed in excess of the maximum allowable expenditure will be transferred to the Other Accommodation envelope;

i) adjustments based on expenditures reported as Incontinence Supplies where licensees that meet their Occupancy Targets are limited to a maximum expenditure up to an amount equal to $1.20 per resident day based on their Maximum Resident Days in the NPC envelope. Licensees that fail to achieve their Occupancy Targets are limited to a maximum expense up to an amount equal to $1.20 per Actual Resident Day in their NPC envelope. Separate calculations apply to Convalescent Care beds where licensees must achieve their Target Convalescent Care Resident Days to expense an amount equal to $1.20 per resident day based on Maximum Resident Days for Convalescent Care beds in the NPC envelope. If the licensee does not achieve their Target Convalescent Care Resident Days, the maximum expenditure for Incontinence Supplies in the NPC envelope for Convalescent Care beds is limited to an amount equal to $1.20 per actual Convalescent Care Resident Day. Costs incurred and expensed in excess of the maximum allowable expenditure will be transferred to the Other Accommodation envelope;
j) adjustments based on the expenditures reported as Physician On Call expenditures where the licensee may pay and expense in the NPC envelope up to the maximum allowable funding of $10,000 for licensees with fewer than 100 beds, or $100 per bed per year to a maximum of $30,000 for licensees with equal to or greater than 100 beds. Where a licensee fails to expense the maximum allowable expenditure in the NPC envelope, the difference between the Physician On Call funding and the actual expenditure will be recovered. Costs incurred and expensed in excess of the maximum allowable expenditure will be transferred to the Other Accommodation envelope;
k) adjustments based on the expenditures reported as Registered Practical Nurse expenditures where the licensee may pay and expense in the NPC envelope up to the maximum allowable funding.[21] Where a licensee fails to expense the maximum allowable expenditure in the NPC envelope, the difference between the Registered Practical Nurse funding and the actual expenditure will be recovered. Costs incurred and expensed in excess of the maximum allowable expenditure will be transferred to the Other Accommodation envelope. Separate calculations apply to Convalescent Care Beds. Funding will be prorated according to the total actual expenditures by bed category, up to the maximum allowable funding;
l) adjustments based on reasonability, eligibility and/or admissibility of expenditures in accordance with the Eligible Expenditures Guidelines in effect for the period under consideration and the Envelope Definitions outlined in the *Eligible Expenditures for LTC Homes Policy,* the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" and the *LTCH Level of Care Per Diem Funding Policy*;
m) adjustments based on extraordinary non-arms length charges above fair market value or normal business practices;
n) adjustments based on the terms and conditions of funding and use of funding requirements as outlined in the L-SAA, any direct funding agreement between the Minister and a licensee, the applicable policies and report submission instructions;[22]
o) adjustments based on estimates from other sources as a result of licensees failing to submit the requested reports; or
p) penalties where applicable.

[21] Please refer to the *Registered Practical Nurses in Long-Term Care Homes Initiative Funding Policy* for further information on the terms and conditions of funding and funding calculations.
[22] Please refer to the applicable Non-Level of Care Funding policies, the *LTCH Level of Care Per Diem Funding Policy* and the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" for information on special terms and conditions of funding.

vii. The Level of Care Per Diem funding may be adjusted based on actual occupancy through the Long-Term Care Home Annual Report reconciliation process.[23] If the licensee achieved their Occupancy Targets, excluding Convalescent Care Beds, as specified on their Subsidy Calculation Worksheet, the Level of Care Per Diem funding will be based on their Maximum Resident Days. However, licensees that fail to meet their Occupancy Targets, excluding Convalescent Care Beds, will have the Level of Care Per Diem funding adjusted to actual occupancy. The Actual Resident Days, excluding Convalescent Care Beds, as reported on the Long-Term Care Home Annual Report will be compared to the target calculations, excluding Convalescent Care Beds, as stated on the licensee's Subsidy Calculation Worksheet to determine if a licensee has achieved their Occupancy Target.[24]

viii. For licensed Convalescent Care Beds, in addition to receiving the Base Level of Care Per Diem funding at Maximum Convalescent Care Resident Days[25], licensees who achieve actual occupancy of equal to or greater than 80% on their licensed Convalescent Care Beds will retain 100% of the Additional Subsidy. Licensees who achieve actual occupancy below 80% on their licensed Convalescent Care Beds will have their Additional Subsidy adjusted to actual Convalescent Care Bed Resident Days. The actual Convalescent Care Resident Days as reported on the Long-Term Care Home Annual Report will be compared to the Target Convalescent Care Resident Days as stated on the licensee's Subsidy Calculation Worksheet to determine if a licensee has achieved their Convalescent Care Bed's occupancy target.[26]

ix. The Level of Care Per Diem funding for each envelope, as ascertained in accordance with Section 2.3.1 (vii) above, is added to the applicable Non-Level of Care Funding allocated by envelope.[27] The sum of the Level of Care Per Diem funding and Non-Level of Care Funding by envelope represents the Approved Expenditures by envelope. Level of Care Per Diem funding for Convalescent Care Beds will be calculated in accordance with Section 2.3.1 (viii). Subject to the terms and conditions of funding, Non-Level of Care Funding as applicable to Convalescent Care Beds will be either: prorated by envelope based on the percentage of Convalescent Care Beds as compared to the total Licensed Beds, or where applicable, Non-Level of Care Funding will be allocated based on total actual expenditures by bed category, up to the maximum allowable funding.[28] The Level of Care Per Diem funding by envelope for Convalescent Care Beds will be added to the Non-Level of Care Funding by envelope for Convalescent Care Beds to determine the Approved Expenditures by envelope for Convalescent Care Beds.

x. The Approved Expenditures by envelope are compared to the Allowable Expenditures by envelope as determined following a review by Ministry staff on behalf of a LHIN and the Ministry. Separate calculations apply to Convalescent Care beds whereby the Approved Expenditures by envelope for Convalescent Care Beds are compared to the Allowable Expenditures by envelope for Convalescent Care Beds as determined following a review by Ministry staff on behalf of a LHIN and the Ministry. To determine the Allowable Expenditures, Ministry staff on behalf of a LHIN and the Ministry will review the expenditures for each envelope as reported on the licensee's Long-Term Care Home Annual Report submission and, if applicable, adjust expenditures in accordance with Section 2.3.1 (vi) (d) through (n). The eligibility of expenditures for each of the envelopes will be subject to the assessment criteria in accordance with the *Eligible Expenditures for LTC Homes Policy* and *LTCH Level of Care Per Diem Funding Policy*.

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[23] Please refer to the *LTCH Cash Flow Policy* and *LTCH Occupancy Targets Policy* for further information, in addition to Section 2.2.4 of this policy document.

[24] Beds funded under the Occupancy Reduction Program will be funded their Level of Care Per Diem funding as per the terms and conditions of funding in accordance with the *LTCH Non-Capital Occupancy Reduction Protection Guidelines* or the *Policy for Funding Construction Costs of Long-Term Care Homes,* Part 4 Occupancy Reduction Protection as applicable.

[25] Ibid.

[26] For further information on Occupancy Target calculations, please refer to the *LTCH Occupancy Targets Policy* and the "Long-Term Care Home Subsidy Calculation Worksheet Technical Instructions and Guidelines".

[27] The Non-Level of Care Funding allocated by envelope will be defined in the terms and conditions of funding of the L-SAA and/or any direct funding agreement between the Minister and a licensee and/or other Policy documents and/or other reconciliation reports informed by those same agreements and/or Policy documents.

[28] Please refer to the Non-Level of Care Funding policy and/or direct funding agreement for further information on determining how funding will be split between Convalescent Care beds as compared to total Licensed Beds and applied according to the envelope..

xi. The licensee may be contacted and a request may be made for the provision of additional information or clarification if:

(a) variances exist between revenues and/or expenditures reported on previous report submissions as compared to the current Annual Report submission, or,

(b) further information is required in order to determine the reasonability, eligibility or admissibility of expenditures reported on the current Annual Report.

If a licensee fails to provide an explanation or the requested information by the required due date as stated in the request for additional information, the reconciliation will be finalized and adjustments to cash flow may be made in accordance with Section 2.3.1 (vi) (a) through (p).

xii. Following a determination of the Allowable Expenditures for each of the three recoverable envelopes, which are Nursing and Personal Care, Program and Support Services and Raw Food, the Allowable Expenditures by envelope is compared to the Approved Expenditures by envelope to determine the Eligible Expenditures by envelope. The Eligible Expenditures represents the lesser of the Approved Expenditures or the Allowable Expenditures for each of the three recoverable envelopes. For the Other Accommodation Envelope, the Approved Expenditures will equal the Eligible Expenditures.[29] For Convalescent Care Beds, following a determination of the Allowable Expenditures for each of the three recoverable envelopes, which are Nursing and Personal Care, Program and Support Services and Raw Food, the Allowable Expenditures by envelope for Convalescent Care Beds is compared to the Approved Expenditures by envelope for Convalescent Care Beds to determine the Eligible Expenditures by envelope for Convalescent Care Beds. The Eligible Expenditures for Convalescent Care Beds represents the lesser of the Approved Expenditures for Convalescent Care Beds or the Allowable Expenditures for Convalescent Care Beds for each of the three recoverable envelopes. For the Other Accommodation Envelope, the Approved Expenditures for Convalescent Care Beds will equal the Eligible Expenditures for Convalescent Care Beds.[30] A surplus in the Nursing and Personal Care, Program and Support Services and Raw Food envelopes is recovered and repayable to the Ministry. Additional funding is not provided to offset deficits. The licensee may retain surpluses in the Other Accommodation envelope.[31] The funding provided within each envelope is allocated for expenditures that are eligible within the definition of that envelope. Funding is not transferrable from one envelope to the other, and surpluses in one envelope may not be used to offset deficits in another, with the exception of funds from the Other Accommodation envelope, which may be used for purchases in any envelope and do not require prior approval.[32] Funding is provided to each licensee's home for the sole use of that home and therefore, funding may not be transferred from one licensee's home to another home owned, operated or managed by the same licensee, from one licensee's home to any other home, or from one licensee to any other licensee.

Despite the rule that a surplus in the Nursing and Personal Care, Program and Support Services and Raw Food envelopes is recovered and repayable to the Ministry, for the period January 1, 2011 to December 31, 2011, unused funding for convalescent care beds in the NPC and PSS envelopes, may be carried forward and reconciled as part of the 2012 overall reconciliation as follows:

(a) The unused funding that may be carried forward to 2012 (Unused Funding) shall be:

(i) for the NPC envelope, the lesser of
1. the difference between the Approved Expenditure and the Allowable Expenditure; and
2. $5.56 x the number of convalescent care resident days approved to be funded for the period April 1, 2011 to December 31, 2011 in accordance with the occupancy target for convalescent care beds set out in the LTCH Occupancy Targets Policy;

(ii) for the PSS envelope, the lesser of

[29] Special restrictions and conditions apply to licensees in receipt of Red Circle funding. Please refer to the Appendix to the *LTCH Recovery and Reconciliation Policy* for further information.
[30] Ibid.
[31] Ibid.
[32] Ibid.

1. the difference between the Approved Expenditure and the Allowable Expenditure; and
2. $2.39 x the number of convalescent care resident days approved to be funded for the period April 1, 2011 to December 31, 2011 in accordance with the occupancy target for the convalescent care beds set out in the LTCH Occupancy Targets Policy.

(b) Unused Funding shall be determined by the Ministry on behalf of the LHINs and the Ministry through the 2011 overall reconciliation,

(c) All Unused Funding carried forward to 2012 must be spent by March 31, 2012 and shall be applied against eligible expenses under the NPC and PSS envelopes for convalescent care beds.

xiii. Non-Level of Care Funding that is not allocated among envelopes as outlined in the licensee's L-SAA and/or the direct funding agreements between the Minister and a licensee and/or applicable Policy documents, will be added to the sum of the Eligible Expenditures of the four envelopes. The result is the Total Eligible Expenditures.

xiv. In order to determine the Allowable Subsidy, the Total Recoverable Revenue is deducted from the Total Eligible Expenditures. The Total Recoverable Revenue consists of the sum of the actual Resident Co-Payment Revenue charged,[33] the Other Recoverable Revenue[34] and the Bad Debt Adjustment[35] from the Long-Term Care Home Annual Report submission, subject to review and verification. The actual Resident Co-Payment Revenue may be subject to adjustments in accordance with Section 2.3.1 (vi) (b) and (c).

xv. The Allowable Subsidy is then compared to the cash flow advanced as monthly payments for the period, plus or minus adjustments that apply to that same twelve-month period but which may have occurred before or after the same twelve-month period, to determine the Final Settlement Amount. Cash flow that is greater than the Allowable Subsidy results in a recovery from the licensee. Cash flow that is less than the Allowable Subsidy results in a payment to the licensee.

xvi. Following the determination of the Final Settlement Amount, the Ministry will provide written notification to each LHIN identifying the respective licensees within their LHIN for which the Long-Term Care Home Annual Report reconciliation process has been completed, together with a list of the recoveries and/or payments due from/to each licensee for the twelve-month period under review. The LHIN will be required to review this list and approve the recovery and/or payment for each licensee. The signed report will then be returned to the Ministry and the recoveries and/or payments to the licensees will be processed.

xvii. Each licensee will be notified in writing of their Final Settlement Amount for the twelve-month period under review. The notification will include the timeline to recover and/or make payment of the Final Settlement Amount, and the required adjustments to future payment notices. If applicable, recoveries to the Crown may be in the form of a lump sum payment in full by bank draft payable to the Minister of Finance. An Overall Reconciliation Report will accompany the notification to the licensee.

xviii. Licensees will have an opportunity to identify errors and omissions and to provide revised information to their Long-Term Care Home Annual Report submissions for a period of sixty (60) days from the date of the notification letter identified in Section 2.3.1 (xvii) by the LHINs and/or Ministry. The LHINs and/or Ministry may require the licensee to provide more information, as applicable and as determined by the LHINs and/or Ministry. Requests for revisions that are received after the 60th day will not be accepted, nor will subsequent requests for revision to the Annual Report where a second notification letter identified in Section 2.3.1 (xvii) has been

[33] The actual total Resident Revenue charged includes Prior Period Revenues for basic accommodation charges collected in the current period. Please refer to the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" for information on reporting Prior Period Revenues.

[34] For further information on the types of revenues to be reported as Other Recoverable Revenue, please refer to the *LTCH Furnishings and Equipment Management Policy*, the "Long-Term Care Home Annual Report Technical Instructions and Guidelines" in effect for the period under review, the L-SAA and the direct funding agreements between the Minister and a licensee.

[35] For further information on Bad Debt Adjustments, please refer to the *LTCH Bad Debt Reimbursement Policy*.

provided to a licensee. The second notification letter will be the final notification letter provided to a licensee and further revisions will not be accepted.

xix. The requirements, terms and conditions as they pertained to the original submission of the Long-Term Care Home Annual Report remain in effect for any revisions made to the Long-Term Care Home Annual Report. For further clarity, revised auditor's statements identifying adjustments to the Long-Term Care Home Annual Report must accompany any revisions to a Long-Term Care Home Annual Report, as an auditor's statement is a requirement of the original submission.

2.4 Recoveries and Payments

If upon completion of an in-year or year-end reconciliation of funding, it is determined that an adjustment to a licensee's cash flow is warranted, monies will be recovered and/or paid based on a schedule. The schedule as outlined below will not be limited by the cumulative total of all recoveries. Rather, the schedule of recoveries shall apply to each in-year or year-end recovery independently. The recovery schedule as stated below will be utilized:

a. $50,000 or less to be recovered in one month,

b. $50,001 to $200,000 to be recovered between one to three months,

c. $200,001 to $1,000,000 to be recovered between three and six months, and

d. greater than $1,000,000 to be recovered between six and nine months.

Payments in full will be made at the earliest possible date.

Recoveries for licensees with 50 beds or less will be tailored based on their cash flow.

3.1 References to Other Policy Documents and Technical Instructions and Guidelines

For further information, please refer to:

Policy –
Beds in Abeyance Policy
Convalescent Care Program
Eligible Expenditures for LTC Homes Policy
Fill Rate Guidelines for New and Redeveloped/Retrofitted "D" Long-Term Care Facilities
Guide for Rate Reductions
LTCH Bad Debt Reimbursement Policy
LTCH Cash Flow Policy
LTCH Fill Rate Guidelines for New Interim LTC Beds
LTCH Funding Policy for Suspension of Admissions due to Outbreaks
LTCH Furnishings and Equipment Management Policy
LTCH Level of Care Per Diem Funding Policy
LTCH Level of Care Per Diem Funding Summary
LTCH Municipal Tax Allowance Policy
LTCH Non-Capital Occupancy Reduction Protection Guidelines
LTCH Occupancy Targets Policy
Policy for Funding Construction Costs of Long-Term Care Homes
Registered Practical Nurses in Long-Term Care Homes Initiative Funding Policy

Technical Instructions and Guidelines[36] -
Manual for Awardees/Operators in the Preparation for Occupancy
Municipal Tax Allowance Application Instructions

[36] Report submission instructions and technical instructions and guidelines are issued annually. Consult the applicable document in effect for the period for which the report data is being submitted and reviewed.

In-Year Revenue/Occupancy Report Submission Instructions
Long-Term Care Home Annual Report Technical Instructions and Guidelines
Long-Term Care Home Subsidy Calculation Worksheet Technical Instructions and Guidelines

Ontario

Ministry of Health
and Long-Term Care

Long-Term Care Homes Financial Policy

Policy: LTCH Convalescent Care Additional Subsidy Funding Summary	Date: April 1, 2011

Convalescent care beds receive the base Level of Care (LOC) per diem funding, as set in the *Level- of- Care Per Diem Funding Summary* for the applicable period. Convalescent care beds also receive an additional subsidy per diem (Additional Subsidy).

The amount of the Additional Subsidy together with a breakdown of how the subsidy is allocated between three funding envelopes is as follows:

Period	Nursing and Personal Care Envelope	Program and Support Services Envelope	Other Accommodation Envelope	**Total**
Per Diem Amount Prior to April 1, 2011	$39.61	$16.98	$5.00	**$61.59**
Per Diem Amount effective April 1, 2011	$45.17	$19.37	$5.70	**$70.24**

The Additional Subsidy amounts are set by the Ministry and are updated by the Ministry.

Please refer to the *Level-of-Care Per Diem Funding Policy* for further details on the level-of-care funding.