August 4, 2015

Dear [Redacted]

Re: Your request for access to information under Part II of the Access to Information and Protection of Privacy Act [Our File #: HCS/044/2015]

On July 7, 2015, the Department of Health and Community Services (the Department) received your request for access to the following records/information:

"At 12:14am ?? 7 Jul 2015, Minister Stephen Kent indicated on Twitter the following with respect to the privatization of long term care and the recent RFP announcing the government’s plan to move forward with this privatization: "Been on the radar since October. And lots of evidence to support the plan." Please provide the information that the Minister of Health was referencing in this Tweet."

On July 16, 2015, the Department asked for further clarification from you regarding the request and you provided the following: "all evidence, analysis, data, reports (consultant and otherwise) relating to privatization and P3s held by the Department as highlighted in the request". Further clarification was provided on July 30, 2015 when you requested no emails or reports that have already been provided to you in previous requests.

The Department has reviewed your request in the context of the Access to Information and Protection of Privacy Act (the Act) and Bruce Cooper, Deputy Minister, made a decision and is pleased to inform you that access to these records has been granted, in part. In accordance with your request for a copy of the records, the appropriate copies have been enclosed. Some information has been refused in accordance with the following exceptions to disclosure, as specified in the Act:

29. (1) The head of a public body may refuse to disclose to an applicant information that would reveal

(a) advice, proposals, recommendations, analyses or policy options developed by or for a public body or minister;
35. (1) The head of a public body may refuse to disclose to an applicant information which could reasonably be expected to disclose

(a) trade secrets of a public body or the government of the province;

(d) information, the disclosure of which could reasonably be expected to result in the premature disclosure of a proposal or project or in significant loss or gain to a third party;

(f) positions, plans, procedures, criteria or instructions developed for the purpose of contractual or other negotiations by or on behalf of the government of the province or a public body, or considerations which relate to those negotiations;

(g) information, the disclosure of which could reasonably be expected to prejudice the financial or economic interest of the government of the province or a public body;

39. (1) The head of a public body shall refuse to disclose to an applicant information

(a) that would reveal

   (i) trade secrets of a third party, or

   (ii) commercial, financial, labour relations, scientific or technical information of a third party;

(b) that is supplied, implicitly or explicitly, in confidence; and

(c) the disclosure of which could reasonably be expected to

   (i) harm significantly the competitive position or interfere significantly with the negotiating position of the third party,

   (ii) result in similar information no longer being supplied to the public body when it is in the public interest that similar information continue to be supplied,

   (iii) result in undue financial loss or gain to any person, or

   (iv) reveal information supplied to, or the report of, an arbitrator, mediator, labour relations officer or other person or body appointed to resolve or inquire into a labour relations dispute.

The following pages are exempted under the above noted sections of the Act and have been removed:

- Pages 79-95, 110-111, 121, 124, and 139-149.

Contained within the responsive records is a Request for Quote (RFQ) document template. Please note, this document was never released as the Department went straight to a Request for Proposal (RFP).
As required by 8(2) of the Act, we have severed appropriate information and have provided you with records that are responsive to your request. Please be advised that you may appeal this decision and ask the Information and Privacy Commissioner to review the decision to provide partial access to the requested information, as set out in section 42 of the Act (a copy of this section of the Act has been enclosed for your reference). A request to the Commissioner must be made in writing within 15 business days of the date of this letter or within a longer period that may be allowed by the Commissioner. Your appeal should identify your concerns with the request and why you are submitting the appeal.

The appeal may be addressed to the Information and Privacy Commissioner is as follows:

Office of the Information and Privacy Commissioner
2 Canada Drive
P. O. Box 13004, Stn. A
St. John’s, NL. A1B 3V8

Telephone: (709) 729-6309
Toll-Free: 1-877-729-6309
Facsimile: (709) 729-6500

You may also appeal directly to the Supreme Court Trial Division within 15 business days after you receive the decision of the public body, pursuant to section 52 of the Act (a copy of this section of the Act has been enclosed for your reference).

Please be advised that responsive records will be published following a 72 hour period after the response is sent electronically to you or five business days in the case where records are mailed to you. It is the goal to have the responsive records posted to the Office of Public Engagement’s website within one business day following the applicable period of time. Please note that requests for personal information will not be posted online.

If you have any further questions, please contact the undersigned by telephone at 709-729-7007 or by email at angelapower@gov.nl.ca.

Sincerely,

Angela Power
ATIPP Coordinator

/Encl.

ATIP/0332/002/004
Long-Term Care Demand Projections
Avalon Peninsula

Background:
- In June 2011, the Economics and Statistics Branch (ESB) signed a memorandum of understanding (MOU) with the Department of Health and Community Services (DOHCS) regarding work required to "enable the quantitative assessment and analysis of long-term care (LTC) needs for Newfoundland and Labrador (NL)". It is expected that an aging population, and consequently an increasing number of seniors requiring LTC, will cause future LTC service needs to rise.
- While these projections focus on all age groups present in LTC facilities, ages 75+ will be the main driver of growth. The rate of growth in the provincial population age 75+ has slowed over the past 15 years because of lower levels of births in the 1920s and the first half of the 1930s, but this trend will not continue. Growth in the 75+ population will increase over the 2014–2020 period as individuals born in the late 1930s and early 1940s move into the 75+ age category. This growth will further accelerate when the large baby boomer group starts turning 75 beginning in 2021. To plan and manage this growth optimally, DOHCS has partnered with ESB on assessing LTC demand.
- ESB has developed projections for the Avalon Peninsula from 2014 to 2026.\(^1\)
- Within the Avalon Peninsula, the population 75+ increased 21.7% (from 12,801 to 15,573) in the 13 year period between 2000 and 2013. According to the province's population projections, the population 75+ will increase about 76% (from 15,573 to 27,383) in the 13 year period between 2013 and 2026 (see Figure 1).

Figure 1: Population 75+ (left axis) and Change in Population 75+ (right axis)
Avalon Peninsula, 1986-2026

\[\text{Figure 1: Population 75+ (left axis) and Change in Population 75+ (right axis)}\]

\[\text{Avalon Peninsula, 1986-2026}\]

\(^1\) The Avalon Peninsula encompasses Economic Zones 17, 18, 19 and 20 (see Appendix A on page 4 for map of Economic Zones).
Projection Summary:

- These LTC projections are based on two main datasets:
  - Population projections by age and sex for Economic Zones 17, 18, 19 and 20 from the Economic Research and Analysis (ERA) Division within ESB.
  - LTC resident data by age and sex from the Canadian Institute for Health Information (CIHI). The data are collected from the seven LTC facilities on the Avalon Peninsula contributing data to the InterRAI Minimum Data Set (MDS) 2.0 as of June 30, 2014. Since implementing MDS 2.0, these seven LTC facilities have submitted data on 2,127 LTC residents, the majority of whom entered a LTC facility between 2010 and 2014.  
- The population projections and LTC resident data allow for the calculation of current estimates of LTC utilization (use) rates by age and sex.
- For the purpose of these projections, as defined by DOHCS, total LTC demand for the Avalon Peninsula is the sum of total LTC beds in the region plus 70% of the average Eastern Health LTC waitlist over the January 2012 to August 2014 period.
- In terms of current LTC bed supply, there are currently 14 LTC facilities and 1,451 LTC beds on the Avalon Peninsula (see Appendix B on page 5 for map of the Eastern Health region).
- It is assumed that current demand for LTC beds in the Avalon Peninsula exceeds supply, as an analysis of Eastern Health LTC waitlist data indicates that there has been an unmet demand for LTC beds in the region over the period for which waitlist data is available. The average number of people on the Eastern Health LTC waitlist over the January 2012 to August 2014 time frame was 108.7, and DOHCS estimates that the Avalon Peninsula accounts for approximately 70% of the Eastern Health LTC waitlist. Therefore, current demand for LTC beds (and the starting point for these projections) is assumed to be 1,527 (i.e. 1,451 LTC beds plus an average of 76 people on the waitlist).
- The LTC projections consider two main scenarios:
  - The first scenario assumes constant 2013 LTC use rates by age and sex over the projection period.
  - The second scenario assumes declining 2013 LTC use rates over the projection period based on the trend reflected in Statistics Canada’s Residential Care Facilities (RCF) survey.
- Even though the trend in Statistics Canada’s RCF survey suggests that LTC use rates will most likely continue to decrease slightly in the coming years, there are qualitative factors that could potentially suggest otherwise (e.g. emergence and/or presence of multiple chronic conditions, increase of age related conditions, etc.). To this end, a third scenario (for illustrative purposes only) was considered in which the age and sex specific LTC use rates from the constant scenario increase 10% over the 2013–2026 projection period.
- Table 1 and Figure 2 provide a summary of the LTC projections for the Avalon Peninsula for the three scenarios outlined above.

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2 The seven LTC facilities on the Avalon Peninsula submitting resident data to the MDS 2.0 as of June 30, 2014 are Agnes Pratt Home (St. John’s), Harbour Lodge Nursing Home (Carbonear), Hoyles-Escasoni Complex (St. John’s), Interfaith Citizens Home (Carbonear), Lion’s Manor (Placentia), Masonic Park Nursing Home (Mount Pearl) and St. Patrick’s Mercy Home (St. John’s).
Table 1: Projected LTC Demand: Constant Use Rate Scenario, Declining Use Rate Scenario, and 10% Increase in Use Rate Scenario, Avalon Peninsula, 2013-2026

<table>
<thead>
<tr>
<th>Scenario</th>
<th>LTC Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
</tr>
<tr>
<td>Scenario 1: Constant LTC Use Rates</td>
<td>1,527</td>
</tr>
<tr>
<td>Scenario 2: Declining LTC Use Rates</td>
<td>1,527</td>
</tr>
<tr>
<td>Scenario 3: 10% Increase in Constant LTC Use Rates</td>
<td>1,527</td>
</tr>
</tbody>
</table>

- Based on historical trends, Scenario 2 appears to be the most likely outcome, but close monitoring of LTC needs should continue in the coming years in order to detect, plan and react to other possible outcomes.
- The projections in this report suggest an impending need for additional LTC beds in the Avalon Peninsula in the decades to come. Based on population aging trends alone, it appears that the demand for LTC in this region will increase significantly. As a result, the level of LTC beds will have to increase correspondingly, or alternative forms of care will be needed if this demand is to be met.

Figure 2: Projected LTC Demand: Constant Use Rate Scenario, Declining Use Rate Scenario, and 10% Increase in Use Rate Scenario, Avalon Peninsula, 2013-2026

Appendix A: Newfoundland and Labrador Economic Zones Map

Economic Zones
Newfoundland & Labrador
Appendix B: Avalon Peninsula LTC Facilities

Long Term Care Homes

<table>
<thead>
<tr>
<th>Beds</th>
<th>Submitting MDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - 31</td>
<td>Labrador-Grenfell Health Authority</td>
</tr>
<tr>
<td>40 - 59</td>
<td>Western Health Authority</td>
</tr>
<tr>
<td>61 - 83</td>
<td>Central Health Authority</td>
</tr>
<tr>
<td>101 - 134</td>
<td>Yes, Eastern Health Authority</td>
</tr>
<tr>
<td>200 - 377</td>
<td>No</td>
</tr>
</tbody>
</table>

Map of Avalon Peninsula showing locations of long term care homes.
Long-Term Care Demand Projections
Central Regional Health Authority
December 15, 2014

Background:
- In June 2011, the Economics and Statistics Branch (ESB) signed a memorandum of understanding (MOU) with the Department of Health and Community Services (DOHCS) regarding work required to “enable the quantitative assessment and analysis of long-term care (LTC) needs for Newfoundland and Labrador (NL).” It is expected that an aging population, and consequently an increasing number of seniors requiring LTC, will cause future LTC service needs to rise.
- While these projections focus on all age groups present in LTC facilities, the majority of LTC residents are 75+ and changes in this age group is expected to be the main driver of growth. The rate of growth in the provincial population age 75+ has slowed over the past 15 years because of lower levels of births in the 1920s and the first half of the 1930s, but this trend will not continue. Growth in the 75+ population will increase over the 2014–2020 period as individuals born in the late 1930s and early 1940s move into the 75+ age category. This growth will further accelerate when the large baby boomer group starts turning 75 beginning in 2021. To plan and manage this growth optimally, DOHCS has partnered with ESB on assessing LTC demand.
- Within the Central Health region, the population 75+ increased 32.6% (from 5,975 to 7,923) in the 13 year period between 2000 and 2013. According to population projections, the population 75+ will increase about 59% (from 7,923 to 12,593) in the 13 year period between 2013 and 2026. See Figure 1 for a graph of the population 75+, the change in the population 75+ and the projected population 75+ for the Central Health region.

Figure 1: Population 75+ (left axis) and Change in Population 75+ (right axis)
Central Health Region, 1986-2026
Projection Summary:

- ESB has prepared LTC demand projections for the Central Health region and each of the Economic Zones within the region from 2014 to 2026.¹
- These LTC demand projections are based on two main datasets:
  - Population projections by age and sex for the Central Health region and Economic Zones 11, 12, 13 and 14 from the Economic Research and Analysis (ERA) Division.
  - Age and sex data on current and deceased LTC residents. These data were collected by the Canadian Institute for Health Information (CIHI) from the 10 LTC facilities in the Central Health region submitting data to the InterRAI Minimum Data Set (MDS) 2.0 as of June 30, 2014. Since implementing MDS 2.0, these 10 LTC facilities have submitted data on 543 LTC residents, the majority of whom entered a LTC facility between 2011 and 2014.²
- The LTC resident data allow for the estimation of 2013 LTC utilization (use) rates by age and sex for the Central Health region. These 2013 Central Health LTC use rates are multiplied by population projections by age and sex for Economic Zones 11, 12, 13 and 14 to estimate LTC demand for each zone. By doing so, it is assumed that the 2013 LTC use rates for each Economic Zone within the region are the same as the 2013 Central Health LTC use rates. This is a reasonable assumption given that there is no reason to believe that the profile of LTC residents in one part of the Central Health region are significantly different than the profile of LTC residents in any other part of the region.
- For the purpose of these projections, as defined by DOHCS, total LTC demand for the Central Health region is the sum of total LTC beds in the region plus the average Central Health LTC waitlist over the January 2012 to September 2014 period.
- Table 1 provides the current LTC bed supply for the Economic Zones 11-14 and the Central Health region.³

Table 1: Current LTC Bed Supply, Economic Zones 11, 12, 13, 14 and Central Health Region

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of LTC Facilities</th>
<th>Number of LTC Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Zone 11</td>
<td>2</td>
<td>95</td>
</tr>
<tr>
<td>Economic Zone 12</td>
<td>3</td>
<td>161</td>
</tr>
<tr>
<td>Economic Zone 13</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Economic Zone 14</td>
<td>5</td>
<td>251</td>
</tr>
<tr>
<td>Central Health Region</td>
<td>11</td>
<td>519</td>
</tr>
</tbody>
</table>

- The current demand for LTC beds in the Central Health region exceeds supply as indicated by the Central Health LTC waitlist data. The average number of people on the Central Health LTC waitlist over the January 2012 to September 2014 time frame was 94.4. Therefore, current demand for LTC beds (and the starting point for these projections) is assumed to be 613 (i.e. 519 LTC beds plus an average of 94 people on the waitlist).

¹ The Central Health region encompasses Economic Zones 11, 12, 13 and 14. See Appendix A on page 7 for map of the Health Regions and Economic Zones.
² See Appendix B on page 8 for a list of the 10 LTC facilities in the Central Health region submitting data to MDS 2.0 as of June 30, 2014.
³ See Appendix C on page 9 for a map of the LTC facilities in the Central Health region and its associated Economic Zones.
• The LTC demand projections consider two main scenarios:
  - The first scenario assumes constant 2013 LTC use rates by age and sex over the
    projection period.
  - The second scenario assumes declining 2013 LTC use rates over the projection period
    based on the trend reflected in Statistics Canada’s Residential Care Facilities (RCF)
    Survey.

• Even though Statistics Canada’s RCF Survey suggests a slight downward trend in LTC use
  rates, there are qualitative factors that could potentially alter future trends (e.g. emergence
  and/or presence of multiple chronic conditions, increase of age related issues, possible shifts
  in the availability of informal caregivers, etc.). To this end, a third scenario (for illustrative
  purposes only) was considered in which the age and sex specific LTC use rates from the
  constant scenario increase 10% over the 2013–2026 projection period. These three scenarios
  provide a range of possible outcomes for LTC demand.

• Tables 2, 3 and 4 list the projected LTC demand for Economic Zones 11-14 and the Central
  Health region for the three scenarios outlined above. Figures 2, 3, 4, 5 and 6 provide a
  graphical summary of the LTC projections for Economic Zones 11-14 and the Central Health
  region.

Table 2: Projected LTC Demand – Constant Use Rate Scenario,
Economic Zones 11, 12, 13, 14 and Central Health Region, 2013-2026

<table>
<thead>
<tr>
<th>Region</th>
<th>LTC Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
</tr>
<tr>
<td>Economic Zone 11</td>
<td>89</td>
</tr>
<tr>
<td>Economic Zone 12</td>
<td>174</td>
</tr>
<tr>
<td>Economic Zone 13</td>
<td>38</td>
</tr>
<tr>
<td>Economic Zone 14</td>
<td>312</td>
</tr>
<tr>
<td>Central Health Region</td>
<td>613</td>
</tr>
</tbody>
</table>

Table 3: Projected LTC Demand – Declining Use Rate Scenario,
Economic Zones 11, 12, 13, 14 and Central Health Region, 2013-2026

<table>
<thead>
<tr>
<th>Region</th>
<th>LTC Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
</tr>
<tr>
<td>Economic Zone 11</td>
<td>89</td>
</tr>
<tr>
<td>Economic Zone 12</td>
<td>174</td>
</tr>
<tr>
<td>Economic Zone 13</td>
<td>38</td>
</tr>
<tr>
<td>Economic Zone 14</td>
<td>312</td>
</tr>
<tr>
<td>Central Health Region</td>
<td>613</td>
</tr>
</tbody>
</table>

Table 4: Projected LTC Demand – 10% Increase in Constant Use Rate Scenario,
Economic Zones 11, 12, 13, 14 and Central Health Region, 2013-2026

<table>
<thead>
<tr>
<th>Region</th>
<th>LTC Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
</tr>
<tr>
<td>Economic Zone 11</td>
<td>89</td>
</tr>
<tr>
<td>Economic Zone 12</td>
<td>174</td>
</tr>
<tr>
<td>Economic Zone 13</td>
<td>38</td>
</tr>
<tr>
<td>Economic Zone 14</td>
<td>312</td>
</tr>
<tr>
<td>Central Health Region</td>
<td>613</td>
</tr>
</tbody>
</table>
Figure 2: Projected LTC Demand for Various Scenarios, Economic Zone 11, 2013-2026

![Economic Zone 11](image)

Figure 3: Projected LTC Demand for Various Scenarios, Economic Zone 12, 2013-2026

![Economic Zone 12](image)
Figure 4: Projected LTC Demand for Various Scenarios, Economic Zone 13, 2013-2026

Figure 5: Projected LTC Demand for Various Scenarios, Economic Zone 14, 2013-2026
Based on historical trends, the declining use rate scenario appears to be the most likely outcome, but close monitoring of LTC needs should continue in the coming years in order to detect, plan and react to other possible outcomes.

The projections in this report suggest an impending need for additional LTC beds in the Central Health region in the years ahead regardless of which scenario could occur. Based on population aging trends alone, it appears that the demand for LTC in this region will increase significantly. As a result, the level of LTC beds will have to increase correspondingly, or alternative forms of care will be needed to meet demand.

Note that the accuracy of these LTC demand projections is subject to the quality of the data used in their formulation. Data discrepancies could alter the projections significantly and should be addressed accordingly.

Prepared by: N. Morrow (Economic Research and Analysis, Economics and Statistics Branch)
### Appendix B: Central Health LTC Facilities Submitting Data to MDS 2.0 as of June 30, 2014

<table>
<thead>
<tr>
<th>LTC Facility</th>
<th>Health Region</th>
<th>Economic Zone</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baie Verte Health Centre</td>
<td>Central Health</td>
<td>11</td>
<td>Baie Verte</td>
</tr>
<tr>
<td>Valley Vista Senior Citizens’ Home</td>
<td>Central Health</td>
<td>11</td>
<td>Springdale</td>
</tr>
<tr>
<td>A.M. Guy Memorial Health Centre</td>
<td>Central Health</td>
<td>12</td>
<td>Buchans</td>
</tr>
<tr>
<td>Dr. Hugh Twomey Health Centre</td>
<td>Central Health</td>
<td>12</td>
<td>Botwood</td>
</tr>
<tr>
<td>Connaigre Peninsula Health Centre</td>
<td>Central Health</td>
<td>13</td>
<td>Harbour Breton</td>
</tr>
<tr>
<td>Bonnews Health Lodge</td>
<td>Central Health</td>
<td>14</td>
<td>New-Wes-Valley</td>
</tr>
<tr>
<td>Fogo Island Health Centre</td>
<td>Central Health</td>
<td>14</td>
<td>Fogo Island</td>
</tr>
<tr>
<td>Lakeside Homes</td>
<td>Central Health</td>
<td>14</td>
<td>Gander</td>
</tr>
<tr>
<td>North Haven Manor</td>
<td>Central Health</td>
<td>14</td>
<td>Lewisporte</td>
</tr>
<tr>
<td>Notre Dame Bay Memorial Health Centre</td>
<td>Central Health</td>
<td>14</td>
<td>Twillingate</td>
</tr>
</tbody>
</table>
Appendix C: Central Health Region LTC Facilities

Long Term Care Homes

<table>
<thead>
<tr>
<th>Beds</th>
<th>Submitting MDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - 31</td>
<td>No</td>
</tr>
<tr>
<td>40 - 59</td>
<td>Yes</td>
</tr>
<tr>
<td>61 - 83</td>
<td>Yes</td>
</tr>
<tr>
<td>101 - 134</td>
<td>No</td>
</tr>
<tr>
<td>209 - 377</td>
<td>No</td>
</tr>
</tbody>
</table>

- Labrador-Grenfell Health Authority
- Western Health Authority
- Central Health Authority
- Eastern Health Authority
- Economic Zone

Map of Central Health Region showing Long Term Care Homes locations in Newfoundland and Labrador. Additional labels and notations are present, indicating beds ranges and MDS submission status.
Long-Term Care Demand Projections
St. John’s Urban Region

Background:

- In June 2011, the Economics and Statistics Branch (ESB) signed a memorandum of understanding (MOU) with the Department of Health and Community Services (DOHCS) regarding work required to “enable the quantitative assessment and analysis of long-term care (LTC) needs for Newfoundland and Labrador (NL)”. It is expected that an aging population, and consequently an increasing number of seniors requiring LTC, will cause future LTC service needs to rise.

- While these projections focus on all age groups present in LTC facilities, ages 75+ will be the main driver of growth. The rate of growth in the provincial population age 75+ has slowed over the past 15 years because of lower levels of births in the 1920s and the first half of the 1930s, but this trend will not continue. Growth in the 75+ population will increase over the 2013–2020 period as individuals born in the late 1930s and early 1940s move into the 75+ category. This growth will further accelerate when the large baby boomer group begins turning 75 starting in 2021. To plan and manage this growth optimally, DOHCS has partnered with ESB on assessing LTC demand.

- ESB has developed projections for the St. John’s urban region from 2013 to 2026.¹

- Within the St. John’s urban region, the population 75+ increased 27.5% (from 9,329 to 11,895) in the 13 year period between 2000 and 2013. According to the province’s population projections, the population 75+ will increase about 77% (from 11,895 to 21,083) in the 13 year period between 2013 and 2026 (see Figure 1).

Figure 1: Population 75+ (left axis) and Change in Population 75+ (right axis)
St. John’s Urban Region, 1986-2026

¹ As defined by the Department of Health and Community Services, the St. John’s urban region encompasses Economic Zones 19 and 20 (see map on page 4). Previous projections submitted for the “St. John’s Metro” region relied on trends in population data for Economic Zone 19 alone.
Projection Summary

- These LTC projections are based on two main datasets:
  - Economic Zone 19 and 20 population projections by age and sex from the Economic Research and Analysis (ERA) Division within ESB.
  - LTC resident data by age and sex from the Canadian Institute for Health Information (CIHI). These data are collected from the three LTC facilities in the St. John’s urban region currently submitting InterRAI Minimum Data Set (MDS) 2.0 data, and includes information for 1,361 LTC residents of all ages at time of entry into LTC, the majority of whom entered a LTC facility between 2008 and 2013. Combined with population estimates, these data allow for the calculation of current estimates of LTC utilization (use) rates by age and sex.

- For the purpose of these projections, as defined by DOHCS, total LTC demand for the St. John’s urban region is the sum of total LTC beds in the region plus 70% of the average Eastern Health LTC waitlist over the January 2011 to May 2014 period.

- In terms of current LTC bed supply, DOHCS indicates there are currently 10 LTC homes and 1,171 LTC beds in the St. John’s urban region (see map inset on page 5).

- It is assumed that current demand for LTC beds in the St. John’s urban region exceeds supply, as an analysis of Eastern Health LTC waitlist data provided by DOHCS indicates that there has been an unmet demand for LTC beds in the region over the time span for which data is available. The average number of people on the Eastern Health LTC waitlist over the January 2011 to May 2014 time frame was 108. It is estimated that the St. John’s urban region accounts for approximately 70% of the Eastern Health LTC waitlist. Therefore, current demand for LTC beds (and the starting point for these projections) is assumed to be 1,247 (i.e., 1,171 LTC beds plus the average of 76 people on the waitlist).

- The LTC projections consider two main scenarios:
  - The first scenario assumes constant 2013 LTC use rates by age and sex over the projection period (derived from a combination of MDS 2.0 data, total LTC demand as outlined above and population by age and sex).
  - The second scenario assumes declining 2013 LTC use rates over the projection period based on the trend reflected in the historical data set obtained from Statistics Canada’s Residential Care Facilities (RCF) survey.

- In addition, although available historical data suggests that LTC use rates will most likely continue to decrease slightly in the coming years, there are qualitative factors that could potentially suggest otherwise (e.g., emergence and/or presence of multiple chronic conditions, increase of age related conditions, etc.). To this end, a third scenario (for illustrative purposes only) was considered in which the age and sex specific LTC use rates from the constant scenario increase 10% over the 2013–2026 projection period.

- Table 1 and Figure 2 provide a summary of the LTC projections for the St. John’s urban region for the three scenarios outlined above.

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2 There are a total of 10 LTC facilities in the St. John’s urban region. As of December 31, 2013, three of these LTC facilities were submitting data to CIHI. These include Hoyles/Escasoni Complex (St. John’s), Masonic Park Nursing Home (Mount Pearl) and St. Patrick’s Mercy Home (St. John’s).
Table 1: Projected LTC Demand: Constant Use Rate Scenario, Declining Use Rate Scenario, and 10% Increase in Use Rate Scenario, St. John’s Urban Region, 2013-2026

<table>
<thead>
<tr>
<th>Scenario</th>
<th>LTC Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
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<tr>
<td>Scenario 1: Constant LTC Use Rates</td>
<td>1,247</td>
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<tr>
<td>Scenario 2: Declining LTC Use Rates</td>
<td>1,247</td>
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<tr>
<td>Scenario 3: 10% Increase in LTC Use Rates</td>
<td>1,247</td>
</tr>
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</table>

- Based on historical trends, Scenario 2 appears to be the most likely outcome, but close monitoring of LTC needs should continue in the coming years in order to detect, plan and react to other possible outcomes.
- The projections in this report suggest an impending need for additional LTC in the St. John’s urban region in the decades to come. Based on population aging trends alone, it appears that the demand for LTC in this region will increase significantly. As a result, the level of LTC will have to increase correspondingly, or alternative forms of care will be needed if this demand is to be met.

Figure 2: Projected LTC Demand: Constant Use Rate Scenario, Declining Use Rate Scenario, and 10% Increase in Use Rate Scenario, St. John’s Urban Region, 2013-2026
Figure 3: Newfoundland and Labrador Economic Zones Map

Economic Zones
Newfoundland & Labrador
Figure 4: St. John’s Urban Region LTC Facilities (Inset plus Bell Island)

Long Term Care Homes

<table>
<thead>
<tr>
<th>Beds</th>
<th>Submitting</th>
<th>Labrador-Grenfell Health Authority</th>
<th>Western Health Authority</th>
<th>Central Health Authority</th>
<th>Eastern Health Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - 31</td>
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<td>40 - 59</td>
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<td>209 - 377</td>
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</table>

Prepared by: D. Penney (Economic Research and Analysis, Economics and Statistics Branch)
June 2014
Long-Term Care Demand Projections
Western Regional Health Authority

Background:
- In June 2011, the Economics and Statistics Branch (ESB) signed a memorandum of understanding (MOU) with the Department of Health and Community Services (DOHCS) regarding work required to "enable the quantitative assessment and analysis of long-term care (LTC) needs for Newfoundland and Labrador (NL)". An aging population, and consequently an increasing number of seniors requiring LTC, will cause future LTC service needs to rise.

- While these projections focus on the 65+ age group, ages 75+ will be the main driver of growth. The rate of growth in the provincial population age 75+ has slowed over the past 15 years because of lower levels of births in the 1920s and the first half of the 1930s, but this trend will not continue. Growth in the 75+ population will increase over the 2013–2020 period as individuals born in the late 1930s and early 1940s move into the 75+ category. This growth will further accelerate when the large baby boomer group begins turning 75 starting in 2021. To plan and manage this growth optimally, DOHCS has partnered with ESB on assessing LTC demand.

- In March 2014, DOHCS requested that ESB prioritize the Western Health region as most urgent. Based on this request, ESB has developed projections for this region from 2013 to 2026.

- Within the Western Health region, the population 75+ increased 43.7% (from 4,309 to 6,194) in the 13 year period between 2000 and 2013. According to the province’s population projections, the population 75+ will increase about 63% (from 6,194 to 10,112) in the 13 year period between 2013 and 2026 (see Figure 1).

Figure 1: Population 75+ (left axis) and Change in Population 75+ (right axis)
Western Health Region, 1986-2026
Projection Summary:

- These LTC projections are based on two main datasets:
  - Western Health region population projections by age and sex from the Economic Research and Analysis (ERA) Division within ESB.
  - LTC resident data by age and sex from the Canadian Institute for Health Information (CIHI). These data are collected from the 20 LTC homes in NL currently submitting InteRAI Minimum Data Set (MDS) 2.0 data, and includes information for 2,252 LTC residents age 65+, the majority of whom entered a LTC home between 2008 and 2013.\(^1\)
  - Combined with population estimates, these data allow for the calculation of current estimates of LTC utilization (use) rates by age and sex.

- Currently there are no LTC homes in the Western Health region submitting MDS 2.0 data to CIHI. The resident age and sex distributions for LTC homes in the Western Health region are assumed to be similar to that of the LTC homes submitting MDS 2.0 data. Half of the 20 submitting LTC homes are located in the Eastern Health region, and the remaining 10 in the Central Health region.\(^2\)

- In terms of current LTC bed supply, DOHCS indicates there are currently six LTC homes and 474 LTC beds in the Western Health region (see map on page 4).

- It is assumed that current demand for LTC beds in the Western Health region exceeds supply, as an analysis of Western Health LTC waitlist data provided by DOHCS indicates that there has been an unmet demand for LTC beds in the region over the time span for which data is available. The average number of people on the waitlist over the January 2012 to February 2014 time frame was 43. Therefore, current demand for LTC beds (and the starting point for these projections) is assumed to be 517 (i.e. 474 LTC beds plus the average of 43 people on the waitlist).

- The LTC projections consider two main scenarios:
  - The first scenario assumes constant 2013 LTC use rates (derived from MDS 2.0 data) by age and sex over the projection period.
  - The second scenario assumes declining 2013 LTC use rates over the projection period based on the trend reflected in the historical data set obtained from Statistics Canada’s Residential Care Facilities (RCF) survey.

- In addition, although available historical data suggests that LTC use rates will most likely continue to decrease slightly in the coming years, there are qualitative factors that could potentially suggest otherwise (e.g. emergence and/or presence of multiple chronic conditions, increase of age related conditions, etc.). To this end, a third scenario (for illustrative purposes only) was considered in which the age and sex specific LTC use rates from the constant scenario increase 10% over the 2013–2026 projection period.

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\(^1\) There are a total of 40 LTC homes in NL. As of December 31, 2013, only 20 were submitting data to CIHI.

\(^2\) The 20 LTC facilities across NL currently using the MDS 2.0 system and submitting to CIHI are: A.M. Guy Memorial Health Centre (Buchans), Baie Verte Peninsula Health Centre, Bonnies Lodge (New-Wes-Valley), Connaigre Peninsula Health Centre (Harbour Breton), Dr. Hugh Twomey Health Centre (Botwood), Fogo Island Health Centre, Green Bay Health Centre (Springdale), Lakeside Homes (Gander), North Haven Manor (Lewispore), Notre Dame Bay Memorial Health Centre (Twillingate), Blue Crest Interfaith Home (Grand Bank), Dr. Albert O’Mahony Memorial Manor (Clarenville), Golden Heights Manor (Bonavista), Harbour Lodge Nursing Home (Carbonera), Hoyles/Escasoni Complex (St. John’s), Interfaith Citizens Home (Carbonera), Masonic Park Nursing Home (Mount Pearl), Lion’s Manor (Placentia), St. Patrick’s Mercy Home (St. John’s) and U.S. Memorial Health Centre (St. Lawerence).
• Table 1 and Figure 2 provide a summary of the LTC projections for the Western Health region for the three scenarios outlined above.

**Table 1: Projected LTC Demand (age 65+): Constant Use Rate Scenario, Declining Use Rate Scenario, and 10% Increase in Use Rate Scenario, Western Health Region, 2013-2026**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>2013</th>
<th>2017</th>
<th>2022</th>
<th>2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario 1: Constant LTC Use Rates</td>
<td>517</td>
<td>589</td>
<td>701</td>
<td>809</td>
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<tr>
<td>Scenario 2: Declining LTC Use Rates</td>
<td>517</td>
<td>569</td>
<td>656</td>
<td>742</td>
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<tr>
<td>Scenario 3: 10% Increase in LTC Use Rates</td>
<td>517</td>
<td>601</td>
<td>739</td>
<td>879</td>
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</table>

• Based on historical trends, Scenario 2 appears to be the most likely outcome, but close monitoring of LTC needs should continue in the coming years in order to detect, plan and react to other possible outcomes.

• The projections in this report suggest an impending need for additional LTC in the Western Health region in the decades to come. Based on population aging trends alone, it appears that the demand for LTC in this region will increase significantly. As a result, the level of LTC will have to increase correspondingly, or alternative forms of care will be needed if this demand is to be met.

**Figure 2: Projected LTC Demand (age 65+): Constant Use Rate Scenario, Declining Use Rate Scenario, and 10% Increase in Use Rate Scenario, Western Health Region, 2013-2026**
Figure 3: Western Health Region LTC Homes

Long Term Care Homes

Beds Submitting MDS
- Labrador-Grenfell Health Authority
- Western Health Authority
- Central Health Authority
- Eastern Health Authority

Prepared by: D. Penney (Economic Research and Analysis, Economics and Statistics Branch)
April 23, 2014
Long-Term Care Projections
Western Regional Health Authority

Background:
- In June 2011, the Economics and Statistics Branch (ESB) signed a memorandum of understanding (MOU) with the Department of Health and Community Services (DOHCS) regarding work required to “enable the quantitative assessment and analysis of long-term care (LTC) needs for Newfoundland and Labrador (NL)”. An aging population, and consequently an increasing number of seniors requiring LTC, will cause future LTC service needs to rise.
- While these projections focus on the 65+ age group, ages 75+ will be the main driver of growth. The rate of growth in the provincial population age 75+ has slowed over the past 15 years because of lower levels of births in the 1920s and the first half of the 1930s, but this trend will not continue. Growth in the 75+ population will increase over the 2013–2020 period as individuals born in the late 1930s and early 1940s move into the 75+ category. This growth will further accelerate when the large baby boomer group begins turning 75 starting in 2021. To plan and manage this growth optimally, DOHCS has partnered with ESB on assessing LTC demand.
- In March 2014, DOHCS requested that ESB prioritize the Western Health region as most urgent. Based on this request, ESB has developed projections for this region from 2013 to 2026.
- Within the Western Health region, the population 75+ increased 43.7% (from 4,309 to 6,194) in the 13 year period between 2000 and 2013. According to the province’s population projections, the population 75+ will increase about 63% (from 6,194 to 10,112) in the 13 year period between 2013 and 2026 (see Figure 1).

Figure 1: Population 75+ (left axis) and Change in Population 75+ (right axis)
Western Health Region, 1986-2026
Projection Summary:

- These LTC projections are based on two main datasets:
  - Western Health region population projections by age and sex from the Economic Research and Analysis (ERA) Division within ESB.
  - LTC resident data obtained by ERA from the Canadian Institute for Health Information (CIHI). These data are collected from 12 LTC homes in NL currently submitting InterRAI Minimum Data Set (MDS) 2.0 data, and includes information for 1,741 LTC residents age 65+, the majority of whom entered a LTC home between 2008 and 2013. Combined with population estimates, these data allow for the calculation of current estimates of LTC utilization (use) rates by age and sex.

- Currently there are no LTC homes in the Western Health region submitting MDS 2.0 data to CIHI. The LTC resident age and sex distributions used in these projections are derived from available data from the 12 LTC homes that are currently submitting. The majority (10) of the reporting LTC homes are located in the Eastern Health region, and the remaining two in the Central Health region.1

- In terms of current LTC bed supply, DOHCS indicates there are currently six LTC homes and 474 LTC beds in the Western Health region (see map on page 4).

- The central assumption behind these LTC projections is that current LTC demand is essentially 100% of capacity/beds for the LTC homes in the region; or, supply equals demand. This assumption embodies the notion that current waitlist fluctuations for LTC are part of a natural process of moving people in and out of the system, and does not represent excess demand.

- The LTC projections consider two main scenarios:
  - The first scenario assumes constant 2013 LTC use rates (derived from MDS 2.0 data) by age and sex over the projection period.
  - The second scenario assumes declining 2013 LTC use rates over the projection period based on the trend reflected in the historical data set obtained from Statistics Canada’s Residential Care Facilities (RCF) survey.

- In addition, although available historical data suggests that LTC use rates will most likely continue to decrease slightly in the coming years, there are qualitative factors that could potentially suggest otherwise (e.g., emergence and/or presence of multiple chronic conditions, increase of age related conditions, etc.). To this end, a third scenario (for illustrative purposes only) was considered in which the age and sex specific LTC use rates from the constant scenario increase 10% over the 2013–2026 projection period.

- Table 1 and Figure 2 provide a summary of the LTC projections for the Western Health region for the three scenarios outlined above.

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1 The 12 LTC facilities across NL currently using the MDS 2.0 system and reporting to CIHI are: A.M. Guy Memorial Health Centre (Buchans), Baie Verte Peninsula Health Centre, Blue Crest Interfaith Home (Grand Bank), Interfaith Citizens Home (Carbonear), Dr. Albert O’Mahony Memorial Manor (Clarenville), Golden Heights Manor (Bonavista), Harbour Lodge Nursing Home (Carbonear), Hoyles/Escasoni Complex (St. John’s), Masonic Park Nursing Home (Mount Pearl), Lion’s Manor (Placentia), St. Patrick’s Mercy Home (St. John’s) and U.S. Memorial Health Centre (St. Lawerence).
Table 1: Projected LTC Demand (age 65+): Constant Use Rate Scenario, Declining Use Rate Scenario, and 10% Increase in Use Rate Scenario, Western Health Region, 2013-2026

<table>
<thead>
<tr>
<th>Scenario</th>
<th>2013</th>
<th>2017</th>
<th>2022</th>
<th>2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario 1: Constant LTC Use Rates</td>
<td>474</td>
<td>540</td>
<td>644</td>
<td>741</td>
</tr>
<tr>
<td>Scenario 2: Declining LTC Use Rates</td>
<td>474</td>
<td>521</td>
<td>602</td>
<td>681</td>
</tr>
<tr>
<td>Scenario 3: 10% Increase in LTC Use Rates</td>
<td>474</td>
<td>551</td>
<td>679</td>
<td>806</td>
</tr>
</tbody>
</table>

- Based on historical trends, Scenario 2 appears to be the most likely outcome, but close monitoring of LTC needs should continue in the coming years in order to detect, plan and react to other possible outcomes.
- The projections in this report suggest an impending need for additional LTC in the Western Health region in the decades to come. Based on population aging trends alone, it appears that the demand for LTC in this region will increase significantly. As a result, the level of LTC will have to increase correspondingly, or alternative forms of care will be needed if this demand is to be met.

Figure 2: Projected LTC Demand (age 65+): Constant Use Rate Scenario, Declining Use Rate Scenario, and 10% Increase in Use Rate Scenario, Western Health Region, 2013-2026
Long-Term Care Demand Projections
Labrador-Grenfell Health Region

Background:

- In June 2011, the Economics and Statistics Branch (ESB) signed a memorandum of understanding (MOU) with the Department of Health and Community Services (DOHCS) regarding work required to “enable the quantitative assessment and analysis of long-term care (LTC) needs for Newfoundland and Labrador (NL)”. It is expected that an aging population, and consequently an increasing number of seniors requiring LTC, will cause future LTC service needs to rise.

- While the projections in this report focus on all age groups present in LTC facilities, the 75+ population will be the main driver of growth. The rate of growth in the provincial 75+ population has slowed over the past 15 years because of lower levels of births in the 1920s and the first half of the 1930s, but this trend will not continue. Growth in the provincial 75+ population will increase over the 2014–2020 period as individuals born in the late 1930s and early 1940s move into the 75+ age category. This growth will further accelerate when the large baby boomer group starts turning 75 beginning in 2021. To plan and manage this growth optimally, DOHCS has partnered with ESB on assessing LTC demand.

- Within the Labrador-Grenfell Health (LGH) region, the population 75+ increased 49.2% (from 1,029 to 1,535) in the 13 year period between 2000 and 2013. According to population projections, the population 75+ will increase about 67% (from 1,535 to 2,569) in the 13 year period between 2013 and 2026. See Figure 1 for a graph of the population 75+, the change in the population 75+ and the projected population 75+ for the LGH region.

Figure 1: Population 75+ (left axis) and Change in Population 75+ (right axis)
Labrador-Grenfell Health Region, 1986-2026
Projection Summary:
- ESB has prepared LTC demand projections for the LGH region from 2014 to 2026. ESB has also prepared LTC demand projections for the Northern Peninsula portion of the LGH region from 2014 to 2026.¹
- These LTC projections are based on three main datasets:
  - Population projections by age and sex for the LGH region and Economic Zones 6 and 7 from the Economic Research and Analysis (ERA) Division within ESB.
  - Age and sex data on current LTC residents. These data were collected by the Canadian Institute for Health Information (CIHI) from 22 LTC facilities in the province submitting data to the InterRAI Minimum Data Set (MDS) 2.0 as of June 30, 2014. Since implementing the MDS 2.0, these 22 LTC facilities have submitted data on 1,145 current LTC residents, the majority of who entered a LTC facility between 2011 and 2014.²
  - Age and sex data on deceased LTC residents from the ESB LTC Historical Dataset. These data were collected, key-entered, and validated by the Newfoundland and Labrador Statistics Agency (NLSA) within ESB from two LTC facilities in the LGH region.³ These LTC facilities have data on 200 deceased residents who were assessed between 2000 and 2009.
- As of June 30, 2014, there were no LTC facilities in the LGH region submitting data to the MDS 2.0. As a result, ESB estimated an age and sex distribution for current LGH LTC residents to be used in both the LTC demand projections for the LGH region and the Northern Peninsula portion of the LGH region. This was completed in the following steps:
  - An average of the MDS 2.0 age distribution for current LTC residents in NL and the ESB LTC Historical Dataset age distribution for deceased LTC residents in the LGH region was multiplied by the total of the current number of LTC beds in the LGH region plus the average number of people on the waitlist for the LGH region.
  - The total for each age group was then multiplied by a sex distribution for that respective age group from the MDS 2.0 for current LTC residents to get an estimated age and sex distribution for the LGH region.
- The population projections and estimated LTC age and sex splits allow for the estimation of current LTC utilization (use) rates by age and sex for the LGH region.
- For the purpose of these projections, total LTC demand for the LGH region is the sum of the number of LTC beds in the region plus the average LTC waitlist for the LGH region over the January 2012 to September 2014 period. Total LTC demand for the Northern Peninsula portion of the LGH region is the sum of the number of LTC beds in the John M. Gray Health Centre in St. Anthony plus the average LTC waitlist for the same facility over the November 2012 to October 2014 period (excluding August 2013, October 2013, and November 2013 because LTC waitlist data was not available for these months).

¹ The LGH region encompasses Economic Zones 1-6 and a part of Economic Zone 7. The Northern Peninsula portion of the LGH region encompasses Economic Zone 6 and a part of Economic Zone 7. See Appendix A on page 6 for a map of the Health Regions and Economic Zones.
² See Appendix B on page 7 for a list of the 23 LTC facilities submitting data to the MDS 2.0 as of June 30, 2014. In total, there are 41 LTC facilities in the province. Given that the age distribution of residents in the Hoyles-Escasoni Complex is distinctly different than the age distribution of residents in the other LTC facilities in the province, data from the Hoyles-Escasoni Complex was not used in the LTC demand projections in this report.
³ The ESB LTC Historical Database has resident data from two LTC facilities in the LGH region: the John M. Gray Health Centre (St. Anthony) and the Happy Valley-Goose Bay LTC Home (Happy Valley-Goose Bay).
• In terms of current LTC bed supply, there are currently four LTC facilities and 117 LTC beds in the LGH region, and one LTC facility and 47 LTC beds in the Northern Peninsula portion of the LGH region.4

• It is assumed that current demand for LTC beds in the LGH region and the Northern Peninsula portion of the LGH region exceeds supply. An analysis of LTC waitlist data for the LGH region and the John M. Gray Health Centre indicates that there has been an unmet demand for LTC beds over the periods for which LTC waitlist data is available.
  - The average number of people on the LTC waitlist for the LGH region over the January 2012 to September 2014 period was 20.4. Therefore, current demand for LTC beds in the LGH region (and the starting point for the projections) is assumed to be 137 (i.e. 117 LTC beds plus an average of 20.4 people on the waitlist).
  - The average number of people on the LTC waitlist for the John M. Gray Health Centre over the November 2012 to October 2014 period was 6.5. Therefore, current demand for LTC beds in Northern Peninsula portion of the LGH region (and the starting point for the projections) is assumed to be 54 (i.e. 47 LTC beds plus an average of 6.5 people on the waitlist).

• The LTC projections consider two main scenarios:
  - The first scenario assumes constant 2013 LTC use rates by age and sex over the projection period.
  - The second scenario assumes declining 2013 LTC use rates over the projection period based on the trend reflected in Statistics Canada’s Residential Care Facilities (RCF) survey.

• Even though the trend in Statistics Canada’s RCF survey suggests that LTC use rates will most likely continue to decrease slightly in the coming years, there are qualitative factors that could potentially suggest otherwise (e.g. emergence and/or presence of multiple chronic conditions, increase of age related conditions, etc.). To this end, a third scenario (for illustrative purposes only) was considered in which the age and sex specific LTC use rates from the constant scenario increase 10% over the 2013–2026 projection period.

• Table 1 and Figure 2 provide a summary of the LTC projections for the LGH region for the three scenarios outlined above. Similarly, Table 2 and Figure 3 provide a summary of the LTC projections for the Northern Peninsula portion of the LGH region for the three scenarios outlined above.

Table 1: Projected LTC Demand: Constant Use Rate Scenario, Declining Use Rate Scenario, and 10% Increase in Use Rate Scenario, Labrador-Grenfell Health Region, 2013-2026

<table>
<thead>
<tr>
<th>Scenario</th>
<th>LTC Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
</tr>
<tr>
<td>Scenario 1: Constant LTC Use Rates</td>
<td>137</td>
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<tr>
<td>Scenario 2: Declining LTC Use Rates</td>
<td>137</td>
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<tr>
<td>Scenario 3: 10% Increase in Constant LTC Use Rates</td>
<td>137</td>
</tr>
</tbody>
</table>

4 See Appendix C on page 8 for a map of the LTC facilities in the LGH region.
Table 2: Projected LTC Demand: Constant Use Rate Scenario, Declining Use Rate Scenario, and 10% Increase in Use Rate Scenario, Northern Peninsula Portion of the LGH Region, 2013-2026

<table>
<thead>
<tr>
<th>Scenario</th>
<th>LTC Demand</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>2013</td>
</tr>
<tr>
<td>Scenario 1: Constant LTC Use Rates</td>
<td>54</td>
</tr>
<tr>
<td>Scenario 2: Declining LTC Use Rates</td>
<td>54</td>
</tr>
<tr>
<td>Scenario 3: 10% Increase in Constant LTC Use Rates</td>
<td>54</td>
</tr>
</tbody>
</table>

- Based on historical trends, Scenario 2 appears to be the most likely outcome, but close monitoring of LTC needs should continue in the coming years in order to detect, plan and react to other possible outcomes.
- The projections in this report suggest an impending need for additional LTC beds in the Northern Peninsula portion of the LGH region and the health region as a whole in the decades to come. Based on population aging trends alone, it appears that the demand for LTC in this region will increase significantly. As a result, the level of LTC beds will have to increase correspondingly, or alternative forms of care will be needed if this demand is to be met.

Figure 2: Projected LTC Demand: Constant Use Rate Scenario, Declining Use Rate Scenario, and 10% Increase in Use Rate Scenario, Labrador-Grenfell Health Region, 2013-2026
Figure 3: Projected LTC Demand: Constant Use Rate Scenario, Declining Use Rate Scenario, and 10% Increase in Use Rate Scenario, Northern Peninsula Portion of LGH Region, 2013-2026

Appendix A: Newfoundland and Labrador’s Health Regions and Economic Zones

Newfoundland & Labrador

Health Region

- Labrador-Grenfell Health Authority
- Western Health Authority
- Central Health Authority
- Eastern Health Authority

Economic Zone

NZ

0 60 120 240

Department of Finance
Newfoundland & Labrador Statistics Agency
Social and Economic Spatial Analysis Unit
### Appendix B: LTC Facilities Submitting Data to the MDS 2.0 as of June 30, 2014

<table>
<thead>
<tr>
<th>LTC Facility</th>
<th>Health Region</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.M. Guy Memorial Health Centre</td>
<td>Central Health</td>
<td>Buchans</td>
</tr>
<tr>
<td>Baie Verte Health Centre</td>
<td>Central Health</td>
<td>Baie Verte</td>
</tr>
<tr>
<td>Bonnovs Health Lodge</td>
<td>Central Health</td>
<td>New-Wes-Valley</td>
</tr>
<tr>
<td>Connaigre Peninsula Health Centre</td>
<td>Central Health</td>
<td>Harbour Breton</td>
</tr>
<tr>
<td>Dr. Hugh Twomey Health Centre</td>
<td>Central Health</td>
<td>Botwood</td>
</tr>
<tr>
<td>Fogo Island Health Centre</td>
<td>Central Health</td>
<td>Fogo Island</td>
</tr>
<tr>
<td>Lakeside Homes</td>
<td>Central Health</td>
<td>Gander</td>
</tr>
<tr>
<td>North Haven Manor</td>
<td>Central Health</td>
<td>Lewisporte</td>
</tr>
<tr>
<td>Notre Dame Bay Memorial Health Centre</td>
<td>Central Health</td>
<td>Twillingate</td>
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<tr>
<td>Valley Vista Senior Citizens’ Home</td>
<td>Central Health</td>
<td>Springdale</td>
</tr>
<tr>
<td>Agnes Pratt Home</td>
<td>Eastern Health</td>
<td>St. John’s</td>
</tr>
<tr>
<td>Blue Crest Interfaith Home</td>
<td>Eastern Health</td>
<td>Grand Bank</td>
</tr>
<tr>
<td>Dr. Albert O’Mahony Memorial</td>
<td>Eastern Health</td>
<td>Clarenville</td>
</tr>
<tr>
<td>Golden Heights Manor</td>
<td>Eastern Health</td>
<td>Bonavista</td>
</tr>
<tr>
<td>Harbour Lodge Nursing Home</td>
<td>Eastern Health</td>
<td>Carbonear</td>
</tr>
<tr>
<td>Hoyles-Escasoni Complex</td>
<td>Eastern Health</td>
<td>St. John’s</td>
</tr>
<tr>
<td>Interfaith Citizens’ Home</td>
<td>Eastern Health</td>
<td>Carbonear</td>
</tr>
<tr>
<td>Masonic Park Nursing Home</td>
<td>Eastern Health</td>
<td>Mount Pearl</td>
</tr>
<tr>
<td>Placentia Health Centre</td>
<td>Eastern Health</td>
<td>Placentia</td>
</tr>
<tr>
<td>St. Patrick’s Mercy Home</td>
<td>Eastern Health</td>
<td>St. John’s</td>
</tr>
<tr>
<td>U.S. Memorial Health Centre</td>
<td>Eastern Health</td>
<td>St. Lawrence</td>
</tr>
<tr>
<td>Calder Health Centre</td>
<td>Western Health</td>
<td>Burgeo</td>
</tr>
<tr>
<td>Rufus Guinchard Health Care Centre</td>
<td>Western Health</td>
<td>Port Saunders</td>
</tr>
</tbody>
</table>
Appendix C: LTC Facilities in the Labrador-Grenfell Health Region

Long Term Care Homes

<table>
<thead>
<tr>
<th>Beds</th>
<th>Submitting MDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - 31</td>
<td>No</td>
</tr>
<tr>
<td>40 - 59</td>
<td>Yes</td>
</tr>
<tr>
<td>61 - 83</td>
<td></td>
</tr>
<tr>
<td>101 - 134</td>
<td>N</td>
</tr>
<tr>
<td>209 - 377</td>
<td></td>
</tr>
</tbody>
</table>

Legend:
- Labrador-Grenfell Health Authority
- Western Health Authority
- Central Health Authority
- Eastern Health Authority

Map showing locations of facilities with numbers indicating bed capacity and symbols indicating whether they submit MDS data.

Department of Finance
Newfoundland & Labrador Statistics Agency
Social and Economic Spatial Analysis Unit

Map scale: 1:2,000,000
Background:
- In June 2011, the Economics and Statistics Branch (ESB) signed a memorandum of understanding (MOU) with the Department of Health and Community Services (DOHCS) regarding work required to “enable the quantitative assessment and analysis of long-term care (LTC) needs for Newfoundland and Labrador (NL).” It is expected that an aging population, and consequently, an increasing number of seniors requiring LTC will cause future LTC service needs to rise.
- While these projections focus on all age groups present in LTC facilities, the majority of LTC residents are 75+ and changes in this age group are expected to be the main driver of the demand for LTC. The rate of growth in the provincial population age 75+ has slowed over the past 15 years because of lower levels of births in the 1920s and the first half of the 1930s, but this trend will not continue. Growth in the 75+ population will increase over the 2015–2020 period as individuals born in the late 1930s and early 1940s move into the 75+ age category. This growth will further accelerate when the large “baby boomer” group starts turning 75 beginning in 2021. To plan and manage this growth optimally, DOHCS has partnered with ESB on assessing LTC demand.¹
- Within the Eastern Health region, the population 75+ increased 21.5% (from 15,941 to 19,363) in the 13 year period between 2000 and 2013. According to population projections, the population 75+ will increase 75.0% (from 19,363 to 33,884) in the 13 year period between 2013 and 2026. Figure 1 provides a graphical summary of the population 75+, the change in the population 75+ and the projected population 75+ for the Eastern Health region.

Figure 1: Population 75+ (left axis) and Change in Population 75+ (right axis)
Eastern Health Region, 1986-2026

¹The baby boomer group is defined as individuals born between 1946 and 1964.
Analysis:

i. LTC Demand Projections

- ESB has prepared LTC demand projections for the Eastern Health region and each of the Economic Zones within the health region (i.e. Economic Zones 15-20) from 2014 to 2026.

- These LTC demand projections are based on two main datasets:
  - Age and sex data on current and deceased LTC residents in the Eastern Health region, the majority of whom entered a LTC facility between 2011 and 2014. These data were collected by the Canadian Institute for Health Information (CIHI) from the LTC facilities in the Eastern Health region submitting data to the InterRAI Minimum Data Set (MDS) 2.0 as of September 30, 2014.²

- The LTC resident data allow for the estimation of 2013 LTC utilization (use) rates by age and sex for the Eastern Health region. The 2013 LTC use rates are multiplied by population projections by age and sex for each of the Economic Zones within the Eastern Health region to project LTC demand for each zone. The projected LTC demand for the Eastern Health region is the sum of the projected LTC demands for each of the Economic Zones within the Eastern Health region.

- Resident age and sex data from all of the LTC facilities in the Eastern Health region submitting data to the MDS 2.0 were used in the estimation of 2013 LTC use rates for Economic Zone 19. However, resident age and sex data from all of the LTC facilities in the Eastern Health region submitting data to the MDS 2.0, excluding the Hoyles-Escasoni Complex and the Veteran’s Pavilion (both of which are located in Economic Zone 19), were used in the estimation of 2013 LTC use rates for Economic Zones 15, 16, 17, 18 and 20.

- By doing so, it is assumed that:
  - Economic Zone 19 has different 2013 LTC use rates than Economic Zones 15, 16, 17, 18 and 20. This is a reasonable assumption given that the age distribution of residents in the Hoyles-Escasoni Complex and the Veteran’s Pavilion are distinctly different than the age distribution of residents in the other LTC facilities in the province.
  - Economic Zones 15, 16, 17, 18 and 20 have the same 2013 LTC use rates. This is also a reasonable assumption because the profile of LTC residents in one of these Economic Zones is not significantly different than the profile of LTC residents in one of the other Economic Zones.

² See Appendix A on page 11 for a list of the 12 LTC facilities in the Eastern Health region submitting data to the MDS 2.0 as of September 30, 2014.
• Table 1 summarizes the entry age distribution of LTC residents in the Eastern Health region.  

Table 1: Entry Age Distribution of LTC Residents, Eastern Health Region

<table>
<thead>
<tr>
<th>Entry Age Group</th>
<th>All Eastern Health LTC Facilities</th>
<th>Hoyles-Escasoni Complex and Veteran’s Pavilion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (%)</td>
<td>Female (%)</td>
</tr>
<tr>
<td>59 and younger</td>
<td>10.1</td>
<td>4.7</td>
</tr>
<tr>
<td>60 to 64</td>
<td>6.0</td>
<td>2.5</td>
</tr>
<tr>
<td>65 to 69</td>
<td>7.6</td>
<td>4.9</td>
</tr>
<tr>
<td>70 to 74</td>
<td>13.8</td>
<td>8.0</td>
</tr>
<tr>
<td>75 to 79</td>
<td>18.8</td>
<td>16.1</td>
</tr>
<tr>
<td>80 to 84</td>
<td>18.6</td>
<td>18.9</td>
</tr>
<tr>
<td>85 to 89</td>
<td>16.0</td>
<td>23.0</td>
</tr>
<tr>
<td>90 and older</td>
<td>8.9</td>
<td>21.9</td>
</tr>
</tbody>
</table>

• Table 2 lists the current LTC bed supply for Economic Zones 15-20 and the Eastern Health region.

Table 2: Current LTC Bed Supply, Economic Zones 15-20 and Eastern Health Region

<table>
<thead>
<tr>
<th>Economic Zone or Health Region</th>
<th>Number of LTC Facilities</th>
<th>Number of LTC Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Zone 15</td>
<td>3</td>
<td>126</td>
</tr>
<tr>
<td>Economic Zone 16</td>
<td>2</td>
<td>101</td>
</tr>
<tr>
<td>Economic Zone 17</td>
<td>3</td>
<td>205</td>
</tr>
<tr>
<td>Economic Zone 18</td>
<td>1</td>
<td>75</td>
</tr>
<tr>
<td>Economic Zone 19</td>
<td>10</td>
<td>1,201</td>
</tr>
<tr>
<td>Economic Zone 20</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Eastern Health Region</td>
<td>19</td>
<td>1,708</td>
</tr>
</tbody>
</table>

• According to the MDS 2.0 resident data, 0.4% of LTC residents that lived in the Eastern Health region prior to entering LTC were residents of a LTC facility in another health region. As a result, the estimated number of LTC residents that lived in the Eastern Health region, but were residents of a LTC facility in another health region is 6 (i.e. 0.4% of 1,708).

• The MDS 2.0 resident data also indicates that 1.6% of residents in an Eastern Health LTC facility lived in another health region prior to entering LTC. Thus, the estimated number of LTC residents in an Eastern Health LTC facility that lived in another health region is 27 (i.e. 1.6% of 1,708).

• The demand for LTC beds in the Eastern Health region exceeds supply as indicated by the Eastern Health LTC waitlist data. The monthly average number of people on the Eastern Health LTC waitlist over the January 2012 to November 2014 time frame was 109.

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3 Note that the percentages in each column do not necessarily sum to 100 because of independent rounding.
4 See Appendix B on page 12 for a map of the LTC facilities in the Eastern Health region and its associated Economic Zones.
• Table 3 provides a breakdown of the current demand for LTC beds in the Eastern Health region.

Table 3: Current Demand for LTC Beds, Eastern Health Region

<table>
<thead>
<tr>
<th>Demand Source</th>
<th>Number of LTC Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC beds in Eastern Health region</td>
<td>1,708</td>
</tr>
<tr>
<td>Estimated number of LTC residents who lived in the Eastern Health region,</td>
<td></td>
</tr>
<tr>
<td>but were LTC residents in another health region</td>
<td>-6</td>
</tr>
<tr>
<td>Estimated number of LTC residents in an Eastern Health LTC facility that</td>
<td></td>
</tr>
<tr>
<td>lived in another health region</td>
<td>27</td>
</tr>
<tr>
<td>Average Eastern Health LTC Waitlist</td>
<td>109</td>
</tr>
<tr>
<td>Current demand for LTC beds in Eastern Health region</td>
<td>1,838</td>
</tr>
</tbody>
</table>

• The LTC demand projections consider two main scenarios:
  - The first scenario assumes constant 2013 LTC use rates by age and sex over the projection period.
  - The second scenario assumes declining 2013 LTC use rates over the projection period based on the trend reflected in Statistics Canada’s Residential Care Facilities (RCF) Survey.

• Even though Statistics Canada’s RCF Survey suggests a slight downward trend in LTC use rates, there are qualitative factors that could potentially alter future trends (e.g. emergence and/or presence of multiple chronic conditions, increase of age related issues, possible shifts in the availability of informal caregivers, etc.). To this end, a third scenario (for illustrative purposes only) was considered in which the age and sex specific LTC use rates from the constant scenario increase 10% over the 2013–2026 projection period. These three scenarios provide a range of possible outcomes for LTC demand.

• Table 4 provides a summary of the projected LTC demand for Economic Zones 15-20 and the Eastern Health region for the three scenarios outlined above.5

Table 4: Projected LTC Demand, Economic Zones 15-20 and Eastern Health Region, 2013-2026

<table>
<thead>
<tr>
<th>Economic Zone or Health Region</th>
<th>Constant Use Rate Scenario</th>
<th>Declining Use Rate Scenario</th>
<th>10% Increase in Constant Use Rate Scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
<td>2017</td>
<td>2022</td>
</tr>
<tr>
<td>Economic Zone 15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic Zone 16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic Zone 17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic Zone 18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic Zone 19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic Zone 20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eastern Health Region</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5 Note that the numbers in each column do not necessarily sum to the Eastern Health region total because of independent rounding.
The projection estimates in Table 4 indicate the number of individuals from that Economic Zone or health region that will require LTC in that year. The estimates do not say anything about where these individuals will receive their LTC. For instance, the projection estimates in Table 4 indicate that 58 individuals from Economic Zone 20 will require LTC in 2017 (according to the constant use rate scenario). However, there is no LTC facility in Economic Zone 20. As a result, these individuals will have to go to a LTC facility in another Economic Zone to receive their LTC.

ii. LTC Beds Required to Meet the Projected Eastern Health LTC Demand

- Using the LTC demand projection estimates and the MDS 2.0 data on the migration patterns of LTC residents that lived in the Eastern Health region prior to entering an Eastern Health LTC facility, ESB has estimated the number of LTC beds required in Economic Zones 15-19 and the Eastern Health region from 2014 to 2026 to meet the projected Eastern Health LTC demand.
- Table 5 describes the migration patterns of LTC residents that lived in the Eastern Health region prior to entering an Eastern Health LTC facility.\(^6\)

<table>
<thead>
<tr>
<th>Economic Zone Prior to Entering LTC</th>
<th>Economic Zone 15</th>
<th>Economic Zone 16</th>
<th>Economic Zone 17</th>
<th>Economic Zone 18</th>
<th>Economic Zone 19</th>
<th>Economic Zone 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Zone 15</td>
<td>79.3</td>
<td>0.0</td>
<td>2.8</td>
<td>6.1</td>
<td>11.0</td>
<td>N/A</td>
</tr>
<tr>
<td>Economic Zone 16</td>
<td>0.0</td>
<td>91.8</td>
<td>0.6</td>
<td>0.0</td>
<td>6.9</td>
<td>N/A</td>
</tr>
<tr>
<td>Economic Zone 17</td>
<td>0.7</td>
<td>0.0</td>
<td>85.5</td>
<td>4.6</td>
<td>9.2</td>
<td>N/A</td>
</tr>
<tr>
<td>Economic Zone 18</td>
<td>0.8</td>
<td>0.0</td>
<td>1.6</td>
<td>88.6</td>
<td>8.9</td>
<td>N/A</td>
</tr>
<tr>
<td>Economic Zone 19</td>
<td>0.5</td>
<td>0.1</td>
<td>0.8</td>
<td>0.3</td>
<td>98.0</td>
<td>N/A</td>
</tr>
<tr>
<td>Economic Zone 20</td>
<td>0.0</td>
<td>0.0</td>
<td>3.6</td>
<td>2.4</td>
<td>94.0</td>
<td>N/A</td>
</tr>
</tbody>
</table>

According to the migration patterns of LTC residents within the Eastern Health region, the majority of LTC residents lived and received their LTC in the same Economic Zone. However, given that there is no LTC facility in Economic Zone 20, the majority of LTC residents that lived in that Economic Zone prior to entering a LTC facility received their LTC in Economic Zone 19.

\(^6\) Note that the percentages in each row do not necessarily sum to 100 because of independent rounding and individuals who lived in the Eastern Health region, but were LTC residents in another health region.
• Table 6 provides a summary of the LTC beds required in Economic Zones 15-19 and the Eastern Health region to meet the projected Eastern Health LTC demand for the three scenarios outlined above. These estimates are based on the LTC demand projection estimates in Table 4 and the migration patterns of LTC residents within the Eastern Health region in Table 5.\(^7\)

**Table 6: LTC Beds Required to Meet the Projected Eastern Health LTC Demand**

<table>
<thead>
<tr>
<th>Economic Zone or Health Region</th>
<th>Constant Use Rate Scenario</th>
<th>Declining Use Rate Scenario</th>
<th>10% Increase in Constant Use Rate Scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
<td>2017</td>
<td>2022</td>
</tr>
<tr>
<td>Economic Zone 15</td>
<td>180</td>
<td>200</td>
<td>235</td>
</tr>
<tr>
<td>Economic Zone 16</td>
<td>123</td>
<td>136</td>
<td>161</td>
</tr>
<tr>
<td>Economic Zone 17</td>
<td>255</td>
<td>278</td>
<td>333</td>
</tr>
<tr>
<td>Economic Zone 18</td>
<td>83</td>
<td>90</td>
<td>101</td>
</tr>
<tr>
<td>Economic Zone 19</td>
<td>1,191</td>
<td>1,337</td>
<td>1,594</td>
</tr>
<tr>
<td>Eastern Health Region</td>
<td>1,832</td>
<td>2,041</td>
<td>2,423</td>
</tr>
</tbody>
</table>

### iii. LTC Beds Required to Meet the Projected Total LTC Demand

- Using the LTC demand projection estimates and the MDS 2.0 data on the migration patterns of LTC residents that lived in the Central, Western, or Labrador-Grenfell health regions prior to entering an Eastern Health LTC facility, ESB has also estimated the number of LTC beds required in Economic Zones 15-19 and the Eastern Health region from 2014 to 2026 to meet the projected total LTC demand.
- Table 7 describes the migration patterns of LTC residents that lived in the Central, Western, or Labrador-Grenfell Health regions prior to entering an Eastern Health LTC facility.

**Table 7: Migration Patterns of LTC Residents from the Other Health Regions**

<table>
<thead>
<tr>
<th>Economic Zone</th>
<th>% of LTC residents that did not live in the Eastern Health region prior to entering an Eastern Health LTC facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic Zone 15</td>
<td>0.5</td>
</tr>
<tr>
<td>Economic Zone 16</td>
<td>0.0</td>
</tr>
<tr>
<td>Economic Zone 17</td>
<td>0.5</td>
</tr>
<tr>
<td>Economic Zone 18</td>
<td>0.7</td>
</tr>
<tr>
<td>Economic Zone 19</td>
<td>2.2</td>
</tr>
<tr>
<td>Economic Zone 20</td>
<td>N/A</td>
</tr>
</tbody>
</table>

- According to the migration patterns of LTC residents from the other health regions, the majority of LTC residents that did not live in the Eastern Health region prior to entering an Eastern Health LTC facility received their LTC in Economic Zone 19.

---

\(^7\) Note that the numbers in each column do not necessarily sum to the Eastern Health region total because of independent rounding.
• Table 8 provides a summary of the LTC beds required in Economic Zones 15-19 and the Eastern Health region to meet the projected total LTC demand for the three scenarios outlined above. These estimates are based on the LTC demand projection estimates in Table 4, the migration patterns of LTC residents that lived in the Central, Western, or Labrador-Grenfell Health regions prior to entering an Eastern Health LTC facility in Table 7, and the number of LTC beds required to meet the projected Eastern Health LTC demand in Table 6.8

Table 8: LTC Beds Required to Meet the Projected Total LTC Demand
Economic Zones 15-19 and Eastern Health Region, 2013-2026

<table>
<thead>
<tr>
<th>Economic Zone or Health Region</th>
<th>Constant Use Rate Scenario</th>
<th>Declining Use Rate Scenario</th>
<th>10% Increase in Constant Use Rate Scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
<td>2017</td>
<td>2022</td>
</tr>
<tr>
<td>Economic Zone 15</td>
<td>181</td>
<td>201</td>
<td>236</td>
</tr>
<tr>
<td>Economic Zone 16</td>
<td>123</td>
<td>136</td>
<td>161</td>
</tr>
<tr>
<td>Economic Zone 17</td>
<td>257</td>
<td>280</td>
<td>335</td>
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<tr>
<td>Economic Zone 18</td>
<td>84</td>
<td>90</td>
<td>101</td>
</tr>
<tr>
<td>Economic Zone 19</td>
<td>1,215</td>
<td>1,364</td>
<td>1,626</td>
</tr>
<tr>
<td>Eastern Health Region</td>
<td>1,859</td>
<td>2,071</td>
<td>2,460</td>
</tr>
</tbody>
</table>

• Figures 2-7 provide a graphical summary of the LTC beds required in Economic Zones 15-19 and the Eastern Health region to meet the projected total LTC demand.

Figure 2: LTC Beds Required for Various Scenarios, Economic Zone 15, 2013-2026

![Economic Zone 15 graph](image_url)

---

8 Note that the numbers in each column do not necessarily sum to the Eastern Health region total because of independent rounding.
Figure 3: LTC Beds Required for Various Scenarios, Economic Zone 16, 2013-2026

Figure 4: LTC Beds Required for Various Scenarios, Economic Zone 17, 2013-2026
Figure 5: LTC Beds Required for Various Scenarios, Economic Zone 18, 2013-2026

Economic Zone 18

LTC Demand


84 110 119 131

--- Constant LTC Use Rates --- Declining LTC Use Rates --- 10% Increase in LTC Use Rates

Figure 6: LTC Beds Required for Various Scenarios, Economic Zone 19, 2013-2026

Economic Zone 19

LTC Demand


1,215 1,753 1,893 2,091

--- Constant LTC Use Rates --- Declining LTC Use Rates --- 10% Increase in LTC Use Rates
Based on historical trends, the declining use rate scenario appears to be the most likely scenario, but close monitoring of LTC needs should continue in the coming years in order to detect, plan and react to other possible outcomes.

The projections in this report suggest an impending need for additional LTC beds in the Eastern Health region in the years ahead regardless of which scenario could occur. Based on population aging trends alone, it appears that the demand for LTC in this region will increase significantly. As a result, the level of LTC beds will have to increase correspondingly, or alternative forms of care will be needed to meet demand.

Note that the accuracy of these LTC demand projections is subject to the quality of the data used in their formulation. Data discrepancies could alter the projections significantly and should be addressed accordingly.

Prepared by: N. Morrow (Economic Research and Analysis, Economics and Statistics Branch)
Appendix A: Eastern Health LTC Facilities Submitting Data to the MDS 2.0 as of September 30, 2014

<table>
<thead>
<tr>
<th>LTC Facility</th>
<th>Economic Zone</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Albert O’Mahoney Memorial</td>
<td>15</td>
<td>Clarenville</td>
</tr>
<tr>
<td>Golden Heights Manor</td>
<td>15</td>
<td>Bonavista</td>
</tr>
<tr>
<td>Blue Crest Interfaith Home</td>
<td>16</td>
<td>Grand Bank</td>
</tr>
<tr>
<td>U.S. Memorial Health Centre</td>
<td>16</td>
<td>St. Lawrence</td>
</tr>
<tr>
<td>Harbour Lodge Nursing Home</td>
<td>17</td>
<td>Carbonear</td>
</tr>
<tr>
<td>Interfaith Citizens’ Home</td>
<td>17</td>
<td>Carbonear</td>
</tr>
<tr>
<td>Placentia Health Centre</td>
<td>18</td>
<td>Placentia</td>
</tr>
<tr>
<td>Agnes Pratt Home</td>
<td>19</td>
<td>St. John’s</td>
</tr>
<tr>
<td>Masonic Park Nursing Home</td>
<td>19</td>
<td>St. John’s</td>
</tr>
<tr>
<td>Hoyles-Escasoni Complex</td>
<td>19</td>
<td>St. John’s</td>
</tr>
<tr>
<td>St. Patrick’s Mercy Home</td>
<td>19</td>
<td>St. John’s</td>
</tr>
<tr>
<td>Veteran’s Pavilion</td>
<td>19</td>
<td>St. John’s</td>
</tr>
</tbody>
</table>
Appendix B: Economic Zones and LTC Facilities in the Eastern Health Region

Long Term Care Homes

<table>
<thead>
<tr>
<th>Beds</th>
<th>Submitting MDS</th>
<th>Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - 31</td>
<td>No</td>
<td>Labrador-Grenfell Health Authority</td>
</tr>
<tr>
<td>40 - 59</td>
<td>Yes</td>
<td>Western Health Authority</td>
</tr>
<tr>
<td>61 - 83</td>
<td>Yes</td>
<td>Central Health Authority</td>
</tr>
<tr>
<td>101 - 134</td>
<td></td>
<td>Eastern Health Authority</td>
</tr>
<tr>
<td>209 - 377</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Economic Zone

Inset: Department of Finance
Newfoundland & Labrador Statistics Agency
Social and Economic Spatial Analysis Unit

Economic Zones: EZ 12, EZ 14, EZ 15, EZ 17, EZ 19, EZ 20
Facilities: Bonavista Golden Heights, Bonavista Health Centre, Clarenville, etc.
Long-Term Care Demand Projections
Central Regional Health Authority

Background:
- In June 2011, the Economics and Statistics Branch (ESB) signed a memorandum of understanding (MOU) with the Department of Health and Community Services (DOHCS) regarding work required to “enable the quantitative assessment and analysis of long-term care (LTC) needs for Newfoundland and Labrador (NL)”. An aging population and consequently an increasing number of seniors requiring LTC, will likely cause future LTC service needs to rise.
- While these projections focus on all age groups present in LTC facilities, ages 75+ will be the main driver of growth. The rate of growth in the provincial population age 75+ has slowed over the past 15 years because of lower levels of births in the 1920s and the first half of the 1930s, but this trend will not continue. Growth in the 75+ population will increase over the 2013–2020 period as individuals born in the late 1930s and early 1940s move into the 75+ category. This growth will further accelerate when the large baby boomer group begins turning 75 starting in 2021. To plan and manage this growth optimally, DOHCS has partnered with ESB on assessing LTC demand.
- ESB has developed projections for the Central Health region from 2013 to 2026.¹
- Within the Central Health region, the population 75+ increased 32.6% (from 5,975 to 7,923) in the 13 year period between 2000 and 2013. According to the province’s population projections, the population 75+ will increase 58.9% (from 7,923 to 12,593) in the 13 year period between 2013 and 2026 (see Figure 1).

Figure 1: Population 75+ (left axis) and Change in Population 75+ (right axis)
Central Health Region, 1986-2026

¹ See page 4 for a map of the Central Health region.
Projection Summary:

- These LTC projections are based on two main datasets:
  - Central Health region population projections by age and sex from the Economic Research and Analysis (ERA) Division within ESB.
  - LTC resident data by age and sex from the Canadian Institute for Health Information (CIHI). These data are collected from the 10 LTC facilities in the Central Health region currently submitting InterRAI Minimum Data Set (MDS) 2.0 data, and includes information for 423 LTC residents, the majority of whom entered a LTC home between 2008 and 2013. Combined with population estimates, these data allow for the calculation of current estimates of LTC utilization (use) rates by age and sex.
- In terms of current LTC bed supply, DOHCS indicates there are currently 11 LTC facilities and 519 LTC beds in the Central Health region (see map on page 4).
- It is assumed that current demand for LTC beds in the Central Health region exceeds supply, as an analysis of Central Health LTC waitlist data provided by DOHCS indicates that there has been an unmet demand for LTC beds in the region over the time span for which data is available. The average number of people on the waitlist over the January 2012-April 2014 time frame was 97. Therefore, current demand for LTC beds (and the starting point for these projections) is assumed to be 616 (i.e. 519 LTC beds plus the average of 97 people on the waitlist).
- The LTC projections consider two main scenarios:
  - The first scenario assumes constant 2013 LTC use rates by age and sex over the projection period (derived from a combination of MDS 2.0 data, total LTC demand as outlined above and population by age and sex).
  - The second scenario assumes declining 2013 LTC use rates over the projection period based on the trend reflected in the historical data set obtained from Statistics Canada’s Residential Care Facilities (RCF) survey.
- In addition, although available historical data suggests that LTC use rates will most likely continue to decrease slightly in the coming years, there are qualitative factors that could potentially suggest otherwise (e.g. emergence and/or presence of multiple chronic conditions, increase of age related conditions, etc.). To this end, a third scenario (for illustrative purposes only) was considered in which the age and sex specific LTC use rates from the constant scenario increase 10% over the 2013-2026 projection period.
- Table 1 and Figure 2 provide a summary of the LTC projections for the Central Health region for the three scenarios outlined above.

---

2 There are a total of 11 LTC facilities in the Central Health region. As of December 31, 2013, 10 of these LTC facilities were submitting data to CIHI. These include: A.M. Guy Memorial Health Centre (Buchans), Baie Verte Peninsula Health Centre, Bonnies Lodge (Brookfield), Connaigre Peninsula Health Centre (Harbour Breton), Dr. Hugh Twomey Health Centre (Botwood), Fogo Island Health Centre, Green Bay Health Centre (Springdale), Lakeside Homes (Gander), North Haven Manor (Levisporte), and Notre Dame Bay Memorial Health Centre (Twillingate). The only LTC facility not submitting to CIHI was Carmelite House (Grand Falls-Windsor).
Table 1: Projected LTC Demand: Constant Use Rate Scenario, Declining Use Rate Scenario, and 10% Increase in Use Rate Scenario, Central Health Region, 2013-2026

<table>
<thead>
<tr>
<th>Scenario</th>
<th>LTC Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
</tr>
<tr>
<td>Scenario 1: Constant LTC Use Rates</td>
<td>616</td>
</tr>
<tr>
<td>Scenario 2: Declining LTC Use Rates</td>
<td>616</td>
</tr>
<tr>
<td>Scenario 3: 10% Increase in LTC Use Rates</td>
<td>616</td>
</tr>
</tbody>
</table>

- Based on historical trends, Scenario 2 appears to be the most likely outcome, but close monitoring of LTC needs should continue in the coming years in order to detect, plan and react to other possible outcomes.
- The projections in this report suggest an impending need for additional LTC in the Central Health region in the decades to come. Based on population aging trends alone, it appears that the demand for LTC in this region will increase significantly. As a result, the level of LTC will have to increase correspondingly, or alternative forms of care will be needed if this demand is to be met.

Figure 2: Projected LTC Demand: Constant Use Rate Scenario, Declining Use Rate Scenario, and 10% Increase in Use Rate Scenario, Central Health Region, 2013-2026
Figure 3: Central Health Region LTC Facilities

Long Term Care Homes

<table>
<thead>
<tr>
<th>Beds</th>
<th>Submitting MDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - 31</td>
<td>No</td>
</tr>
<tr>
<td>40 - 59</td>
<td>Yes</td>
</tr>
<tr>
<td>61 - 83</td>
<td>Yes</td>
</tr>
<tr>
<td>101 - 134</td>
<td>Yes</td>
</tr>
<tr>
<td>209 - 377</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Prepared by: N. Morrow (Economic Research and Analysis, Economics and Statistics Branch)
July 2014
Government of Newfoundland and Labrador

Long Term Care Planning Project

Discussion Document

Deena Waddleton
June 11, 2014
DRAFT CONFIDENTIAL

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Background

In 2012, the Department of Health and Community Services released Close to Home: A Strategy for Long-Term Care and Community Support Services, 2012 which aims to integrate services and make system improvements over the next ten years. The Long-Term Care and Community Support (LTC&CSS) sector is vast encompassing home support and residential care options for seniors, individuals with disabilities and services for children with disabilities. The demand for LTC& CSS is expected to increase due to our ageing population. Currently there are approximately 91,000 seniors in the province, representing about 16 per cent of the population. It is expected that the number of seniors in the province will increase to approximately 130,000 or 25 per cent of the population by 2026 (Department of Finance). Therefore it is crucial that Government plan appropriately to meet the needs of the population in the most fiscally responsible manner possible.

Purpose

A specific goal outlined in the LTC & CSS strategy is “to ensure an adequate supply of long term care (LTC) facility beds to meet the population needs.” To this end the Department of Health and Community Services is engaged in a project to determine the future demand for LTC beds in the province and to provide an analysis of the various options to meet the demand. Options to be explored include increasing capacity in the public system through expansion of existing infrastructure or new construction; or engaging the private sector through some form of public-private partnership. The financial and policy implications of each option are explored below.

The LTC planning project is informed by a LTC bed projection modeling study carried out by the Economic Research and Analysis (ERA) Division of the Department of Finance, a literature review and jurisdictional scan of practices in other provinces in Canada, an analysis of the demographic characteristics of current LTC residents, and consultations with RHA staff. While this work will inform provincial policy, the first phase will involve an analysis of the need in the St. John’s area. Recommendations will be made to Government on how best to meet the anticipated need for LTC services.

Current status of LTC in Newfoundland and Labrador

As of March, 2014, there are 2786 LTC beds in 41 LTC facilities or health centres in the province. In the St. John’s area there are 1171 LTC beds. The new LTC facility in St. John’s, scheduled to open September, 2014 will have an additional 61 LTC beds. The number and location of the LTC beds in the St. John’s area is included in Table 1.
Table 1: Number and type of LTC beds in the St. John’s area (March 2014)

<table>
<thead>
<tr>
<th>Site</th>
<th>Location</th>
<th># of Beds</th>
<th>Protective Care Beds</th>
<th>Wanderguard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waterford Hospital</td>
<td>St. John's</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Walter Templeman</td>
<td>Bell Island</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agnes Pratt</td>
<td>St. John's</td>
<td>134</td>
<td>26</td>
<td>28</td>
</tr>
<tr>
<td>Glenbrook Lodge</td>
<td>St. John's</td>
<td>104</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masonic Park</td>
<td>St. John's</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hoyles/Escasoni</td>
<td>St. John's</td>
<td>375</td>
<td>24</td>
<td>83</td>
</tr>
<tr>
<td>Saint Luke's</td>
<td>St. John's</td>
<td>117</td>
<td></td>
<td>31</td>
</tr>
<tr>
<td>St. Patrick's</td>
<td>St. John's</td>
<td>210</td>
<td></td>
<td>76</td>
</tr>
<tr>
<td>Veteran's Pavilion</td>
<td>St. John's</td>
<td>56</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chancellor Park*</td>
<td>St. John's</td>
<td>70</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>1171</strong></td>
<td><strong>77</strong></td>
<td><strong>218</strong></td>
</tr>
</tbody>
</table>

* Private LTC Facility, Eastern Health (EH) subsidizes 70 beds.
Additional bed capacity (61 beds) will be available September 2014 in the new St. John’s LTC home.

# Wanderguard is a wandering alert system that is intended to sound an alarm when a resident leaves the unit and does not necessarily prevent elopement.

^ Protective Care units are locked units and are better able to provide a secure and safe environment to manage residents with dementia.

Currently, most public LTC facilities in the province are at or near full capacity (Dr. Walter Templeman occupancy ~60% and Veteran’s Pavilion occupancy ~80%) and there is a wait list for placement in LTC. As of March 2014, there were 249 individuals waiting for LTC placement in the province, of these 97 individuals were waiting in Eastern Health (EH) (LTC Statistics report, EH).

According to statistics provided to the Department by EH, (Figure 1 and 2), the waitlist for LTC services has remained fairly static at approximately 100 clients per month since early 2010 (Figure 1). For 2013, 1382 individuals were waitlisted for LTC and 616 were placed (Figure 2). While it is recognized that some clients wait longer, approximately 45 clients are placed monthly (Figure 2). Wait times can range from less than 30 days to almost one year and are impacted by many factors including the health care needs of the client, requirement for protective care, sex, willingness to move to home that is not the preferred choice.
Approximately 10 per cent of all LTC residents in the St. John’s area are under 65 years of age. It is likely this population is comprised of individuals with challenging behaviors (intellectual disabilities or mental health issues) who are difficult to place as there are few alternative appropriate placement options in the community. Indeed an analysis of the demographics of the
LTC residents at the Waterford (Teledata, May 2014) revealed that approximately 50 per cent of the residents were categorized as Level 1 or 2 compared to only 3 per cent Level 1 or 2 in all other St. John’s facilities. Further analysis is required to gain a better understanding of the needs of the under 65 population in LTC.

According to Teledata, approximately 65 per cent of all residents are female. The largest demographic group is females over the age of 85 years old, which makes up over 33 per cent of the population of all LTC residents in the St. John’s area.

As indicated above approximately 3 per cent of LTC residents in St. John’s facilities (excluding Waterford) have been assessed as requiring Level 1 (9 residents) or 2 (21 residents) care (Teledata report, May 2014, average 2013-14,). This may represent spousal admissions or residents who were placed some time ago before policies related to level of care were strictly enforced or clients who were assessed and placed as Level 3 but whose care needs decreased and are now assessed as requiring Level 2 care.

<table>
<thead>
<tr>
<th>Demographic</th>
<th>EH</th>
<th>St. John’s</th>
<th>St. John’s excluding Waterford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents under 65 (%)</td>
<td>10</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Female residents (%)</td>
<td>65</td>
<td>66</td>
<td>68</td>
</tr>
<tr>
<td>Level 1&amp;2 (%)</td>
<td>5.6</td>
<td>5.5</td>
<td>2.9</td>
</tr>
</tbody>
</table>

It is important to have a thorough understanding of the demographics and care needs of the current LTC population to identify opportunities to improve LTC bed utilization and to ensure effective and appropriate planning for the future LTC residents in the St. John’s area.

*Projected Long Term Care Demand*

*LTC Bed Projection Study*

In 2010 DHCS engaged the Economic Research and Analysis Division (ERA) in the Economic Statistic Branch (ESB) of the Department of Finance to develop a model to assist in projecting future LTC needs.

The LTC bed projection study will be completed in two phases. Phase 1 involves modeling the core determinants of LTC placement (age, sex, marital status). Phase 2 involves coding the data to refine the model to predict the impact of factors such as incidence of chronic disease, life expectancy, outmigration and efficiencies realized through improvements in the LTC&CSS
sector. Phase 1 is expected to be completed by July 2014; while Phase 2 is expected to be completed by Fall 2015.

The LTC projections were informed by the following datasets:

- Population projections by age and sex from the ESB.

- The Resident Assessment Instrument-Minimal Data Set (RAI-MDS) 2.0 which provides counts of current residents by age and sex. At the time of this report 10 of 41 LTC facilities (includes health centres) were reporting to the Canadian Institute of Health Information (CIHI). These data, combined with population estimates, allow for the calculation of current estimates of LTC use rates by age and sex.

- The number of LTC beds in St. John’s region (1182, as of 2013).

- Statistic Canada’s Residential Care Facilities (RCF) survey which includes resident data (age and sex) for 1986-2009. These data, combined with population estimates, were used to examine how LTC use rates have changed over time in NL. This was used as a proxy for how LTC use rates may have changed over time in the St. John’s area.

As shown in Figure 3, the population 75 years and older is expected to increase from approximately 11,300 to 17,000 in the next 12 years (2014 to 2026). This sharp increase, attributable to the aging “baby boomer” population, is the main driver of future demand for LTC beds. As shown in Table 3, the ERA Division predicts that the number of new LTC beds required in the St. John’s area by 2026 is between 410-698.

**Figure 3: Population and Change in population of the 75+ age group in the St. John’s Metro from 1986-2026**
Table 3: Projected number of LTC beds required by 2026

<table>
<thead>
<tr>
<th>Scenario</th>
<th>LTC Demand</th>
<th>LTC capacity required by 2026</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2026</td>
</tr>
<tr>
<td>Constant LTC Use Rates</td>
<td>1182</td>
<td>1773</td>
</tr>
<tr>
<td>Declining LTC Use Rates</td>
<td>1182</td>
<td>1592</td>
</tr>
<tr>
<td>10% Increase in LTC Use Rates</td>
<td>1182</td>
<td>1880</td>
</tr>
</tbody>
</table>

An analysis of data available from Statistic Canada’s RCF survey (which was used to inform development of Scenario 2, Table 3) noted that the LTC utilization rate decreased from 1986-2009. The most marked decrease in LTC utilization rates occurred in 1996-1997 which coincided with the introduction of the Single Entry System (for LTC placement) in 1995. It is therefore reasonable to predict that other new initiatives will also have an impact on improving LTC bed utilization.

It is important to note that these projected numbers (Table 3) do not factor in the impact of initiatives to improve LTC bed utilization. While it is anticipated that new initiatives underway as part of the LTC & CSS strategy may promote appropriate LTC bed utilization through improved assessment and placement, the impact of such initiatives is unknown at this time.

It should also be noted that while it is predicted that more LTC beds will be required due to the projected increase in the 75 years and older population, this trend is largely driven by the baby boomer population and is not expected to continue. Although not shown in the graphs above the increased demand created by the aging baby boomer population is expected to decline (staring ~ 2040) due to the declining birth rates post baby boom era. The impact of factors other than age, such as prevalence of chronic disease, family constitution, and outmigration are being modeled as part of Phase 2 of the LTC bed modeling project.

**Potential Options to address LTC demand**

The data in Table 3 provides an estimate of the number of LTC beds required by 2026. A multi-year plan for increasing bed capacity is required to meet the projected need. Other jurisdictions have addressed the need for LTC through a mix of public and public-private partnerships (reviewed below). A number of possible options exist to meet demand in the St. John’s area including:

1. Increase capacity solely through investments in the public system either by:
   a) renovation or expansion of existing public LTC homes
   b) construction of new LTC facilities
2. Engage the private sector for the provision of LTC services including:
   a) subsidize additional beds at Chancellor Park (private Level 3 facility)
   b) purchase Chancellor Park
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c) issue a Request for Proposal (RFP) for renovation of existing privately owned facilities (e.g. assisted living homes)
d) issue a RFP for new construction (through the private sector)

In addition, the demand for LTC beds could be addressed by some or a combination of all these options. Each will be explored in more detail below.

Increase capacity in the public system

Renovation or expansion of existing public LTC facilities
Decision making related to the construction of new public LTC facilities requires a review of current and future infrastructure requirements in the St. John’s area. There are currently 10 LTC facilities in the St. John’s area. While adequate maintenance and renovations can extend the lifespan of facilities (e.g. Waterford Hospital dates back to 1854), the design/layout of older facilities may not be conducive to providing the level of care in accordance with today’s best practices and standards (e.g. single rooms).

Table 4: Summary of the ages of the long term care facilities in the St. John’s area:

<table>
<thead>
<tr>
<th>Facility</th>
<th>Construction Date</th>
<th>Remaining Building Life Expectancy</th>
<th>Estimated Renovation Costs (next 5 years)</th>
<th>Estimated Renovation Costs (6 – 12 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agnes Pratt</td>
<td>Original: 1958</td>
<td>15 - 20 years</td>
<td>$7.3M</td>
<td>$2.8M</td>
</tr>
<tr>
<td></td>
<td>Extension: 1987</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glenbrook Lodge</td>
<td>Original: 1901</td>
<td>5 - 10 years</td>
<td>$8.7M</td>
<td>$2.9M</td>
</tr>
<tr>
<td></td>
<td>Renovated: 1976</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Luke’s</td>
<td>Original: 1963</td>
<td>10 – 15 years</td>
<td>$6.5M</td>
<td>$2.3M</td>
</tr>
<tr>
<td></td>
<td>Renovated: 1975</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Patrick’s</td>
<td>Original: 1958</td>
<td>5 – 10 years</td>
<td>$17.8M</td>
<td>$6.6M</td>
</tr>
<tr>
<td></td>
<td>Renovated: 1985</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hoyles Escasoni</td>
<td>Original: 1965</td>
<td>N/A. Residents to be relocated to new St. John’s LTC in Sept/2014.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Masonic Park</td>
<td>Original: 1982</td>
<td>10 – 15 years</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td></td>
<td>Renovated: 1997</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. John’s LTC Facility</td>
<td>Original: To open Sept/2014</td>
<td>60+ years</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Veterans Pavilion</td>
<td>Original:</td>
<td>Not assessed. Federal Gov’t owned.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Dr. Walter Templeman</td>
<td>Original: 1965</td>
<td>15 – 20 years</td>
<td>$5.4M</td>
<td>$6.3M</td>
</tr>
<tr>
<td></td>
<td>Renovated: 1992</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chancellor Park</td>
<td>Original: 1991</td>
<td>Not assessed. Privately owned.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td>$45.7</td>
<td>$20.9</td>
</tr>
</tbody>
</table>
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As indicated in Table 4 a number of St. John’s facilities, particularly St. Patrick’s Home (210 beds) and Glenbrook Lodge (104 beds) are nearing the end of the building life expectancy and will require replacement or redevelopment in the next 5-15 years.

The estimated future renovation costs of LTC facilities (Table 4) was obtained using Eastern Health’s Facility Management system and is provided as a very rough estimate (to be verified by EH). As shown in Table 4, approximately $67M will be required for renovations over the next 12 years to maintain LTC facilities in the St. John’s area.

It should be recognized that this cost does not account for any unexpected compromise of the system or building components. Furthermore, these figures simply represent required repair or renovation cost to the existing infrastructure and does not include major redevelopment projects to either increase bed numbers, or to address or improve any shortcomings in building layouts with respect to service delivery or quality of care issues.

Construction of new facility

Based on financial reports provided to the Department (Teledata, May 2014) the average estimated operating cost of a publicly funded LTC bed is $9,500 per month per resident. This is expected to be similar for new construction.

The cost of constructing new infrastructure, (a new building, or an extension to an existing facility) in 2014 is estimated at $373,500 per resident bed (i.e.$385/sq ft @ 970/sq ft per resident bed). It is reasonable to use 3 per cent annual inflationary rate increase to predict future construction costs of LTC homes built through the public system, therefore the cost will depend on the construction start date.

Engage the private sector in the provision of LTC services

Public-Private Partnering in the LTC sector in NL

Newfoundland and Labrador (NL) has limited experience with public-private partnering (PPP) for the provision of LTC services. Eastern Health has partnered with Chancellor Park (CP), a private, accredited LTC home since 2006. In a 2007 report (Walters et al. 2007) where Eastern Health reviewed the arrangement with CP, EH reported that there are monthly meeting to assess residents’ status, staffing resources and quality of care. The report noted that Chancellor Park met all care and quality monitoring indicators and no issues were noted with respect to compliance of LTC Operational Standards. Eastern Health currently subsidizes 70 beds at Chancellor Park at a cost of $8,060 per month per resident and provides equipment and some allied health support.
Jurisdictional Scan/Literature review

In an effort to inform planning and policy related to the utilization of the private sector for the provision of LTC, a jurisdictional scan and literature review was completed to determine the models of PPP, the risks and benefits of entering PPP and identification of strategies to mitigate risks.

Literature Review

Few Canadian studies are available comparing the for-profit and non-profit LTC sectors. Many of the studies that do exist are quite old (early 2000s) (Berta et al., 2005) are not peer reviewed or were published by special interest groups e.g. unions (Reichwein, 2011, Jansen, 2011).

Publications report (McGregor and Ronald, 2011 and references within, Bower and Campanella, 2013) that while LTC is not included under the Canada Health Act, the majority of the funding is public noting a mix of service providers, including public (municipal or provincial government owned and operated), private for-profit and private non-profit. In addition there are also a number of solely privately funded LTC facilities (sometimes known as Assisted Living facilities) that may not be licensed or regulated by local governments.

Staffing levels are quoted as a commonly accepted quality of care indicator. Studies have suggested that non-profit and publicly operated nursing homes have higher staffing levels. Since staffing is a major cost in the provision of LTC it is suggested that for-profit homes reduce staffing levels to increase profit margin and this negatively impacts quality of care (McGregor and Ronald, 2011, McGregor et al. 2010, Comondere et al. 2009).

Many studies reference a systematic review and meta-analysis published by Comondere et al. in 2009. This group reported that in studies where a statistical significance was detected, 40 of 82 studies (published from 1965-2003) favored a trend toward a higher quality of care in non-profit facilities, while 3 of 82 studies favored for-profit nursing homes. The quality of care indicators measured were pressure ulcer prevalence, physical restraint prevalence, deficiencies on government surveys, urethral catheterization, mortality, psychotic drug use, feeding tube use, hospital admission rates. Hillmer et al., 2005 also completed a systematic review of 38 studies published between 1990 and 2002 and reported similar findings that there was a trend towards lower quality of care in for-profit homes compared to non-profit homes. A large number of studies in both reviews showed no significant difference in quality of care by ownership. It is important to note that the majority of the studies in both reviews were from the United States (US). It is not clear if these findings can be translated to Canada.

Statistics Canada’s Residential Care Facility Survey has been used to investigate staffing intensity by facility ownership from 1996-2002 in both ON (Berta et al. 2005) and BC
(McGregor et al. 2010). Both studies found that the staffing levels in for-profit facilities were less than non-profit and public LTC homes. However, it was not determined if the difference in staffing was due to differences in resident care needs. Interestingly both provinces have LTC legislation but do not mandate minimum hours of care per day.

In a large review of LTC facilities in Manitoba, Doupe et al. (2006) detected higher incidences of quality of care indicators in for-profit versus public facilities, however no differences in staffing levels were reported.

No publications were found that supported the for-profit LTC homes, although it is likely that such a report would only come from the for-profit LTC sector.

It is important to note that the monitoring of quality indicators is not typically used to identify good or bad quality health care rather to identify areas where best practices exist that may be translated to other settings, and to identify areas that may need improvement. Quality monitoring may be a means to open communication between a service provider and a licensing or regulatory body to work collaboratively to address areas of concern.

Despite the fact that the private sector has been involved in the provision of LTC for many years and services are provided to a large number of residents both in Canada and in other jurisdictions, there were relatively few publications on the subject. This may suggest that there are few issues to report or that there is little funding to support research on seniors residential care options.

Interestingly, authors who reported that the quality of care may be inferior in for-profit homes than in non-profit or public facilities acknowledge that Governments will likely continue to partner with the private sector for the provision of services and suggest ways to mitigate risks. Most feel it is important to license facilities, ensure compliance with regulations, perform unannounced inspections, ensure good information systems are in place, promote greater accountability and transparency through public reporting, and ensure residents have an opportunity to express concerns in a safe environment (e.g. resident councils and confidential surveys).

Jurisdictional Scan

All provinces in Canada are faced with the issue of how to provide services to an aging population while maintaining the principles of aging in place and ensuring system sustainability.

Results from a literature review (discussed above) suggest that all provinces in Canada have entered into some form of public-private partnership for the provision of LTC services (McGregor and Roland, 2011). To date Newfoundland and Labrador (NL) has limited experience
with PPP for the provision of nursing home care. Since 2006, EH has partnered with Chancellor Park, a private Level 3 LTC facility to provide care to 70 subsidized residents.

To gain a better understanding of the practices in other jurisdictions a questionnaire (Appendix A) was sent to all provincial and territorial governments. Responses were received from six jurisdictions, Yukon does not utilize the private sector to deliver long term care, therefore did not complete the survey. To date no responses have been obtained from New Brunswick (NB), Saskatchewan (SK), Quebec (QC), Prince Edward Island (PE), Northwest Territories (NT) and Nunavut (NU), although NB and SK have indicated they are working on a response.

Across Canada, public private partnership arrangements vary somewhat. In Ontario (ON) and Nova Scotia (NS), LTC facilities may be operated by the private sector (for-profit and non-profit) and the public sector through municipal governments. The provincial government or the regional health authority (RHA) structure does not directly own or operate LTC facilities. The RHAs in British Columbia (BC) operate public LTC facilities and also contract LTC beds in the private (for-profit and non-profit) LTC sector. Alberta (AB) has three types of LTC homes private for-profit, private non-profit and public.

Based on the results of the scan, the proportion of LTC beds operated by the for-profit sector is approximately 25-33% in all provinces except for ON which is approximately 60%. The proportion of private LTC beds in provinces that did not respond to the questionnaire as reported in McGregor and Ronald, 2011 was PE 41%, SK 8%, NB 5% (accurate as of 2008).

**Funding Models (Capital and Redevelopment)**

There is little information available related to the funding models for new construction of private LTC homes as many provinces are not building new facilities. In provinces where new LTC construction projects (BC and NS) have been initiated recently, Government issued a request for proposals (RFP).

In NS, capital funding is provided for new infrastructure and new mortgages are obtained through Housing NS where Government is the default guarantor of the mortgage. Once a RFP is approved, the service provider and the health authority enter into a Development Agreement which outlines details related to the acquisition of land, development of the facility, equipment, and licensing and inspection process.

Capital project costs for new for-profit LTC homes in MB are funded through a capital per diem rate provided with operating provisions. Similarly, AB has entered into operating agreements with for-profit providers who have built LTC facilities.

Government funding may also be provided for maintenance and repairs of existing facilities for example NS provides *Start Up Funding* and *Capital Renewal Reserve Funding* for new and
existing facilities while ON has a *Capital Redevelopment Fund* for renovation of aging LTC facilities.

All provinces (that responded to the scan) have legislation in place that applies equally to all types of LTC service providers. In addition to legislation, some provinces have developed some form of a Service Agreement (NS, AB, ON); a legal document which outlines the requirements, performance expectations and accountabilities of operators of LTC homes.

Typically the time frame for agreements is 20-25 years. Some provinces have shorter terms (10 years) for older homes thereby allowing Government to terminate agreements if redevelopment or renovations have not been made to the LTC home.

**Funding models (Client Based)**

Although funding models vary the following similarities are apparent across jurisdictions:

- LTC facilities are paid per diem rates per resident
- Most provinces have a Care and Accommodation model (where care is publicly funded and accommodation is the responsibility of the client).
- Clients contribute to the cost of their care based on their ability to pay
- Government covers any shortfall of funding on behalf of the client

Ontario and NS have a model using funding envelopes. Government provides per diem funding (envelops) for direct care, food and programming and support services (in NS this is known as the protected envelop). Accommodation (laundry, housekeeping) funding is in another envelop (unprotected envelop). The LTC operator must show the funding provided for direct care and food (protected envelop) has been spent. If a surplus exists this must be returned to Government. No profit can be made on direct care and food. LTC operators may keep any surplus from the unprotected envelop as profit.

In BC, the RHAs negotiate a per diem rate with private providers; this may be established through the RFP process.

In ON all LTC homes receive the same per diem rate regardless of ownership type. Both ON and AB arrive at a funding rate for care services using the principal of activity based funding. In this model funding for appropriate staffing and programming is aligned with the needs of the residents (Sutherland et al. 2013). Basically higher funding levels are provided to care for residents with higher health care needs. Data to inform resident acuity is available from MDS RAI 2.0.

**Monitoring and Accountability**

All LTC facilities are inspected at least annually. Performance monitoring is completed by either Ministry of Health staff or RHA staff. In BC, more frequent inspections may be completed based
on the results of a risk assessment tool (developed in BC). Some level of public reporting is available in BC, AB and ON. In addition, ON uses MIS (Management Information System), a financial reporting system.

**Staffing**

Staffing requirements including hours of care per day and staff type are not mandated in both BC and ON, rather, LTC operators must ensure sufficient staff to meet the needs of residents as outlined in their care plans. Other provinces, (NS, MB and AB) have some minimum staffing levels and staff type mandated in legislation or policy.

**Challenges and Opportunities**

Some respondents noted that private facilities often have better accommodations which may benefit the publicly funded residents as well as the private paying residents. It was suggested that the for-profit sector has a strong ability to deliver projects and is often the driver of innovation.

One challenge noted in ON was the lack of redevelopment of older LTC homes, despite the availability of Capital Redevelopment Funding. A challenge noted in AB was the reluctance of some developers to operate in some locations. They also noted project over-runs sometimes occurred when dealing with developers with limited project management skills.

None of the respondents noted quality of care concerns in the for-profit homes. One respondent noted that the quality of homes varies and is not necessarily dependent on ownership type. Issues related to recruitment and retention of staff were noted for both the public and private sectors.

**Options for engaging the private sector in NL**

**Subsidize additional beds at CP**

Chancellor Park has capacity for at least 150 beds. The owner reports average occupancy levels at 100-105 residents, 70 of which are subsidized by Eastern Health. There is potential to increase LTC bed capacity by 40-45 beds. As recently as February 2014, the owner of CP submitted a proposal to EH and the Department requesting an increase in the number of subsidized beds at CP. Chancellor Park has reportedly faced financial difficulties due to increasing vacancy rates. In addition to increasing LTC bed capacity in the St. John’s area, increasing the number of subsidized beds may help ensure the viability of CP and avoid displacement of approximately 100 residents.

**Purchase CP**

In 2009, the Department was directed to enter into negotiations to purchase CP. In the fall of 2009, three independent appraisals determined the cost to purchase CP was between $29M and
$36M. At the same time Eastern Health estimated the cost of the required renovations to rooms, kitchen, laundry, etc. was in the order of $2.5 M. [s.35(1)(f)]

**Issue a RFP for renovation of existing facilities**

In the St. John’s area there are a number of Assisted Living facilities for seniors with various care needs. In addition personal care homes are licensed to provide care and accommodations to seniors with low care needs. It is possible that either of these service providers may respond to an RFP to renovate their facilities to meet the needs of individuals requiring Level 3 and 4 care.

This option requires further analysis and development of a sound funding model.

**Issue a RFP for new construction**

It is difficult to predict the response rate for a RFP for new LTC construction in the St. John’s area; however large corporations have constructed LTC homes in Nova Scotia and New Brunswick recently. It is reasonable to assume that some of these companies would respond to a RFP in NL. Further analysis of the potential efficiencies of building LTC facilities through the private sector is required as is the development of a funding model.

**Conclusion**

A number of possible options exist to meet the projected LTC needs of the St. John’s area. These include investment in the public system, through construction of new facilities or renovation of existing facilities and/or partnering with the private sector to provide LTC services.

While a more detailed analysis is required, engaging the private sector would likely require:

- Development of comprehensive legislation. In the absence of LTC legislation, it is imperative that detailed policies and legally sound contracts be developed to protect all stakeholders.

- Development of sound funding models to determine the per diem rate per resident. These could be based on client care needs (case mix index), the operating costs of the facility and could include protected funding envelopes.

- Comparative cost analysis of capital costs

- An analysis of how future relationships with private providers will be managed. The partnership between EH and CP has been closely monitored by EH.
As the final province in Canada to consider engagement of the for-profit sector for the provision of LTC (to date this has been limited to a single provider), NL is in a unique position to further investigate best practices in PPP in other jurisdictions and to develop a program that meets the needs of our LTC residents and the requirements of Government.
References:


Bowden and Campanella, 2013, From Bad to Worse Residential Elder Care in Alberta, Parkland Institute, Edmonton Alberta, web access


Doupe et al. 2006 Using Administrative Data to Develop Indicators of Quality Care in Personal Care Homes, Winnipeg, Manitoba Centre for Health Policy.

Hillmer et al. 2005, Nursing Home Profit Status and Quality of Care: Is there any Evidence of an Association? Medical Care Research and Review, Vo. 62 No.2, 139-166.


Reichwein, 2011, Alberta's Long-Term Care Services are in Crisis, Healthcare Papers, Vol. 10 No.4, 51-56.

Sutherland et al., 2013 The Alberta Health Services Patient/Care-Based Funding Model for Long Term Care. A review and analysis. UBC Centre for Health Services and Policy Research. Web access

Appendix A

Presently in Newfoundland and Labrador, all long term care facilities are publicly funded with the exception of one, where Government provides funding for 70 subsidized clients. Newfoundland and Labrador is interested in learning about models of public private partnerships in the long term care sector.

Please provide information specific to the long term care sector (residential care homes providing 24h professional nursing care).

1. Has your government entered into public private partnerships in the provision of Long Term Care (nursing homes that provide 24/7 nursing care)? If no, could you share why not?

2. If yes, can you describe the nature of the partnership?
   - What is the nature/terms of the contract? (Is the Ministry or Health Authority a partner? Does Government provide funding for infrastructure, operating costs, or direct client subsidies?)
   - What is the process for entering partnership? (Request for Proposal, tender, acceptance of unsolicited proposals)
   - What are time frames for agreements?
   - What is the renewal process?
   - What is the funding model? (block funding to private provider or individual client subsidy)
   - How is the rate paid to private provider determined? (Does Government propose the rate, is it negotiated with individual facilities, or do facility owners/managers propose the rate as part of tendering process?)
   - Can you estimate the average cost of a LTC bed in a private versus public facility?

3. Are there provincial standards, policies or legislation in place governing the provision of LTC services? If yes, could you share these?

4. What processes are in place for licensing, monitoring and regulation of private LTC facilities?
   - How is quality of care monitored in a public facility?
   - Are facility inspections completed?
   - Does the Health Authority/Ministry provide staff for oversight of private facilities? If yes, please describe nature of the arrangement and type of staff?
   - Are there minimum staffing requirements? (type of provider: RN, LPN, Personal Care Attendant?)
   - Is there a minimum number of hours of care per resident per day mandated in private facilities? How does this compare to public facilities?
5. What accountability measures are in place?
   - Reporting to the Ministry?
   - Public reporting?
   - How is data collected? *(In provinces where there is a mix of public and private, is the same reporting system used to monitor quality of care indicators, client health files and financial data? Are these systems electronic or paper based?)*

6. How are clients assessed for placement? Who decides where a client is placed? *(the Health Authority, Manager of the private facility, client choice?)*

7. What have been your overall experiences with managing public private partnerships for the provision of long term care? Can you share information on the strengths and challenges experienced? *(recruitment and retention of staff, quality of care, type of client admitted, collaboration among public and private LTC providers, costs, issues dealing with private providers, unplanned closures, bankruptcy?)* How have any challenges been addressed?

8. Any other comments?
Information Note
Department of Health and Community Services

Title: Long term care planning for Western Health.

Issue: To determine the number of long term care beds required in the new LTC facility planned for Corner Brook.

Background and Current Status:

- In 2010 DHCS engaged the Economic Research and Analysis Division (ERA) in the Department of Finance to develop a model to assist in projecting the LTC needs for the province. This project will be completed in two phases. Phase 1, which has been completed, involved collecting data related to the core determinants of LTC placement (age, sex, marital status). Phase 2 involves coding data to refine the model including the impact of factors such as incidence of chronic disease, life expectancy, outmigration and efficiencies realized through improvements in the long term care and community support sector. Phase 2 will be completed by Fall 2015.

- To date bed projection data has been received for the St. John’s region, Conception Bay North, Central Health and Western Health (WH). All data sets provide LTC bed projections based on three possible scenarios:
  - Scenario 1 assumes that LTC utilization rates based on age and sex will remain constant using 2012 data.
  - Scenario 2 uses data from Statistic Canada’s Resident Care Facility survey which showed that LTC use rates declined over the survey period (1986-2009). It is important to note that while this scenario assumes utilization rates will continue to decrease, significant increases in the population aged 75 years is projected, resulting in a net increase in the number of LTC beds required. This decreased LTC use rate may be due in part to changes in policies related to the assessment and placement of residents who truly require LTC. Further improvements in LTC utilization may be realized with enhancements to the LTC and Community Support Services sector through implementation of the LTC strategy.
  - Scenario 3 assumes a 10% increase over the projections to account for the lack of information to model other factors which may increase LTC utilization rates such as increasing incidence of chronic disease, outmigration, and fewer children to care for elderly parents, etc. With the completion of phase two by Fall 2015, the level of projection growth due to these dynamics will be refined.

- Information for Western Health, provided by ERA, is being utilized to inform the planning of the new LTC facility in Corner Brook. ERA used population projections for the Western
region and demographic data from LTC residents in the St. John’s area as a proxy, as the data was incomplete for Western Health at the time the analysis was completed.

- To further refine the projections for Western Health, LTC waitlist data for the past two years in the Western Health region were incorporated into the model. An analysis of past waitlist data from January 2012 to February 2014 revealed that on average 43 individuals are waitlisted for LTC placement monthly in the WH region. See note 1 below table 1.

- The province maintains a waitlist for LTC; on average there are approximately 10 people waiting per 100 beds (see Annex A for detailed information). Clients waiting for LTC beds may be waiting in the community, a personal care home or an acute care facility (Alternate Level of Care clients). The Department supports a reasonable wait list for LTC beds as it allows for optimal and efficient utilization of beds. While it is known that other jurisdictions across Canada maintain waitlist for LTC beds, to date the Department has not completed a comparative analysis to inform an appropriate wait list number.

- Stantec, the company engaged to develop a functional and design plan for the new Corner Brook Hospital and the adjacent LTC facility also provided information regarding the projected need for LTC beds in WH. Stantec used a model that predicts that 100 per 1000 people aged 75 years and older will require LTC. According to Stantec this methodology has been used in other provinces in Canada in LTC planning, e.g., Ontario and Saskatchewan. Through this method Stantec advised we require 212 new beds in Western NL, however, Government decided to initiate planning for 100 of the new beds on the Corner Brook campus with future bed requirements to be determined when the bed projection model is ready to return provincial level data.

- The ERA Division has analyzed the methodology used by Stantec and advises that the ERA model, even in its preliminary stages, is much more robust. Stantec uses a basic calculation based on a single broad assumption, while only encompassing the population 75+. The methodology used by ERA Division predicts future LTC demand for all ages based on actual region specific LTC resident distributions, in combination with detailed population projections that uses information/assumptions about fertility, mortality and migration to produce population projections for NL and its sub-regions.

- Based on this analysis, the Department contends that the ERA method is more appropriate than Stantec’s methodology because the ERA methodology is informed by demographic data of NL residents and factors in LTC utilization rates of NL residents. For example:

  - According to Stantec’s model, 607 LTC beds were required in 2012, significantly higher than the current LTC demand for the WH region which is approximately 517 (474 existing LTC beds plus 43 on average waiting for LTC placement).

  - A review of current LTC residents in NL indicates a utilization rate of approximately 65 per 1000 population over 75 years of age. This is significantly lower than the ratio used in the projections prepared by Stantec.
Table 1 below details the LTC bed projection numbers for WH utilizing ERA methodology and Stantec methodology.

Table 1: LTC bed projections for WH Region

<table>
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<tr>
<th>Scenario*</th>
<th>LTC demand 2014</th>
<th>LTC demand 2017</th>
<th>LTC demand 2022</th>
<th>LTC demand 2026</th>
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<tbody>
<tr>
<td>1. Constant use 517**</td>
<td>589</td>
<td>115</td>
<td>701</td>
<td>227</td>
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<td>2. Declining use 517</td>
<td>569</td>
<td>95</td>
<td>656</td>
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<td>3. 10% increase 517</td>
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<td>127</td>
<td>739</td>
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<td>Stantec***</td>
<td>686</td>
<td>212</td>
<td>844</td>
<td>370</td>
<td>1011</td>
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Note 1* Data from the ERA uses demographic data from the S John's area as a proxy for WH residents
**Includes the average wait list of 43 clients
**Uses 100/1000 people over age 75 years will require LTC

- Western Health currently has 474 LTC beds. As of July 7, 2014, 52 individuals were waiting for LTC placement in the WH region with 37 waiting in acute care. Of the 52 clients waiting, 45 (87%) are requesting placement in Corner Brook LTC.

- As the facility is scheduled to open in 2017/18, ERA projections for 2022 are used to predict the LTC bed requirements (656 beds). The ERA Division advises that based on available historical data LTC utilization rates will most likely continue to decline, therefore, the declining use scenario (#2), in Table 1 as above, is used for projecting the number of beds required.
Annex 1
Average LTC waitlist data

<table>
<thead>
<tr>
<th>RHA</th>
<th>Number of LTC bed</th>
<th>Average number clients waiting for LTC placement monthly</th>
<th>Number waiting per 100 LTC beds</th>
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<tr>
<td>EH</td>
<td>1678</td>
<td>108</td>
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<td>CH</td>
<td>519</td>
<td>98</td>
<td>18.9</td>
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<td>WH</td>
<td>474</td>
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<td>LGH</td>
<td>117</td>
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<td>NL</td>
<td>2788</td>
<td>271</td>
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Annex C

Financial Advisory Service- Scope of Work

The proposed scope of work for the Fairness Advisory Services includes:

1. Evaluate the financial capacity of the proponents
2. Analyze the financial proposal submitted by the proponents
3. Provide written report outlining the findings for each proposal

Proponents

○ PPP Canada has pre-qualified several firms to provide financial and business case advisory services. The pre-qualified firms are as follows:
  1. Deloitte
  2. Ernst & Young
  3. Grant Thornton Raymond Chabot
  4. KPMG
  5. PricewaterhouseCoopers
Annex E
Newfoundland and Labrador
Long Term Care Project

Project Execution Plan

Draft Date: April 20, 2015
# Project Execution Plan

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<tr>
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<td>Cindy Paquette</td>
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<tr>
<td>5.1</td>
<td>Project Planning Phase</td>
<td>10</td>
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<tr>
<td>5.2</td>
<td>Pre-Procurement</td>
<td>10</td>
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</tr>
<tr>
<td>7</td>
<td>PROJECT SCHEDULE</td>
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<td>Project Schedule</td>
<td>16</td>
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<td>8</td>
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<td>17</td>
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<td>8.1</td>
<td>Anticipated Financial Outcomes</td>
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<td>8.2</td>
<td>Project Planning and Procurement Budget</td>
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1. PROJECT EXECUTION PLAN PURPOSE

The Project Execution Plan (PEP) serves as a reference document to guide all aspects of the project from its current phase of pre-procurement through to financial close.

The PEP provides the basis for approval to proceed with detailed project planning and serves as an agreement between the various stakeholders that the project will be planned and executed in accordance with the content of the document. The PEP also represents a commitment to dedicate the necessary time and resources to successfully execute the project.

The PEP has the following important functions:

- Provides a high-level common understanding of the project;
- Documents key strategic decisions on policy positions;
- Identifies project principles and objectives;
- Establishes a governance structure for the project and defines the relationship between the project owner, stakeholders and the project team;
- Establishes a timeline for project delivery and identifies key critical path schedule activities;
- Establishes the project budget and identifies sources of funding;
- Introduces the project communications plan;
- Identifies key project risks and associated mitigation strategies;
- Authorizes the project team to secure the resources required to proceed to the Pre-Procurement Phase of the project; and
- Provides a framework for reporting.

2. PROJECT BACKGROUND

All three of the regional health authorities in Newfoundland and Labrador (NL) are facing severe shortages in the long term care beds necessary to provide quality residential care to the province's elderly citizens. As is the case in other jurisdictions across Canada, demand is expected to rise as the baby boomer population moves through higher age brackets. Provincially, the 75+ population is projected to increase 77% (from 11,895 to 21,083) over the next 12 years.
Exacerbating the current shortfall and projected demand caused by an aging population are challenges relating to the provision of specialized care service, suitable dementia care and resourcing shortages and their impact on other parts of the health care system. Approximately 20 per cent of acute care beds occupied by Alternate Level of Care (ALC) clients and approximately 50% of ALC clients are waiting LTC placement.

The Province's "Close to Home: Long Term Care and Community Support Services Strategy" (2012) includes a commitment to ensuring an adequate supply of long term care beds and to providing services in the most fiscally responsible manner available.
3  PROJECT DESCRIPTION

3.1  DESCRIPTION

The Newfoundland and Labrador Long Term Care Project includes four long term care facilities with sites located in Corner Brook, Gander, Grand Falls-Windsor, and St. John's and the provision of care services consistent with provincial standards at each facility.

3.2  SITE, SCOPE AND CHARACTERISTICS

The four sites and their attendant characteristics are described in Table 1 below.

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of LTC Beds</th>
<th>Site Provided By</th>
<th>Health Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corner Brook</td>
<td>120</td>
<td>NL</td>
<td>Western</td>
</tr>
<tr>
<td>Gander</td>
<td>70</td>
<td>Private Partner</td>
<td>Central</td>
</tr>
<tr>
<td>Grand Falls/Windsor</td>
<td>50</td>
<td>Private Partner</td>
<td>Central</td>
</tr>
<tr>
<td>St. John’s</td>
<td>120</td>
<td>Private Partner</td>
<td>Eastern</td>
</tr>
</tbody>
</table>

3.3  CORNER BROOK SITE

The Corner Brook long term care facility will be developed on land provided by the Western Health Regional Health Authority (Western). On this property, water treatment, sewer, and an access ring road will be provided by Western as part of an enabling works package. The private partner will be responsible for connecting with Newfoundland Power.

The building on this site will be expected to accommodate a total of 159 beds broken down as follows:

- 120 long term care
- 15 palliative care
- 14 restorative care
- 10 rehabilitative care

At this facility, the private partner will provide care services for the 120 long term care beds. The private partner will also be responsible for leasing space within the same building for the 39 beds targeting other residents, but care service for these beds will be provided by Western.
3.4 CARE MODEL

The current care model used in NL long term care facilities is described in Table 2. This model is expected to be carried through to the new long term care facilities.

Table 2: Services Provided by Private Partner

<table>
<thead>
<tr>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing hours per resident per day (3.2 to 3.4 hours)</td>
</tr>
<tr>
<td>Interdisciplinary Team</td>
</tr>
<tr>
<td>• Recreation Specialists</td>
</tr>
<tr>
<td>• Recreation Workers</td>
</tr>
<tr>
<td>• Social Workers</td>
</tr>
<tr>
<td>• OP/PT</td>
</tr>
<tr>
<td>Clinical Oversight</td>
</tr>
</tbody>
</table>

3.5 CLIENT PROFILE

The long term care facilities will provide care and accommodations to individuals with high care needs (Level III and IV). Individuals will require access to 24 h professional nursing care. The client group is predominantly composed of frail, elderly seniors, many of whom have moderate to severe dementia and who require significant assistance with instrumental and functional activities of daily living. The client profile is further described in Table 3.

Table 3: Expected Client Profile Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed Gender</td>
<td>Y</td>
</tr>
<tr>
<td>Moderate to Severe Dementia (challenging, responsive behaviour)</td>
<td>~50%</td>
</tr>
<tr>
<td>Multiple Co Morbidities</td>
<td>~80 to 90%</td>
</tr>
<tr>
<td>Mental Health Issues</td>
<td>~30 to 40%</td>
</tr>
<tr>
<td>Functionally Impaired Requiring mechanical assistance for transfer</td>
<td>~70 to 75%</td>
</tr>
<tr>
<td>Average Age</td>
<td>84</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>~2 years</td>
</tr>
<tr>
<td>Impaired Instrumental and Functional Activities in Daily Living</td>
<td>100%</td>
</tr>
</tbody>
</table>
3.6 BUSINESS MODEL

The business model for the Project will require a private partner(s) to build, finance and maintain the facility and provide care services consistent with the requirements of NL as described in the contract. The care component of the contract will be met by a service provider and will include minimum care requirements, performance measures, reporting requirements and various provisions related to quality care for the residents. [s.35(1)(g)]

3.7 DEAL STRUCTURE

[s.35(1)(f), s.35(1)(g)]
4. PROJECT GOALS AND OBJECTIVES

4.1 GOALS

Goals are the overriding, long-term aims of the Project. They are not measureable, but describe what NL expects to achieve over the long term. The project team identified the following three goals:

- Deliver high quality, resident-centred care, as defined by Ministry of Health standards, and is equivalent to quality of care offered by publicly-provided services
- Ensure sustainable health care through innovation, productivity, and efficiency
- Cultivate an engaged workforce and healthy workplace

4.2 PROJECT OBJECTIVES

Objectives are measureable, tangible outcomes. They are grounded in the goals, but can be measured at points in time.

1. A therapeutic and age-friendly environment that supports the health and wellness of residents, as measured by:
   - Compliance with provincial nursing skill mix guidelines;
   - Meeting or exceeding all relevant Accreditation Canada standards;
   - Meeting or exceeding Required Organizational Practices (ROPs); and
   - Cleanliness audit results that are consistent with standards achieved at public facilities within the same region.

2. A home-like and age-friendly resident environment that provides comfort and meets the cognitive, social, physical, and spiritual needs of the residents. This will be measured by resident and family surveys and will include:
   - Quality and quantity of communications with residents and family;
   - Food satisfaction, including choice and quality;
   - Respect for confidentiality;
   - Care provided by appropriately skilled staff; and
   - Mission, vision, goals and objectives are clear, well-integrated, coordinated and understood both internally and externally.

3. Cost of service delivery decreased by 15-20 per cent over current level in public NL facilities.
4. Enhanced recruitment and retention of staff, as measured by a 10 to 20 per cent improvement in all of the following measures per LTC bed:

- Staff turnover rate;
- Sick leave/injury rate;
- Grievances; and
- Overtime hours.

5. A collaborative working relationship between public and private care providers, including:

- Sharing and implementation of best practices; and
- Common reporting requirements.
5. **APPROACH**

5.1 **PROJECT PLANNING PHASE**

The project planning phase is a confidential, internal process intended to clarify project objectives, scope, schedule and budget before embarking on the competitive selection process. The key deliverable is a project execution plan that includes a summary of the planning phase and contemplated tasks in subsequent phases.

The major activities for this phase are:

- Meeting with NL team;
- Data collection;
- Resolution of key program issues;
- Establishment of governance and project teams;
- Market sounding strategy / RFEI draft;
- RFP outline describing the key terms and decisions;
- Communications plan outline; and
- Project Execution Plan for approval.

5.2 **PRE-PROCUREMENT**

The key deliverable of this phase is a completed RFQ or RFP, depending on the outcome of market sounding.

The major activities for this phase are:

- Public announcement indicating a commitment to the LTC program;
- Preparation of market sounding material, research on potential participants;
- Market sounding to determine interest;
- Engage legal advisor if not provided by GNL Justice;
- Complete preparation of RFQ/RFP;
- Program review; and
- Securing approval for release of the RFQ or RFP.
5.3 COMPETITIVE SELECTION PROCESS

The main objective of the competitive selection process is to run a fair and transparent procurement process with robust competition that results in an executed contract delivering value for money to NL taxpayers.

5.3.2 Request for Proposals (RFP)

The key deliverable of this phase is a successful proposal for each facility ready for government approval. The major activities are:

- Public announcement naming the successful proponents;
- Issue, manage the process, and evaluate RFP responses;
- Business to business networking session; and
- One collaborative meeting with each team.

5.3.3 Preferred Proponent

The key deliverable of this phase is an executed services contract with the preferred proponent.

The major activities are:

---

1 Assumption is that there will be one procurement process for all four facilities, but procurement can be done in repeat packages if doing so is determined to provide best value and/or in the case of different levels of readiness at each location.
- Public announcement naming the preferred proponent for each facility;
- Contract negotiations;
- Government of NL approval of the contract for each facility;
- Contract execution; and
- Announcement of the contract awarding along with project details.
6. PROJECT GOVERNANCE

6.1 ORGANIZATIONAL STRUCTURE

The Project will be governed by a structure that emphasizes the day-to-day management by the project team. Project oversight will be provided by a steering committee. In addition, approvals will be required by the Government of NL at key milestones:

Figure 1 illustrates the organizational structure for the project and the reporting structure, and identifies the key positions on the project team.

6.1.1 Steering Committee

A project steering committee provides guidance and decisions to the project team. The project steering committee is composed of deputy ministers from the Ministry of Health and Community Services and the Ministry of Transportation and Works, as well as an executive from Partnerships BC. Partnerships BC is a company retained by NL to assist with the development and successful delivery of the Project.

The Steering Committee Terms of Reference are included in Appendix A.

6.1.2 Project Management

The project director is responsible for the day-to-day management of the project and oversees leads for the following functional areas:

- Communications
- Clinical
- Commercial (including procurement and legal)
- Project Cost Management

NL will lead communications and clinical. In these areas, NL will be supported by Partnerships BC. Partnerships BC will lead Commercial and provide the project director role during the procurement period or until NL finds a suitable person to manage the project during implementation. During the procurement period, NL will provide support for the commercial role and will work closely with the Partnerships BC staff to provide essential local knowledge and participate in knowledge transfer to NL.

The Project Team Terms of Reference are included in Appendix B.
Figure 1: Project Organizational Structure

<NTD: Names to be added>
6.2 APPROVALS

Table 5 below outlines the approvals required for each task in the Project.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Required Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Execution Plan</td>
<td>Steering Committee / Government of NL</td>
</tr>
<tr>
<td>Market Sounding/RFQ Release</td>
<td>Steering Committee / Government of NL</td>
</tr>
<tr>
<td>RFP Release</td>
<td>Steering Committee</td>
</tr>
<tr>
<td>Preferred Proponent(s)</td>
<td>Steering Committee</td>
</tr>
<tr>
<td>Financial Close</td>
<td>Steering Committee / Government of NL</td>
</tr>
</tbody>
</table>

6.3 PROJECT OFFICE AND ADMINISTRATION

The project office will be located in St. John’s, which will form the base for the project team through all phases of the Project. Key meetings to finalize technical, commercial and procurement deliverables will be in St. John’s. This will include evaluation of RFQ and RFP submissions. The St. John’s office will employ the necessary technologies to allow key team members outside of St. John’s to have real-time access to all Project information. There will be weekly teleconference meetings for project team members. Documents will be shared via a SharePoint site.

Partnerships BC will be responsible for maintaining procurement document control and quality. Only final drafts of project documents will be retained. Quality will be facilitated through the use of Partnerships BC templates and use of a rigorous peer review process.

6.4 REPORTING

The project team will report through the project director on a monthly basis to the Steering Committee or, in the absence of a Steering Committee meeting, directly to Bruce Cooper.
7 PROJECT SCHEDULE

7.1 PROJECT SCHEDULE

Key Project milestones are shown in the tables below. Table 6 describes the schedule if an RFQ phase is used in the process, while the schedule in Table 7 assumes the Project goes directly to RFP. The decision to proceed with an RFQ process prior to RFP will be made based on intelligence gathered during the market sounding exercise, which will take place during the pre-procurement phase.

Table 6: Target Schedule with RFQ

<table>
<thead>
<tr>
<th>Task</th>
<th>Target Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Planning Phase</td>
<td>April 2015</td>
</tr>
<tr>
<td>Pre-Procurement Phase</td>
<td>May to June 2015</td>
</tr>
<tr>
<td>RFQ</td>
<td>July to August 2015</td>
</tr>
<tr>
<td>RFP</td>
<td>September to November 2015</td>
</tr>
<tr>
<td>Preferred Proponent Negotiations</td>
<td>December 2015</td>
</tr>
<tr>
<td>Contract Execution</td>
<td>December 31, 2015</td>
</tr>
</tbody>
</table>

Table 7: Target Schedule without RFQ

<table>
<thead>
<tr>
<th>Task</th>
<th>Target Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Planning Phase</td>
<td>April 2015</td>
</tr>
<tr>
<td>Pre-Procurement Phase</td>
<td>May to June 2015</td>
</tr>
<tr>
<td>RFP</td>
<td>July to September 2015</td>
</tr>
<tr>
<td>Preferred Proponent Negotiations</td>
<td>October 2015</td>
</tr>
<tr>
<td>Contract Execution</td>
<td>October 31, 2015²</td>
</tr>
</tbody>
</table>

² The NL provincial election is expected in early November and this may result in a delay in executing the contracts.
9 COMMUNICATIONS

9.1 PROJECT COMMUNICATIONS PLAN

Communications planning and implementation is critical to achieving strong community and stakeholder support for, and awareness of, the Project. A communications plan has been drafted for the Project, with the overarching goal to position the Project and its related procurement strategy in a way that results in broad community and stakeholder understanding and support. The communications plan is included as Appendix C.
The practice of risk management is implicit in the project team’s role and inherent in the project management methodology. The project team supports the early identification and mitigation of risks. All issues are tracked and communicated throughout the Project and all project team members are responsible for mitigating any risks that may hinder achievement of the Project’s objectives.

Risk management principles include:

- Immediate communication of identified risks or potential issues;
- Pro-active mitigation strategies;
- Centralized issues tracking;
- Continual review of identified risks; and
- Risk allocation to the party or parties most appropriate to deal with them.

Proactive and effective risk management is one of the primary purposes of all key management processes outlined in the PEP. In addition to usual risks related to budget, schedule and quality, the key project risks in the planning and procurement phases are briefly described in Table 9.
# APPENDICES

<table>
<thead>
<tr>
<th>Appendix A</th>
<th>Steering Committee Terms of Reference</th>
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</thead>
<tbody>
<tr>
<td>Appendix B</td>
<td>Project Team Terms of Reference</td>
</tr>
<tr>
<td>Appendix C</td>
<td>Communications Plan</td>
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<tr>
<td>Appendix D</td>
<td>Market Sounding Package</td>
</tr>
<tr>
<td>Appendix E</td>
<td>RFP Outline</td>
</tr>
<tr>
<td>Appendix F</td>
<td>Sample Care Agreement</td>
</tr>
<tr>
<td>Appendix H</td>
<td>Sample Lease Agreement</td>
</tr>
</tbody>
</table>
APPENDIX A: STEERING COMMITTEE TERMS OF REFERENCE

Role and Function of the Steering Committee

The Steering Committee is responsible to provide overall direction and key decision-making for the Project, with particular reference to scope, budget, schedule, procurement and communications.

Scope

Steering Committee approval is required for:

1. Scope definition.
2. Any material scope changes with a material scope change generally being one that cannot be absorbed within approved budgets.

Budget

Steering Committee approval is required for:

1. Any material deviation in expenditures and cash flows compared to the approved budget. These items will be included in a monthly status report to the Steering Committee.
2. Any material change orders.
3. Any material changes to cash flow profile.

Schedule

Steering Committee approval is required for:

1. Any material deviations from the Project schedule.

Procurement

Steering Committee endorsement is required for:

1. Release of the RFQ
2. RFQ shortlist
3. Release of the RFP
4. Confirmation of the Preferred Proponent
5. Final negotiated deal
6. **Project Report**

**Communication / consultation**

Steering Committee approval is required for:

1. Any significant deviations from the communications / consultation plan.
2. The messaging and processes to address any politically sensitive / controversial issues.

**MEMBERSHIP**

The Steering Committee shall be comprised of XXXXXXXX.

**ACCOUNTABILITIES AND REPORTING RELATIONSHIPS**

The Steering Committee makes recommendations to Cabinet.

The Project Director is accountable to and takes direction from the Steering Committee Chair.

**MEETING SCHEDULE**

The Steering Committee will meet once every two months or at the call of the Chair.
APPENDIX B: PROJECT TEAM TERMS OF REFERENCE

Role and Function of the Project Team

MEMBERSHIP
The Project Team membership shall be comprised of the following:

xxxxxx.

ACCOUNTABILITIES AND REPORTING RELATIONSHIPS
The Project Team reports to the project director.

RESPONSIBILITIES
The responsibilities of the Project Team are to:

1. Carry out all phases and tasks of the project.
2. Provide, prepare and consolidate relevant documentation.
3. Ensure project deadlines are met.
4. Provide updates to staff through departmental meetings and/or documentation.
5. Produce the RFQ and RFP.
6. Produce and ensure quality of all deliverables.
7. Recommend an RFQ shortlist.
8. Recommend a Preferred Proponent.
9. Review and commit to detailed project management deliverables.

MEETING SCHEDULE
The Project Management Team will meet by teleconference on a weekly basis or at the call of the Chair.
Newfoundland & Labrador
Long Term Care Project

Market Sounding Package

May 2015
MARKET SOUNDING PURPOSE

The purpose of this market sounding is to assess private sector interest in a project that involves building, maintaining and operating four long term care facilities in St. John's, Corner Brook and XXXXXX, Newfoundland.

BACKGROUND

<To be added>

CARE MODEL AND CLIENT PROFILE

<To be added>
ANTICIPATED DEAL STRUCTURE

All of the long term care facilities will be procured using a contract that is based on a combination lease and service provision agreement. The private partner will build, finance and maintain the facility and provide care services consistent with the requirements of NL as described in the RFP. The Government of NL will compensate the private partner using a per diem model.

The split agreement will be based on the following assumptions:

1. The building lease will be for 20 - 30 years; and
2. The care agreement will be subject to termination with 365 day's notice. If the private partner cannot find a suitable replacement care provider, NL will have the right to provide care using the public sector.

QUESTIONS

(a) Is this an appealing opportunity for your company?
(b) How long would you like the lease to be?
(c) How would you treat ownership of the building at the end of the lease term?
(d) How long should the RFP period be if the private partner is expected to provide the land for the facility(ies)?
(e) Would there be an advantage to the public sector owner to bundling all four facilities into one project or are they best procured individually?
(f) How would the requirement to use unionized workers affect:
   i. Your decision to participate in this opportunity; and
   ii. Your commercial terms?
(g) Would the opportunity to add for-profit segments such as private beds or retail space to the Project make the opportunity more appealing?
(h) What, if any, opportunities do you see for innovation in how the project is delivered?
(i) What are the major risks inherent in this project from the private sector perspective?
(j) Any further comments?

RESPONSE FORMAT

Telephone and/or face-to-face meetings can be arranged and are being planned for the first half of May 2015.
CONFIDENTIALITY

All of the responses will be treated in confidence. Information provided by participants, as well as the corporate name of the participants, may be included in a market sounding report. However, the information will not be attributed to individual participants.

CONTACT

Questions regarding this market sounding should be directed to:

  Cindy Paquette
  Partnerships British Columbia Inc.
  Ph: (250) 475-4677
  Cindy.paquette@partnershipsbc.ca

DISCLAIMER

The information contained in this package is preliminary and for the purposes of the market sounding only. The project described herein has not received government approval to proceed and, if approved, may not proceed on the scope, schedule and/or budget described in this package.
APPENDIX E – RFP OUTLINE

SUMMARY OF KEY INFORMATION

1 INTRODUCTION
   1.1 RFP Purpose
   1.2 Eligibility to Participate

2 RFP PROCUREMENT PROCESS
   2.1 Estimated Timeline
   2.2 Collaborative Meeting
   2.3 Business-to-Business Networking Session
   2.4 Comments on the Draft Contract
   2.5 Data Room

3 KEY PROJECT ELEMENTS
   3.1 Municipal Approvals
   3.2 Facility Design and Construction
   3.3 Equipment
   3.4 Residential Care Services

4 AFFORDABILITY
   4.1 Affordability Requirements

5 PROPOSAL REQUIREMENTS
   5.1 Participation Agreement
   5.2 Proposal Form and Content
   5.3 Interest Rate Movement Protection

6 SUBMISSION INSTRUCTIONS
   6.1 Submission Times and Submission Location
   6.2 Number of Copies
   6.3 No Fax or Email Submission
   6.4 Language of Proposals
   6.5 Receipt of Complete RFP
   6.6 Enquiries
6.7 Electronic Communication
6.8 Addenda
6.9 Intellectual Property Rights
6.10 Definitive Record
6.11 Amendments to Proposals
6.13 Validity of Proposals
6.14 Material Change after Submission Time for Financial Submissions

7 EVALUATION
7.1 Mandatory Requirements
7.2 Evaluation of Proposals

8 SELECTION OF PREFERRED PROPONENT AND AWARD
8.1 Selection and Award
8.2 Final Draft Contract
8.3 Preferred Proponent Security Deposit
8.4 Return of Security Deposit
8.5 Retention of Security Deposit
8.6 Communication Regarding Progress to Contract Execution
8.9 Partial Compensation for Participation in this RFP
8.10 Debriefs

9 CONFLICT OF INTEREST AND RELATIONSHIP DISCLOSURE
9.1 Reservation of Rights to Disqualify
9.2 Relationship Disclosure
9.3 Use or Inclusion of Restricted Parties
9.4 Current Restricted Parties
9.8 Decisions Final and Binding
9.9 Shared Use
9.10 Exclusivity

10 RFP TERMS AND CONDITIONS
10.1 No Obligation to Proceed
10.2 No Contract
10.3 Freedom of Information and Protection of Privacy Act
10.4 Cost of Preparing the Proposal
10.5 Confidentiality of Information
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Communications Plan
Department of Health and Community Services

Title: Long Term Care Pre-Budget Announcement April 28

Issue: Plan for pre-budget announcement of the Provincial Government committed to engage Partnerships British Columbia to co-ordinate a Request for Proposals for the construction operation and ownership of long-term care facilities in Corner Brook, Grand Falls-Windsor, Gander and St. John’s, which will see a total of 360 long-term care beds for the western, central and eastern regions of Newfoundland.

<table>
<thead>
<tr>
<th>Consulted with:</th>
<th>Date drafted:</th>
<th>Announcement date:</th>
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<tbody>
<tr>
<td>Denise Tubrett, HCS</td>
<td>April 20, 2015</td>
<td>TBD 2015</td>
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<td>Revised date: April 22, 2015</td>
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A. COMMUNICATIONS ANALYSIS

Public Environment

- Issues related to long term care (LTC) are constantly in the media. From specific patient cases to larger regional issues of wait lists and lack of adequate beds or workforce deficiencies, the topic garners a lot of attention from patients, families, opposition parties and the media.

- Since 2004, the Provincial Government opened several new long-term care facilities and protective care units. New LTC facilities have opened in Clarenville, Corner Brook, Happy Valley-Goose Bay, Lewisporte, St. John’s and additional facilities are under construction and development in Carbonear and Corner Brook respectively. Protective care units have opened in Corner Brook, Lewisporte and Bonavista and two additional units are under development in Clarenville and the Burin Peninsula.

- In June 2012, a 10-year strategy titled Close to Home: A Strategy for Long-Term Care and Community Support was released by the Provincial Government.

- In the Fall of 2014, the media focused on the opening of the new St. John’s long-term care facility and the fact that 30 of the new beds added to the system would not be available until April 2015 when additional LPNs could be hired and trained to provide the necessary staffing complement.

- Opposition parties routinely ask how the Provincial Government will address long-term care needs, asking for a plan on how the issue of wait lists and new beds will be addressed.

- The population of Newfoundland and Labrador 75 years of age and older will increase 77 per cent (from 11,895 to 21,083) between 2013 and 2026.

- The issue of wait lists for long-term care beds is routinely raised by members of the public, as well as the high number of individuals who require an alternative level of care who reside in an acute care bed. This issue also manifests itself in the media through stories of emergency departments being at overcapacity due to a lack of
acute care beds, or surgeries that are delayed as a result of access to acute care beds.

- Public, private partnerships with respect to the delivery of long-term care are not a common occurrence in Newfoundland and Labrador. Currently only 2.5 per cent of long-term care beds in the province are managed by a for-profit agency. In comparison, approximately 60 per cent of the long-term care beds in Ontario are managed by for-profit or not-for-profit agencies and most other provinces and territories range from 25 to 40 per cent of long-term care beds being managed by non-government agencies.

- During a speech to Rotary in March Premier Davis mentioned that the Provincial Government was exploring options for public-private partnerships. Since then, the issue has surfaced in the media. To date, opinion from stakeholder groups is predictable and polarized.

- In a March 28 letter to the editor of The Telegram. St. John's Board of Trade Kim Keating wrote: "We ask federal, provincial and municipal governments to consider infrastructure delivery options that make the best use of both the public and private sector resources. We also encourage government to examine P3 frameworks, core principles and identify potential projects."

- In response, Bill Hynd, co-chair of Social Justice Co-operative NL wrote: "P3s are the privatization smiley face. They are offered as the solution to a financial shortfall that is due in large part to tax cuts that benefitted corporate interests and the well-to-do. And despite the fact they have proven a huge waster of public money, corporate interests continue to promote them as a panacea to our fiscal woes.

- On April 13, Canadian Council for Public-Private Partnerships President and CEO Mark Romoff countered: "Today there are 222 P3 projects across the country and across a wide variety of priority sectors of the economy, and because of our strong track record of success, Canada's P3 model is viewed internationally as “best in class.” The citizens of Newfoundland and Labrador deserve no less."

- In the April 21 Federal Budget, Finance Minister Joe Oliver imposed a restriction on access to its new $1 billion Public Transit Fund by restricting access only to cities that are open to public-private partnerships. "Canada is home to some of the world's largest and most experienced private-sector infrastructure investors," Minister Oliver told the House of Commons. "This fund will require their involvement and expertise to deliver projects in a manner that is affordable for taxpayers and efficient for commuters."

**Strategic Considerations**

- Newfoundland and Labrador has an aging population due to the increasing age of the baby-boomer generation. The number of individuals in the province over the age of 75 will increase by 77 per cent (11,895 to 21,083) between 2013 and 2026.

- On an ongoing basis there are people on wait lists in the community, personal care homes or alternative level of care (ALC) patients waiting for long-term care beds in nearly all regions of the province.

- Provincially, 20 per cent of acute care beds are occupied by ALC patients. Of this, approximately 60 per cent of these patients require long-term care beds.
In 2013-14, approximately 50 per cent of admissions to LTC beds were referred from acute care.

The average cost of an acute care bed is $45,000 per month compared to approximately $10,000 in LTC.

Public/private partnerships for the delivery of long-term care services are very limited in this province. Only one private for-profit facility provides long-term care through the publicly funded system, accounting for only 2.5 per cent of long-term care beds in the province. However, all personal care homes in the province, approximately 90, which provide care to individuals with lower care needs, are all private agencies with mainly publicly-funded clients.

Most provinces have a combination of public and private agencies providing long-term care, up to 60 per cent in Ontario and an average of 25 to 40 per cent in other provinces and territories.

A number of studies show that there is no significant difference in the quality of care between for-profit/non-profit and public sectors with respect to the delivery of LTC.

It is estimated that the monthly cost per LTC bed in a private facility would be approximately $1,900 less per month than a publicly-funded bed.

Utilizing private partnerships to deliver LTC services would leave the regional health authorities to manage program areas but the responsibility for issues related to maintenance of the building and operations (staffing) would remain with the private agency.

Nursing issues around recruitment, retention and sick time are regular issues with LTC nursing staff employed at Regional Health Authority facilities. A privately run facility would be required to maintain an appropriate staff complement as per any agreement between the Provincial Government and the agency. A private agency may have more flexibility in retaining and managing these issues.

Labour unions may also see the increased use of private agencies as a threat to their members, as new positions that are required to staff these facilities (e.g. LPNs and RNs) may not be unionized positions.

Since 2008, 5 new LTC facilities have been built in Clarenville, Lewisporte, Happy Valley-Goose Bay, Corner Brook and St. John's and Protective Care Residences in Corner Brook, Lewisporte and Bonavista. Most of these facilities replaced existing beds already in the system, although during that period approximately 230 new long-term care beds were added to the system.

Future projects under construction or in the planning phase in Carbonear, Clarenville, Happy Valley-Goose Bay, Corner Brook and Burin will result in the creation of approximately 185 new beds to the long-term care system in the coming years.

Central Health is currently undertaking a review of its long-term care needs to determine what additional resources are required to address this issue within its region.

Opposition parties would likely support a strategy to outline planning for new beds to be added to the LTC system. However, it is likely opposition members
will be critical that there has not been a plan in place previously, considering that additional beds are needed now and not several years down the road.

**Target Audiences**

*Internal*
- Health and Community Services
- Seniors, Wellness and Social Development
- Child, Youth and Family Services
- Finance
- Human Resource Secretariat
- Office of Public Engagement
- Premier’s Office
- Cabinet Secretariat
- Communications Branch
- MHAs

*External*
- Regional Health Authorities
- Newfoundland and Labrador Medical Association
- Registered Nurses’ Union Newfoundland and Labrador
- Newfoundland and Labrador Council of Health Professionals
- Association of Allied Health Professionals of Newfoundland and Labrador
- College of Licensed Practical Nurses of Newfoundland and Labrador
- Newfoundland and Labrador College of Dietitians
- Association of Newfoundland Psychologists
- Association of Registered Nurses of Newfoundland and Labrador
- Newfoundland and Labrador Association of Occupational Therapists
- Newfoundland and Labrador Association of Social Workers
- Newfoundland and Labrador Physiotherapy Association
- Newfoundland and Labrador Therapeutic Recreation Association
- Municipal governments
- Opposition parties
- Media
- General public

**Consultations**
- Regular engagement with other government departments and stakeholders has taken place including ongoing conversation on these issues.

**Communications Objectives**
- To communicate that the Provincial Government is moving forward with future planning of long-term care beds to address a growing demand.
- To demonstrate that the Provincial Government is strategically investing in new long-term care beds to meet a specific demand as the baby boomer population ages.
• To bring awareness to the ongoing investments and enhancements being made to the delivery of long-term care services as a result of *Close to Home: A Strategy for Long-Term Care and Community Support*.

**B. COMMUNICATIONS STRATEGY**

**Overall Approach**
• The delivery of long-term care services is a regular media, opposition and public issue. It is recommended that if approval is given to proceed with the recommended alternative, that this course of action be publicly communicated.
• By laying out the plan as to how the Provincial Government will address long-term care bed availability, it will demonstrate a cohesive plan for its ongoing and future delivery.
• Communicating through a news release and/or event is recommended.

**Key Messages**

**Project Benefits**
• This project represents a significant investment in the delivery of quality, sustainable, health care services for our senior citizens.
• These new facilities will deliver 360 net-new beds, which means wait-list times will be reduced freeing up acute-care beds in hospitals that are urgently needed by patients.
• These new long-term care facilities will have an immediate, positive impact for many families by allowing their elderly family members to stay in their communities close to home while receiving quality care in a supportive environment.
• Today’s announcement means we are one step closer to getting shovels in the ground. We are moving forward with the competitive process to select a private partner to help us build and operate these new facilities.
• This project demonstrates our commitment to working with our partners in the health care sector to ensure Newfoundlanders get the best health long-term care for its seniors now and in the future.
• This project allows us to fulfill goals set out in the Close to Home long-term care strategy that aims to support people living at home longer and ensuring that when long-term care is needed, it is there for people throughout the province.
• New jobs will be created during the construction period and at the facilities once they become operational.
• What we are proposing is simple: the private sector puts up all of the costs to build the facility and will only see a return on their investment when the facility is operational – this is a huge incentive to build on-time and on-budget.
• When operational, the facility is owned and operated privately, with government funding its operation only through paying on a per-bed basis over the course of a twenty-year lease agreement. The province would retain the option to exit the lease with a one-year notice.
Service Agreement with the private sector

- This project will be delivered through a service agreement with the private sector.
- By involving the private sector, we are looking to leverage their experience and expertise in building quality homes for seniors on-time and on-budget, that incorporate the latest in design innovations from across Canada.
- We recognize that the private sector already plays a significant role in health care in Newfoundland and Labrador and will continue to do so into the future.
- We have an excellent track record of working with private sector and a good example is Chancellor Park whereby the private sector is successfully delivering long-term health care services.
- We have great confidence in the care that has been provided at this facility to date and feel that residents will continue to receive the care they need at this facility.
- In addition, these service providers will be required to deliver high-quality health care services to the standards defined by government.
- We are committed to the delivery of high-quality, efficient health and community services that are accessible, available universally, publically administered and comprehensive.
- Our goal is for the people of the province to have better health, and to provide better care to residents while achieving the best value possible.
- We spend more per capita on health care than any other province. We have an obligation and duty to consider all possible options to ensure health system sustainability and we will consider all options and learn from the experiences of other provinces.
- Chancellor Park is a great example of where the private sector is successfully delivering long-term health care services, provides long-term care through the publicly-funded system, accounting for only 2.5 per cent of long-term care beds in the province.
- Since 2006, the Provincial Government has had an ongoing relationship with Chancellor Park, the province’s only privately run facility that provides publicly subsidized long-term care beds.
- Currently, Chancellor Park provides care to 70 subsidized long-term care residents in the St. John’s region.
- Eastern Health plays an oversight role with Chancellor Park to ensure that the clients are receiving the appropriate levels of care as would be received at an Eastern Health facility.
- Meanwhile, all personal care homes in the province, approximately 90, which provide care to individuals with lower care needs, are all private agencies with mainly publicly funded clients.
- Most provinces have a combination of public and private agencies providing long-term care, up to 60 per cent in Ontario and an average of 25 to 40 per cent in other provinces and territories.
- We believe there is tremendous opportunity in the private sector for providing long-term care. The delivery of long-term care services is an essential component of Newfoundland and Labrador’s health care system.
Long term Care – General

- More than 20,000 Newfoundlanders and Labradors make use of of the long-term care and community support services program every year.
- In 2014-15, approximately $695 million was provided for long-term care and community support services, including over $169 million annually for the home support program.
- As we are all aware, our population is aging and with that comes an increased need for long-term care beds and community support services.
- Recognizing that between 2013 and 2026, residents 75 years of age and older will increase by 77 per cent (from 11,895 to 21,083), we are moving forward with plans to ensure that there is sufficient long-term care bed capacity to meet the projected need.
- This planning will complement ongoing initiatives outlined within the Close to Home long-term care strategy that aims to support people living at home longer and ensuring that when long-term care is needed, it is there for people throughout the province.
- The Provincial Government currently operates 2,818 long-term care beds in 41 facilities throughout the province. Of these, 1,201 long-term care beds are in the St. John’s area.

Close to Home long-term care strategy

- In June 2012, the 10-year Close to Home strategy was released, with the goal of transforming and enhancing the delivery of long-term care services.
- Several new initiatives of the strategy have been implemented including:
  - The Age-Friendly Newfoundland and Labrador Transportation Pilot Project which is funding five groups across the province to provide affordable and reliable transportation to older adults and those with mobility challenges for outings such as medical and banking appointments, social activities and grocery shopping.
  - The Enhanced Care in Personal Care Homes Pilot Project which is allowing seniors who would be required to move to a long-term care facility, to receive enhanced levels of quality care in a personal care home, allowing them to live in a setting more like their own home.
  - Increased financial support has been provided to personal care and community care home operators, as well as home support agencies to ensure that these health care providers remain viable.
  - Introduction of a subsidy to provide respite care in personal care homes.
  - The addition of new palliative care comfort beds in long-term care facilities and health care centres.
  - Implementation of the Paid Family Caregiving Option which increases a new home support client’s flexibility and choice for care by making it easier for adults to hire a family member.
  - The Community Rapid Response Pilot Project, once implemented, will utilize four teams of health professionals in Grand Falls-Windsor, Corner Brook and two in St. John’s to provide enhanced health care follow-up
services in people's homes to patients who present at an emergency department.

**New Long-Term Care Infrastructure**

- Since 2004, the Provincial Government has opened several new long-term care facilities and protective care units. New long-term care facilities have opened in Clarenville, Corner Brook, Happy Valley-Goose Bay, Lewisporte, St. John's and additional facilities are under construction and development in Carbonear and Corner Brook respectively.
- Protective community care units have opened in Corner Brook, Lewisporte and Bonavista and two additional units are under development in Clarenville and the Burin Peninsula.
- Additionally, 30 beds in the new St. John's long-term care facility that have not yet opened will also be added to the system and are expected to open soon once the new staff has completed their orientation and training.
- Since 2008, approximately 230 new long-term care beds were added to the system.
- Future projects under construction or in the planning phase in Carbonear, Clarenville, Happy Valley-Goose Bay, Corner Brook and Burin will result in the creation of approximately 185 new beds to the long-term care system in the coming years.

**Chancellor Park**

- Since 2006, the Provincial Government has had an ongoing relationship with Chancellor Park, the province's only privately run facility that provides publicly subsidized long-term care beds.
- Currently, Chancellor Park provides care to 70 subsidized long-term care residents in the St. John's region.
- We have great confidence in the care that has been provided at this facility to date and feel that residents will continue to receive the care they need at this facility.
- Eastern Health plays an oversight role with Chancellor Park to ensure that the clients are receiving the appropriate levels of care as would be received at an Eastern Health facility.

**Health Care Infrastructure**

- In our province of more than 500,000 people, we have 15 hospitals, 23 community health centres, 119 community clinics, and 23 long-term care facilities.
- Since 2004, we have invested approximately $1.4 billion in health care infrastructure including new facilities, repairs and renovations to existing facilities and for new equipment.
- Over the past 10 years there have been approximately 35 health care infrastructure projects constructed or under development and there are currently 9 projects ongoing, excluding those approved in Budget 2014.
The Announcement and Materials

- It is recommended that the announcement take place in the morning either just before or just after the April 30 Provincial Budget.
- Given the sensitivities around the linkages to the long-term care and the replacement of the Western Memorial Regional Hospital, it is recommended the event take place in Corner Brook at the Corner Brook Long Term Care Home. The modern 250-bed facility could be acknowledged as an example of record of accomplishment in long-term care, with the announcement building on that positive record of continuing to meet the demand for long-term care. While the means may be somewhat different, the goal of providing quality long-term care remains the same.
- The event will be simple, with the Minister of Health and Community Services speaking following an introduction by Western Health CEO. While the event is in Corner Brook it will be couched as a more broadly focused announcement, one that marks a significant milestone to advance the provincial long-term care strategy. Meanwhile it will be stressed how important the announcement is to the Western Region, necessitating the need to make the announcement there and to assure people that the plan to replace Western Memorial Regional Hospital continues.
- It should be noted in the announcement that follow up events will occur in western and central regions, in order to provide them with details of plans for additional long-term care beds there.
- If the Minister’s schedule will allow, it is recommended he spend as much time in the area meeting with community leaders and engaging stakeholders and media – this will help to mitigate the appearance of a “fly-in fly-out” announcement.

- Event material:
  - News release
  - Speaking notes
  - Key messages
  - Q&As

Minister’s Involvement

- The Minister of Health and Community Services will be the lead spokesperson.

Interdepartmental Co-ordination

- NA

Briefing of Members of the House of Assembly

- The Minister of Health and Community Services will brief MHAs as required.

Internal Communications

- Staff with Health and Community Services will be made aware of any actions requiring their involvement.

Evaluation Criteria
• Communications will monitor media to ensure messages are being received correctly.

Budget

N/A

Prepared by:  John Tompkins
Approved by:  Bruce Cooper
Request for Qualifications

Newfoundland and Labrador
Long Term Care Project

RFQ #XXXX

May XX, 2015

partnerships
British Columbia
| **RFQ TITLE** | The title of this RFQ is: 
RFQ – Newfoundland and Labrador Long Term Care Project  
Please use this title on all correspondence. |
| **CONTACT PERSON** | The Contact Person for this RFQ is:  
Catherine Silman  
Email: catherine.silman@partnershipsbc.ca  
Please direct all Enquiries, by email, to the above named Contact Person.  
No telephone Enquiries please. |
| **ENQUIRIES** | Respondents are encouraged to submit Enquiries at an early date and prior to 15:00 Newfoundland Time on the day that is 10 Business Days before the Submission Time to permit consideration by the Owner; the Owner may, in its discretion, decide not to respond to any Enquiry. |
| **RECEIPT CONFIRMATION FORM** | The Addenda and any further information relating to this RFQ will be directed only to parties who have completed and returned the Receipt Confirmation Form. |
| **SUBMISSION TIME** | The Submission Time is:  
2:00 PM Newfoundland Time on June 6, 2015 |
| **SUBMISSION LOCATION** | Responses are to be submitted to:  
XXXXXXXXXX  
Attention: <Contact Person> |
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1.1 PURPOSE OF THIS RFQ

The purpose of this Request for Qualifications ("RFQ") is to invite interested parties to submit Responses indicating their Interest in, and qualifications for, the Newfoundland and Labrador Long Term Care Project ("the Project"). Based on these Responses, the Government of Newfoundland and Labrador and the respective regional health authorities ("NL" or the "Owner") intend to select, in accordance with the terms of this RFQ, a shortlist of Proponents to be invited to participate in the next stage of the competitive selection process, the Request for Proposals ("RFP") stage. NL's objective will be to have three qualified teams competing for each site. Depending on the results of the RFQ, the RFP phase may be split into individual procurements.

This RFQ is not a tender or an offer or a request for proposals, and there is no intention by the Owner to make an offer by issuing this RFQ.

Under the competitive selection process, the Owner is seeking to enter into a split agreement comprised of lease agreement (the "Lease Agreement") and a residential care services agreement (the "RCSA") with a qualified entity (the "Private Partner") to design and construct up to four long term care facilities in four cities in Newfoundland.

If a capitalized term used in this RFQ is not defined in Section 6 of this RFQ, it will be defined in the section of the RFQ in which it is first used.

1.2 ADMINISTRATION OF THIS RFQ

Partnerships British Columbia Inc. ("Partnerships BC") is managing this RFQ and the Competitive Selection Process on behalf of the Owner.

1.3 ELIGIBILITY

Any interested party, or parties, may submit a Response to this RFQ. Respondents may be individuals, corporations, joint ventures, partnerships or any other legal entities. If the Respondent is not a legal entity, the Respondent shall act through the legal entity or entities comprising the Respondent.
2  THE PROJECT

2.1  PROJECT TEAM

2.1.1  Government of Newfoundland and Labrador

NL's Ministry of Health and Community Services is the primary agent involved in procurement of the
Project on behalf of the regional health authorities. The regional health authorities will be signatories to
the respective contracts in their jurisdictions. Additional information about the Ministry of Health and
Community Services is available at http://www.health.gov.nl.ca/health/

The 4 separate facilities will be distributed throughout NL's three regional health authorities. Additional
information about each of them is available at the following URLs:

  Western Regional Health Authority ("Western"): http://www.westernhealth.nl.ca/
  Central Regional Health Authority ("Central"): http://www.centralhealth.nl.ca/
  Eastern Regional Health Authority ("Eastern"): http://www.easternhealth.nl.ca/

2.1.2  Partnerships BC

Partnerships BC was established by the Province of British Columbia to structure and implement
partnership delivery solutions for public infrastructure. The Owner has engaged Partnerships BC to
manage the procurement of the Project and to provide guidance to NL to enable NL to establish a core of
knowledge to manage future projects.

Additional information about Partnerships BC is available at www.partnershipsbc.ca.

2.2  LONG TERM CARE PROJECT

All three of the regional health authorities in NL have significant wait lists and are facing increasing
shortages in the long term care beds necessary to provide quality residential care to the province's elderly
and vulnerable citizens. As is the case in other jurisdictions across Canada, demand for quality long term
care is expected to rise as the baby boomer population moves through higher age brackets. Provincially,
the 75+ population is projected to increase 77% (from 11,895 to 21,083) over the next 12 years.

Exacerbating the current shortfall and projected demand caused by an aging population are challenges
relating to the provision of specialized care service, suitable dementia care and resourcing shortages, all
of which are having an impact throughout the health care system. Approximately 20 per cent of acute
care beds are occupied by Alternate Level of Care (ALC) clients and approximately 50% of ALC clients
are waiting long term care placement. Consequently adding capacity for long term care beds will also take pressure off the acute care sector.

The Province's "Close to Home: Long Term Care and Community Support Services Strategy" (2012) includes a commitment to ensuring an adequate supply of long term care beds and to providing services in the most fiscally responsible manner available.

2.2.1 Care Model

The current care model used in NL long term care facilities is described in Table 1. This model is expected to be carried through to the new long term care facilities.

<table>
<thead>
<tr>
<th>Table 1: Services Provided by Private Partner</th>
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<td>Nursing hours per resident per day (3.2 to 3.4 hours)</td>
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<td>• Recreation Workers</td>
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<td>• Social Workers</td>
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<td>• OP/PT</td>
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</table>

2.2.2 Client profile

The long term care facilities will provide care and accommodations to individuals with high care needs (Level III and IV). Individuals will require access to 24 h professional nursing care. The client group is predominantly composed of frail, elderly seniors, many of whom have moderate to severe dementia and who require significant assistance with instrumental and functional activities of daily living. The client profile is further described in Table 2.

<table>
<thead>
<tr>
<th>Table 2: Expected Client Profile Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristic</td>
</tr>
<tr>
<td>Mixed Gender</td>
</tr>
<tr>
<td>Moderate to Severe Dementia (challenging, responsive behaviour)</td>
</tr>
<tr>
<td>Multiple Co Morbidities</td>
</tr>
</tbody>
</table>
2.2.3 Project Goals

- Deliver high quality, resident-centred care, as defined by Ministry of Health standards, and is equivalent to quality of care offered by publicly-provided services
- Ensure sustainable health care through innovation, productivity, and efficiency
- Cultivate an engaged workforce and healthy workplace

2.3 PROJECT SCOPE

The Newfoundland and Labrador Long Term Care Project includes the leasing and care services for four long term care facilities (the “Facilities”) with sites located in Corner Brook, Gander, Grand Falls-Windsor, and St. John’s.

The care services will be consistent with provincial standards at each facility and generally will be for residents with care needs at a level 3 or 4 degree of need (i.e. most severe on a 4 point scale).

Proponents will have an option of submitting a proposal on any or all of the sites. The Owner will select the proposals that offer a combination of value and demonstrated ability to provide quality care and may choose one or multiple proponents to deliver the services.

The four sites and their attendant characteristics are described in Table 3 below.
<table>
<thead>
<tr>
<th>Corner Brook</th>
<th>120</th>
<th>NL</th>
<th>Western</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gander</td>
<td>70</td>
<td>Private Partner</td>
<td>Central</td>
</tr>
<tr>
<td>Grand Falls/Windsor</td>
<td>50</td>
<td>Private Partner</td>
<td>Central</td>
</tr>
<tr>
<td>St. John's</td>
<td>120</td>
<td>Private Partner</td>
<td>Eastern</td>
</tr>
</tbody>
</table>

2.4 CORNER BROOK SITE

The Corner Brook facility will be developed on land provided by the Western Health Regional Health Authority (Western).

The building on this site will be expected to accommodate a total of 159 beds broken down as follows:

- 120 long term care
- 15 palliative care
- 14 restorative care
- 10 rehabilitative care

At this facility, the private partner will provide care services for the 120 long term care beds. The private partner will also be responsible for providing space within the same building for the 39 beds targeting other residents, but care service for these beds will be provided by the Western Regional Health Authority.

2.5 ADVANCE WORK BY THE OWNER

The site for the Corner Brook project will be provided by the Western Regional Health Authority. On this site, water treatment, sewer, and an access ring road will be provided by Western Regional Health Authority as part of an enabling works package. The private partner will be responsible for connecting with Newfoundland Power.

Sites for the facilities in Gander, Great Falls-Windsor and St. John's will be selected and purchased by the Private Partner at locations within general geographic limits that will be provided in the RFP.

2.6 GENERAL SCOPE OF PRIVATE PARTNER'S RESPONSIBILITY

2.6.1 Split Agreement

The Project will be managed under a split agreement with the following components:
(a) Lease Agreement; and

(b) Residential Care Services Agreement (RCSA).

The Owner intends to attach an Initial Draft Lease Agreement and an Initial Draft RCSA to the RFP which will describe the facility and care requirements.

2.6.2 General Scope of Responsibility

The Owner anticipates that the general scope of the Private Partner’s responsibility under the Lease Agreement will be as follows:

(a) Design

The Private Partner will be responsible for all aspects of the design for the Project including the integration of the various building components with each other. The final design will comply with the statement of requirements and all applicable laws, including the zoning of each local government.

(b) Construction

The Private Partner will be completely responsible for:

(1) purchasing the sites or for the Corner Brook facility, concluding a long term ground lease with the regional health authority;

(2) obtaining all permits and approvals necessary for construction of the Project;

(3) provision of utilities and other site services required to support each Facility, including off-site works as required to connect to existing municipal infrastructure;

(4) design and construction of the Project; and

(5) substantial completion of the Project by the target substantial completion date.

(c) Payment

The Owner will pay the Private Partner a lease payment for the building plus a per diem per resident based on 100% occupancy for rooms available in the Facility that provide the agreed upon space and care. The care will have to meet accreditation standards and other health care standards as generally applicable to publicly run facilities. If care standards do not meet requirements, deductions from the payments will be made.

(d) Communication and Consultation
The Owner and Private Partner will work together on all aspects of public communication and consultation as set out in the Lease Agreement and the RCSA.

2.7 COMMERCIAL TERMS

The following are some of the key commercial terms that the Owner anticipates will be included in the Lease Agreement and the RCSA:

(a) Payment: The Owner will make monthly payments to the Private Partner based on a lease payment for the building and a per diem as defined in the contracts;

(b) The building lease term will be open to negotiation but is anticipated to be for 20 years. The lease will contain an option to renew;

(c) The ground lease for the site in Corner Brook is open for negotiation but is anticipated to be 50 years. The building on the Corner Brook site will have similar lease characteristics as the other facilities except that there will be additional space leased to accommodate 39 specialized beds that will be operated by the Owner;

(d) Termination: the RCSA will be subject to termination by the Health Authority with 365 days’ notice for poor performance;

(e) Organized labour will be permitted at any or all of the sites but there are no successor rights as these are new facilities and there is no requirement to sign on to a master collective agreement.

3 COMPETITIVE SELECTION PROCESS

This section describes the process that the Owner expects to use in the selection of a Preferred Proponent or Preferred Proposents and the execution of the Contracts. The anticipated competitive selection process includes two stages: (a) the RFQ stage and (b) the RFP stage, which includes contract execution.

3.1 RFQ STAGE

The Owner intends to select, in accordance with the terms of this RFQ, a shortlist which the Owner anticipates will be no more than three Proponents for each site, and then issue an RFP to that shortlist only, from which the Preferred Proponent will be selected in accordance with the terms of the RFP.
3.2 RFP STAGE

The Owner’s objective at the RFP stage is to select the Preferred Proponent with whom it may enter into lease and service contracts. The RFP stage is expected to include:

3.2.1 Collaborative Meeting

The RFP stage will include an open dialogue at a meeting (the “Collaborative Meeting”) relating to technical and commercial matters. Proponents may provide comments on Project-specific issues raised through the process. Attendance at the Collaborative Meeting is anticipated to be in person.

In accordance with the terms of the RFP, the Proponents will be expected to an agenda and background information one week in advance of the Collaborative Meeting for the Owner’s review.

The RFP stage will allow Proponents to provide input on the draft contracts as follows:

(a) the Owner will invite each Proponent to review the Initial Draft Lease Agreement and Initial Draft Residential Care Services Agreement as attached to the RFP and then meet confidentially and separately with the Owner to discuss any comments or amendments that the Proponent requests to be considered;

(b) the Owner will consider all comments and requested amendments received from the Proponents and may, in its discretion, amend the Initial Draft Agreements and by one or more Addenda issue a revised Initial Draft Agreements; and

(c) Proponents will have the opportunity to propose value-add solutions requiring specific amendments to the Initial Draft Agreements as part of their RFP proposals.

3.2.2 RFP Submission

The form of the RFP submission will be described in the RFP and will address both technical and financial aspects of the Project. It is anticipated that the financial and technical aspects of the proposal will be combined into one submission. The RFP submission is expected to include the following:

(a) a fully binding Proposal to design and build the Project;

(b) a description of the proposed site(s) supported by a letter from the vendor(s) committing to a sale should the Preferred Proponent’s proposal be accepted;

(c) a commitment to enter into the Lease Agreement and Residential Care Services Agreement by the Private Partner; and
(d) committed pricing for the Project, based on a per diem covering both capital and operating costs. The operating component will be subject to an initial client profile provided by the Owner and subject to change as the profile is adjusted over time.

3.3 COMPENSATION FOR PARTICIPATION IN THE COMPETITIVE SELECTION PROCESS

The Owner will not provide any compensation to Respondents for participating in the RFQ stage of the Competitive Selection Process.

If the Competitive Selection Process continues into the RFP stage, the Owner intends to make provision for partial compensation in the amount of $50,000, inclusive of all taxes, payable to each unsuccessful Proponent in accordance with the terms of the RFP.

3.4 COMPETITIVE SELECTION TIMELINE

The following is the Owner’s estimated timeline for the Competitive Selection Process and the Project:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>RFQ issue date</td>
<td>May 13</td>
</tr>
<tr>
<td>Introductory Project Meeting</td>
<td>May 20</td>
</tr>
<tr>
<td>RFQ Submission Time</td>
<td>June 10</td>
</tr>
<tr>
<td>Respondent interviews (optional)</td>
<td>June 17</td>
</tr>
<tr>
<td>Announce Shortlisted Respondents</td>
<td>July 15</td>
</tr>
<tr>
<td>Issue RFP and Initial Lease Agreement and Initial RCSA</td>
<td>July 15</td>
</tr>
<tr>
<td>Collaborative Meeting</td>
<td>August 15</td>
</tr>
<tr>
<td>Submission Time for Technical and Financial Submissions</td>
<td>October 7</td>
</tr>
<tr>
<td>Selection of Preferred Proponent</td>
<td>October 21</td>
</tr>
<tr>
<td>Complete negotiations and site purchases</td>
<td>November 18</td>
</tr>
<tr>
<td>Contract Award</td>
<td>November 30</td>
</tr>
</tbody>
</table>

All dates in the above timeline are subject to change at the discretion of the Owner.

3.5 INTRODUCTORY PROJECT MEETING

The Owner intends to hold an introductory meeting, via webinar, to introduce the Project to which all interested parties will be invited. The date of this meeting will be MM/DD, 2015. All parties who wish to participate should complete and submit a Receipt Confirmation Form for further details. Participation will not be mandatory.
A list of registered participants will be made available to everyone participating or who has submitted a Receipt Confirmation Form. Minutes will not be prepared or circulated. No information from the meeting may be relied upon unless set out in an Addendum or a response to an Enquiry under Section 4.7.

SUBMISSION And process INSTRUCTIONS

3.6 MANDATORY REQUIREMENTS

Responses to this RFQ must be received at the Submission Location before the Submission Time as stated in the Summary of Key Information. Responses received after the Submission Time will not be considered and will be returned unopened. All times will be determined with reference to the clock used by the Contact Person for that purpose.

3.7 RESPONSE FORM AND CONTENT

Responses to this RFQ should be in the form and content described in Appendix A.

3.8 LANGUAGE OF RESPONSES AND ENQUIRIES

Responses and Enquiries should be in English. Any portion of a Response not in English may not be evaluated, and any Enquiry not in English may not be considered.

3.9 EMAIL SUBMISSION

Responses submitted by email will be accepted but the Owner will not be responsible for any technical issues that prevent delivery of the email and receipt by the Submission Time. The time the email is received by the Contact Person will be the receipt time for the purposes of Section 4.1.

3.10 RECEIPT OF COMPLETE RFQ

Respondents are solely responsible to ensure that they have received the complete RFQ, as listed in the Table of Contents of this RFQ, plus any Addenda. Each and every Response is deemed to be made on the basis of the complete RFQ issued prior to the Submission Time. The Owner accepts no responsibility for any Respondent that does not receive all RFQ information.

3.11 RECEIPT CONFIRMATION FORM

Any further information relating to this RFQ will be directed only to parties who have completed and returned the Receipt Confirmation Form (Appendix B). This form will be completed, executed and delivered to the Contact Person via email.
3.12 ENQUIRIES

All enquiries regarding any aspect of this RFQ should be directed to the Contact Person by email (each an “Enquiry”). Respondents are encouraged to submit Enquiries at an early date and prior 5 Business Days before the Submission Time to permit consideration by the Owner; the Owner may, in its discretion, decide not to respond to any Enquiry.

The following will apply to any Enquiry:

(a) any responses will be in writing;

(b) Enquiries to, and responses from, the Contact Person will be recorded;

(c) a Respondent may request that an Enquiry and the response to an Enquiry be kept confidential if the Respondent considers the Enquiry to be commercially sensitive, and if the Owner decides that an Enquiry or the response or both should be distributed to all Respondents, then subject to Section 4.7 (d), the Owner will permit the enquirer to withdraw the Enquiry rather than receive a response;

(d) subject to Section 3.12 (c), any Enquiry and response may, in the Owner’s discretion, be distributed to all Respondents, if the Owner in its discretion considers the matter to be a matter of substance or a matter that should be brought to the attention of all Respondents for purposes of fairness in, or maintaining the integrity of, the Competitive Selection Process. The Owner may keep either or both the Enquiry and response confidential if in the judgment of the Owner it is fair or appropriate to do so; and

(e) the Owner may, in its discretion, decline to respond to any Enquiry.

3.13 UNOFFICIAL INFORMATION

Information offered to Respondents in respect of this RFQ from sources other than the Contact Person is not official, may be inaccurate, and should not be relied on in any way, by any person for any purpose.

3.14 DELIVERY AND RECEIPT OF FAX AND EMAIL COMMUNICATIONS

No fax communication with the Contact Person is permitted with respect to the Project.

The following provisions shall apply to any communications with the Contact Person, or the delivery of documents to the Contact Person, by email where such email communications or delivery is permitted by the terms of this RFQ:

The Owner does not assume any risk or responsibility or liability whatsoever to any Respondent:
(a) for ensuring that any electronic email system being operated for the Owner or Partnerships BC is in good working order, able to receive emails, or not engaged in receiving other emails such that a Respondent’s email cannot be received; and/or

(b) if a permitted email communication or delivery is not received by the Contact Person, or received in less than its entirety, within any time limit specified by this RFQ.

All permitted email communications with, or delivery of documents to, the Contact Person will be deemed as having been received by the Contact Person on the dates and times indicated on the Contact Person’s electronic equipment or by the clock used by the Contact Person for that purpose.

3.15 ADDENDA

The Owner may, in its absolute discretion through the Contact Person, amend or clarify the terms or contents of this RFQ at any time before the Submission Time by issuing a written Addendum. Written Addenda are the only means of amending or clarifying this RFQ, and no other form of communication, whether written or oral, including written responses to Enquiries as provided by Section 3.12, will be included in, or will in any way amend or clarify this RFQ. Only the Contact Person is authorized to amend or clarify this RFQ by issuing an Addendum. No other employee or agent of the Owner is authorized to amend or clarify this RFQ. The Owner will send a notification of any Addendum to all parties who have delivered a completed Receipt Confirmation Form.

3.16 DEFINITIVE RECORD

If there is any inconsistency between the paper form of a document and the digital, electronic or other computer readable form, the electronic conformed version of the RFQ in the custody and control of the Owner prevails.

3.17 REVISIONS PRIOR TO THE SUBMISSION TIME

A Respondent may amend or withdraw its Response at any time prior to the Submission Time by delivering written or email notice to the Contact Person at the Submission Location prior to the Submission Time.

3.18 RESPONSE DECLARATION FORM

Respondents are required to complete the Response Declaration Form, substantially in the form attached as Appendix D or as otherwise acceptable to the Owner in the Owner’s discretion, and should include the completed form as part of its Response. The Response Declaration Form will be executed by a signatory
with authority to bind each member of the Respondent Team, and for clarity such signatory may be different than the Respondent's Representative.

3.19 RELATIONSHIP DISCLOSURE FORM

Respondents are required to complete the Relationship Disclosure Form, substantially in the form attached as Appendix E, or as otherwise acceptable to the Owner in the Owner’s discretion, and should include the completed form as part of their Response. The Relationship Disclosure Form will be executed by a signatory with authority to bind each member of the Respondent Team, and for clarity such signatory may be different than the Respondent's Representative.
The evaluation of Responses will be carried out by the Owner with assistance from other persons as the Owner may decide it requires, including technical, financial, legal and other advisors or employees of the Owner or Partnerships BC.

4.1 EVALUATION CRITERIA

The Owner will evaluate Responses by application of the Evaluation Criteria as outlined in Appendix A.

4.2 EVALUATION AND SELECTION PROCEDURES

The Owner will evaluate Responses based on the information described in Table 3 of Appendix A, and may, in its discretion, also consider any or all additional information received from the steps described in (a) to (e) below.

To assist in the evaluation of the Responses, the Owner may, in its discretion, but is not required to:

(a) conduct reference checks relevant to the Project with any or all of the references cited in a Response to verify any and all information regarding a Respondent, inclusive of its directors/officers and Key Individuals;

(b) conduct any additional investigations and/or seek any additional information that it considers necessary in the course of the Competitive Selection Process, including with respect to Nominated Projects and projects in which a Respondent Team member has been involved in the last ten years but which are not Nominated Projects;

(c) seek clarification of a Response or supplementary information from any or all Respondents;

(d) request interviews with any, some, or all Respondents to clarify any questions or considerations based on the information included in Responses or seek any supplementary information; and

(e) rely on and consider in the evaluation of Responses any information obtained as a result of such reference checks, investigations, requests for clarification or supplementary information, interviews, and/or any additional information that it receives during the evaluation process.

The Owner is not obligated to complete a detailed evaluation of all Responses and may, in its discretion, after completing a preliminary review of all the Responses, discontinue detailed evaluation of any Respondent who, when compared to the other Respondents, the Owner judges is not in contention to be shortlisted.
The Owner will notify Respondents of the RFQ results by sending a written notice to the Respondent's Representative.

The Owner will conduct a debriefing, upon request, for any Respondent if the debriefing is requested within 90 days after a shortlist has been announced. In a debriefing the Owner will discuss the relative strengths and weaknesses of that Respondent's Response, but the Owner will not disclose or discuss any confidential information of another Respondent.

4.3 INTERVIEWS

Respondents may be required by the Owner to have interviews regarding their Response during the evaluation process at the request of the Owner. The interviews should be specific to the Project and may not contain any marketing information of the Respondent or any member of the Respondent Team.

4.4 CHANGES TO RESPONDENT TEAMS

The Owner intends to issue the RFP only to Respondents that have been shortlisted under this RFQ as Proponents for the RFP process. If for any reason after the Submission Time a Respondent wishes or requires to add, remove or otherwise change a member of its Respondent Team, or there is a material change in ownership or control (which includes the ability to direct or cause the direction of the management actions or policies of a member) of a member of the Respondent Team, or there is a change to the legal relationship among any or all of the Respondent and its Respondent Team members, then the Respondent must submit a written application to the Owner for approval, including supporting information that may assist the Owner in evaluating the change. The Owner, in its discretion, may grant or refuse an application under this Section, and in exercising its discretion the Owner will consider the objective of achieving a Competitive Selection Process that is not unfair to the other Respondents. For clarity:

(a) if the application is made after the Proponents have been determined, the Owner may refuse to permit a change to the membership of a Respondent Team if the change would, in the Owner's judgment, result in a weaker team than was originally shortlisted; or

(b) the Owner may, in the exercise of its discretion, permit any changes to a Respondent Team, including changes as may be requested arising from changes in ownership or control of a Respondent or a Respondent Team member, or changes to the legal relationship among the Respondent Team members such as the creation of a new joint venture or other legal entity or relationship in place of the Respondent Team.
The Owner's approval may include such terms and conditions as the Owner may consider appropriate. This Section 4.4 shall apply until issuance of the RFP.
5.1 NO OBLIGATION TO PROCEED

This RFQ does not commit the Owner in any way to proceed to an RFP stage or award a contract, and the Owner reserves the complete right to, at any time, reject all Responses and to terminate the Competitive Selection Process established by this RFQ and proceed with the Project in some other manner as the Owner may decide in its discretion.

5.2 ACCESS TO INFORMATION AND PROTECTION OF PRIVACY ACT AND FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT

The Owner is subject to the Newfoundland and Labrador Access to Information and Protection of Privacy Act R.S.Y. 2002, c.1 ("ATIPPA"), which gives people a right of access to records in the custody or control of the Owner, with certain exceptions. In addition, Partnerships BC is subject to the Freedom of Information and Protection of Privacy Act, R.S.B.C. 1996 c.165 ("FOIPPA").

Once a Response is submitted to the Owner and Partnerships BC, it is subject to ATIPPA and FOIPPA respectively.

For NL, the ATIPPA can be accessed as follows:
http://www.atipp.gov.nl.ca/

For British Columbia, the FOIPPA can be accessed as follows:

5.3 CONFIDENTIALITY OF OWNER INFORMATION

All non-public information pertaining to, or provided by or on behalf of, Partnerships BC or the Owner obtained by a Respondent as a result of participation in this RFQ is confidential and will not be disclosed without written authorization from Partnerships BC or the Owner (as applicable). Except as expressly stated in this RFQ and subject to the ATIPPA, FOIPPA or other applicable legislation, all documents and other records submitted in response to this RFQ will be considered confidential; however, such information or parts thereof may be released pursuant to requests under ATIPPA, FOIPPA or other applicable legislation.

By submitting a Response, a Respondent will be deemed to have agreed to all the terms of the Confidentiality Agreement attached as part of Appendix C to this RFQ.
Proponents will also be required to sign a Participation Agreement as a condition of participating in the RFP, and such agreement will include confidentiality and other provisions. The Owner expects that the form of the Participation Agreement will be substantially as set out in Appendix F.

The Owner has engaged Partnerships BC. Partnerships BC has been and continues to be involved in other projects, and the Owner may receive information in respect of other projects that may be relevant to the Project. Subject to the terms of the RFQ, including limitations on "Commercial in Confidence" information under Section 3.2.1 (Collaborative Meetings) and Section 4.7 (Enquiries), the Owner may, in its discretion, disclose information that is available from this Project to Partnerships BC and other projects and may obtain information from other projects.

5.4 COST OF PREPARING THE RESPONSE

Each Respondent is solely responsible for all costs it incurs in the preparation of its Response, including without limitation all costs of providing information requested by the Owner, attending meetings, and conducting due diligence.

5.5 NO REPRESENTATION OR WARRANTY

Each Respondent acknowledges by its submission of a Response that it has investigated and satisfied itself of every condition that affects the Project. Each Respondent further acknowledges and represents that its investigations have been based on its own examination, knowledge, information and judgment, and not upon any statement, representation or information made or given by the Owner, the Contact Person or any advisor to the Owner, other than the information contained in this RFQ. Submission of a Response is deemed to be conclusive evidence that the Respondent has made such investigations and that the Respondent is willing to assume, and does assume, all risks affecting the Project, except as otherwise specifically stated in this RFQ. The Owner accepts no responsibility for any Respondent lacking any information.

5.6 RESERVATION OF RIGHTS

The Owner reserves the right, in its discretion, to exercise any or all of the following rights:

(a) amend the scope of the Project, modify, cancel or suspend the RFQ process or any or all stages of the Competitive Selection Process, at any time for any reason;

(b) accept or reject any Response based on the Evaluation Criteria as evaluated by the Owner;
(c) disqualify a Response that fails to meet the Mandatory Requirements set out in Section 3.6 of this RFQ, or for any of the reasons set out in Part 2 of Appendix A, or any other reason the Owner determines appropriate;

(d) waive a defect, irregularity, non-conformity or non-compliance in or with respect to a Response or failure to comply with the requirements of this RFQ, except for Mandatory Requirements, and accept that Response even if such a defect, irregularity, non-conformity or non-compliance or failure to comply with the requirements of this RFQ would otherwise render the Response null and void;

(e) not accept any or all Responses;

(f) reject or disqualify any or all Response(s) for any reason without any obligation, compensation or reimbursement to any Respondent or any of its team members;

(g) re-advertise for new Responses, call for quotes, proposals or tenders, or enter into negotiations for this Project or for work of a similar nature;

(h) make any changes to the terms of the business opportunity described in this RFQ; and

(i) amend, from time to time, any date, any time period or deadline provided in this RFQ, upon written notice to all Respondents who submitted a Receipt Confirmation Form.

5.7 LIMITATION OF DAMAGES

Each Respondent, by submitting a Response, agrees that in no event will the Owner or Partnerships BC, or any of their employees, advisors or representatives, be liable, under any circumstances, for any Claim, or to reimburse or compensate the Respondent in any manner whatsoever, including but not limited to costs of preparation of the Response, loss of anticipated profits, loss of opportunity, or for any other matter. Without in any way limiting the above, each Respondent specifically agrees that it will have absolutely no Claim against the Owner or any of its employees, advisors or representatives if the Owner for any reason whatsoever:

(a) does not select a shortlist of Respondents;

(b) suspends, cancels or in any way modifies the Project or the Competitive Selection Process (including modification of the scope of the Project or modification of this RFQ or both);

(c) accepts any compliant or non-compliant Response or selects a shortlist of one or more Respondent(s);

(d) under the terms of this RFQ, permits or does not permit a Restricted Party to advise, assist or participate as part of a Respondent Team; or
(e) for any breach or fundamental breach of contract or legal duty of the Owner, whether express or implied.

The Respondent waives any and all Claims whatsoever, including Claims for loss of profits or loss of opportunity, if the Respondent is not shortlisted in the Competitive Selection Process or for any other reason whatsoever.

5.8 OWNERSHIP OF RESPONSES

All Responses submitted to the Owner or Partnerships BC become the property of the Owner.

5.9 DISCLOSURE AND TRANSPARENCY

The Owner is committed to an open and transparent Competitive Selection Process while understanding the Respondents' need for protection of confidential commercial information. To assist the Owner in meeting its commitment, Respondents will cooperate and extend all reasonable accommodation to this endeavour.

The Owner expects to disclose the following information during this stage of the Competitive Selection Process: this RFQ document, the number of Respondents, and the names of Proponents.

To ensure that all public information generated about the Project is fair and accurate and will not inadvertently or otherwise influence the outcome of the Competitive Selection Process, the disclosure of any public information generated in relation to the Project, including communications with the media and the public, will be coordinated with, and is subject to prior approval of, the Owner.

Respondents will notify the Owner of any and all requests for information or interviews received from the media.

Respondents will ensure that all members of the Respondent Team and all others associated with the Respondent also comply with these requirements.

5.10 NO COMMUNICATION OR COLLUSION

By submitting a Response, a Respondent, on its own behalf and as authorized agent of each firm, corporation or individual member of the Respondent Team, represents and confirms to the Owner, with the knowledge and intention that the Owner may rely on such representation and confirmation, that its Response has been prepared without collusion or fraud, and in fair competition with Responses from other Respondents.
Respondents and their Respondent Team members are not to discuss or communicate, directly or indirectly, with other Respondents or their Respondent Team members or any of their respective directors, officers, employees, consultants, advisors, agents or representatives regarding the preparation, content or submission of their Responses or any other aspect of the Competitive Selection Process.

5.11 NO LOBBYING

Respondents and their respective Respondent Teams, the members of their Respondent Teams, and their respective directors, officers, employees, consultants, agents, advisors and representatives will not engage in any form of political or other lobbying whatsoever in relation to the Project, this RFQ, or the Competitive Selection Process, including for the purpose of influencing the outcome of the Competitive Selection Process. Further, no such person (other than as expressly contemplated by this RFQ) will attempt to communicate in relation to the Project, this RFQ, or the Competitive Selection Process, directly or indirectly, with any representative of the Owner, the Government of Newfoundland and Labrador (including any Minister or Deputy Minister, any member of the Steering Committee, or any Members of the House of Assembly, or any employee of the Owner), Partnerships BC, any Restricted Parties, or any director, officer, employee, agent, advisor, consultant or representative of any of the foregoing, as applicable, for any purpose whatsoever.

In the event of any lobbying or communication in contravention of this Section by any Respondent, Respondent Team members, or their respective directors, officers, employees, consultants, agents, advisors or representatives, the Owner in its discretion may at any time, but will not be required to, reject any and all Responses submitted by that Respondent without further consideration.

5.12 RELATIONSHIP DISCLOSURE AND REVIEW PROCESS

The Owner reserves the right to disqualify any Respondent that in the Owner's opinion has a conflict of interest or an unfair advantage, whether it is existing now or is likely to arise in the future, or may permit the Respondent to continue and impose such conditions as the Owner may consider to be in the public interest or otherwise required by the Owner.

Respondents will submit the form attached as Appendix E and disclose all conflicts of interest or unfair advantage.

Respondents, including all firms, corporations or individual member of a Respondent Team, will promptly disclose to the Contact Person any potential conflict of interest and existing business relationships they may have with the Owner, Partnerships BC or any members of the Owner or others providing advice or services to the Owner with respect to the Project, or any other matter that gives rise, or might give rise, to
an unfair advantage. At the time of such disclosure, the Respondent will advise the Contact Person how the Respondent proposes to mitigate, minimize or eliminate the situation.

For the purposes of this RFQ, references to unfair advantage include references to confidential information that is not, or would not reasonably be expected to be, available to all Respondents.

The Owner and the Conflict of Interest Adjudicator (the "COI Adjudicator") may, in their discretion, consider actual, perceived or potential conflicts of interest and unfair advantage.

5.12.1 Use or Inclusion of Restricted Parties

The Owner may, in its discretion, disqualify a Respondent, or may permit a Respondent to continue and impose such conditions as the Owner may consider to be in the public interest or otherwise required by the Owner, if the Respondent is a Restricted Party, or if the Respondent uses a Restricted Party:

(a) to advise or otherwise assist the Respondent respecting the Respondent’s participation in the Competitive Selection Process; or

(b) as a Respondent Team member or as an employee, advisor or consultant to the Respondent or a Respondent Team member.

Each Respondent is responsible, and bears the onus, to ensure that neither the Respondent nor any Respondent Team member uses or seeks advice or assistance from any Restricted Party or includes any Restricted Party in the Respondent Team except as permitted by this Section 5.12.1.

5.12.2 Current Restricted Parties

At this RFQ stage, and without limiting the definition of Restricted Parties, the Owner has identified the following persons as Restricted Parties:

- Xxx (Fairness Advisor)
- The Owner and Partnerships BC, including their former and current employees who fall within the definition of Restricted Party.

This is not an exhaustive list of Restricted Parties. Additional persons may be added to or deleted from the list during any stage of the Competitive Selection Process through an Addendum.

5.12.3 Shared Use

A Shared Use Person is a person identified by the Owner as eligible to enter into arrangements with any and all Respondents but may not enter into exclusive arrangements with any Respondent. As of the date of this RFQ, no Shared Use Persons have been identified.
5.12.4 Conflict of Interest Adjudicator

The Owner has appointed a COI Adjudicator to provide decisions on conflicts of interest or unfair advantage issues, including whether any person is a Restricted Party.

The COI Adjudicator and the Owner may make decisions or exercise rights under this Section 5.12 and this RFQ for conflicts of interest, unfair advantage whether addressed in advance or otherwise, and all provisions of this Section 5.12 will apply with such modifications as the Owner or the COI Adjudicator may consider necessary.

The Owner or the COI Adjudicator, as applicable, has discretion to establish the relevant processes from time to time.

There is no requirement for all issues to be referred to the COI Adjudicator.

5.12.5 Request for Advance Decision

A Respondent or a prospective member or advisor of a Respondent Team who has any concerns regarding whether a current or prospective employee, advisor or member of that Respondent Team is or may be a Restricted Party or has a concern about any conflict or unfair advantage it may have, is encouraged to request an advance decision in accordance with this section.

To request an advance decision on whether a person is a Restricted Party, a Respondent or prospective team member or advisor of that Respondent Team should submit to the Contact Person, not less than 10 Business Days prior to the Submission Time by email, the following information:

(a) names and contact information of the Respondent and the person for which the advance opinion is requested;

(b) a description of the relationship that raises the possibility or perception of a conflict of interest or unfair advantage;

(c) a description of the steps taken to date, and future steps proposed to be taken, to mitigate the conflict of interest or unfair advantage, including the effect of confidential information; and

(d) copies of any relevant documentation.

The Owner may make an advance decision or may refer the request for an advance decision to the COI Adjudicator. If the Owner refers the request to the COI Adjudicator, the Owner may provide input regarding the issues raised to the COI Adjudicator.
Subject to Section 5.2, all requests for advance decisions will be treated in confidence. If a Respondent or prospective team member or advisor becomes a Restricted Party, it may be listed in an Addendum or in subsequent Competitive Selection Process documents as a Restricted Party.

5.12.6 The Owner May Request Advance Decision

The Owner may also independently make advance decisions, or may seek an advance decision from the COI Adjudicator, where the Owner identifies a potential conflict, unfair advantage or a person who may be a Restricted Party. The Owner will, if it seeks an advance decision from the COI Adjudicator, provide the COI Adjudicator with relevant information in its possession. If the Owner seeks an advance decision from the COI Adjudicator, the Owner will give notice to the possible Respondent and may give notice to the possible Restricted Party so that they may provide input regarding the issues raised to the COI Adjudicator.

The onus is on the Respondent to clear any potential conflict, unfair advantage, or Restricted Party, or to establish any conditions for continued participation, and the Owner may require that the Respondent make an application under Section 5.12.5.

5.12.7 Decisions Final and Binding

The decision of the Owner or the COI Adjudicator, as applicable, is final and binding on the persons requesting the ruling and all other parties including Respondents, Respondent Team members and the Owner. The Owner or the COI Adjudicator, as applicable, has discretion to establish the relevant processes from time to time, including any circumstance in which a decision may be amended or supplemented.

5.12.8 Exclusivity

Unless permitted by the Owner in its discretion or permitted as a Shared Use Person, each Respondent will ensure that no member of its Respondent Team, any firm or employer of any of its Key Individuals, or any Affiliated Person of any member of its Respondent Team, or any firm or employer of any of its Key Individuals, participates as a member of any other Respondent Team.

If the Respondent contravenes the foregoing, the Owner reserves the right to disqualify the Respondent, or to permit the Respondent to continue and impose such conditions as may be required by the Owner. Each Respondent is responsible, and bears the onus, to ensure that the Respondent, each member of its Respondent Team, and their respective Affiliated Persons do not contravene the foregoing.

A Respondent or a prospective Respondent Team member who has any concerns regarding whether participation does, or will, contravene the foregoing is encouraged to request an advance decision. To request an advance decision on matters related to exclusivity, the Respondent or prospective
Respondent Team member should submit to the Contact Person, not less than ten (10) Business Days prior to the Submission Time by email, the following information:

(a) names and contact information of the Respondent or prospective Respondent Team member making the disclosure;

(b) a description of the relationship that raises the possibility of non-exclusivity;

(c) a description of the steps taken to date, and future steps proposed to be taken, to mitigate any material adverse effect, or potential material adverse effect, of the non-exclusivity on the competitiveness or integrity of the Competitive Selection Process; and

(d) copies of any relevant documentation.

The Owner may require additional information or documentation to demonstrate to the satisfaction of the Owner in its discretion that no such non-exclusivity exists or, if it does, that measures satisfactory to the Owner in its discretion have been or will be implemented to eliminate or mitigate any risk to the competitiveness or integrity of the Competitive Selection Process.

5.12.9 Exclusivity – the Owner May Request Advance Decisions

The Owner may also independently make advance decisions, or may seek an advance decision from the COI Adjudicator, where the Owner identifies a matter related to exclusivity. The Owner will, if it seeks an advance decision from the COI Adjudicator, provide the COI Adjudicator with relevant information in its possession. If the Owner seeks an advance decision from the COI Adjudicator, the Owner will give notice to the Respondent so that it may make its own response to the COI Adjudicator.

The onus is on the Respondent to clear any matter related to exclusivity or to establish any conditions for continued participation, and the Owner may require that the Respondent make an application under Section 5.12.8.

5.12.10 Exclusivity – Decisions Final and Binding

The decision of the Owner or the COI Adjudicator, as applicable, is final and binding on the persons requesting the ruling and all other parties including Respondents, Respondent Team members and the Owner. The Owner or the COI Adjudicator, as applicable, has discretion to establish the relevant processes from time to time, including any circumstance in which a decision may be amended or supplemented.

The Owner may provide any decision by the Owner or the COI Adjudicator regarding matters related to exclusivity to all Respondents if the Owner, in its discretion, determines that the decision is of general application.
5.13 FAIRNESS ADVISOR

The Owner has appointed XXXX as the Fairness Advisor to monitor the Competitive Selection Process. The Fairness Advisor will act as an independent observer of the fairness of the implementation of the Competitive Selection Process, up to the selection of a Preferred Proponent. The Fairness Advisor will provide a written report to the Owner that the Owner will make public.

The Fairness Advisor will be:

(a) provided full access to all documents, meetings and information related to the process under this RFQ which the Fairness Advisor, in its discretion, decides is required; and

(b) kept fully informed by the Owner of all documents and activities associated with this RFQ.

Respondents may contact the Fairness Advisor directly with regard to concerns about the fairness of the Competitive Selection Process.
6.1 DEFINITIONS

Unless otherwise defined in this RFQ, in this RFQ capitalized terms have the following meanings:

"Access to Information and Protection of Privacy Act" or "ATIPPA" has the meaning set out in Section 5.2.

"Addenda" or "Addendum" means each amendment to this RFQ issued by the Contact Person as described in Section 3.15.

"Affiliated Persons", or affiliated persons, or persons affiliated with each other, are:

(a) a corporation and

(1) a person by whom the corporation is controlled,

(2) each member of an affiliated group of persons by which the corporation is controlled, and

(3) a spouse or common-law partner of a person described in subparagraph (1) or (2) or (b);

(b) two corporations, if

(1) each corporation is controlled by a person, and the person by whom one corporation is controlled is affiliated with the person by whom the other corporation is controlled,

(2) one corporation is controlled by a person, the other corporation is controlled by a group of persons, and each member of that group is affiliated with that person, or

(3) each corporation is controlled by a group of persons, and each member of each group is affiliated with at least one member of the other group;

(c) a corporation and a partnership, if the corporation is controlled by a particular group of persons, each member of which is affiliated with at least one member of a majority interest group of partners of the partnership, and each member of that majority interest group is affiliated with at least one member of the particular group;

(d) a partnership and a majority interest partner of the partnership;

(e) two partnerships, if

(1) the same person is a majority interest partner of both partnerships,

(2) a majority interest partner of one partnership is affiliated with each member of a majority interest group of partners of the other partnership, or

(3) each member of a majority interest group of partners of each partnership is affiliated with at least one member of a majority interest group of partners of the other partnership;
(f) a person and a trust, if the person
(1) is a majority interest beneficiary of the trust, or
(2) would, if this subsection were read without reference to this paragraph, be affiliated with a
majority interest beneficiary of the trust; and
(g) two trusts, if a contributor to one of the trusts is affiliated with a contributor to the other trust and
(1) a majority interest beneficiary of one of the trusts is affiliated with a majority interest
beneficiary of the other trust,
(2) a majority interest beneficiary of one of the trusts is affiliated with each member of a majority
interest group of beneficiaries of the other trust, or
(3) each member of a majority interest group of beneficiaries of each of the trusts is affiliated with
at least one member of a majority interest group of beneficiaries of the other trust.

"Business Day(s)" means a standard day for conducting business, excluding government holidays and
weekends.

"Claim" means any claim, demand, liability, damage, loss, suit, action, or cause of action, whether arising
in contract, tort or otherwise, and all costs and expenses relating thereto.

"Collaborative Meeting" has the meaning set out in Section 3.2.1.

"Conflict of Interest Adjudicator" or "COI Adjudicator" has the meaning set out in Section 5.12.3.

"Competitive Selection Process" means the overall process for the selection of a Preferred Proponent
for the Project including, but not limited to, this RFQ.

"Confidential Information" has the meaning set out in Appendix C.

"Confidentiality Agreement" means the agreement referred to in Appendix C to this RFQ.

"Contact Person" means the person identified as such in the Summary of Key Information, or such other
person as may be appointed by the Owner for that purpose.

"Private Partner" of a Respondent means an individual, corporation, joint venture, partnership or other
legal entity who will have the direct responsibility to deliver the Project, as described in the Respondent’s
Response and as may be changed pursuant to this RFQ.

"Enquiry" has the meaning set out in Section 3.12.

"Evaluation Criteria" means the criteria referred to in Section 2.2 of Appendix A to this RFQ.

"Facilities" has the meaning set out in Section 2.3.
“Fairness Advisor” has the meaning set out in Section 5.13.

“Freedom of Information and Protection of Privacy Act” or “FOIPPA” has the meaning set out in Section 5.2.

“HST” means Harmonized Sales Tax.

“Initial Draft Lease Agreement” means XXXXXXX

“Initial Draft Residential Care Services Agreement” means the preliminary Residential Care Services Agreement that will be attached to the RFP.

“Guarantor” means an entity providing financial and/or performance support to the Private Partner by way of a guarantee or a commitment to provide a parent company guarantee or other proposed credit support in relation to the Project, as described in the Respondent’s Response and as may be changed pursuant to this RFQ.

“Lease Agreement” means the draft form of the Lease Agreement issued under the RFP, as amended pursuant to the terms of the RFP.

“Mandatory Requirements” means the submission requirements set out in Section 3.6.

“Minimum Requirements” has the meaning set out in Appendix A of this RFQ.

“Nominated Projects” has the meaning set out in Section 1 of the Evaluation Criteria in Appendix A of this RFQ, and as requested in Form A-1 Nominated Project Details of Appendix A of this RFQ.

“Owner” means the Government of Newfoundland and Labrador represented by the Ministry of Health and Community Services and agencies of the government including regional health authorities.

“Participation Agreement” means the form substantially as attached as Appendix F to this RFQ.

“Partnerships BC” means Partnerships British Columbia Inc.

“Preferred Proponent” means the Proponent selected by the Owner pursuant to the RFP to finalize the Design-Build Agreement.

“Project” has the meaning set out in Section 2.

“Proponent” means a Respondent who has been shortlisted under this RFQ to be eligible to submit a Proposal in response to the RFP.

“Proposal” means the submission prepared by a Proponent in response to the Request for Proposals.

“Receipt Confirmation Form” means the form substantially as attached as Appendix B to this RFQ.
"Relationship Disclosure Form" means the form substantially as attached as Appendix E to this RFQ.

"Residential Care Services Agreement" or "RCSA" means the draft form of the Residential Care Services Agreement issued under the RFP, as amended pursuant to the terms of the RFP.

"Respondent" means:

(a) before the Submission Time any party described in Section 1.3 that has signed and submitted a Receipt Confirmation Form confirming an intention to submit a Response; and

(b) after the Submission Time any party described in Section 1.3 that has submitted a Response.

"Respondent's Representative" means the person, identified in the Receipt Confirmation Form (Appendix B) and Response Declaration Form (Appendix D), who is fully authorized to represent the Respondent in any and all matters related to its Response.

"Response" means the formal response to this RFQ by a Respondent.

"Response Declaration Form" means the form substantially as attached as Appendix D to this RFQ.

"Restricted Party" means those persons (including their former and current employees) who have a conflict of interest or had, or currently have, participation or involvement in the Competitive Selection Process or the design, planning or implementation of the Project, and who have or may provide a material unfair advantage, including without limitation as a result of any Confidential Information that is not, or would not reasonably be expected to be, available to all other Respondents.

"RFP" means the Request for Proposals, which may be issued by the Owner as a stage of the Competitive Selection Process.

"RFQ" means this Request for Qualifications, including the Appendices, issued by the Owner as the first stage of the Competitive Selection Process.

"Shared Use Person" means those persons, if any, who are specifically named in Section 5.12.3.

"Site" means the site upon which the Project is to be constructed in each of the four locations described in Section 2.3.

"Submission Location" means the submission location identified as such in the Summary of Key Information.

"Submission Time" means the time and date indicated as such in the Summary of Key Information.

6.2 INTERPRETATION

In this RFQ:
(a) when an action, decision, consent, approval or any other thing is said to be in the Owner's
"discretion" or words of like effect, unless the context otherwise requires it means the sole,
absolute and unfettered discretion of the Owner;

(b) the use of headings is for convenience only and headings are not to be used in the interpretation
of this RFQ;

(c) a reference to a Section or Appendix, unless otherwise indicated, is a reference to a Section of,
or Appendix to, this RFQ;

(d) words imputing any gender include all genders, as the context requires, and words in the singular
include the plural and vice versa;

(e) the word "including" when used in this RFQ is not to be read as limiting;

(f) all dollar values are Canadian dollars unless otherwise indicated;

(g) a reference to a "person" includes a reference to an individual, legal personal representative,
corporation, body corporate, firm, partnership, trust, trustee, syndicate, joint venture, limited
liability company, association, unincorporated organization, union or government authority; and

(h) each Appendix attached to this RFQ is an integral part of this RFQ as if set out at length in the
body of this RFQ.
### Table of Contents – Appendix A

- Part 1. Response Guidelines
- Part 2. Evaluation
- Part 3. Response Format

Attached Sample Forms:
- Form A-1: Nominated Projects Summary Matrix
- Form A-2: Nominated Project Details
- Form A-3: Past Performance Template – Developer
- Form A-4: Past Performance Template – Service Provider
Part 1. Response Guidelines

Responses should:

(a) be clearly marked with the words, "Response to RFQ – NL Long Term Care Project" and addressed to the Submission Location;

(b) include all of the information requested in this Appendix A. Materials that are not requested in this Appendix A will not be evaluated;

(c) be limited to 50 double-sided sheets (100 pages), including appendices, for Package 2 including the Key Individual resumes but excluding the Form A-1, Package 3 (Financial information), and appendices. Material submitted which exceeds the page limit may not be evaluated, at the discretion of the Owner;

(d) appendices should not include items not requested in this Appendix A;

(e) be on 8.5" x 11" paper size with a minimum font size of 11 point; and

(f) be submitted as follows:

<table>
<thead>
<tr>
<th>Package</th>
<th>Contents</th>
<th>Number of Copies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Package 1</td>
<td>1. Transmittal Letter;</td>
<td>One hard copy; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One electronic copy</td>
</tr>
<tr>
<td></td>
<td>2. Response Declaration Form (see Appendix D) signed by the Respondent;</td>
<td>One hard copy; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One electronic copy</td>
</tr>
<tr>
<td></td>
<td>3. Relationship Disclosure Form (see Appendix E) signed by the Respondent.</td>
<td>One hard copy; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One electronic copy</td>
</tr>
<tr>
<td>Package 2</td>
<td>Response (see Part 3 of this Appendix A) excluding the financial</td>
<td>3 bound copies, one marked &quot;Master&quot;;</td>
</tr>
<tr>
<td></td>
<td>information provided in Package 3. Section 1 materials to be bound</td>
<td>and</td>
</tr>
<tr>
<td></td>
<td>separately.</td>
<td>One electronic copy</td>
</tr>
<tr>
<td>Package 3</td>
<td>Financial information (see Section 4 of Part 3 of this Appendix A).</td>
<td>3 bound copies, one marked &quot;Master&quot;;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One electronic copy</td>
</tr>
</tbody>
</table>
Part 2. Evaluation

2.1 Minimum Requirements

The Owner will evaluate Responses and determine in its discretion if the Respondent Team adequately meets the Minimum Requirements stated in Table 1. Should any Respondent Team fail to adequately meet the Minimum Requirements, the Owner may discontinue the evaluation of that Respondent Team’s Response in accordance with Sections 5.2 and 6.6 of this RFQ.

### Table 4: Minimum Requirements

<table>
<thead>
<tr>
<th>Financial Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sufficient financial capacity of the Private Partner to undertake the Project. See Section 4 of Response Format (Part 3 of Appendix A).</td>
</tr>
</tbody>
</table>

2.2 Evaluation Criteria

Subject to Section 5.2, for those Respondent Teams that adequately meet the Minimum Requirements, the Owner will evaluate Responses by applying the Evaluation Criteria and weighting in Table 2.

The Evaluation Criteria and Weighting is represented in the Table 2 below.

### Table 2: Evaluation Criteria and Weighting

<table>
<thead>
<tr>
<th>Section</th>
<th>Evaluation Criteria</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 2 Developer</td>
<td>Strength and relevance of demonstrated experience and capability of the Private Partner to undertake the Project with respect to the following:  2.1 Project Development and Management Experience  2.2 Key Project Considerations  2.3 Developer Performance</td>
<td>30 points</td>
</tr>
<tr>
<td>Section 3 Service Provider</td>
<td>Strength and relevance of demonstrated experience and capability to undertake the design of the Project based on the following:  3.1 Service Provider Experience and Capability  3.2 Service Provider Performance  3.3 Service Provider programs offered in currently owned facilities that provide care to the equivalent of Level 3 or 4 residents  3.4 Service Provider philosophy of care and alignment with Project goals.</td>
<td>70 points</td>
</tr>
<tr>
<td>Section</td>
<td>Evaluation Criteria</td>
<td>Weighting</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
</tbody>
</table>
| Financial  | 4.1 Demonstration of sufficient financial resources of the Developer and the Service Provider to undertake the construction and operation of the Project as demonstrated by:  
   a) Company income and balance sheets  
   b) Credit checks for each of the main sponsors  
   c) Proof of insurance  
   d) Evidence of consent to bond | Pass/Fail  |
| Total      |                                                                                     | 100 points|

### 2.3 Disqualification of Responses

Without limitation, the Owner may, in its discretion, disqualify a Response if:

(a) investigations reveal any criminal affiliations or activities by the Respondent or a member of the Respondent Team and such affiliations or activities would, in the sole opinion of the Owner, interfere with the integrity of the Competitive Selection Process; or

(b) the Response includes a false or misleading statement, claim or information.

The Respondent and any member of the Respondent Team may be required to undertake a criminal records check in order to participate in the Project.
Part 3. Response Format

Respondents should use the section numbers and titles provided in Table 3 below in preparing their Responses.

Table 3: Response Content Requirements

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Response Content Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Introduction and Nominated Projects</td>
<td></td>
</tr>
</tbody>
</table>
| 1.1     | Proposed Respondent Team and Organization | a) Provide the legal name of the entity for the Private Partner, Design Firm and Service Provider with short description for publication of teams shortlisted for the RFP stage.  
b) Provide organization chart(s), at the corporate level, including lead individuals, which shows the relationships between the Respondent Team. Describe the management structure within the Respondent Team and how the Private Partner, Design Team and Service Provider will be integrated.  
c) Describe the business relationships and proposed roles among the Respondent Team members (e.g., corporation, joint-venture, partnership). |
| 1.2     | Contact Information | Provide the name and contact details for the Respondent’s Representative.  
Please note: The Respondent’s Representative will be the only person to receive communication from the Contact Person regarding this RFQ.  
Respondent’s Representative:  
i. Name;  
ii. Employer;  
iii. Mailing/courier addresses;  
iv. Telephone number;  
v. Email address; and  
vi. Website address. |
| 1.3     | Nominated Projects | Submit a maximum of nine (9) Nominated Projects ("Nominated Projects") using Form A-2 of this Appendix A. Note that more current Nominated Projects (completed within the last 10 years) may be considered to have greater relevance than older ones.  
Confirm that each reference contact is aware their name is being included and is willing to provide a reference to the |
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Response Content Requirements</th>
</tr>
</thead>
</table>
| 2.0     | Developer                                 | **2.1 Project Development and Management Experience**<br>a) Using up to three (3) Nominated Projects relevant to each sub-section below, describe the Private Partner's experience and capability for each of the following:<br>i. Developing, managing, and delivering projects similar in scope and size to the Project;<br>ii. Assembling, managing, and coordinating multi-disciplinary teams including design and construction integration, also describe how the Respondent proposes to incorporate lessons learned into the Project;<br>iii. Managing the design process in consultation with a healthcare client;<br>iv. Demonstrate the Private Partner's ability to deliver the project collaboratively (in a spirit of partnership) with the Owner and/or the Owner's agents; and<br>b) For all the Nominated Projects referenced in section 2.1 (a) i, iii, v, describe how well the Private Partner met the design and construction performance requirements, including the response to any challenges experienced with interpretation of specifications, schedule, budget or other. Provide a list of challenges that were not readily resolved with a brief explanation of the issue and its resolution.  
|         | **2.2 Key Project Considerations**         | In a maximum of two double-sided sheets for each topic below (six pages), describe:<br>a) Key considerations for the Project under the headings of challenges, risks and opportunities that the Respondent deems important to the success of the Project;<br>b) How each Respondent Team member is suited to address these considerations; and<br>c) With reference to the organization charts provided in Section 1.1, describe how the integrated team is uniquely suited to successfully address these considerations.  
|         | **2.3 Developer Performance**              | In addition to the Nominated Projects, and using Form A-3, list all projects similar in scope that the Developer (or builder, if different than the Developer) has completed, or are underway, within the last ten (10) years. The Owner, in its discretion, may seek additional information relating to these projects  
|         | **3. Care Service Provider**               | **3.1 Care Provider Experience and Capability**<br>a) Using up to three (3) Nominated Projects relevant to each sub-section, describe the Care Provider's experience and capability for each of the following:<br>i. Setting up supportive programs for Level 3 or 4 residents  

Newfoundland Labrador

partnerships British Columbia
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Response Content Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ii.</td>
<td>Establishing open and informative communication opportunities with residents and family members</td>
</tr>
<tr>
<td></td>
<td>iii.</td>
<td>Creating a program with demonstrated positive outcomes</td>
</tr>
<tr>
<td></td>
<td>b)</td>
<td>For each of the Nominated Projects referenced in 3.1(a), describe how well the Care Service Provider met the performance requirements, including the response to any challenges experienced – for example with unique health care challenges, accreditation issues, challenging clients or family members. Provide a list of issues that were not readily resolved with a brief explanation of the challenge and its resolution.</td>
</tr>
<tr>
<td>3.2</td>
<td>Design Firm Performance</td>
<td>In addition to the Nominated Projects, and using Form A-4, list all projects similar in scope that the Design Firm has completed, or are underway, within the last ten (10) years. The Owner, in its discretion, may seek additional information relating to these projects.</td>
</tr>
<tr>
<td>4.</td>
<td>Financial Capacity</td>
<td>Demonstrate the financial capacity of the Respondent Team (Private Partner or Guarantor as applicable) by providing the following:</td>
</tr>
<tr>
<td>4.1</td>
<td>Financial Capacity</td>
<td>a) Provide financial statements including an income statement and balance sheet for each of the Developer and Service Provider for the last two years;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) Provide a letter of authorization for the Owner to request a credit check for the Developer and Service Provider;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) Written confirmation, generally in the form of the Insurance Undertakings contained in Appendix H and Appendix I, from an insurer, that the following coverages will be available for the Project if the Respondent is awarded a contract:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Commercial general liability insurance coverage of not less than $10 million inclusive per occurrence; $20 million general aggregate for bodily injury; death and damage to property including loss of use thereof; product/completed operations liability with a limit of $10 million annual aggregate; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ii. Professional liability insurance coverage of not less than $5 million per occurrence and $5 million aggregate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d) Written confirmation, substantially in the form of the Bonding Undertaking contained in Appendix G, from a surety, that the surety will issue Bonds, including a 50% performance bond and a 50% labour and materials payment bond written by a surety, or sureties, authorized to conduct business in NL, if the Respondent is awarded a contract.</td>
</tr>
</tbody>
</table>
Form A-2 Nominated Project Details

Identify Respondent, Respondent Team Member, and number projects sequentially 1 through 9. Maximum 3 pages in length per project.

<table>
<thead>
<tr>
<th>Item</th>
<th>Notes to Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of project</td>
<td>Details including official project name and contract number.</td>
</tr>
<tr>
<td>Location of project</td>
<td>Country, territory/province/state, facility/highway/road, site or project extent.</td>
</tr>
<tr>
<td>Project owner</td>
<td>Organization name.</td>
</tr>
<tr>
<td>Reference contact details</td>
<td>Current information for key client contacts (individuals), including name, title, role, telephone numbers, email addresses, mailing address and preferred language of correspondence. By providing this information you are authorizing the Owner or the Owner’s representatives to contact these individuals for all purposes, including gathering information and documentation, in connection with this RFQ.</td>
</tr>
<tr>
<td>Relevance</td>
<td>Describe the relevance of the Nominated Project to the Project (e.g. service provider contract, experience working with a provincial residential care services agreement or similar contract, experience with long-term care facilities, building and designing in remote locations, specifically in NL or similar location, knowledge of the local trades, and the local labour market).</td>
</tr>
<tr>
<td>Contract period (term)</td>
<td>Contract commencement date, end of construction date and contract end date.</td>
</tr>
<tr>
<td>Time period of involvement</td>
<td>Commencement date and duration.</td>
</tr>
<tr>
<td>Description of project</td>
<td>Capital value, scope and complexity, type of residents served.</td>
</tr>
<tr>
<td>Current status of project</td>
<td>Describe the current status of the project relative to key milestone events.</td>
</tr>
<tr>
<td>Contract model</td>
<td>Contract structure e.g. public private partnership, design-build, stipulated sum contract.</td>
</tr>
<tr>
<td>Role(s) on project</td>
<td>Specific role, duties and responsibilities of applicable Respondent Team members.</td>
</tr>
<tr>
<td>Joint Venture</td>
<td>If the project involved a joint venture, identify the joint venture partner(s) and discuss the breakdown of responsibility between the parties.</td>
</tr>
<tr>
<td>Performance</td>
<td>Describe the performance in meeting obligations related to the contract. Describe the level of achievement of performance specifications, including any cured or uncured contractual details.</td>
</tr>
<tr>
<td>Other information</td>
<td>Any information the Respondent considers relevant to the Evaluation Criteria.</td>
</tr>
</tbody>
</table>
Form A-3 Past Performance Template – Private Partner

If any of the projects referenced below involved a joint venture, identify the joint venture partner(s) and briefly describe the breakdown of responsibility between the parties.

<table>
<thead>
<tr>
<th>Project Number</th>
<th>Project Name</th>
<th>Project Owner</th>
<th>Project Details</th>
<th>Project Progress</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Type (e.g. healthcare)</td>
<td>Project stage (i.e. construction completion forecasted, or achieved (month/year))</td>
<td>Design Builder? Lead Architect? Constructor? Joint Venture? Other?</td>
</tr>
</tbody>
</table>

|                |              |               | Size (i.e. Capital Cost) |                     |      |
|                |              |               | Location                |                     |      |

Form A-4 Past Performance Template – Design Firm

If any of the projects referenced below involved a joint venture, identify the joint venture partner(s) and briefly describe the breakdown of responsibility between the parties.

<table>
<thead>
<tr>
<th>Project Number</th>
<th>Project Name</th>
<th>Project Owner</th>
<th>Project Details</th>
<th>Project Progress</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Type (e.g. healthcare)</td>
<td>Project stage (i.e. construction completion forecasted, or achieved (month/year))</td>
<td>Lead Architect? Other?</td>
</tr>
</tbody>
</table>

|                |              |               | Size (i.e. Capital Cost) |                     |      |
|                |              |               | Location                |                     |      |
APPENDIX B  RECEIPT CONFIRMATION FORM

(To be submitted by the Respondent's Representative on receipt of this RFQ)

Request for Qualifications

NL Long Term Care Project

To receive any further distributed information

about this Request for Qualifications,

please execute and email both pages of this

Receipt Confirmation Form as soon as possible to:

Email: catherine.silman@partnershipsbc.ca

Respondent Contact Information

Name of Respondent: _______________________________________________________

Street Address: ____________________________________________________________

City: ___________________________ Postal/Zip Code: ____________________________

Province/State: ___________________________ Country: ____________________________

Mailing Address, if different: ________________________________________________

Email Address: ___________________________ Telephone: __________________________

Newfoundland Labrador partnerships British Columbia
Contact Person: _____________________________________________________________________________________

ACKNOWLEDGMENT OF TERMS OF RFQ AND CONFIDENTIALITY

The undersigned is a duly authorized representative of the Respondent and has the power and authority to sign this Receipt Confirmation Form on behalf of such Respondent or other interested party.

The Respondent or other interested party hereby acknowledges receipt and review of this RFQ and all of the terms and conditions contained therein, including, without limitation, all appendices attached thereto and agrees to comply with all of the terms and conditions set out in this RFQ.

For greater certainty, the Respondent or other interested party in executing this Receipt Confirmation Form agrees to comply with the Confidentiality Agreement provisions set out in Appendix C of this RFQ.

Respondent’s Representative or other interested party:

________________________________________________________________________________________________________
Authorized Signature

________________________________________________________________________________________________________
Name of the Authorized Signatory

________________________________________________________________________________________________________
Title

________________________________________________________________________________________________________
Date
APPENDIX C CONFIDENTIALITY AGREEMENT

1. Interpretation

In this Agreement:

(a) Agreement means this Appendix C, which is subject to the RFP,

(b) Confidential Information means all documents, knowledge and information provided by the Owner or any of its Representatives (the Disclosing Party) to, or otherwise obtained by, the Recipient or any of its Representatives (the Receiving Party), whether before or after the date of this Agreement, and whether orally, in writing or other visual or electronic form in connection with or relevant to the Project, this RFQ, the RFP or the Competitive Selection Process including, without limitation, all design, operational and financial information, together with all analyses, compilations, data, studies, photographs, specifications, manuals, memoranda, notes, reports, maps, documents, computer records or other information in hard copy, electronic or other form obtained from the Disclosing Party or prepared by the Receiving Party containing or based upon any such information. Notwithstanding the foregoing, Confidential Information does not include information that:

(1) is or subsequently becomes available to the public, other than through a breach of this Agreement by the Receiving Party or through a breach of a Confidentiality Agreement which another person has entered into concerning the Confidential Information;

(2) is subsequently communicated to the Receiving Party by an independent third party, other than a third party introduced to the Receiving Party by the Disclosing Party or connected with the Project, without breach of this Agreement and which party did not receive such information directly or indirectly under obligations of confidentiality;

(3) was rightfully in the possession of the Receiving Party or was known to the Receiving Party before the date of this Agreement and did not originate, directly or indirectly, from the Disclosing Party;

(4) was developed independently by the Receiving Party without the use of any Confidential Information; or

(5) is required to be disclosed pursuant to any judicial, regulatory or governmental order validly issued under applicable law.

(c) Permitted Purposes means evaluating the Project, preparing a Response, and any other use permitted by this Agreement.
(d) Recipient means a Respondent or any other interested party who completes a Receipt Confirmation Form.

(e) Representative means a director, officer, employee, agent, accountant, lawyer, consultant, financial advisor, subcontractor, Key Individual, or other member of a Respondent Team or any other person contributing to or involved with the preparation or evaluation of Responses or proposals, as the case may be, or otherwise retained by the Recipient, the Owner or Partnerships BC in connection with the Project.

(f) all capitalized terms not otherwise defined in this Agreement have the respective meanings ascribed to them in Section 6.

2. Confidentiality
The Recipient will keep all Confidential Information strictly confidential and will not without the prior written consent of the Owner, which may be unreasonably withheld, disclose, or allow any of its Representatives to disclose, in any manner whatsoever, in whole or in part, or use, or allow any of its Representatives to use, directly or indirectly, the Confidential Information for any purpose other than the Permitted Purposes. The Recipient will make all reasonable, necessary and appropriate efforts to safeguard the Confidential Information from disclosure to any other person except as permitted in this Agreement, and will ensure that each of its Representatives agrees to keep such information confidential and to be bound by the terms contained herein.

3. Ownership of Confidential Information
The Owner owns all right, title and interest in the Confidential Information and, subject to any disclosure requirements under applicable law, and except as permitted by this Agreement, the Recipient will keep all Confidential Information that the Recipient receives, has access to, or otherwise obtains strictly confidential for a period of three years after the date of this Agreement, and will not, without the prior express written consent of an authorized representative of the Owner, which may be unreasonably withheld, use, divulge, give, release or permit or suffer to be used, divulged, given or released, any portion of the Confidential Information to any other person for any purpose whatsoever.

4. Limited Disclosure
The Recipient may disclose Confidential Information only to those of its Representatives who need to know the Confidential Information for the purpose of evaluating the Project and preparing its Response or proposal as applicable and on the condition that all such Confidential Information be retained by each of those Representatives as strictly confidential. The Recipient will notify Partnerships BC, on request, of the identity of each Representative to whom any Confidential Information has been delivered or disclosed.
5. Destruction on Demand

On written request, the Recipient will promptly deliver to Partnerships BC or destroy all documents and copies thereof in its possession or control constituting or based on the Confidential Information and the Recipient will confirm that delivery or destruction to Partnerships BC in writing, all in accordance with the instructions of Partnerships BC; provided, however, that the Receiving Party may retain one copy of any Confidential Information that it may be required to retain or furnish to a court or regulatory authority pursuant to applicable law.

6. Acknowledgment of Irreparable Harm

The Recipient acknowledges and agrees that the Confidential Information is proprietary and confidential and that the Owner or Partnerships BC may be irreparably harmed if any provision of this Agreement were not performed by the Recipient or any party to whom the Recipient provides Confidential Information in accordance with its terms, and that any such harm could not be compensated reasonably or adequately in damages. The Recipient further acknowledges and agrees that the Owner will be entitled to injunctive and other equitable relief to prevent or restrain breaches of any of the provisions of this Agreement by the Recipient or any of its Representatives, or to enforce the terms and provisions hereof, by an action instituted in a court of competent jurisdiction, which remedy or remedies are in addition to any other remedy to which the Owner may be entitled at law or in equity.

7. Waiver

No failure to exercise, and no delay in exercising, any right or remedy under this Agreement by the Owner will be deemed to be a waiver of that right or remedy. No waiver of any breach of any provision of this Agreement will be deemed to be a waiver of any subsequent breach of that provision or of any similar provision.

8. Severability

If any portion of this Agreement is found to be invalid or unenforceable by law by a court of competent jurisdiction then that portion will be severed and the remaining portion will remain in full force and effect.

9. Enurement

This Agreement enures to the benefit of the Owner and Partnerships BC and binds the Recipient and its successors.
APPENDIX D: RESPONSE DECLARATION FORM

1. This Response Declaration Form will be executed by the Respondent.
2. By executing this Response Declaration Form, the Respondent agrees to the provisions of this RFQ and this Response Declaration Form.
3. Capitalized terms in this Response Declaration Form are defined in Section 7 of this RFQ.

[RFQ Respondent's Letterhead]

To: Government of Newfoundland and Labrador, c/o Partnerships British Columbia Inc.
Attention: Catherine Silman, Contact Person
Re: Request for Qualifications entitled “Newfoundland and Labrador Long Term Care Project”

[Insert Respondent Name] Response

In consideration of the Owner’s agreement to consider Responses in accordance with the terms of this RFQ, the Respondent hereby agrees, confirms and acknowledges, on its own behalf and on behalf of each member of the Respondent Team, that:

(a) Response

(1) This Response Declaration Form has been duly authorized and validly executed;
(2) The Respondent is bound by all statements and representations in its Response;
(3) Its Response is in all respects a fair Response made without collusion or fraud; and
(4) The Owner reserves the right to verify information in the Respondent’s Response and conduct any background investigations including criminal record investigations, verification of the Response, credit enquiries, litigation searches, bankruptcy registrations and taxpayer information investigations or other investigations on all or any of the Respondent Team members, and by submitting a Response the Respondent agrees that they consent to the conduct of all or any of those investigations by the Owner.
(b) Acknowledgements with Respect to this RFQ

(1) The Respondent has received, read, examined and understood the entire RFQ including all of the terms and conditions, all documents listed in this RFQ's Table of Contents, and any and all Addenda;

(2) The Respondent agrees to be bound by the entire RFQ including all of the terms and conditions, including without limitation Section 5.7, all documents listed in this RFQ's Table of Contents, and any and all Addenda;

(3) The Respondent's representative identified below is fully authorized to represent the Respondent in any and all matters related to its Response, including but not limited to providing clarifications and additional information that may be requested in association with this RFQ;

(4) The Respondent has disclosed all relevant relationships, in accordance with the instructions and format outlined in the Relationship Disclosure Form; and

(5) The Respondent has had sufficient time to consider, and has satisfied itself as to the applicability of the material in this RFQ and any and all conditions that may in any way affect its Response.

(c) Evaluation of Responses

(1) This RFQ is not an offer, a tender or a request for proposals; it is a Request for Qualifications and the responsibility of the Owner is limited to consider Responses in accordance with this RFQ.

(d) Consent of Respondent Team

(1) The Respondent has obtained the express written consent and agreement of each member of the Respondent Team, as listed below, to all the terms of this Response Declaration Form.

(e) The Respondent Team consists of:

<table>
<thead>
<tr>
<th>Name of Respondent Team Member - Firm</th>
<th>Address</th>
<th>Role on Team</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Newfoundland Labrador

partnerships

British Columbia
<table>
<thead>
<tr>
<th>Name of Respondent Team Member - Individual</th>
<th>Address</th>
<th>Role on Team</th>
<th>Key Individual (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any individual mentioned in the Response must be included in the table above.

**RESPONDENT**

Name of Firm

Address

Address

Name of Authorized Signatory

Signature

**RESPONDENT'S REPRESENTATIVE**

Name

Email Address

Telephone

If the Respondent is a joint venture, consortium or special purpose entity – by each of its joint venture or consortium members, as applicable.
APPENDIX E: RELATIONSHIP DISCLOSURE FORM

This Form will be completed by the Respondent on its own behalf and on behalf of each member of the Respondent Team.

The Respondent declares on its own behalf and on behalf of each member of the Respondent Team that:

(a) this declaration is made to the best of the knowledge of the Respondent and, with respect to relationships of each member of the Respondent Team, to the best of the knowledge of that member.

(b) the Respondent and the members of the Respondent Team have reviewed the definition of Restricted Parties and the non-exhaustive list of Restricted Parties in Section 5.12.2.

(c) the following is a full disclosure of all known relationships that the Respondent and each member of the Respondent Team has, or has had, with:

(1) the Owner;

(2) any listed Restricted Party;

(3) any current shareholders, directors or officers, as applicable, of the Owner or any listed Restricted Party;

(4) any former shareholders, directors or officers, as applicable, of the Owner or any listed Restricted Party, who ceased to hold such position within two calendar years prior to the Submission Time; and/or

(5) any other person who, on behalf of the Owner or a listed Restricted Party, has been involved in the Competitive Selection Process or the design, planning or implementation of the Project or has confidential information about the Project or the Competitive Selection Process.
<table>
<thead>
<tr>
<th>Name of Respondent Team Member</th>
<th>Name of Party with Relationship</th>
<th>Details of the Nature of the Relationship with the Listed Restricted Party/Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. Firm Name Ltd.</td>
<td>Partnerships BC</td>
<td>Firm Name Ltd. is working with Partnerships BC on Project X.</td>
</tr>
<tr>
<td>e.g. John Smith</td>
<td>Owner Name</td>
<td>Respondent Team member was an employee/advisor to the Restricted Party from _____ to _____</td>
</tr>
</tbody>
</table>

(Each Respondent Team to submit one Relationship Disclosure Form. Add additional pages as required. Corporate disclosures only need to be provided once and not repeated for every individual of that company).

**NAME OF RESPONDENT**

Address

Email Address

Telephone

Name of Authorized Signatory for Respondent

Signature

Newfoundland Labrador

partnerships British Columbia
APPENDIX F: PARTICIPATION AGREEMENT

[Insert Date]

Government of Newfoundland and Labrador
c/o Partnerships British Columbia Inc.

Attention: Catherine Silman, Contact Person

Dear Sir/Madam:

Re: Newfoundland and Labrador Long Term Care Project – Participation Agreement in respect of the Request for Proposals issued by Government of Newfoundland and Labrador on [Insert Date], as amended or otherwise clarified from time to time, including by all Addenda (the “RFP”)

This letter agreement sets out the terms and conditions of the Participation Agreement between [Insert Proponent Name] (the “Proponent”) and the Owner, pursuant to which the Proponent agrees with the Owner as follows:

1. **Defined Terms.** Capitalized terms not otherwise defined in this Participation Agreement have the meanings given to them in the RFP.

2. **Participation.** The Proponent agrees that as a condition of participating in the RFP, including the Competitive Selection Process, Collaborative Meetings and access to the Data Room, the Proponent will comply with the terms of this Participation Agreement and the terms of the RFP.

3. **Confidentiality.** The Proponent will comply with, and will ensure that all of the Proponent Team members and others associated with the Proponent also comply with, the Confidentiality Conditions attached as Schedule 1 to this Participation Agreement, all of which conditions are expressly included as part of this Participation Agreement.

4. **Terms of RFP.** The Proponent will comply with and be bound by, and will ensure that all of the Proponent Team members and others associated with the Proponent also comply with and are bound by, the provisions of the RFP all of which are incorporated into this Participation Agreement by reference. Without limiting the foregoing, the Proponent agrees:
(a) that the terms of this Participation Agreement do not limit the Proponent’s obligations and requirements under the RFP, any Data Room agreement, or any other document or requirement of the Owner;

(b) to be bound by the disclaimers, limitations and waivers of liability and Claims and any indemnities contained in the RFP, including Section 10.13 (Limitation of Damages) of the RFP. In no event will the liability of the Owner exceed the amount calculated pursuant to Section 8.9 (Partial Compensation for Participation in the RFP) of the RFP;

(c) that the Owner’s and the Proponent’s obligations in respect of payments of partial compensation or other similar payment are as set out in Section 8.10 (Partial Compensation for Participation in the RFP) of the RFP; and

(d) that the Owner’s and the Proponent’s obligations in respect of the Preferred Proponent Security Deposit are as set out in Sections 8.3, 8.4 and 8.5 of the RFP.

5. **Amendments.** The Proponent acknowledges and agrees that:

   (a) the Owner may in its discretion amend the RFP at any time and from time to time; and

   (b) by submitting a Proposal the Proponent accepts, and agrees to comply with, all such amendments and, if the Proponent does not agree to any such amendment, the Proponent’s sole recourse is not to submit a Proposal.

6. **General.**

   (a) **Capacity to Enter Agreement.** The Proponent hereby represents and warrants that:

      (1) it has the requisite power, authority and capacity to execute and deliver this Participation Agreement;

      i. this Participation Agreement has been duly and validly executed by it, or on its behalf by the Proponent’s duly authorized representatives; and

      ii. this Participation Agreement constitutes a legal, valid and binding agreement enforceable against it in accordance with its terms.

   (b) **Survival following cancellation of the RFP.** Notwithstanding anything else in this Participation Agreement, if the Owner, for any reason, cancels the Competitive Selection Process or the RFP, the Proponent agrees that it continues to be bound by, and will continue to comply with, Section 3 of this Participation Agreement.
(c) **Severability.** If any portion of this Participation Agreement is found to be invalid or unenforceable by law by a court of competent jurisdiction, then that portion will be severed and the remaining portion will remain in full force and effect.

(d) **Ensures.** This Participation Agreement ensures the benefit of the Owner and binds the Proponent and its successors.

(e) **Applicable Law.** This Participation Agreement is deemed to be made pursuant to the laws of the Government of Newfoundland and Labrador and the laws of Canada applicable therein and will be governed by and construed in accordance with such laws.

(f) **Headings.** The use of headings is for convenience only and headings are not to be used in the interpretation of this Participation Agreement.

(g) **Gender and Number.** In this Participation Agreement, words imputing any gender include all genders, as the context requires, and words in the singular include the plural and vice versa.

(h) **Including.** The word “including” when used in this Participation Agreement is not to be read as limiting.

Yours truly,

Name of Proponent

Authorized Signatory

---

**Newfoundland Labrador**

**partnerships**

**British Columbia**
SCHEDULE 1
Confidentiality Conditions

1. Definitions. In these confidentiality conditions:

(a) Confidential Information means all documents, knowledge and information provided by the
Disclosing Party to, or otherwise obtained by, the Receiving Party, whether before or after the
date of the RFP, whether orally, in writing or other visual or electronic form in connection with or
relevant to the Project, the RFP, this RFQ or the Competitive Selection Process, including,
without limitation, all design, operational and financial information, together with all analyses,
compilations, data, studies, photographs, specifications, manuals, memoranda, notes, reports,
maps, documents, computer records or other information in hard copy, electronic or other form
obtained from the Disclosing Party or prepared by the Receiving Party containing or based upon
any such information. Notwithstanding the foregoing, Confidential Information does not include
information that:

(1) is or subsequently becomes available to the public, other than through a breach by the
Receiving Party of the terms of this Schedule 1;

i. is subsequently communicated to the Receiving Party by an independent third party,
other than a third party introduced to the Receiving Party by the Disclosing Party or
connected with the Project, without breach of this Schedule 1 and which party did not
receive such information directly or indirectly under obligations of confidentiality;

ii. was rightfully in the possession of the Receiving Party or was known to the Receiving
Party before the date of the RFP and did not originate, directly or indirectly, from the
Disclosing Party;

iii. was developed independently by the Receiving Party without the use of any
Confidential Information; or

iv. is required to be disclosed pursuant to any judicial, regulatory or governmental order
validly issued under applicable law;

(b) Disclosing Party means the Owner or any of its Representatives;

(c) Permitted Purposes means evaluating the Project, preparing a Proposal, and any other use
permitted by the RFP or this Participation Agreement;
(d) **Receiving Party** means the Recipient or any of its Representatives;

(e) **Recipient** means a Proponent or any other interested party who completes a Receipt Confirmation Form; and

(f) **Representative** means a director, officer, employee, agent, accountant, lawyer, consultant, financial advisor, subcontractor, Key Individual, or any other person contributing to or involved with the preparation or evaluation of Proposals or proposals, as the case may be, or otherwise retained by the Recipient, the Owner or Partnerships BC in connection with the Project.

2. **Confidentiality.** The Recipient will keep all Confidential Information strictly confidential and will not without the prior written consent of the Owner, which may be unreasonably withheld, disclose, or allow any of its Representatives to disclose, in any manner whatsoever, in whole or in part, or use, or allow any of its Representatives to use, directly or indirectly, the Confidential Information for any purpose other than the Permitted Purposes. The Recipient will make all reasonable, necessary, and appropriate efforts to safeguard the Confidential Information from disclosure to any other person except as permitted in this Schedule 1, and will ensure that each of its Representatives agrees to keep such information confidential and to act in accordance with the terms contained herein.

3. **Ownership of Confidential Information.** The Owner owns all right, title and interest in the Confidential Information and, subject to any disclosure requirements under applicable law, and except as permitted by this Schedule 1, the Recipient will keep all Confidential Information that the Recipient receives, has access to, or otherwise obtains strictly confidential for a period of three years after the date of the RFP, and will not, without the prior express written consent of an authorized representative of the Owner, which may be unreasonably withheld, use, divulge, give, release or permit or suffer to be used, divulged, given or released, any portion of the Confidential Information to any other person for any purpose whatsoever.

4. **Limited Disclosure.** The Recipient may disclose Confidential Information only to those of its Representatives who need to know the Confidential Information for the purpose of evaluating the Project and preparing its Proposal or proposal as applicable and on the condition that all such Confidential Information be retained by each of those Representatives as strictly confidential. The Recipient will notify Partnerships BC, on request, of the identity of each Representative to whom any Confidential Information has been delivered or disclosed.

5. **Destruction on Demand.** On written request, the Recipient will promptly deliver to Partnerships BC or destroy all documents and copies thereof in its possession or control constituting or based on the Confidential Information and the Recipient will confirm that delivery or destruction to Partnerships BC in writing, all in accordance with the instructions of Partnerships BC (for this purpose information
stored electronically will be deemed destroyed upon removal from all storage systems and devices); provided, however, that the Receiving Party may retain one copy of any Confidential Information that it may be required to retain or furnish to a court or regulatory authority, pursuant to applicable law.

6. **Acknowledgment of Irreparable Harm.** The Recipient acknowledges and agrees that the Confidential Information is proprietary and confidential and that the Owner or Partnerships BC may be irreparably harmed if any provision of this Schedule 1 were not performed by the Recipient or any party to whom the Recipient provides Confidential Information in accordance with its terms, and that any such harm could not be compensated reasonably or adequately in damages. The Recipient further acknowledges and agrees that the Owner will be entitled to injunctive and other equitable relief to prevent or restrain breaches of any provision of this Schedule 1 by the Recipient or any of its Representatives, or to enforce the terms and provisions hereof, by an action instituted in a court of competent jurisdiction, which remedy or remedies are in addition to any other remedy to which the Owner may be entitled at law or in equity.

7. **Waiver.** No failure to exercise, and no delay in exercising, any right or remedy under this Schedule 1 by the Owner will be deemed to be a waiver of that right or remedy.
Date: [Insert Date]

No: [To be inserted]

To: Government of Newfoundland and Labrador

Re: Request for Qualifications

Newfoundland and Labrador Long Term Care Project

We ____________________________, (name of Surety), a corporation created and existing under the laws of Canada and duly authorized to transact the business of Suretyship in Canada as Surety, are the Surety for ____________________________, (Respondent). Our client has demonstrated to us in the past an ability to complete its projects in accordance with the conditions of its contracts and we have no hesitation in recommending its services to you.

Our client wishes to be prequalified as a Respondent on the captioned Project, which we understand will require a Performance Bond in the approximate amount of $67 million and a Labour and Materials Payment Bond in the approximate amount of $67 million. Based on the limited information available at this time, and subject to our assessment of the Newfoundland and Labrador Long Term Care Project, and our client's work program at the time of submission of its Response, we do not anticipate a problem in supporting the captioned Project and supplying the requisite bonds if asked to do so. However, the execution of any bonds will be subject to an assessment of the final contract terms, conditions, financing and bond forms by our client and us.

If we can provide any further assurances or assistance, please don't hesitate to call upon us.

(Name of Surety)

______________________________ (Seal)

______________________________
Attorney-In-Fact
UNDEARTAKING OF COMMERCIAL GENERAL LIABILITY INSURANCE

Name of Respondent submitting a Response to the Request for Qualifications for the Newfoundland and Labrador Long Term Care Project:

________________________________________________________________________

We, the undersigned, as authorized representatives on behalf of [Insert Name of insurance Provider] do hereby undertake and agree to provide “Wrap-Up” Commercial General Liability insurance in the amount of TEN MILLION DOLLARS ($10,000,000.00) inclusive per occurrence, TWENTY MILLION DOLLARS ($20,000,000.00) general aggregate for bodily injury, death and damage to property including loss of use thereof, product/completed operations liability with a limit of TEN MILLION DOLLARS ($10,000,000.00) annual aggregate for the Newfoundland and Labrador Long Term Care Project, subject to underwriting.

If such a policy is written, a certified copy of the policy will be provided to the Government of Newfoundland and Labrador.

Dated at _____________________________

This ____________ day of _________________, 20__

SIGNED: __________________________________________

(Duly Authorized Representative of Insurance Company)

Newfoundland Labrador

partnerships

UNDEARTAKING OF PROFESSIONAL LIABILITY INSURANCE

Name of Respondent submitting a Response to the Request for Qualifications for the Newfoundland and Labrador Long Term Care Project:

__________________________________________

We, the undersigned, as authorized representatives on behalf of [Insert Name of Insurance Provider] do hereby undertake and agree to provide Single Project Group Professional Liability insurance in the amount of not less than FIVE MILLION DOLLARS ($5,000,000.00) inclusive of any one claim for the Newfoundland and Labrador Long Term Care Project, subject to underwriting.

If such a policy is written, a certified copy of the policy will be provided to the Government of Newfoundland and Labrador.

Dated at _________________________________

This __________ day of ______________________, 20 ___

SIGNED: _________________________________

(Duly Authorized Representative of Insurance Company)

Newfoundland Labrador

partnerships

British Columbia
Memorandum

25 March 2015

To: Rosemarie Goodyear, CEO Central Health

From: EY (Ernst & Young)

Subject: Supplemental memorandum to the “Central Health Long Term Care Needs Assessment - Presentation of Findings to the Department of Health and Community Services” dated 10 March 2015.

1. Suitability of an alternative delivery model for additional Nursing Home beds in Gander (Lakeside) and Grand Falls-Windsor (Carmelite).

There is a continuum of options that may be available to Central Health with respect to the future procurement of new nursing home facilities and the recapitalization and/or expansion of existing facilities. These options range from conventional Crown construct projects (e.g. design build, design bid build) to innovative transactions (e.g. sale lease back, lease leaseback), to public private partnerships (“P3”). Each procurement or transaction option along the continuum has different merits, applicability, advantages and disadvantages. Considerations including access to capital, risk tolerance, implementation schedule, etc. contribute to the selection of best value procurement and transaction options.

It is EY’s observation that recent P3 arrangements pursued in the nursing home space in Atlantic Canada have deviated slightly from some conventional P3 arrangements, largely as a result of the financial deal structure. More specifically, recent examples of nursing home procurement in Atlantic Canada have favoured smooth operating payments as opposed to some P3 arrangements that may include capital expenditures. Regardless of deviations from traditional P3 projects, recent transactions exhibit many of the benefits of conventional P3 projects, including risk transfer.

There is no single rule on project dollar value thresholds that are suitable for P3s. While many public sector organizations have identified a minimum capital project of $100M for P3, there are plenty of industry examples for P3 projects in the range of $50M - $100M.

The following provides additional considerations for Central Health with respect to the suitability of alternative delivery models for the recommended new nursing home facility in Gander and the increase in beds in Grand Falls-Windsor.
Gander
The proposed solution for Gander (Lakeside) is a replacement of approximately 158 beds. Research indicates this number of beds to be suitable for consideration of a P3 or similar arrangement. Further, the project costs of the project are likely to exceed $70M rendering it more attractive to private sector partners. The structure of the transaction, i.e. Design Build Finance Operate Maintain (“DBFOM”) or similar, will be an important consideration should the P3 option be pursued.

Grand Falls-Windsor
The proposed solution for Grand Falls-Windsor (Carmelite) is an addition of approximately 34 beds. Research indicates that traditional P3 projects are difficult to achieve when considering additions to Crown owned facilities. However, there are transaction options which could mitigate some of the capital expenses associated with a traditional P3. For example, Central Health could consider a sale lease back in order to achieve its objectives of additional beds with minimized capital outlay.

2. Potential structure of the procurement and / or transaction model

The proposed solution for Gander (Lakeside) is a replacement of approximately 158 beds which may be suitable for procurement via P3 or similar.

- Description:
  - A P3 structure means a long-term contractual relationship between the Health Authority/Government and the private sector which involves: the provision of goods or services to meet defined output specification; the integration of multiple project phases; a transfer of selected risks to the private sector; and a performance-based payment mechanism. The private partner is responsible for all or almost all of the design, construction, private finance, and/or maintenance activities for the asset. Upon construction completion, the asset is maintained by the private partner for a long-term concession period before hand-back to the Crown (if desired).

- Advantages:
  - Central Health retains full ownership over the asset (if desired).
  - Certain risks are shifted to the private sector partner. Central Health can withhold payments (or charge a penalty) if the project is not completed on time or does not perform pursuant to the output specifications.
  - Private partner may have more experience and qualifications with building these types of projects resulting in construction and operational efficiencies.

- Disadvantages:
  - Some control of the project is relinquished as the majority of the responsibility is placed in the hands of the private sector party.
The proposed solution for Grand Falls Windsor (i.e. Carmelite) is an addition of approximately 34 beds which may be suitable for a sale lease back.

- **Description:**
  - A sale lease back structure involves a parcel of land or building that is sold to a private partner, who completes either a recapitalization (of an existing building) or construction (of a new building/building addition) and leases the completed project back on a long-term basis.

- **Advantages:**
  - Increased liquidity by selling the property and stabilized cash outflows over the long term.
  - Ability to retire outstanding debt related to the property.
  - Ability to leverage the private sector in construction requirements without large capital requirements.

- **Disadvantages:**
  - Central Health may have to move out and find a new location at the end of the lease if the owner does not want to renew the lease.
  - Vendor relinquishes control of the land and long-term value appreciation.

3. **A description, based on recent experience in other Canadian jurisdictions (size/content) for private investment**

For traditional P3s, the market still cites capital costs of $75M to $100M as a minimum project size, but there are some P3s that have successfully closed that are smaller in size. The threshold ultimately depends on a number of factors including the type of project, market readiness, term, project economics, etc.

A recent example of procurement for nursing homes in Atlantic Canada involved a modified P3 approach whereby many desired P3 project attributes were observed; however, an innovative financial structure was deployed. More specifically, in the recent example, the private sector partner was retained to develop new nursing home facilities based on a transaction whereby the private partner was responsible for all aspects of a typical DBFOM, but the payment mechanism was a per diem rate based on occupancy terms. In that recent example, the capital outlay from the government was negated and operating payments were negotiated.

4. **Suggested next steps**

It is suggested that Central Health consider the development of a comprehensive business case for the procurement of the new nursing home facility in Gander and the increase in beds in Grand Falls-Windsor. The business case should also consider a market sounding to ensure there is an appropriate solution that is supported by the market.
Potential copyright material

If you wish to obtain a copy please contact the ATIPP Office at (709) 729-7072 or atippoffice@gov.nl.ca.
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<tr>
<td>Contact</td>
<td>Written response received from Joanne Boomer May 8, 2014 <a href="mailto:joanne.boomer@gov.bc.ca">joanne.boomer@gov.bc.ca</a></td>
<td>Matt Warwick <a href="mailto:Matt.warwick@gov.ab.ca">Matt.warwick@gov.ab.ca</a> April 16, 2014</td>
<td>Robert Francis 416-212-7137 April 16, 2014</td>
<td>Glandra Keenan 902-424-5701 Lorene Mahoney 204-788-8538</td>
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<td>Has your government entered into public private partnerships in the provision of Long Term Care (nursing homes that provide 24/7 nursing care)? If no, could you share why not?</td>
<td>Yes. There are 4 types of facilities: * Privately operated but not publicly funded</td>
<td>Yes. In Alberta there are different types of long-term care operators, including private for-profit, not-for-profit, and public operators. Each represents approximately 33% of the LTC market. Long-term care operators (irrespective of their ownership type) receive public funding for health care administration and residents are required to pay an accommodation charge to cover the cost of accommodation related services (housing, meals, housekeeping, etc.). LTC in Alberta must have 24 hour nursing care available. Income support is available to LTC residents through the Alberta Seniors Benefit program, which provides as monthly benefit to eligible residents. Alberta Health Services (AHS) is the single health authority in Alberta which delivers medical care on behalf of the Government of Alberta's Ministry of Health, including LTC services. AHS owns and operates public facilities, and also administers the LTC system in Alberta. In addition, there can be facilities in which residents pay privately for their health services. These facilities would not be covered under the Acts mentioned in this document.</td>
<td>Yes. For profit, non-profit (run by charitable organizations) and public (run by municipal governments).</td>
<td>Yes. 3 types- For-profit, non-profit and municipal. None are operated by Government or a district health authority (DHA). No, the Manitoba government has not entered into public private partnerships with operators of the PCHs for PCH services. PCH services in Manitoba are delivered through a RHA structure. Manitoba’s 125 licensed nursing homes are administered by the RHAs and licensed by the Government. The majority of facilities are owned and operated by each respective RHA. Seventeen facilities (25 % of the PCH beds in Manitoba) are privately owned and operated.</td>
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<td>What is the nature/length of the contract? Is the Ministry or Health Authority a partner? Does Government provide funding for infrastructure, operating costs, or direct client</td>
<td>Regional health authorities, responsible for the delivery of LTC services in their respective areas, have made agreements with several for profit and not-for-profit.</td>
<td>Alberta does not have plans currently to build any new LTC facilities (with the exception of one planned for Fort McMurray). Historically, private and not-for-profit LTC providers received funding for new projects from the Province. Ministry of Health (MOH) is responsible for establishing legislation and regulations including licensing and inspections. As outlined in Government provides funding. A Development Agreement (have copy of one) between the service provider and the MOH outlines details related to acquisition of...</td>
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<td>subsidies?</td>
<td>profit service providers to build and operate LTC facilities. The result is that the provider owns the facility, provides the care and other required services and the health authorities contract for a specific number of beds at a negotiated per diem rate. The regional health authority negotiates a daily per diem which is intended to cover all of the provider's operating costs. (The daily per diem factors in the client contribution which the client pays to the facility). From time to time, health authorities provide grants for equipment and renovations to providers.</td>
<td>profit operators have often paid upfront to build a facility, and then entered into operating agreements with AHS. However, AHS has funded the construction of some facilities on an exception basis. Maximum accommodation charges are set in regulation and vary depending on room type, and are one large source of revenue for all operators. Direct client care is funded by AHS based on the Patient Care Based Funding model. Ongoing capital funding is not provided to any LTC facilities, which must find the funding internally by allocating accommodation revenue to this area. A Master Service Agreement between AHS and the operator is created which includes the terms of operation.</td>
<td>legislation, each LTCF must have a service accountability agreement. This is between the LHIN and the home. No new LTC facilities have been built since 1998. Government provides some capital funding through the capital redevelopment fund, operating funding is provided, low income clients receive financial assistance. Clients are subjected to income test.</td>
<td>land, development of facility, equipment, inspection, licensing, and occupancy. Government provides funding for infrastructure. Mortgages are obtained through Housing NS. Govt is default guarantor of the mortgage. Start-up funding for staffing, operational etc is available.</td>
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What is the process for entering partnership? (Request for Proposal, tender, acceptance of unsolicited proposals)

RFP

The Alberta Government has made a policy decision to maintain publicly funded LTC spaces in the province at approximately 14,500. Therefore, there is no one official process for the public-private partnership in building a facility. There was no consistent approach across the province historically as there was 17 Health Regions, with a high level of diversity. That has gradually been reduced to one Health Board (AHS), but as so few LTC facilities have been built in the past few years, there has been no need for the development of a unified provincial policy.

Once the facility is built, a Master Service Agreement is negotiated between the operator and AHS. The Master Service Agreement includes:
- Recruitment and Employment

Not really applicable since no new facilities are being built. The process for entering partnership is the licensing process. New business must gain entry into the market through the purchase of a new license. Ministry reviews any transactions. Legislation states it is not possible to transfer a NP home to a FP home. Does the Ministry control the market through the licensing purchasing process

RFP for new build. There have been some exceptions to this. DHA has service agreement (SA) with new LTCF. Some older facilities signed SAs with DHA for 10 year terms. DHA enter into development agreement.
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| British Columbia | * Responsibilities of the Service Provider/AHS  
* Subcontracting  
* Representations  
* Services  
* Funding  
* Compliance  
* Term (including renewal)  
* Changes to Services  
* Default and Remedies  
* Termination  
* Force Majeure  
* Indemnity and Liability  
* Termination Assistance  
* Insurance  
* Confidentiality  
* Audit and Investigation  
* Contract Administration | | | |
| Alberta | Varies, negotiated between AHS and operator. | | New homes: 25 years, older homes 15 years (needs verification). The difference is to promote the older homes to avail of the capital development fund to improve their property. It allows the MOH the opportunity to terminate agreement if home has not made improvements. | 25 years, tied to the length of the mortgage. 10 year for older buildings. |
| What are time frames for agreements? | This varies; most are likely a fixed term of 20 years, or an indefinite term with a one year termination clause. | | | |
| What is the renewal process? | Contact a regional health authority for this information as it likely varies depending on the current contractual arrangement. | From the Master Service Agreement:  
(a) AHS may offer to renew this Agreement for an additional period following the expiry of the initial term.  
(b) If AHS wishes to renew this Agreement, it will provide Notice to the Service Provider at least six months prior to the end of the Term.  
(c) If AHS and the Service Provider both wish to renew this Agreement, the parties will negotiate in good faith the terms of such renewal.  
(d) If AHS and the Service Provider are unable to agree upon the terms of the renewal of this Agreement as | Licensing process under new LTC legislation | Annual licensing process. |
of two months prior to the end of the Term:
(i) if the parties wish to continue negotiating, this Agreement will be extended on the same terms and conditions as then in effect for a period of up to six months (the "Extension Period"). During the Extension Period, AHS and the Service Provider will continue to negotiate in good faith regarding renewal of this Agreement. If AHS and the Service Provider are unable to reach agreement on the renewal of this Agreement during the Extension Period, this Agreement will terminate upon expiration of the Extension Period and the parties may enter into a termination assistance plan as contemplated in Subsection 14.1(b); or
(ii) if the parties do not wish to continue negotiating, this Agreement will expire at the end of the Term and the parties may enter into a termination assistance plan as contemplated in Subsection 14.1(b).

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| What is the funding model? (block funding to private provider or individual client subsidy) | Regional health authorities have established funding models which generally include categories for care services, non-care services, overhead, supplies and other to arrive at an overall per diem rate per bed. Clients pay a monthly fee based on their after tax income. Generally speaking, the health authority pays the facility the difference between the per diem rate and the calculated daily client fee. Health authorities expect facilities to maintain an occupancy rate of about 98%. | The current funding model for private, not-for-profit, and public LTC delivery includes:
1) Accommodation charges which Alberta Health regulates based on room type. Accommodation charges include such costs as meals, housekeeping, laundry, building maintenance, and utilities.
2) Funding for care services in the form of Patient/Care Based Funding, in which funding contains a variable component based on client acuity, a fixed component determined by the number of beds and resident care management hours, and a quality component, which includes a separate funding LTC homes are provided a per diem per resident- same regardless of home type. See email from Robert. Specific envelopes based on care provided. Ministry provides certain block funding which the home must account for- if not all spent- the home must return extra to Ministry. No profit can be made on care services. Profits are made on accommodation costs. See additional data provided by Robert Francis | Every year service provider has budget approved includes staffing, capital, costs, mortgage. New builds use protected (health care staff) and unprotected (management and support staff) funding envelopes (as funding model). Indexing is built in. Resident contributes to cost of care, undergoes a financial assessment. In 2012 $102/day was max paid by clients. |
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<td>pool associated with the quality of care and service provided by a facility. LTC operators do not receive ongoing direct capital funding from Alberta Health or AHS. The province does have money for medically necessary refurbishments, but only for public facilities (those that are AHS owned and operated). However, there is currently no policy on how best to allocate it, and therefore it is not currently available. As well, it is important to note that while operators are private, the health services are funded publically.</td>
<td>The rates are negotiated between regional health authorities and service providers. Sometimes the rates are established in advance through the RFP. Regional health authorities also operate their own facilities and have a good sense as to what these costs are.</td>
<td>The health funding provided to public, non-profit, and private operators includes direct care funding from AHS through the Patient Care Based Funding model, which is explained elsewhere in this questionnaire.</td>
<td>Significant work done to develop a model based on type of care required. The rate can increase typically increase based on inflation rate is provided subject to budget approval. Funding can be adjusted based on care requirements as determined through data available from CIHI (RUGs). Increased funding based on case mix (CMI) provides some incentive to care for higher acuity residents. The rate paid for Nursing &amp; PC below can vary based on CMI- below is an average based on CMI of 100. Per diem rates: Ministry Pays Nursing &amp; Personal care- $88.93 Programming &amp; Support- $8.60 Raw Food- $7.80 Other Accommodation- $52.76 Client pays $56.14* Govt makes rate reductions to those not able to pay basic amount</td>
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<td><strong>Can you estimate the average cost of a LTC bed in a private versus public facility?</strong></td>
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<td>In terms of building each unit, the cost is ranges $500k to $700k for each LTC bed historically. Health funding uses the same model whether the LTC facility is private, AHS, or non-profit operated.</td>
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<td>Based on above the average amount paid to LTC home for operating costs is ~ $6500 per month. The revenue for home could be greater if private pay clients pay more than the $56.14 per day.</td>
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<td>Estimated cost to build a new bed through RFP is ~ 197K. Cost to replace a NH bed outside RFP was negotiated ~ 370K. One provider was awarded a large # of beds at better price per unit.</td>
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<td><strong>Are there provincial standards, policies or legislation in place governing the provision of LTC services? If yes, could you share these?</strong></td>
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<td>The Community Care and Assisted Living Act (CCALA) is the legislation that governs long term care from a licensing/inspection/monitoring perspective. The Residential Care Regulation provides the more detailed requirements that a facility (either funded or purely private pay) must meet. The CCALA is a regulatory statute. In BC the funding body (in this case Home and Community Care) does not have its own internal inspection and investigation system. These functions are carried out under the authority of the CCALA, which applies to a broad range of residential care facilities, including Long Term Care, Community Living, Acquired Injury, Mental Health and Substance Use, and Hospice.</td>
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<td>In Alberta the legislation consists of the Nursing Homes Operation Regulation, Nursing Homes General Regulation, the Nursing Homes Act, and Hospitals Act.</td>
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<td>Yes Legislation available on website.</td>
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<td>Yes- Homes for special care Act</td>
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<td><strong>The RHAs are responsible for resource development in their specific region. The RHA must approve a business plan submitted by an applicant.</strong></td>
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<td>Under the Regional Health Authorities Act 28(1), &quot;No person may construct, establish, operate, renovate, expand, convert or relocate a hospital or personal care home in a health region without the approval of the regional health authority for that health region, or if two regional health authorities are established in the City of Winnipeg, without the approval the regional health authority that is responsible for the health services provided or proposed to be provided in the hospital or personal care home.&quot;</td>
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<td>The Regional Health Authorities Act <a href="http://web2.gov.mb.ca/laws/statutes/ccs/mr034e.php">http://web2.gov.mb.ca/laws/statutes/ccs/mr034e.php</a></td>
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<td>Under The Health Services Insurance Act 3(2) the minister has the power &quot;to ensure that adequate standards are maintained in hospitals.&quot;</td>
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<td>The link to the Residential Care Regulation is not working right now, so I've included a link to our webpage, from which you can access the regulations.</td>
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<td><a href="http://www.health.gov.bc.ca/ccfl/legislation/">http://www.health.gov.bc.ca/ccfl/legislation/</a></td>
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<td>In addition, facilities that receive funding (are subsidized) must meet the requirements of the Home and Community Care policy manual.</td>
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<td>personal care homes and related health facilities, including standards respecting supervision, licensing, equipment and inspection, or to make such arrangements as the minister considers necessary to ensure that adequate standards are maintained*. Further provisions set out in Section 118 of The Health Services Insurance Act state:</td>
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<td>A person may apply for a personal care home license by filing an application with the minister in accordance with, and including the information and the fee required by, the regulations.</td>
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<td>An application may be made under subsection (2) only if the operation of the personal care home has been approved under subsection 28(1) of The Regional Health Authority Act.</td>
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<td>The Health Services Insurance Act and Personal Care Home Standards and Licensing Regulations under the Act speak to the licensing and inspection processes, and set out legislated care standards.</td>
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<td>MH HLS ensures compliance with the legislated Standards through the Personal Care Homes Standards Reviews and licensing process.</td>
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<td>The Health Services Insurance Act</td>
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<td><a href="http://web2.gov.mb.ca/laws/statutes/ccslm/030e.php">http://web2.gov.mb.ca/laws/statutes/ccslm/030e.php</a></td>
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<td>What processes are in place for licensing, monitoring and regulation of private LTC facilities?</td>
<td>Outlined in legislation</td>
<td>Outlined in legislation and LTC Accommodation Standards</td>
<td>Outlined in legislation.</td>
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<td>How is quality of care monitored in a public facility?</td>
<td>Licensing officers, who are employees of the Health Authorities, inspect and monitor licensed residential care facilities under the authority of the CCALA. The process is the same for all facilities. The CCALA is flexible enough to cover a broad diversity of care types.</td>
<td>The Long-Term Care Accommodation Standards apply to voluntary, public and private organizations operating long-term care accommodations. All long-term care accommodations in the province of Alberta are monitored for compliance to the accommodation standards by Licensing Inspectors at least once annually. The health care services provided in LTC facilities, whether they are publicly or privately operated, are provided in accordance with the Continuing Care Health Service Standards. These standards are designed to guide staff in providing quality, comprehensive, individualized care based on the assessed needs of each client. Compliance with the standards is mandatory for publicly funded continuing care service providers, and inspection audits are conducted regularly.</td>
<td>Long Term Care Home Quality Inspection Program. All homes are inspected at least once per year. Respond to complaints which are prioritized based on risk level. Program regulations and Legislation. Monitored during yearly review. Protection of persons in care- self reporting or staff reporting- complaints are investigated. There also can be unannounced visits. Homes are mandated to report critical incidents, falls, medication errors etc.</td>
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<td>Are facility inspections completed?</td>
<td>Yes, typically they are conducted annually, unless there is a higher risk (we have a risk assessment tool) in which case they would be</td>
<td>Ministry performs facility inspections. These are done annually. Monitored for compliance and follow up.</td>
<td>Yearly inspections are completed by all authorities having jurisdiction over the home.</td>
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<td>inspected more frequently.</td>
<td>standards by Licensing Inspectors at least once annually. Inspection audits are conducted regularly for compliance to the Continuing Care Health Service Standards.</td>
<td>complaints. Use an inspection tool (from US).</td>
<td>No Ministry or Health Authority staff are involved in operational aspects of LTC homes. Only if significant failing of the home.</td>
<td>No. DHA staff help support the homes in service provision and to manage general operating issues. There is a program for clients with challenging behaviors. DHA or DHV staff do not provide direct oversight.</td>
</tr>
<tr>
<td><strong>Does the Health authority/Ministry provide staff for oversight of private facilities? If yes, please describe nature of the arrangement and type of staff?</strong></td>
<td>In BC facilities are inspected under the same Act (CCALA) and by the same staff whether they are funded or purely private pay.</td>
<td>Standards apply to all voluntary, public and private organizations operating long-term care accommodations. Employees connected with the licensing of facilities are involved.</td>
<td>No.</td>
<td></td>
</tr>
<tr>
<td><strong>Are there minimum staffing requirements? (type of provider: RN, LPN, Personal Care Attendant?)</strong></td>
<td>No, the Residential Care Regulation is outcome focused, as it covers a broad diversity of care types. The operator must have sufficient staff with appropriate training in place at all times. This will vary depending on the type of care, the layout of the facility, the needs of the persons in care etc. For example, appropriate staffing (and staff training) would be very different for a 150 bed long term care facility than for a group home for persons with developmental disabilities.</td>
<td>In LTC, for privately, publically, and not-for-profit facilities which receive public funding, the number of hours of care per resident is 1.9 with no further specification of how much needs to be provided by an RN, LPN or HCA. Alberta’s publicly funded LTC also requires an RN be accessible at all times. Alberta has achieved an average of 3.6 paid hours per resident per day. Of the 1.9 hours, a minimum of 22% must be direct nursing care on average. The exception is auxiliary hospitals, which would be covered under the Hospitals Act, which does not specify a minimum number of direct care hours.</td>
<td>Not mandated. Within the legislation there are specific requirements for specific situations. Mandated to have 24/7 nursing, dietary staff etc. Staffing plans of the homes have to ensure appropriate staff to meet the needs of the residents. Ministry monitors staffing closely.</td>
<td>Staffing outlined in regulations, <a href="http://novascotia.ca/dhl/wccs/policies/Long-Term-Care-Facility-Program-Requirements.pdf">http://novascotia.ca/dhl/wccs/policies/Long-Term-Care-Facility-Program-Requirements.pdf</a></td>
</tr>
<tr>
<td><strong>Is there a minimum number of hours of care per resident per day mandated in private facilities? How does this compare to public facilities?</strong></td>
<td>Not mandated by law for either publicly subsidized or private pay.</td>
<td>See above</td>
<td>No. Homes are expected to provide individualized care to residents according to their care plans. Homes are expected to have appropriate staff to meet the care needs. Same legislation applies to all types of LTC facilities.</td>
<td>Min. access to 1h nursing care (indicated in regs link above) and 2.45 h personal care time per day (not indicated in regs but was communicated from contact). In past when don’t have coverage of RN have to have a plan to provide nursing support. In new facilities funding is through protected envelop- have to give back any money not used for staffing- perhaps decreases the ability to cut staffing- to save money.</td>
</tr>
<tr>
<td><strong>What accountability measures are in place? Reporting to the Ministry?</strong> Public</td>
<td>Chapter 3 of the BC Home and Community Care Policy Manual, Reportable incidents related to the Long-Term Care Accommodation</td>
<td>Public reporting of facility inspections, Quality of care</td>
<td>Don’t have RAI MDS. Reports required for licensing are made</td>
<td></td>
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<tr>
<td>BC/ALBERTA</td>
<td>MINSK</td>
<td>ONTARIO</td>
<td>NS/NOVA SCOTIA</td>
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</tbody>
</table>
| lays out the general responsibilities for health authorities in applying a performance management approach, including monitoring of services (including residential care). (HCC web site: gov.bc.ca/hcc HCC policy manual: www.gov.bc.ca/hccpolicymanual) Public reporting for the licensing component, health authorities post summary inspections of routine and follow up inspections on their Community Care Facility Licensing websites. | Standards must be submitted to Alberta Health by an operator or Alberta Health Services within two business days of the incident occurring. A reportable incident can include an event related to the accommodation standards that has occurred causing: • death or serious harm to a resident; • a resident unaccounted for; • extensive damage to the accommodation; or, • an unplanned event causing activation of a contingency plan. Reportable Incidents must also be forwarded to Alberta Health for incidents relating to the Continuing Care Health Service Standards. The Public Reporting website provides information about compliance and complaints related to LTC accommodations, and is updated as visits occur. Specific information provided includes: • Accommodation information: accommodation name, address, contact name, telephone and fax numbers, operator and capacity. • Complaint information: list of standards met and not met, date of non-compliance, the due date for compliance to be met, and a link to a Compliance Action Plan. • Complaint Information: complaint type, number of verified complaints in the accommodation and total number of complaints for all accommodations for each complaint type. Complaint details will give information on the date complaint received, the complaint type and the risk factor associated with the complaint. | indicators are reported through Health Quality Ontario.ca. This is used— but probably not enough for decision making. In addition facilities report to CIHI. Ministry inspectors review CIHI data. All homes have RAI MDS electronic reporting system Financial reporting to the Ministry. Homes use CHRS MIS Ontario Healthcare Reporting System/ Management Information system for financial and statistical reporting. Mandatory reporting on critical incidents (falls), | to the Department. Critical incident reporting is mandatory. The LTCF and the Dept work to develop a framework for collection of performance measures and a continuous quality improvement plan. No public reporting on waitlists, facility inspections or licensing process. | How is data collected? (In provinces please refer to chapter 3 of the * Operators collect Resident RAI MDS 2.0 The home must have an
<table>
<thead>
<tr>
<th>BRITISH COLUMBIA</th>
<th>ALBERTA</th>
<th>ONTARIO</th>
<th>NOVA SCOTIA</th>
<th>MANITOBA</th>
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<tr>
<td>where there is a mix of public and private, is the same reporting system used to monitor quality of care indicators, client health files and financial data? Are these systems electronic or paper based?) policy manual referenced above) Health Authorities must submit data to the Ministry and other parties as directed by the Ministry</td>
<td>Assessment Instrument (RAI) 2.0 data, which is submitted to AHS. This information is assessed upon a resident's admission to a facility, quarterly, as well as after any major changes. Operators have their own electronic programs which are able to collect and submit data to AHS electronically. The same method is used in public and private facilities. Financial data is collected by the Financial Information Reporting Management System (FIRMS), which collects cost data from AHS operated sites, as well as private operators which receive public funding. Reporting is voluntary, but data is received from the majority of private operators.</td>
<td>CHRIS MIS-not clear if this is mandatory Public reporting Electronic. Report on bed utilization, expenditures, resident co-pay. Provide balance sheet information. For-profits.</td>
<td>information management system that is capable of reporting to CIHRs Continuing Care reporting system (CCRS). A particular system is not mandated. Homes do not have RAI MDS 2.0.</td>
<td></td>
</tr>
<tr>
<td>How are clients assessed for placement? Who decides where a client is placed? (the Health Authority, Manager of the private facility, client choice?)</td>
<td>For private pay the manager of the facility will need to assess. For publicly subsidized, the health authority assesses. Home and Community Care Policy Manual outlines health authority responsibilities in determining the appropriate placement. Chapter 6 has sections on service needs determination split up for short term and long term care. Chapter 2 provides general information about referral, intake and assessment. (HCC policy manual: <a href="http://www.gov.bc.ca/hccpolicymanual">www.gov.bc.ca/hccpolicymanual</a>)</td>
<td>Alberta Health Services applies an admission policy to LTC residents. This involves clients receiving an assessment based on their level of acuity and care needs. A First Available Bed Policy is then applied, which involves a resident moving to the first appropriate living option, which is generally a certain geographical range from their home. The exact distance they can be moved depends on the health region they reside in. Policies are currently being developed to unify this distance across the province. Operator refusal to accept certain residents has not been an issue that we are aware of.</td>
<td>Clients requiring support must present at a Community Care Access Centre (CCAC) office within each LHIN. Clients are assessed for LTC placement or home support. The CCACs manage the waitlist and prioritize clients. Clients can choose up to 5 LTC homes. Homes can decline for a specific reason- don't have services or capabilities to care for clients.</td>
<td>Self-referral or physician referral to intake officer at Continuing Care Offices. Single Entry System- use RAI Home care for assessment and placement. Approval of application is made by Classification Officers Client choice of placement, FAB policy within 100kms for clients waiting in hospital. Clients have option to defer placement for up to 3 months. The facility has the choice of admission. The facility has the right to refuse admission if it can demonstrate that it does not have the resources to meet the applicant's care needs. DHW staff regularly review the rate of refusal as part of the license renewal process. DHW also has a program to help service providers manage clients with challenging behaviors.</td>
</tr>
<tr>
<td>What have been your overall experiences with managing public private partnerships for the provision of long term care? Can you share information on the strengths and challenges experienced? (recruitment)</td>
<td>Best addressed by the Health Authorities * Overall it has been a positive experience. * Alberta has partnered with groups that have strong capabilities to deliver the construction of projects. * Alberta enjoys the mix of public</td>
<td>Operators try to maximize the number of private rooms. Homes have to offer a minimum of 40% basic accommodations. Challenge- many beds are in old</td>
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408
<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>ALBERTA</th>
<th>ONTARIO</th>
<th>NOVA SCOTIA</th>
<th>MANITOBA</th>
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<tr>
<td>and private model, as private facilities are often higher quality, and therefore having publically subsidized rooms in the same facility means that rooms also have these higher standard facilities as a spillover effect. * Challenges include limited interest in private facilities operating in some locations, as well as that developers may have limited experiences in project developments (e.g. Risks involved include being over-budget/lacking project management skills).</td>
<td>facilities. Ministry committed to funding capital costs and expected the home to redevelop - the money has not been enough to encourage redevelopment.</td>
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<td>Any other comments</td>
<td>As per our telephone conversation, here are the links you requested: Continuing Care Health Service Standards: <a href="http://www.health.alberta.ca/documents/Continuing-Care-Standards-2008.pdf">http://www.health.alberta.ca/documents/Continuing-Care-Standards-2008.pdf</a> Long-term Care Facility Public Reporting Information: <a href="http://aasareporting.gov.ab.ca/estrall/">http://aasareporting.gov.ab.ca/estrall/</a> Accommodation Standards and Licensing: <a href="http://www.health.alberta.ca/documents/CC-Accommodation-Guide4-2013.pdf">http://www.health.alberta.ca/documents/CC-Accommodation-Guide4-2013.pdf</a></td>
<td>Without the for-profit sector would not be able to meet demand. Some operators of municipal homes want to stop providing this service. Much innovation is driven from the for-profit sector. Issues with recruitment and retention of staff is similar in all types of LTC homes Instead of focusing on what a home must do - the focus is outcome based - LTC homes are given the flexibility to achieve the outcomes.</td>
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<td><strong>SASKATCHEWAN</strong></td>
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<tr>
<td><strong>Contact</strong></td>
<td>Leanne Reif: 780-646-1388</td>
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<tr>
<td><strong>Has your government entered into public private partnerships in the provision of Long Term Care (nursing homes that provide 24/7 nursing care)? If no, could you share why not?</strong></td>
<td><strong>Long-term care:</strong> In Saskatchewan, regional health authorities may operate SCHs directly or through affiliation/contract. Affiliated/contracted agencies can be either non-profit corporations of for-profit corporations. For example, Extendicare Canada Inc. is a private company that has been contracted by three regional health authorities to provide long-term care services. One long-term care facility is currently proceeding through the P3 model for construction.</td>
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<tr>
<td><strong>Personal Care Homes (PCH)</strong></td>
<td>PCHs are not publicly funded. They provide private accommodation and care options for adults with usually lighter care needs. It is important to note that it is not necessary for PCH residents to demonstrate a need to be admitted. A resident is admitted when he or she chooses this service option. The resident pays for their care in a PCH.</td>
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<tr>
<td><strong>The Ministry of Health’s role</strong></td>
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<td>Saskatchewan</td>
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<td>respecting personal care homes is one of licensing and monitoring to ensure that the residents who live in these homes receive safe and appropriate care according to the requirements under The Personal Care Homes Act.</td>
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<td>The Ministry of Health does not regulate rates charged in Personal Care Homes.</td>
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<td>The type of care provided in personal care homes varies from home to home and personal care home operators may decide who to admit to the home based on the services they are able to provide.</td>
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<td>A Personal Care Home Benefit (PCHB) was created in 2012 that provides seniors with monthly financial assistance to help with the cost of living in a licensed personal care home. The benefit supplements the difference between a senior’s monthly income and a threshold of $1950 per month.</td>
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</table>

What is the nature/terms of the contract? (Is the Ministry or Health Authority a partner? Does Government provide funding for infrastructure, operating costs, or direct client subsidies?)

The Ministry of Health provides global funding to the regional health authorities for operating costs. Regional health authorities are then responsible for the delivery of health programs and services. Regional Health Authorities may operate a SCH directly or through affiliation/contract. They are designated by the Minister under The Regional Health Services Act.
<table>
<thead>
<tr>
<th>What is the process for entering partnership? (Request for Proposal, tender, acceptance of unsolicited proposals)</th>
<th>A business case is developed to determine if a P3 is the best procurement method. Request For Proposals (RFP) are solicited from consortiums interested in the project. The RFPs are evaluated and Requests for Qualifications (RFQ) are solicited from the top 3 proposals. The acceptance of one of these submissions is approved to move to development of the project.</th>
</tr>
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<tbody>
<tr>
<td>New facilities built/under construction are an 80/20 local share partnership (80% government and 20% local share) for capital costs. The P3 process has a number of contract terms depending on the negotiated scope of the contract. For instance a full scope P3 would consist of a &quot;Design, Build, Finance, Operate, Maintain&quot; (DBFOM) Contract. There are a variety of options to the contract and in the case of the only LTC facility in Saskatchewan proceeding under a P3 model it is proceeding under a DBFM, with the health region operating the facility. The Ministry could be a partner in the Financing portion of the contract to reduce the overall cost of the project.</td>
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<tr>
<td>What are time frames for agreements?</td>
<td>Generally the contracts are for 30 years.</td>
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<tr>
<td>What is the renewal process?</td>
<td>In most cases the facility is turned back to the owner.</td>
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<tr>
<td>What is the funding model? (block funding to private provider or individual client subsidy)</td>
<td>The Ministry of Health provides funding to the Regional Health Authorities (RHAs). The RHAs are then responsible for the delivery of health programs and services. Resident's pay an income tested charge based on annual reported income from Line 150 of the Income Tax Return, which includes earned interest from bank accounts and investments. Personal assets (land, bank accounts, etc) are not taken into account in determining the resident charge. The Government of Saskatchewan covers approximately 80% of the overall cost of LTC.</td>
</tr>
<tr>
<td>How is the rate paid to private provider determined? (Does Government propose the rate, is it negotiated with individual facilities, or do facility owners/managers propose the rate as part of tendering process?)</td>
<td>The rate paid to a P3 provider is determined through RFQ and approval stage. This is the final cost unless there are changes to the contract. Ministry of Health provides RHAs with a global budget to provide programs and services. RHAs work with the individual facilities to determine funding.</td>
</tr>
<tr>
<td>Can you estimate the average cost of a LTC bed in a private versus public facility?</td>
<td>The average provincial cost of a LTC bed, including resident fees, of providing LTC is estimated to be $87,400 per bed per year (about $7,283 per month on average) based on 2013-14 RHA budget. PCHs are privately owned and operated. In 2014-15, the average monthly cost of PCH in SK ranged between</td>
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<tr>
<td>Saskatchewan:</td>
<td></td>
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<tr>
<td>Are there provincial standards, policies or legislation in place governing the provision of LTC services? If yes, could you share these?</td>
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<td>$1000.00 and $3500.00 and up.</td>
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<tr>
<td>The Program Guidelines for Special-care Homes</td>
<td></td>
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<tr>
<td>The Special-care Homes Rates Regulations, 2011</td>
<td></td>
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<tr>
<td>The Housing and Special-care Homes Regulations</td>
<td></td>
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<tr>
<td>The Regional Health Services Act</td>
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<tr>
<td>The Facility Designation Regulations</td>
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<tr>
<td>Personal Care Homes (PCH)</td>
<td></td>
</tr>
<tr>
<td>Personal Care Homes Regulations and Personal Care Home Reporting Regulations <a href="http://www.qp.gov.sk.ca/documents/English/Regulations/Regulations/P6-01R2.pdf">http://www.qp.gov.sk.ca/documents/English/Regulations/Regulations/P6-01R2.pdf</a></td>
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<tr>
<td>What processes are in place for licensing, monitoring and regulation of private LTC facilities?</td>
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<tr>
<td>Regional Health Authorities are responsible for the planning, organization, delivery and evaluation of health services it provides. The</td>
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<td>SASKATCHEWAN</td>
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<tr>
<td>Inspections of personal care homes are completed on a regular basis by Ministry staff as part of the monitoring process. Inspections occur before initial licensing and at the time of relicensing. Other monitoring tools include follow up phone calls, unannounced drop in visits, request to submit a written report, etc. All complaints are investigated. Personal care home must provide staffing to meet the individual needs of each resident. Personal care homes are staffed 24 hours/day and homes with 31 or more residents must ensure a health care professional (i.e. RN/RPN/LPN) is working in the home on a regular basis. Other staffing requirements include: trained care aides, personal care worker course, medication assistance module, food service sanitation, standard first aid.</td>
<td></td>
</tr>
<tr>
<td>What accountability measures are in place? Reporting to the Ministry? Public reporting How is data collected? (In provinces where there is a mix of public and private, is the same reporting system used to monitor quality of care indicators, client health files and financial data? Are these systems electronic or paper based?)</td>
<td></td>
</tr>
<tr>
<td>Long-term care facilities complete MDS assessments that the Ministry has access to. Admissions and discharges in long-term care are reported to the Ministry electronically as they occur. Legislation also outlines reporting requirements and expectations: The Program Guidelines for Special-care Homes. The Special-care Homes Rates Regulations, 2011 The Housing and Special-care Homes Regulations The Regional Health Services</td>
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<td>SASKATCHEWAN</td>
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<td>---------------</td>
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<tr>
<td><strong>Act</strong></td>
<td><strong>How are clients assessed for placement? Who decides where a client is placed? (the Health Authority, Manager of the private facility, client choice?)</strong></td>
</tr>
<tr>
<td>The same reporting system is used for public and private special-care homes to monitor quality of care indicators and admissions/discharges from LTC. Both systems are electronic.</td>
<td>The regional health authority (RHA) has overall responsibility for long-term care services in the region, including managing the special-care home placement process. The assessment of individuals for placement in special-care homes (nursing homes) is the responsibility of the RHA. A provincial assessment tool is used and each RHA has a single point of entry.</td>
</tr>
<tr>
<td><strong>Personal Care Homes (PCH)</strong></td>
<td><strong>Personal Care Homes (PCH)</strong></td>
</tr>
<tr>
<td>Standards are evaluated during the inspection and complaint investigation processes. A standard operational review tool is used to complete all inspections. An outcome of visit report is left for the licensee to follow up and the licensee completes and submits a written report to explain their actions to correct a deficiency and meet the standards. Also, a complaint investigation process is followed that includes a written report.</td>
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<td>SASKATCHEWAN</td>
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<tr>
<td>PCH residents do not need to demonstrate a need to be admitted. A resident is admitted when he or she chooses this service option. PCH licensees are responsible for requesting assessments from the health region upon the resident's admission to the PCH and at least every two years or when care needs change.</td>
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</tbody>
</table>

What have been your overall experiences with managing public-private partnerships for the provision of long term care? Can you share information on the strengths and challenges experienced? (recruitment and retention of staff, quality of care, type of client admitted, collaboration among public and private LTC providers, costs, issues dealing with private providers, unplanned closures, bankruptcy?) How have any challenges been addressed?

Generally speaking, all long-term care facilities face similar challenges whether region owned/operator or contracted (i.e.) recruitment/retention issues, aging infrastructure, clients with complex needs etc. We haven't had any bankruptcies or unplanned closures.

Personal Care Homes (PCH) Inspections of personal care homes by Ministry staff are completed on a regular basis as part of the monitoring process. Public reporting of inspection results is available online to provide residents and families with more information to consider when selecting a personal care home.

http://www.health.gov.sk.ca/pch-inspections. These inspection results show some of the challenges in the personal care home sector.

Any other comments
### LTC Bed Projections Western Health

<table>
<thead>
<tr>
<th>Scenario</th>
<th>LTC demand 2017</th>
<th>Beds required by 2017</th>
<th>New Bed capacity required by 2017</th>
<th>LTC demand 2021</th>
<th>Beds required by 2021</th>
<th>New bed capacity required by 2021</th>
<th>LTC demand 2026</th>
<th>Beds required by 2026</th>
<th>New bed capacity required by 2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant use</td>
<td>589</td>
<td>589</td>
<td>115</td>
<td>701</td>
<td>666</td>
<td>192</td>
<td>809</td>
<td>769</td>
<td>295</td>
</tr>
<tr>
<td>Declining use</td>
<td>569</td>
<td>569</td>
<td>95</td>
<td>656</td>
<td>623</td>
<td>149</td>
<td>742</td>
<td>705</td>
<td>231</td>
</tr>
<tr>
<td>10% increase</td>
<td>601</td>
<td>601</td>
<td>127</td>
<td>739</td>
<td>702</td>
<td>228</td>
<td>879</td>
<td>835</td>
<td>361</td>
</tr>
</tbody>
</table>

- Number of LTC beds (as of September 2014) = **474**
- Average number waiting for LTC placement (Jan 2012-Feb 2014 used for projections) = **43**
- Average number waiting in acute care for LTC placement = **37** (range 23 to 61)
- Average number waiting in community* for LTC placement = **16** (range 10 to 40)
- Average number placed in LTC monthly (January 2013-August 2014) = **15** (range 10-19)
- Reasonable waitlist = not applied in WH due to decrease in acute care beds in new hospital

Initiatives under the LTC & CSS strategy are expected, with time, to decrease the demand for LTC beds. It is anticipated that this will not be realized by 2017 but is predicted to decrease demand by 5% by 2021 and 2026.

In Table 1:

- LTC demand = projection provided by ERA (assumes a zero waitlist)
- “Beds required” = (LTC demand – 5% for 2021 & 2026)
- “New bed capacity” = Beds required – bed capacity currently available (474)

The LTC bed projection data are informed by population projections, LTC utilization rates, trending data of LTC waitlists and the predicted impact of initiatives underway as part of the Long Term Care and Community Support Services Strategy.

For planning purposes, the Department is utilizing data from the declining use scenario, therefore it is predicted that by 2026, **231** new LTC beds will be required in the WH region.

* different time period used to determine wait list for projections compared to placement data
LTC bed projections Avalon region (St. John’s, Carbonear, Placentia)

<table>
<thead>
<tr>
<th>Scenario</th>
<th>LTC demand 2017</th>
<th>Beds required by 2017</th>
<th>New Bed capacity required by 2017</th>
<th>LTC demand 2021</th>
<th>Beds required by 2021</th>
<th>New bed capacity required by 2021</th>
<th>LTC demand 2026</th>
<th>Beds required by 2026</th>
<th>New bed capacity required by 2026</th>
</tr>
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<tbody>
<tr>
<td>Constant use</td>
<td>1700</td>
<td>1660</td>
<td>126</td>
<td>1950</td>
<td>1817</td>
<td>278</td>
<td>2356</td>
<td>2198</td>
<td>664</td>
</tr>
<tr>
<td>Declining use</td>
<td>1661</td>
<td>1621</td>
<td>87</td>
<td>1865</td>
<td>1732</td>
<td>198</td>
<td>2196</td>
<td>2046</td>
<td>511</td>
</tr>
<tr>
<td>10% increase</td>
<td>1749</td>
<td>1709</td>
<td>175</td>
<td>2065</td>
<td>1927</td>
<td>388</td>
<td>2584</td>
<td>2415</td>
<td>881</td>
</tr>
</tbody>
</table>

- Number of LTC beds (2014) = **1451**
- Average number waiting for LTC placement (January 2012-September 2014) = 70% EH waitlist = 76 (EH advises no waitlist for Carbonear, no significant waitlist Placentia)
- LTC demand 2014 = 1451 + average waitlist (76) = **1527**
- Average number waiting in acute care for LTC placement in EH = **50** (range 31 to 74) (70% of EH total = 35)
- Average number of ALC clients = **36** (St. John’s only). Since beds available in Carbonear and Placentia, # waiting ALC in these communities should be negligible
- Average number waiting in community for LTC placement in EH = **59** (range 53 to 73)
- Average number placed in LTC monthly in EH = **50** (range 32-66)
- Reasonable waitlist = total waitlist – ALC clients (76-36 = 40)

- Initiatives under the LTC & CSS strategy are expected, with time, to decrease the demand for LTC beds. It is anticipated that this will not be realized by 2017 but is predicted to decrease demand by 5% by 2021 and 2026.

- Current LTC bed capacity in Avalon region = 1451 beds
- Total new LTC bed capacity by 2017 = 1451 + 60 (SJLTC) + 23 (Carbonear LTC) = 1534

In Table 1:
- LTC demand = projection provided by ERA (assumes a zero waitlist)
- “Beds required” = (LTC demand – 5% for 2021 & 2026) – waitlist (40)
- “New bed capacity” = Beds required – bed capacity available by 2017

Notes:
- According to MDS data, approximately 11% of residents in Lion’s Manor in Placentia are from Carbonear, and 14% are from Clarenville. This is likely because there are no PCU beds in Carbonear and Clarenville. Opening of the new LTC facility in Carbonear with PCU beds may increase occupancy rate.
LTC bed projections Labrador-Grenfell Health region

<table>
<thead>
<tr>
<th>Scenario</th>
<th>LTC demand 2017</th>
<th>Beds required by 2017</th>
<th>New Bed capacity required by 2017</th>
<th>LTC demand 2021</th>
<th>Beds required by 2021</th>
<th>New bed capacity required by 2021</th>
<th>LTC demand 2026</th>
<th>Beds required by 2026</th>
<th>New bed capacity required by 2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant use</td>
<td>158</td>
<td>152</td>
<td>7</td>
<td>184</td>
<td>169</td>
<td>24</td>
<td>217</td>
<td>200</td>
<td>55</td>
</tr>
<tr>
<td>Declining use</td>
<td>154</td>
<td>148</td>
<td>3</td>
<td>175</td>
<td>160</td>
<td>15</td>
<td>201</td>
<td>185</td>
<td>40</td>
</tr>
<tr>
<td>10% increase</td>
<td>162</td>
<td>156</td>
<td>11</td>
<td>195</td>
<td>179</td>
<td>34</td>
<td>238</td>
<td>220</td>
<td>75</td>
</tr>
</tbody>
</table>

- Number of LTC beds (2014) = **117**
- Average number waiting for LTC placement (January 2012-September 2014) = **20**
- Average number waiting in acute care for LTC placement = **14** (range 7 to 35)
- Average number waiting in community for LTC placement = **11** (range 5 to 15)
- Average number placed in LTC monthly = **3** (range 0-6)
- Reasonable waitlist = total waitlist – ALC clients (20-14 = 6)

- Initiatives under the LTC & CSS strategy are expected, with time, to decrease the demand for LTC beds. It is anticipated that this will not be realized by 2017 but is predicted to decrease demand by 5% by 2021 and 2026.

- New LTC bed capacity in LGH = 8 beds in Labrador City and 20 beds in HV-GB = 28 beds
- Total LTC bed capacity by 2017 = 117 + 28 beds = 145

In Table 1:
- LTC demand = projection provided by ERA (assumes a zero waitlist)
- “Beds required” = (LTC demand – 5%) – waitlist (for years 2021 and 2026 only)
- “New bed capacity” = Beds required – bed capacity available by 2017
LTC bed projections Eastern Health region

<table>
<thead>
<tr>
<th>Scenario</th>
<th>LTC demand 2017</th>
<th>Beds required by 2017</th>
<th>New Bed capacity required by 2017</th>
<th>LTC demand 2022</th>
<th>Beds required by 2022</th>
<th>New bed capacity required by 2022</th>
<th>LTC demand 2026</th>
<th>Beds required by 2026</th>
<th>New bed capacity required by 2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant use</td>
<td>2071</td>
<td>2012</td>
<td>239</td>
<td>2460</td>
<td>2278</td>
<td>505</td>
<td>2860</td>
<td>2658</td>
<td>885</td>
</tr>
<tr>
<td>Declining use</td>
<td>2017</td>
<td>1958</td>
<td>185</td>
<td>2326</td>
<td>2151</td>
<td>378</td>
<td>2647</td>
<td>2456</td>
<td>683</td>
</tr>
<tr>
<td>10% increase</td>
<td>2136</td>
<td>2077</td>
<td>304</td>
<td>2635</td>
<td>2444</td>
<td>671</td>
<td>3160</td>
<td>2943</td>
<td>1170</td>
</tr>
</tbody>
</table>

- Number of LTC beds currently open = 1723 (includes 15 new beds opened at CP)
- Average number waiting for LTC placement (January 2012-September 2014) = 109
- Average number waiting in acute care for LTC placement = EH = 50 (range 31 to 74)
- Average number waiting in community for LTC placement = 59 (range 53 to 73)
- Average number placed in LTC monthly = 50 (range 32-66)
- Acceptable waitlist = total waitlist – clients coming from acute care (109-50 = 59)

- Initiatives under the LTC & CSS strategy are expected, with time, to decrease the demand for LTC beds. It is anticipated that this will not be realized by 2017 but is predicted to decrease demand by 5% by 2021 and 2026.

- Total new LTC bed capacity in EH region under construction = current + new beds = 1723 + 15 SJLTC + 23 Carbonear + 12 Clarenville = 1773
- New capacity by 2018 = 1773

In Table 1:
- LTC demand = projection provided by ERA (assumes a zero waitlist)
- “Beds required” = (LTC demand – 5% for 2021 & 2026) – waitlist (40)
- “New bed capacity” = Beds required – bed capacity available by 2018
### LTC bed projections St. John’s region

<table>
<thead>
<tr>
<th>Scenario</th>
<th>LTC demand 2017</th>
<th>Beds required by 2017</th>
<th>New Bed capacity required by 2017</th>
<th>LTC demand 2022</th>
<th>Beds required by 2022</th>
<th>New bed capacity required by 2022</th>
<th>LTC demand 2026</th>
<th>Beds required by 2026</th>
<th>New bed capacity required by 2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant use</td>
<td>1398</td>
<td>1358</td>
<td>127</td>
<td>1668</td>
<td>1545</td>
<td>314</td>
<td>1939</td>
<td>1802</td>
<td>571</td>
</tr>
<tr>
<td>Declining use</td>
<td>1366</td>
<td>1326</td>
<td>95</td>
<td>1588</td>
<td>1469</td>
<td>238</td>
<td>1809</td>
<td>1679</td>
<td>448</td>
</tr>
<tr>
<td>10% increase</td>
<td>1438</td>
<td>1398</td>
<td>167</td>
<td>1778</td>
<td>1649</td>
<td>418</td>
<td>2127</td>
<td>1990</td>
<td>759</td>
</tr>
</tbody>
</table>

- Number of LTC beds (as of July 2014 used for projections) = 1171
- Average number waiting for LTC placement (January 2012-September 2014) = 70% EH waitlist = 76
- Average number waiting in acute care for LTC placement = EH = 50 (range 31 to 74) (70% of EH total = 35)
- Average number of ALC clients = 36
- Average number waiting in community for LTC placement = 59 (range 53 to 73)
- Average number placed in LTC monthly = 50 (range 32-66)
- Acceptable waitlist = total waitlist – ALC clients  (76-36 = 40)

- Initiatives under the LTC & CSS strategy are expected, with time, to decrease the demand for LTC beds. It is anticipated that this will not be realized by 2017 but is predicted to decrease demand by 5% by 2021 and 2026.

- New LTC bed capacity in St. John’s region = 1171 + 60 beds SJLTC beds = 1231

In Table 1:
- LTC demand= projection provided by ERA (assumes a zero waitlist)
- “Beds required” = (LTC demand – 5% for 2021 & 2026) – waitlist (40)
- “New bed capacity” = Beds required – bed capacity available by 2017
LTC Bed Projections Central Health

<table>
<thead>
<tr>
<th>Scenario</th>
<th>LTC demand 2017</th>
<th>Beds required by 2017</th>
<th>New Bed capacity required by 2017</th>
<th>LTC demand 2021</th>
<th>Beds required by 2021</th>
<th>New bed capacity required by 2021</th>
<th>LTC demand 2026</th>
<th>Beds required by 2026</th>
<th>New bed capacity required by 2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant use</td>
<td>679</td>
<td>641</td>
<td>122</td>
<td>760</td>
<td>684</td>
<td>165</td>
<td>893</td>
<td>810</td>
<td>291</td>
</tr>
<tr>
<td>Declining use</td>
<td>662</td>
<td>624</td>
<td>105</td>
<td>724</td>
<td>650</td>
<td>131</td>
<td>828</td>
<td>749</td>
<td>230</td>
</tr>
<tr>
<td>10% increase</td>
<td>699</td>
<td>661</td>
<td>142</td>
<td>803</td>
<td>725</td>
<td>206</td>
<td>980</td>
<td>893</td>
<td>374</td>
</tr>
</tbody>
</table>

- Number of LTC beds (as of September 2014) = 519
- Average number waiting for LTC placement (January 2012-September 2014) = 94
- Average number waiting in acute care for LTC placement = 56 (range 35 to 71)
- Average number waiting in community for LTC placement = 36 (range 30 to 46)
- Average number placed in LTC monthly (January 2013-August 2014) = 23 (range 13-35)
- Acceptable waitlist = total waitlist – clients in acute care (94-56 = 38)

- Initiatives under the LTC & CSS strategy are expected, with time, to decrease the demand for LTC beds. It is anticipated that this will not be realized by 2017 but is predicted to decrease demand by 5% by 2021 and 2026.

In Table 1:
- LTC demand= projection provided by ERA (assumes a zero waitlist)
- “Beds required” = (LTC demand – 5% for 2021 & 2026) – waitlist (38)
- “New bed capacity” = Beds required – bed capacity currently available (519)

The LTC bed projection data are informed by population projections, LTC utilization rates, trending data of LTC waitlists and the predicted impact of initiatives underway as part of the Long Term Care and Community Support Services Strategy.

For planning purposes, the Department is utilizing data from the declining use scenario, therefore it is predicted that by 2026, 230 new LTC beds will be required in the CH region.
- EY Analysis
- Using data for each economic zone

<table>
<thead>
<tr>
<th>Economic zone</th>
<th>Projected Demand (EY)</th>
<th>Projected Demand (ERA)</th>
<th>New beds required (EY) by 2026</th>
<th>New beds required (ERA) by 2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>EZ11</td>
<td>146</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EZ12</td>
<td>245</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EZ13</td>
<td>19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EZ14</td>
<td>379</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CH (total)</td>
<td>789</td>
<td>828</td>
<td>193</td>
<td>230</td>
</tr>
</tbody>
</table>

- Using our methodology for waitlist (38) and 5% impact of initiatives reduces to 712 Demand EY
- Number of beds in CH = 519
- EY recommends to build less with more investment in CSS


<table>
<thead>
<tr>
<th>Scenario</th>
<th>LTC demand 2017</th>
<th>Beds required by 2017</th>
<th>New Bed capacity required by 2017</th>
<th>LTC demand 2021</th>
<th>Beds required by 2021</th>
<th>New bed capacity required by 2021</th>
<th>LTC demand 2026</th>
<th>Beds required by 2026</th>
<th>New bed capacity required by 2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant use</td>
<td>60</td>
<td>56</td>
<td>9</td>
<td>66</td>
<td>59</td>
<td>12</td>
<td>77</td>
<td>69</td>
<td>22</td>
</tr>
<tr>
<td>Declining use</td>
<td>59</td>
<td>55</td>
<td>8</td>
<td>63</td>
<td>59</td>
<td>14</td>
<td>72</td>
<td>64</td>
<td>17</td>
</tr>
<tr>
<td>10% increase</td>
<td>62</td>
<td>58</td>
<td>11</td>
<td>70</td>
<td>67</td>
<td>20</td>
<td>85</td>
<td>77</td>
<td>30</td>
</tr>
</tbody>
</table>

- Number of LTC beds (2014) in St. Anthony = 47
- Average number waiting for LTC placement (January 2012-September 2014) = 7
- Average number waiting in acute care for LTC placement = 3 (range 0 to 6)
- Average number waiting in community for LTC placement = 3 (range 0 to 7)
- Average number placed in LTC monthly = unknown for St. Anthony
- Reasonable waitlist = total waitlist – ALC clients (7-3 = 4)

- Initiatives under the LTC & CSS strategy are expected, with time, to decrease the demand for LTC beds. It is anticipated that this will not be realized by 2017 but is predicted to decrease demand by 5% by 2021 and 2026.

- Total LTC bed capacity in St. Anthony = 47

In Table 1:
- LTC demand = projection provided by ERA (assumes a zero waitlist)
- “Beds required” = (LTC demand – 5% for years 2021 and 2026 only) – (waitlist of 4)
- “New bed capacity” = Beds required – bed capacity by 2017

*Notes:
1. ERA used Economic Zone 6 and 15% of Economic Zone 7 (shared with Western Health region) to project beds required in the St. Anthony area.

2. ERA advises that based on historical LTC utilization rates, the declining use scenario is most likely, so data from this scenario are used in future planning.
Potential copyright material

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REQUEST FOR PROPOSALS
NL LONG TERM CARE PROJECT

June 30, 2015
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B. Statement of Requirements
C. Residential Care Service Agreement
Request for Proposals

Newfoundland and Labrador
Long Term Care Project

June 30, 2015
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<thead>
<tr>
<th>SUMMARY OF KEY INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RFP TITLE</strong></td>
</tr>
<tr>
<td>The title of this RFP is:</td>
</tr>
<tr>
<td>RFP – NL Long Term Care Project</td>
</tr>
<tr>
<td>Proponents should use this title on all correspondence.</td>
</tr>
<tr>
<td><strong>CONTACT PERSON</strong></td>
</tr>
<tr>
<td>The Contact Person for this RFP is:</td>
</tr>
<tr>
<td>Catherine Silman</td>
</tr>
<tr>
<td>Email: <a href="mailto:Catherine.silman@partnershipsbc.ca">Catherine.silman@partnershipsbc.ca</a></td>
</tr>
<tr>
<td>Please direct all Enquiries, in writing, to the above named Contact Person. <strong>No telephone or fax enquiries please.</strong></td>
</tr>
<tr>
<td><strong>ENQUIRIES</strong></td>
</tr>
<tr>
<td>Proponents are encouraged to submit Enquiries at an early date and no later than 10 Business Days before the Submission Time for Proposals. The GNL may, in its discretion, decide not to respond to any Enquiry.</td>
</tr>
<tr>
<td><strong>COLLABORATIVE MEETING SUBMISSION TIME</strong></td>
</tr>
<tr>
<td>July 23, 2015 at 3:00 pm NDT</td>
</tr>
<tr>
<td><strong>SUBMISSION TIME FOR PROPOSALS</strong></td>
</tr>
<tr>
<td>August 24, 2015 at 3:00 NDT</td>
</tr>
<tr>
<td><strong>SUBMISSION LOCATION</strong></td>
</tr>
<tr>
<td>The Submission Location is:</td>
</tr>
<tr>
<td>Tendering and Contracts</td>
</tr>
<tr>
<td>Department of Transportation and Works</td>
</tr>
<tr>
<td>Ground Floor, East Block, Confederation Building</td>
</tr>
<tr>
<td>St. John’s, NL A1B 4J6</td>
</tr>
<tr>
<td>Attention: Ian Duffett</td>
</tr>
<tr>
<td><strong>DELIVERY HOURS</strong></td>
</tr>
<tr>
<td>Deliveries will be accepted at the Submission Location on weekdays (excluding Statutory Holidays) from 08:30 to 16:00 NDT</td>
</tr>
</tbody>
</table>
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1 INTRODUCTION

1.1 PURPOSE OF THIS RFP

The purpose of this request for proposals ("RFP") is to invite Proponents to prepare and submit Proposals for the development, operations, and delivery of care services for four long term care facilities (the "Facilities") in Northeast Avalon, Grand Falls-Windsor area, Gander area and Corner Brook (the "Project") under a Residential Care Services Agreement ("RCSA") and Statement of Requirements ("SOR") Agreement (the "Agreements").

If a capitalized term used in this RFP is not defined in Section 11 of this RFP, it will be defined in the section of the RFP in which it is first used.

1.2 ELIGIBILITY TO PARTICIPATE IN THIS RFP

Any interested party, or parties, may submit a Proposal to this RFP. Proponents may be individuals, corporations, joint ventures, consortia, partnerships or any other legal entities. If the Proponent is not a legal entity, the Proponent shall act through the legal entity or entities comprising the Proponent.

Proponents who are seeking to submit a proposal should: be a Contractor, Builder, or Care Provider.
2 THE PROJECT

2.1 BACKGROUND

In 2012, the Department of Health and Community Services released Close to Home: A Strategy for Long-Term Care and Community Support Services, which aims to integrate services and make system improvements over a ten year period. The long term care and community support sector is vast, encompassing home support and residential care options for seniors, individuals with disabilities and services for children with disabilities. The strategy supports a number of initiatives that focus on maintaining clients in their homes. However, it is recognized that as care requirements increase some clients will require long term care placement with 24-hour access to professional nursing services. For this reason the strategy includes a specific goal "to ensure an adequate supply of long term care (LTC) facility beds to meet the population needs".

Long term care facilities provide residential care and accommodations to individuals with high care needs who require on-site professional nursing services (Level III or Level IV clients). Meeting the current demand for long term care beds in the province is challenging and it is anticipated that the demand for long term care beds will increase mainly due to our aging population. Provincially, the population of individuals aged 75 years and over is projected to increase by 77 per cent over the next 12 years.

In addition, the inability of the long term care system to meet the growing demand for long term care beds significantly impacts acute care service delivery and contributes to increased wait times in emergency departments, and delayed or cancelled surgeries. In response to the projected need for long term care services, the GNMI has endorsed an increase in the number of long term care beds in three of the province’s four regional health regions.

2.2 PROJECT OBJECTIVES

The overall purpose of the Project is to deliver 360 new long term care beds to support the care of seniors and other individuals with high care needs in Newfoundland and Labrador. In support of this purpose are the following three objectives:

- Deliver high quality, resident-centred care, as defined by Department of Health and Community Services standards, and which is equivalent to the quality of care offered by publicly-provided services;
- Ensure sustainable health care through innovation, productivity, and efficiency; and
- Cultivate an engaged workforce and healthy workplace.
2.3 PROJECT TEAM

2.3.1 Government of Newfoundland and Labrador

The Government of Newfoundland and Labrador (GNL), through the Department of Health and Community Services and the Department of Transportation and Works, is administering this RFP.

2.3.2 Department of Health and Community Services

The Department of Health and Community Services provides a leadership role in health and community services programs and policy development for the province. This involves working in partnership with a number of key stakeholders including regional health authorities, community organizations, professional associations, post-secondary educational institutions, unions, consumers and other government departments.

More information on the Department of Health and Community Services can be found at:


2.3.3 Department of Transportation and Works

The Department of Transportation and Works is responsible for the construction and maintenance of the provincial highways; the provision of the provincial ferry services; management of the provincial government fleet of light vehicles and heavy equipment; operation and maintenance of the provincial government air ambulances and water bombers; and construction and management of provincial government buildings.

More information on the Department of Transportation and Works can be found at:


2.3.4 Regional Health Authorities

Three of Newfoundland and Labrador’s four regional health authorities are procuring long term care services through this RFP:

- Western Regional Health Authority ("Western Health") – [http://www.westernhealth.nl.ca/](http://www.westernhealth.nl.ca/);  
- Central Regional Health Authority ("Central Health") - [http://www.centralhealth.nl.ca/](http://www.centralhealth.nl.ca/); and  

(Collectively the “Regional Health Authorities” and each a “Health Authority”).

The Agreements for each Facility will be signed by the appropriate regional health authority.
2.3.5 Partnerships BC

Partnerships BC was established by the Province of British Columbia to structure and implement partnership delivery solutions for public infrastructure. Partnerships BC works with jurisdictions throughout Canada to support the public sector in implementing capital projects. The Government of Newfoundland and Labrador has engaged Partnerships BC to manage the procurement of the Project. More information on Partnerships BC can be found at:

- [http://www.partnershipsbc.ca](http://www.partnershipsbc.ca)
3 KEY PROJECT ELEMENTS

Any description or overview of the Agreements in this RFP is provided for convenience only and does not replace, supersede, supplement or alter the Initial Draft Agreements or Final Draft Agreements. If there are any inconsistencies between the terms of the Final Draft Agreements and the description or overview of those terms set out in this RFP or the Final Draft Agreements, the terms of the Final Draft Agreements will prevail.

3.1 FACILITIES

The Contractor will be responsible to design and construct the Facilities in accordance with the SOR Agreement.

3.2 SERVICES

The Contractor will be responsible to provide all Services related to the care and accommodation of residents including nursing, occupational therapy, physiotherapy, social work, nutrition, recreation, food preparation, laundry, and housekeeping.

3.3 SITES

The Facilities will be located in each of the four areas described in Table 1 below. The Contractor will be responsible for providing the Sites in Gander, Grand Falls-Windsor area and the Northeast Avalon. Further information regarding the GNL’s requirements for these Sites, including geographic boundaries, can be found in the Data Room. The Site in Corner Brook will be provided by Western Health. See Section 3.4 for further details regarding the Corner Brook Site.

The four sites and their attendant characteristics are described in Table 1 below.

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of LTC Beds</th>
<th>Site Provided By</th>
<th>Health GNL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corner Brook</td>
<td>120</td>
<td>NL</td>
<td>Western Health</td>
</tr>
<tr>
<td>Gander</td>
<td>70</td>
<td>Contractor</td>
<td>Central Health</td>
</tr>
<tr>
<td>Grand Falls-Windsor</td>
<td>50</td>
<td>Contractor</td>
<td>Central Health</td>
</tr>
<tr>
<td>Northeast Avalon</td>
<td>120</td>
<td>Contractor</td>
<td>Eastern Health</td>
</tr>
</tbody>
</table>
3.4 CORNER BROOK SITE

The Corner Brook Facility will be developed on a Site identified by Western Health. The Contractor will be responsible to purchase the Site from Western Health at fair market value. The Site is zoned for a long term care facility.

Water, sewer, and an access ring road to the edge of the Site will be provided by Western Health. The Contractor will be assessed a fee for the provision of such services per annum based on their fair market value of the same. The Contractor will be responsible for connecting with Newfoundland Power and for snow removal.

Materials relating to the Corner Brook Site, including survey drawings, will be available in the Data Room. Proponents who wish to tour the Corner Brook Site prior to the Submission Time for Proposals may make arrangements to do so by submitting a request by email to the Contact Person.

3.5 INDICATIVE CARE MODEL

The current care model used in NL long term care facilities is described in Table 2. This model is expected to be implemented at the Facilities.

Table 2: Services Provided by Care Provider

<table>
<thead>
<tr>
<th>Nursing hours per resident per day (average 3.4 hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interdisciplinary Team</td>
</tr>
<tr>
<td>- Recreation</td>
</tr>
<tr>
<td>- Dietitian</td>
</tr>
<tr>
<td>- Social Workers</td>
</tr>
<tr>
<td>- Physiotherapy</td>
</tr>
<tr>
<td>- Occupational Therapy</td>
</tr>
<tr>
<td>Clinical Oversight*</td>
</tr>
<tr>
<td>Consultation Services</td>
</tr>
<tr>
<td>- Speech Pathology</td>
</tr>
<tr>
<td>- Respiratory Therapy</td>
</tr>
<tr>
<td>Pharmaceutical Services</td>
</tr>
</tbody>
</table>

*Defined as physician or physician and nurse practitioner care
3.6 RESIDENT PROFILE

The Facilities will provide care and accommodations to individuals with high care needs (Level III and Level IV). The resident group is predominantly composed of frail, elderly seniors, many of whom have moderate to severe dementia and who require significant assistance with instrumental and functional activities of daily living. These individuals require on-site access to 24-hour professional nursing care.

The Northeast Avalon Facility will include among the 120 beds provided by the Contractor 48 beds for residents with mild to moderate dementia (Level I and Level II). These individuals are typically cared for in protective community residences and require a different model of care that requires a different ratio of care provider hours.

The population may include some adults with severe physical and or intellectual disabilities, but the typical resident profile is described in Table 3.

Table 3: Expected Resident Profile Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed Gender</td>
<td>Yes</td>
</tr>
<tr>
<td>Moderate to Severe Dementia (challenging,</td>
<td>~50%</td>
</tr>
<tr>
<td>responsive behaviour)</td>
<td></td>
</tr>
<tr>
<td>Multiple Co-Morbidities</td>
<td>~80 to 90%</td>
</tr>
<tr>
<td>Mental Health Issues</td>
<td>~30 to 40%</td>
</tr>
<tr>
<td>Functionally Impaired (requiring mechanical</td>
<td>~70 to 75%</td>
</tr>
<tr>
<td>assistance for transfer)</td>
<td></td>
</tr>
<tr>
<td>Average Age</td>
<td>84</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>~2 years</td>
</tr>
<tr>
<td>Impaired Instrumental and Functional Activities in Daily Living</td>
<td>100%</td>
</tr>
</tbody>
</table>

3.7 EQUIPMENT

The Contractor will be responsible to procure and deliver the equipment, furniture, and fittings in accordance with the terms of the Agreements.
3.8 RESIDENTIAL CARE SERVICES AGREEMENT

The RCSA has a term of 25 years and will include a termination clause for breach of contract which will be subject to a remediation period determined by the Regional Health Authority, based on the nature of the breach. Either party may also terminate the RCSA with five years' notice to the other party.

Proponents will make a price proposal based on a per resident per diem. The per diem will be based on two funding envelopes. The Protected Envelope will include costs associated with the provision of care as described in the RCSA. Funding for the Protected Envelope will be allocated based on a funding letter from the Minister of Health and Community Services and will be reassessed annually, but commensurate with the required level of care.

The Unprotected Envelope will be composed of all other costs associated with providing the Services, including the provision, maintenance, and life cycle of the Facility. Funding for the Unprotected Envelope will be based on the Contractor's price proposal. Operating costs in the Unprotected Envelope will be indexed annually based on the all-items Consumer Price Index (CPI) for Newfoundland and Labrador.

The GNL will make per diem payments for 100 per cent of the Beds that are Available throughout the term of the RCSA, subject to the provisions of the RCSA.

3.9 STATEMENT OF REQUIREMENTS AGREEMENT

The SOR Agreement defines the physical space to be provided in order for the Facility to be acceptable as suitable long term care accommodation. Construction and continued maintenance to the standards indicated in the SOR Agreement will be a prerequisite for rooms to be considered Available.

3.10 ALTERNATIVE CONTRACT STRUCTURE

Proponents will be asked to provide an Alternative Pricing Proposal on a split agreement contract structure that includes the RCSA and a standard commercial lease agreement generally in the form of the Indicative Lease Agreement.
4 RFP PROCUREMENT PROCESS

4.1 ESTIMATED TIMELINE

The following is the GNL's estimated timeline for the Procurement:

<table>
<thead>
<tr>
<th>Task</th>
<th>Target Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>RFP and Initial Draft Agreements Release</td>
<td>June 30</td>
</tr>
<tr>
<td>Proponents' Meeting (by conference call)</td>
<td>July 7</td>
</tr>
<tr>
<td>Collaborative Meetings (in St. John's)</td>
<td>Week of July 27</td>
</tr>
<tr>
<td>Release of Final Draft Agreements</td>
<td>August 17</td>
</tr>
<tr>
<td>Submission Time for Proposals</td>
<td>August 24</td>
</tr>
<tr>
<td>Preferred Proponents</td>
<td>October 2</td>
</tr>
<tr>
<td>Negotiations</td>
<td>October 2 – 7</td>
</tr>
<tr>
<td>Contract Execution</td>
<td>October 8</td>
</tr>
</tbody>
</table>

All dates in the above timeline are subject to change at the discretion of the GNL.

4.2 PROONENTS' MEETING

The GNL intends to hold a Proponents' Meeting, via teleconference, to introduce the Project. All interested parties who have submitted a signed Participation Agreement (Appendix C) will be invited to attend. Attendance is not mandatory. The date of this meeting will be July 7, 2015.

A list of registered attendees will be made available to everyone who has submitted a Participation Agreement. Minutes will not be prepared or circulated. No information from the meeting may be relied upon unless set out in an Addendum or a response to an Enquiry under Section 6.5.

4.3 COLLABORATIVE MEETING

The GNL intends to make available certain of its personnel, consultants and advisors (the “GNL Representatives”) to participate in a Collaborative Meeting with each Proponent.

Only Proponents who have submitted a completed Participation Agreement (Appendix C) may participate in a Collaborative Meeting. In addition, Proponents wishing to participate in a Collaborative Meeting with the GNL must submit a request by email to the Contact Person no later than July 13, 2015.

The GNL may, at its discretion, choose to not hold a Collaborative Meeting.

The GNL expects the Collaborative Meeting to take place as follows:
(a) the purpose of the Collaborative Meeting is to provide a process that will assist Proponents in developing optimal solutions for the Project while minimizing the risk that a Proponent's solution is unresponsive to the GNL's requirements, and in particular:

1. to permit the Proponent's Representatives to provide the GNL Representatives with comments and feedback on material issues such as provisions of the Initial Draft Agreements;

2. to permit a Proponent to discuss with the GNL potential solutions and approaches that the Proponent may be considering for various aspects of its Proposal; and

3. to permit a Proponent to discuss with the GNL the evaluation criteria relating to Appendix A of this RFP;

(b) in advance of the Collaborative Meeting, and no later than the Collaborative Submission Time, each Proponent is strongly encouraged to provide the GNL with a proposed meeting agenda, a list of prioritized issues it would like to discuss, and any materials relevant to such issues. Material submitted after the Collaborative Meeting Submission Time may not be reviewed by the GNL. The GNL may provide Proponents with comments on the agenda and a list of any prioritized issues the GNL would like to discuss;

(c) the GNL will determine which GNL Representatives will be present at the Collaborative Meeting;

(d) except as may be expressly stated otherwise in this RFP, the GNL will retain all information received from a Proponent during a Collaborative Meeting as strictly confidential, and will not disclose such information to the other Proponents or any third party. The GNL may disclose such information to its consultants and advisors who are assisting or advising the GNL with respect to the Project;

(e) at the Collaborative Meeting, a Proponent may have such officers, directors, employees, consultants and agents of the Proponent and the Proponent Team members present as the Proponent considers reasonably necessary for effective communication with the GNL and to fulfil the objectives of the Collaborative Meeting, provided that the GNL may, in its discretion, limit the number of participants at any one meeting. Participation in the Collaborative Meeting is in person only unless otherwise permitted at the discretion of the GNL;

(f) to facilitate free and open discussion, Proponents should note that any comments provided by or on behalf of the GNL during the Collaborative Meeting, including in respect of any particular matter raised by a Proponent or which is included in any documents or information provided by a Proponent prior to or during the Collaborative Meeting, and any positive or negative views, encouragement or endorsements expressed by or on behalf of the GNL during the Collaborative Meeting to anything said or provided by Proponents, will not in any way bind the GNL and will not
be deemed or considered to be an indication of a preference by the GNL even if adopted by the Proponent;

(g) if for the purposes of the preparation of its Proposal a Proponent wishes to rely upon anything said or indicated at the Collaborative Meeting, then the Proponent must submit an Enquiry describing the information it would like to have confirmed and request that the GNL provide that information to the Proponent in written form and, if such information relates to a clarification, explanation or change to a provision of this RFP or the RCSA, request an Addendum to this RFP clarifying and amending the provision in question;

(h) by participating in the Collaborative Meeting a Proponent confirms its agreement with these procedures and acknowledges that the meetings are an integral part of the procurement process as described in this RFP and are in the interests of all parties;

(i) the GNL anticipates holding one Collaborative Meeting with each Proponent prior to the Submission Time. Following the release of the RFP, the GNL will consult with each Proponent to confirm a specific date for the Collaborative Meeting. If the GNL considers it desirable or necessary to schedule additional Collaborative Meetings, the GNL may, in its discretion, schedule them;

(j) Proponents may request that the GNL schedule additional Collaborative Meetings on specific topics by providing the request in writing to the Contact Person with proposed dates and details of the topic or topics to be discussed; and

(k) it is expected that Collaborative Meeting will be held in St. John’s, Newfoundland.

4.4 COMMENTS ON THE AGREEMENTS

Each Proponent should review the Initial Draft Agreements for the purpose of identifying any issues or provisions that the Proponent would like to see clarified or amended. Following such review:

(a) the GNL will invite Proponents as part of the Collaborative Meeting process to discuss possible clarifications or amendments to the Initial Draft Agreements, including with respect to commercial, legal, design and construction, and care services aspects of the Project;

(b) no later than the Collaborative Meeting Submission Time, each Proponent should provide the GNL with a prioritized list of requested changes, if any, to the Initial Draft Agreements, together with the agenda and issues list described in this Section 4.3(b); and

(c) the GNL will consider all comments and requested clarifications or amendments received from the Proponents in the Collaborative Meeting and may respond to some or all of the comments received, and will amend the Initial Draft Agreements as the GNL may determine in its discretion.
Prior to the Submission Time, the GNL intends to issue by Addendum one or more revised drafts of the RCSA, SOR Agreement and Indicative Lease Agreement, including ones that will be identified as the Final Draft RCSA, the Final Draft SOR Agreement and the Final Draft Indicative Lease Agreement (collectively as the "Final Draft Agreements"). The Final Draft Agreements will be the common basis for the preparation of all Proposals, and Proponents should not in their Proposal make any modifications, changes or additions to the Final Draft Agreements except for modifications, changes or additions provided for in Section 8.2.

4.5 DATA ROOM

The GNL has established a website to be used as an electronic Data Room in which it has placed documents in the possession of the GNL that the GNL has identified as relevant to the Project, and that may be useful to Proponents. The GNL does not make any representation as to the relevance, accuracy or completeness of any of the information available in the Data Room except as the GNL may advise in writing with respect to a specific document. The GNL will grant Proponents access to the Data Room and will require Proponents to execute an agreement to keep information contained in the Data Room confidential.

The information in the Data Room may be supplemented or updated from time to time. Although the GNL will attempt to notify Proponents of all updates, Proponents are solely responsible for ensuring they check the Data Room frequently for updates and to ensure the information used by the Proponents is the most current, updated information.

4.6 FAIRNESS ADVISOR

The GNL has appointed the Honourable David G. Riche, Q.C. (the "Fairness Advisor") to monitor the Competitive Selection Process.

The Fairness Advisor will provide a written report to the GNL that the GNL will make public.

The Fairness Advisor will be:

(a) provided with full access to all documents, meetings and information related to the evaluation processes under this RFP that the Fairness Advisor, in its discretion, decides is required; and

(b) kept fully informed by the GNL of all documents and activities associated with this RFP.

Proponents may contact the Fairness Advisor directly with regard to concerns about the fairness of the Competitive Selection Process. Contact information for the Fairness Advisor will be provided in the Data Room.
The Fairness Advisor may also provide decisions on conflicts of interest, unfair advantage or exclusivity issues, including whether any person is a Restricted Party. The GNL may, at its discretion, refer matters to the Fairness Advisor.
5 PROPOSAL REQUIREMENTS

5.1 PARTICIPATION AGREEMENT

As a condition of participating in this RFP each Proponent must sign and deliver to the Contact Person a Participation Agreement, substantially in the form attached as Appendix C or otherwise acceptable to the GNL in its discretion. Proponents will not be permitted to participate in the Collaborative Meeting, access the Data Room, or participate further in the Competitive Selection Process unless and until they have signed and delivered a Participation Agreement as required by this Section.

5.2 PROPOSAL FORM AND CONTENT

Proposals should be in the form, and include the content, described in Appendix B. Each Proponent may only submit one Proposal for each Facility.
6 SUBMISSION INSTRUCTIONS

6.1 SUBMISSION TIMES AND SUBMISSION LOCATION

Proposents must submit the Proposal to the Submission Location by the Submission Time. The Submission should be composed of the following:

(a) the cover letter (and all attachments) to the Submission as described in the Submission Section of Appendix B; and

(b) the portion of the Proposal Requirements described in the Submission Section of Appendix B.

6.2 NO FAX OR EMAIL SUBMISSION

Proposals submitted by fax or email will not be accepted, except as specifically permitted in this RFP.

6.3 LANGUAGE OF PROPOSALS

Proposals should be in English. Any portion of a Proposal not in English may not be evaluated.

6.4 RECEIPT OF COMPLETE RFP

Proposents are responsible to ensure that they have received the complete RFP, as listed in the table of contents of this RFP, plus any Addenda. A submitted Proposal will be deemed to have been prepared on the basis of the entire RFP issued prior to the Submission Time. The GNL accepts no responsibility for any Proponent lacking any portion of this RFP.

6.5 ENQUIRIES

All enquiries regarding any aspect of this RFP should be directed to the Contact Person by email (each an "Enquiry").

Proposents are encouraged to submit Enquiries at an early date to permit consideration by the GNL and no later than 3:00 pm NDT on the day that is ten (10) Business Days before the Submission Time.

The GNL may, in its discretion, decide to not respond to any Enquiry.

All Enquiries regarding any aspect of this RFP should be directed to the Contact Person by email, and the following applies to any Enquiry:

(a) responses to an Enquiry will be in writing;
(b) all Enquiries, and all responses to Enquiries from the Contact Person, will be recorded by the GNL;

(c) the GNL is not required to provide a response to any Enquiry;

(d) a Proponent may request that a response to an Enquiry be kept confidential by clearly marking the Enquiry “Commercial in Confidence” if the Proponent considers that the Enquiry is commercially confidential to the Proponent;

(e) if the GNL decides that an Enquiry marked “Commercial in Confidence”, or the GNL’s response to such an Enquiry, must be distributed to all Proponents, then the GNL will permit the enquirer to withdraw the Enquiry rather than receive a response and if the Proponent does not withdraw the Enquiry, then the GNL may provide its response to all Proponents;

(f) notwithstanding Sections 6.5 (d) and (e)

(1) if one or more other Proponents submits an Enquiry on the same or similar topic to an Enquiry previously submitted by another Proponent as “Commercial in Confidence”, the GNL may provide a response to such Enquiry to all Proponents; and

(2) if the GNL determines there is any matter which should be brought to the attention of all Proponents, whether or not such matter was the subject of an Enquiry, including an Enquiry marked “Commercial in Confidence”, the GNL may, in its discretion, distribute the Enquiry, response or information with respect to such matter to all Proponents.

Information offered from sources other than the Contact Person with regard to this RFP is not official, may be inaccurate, and should not be relied on in any way, for any purpose.

6.6 ELECTRONIC COMMUNICATION

Proponents should only communicate with the Contact Person by email. Other methods of communication, including telephone or fax, are discouraged. The Contact Person will not respond to any communications sent by fax.

The following provisions will apply to any email communications with the Contact Person, or the delivery of documents to the Contact Person by email where such email communications or deliveries are permitted by the terms of this RFP:

(a) the GNL does not assume any risk or responsibility or liability whatsoever to any Proponent:

(1) for ensuring that any electronic email system being operated for the GNL or Partnerships BC is in good working order, able to receive transmissions, or not
engaged in receiving other transmissions such that a Proponent's transmission
cannot be received; or

(2) if a permitted email communication or delivery is not received by the GNL or
Partnerships BC, or received in less than its entirety, within any time limit specified by
this RFP; and

(b) all permitted email communications with, or delivery of documents by email to, the Contact
Person will be deemed as having been received by the Contact Person on the dates and times
indicated on the Contact Person's electronic equipment.

6.7 ADDENDA

The GNL may, in its discretion and through the Contact Person, amend this RFP at any time by issuing a
written Addendum. Written Addenda are the only means of amending or clarifying this RFP, and no other
form of communication whether written or oral, including written responses to Enquiries as provided by
Section 6.5, will be included in, or in any way amend, this RFP. Only the Contact Person is authorized to
amend or clarify this RFP by issuing an Addendum. No other employee or agent of the GNL is authorized
to amend or clarify this RFP. The GNL will provide a copy of all Addenda to all Proponents.

6.8 INTELLECTUAL PROPERTY RIGHTS

(a) Grant of License

Subject to Section 6.8 (b), by submitting a Proposal, each Proponent will, and will be deemed to have:

(1) granted to the GNL a royalty-free license without restriction to use for this Project any
and all of the information, ideas, concepts, products, alternatives, processes,
recommendations, suggestions and other intellectual property or trade secrets
(collectively the 'Intellectual Property Rights') contained in the Proponent's
Proposal, or that are otherwise disclosed by the Proponent to the GNL; and

(2) in favour of the GNL, waived or obtained, a waiver of all moral rights contained in the
Proposal.

Proponents will not be responsible or liable for any use by the GNL or any sub-licensee or
assignee of the GNL of any Intellectual Property Rights contained in a Proposal.

(b) Exceptions to License

The license granted under Section 6.8 (a) does not extend to Third Party Intellectual Property
Rights to non-specialized third-party technology and software that are generally commercially
available. By submitting a Proposal, each Proponent represents to the GNL that it owns or has, and will continue to own or have at the Submission Time for Proposals, all necessary rights to all Third Party Intellectual Property Rights contained in its Proposal or otherwise disclosed by the Proponent to the GNL and, subject to the foregoing exceptions, has the right to grant a license of such Third Party Intellectual Property Rights in accordance with Section 6.8 (a).

6.9 DEFINITIVE RECORD

The electronic conformed version of the document in the custody and control of the GNL prevails.

6.10 AMENDMENTS TO PROPOSALS

A Proponent may amend any aspect of its Proposal by delivering written notice, or written amendments, to the Submission Location prior to the Submission Time.

A Proponent may not amend any aspect of its Proposal except as set out above.

6.11 CHANGES TO PROONENT TEAMS

If for any reason a Proponent wishes or requires to add, remove or otherwise change a member of its Proponent Team after submitting a Proposal, or there is a material change in ownership or control (which includes the ability to direct or cause the direction of the management actions or policies of a member) of a member of the Proponent Team, or there is a change to the legal relationship among any or all of the Proponent and its Proponent Team members, then the Proponent must submit a written application to the GNL for approval, including supporting information that may assist the GNL in evaluating the change. The GNL, in its discretion, may grant or refuse an application under this Section, and in exercising its discretion the GNL will consider the objective of achieving a competitive procurement process that is not unfair to the other Proponents. For clarity:

(a) the GNL may refuse to permit a change to the membership of a Proponent Team if the change would, in the GNL's judgment, result in a weaker team than was originally shortlisted; or

(b) the GNL may, in the exercise of its discretion, permit any changes to a Proponent Team, including changes as may be requested arising from changes in ownership or control of a Proponent or a Proponent Team member, or changes to the legal relationship among the Proponent and/or Proponent Team members, such as the creation of a new joint venture or other legal entity or relationship in place of the Proponent Team originally shortlisted.

The GNL's approval may include such terms and conditions as the GNL may consider appropriate.
6.12 VALIDITY OF PROPOSALS

By submitting a Proposal, each Proponent agrees that its Proposal, including all prices and input costs, will remain fixed and irrevocable from the Submission Time for Proposals until midnight at the end of the 60th day following the Submission Time for Proposals (the "Proposal Validity Period").

6.13 MATERIAL CHANGE AFTER SUBMISSION TIME FOR PROPOSALS

A Proponent will give immediate notice to the GNL of any material change that occurs to a Proponent after the Submission Time, including a change to its membership or a change to the Proponent's financial capability.
7 EVALUATION

7.1 MANDATORY REQUIREMENTS

The GNL has determined that the following are the Mandatory Requirements:

(a) the Proponent must have signed and delivered to the Contact Person the Participation Agreement in accordance with Section 5.1; and

(b) the Proposal must be received at the Submission Location before the Submission Time.

7.2 EVALUATION OF PROPOSALS

The GNL will evaluate Proposals in the manner set out in Appendix A. The GNL will not evaluate a Proposal if it has been rejected, or if the applicable Proponent has been disqualified, in accordance with this RFP.

The GNL may, in its discretion, take any one or more of the following steps, at any time and from time to time, in connection with the review and evaluation, including ranking, of any aspect of a Proposal, including if the GNL considers that any Proposal, or any part of a Proposal, requires clarification or more complete information, contains defects, ambiguities, alterations, qualifications, omissions, inaccuracies or misstatements, or does not for any reason whatsoever satisfy the GNL that the Proposal meets any requirements of this RFP at any time, or for any other reason the GNL in its discretion deems appropriate and in the interests of the GNL and this RFP, or either of them:

(a) waive any such defect, ambiguity, alteration, qualification, omission, inaccuracy, misstatement or failure to satisfy, and any resulting ineligibility on the part of the Proponent, or any member of the Proponent Team;

(b) independently consider, investigate, research, analyze, request or verify any information or documentation whether or not contained in any Proposal;

(c) request interviews or presentations with any, all or none of the Proponents to clarify any questions or considerations based on the information included in Proposals during the evaluation process, with such interviews or presentations conducted in the discretion of the GNL, including the time, location, length and agenda for such interviews or presentations;

(d) conduct reference checks relevant to the Project with any or all of the references cited in a Proposal and any other persons (including persons other than those listed by Proponents in any part of their Proposals) to verify any and all information regarding a Proponent, inclusive of its directors/officers and Key Individuals, and to conduct any background investigations that it
considers necessary in the course of the Competitive Selection Process, and rely on and consider any relevant information from such cited references in the evaluation of Proposals;

(e) conduct credit, criminal record, litigation, bankruptcy, taxpayer information and other checks;

(f) not proceed to review and evaluate, or discontinue the evaluation of any Proposals and disqualify the Proponent from this RFP; and

(g) seek clarification or invite more complete, supplementary, replacement or additional information or documentation from any Proponent or in connection with any Proposal or any part of their component packages.

Without limiting the foregoing or Appendix A, the GNL may, in its discretion (and without further consultation with the Proponent), reject any Proposal which in the opinion of the GNL: (i) is materially incomplete or irregular, (ii) contains omissions, exceptions or variations (including any modifications, changes or additions to the Final Draft Agreements, other than as provided for in Section 8.2, (iii) contains any false or misleading statement, claims or information, or (iv) contains any false statements, criminal affiliations or activities by a Proponent or Proponent Team member.

To enable the GNL to take any one or more of the above-listed steps, the GNL may enter into separate and confidential communications of any kind whatsoever, with any person, including any Proponent. The GNL has no obligation whatsoever to take the same steps, or to enter into the same or any communications in respect of all Proponents and Proposals, or in respect of any Proponent, including the Proponent whose Proposal is the subject of the review or evaluation, as the case may be.

The review and evaluation, including the ranking, of any Proposal may rely on, take into account and include any information and documentation, including any clarification, more complete, supplementary and additional or replacement information or documentation, including information and documentation obtained through any of the above-listed investigations, research, analyses, checks, and verifications.

Proponents may not submit any clarifications, information or documentation in respect of the Proposal after the Submission Time for Proposals without the prior written approval of the GNL or without an invitation or request by the GNL.

If any information, including information as to experience or capacity, contained in a Proposal is not verified to the GNL’s satisfaction, the GNL may, in its discretion, not consider such cited experience, capacity or other information.

The GNL is not bound by industry custom or practice in taking any of the steps listed above, in exercising any of its discretions, in formulating its opinions and considerations, exercising its discretions in making
any decisions and determinations, or in discharging its functions under or in connection with this RFP, or in connection with any Proponent, Proposal, or any part of any Proposal.

As part of the evaluation of a Proposal, the GNL may identify that the GNL is not satisfied that the Proposal meets one or more requirements of the Final Draft Agreements. The GNL may, but is not required to, reject the Proposal in accordance with the terms of this RFP. If the GNL does not exercise its discretion to reject the Proposal, the GNL may provide to the Proponent a list of the items that the GNL is not satisfied meet the requirements of the Final Draft Agreements. The Proponent will, if selected as Preferred Proponent, be required to comply with the requirements of the Final Draft Agreements, including by rectifying any non-compliances (material or otherwise) in its Proposal.

The GNL is not responsible for identifying all areas in which a Proposal does not meet the requirements of the Final Draft Agreements. Irrespective of whether the GNL has identified or has failed to identify any such areas, a Proponent is not relieved in any way from meeting the requirements of this RFP, and if selected as Preferred Proponent will not be relieved from meeting all requirements of the Final Draft Agreements, including by rectifying any non-compliances (material or otherwise) in its Proposal.
8 SELECTION OF PREFERRED PROONENT AND AWARD

8.1 SELECTION AND AWARD

The GNL may select a Preferred Proponent for each Facility. The selection and award process described in this Section 8.1 will be done separately for each Facility.

Once the Preferred Proponents have been selected, each Preferred Proponent's representative will be notified in writing of its selection as a Preferred Proponent (the "Selection Notice"). The Selection Notice will constitute the only valid notice of a Proponent's selection as the Preferred Proponent, and will not constitute in any way confirmation of an award of a contract to the Preferred Proponent. The GNL will not be obligated in any manner to any Proponent until appropriate written Agreements have been duly executed.

The GNL will invite the Preferred Proponent to enter into final discussions to settle all terms of the Project Agreement, based on the Preferred Proponent's Proposal, including any clarifications that the Preferred Proponent may have provided during the evaluation of Proposals.

If for any reason the GNL determines that it is unlikely to reach final agreement with the Preferred Proponent, then the GNL may terminate the discussions with the Preferred Proponent and proceed in any manner that the GNL may decide, in consideration of its own best interests, including:

(a) terminating the procurement process entirely and proceeding with some or all of the Project in some other manner, including using other contractors; or

(b) inviting one of the other Proponents to enter into discussions to reach final agreement for completing the Project.

Any final approvals required by the GNL will be conditions precedent to the final execution or commencement of the RCSA.

8.2 FINAL DRAFT AGREEMENT

It is the intention of the GNL that:

(a) any issues with respect to the Initial Draft Agreements will be discussed during the Collaborative Meeting and fully considered prior to issuance of the Final Draft Agreements; and

(b) once issued, the Final Draft Agreements will not be further substantively modified and will be executed by the Preferred Proponent without further substantive amendment, except for changes, modifications and additions:
(1) relating to the determination by the GNL, in its discretion, of which:

   i. parts, if any, of the Proposal are to be incorporated by reference or otherwise, into the Final Draft Agreements or otherwise pursuant to express provisions of the Final Draft Agreements; or

   ii. modifications, changes or additions, if any, proposed by a Proponent pursuant to Section 8.2(b)(2) that are acceptable to the GNL;

(2) to those provisions or parts of the Final Draft Agreements that are indicated as being subject to completion or finalization, or which the GNL determines in its discretion require completion or finalization, including provisions that require:

   i. modification or the insertion or addition of information relating to the Contractor formation (e.g., corporate, partnership or trust structure) and funding structure; and

(3) required by the GNL to complete, based on the Proposal, any provision of the Final Draft Agreements, including changes, modifications and additions contemplated in or required under the terms of the Final Draft Agreements;

(4) that are necessary to create or provide for a legally complete, enforceable and binding agreement; or

(5) that enhance clarity in legal drafting.

The GNL also reserves the right in its discretion to negotiate changes to the Final Draft Agreements and to the Preferred Proponent's Proposal.

Upon Contract Execution, the Agreements, and the instruments and documents to be executed and delivered pursuant to it, supersede (except as expressly incorporated therein) the RFP and the Proposal submitted in respect of the Contractor.

8.3 PREFERRED PROONENT SECURITY DEPOSIT

Subject to the terms of this RFP:

(a) the GNL may invite the Preferred Proponent to deliver the Preferred Proponent Security Deposit on or before the date and time specified by the GNL, such date not to be earlier than 10 Business Days after notification of the appointment of the Preferred Proponent; and

(b) the Preferred Proponent's eligibility to remain the Preferred Proponent is conditional upon the Preferred Proponent delivering the Preferred Proponent Security Deposit to the GNL on or before the date and time specified by the GNL.
8.4 RETURN OF SECURITY DEPOSIT

Subject to Section 8.5, the GNL will return the Preferred Proponent Security Deposit to the Preferred Proponent:

(a) within 10 Business Days after receipt by the GNL of notice of demand from the Preferred Proponent, if:

(1) the GNL exercises its right under Section 10.1 to terminate this RFP prior to entering into the Agreements for reasons unrelated to the Preferred Proponent or any member of the Preferred Proponent’s Proponent Team; or

(2) the GNL fails, within the Proposal Validity Period, to execute and deliver an agreement substantially in the form of the Final RCSA finalized by the GNL in accordance with Section 8.2, provided that such failure is not the result of:

i. the failure of the Preferred Proponent to satisfy any conditions set out in the Final Draft Agreements, or

ii. any extensions to the Proposal Validity Period arising from any agreement by the GNL to negotiate changes to the Final Draft Agreements pursuant to Section 8.2; or

(b) within 10 Business Days after Contract Execution with such Preferred Proponent.

8.5 RETENTION OF SECURITY DEPOSIT

Notwithstanding any receipt by the GNL of the notice described in Section 8.4, the GNL may, in its discretion, draw on, retain and apply the proceeds of the Preferred Proponent Security Deposit for the GNL’s own use as liquidated damages, if:

(a) the Proponent or any Proponent Team member is in material breach of any term of this RFP or the Participation Agreement; or

(b) after receipt of written notice from the GNL:

(1) the Preferred Proponent fails to execute and deliver agreements substantially in the form of the Final Draft Agreements finalized by the GNL in accordance with Section 8.2; or

(2) Contract Execution fails to occur within 30 days (or such longer period as the parties may agree) of receipt of such notice from the GNL,

unless:
(3) any such failure was the result of a significant event which could not have been reasonably prevented by, or was beyond the reasonable control of, the Preferred Proponent; and

(4) the Preferred Proponent demonstrates to the GNL’s satisfaction, acting reasonably, that the occurrence of such significant event would materially frustrate or render it impossible for the Preferred Proponent to perform its obligations under the RCSA for a continuous period of 180 days as if the RCSA was in force and effect.

8.6 DEBRIEFS

The GNL will, following Contract Execution, upon request from a Proponent and within 60 days of Contract Execution, conduct a debriefing for that Proponent.
9 CONFLICT OF INTEREST AND RELATIONSHIP DISCLOSURE

9.1 RESERVATION OF RIGHTS TO DISQUALIFY

The GNL reserves the right to disqualify any Proponent that in the GNL’s opinion has a conflict of interest or an unfair advantage (including access to any confidential information not available to all Proponents), whether real, perceived, existing now or likely to arise in the future, or may permit the Proponent to continue and impose such conditions as the GNL may consider to be in the public interest or otherwise required by the GNL.

9.2 RELATIONSHIP DISCLOSURE

Each Proponent, including each member of the Proponent Team, should fully disclose all relationships they may have with the GNL, any Restricted Party, or any other person providing advice or services to the GNL with respect to the Project or any other matter that gives rise, or might give rise, to a conflict of interest or an unfair advantage:

(a) by submission of completed Relationship Disclosure Forms with its Proposal; and

(b) at any time during the Competitive Selection Process by written notice addressed to the Contact Person promptly after becoming aware of any such relationship.

At the time of such disclosure, the Proponent will include sufficient information and documentation to demonstrate that appropriate measures have been, or will be, implemented to mitigate, minimize or eliminate the actual, perceived or potential conflict of interest or unfair advantage, as applicable. The Proponent will provide such additional information and documentation and implement such additional measures as the GNL may require in its discretion in connection with the consideration of the disclosed relationship and proposed measures. The GNL may, in its discretion, refer difficult relationship issues to the Fairness Advisor for an opinion or guidance.

9.3 USE OR INCLUSION OF RESTRICTED PARTIES

The GNL may, in its discretion, disqualify a Proponent, or may permit a Proponent to continue and impose such conditions as the GNL may consider to be in the public interest or otherwise required by the GNL, if the Proponent is a Restricted Party, or if the Proponent uses a Restricted Party:

(a) to advise or otherwise assist the Proponent respecting the Proponent’s participation in the Competitive Selection Process; or

(b) as a Proponent Team member or as an employee, advisor or consultant to the Proponent or a Proponent Team member.
Each Proponent is responsible to ensure that neither the Proponent nor any Proponent Team member uses or seeks advice or assistance from any Restricted Party, or includes any Restricted Party in the Proponent Team.

**9.4 CURRENT RESTRICTED PARTIES**

At this RFP stage, and without limiting the definition of Restricted Parties, the GNL has identified the following persons as Restricted Parties:

(a) Hon. David G. Riche, Q.C.;
(b) Caledonia Solutions, Canada, Inc;
(c) Central Health;
(d) Eastern Health;
(e) Western Health; and
(f) the GNL and Partnerships BC, including their former and current employees who fall within the definition of Restricted Party.

This is not an exhaustive list of Restricted Parties. Additional persons may be added to, or deleted from, the list during any stage of the Competitive Selection Process through an Addendum.

**9.5 REQUEST FOR ADVANCE DECISION**

A Proponent or a prospective member or advisor of a Proponent who has any concerns regarding whether a current or prospective employee, advisor or member of that Proponent is, or may be, a Restricted Party, or has a concern about any conflict or unfair advantage it may have, is encouraged to request an advance decision by submitting to the Contact Person, not less than ten (10) Business Days prior to the Submission Time, by email, the following information:

(a) names and contact information of the Proponent and the person for which the advance opinion is requested;

(b) a description of the relationship that raises the possibility or perception of a conflict of interest or unfair advantage;

(c) a description of the steps taken to date, and future steps proposed to be taken, to mitigate the conflict of interest or unfair advantage, including the effect of confidential information; and

(d) copies of any relevant documentation.
The GNL may make an advance decision or may refer the request for an advance decision to the Fairness Advisor. If the Owner refers the request to the Fairness Advisor, the GNL may make its own submission to the Fairness Advisor.

If a Proponent or prospective team member or advisor becomes a Restricted Party, it may be listed in an Addendum or in subsequent Competitive Selection Process documents as a Restricted Party.

9.6 THE OWNER MAY REQUEST ADVANCE DECISIONS

The GNL may also independently make advance decisions, or may seek an advance decision from the Fairness Advisor where the GNL identifies a potential conflict, unfair advantage, or a person who may be a Restricted Party. The GNL will, if it seeks an advance decision from the Fairness Advisor, provide the Fairness Advisor with relevant information in its possession. If the GNL seeks an advance decision from the Fairness Advisor, the GNL will give notice to the Proponent, and may give notice to the possible Restricted Party so that it may make its own response to the Fairness Advisor.

The onus is on the Proponent to clear any potential conflict, unfair advantage, or Restricted Party, or to establish any conditions for continued participation, and the GNL may require that the Proponent make an application under Section 9.5.

9.7 DECISIONS FINAL AND BINDING

The decision of the GNL or the Fairness Advisor, as applicable, is final and binding on the persons requesting the ruling and all other parties including Proponents, Proponent Team members and the GNL. The GNL or the Fairness Advisor, as applicable, has discretion to establish the relevant processes from time to time, including any circumstances in which a decision may be amended or supplemented.

The GNL may provide any decision by the GNL or the Fairness Advisor regarding conflicts of interest to all Proponents if the GNL, in its discretion, determines that the decision is of general application.

9.8 SHARED USE

A Shared Use Person is a person identified by the GNL as eligible to do work for more than one Proponent, including a person who has unique or specialized information or skills such that the GNL considers in its discretion their availability to all Proponents to be desirable in the interests of the Competitive Selection Process. Any Shared Use Person will be required to agree not to enter into exclusive arrangements with any Proponent.

No Shared Use Persons have been identified for this Project.
9.9 EXCLUSIVITY

Unless permitted by the GNL in its discretion or permitted as a Shared Use Person, each Proponent will ensure that no member of its Proponent Team, or any Affiliated Person of any member of its Proponent Team, participates as a member of any other Proponent Team. The provisions of this section do not apply to site selection. For example, a real estate agent can provide advice to more than one team, and more than one team can submit a proposal based on the same site providing there is no evidence of collusion or unfair practices.

If a Proponent contravenes the foregoing, the GNL reserves the right to disqualify the Proponent or may permit the Proponent to continue and impose such conditions as may be required by the GNL. Each Proponent is responsible, and bears the onus, to ensure that the Proponent, its Proponent Team members and their respective Affiliated Persons do not contravene the foregoing.

A Proponent or a prospective Proponent Team member who has any concerns regarding whether participation does or will contravene the foregoing is encouraged to request an advance decision in accordance with this Section through the following process:

(a) to request an advance decision on matters related to exclusivity, the Proponent or prospective Proponent Team member should submit to the Contact Person, not less than ten (10) Business Days prior to the Submission Time for Proposals by email, the following information:

(1) names and contact information of the Proponent or prospective Proponent Team member making the disclosure;

(2) a description of the relationship that raises the possibility of non-exclusivity;

(3) a description of the steps taken to date, and future steps proposed to be taken, to mitigate any material adverse or potential material adverse effect of the non-exclusivity on the competitiveness or integrity of the Competitive Selection Process; and

(4) copies of any relevant documentation.

The GNL may require additional information or documentation to demonstrate to the satisfaction of the GNL in its discretion that no such non-exclusivity exists or, if it does, that measures satisfactory to the GNL in its discretion have been or will be implemented to eliminate or mitigate any risk to the competitiveness or integrity of the Competitive Selection Process.

9.9.1 Exclusivity – the GNL May Request Advance Decisions

The GNL may also independently make advance decisions, or may seek an advance decision where the GNL identifies a matter related to exclusivity. The GNL will, if it seeks an advance decision from the
Fairness Advisor, provide the Fairness Advisor with relevant information in its possession. If the GNL seeks an advance decision from the Fairness Advisor, the GNL will give notice to the Proponent so that it may make its own response to the Fairness Advisor.

The onus is on the Proponent to clear any matter related to exclusivity or to establish any conditions for continued participation, and the GNL may require that the Proponent make an application under Section 9.9.

9.9.2 Exclusivity – Decisions Final and Binding

The decision of the GNL or the Fairness Advisor, as applicable, is final and binding on the persons requesting the ruling and all other parties including Proponents, Proponent Team members and the GNL. The GNL or the Fairness Advisor, as applicable, has discretion to establish the relevant processes from time to time, including any circumstances in which a decision may be amended or supplemented.

The GNL may provide any decision by the GNL or the Fairness Advisor regarding matters related to exclusivity to all Proponents if the GNL, in its discretion, determines that the decision is of general application.
10 RFP TERMS AND CONDITIONS

10.1 NO OBLIGATION TO PROCEED

This RFP does not commit the GNL to select a Preferred Proponent or enter into the Agreements, and the GNL reserves the complete right to at any time reject any or all Proposals, and to terminate this RFP and the Competitive Selection Process and proceed with the Project in some other manner.

10.2 NO CONTRACT

Other than to the extent provided in the Participation Agreement, this RFP is not a contract between the GNL and any Proponent, nor is this RFP an offer or an agreement to purchase work, goods or services. No contract of any kind for work, goods or services whatsoever is formed under, or arises from this RFP, or as a result of, or in connection with, the submission of a Proposal, unless the GNL and the Preferred Proponent execute and deliver the RCSA, and then only to the extent expressly set out in the RCSA.

10.3 ACCESS OF INFORMATION AND PROTECTION OF PRIVACY ACT AND FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT

The GNL is subject to the Newfoundland and Labrador Access to Information and Protection of Privacy Act S.N.L. 2015, c.A-1.2 ("ATIPPA"), which gives individuals a right of access to records in the custody or control of the GNL, with certain exceptions. In addition, Partnerships BC is subject to the Freedom of Information and Protection of Privacy Act, R.S.B.C. 1996 c.165 ("FOIPPA").

By submitting a Proposal, the Proponent represents and warrants to the GNL that the Proponent has complied with applicable Laws, including by obtaining from each person any required consents and authorizations to the collection of information relating to such individual and to the submission of such information to the GNL and the use, distribution and disclosure of such information as part of the Proposal for the purposes of, or in connection with, this RFP and the Competitive Selection Process.

10.4 COST OF PREPARING THE PROPOSAL

Each Proponent is solely responsible for all costs it incurs in the preparation of its Proposal, including all costs of providing information requested by the GNL, attending meetings and conducting due diligence.

10.5 CONFIDENTIALITY OF INFORMATION

All information pertaining to the Project received by any Proponent or Proponent Team member through participation in this RFP is confidential and may not be disclosed without written authorization from the Contact Person, and in no event will a Proponent discuss the Project with any member of the public or the
media without the prior written approval of the GNL. Except as expressly stated in this RFP, and subject to ATTIPA, FOIPPA or other applicable legislation, all documents and other records submitted in response to this RFP will be considered confidential.

The GNL has engaged Partnerships BC. Partnerships BC has been, and continues to be, involved in other projects, and the GNL may receive information in respect of other projects which may be relevant to the Project. Subject to the terms of this RFP, including limitations on “Commercial in Confidence” information under Section 4.3 [Collaborative Meetings] and Section 6.5 [Enquiries] the GNL may, in its discretion, disclose information that is available from the Project to Partnerships BC and other projects, and may obtain information from other projects.

10.6 GENERAL RESERVATION OF RIGHTS

The GNL reserves the right, in its discretion, to:

(a) amend the scope of the Project and/or modify, cancel or suspend the Competitive Selection Process at any time for any reason;

(b) accept or reject any Proposal based on the GNL’s evaluation of the Proposals in accordance with Appendix A, and in particular the GNL is not obliged to select the Proposal with the lowest Cost of the Proposal;

(c) reject a Proposal that fails to meet the Mandatory Requirements;

(d) waive a defect, irregularity, non-conformity or non-compliance in or with respect to a Proposal or failure to comply with the requirements of this RFP except for Mandatory Requirements, and accept that Proposal even if such a defect, irregularity, non-conformity or non-compliance or failure to comply with the requirements of this RFP would otherwise render the Proposal null and void;

(e) reject, disqualify or not accept any or all Proposals without any obligation, compensation or reimbursement to any Proponent or any of its team members;

(f) re-advertise for new Proposals to this or a modified RFP, call for quotes, proposals or tenders, or enter into negotiations for this Project or for work of a similar nature;

(g) make any changes to the terms of the business opportunity described in this RFP;

(h) negotiate any aspects of a Preferred Proponent’s Proposal; and

(i) amend, from time to time, any date, time period or deadline provided in this RFP, upon written notice to all Proponents.
10.7 NO COLLUSION

Proponents and Proponent Team members, their employees and representatives involved with the Proposal, will not discuss or communicate, directly or indirectly, with any other Proponent or any director, officer, employee, consultant, advisor, agent or representative of any other Proponent (including any Proponent Team member of such other Proponent) regarding the preparation, content or representation of their Proposals.

By submitting a Proposal, a Proponent, on its own behalf and as authorized agent of each firm, corporation or individual member of the Proponent and Proponent Team, represents and confirms to the GNL, with the knowledge and intention that the GNL may rely on such representation and confirmation, that its Proposal has been prepared without collusion or fraud, and in fair competition with Proposals from other Proponents.

10.8 NO LOBBYING

Proponents, Proponent Team members, and their respective directors, officers, employees, consultants, agents, advisors and representatives will not engage in any form of political or other lobbying whatsoever in relation to the Project, this RFP, or the Competitive Selection Process, including for the purpose of influencing the outcome of the Competitive Selection Process. Further, no such person (other than as expressly contemplated by this RFP) will attempt to communicate in relation to the Project, this RFP, or the Competitive Selection Process, directly or indirectly, with any representative of the GNL (including any Minister or Deputy Minister, or any Members of the House Assembly, or any employee of the GNL), Partnerships BC, any Restricted Parties, or any director, officer, employee, agent, advisor, consultant or representative of any of the foregoing, as applicable, for any purpose whatsoever.

In the event of any lobbying or communication in contravention of this Section, the GNL in its discretion may at any time, but will not be required to, reject any and all Proposals submitted by that Proponent without further consideration or compensation.

10.9 OWNERSHIP OF PROPOSALS

All Proposals submitted to the GNL become the property of the GNL and will be received and held in confidence by the GNL, subject to the provisions of ATIPPA, 2015, FOIPPA and this RFP.

10.10 DISCLOSURE AND TRANSPARENCY

The GNL is committed to an open and transparent procurement process. To assist the GNL in meeting its commitment, Proponents will cooperate and extend all reasonable accommodation to this endeavour.
The GNL expects to publicly disclose the following information during this stage of the Competitive Selection Process:

(a) the RFP;
(b) the number of Proponents; and
(c) the name of Proponents.

Following Contract Execution, the GNL expects to publicly disclose:

(a) the Fairness Advisor’s report; and
(b) the executed Agreements excluding those portions that may be redacted pursuant to the application of ATIPPA, 2015.

Each Proponent agrees that:

(a) to ensure that all public information generated about the Project is fair and accurate and will not inadvertently or otherwise influence the RFP process, the disclosure of any public information generated in relation to the Project, including communications with the media and the public, must be coordinated with, and is subject to prior written approval of, the GNL;

(b) it will notify the GNL of any and all requests for information or interviews received from the media; and

(c) it will ensure that all of the Proponent Team members and others associated with the Proponent comply with the requirements of this RFP.

10.11 LIMITATION OF DAMAGES

Each Proponent on its own behalf and on behalf of the Proponent Team and any member of a Proponent Team:

(a) agrees not to bring any Claim against the GNL or any of its employees, advisors or representatives for damages in excess of the amount equivalent to the reasonable costs incurred by the Proponent in preparing its Proposal for any matter in respect of this RFP or Competitive Selection Process, including:

   (1) if the GNL accepts a non-compliant proposal or otherwise breaches, or fundamentally breaches, the terms of this RFP or the Competitive Selection Process; or

   (2) if the Project or Competitive Selection Process is modified, suspended or cancelled for any reason (including modification of the scope of the Project or modification of this RFP or both) or the GNL exercises any rights under this RFP; and
(b) waives any and all Claims against the GNL or any of its employees, advisors or representatives
for loss of anticipated profits or loss of opportunity if no agreement is made between the GNL and
the Proponent for any reason, including:

(1) if the GNL accepts a non-compliant proposal or otherwise breaches or fundamentally
breaches the terms of this RFP or the Competitive Selection Process; or

(2) if the Project or Competitive Selection Process is modified, suspended or cancelled
for any reason (including modification of the scope of the Project or modification of
this RFP or both) or the GNL exercises any rights under this RFP.
11 DEFINITIONS AND INTERPRETATION

11.1 DEFINITIONS

Capitalized terms in this RFP that are not defined in this Section have the meaning given in the RCSA or SOR Agreement.

In this RFP:

"Access to Information and Protection of Privacy Act" or "ATIPPA, 2015" has the meaning set out in Section 10.3.

"Addenda" or "Addendum" means an addendum to this RFP issued by the Contact Person as described in Section 6.7.

"Affiliated Persons", or affiliated persons, or persons affiliated with each other, are:

(a) a corporation and

(1) a person by whom the corporation is controlled,

(2) each member of an affiliated group of persons by which the corporation is controlled, and

(3) a spouse or common-law partner of a person described in subparagraph (1) or (2);

(b) two corporations, if

(1) each corporation is controlled by a person, and the person by whom one corporation is controlled is affiliated with the person by whom the other corporation is controlled,

(2) one corporation is controlled by a person, the other corporation is controlled by a group of persons, and each member of that group is affiliated with that person, or

(3) each corporation is controlled by a group of persons, and each member of each group is affiliated with at least one member of the other group;

(c) a corporation and a partnership, if the corporation is controlled by a particular group of persons each member of which is affiliated with at least one member of a majority-interest group of partners of the partnership, and each member of that majority-interest group is affiliated with at least one member of the particular group;

(d) a partnership and a majority-interest partner of the partnership;

(e) two partnerships, if
(1) the same person is a majority-interest partner of both partnerships,
(2) a majority-interest partner of one partnership is affiliated with each member of a majority-interest group of partners of the other partnership, or
(3) each member of a majority-interest group of partners of each partnership is affiliated with at least one member of a majority-interest group of partners of the other partnership;

(f) a person and a trust, if the person
   (1) is a majority-interest beneficiary of the trust, or
   (2) would, if this subsection were read without reference to this paragraph, be affiliated with a majority-interest beneficiary of the trust; and

(g) two trusts, if a contributor to one of the trusts is affiliated with a contributor to the other trust and
   (1) a majority-interest beneficiary of one of the trusts is affiliated with a majority-interest beneficiary of the other trust,
   (2) a majority-interest beneficiary of one of the trusts is affiliated with each member of a majority-interest group of beneficiaries of the other trust, or
   (3) each member of a majority-interest group of beneficiaries of each of the trusts is affiliated with at least one member of a majority-interest group of beneficiaries of the other trust.

"Agreements" means the RCSA and the SOR Agreement and the Indicative Lease Agreement.

"Alternative Pricing Proposal" means the price of the Proposal based on the RCSA and Indicative Lease Agreement.

"Builder" means the private sector company that will design and build the Facility.

"Builder's Lead" means the individual responsible for leading the Builder during construction of the Facility, as described in the Proponent's Proposal and as may be changed pursuant to this RFP.

"Business Day(s)" means a standard day for conducting business, excluding government holidays and weekends.

"Care Provider" means the private sector company that will operate the Facility and deliver the care services.

"Claim" means any claim, demand, suit, action, or cause of action, whether arising in contract, tort or otherwise, and all costs and expenses relating thereto.
“Collaborative Meeting” has the meaning set out in Section 4.3.

“Collaborative Meeting Submission Time” means the date and time identified as such in the Summary of Key Information.

“Competitive Selection Process” means the overall process for the selection of a Preferred Proponent for the Project including, but not limited to, this RFP stage.

“Contact Person” means the person identified as such in the Summary of Key Information.

“Contract Execution” means the time when the RCSA and all other agreements related to the Project have been executed and delivered and all conditions to the effectiveness of the RCSA have been satisfied.

“Contractor” means the entity that will execute the RCSA and be responsible for meeting all obligations of the Agreements.

“Contractor’s Lead” means the individual responsible for leading the Contractor in the delivery of the Project, as described in the Proponent’s Proposal and as may be changed pursuant to this RFP.

“Director of Care” means the individual responsible for leading the Care Provider in the delivery of Services, as described in the Proponent’s Proposal and as may be changed pursuant to this RFP.

“Enquiry” has the meaning set out in Section 6.5.

“Facility” or “Facilities” means the buildings, related structures, utility connections, landscaping and other improvements to be constructed by the Builder.

“Fairness Advisor” has the meaning set out in Section 4.6.

“Final Draft Agreements” has the meaning set out in Section 4.4

“Freedom of Information and Protection of Privacy Act” or “FOIPPA” has the meaning set out in Section 10.3.

“Guarantor” means an entity providing financial and/or performance support to the Contractor by way of a guarantee or a commitment to provide a parent company guarantee or other proposed credit support in relation to the Project, as identified in the Proponent’s RFP Proposal and as may have been changed pursuant to the RFP or as may be changed pursuant to this RFP.

“Indicative Lease Agreement” means the document with the same name in the Data Room.
"Initial Draft Agreements" means the draft contracts labeled "Initial Draft Residential Care Services Agreement" and "Initial Draft Statement of Requirements Agreement" and "Indicative Lease Agreement" posted in the Data Room.

"Intellectual Property Rights" has the meaning set out in Section 6.8.

"Key Individual(s)" of a Proponent means the specific individuals, exclusive to the Proponent, filling the following roles (or equivalent), as identified in the Proponent’s Proposal and as may be changed pursuant to this RFP:

- Contractor’s Lead
- Builder’s Lead
- Director of Care

Key Individuals may fill multiple roles provided they have the qualifications and experience for all the roles. A Key Individual role may only be filled by one individual.

"Mandatory Requirements" means the requirements described in Section 7.1.

"Minimum Requirements" has the meaning set out in Appendix A of this RFP.

"Multiple Facility Discount" means a discount offered by a Proponent if the Proponent is named Preferred Proponent for more than one Facility.

"GNL" means the Government of Newfoundland or Labrador.

"GNL Representatives" has the meaning set out in Section 4.3.

"Participation Agreement" has the meaning set out in 5.1.

"Partnerships BC" means Partnerships British Columbia Inc.

"Preferred Proponent" means the Proponent selected by the GNL pursuant to this RFP to finalize the Agreements.

"Preferred Proponent Security Deposit" means an irrevocable letter of credit in the amount of $100,000 for each Facility in the form set out in Appendix G or in such other form acceptable to the GNL in its discretion.

"Price Proposal" means the total per diem per resident the GNL will pay for the Beds and the Services.

"Project" has the meaning set out in Section 1.1.
“Proponent” means

(a) before the Submission Time for Proposals any party described in Section 1.2 that has signed and submitted a Participation Agreement confirming an intention to submit a Proposal; and

(b) after the Submission Time for Proposals any party described in Section 1.2 who has submitted a Proposal.

“Proponent Team” means a Contractor, Builder, and Care Provider, as identified in the Proponent’s Proposal.

“Proponent’s Representative” means the individual identified in the Proposal Declaration Form who is fully authorized to represent the Proponent in any and all matters related to its Proposal, including but not limited to providing clarifications and additional information that may be requested in association with this RFP.

“Proposal” means a proposal submitted in response to this RFP.

“Proposal Requirements” means the requirements described in Appendix B.

“Proposal Validity Period” has the meaning set out in Section 6.12.

“Regional Health Authorities” has the meaning set out in Section 2.3.4.

“Relationship Disclosure Form” means a form substantially as set out in Appendix D or as otherwise acceptable to the GNL.

“Request for Proposals” or “RFP” means this request for proposals including all appendices, as may be amended by Addenda.

“Residential Care Services Agreement” or “RCSA” has the meaning set out in Section 1.1.

“Restricted Party” means those persons (including their former and current employees) who had, or currently have, participation or involvement in the Competitive Selection Process or the design, planning or implementation of the Project, and who may provide a material unfair advantage or confidential information to any Proponent that is not, or would not reasonably be expected to be, available to other Proponents.

“Selection Notice” has the meaning set out in Section 8.1.

“Shared Use Person” has the meaning set out in Section 9.8.

“Site” has the meaning set out in Section 3.3.
"Statement of Requirements Agreement" or "SOR Agreement" has the meaning set out in Section 3.9.

"Submission Location" means the submission location identified as such in the Summary of Key Information.

"Submission Time for Proposals" means the date and time identified as such in the Summary of Key Information.

"Third Party Intellectual Property Rights" means all Intellectual Property Rights of any person who is not a member of, or a related party to, a member of the Proponent Team.

11.2 INTERPRETATION

In this RFP:

(a) any action, decision, determination, consent, approval or any other thing to be performed, made, or exercised by or on behalf of the GNL, including the exercise of "discretion" or words of like effect, unless the context requires it, is at the sole, absolute and unfettered discretion of the GNL;

(b) the use of headings is for convenience only and headings are not to be used in the interpretation of this RFP;

(c) a reference to a Section or Appendix, unless otherwise indicated, is a reference to a Section of, or Appendix to, this RFP;

(d) words imputing any gender include all genders, as the context requires, and words in the singular include the plural and vice versa;

(e) the word "including" when used in this RFP is illustrative only and is not to be read as limiting or exhaustive;

(f) a reference to a "person" includes a reference to an individual, legal personal representative, corporation, body corporate, firm, partnership, trust, trustee, syndicate, joint venture, limited liability company, association, unincorporated organization, union or government authority; and

(g) each Appendix attached to this RFP is an integral part of this RFP as if set out at length in the body of this RFP.
APPENDIX A: EVALUATION OF PROPOSALS

The GNL will evaluate the Proposals in accordance with this Appendix A.

Subject to the terms of this RFP, including Section 7.1 [Mandatory Requirements] and Section 7.2 [Evaluation of Proposals], the GNL will evaluate each Proposal to determine whether the GNL is satisfied that the Proposal substantially meets the following requirements:

1. Minimum Requirements

   The GNL will evaluate Proposals and determine in its discretion if the Proponent adequately meets the Minimum Requirements stated in Table 1. Should any Proponent fail to adequately meet the Minimum Requirements, the GNL may discontinue the evaluation of that Proponent’s Proposal in accordance with Sections 6.2 and 9.6. of this RFP.

   **Table 1: Minimum Requirements**

   **Financial Capacity**

   Sufficient financial capacity of each of the following Proponent Team members to undertake their respective obligations to the Project:
   a) Contractor
   b) Builder
   c) Care Provider
   d) Guarantor(s) (if applicable)

   as demonstrated by the Proponent’s response to the content requirements set out in Section 1.5 of Appendix B of this RFP.

Proposals meeting the Minimum Requirements will continue to be evaluated as described below.

2. Proposals

Subject to Section 7.2, for those Proponents that adequately meet the Minimum Requirements, the GNL will then evaluate the Proposal to determine whether the GNL is satisfied that the Proposal substantially meets the following requirements:

(a) the provisions of this RFP, including the requirements set out in:

   (1) Appendix B of this RFP; and

   (2) the Final Draft Agreements;

(b) demonstration that the Proponent has a good understanding of the Project and the obligations of the Contractor under the Agreements; and

(c) demonstration that the Proponent is capable of:

   (1) performing the obligations and responsibilities of the Contractor and
(2) delivering the Project in accordance with the Agreements.

If the GNL is not satisfied that the Proposal substantially meets the above requirements, the GNL may reject the Proposal and not evaluate it further.

The GNL will then score the extent to which a Proponent's Proposal satisfies the evaluation criteria described in Table 2 of Appendix A. Table 2 describes these evaluation criteria and indicates the maximum points available for each criterion.

Each Proposal must score a minimum of 60 per cent of the available points in each of Sections 1, 2 and 3 to have Section 4.0 evaluated and scored.

In scoring Section 4.0 [Financial Submission], the GNL will choose which contract structure is most advantageous to the GNL and all Proposals will be scored on the basis of either the Pricing Proposal or the Alternate Pricing proposal.

3 Ranking Proposals

Proposals that have not been rejected will be ranked according to the following process:

The Proposal that offers the most advantageous solution to the GNL by achieving the highest number of points as set out in Table 2 below will receive the highest ranking and be designated the highest-ranked Proposal.
Table 2: Evaluation Criteria

<table>
<thead>
<tr>
<th>Section</th>
<th>Criteria</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td><strong>Proponent Team</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strength and relevance of demonstrated experience and capability of the Contractor, Builder,</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>and Care Provider to undertake the Project as demonstrated by previous projects:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Value (CDNS);</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Number of beds;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Client profile;</td>
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</tr>
<tr>
<td></td>
<td>d) Care model (Care Provider only);</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e) Completion date (more recent projects will be considered more relevant); and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>f) Level of accreditation.</td>
<td></td>
</tr>
<tr>
<td>2.0</td>
<td><strong>Service Delivery</strong></td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>The extent to which the proposed services included in the Protected Envelope meet or exceed the</td>
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<td></td>
<td>requirements of Appendix B of the RCSA including:</td>
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<td></td>
<td>a) Residents' access to allied health staff;</td>
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<td></td>
<td>b) Staffing and program requirements for residents with mild to moderate dementia (for Northeast Avalon only)</td>
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</tr>
<tr>
<td></td>
<td>c) Human resources strategy;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d) Quality improvement and assurance plans;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e) Resident Programs; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>f) Approach to meal planning and preparation.</td>
<td></td>
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<tr>
<td>3.0</td>
<td><strong>Facility</strong></td>
<td>20</td>
</tr>
<tr>
<td>3.1 Site</td>
<td>The extent to which the proposed Site meets the requirements of the GNL and accommodates the</td>
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<td></td>
<td>unique needs of residents, including:</td>
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<td></td>
<td>a) Size of the Site and access to municipal services;</td>
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<tr>
<td></td>
<td>b) Proximity to an acute care hospital;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Access to community health services;</td>
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</tr>
<tr>
<td></td>
<td>d) Access to bus routes (where applicable);</td>
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<td></td>
<td>e) Pleasing views;</td>
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</tr>
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<td></td>
<td>f) Access to natural green space; and</td>
<td></td>
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<tr>
<td></td>
<td>g) Within a residential area or having a residential feel.</td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Criteria</td>
<td>Points</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
</tbody>
</table>
| 3.2 Building Design and Layout | The suitability of the proposed Facility for meeting the GNL’s requirements including the extent to which the:  
   a) interior design of the Facility provides a positive, home-like environment and contributes to the well-being of residents, staff and visitors;  
   b) design is residential in appearance; and blends into the residential neighborhood;  
   c) design of the outdoor environment contributes to the well-being of the residents;  
   d) overall design supports the principles of age friendly environment especially recognizing the unique needs of residents with dementia and complex medical conditions.  
   e) design supports sustainability in building operations.  |        |
| 3.3 Maintenance and Life Cycle | The extent to which the proposed plans will ensure a clean, safe and well-maintained Facility.                                                                                                              |        |
| 4.0 Financial Submission  | The total cost to the GNL of the Proponent’s Proposal, with respect to the following:  
   a) Pricing Proposal; and  
   b) Alternative Contract Structure                                                                                                           | 30     |
| Total Points             |                                                                                                                                                                                                          | 100    |
APPENDIX B: PROPOSAL REQUIREMENTS

Each Proposal for each Facility must include three packages as described below.

Package 1: Transmittal Package

Package 2: Technical Package
   Section 1. Proponent Team
   Section 2. Service Delivery
   Section 3. Facility

Package 3: Financial Package (submitted in a separate, sealed envelope)
   Section 4. Financial

Each Proponent should submit five hard copies numbered 1 through 5; and one electronic copy (USB flash drive in PDF format, with a label on each describing its contents) appropriately packaged and clearly marked “Request for Proposals for NL Long Term Care Project”.

The tables below describe the requirements for the Proposal and Transmittal Package. For ease of reference, Proposals should be written using the section numbers and titles as indicated with variations, if any, clearly identified. Where the Proponent believes there is a redundant request in the requirements of the RFP, the Proponent can prepare the information in one location and clearly refer the evaluators to this location as applicable.

Where a narrative explanation is required, Proponents should limit their narrative to 1,000 words in each case.

Proponents should provide required drawings in 11" x 17" format. Where provided electronically, drawings must be to scale and in PDF format.

Defined terms have the meaning set out in the RFP or the Final Draft Agreements as the context may require. References to schedules and appendices are to the schedules and appendices to the Agreements unless otherwise specified.
Table 1: Transmittal Package for Proposal

Package 1: Transmittal Package For Proposal

The transmittal package is to contain the following information and documents:

a) Indicate which Facility or Facilities the Proposal is referencing.

b) Name and contact details for the Proponent's Representative.
   
   Please note: The Proponent's Representative will be the only person to receive communications from the Contact Person regarding the RFP.
   
i. Name;
   ii. Employer;
   iii. Mailing/courier addresses;
   iv. Telephone number; and
   v. Email address.

c) Provide the Company/Firm name and names of the Key Individuals for the following team members:

   i. Builder, and
   ii. Care Provider.

   Proponents should submit the required information in the following format:

<table>
<thead>
<tr>
<th>Individual's Name</th>
<th>Company Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

d) Relationship Disclosure Form(s)

e) Overview table of contents for all parts of the Proposal.
The Proposal should address the requirements set out in the tables below. Proponents should use the section numbers and corresponding titles shown in these tables in their Proposal to demonstrate to the satisfaction of the Owner that the Proponent is capable of performing the obligations and responsibilities of the Contractor and delivering the Project in accordance with the Agreements, and that the Proponent has a good understanding of the Project and the work.

<table>
<thead>
<tr>
<th>Section No.</th>
<th>Title</th>
<th>Contents (Package 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Proponent Team</td>
<td>Proposal Requirements</td>
</tr>
</tbody>
</table>
| 1.1         | Team Organization              | a) Provide a list of Proponent Team Members, including the Contractor, Builder and Care Provider if these are different entities, and the responsibilities of each;  
b) Provide the business relationships amongst the Proponent Team members (e.g., corporation, joint venture, partnership, subcontractor agreement, consultant service agreement). |
| 1.2         | Proponent Team Portfolio of Experience | a) Provide in a table format the following details on the portfolio of up to 10 residential care home projects in which members of the Proponent Team have either led or had a significant role.  
i. Project name;  
ii. Project location;  
iii. Number of beds;  
iv. Services provided;  
v. Level of provincial or national accreditation; and  
vi. Names of team members involved. |
| 1.3         | Care Provider Experience       | a) Describe the Care Provider's experience and capability by providing details on a maximum of three residential care home projects in which the Care Provider has been responsible for the provision of care services and include the following information for each:  
i. Name and location of facility;  
ii. Name of health authority; |
<table>
<thead>
<tr>
<th>Section No.</th>
<th>Title</th>
<th>Contents (Package 2)</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>iii. Number of beds;</td>
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<td></td>
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<td>iv. Client profile;</td>
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<td></td>
<td></td>
<td>v. Care model; and</td>
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<td></td>
<td></td>
<td>vi. Description of how resident and family satisfaction was measured and the results and how complaints and occurrences were addressed.</td>
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<td>vii. Describe initiatives that addressed trends in senior’s services or areas requiring improvement as identified through performance monitoring.</td>
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<td>b) Provide a reference for each project listed in 1.3(a), including:</td>
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<td></td>
<td>• Reference Name and Title</td>
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<td>• Organization</td>
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<td>• Telephone Number</td>
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<td>• Email Address</td>
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<td></td>
<td>Ensure each reference has been previously contacted and agreed to act as a referee.</td>
</tr>
<tr>
<td>1.4</td>
<td>Builder Experience</td>
<td>a) Describe the Builder’s experience and capability by providing a maximum of three examples of residential care facilities the Builder, and include the following information:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Name and location of facility;</td>
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<td></td>
<td></td>
<td>ii. Name of health authority;</td>
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<tr>
<td></td>
<td></td>
<td>iii. Number of beds;</td>
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<td></td>
<td></td>
<td>iv. Age of facility;</td>
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<td></td>
<td></td>
<td>v. How the building design addressed the unique needs of elderly residents; and</td>
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<tr>
<td></td>
<td></td>
<td>vi. Summary of actual budget and schedule for the Project against required budget and schedule.</td>
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<td></td>
<td></td>
<td>b) Provide a reference for each project listed in 1.4(a), including:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reference Name and Title</td>
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<td>• Organization</td>
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<td>• Telephone Number</td>
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<td>• Email Address</td>
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<td></td>
<td>Ensure each reference has been previously contacted and agreed to act as a referee.</td>
</tr>
<tr>
<td>1.5</td>
<td>Financial Capacity</td>
<td>To address the Minimum Requirements stated in Table 1 of Appendix A:</td>
</tr>
<tr>
<td>Section No.</td>
<td>Title</td>
<td>Contents (Package 2)</td>
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<td></td>
<td></td>
<td>a) Provide the following information for each of the Contractor, the Builder, the Care Provider, and the Guarantor(s) (if applicable):</td>
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<tr>
<td></td>
<td></td>
<td>i. Copies of annual audited financial statements and the notes to the financial statements, or other similar financial information, for each of the last three fiscal years (entire annual reports should not be provided);</td>
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<tr>
<td></td>
<td></td>
<td>ii. If available, copies of the interim financial statement for each quarter since the last fiscal year for which audited statements are provided;</td>
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<td></td>
<td>iii. Details of any material off-balance sheet financing arrangements currently in place;</td>
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<td></td>
<td>iv. Details of any material events that may affect the entity’s financial standing since the last annual or interim financial statements provided;</td>
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<tr>
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<td></td>
<td>v. Details of any credit rating, including any downgrades of credit rating in last five years;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>vi. Details of any bankruptcy, insolvency, company creditor arrangement or other insolvency proceedings in the last three fiscal years, and any litigation or other material adverse proceedings (arbitration or regulatory investigations or proceedings) that are still outstanding that may affect the Respondent Team’s ability to perform its obligations in relation to the Project; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>vii. For entities where financial statements are provided for a parent company, rather than the entity listed in a) provide evidence of the parent company’s willingness to act as a Guarantor, providing a guarantee in respect of the entity listed in this section a).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) With reference to the information provided in Section a), briefly describe in the context of the entity’s proposed role and project obligations:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. The Contractor’s capacity to fund the Project (e.g. discuss credit rating, net assets, liquid assets, letters of commitment);</td>
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<tr>
<td></td>
<td></td>
<td>ii. The Builder’s capacity to undertake its project obligations (e.g. discuss net and total asset size relative to Project scope, financial viability and ability to provide performance security, and describe support of the Builder, including by a Guarantor (as applicable)); and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>iii. The Care Provider’s capacity to undertake its project obligations (e.g. financial viability, revenues relative to the size of the Project).</td>
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<td></td>
<td>c) Demonstrate the financial capacity of the Contractor by providing the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Written confirmation, generally in the form of the Insurance Undertakings contained in Appendix K and Appendix L, from an insurer, that the following coverages will be available for the Project if the Proponent is awarded a contract:</td>
</tr>
</tbody>
</table>
|             |       | ▪ Commercial general liability insurance coverage of not less than $10 million inclusive per occurrence; $20 million general aggregate for bodily injury; death and damage to

**partnerships**

*British Columbia*
<table>
<thead>
<tr>
<th>Section No.</th>
<th>Title</th>
<th>Contents (Package 2)</th>
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<tbody>
<tr>
<td></td>
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<td>property including loss of use thereof; product/completed operations liability with a limit of $10 million annual aggregate; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Professional liability insurance coverage of not less than $5 million per occurrence and $5 million aggregate.</td>
</tr>
<tr>
<td>1.6</td>
<td>Key Individuals</td>
<td>a) Provide the name and relevant experience for each of the following Key Individuals (If one individual is serving as two or more of these Leads, please provide the information only once):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Builder's Lead; and</td>
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<td></td>
<td></td>
<td>ii. Director of Care</td>
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<td></td>
<td></td>
<td>iii. Contractor's Lead</td>
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<td></td>
<td></td>
<td>b) Provide references for each of the Key Individuals listed in Section 1.6, including:</td>
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<tr>
<td></td>
<td></td>
<td>i. Reference Name and Title;</td>
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<td>ii. Organization;</td>
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<td>iii. Telephone Number; and</td>
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<td></td>
<td></td>
<td>iv. Email Address.</td>
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<tr>
<td></td>
<td></td>
<td>Ensure each reference has been previously contacted and agreed to act as a referee.</td>
</tr>
<tr>
<td>2.</td>
<td>Service Delivery</td>
<td>Proposal Requirements</td>
</tr>
<tr>
<td>2.1</td>
<td>Approach</td>
<td>a) Describe the Care Provider's philosophy, mission, values, beliefs and policies with regard to the provision of care services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) Outline how the Proponent will develop services in conjunction with evidence-based leading practices, health management data, the Owner's strategic goals, value for money and compliance with regulatory requirements described in the RCSA.</td>
</tr>
<tr>
<td>2.2</td>
<td>Staffing</td>
<td>a) Describe the Care Provider's care model and provide details using the spreadsheet in Appendix J. For the Northeast Avalon Facility only, provide a separate care model for the 48 Beds for residents with mild to moderate dementia.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) Provide the Care Provider's human resources philosophy and staffing plan for the Facility that includes the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Staff recruitment, screening and hiring strategy;</td>
</tr>
<tr>
<td>Section No.</td>
<td>Title</td>
<td>Contents (Package 2)</td>
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<tr>
<td>-------------</td>
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<td></td>
<td>ii. Start up / orientation and ongoing training;</td>
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<td></td>
<td>iii. Professional development and education policy and opportunities;</td>
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<td></td>
<td>iv. Competency monitoring and on-site supervision (days, weekends, statutory holidays and emergencies);</td>
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<td></td>
<td></td>
<td>v. Physician availability, coverage and payment mechanism; and</td>
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<td></td>
<td>vi. Plan for on-site supervision (include days, weekends, statutory holidays, and emergencies).</td>
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<tr>
<td>c)</td>
<td></td>
<td>Describe the Care Provider’s plan for Facility start-up.</td>
</tr>
<tr>
<td>d)</td>
<td></td>
<td>Describe the programs that the Care Provider will implement to enhance residents’ physical, mental, and emotional well-being.</td>
</tr>
<tr>
<td>e)</td>
<td></td>
<td>Describe the approach to food planning and preparation.</td>
</tr>
<tr>
<td>2.3</td>
<td>Quality Improvement and Assurance Plan</td>
<td>a) Describe the Care Provider’s quality improvement and assurance plan for the Facility.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) Describe the Care Provider’s performance measurement plan, including how program outcomes and client satisfaction will be achieved.</td>
</tr>
<tr>
<td>2.4</td>
<td>Care Services Value Add</td>
<td>a) Describe any innovations or value add propositions the Care Provider can offer in addition to meeting the requirements of the RCSA.</td>
</tr>
<tr>
<td>3.</td>
<td>FACILITY</td>
<td></td>
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<tr>
<td>3.1</td>
<td>Site</td>
<td>a) Provide a description of the site where the Builder intends to construct the Facility, including size, municipal address and legal description.</td>
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<tr>
<td></td>
<td></td>
<td>b) Describe the ownership status – if not under the ownership of the Builder at the Submission Time for Proposals, describe the extent to which it has been secured.</td>
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<tr>
<td></td>
<td></td>
<td>c) Describe the current zoning and, where applicable, the status of re-zoning and the average length of time for a re-zoning process for the City;</td>
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<td>d) Describe current status of servicing to the site and any unique requirements; and</td>
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<td>e) Describe how the site characteristics meet the requirements of the SOR Agreement.</td>
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<td>3.2</td>
<td>Building Design and Layout</td>
<td>Submit floor plans and supporting materials necessary to demonstrate that the Facility meets the program requirements as described in Schedule A of the SOR Agreement [Functional Requirements].</td>
</tr>
<tr>
<td>Section No.</td>
<td>Title</td>
<td>Contents (Package 2)</td>
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</table>
| 3.3        | Maintenance and Life Cycle    | a) Describe approach to building maintenance, janitorial services, site maintenance, and snow clearing.  
b) Provide a preliminary schedule of major building element replacements or rehabilitations planned over the term of the RCSA. |
| 3.4        | Schedule                      | Provide a project schedule indicating when the Facility will be constructed and ready for occupancy. |
| 4.0        | FINANCIAL                     | Proposal Requirements                                                                 |
| 4.1        | Pricing Proposal              | a) Provide a Per Diem per resident based on the following two components:  
i. the Protected Envelope comprised of Program Costs and Raw Food Costs; and  
ii. the Unprotected Envelope comprised of all other costs.  
b) Provide a breakdown of the costs associated with the Protected and Unprotected Envelopes using the spreadsheet in Appendix J.  
c) For the Northeast Avalon Facility only, provide a separate Per Diem per resident and cost breakdown for the 48 Beds for residents with mild to moderate dementia. |
| 4.2        | Alternative Pricing Proposal  | Provide an Alternative Pricing Proposal based on an alternative contract structure that includes the RCSA and a standard commercial lease agreement generally in the form of the Indicative Lease Agreement. |
| 4.4        | Multiple Facility Discount    | a) If a Multiple Facility Discount is proposed, indicate the adjusted prices and associated conditions for the prices to be applied. |
APPENDIX C PARTICIPATION AGREEMENT

[Insert Month, Day Year]

Government of Newfoundland and Labrador
c/o Partnerships British Columbia Inc.
300 – 707 Fort Street
Victoria, BC V8W 3G3

Attention: Catherine Silman, Contact Person

Dear Sirs/Mesdames:

Re: Newfoundland and Labrador Long Term Care Project – Participation Agreement in respect of the Request for Proposals issued by the Government of Newfoundland and Labrador on June 30, 2015 as amended or otherwise clarified from time to time, including by all Addenda (the "RFP")

This letter agreement sets out the terms and conditions of the Participation Agreement between [Insert Name of Proponent] (the "Proponent") and the GNL, pursuant to which the Proponent agrees with the GNL as follows:

(a) Defined Terms. Capitalized terms not otherwise defined in this Participation Agreement have the meanings given to them in the RFP.

(b) Participation. The Proponent agrees that as a condition of participating in the RFP, including the Competitive Selection Process, Proponents' Meeting, Collaborative Meeting and access to the Data Room, the Proponent will comply with the terms of this Participation Agreement and the terms of the RFP.

(c) Confidentiality. The Proponent will comply with, and will ensure that all of the Proponent Team members and others associated with the Proponent also comply with, the confidentiality conditions attached as Schedule 1 to this Participation Agreement, all of which conditions are expressly included as part of this Participation Agreement.

(d) Terms of RFP. The Proponent will comply with and be bound by, and will ensure that all of the Proponent Team members and others associated with the Proponent also comply with and are bound by, the provisions of the RFP, all of which are incorporated into this Participation Agreement by reference. Without limiting the foregoing the Proponent agrees:

(1) that the terms of this Participation Agreement do not limit the Proponent's obligations and requirements under the RFP, any Data Room agreement, or any other document or requirement of the GNL; and
(2) to be bound by the disclaimers, limitations and waivers of liability and claims and any indemnities contained in the RFP, including Section 10.11 (Limitation of Damages) of the RFP.

(e) Amendments. The Proponent acknowledges and agrees that:

(1) the GNL may in its discretion amend the RFP at any time and from time to time; and

(2) by submitting a Proposal the Proponent accepts, and agrees to comply with, all such amendments and, if the Proponent does not agree to any such amendment, the Proponent’s sole recourse is not to submit a Proposal.

(f) General.

(1) Capacity to Enter Agreement. The Proponent hereby represents and warrants that:

i. it has the requisite power, authority and capacity to execute and deliver this Participation Agreement;

ii. this Participation Agreement has been duly and validly executed by it, or on its behalf by the Proponent’s duly authorized representatives; and

iii. this Participation Agreement constitutes a legal, valid and binding agreement enforceable against it in accordance with its terms.

(2) Survival following cancellation of the RFP. Notwithstanding anything else in this Participation Agreement, if the GNL, for any reason, cancels the Competitive Selection Process or the RFP, the Proponent agrees that it continues to be bound by, and will continue to comply with, Section (c) of this Participation Agreement.

(3) Severability. If any portion of this Participation Agreement is found to be invalid or unenforceable by law by a court of competent jurisdiction, then that portion will be severed and the remaining portion will remain in full force and effect.

(4) Enurement. This Participation Agreement enures to the benefit of the GNL and binds the Proponent and its successors.

(5) Applicable Law. This Participation Agreement is deemed to be made pursuant to the laws of the Province of Newfoundland and Labrador and the laws of Canada applicable therein and will be governed by and construed in accordance with such laws.

(6) Headings. The use of headings is for convenience only and headings are not to be used in the interpretation of this Participation Agreement.

Newfoundland Labrador
(7) **Gender and Number.** In this Participation Agreement, words imputing any gender include all genders, as the context requires, and words in the singular include the plural and vice versa.

(8) **Including.** The word including when used in this Participation Agreement is not to be read as limiting.

Yours truly.

__________________________
(Name of Proponent)

__________________________
(Name of Proponent's Representative)

__________________________
Authorized Signatory

__________________________
E-mail Address

__________________________
Name of Authorized Signatory (please print)

__________________________
Telephone Number
SCHEDULE 1 – Confidentiality Conditions

(a) Definitions. In these confidentiality conditions:

(1) Confidential Information means all documents, knowledge and information provided by the Disclosing Party to, or otherwise obtained by, the Receiving Party, whether before or after the date of the RFP, whether orally, in writing or other visual or electronic form in connection with or relevant to the Project, the RFP or the Competitive Selection Process, including, without limitation, all design, operational and financial information, together with all analyses, compilations, data, studies, photographs, specifications, manuals, memoranda, notes, reports, maps, documents, computer records or other information in hard copy, electronic or other form obtained from the Disclosing Party or prepared by the Receiving Party containing or based upon any such information. Notwithstanding the foregoing, Confidential Information does not include information which:

   i. is or subsequently becomes available to the public, other than through a breach by the Receiving Party of the terms of this Schedule 1;

   ii. is subsequently communicated to the Receiving Party by an independent third party, other than a third party introduced to the Receiving Party by the Disclosing Party or connected with the Project, without breach of this Schedule 1 and which party did not receive such information directly or indirectly under obligations of confidentiality;

   iii. was rightfully in the possession of the Receiving Party or was known to the Receiving Party before the date of the RFP and did not originate, directly or indirectly, from the Disclosing Party;

   iv. was developed independently by the Receiving Party without the use of any Confidential Information; or

   v. is required to be disclosed pursuant to any judicial, regulatory or governmental order validly issued under applicable law;

(2) Disclosing Party means the GNL or any of its Representatives;

(3) Permitted Purposes means evaluating the Project, preparing a Proposal, and any other use permitted by the RFP or this Participation Agreement;

(4) Receiving Party means a Proponent or any of its Representatives;

(5) Representative means a director, officer, employee, agent, accountant, lawyer, consultant, financial advisor, subcontractor, Equity Provider, Key Individual, Project team members or any other person contributing to or involved with the preparation or evaluation of Proposals or
proposals, as the case may be, or otherwise retained by the Receiving Party, the GNL or Partnerships BC in connection with the Project.

(b) Confidentiality. The Receiving Party will keep all Confidential Information strictly confidential and will not without the prior written consent of the GNL, which may be unreasonably withheld, disclose, or allow any of its Representatives to disclose, in any manner whatsoever, in whole or in part, or use, or allow any of its Representatives to use, directly or indirectly, the Confidential Information for any purpose other than the Permitted Purposes. The Receiving Party will make all reasonable, necessary, and appropriate efforts to safeguard the Confidential Information from disclosure to any other person except as permitted in this Schedule 1, and will ensure that each of its Representatives agrees to keep such information confidential and to act in accordance with the terms contained herein.

(c) Ownership of Confidential Information. The GNL owns all right, title and interest in the Confidential Information and, subject to any disclosure requirements under applicable law, and except as permitted by this Schedule 1, the Receiving Party will keep all Confidential Information that the Receiving Party receives, has access to, or otherwise obtains strictly confidential for a period of three years after the date of the RFP, and will not, without the prior express written consent of an authorized representative of the GNL, which may be unreasonably withheld, use, divulge, give, release or permit or suffer to be used, divulged, given or released, any portion of the Confidential Information to any other person for any purpose whatsoever.

(d) Limited Disclosure. The Receiving Party may disclose Confidential Information only to those of its Representatives who need to know the Confidential Information for the purpose of evaluating the Project and preparing its Proposal or proposal as applicable and on the condition that all such Confidential Information be retained by each of those Representatives as strictly confidential. The Receiving Party will notify Partnerships BC, on request, of the identity of each Representative to whom any Confidential Information has been delivered or disclosed.

(e) Destruction on Demand. On written request, the Receiving Party will promptly deliver to Partnerships BC or destroy all documents and copies thereof in its possession or control constituting or based on the Confidential Information and the Receiving Party will confirm that delivery or destruction to Partnerships BC in writing, all in accordance with the instructions of Partnerships BC (for this purpose information stored electronically will be deemed destroyed upon removal from all storage systems and devices); provided, however, that the Receiving Party may retain one copy of any Confidential Information which it may be required to retain or furnish to a court or regulatory authority pursuant to applicable law.

(f) Acknowledgment of Irreparable Harm. The Receiving Party acknowledges and agrees that the Confidential Information is proprietary and confidential and that the GNL or Partnerships BC may
be irreparably harmed if any provision of this Schedule 1 were not performed by the Receiving Party or any party to whom the Receiving Party provides Confidential Information in accordance with its terms, and that any such harm could not be compensated reasonably or adequately in damages. The Receiving Party further acknowledges and agrees that the GNL will be entitled to injunctive and other equitable relief to prevent or restrain breaches of any provision of this Schedule 1 by the Receiving Party or any of its Representatives, or to enforce the terms and provisions hereof, by an action instituted in a court of competent jurisdiction, which remedy or remedies are in addition to any other remedy to which the GNL may be entitled at law or in equity.

Waiver. No failure to exercise, and no delay in exercising, any right or remedy under this Schedule 1 by the GNL will be deemed to be a waiver of that right or remedy.
APPENDIX D PROPOSAL DECLARATION FORM

1. This Proposal Declaration Form will be executed by the Proponent.

2. By executing this Proposal Declaration Form, the Proponent agrees to the provisions of this RFP and this Proposal Declaration Form.

3. Capitalized terms in this Proposal Declaration Form are defined in Section 10 of this RFP.

[Proponent's Letterhead]

To: [Insert organization and Submission Location]

Attention: [Insert Contact Person]

Re: Request for Proposals entitled [Insert Project Name]

[Insert Proponent Name] Response

In consideration of the GNL's agreement to consider Proposals in accordance with the terms of this RFP, the Proponent hereby agrees, confirms and acknowledges, on its own behalf and on behalf of each member of the Proponent Team, that:

(a) Proposal

(1) this Proposal Declaration Form has been duly authorized and validly executed;

(2) the Proponent is bound by all statements and representations in its Proposal;

(3) its Proposal is in all respects a fair Proposal made without collusion or fraud; and

(4) the GNL reserves the right to verify information in the Proponent's Proposal and conduct any background investigations including criminal record investigations, verification of the Proposal, credit enquiries, litigation searches, bankruptcy registrations and taxpayer information investigations or other investigations on all or any of the Proponent Team members, and by submitting a Proposal the Proponent agrees that they consent to the conduct of all or any of those investigations by the GNL.
(b) Acknowledgements with Respect to this RFP

(1) the Proponent has received, read, examined and understood the entire RFP including all of the terms and conditions, all documents listed in this RFP's Table of Contents, and any and all Addenda;

(2) the Proponent agrees to be bound by the entire RFP including all of the terms and conditions, including without limitation Section 9, all documents listed in this RFP's Table of Contents, and any and all Addenda;

(3) the Proponent's representative identified below is fully authorized to represent the Proponent in any and all matters related to its Proposal, including but not limited to providing clarifications and additional information that may be requested in association with this RFP;

(4) the Proponent has disclosed all relevant relationships, in accordance with the instructions and format outlined in the Relationship Disclosure Form; and

(5) the Proponent has had sufficient time to consider, and has satisfied itself as to the applicability of the material in this RFP and any and all conditions that may in any way affect its Response.

(c) Evaluation of Responses

(1) this RFP is not an offer, a tender or a request for qualifications; it is a Request for Proposals and the responsibility of the GNL is limited to consider Proposals in accordance with this RFP.

(d) Consent of Proponent Team

(1) the Proponent has obtained the express written consent and agreement of each member of the Proponent Team, as listed below, to all the terms of this Proposal Declaration Form.

(e) The Proponent Team consists of:

<table>
<thead>
<tr>
<th>Name of Proponent Team Member - Firm</th>
<th>Address</th>
<th>Role on Team</th>
<th>Equity Provider (Y/N)</th>
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APPENDIX E  RELATIONSHIP DISCLOSURE FORM

This form must be completed by the Proponent Team on its own behalf and on behalf of each member of the Proponent Team.

The Proponent declares on its own behalf and on behalf of each member of the Proponent Team that:

(a) this declaration is made to the best of the knowledge of the Proponent and, with respect to relationships of each member of the Proponent Team, to the best of the knowledge of that member;

(b) the Proponent and the members of the Proponent Team have reviewed the definition of Restricted Parties and the non-exhaustive list of Restricted Parties;

(c) the following is a full disclosure of all known relationships the Proponent and each member of the Proponent Team has, or has had, with:

(1) the GNL;

(2) any listed Restricted Party;

(3) any current employees, shareholders, directors or officers, as applicable, of the GNL or any listed Restricted Party;

(4) any former shareholders, directors or officers, as applicable, of the GNL or any listed Restricted Party, who ceased to hold such position within two calendar years prior to the Submission Time for Proposals; and

(5) any other person who, on behalf of the GNL or a listed Restricted Party, has participated or been involved in the Competitive Selection Process or the design, planning or implementation of the Project or has confidential information about the Project or the Competitive Selection Process.
<table>
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<tr>
<th>Name of PropONENT Team Member</th>
<th>Name of Party with Relationship (e.g., list GNL, Restricted Party)</th>
<th>Details of the Nature of the Relationship with the listed Restricted Party/Person (e.g., Proponent Team member was an advisor to the Restricted Party from 2005-2006)</th>
</tr>
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<tbody>
<tr>
<td>e.g. Firm Name Ltd.</td>
<td>Partnerships BC</td>
<td>Firm Name Ltd. is working with Partnerships BC on Project X.</td>
</tr>
<tr>
<td>e.g. John Smith</td>
<td>GNL Name</td>
<td>Employee from 19XX – 20XX</td>
</tr>
</tbody>
</table>

(Each Proponent Team to submit one Relationship Disclosure Form. Add additional pages as required. Corporate disclosures need only be provided once and not repeated for every individual of that company).

NAME OF PROPOSENT:

Name of Firm – Proponent:

Address:

Email Address:

Telephone:

Name of Authorized Signatory for Proponent:

Signature:

If the Proponent is a joint venture, consortium or special purpose entity – by each of its joint venture or consortium members, as applicable, as identified in the Proposal as the Contractor or the Proponent Team lead(s), or as otherwise acceptable to the GNL.
APPENDIX F  PROPOONENT COMMENTS FORM

(Collaborative Meeting – s. 4.3(b))

Newfoundland and Labrador Long Term Care Project

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<tr>
<th>Section</th>
<th>Proposed Change (including detailed drafting)</th>
<th>Reasons for Proposed Change</th>
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APPENDIX G  PREFERRED PROPONENT SECURITY DEPOSIT

[Note: The Preferred PropONENT Security Deposit should be a Letter of Credit substantially in the following form, issued by, or confirmed by, a Canadian chartered bank acceptable to the GNL in its discretion and be callable at the bank’s counters in St. John’s, NL.]

TO: <Insert relevant Regional Health Authority>
<>
(the “Beneficiary”)

RE PREFERRED PROPONENT SECURITY DEPOSIT

IRREVOCABLE LETTER OF CREDIT NO:___

Dear Sirs:

At the request of our client, __________________ (the Customer), we hereby issue in your favour our irrevocable letter of credit No. ____________________ (Letter of Credit) for a sum not exceeding in the aggregate one hundred thousand dollars (CDN $100,000) effective immediately.

This bank will immediately pay to you under this Letter of Credit any amount or amounts claimed, not exceeding in the aggregate the sum of CDN $100,000 upon your written demand(s) for payment being made upon us at our counter during normal business hours. [Note: insert address of Bank in St. John’s, NL], Canada referencing this irrevocable Letter of Credit No. _____________ dated ____________.

Partial drawings are permitted.

This Letter of Credit is issued subject to Uniform Customs and Practice for Documentary Credits, 2007 Revision, ICC Publication No. 600.

Drawings up to the full amount of the Letter of Credit may be made where the drawing is accompanied by a certificate executed by an authorized signatory of the Beneficiary stating that:

(a) the person signing the certificate is an authorized signatory of the Beneficiary; and

Newfoundland Labrador partnerships British Columbia
(b) the Beneficiary is entitled to draw upon this Letter of Credit.

Any drawings made under this Letter of Credit must be accompanied by the original or certified copy of this Letter of Credit, together with an original certificate complying with the conditions set out above.

We will honour your written demand(s) for payment on presentation without enquiring whether you have a legitimate claim between yourself and our said Customer.

All banking charges are for the account of the Customer.

This Letter of Credit will remain in full force and effect and, unless renewed, will expire at the close of business on [Insert Date].

Notice of non-renewal will be provided to the Beneficiary in writing by registered mail by not later than 20 Business Days before the expiry date.

________________________________________  _________________________________________
Authorized Signatory                        Authorized Signatory
APPENDIX H. INITIAL DRAFT RESIDENTIAL CARE SERVICES AGREEMENT

Posted in Data Room.
APPENDIX I  INITIAL DRAFT STATEMENT OF REQUIREMENTS AGREEMENT

Posted in Data Room.
APPENDIX J: CARE MODEL AND CAPITAL COST SPREADSHEET

Posted in Data Room.
APPENDIX K  INSURANCE UNDERTAKINGS - COMMERCIAL

UNDERTAKING OF COMMERCIAL GENERAL LIABILITY INSURANCE

Name of Proponent submitting a Proposal to the Request for Proposals for the Newfoundland and Labrador Long Term Care Project:

_____________________________________________________________________

We, the undersigned, as authorized representatives on behalf of [Insert Name of Insurance Provider] do hereby undertake and agree to provide "Wrap-Up" Commercial General Liability Insurance in the amount of TEN MILLION DOLLARS ($10,000,000.00) inclusive per occurrence, TWENTY MILLION DOLLARS ($20,000,000.00) general aggregate for bodily injury, death and damage to property including loss of use thereof, product/completed operations liability with a limit of TEN MILLION DOLLARS ($10,000,000.00) annual aggregate for the Whitehorse Continuing Care Project, subject to underwriting.

If such a policy is written, a certified copy of the policy will be provided to the Government of Newfoundland and Labrador.

Dated at ____________________________________________________________________

This __________ day of ____________________, 20___

SIGNED: ___________________________________________________________________

(Duly Authorized Representative of Insurance Company)
APPENDIX L  INSURANCE UNDERTAKINGS - PROFESSIONAL

UNDERTAKING OF PROFESSIONAL LIABILITY INSURANCE

Name of Proponent submitting a Proposal to the Request for Proposal for the Newfoundland and Labrador Long Term Care Project:


We, the undersigned, as authorized representatives on behalf of [Insert Name of Insurance Provider] do hereby undertake and agree to provide Single Project Group Professional Liability insurance in the amount of not less than FIVE MILLION DOLLARS ($5,000,000.00) inclusive of any one claim for the Newfoundland and Labrador, subject to underwriting.

If such a policy is written, a certified copy of the policy will be provided to the Government of Newfoundland and Labrador.

Dated at ________________________________

This __________ day of __________________, 20___

SIGNED: ________________________________

(Duly Authorized Representative of Insurance Company)
Contract No: XXXX-NH

STATEMENT OF REQUIREMENTS AGREEMENT dated the ______ day of __________, 2015

BETWEEN:

__________________________________________
REGионаl Health Authority
(hereinafter referred to as the "Regional Health Authority") established and existing under and pursuant to the Regional Health Authorities Act, S.N.L. 2006, chapter R - 7.1

of the First Part

- and -

__________________________________________
XXX, (hereinafter referred to as the Contractor [ insert the name(s) of the Group, Joint Venture or other Juridical Entity defined in the Contractor's Proposal as accepted by the Regional Health Authority that will be responsible for developing the Facility and providing its services]

of the Second Part

WHEREAS

• The Regional Health Authority and the Contractor are parties to a Residential Care Service Agreement pursuant to which the Contractor intends to construct and operate a new ____ bed long term care facility in ____________, Newfoundland and Labrador;

• The Residential Care Service Agreement requires that the Contractor provide services in facilities with particular physical requirements and characteristics;

• The Contractor wishes to ensure the facility to be constructed to provide the services under the Residential Care Service Agreement will meet the requirements of the RCSA and obtain the approval required for the commencement of that Agreement;

WITNESS that in consideration of the mutual covenants, promises and agreements contained herein, and other good and valuable consideration, the Parties to this Agreement agree as follows:

ARTICLE 1 - DEFINITIONS

1.1 In this Agreement, the following terms have the meanings set out below:
(a) "Agreement" means this Agreement, including the Schedules and Appendices to this Agreement, as it or they may be amended or supplemented from time to time;

(b) "Applicable Law" means, with respect to any Person, property, transaction, event or other matter, any law, rule, statute, regulation, order, judgment, decree, treaty or other requirement having the force of law relating or applicable to such Person, property, transaction, event or other matters. Applicable Law also includes, where appropriate, any interpretation of the law (or any part) by any Person with jurisdiction over it, or charged with its administration or interpretation;

(c) "Approved Budget" means the total combined budget for the Facility determined in accordance with the Residential Care Service Agreement;

(d) "Beds" mean the Long Term Care Beds and any other Beds that are approved for the Contractor pursuant to this Agreement;

(e) "Business Day" means any day except Saturday, Sunday or other day on which the Newfoundland and Labrador Provincial Government is not open for business;

(f) "Confidential Information" means any and all information of which either Party becomes aware, or which one Party received (either directly or indirectly) from the other Party or otherwise, in connection with or relating to the RSCE or this Agreement, including all personal information and records, and all business, technical, and other proprietary information of either Party;

(g) "Contractor's Personnel" means the controlling shareholders (if any), directors, officers, employees, agents or other representatives of the Contractor and any team members and affiliates and their shareholders, directors, officers, employees, agents or other representatives. For the purposes of Article 8 (Liability and Indemnification) only, "Contractor's Personnel" shall, in addition to the foregoing, include the contractors and subcontractors for the construction and their respective shareholders, directors, officers, employees, agents or other representatives;

(h) "Day" means a calendar day;

(i) "Department" means the Newfoundland and Labrador Department of Health and Community Services;

(j) "Design Development" means the preparation by an architect or engineer or by both based on schematic design studies for the Facility, for review by the Regional Health Authority of the design development documents for the Facility and the Beds and the Services consisting of drawings and other documents and narrative that fix and describe the size and character of the entire project as to structural, mechanical and electrical systems, materials and such other essentials as may be appropriate and in keeping with the Statement of Requirements.
(k) "Development of Beds and Services and Facility" means the taking and completion by the Contractor of all steps necessary to ready the Beds for Occupancy by the Occupancy Date and the Services ready for delivery at the Facility that the Contractor is developing for such purpose in accordance with the Residential Care Service Agreement, including provision of a site for the Facility that will be owned by the Contractor and be the Site, and the design, construction, and all other work to be performed and steps taken by or on behalf of the Contractor to complete the Facility (including the furnishing, fittings, and equipment thereof);

(l) "Facility" means the Long Term Care Facility being developed by the Contractor pursuant to the Agreement for which the Beds and Services are being approved and for greater certainty, includes the Beds and the common areas and common elements which will be used for the Beds developed and Services and the related services by the Contractor pursuant to this Agreement, but excludes any other part of a building which will be used for purposes not directly related to the Beds and Services and related services approved pursuant to this Agreement, and includes furnishings, fittings and equipment and any and all other assets and personal property related to the same;

(m) "Force Majeure" has the meaning set forth in Section 8.5;

(n) "Newfoundland and Labrador Long Term Care Operational Standards" includes the policies, guidelines, directives and information as listed in Schedule "C" related to Long Term Care and the operation of the Beds and provision of the Services, and includes any amendments to the same made by the Regional Health Authority and/or the Department and any statute or regulation of the Province of Newfoundland and Labrador that replaces, supplements or modifies the same;

(o) "Occupancy" means the admission of the first person as a Resident of the Facility and the commencement of the delivery of Services;

(p) "Occupancy Date" has the meaning as set out in the RCSA;

(q) "Party" means a Party to this Agreement, and any references to a Party includes the successor and permitted assigns;

(r) "Person" is to be broadly interpreted and includes an individual, a corporation, a partnership, a trust, a joint venture, an unincorporated organization, an association, the government of a country or any political subdivision thereof, or any agency or department of any such government, and the executors, administrators or other legal representatives of an individual in such capacity;

(s) "Pre-Approval Inspection" means the review to be conducted by the Regional Health Authority and or the Department as specified in Section 3.1 to determine if the Facility, the Beds and the Service warrant the granting of Service Approval;
“Proposal” means the Contractor’s Proposal, entitled “___________ Long Term Care Bed Facility and related Services”, attached to and incorporated into this Agreement as Schedule “B”;

“Province” means the Province of Newfoundland and Labrador;

“Resident” means a person who is admitted to a Facility in accordance with the Facility Placement Policy of the Regional Health Authority as referenced in the Newfoundland and Labrador Long Term Care Operational Standards;

“Residential Care Service Agreement” means the agreement between the Parties executed contemporaneously with this Agreement and which sets out the terms and conditions for the supply of Beds and Services to the RHA by the Contractor through the Facility;

“Request for Proposals” means the request for proposals issued by Newfoundland and Labrador Provincial Government on behalf of the Regional Health Authority and any amendments thereto which resulted in this Agreement

“Service Approval” means the approval issued by the Regional Health Authority with the consent of the Department or by the Department (as the case might be) pursuant to and in accordance with the Service Approval Process.

“Service Approval Inspection” has the meaning set forth in Section 3.4;

“Service Approval Process” means the process referenced in Article 3 of this Agreement;

“Services” includes accommodation, programs, goods, social work services, physiotherapy services, dietary services, recreational therapy and occupational therapy services, dietician services, pharmaceutical management, and personal and skilled nursing care related to the Beds and the Facility to be developed under this Agreement and to be operated under the Residential Care Service Agreement;

“Site” means the Site approved by the Regional Health Authority pursuant to the Request for Proposals and the Proposal on which the Facility will be situated;

“Statement of Requirements” means the Regional Health Authority’s statement of requirement for the Facility which is attached as Schedule “A” to this Agreement.

“Step” means the sequential increments of the Statement of Requirements;

“Subcontractor” means a supplier (other than a general contractor or construction manager) who or which supplies equipment, other goods or services for the construction;
(gg) “Submission Reports” means those submissions referenced in the Statement of Requirements; and

(hh) “Term” means the term of this Agreement as set forth in Section 8.1 (Term).

1.2 **Headings and Division**

The division of this Agreement into Articles and Sections and the insertion of headings are for convenience of reference only, and are not intended to effect the construction or interpretation of this Agreement.

1.3 **Calculation of Time**

Unless otherwise specified, time periods within or following which any payment is to be made or any act is to be done shall be calculated by excluding the day on which the period commences and including the day on which the period ends.

1.4 **Number and Gender**

Unless the context requires otherwise, words importing the singular include the plural and vice versa and words importing gender include all genders.

1.5 **Including**

The word “including” when following any general term or statement to the specific matter immediately following the word “including” or to similar matters, and the general term or statement will be construed as referring to all matters that reasonably could fall with the broadest possible scope of the general term or statement.

1.6 **Statute**

Unless otherwise specified, each reference to a statute is deemed to be a reference to that statute, as amended or re-enacted from time to time, and each reference to a statute is a Newfoundland and Labrador statute.

1.7 **Schedules and Appendices**

The following Schedules and Appendices are incorporated into and form part of this Agreement:

(a) Schedule “A” – Statement of Requirements;

(b) Schedule “B” – Contractor’s Proposal;

(c) Schedule “C” – Newfoundland and Labrador Long Term Care Operational Standards;
(d) Schedule “D” - Facility Development Status Report; and

(e) Schedule “E” – Site and Facility Location - Specific Requirements

ARTICLE 2 - DEVELOPMENT OF BEDS AND SERVICES AND FACILITY

2.1 Development of Beds and Services and Facility

(1) The Contractor shall cause the Development of Beds and Services and Facility to occur in accordance with all Applicable Law, this Agreement and the Schedules and Appendices to this Agreement. Specifically, the Contractor will develop the Facility in accordance with the Contractor's Proposal as set out in Schedule “B”, and the Site-specific provisions in Schedule “E”, subject to this Agreement.

(2) Subject to compliance with the processes of Article 3, the RHA acknowledges that compliance with this Agreement in the Development of Beds and Services and Facility will result in a Facility which is given Service Approval under the RCSA.

2.2 Cost and Financing

(1) The construction, design, furnishing, fittings, and equipment of the Facility are at the sole cost of the Contractor.

(2) The RHA shall have no liability for any costs relating to the construction, design, furnishing, fittings, and equipment of the Facility as a result of this Agreement. Notwithstanding that any process under this Agreement through which the Contractor may incur additional costs as a result of consultation with the RHA, the RHA shall have no liability for such costs and any such costs shall be at the exclusive risk of the Contractor. Other than making the payments contemplated and provided for in the Residential Care Service Agreement, the Regional Health Authority shall not have any legal or other obligations to make any payment to the Contractor under or pursuant to this Agreement or the Residential Care Service Agreement.

(3) The RHA shall have no liability under or any other responsibility for the terms and conditions of any financing arrangements that the Contractor may require or wish for any other reason to put in place related the Development of the Beds and the Services and the Facility.

(4) At the request of the RHA, the terms and conditions of any financing arrangements related to financing of the Development of the Beds and the Services and the Facility must be disclosed to the Regional Health Authority by the Contractor.

(5) The Regional Health Authority acknowledges that the Contractor’s financing arrangements may require various types of charges or encumbrances to be placed on and
registered against the Facility and its operation pursuant to the Residential Care Service Agreement. However any and all risk in connection with such financing and the debt servicing costs associated with the same including any and all costs of borrowing, renewal fees, and other applicable costs related to the same shall be to the sole responsibility of and at the risk of the Contractor.

2.3 Design Development Review Process

(1) The Contractor shall as part of this Agreement pursuant to the Statement of Requirements complete Design Development and provide in accordance with the Statement of Requirements ninety five percent (95%) complete construction drawings for review by the Regional Health Authority to ensure compliance with the Statement of Requirements.

(2) The Regional Health Authority and the Department shall review the Submission Reports and shall provide a response to the Contractor for each Submission, within fifteen (15) days of each submittal.

(3) The Contractor will provide monthly status reports in accordance with Schedule “D” or as agreed with the Regional Health Authority.

(4) Where the Regional Health Authority’s response is “approved with comments” or “not approved,” the Regional Health Authority shall provide in writing, comments or reasons for rejection.

(5) In the event the Contractor proceeds to the next Step without having received the Regional Health Authority’s approval as aforesaid, the Contractor will be required to meet the requirements for Regional Health Authority Approval for any such Step, at the Contractor’s sole cost.

(6) Where the Contractor is required to make changes and must re-submit the Submission Report, a new date and time for the Regional Health Authority’s response will be in effect in accordance with (2) above.

(7) In addition to the provisions relating to the extension of the Occupancy Date in the RCSA, where the Regional Health Authority fails to meet the response timelines for Submission Reports in (2) above and the Contractor can demonstrate that the delay in meeting the response timelines has resulted in a failure by the Contractor to meet the requirements for the Occupancy Date, the Occupancy Date shall be extended to the extent of such delay.

2.4 Inspection During Development of Beds and Services and Facility

(1) The Regional Health Authority shall be entitled, on twenty four (24) hours’ notice to the Contractor, at any time and from time to time on any Business Day before the Development of Beds and Services and Facility has been completed to enter upon the Site and inspect the Site, the Facility and progress of the Development of Beds and Services and Facility, provided that the Regional Health Authority shall not unduly interfere with or
cause the delay of the Development of Beds and Services and Facility during the course of such an inspection.

2.5 **Timing**

(1) The Contractor shall carry out and complete the Development of Beds and Services and Facility and shall ensure that Occupancy has been attained by the Occupancy Date. The Regional Health Authority may, at any time, in the Regional Health Authority’s sole and absolute determination, extend the Occupancy Date or any or all of the deadlines set forth in this Agreement.

(2) The Contractor shall submit to the Regional Health Authority any information relating to the Development of Beds and Services and Facility which the Regional Health Authority may request during and in connection with the Development of Beds and Services and Facility.

(3) The Contractor shall notify the Regional Health Authority in writing promptly if any Submission Report is overdue under the terms of this Agreement or upon becoming aware of any actual or threatened occurrence or condition which would reasonably be expected to cause a delay in meeting the Occupancy Date; and

(4) In the event of a delay, the Contractor will use its best efforts to perform its obligations under this Agreement, including rearranging and rescheduling the work on the Development of Beds and Services and Facility so as to minimize the ultimate delay in completion of the Development of Beds and Services and Facility (in a timely manner utilizing such and all resources reasonably required in the circumstances, including obtaining supplies or services from other sources if the same are reasonably available.)

(5) The Contractor shall be responsible for the care, maintenance and protection of the Development of Beds and Services and Facility in the event of a shutdown or delay.

2.6 **Change**

(1) The commitment in section 2.1(2) shall not apply where the Contractor implements any changes which cause an delay in meeting the Occupancy Date or affect the Development of Beds and Services and Facility in any material respect from what is required under this Agreement (including the Schedules hereto) without the prior written approval of the Regional Health Authority.

(2) The Contractor need not obtain approval of the Regional Health Authority, but shall notify the Regional Health Authority of a change if the change contemplated:

(a) will not cause any delay in meeting the Occupancy Date; and

(b) will not result in any non-compliance of the Development of Beds and Services and Facility with this Agreement, the Schedules, or any Applicable Law.
(3) Where the change contemplated is required by Applicable Law, the Contractor shall notify the Regional Health Authority.

2.7 Amendment

(1) No amendment of or departure from the terms and conditions of this Agreement will be effective unless evidenced by an agreement executed by both Parties, except that the Regional Health Authority may by providing notice of such amendments to the Contractor in writing, unilaterally amend all or any part of:

(a) this Agreement if the changes to Applicable Law require amendment;

(b) the Schedules hereto from time to time and at any time, acting reasonably; and

(c) any other provision of this Agreement and any document contemplated hereby that specifically provides that the Regional Health Authority is entitled to unilaterally amend such provision or document, acting reasonably. The Contractor will comply with such amended requirements within such period of time as the Regional Health Authority may in its notice require.

(2) The Regional Health Authority acknowledges and agrees if any such amendments, departures or changes are carried out by the Regional Health Authority, the Parties agree that to the extent such amendments, departures or changes result in an increase in any manner to the costs of the Development, such additional costs shall result in an applicable increase in the capital costs of the Development of Beds and Services and Facility as agreed upon by the Parties acting reasonably and an appropriate related adjustment in the Approved Budget as agreed upon by the Parties acting reasonably

2.8 Occupancy

(1) The Contractor shall in accordance with the Contractor’s Proposal as accepted by the Regional Health Authority carry out and complete the Development of the Beds and the Services and shall ensure that Occupancy has been attained by the Occupancy Date and that the Beds and Services are ready to be provided to Residents by the Contractor in accordance with this Agreement. The Regional Health Authority may, at any time, in the Regional Health Authority’s sole and absolute determination, extend the Occupancy Date or any or all of the deadlines set forth in this Agreement, if the Regional Health Authority determines that the Beds are Unavailable as of the Occupancy Date.

(2) The Contractor shall notify the Regional Health Authority in writing upon becoming aware of any actual or threatened occurrence or condition which would reasonably be expected to cause a delay in meeting the Occupancy Date set forth in the Agreement.

ARTICLE 3 - SERVICE APPROVAL

3.1 Pre-Approval Inspection
(1) The Contractor shall notify the Regional Health Authority in writing, twenty (20) Business Days prior to the date on which the Contractor reasonably expects Occupancy to be attainable.

(2) Once the Contractor has notified the Regional Health Authority, the Regional Health Authority shall arrange a time and date with the Contractor for a Pre-Approval Inspection by the Regional Health Authority and/or the Department (as the case may be), which date for the Pre-Approval Inspection shall be within twenty (20) Business Days prior to the expected date of Occupancy in (1).

(3) The Regional Health Authority and the Department (as the case may be), shall be entitled at the time and on the date set for the Pre-Approval Inspection to enter upon the Site (including the Facility) to conduct the Pre-Approval Inspection.

3.2 Postponement

(1) If it is readily apparent to the Regional Health Authority, in the sole and absolute determination of the Regional Health Authority (as the case might be), that a substantial amount of further work is required on the Development of Beds and Services and Facility in order to attain Service Approval, the Regional Health Authority shall be entitled, at the Regional Health Authority's option, not to conduct or to complete the Pre-Approval Inspection. In such event, the Regional Health Authority shall notify the Contractor that the Regional Health Authority and/or the Department (as the case might be) will not conduct or complete the Pre-Approval Inspection at such time, and will, if requested, give reasons for the decision.

(2) The Contractor shall perform such further work on the Development of Beds and Services and Facility as is necessary in order to attain Service Approval and a new time and date for the Pre-Approval Inspection shall be arranged in accordance with Section 3.1.

3.3 Conditions

(1) The Regional Health Authority and/or the Department shall be entitled to impose on the Contractor conditions, acting reasonably and with reference to the scope and content of the Site and Facility contemplated by Schedules “A” and “B” attached hereto, for the approval of the Facility for Service Approval requiring the Contractor to repair, improve or modify any aspect of the Facility (for greater certainty, including the common areas and common elements which will be used, at least in part, for the Beds being developed by the Contractor pursuant to this Agreement but not including any other part of the building which will not be used for the Beds being developed by the Contractor pursuant to this Agreement. Such conditions shall be in writing.

(2) The Contractor shall complete all such repairs, improvements or modifications set out in subsection (1) within the time period specified by the Regional Health Authority and/or the Department. For greater certainty, the Regional Health Authority’s and/or the Department’s approval (as the case might be) of the Facility for Service Approval shall be
conditional on completion of such repairs, improvements or modifications to the satisfaction of the Regional Health Authority and/or the Department (as the case might be).

3.4 **Service Approval Inspection**

(1) Upon the Contractor further to Section 3.2 providing notice to the Regional Health Authority and/or the Department (as the case might be) that conditions giving rise to the Facility and the Beds and the Services not being ready for Pre-Approval Inspection have been remedied, the Regional Health Authority and/or the Department (as the case might be) shall conduct a Service Approval Inspection within ten (10) Business Days of receiving such notice.

3.5 **Service Approval**

(1) Within ten (10) Business Days following completion of a Service Approval Inspection, the Regional Health Authority and/or the Department (as the case might be) shall notify the Contractor, in writing, whether the Regional Health Authority and/or the Department (as the case might be) will grant Service Approval or not grant the Facility, the Beds and the Services Service Approval, together with the reasons for not granting Service Approval. If the Regional Health Authority and/or the Department (as the case might be) does not grant Service Approval to the Facility, the Beds and the Services (whether after the first or any subsequent Service Approval Inspection), the Contractor shall satisfy any conditions for Service Approval imposed by the Regional Health Authority and/or the Department (as the case might be) pursuant to Section 3.3 and address any other issues raised by the Regional Health Authority and/or the Department (as the case might be) in such notice to the satisfaction of the Regional Health Authority and/or the Department (as the case might be). In such case, the Regional Health Authority and/or the Department (as the case might be) may arrange and conduct one or more subsequent Service Approval Inspection in accordance with Section 3.4.

(2) In the event the Regional Health Authority and/or the Department (as the case might be) approves the Facility, the Beds and the Services, the Regional Health Authority and/or the Department (as the case might be) shall grant Service Approval to the Contractor.

**ARTICLE 4 - REPRESENTATIONS, WARRANTIES AND COVENANTS**

4.1 **Representations and Warranties**

(1) The Contractor hereby represents and warrants to the Regional Health Authority as follows:

(a) The Contractor is a corporation incorporated and validly subsisting on the laws of its incorporation. The Contractor has the necessary corporate power and authority to own its property and assets and carry on its business in the Province of Newfoundland and Labrador. No act or processing has been taken by or against
the operation in connection with the dissolution, liquidation, winding-up, bankruptcy or reorganization of the operator.

(b) The Contractor has the full power and authority to enter into this Agreement and all other agreements and instruments to be executed by it as contemplated herein (including the Service Agreement), and to carry out its obligations under this Agreement as such other agreements and instruments, and the Contractor has taken all necessary action to authorize the execution, delivery and performance of its obligations under this Agreement and such other agreements and instruments, and the Contractor has taken all necessary action to authorize the execution, delivery and performance of its obligations under this Agreement and such other agreements and instruments.

(c) The Contractor holds, or will hold by the time the Contractor is required, all permits, licenses, consents, intellectual property rights, registrations and authorizations required to conduct its affairs and perform its obligations under this Agreement and such other agreements and instruments referred to in Section 5.1(b). This Agreement constitutes a legal, valid and binding obligation of the Contractor enforceable against the Contractor in accordance with its terms, subject to limitations on enforcement imposed by bankruptcy, insolvency, reorganization or other laws affecting creditor's rights generally and subject to general principles of equity.

(d) The execution, delivery and performance by the Contractor of this Agreement and such other agreements and instruments referred to in paragraph (b):

(i) do not and will not conflict with, result in a breach or violation of or constitute a default under any Applicable Law or any agreement, instrument or other document to which the Contractor is a party or by which the Contractor or any of its property or assets are bound, except for violations which do not relate to the Site, the Facility or the Development of Beds and Services and Facility or will not, in the aggregate, have a material adverse effect on the present or future business, operations, property, prospects or condition (financial or otherwise) of the Contractor; and

(ii) do not and will not conflict with, result in a breach or violation of, or constitute a default under its constituting documents or bylaws or any unanimous shareholders agreement among the shareholders of the Contractor.

(e) All written statements made or furnished by or on behalf of the Contractor to the Regional Health Authority and/or the Department (as the case might be) in connection with the transactions contemplated by this Agreement, were, as of the time such statements were made, true in all material respects and remain true in all material respects on the date hereof, and such statements do not contain any untrue statement of a material fact or omit a material fact necessary to make such
statements not misleading. All such statements, taken as a whole, do not contain any untrue statement of a material fact or omit a material fact necessary to make such statements or the statements contained herein not misleading. All expressions of expectation, intention, belief and opinion contained therein were honestly made on reasonable grounds after due and careful inquiry by the Contractor (and any other person who furnished such material). There is no fact which the Contractor has not disclosed to the Regional Health Authority and/or the Department (as the case might be) in writing which adversely or materially affects, or so far as the Contractor can now reasonably foresee, will adversely and materially affect its business, operations, property, prospects, liabilities or condition (financial or otherwise), or its ability to perform its obligations under this Agreement or to operate the Beds and the Facility in accordance with the Service Agreement.

4.2 Covenants

(1) In addition to any other covenants and agreements of the Contractor in this Agreement the Contractor agrees and covenants with the Regional Health Authority that the Contractor shall not:

(a) develop the Beds and the Services in any location other than the Site which has been approved by the Regional Health Authority pursuant to this Agreement; or

(b) sell, assign, convey or otherwise dispose of the Contractor’s interest in the Site without the prior written consent of the Regional Health Authority.

(2) The Contractor confirms that it will advise the Regional Health Authority in respect of any material change in the ownership of the Contractor.

ARTICLE 5 - CONFIDENTIALITY

5.1 The Contractor, its contractors, consultants, employees, servants, agents, subcontractors or students shall treat as confidential and not make public or divulge, during, as well as after, the term of this Agreement, any information or material related to the work herein described including information obtained through contact with personnel of the Province or other persons without having obtained the Regional Health Authority’s consent thereto in writing.

5.2 The Regional Health Authority agrees to treat as confidential all information provided to the Regional Health Authority by the Contractor, subject to the obligations on the RHA at law including the Access to Information and Protection of Privacy Act, 2015 and the Personal Health Information Act.

5.3 The Contractor acknowledges and confirms that it has read and understands its obligations under Access to Information and Protection of Privacy Act, 2015 and the Personal Health Information Act.
Information Act and that the Contractor hereby undertakes, covenants and agrees to be bound by and comply with the obligations imposed on it under the Access to Information and Protection of Privacy Act, 2015 and the Personal Health Information Act.

5.4 The Contractor further covenants, warrants and represents to the Regional Health Authority that it will not at any time provide or allow the release of personal information to which it has access in its capacity as a Contractor to the Regional Health Authority in response to any “request or demand for disclosure” or permit or allow the “unauthorized disclosure of personal information” as each of those terms or concepts are defined or referenced in the Access to Information and Protection of Privacy Act, 2015 and the Personal Health Information Act.

5.5 The Contractor shall at all times strictly enforce such security arrangements as may be required to protect all personal information that it collects or uses on behalf of the Regional Health Authority and shall confirm in writing to the Regional Health Authority, upon request, the details of those security arrangements.

5.6 All personal information that the Contractor obtains or becomes aware of while providing services to the Regional Health Authority is not and shall not be or deemed to be property of the Contractor; and the Contractor expressly confirms that it will not, either directly or indirectly, acquire any rights to use or own any such personal information except the right to use it for the sole purpose of fulfilling its obligations to the Regional Health Authority and/or Residents hereunder.

5.7 The parties expressly agree that the laws of the Province of Newfoundland and Labrador shall apply to this Agreement and to any breach by the Contractor of its obligations under this clause or under the Access to Information and Protection of Privacy Act, 2015 and the Personal Health Information Act.

5.8 The Parties agree that the Regional Health Authority shall retain all rights (including, without limitation, all intellectual property rights), title, and interest in any and all Confidential Information provided to the Regional Health Authority pursuant to this Agreement.

ARTICLE 6 - CONFLICT OF INTEREST

6.1 The Contractor shall not, and shall cause the Contractor’s Personnel not to, engage in any activity where such activity could create a conflict of interest (actual or potentially in the sole and absolute determination of the Regional Health Authority in connection with the transactions contemplated by this Agreement (including the development of Beds and the Services). The Contractor acknowledges and agrees that it shall be a conflict of interest for it or any of the Contractor’s Personnel to use confidential information of the Regional Health Authority or the Department or of any Resident (including the confidential information) relevant to the Development of Beds and the Services where the Regional Health Authority has not specifically authorized such use.
6.2 The Contractor shall disclose to the Regional Health without delay any actual or potential situation that may be reasonably interpreted as being either a conflict of interest or a potential conflict of interest on the part of the Contractor or any of the Contractor’s Personnel.

6.3 During the term and after the termination or expiry of this Agreement, the Contractor shall not, and shall cause the Contractor’s Personnel to not, directly or indirectly improperly use for personal or any other type of gain any information obtained in connection with the transactions contemplated by this Agreement.

6.4 The Contractor shall make all reasonable efforts to ensure that the Contractor’s Personnel do not violate this Article. Such efforts shall include, but shall not be limited to, bringing prohibitions under this Article to the attention of all such persons.

ARTICLE 7 - LIABILITY AND INDEMNIFICATION

7.1 Limitation of Liability

(1) The Regional Health Authority and the Regional Health Authority’s officers, employees, volunteers, agents and other representatives and successors and assigns shall not be liable to the Contractor or the Contractor’s Personnel for any losses, expenses, costs, claims, damages (including incidental, indirect and consequential damages) and liabilities arising in connection with or as a result of:

(a) anything done or omitted to be done by the Contractor or the Contractor’s Personnel in carrying out the Development of Beds and Services and Facility or otherwise in the performance of the Agreement or the obligations under the Development summary;

(b) the selection of the Site, or the Development of Beds and Services and Facility, or any other matter on which the Regional Health Authority may be required or requested to give consent or approval, notwithstanding any consent to or approval of any of the foregoing by the Regional Health Authority; or

(c) termination of this Agreement pursuant to Section 9.2 (Termination by Regional Health Authority or Section 10.6 (Severability)).

(2) The Regional Health Authority and the Regional Health Authority’s officers, employees, independent contractors, subcontractors, agents, successors and assigns shall not be liable for any injury or damage (including death) to the person or for the loss or damage to the property of the Contractor, in any manner based upon, occasioned by, or in any way attributable to the Contractor’s Services under this Agreement unless such injury, loss, or damage is caused solely and directly by the negligence of an officer, or servant of the Regional Health Authority while acting within the scope of his employment.
7.2 **Indemnification by Contractor**

(1) The Contractor shall indemnify and save harmless the Regional Health Authority and the Regional Health Authority’s officers, employees, volunteers, agents and other representatives, successors and assigns (collectively, the “Indemnified Parties”) from any and all losses, damages (including incidental, indirect and consequential damages), liabilities, judgments, claims, demands, causes of action, suits, actions or other proceedings of any kind or nature and expenses (including legal fees on a solicitor and solicitor’s own client basis) which the Indemnified Parties, or any of them, may suffer or incur arising in connection with or as a result of anything done or omitted to be done by the Contractor or the Contractor’s Personnel in carrying out the Development of Beds and Services and Facility or otherwise in the performance of this Agreement or the obligations under the Schedules to the Agreement or otherwise in connection with this Agreement, or the Schedules, including any breach by the Contractor of its obligations under, or its representations, warranties and covenants set forth in this Agreement, or the Schedules. This indemnity will survive completion of this Agreement.

(2) The indemnity referred to in this Article 7.2 shall not extend to any costs, losses, damages, judgments, claims, demands, suits, actions, causes of action or other proceedings of any kind or nature to the extent they are based on, occasioned by, or attributable to anything negligently done or omitted to be done by the Regional Health Authority or the Regional Health Authority’s staff in connections with this Agreement or the performance of this Agreement.

**ARTICLE 8 - TERM AND TERMINATION**

8.1 **Term**

(1) The Term of this Agreement shall commence on the date of execution of this Agreement.

(2) The Term of this Agreement shall end upon the earlier of:

(a) termination pursuant to Article 8.2 below;

(b) termination pursuant to Article 9 below; or

(c) Occupancy.

8.2 **Termination by Regional Health Authority**

(1) The Regional Health Authority, without liability, cost or penalty, may, in the Regional Health Authority’s sole and absolute determination and without prejudice to any other rights or remedies of the Regional Health Authority under this Agreement or at law or in equity, terminate this Agreement immediately upon giving written notice to the Contractor if any of the following events or conditions have occurred or exist:
the Contractor has failed to comply with Section 2.1;

subject to (3) below, the Regional Health Authority is of the opinion that there has been a material breach by the Contractor of any term, warranty, representation, condition, covenant or other provision of this Agreement or the Schedules to this Agreement;

the Contractor is adjudged bankrupt or is insolvent according to the provisions of the Bankruptcy and Insolvency Act, R.S.C. 1985, c. B-3, and the regulations made thereunder, or any bankruptcy, reorganization, arrangement, insolvency, liquidation or winding-up proceedings or any other proceedings for the benefit of creditors generally are instituted by or against the Contractor (including an assignment, proposal, compromise or arrangement for the benefit of creditors);

a receiver, and manager, trustee or other official with similar powers is appointed for the Contractor or all or a substantial part of the property of the Contractor, or the Contractor files for the appointment of any such official, prior to Occupancy, provided that at the time the Regional Health Authority notifies the Contractor of the termination of this clause, such official (or a replacement thereof) has not sold, assigned or transferred the property of the Contractor with the consent of the Regional Health Authority pursuant to Section 9.10 (Assignment) to another person who will assume the obligations of the Contractor under this Agreement;

the Contractor ceases, or notifies the Regional Health Authority of its intention to cease carrying on business as presently carried on by it or any steps are taken to dissolve the Contractor or the Contractor is not, or ceases to be, qualified under Applicable Law to operate the Facility;

the indebtedness of the Contractor under any financing arrangements for the Development of Beds and Services and Facility has been declared due and payable by the creditor(s) thereunder prior to the date or dates on which such indebtedness would otherwise have been due thereunder;

the financing arrangements made by the Contractor for the Development of Beds and Services and Facility are cancelled or no longer available to the Contractor and have not been replaced in a timely manner by comparable financing arrangements approved by the Regional Health Authority; or

the Contractor has sold, conveyed or disposed of the Contractor’s interest in the Site, except with the prior written consent of the Regional Health Authority.

(2) In the event the Contractor, subject to Section 8.5 (Force Majeure) or Section 2.3 fails to cause the Development of Beds and Services and Facility to occur by the Occupancy Date:

the Regional Health Authority will notify the Contractor of the default ("Default Notice") and the period of time, as determined by the Regional Health Authority at
the Regional Health Authority’s sole discretion, within which such default must be remedied by the Contractor (The “Remedy Period”);

(b) the Contractor will either:

(i) remedy such default within the Remedy Period; or

(ii) if such default cannot reasonably be remedied within the Remedy Period, then the Contractor will promptly notify the Regional Health Authority in writing that this is the case (together with the reasons therefore) and, within thirty (30) days of the Default Notice, will deliver to the Regional Health Authority a plan satisfactory to the Regional Health Authority for rectification of such default, which plan will include a time frame within which such rectification will be achieved;

(c) this Agreement will terminate on the last day of the Remedy Period unless:

(i) the Contractor remedies such default to the satisfaction of the Regional Health Authority; or

(ii) the Contractor delivers a rectification plan that is satisfactory to the Regional Health Authority and remedies such default to the satisfaction of the Regional Health Authority on or before the date specified in the rectification plan; and

(d) The Contractor acknowledges that in addition to any remedy available to the RHA under this Agreement or at law as a result of any delay in causing the Development of Beds and Services and Facility to occur by the Occupancy Date, it may be liable to the RHA under the RSCL for liquidated damages as prescribed therein.

(3) In the event that the Regional Health Authority (acting in its sole discretion) is of the opinion that there has been a breach by the Contractor of any term, warranty, representation, condition, covenant or other provision of this Agreement or the Schedules that would jeopardize the Contractor’s ability to discharge the Contractor’s obligations to provide the Beds and the Services required of the Contractor under this Agreement and such breach is not remedied within forty-five (45) days (the “Cure Period”) after the Contractor receives from the Regional Health Authority written notice of such breach setting out particulars thereof, then, in any such event, in addition to the Regional Health Authority’s other rights and remedies under this Agreement or at law or in equity, the Regional Health Authority shall have the right to terminate this Agreement immediately upon giving notice of termination to the Contractor to that effect at the end of the Cure Period, provided, however, that if such breach is of such a nature that it cannot be completely cured or remedied within the Cure Period, or the Contractor is not proceeding in a manner satisfactory to the Regional Health Authority with, the Regional Health Authority shall have the right to terminate this Agreement immediately upon giving notice.
of termination to the Contractor prior to the end of the Cure Period. This provision does not apply to terminations other than terminations pursuant to (1)(b) above.

(4)

8.3 **Effective Date and Consequences of Termination**

(1) In the event of early termination of this Agreement:

(a) The effective date of the termination shall be the last day of the notice period, if any, and if there is no notice period, immediately upon the Regional Health Authority giving notice of termination to the Contractor.

(b) The Contractor shall have no further entitlement to develop the Beds, the Services and the Facility under this Agreement and there shall be no obligation on the Regional Health Authority to provide to the Contractor a Service Approval; and

(c) All rights and obligations of the Contractor and the Regional Health Authority under this Agreement shall cease upon any termination of this Agreement subject to Section 9.5 (Survival of Certain Terms).

8.4 **Force Majeure**

(1) If, as a result of an event of Force Majeure (as defined below), the Contractor fails to perform or comply with any of its obligations under this Agreement, such failure shall not constitute a default or breach of this Agreement.

(2) Dates and times by which the Contractor is required to render performance under this Agreement shall be postponed automatically to the extent and for the period of time that the Contractor is prevented from meeting them by an event of Force Majeure.

(3) Force Majeure shall include causes beyond the Contractor’s control which are not avoidable by the exercise of reasonable foresight and shall include but not be limited to acts of God, acts of war, riots, epidemics, fire, strikes, labour disruptions or lockouts, other than such as are caused by the actions or omissions of the Contractor.

(4) For greater certainty the Parties hereto agree that impecuniosity on the part of the Contractor shall not be regarded as an event of “Force Majeure”.

(5) The Contractor must notify the Regional Health Authority immediately, in writing and in detail of the nature of such event of Force Majeure and the probable outcome.

**ARTICLE 9 - GENERAL PROVISIONS**

9.1 **Entire Agreement**
This Agreement and the Schedules to this Agreement constitute the entire agreement between the Parties hereto pertaining to the subject matter of this Agreement and supersede all prior agreements and understandings, collateral, oral, or otherwise. There are no conditions, warranties, representations or other agreements between the Parties in connection with the subject matter of this Agreement (whether oral or written, expressed or implied, statutory or otherwise), except as specifically set forth or incorporated by reference in this Agreement or in the Schedules. No modification of this Agreement shall be binding upon the Parties to this Agreement unless in writing and executed by the Designated Representatives of the Contractor and the Regional Health Authority, as specified in Section 9.13 (Designated Representatives).

9.2 **Conflict**

(1) In the event there is any conflict between the terms of:

(a) Applicable Law;

(b) this Agreement; or

(c) the Schedules to this Agreement;

the terms of the Applicable Law or the document that is higher on the list takes precedence.

(2) For greater certainty the Parties further agree that in the event of any conflict between the Contractor’s Proposal and the remaining content of this Agreement including its Schedules, the remaining terms and conditions of this Agreement and its Schedules shall prevail.

9.3 **Further Assurances**

The Contractor agrees to promptly perform, make, execute, deliver or cause to be performed, made, executed, or delivered, all such further acts and documents as the Regional Health Authority may reasonably require for the purpose of giving effect to this Agreement.

9.4 **Independent Contractor**

The Contractor and the Regional Health Authority are independent contractors and neither of them shall be deemed to be employee, agent, partner of, or in a joint venture with the other. The Contractor’s Personnel shall not be deemed to be the employees, agents, partners of, or in a joint venture with the Regional Health Authority.

9.5 **Survival of Certain Terms**

The representations, covenants, warranties, indemnities and limitations of liability set out in Article 4 (Representations, Warranties and Covenants) of this Agreement shall survive the termination or expiry of this Agreement, and shall bind the Parties and their successors and assigns, for a period of six (6) years after termination. The representations set out in Article 5
(Confidentiality), Article 7 (Liability and Indemnification), and this Section 9.5 (Survival) of this Agreement shall survive the termination or expiry of this Agreement and shall bind the Parties and their successors and assigns, for a period of time equivalent to the life in being of Her Majesty, Queen Elizabeth the Second, her heirs and successors according to law plus twenty (20) years.

9.6 **Enurement**

This Agreement shall enure to the benefit of and be binding upon the respective successors and permitted assigns of each of the Parties.

9.7 **Severability**

If any provision of this Agreement is invalid, illegal or unenforceable, such provision shall be severed from the balance of this Agreement and the remaining provisions of this Agreement shall continue in full force provided that such remaining provisions express the intent of the Parties. If the intent of either Party cannot be preserved, this Agreement shall be either renegotiated or terminated by either Party, without liability, cost or penalty to the other Party, upon thirty (30) days’ prior written notice to the other Party.

9.8 **Waiver**

No waiver of any breach of this Agreement shall operate as a waiver of any subsequent breach or of the breach of any other provision of this Agreement. No provision of this Agreement shall be deemed to be waived, and no breach excused, unless such waiver or the consent excusing the breach is in writing and signed by the Party that is purported to have given such a waiver or consent. No delay or omission on the part of any Party to this Agreement to avail itself of any right it may have under this Agreement shall operate as a waiver of any such right. No waiver or failure to enforce any of the provisions of this Agreement shall in any way effect the validity of this Agreement or any part hereof.

9.9 **Rights and Remedies Cumulative**

The rights and remedies of the Parties to this Agreement are cumulative, in addition to and not in substitution for any rights and remedies provided at law or in equity.

9.10 **Assignment**

(1) The Contractor shall not assign, transfer, or pledge, directly or indirectly, any of its rights or obligations under this Agreement except with the consent of the Regional Health Authority which shall not be unreasonably withheld.

(2) The Regional Health may, in the Regional Health Authority’s sole discretion, assign the Regional Health Authority’s interest in this Agreement.

9.11 **Time of the Essence**

Time shall be of the essence.
9.12 Publicity

The Contractor shall notify the Regional Health Authority in advance of any proposed publicity or publications by or on behalf of the Contractor relating to this Agreement or the development (including press releases and press conferences but excluding brochures, pamphlets, books or other marketing materials intended to promote or advertise Beds in the Facility), where feasible, and shall use reasonable efforts to make such changes thereto as reasonably requested by the Regional Health Authority.

9.13 Designated Representatives

(1) For purposes of this Agreement, the designated representatives are as follows:

(a) the designated representative of the Regional Health Authority is:

TO BE DETERMINED

(b) the designated representative of the Contractor, who shall be an authorized signing officer of the Contractor is:

TO BE DETERMINED

(2) Any Party may designate different representatives, addresses, telephone or facsimile numbers, email contact information by notifying the other Party in accordance with Section 10.13 (Notice).

9.14 Notice

(1) Any notice, request, demand, consent, approval or authorization (each, a notice) required, permitted or contemplated under this Agreement, shall be in writing, whether or not such Notice is expressly stated herein to be provided or made in writing, (unless a provision of this Agreement expressly provides otherwise); under the signature of the respective designated representative as specified in Section 10.12 (Designated Representatives); and delivered by courier or personal delivery addressed to the designated representative of the Party to whom it is intended to specify in Section 10.12 (Designated Representatives).

(2) A notice delivered by courier on a Business Day is deemed to be received by the addressee on the day that it is sent. If the notice is so sent or delivered after the end of the Business Day, then it is deemed to be received by the addressee on the following Business Day. If the notice is so sent or delivered on a day other than a Business Day, then it is deemed to be received by the addressee on the following Business Day.

9.15 Governing Law

This Agreement shall be governed by, subject to, and interpreted in accordance with the laws of the Province of Newfoundland and Labrador and the laws of Canada applicable therein, and the
Parties agree to submit to the jurisdiction of the courts of the Province of Newfoundland and Labrador.

9.16 Compliance with Laws

The Contractor shall comply any federal, provincial or municipal legislation having application and will consult, as necessary, with the respective authority having jurisdiction to ensure compliance with all applicable legislation including payment of any permit or license fees, or relevant taxes. The Contractor is responsible for all costs associated with such compliance.

9.17 Joint and Several Liability

In the event that the Contractor is comprised of more than one Party, each of such Parties shall execute and deliver this Agreement and shall be jointly and severally liable in all respects under and in connection with this Agreement.
IN WITNESS WHEREOF the Parties hereto execute this Agreement as of the date first written above.

SIGNED, SEALED AND DELIVERED in the presence of:

__________________________________________
Witness

Date:_____________________________________

__________________________________________
Per:
Date:_____________________________________

REGIONAL HEALTH AUTHORITY

__________________________________________
Witness

Date:_____________________________________

CONTRACTOR

__________________________________________
Per:
Date:_____________________________________
Schedule A

Statement of Requirements

Introduction

In April 2015, the Government of Newfoundland and Labrador approved the provision and funding of 360 new residential long term care beds to meet the growing needs of an aging population. The beds will be distributed between four Facilities as described in the table below.

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of LTC Beds</th>
<th>Site Provided By</th>
<th>Health GNL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corner Brook</td>
<td>120</td>
<td>NL</td>
<td>Western Health</td>
</tr>
<tr>
<td>Gander</td>
<td>70</td>
<td>Contractor</td>
<td>Central Health</td>
</tr>
<tr>
<td>Grand Falls-Windsor</td>
<td>50</td>
<td>Contractor</td>
<td>Central Health</td>
</tr>
<tr>
<td>Northeast Avalon</td>
<td>120</td>
<td>Contractor</td>
<td>Eastern Health</td>
</tr>
</tbody>
</table>

The Facilities will provide care and accommodations to individuals with high care needs (Level III and Level IV). The resident group is predominantly composed of frail, elderly seniors, many of whom have moderate to severe dementia and who require significant assistance with instrumental and functional activities of daily living.

The Northeast Avalon Facility will include among the 120 beds provided by the Contractor 48 beds for residents with mild to moderate dementia (Level I and Level II). These individuals are typically cared for in protective community residences and require a different model of care that includes a different mix of care providers.

This document provides the functional and design requirements of for each Facility. All Facilities must be fully compliant with all relevant codes, standards and legislation that apply in the Province of Newfoundland and Labrador.

1. Resident Profile

The Facility will be equipped to accommodate residents who are assessed as Level III or Level IV, based on the outcomes of a standardized assessment performed by the Regional Health Authority.

Level III residents will exhibit some or all of the following:

- Dependent for transfer or mobility;
- Requiring assistance to turn or move about in bed;
- Dependent for assistance with dressing, washing, grooming and bathing;
- Incontinence of bladder and/or bowel
- Requiring supervision and assistance with eating
- Requiring daily professional care;
- Sensory deficits that interfere with activities of daily living and requiring ongoing assistance;
• Severe cognitive impairment;
• Sensory/perceptual deficit that interferes with understanding and expressing needs;
• Management problems due to behaviour, e.g. wandering, aggressiveness, and hostility;
• Varying degrees of difficulty with orientation to place or person; and
• Medical conditions that require continuous supervision and frequent professional intervention.

Level IV residents will exhibit some or all of the following:

• Non-responsive or responsive only to tactile or painful stimuli; and
• Requiring a medical device to compensate for the loss of a vital body function and ongoing professional health care.

2. General Description of Facility Requirements

The Facility will be based on current evidence-based design principles. The design will incorporate current best practice guidelines from the Centre for Health Care Design (www.healthdesign.org) or other referenced expert sources. The Facility must achieve and maintain full accreditation by Accreditation Canada. (https://www.accreditation.ca)

All parts of the Facility must be wheelchair accessible.

The environment will promote privacy and support resident and family connections. Beds will be provided in residential-style neighbourhoods. The designs will be homelike in nature, promoting flexibility, independence and a sense of community.

Each neighbourhood will have a wandering loop and a living and dining area that fosters social interaction and companionship. Facility communal spaces will be provided to further encourage social interaction. These areas will be equally accessible to all residents.

Each resident will have a private bedroom with ensuite toilet, sink and shower. Residents and families will be encouraged to personalize their neighbourhood and their individual rooms, so the neighbourhood reflects personalities of the residents.

Appropriate furniture, amenities and objects will be located throughout the neighbourhoods. Pictures, plants and other features will reinforce a homelike environment.

All individual neighbourhoods will be designed to be secured if necessary.

Ten percent of all resident rooms are to be designed to accommodate bariatric residents.

All items of furniture and fixed equipment will be provided by the Contractor. All equipment will meet regional policies and standards for infection prevention and control. Adequate hand washing sinks and secondary hand sanitizing stations will be provided to meet best practice in infection prevention and control.
Noise transfer will be minimized in common areas through use of material, furniture, fixtures, and equipment selections that aid in sound absorption. All furniture will be upholstered with a cleanable material that meets infection prevention and control standards, guidelines and best practice. Access to quiet space for family/resident space in each neighbourhood or between neighbourhoods is required.

**Special requirements for bariatric residents**

Bariatric individuals are considered to be those within the range of 225 kg to 453 kg. Such persons generally need larger furnishings, larger equipment, and larger physical spaces to manoeuvre. For bariatric residents, additional space is needed for staff (usually two or more) to assist them when providing care.

The design will meet the following requirements for bariatric residents in all communal or shared-use areas:

- Accessible communal areas and pathways to these areas;
- At least 10% of all furnishings and equipment in communal areas designed to accommodate bariatric residents;
- Door openings in all communal areas, including living and dining areas and corridors, a minimum of 1220 mm wide;
- Floor space and clear areas adequate to accommodate the movement and placement of larger furnishings and equipment;
- Sufficient space to allow for care by multiple caregivers;
- Sufficient space between items of furniture, equipment or physical structures to enable righting a person who has fallen;
- All handrails in corridors, pathways, communal areas and resident service spaces designed to safely support a weight of at least 453 kg;
- Shared-use areas that are equipped with a resident lift system, including bathing suites and rehabilitation areas, and where bariatric residents may be cared for, equipped with ceiling mounted track and motorized resident lift suitable to safely lift and transport weights up to 453 kg.

Resident rooms designated for bariatric residents will include the following:

- Clear space of at least 1500 mm on three sides of the bed and sufficient clear space to accommodate large mobility aids and other portable equipment (e.g. walker, wheelchair, commode);
- Entry door openings of at least 1500 mm;
- Ceiling-mounted lift and track system a safely lift and transport weights up to 453 kg with a track extending to both sides of the bed and from the bed to the washroom;
- Bed able to safely accommodate a resident weighing up to 453 kg (Note: beds for bariatric persons are longer and wider than a standard bed — typically not less than 2285 mm long (2490 mm extended) × 1118 mm wide (1574 mm with side rails);
- Bed with weight scales; and
- Room handrails able to safely support at least 453 kg.
Washrooms for resident bedrooms for bariatric persons will be designed and equipped with the following features:

- Entry door openings of at least 1500 mm in width;
- A sink able to support a minimum of 363 kg downward force;
- A floor-mounted toilet able to support at least 453 kg;
- Toilet position compatible with the use of a bariatric commode;
- Toilet paper dispenser mounted in a location within easy reach of a bariatric resident;
- Rooms equipped with grab bars that are appropriately sized and positioned for use by a bariatric person, able to support a 363 kg downward force and extending behind and beside the toilet, subject to accessibility codes and regulations;
- Open-plan toilet and shower area with no floor lip, with floor appropriately sloped to a drain, and a shower equipped with a handheld spray nozzle on a side wall.

Special requirements for residents at end of life

The Facility will include enhanced suites that will comfortably accommodate a large family and support residents at end of life.

- 3 suites in the Facility in Corner Brook
- 2 suites in the Facility in the Northeast Avalon
- 2 suites in the Facility in Gander
- 2 suites in the Facility in Grand Falls-Windsor

3. General Outdoor Design Requirements and Landscaping

The Site will be landscaped to provide an appropriate residential feel and look while providing appropriate space for residents to enjoy outdoor activities. All outdoor areas will be free of barriers and tripping hazards. Appropriate seating areas will be provided in paved areas and pathways.

Unobstructed and discrete entry for emergency vehicles is required.

Parking restrictions will be applied to areas where emergency vehicles require access. Adequate space will be provided on site for staff and visitor parking as well as shipping and receiving functions.

The landscaping will include secure fencing, age-friendly outdoor furniture, and will have raised flowerbeds incorporated into the design. There will also be shaded and weather protected areas for residents. The pathway will be patterned to provide an age-friendly closed wandering loop in each patio area. Pavement color will be consistent throughout and non-glare surfaces will be used. The use of stairs and ramps will be minimized, and a barrier free access will be provided. All stairs will have handrails. Lighting for pathways and outdoor spaces will not impact on resident rooms and other indoor spaces.
Service areas, including fuel tanks, waste disposal, and receiving, will be screened from resident areas.

Building Configuration

Subject to site constraints, the design will be low-rise to create the sense of neighbourhood living environments for residents. Each neighbourhood will accommodate no more than 16 bedrooms, along with resident spaces, but neighborhoods may share support service or staff areas.

Residents will have at-grade access through common areas and outdoor spaces throughout the site. All doors leading to the garden area will have power door operators suitable for the resident profile. All doorways will be fit for the purpose of access and egress by elderly residents. Doorways at the main or secondary entrances to the Facility will be equipped with power assisted door operators on both the interior and exterior doors.

The individual resident neighbourhoods will be designed such that residents, staff and families are not required to travel through one resident house to access another. Administrative and service areas will be located separately from the resident areas. Common areas within the neighbourhoods will have views to the exterior and or garden areas. There will be no “dead-end” corridors in the resident areas and all rooms will be located on a well-designed walking loop with good sight lines for staff. There must be appropriately scaled spaces, architectural detailing and materials that are familiar, age-friendly and homelike.

4. Resident Neighbourhood Design Requirements

Resident Bedroom - This is a private space where residents’ personal activities of daily living (e.g. reading, watching TV, sleeping, grooming and dressing) will occur.

Each resident bedroom will be large enough to accommodate one resident, a guest(s) and necessary staff/resident support activities. The room will be large enough to allow a minimum clearance around the bed of 1.5 metres on either side and 1.2 metres at the end.

The location of the bed in each room will be designed to ensure residents have a lit path to the washroom and the room configured in such a way that residents do not have to cross the room to access the washroom.

Each room will include the following:

- bedside table, locker, lockable clothes closet, dresser, and fixed shelves;
- motorized resident lift on a ceiling-mounted track above the bed that is able to transfer a resident to the bathroom in an appropriate, safe and dignified manner;
- multi-purpose chair situated with a view to the outside, and able to recline allowing a family member to stay overnight as necessary;
• appropriate age-friendly handrails on walls surrounding the bed to enable residents to support themselves from the bed to the washroom;
• necessary cabling and connections for TV and telephone;
• access to wireless internet capability;
• lockable cupboard for clothing and personal items; and
• memory display cabinet; and
• visual cues to enhance resident comfort and assist residents and families with way finding.

All furniture within the room will be comfortable, residential in nature, and upholstered with a cleanable material that meets infection prevention and control standards.

Each resident room will have access to fresh air from an opening window section that is risk free from access or falls and fitted with a bug screen.

Additional lockable storage space will be provided within the Facility for seasonal resident clothing storage.

Each neighbourhood will have one family unit where two adjoining rooms with a lockable interconnecting door or moveable wall panel can be created for residents with friends, siblings or spouse who wish to be together.

All bedroom doors will provide an opening, in a two-part opening door design, with the smaller section able to remain closed when the main door is in use, to provide easy access and egress for residents and staff, as well as the movement of beds or other equipment.

Resident Washroom - This is a private space where a resident can conduct personal care activities in an environment that supports privacy, safety, dignity and independence. Each resident washroom will have a sink, toilet, shower and mirror to accommodate all resident heights. The room will have nurse call capabilities, a resident supply cupboard, a secure staff supplies cabinet, and a nightlight. The toilet will not be visible from the corridor at any time.

Resident Assisted Bathing Suite – This is a space where residents will receive assisted bathing in a pleasurable, safe, dignified, private and comfortable environment. Each neighbourhood will have a minimum of one combined resident assisted bathing/shower room. Each one will include the following:

• mechanical ceiling lift;
• bathing tub with hair shower attachment;
• sufficient secure storage space for cleaning supplies, soaps and shampoo;
• hand sink, soap dispenser and paper towel dispenser;
• shower with securely mounted grab bars on one wall; and
• a separate washroom with toilet and a sink accessible only from within the bathing suite.
The shower will have sufficient space to accommodate a shower chair so that a resident can be showered in a seated position. The bathtub will be located such that it can provide wheelchair and staff support access on three sides.

The assisted bathing suite will be ventilated to remove moisture and odour. Bath and shower areas will have individual quick response room temperature control capable of maintaining a comfortable temperature for bathing (up to 30°C (85°F) and be separate from surrounding rooms and areas.

**Resident Living Room** - This is a common space where residents will interact with other residents, family members, visitors and staff in a comfortable, homelike and relaxed atmosphere that enhances resident quality of life. Activities may include reading, conversing, celebrating, family visiting, game playing, and television watching.

Each resident living room will be large enough to accommodate residents living within the neighbourhood, visitors and support staff and designed to accommodate resident activities.

Each resident living room will be designed and finished to create a homelike feel and will include the following:

- focal point (e.g. electric fireplace);
- shelving for storage
- adjacent space for wheelchairs and walkers;
- seating able to support multiple activities;
- nearby washroom; and
- a clear view to the outdoors.

For neighbourhoods with resident living rooms located on the ground floor, outdoor access will be nearby with a walkout patio and garden.

**Resident Dining Room** - This is a space where residents will enjoy a positive dining experience in a comfortable, homelike and relaxed atmosphere. Resident dining rooms will also be used for small group activities.

Resident dining rooms will adjoin the living room and be large enough to accommodate all residents living within the neighbourhood plus visitors and support staff.

Each resident dining room will include the following:

- square tables and chairs with armrests;
- storage for housekeeping equipment;
- storage space for wheelchairs and walkers;
- two hand wash sinks located immediately adjacent to the dining room area for use by both staff and residents;
- nearby washroom; and
- a clear view to the outdoors.

For ground floor resident dining rooms, direct access to an outside walkout patio area and garden will be provided.

Noise in the resident dining areas will be minimized through material and furniture and fixed equipment selections that aid in the sound absorption.

**Staff and other support space** - Adequate space will be provided for staff support functions in both the neighbourhood and communal space. These spaces will be large enough to include a washroom on each floor, meeting rooms and general space to meet other staff needs.

All resident areas will have good sight lines and be designed so staff can easily observe resident activity, particularly from any proposed nursing stations. Medication and treatments will be securely stored and prepared in a dedicated space that is fully compliant with all policies and provincial regulations. A private office/family meeting room in close proximity to the nursing station will be provided in each neighbourhood.

5. **Other communal and ancillary spaces**

**Resident Laundry** – On site laundry facilities will be provided for the laundering of residents personal clothing.

**Clean Utility Rooms** - This is a space where clean linen will be stored before distribution and it must meet infection control standards. Work surfaces will be easily cleaned and impermeable to moisture.

Clean utility rooms will be for staff use only.

**Soiled Utility Room** - A dedicated space will be provided for safe handling of all soiled materials in accordance with required operational practice and accreditation standards.

**Multi-Purpose Room(s)** – The Facility will include a space for communal group recreation activities that support meaningful residential activities and social interactions. These may include leisure pursuits, sensory stimuli, concerts and music related programs, and/or religious purposes. Each multi-purpose room will be large enough to accommodate residents of interconnecting neighbourhoods, be centrally-located and designed to be used flexibly for a variety of purposes.

Each multi-purpose room will include the following:

- an area designed for spiritual reflection;
- a large lockable closet/ storage locker provided for items used in religious services; and
- a smaller room, or part of the larger room able to be partitioned, with seating up to 12 persons, for use by residents for family gatherings, special occasions and/or spiritual purposes or religious activity.
Rehabilitation Space - This is a space where residents will receive rehabilitation services such as physiotherapy and occupational therapy. Each rehabilitation space will have a ceiling mounted track and lift.

Treatment Room - A multi-purpose consulting/treatment room will be provided in each Facility and will contain a desk, chair, examination couch/chair, and have Internet connections to facilitate tele-health capability.

Other services - Proponents must be able to provide hair dressing/beauty salon services, accessible to all residents.

Entrance Foyer - This is a space that will provide a welcoming entry to the Facility for residents, families and visitors. The entrance foyer will include a covered vehicle drop-off/pick up area with adequate clearance for ambulances and service vehicles. The outside entrance doors will be designed to prevent drafts.

Central Kitchen/Food Storage - A production kitchen will be located in the Facility. Storage of dry goods, supplies, refrigerated and frozen food, wet and dry garbage and recycling will have their own storage room/location and be compliant with policies and regulations that outline storage and sanitation for goods in that area.

Housekeeping Rooms – Each floor will include space for housekeeping equipment and supplies to be stored. Each housekeeping room will have sufficient space for the secure storage of chemicals and other cleaning supplies, chemical dispensing units, storage carts and other housekeeping equipment, and provide adequate arrangement to meet provisional occupational health and safety requirements.

Each housekeeping room will be equipped with the following:

- hot and cold water supply;
- service sink;
- hand wash sink;
- floor drain;
- sufficient stock so staff do not have to leave the neighbourhood to obtain supplies; and
- space for a recycling program.

Surfaces in direct contact with water will be smooth, easily cleaned and impermeable to moisture. This space is for staff use only.

Plant/Maintenance/Shipping and Receiving - A space will be provided to support the ongoing maintenance activities of the building and building components. It will contain storage space for maintenance equipment, floor plans, operating manuals as well as portable machinery and tools. There will be physical separation and good acoustical control between the plant/maintenance areas and resident areas of the Facility. Sufficient space will be provided for receiving and breaking down of supplies as well as shipping of products. Grounds and gardening maintenance equipment such as snow blowers and lawn mowers will be securely stored in a separate building or shed.
Service/Equipment Rooms – The Facility will include space sufficient to meet the needs of the Contractor’s design, care model, and maintenance requirements.

Materials Management – This space will provide year round access for delivery, storage and distribution of supplies and equipment. There will be a dedicated receiving entrance separate from the main entrance of the Facility. General storage – This space will be a temperature controlled room with wire shelving and secure access to ensure products are maintained at the highest quality.

Cold storage – This space will have direct access to the delivery area and access to inside the Facility to ensure deliveries remain in a controlled environment.

Administration - The design will include spaces where administrative and clinical staff can provide for the overall management of the Facility and the delivery of services to the residents. It will include a meeting room and secure storage space for files and records.

Environmental – The building will be designed to ensure the temperature throughout the Facility remains within an acceptable range, through the installation of appropriate ventilation and air conditioning. For the purposes of this contract, this range is defined with minimum temperature of 18°C and maximum temperature of 25°C for each room in the Facility, unless agree otherwise.

Appropriate arrangements will be made for acceptable standby heating in the event of system failure. The Contractor will provide and ensure redundancy in all Facility systems so that the building will remain functional if there are utility or system failures. The building must be fully compliant with fire safety legislation and be fully sprinklered.

Electrical Systems - Provide redundancy in systems and emergency power generators so that the building will remain functional if there are utility or system failures.

Each resident bedroom will be equipped with a smoke detector, separately annunciated at a central location. A staff response system will be provided and located at each bed and resident washroom, bathing areas and other resident activity areas. Corridor dome lights will be provided over resident room doors to announce normal, bed alarm, or emergency call. An overhead paging system will be provided and is to be used for emergencies only.

Each bedroom will be equipped with appropriately located and aesthetically appealing light fixtures that have a non-institutional appearance. Exterior doors will be alarmed and separately annunciated at a central location. Local control will be provided through the use of keypads and magnetic locks. Each Facility will have the ability to be secured to prevent resident elopement. A connection to the fire alarm system will provide an override where required by code.
Schedule “B”

Newfoundland and Labrador Long Term Care Operational Standards

The Newfoundland and Labrador Long Term Care Operational Standards, 2005 are located at (http://www.health.gov.nl.ca/health/publications/long_term_care_standard.pdf). They are to be read in conjunction with the Supplemental Standards set out below.

These Standards are under review and will be amended from time to time during the course of the Agreement by the Regional Health Authority.

[NTD: Contract for Northeast Avalon will be required to specify the Contractor’s compliance with the Provincial Protective Community Residence Operational Standards, or with the alternatives as agreed between the Regional Health Authority and the Contractor, for the 48 beds specified for mild to moderate dementia Residents.]

Supplemental Standards to the Newfoundland and Labrador Long Term Care Operational Standards

1 Administration

1.1 Management of the Facility

(1) Outcome

Residents live in a Facility that is effectively and efficiently managed and that promotes quality of life.

(2) Requirements

The Contractor shall ensure:

(a) There is a designated administrator responsible for the over-all management of the Facility. When the administrator is absent, on-site administrative authority is delegated to an appropriate individual.

(b) A current organizational chart, available to all staff, outlines the relationships between departments and the lines of authority.

(c) The Facility is fully compliant with the Newfoundland and Labrador Long Term Care Operational Standards, relevant policies, and other applicable legislation as determined by the Minister of Health and Community Services or a delegate.

(d) The staff has access to, and complies with recent, applicable requirements, reports, and legislative updates.

(e) The development of a statement of the Facility’s mission, vision, values, philosophy of care, code of ethics, and range of services.

(f) The development of a Resident Bill of Rights and Responsibilities.

(g) There is a process in place to ensure medications are administered, recorded and monitored by appropriate staff and that there is a process to ensure the identity of residents prior to medication administration.

(h) That the necessary operational policies and procedures are developed, documented, implemented and are reviewed/revised annually. Required operational policies shall include but are not limited to:

• Protection of residents from abuse
• Least restraint
• Extremes of internal temperature
• Disclosure of wrongdoing
• Integrated quality improvement
Disclosure of adverse events
Risk management
Incident reporting
Occurrence reporting
Complaints and Compliments
Management of resident funds
Smoking
Safety Alerts
Safer Needles in the Workplace
Medication review processes
Falls Prevention
Skin and wound care
Infection prevention and control

2 [Deleted]

3 Moving In

3.1 Outcome

Individuals suitable for placement in a long term care Facility are supported during the moving in process.

All individuals presenting with a care need will be assessed using the interRAI Home Care assessment tool. Individuals assessed as requiring Level III or IV (see Appendix A) may be offered placement in a long term care Facility.

3.2 Requirements

The Contractor must:

(1) Participate in the regional single-entry system of assessment and placement, managed by the Regional Health Authority.

(2) For the Beds covered by the Residential Services Care Agreement, not admit individuals that are not referred by the Regional Health Authority.

(3) Provide services to individuals deemed eligible by the assessment process and referred by the Regional Health Authority.

(4) Have the capability to accept clients 8am to 8pm, 7 days per week.

(5) Notify the Regional Health Authority of a bed vacancy within 8 hours of a discharge.

(6) Have a maximum of 2 Beds be Unavailable for more than 3 days each at any point in time.
(7) Work with the Regional Health Authority to facilitate discharge of residents whose care needs decrease such that Level III care is no longer required.

4 Labour Disruption Contingency Plan

4.1 Outcome

Residents continue to receive quality care and services in the event of a labour-management dispute.

4.2 Requirements

The Contractor shall ensure:

(1) Essential services continue to be provided to residents whenever there is a reduction in the number of staff members available to serve the residents as a result of a labour-management dispute.

(2) A labour disruption business continuity plan will be developed including a detailed schedule of staffing.

(3) The business continuity plan will be approved by the Regional Health Authority or the Department of Health and Community Services or designate.

5 Inspections

5.1 Outcome

The Facility is inspected by all applicable authorities having jurisdiction.

5.2 Requirements

The Contractor shall ensure:

(1) Compliance with the Provincial Long Term Care Operational Standards and the Service Agreement (if applicable) and have a Service Approval.

(2) Inspection reports and recommendations from authorities having jurisdiction are retained. Compliance with recommendations and requirements are undertaken and evidenced by appropriate documentation. Such documentation is maintained in a common file for access by staff responsible for inspections and monitoring.

(3) Compliance with all applicable legislation including, but not limited to:

- The Buildings Accessibility Act and Regulations
- Food and Drug Act and Associated Regulations
- Health and Community Services Act and Regulations
- The National Building Code and National Fire Code of Canada
- Smoke Free Environment Act and Regulations
- Occupational Health and Safety Act
- Adult Protection Act
- Personal Health Information Act

(4) Compliance with any other legislation, acts, regulations as determined by the Minister and any new or revised inspection processes for all applicable jurisdictions.

6 Monitoring

6.1 Outcome

The Facility is monitored for compliance with the NL LTC Operational Standards

6.2 Requirement

The Contractor shall ensure:

(1) Staff participate in the quarterly and annual review process.

(2) Regional Health Authority monitoring staff are provided with all requested documentation.

(3) Corrective action is undertaken in the time frames recommended and documentation of same exists.

7 Facility Condition

7.1 Outcome

The facility and site are kept in a condition that provides a clean, comfortable and secure environment that optimizes the quality of life for residents and family and supports the delivery of quality resident accommodation and care.

7.2 Requirements

The Contractor shall ensure that the Facility and all elements of the Facility are maintained in a manner consistent with a reasonably prudent owner maintaining a first-class long term care Facility in Canada, including the following:

(1) That site development and building alterations or change of use of space from that originally intended have prior approval of the Regional Health Authority in consultation with Service NL.

(2) That repairs and alterations to long term care Facility meet Infection Prevention and
Control Standards.

(3) That long term care Facility maintenance is carried out in accordance with all relevant legislation and meets all Operational Standards.

(4) That materials, systems, equipment and furnishings are maintained in good working order so that they maintain the functionality originally intended;

(5) Interior and exterior building elements such as walls, floors, ceilings, roof areas, windows and doors are all maintained so that the building is attractive, weather resistant and functional;

(6) That building systems and components perform to originally intended standards for control of water (including vapour and condensation) and air movement;

(7) Hard and soft landscaped areas are maintained so that they contribute to the overall aesthetics and support the residential character of the Facility; and

(8) Mechanical and electrical systems are maintained, repaired and renewed as needed to maintain a comfortable environment suitable for care and consistent with operational needs.

8 Information Management

8.1 Outcome

Adoption of an Information Management approach is intended to produce quality data, support accountability and quality improvement through improved performance measurement and support evidence-based decision-making.

8.2 Requirements

The Contractor shall ensure:

(1) The Facility has information systems that:
   
   • Support the principles of client-centred care
   • Makes available useful, relevant, quality information to inform decision-making
   • Focuses on outcomes related to care provision and service delivery
   • Ensures compliance with the Personal Health Information Act and as well as any other applicable legislation

(2) The Facility must use interRAI-MDS 2.0 for assessment and on-going resident
assessment and care planning and contribute to the Canadian Institute for Health Information’s (CIHI) Continuing Care Reporting system (CCRS).

(3) A secure client health record is implemented.

(4) A policy on document retention exists and that documents are retained for seven years.

(5) A mechanism for the documentation and investigation of occurrence and incident reporting.

(6) A mechanism for secure financial and statistical reporting as outlined in the performance monitoring framework.

9 Mandatory Incident/Occurrence Reporting to the Regional Health Authority:

9.1 Outcome

Required reports and information are provided to the Regional Health Authority in a timely manner.

9.2 Requirements:

The Contractor shall ensure:

(1) There is a written policy and procedure in place to ensure all occurrences, incidents and accidents are documented and reported.

(2) There is a system in place to document and track occurrence, incident and accident reports.

(3) Major incidents (missing resident, incident involving a resident that requires reporting to law enforcement, a suspicious death, homicide, suicide, fire, major flood, labour dispute impacting the operations of the Facility), in addition to any involvement of law enforcement, are verbally reported to the Regional Health Authority immediately. A written report describing the incident and action taken shall be submitted within five working days of the incident.

10 Human Resource Management

10.1 Outcome

The Staff complement will support the achievement of outcomes in all program areas through a team based resident-centred approach.

The Facility promotes an environment of team based resident care supported by:
• Integrated care planning
• Scheduled team meetings
• Referrals among providers
• Supporting residents and families to be partners in care by promoting choice, empowerment, autonomy, and independence in everyday life
• Providing a clear statement of role expectations where team work is emphasized
• Enabling self-led work teams and increased decision-making
• Encouraging decision-making as close to the resident as possible
• Enabling flexible scheduling of activities of daily living without set schedules
• Supporting innovative and alternative approaches of care delivery
• Enabling staff to consistently work with the same residents.

10.2 Requirements

The Contractor must ensure:

(1) The Facility provide clinical Registered Nurse coverage 24 hours per day, seven days per week.

(2) Residents receive on average 3.4 hours of direct nursing care per day (RN, LPN, PCA).

(3) A skill mix ratio of 14% Registered Nurse: 46% Licensed Practical Nurse: 40% Personal Care Attendant.

(4) Access to allied health staff (OT, PT, dietitian, social work, and recreation) in accordance with resident care needs.

(5) Residents are assisted to access dental, optometry and other health appointments, in accordance with the resident’s care plan.

(6) The development of a written human resource plan that anticipates human resource needs to provide required services.

(7) There are policies and procedures related to recruitment, hiring, orientation and continuing competencies of staff members.

(8) Staff members individually and collectively have the skills and experience to deliver the services and care which the setting offers to provide.

(9) The verification of the current licensure, certification, registration or other credentials of
staff members and volunteers prior to the staff members assuming job responsibilities and shall have procedures for verifying that current status is maintained.

(10) The maintenance of documentation of a clear certificate of conduct, a vulnerable sector check for staff members and volunteers, as well as pre-employment health screening and immunizations as may be required.

(11) The allocation of staff members is appropriate in number and qualifications, reflecting the needs of residents and the layout of the Facility, and funded direct care hours are utilized, as intended.

(12) There is a current job description for each position that clearly defines the role, responsibilities, and scope of position that is reviewed annually.

(13) There is a formalized performance management process in place, which evaluates the staff member's performance before probation period, biannually and more frequently, as necessary.

11 Hiring Requirements

11.1 Outcome

Staff members have an appropriate educational level that supports program outcomes and staff have a clear code of conduct.

11.2 Requirements

The Contractor shall ensure:

(1) That key staff have the minimal education and experience required as listed below.

Minimum Education Requirements and Experience – Long Term Care Facility

<table>
<thead>
<tr>
<th>Position</th>
<th>Education and Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Care Manager</td>
<td>Graduation from accredited school of nursing, ARNNL registered</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>Graduation from accredited school of nursing, ARNNL registered</td>
</tr>
<tr>
<td>Licensed Practical Nurse</td>
<td>Graduation from accredited program, CLPNNL registered</td>
</tr>
<tr>
<td>Personal Care Attendant</td>
<td>High School diploma, graduation from approved PCA course</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>Graduation from approved program, NLAOT registered</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>Graduation from approved program, NLCP registered</td>
</tr>
<tr>
<td>Rehab assistant</td>
<td>Graduation from approved Rehab. Assistant program.</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Graduation from approved program, NLASW registered</td>
</tr>
<tr>
<td>Dietitian</td>
<td>Graduation from accredited program, NLCD registered</td>
</tr>
<tr>
<td>Recreation Therapy Worker</td>
<td>Diploma in recreation or therapeutic recreation</td>
</tr>
<tr>
<td>Recreation Specialist</td>
<td>Graduation from approved program, NCTRc certified</td>
</tr>
<tr>
<td>Speech Language Pathology</td>
<td>Graduation from approved program, CASLPA certified</td>
</tr>
</tbody>
</table>
(2) All employees must have a clear certificate of conduct and a vulnerable sector check.

(3) Each profession has a list of core competencies which should be met on hiring or as part of continuing education throughout the first year of hire.

(4) New employees and volunteers will complete an initial orientation to the Facility that is timely and documented including but not limited to:

- Resident values
- Confidentiality and Privacy (Personal Health Information Act)
- Ethics
- Continuous quality improvement
- Team work
- Understanding the needs of the cognitively impaired
- Infection prevention and control, including proper hand washing technique
- Emergency procedures including fire safety and disaster plan
- Heimlich maneuver
- Information on abuse, neglect, and misappropriation of funds
- Adult Protection Act
- Workplace Hazardous Materials Information Systems
- Specific job duties and responsibilities
- Diversity
- Organizational values
- Facility policies and procedures
- Body mechanics
- Occupational health and safety

(5) The completed orientation checklist is signed and dated by the employee and maintained in the employee’s personnel file.

(6) Volunteers receive orientation, are supervised, are supported in their role, and do not replace paid staff members.

(7) Ongoing education to meet the needs of the resident population is provided to staff members by qualified individuals.

(8) Contracted personnel will work under the policies and procedures of the Contractor.

(9) Contracted personnel responsibilities and communication processes are clearly defined by written policy.

12 Continuing Education

12.1 Outcome
Staff and volunteers have the necessary knowledge, skills, and abilities to provide quality care and service.

12.2 Requirements

The Contractor shall ensure:

(1) Staff members and volunteers receive regular in-service on the following:

- Resident values
- Resident safety
- Confidentiality
- Continuous quality improvement
- Infection prevention and control and hand hygiene
- Emergency procedures including fire safety, disaster planning, and universal codes

(2) There is a policy for ongoing education for staff members that includes, at a minimum:

- Identified learning needs of staff;
- New equipment;
- Changing resident needs
- Annual education on Safe Resident Handling; and
- Mandatory professional education, e.g. basic cardiac life support and First Aid.

(3) Annual attendance record of individual staff participation, which includes the date of the in-service/education session attended are maintained.

Reference:

Appendix A
Levels of Care

An individual may be a high level in one category and a low level in another, however, it is the professional judgment that determines the overall level of care requirement. The level of care recommendation is made by the professional completing the assessment and confirmed by the Assessment and Placement Committee or the Single Entry Coordinator.

CATEGORIES

PERSONAL FUNCTIONS: The Applicant/Resident

Level I

• Is independently mobile, with or without mechanical aids, inclusive of a wheelchair.
• May need specialized aids for independently transferring.
• May require limited assistance with bathing, dressing, and/or grooming.
• May require reminder for routine toileting.
• May require minimal assistance with toileting.
• May need nutritional monitoring.
• May have sensory deficit which interferes with activities of daily living and may or may not require minimal assistance.

Level II

• May be independently mobile with or without mechanical aids, inclusive of a wheelchair
• May need specialized aids for one person assist for transferring.
• May need a moderate amount of assistance with bathing, dressing and grooming.
• May require a reminder of and/or assistance with routine toileting to avoid frequent incontinence of bowel and/or bladder.
• May require nutritional monitoring of and/or assistance with eating.
• May have sensory deficit which interferes with activities of daily living and requires moderate assistance.

Level III

• Is dependent for transfer or mobility.
• Requires assistance to turn and move about in bed.
• Is dependent for assistance with dressing, washing, grooming and bathing.
• Has incontinence of bladder and/or bowel.
• Requires supervision and assistance with eating or requires feeding.
• Requires daily professional care.
• May have sensory deficit which interferes with activities of daily living and requires ongoing assistance.

Level IV

• See Medical Status/Level 4
MENTAL/SENSORY/PERCEPTUAL: The Applicant/Resident

Level I

- May have full use of mental functions.
- May have a sensory/perceptual deficit but with adaptation will have the ability to be responsive, understand simple instructions, and express needs.
- May demonstrate mild difficulties in orientation to day, time and place.
- May demonstrate mild difficulty with memory and recall.
- May have inappropriate behaviour which does not interfere with other people.

Level II

- May have mental functioning with moderate cognitive impairment.
- Is responsive to verbal stimuli; may have some difficulty with simple instructions, number and time concepts.
- May have sensory/perceptual deficit but even with adaptation needs assistance for understanding and expressing needs.
- May tend to pace or wander in own environment, but is not at risk for elopement.
- May demonstrate inappropriate behaviour which may interfere with others which can be stabilized.

Level III

- May have severe cognitive impairment.
- May have a sensory/perceptual deficit and even with adaptation needs ongoing assistance for understanding and expressing needs.
- May present with management problems due to behaviour, e.g., wandering, aggressiveness, hostility.
- May demonstrate varying degrees of difficulty with orientation to place or person.

Level IV

- Only responsive to tactile or painful stimuli or is non-responsive.
- See Medical Status/Level 4.

MEDICAL STATUS: The Applicant/Resident

Level I

- May have medical problems that are stabilized and do not require daily professional supervision.
- May require accompaniment for (doctors, dentists, specialists, etc.) visits.
- May require therapies (e.g. oxygen concentrator, ventolin masks) or procedures (e.g. colostomies) and is able to independently complete care required.
Level II

- May require therapies (oxygen concentrator, ventolin masks) or procedures (e.g. colostomies).
- Requires assistance to complete task.
- May require assistance with set up and/or cleaning of equipment.
- Will require professional monitoring.

Level III

- Has medical problem(s) which require continuous supervision and may require frequent professional intervention.

Level IV

- May be technology dependent or need both a medical device to compensate for the loss of a vital body function and ongoing professional health care to maximize functioning or prevent further disability e.g. tracheotomy, enteral feed, vascular access device, mechanical ventilation.
Schedule “C”

Facility Funding Policy and Approved Budget

ARTICLE 1 - Policy

1.1 This policy describes the provision of funding available to a Contractor.

ARTICLE 2 - Definitions

Terms used in this Policy shall have the following meanings:

(a) “Approved Budget” is the combined total budget for the Protected and Unprotected Envelopes.

(b) “Client Contribution” is that amount that a Resident is required to contribute to the cost of Long Term Care services, to a monthly maximum of $2,800, as determined through the Long Term Care financial assessment process.

(c) “Long Term Care Financial Assessment” is the policy and process to determine the amount that a client is expected to contribute to the cost of Services (Appendix 1).

(d) “Protected Envelope” is the portion of the Approved Budget that is designated for Program Costs and Raw Food Costs.

(e) “Program Costs” is the services, items required to deliver the program of LTC, including staffing and associate support services.

(f) “Unprotected Envelope” is the portion of the Approved Budget that is designated for capital costs, maintenance and non-care related services.

(g) “Raw Food Costs” are the costs established per Section 5.3.

(h) “Resident” means an individual assessed and approved for admission to a long term care facility, in accordance with the Placement Policy of the Regional Health Authority.

(i) “Resident Care Services Agreement” (RCSA) is the agreement between the Contractor and the Regional Health Authority outlining program requirements for the provision of Services, to which this Facility Funding Policy and Approved Budget forms a schedule.

(j) “Regional Health Authority” (Regional Health Authority) is the autonomous body authorized to provide and responsible for the delivery of health and community services, on behalf of the Department of Health and Community Services.
(k) "Service Approval" is the approval issued by the Regional Health Authority that determines that a LTC Bed is available and suitable, meeting all requirements, for use by Residents.

(l) "Services" means long term care services as specified in the RCSA.

ARTICLE 3 - CLIENT CONTRIBUTION

3.1 Clients are financially assessed by the Regional Health Authority, using the Long Term Care Financial Assessment Policy, to determine the amount of the client contribution, to a monthly maximum of $2,800 for Services.

3.2 The Contractor will receive written notification of the client contribution for each resident and will be responsible to collect the client contribution for each Resident.

3.3 The Regional Health Authority is the payer of last resort for Services.

ARTICLE 4 - APPROVED BUDGET

4.1 The Approved Budget will be provided as a per diem in two distinct funding envelopes, the Protected Envelope and the Unprotected Envelope. The Contractor will be informed annually of their Approved Budget for the provision of Services.

4.2 The Contractor is expected to operate within the Approved Budget. The Regional Health Authority agrees that the Contractor is entitled to manage the Facility and to deploy resources, under the Protected Envelope, while ensuring that required standards and outcomes are achieved as set out in the RCSA and Long Term Care Operational Standards. In addition, the Regional Health Authority acknowledges that decision making authority with respect to human resource issues reside with the Contractor, and that the Contractor has the full rights of an employer including, but not limited to, the recruitment and retention of personnel and the right to develop personnel policies and practices, in accordance with the Long Term Care Operational Standards and the RCSA.

ARTICLE 5 - PROTECTED ENVELOPE

5.1 The Protected Envelope is inclusive of Program Costs and Raw Food Costs as agreed between the Contractor and the Regional Health Authority as set out in the table attached as Appendix 1.

5.2 Program Cost is inclusive of:

(1) Resident Care Staff

The Regional Health Authority will fund Registered Nurses, Licensed Practical Nurses, Personal Care Attendants Assistants, and/or other supportive positions, based on the number of approved beds, the Long Term Care Operational Standards, and subject to available resources.
(2) Program Support Staff

The Regional Health Authority will fund Dieticians, Physiotherapists, Occupational Therapists, Social Workers, Recreation staff, and/or other supportive positions, based on the number of approved beds and the Long Term Care Operational Standards, and subject to available resources.

(3) Employee Benefits

The Regional Health Authority will fund a standardized benefit rate for the sector, as approved by the Department of Health, to each Facility which will encompass Canada Pension Plan, Employment Insurance, Workers Compensation, Pension, and applicable employer premiums for Group Insurances such as Life, Health, and Medical. Unique supplemental rates will be applied as approved by the Department of Health.

(4) Operational Costs

The Regional Health Authority will fund Resident care and program support supplies necessary to fulfill Long Term Care Operational Requirements at approved rates as determined by the Regional Health Authority.

5.3 The Raw Food Costs, which include Meal Days, Specialty Products, and Supplements (all as defined below), for Residents in the Facility, will be funded at approved rates determined as follows:

(1) Raw Food Costs include the costs of all the ingredients and food items necessary to create a meal day, which includes the food products on the menu, supplements, and any specialty products required to meet the daily nutritional needs of the Residents.

(2) Meal Day is one 24 hour period, which includes 3 nutritious meals (as per recommendations of Canada’s Food Guide) with at least 2 choices per meal plus beverages, and two snacks throughout the day. A snack should be at least a beverage and a food item such as a starch or fruit. Provision will be made for variation which may be required cultural/religious reasons.

(3) Specialty Products are particular food products needed to support therapeutic diets, e.g. gluten-free, calorie reduced, low sodium, low fat.

(4) Supplements are enteral nutritional formulae, either homemade or purchased; to meet a Resident’s assessed nutritional need; and calcium and vitamin D food enrichment.

5.4 In any given year, funding from the Protected Envelope not used for its intended purpose will be forfeited or, if advanced, recovered. Any budgetary deficits will not be funded by the Regional Health Authority.

ARTICLE 6 - UNPROTECTED ENVELOPE

6.1 The Unprotected Envelope will include Capital Costs, Services Costs and all other costs,
overheads, profits and return on investment required to provide the Services that are not included in the Protected Envelope and as are agreed between the Contractor and the Regional Health Authority and set out in the Appendix 2 hereto.

6.2 Funding under the Unprotected Envelope shall be adjusted annually in accordance with indexed the all-items Consumer Price Index (CPI) for NL as follows:

(a) Capital Costs shall not be indexed; and

(b) The Regional Health Authority will index operational costs annually based on the all-items Consumer Price Index (CPI) for NL.

6.3 The Contractor is expected to operate within the Unprotected Envelope portion of the Approved Budget with respect to the service requirements to meet the Long Term Care Operational Standards and the legal obligations described in the RCSA. Any surplus may be retained by the Contractor, any deficits will not be funded by the Regional Health Authority.

6.4 Quarterly reconciliations will be conducted by the Regional Health Authority to compare estimated resident contribution to actuals. If the Contractor collects more from Residents than estimated, the amount will be recovered by the Regional Health Authority. If the amount the Contractor is responsible for collecting from Residents is less than estimated, the Department of Health will subsidize these costs.
Appendix 1 to Schedule C

(Description of Protected Costs to be agreed between the parties)
Appendix 2 to Schedule C

(Description of Unprotected Costs to be agreed between the parties)
Schedule “D”

To The Statement of Requirements

Facility Development Status Report

The Contractor is to provide a monthly report indicating the status of the facility construction no later than the 10th of each month. The monthly report shall provide a brief narrative describing the work completed during the month (photographs included) as well as planned activities for the next month in each of the following categories:

1. Environmental including sedimentation control
2. Site work including civil construction
3. Landscaping
4. Structural
5. Building envelope
6. Architectural including finishes and door hardware
7. Conveying systems
8. Mechanical
   a. Fire suppression
   b. Plumbing
   c. HVAC
   d. Integrated automation
9. Electrical
10. Utilities
11. Specialty systems including but not limited to:
   a. Food Service
   b. Laundry
   c. Access control

The Contractor will develop and maintain a project risk register with particular emphasis on any risks that may impact project schedule. The Contractor will clearly articulate any change in project risks and identify risk management strategy.
Schedule “E” to the Statement of Requirements

Site and Facility Location – Specific Requirements

1. Specific Requirements for Western Health

120 long-term care beds are to be provided in a stand-alone building on a designated site in Corner Brook that has been nominated by Western Regional Health Authority (Western Health). The site will be sold to the Contractor at fair market value. Water, storm and sanitary sewer will be provided to the edge of the site as well as an access roadway. These services have been installed in advance by Western Health and there will be a metered charge to the contractor for water and sewer use. The contractor will be responsible for the cost of all meter installation.

Area:
The long term care service provider will purchase, at fair market value, the area enclosed by the Ring Road and the extent of Phase 1 construction as noted in the drawing PH1-01 included in the electronic data room. The schematic footprint, parking lots and landscaping are included for illustrative purposes only. The Contractor will be expected to design, construct and operate the facility within the designated area. A detailed survey and will be provided to the Contractor.

Site Services:
External services will be provided to the long term care site. The Ring Road will be constructed to support site transportation including curb, gutter sidewalks and asphalt. Site services such as water, sanitary sewer, and storm systems are installed and capped inside the LTC area for future use by the Contractor. Fire hydrants and site lighting along the Ring Road will be installed and will be operated and maintained by Western Health. A drawing describing the existing site services and location is provided in the electronic data room.

There is limited area for snow management on the site. The Contractor will propose an appropriate snow management area along the western side of the Ring Road. This area will be subject to approval of Western Health.

Electrical and telecommunications service will be the responsibility of the Contractor.

Installation of all services within the long term care area will be the responsibility of the Contractor. This will include, but is not limited to the following:

- Connections to the water, sanitary and storm water systems
- Any parking lot or exterior lighting that is within the boundaries of the ground lease area
- Installation of any fire hydrants within the ground lease area
- All electrical and telecommunications connections from the utility to the facility
- Any and all exterior signage
The Contractor will be expected to operate and maintain all areas within the long term care area.

Limitations
The long term plan for the site includes the development of a regional acute care facility. The Contractor will not negatively impact the development or operation of the acute care facility. This will include but is not limited to:

- Disposal of any and all surplus material
- Maintaining current rough grades for all areas outside the long term care area
- The Contractor will complete an emissions dispersion study during design to ensure that any exhaust from the facility will not negatively impact air quality in the new acute care facility. The Long Term Care service provider will be responsible for completing regular monitoring to confirm compliance.

2. Specific Requirements for Central Health

The 120 long-term residential beds are to be provided in 2 separate buildings, the first a 70 bed unit in the municipal boundaries of Gander, and the second, a 50 bed unit to be provided within the boundaries of the municipalities of Grand Falls-Windsor and Bishop’s Falls.

3. Summary Requirements for Eastern Health

A Facility is to be provided within the municipal boundaries of the cities of St. John’s, Mount Pearl, or the towns of Paradise and Conception Bay South. The Facility will have 120 long-term care beds, of which 72 beds be used to accommodate long-term care residents and 48 beds will be used to care for residents with mild to moderate dementia. The Facility’s construction will require that these 48 Beds will be clustered or grouped such that they are distinct from and can be provided a different level of Service delivery model and programming, consistent with that required for such a population from that provided to the remainder of the Beds in the Facility.
RFP Contract No: XXXXXX

RESIDENTIAL CARE SERVICE AGREEMENT dated the ______ day of
______________________, 2015

BETWEEN:

_________ Regional Health Authority, established and existing under and
pursuant to the Regional Health Authorities Act, S.N.L. 2006, chapter R -
7.1

(hereinafter referred to as the “Regional Health Authority”)

OF THE FIRST PART

- and -

XXXXX, [insert the name(s) of the Group, Joint Venture or other Juridical Entity
defined in the Contractor’s Proposal as accepted by the Regional Health Authority
that will be responsible for developing the Facility and providing its services]

(hereinafter referred to as the “Contractor”)

OF THE SECOND PART

WHEREAS

• The Regional Health Authority require the provision of ____ long term care beds and
associated services in the community of ______ for a period of 25 years; and

• Through the Request for Proposals process the Regional Health Authority selected the
Contractor for the provision of these services, and through further negotiations the Regional
Health Authority and the Contractor have subsequently agreed to the terms and conditions for
the provision to the Regional Health Authority of the Long Term Care Beds and related
Services as described in this Agreement.

WITNESSETH that in consideration of the mutual covenants, promises and agreements
contained in this Agreement, and other good and valuable consideration, the receipt and
sufficiency of which are hereby acknowledged, the Parties to this Agreement agree as follows:

ARTICLE 1 - INTERPRETATION

1.1 Definitions

In this Agreement
(a) "Agreement" means this Agreement, including the Schedules to this Agreement as they may be amended from time to time;

(b) "Applicable Law" means, with respect to any Person, property, transaction, event or other matter, any law, rule, statute, regulation, order, judgment, decree, treaty or other requirement having the force of law relating or applicable to such Person, property, transaction, event, or other matter. Applicable Law also includes, where appropriate, any interpretation of the Applicable Law by any person having jurisdiction over it;

(c) "Approved Budget" means the total amount of funding that will be made available to the Contractor on an annual basis on an annual budget taking into account the Unprotected Envelope per diem rate with applicable charges in accordance with Article 4 and the Protected Envelope per diem rate as prescribed by and determined in the manner set out in this Agreement and in Schedule C and any amendments thereto. This amount will be confirmed with the Contractor in an Annual Funding Letter;

(d) "Authorized Client Contribution" means the amount for long term care that a Resident is required to pay to the Contractor in accordance with the Long Term Care Financial Assessment Policy and is appended as Schedule "C" to this Agreement;

(e) "Available" means a Bed that has been prepared and maintained in compliance with Article 7.2 of Schedule "B" and is ready for use and occupation by a Resident and for which the required level of care and Services acceptable to the Regional Health Authority can be provided to a Resident in accordance with the standard of care and Services prescribed under this Agreement, including the related ancillary support facilities required to provide the Services, whether or not the Regional Health Authority has a Resident available to occupy that Bed and room.

(f) "Beds" means the Long Term Care Beds and any other Beds provided to the Regional Health Authority and operated under this Agreement;

(g) "Business Day" means any day except Saturday, Sunday or other day on which the Newfoundland and Labrador Provincial Government is not open for business;

(h) "Confidential Information" means any and all information of which either Party becomes aware, or which one Party received (either directly or indirectly) from the other Party or otherwise, in connection with or relating to the Services, the Facility or this Agreement, including all personal information and records, and all business, technical, and other proprietary information of either Party;

(i) "Contractor's Personnel" means the controlling shareholders (if any), directors, officers, employees, agents, subcontractors or other representatives of the
Contractor and any team member and affiliates and their Shareholders, directors, officers, employees, agents, or other representatives;

(j) “Contractor’s Proposal” means the proposal submitted in response to the Request for Proposals.

(k) “Day” means calendar day;

(l) “Department” means the Newfoundland and Labrador Department of Health and Community Services;

(m) “Development of the Beds and the Services” means the doing of all things by, for or on behalf of the Contractor at the cost of the Contractor or those with whom the Contractor contracts to have the Beds and the Services in the Facility where they are to be located ready for Occupancy and Available, including as may be necessary the purchase of a site, construction, and all other work to be performed and steps taken by, for or on behalf of the Contractor to make the Beds and the Services in the Facility (including the furnishing, fittings, and equipment thereof), ready to operate in accordance with this Agreement and in conformity with Statement of Requirements Agreement;

(n) “Director of Care” means the member of the Contractor’s Personnel named by the Contractor to supervise and oversee the Contractor’s day to day delivery of the Beds and the Services at the Facility pursuant to this Agreement.

(o) “Facility” means the Long Term Care Facility located at ____________, Newfoundland and Labrador in which the Beds and Services provided under this Agreement are located, and for greater certainty, includes the Beds and the common areas and common elements which will be used, at least in part, for the Beds and the Services but excludes any other part of the building which will be used for other uses other than Long Term Care and which will not be used for the Beds and the Services being operated by the Contractor pursuant to this Agreement;

(p) “Funding Amendment” means an amendment to the funding provisions of this Agreement, including an adjustment to the Annual Budget or an amendment to the terms upon which the Annual Budget are provided, pursuant to Article 4.

(q) “Interim Administrator” means the person appointed by the Regional Health Authority pursuant to section 13.2(1)(b)(iv) to take over and administer on an interim basis the Beds and the delivery of the Services for Residents associated with and related to the Beds at the Facility until such time as the breach giving rise to such appointment is remedied or the Agreement is terminated by the Regional Health Authority.
(r) “Minister” means the Minister of Health and Community Services or a representative thereof;

(s) “Newfoundland and Labrador Long Term Care Operational Standards” includes the policies, guidelines, directives and information as listed in Schedule “B” related to Long Term Care and the operation of the Beds and provision of the Services, set out or referenced in Schedule “B” to this Agreement and includes any amendments to the same made by the Regional Health Authority and/or the Department and any statute or regulation of the Province of Newfoundland and Labrador that replaces, supplements or modifies the same;

(t) “Occupancy” means the admission of the first Person as a Resident of the Facility and the commencement of the delivery of Services;

(u) “Occupancy Date” means ;

(v) “Party” means a Party to this Agreement, and any reference to a Party includes the successor and permitted assigns;

(w) “Per Diem Payment” means the payment, to the Contractor calculated pursuant to Article 4;

(x) “Performance Assessment” means the Regional Health Authority’s assessment of the extent to which the Contractor is or is not providing Beds and Services in accordance with the Program Requirements and Newfoundland and Labrador Long Term Care Operational Standards;

(y) “Person” is to be broadly interpreted and includes an individual, a corporation, partnership, trust, a joint venture, an unincorporated organization, an association, the government of a country or any political subdivision thereof, or any agency or department of any such government, and the executors, administrators or other legal representative of an individual of such capacity;

(z) “Personal Information” means Personal Information as defined in the Access to Information and Protection of Privacy Act, 2015, and the Personal Health Records Act which is collected, acquired or obtained by or on behalf of the Regional Health Authority, or by the Contractor in relation to providing the Services;

(aa) “Program and Raw Food Costs” means the health care and raw food costs referred to in Schedule “C” to this Agreement.

(bb) “Program Requirements” means those written requirements established by the Regional Health Authority and as amended from time to time and which are applicable to the Services, the Facility and the Contractor and as outlined in Schedule “B” to this Agreement;
“Protected Envelope” means the portion of the Per Diem Payment for Program and Raw Food Costs that is funded at rates approved by the Regional Health Authority in accordance with Schedule “C”, and forms part of the Approved Budget;

“Province” means the Province of Newfoundland and Labrador;

“Request for the Proposals” means the request for proposals issued by the Department on behalf of the Regional Health Authority and any amendments thereto which resulted in this Agreement.

“Reports” means the financial, statistical and other reports referred to in Section of this Agreement that are identified in Schedule “D” to this Agreement.

“Resident” means a person who is admitted to a Facility in accordance with the Placement Policy of the Regional Health Authority as referenced in the Newfoundland and Labrador Long Term Care Operational Standards;

“Service Approval” means the approval issued by the Regional Health Authority under the Statement of Requirements Agreement between the Regional Health Authority and the Contractor relating to the Facility;

“Services” includes accommodation, programs, goods, social work services, physiotherapy services, dietary services, recreational therapy and occupational therapy services, dietician services, pharmaceutical management, and personal and skilled nursing care related to the Beds operated under this Agreement, as described in the Newfoundland and Labrador Long Term Care Operational Standards included in Schedule “B”;

“Significant Risk” means a risk, where it is determined that there has been a breach of this Agreement by the Contractor, which in the opinion of the Regional Health Authority acting in its sole discretion has caused significant risk to the health or safety of a Resident, staff or member of public;

“Site” means the piece of real property referenced in the Contractor’s Proposal on which the Facility which houses the Beds and the Services will be located;

“Staffing Model” means the staffing model set out in Schedule B to this Agreement and includes any amendments made to the same by the Regional Health Authority or the Department during the term of this Agreement;

“Statement of Requirements Agreement” means the agreement between the Parties executed contemporaneously with this Agreement and which establishes the Service Approval process for the Facility, such Service Approval being required under this Agreement.
“Suitability Assessment” means the Regional Health Authority’s assessment of the extent to which the Beds and the Services, the Facility in which they are being offered and the Contractor’s Personnel, all or any one of them, is or is not suitable to meet the Services needs of Residents and the requirements of this Agreement;

“Term” means the term of this Agreement as set forth in Article 8 together with any extensions or renewals thereof;

“Unprotected Envelope” means the portion of the Per Diem Payment for the Unprotected Envelope that is funded at rates approved by the Regional Health Authority in accordance with Schedule “C”, and forms part of the Approved Budget.

“Unavailable” means the conditions that must exist under this Agreement for a Bed to be considered unavailable resulting in the Regional Health Authority not being obligated to make a Per Diem Payment to the Contractor in respect of that Bed. In this regard, a Bed is considered to be unavailable when and as long as it and the room in which it is situated is not accepted by the Regional Health Authority as ready for use and occupation by a Resident and a level of care and Services acceptable to the Regional Health Authority cannot be provided to a Resident in accordance with the standard of care and Services prescribed by the Regional Health Authority under and pursuant to this Agreement, whether or not the Regional Health Authority has a Resident available to occupy that Bed and room.

1.2 **Headings and Division**

The division of this Agreement into sections and the insertion of headings are for convenience of reference only, and are not intended to affect the construction or interpretation of this Agreement.

1.3 **Calculation of Time**

Unless otherwise specified, time periods within or following which any payment is to be made or any act is to be done shall be calculated by excluding the day on which the period commences and including the day on which the period ends.

1.4 **Number and Gender**

Unless the context requires otherwise, words importing the singular include the plural and vice-versa and words importing gender include all genders.

1.5 **Including**

The word “including” when following any general term or statement to the specific matter immediately following the word “including” or to similar matters, and the general term or
statement will be construed as referring to all matters that reasonably could fall with the broadest possible scope of the general term or statement.

1.6 Statute

Unless otherwise specified, each reference to a statute is deemed to be a reference to that statute, and to the regulations made under that statute, as amended or re-enacted from time to time, and each reference to a statute is a reference to a Newfoundland and Labrador statute.

1.7 Schedules

The following Schedules and Appendices are incorporated into and form part of this Agreement:

Schedule “A” - Contractor’s Proposal;

Schedule “B” - Newfoundland and Labrador Long Term Care Operational Standards;

Schedule “C” - Facility Funding Policy;

Schedule “D” - Reporting Requirements / Performance Monitoring Framework

1.8 Conflict

(1) In the event there is any conflict between the terms of:

(a) Applicable Law;

(b) This Agreement; and

(c) The Schedules to this Agreement

the terms of the Applicable Law or the document that is higher on the list takes precedence.

(2) For greater certainty the Parties further agree that in the event of any conflict between the Contractor’s Proposal and the remaining content of this Agreement including its Schedules, the remaining terms and conditions of this Agreement and its Schedules shall prevail.

1.9 Department of Health and Community Services

Any reference in this Agreement, Schedule and Appendices attached hereto, to the Department, is, for the purposes of this Agreement, a reference to the Newfoundland and Labrador Department of Health and Community Services.
ARTICLE 2 - SERVICES AND OTHER CONTRACTOR RESPONSIBILITY AND ACCOUNTABILITY

2.1 Contractor’s Obligations

(1) The Contractor shall:

(a) Ensure that by the Occupancy Date at the sole cost of the Contractor, that:

(i) the Facility possesses a Service Approval under the Statement of Requirements; and

(ii) the Beds and the Services referenced in this Agreement to be ready for Occupancy and Available;

(b) operate and provide the _______ Beds at the Facility; consisting of _______ Long Term Care Beds, _______ Beds for ______, and ________ Beds for ______ and

(c) operate the Facility and provide the Services at the Facility;

all in accordance with all Applicable Laws, this Agreement and the Schedules to this Agreement.

(2) The Contractor shall operate the number and designation of Beds as set out in Section (1) and shall not make any change to the number or designation of such Beds without the prior written approval of the Regional Health Authority.

(3) In the event the Contractor contravenes (2), the Regional Health Authority may, at the Regional Health Authority’s discretion:

(a) reduce funding for those Beds in accordance with Section 7.1; and

(b) provide notice to the Contractor in accordance with Article 21.

(4) All financing related to the Facility and to the Contractor’s operation of the Facility and provision of the Beds and the Services referenced in this Agreement shall be the Contractor’s sole responsibility. Financing terms must be disclosed to the Regional Health Authority and the Department. The Regional Health Authority acknowledges that Contractor’s agreements with Lenders may require encumbrances to be registered against the Facility. The Contractor shall assume all risks associated with such financing and any and all of the incremental or other debt servicing costs during the Term and any Renewal, including potential increased costs of borrowing, renewal fees, and other applicable costs. In no circumstances will the Regional Health Authority or the Department be responsible for these potential costs or any financing costs of the Contractor related to the Facility or its operation. Neither will the Regional Health Authority make any adjustment to the Per Diem Payments based on or related to any such financing arrangements made by the Contractor.
(5) During the period of time prior to the Occupancy Date that the Facility, the Beds and the Services are under development, i.e., the Development of the Beds and the Services by the Contractor, the Contractor will permit the Regional Health Authority and/or the Department on One (1) Business Day notice to the Contractor, at any time and from time to time on any Business Day to enter upon the Site and inspect the Site, the Facility, the Beds and/or the Services and progress of the Development of the Facility, provided that the Regional Health Authority and/or the Department shall not unduly interfere with or cause the delay of the Development of the Beds and the Services during the course of such an inspection.

2.2 Occupancy

(1) The Contractor shall in accordance with the Contractor’s Proposal as accepted by the Regional Health Authority carry out and complete the Development of the Beds and the Services and shall ensure that Occupancy has been attained by the Occupancy Date and that the Beds and Services are ready to be provided to Residents by the Contractor in accordance with this Agreement. The Regional Health Authority may, at any time, in the Regional Health Authority’s sole and absolute determination, extend the Occupancy Date or any or all of the deadlines set forth in this Agreement, if the Regional Health Authority determines that the Beds are Unavailable as of the Occupancy Date.

(2) The Contractor shall notify the Regional Health Authority in writing upon becoming aware of any actual or threatened occurrence or condition which would reasonably be expected to cause a delay in meeting the Occupancy Date set forth in the Agreement.

2.3 Post Occupancy

(1) Following Occupancy and the Occupancy Date the Contractor will:

(a) Provide the Beds and the Services to Residents in the Facility in accordance with the terms of this Agreement;

(b) ensure that the Beds and the Services are made available on a continuous and consistent basis throughout the term of the Agreement;

(c) be responsible for the quality of the Beds and the Services, and in this regard will provide the highest possible quality Beds and Services and without limiting the foregoing, will provide such Beds and Services in accordance with the higher of the following standards:

(i) the standard of care, skill and diligence exercised by a competent person providing services similar to the Services;

(ii) the requirements set by the Regional Health Authority from time to time in the Schedules to this Agreement;
(iii) Accreditation through Accreditation Canada; and
(iv) Applicable Laws;

(d) take such measures as are necessary to ensure there are no material health or safety risks to Residents, staff or members of the public, including such measures as may be required by:

(i) the Regional Health Authority;

(ii) the Department;

(iii) Applicable Law; and

(iv) prudent management practices;

(e) make best efforts to ensure that the Facility and the Beds and the Services is, at all times, maintained and operated in a safe and appropriate manner so as to constitute a safe and appropriate environment for Residents, staff and members of the public;

(f) ensure (and the Contractor hereby represents) that it does and will at all times have the right to the use of the Facility for the purposes of and in accordance with the Agreement;

(g) collaborate and participate with the Regional Health Authority and use best efforts to develop, and then implement, such changes as the Regional Health Authority may require in order to add or alter Services, improve Services and reduce costs to the health care system, all within such period of time as the Regional Health Authority may require;

(h) collaborate and participate with the Regional Health Authority to develop, and then implement, such changes as the Regional Health Authority may require in connection with the revision of the service delivery models to achieve its long term goals of delivering health care services in an easily accessible and highly integrated manner across the continuum of care, all within such period of time as the Regional Health Authority may require. Without limiting the generality of the foregoing, such required changes may include changes to the nature of the Services and the method of delivery of such Services;

(i) take steps to ensure avoidance of conflicts of interest between the interests of the Contractor or the Contractor’s Personnel, on the one hand, and those of the Regional Health Authority on the other. If the Contractor or any the Contractor’s Personnel become aware of any such conflicts, the Contractor will promptly disclose to the Regional Health Authority the facts and circumstances pertaining to the same; and
(j) promptly advise the Regional Health Authority in writing of any circumstances that may materially adversely affect the ability of the Contractor to meet its obligations to provide the Services on the terms set out herein.

(2) Without limitation to its other obligations under the Agreement the Contractor is and shall be required to be accredited with Accreditation Canada at all times during the term of this Agreement at its own cost. If on the Effective Date the Contractor does not hold a current accreditation certificate or meet the standards of such other Authority-approved quality assurance process (“Accreditation”), the Contractor will: (a) begin such process within One (1) year of the Occupancy Date; (b) achieve Accreditation within two (2) years of the Occupancy Date; and (c) maintain Accreditation throughout the remainder of the term of this Agreement. The Contractor will provide the Regional Health Authority with such other information as the Authority may require in connection with its compliance with this Section.

2.4 Bed Designation

(1) The Contractor agrees that it will designate Beds and space within and among the complement of Beds referenced in Section 2.1(1), as directed by the Regional Health Authority.

(2) In the event the Contractor incurs any additional costs as a result of a change in the designation of Beds and space under Section 2.11(1), the matter of the compensation payable by the Regional Health Authority to the Contractor as a result of such additional costs will be resolved through negotiation and agreement between the Parties, acting reasonably.

2.5 Liquidated Damages Upon Delay in Occupancy

(1) To the extent that all Beds under this Agreement are not Available as required by this Agreement by the Occupancy Date, the Regional Health Authority may at its sole discretion require the Contractor to pay to it liquidated damages in an amount calculated as:

(a) a per diem rate for each Bed that is not Available, calculated and based upon the Per Diem rate per Bed that the Regional Health Authority would have paid to the Contractor for each such Bed per day had it been Available in accordance with this Agreement; multiplied by

(b) each day beyond which the Occupancy Date for which each Bed is not Available.

2.6 Liquidated Damages Upon Abandonment

(1) In the event the Regional Health Authority determines that the Contractor will not satisfy its obligations by the Occupancy Date or otherwise determines that the Contractor has abandoned the project in accordance with Section 13.2(1)(a)(i), the Contractor will
compensate the Regional Health Authority for the additional time needed by the Regional Health Authority to either find an alternate contractor or to construct the Beds itself. Such compensation shall be payable on demand by the Regional Health Authority at any point after the determination above is made.

(2) The compensation will be calculated in accordance with Section 2.11 using the Regional Health Authority’s estimate of additional time as the basis for the calculation to a maximum of $500,000.

(3) The Contractor will secure this potential obligation with a letter of credit in the amount of $500,000 that the Regional Health Authority can draw on immediately once abandonment has occurred.

(4) Should the actual delay be less than the amount of time the Regional Health Authority estimates, a credit will be returned for the difference between the estimate and actual delay.

2.7 Liquidated Damages Generally

(1) The damages payable under sections 2.11 or 2.12 are in addition to any other remedies available to the Regional Health Authority, including termination.

(2) The Contractor agrees that such damages shall be payable as liquidated damages without proof of specific loss or damage and are payable whether or not the Regional Health Authority incurs or mitigates the Regional Health Authority’s damages.

(3) The Contractor acknowledges that such liquidated damages are not a penalty but represent a reasonable pre-estimate of the damages that the Regional Health Authority will suffer as result of the delay in achieving the Occupancy Date. The Contractor has taken the possibility of these damages into account in the pricing of its Proposal and acknowledges that the Regional Health Authority has relied on this opportunity to recover such damages in entering into this Agreement.

ARTICLE 3 - STAFFING

3.1 Staffing Model

(1) The Contractor agrees that it will implement the Staffing model referenced in this Agreement, the Contractor’s Proposal appended as Schedule “A” to this Agreement, and the Newfoundland and Labrador Long Term Care Operational Standards appended as Schedule “B” to this Agreement.

(2) In the event the Contractor is unable to implement a staffing model due to circumstances beyond the control of the Contractor, which will be determined at the Regional Health Authority’s sole discretion, the Regional Health Authority may negotiate funding in accordance with an alternate staffing model with the Contractor that is acceptable to the Regional Health Authority or may decline to accept affected Beds as Beds Unavailable if
an alternate staffing model that is acceptable to the Regional Health Authority cannot be implemented.

ARTICLE 4 - APPROVED BUDGET AND PAYMENT OF FUNDING

4.1 Approved Budget and Payment

(1) The Approved Budget for the Contractor shall be determined annually as the aggregate of the Protected Envelope and Unprotected Envelope, in accordance with this Agreement and Facility Funding Policy appended as Schedule “C” to this Agreement. The Annual Budget may be adjusted from time to time throughout the term of this Agreement on the terms set out herein.

(2) The Regional Health Authority shall pay the Contractor the Approved Budget on the basis of a per diem payment for each Bed in the Facility, calculated on the assumption of 100% Availability of each Bed (the “Per Diem”). Such payment and calculation is subject to being reduced pursuant to Article 7. The amount of such payment shall be calculated and paid monthly in advance on the first day of each month until the end of this Agreement.

(3) Payment of the Approved Budget, through payment of the Protected and Unprotected Envelope as set out herein, shall be the total financial obligation of the Regional Health Authority under this Agreement except as otherwise specifically stated in this Agreement. The Regional Health Authority will not be responsible or liable for any operating or working capital deficits incurred in the Contractor’s operations or as a result of this Agreement or otherwise. The Contractor will accept such payment in full satisfaction of the financial obligations of the Regional Health Authority under this Agreement.

(4) In the event of Changes to the funding allocation from Government to the Regional Health Authority such that the Regional Health Authority at its sole discretion determines that an Funding Amendment is necessary or desirable, or if the Regional Health Authority at its sole discretion otherwise determines that such a Funding Amendment is necessary or desirable, then

(a) prior to making any Funding Amendment but without limitation to its rights pursuant to (b) below, the Regional Health Authority will discuss the Funding Amendment, including any contemplated changes to the number of Residents, types of Residents, extent and level of Services and amount payable for the Services as a result of the Funding Amendment, with the Contractor. Promptly following such discussion, the Contractor will develop a plan, in form and content acceptable to the Regional Health Authority, that minimizes the negative effects of such changes on the Contractor, the Residents and the Regional Health Authority; and

(b) notwithstanding any provision herein to the contrary, the Regional Health Authority may unilaterally impose the Funding Amendment, and such amendment will be binding on the Contractor on such date as the Regional Health Authority
may specify by notice to the Contractor. Any disagreement between the Contractor and the Regional Health Authority regarding any Funding Amendment will not be subject to dispute resolution in accordance with Article 22 Dispute Resolution.

(5) In the event of:

(a) Changes to Applicable Law,

(b) Changes to the standards, policies, guidelines or directives applying to the Regional Health Authority and the Contractor’s obligations under this Agreement; or

(c) Changes to the standards, policies, guidelines or directives of the Regional Health Authority applying to the Contractor’s obligations under this Agreement;

(collectively the “Changes”), the Annual Budget as agreed between the Parties is assumed to include contingencies relating to the incidental or non-material costs for such Changes, and no Funding Amendment will be required.

(6) In the event either the Regional Health Authority and / or the Contractor determine actual or potential material cost implications as a result of compliance with Changes as described in section (5) above, it shall notify the other Party of such implications. The Parties will discuss the need for a Funding Amendment or other alternatives, including any contemplated changes to the number of Residents, types of Residents, extent and level of Services and amount payable for the Services as a result of a Funding Amendment. In the event the Parties are unable to agree on the need or amount of a Funding Amendment, the ultimate discretion respecting any Funding Amendment will be with the Regional Health Authority, acting reasonably, and such decision will be subject to dispute resolution under Article 22 Dispute Resolution.

(7) Notwithstanding any other provision of this Agreement, the provision of funding by the Regional Health Authority to the Contractor pursuant to this Agreement is subject to sufficient funding being available to the Regional Health Authority from the Province in the fiscal year of the Regional Health Authority during which the payment becomes due.

(8) Funds provided by the Regional Health Authority to the Contractor pursuant to this Agreement will be utilized solely for the provision of the Services to Residents.

4.2 Protected Envelope

(1) The Protected Envelope portion of the Approved Budget will be calculated on a per diem basis in accordance with Schedule “C”.

(2) For those elements of the Contractor’s operation which are included in the Protected Envelope, the Contractor shall operate within its Protected Envelope throughout the term of this Agreement. At the end of each year:
(a) Any unspent funds received that relate to the Protected Envelope portion of the Per Diem Payment of the Approved Budget shall be returned to the Regional Health Authority within thirty (30) days of the end of the year to which the unspent funds relates; and

(b) Payment of any costs that exceed the amount of the Protected Envelope shall be borne by and be the sole responsibility of the Contractor.

4.3 Unprotected Envelope

(1) The Unprotected Envelope portion of the Approved Budget will be calculated on a per diem basis in accordance with the methodology set out in Schedule “C” and this Agreement.

(2) The Contractor agrees that any return on investment is included in the Unprotected Envelope portion of the Approved Budget.

(3) The Contractor shall operate within its Unprotected Envelope throughout the term of this Agreement.

(4) The Contractor is and shall be responsible for all costs that form part of the Unprotected Envelope and may retain and keep any savings that accrue to the Contractor’s benefit should the Contractor not spend the full amount of the Unprotected Envelope in a given Approved Budget, provided the Contractor has provided the Beds and the Services in accordance with this Agreement.

4.4 Authorized Client Contribution Adjustment

(1) The Contractor is responsible for collecting the Authorized Client Contribution for each Resident in accordance with the Department’s Long Term Care Financial Assessment Policy as outlined in Schedule "C" as amended by the Department acting in its sole discretion from time to time.

(2) The Regional Health Authority will fund the difference between the amount the Contractor is responsible for collecting in accordance with Section 4.4(1) and the Approved Budget.

4.5 Dispute Resolution – Non-Payment

(1) The Contractor may, where the Regional Health Authority fails to pay any amount, excluding an amount or amounts under Article 7 Reduction of Funding:

(a) provide the Regional Health Authority with written notice of such non-payment with a thirty (30) day deadline for payment;

(b) if nonpayment continues, the Contractor may refer this matter to an independent third party agreed to by both Parties for purposes of mediation; and
(c) if the dispute is not settled within 30 days after the dispute is referred to mediation, then either Party may refer the dispute to arbitration pursuant to the Arbitration Act.

ARTICLE 5 - USE OF FUNDING

5.1 Cost Transfer

(1) The Contractor shall apply those parts of the Approved Budget for each of the Program and Raw Food Costs to each such cost respectively and shall not transfer any such portion of the Program Costs and Raw Food Costs to any other costs or the Unprotected Envelope.

(2) The Contractor may transfer any or all of the Approved Budget for the Unprotected Envelope within the Unprotected Envelope without prior written approval of the Regional Health Authority, provided that the standards and criteria for accommodation as set out in Schedule “B” and “C” have been complied with by the Contractor.

ARTICLE 6 - FINANCIAL, STATISTICAL AND OTHER REPORTS

6.1 Timing

(1) The Contractor shall provide the Reports being the financial, statistical and other reports identified in Schedule “D” in the time frames referenced and indicated in Schedule E, including, the following financial reports annually, within four (4) months of the fiscal year end:

(a) Audited Financial Statements for the Contractor as a corporate or juridical entity and the Facility;

(b) a copy of the Annual Auditor’s Management Letter;

(c) details of expenditures related to the Protected Envelope and the Unprotected Envelope; and

(d) a Business Plan and a Budget for the upcoming year that meets the requirements of the Regional Health Authority; and

(2) The Regional Health Authority may, at any time and for any reason, request that the Contractor provide information in respect of the Occupancy of, and revenues accrued to the Contractor of, for and in respect of any or all of the Beds.

6.2 Financial Records

(1) The Contractor shall maintain proper financial records and books of account in respect of the application and expenditure of the funding provided by the Regional Health Authority under this Agreement for the previous seven (7) year period.
(2) The Contractor shall allow the Regional Health Authority’s staff or such other person as appointed by the Regional Health Authority to inspect or audit said books or records at all reasonable times both during the term and a period of seven (7) years following any termination or expiry of this Agreement.

(3) The Regional Health Authority’s staff shall have the right, upon providing a receipt to the Contractor, to remove any of the financial records and books of accounts as set out in Section 6.2(1) of this Agreement for the purpose of making copies and shall promptly return to the place from which they were removed.

ARTICLE 7 - REDUCTION OF FUNDING

7.1 Suspension of Admissions and Payments

(1) The Regional Health Authority may suspend the admission of Residents to the Facility, and reduce or withhold payments associated with the Beds and the Services provided under this Agreement in the manner specified in Section 7.2, where the Contractor:

(a) has not complied with any and all conditions set out in the Service Approval or any subsequently issued Service Approval or by the deadline (if any) for complying with any and all such conditions set out in the Service Approval or any notice or directive issued pursuant to it;

(b) has not complied with any other notice of non-compliance with this Agreement within thirty (30) days’ written notice of such non-compliance by the Regional Health Authority; and

(c) has not maintained the bedrooms, common areas or support areas in such a manner so that the Beds are Available.

7.2 Adjustment in Per Diems Post-Occupancy

(1) Without restricting the generality of Section 7.1, if following Occupancy:

(a) a Bed becomes Unavailable due to lack of maintenance, the existence of a defect in the Facility or any part of it or as a result of a breach of the terms and conditions of this Agreement by the Contractor, payment to the Contractor will be reduced by the Per Diem Payment associated with that Bed that would have been made to the Contractor by the Regional Health Authority, if it were Available.

(b) a Bed that was Unavailable, or that is determined by the Regional Health Authority acting in its sole discretion should have been deemed and declared Unavailable, is determined to have been occupied by a Resident during the period that it should have been declared to be Unavailable, the Per Diem Payment for that Bed shall be reduced to fifty (50) percent of the Per Diem Payment that would have been
applicable to that Bed had it been available, unless waived by the Regional Health Authority.

(c) If more than 2 Beds at the Facility are Unavailable for any more than 3 days, the Regional Health Regional Health Authority may reduce aspects of its per diem calculations based on the presumption of 100% Availability to reflect the actual Availability of Beds as opposed to the presumption of, subject to the following:

(i) The Contractor will abide by such procedures with respect to the determination by the Regional Health Authority of the Availability of Beds of the Facility as may be determined by the Regional Health Authority from time to time, and will report to the Regional Health Authority regarding its Availability of Beds as and when required by the Regional Health Authority.

(ii) Calculation by the Regional Health Authority of the Availability of Beds to be maintained by the Contractor will exclude:

(1) vacancies that are due to temporary absences of Residents as permitted by policies to that effect of the Regional Health Authority;

(2) vacancies that are due to a Regional Health Authority approved temporary closure to admission of Residents (e.g. due to redevelopment);

(3) vacancies that are due to a Medical Health Officer order of temporary closure to admission of Residents (e.g. due to an infectious outbreak);

(4) beds designated as beds for Residents receiving Services other than long term care, if applicable; and

(5) such other vacancies or exclusions as the Regional Health Authority may approve from time to time.

7.3 **Contractor Charging for Services**

The Contractor is not permitted to charge Residents for the provision of Services, except for those Services as included in a “chargeable services list” which will be issued by the Regional Health Authority from time to time. Where the Regional Health Authority, in Regional Health Authority’s sole discretion, acting reasonably, determines that the Contractor is charging the Residents for Services contrary to this Agreement, the Regional Health Authority shall deduct the amount of those charges from the Annual Budget and the Contractor shall reimburse the Resident the full amount. Failure to do so will result in that amount being deducted, by the Regional Health Authority, from the Annual Budget on a monthly or other basis and paid to the Resident.
7.4 **Failure to Repair**

Where the Contractor fails to conduct maintenance, repairs, or to make a replacement in accordance with a condition of this Agreement, the Contractor agrees that the Regional Health Authority may arrange for such maintenance, repairs, or replacement and deduct the cost thereof from the Annual Budget. The Contractor hereby gives the representatives of the Regional Health Authority, including any agent or subcontractor; authority to enter into the Facility and to conduct such work as may be required to affect such maintenance, repairs, or replacement during work hours or after work hours as may be reasonably required to minimize the disruption of the Facility.

**ARTICLE 8 - TERM**

8.1 This Agreement shall be effective from the date of execution, and shall run from that date to the date which is twenty-five years thereafter, subject to the provisions respecting termination herein.

8.2 Either Party may terminate this Agreement without cause or reason on five (5) years notice to the other Party, during which time the Contractor on or before year 3 of the notice period unless the Parties otherwise agree shall put the Transition Plan into effect.

8.3 Where the Contractor receives such notice, the Contractor will put into effect, as soon as it is reasonably possible, the Transition Plan as referenced in Article 13.

**ARTICLE 9 - CONFIDENTIALITY**

9.1 The Contractor and the Contractor’s Personnel shall hold confidential and shall not disclose or release to any person at any time during or following the termination of this Agreement, except in accordance with Applicable Law, any document that may identify or identifies any Resident in receipt of Services without obtaining the written consent of the Resident, or the Resident’s lawful representative, prior to the release or disclosure of such information.

9.2 The Contractor and the Contractor’s Personnel shall treat as confidential and not make public or divulge during as well as after, the term of this Agreement, any information or material related to the work herein described including information obtained through contact with personnel of the Regional Health Authority, Residents or other persons without having obtained the Regional Health Authority’s consent, and, as applicable, the consent of Residents and other persons thereto in writing.

9.3 The Regional Health Authority agrees subject to the *Access to Information and Protection of Privacy Act, 2015* and the *Personal Health Information Act* to treat as confidential all information provided to the Regional Health Authority by the Contractor.

9.4 The Contractor acknowledges and confirms that it has read and understands its obligations under *Access to Information and Protection of Privacy Act, 2015* and the *Personal Health Information Act*.
Information Act and that the Contractor hereby undertakes, covenants and agrees to be bound by and comply with the obligations imposed on it under the Access to Information and Protection of Privacy Act, 2015 and the Personal Health Information Act.

9.5 The Contractor further covenants, warrants and represents to the Regional Health Authority that it will not at any time provide or allow the release of personal information to which it has access in its capacity as a Contractor to the Regional Health Authority in response to any “request or demand for disclosure” or permit or allow the “unauthorized disclosure of personal information” as each of those terms or concepts are defined or referenced in the Access to Information and Protection of Privacy Act, 2015 and the Personal Health Information Act.

9.6 The Contractor shall at all times strictly enforce such security arrangements as may be required to protect all personal information that it collects or uses on behalf of the Regional Health Authority and shall confirm in writing to the Regional Health Authority, upon request, the details of those security arrangements.

9.7 All personal information that the Contractor obtains or becomes aware of while providing services to the Regional Health Authority is not and shall not be or deemed to be property of the Contractor; and the Contractor expressly confirms that it will not, either directly or indirectly, acquire any rights to use or own any such personal information except the right to use it for the sole purpose of fulfilling its obligations to the Regional Health Authority and/or Residents hereunder.

9.8 The parties expressly agree that the laws of the Province of Newfoundland and Labrador shall apply to this Agreement and to any breach by the Contractor of its obligations under this clause or under the Access to Information and Protection of Privacy Act, 2015 and the Personal Health Information Act.

9.9 The Parties agree that the Regional Health Authority shall retain all rights (including, without limitation, all intellectual property rights), title, and interest in any and all Confidential Information provided to the Regional Health Authority pursuant to this Agreement.

ARTICLE 10 - LIMITATION OF LIABILITY AND INDEMNIFICATION

10.1 Limitation of Liability

(1) The Regional Health Authority and the Regional Health Authority’s officers, employees, volunteers, agents and other representatives and successors and assigns shall not be liable to the Contractor or the Contractor’s Personnel for any losses, expenses, costs, claims, damages (including incidental, indirect and consequential damages) and liabilities arising in connection with or as a result of anything done or omitted to be done by the Contractor or the Contractor’s Personnel in carrying out the performance of the Agreement unless such injury, loss, or damage is caused solely and directly by the negligence of an officer, or
servant of the Regional Health Authority while acting within the scope of his or her employment.

(2) The Regional Health Authority and the Regional Health Authority's officers, employees, independent contractors, subcontractors, agents, successors and assigns shall not be liable for any injury or damage (including death) to the person or for the loss or damage to the property of the Contractor, in any manner based upon, occasioned by, or in any way attributable to the Contractor's Services under this Agreement unless such injury, loss, or damage is caused solely and directly by the negligence of an officer, or servant of the Regional Health Authority while acting within the scope of his or her employment.

10.2 **Indemnification by Contractor**

(1) The Contractor shall indemnify and save harmless the Regional Health Authority and its officers, employees, volunteers, agents and other representatives, successors and assigns (collectively, the "Indemnified Parties") from any and all losses, damages (including incidental, indirect and consequential damages), liabilities, judgment, claims, demands, causes of action, suits, actions or other proceedings of any kind or nature and expenses (including legal fees on a solicitor and solicitor's own client basis) which the Indemnified Parties, or any of them, may suffer or incur arising in connection with or as a result of anything done or omitted to be done by the Contractor or the Contractor's Personnel in the performance of this Agreement, including any breach by the Contractor of its obligations under, or its representations, warranties and covenants set forth in, this Agreement. The indemnity referred to in this Section 10.2 shall not extend to any costs, losses, damages, judgments, claims, demands, suits, actions, causes of action, contracts or other proceedings of any kind or nature to the extent that they are based on, occasioned by, or attributable to anything negligently done or omitted to be done by the Regional Health Authority or the Regional Health Authority's staff in connection with this Agreement or the performance of this Agreement.

(2) The indemnity referred to in this Article 10.2 shall not extend to any costs, losses, damages, judgments, claims, demands, suits, actions, causes of action or other proceedings of any kind or nature to the extent they are based on, occasioned by, or attributable to anything negligently done or omitted to be done by the Regional Health Authority or the Regional Health Authority's staff in connections with this Agreement or the performance of this Agreement.

**ARTICLE 11 - INSURANCE**

11.1 The Contractor shall protect itself from and against all claims that might arise from anything done or omitted to be done by the Contractor or the Contractor's personnel under this Agreement, and more specifically, all claims that might arise from anything done or omitted to be done under this Agreement resulting in bodily injury (including personal injury), death, or property damage, including loss of use thereof, if caused.
11.2 The Contractor shall purchase and maintain in full force and effect insurances to protect itself, the Contractor's Personnel, the Contractor's contractors and subcontractors, their successors and assigns and their respective directors, officers, employees, agents and servants, and any volunteers, involved in the Services and the Regional Health Authority for the purposes and risks outlined herein:

(1) All Risk Property Insurance, which shall include flood and earthquake insurance, for all risks of loss of or damage to the Facility including coverage for the costs of demolition, debris removal, pollution cleanup, contamination, hurricane, lightning, vandalism and the increased costs to repair or replace resulting from application of bylaws or ordinances. The coverage shall be at 100% replacement cost value, except for debris removal which shall be at 25% of replacement cost value, pollution cleanup coverage of $1,000,000 and no co-insurance will be permitted. This insurance will include the following provisions:

(a) policy limit equal to the replacement value of the Facility;
(b) annual aggregate limits permitted for earthquake coverage and flood coverage, separately; no other policy aggregates permitted;
(c) maximum deductible of one hundred thousand dollars ($100,000) per occurrence (or two hundred thousand dollars ($200,000) combined property damage and business interruption);
(d) primary insurance without right of contribution of any insurance carried by the Regional Health Authority;
(e) coverage for valuable papers and records;
(f) coverage for expediting and extra expenses;
(g) thirty (30) days prior written notice of cancellation or material change to the Regional Health Authority by the insurer;
(h) waiver of insurer's right of subrogation against the Regional Health Authority; and
(i) breach of any of the terms or conditions of the policy, or any negligence or willful act or omission or false representation by an insured or any other person, shall not invalidate the insurance with respect to the Regional Health Authority.

(2) Business Interruption Insurance to include the loss of earnings resulting from a peril insured under the All Risks Property Insurance. Coverage shall be $2,000,000 and no co-insurance will be permitted. This insurance will include the following provisions:

(a) it shall be written on a per-occurrence basis of All Risk Property insurance;
(b) a maximum deductible of one hundred thousand dollars ($100,000) per occurrence (or two hundred thousand dollars ($200,000) combined Property Damage and Business Interruption);

(c) primary insurance without right of contribution of any insurance carried by the Regional Health Authority; and

(d) coverage for loss of use without property damage.

(3) Commercial General Liability Insurance including liabilities arising out of property damage, personal injury and bodily injury including death resulting from any activity connected with the existence, management, maintenance and operation of the Facility. Coverage shall be $5,000,000. All such policies shall name the Regional Health Authority as an additional insured, their successors and assigns, and their respective directors, officers, and employees. This insurance will include the following provisions:

(a) to be written on a per-occurrence basis (can be structured as primary plus supplementary layers or primary plus Umbrella and/or Excess);

(b) sudden and Accidental Pollution coverage for all insured perils;

(c) nil deductible for Bodily Injury;

(d) maximum deductible for damage to property will be $1,000 per claim;

(e) product and completed operations liability;

(f) owner’s and contractor’s protective liability;

(g) annual aggregate limits permitted for malpractice exposures;

(h) blanket written and oral contractual liability;

(i) contingent employers liability;

(j) personal injury liability;

(k) broad form occurrence property damage;

(l) non-owned automobile liability;

(m) cross liability and separation of interests with respect to each Insured;

(n) the Regional Health Authority and its respective directors, officers, and employees shall be included as insured;
(e) breach of any of the terms or conditions of the policy, or any negligence or willful act or omission or false representation by an Insured or any other person, shall not invalidate the insurance with respect to the Regional Health Authority;

(p) primary insurance without right of contribution of any other insurance carried by the Regional Health Authority; and

(q) the insurer shall provide thirty (30) days' prior written notice of material change or cancellation to the Regional Health Authority.

(4) Boiler and Machinery Insurance on a broad form basis covering all insurable objects located in the Facility with coverage for any one occurrence or claim of not less than the full replacement value of the Facility and any contents thereof; and

(5) Automobile Liability on all vehicles owned, operated or licensed in the name of the Contractor, in an amount no less than $5,000,000.

11.3 All policies are to be issued by financially sound insurers licensed to carry on business in Canada and subject to approval by the Regional Health Authority. The Contractor shall not cancel or materially change the policy without thirty (30) days' prior written notice to the Regional Health Authority.

11.4 Certified copies of all insurance policies and related documentation, in form and content acceptable to the Regional Health Authority, must be delivered to the Regional Health Authority prior to the Occupancy Date and Occupancy of the Facility. Certificates of insurance evidencing renewal or replacement insurances, in form and content acceptable to the Regional Health Authority, shall be provided to the Regional Health Authority no later than fifteen (15) days prior to the expiration of existing policies. Upon request from the Regional Health Authority or its designated representative, certified copies of any policy or policies shall be provided promptly.

11.5 All operating insurance policies must include a provision whereby the Regional Health Authority (or its nominee) may, but will not be obligated to, assume direction and control of the insurance policy in the event the Contractor or any of its successors or assigns default in its obligations under this Agreement.

ARTICLE 12 - REPRESENTATIONS, COVENANTS AND WARRANTIES

12.1 Representations and Warranties

(1) The Contractor hereby represents and warrants to the Regional Health Authority as follows:

(a) The Contractor is a corporation incorporated and validly subsisting on the laws of its incorporation. The Contractor has the necessary corporate power and authority to own its property and assets and carry on its business in the Province of
Newfoundland and Labrador. No act or processing has been taken by or against the operation in connection with the dissolution, liquidation, winding-up, bankruptcy or reorganization of the operator.

(b) The Contractor has the full power and authority to enter into this Agreement and all other agreements and instruments to be executed by it as contemplated herein (including the Service Agreement), and to carry out its obligations under this Agreement as such other agreements and instruments, and the Contractor has taken all necessary action to authorize the execution, delivery and performance of its obligations under this Agreement and such other agreements and instruments, and the Contractor has taken all necessary action to authorize the execution, delivery and performance of its obligations under this Agreement and such other agreements and instruments.

(c) The Contractor holds, or will hold by the time the Contractor is required, all permits, licenses, consents, intellectual property rights, registrations and authorizations required to conduct its affairs and perform its obligations under this Agreement and such other agreements and instruments referred to in Section 12.1(b).

(d) This Agreement constitutes a legal, valid and binding obligation of the Contractor enforceable against the Contractor in accordance with its terms, subject to limitations on enforcement imposed by bankruptcy, insolvency, reorganization or other laws affecting creditor’s rights generally and subject to general principles of equity.

(e) The execution, delivery and performance by the Contractor of this Agreement and such other agreements and instruments referred to in paragraph (b):

(i) do not and will not conflict with, result in a breach or violation of or constitute a default under any Applicable Law or any agreement, instrument or other document to which the Contractor is a party or by which the Contractor or any of its property or assets are bound, except for violations which do not relate to the Site, the Facility or the Development of Beds and Services and Facility or will not, in the aggregate, have a material adverse effect on the present or future business, operations, property, prospects or condition (financial or otherwise) of the Contractor; and

(ii) do not and will not conflict with, result in a breach or violation of, or constitute a default under its constituting documents or bylaws or any unanimous shareholders agreement among the shareholders of the Contractor.

(f) All written statements made or furnished by or on behalf of the Contractor to the Regional Health Authority and/or the Department (as the case might be) in connection with the transactions contemplated by this Agreement, were, as of the
time such statements were made, true in all material respects and remain true in all material respects on the date hereof, and such statements do not contain any untrue statement of a material fact or omit a material fact necessary to make such statements not misleading. All such statements, taken as a whole, do not contain any untrue statement of a material fact or omit a material fact necessary to make such statements or the statements contained herein not misleading. All expressions of expectation, intention, belief and opinion contained therein were honestly made on reasonable grounds after due and careful inquiry by the Contractor (and any other person who furnished such material). There is no fact which the Contractor has not disclosed to the Regional Health Authority and/or the Department (as the case might be) in writing which adversely or materially affects, or so far as the Contractor can now reasonably foresee, will adversely and materially affect its business, operations, property, prospects, liabilities or condition (financial or otherwise), or its ability to perform its obligations under this Agreement or to operate the Beds and the Facility in accordance with the Service Agreement.

12.2 Regional Health Authority Rights

(1) The Regional Health Authority shall not in any way be limited or prejudiced in enforcing any right or remedy available at law or in equity relating to any representation, warranty or covenant contained in Section 12.1 of this Agreement.

(2) In addition to any and all other rights and remedies provided for in this Agreement, the Regional Health Authority shall have the right to demand the correction of any breach of any representation, warranty or covenant in Article 12 of this Agreement and in the event that such correction is not made by the Contractor, as applicable, within a reasonable period of time, the Regional Health Authority shall have the right to terminate this Agreement pursuant to Article 21 by giving thirty (30) days’ written notice to the Contractor.

(3) The Contractor shall not sell, assign, convey or otherwise dispose of the Contractor’s interest in the Site without the prior written consent of the Regional Health Authority.

ARTICLE 13 - TERMINATION

13.1 Term

(1) The term of this Agreement will commence on the Effective Date of this Agreement referenced in Section 8.1 and will continue until the date that is twenty-five (25) years thereafter unless earlier terminated in accordance with Section 8.2, Section 12.2 or this Article 13 ("Termination").

13.2 Termination
(1) Notwithstanding any other provision of this Agreement, this Agreement may be terminated:

(a) at the option of the Regional Health Authority, upon the occurrence of any of the following events:

(i) the Regional Health Authority, acting in its sole discretion forms the opinion that the Facility will not be ready for Occupancy on the Occupancy date as a result of the failure of the Contractor to proceed with Development of the Beds and the Services in a timely manner in accordance with the Terms of its Proposal as accepted by the Regional Health Authority and modified by the terms of this Agreement.

(ii) a cancellation or deemed cancellation of the Service Approval pursuant to this Agreement;

(iii) a Significant Risk;

(iv) a resolution is passed or a petition is filed for the Contractor’s liquidation or winding up;

(v) the Contractor commits an act of bankruptcy, makes an assignment for the benefit of its creditors or otherwise acknowledges its insolvency; a bankruptcy petition is filed or presented against the Contractor or a proposal under the Bankruptcy and Insolvency Act (Canada) is made by the Contractor; a compromise or arrangement is proposed in respect of the Contractor under the Companies Creditors Arrangement Act (Canada) or any legislation of similar purport; a receiver or receiver-manager of any of the Contractor’s property is appointed; or the Contractor ceases, in the Regional Health Authority’s reasonable opinion based on generally accepted accounting principles, to carry on business as a going concern;

(vi) failure by the Contractor to initiate a Contingency Plan or Emergency Response immediately upon a Force Majeure unless such failure was caused directly by the Force Majeure;

in which case, the Regional Health Authority will notify the Contractor in writing of the termination of this Agreement as a result of the occurrence of such event and will specify in such notice the effective date that this Agreement will terminate, which effective date may be immediate.

(b) If the Regional Health Authority determines, whether through a Suitability Assessment or otherwise, that the Contractor has failed to comply with a term or condition of this Agreement that is not set out in Section 13.2(a), and that in the opinion of the Regional Health Authority (acting in its sole discretion) such failure affects the Contractor’s ability to discharge the Contractor’s obligations to provide
the Beds and the Services required of the Contractor under this Agreement, the Regional Health Authority may declare a default of the Agreement, in which case:

(i) the Regional Health Authority will notify the Contractor in writing of the nature of the default (the “Default Notice”) and the period of time, as determined by the Regional Health Authority at its sole discretion, within which such default must be remedied by the Contractor (the “Remedy Period”);

(ii) the Contractor will either:

(A) remedy such default within the Remedy Period;

(B) if such default cannot reasonably be remedied within the Remedy Period, then the Contractor will promptly notify the Regional Health Authority in writing that this is the case (and together with the reasons therefore) and within thirty (30) days of the date of the Default Notice, will deliver to the Regional Health Authority a plan satisfactory to the Regional Health Authority for rectification for such default, which plan will include a time frame within which rectification will be achieved;

(iii) this Agreement will terminate on the last day of the Remedy Period unless the Contractor either:

(A) remedies such default to the satisfaction of the Regional Health Authority before such date; or

(B) delivers a rectification plan that is satisfactory to the Regional Health Authority in remedy of such default to the satisfaction of the Regional Health Authority on or before the date specified in the rectification plan;

(iv) alternately without prejudice to any other legal right or remedy that the Regional Health authority may have, including a subsequent right of termination, the Regional Health Authority may appoint an Interim Administrator to take over and administer on an interim basis the Beds and the delivery of the Services for Residents associated with and related to the Beds at the Facility until such time as the breach giving rise such appointment is remedied or the Agreement is terminated by the Regional Health Authority. The Contractor shall cooperate with the person so appointed by the Regional Health Authority and take direction from that person in the running of the Facility in so far as it relates to the Beds and the provision of Services to Residents until the circumstance giving rise to the appointment of the Interim Administrator is remedied to the satisfaction of the Regional Health Authority or the Agreement is terminated. Further, the
Parties agree that until such time as the circumstance giving rise to the appointment of the Interim Administrator is remedied to the satisfaction of the Regional Health Authority that the amounts of monies that would otherwise be payable to the Contractor monthly as part of the Approved Budget shall be made available to the Interim Administrator for the purpose of paying the operating costs of the Facility associated with the Beds and the provision of the Services to the Residents during the period that the Interim Administrator is appointed to so act. Any such appointment of an Administrator shall be in writing in the form of a letter from the Regional Health Authority to the Contractor as shall any letter informing the Contractor that the Interim Administrator has ceased to so act.

(2) From the date that notice of such termination pursuant to Section 13.2 or Section 8.2, or Section 12.2 (as the case might be) to and including the effective date of the termination, this Agreement will be performed by the Parties in accordance with its terms. The Contractor will, promptly, following delivery of such notice of termination, provide to the Regional Health Authority a transition plan, in form and content satisfactory to the Regional Health Authority, to ensure the orderly transfer of Residents and wind up of the Services (the “Transition Plan”). The Contractor will commence the implementation of the Transition Plan on such date as the Regional Health Authority may determine.

(3) The Regional Health Authority may request the Contractor continue to provide the Services after the date of termination of this Agreement pursuant to, Section 12.2 or Section 13.2, for such period of time as the Regional Health Authority may deem necessary up to a maximum of six (6) months after the date of such termination but not beyond the 25 year term set out in Section 8.1 (the “Transition Period”) in order to ensure the welfare of the Residents until reasonable alternate arrangements can be made for the Residents by the Regional Health Authority. If the Regional Health Authority makes such a request, then:

(a) the Contractor will provide the Services on the terms set out in, and will otherwise comply with and be bound by, this Agreement during such Transition Period; and

(b) the Regional Health Authority will pay to the Contractor such amount as the Contractor may be entitled to receive pursuant to this Agreement for Services provided in accordance with Section 13.4(a) during the Transition Period and otherwise will be under no further obligation to the Contractor.

13.5 Without limitation to any other rights available to the Regional Health Authority hereunder or otherwise in such circumstances, the Regional Health Authority may, at Regional Health Authority’s option, on the happening of any of the events described in Sections 13.2(a), or (b) take any actions, whether in its own name or the name of the Contractor, that may reasonably be required to cure the default, in which case all payments, costs and expenses incurred therefore will be payable by the Contractor to the Regional Health Authority on demand and set off against any present or future sums owing by the Regional Health Authority to the Contractor.
ARTICLE 14 - AMENDMENT

14.1 No amendment of or departure from the terms and conditions of this Agreement will be effective unless evidenced by an agreement executed by both Parties, except that the Regional Health Authority may, by providing notice of such amendments to the Contractor in writing, unilaterally amend all or any part of:

(a) this Agreement if the changes to Applicable Law require amendment;

(b) the Schedules hereto, except Schedule “C” from time to time and at any time; and

(c) any other provision of this Agreement and any document contemplated hereby that specifically provides that the Regional Health Authority is entitled to unilaterally amend such provision or document. The Contractor will comply with such amended requirements within such period of time as the Regional Health Authority may in its notice require.

14.2 The Regional Health Authority acknowledges and agrees that if any such amendments, departures or changes as outlined in Section 14.1 and carried out by the Regional Health Authority, to the extent such amendments, departures, or changes result in an increase in any manner to the costs of the Contractor, such additional costs shall result in an applicable increase in the Approved Budget, reflected in the Protected Envelope or Authorized Client Contribution.

ARTICLE 15 - NO ASSIGNMENT, TRANSFER, SALE, ETC.

15.1 The Contractor will not, without the prior written approval of the Regional Health Authority, which approval will not be unreasonably withheld:

(a) subcontract any obligation of the Contractor under this Agreement except to the extent that such contracting is for the provision of particular Services;

(b) assign, either directly or indirectly, this Agreement or any of its rights or obligations under this Agreement;

(c) sell, transfer, lease, sublease or otherwise dispose of all or a material part of its rights or interests in the Facility, or of the assets used for or in connection with the provision of the Beds and the Services; or

(d) make a change to the Contractor’s Director of Care or to the duties of the Contractor’s Director of Care or the structure or composition of the Contractor’s Services care team.

15.2 The Contractor will seek the approval referred to in Section 15.1 at least ninety (90) days before the date that it wishes to carry out the action for which approval is being sought. The Contractor will provide the Regional Health Authority will all information and documents
that the Regional Health Authority reasonably requests concerning any of the events listed in Section 15.1 above.

15.3 In determining whether or not to grant its approval pursuant to Section 15.1, the Regional Health Authority will be entitled to impose any additional or modified terms and conditions (with respect to the Beds and the Services, the third party, the third party’s operations or otherwise) which the Regional Health Authority, acting reasonably, deems to be necessary to ensure the continued and affective provision of the Beds and the Services. The Regional Health Authority at its sole discretion will determine whether the third party will sign a new agreement or an assignment and assumption agreement (either of which may contain the aforementioned additional or modified terms and conditions).

15.4 The Contractor agrees to reimburse the Regional Health Authority for all reasonable costs and expenses, including reasonable internal costs and legal fees and disbursements, incurred by the Regional Health Authority in connection with any requests for approval pursuant to Section 15.1.

15.5 The Regional Health Authority may, in the Regional Health Authority’s sole discretion, assign the Regional Health Authority’s interest in this Agreement.

15.6 The Contractor confirms that it will advise the Regional Health Authority in respect of any material change in the ownership of the Contractor.

ARTICLE 16 - NO LICENSE OR INTERFERENCE WITH STATUTORY POWERS

16.1 This Agreement does not operate as a permit, license, approval or other statutory authority which the Contractor may be required to obtain from the Regional Health Authority or the Department in order to provide the Beds and the Services. Nothing in this Agreement is to be construed as interfering with the exercise by the Regional Health Authority or the Department of any statutory power or duty. Without limiting the generality of the foregoing, the Contractor acknowledges that:

(a) nothing hereunder in any way

(i) obligates the Regional Health Authority or the Department (as the case might be) to issue or renew, or constitutes consent or approval by the Regional Health Authority or the Department to issue or renew, any applicable license, permit or approval to operate the Facility; and

(ii) constitutes any other consent or approval, pursuant to any applicable law, by the Regional Health Authority or the Department (as the case might be) in respect of Service Renewal, a license, permit or approval to operate the Facility; and
(b) any obligations of the Contractor contained herein will be in addition to any requirements under applicable law and nothing contained herein will release the Contractor of any requirements of any applicable law.

ARTICLE 17 - LABOUR AND EMPLOYMENT

17.1 The parties acknowledge that certain Persons providing the Services may also be employed or engaged to perform services for the Regional Health Authority, and consequently the parties agree that no Person employed or engaged by or otherwise associated with the Contractor in the performance of the Services (whether or not such Person is also employed by the Regional Health Authority to perform services) is, in connection with such Person's performance of the Services:

(a) an employee of or in an employment relationship of any kind with the Regional Health Authority; or

(b) in any way entitled to any terms or conditions of employment or any employment benefits of any kind whatsoever from the Regional Health Authority under any collective agreement or otherwise including private programs or coverage and statutory programs or coverage, whether under the Labour Standards Act, the Workplace Health, Safety and Compensation Act, the Employment Insurance Act (Canada), health plan contributions, or otherwise.

17.2 The Regional Health Authority will have no liability or responsibility for the withholding, collection or payment of income taxes, employment insurance, statutory or other taxes or payments of any other nature on behalf of, or for the benefit of, the Contractor or any other Persons in connection with the provision of the Services.

17.3 The Contractor is the sole decision-making authority regarding planning and implementing human resource issues for its own personnel with respect to the Facility and the Services.

17.4 With respect to the Facility and the Services, the Contractor has the full rights of an employer including the right:

(a) to ratify a collective agreement;

(b) to control the selection, retention, discipline, layoff and termination of personnel;

(c) to develop personnel policies and practices;

(d) if applicable, to direct participation with an association of employers; and

(e) if applicable, to contract out services provided that:

(i) the Contractor notifies the Regional Health Authority of its intention and plan regarding such contracting out; and
(ii) any plans to contract out any Services relating to direct care delivery require the prior written approval of the Regional Health Authority, which approval will not be unreasonably withheld.

17.5 The Contractor will comply with all medical, nursing and other professional staff governance provisions binding upon the Contractor in respect of the Contractor’s operations and this Agreement and will ensure that the Services are provided only by or under the supervision of competent, qualified personnel meeting professional qualifications as required by Applicable Law and Schedule “B” of this Agreement.

17.6 The Contractor will implement all appropriate and/or required pre-employment screening mechanisms prior to employing or engaging any individual to provide the Services, including causing criminal record checks to be made in response of all new individuals employed or contracted by the Contractor to provide service to Residents, prior to the Contractor hiring or contracting for the Services of such individuals.

17.7 The Contractor will ensure that all staff maintain a level of training appropriate for the provision of quality care as required by Schedule “B” to this Agreement.

17.8 The Contractor is fully responsible to the Regional Health Authority for acts and/or omissions of its employees, subcontractors and any other persons directly or indirectly employed or engaged by the Contractor. No subcontract, whether consented by the Regional Health Authority to or not, will relieve the Contractor from any of its obligations under this Agreement.

ARTICLE 18 - PROGRAM REQUIREMENTS

18.1 Without limitation to its obligations to be responsible for the quality of the Services pursuant to Section 2.15, the Contractor will comply with the Program Requirements as outlined in Schedule “B”, and the Regional Health Authority and the Contractor will review and assess the Services provided by the Contractor according to the terms of this Agreement.

18.2 The Contractor will allow employees, agents, contractors or other representatives of the Regional Health Authority, at the Regional Health Authority’s request at any time from time to time and without notice to the Contractor, to monitor and have access to the Facility and to any resident in any Facility in order to assess the condition of the Facility, including any issues arising out of a suitability risk assessment, and to ensure compliance with the terms of this Agreement, including a Suitability Assessment.

ARTICLE 19 - GENERAL PROVISIONS

19.1 This Agreement constitutes the entire agreement between the Parties pertaining to the subject matter hereof and supersedes all prior agreements, understandings, negotiations and discussions, whether oral or written, of the Parties hereto pertaining to the subject matter hereof.
19.2 The rights and remedies of the Parties to this Agreement are cumulative and may be exercised singularly or concurrently, and are in addition to and not in substitution and without limitation to the rights and remedies provided for at law or in equity.

19.3 The Contractor agrees to promptly perform, make, execute, deliver or cause to be performed, made, executed, or delivered, all such further acts and documents as the Regional Health Authority may reasonably require for the purpose of giving effect to this Agreement.

19.4 This Agreement and each of the other documents contemplated by or delivered under or in connection with this Agreement are governed exclusively by and are to be in force, construed and interpreted exclusively in accordance with the laws of Newfoundland and Labrador and the laws of Canada applicable in Newfoundland and Labrador which will be deemed to be the proper law of this Agreement without regard to conflict of law requirements. The Parties hereto hereby attorn to the exclusive jurisdiction of the courts of Newfoundland and Labrador.

19.5 The obligations of this Agreement that by their nature should survive termination or expiration of, including the obligations of the Contractor set out Articles 5, 8 and 9, will survive termination or expiration of this Agreement for any reason whatsoever, either by the Regional Health Authority, the Contractor or their respective successors and permitted assigns.

19.6 No waiver of any provision hereof is binding unless it is in writing and signed by the Parties except that any provision that gives rights or benefits to a particular Party may be waived, signed only by the Party that has a right under, or holds the benefit, the provision being waived if that Party promptly sends a copy of the executed waiver to the other Party. No failure to exercise and no delay in exercising any right or remedy hereunder will be deemed to be a waiver of that right or remedy. No waiver of any breach of any provision hereof will be deemed to be a waiver of any subsequent breach of that provision or of any similar provision.

19.7 Where the Contractor is a corporation, the signatory or signatories signing this Agreement on behalf of the Contractor represent and warrant that they have been duly authorized by the Contractor to enter into and execute this Agreement on its behalf.

19.8 The Parties are and shall at all times remain independent parties and nothing contained herein shall be construed as constituting a partnership, joint venture or agency arrangement between the Parties. Rather the Contractor and the Regional Health Authority are independent contractors and neither of them shall be deemed to be employee, agent, partner of, or in a joint venture with the other. The Contractor's Personnel shall not be deemed to be the employees, agents, partners of, or in a joint venture with the Regional Health Authority.

19.9 This Agreement shall enure to the benefit of and be binding upon the respective successors and permitted assigns of each of the Parties.
19.10 If any provision of this Agreement is invalid, illegal or unenforceable, such provision shall be severed from the balance of this Agreement and the remaining provisions of this Agreement shall continue in full force provided that such remaining provisions express the intent of the Parties. If the intent of either Party cannot be preserved, this Agreement shall be either renegotiated or terminated by either Party, without liability, cost or penalty to the other Party, upon thirty (30) days’ prior written notice to the other Party.

19.11 No waiver of any breach of this Agreement shall operate as a waiver of any subsequent breach or of the breach of any other provision of this Agreement. No provision of this Agreement shall be deemed to be waived, and no breach excused, unless such waiver or the consent excusing the breach is in writing and signed by the Party that is purported to have given such a waiver or consent. No delay or omission on the part of any Party to this Agreement to avail itself of any right it may have under this Agreement shall operate as a waiver of any such right. No waiver or failure to enforce any of the provisions of this Agreement shall in any way affect the validity of this Agreement or any part hereof.

ARTICLE 20 - FORCE MAJEURE

20.1 If the Contractor is delayed or prevented from exercising its obligations or making deliveries in accordance with this Agreement due to unforeseeable or unexpected circumstances beyond the reasonable control of a Contractor, including labour interruptions including strikes, walkouts or labour disputes (of third parties other than the Contractor or the Contractor's employees), civil insurrection, fire, explosion, act of God, or terrorism or any threat of war, terrorism or other such similar causes (being collectively referred to herein as a “Force Majeure”), provided that it could not have been prevented by reasonable precautions and could not reasonably have been circumvented by the Contractor through the use of alternate resources, then such failure to meet obligations or make deliveries shall not be a breach of this Agreement, except that the Contractor has the obligations to provide Beds and initiate Services in the event of a Force Majeure in accordance with a Contingency Plan or Emergency Response as required by Appendix C of Schedule “A”, as agreed upon and updated from time to time in joint agreement between the Contractor and the Regional Health Authority.

20.2 For greater certainty, no Force Majeure will excuse the Contractor from initiating such Contingency Plan or Emergency Response as is in force at the time that any Force Majeure occurs, except to the extent that the event triggering the Force Majeure precludes initiation of the Contingency Plan or Emergency Response.

20.3 For greater certainty the Parties hereto agree that impecuniosity on the part of the Contractor shall not be regarded as an event of “Force Majeure”.

ARTICLE 21 - NOTICE

21.1 Each notice to a Party to this Agreement will be given in writing. A notice may be given by personal delivery or through electronic transmission by email, or by regular mail to the
designated representative of each Party identified in Section 21.2 of this Agreement and will be validly given if delivered to such representative of such Party at the address set out.

21.2 For purposes of this Agreement, the designated representatives are as follows:

(a) The designated representative of the Regional Health Authority is ______________________;

(b) The designated representative of the Contractor, who shall be an authorized signing officer of the Contractor is ______________________.

21.3 A notice sent by electronic transmission by email, or delivered by courier or other personal delivery and received in such manner between 8:30 and 4:30 p.m. on any day is deemed to be received by and given to the addressee on the day that it is sent. If the notice is received after 4:30 p.m. on any day, then it is deemed to be received by and given to the addressee on the following day. Notices sent by regular mail are deemed to have been received on the seventh Business Day after the day in which it was sent. In any case notices received on a day other than a day the Regional Health Authority is open for business are deemed to be received by and given to the addressee on the next day the Regional Health Authority is open for business.

ARTICLE 22 - DISPUTE RESOLUTION

22.1 The Service Provider and the Authority agree to work together towards resolution of disputes in accordance with this Article. Subject to Sections 9.5 and except for any disputes relating to: (a) termination of this Agreement; (b) the placement of Residents; (c) issues governed by Article 4.5; (d) a Significant Risk; or (e) matters governed by Applicable Law none of which will be subject to this Article 22, any dispute, controversy or claim arising between the parties with respect to or relating to this Agreement will be promptly referred first to the appropriate representative of each of the Authority and the Service Provider. Unless such representatives agree to proceed directly to arbitration, if such representatives have not resolved such dispute within 10 days after the dispute is referred to them, the dispute will be referred to mediation.

22.2 A dispute referred to mediation pursuant to Section 22.1 will be mediated by a neutral Person agreed to by the parties. If the dispute is not settled within 30 days after the dispute is referred to mediation, then either party may refer the dispute to arbitration.

22.3 At any time after the expiry of the 30 day period referred to in Section 22.2 either party may elect to commence arbitration by giving the other party written notice of its intention to do so (the “Arbitration Notice”). Within 7 days after receipt by the other party of the Arbitration Notice, the matter will be submitted to arbitration under the Arbitration Act. The award of the arbitrator will be final and binding on the parties.
IN WITNESS WHEREOF the Parties hereto execute this Agreement as of the date first written above.

SIGNED, SEALED AND DELIVERED

in the presence of:

______________________________
Witness
Date:________________________

______________________________
REGIONAL HEALTH AUTHORITY

Per:
Date:________________________

______________________________
CONTRACTOR

Per:
Date:________________________
Schedule “A”

Contractor’s Proposal
1

Schedule “B”

Newfoundland and Labrador Long Term Care Operational Standards

See Draft in Data Room
1

Schedule “C”

Facility Funding Policy

See Draft in Data Room
Schedule “D”

Reporting Requirements / Performance Monitoring Framework

See Draft in Data Room
Schedule “B”

Newfoundland and Labrador Long Term Care Operational Standards

The Newfoundland and Labrador Long Term Care Operational Standards, 2005 are located at (http://www.health.gov.nl.ca/health/publications/long_term_care_standard.pdf). They are to be read in conjunction with the Supplemental Standards set out below.

These Standards are under review and will be amended from time to time during the course of the Agreement by the Regional Health Authority.

[NTD: Contract for Northeast Avalon will be required to specify the Contractor’s compliance with the Provincial Protective Community Residence Operational Standards, or with the alternatives as agreed between the Regional Health Authority and the Contractor, for the 48 beds specified for mild to moderate dementia Residents.]

Supplemental Standards to the Newfoundland and Labrador Long Term Care Operational Standards

1 Administration

1.1 Management of the Facility

(1) Outcome

Residents live in a Facility that is effectively and efficiently managed and that promotes quality of life.

(2) Requirements

The Contractor shall ensure:

(a) There is a designated administrator responsible for the over-all management of the Facility. When the administrator is absent, on-site administrative authority is delegated to an appropriate individual.

(b) A current organizational chart, available to all staff, outlines the relationships between departments and the lines of authority.

(c) The Facility is fully compliant with the Newfoundland and Labrador Long Term Care Operational Standards, relevant policies, and other applicable legislation as determined by the Minister of Health and Community Services or a delegate.

(d) The staff has access to, and complies with recent, applicable requirements, reports, and legislative updates.

(e) The development of a statement of the Facility’s mission, vision, values, philosophy of care, code of ethics, and range of services.

(f) The development of a Resident Bill of Rights and Responsibilities.

(g) There is a process in place to ensure medications are administered, recorded and monitored by appropriate staff and that there is a process to ensure the identity of residents prior to medication administration.

(h) That the necessary operational policies and procedures are developed, documented, implemented and are reviewed/revised annually. Required operational policies shall include but are not limited to:

- Protection of residents from abuse
- Least restraint
- Extremes of internal temperature
- Disclosure of wrongdoing
- Integrated quality improvement
- Disclosure of adverse events
- Risk management
- Incident reporting
- Occurrence reporting
- Complaints and Compliments
- Management of resident funds
- Smoking
- Safety Alerts
- Safer Needles in the Workplace
- Medication review processes
- Falls Prevention
- Skin and wound care
- Infection prevention and control

2 [Deleted]

3 Moving In

3.1 Outcome

Individuals suitable for placement in a long term care Facility are supported during the moving in process.

All individuals presenting with a care need will be assessed using the interRAI Home Care assessment tool. Individuals assessed as requiring Level III or IV (see Appendix A) may be offered placement in a long term care Facility.

3.2 Requirements

The Contractor must:

1. Participate in the regional single-entry system of assessment and placement, managed by the Regional Health Authority.

2. For the Beds covered by the Residential Services Care Agreement, not admit individuals that are not referred by the Regional Health Authority.

3. Provide services to individuals deemed eligible by the assessment process and referred by the Regional Health Authority.

4. Have the capability to accept clients 8am to 8pm, 7 days per week.

5. Notify the Regional Health Authority of a bed vacancy within 8 hours of a discharge.

6. Have a maximum of 2 Beds be Unavailable for more than 3 days each at any point in time.
(7) Work with the Regional Health Authority to facilitate discharge of residents whose care needs decrease such that Level III care is no longer required.

4 Labour Disruption Contingency Plan

4.1 Outcome

Residents continue to receive quality care and services in the event of a labour-management dispute.

4.2 Requirements

The Contractor shall ensure:

(1) Essential services continue to be provided to residents whenever there is a reduction in the number of staff members available to serve the residents as a result of a labour-management dispute.

(2) A labour disruption business continuity plan will be developed including a detailed schedule of staffing.

(3) The business continuity plan will be approved by the Regional Health Authority or the Department of Health and Community Services or designate.

5 Inspections

5.1 Outcome

The Facility is inspected by all applicable authorities having jurisdiction.

5.2 Requirements

The Contractor shall ensure:

(1) Compliance with the Provincial Long Term Care Operational Standards and the Service Agreement (if applicable) and have a Service Approval.

(2) Inspection reports and recommendations from authorities having jurisdiction are retained. Compliance with recommendations and requirements are undertaken and evidenced by appropriate documentation. Such documentation is maintained in a common file for access by staff responsible for inspections and monitoring.

(3) Compliance with all applicable legislation including, but not limited to:

- The Buildings Accessibility Act and Regulations
- Food and Drug Act and Associated Regulations
- Health and Community Services Act and Regulations
- The National Building Code and National Fire Code of Canada
- Smoke Free Environment Act and Regulations
- Occupational Health and Safety Act
- Adult Protection Act
- Personal Health Information Act

(4) Compliance with any other legislation, acts, regulations as determined by the Minister and any new or revised inspection processes for all applicable jurisdictions.

6 Monitoring

6.1 Outcome

The Facility is monitored for compliance with the NL LTC Operational Standards

6.2 Requirement

The Contractor shall ensure:

(1) Staff participate in the quarterly and annual review process.

(2) Regional Health Authority monitoring staff are provided with all requested documentation.

(3) Corrective action is undertaken in the time frames recommended and documentation of same exists.

7 Facility Condition

7.1 Outcome

The facility and site are kept in a condition that provides a clean, comfortable and secure environment that optimizes the quality of life for residents and family and supports the delivery of quality resident accommodation and care.

7.2 Requirements

The Contractor shall ensure that the Facility and all elements of the Facility are maintained in a manner consistent with a reasonably prudent owner maintaining a first-class long term care Facility in Canada, including the following:

(1) That site development and building alterations or change of use of space from that originally intended have prior approval of the Regional Health Authority in consultation with Service NL.

(2) That repairs and alterations to long term care Facility meet Infection Prevention and
Control Standards.

(3) That long term care Facility maintenance is carried out in accordance with all relevant legislation and meets all Operational Standards.

(4) That materials, systems, equipment and furnishings are maintained in good working order so that they maintain the functionality originally intended;

(5) Interior and exterior building elements such as walls, floors, ceilings, roof areas, windows and doors are all maintained so that the building is attractive, weather resistant and functional;

(6) That building systems and components perform to originally intended standards for control of water (including vapour and condensation) and air movement;

(7) Hard and soft landscaped areas are maintained so that they contribute to the overall aesthetics and support the residential character of the Facility; and

(8) Mechanical and electrical systems are maintained, repaired and renewed as needed to maintain a comfortable environment suitable for care and consistent with operational needs.

8 Information Management

8.1 Outcome

Adoption of an Information Management approach is intended to produce quality data, support accountability and quality improvement through improved performance measurement and support evidence-based decision-making.

8.2 Requirements

The Contractor shall ensure:

(1) The Facility has information systems that:

- Support the principles of client-centred care
- Makes available useful, relevant, quality information to inform decision-making
- Focuses on outcomes related to care provision and service delivery
- Ensures compliance with the Personal Health Information Act and as well as any other applicable legislation

(2) The Facility must use interRAI-MDS 2.0 for assessment and on-going resident
assessment and care planning and contribute to the Canadian Institute for Health Information’s (CIHI) Continuing Care Reporting system (CCRS).

(3) A secure client health record is implemented.

(4) A policy on document retention exists and that documents are retained for seven years.

(5) A mechanism for the documentation and investigation of occurrence and incident reporting.

(6) A mechanism for secure financial and statistical reporting as outlined in the performance monitoring framework.

9 Mandatory Incident/Occurrence Reporting to the Regional Health Authority:

9.1 Outcome

Required reports and information are provided to the Regional Health Authority in a timely manner.

9.2 Requirements:

The Contractor shall ensure:

(1) There is a written policy and procedure in place to ensure all occurrences, incidents and accidents are documented and reported.

(2) There is a system in place to document and track occurrence, incident and accident reports.

(3) Major incidents (missing resident, incident involving a resident that requires reporting to law enforcement, a suspicious death, homicide, suicide, fire, major flood, labour dispute impacting the operations of the Facility), in addition to any involvement of law enforcement, are verbally reported to the Regional Health Authority immediately. A written report describing the incident and action taken shall be submitted within five working days of the incident.

10 Human Resource Management

10.1 Outcome

The Staff complement will support the achievement of outcomes in all program areas through a team based resident-centred approach.

The Facility promotes an environment of team based resident care supported by:
• Integrated care planning
• Scheduled team meetings
• Referrals among providers
• Supporting residents and families to be partners in care by promoting choice, empowerment, autonomy, and independence in everyday life
• Providing a clear statement of role expectations where team work is emphasized
• Enabling self-led work teams and increased decision-making
• Encouraging decision-making as close to the resident as possible
• Enabling flexible scheduling of activities of daily living without set schedules
• Supporting innovative and alternative approaches of care delivery
• Enabling staff to consistently work with the same residents.

10.2 Requirements

The Contractor must ensure:

(1) The Facility provide clinical Registered Nurse coverage 24 hours per day, seven days per week.

(2) Residents receive on average 3.4 hours of direct nursing care per day (RN, LPN, PCA).

(3) A skill mix ratio of 14% Registered Nurse: 46% Licensed Practical Nurse: 40% Personal Care Attendant.

(4) Access to allied health staff (OT, PT, dietitian, social work, and recreation) in accordance with resident care needs.

(5) Residents are assisted to access dental, optometry and other health appointments, in accordance with the resident’s care plan.

(6) The development of a written human resource plan that anticipates human resource needs to provide required services.

(7) There are policies and procedures related to recruitment, hiring, orientation and continuing competencies of staff members.

(8) Staff members individually and collectively have the skills and experience to deliver the services and care which the setting offers to provide.

(9) The verification of the current licensure, certification, registration or other credentials of
staff members and volunteers prior to the staff members assuming job responsibilities and shall have procedures for verifying that current status is maintained.

(10) The maintenance of documentation of a clear certificate of conduct, a vulnerable sector check for staff members and volunteers, as well as pre-employment health screening and immunizations as may be required

(11) The allocation of staff members is appropriate in number and qualifications, reflecting the needs of residents and the layout of the Facility, and funded direct care hours are utilized, as intended.

(12) There is a current job description for each position that clearly defines the role, responsibilities, and scope of position that is reviewed annually.

(13) There is a formalized performance management process in place, which evaluates the staff member’s performance before probation period, biannually and more frequently, as necessary.

11 Hiring Requirements

11.1 Outcome

Staff members have an appropriate educational level that supports program outcomes and staff have a clear code of conduct.

11.2 Requirements

The Contractor shall ensure:

(1) That key staff have the minimal education and experience required as listed below.

Minimum Education Requirements and Experience – Long Term Care Facility

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Minimum Education/Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Care Manager</td>
<td>Graduation from accredited school of nursing, ARNNL registered</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>Graduation from accredited school of nursing, ARNNL registered</td>
</tr>
<tr>
<td>Licensed Practical Nurse</td>
<td>Graduation from accredited program, CLPNNL registered</td>
</tr>
<tr>
<td>Personal Care Attendant</td>
<td>High School diploma, graduation from approved PCA course</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>Graduation from approved program, NLAOT registered</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>Graduation from approved program, NLCP registered</td>
</tr>
<tr>
<td>Rehab assistant</td>
<td>Graduation from approved Rehab. Assistant program.</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Graduation from approved program, NLASW registered</td>
</tr>
<tr>
<td>Dietitian</td>
<td>Graduation from accredited program, NLCD registered</td>
</tr>
<tr>
<td>Recreation Therapy Worker</td>
<td>Diploma in recreation or therapeutic recreation</td>
</tr>
<tr>
<td>Recreation Specialist</td>
<td>Graduation from approved program, NCTRC certified</td>
</tr>
<tr>
<td>Speech Language Pathology</td>
<td>Graduation from approved program, CASLPA certified</td>
</tr>
</tbody>
</table>
(2) All employees must have a clear certificate of conduct and a vulnerable sector check.

(3) Each profession has a list of core competencies which should be met on hiring or as part of continuing education throughout the first year of hire.

(4) New employees and volunteers will complete an initial orientation to the Facility that is timely and documented including but not limited to:

- Resident values
- Confidentiality and Privacy (Personal Health Information Act)
- Ethics
- Continuous quality improvement
- Team work
- Understanding the needs of the cognitively impaired
- Infection prevention and control, including proper hand washing technique
- Emergency procedures including fire safety and disaster plan
- Heimlich maneuver
- Information on abuse, neglect, and misappropriation of funds
- Adult Protection Act
- Workplace Hazardous Materials Information Systems
- Specific job duties and responsibilities
- Diversity
- Organizational values
- Facility policies and procedures
- Body mechanics
- Occupational health and safety

(5) The completed orientation checklist is signed and dated by the employee and maintained in the employee’s personnel file.

(6) Volunteers receive orientation, are supervised, are supported in their role, and do not replace paid staff members.

(7) Ongoing education to meet the needs of the resident population is provided to staff members by qualified individuals.

(8) Contracted personnel will work under the policies and procedures of the Contractor.

(9) Contracted personnel responsibilities and communication processes are clearly defined by written policy.

12 Continuing Education

12.1 Outcome
Staff and volunteers have the necessary knowledge, skills, and abilities to provide quality care and service.

12.2 Requirements

The Contractor shall ensure:

(1) Staff members and volunteers receive regular in-service on the following:

- Resident values
- Resident safety
- Confidentiality
- Continuous quality improvement
- Infection prevention and control and hand hygiene
- Emergency procedures including fire safety, disaster planning, and universal codes

(2) There is a policy for ongoing education for staff members that includes, at a minimum:

- Identified learning needs of staff;
- New equipment;
- Changing resident needs
- Annual education on Safe Resident Handling; and
- Mandatory professional education, e.g. basic cardiac life support and First Aid.

(3) Annual attendance record of individual staff participation, which includes the date of the in-service/education session attended are maintained.

Reference:

Appendix A
Levels of Care

An individual may be a high level in one category and a low level in another, however, it is the professional judgment that determines the overall level of care requirement. The level of care recommendation is made by the professional completing the assessment and confirmed by the Assessment and Placement Committee or the Single Entry Coordinator.

CATEGORIES

PERSONAL FUNCTIONS: The Applicant/Resident

Level I

• Is independently mobile, with or without mechanical aids, inclusive of a wheelchair.
• May need specialized aids for independently transferring.
• May require limited assistance with bathing, dressing, and/or grooming.
• May require reminder for routine toileting.
• May require minimal assistance with toileting.
• May need nutritional monitoring.
• May have sensory deficit which interferes with activities of daily living and may or may not require minimal assistance.

Level II

• May be independently mobile with or without mechanical aids, inclusive of a wheelchair.
• May need specialized aids for one person assist for transferring.
• May need a moderate amount of assistance with bathing, dressing and grooming.
• May require a reminder of and/or assistance with routine toileting to avoid frequent incontinence of bowel and/or bladder.
• May require nutritional monitoring of and/or assistance with eating.
• May have sensory deficit which interferes with activities of daily living and requires moderate assistance.

Level III

• Is dependent for transfer or mobility.
• Requires assistance to turn and move about in bed.
• Is dependent for assistance with dressing, washing, grooming and bathing.
• Has incontinence of bladder and/or bowel.
• Requires supervision and assistance with eating or requires feeding.
• Requires daily professional care.
• May have sensory deficit which interferes with activities of daily living and requires ongoing assistance.

Level IV

• See Medical Status/Level 4
MENTAL/SENSORY/PERCEPTUAL: The Applicant/Resident

Level I

- May have full use of mental functions.
- May have a sensory/perceptual deficit but with adaptation will have the ability to be responsive, understand simple instructions, and express needs.
- May demonstrate mild difficulties in orientation to day, time and place.
- May demonstrate mild difficulty with memory and recall.
- May have inappropriate behaviour which does not interfere with other people.

Level II

- May have mental functioning with moderate cognitive impairment.
- Is responsive to verbal stimuli; may have some difficulty with simple instructions, number and time concepts.
- May have sensory/perceptual deficit but even with adaptation needs assistance for understanding and expressing needs.
- May tend to pace or wander in own environment, but is not at risk for elopement.
- May demonstrate inappropriate behaviour which may interfere with others which can be stabilized.

Level III

- May have severe cognitive impairment.
- May have a sensory/perceptual deficit and even with adaptation needs ongoing assistance for understanding and expressing needs.
- May present with management problems due to behaviour, e.g., wandering, aggressiveness, hostility.
- May demonstrate varying degrees of difficulty with orientation to place or person.

Level IV

- Only responsive to tactile or painful stimuli or is non-responsive.
- See Medical Status/Level 4.

MEDICAL STATUS: The Applicant/Resident

Level I

- May have medical problems that are stabilized and do not require daily professional supervision.
- May require accompaniment for (doctors, dentists, specialists, etc.) visits.
- May require therapies (e.g. oxygen concentrator, ventolin masks) or procedures (e.g. colostomies) and is able to independently complete care required.
Level II

- May require therapies (oxygen concentrator, ventolin masks) or procedures (e.g. colostomies).
- Requires assistance to complete task.
- May require assistance with set up and/or cleaning of equipment.
- Will require professional monitoring.

Level III

- Has medical problem(s) which require continuous supervision and may require frequent professional intervention.

Level IV

- May be technology dependent or need both a medical device to compensate for the loss of a vital body function and ongoing professional health care to maximize functioning or prevent further disability e.g. tracheotomy, enteral feed, vascular access device, mechanical ventilation.
Schedule “C”

Facility Funding Policy and Approved Budget

ARTICLE 1 - Policy

1.1 This policy describes the provision of funding available to a Contractor.

ARTICLE 2 - Definitions

Terms used in this Policy shall have the following meanings:

(a) “Approved Budget” is the combined total budget for the Protected and Unprotected Envelopes.

(b) “Client Contribution” is that amount that a Resident is required to contribute to the cost of Long Term Care services, to a monthly maximum of $2,800, as determined through the Long Term Care financial assessment process.

(c) “Long Term Care Financial Assessment” is the policy and process to determine the amount that a client is expected to contribute to the cost of Services (Appendix 1).

(d) “Protected Envelope” is the portion of the Approved Budget that is designated for Program Costs and Raw Food Costs.

(e) “Program Costs” is the services, items required to deliver the program of LTC, including staffing and associate support services.

(f) “Unprotected Envelope” is the portion of the Approved Budget that is designated for capital costs, maintenance and non-care related services.

(g) “Raw Food Costs” are the costs established per Section 5.3.

(h) “Resident” means an individual assessed and approved for admission to a long term care facility, in accordance with the Placement Policy of the Regional Health Authority.

(i) “Resident Care Services Agreement” (RCSA) is the agreement between the Contractor and the Regional Health Authority outlining program requirements for the provision of Services, to which this Facility Funding Policy and Approved Budget forms a schedule.

(j) “Regional Health Authority” (Regional Health Authority) is the autonomous body authorized to provide and responsible for the delivery of health and community services, on behalf of the Department of Health and Community Services.
(k) "Service Approval" is the approval issued by the Regional Health Authority that determines that a LTC Bed is available and suitable, meeting all requirements, for use by Residents.

(l) "Services" means long term care services as specified in the RCSA.

ARTICLE 3 - CLIENT CONTRIBUTION

3.1 Clients are financially assessed by the Regional Health Authority, using the Long Term Care Financial Assessment Policy, to determine the amount of the client contribution, to a monthly maximum of $2,800 for Services.

3.2 The Contractor will receive written notification of the client contribution for each resident and will be responsible to collect the client contribution for each Resident.

3.3 The Regional Health Authority is the payer of last resort for Services.

ARTICLE 4 - APPROVED BUDGET

4.1 The Approved Budget will be provided as a per diem in two distinct funding envelopes, the Protected Envelope and the Unprotected Envelope. The Contractor will be informed annually of their Approved Budget for the provision of Services.

4.2 The Contractor is expected to operate within the Approved Budget. The Regional Health Authority agrees that the Contractor is entitled to manage the Facility and to deploy resources, under the Protected Envelope, while ensuring that required standards and outcomes are achieved as set out in the RCSA and Long Term Care Operational Standards. In addition, the Regional Health Authority acknowledges that decision making authority with respect to human resource issues reside with the Contractor, and that the Contractor has the full rights of an employer including, but not limited to, the recruitment and retention of personnel and the right to develop personnel policies and practices, in accordance with the Long Term Care Operational Standards and the RCSA.

ARTICLE 5 - PROTECTED ENVELOPE

5.1 The Protected Envelope is inclusive of Program Costs and Raw Food Costs as agreed between the Contractor and the Regional Health Authority as set out in the table attached as Appendix 1.

5.2 Program Cost is inclusive of:

(1) Resident Care Staff

The Regional Health Authority will fund Registered Nurses, Licensed Practical Nurses, Personal Care Attendants Assistants, and/or other supportive positions, based on the number of approved beds, the Long Term Care Operational Standards, and subject to available resources.
(2) Program Support Staff

The Regional Health Authority will fund Dieticians, Physiotherapists, Occupational Therapists, Social Workers, Recreation staff, and/or other supportive positions, based on the number of approved beds and the Long Term Care Operational Standards, and subject to available resources.

(3) Employee Benefits

The Regional Health Authority will fund a standardized benefit rate for the sector, as approved by the Department of Health, to each Facility which will encompass Canada Pension Plan, Employment Insurance, Workers Compensation, Pension, and applicable employer premiums for Group Insurances such as Life, Health, and Medical. Unique supplemental rates will be applied as approved by the Department of Health.

(4) Operational Costs

The Regional Health Authority will fund Resident care and program support supplies necessary to fulfill Long Term Care Operational Requirements at approved rates as determined by the Regional Health Authority.

5.3 The Raw Food Costs, which include Meal Days, Specialty Products, and Supplements (all as defined below), for Residents in the Facility, will be funded at approved rates determined as follows:

(1) Raw Food Costs include the costs of all the ingredients and food items necessary to create a meal day, which includes the food products on the menu, supplements, and any specialty products required to meet the daily nutritional needs of the Residents.

(2) Meal Day is one 24 hour period, which includes 3 nutritious meals (as per recommendations of Canada's Food Guide) with at least 2 choices per meal plus beverages, and two snacks throughout the day. A snack should be at least a beverage and a food item such as a starch or fruit. Provision will be made for variation which may be required cultural/religious reasons.

(3) Specialty Products are particular food products needed to support therapeutic diets, e.g. gluten-free, calorie reduced, low sodium, low fat.

(4) Supplements are enteral nutritional formulae, either homemade or purchased; to meet a Resident's assessed nutritional need; and calcium and vitamin D food enrichment.

5.4 In any given year, funding from the Protected Envelope not used for its intended purpose will be forfeited or, if advanced, recovered. Any budgetary deficits will not be funded by the Regional Health Authority.

ARTICLE 6 - UNPROTECTED ENVELOPE

6.1 The Unprotected Envelope will include Capital Costs, Services Costs and all other costs,
overheads, profits and return on investment required to provide the Services that are not included in the Protected Envelope and as are agreed between the Contractor and the Regional Health Authority and set out in the Appendix 2 hereto.

6.2 Funding under the Unprotected Envelope shall be adjusted annually in accordance with indexed the all-items Consumer Price Index (CPI) for NL as follows:

(a) Capital Costs shall not be indexed; and

(b) The Regional Health Authority will index operational costs annually based on the all-items Consumer Price Index (CPI) for NL.

6.3 The Contractor is expected to operate within the Unprotected Envelope portion of the Approved Budget with respect to the service requirements to meet the Long Term Care Operational Standards and the legal obligations described in the RCSA. Any surplus may be retained by the Contractor, any deficits will not be funded by the Regional Health Authority.

6.4 Quarterly reconciliations will be conducted by the Regional Health Authority to compare estimated resident contribution to actuals. If the Contractor collects more from Residents than estimated, the amount will be recovered by the Regional Health Authority. If the amount the Contractor is responsible for collecting from Residents is less than estimated, the Department of Health will subsidize these costs.
Appendix 1 to Schedule C

(Description of Protected Costs to be agreed between the parties)
Appendix 2 to Schedule C

(Description of Unprotected Costs to be agreed between the parties)
Schedule D

Reporting Requirements / Performance Monitoring Framework

The Service Provider must comply with all relevant legislation and Acts, including but not limited to:
- The Buildings Accessibility Act and Regulations
- Food and Drug Act and Associated Regulations
- Health and Community Services Act and Regulations
- The National Building Code and National Fire Code of Canada
- Smoke Free Environment Act and Regulations
- Occupational Health and Safety Act
- Personal Health Information Act
- Adult Protection Act
- The Advanced Health Care Directives Act
- Any other legislation, acts, regulations as determined by the Minister

INSPECTIONS AND MONITORING
If as a result of an inspection it is determined that the Facility is non-compliant with the NL LTC Standards, or otherwise with the requirements of the RSCA, this may be grounds for the Regional Health Authority to determine that a Bed or Beds are Unavailable or grounds for a reduction in funding in accordance with Article 7 of the RCSA.

INSPECTIONS
Long term care homes will be inspected annually (or more frequently in the event of a suspected outbreak, complaint or a re-inspection) by the Regional Health Authority, Service NL or other provincial agency as designated by the Regional Health Authority. Inspection activity may be announced or un-announced.
- Fire Life Safety
  - Fire Evacuation Floor Plan
  - Staff trained on fire evacuation
  - Functioning sprinkler system
  - Functioning fire alarm system
  - Appropriate use and storage of Oxygen systems
  - Emergency lighting

- Environmental Health
  - Physical condition of facility (floors, walls, pest control, safety hazards)
  - Water supply, sewage, waste disposal
  - Heating, lighting and temperature control
  - Food sanitation (storage, equipment, hand washing, temperature, cleanliness)
MONITORING:
Long term care homes will be inspected regularly, with casual inspections conducted regularly and formal inspections annually by the Regional Health Authority, Service NL or other provincial agency as designated by the Regional Health Authority. Inspection activity may be announced or un-announced. Monitoring activity may be announced or un-announced at a frequency determined by the Department of Health and Community Services.

A draft list of indicators is included.

<table>
<thead>
<tr>
<th>PHYSICAL BUILDING SPACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space and chairs are available for visiting in resident rooms.</td>
</tr>
<tr>
<td>Temperature is maintained in resident rooms and open spaces within stipulated parameters.</td>
</tr>
<tr>
<td>There are small, private visiting areas for residents and their guests.</td>
</tr>
<tr>
<td>Equipment storage space is available; equipment is stored out of sight.</td>
</tr>
<tr>
<td>Bathing rooms are small, warm, pleasantly decorated and non-institutional.</td>
</tr>
<tr>
<td>Safe, comfortable outdoor space is accessible to residents and families.</td>
</tr>
<tr>
<td>Residents are offered a pleasant meal experience in small, family-style dining rooms.</td>
</tr>
<tr>
<td>Signage is clear and way-finding features are finished in non-glare matte.</td>
</tr>
<tr>
<td>The building is tastefully decorated, clean and pleasant smelling.</td>
</tr>
<tr>
<td>Changes to physical structure of the building are approved before construction commences and the design adheres to industry standards for safety and least restrictive environments.</td>
</tr>
<tr>
<td>The nurse-call system functions and is set to a reasonable sound level.</td>
</tr>
<tr>
<td>Use of the overhead paging system is restricted to emergency use only.</td>
</tr>
<tr>
<td>Use of natural light is maximized.</td>
</tr>
<tr>
<td>Access to telephone and high speed internet wi-fi for Residents and guests</td>
</tr>
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<table>
<thead>
<tr>
<th>FIRE LIFE SAFETY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff receive instruction in fire safety plan</td>
</tr>
<tr>
<td>Fire Life Safety Inspections are completed, documented and issues corrected</td>
</tr>
<tr>
<td>Emergency Preparedness Plan is in place, accessible to staff and staff receive training on plan execution</td>
</tr>
<tr>
<td>The fire alarm system is set to a reasonable sound level.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ENVIRONMENTAL HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Health Inspections are completed, documented and issues corrected</td>
</tr>
<tr>
<td>Housekeeping and janitorial services must be provided in accordance with Regional Health Authority standards</td>
</tr>
<tr>
<td>Laundry services must be provided in accordance with Regional Health Authority standards</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADMINISTRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>The LTC home has a valid license (where applicable), posted in a conspicuous location</td>
</tr>
<tr>
<td>The Service Provider has submitted all mandatory reporting</td>
</tr>
<tr>
<td>A Family/Resident Council is in place, meets regularly and retains documentation.</td>
</tr>
<tr>
<td>The Residents' Bill of Rights and Responsibilities document is posted.</td>
</tr>
</tbody>
</table>
A system to communicate changes and news to families is in place.
Resident and families have access to managers when needed and contact information is posted.
The facility’s mission, vision, and philosophy documents are current and prominently posted.
Resident information is documented in approved format and securely stored.
Does not charge residents for services other than those listed on the Chargeable Services List.
Notifies Placement Services when resident is discharged.

STAFF
- Staff and volunteers meet minimum hiring requirements
- Staff and volunteers receive orientation to home
- Staff receive continuing education
- Staff requirements (hours of care, skill mix) are met
- Continuity of staffing and permanent assignments is maintained.
- Staff meetings are held regularly.
- Staff who do not attend staff meetings can access meeting minutes.
- Workplace injury rates are within acceptable parameters.
- New employees and volunteers have clear Certificate of Conduct

MOVING IN PROTOCOLS
- Residents and families receive verbal and written information about the facility before moving in.
  This information includes information about resident safety.
- A facility tour is available for those who desire it.
- Medical orders and medications are consistently available on the day of admission.
- The new resident receives a tour of the facility when ready.
- Residents and family are provided with information in respect of Advanced Health Care Directives

CARE
- Upon moving in, the RN assesses resident (fall risk, choking risk, skin integrity, mental status,
  transfer/lift status, safety considerations) and an interim care plan is developed and posted within 24 hours.
- Medication Reconciliation is conducted on admission to the facility.
- A care conference is held within eight weeks of admission to establish an individualized, person-centered care plan.
- The resident and/or family are invited to attend the conference.
- The new care plan is reviewed with care staff and is accessible to them.
- Care plans are reviewed and updated at least quarterly or more frequently as required.
- Pharmacy, medicine and nursing collaborate to review medication profiles regularly.
- Residents who resist bathing are given a towel/bed bath, however continued attempts are made to offer and provide therapeutic bathing in a normal environment.
- Residents receive a supported, safe meal service with appropriate levels of supervision.
- The facility has a dedicated Medical Director who visits regularly.
- Medication reviews for each Resident are performed at least quarterly.
- Referrals between team members are documented.
- Members of the Interdisciplinary Team meet and review issues regularly.
The facility has an established partnership with palliative support service providers.

Medication reviews incorporate best practices related to medications and the elderly particularly as it relates to antipsychotic, anti-hypnotic and anti-anxiety medications.

Care plan processes supporting a smooth transition to/from acute care (if accessed) are documented to ensure continuity of care.

**ACTIVITY/SOCIAL PROGRAMMING:**
Activities are hosted at least six days per week. Group and one on one programming is provided.
Therapeutic activities are schedule for residents with cognitive impairment.
Care plans reflect assessment and involvement in activities of interest.
Residents have access to pastoral visitation upon request and church services weekly.

**COMMITMENT TO QUALITY IMPROVEMENT**
Is Accredited by Accreditation Canada.
Has a complaints / compliments process in place and tracks same as part of a quality improvement process.
The Service Provider follows up on complaints.
Resident and family satisfaction is formally evaluated on at least an annual basis.
The home has a continuous quality improvement assurance process in place.
Resident and family satisfaction with meals and nutrition is evaluated on a regular basis. Results and plans are shared with the Resident and Family Councils.

**REPORTING:**
Service providers will be required to report, financial, statistical and quality care indicators to the Regional Health Authority and/or the Department of Health and Community Services, at a frequency determined by the Department.

- Staffing (hours of care, skill mix, access to support staff, training requirements, orientation new staff (Quarterly))
- RAI MDS 2.0 reporting to CIHI (Quarterly)
- Quality of care indicators (e.g. number of falls, use restraints, pressure ulcers) (Quarterly)
- Occurrence and incident reporting (Quarterly)
- Financial and Statistical Reporting (Quarterly)
- Demographic data (number of residents, level of care, age (> or < 65) (Quarterly)
- Confirmation of Accreditation Status from Accreditation Canada and any related documentation including Accreditation Report, and any follow up reporting requirements

**Financial reporting requirements (Quarterly)**

<table>
<thead>
<tr>
<th>REVENUE</th>
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<tbody>
<tr>
<td>Regional Health Authority Grant funding</td>
</tr>
<tr>
<td>Resident contribution</td>
</tr>
<tr>
<td>Resident fee contributed by third party (eg WHSC)</td>
</tr>
<tr>
<td>CMHC Mortgage Interest subsidy</td>
</tr>
<tr>
<td>Revenue</td>
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<tr>
<td>---------</td>
</tr>
<tr>
<td>Investment revenue</td>
</tr>
<tr>
<td>Capital grants</td>
</tr>
<tr>
<td>Protected Envelope disbursement and reconciliation</td>
</tr>
<tr>
<td>Recoveries</td>
</tr>
<tr>
<td>Other offset revenue (e.g. parking, rentals, chargeable extras, gift shop etc.)</td>
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<table>
<thead>
<tr>
<th>Expenditures</th>
<th></th>
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<tbody>
<tr>
<td>STAFFING</td>
<td></td>
</tr>
<tr>
<td>Salary and wages</td>
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<tr>
<td>Accrued salaries and wages</td>
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</tr>
<tr>
<td>Recovered salaries and wages</td>
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<tr>
<td>Benefits</td>
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<tr>
<td>Severance pay</td>
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<tr>
<td>Accrued Holiday Pay expense</td>
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<tr>
<td>Accrued retiring allowance</td>
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<tr>
<td>Purchased services</td>
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<tr>
<td>Other staffing</td>
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<tr>
<th>Property Charges</th>
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<tbody>
<tr>
<td>Rent</td>
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<tr>
<td>Mortgage interest</td>
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<tr>
<td>Property taxes</td>
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<tr>
<td>Maintenance and repairs</td>
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<tr>
<td>Utilities</td>
<td></td>
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<tr>
<td>CMHC replacement reserve</td>
<td></td>
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<tr>
<td>Depreciation - building</td>
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<tr>
<td>Other capital</td>
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<table>
<thead>
<tr>
<th>Administration and Supplies</th>
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<tbody>
<tr>
<td>Food</td>
<td></td>
</tr>
<tr>
<td>Dietary supplies</td>
<td></td>
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<tr>
<td>Incontinence supplies</td>
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<tr>
<td>Medical supplies</td>
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<tr>
<td>Housekeeping/Laundry supplies</td>
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</tr>
<tr>
<td>Administration/Office Expenses (telephone, internet, printing, travel, recruitment, training, interest)</td>
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<tr>
<td>Professional fees/Association Dues/Accreditation</td>
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<tr>
<td>Insurance</td>
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<tr>
<td>Purchases services</td>
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<tr>
<td>Other</td>
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<tr>
<td>Non-operating revenue</td>
<td></td>
</tr>
<tr>
<td>Non-operating expenditures - mortgage principal</td>
<td></td>
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<tr>
<td>Non-operating expenditures - other</td>
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<table>
<thead>
<tr>
<th>Equipment</th>
<th></th>
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<tbody>
<tr>
<td>Minor equipment purchase</td>
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<tr>
<td>--------------------------</td>
<td></td>
</tr>
<tr>
<td>Rental/lease equipment</td>
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**Statistical Reporting Requirements (Quarterly)**

<table>
<thead>
<tr>
<th>GENERAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider location</td>
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<tr>
<td>Mailing address</td>
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<tr>
<td>Provider information</td>
</tr>
<tr>
<td>Assessment date</td>
</tr>
<tr>
<td>Payroll period</td>
</tr>
<tr>
<td>Mortgages/Loans</td>
</tr>
<tr>
<td>Resident Trust Account verification</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>STAFFING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of direct nursing hours worked</td>
</tr>
<tr>
<td>Number of resident bed days</td>
</tr>
<tr>
<td>Hours worked per resident day (Administration and Support, direct care staff)</td>
</tr>
<tr>
<td>Average hourly rate paid (Administration and Support, direct care staff)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESIDENT CENSUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of residents on the last day of reporting period</td>
</tr>
<tr>
<td>Number of residents by level of care</td>
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<tr>
<td>Number of residents by age</td>
</tr>
<tr>
<td>Number of residents admitted during period</td>
</tr>
<tr>
<td>Number of discharges during period</td>
</tr>
<tr>
<td>Number of deaths during period</td>
</tr>
<tr>
<td>Number of transfers during period</td>
</tr>
</tbody>
</table>
Schedule A

Functional Requirements

1. Introduction

In April 2015, the Government of Newfoundland and Labrador approved the provision and funding of 360 new residential and long-term care beds to meet the growing needs of our aging population. These beds are specifically targeted to meet the needs of individuals with high care needs (levels III and IV) who are no longer able to live independently at home with supports, or in a personal care home setting. All facilities will serve individuals with mild to advanced dementia. It should be noted that 48 of the beds to be provided within Eastern Health are intended to serve individuals with mild to moderate dementia. The design of these new facilities will take account of current evidence-based-design principles.

An allocation of 120 beds is to be provided in each of three of the province’s Health Authorities. These additional beds are to be located in Eastern Health, Central Health and Western Health. The 120 Central Health beds are to be provided in two separate physical locations, but will be designed and operated as “one facility on two sites”.

This document provides the functional requirements and design intentions of these four groupings of beds and support services. This document provides a description of both the desired “built environment” and the nature of services that are required to be provided. Beds and support spaces must be fully compliant with all relevant codes, standards and legislation that apply in the Province of Newfoundland and Labrador.

2. Description of residents to be served by these new facilities

Each of these new facilities will be equipped to accommodate residents who require the following programs and levels of care described below.

Resident acuity and levels of care

Typically all residents to be served in these beds will be assessed as level III or IV, however it should be noted that an individual may be a high level in one category and a low level in another, however, it is the staff of the relevant health authority that determines the overall level of care requirement, based on the findings and outcomes of a standardised assessment and confirmed by their professional judgement.

Categories

Level III

- Is dependent for transfer or mobility.
- Requires assistance to turn and move about in bed.
- Is dependent for assistance with dressing, washing, grooming and bathing.
- Has incontinence of bladder and/or bowel.
- Requires supervision and assistance with eating or requires feeding.
- Requires daily professional care.
- May have sensory deficit that interferes with activities of daily living and requires ongoing assistance.
- May have severe cognitive impairment.
- May have a sensory/perceptual deficit and even with adaptation needs ongoing assistance for understanding and expressing needs.
- May present with management problems due to behaviour, e.g. wandering, aggressiveness, and hostility.
- May demonstrate varying degrees of difficulty with orientation to place or person.
- Has medical problem(s) that require continuous supervision and may require frequent professional intervention.

**Level IV**

- Only responsive to tactile or painful stimuli or is non-responsive.
- May be technology dependent or need both a medical device to compensate for the loss of a vital body function and ongoing professional health care to maximize functioning or prevent further disability e.g. tracheotomy, enteral feed, vascular access device, mechanical ventilation.

**Moderate dementia**

- In relation to the 48 Beds in the Eastern Health facility, it is intended that 48 of these beds will accommodate residents who may have a mild or moderate level of cognitive impairment but whose care needs have been assessed as requiring a more supervised residential care environment.
3. General description of required facilities, design, equipment, and services that will apply to all residential care settings

These beds will be provided in a “residential-style” environment. The designs sought in this RFP are to be homelike in nature, promoting choice, empowerment, flexibility, independence and a sense of community. This will enhance the resident’s ability to maximize their mobility as they age in place, and enjoy a community and neighbourhood living experience.

The focus of these environments will be to promote privacy and to stimulate and support resident and family connections within each “neighbourhood”. Each neighbourhood will have their own living and dining areas to foster social interaction and companionship. In addition, each resident will have his or her own wheelchair accessible single (private) bedroom with en-suite toilet and shower. Residents and families will be encouraged to personalize their neighbourhood and their individual rooms, so that the neighbourhood will reflect personalities of the individuals who live there. Each room will have personal memory display cabinets and other visual cues, which will also serve to assist residents and families with way finding. It is also intended that appropriate furniture, amenities and objects will be located throughout the neighbourhoods for resident interaction. Pictures, plants and other features will reinforce a home-like environment.

All resident accommodation described in this section will have the ability for individual neighbourhoods to be secured when required, and will be configured to accommodate maximum visual observation and have an enclosed wandering loop. Ten percent of all resident rooms are to be designed to accommodate bariatric residents. All areas should be wheelchair accessible for the use of all residents.

Beyond the neighbourhood, communal spaces will also be provided to encourage another level of social interaction. These areas will be equally accessible to all residents. All meals for residents are to be prepared and cooked on site.

All items of furniture and fixed equipment will be provided, including specialized seating where required, for use in these facilities, (indoor and outdoor), and all such equipment must meet all regional policies and standards for infection prevention and control. Ensure adequate hand washing sinks and secondary hand sanitizing stations are provided to meet best practice needs in infection prevention and control. Designs will incorporate current best practice guidelines from the Centre for Health Care Design (https://www.healthdesign.org) or other referenced “expert sources”. In addition, the facility(s) must achieve and maintain full accreditation by Accreditation Canada. (https://www.accreditation.ca)

Special requirements for bariatric residents

- All communal areas and pathways to these areas must be accessible for bariatric residents. Bariatric individuals are considered to be those within the range of 225 kg to 453 kg. Such persons generally need larger furnishings, larger equipment, and larger physical spaces to manoeuvre. For bariatric residents, additional space is needed for staff (usually two or more) to assist them when providing care.
- Within all resident communal areas, (i.e. lounges, waiting, dining, multi-purpose, hairdressing, etc.) at least 10% of all furnishings and equipment will be designed to accommodate bariatric persons.
- Door openings in all communal areas including living and dining areas and corridors will be a minimum of 1220 mm wide.
- Adequate floor space and clear areas to accommodate larger furnishings and equipment will be provided to permit the manoeuvring of items into and out of the room.
- Additional space will be provided to allow for care by multiple caregivers when needed.
- Provision of space between items of furniture, equipment or physical structures will be provided to facilitate righting a person who has fallen.
- All handrails in corridors, pathways, communal areas and resident service spaces (i.e. rehabilitation area, exam room, etc.) will be designed to safely support a weight of at least 453kg.
- Shared-use areas equipped with a resident lift system, where bariatric residents may be cared for, will be equipped with ceiling mounted track and motorized resident lift suitable to safely lift and transport weights up to 453 kg. This would include all bathing suites and rehabilitation areas.

Resident bariatric bedrooms will include the following:

- Clear space of at least 1500 mm will be provided on three sides of the bed. Sufficient clear space will be provided to accommodate large mobility aids and other portable equipment (e.g. walker, wheelchair, commode).
- The entry door openings will be at least 1500 mm wide.
- The room will have a ceiling mounted ceiling lift and track system that can safely lift and transport weights up to 453 kg. The track should extend to both sides of the bed, and from the bed to the washroom.
- The bed will be able to safely accommodate a resident weighing up to 453 kg (Beds for bariatric persons are longer and wider than a standard bed — usually not less than 2285 mm long (2490 mm extended) x 1118 mm wide (1574 mm with side rails). Weight scales must be an integral feature of the resident bed.
- The room will be equipped with handrails that can safely support weights of at least 453 kg.

Special requirements for residents at end of life

Each facility will have enhanced suites to support residents at end of life, as follows:
- 3 of the 120 beds in the facility in Corner Brook
- 2 of the 72 in the facility in the Northeast Avalon
- 2 of the 70 beds in the facility in Gander
- 2 of the 50 beds in the facility in Grand Falls-Windsor

These suites will include a resident room, with private three piece bathroom, and an attached sleeping area for family, a galley sink, small refrigerator and small counter for light food preparation. These suites will meet all requirements as described for other resident rooms.

Washrooms for resident bedrooms for bariatric persons will be designed and equipped with the following features:
Entry door openings will be at least 1500 mm wide.

A sink will be provided that can support at least a 363 kg downward force.

A floor-mounted toilet will be provided that is suitable for bariatric residents that can support weights of up to 453 kg.

Toilet position will be compatible with the use of a bariatric commode. Toilet paper dispenser will be mounted in a location where a bariatric resident can easily reach it.

Rooms will be equipped with grab bars that are appropriately sized and positioned for use by a bariatric person and that can support a 363 kg downward force. Grab bars shall extend behind and beside the toilet subject to accessibility codes and regulations.

An open plan toilet and shower area with no floor lip, and with floor appropriately sloped to a drain and a shower equipped with a handheld spray nozzle on a side wall.

4. General Design Requirements and Landscaping

All sites will require landscaping in such a manner that provides an appropriate residential feel and look, and provides space(s) for the residents to enjoy outdoor activities. All such spaces and exits must be wheelchair accessible for all residents, barrier free and have no trip hazards. Appropriate seating areas should be provided in paved areas and pathways. Unobstructed access for emergency vehicles is required. It will also be important to maintain at all times any required clearances under overhead obstructions and by ensuring appropriate layouts in road and driveway design to facilitate ease of use. Parking restrictions will be applied to areas where emergency vehicles are required to access. Adequate space will be provided on site for staff and visitor parking as well as shipping and receiving functions.

The landscaping of outdoor spaces will include features such as secure fencing, age friendly outdoor furniture, and will have raised flowerbeds incorporated into the design. There will also be shaded and weather protected areas for residents. The pathway will be patterned to provide an elder friendly “closed wandering loop” in each patio area. Pavement color will be consistent throughout and non-glare surfaces will be used. The use of stairs and ramps should be minimized wherever possible, and a wheelchair accessible and barrier free alternative access must be provided. All stairs will be provided with handrails. Lighting for pathways and outdoor spaces will be provided and installed in such a way to ensure that glare from the fixtures will not impact on resident rooms and other indoor spaces. Service areas including fuel tanks, waste disposal, and receiving will be screened from resident areas.

Building Configuration

Subject to site constraints, low-rise design is preferred in order to create the sense of small group/ neighbourhood living environments for residents. Each neighbourhood will accommodate no more than 16 bedrooms, resident spaces, and may combine these neighbourhoods in such a model to incorporate shared or mirrored support service or staff areas.

Residents will have “at grade” access to common areas and outdoor spaces throughout the site. For neighbourhoods located at grade, access can be provided from those neighbourhoods. For those neighbourhoods located at higher levels, access to grade must be provided from common areas. All
doors leading to the garden area will be provided with power door operators suitable for the resident profile, and accommodate all types of residents. All doorways must be wheelchair accessible, and fit for the purpose of access and egress by elderly residents who may be walking unaided or with the assistance of one or more staff. In the case of doorways at the main or secondary entrances to the facility, these must also be equipped with power assisted door operators on both the interior and exterior doors accessible for all residents.

The individual resident neighbourhoods will be designed such that residents, staff and families are not required to travel through one resident house to access another. Administrative and service areas will be located separately from the resident areas. Common areas within the neighbourhoods must have views to the exterior and or garden areas. There will be no “dead-end” corridors in the resident areas and all rooms will be located on a well-designed walking loop with good sight lines for staff. There must be appropriately scaled spaces, architectural detailing and materials that are familiar, elder-friendly and as “home-like” as is practical to create a residential atmosphere.

5. Resident Neighbourhood Design Requirements

Resident Bedroom - This is a private space where resident’s personal activities of daily living will occur (e.g. reading, watching TV, sleeping, grooming and dressing). This space will accommodate one resident and a guest(s) and necessary staff/resident support activities. The room must be large enough to ensure that there is adequate clearance around the bed on all three sides to allow the use of mechanical lifting aids, wheelchair and to undertake any other resident/staff activities. Minimum clearances around the bed are 1.5 m on either side of the bed and 1.2 m at the end of the bed. The room will be capable of taking a “smart-bed” with remote monitoring and nurse call capabilities. There will be a ceiling mounted track above the bed for a motorized resident lift, that is able to transfer a resident to the bathroom in an appropriate, safe and dignified manner. There will also be a corner chair situated with a view to the outside, facilitated by appropriate windowsill heights and design. Consideration should be given to providing a multi-purpose chair, which may have the ability to recline and so allow a family member to stay overnight as necessary. All rooms will have necessary cabling and connections for TV and telephone. Wireless internet capability will be provided to resident rooms and common areas. There will also be a lockable cupboard for clothing and personal items (e.g. photos, books and artwork). Furniture will include a bedside table, locker, lockable clothes closet, a dresser, and fixed shelves. All furniture within the room will be comfortable, residential in nature, and upholstered with a cleanable material that meets infection prevention and control standard, guidelines and best practice. All rooms will have the ability for fresh air to be obtained from an opening window section (risk free from access or falls) and any opening portion will be fitted with a bug screen. Additional lockable storage space will be provided within the facility for seasonal resident clothing storage.

Each neighbourhood will also have one “family unit” where two adjoining rooms can be created for residents with friends, siblings or spouses who wish to be together with a lockable interconnecting door or moveable wall panel. All bedroom doors will provide an opening, in a two-part opening door design, with the smaller section being able to remain closed when the main door is in use, to provide easy
access and egress for residents and staff, as well as the movement of beds or other equipment. The location of the bed in each room will be designed to ensure residents have a lit path to the washroom and the room configured in such a way that residents do not have to cross the room to access the bathroom. Appropriate elder friendly handrails must be located on walls surrounding the bed to enable residents to support them from the bed, through to the washroom.

**Resident Washroom** - This is a private space where a resident can conduct personal care activities in an environment that supports privacy, safety, dignity and independence. The space will accommodate one resident and up to two members of staff and be fitted out to suit the needs of residents. Each room will have a sink, toilet, shower and mirror to accommodate all resident heights. The room will have nurse call capabilities, a resident supply cupboard, a secure staff supplies cabinet and a night-light. Resident washroom doors must be large enough to accommodate a wheelchair and any required staff assistance. The toilet will not be visible from the corridor at any time.

**Resident Assisted Bathing Suite** - Provide a minimum of one combined resident assisted bathing/shower room in each neighbourhood. This is a space where residents will receive assisted bathing in a pleasurable, safe, dignified, private and comfortable environment. It will include a bathing tub with hair shower attachment, sufficient secure storage space for cleaning supplies, soaps and shampoo along with a hand sink, soap dispenser and paper towel dispenser, a wheelchair accessible shower with securely mounted grab bars on one wall, and a wheelchair accessible toilet with a privacy screen. The shower will have sufficient space to accommodate a shower chair so that a resident can be showered in a seated position. A mechanical ceiling lift will be provided within these areas to assist staff and residents. The bathtub will be located such that it can provide wheelchair and staff support access on three sides. A separate wheelchair accessible washroom with toilet and a sink will be provided in each suite that is accessible only from the bathing room.

The assisted bathing suite will be ventilated to remove moisture and odour. Bath and shower areas will have individual quick response room temperature control capable of maintaining a comfortable temperature for bathing and be separate from surrounding rooms and areas of up to 30°C (85°F).

**Resident Living Room** - This is a common space where residents will interact with other residents, family members, visitors and staff in a comfortable, homelike and relaxed atmosphere that enhances resident quality of life through activities such as reading, conversing, celebrating, family visiting, playing games and watching television. This space should have a focal point such as an electric fireplace or similar feature. This space will accommodate residents living within the neighbourhood plus visitors and support staff. The resident living room is equipped with shelving for storage, adjacent space for wheelchairs and walkers, and seating that will support several activities at the same time. The living room will have a clear view to the outdoors and is designed and finished to give a homelike feel. For neighbourhoods with living areas located on the ground floor, access to the outside will be nearby with the ground floor having a walkout patio and garden. For rooms on upper floors this access will be provided to a secure balcony or patio to ensure residents can access “outdoor space”.
The living room will have a wheelchair accessible washroom nearby so that residents do not have to travel back to their room during activities. Each neighbourhood will have an adequately sized living room to accommodate resident activities. Noise will be minimized in common areas through use of material, furniture, fixtures and equipment selections that aid in sound absorption. In addition all furniture will be upholstered with a cleanable material that meets infection prevention and control standard, guidelines and best practice. There will be a need to provide access to quiet space for family/resident space in each neighbourhood or between neighbourhoods.

**Resident Dining Room** - This is a space where residents will enjoy a positive dining experience in a comfortable, homelike and relaxed atmosphere and this space can also be used for small group activities. This space will be able to accommodate all residents living within the neighbourhood plus visitors and support staff. Square tables and chairs with armrests will be provided. The resident living room and kitchen adjoin the dining area. Appropriate arrangements need to be incorporated in the design for housekeeping equipment, as well as space for storing wheelchairs and walkers in close proximity to the dining room. To assist with the dining experience, two hand wash sinks must be located immediately adjacent to the dining room area, for use by both staff and residents. The dining room should have a clear view to the outdoors. For ground floor dining areas, direct access to an outside walkout patio area and garden is desirable. A wheelchair accessible bathroom is to be located nearby so that residents do not have to travel back to their suite during activities. Noise should be minimized in common areas through material and furniture and fixed equipment selections that aid in the sound absorption.

**Staff and other support space** - Adequate space will be provided for staff support functions in both the neighbourhood and communal space. These spaces must be large enough to include a wheelchair accessible washroom on each floor, meeting rooms and other staff needs. All resident areas will have good sight lines and designed so that staff can easily observe resident activity, particularly from any proposed nursing stations. Medication and treatments will be securely stored and prepared in a dedicated space will be fully compliant with all policies and provincial regulations. Care staff will be able to manage resident records and meet with staff/families as required. A private office/family meeting room should also be provided for use as needed in each neighbourhood, ideally in close proximity to the nursing station, to promote interdisciplinary team working.

6. **Other communal and ancillary spaces and other related design requirements**

**Resident Laundry** – Adequate arrangements must be provided on site to provide for the laundering of residents personal clothing.

**Clean Utility Rooms** - Work surfaces will be easily cleaned and impermeable to moisture. This space will be for staff use only. This is a space where clean linen will be stored before distribution and must meet infection control standards.
Soiled Utility Room - A dedicated space must be provided for safe handling all soiled materials in accordance with required operational practice and accreditation standards.

Multi-Purpose Room(s) - Each facility will incorporate a space where communal group recreation activities will take place to support meaningful residential activities and social interactions including leisure pursuits, sensory stimuli, concerts and music related programs, and/or religious purposes. This space should be centrally located and designed so that it can be used flexibly for a variety of purposes. This room will have adequate space for residents of connecting neighbourhoods to gather. An area of the space should be designed for spiritual reflection, and there should be a large lockable closet/storage locker provided for items to be used in religious services. In addition a smaller room or part of the larger room capable of being partitioned off, seating up to 12 persons, should be incorporated that may be used by residents for family gatherings, special occasions and/or spiritual purposes or religious activity.

Rehabilitation Space - This is a space where residents will receive rehabilitation services such as physiotherapy and occupational therapy. There will also be a ceiling mounted track and lift in the rehabilitative space.

Hairdressing/Beauty Salon, Café, Treatment Room - As part of the communal areas of each facility, and in order to create a neighbourhood feel, it is expected that the above range of facilities and services will be provided. For the convenience of residents and visiting health professionals, a multi-purpose consulting and treatment room will be provided in each facility. This should contain a desk, chair, examination couch/chair, be wheelchair accessible for all residents, and should have Internet connections to facilitate tele-health capability.

Entrance Foyer - This is a space that will provide a welcoming entry to the facility for residents, families and visitors. A covered vehicle drop off/pick up area with adequate clearance for ambulances and service vehicles must be provided. The outside entrance doors will be designed to prevent drafts.

Central Kitchen/Food Storage - A production kitchen will be located in the facility. Storage of dry goods, supplies, refrigerated and frozen food, wet and dry garbage and recycling will have their own storage room/location and be compliant with policies and regulations that outline storage and sanitation for goods in that area.

Housekeeping Rooms - Space will be located on each floor where housekeeping equipment and supplies will be stored to ensure a clean and safe environment for residents, staff, family, and visitors meeting infection prevention and control best practices. Each housekeeping room will have sufficient space for the secure storage of chemicals and other cleaning supplies, chemical dispensing units, storage carts and other housekeeping equipment, and provide adequate arrangement to meet provisional occupational health and safety requirements. In addition, each room will be equipped with hot and cold water supply, a service sink, a hand wash sink and floor drain. Surfaces in direct contact with water will be smooth, easily cleaned and impermeable to moisture. There will also be a space for a recycling program. It will be stocked so staff do not have to leave the neighbourhood to replenish/obtain supplies. This space is only for staff use.
Plant/Maintenance/Shipping and Receiving - A space will be provided to support the ongoing maintenance activities of the building and building components. It will contain storage space for maintenance equipment, floor plans, operating manuals as well as portable machinery and tools. There will be physical separation and good acoustical control between the plant/maintenance areas and resident areas of the facility. Sufficient space will be provided for receiving and breaking down of supplies as well as shipping of products. Grounds and gardening maintenance equipment such as snow blowers and lawn mowers will be securely stored in a separate building or shed.

Service/Equipment Rooms - This space will be provided by the service provider to suit the needs of their design and maintenance requirements.

Materials Management - General Storage - This space will be a temperature controlled room with wire shelving and secure access to ensure products stay at the highest quality. Cold Storage space will have direct access to the delivery area as well as access to the inside the facility to ensure deliveries remain in a controlled environment. Materials Management space will provide year round access for delivery, storage and distribution of supplies and equipment. There will be a dedicated receiving entrance separate from the main entrance of the facility.

Administration - These will be spaces where administrative and clinical staff will provide for the overall management of the facility and the delivery of services to the residents. It will include a meeting space for staff and families as well as staff education. Secure storage space for files and records will be provided.

Environmental and other Issues - While these facilities are intended to be residential in nature and feel, resident rooms, all communal areas, corridors, kitchen and personal laundry areas will have appropriate ventilation and air conditioning.

Appropriate arrangements will require to be made for acceptable standby heating in the event of system failure. The service provider must provide and ensure redundancy in all facility systems so that the building will remain functional if there are utility or system failures. The building must be fully compliant with fire safety legislation and be fully sprinklered.

Electrical Systems - Provide redundancy in systems and emergency power generators so that the building will remain functional if there are utility or system failures.

Each resident bedroom will be equipped with a smoke detector, separately annunciated at a central location. A staff response system will be provided and located at each bed and resident washroom, bathing areas and other resident activity areas. Corridor dome lights will be provided over resident room doors to annunciate normal, bed alarm, or emergency call. An overhead paging system will be provided and is to be used for emergencies only.

Each bedroom will be equipped with appropriately located and aesthetically appealing light fixtures that have a non-institutional appearance. Exterior doors will be alarmed and separately annunciated at a central location. Local control will be provided through the use of keypads and magnetic locks. Each
facility will have the ability to be secured to prevent resident elopement. A connection to the fire alarm system will provide an override where required by code.

7. Specific Requirements for Western Health

120 long-term care beds are to be provided in a stand-alone building on a designated site in Corner Brook that has been nominated by the health authority. It is proposed that the site be sold to the Contractor at fair market value. Water, storm and sanitary sewer will be provided to the edge of the site as well as an access roadway. These services have been installed in advance by Western Health and there will be a metered charge to the contractor for water and sewer use. The contractor will be responsible for the cost of all meter installation.

8. Specific Requirements for Central Health

The 120 long-term residential beds are to be provided in 2 separate buildings, the first a 70 bed unit in the municipal boundaries of Gander, and the second, a 50 bed unit to be provided within the boundaries of the municipalities of Grand Falls-Windsor and Bishop’s Falls.

9. Summary Requirements for Eastern Health

Of the 120 long-term care beds to be provided under this RFP, a single facility is to be provided within the municipal boundaries of the cities of St. John’s, Mount Pearl, or the towns of Paradise and Conception Bay South. It is intended that 72 beds be used to accommodate long-term care residents and 48 beds are to be used to care for residents with mild to moderate dementia.
Supplemental Standards to the Newfoundland and Labrador Long Term Care Operational Standards

1 Administration

1.1 Management of the Home

(1) Outcome

Residents live in a home that is effectively and efficiently managed and that promotes quality of life.

(2) Requirements

The Service Provider shall ensure:

(a) There is a designated administrator responsible for the over-all management of the home. When the administrator is absent, on-site administrative authority is delegated to an appropriate individual.

(b) A current organizational chart, available to all staff, outlines the relationships between departments and the lines of authority.

(c) The home is fully compliant with the Newfoundland and Labrador Long Term Care Operational Standards, relevant policies, and other applicable legislation as determined by the Minister of Health and Community Services or a delegate.

(d) The staff has access to, and complies with recent, applicable requirements, reports, and legislative updates.

(e) The development of a statement of the home’s mission, vision, values, philosophy of care, code of ethics, and range of services.

(f) The development of a Resident Bill of Rights and Responsibilities.

(g) There is a process in place to ensure medications are administered, recorded and monitored by appropriate staff and that there is a process to ensure the identity of residents prior to medication administration.

(h) That the necessary operational policies and procedures are developed, documented, implemented and are reviewed/revised annually. Required operational policies shall include but are not limited to:

- Protection of residents from abuse
- Least restraint
- Extremes of internal temperature

Draft 19 June 2015 For Discussion Purposes Only Privileged and Confidential Annex I (Annex G included within as Appendix B) LTC Residential Care Service Agreement with Schedules.docx
2 Services Approval (this will be referred to as the licensing process once LTC legislation is developed):

2.1 Outcome

The Service Provider obtains confirmation that the facility and related services have been assessed as suitable for the provision of long term care services prior to operating a long term care home. The Services Approval process requires the applicant to comply with all applicable legislation and the Newfoundland and Labrador Long Term Care Operational Standards.

2.2 Requirements

(1) For new construction, the Service Provider must:

(a) Obtain a Services Approval certificate by submitting an Application for Services Approval form and a facility inspection request. Authorities with jurisdiction will complete an inspection of the facility and services and notify the Service Provider of the outcome of the inspection.

(b) Submit all required information to the RHA and/or DHCS including:

- Proof of ownership/lease of facility
- A clear certificate of conduct of the Service Provider and staff
- Approved staffing plan
- Proof of required insurance
- Proof that the LTC home is compliant with all Fire Life Safety Standards
- Proof that the home is compliant with all Environmental Health Standards
Standards

- Proof of a Food Premises license
- List of directors and board members of corporation

(2) For sale, lease or transfer of ownership, the Service Provider must:

(a) Submit a completed Application for Services Approval form and include:

- Proof of ownership/lease of facility
- Facility floor plan
- Business Plan
- Evidence that the Service Provider has the financial capacity to operate a long term care home.
- Evidence that the Service Provider has experience to operate the home in accordance with all legislation, the Operational Standards and exhibits an understanding of the philosophy of care and service delivery.
- Three References
- A clear certificate of conduct of the Service Provider and staff
- Proof of required insurance
- Proof that the LTC home is compliant with all Fire Life Safety Standards
- Proof that the home is compliant with all Environmental Health Standards
- Proof of a Food Premises license
- List of directors and board members of corporation

(b) The Service Provider must post the Services Approval certificate in a conspicuous location visible to the public.

3 Moving In

3.1 Outcome

Individuals suitable for placement in a long term care home are supported during the moving in process.

All individuals presenting with a care need will be assessed using the interRAI Home Care assessment tool. Individuals assessed as requiring Level III or IV (see Appendix A) may be offered placement in a long term care home.

3.2 Requirements

The Service Provider must:
(1) Participate in the regional single-entry system of assessment and placement, managed by
the Regional Health Authority.
(2) Not admit individuals that are not referred by the Regional Health Authority.
(3) Provide services to individuals deemed eligible by the assessment process and referred by
the Regional Health Authority.
(4) Have the capability to accept clients 8am to 8pm, 7 days per week.
(5) Notify the Regional Health Authority of a bed vacancy within 8 hours of a discharge.
(6) Maintain 98% occupancy, and a bed turnover rate of 1-3 days.
(7) Work with the Regional Health Authority to facilitate discharge of residents whose care
needs decrease such that Level III care is no longer required.

4 Labour Disruption Contingency Plan

4.1 Outcome

Residents continue to receive quality care and services in the event of a labour-management
dispute.

4.2 Requirements

The Service Provider shall ensure:

(1) Essential services continue to be provided to residents whenever there is a reduction in the
number of staff members available to serve the residents as a result of a labour-management dispute.

(2) A labour disruption business continuity plan will be developed including a detailed
schedule of staffing.

(3) The business continuity plan will be approved by the Regional Health Authority or the
Department of Health and Community Services or designate.

5 Inspections

5.1 Outcome
The home is inspected by all applicable authorities having jurisdiction.

5.2 Requirements

The Service Provider shall ensure:

(1) Compliance with the Provincial Long Term Care Operational Standards and the Service Agreement (if applicable) and have a valid Long Term Care Home Service Approval certificate that is posted in a conspicuous location.

(2) Inspection reports and recommendations from authorities having jurisdiction are retained. Compliance with recommendations and requirements are undertaken and evidenced by appropriate documentation. Such documentation is maintained in a common file for access by staff responsible for inspections and monitoring.

(3) Compliance with all applicable legislation including, but not limited to:

- The Buildings Accessibility Act and Regulations
- Food and Drug Act and Associated Regulations
- Health and Community Services Act and Regulations
- The National Building Code and National Fire Code of Canada
- Smoke Free Environment Act and Regulations
- Occupational Health and Safety Act
- Adult Protection Act
- Personal Health Information Act

(4) Compliance with any other legislation, acts, regulations as determined by the Minister and any new or revised inspection processes for all applicable jurisdictions.

6 Monitoring

6.1 Outcome

The home is monitored for compliance with the NL LTC Operational Standards

6.2 Requirement

The Service Provider shall ensure:

(1) Staff participate in the quarterly and annual review process.

(2) RHA monitoring staff are provided with all requested documentation.

(3) Corrective action is undertaken in the time frames recommended and documentation of same exists.
7 Facility Condition

7.1 Outcome

The facility and site are kept in a condition that provides a clean, comfortable and secure environment that optimizes the quality of life for residents and family and supports the delivery of quality resident accommodation and care.

7.2 Requirements

The Service Provider shall ensure:

1. That site development and building alterations or change of use of space from that originally intended have prior approval of the RHA in consultation with Service NL.

2. That repairs and alterations to long term care homes meet Infection Prevention and Control Standards.

3. That long term care home maintenance is carried out in accordance with all relevant legislation and meets all Operational Standards.

4. That repairs and alterations are carried out in accordance with the Department’s Facility Space and Design Requirements.

5. That materials, systems, equipment and furnishings are maintained in accordance with the requirements of the manufacturer/supplier of the product.

6. That a schedule for the preventative maintenance, inspection and repair of equipment is prepared and adhered to.

7. That decommissioned redundant equipment and materials are removed and disposed of appropriately.

8. That issues related to compromised functionality, surface integrity and aesthetic integrity are corrected.

9. That building systems and components perform to originally intended standards for control of water (including vapour and condensation) and air movement.

10. The aesthetic, functional and surface integrity of hard surfaced areas.

11. The aesthetic integrity and heath of lawn areas and plant materials.

12. The aesthetic, functional and surface integrity of all exterior equipment, furnishings and structures; such that, but not limited to: tanks, transformers, outbuildings, lighting, signage, fences and enclosures.
(13) The aesthetic, functional and surface integrity of the building exterior; such as but not limited to: roofs, walls, windows, doors, gutters, downspouts, coatings and sealants.

(14) The aesthetic, functional and surface integrity of interior building components; such as, but not limited to: partitions, ceilings, finish materials, doors, hardware, casework, coatings and sealants.

(15) The functional integrity of all building systems, furnishings and equipment; such as, but not limited to: plumbing, heating, ventilation, power, lighting, emergency power, fire alarm, voice and data.

(16) The aesthetic and surface integrity of all furnishings and equipment and exposed mechanical and electrical systems and components; such as, but not limited to: fixtures, trim, devices, enclosures and fabrics.

(17) That service and access operational clearances required for maintenance are not compromised.

8 Information Management

8.1 Outcome

Adoption of an Information Management approach is intended to produce better data, support accountability and quality improvement through improved performance measurement and support evidence-based decision-making.

8.2 Requirements

The Service Provider shall ensure:

(1) The home has information systems that:

- Support the principles of client-centred care
- Makes available useful, relevant, quality information to inform decision-making
- Focuses on outcomes related to care provision and service delivery
- Ensures compliance with the Personal Health Information Act and as well as any other applicable legislation

(2) The home must use interRAI-MDS 2.0 for assessment and on-going resident assessment and care planning and contribute to the Canadian Institute for Health Information's (CIHI) Continuing Care Reporting system (CCRS).
(3) A secure client health record is implemented.

(4) A policy on document retention exists and that documents are retained for seven years.

(5) A mechanism for the documentation and investigation of occurrence and incident reporting.

(6) A mechanism for secure financial and statistical reporting as outlined in the performance monitoring framework.

9 Mandatory Incident/Occurrence Reporting to the Department of Health and Community Services:

9.1 Outcome

Required reports and information are provided to the Department of Health and Community Services in a timely manner.

9.2 Requirements:

The Service Provider shall ensure:

(1) There is a written policy and procedure in place to ensure all occurrences, incidents and accidents are documented and reported.

(2) There is a system in place to document and track occurrence, incident and accident reports.

(3) Major incidents (missing resident, incident involving a resident that requires reporting to law enforcement, a suspicious death, homicide, suicide, fire, major flood, labour dispute impacting the operations of the home) are verbally reported to the RHA and the Minister’s delegate, within 24 hours of the incident. A written report describing the incident and action taken shall be submitted within five working days of the incident.

(4) Mandatory reports, (occurrence/incident/accident reporting, financial reporting, quality care indicators, staffing) as determined by the Department of Health are submitted, as required.

10 Human Resource Management

10.1 Outcome

The Staff complement will support the achievement of outcomes in all program areas through a team based resident-centred approach.

The home promotes an environment of team based resident care supported by:
• Integrated care planning
• Scheduled team meetings
• Referrals among providers
• Supporting residents and families to be partners in care by promoting choice, empowerment, autonomy, and independence in everyday life
• Providing a clear statement of role expectations where team work is emphasized
• Enabling self-led work teams and increased decision-making
• Encouraging decision-making as close to the resident as possible
• Enabling flexible scheduling of activities of daily living without set schedules
• Supporting innovative and alternative approaches of care delivery
• Enabling staff to consistently work with the same residents.

10.2 Requirements

The Service Provider must ensure:

(1) All nursing homes provide clinical Registered Nurse coverage 24 hours per day, seven days per week.

(2) Residents receive on average 3.4 hours of direct nursing care per day (RN, LPN, PCA).

(3) A skill mix ratio of 14% Registered Nurse: 46% Licensed Practical Nurse : 40% Personal Care Attendant.

(4) Access to allied health staff (OT, PT, dietitian, social work, and recreation) in accordance with resident care needs.

(5) Residents are assisted to access dental, optometry and other health appointments, in accordance with the resident’s care plan.

(6) The development of a written human resource plan that anticipates human resource needs to provide required services.

(7) There are policies and procedures related to recruitment, hiring, orientation and continuing competencies of staff members.

(8) Staff members individually and collectively have the skills and experience to deliver the services and care which the setting offers to provide.
(9) The verification of the current licensure, certification, registration or other credentials of staff members and volunteers prior to the staff members assuming job responsibilities and shall have procedures for verifying that current status is maintained.

(10) The maintenance of documentation of a clear certificate of conduct for staff members and volunteers.

(11) The allocation of staff members is appropriate in number and qualifications, reflecting the needs of residents and the layout of the home, and funded direct care hours are utilized, as intended.

(12) There is a current job description for each position that clearly defines the role, responsibilities, and scope of position that is reviewed annually.

(13) There is a formalized performance management process in place, which evaluates the staff member’s performance before probation period, biannually and more frequently, as necessary.

11 Hiring Requirements

11.1 Outcome

Staff members have an appropriate educational level that supports program outcomes and staff have a clear code of conduct.

11.2 Requirements

The Service Provider shall ensure:

(1) That key staff have the minimal education and experience required as listed below.

Minimum Education Requirements and Experience – Long Term Care Home

<table>
<thead>
<tr>
<th>Position</th>
<th>Education and Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Care Manager</td>
<td>Graduation from accredited school of nursing, ARNNL registered</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>Graduation from accredited school of nursing, ARNNL registered</td>
</tr>
<tr>
<td>Licensed Practical Nurse</td>
<td>Graduation from accredited program, CLPNNL registered</td>
</tr>
<tr>
<td>Personal Care Attendant</td>
<td>High School diploma, graduation from approved PCA course</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>Graduation from approved program, NLAOT registered</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>Graduation from approved program, NLCP registered</td>
</tr>
<tr>
<td>Rehab assistant</td>
<td>Graduation from approved Rehab. Assistant program.</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Graduation from approved program, NLASW registered</td>
</tr>
<tr>
<td>Dietitian</td>
<td>Graduation from accredited program, NLCD registered</td>
</tr>
<tr>
<td>Recreation Therapy Worker</td>
<td>Diploma in recreation or therapeutic recreation</td>
</tr>
<tr>
<td>Recreation Specialist</td>
<td>Graduation from approved program, NCTRC certified</td>
</tr>
</tbody>
</table>
(2) All employees must have a clear certificate of conduct.

(3) Each profession has a list of core competencies which should be met on hiring or as part of continuing education throughout the first year of hire.

(4) New employees and volunteers will complete an initial orientation to the home that is timely and documented including but not limited to:
   - Resident values
   - Confidentiality and Privacy (Personal Health Information Act)
   - Ethics
   - Continuous quality improvement
   - Team work
   - Understanding the needs of the cognitively impaired
   - Infection prevention and control, including proper hand washing technique
   - Emergency procedures including fire safety and disaster plan
   - Heimlich maneuver
   - Information on abuse, neglect, and misappropriation of funds
   - Adult Protection Act
   - Workplace Hazardous Materials Information Systems
   - Specific job duties and responsibilities
   - Diversity
   - Organizational values
   - Facility policies and procedures
   - Body mechanics
   - Occupational health and safety

(5) The completed orientation checklist is signed and dated by the employee and maintained in the employee’s personnel file.

(6) Volunteers receive orientation, are supervised, are supported in their role, and do not replace paid staff members.

(7) Ongoing education to meet the needs of the resident population is provided to staff members by qualified individuals.

(8) Contracted personnel will work under the policies and procedures of the service provider.

(9) Contracted personnel responsibilities and communication processes are clearly defined by written policy.
12 Continuing Education

12.1 Outcome

Staff and volunteers have the necessary knowledge, skills, and abilities to provide quality care and service.

12.2 Requirements

The Service Provider shall ensure:

1. Staff members and volunteers receive regular in-service on the following:
   - Resident values
   - Resident safety
   - Confidentiality
   - Continuous quality improvement
   - Infection prevention and control
   - Emergency procedures including fire safety, disaster planning, and universal codes

2. There is a policy for ongoing education for staff members that includes, at a minimum:
   - Identified learning needs of staff;
   - New equipment;
   - Changing resident needs; and
   - Mandatory professional education, e.g. CPR and First Aid.

3. Annual attendance record of individual staff participation, which includes the date of the in-service/education session attended are maintained.

Reference:


Appendix A
Levels of Care
An individual may be a high level in one category and a low level in another, however, it is the professional judgment that determines the overall level of care requirement. The level of care recommendation is made by the professional completing the assessment and confirmed by the Assessment and Placement Committee or Community Care.

CATEGORIES

PERSONAL FUNCTIONS: The Applicant/Resident

Level I

- Is independently mobile, with or without mechanical aids, inclusive of a wheelchair.
- May need specialized aids for independently transferring.
- May require limited assistance with bathing, dressing, and/or grooming.
- May require reminder for routine toileting.
- May require minimal assistance with toileting.
- May need nutritional monitoring.
- May have sensory deficit which interferes with activities of daily living and may or may not require minimal assistance.

Level II

- May be independently mobile with or without mechanical aids, inclusive of a wheelchair.
- May need specialized aids for one person assist for transferring.
- May need a moderate amount of assistance with bathing, dressing and grooming.
- May require a reminder of and/or assistance with routine toileting to avoid frequent incontinence of bowel and/or bladder.
- May require nutritional monitoring of and/or assistance with eating.
- May have sensory deficit which interferes with activities of daily living and requires moderate assistance.

Level III

- Is dependent for transfer or mobility.
- Requires assistance to turn and move about in bed.
- Is dependent for assistance with dressing, washing, grooming and bathing.
- Has incontinence of bladder and/or bowel.
- Requires supervision and assistance with eating or requires feeding.
- Requires daily professional care.
- May have sensory deficit which interferes with activities of daily living and requires ongoing assistance.

Level IV

- See Medical Status/Level 4
MENTAL/SENSORY/PERCEPTUAL: The Applicant/ Resident

Level I

- May have full use of mental functions.
- May have a sensory/perceptual deficit but with adaptation will have the ability to be responsive, understand simple instructions, and express needs.
- May demonstrate mild difficulties in orientation to day, time and place.
- May demonstrate mild difficulty with memory and recall.
- May have inappropriate behaviour which does not interfere with other people.

Level II

- May have mental functioning with moderate cognitive impairment.
- Is responsive to verbal stimuli; may have some difficulty with simple instructions, number and time concepts.
- May have sensory/perceptual deficit but even with adaptation needs assistance for understanding and expressing needs.
- May tend to pace or wander in own environment, but is not at risk for elopement.
- May demonstrate inappropriate behaviour which may interfere with others which can be stabilized.

Level III

- May have severe cognitive impairment.
- May have a sensory/perceptual deficit and even with adaptation needs ongoing assistance for understanding and expressing needs.
- May present with management problems due to behaviour, e.g., wandering, aggressiveness, hostility.
- May demonstrate varying degrees of difficulty with orientation to place or person.

Level IV

- Only responsive to tactile or painful stimuli or is non-responsive.
- See Medical Status/Level 4.

MEDICAL STATUS: The Applicant/Resident

Level I

- May have medical problems that are stabilized and do not require daily professional supervision.
- May require accompaniment for (doctors, dentists, specialists, etc.) visits.
- May require therapies (e.g. oxygen concentrator, ventolin masks) or procedures (e.g. colostomies) and is able to independently complete care required.
Level II

- May require therapies (oxygen concentrator, ventolin masks) or procedures (e.g. colostomies).
- Requires assistance to complete task.
- May require assistance with set up and/or cleaning of equipment.
- Will require professional monitoring.

Level III

- Has medical problem(s) which require continuous supervision and may require frequent professional intervention.

Level IV

- May be technology dependent or need both a medical device to compensate for the loss of a vital body function and ongoing professional health care to maximize functioning or prevent further disability e.g. tracheotomy, enteral feed, vascular access device, mechanical ventilation.
Appendix B
Service Requirements for Resident Population – Mild to Moderate Dementia

1. Human Resource Management

Outcome

The Staff complement will support the achievement of outcomes in all program areas through a team based resident-centred approach.

The home promotes an environment of team based resident care supported by:

- Integrated care planning
- Scheduled team meetings
- Referrals among providers
- Supporting residents and families to be partners in care by promoting choice, empowerment, autonomy, and independence in everyday life
- Providing a clear statement of role expectations where team work is emphasized
- Enabling self-led work teams and increased decision-making
- Encouraging decision-making as close to the resident as possible
- Enabling flexible scheduling of activities of daily living without set schedules
- Supporting innovative and alternative approaches of care delivery
- Enabling staff to consistently work with the same residents.

Requirements

The Service Provider shall ensure:

1. All residents have access to clinical Registered Nurse coverage 24 hours per day, seven days per week.

2. Residents receive on average 3.8 hours of direct and indirect care per day. Direct care includes personal and medical care; indirect care includes food preparation and housekeeping.

3. A skill mix ratio of 4% Registered Nurse: 10% Licensed Practical Nurse: 86% Personal Care Attendant.
4. Access to allied health staff (OT, PT, dietitian, social work, and recreation) in accordance with resident care needs.

5. The development of a written human resource plan that anticipates human resource needs to provide required services.
1

Schedule “C”

Facility Funding Policy and Approved Budget

ARTICLE 1 - Policy

1.1

This policy describes the provision of funding available to a Service Provider.

ARTICLE 2 - Definitions

Terms used in this Policy shall have the following meanings:

(a) “Annual Approved Budget” is the combined total budget for the Protected and Unprotected Envelopes.

(b) “Client Contribution” is that amount that a Resident is required to contribute to the cost of Long Term Care services, to a monthly maximum of $2,800, as determined through the Long Term Care financial assessment process.

(c) “Long Term Care Financial Assessment” is the policy and process to determine the amount that a client is expected to contribute to the cost of Services (Appendix 1).

(d) “Protected Envelope” is the portion of the Approved Budget that is designated for Program Costs and Raw Food Costs.

(e) “Program Costs” is the services, items required to deliver the program of LTC, including staffing and associate support services.

(f) “Unprotected Envelope” is the portion of the Approved Budget that is designated for capital costs, maintenance and non-care related services.

(g) “Raw Food Costs” are the costs associated with ingredients and food products on the menu, snacks, supplements, and any specialty products required to meet the daily nutritional needs of the Residents.

(h) “Resident” means an individual assessed and approved for admission to a long term care facility, in accordance with the Placement Policy of the RHA.

(i) “Resident Care Services Agreement” (RCSA) is the agreement between the Service Provider and the RHA outlining program requirements for the provision of Services, to which this Facility Funding Policy and Approved Budget forms a schedule.
(j) “Regional Health Authority” (RHA) is the autonomous body authorized to provide and responsible for the delivery of health and community services, on behalf of the Department of Health and Community Services.

(k) “Service Approval” is the approval issued by the RHA that determines that a LTC Bed is available and suitable, meeting all requirements, for use by Residents.

(l) “Services” means long term care services as specified in the RCSA.

ARTICLE 3 - Client Contribution

3.1 Clients are financially assessed by the Regional Health Authority, using the Long Term Care Financial Assessment Policy (Appendix 1), to determine the amount of the client contribution, to a monthly maximum of $2,800 for Services.

3.2 The Service Provider will receive written notification of the client contribution for each resident and will be responsible to collect the client contribution for each Resident.

3.3 The Regional Health Authority is the payer of last resort for Services.

ARTICLE 4 - ANNUAL APPROVED BUDGET

4.1 The Annual Approved Budget Envelope will be provided as a per diem in two distinct funding envelopes, the Protected Envelope and the Unprotected Envelope. The Service Provider will be informed annually of their Approved Annual Budget Envelope for the provision of Services.

4.2 The Service Provider is expected to operate within the Annual Approved Budget. The RHA agrees that the Service Provider is entitled to manage the Facility and to deploy resources, under the Protected Envelope, while ensuring that required standards and outcomes are achieved as set out in the RCSA and Long Term Care Operational Standards. In addition, the RHA acknowledges that decision making authority with respect to human resource issues reside with the Service Provider, and that the Service Provider has the full rights of an employer including, but not limited to, the recruitment and retention of personnel and the right to develop personnel policies and practices, in accordance with the Long Term Care Operational Standards and the RCSA.

ARTICLE 5 - PROTECTED ENVELOPE

5.1 The Protected Envelope is inclusive of Program Costs and Raw Food Costs and is funded at approved rates prescribed by the RHA.

5.2 Program Cost is inclusive of:

(1) Resident Care Staff
The RHA will fund Registered Nurses, Licensed Practical Nurses, Personal Care Attendants Assistants, and/or other supportive positions, based on the number of approved beds, the Long Term Care Operational Standards, and subject to available resources.

(2) Program Support Staff

The RHA will fund Dieticians, Physiotherapists, Occupational Therapists, Social Workers, Recreation staff, and/or other supportive positions, based on the number of approved beds and the Long Term Care Operational Standards, and subject to available resources.

(3) Employee Benefits

The RHA will fund a standardized benefit rate for the sector, as approved by the Department of Health, to each Facility which will encompass Canada Pension Plan, Employment Insurance, Workers Compensation, Pension, and applicable employer premiums for Group Insurances such as Life, Health, and Medical. Unique supplemental rates will be applied as approved by the Department of Health.

(4) Operational Costs

The RHA will fund Resident care and program support supplies necessary to fulfill Long Term Care Operational Requirements at approved rates as determined by the RHA.

5.3 The Raw Food Costs, which include Meal Days, Specialty Products, and Supplements, for Residents in the Facility, will be funded at approved rates determined as follows:

(1) Raw Food Costs include the costs of all the ingredients and food items necessary to create a meal day, which includes the food products on the menu, supplements, and any specialty products required to meet the daily nutritional needs of the Residents.

(2) Meal Day is one 24 hour period, which includes 3 nutritious meals (as per recommendations of Canada’s Food Guide) with at least 2 choices per meal plus beverages, and two snacks throughout the day. A snack should be at least a beverage and a food item such as a starch or fruit.

(3) Specialty Products are particular food products needed to support therapeutic diets, e.g. gluten-free, calorie reduced, low sodium, low fat.

(4) Supplements are enteral nutritional formulae, either homemade or purchased; to meet a Resident’s assessed nutritional need; and calcium and vitamin D food enrichment.

5.4 In any given year, funding from the Protected Envelope not used for its intended purpose will be forfeited or, if advanced, recovered. Any budgetary deficits will not be funded by the RHA.

ARTICLE 6 - UNPROTECTED ENVELOPE
6.1 The Unprotected Envelope is that portion of the Approved Budget for Capital Costs and Services Costs (laundry, food service, maintenance etc.) that is funded at a non-prescribed rate.

6.2 Funding under the Unprotected Envelope shall be indexed as follows:

(a) Capital Costs shall not be indexed; and

(b) The Department of Health will index operational costs annually based on the all-items Consumer Price Index (CPI) for NL.

6.3 The Service Provider is expected to operate within the Unprotected Envelope portion of the Approved Budget with respect to the service requirements to meet the Long Term Care Operational Standards and the legal obligations described in the RCSA. Any surplus may be retained by the Service Provider, any deficits will not be funded by the RHA.

6.4 Quarterly reconciliations will be conducted by the RHA to compare estimated resident contribution to actuals. If the Service Provider collects more from Residents than estimated, the amount will be recovered by the RHA. If the amount the Service Provider is responsible for collecting from Residents is less than estimated, the Department of Health will subsidize these costs.

ARTICLE 7 - Accountability

7.1 The Service Provider will submit all required quarterly and annual financial and statistical data as outlined in the LTC Operational Standards.

7.2 The RHA is responsible for monitoring and reviewing financial and statistical reports and year end reconciliation and recovery of funds, if applicable.

7.3 The RHA is responsible for the submission of information to the Department of Health and Community Services.
Financial Assessment Policy:

Long Term Care; Personal Care/Community Care; & Medically Discharged

1. Rates:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC Facility:</td>
<td>$2,800/mth, effective July 1, 1996</td>
</tr>
<tr>
<td>Medically Discharged:</td>
<td>$1,132.50/mth, effective April 1, 1986</td>
</tr>
<tr>
<td>Personal Care/Community Care</td>
<td>As set by Department</td>
</tr>
</tbody>
</table>

2. Monthly Allowable Expenses/Costs Which May Be Claimed by Spouses Living at Home

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic standard allowance for spouse (includes items not listed below)</td>
<td>$ 900</td>
</tr>
<tr>
<td>Basic standard allowance per additional dependent person</td>
<td>$ 370</td>
</tr>
<tr>
<td>A. A. Fees</td>
<td>Actual</td>
</tr>
<tr>
<td>Burial insurance</td>
<td>Actual</td>
</tr>
<tr>
<td>Cable TV</td>
<td>Actual</td>
</tr>
<tr>
<td>Charge accounts/loans (to date of admission)</td>
<td>Actual</td>
</tr>
<tr>
<td>Employment expenses</td>
<td>Actual</td>
</tr>
<tr>
<td>Expenses related to volunteer activities</td>
<td>Actual</td>
</tr>
<tr>
<td>Furnace insurance</td>
<td>Actual</td>
</tr>
<tr>
<td>Heat and light</td>
<td>Actual</td>
</tr>
<tr>
<td>Home care</td>
<td>Actual</td>
</tr>
<tr>
<td>Income tax</td>
<td>Actual</td>
</tr>
<tr>
<td>Life insurance (existing long-standing policies, spouse is beneficiary)</td>
<td>Actual</td>
</tr>
<tr>
<td>Medical</td>
<td>Actual</td>
</tr>
<tr>
<td>Medical transportation</td>
<td>Actual</td>
</tr>
<tr>
<td>Municipal taxes</td>
<td>Actual</td>
</tr>
<tr>
<td>Property insurance</td>
<td>Actual</td>
</tr>
<tr>
<td>Property maintenance (lawn care, snow clearing, etc.)</td>
<td>Actual</td>
</tr>
<tr>
<td>Rent or mortgage payments</td>
<td>Actual</td>
</tr>
<tr>
<td>RRAP loans</td>
<td>Actual</td>
</tr>
<tr>
<td>Social clubs (Kinsmen, Masonic, etc.)</td>
<td>Actual</td>
</tr>
<tr>
<td>Special foods (diabetics, etc.)</td>
<td>Actual</td>
</tr>
<tr>
<td>Telephone Rental (Medically Discharged only)</td>
<td>Nil</td>
</tr>
<tr>
<td>Transportation to visit spouse (150, 275, 350, see below)</td>
<td>Distance</td>
</tr>
<tr>
<td>TV rental (Medically Discharged only)</td>
<td>Nil</td>
</tr>
<tr>
<td>Union dues</td>
<td>Actual</td>
</tr>
<tr>
<td>Vehicle insurance</td>
<td>Actual</td>
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<tr>
<td>Vehicle license</td>
<td>Actual</td>
</tr>
<tr>
<td>Vehicle payment (loan or lease)</td>
<td>Actual</td>
</tr>
<tr>
<td>Transportation (Distance from facility)</td>
<td></td>
</tr>
</tbody>
</table>
0 to 10 miles  $150
10 to 20 miles  $275
Over 20 miles  $350

The above list is not inclusive of all type costs. Judgment should be used for other costs that may be considered allowable or costs that may be unreasonable. The Financial Services Division should be contacted for decisions respecting costs assessment staff are unsure of.

3. Long Term Care/ Personal Care & Community Care Residents Assessments:

The financial assessment for subsidy for an individual entering Long Term Care, Personal Care or Community Care is based on the incomes and liquid assets of both spouses. For liquid assets, the single base is $10,000 and the combined base is $20,000.

Effective July 1, 1996, Government provided for a 50% split of liquid assets between spouses. Upon application for a subsidy, a couple may request that an exemption of 50% of the total liquid assets take place at the time of admission to the facility. This has been done to provide half the liquid assets to the person remaining at home. This half is not assessed toward the cost of care for the resident in the facility. The other half is intended to go toward the cost of care of the spouse in the facility.

If a division of liquid assets has taken place, the spouse in the community must use those liquid assets to support any shortfall between costs and income. If the resident reaches the $10,000 limit and cannot pay the $2,800, a subsidy is requested. The couple is then assessed as a unit. If the income of the spouse living in the community is greater than the costs, any surplus is to go toward the cost of care of the spouse in the facility. However, the liquid assets of the spouse living in the community are not assessed toward the resident's cost of care. If the liquid assets of the spouse living in the community reaches $10,000 as well as the resident's, an updated financial assessment is completed. Again, if the income of the spouse in the community is greater than the costs, any surplus is to go toward the resident's cost of care. If the costs of the spouse in the community are greater than the income, any of the income of the spouse in the facility may go towards these costs in the community. This would include private income as well as federal maintenance payments. Income from all sources is available to remain with the spouse living in the community to help support the community costs.

A single person entering a facility may still own a residence in the community. In this situation, the operating costs to maintain the home are allowed for a three month period. This is considered an acceptable time to dispose of the residence. These allowable costs are permitted to be paid from all income sources, private and federal maintenance payments, i.e., Old Age Security, OAS/GIS, Canada Pension Plan, C.P.P. or other federal maintenance incomes.

If the single resident has existing debts upon entering the facility, these debts are permitted to be paid from all incomes. With these debts, there is no three month time period like the policy relating to the operating residence costs. The $10,000 liquid asset base is to be used in the financial assessment. Funds above the $10,000 must first be used towards the payment of these debts.
The Following Types of Assets Are Considered Liquid Assets and Are Assessed:
Cash
Bank accounts
Treasury bills
Guaranteed income certificates (individual homes may work to maximize funds where penalties apply to early liquidation)
Bonds
Marketable securities listed on stock exchanges
Marketable commodities listed on commercial exchanges

The Following Types of Assets Are Not Considered Liquid Assets and Are Not Assessed
Shares in private companies and the assets of unincorporated businesses
Prepaid funeral expenses (both spouses)
Real property, including personal residences, cottages, lands, etc.
Tangible personal property, including household effects, motorhomes, jewellery, artworks, etc.
RRSP's
RRIF's
The income provided from RRSP's and RRIF's is to be considered assessable income. Any withdrawal of funds from these plans is to be considered income in the month of withdrawal.

4. Medically Discharged Assessments:

The list of monthly allowable expenses/costs on page 1 also applies to Medically Discharged individuals who are single. As this list is not inclusive of all types of costs, judgment should be used for other costs that may be considered allowable or costs that may be unreasonable. The Financial Services Division should be contacted for decisions respecting costs assessment staff are unsure of.

When determining financial resources from the medically discharged patient, only the patient's income is to be considered for the medically discharged rate of $1,132.50 per month. Liquid or other assets are not to be included in the financial resources available for assessment of the rate.

The income and expenses of the spouse in the community are not to be considered unless specifically requested by the couple. If not requested, only the income of the medically discharged patient is to be assessed towards the medically discharged monthly rate.

If the expenses of the spouse in the community are requested to be taken into account in the assessment, then both spouse's incomes are to be included in determining total incomes and the previous costs are to be used in determining total allowable costs. Any deficit incurred by the spouse in the community can be supported by any of the income of the medically discharged patient. The income is not limited to the private income of the resident. All incomes may be assessed, including all federal maintenance payments. However, the liquid asset base of $20,000 combined is to be used in the financial assessment. Funds in excess of the $20,000 combined must first be used to pay for community expenses before any of the patient's income may be used to pay for these expenses.
If the only person involved is the medically discharged patient, then any ongoing community expenses associated with the patient are also allowed. Any and all of the patient's income may be used towards these expenses. The liquid asset base of $10,000 is to be used in the financial assessment. Funds in excess of $10,000 must first be used to pay community expenses before any of the patient's income may be used to pay for these expenses.

The intent of the medically discharged plan is to provide for care and accommodation for the medically discharged patient. The personal care allowance for the medically discharged patient is $60 per month. It is not the intent to provide for any type expenses other than what would ordinarily be provided for under the hospital insurance plan, (i.e., cable, phone, etc. should be provided for from the resident's/patient's assets, and not income). The income should be assessed towards the medically discharged rate of $1,132.50 per month, with the $60 clothing and personal care allowance coming from income.

Effective July 1, 1996, if a medically discharged patient is offered a long term care placement, and the patient refuses the placement, the long term care rate of $2,800 per month is to be charged effective the date of refusal and the long term care guidelines then apply.
Schedule D

Services Approval

(this will be referred to as the licensing process once LTC legislation is developed)

1 Services Approval (this will be referred to as the licensing process once LTC legislation is developed):

1.1 Outcome

The Service Provider obtains confirmation that the facility and related services have been assessed as suitable for the provision of long term care services prior to operating a long term care home. The Services Approval process requires the applicant to comply with all applicable legislation and the Newfoundland and Labrador Long Term Care Operational Standards.

1.2 Requirements

(4) For new construction, the Service Provider must:

(a) Obtain a Services Approval certificate by submitting an Application for Services Approval form and a facility inspection request. Authorities with jurisdiction will complete an inspection of the facility and services and notify the Service Provider of the outcome of the inspection.

(b) Submit all required information to the RHA and/or DHCS including:

- Proof of ownership/lease of facility
- A clear certificate of conduct of the Service Provider and staff
- Approved staffing plan
- Proof of required insurance
- Proof that the LTC home is compliant with all Fire Life Safety Standards
- Proof that the home is compliant with all Environmental Health Standards
- Proof of a Food Premises license
- List of directors and board members of corporation

(5) For sale, lease or transfer of ownership, the Service Provider must:

(a) Submit a completed Application for Services Approval form and include:

- Proof of ownership/lease of facility
- Facility floor plan
- Business Plan
- Evidence that the Service Provider has the financial capacity to
operate a long term care home.

- Evidence that the Service Provider has experience to operate the home in accordance with all legislation, the Operational Standards and exhibits an understanding of the philosophy of care and service delivery.
- Three References
- A clear certificate of conduct of the Service Provider and staff
- Proof of required insurance
- Proof that the LTC home is compliant with all Fire Life Safety Standards
- Proof that the home is compliant with all Environmental Health Standards
- Proof of a Food Premises license
- List of directors and board members of corporation

(b) The Service Provider must post the Services Approval certificate in a conspicuous location visible to the public.
Schedule E

Reporting Requirements / Performance Monitoring Framework

The Service Provider must comply with all relevant legislation and Acts, including but not limited to:

- The Buildings Accessibility Act and Regulations
- Food and Drug Act and Associated Regulations
- Health and Community Services Act and Regulations
- The National Building Code and National Fire Code of Canada
- Smoke Free Environment Act and Regulations
- Occupational Health and Safety Act
- Personal Health Information Act
- Adult Protection Act
- Any other legislation, acts, regulations as determined by the Minister

INSPECTIONS
Long term care homes will be inspected annually (or more frequently in the event of a suspected outbreak, complaint or a re-inspection) by Service NL. Inspection activity may be announced or un-announced.

- Fire Life Safety
  - Fire Evacuation Floor Plan
  - Staff trained on fire evacuation
  - Functioning sprinkler system
  - Functioning fire alarm system
  - Appropriate use and storage of Oxygen systems
  - Emergency lighting

- Environmental Health
  - Physical condition of facility (floors, walls, pest control, safety hazards)
  - Water supply, sewage, waste disposal
  - Heating, lighting and temperature control
  - Food sanitation (storage, equipment, hand washing, temperature, cleanliness)

REPORTING:
Service providers will be required to report, financial, statistical and quality care indicators to the RHA and/or the Department of Health and Community Services, at a frequency determined by the Department.

- Staffing (hours of care, skill mix, access to support staff, training requirements, orientation new staff (Quarterly)
- RAI MDS 2.0 reporting to CIHI (Quarterly)
- Quality of care indicators (e.g. number of falls, use restraints, pressure ulcers) (Quarterly)
- Occurrence and incident reporting (Quarterly)
- Financial and Statistical Reporting (Quarterly)
- Demographic data (number of residents, level of care, age > or < 65) (Quarterly)
- Confirmation of Accreditation Status from Accreditation Canada and any related documentation including Accreditation Report, and any follow up reporting requirements (Annually)
- Confirmation that employees have clear Certificate of Conduct (Annually)

### Financial reporting requirements (Quarterly)

<table>
<thead>
<tr>
<th>REVENUE</th>
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<tbody>
<tr>
<td><strong>RHA Grant funding</strong></td>
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<tr>
<td><strong>Resident contribution</strong></td>
</tr>
<tr>
<td><strong>Resident fee contributed by third party (e.g. WHSC)</strong></td>
</tr>
<tr>
<td><strong>CMHC Mortgage Interest subsidy</strong></td>
</tr>
<tr>
<td><strong>Investment revenue</strong></td>
</tr>
<tr>
<td><strong>Capital grants</strong></td>
</tr>
<tr>
<td><strong>Recoveries</strong></td>
</tr>
<tr>
<td><strong>Other offset revenue (e.g. parking, rentals, chargeable extras, gift shop etc)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXPENDITURES</th>
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<tbody>
<tr>
<td><strong>STAFFING</strong></td>
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<tr>
<td>Salary and wages</td>
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<tr>
<td>Accrued salaries and wages</td>
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<tr>
<td>Recovered salaries and wages</td>
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<td>Benefits</td>
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<td>Severance pay</td>
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<td>Accrued Holiday Pay expense</td>
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<td>Accrued retiring allowance</td>
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<tr>
<td>Purchased services</td>
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<td>Other staffing</td>
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<table>
<thead>
<tr>
<th>PROPERTY CHARGES</th>
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<tbody>
<tr>
<td><strong>Rent</strong></td>
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<td><strong>Mortgage interest</strong></td>
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<td><strong>Property taxes</strong></td>
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<td><strong>Maintenance and repairs</strong></td>
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<tr>
<td><strong>Utilities</strong></td>
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<tr>
<td><strong>CMHC replacement reserve</strong></td>
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<td><strong>Depreciation - building</strong></td>
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<td><strong>Other capital</strong></td>
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<table>
<thead>
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<th>ADMINISTRATION AND SUPPLIES</th>
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<tr>
<td><strong>Food</strong></td>
</tr>
<tr>
<td>Category</td>
</tr>
<tr>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Dietary supplies</td>
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<tr>
<td>Incontinence supplies</td>
</tr>
<tr>
<td>Medical supplies</td>
</tr>
<tr>
<td>Housekeeping/Laundry supplies</td>
</tr>
<tr>
<td>Administration/Office Expenses (telephone, internet, printing, travel, recruitment, training, interest)</td>
</tr>
<tr>
<td>Professional fees/Association Dues/Accreditation</td>
</tr>
<tr>
<td>Insurance</td>
</tr>
<tr>
<td>Purchases services</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Non-operating revenue</td>
</tr>
<tr>
<td>Non-operating expenditures- mortgage principal</td>
</tr>
<tr>
<td>Non-operating expenditures- other</td>
</tr>
</tbody>
</table>

**EQUIPMENT**

- Minor equipment purchase
- Rental/lease equipment

**Statistical Reporting Requirements (Quarterly)**

**GENERAL INFORMATION**

- Provider location
- Mailing address
- Provider information
- Assessment date
- Payroll period
- Mortgages/Loans
- Resident Trust Account verification

**STAFFING**

- Number of direct nursing hours worked
- Number of resident bed days
- Hours worked per resident day (Administration and Support, direct care staff)
- Average hourly rate paid (Administration and Support, direct care staff)

**RESIDENT CENSUS**

- Number of residents on the last day of reporting period
- Number of residents by level of care
- Number of residents by age
- Number of residents admitted during period
- Number of discharges during period
- Number of deaths during period
- Number of transfers during period

**MONITORING:**

Monitoring activity may be announced or un-announced at a frequency determined by the
Department of Health and Community Services. A draft list of indicators is included.

### PHYSICAL BUILDING SPACE

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space and chairs</td>
<td>available for visiting in resident rooms.</td>
</tr>
<tr>
<td>Equipment</td>
<td>Storage space is available; equipment is stored out of sight.</td>
</tr>
<tr>
<td>Bathing rooms</td>
<td>are small, warm, pleasantly decorated and non-institutional.</td>
</tr>
<tr>
<td>Safe, comfortable outdoor space</td>
<td>is accessible to residents and families.</td>
</tr>
<tr>
<td>Residents</td>
<td>are offered a pleasant meal experience in small, family-style dining rooms.</td>
</tr>
<tr>
<td>Signage</td>
<td>is clear and way-finding features are finished in non-glare matte.</td>
</tr>
<tr>
<td>The building</td>
<td>is tastefully decorated, clean and pleasant smelling.</td>
</tr>
<tr>
<td>Physical structure</td>
<td>of the building are approved before construction commences and the design adheres to industry standards for safety and least restrictive environments.</td>
</tr>
<tr>
<td>Nurse-call system</td>
<td>functions and is set to a reasonable sound level.</td>
</tr>
<tr>
<td>Overhead paging system</td>
<td>Use is restricted to emergency use only.</td>
</tr>
<tr>
<td>Natural light</td>
<td>Use is maximized.</td>
</tr>
<tr>
<td>Access to telephone</td>
<td></td>
</tr>
</tbody>
</table>

### FIRE LIFE SAFETY

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff receive instruction</td>
<td>in fire safety plan.</td>
</tr>
<tr>
<td>Fire Life Safety Inspections</td>
<td>are completed, documented and issues corrected.</td>
</tr>
<tr>
<td>Emergency Preparedness Plan</td>
<td>is in place, accessible to staff and staff receive training on plan execution.</td>
</tr>
<tr>
<td>Fire alarm system</td>
<td>is set to a reasonable sound level.</td>
</tr>
</tbody>
</table>

### ENVIRONMENTAL HEALTH

Environmental Health Inspections are completed, documented and issues corrected.

### ADMINISTRATION

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTC home has a valid license</td>
<td>posted in a conspicuous location.</td>
</tr>
<tr>
<td>Service Provider</td>
<td>has submitted all mandatory reporting.</td>
</tr>
<tr>
<td>A Family/Resident Council</td>
<td>is in place, meets regularly and retains documentation.</td>
</tr>
<tr>
<td>Residents’ Bill of Rights and Responsibilities document</td>
<td>is posted.</td>
</tr>
<tr>
<td>System to communicate changes and news to families</td>
<td>is in place.</td>
</tr>
<tr>
<td>Residents and families</td>
<td>have access to managers when needed and contact information is posted.</td>
</tr>
<tr>
<td>Facility’s mission, vision, and philosophy documents</td>
<td>are current and prominently posted.</td>
</tr>
<tr>
<td>Resident information</td>
<td>is documented in approved format and securely stored.</td>
</tr>
<tr>
<td>Does not charge residents for services other than those listed on the Chargeable Services List</td>
<td></td>
</tr>
<tr>
<td>Notifies Placement Services when resident is discharged.</td>
<td></td>
</tr>
</tbody>
</table>

### STAFF

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff and volunteers meet minimum hiring requirements</td>
<td></td>
</tr>
<tr>
<td>Staff and volunteers receive orientation to home</td>
<td></td>
</tr>
<tr>
<td>Staff receive continuing education</td>
<td></td>
</tr>
<tr>
<td>Staff requirements (hours of care, skill mix)</td>
<td>are met.</td>
</tr>
<tr>
<td>Continuity of staffing and permanent assignments</td>
<td>is maintained.</td>
</tr>
</tbody>
</table>
### Staff meetings are held regularly.  
Staff who do not attend staff meetings can access meeting minutes.  
Workplace injury rates are within acceptable parameters.

### MOVING IN PROTOCOLS  
Residents and families receive verbal and written information about the facility before moving in day. This information includes information about resident safety.  
A facility tour is available for those who desire it.  
Medical orders and medications are consistently available on the day of admission.  
The new resident receives a tour of the facility when ready.  
An Advanced Health Care Directive is completed or levels of intervention are documented.

### CARE  
Upon moving in, the RN assesses resident (fall risk, choking risk, skin integrity, mental status, transfer/lift status, safety considerations) and an interim care plan is developed and posted within 24 hours.  
Medication Reconciliation is conducted on admission to the facility.  
A care conference is held within six weeks of admission to establish an individualized, person-centered care plan.  
The resident and/or family are invited to attend the conference.  
The new care plan is reviewed with care staff and is accessible to them.  
Care plans are reviewed and updated at least quarterly or more frequently as required.  
Pharmacy, medicine and nursing collaborate to review medication profiles regularly.  
Residents who resist bathing are given a towel/bed bath, however continued attempts are made to offer and provide therapeutic bathing in a normal environment.  
Residents receive a supported, safe meal service with appropriate levels of supervision.  
The facility has a dedicated Medical Director who visits regularly.  
Referrals between team members are documented.  
Members of the Interdisciplinary Team meet and review issues regularly.  
The facility has an established partnership with palliative support service providers.  
Medication reviews incorporate best practices related to medications and the elderly particularly as it relates to antipsychotic, anti-hypnotic and anti-anxiety medications.  
Each resident has a current, signed Advanced Health Care Directive on the chart with detailed information on contacting next of kin/ other temporary substitute decision makers.  
Care plan processes supporting a smooth transition to/from acute care (if accessed) are documented to ensure continuity of care.

### ACTIVITY/SOCIAL PROGRAMMING:  
Activities are hosted at least six days per week. Group and one on one programming is provided.  
Therapeutic activities are schedule for residents with cognitive impairment.  
Care plans reflect assessment and involvement in activities of interest.  
Residents have access to pastoral visitation upon request and church services weekly.

### COMMITMENT TO QUALITY IMPROVEMENT  
Is Accredited by Accreditation Canada.
<table>
<thead>
<tr>
<th>Has a complaints/ compliments process in place.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Service Provider follows up on complaints.</td>
</tr>
<tr>
<td>Resident and family satisfaction is evaluated on a regular basis.</td>
</tr>
<tr>
<td>The home has a continuous quality improvement assurance process in place.</td>
</tr>
<tr>
<td>Resident and family satisfaction with meals and nutrition is evaluated on a regular basis. Results and plans are shared with the Resident and Family Councils.</td>
</tr>
<tr>
<td>Contact</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>Written response received from Joanne Boomer May 6, 2014 <a href="mailto:joanne.boomer@gov.bc.ca">joanne.boomer@gov.bc.ca</a></td>
</tr>
<tr>
<td>Has your government entered into public private partnerships in the provision of Long Term Care (nursing homes that provide 24/7 nursing care)? If no, could you share why not?</td>
</tr>
<tr>
<td>What is the nature/terms of the contract? (Is the Ministry or Health Authority a partner? Does Government provide funding for infrastructure, operating costs, or direct client)</td>
</tr>
</tbody>
</table>

Alberta does not have plans currently to build any new LTC facilities (with the exception of one planned for Fort McMurray). Historically, private and not-for-profit entities have been responsible for establishing legislation and regulations including licensing and inspections. As outlined in the Development Agreement (have copy of one) between the service provider and the MOH, facilities would not be covered under the Acts mentioned in this document.
<table>
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<tbody>
<tr>
<td>profit service providers to build and operate LTC facilities. The result is that the provider owns the facility, provides the care and other required services and the health authorities contract for a specific number of beds at a negotiated per diem rate. The regional health authority negotiates a daily per diem which is intended to cover all the provider’s operating costs. (The daily per diem factors in the client contribution which the client pays to the facility). From time to time, health authorities provide grants for equipment and renovations to providers.</td>
<td>profit operators have often paid upfront to build a facility, and then entered into operating agreements with AHS. However, AHS has funded the construction of some facilities on an exception basis. Maximum accommodation charges are set in regulation and vary depending on room type, and are one large source of revenue for all operators. Direct client care is funded by AHS based on the Patient Care Based Funding model. Ongoing capital funding is not provided to any LTC facilities, which must find the funding internally by allocating accommodation revenue to this area. A Master Service Agreement between AHS and the operator is created which includes the terms of operation.</td>
<td>legislation, each LTCF must have a service accountability agreement. This is between the LHIN and the home. No new LTC facilities have been built since 1998. Government provides some capital funding through the capital redevelopment fund, operating funding is provided, low income clients receive financial assistance. Clients are subjected to income test.</td>
<td>land, development of facility, equipment, inspection, licensing, and occupancy. Government provides funding for infrastructure. Mortgages are obtained through Housing NS. Govt is default guarantor of the mortgage. Start-up funding for staffing, operational etc is available.</td>
<td></td>
</tr>
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</table>

| What is the process for entering partnership? (Request for Proposal, tender, acceptance of unsolicited proposals) | RFP | The Alberta Government has made a policy decision to maintain publically funded LTC spaces in the province at approximately 14,500. Therefore, there is no one official process for the public-private partnership in building a facility. There was no consistent approach across the province historically as there was 17 Health Regions, with a high level of diversity. That has gradually been reduced to one Health Board (AHS), but as so few LTC facilities have been built in the past few years, there has been no need for the development of a unified provincial policy. Once the facility is built, a Master Service Agreement is negotiated between the operator and AHS. The Master Service Agreement includes: * Recruitment and Employment Not really applicable since no new facilities are being built. The process for entering partnership is the licensing process. New business must gain entry into the market through the purchase of a new license. Ministry reviews any transactions. Legislation states it is not possible to transfer a NP home to a FP home. Does the Ministry control the market through the licensing purchasing process | RFP for new build. There have been some exceptions to this. DHA has service agreement (SA) with new LTCF. Some older facilities signed SAs with DHA for 10 year terms. DHA enter into development agreement. |
### Practices
- Responsibilities of the Service Provider/AHS
- Subcontracting
- Representations
- Services
- Funding
- Compliance
- Term (including renewal)
- Changes to Services
- Default and Remedies
- Termination
- Force Majeure
- Indemnity and Liability
- Termination Assistance
- Insurance
- Confidentiality
- Audit and Investigation
- Contract Administration

### Time Frames for Agreements
- **British Columbia**: This varies; most are likely a fixed term of 20 years, or an indefinite term with a one year termination clause.
- **Alberta**: Varies, negotiated between AHS and operator.
- **Ontario**: New homes - 25 years, older homes 15 years (needs verification). The difference is to promote the older homes to avail of the capital development fund to improve their property. It allows the MOH the opportunity to terminate agreement if home has not made improvements.
- **Nova Scotia**: 25 years, tied to the length of the mortgage. 10 year for older buildings.
- **Manitoba**: 25 years, tied to the length of the mortgage. 10 year for older buildings.

### Renewal Process
- **British Columbia**: Contact a regional health authority for this information as it likely varies depending on the current contractual arrangement.
- **Alberta**: From the Master Service Agreement:
  (a) AHS may offer to renew this Agreement for an additional period following the expiry of the initial term.
  (b) If AHS wishes to renew this Agreement, it will provide Notice to the Service Provider at least six months prior to the end of the Term.
  (c) If AHS and the Service Provider both wish to renew this Agreement, the parties will negotiate in good faith the terms of such renewal.
  (d) If AHS and the Service Provider are unable to agree upon the terms of the renewal of this Agreement as
- **Ontario**: Licensing process under new LTC legislation
- **Nova Scotia**: Annual licensing process.
of two months prior to the end of the Term:
(i) if the parties wish to continue negotiating, this Agreement will be extended on the same terms and conditions as then in effect for a period of up to six months (the "Extension Period"). During the Extension Period, AHS and the Service Provider will continue to negotiate in good faith regarding renewal of this Agreement. If AHS and the Service Provider are unable to reach agreement on the renewal of this Agreement during the Extension Period, this Agreement will terminate upon expiration of the Extension Period and the parties may enter into a termination assistance plan as contemplated in Subsection 14.1(b); or
(ii) if the parties do not wish to continue negotiating, this Agreement will expire at the end of the Term and the parties may enter into a termination assistance plan as contemplated in Subsection 14.1(b).

What is the funding model? (block funding to private provider or individual client subsidy)

Regional health authorities have established funding models which generally include categories for care services, non-care services, overhead, supplies and other to arrive at an overall per diem rate per bed. Clients pay a monthly fee based on their after tax income. Generally speaking, the health authority pays the facility the difference between the per diem rate and the calculated daily client fee. Health authorities expect facilities to maintain an occupancy rate of about 98%.

The current funding model for private, not-for-profit, and public LTC delivery includes:
1) Accommodation charges which Alberta Health regulates based on room type. Accommodation charges include such costs as meals, housekeeping, laundry, building maintenance, and utilities.
2) Funding for care services in the form of Patient/Care Based Funding, in which funding contains a variable component based on client acuity, a fixed component determined by the number of beds and resident care management hours, and a quality component, which includes a separate funding envelope. LTC homes are provided a per diem per resident- same regardless of home type. See email from Robert. Specific envelopes based on care provided. Ministry provides certain block funding which the home must account for- if not all spent- the home must return extra to Ministry. No profit can be made on care services. Profits are made on accommodation costs. See additional data provided by Robert Francis

LTC homes are provided a per diem per resident- same regardless of home type. See email from Robert. Specific envelopes based on care provided. Ministry provides certain block funding which the home must account for- if not all spent- the home must return extra to Ministry. No profit can be made on care services. Profits are made on accommodation costs. See additional data provided by Robert Francis

Every year service provider has budget approved includes staffing, capital, costs, mortgage. New builds use protected (health care staff) and unprotected (management and support staff) funding envelopes (as funding model). Indexing is built in. Resident contributes to cost of care, undergoes a financial assessment. In 2012 $102/day was max. paid by clients.
pool associated with the quality of care and service provided by a facility.

LTC operators do not receive ongoing direct capital funding from Alberta Health or AHS. The province does have money for medically necessary refurbishments, but only for public facilities (those that are AHS owned and operated). However, there is currently no policy on how best to allocate it, and therefore it is not currently available. As well, it is important to note that while operators are private, the health services are funded publicly.

How is the rate paid to private provider determined? (Does Government propose the rate, is it negotiated with individual facilities, or do facility owners/managers propose the rate as part of tendering process?)

The rates are negotiated between regional health authorities and service providers. Sometimes the rates are established in advance through the RFP. Regional health authorities also operate their own facilities and have a good sense as to what these costs are.

The health funding provided to public, non-profit, and private operators includes direct care funding from AHS through the Patient Care Based Funding model, which is explained elsewhere in this questionnaire.

Significant work done to develop a model based on type of care required. The rate can increase- typically increase based on inflation rate is provided- subject to budget approval. Funding can be adjusted based on care requirements as determined through data available from CIHI (RUGs). Increased funding based on case mix (CMI) provides some incentive to care for higher acuity residents. The rate paid for Nursing & PC below can vary based on CMI- below is an average based on CMI of 100.

Per diem rates:
- Ministry Pays Nursing & Personal care- $88.93
- Programming & Support- $8.60
- Raw Food- $7.60
- Other Accommodation- $52.76

Client pays $56.14* Govt makes rate reductions to those not able to pay basic amount
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</thead>
<tbody>
<tr>
<td><strong>Can you estimate the average cost of a LTC bed in a private versus public facility?</strong></td>
<td>If LTC homes does not spend the nursing, program support and raw food per diem- the money must be returned to the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In terms of building each unit, the cost is ranges $500k to $700k for each LTC bed historically. Health funding uses the same model whether the LTC facility is private, AHS, or non-profit operated. Based on above the average amount paid to LTC home for operating costs is ~ $6500 per month. The revenue for home could be greater if private pay clients pay more than the $56.14 per day. Estimated cost to build a new bed through RFP is ~ 197K. Cost to replace a NH bed outside RFP was negotiated ~ 370K. One provider was awarded a large # of beds at better price per unit.</td>
<td>Yes Legislation available on website.</td>
<td>Yes- Homes for special care Act</td>
<td>The RHAs are responsible for resource development in their specific region. The RHA must approve a business plan submitted by an applicant. Under the Regional Health Authorities Act 28(1), &quot;No person may construct, establish, operate, renovate, expand, convert or relocate a hospital or personal care home in a health region without the approval of the regional health authority for that health region, or if two regional health authorities are established in The City of Winnipeg, without the approval the regional health authority that is responsible for the health services provided or proposed to be provided in the hospital or personal care home.” The Regional Health Authorities Act <a href="http://web2.gov.mb.ca/laws/statutes/ccsm/r034e.php">http://web2.gov.mb.ca/laws/statutes/ccsm/r034e.php</a> Under The Health Services Insurance Act 3(2) the minister has the power &quot;to ensure that adequate standards are maintained in hospitals,</td>
</tr>
<tr>
<td><strong>Are there provincial standards, policies or legislation in place governing the provision of LTC services? If yes, could you share these?</strong></td>
<td>The Community Care and Assisted Living Act (CCALA) is the legislation that governs long term care from a licensing/inspection/monitoring perspective. The Residential Care Regulation provides the more detailed requirements that a facility (either funded or purely private pay) must meet. The CCALA is a regulatory statute. In BC the funding body (in this case Home and Community Care) does not have its own internal inspection and investigation system. These functions are carried out under the authority of the CCALA, which applies to a broad range of residential care facilities, including Long Term Care, Community Living, Acquired Injury, Mental Health and Substance Use, and Hospice. In BC there is also a Continuing Care Act, and this is more about the services that are funded/subsidized rather than the specific standards that must be met. Here are links to the CCALA: <a href="http://www.bclaws.ca/EPLibraries">http://www.bclaws.ca/EPLibraries</a></td>
<td>In Alberta the legislation consists of the Nursing Homes Operation Regulation, Nursing Homes General Regulation, the Nursing Homes Act, and Hospitals Act.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The RHAs are responsible for resource development in their specific region. The RHA must approve a business plan submitted by an applicant. Under the Regional Health Authorities Act 28(1), &quot;No person may construct, establish, operate, renovate, expand, convert or relocate a hospital or personal care home in a health region without the approval of the regional health authority for that health region, or if two regional health authorities are established in The City of Winnipeg, without the approval the regional health authority that is responsible for the health services provided or proposed to be provided in the hospital or personal care home.” The Regional Health Authorities Act <a href="http://web2.gov.mb.ca/laws/statutes/ccsm/r034e.php">http://web2.gov.mb.ca/laws/statutes/ccsm/r034e.php</a> Under The Health Services Insurance Act 3(2) the minister has the power &quot;to ensure that adequate standards are maintained in hospitals,</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
The link to the Residential Care Regulation is not working right now, so I've included a link to our webpage, from which you can access the regulations.

http://www.health.gov.bc.ca/ccf/legislation/

In addition, facilities that receive funding (are subsidized) must meet the requirements of the Home and Community Care policy manual.

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| personal care homes and related health facilities, including standards respecting supervision, licensing, equipment and inspection, or to make such arrangements as the minister considers necessary to ensure that adequate standards are maintained”. Further provisions set out in Section 118 of The Health Services Insurance Act state: A person may apply for a personal care home license by filing an application with the minister in accordance with, and including the information and the fee required by, the regulations.

An application may be made under subsection (2) only if the operation of the personal care home has been approved under subsection 28(1) of The Regional Health Authority Act.

The Health Services Insurance Act and Personal Care Home Standards and Licensing Regulations under the Act speak to the licensing and inspection processes, and set out legislated care standards.

MHHLS ensures compliance with the legislated Standards through the Personal Care Homes Standards Reviews and licensing process.

The Health Services Insurance Act

http://web2.gov.mb.ca/laws/statutes/ccsm/h035e.php
What processes are in place for licensing, monitoring and regulation of private LTC facilities?

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</table>

How is quality of care monitored in a public facility?

| | Licensing officers, who are employees of the Health Authorities, inspect and monitor licensed residential care facilities under the authority of the CCALA. The process is the same for all facilities. The CCALA is flexible enough to cover a broad diversity of care types. | The Long-Term Care Accommodation Standards apply to voluntary, public and private organizations operating long-term care accommodations. All long-term care accommodations in the province of Alberta are monitored for compliance to the accommodation standards by Licensing Inspectors at least once annually. The health care services provided in LTC facilities, whether they are publicly or privately operated, are provided in accordance with the Continuing Care Health Service Standards. These standards are designed to guide staff in providing quality, comprehensive, individualized care based on the assessed needs of each client. Compliance with the standards is mandatory for publicly funded continuing care service providers, and inspection audits are conducted regularly. | Long Term Care Home Quality Inspection Program. All homes are inspected at least once per year. Respond to complaints which are prioritized based on risk level. Program regulations and Legislation. Monitored during yearly review. Protection of persons in care- self reporting or staff reporting- complaints are investigated. There also can be unannounced visits. Homes are mandated to report critical incidents, falls, medication errors etc. | Ministry performs facility inspections. These are done annually. Monitored for compliance and follow up on. Yearly inspections are completed by all authorities having jurisdiction over the home. |

Are facility inspections completed?

<p>| | Yes, typically they are conducted annually, unless there is a higher risk (we have a risk assessment tool) in which case they would be conducted more frequently. | Yes. All long-term care accommodations in the province of Alberta are monitored for compliance to the accommodation standards. | | |</p>
<table>
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<tbody>
<tr>
<td>inspected more frequently.</td>
<td>standards by Licensing Inspectors at least once annually. Inspection audits are conducted regularly for compliance to the Continuing Care Health Service Standards.</td>
<td>complaints. Use an inspection tool (from US).</td>
<td>Standards apply to all voluntary, public and private organizations operating long-term care accommodations. Employees connected with the licensing of facilities are involved.</td>
<td>No Ministry or Health Authority staff are involved in operational aspects of LTC homes. Only if significant failing of the home.</td>
</tr>
<tr>
<td>Does the Health authority/Ministry provide staff for oversight of private facilities? If yes, please describe nature of the arrangement and type of staff?</td>
<td>In BC facilities are inspected under the same Act (CCALA) and by the same staff whether they are funded or purely private pay.</td>
<td>No Ministry or Health Authority staff are involved in operational aspects of LTC homes. Only if significant failing of the home.</td>
<td>No. DHA staff help support the homes in service provision and to manage general operating issues. There is a program for clients with challenging behaviors. DHA or DHW staff do not provide direct oversight.</td>
<td>No. DHA staff help support the homes in service provision and to manage general operating issues. There is a program for clients with challenging behaviors. DHA or DHW staff do not provide direct oversight.</td>
</tr>
<tr>
<td>Are there minimum staffing requirements? (type of provider: RN, LPN, Personal Care Attendant?)</td>
<td>In LTC, for privately, publically, and not-for-profit facilities which receive public funding, the number of hours of care per resident is 1.9 with no further specification of how much needs to be provided by an RN, LPN or HCA. Alberta’s publicly funded LTC also requires an RN be accessible at all times. Alberta has achieved an average of 3.6 paid hours per resident per day. Of the 1.9 hours, a minimum of 22% must be direct nursing care on average. The exception is auxiliary hospitals, which would be covered under the Hospitals Act, which does not specify a minimum number of direct care hours.</td>
<td>Not mandated. Within the legislation there are specific requirements for specific situations. Mandated to have 24/7 nursing, dietary staff etc. Staffing plans of the homes have to ensure appropriate staff to meet the needs of the residents. Ministry monitors staffing closely</td>
<td>Staffing outlined in regulations. <a href="http://novascotia.ca/dhw/ccs/policies/Long-Term-Care-Facility-Program-Requirements.pdf">http://novascotia.ca/dhw/ccs/policies/Long-Term-Care-Facility-Program-Requirements.pdf</a></td>
<td>Staffing ratios depend on type of facility. Regs contain examples. For Continuing Care Assistant Full Scope of Practice Model (CCAs include housekeeping and personal care)- ratios approximate: 12%RN, 8% LPN, 79% CCA. For CCA Direct care Funding Model- ratios approximate 15% RN, 10% LPN, 75% CCA.</td>
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<td>Is there a minimum number of hours of care per resident per day mandated in private facilities? How does this compare to public facilities?</td>
<td>Not mandated by law for either publicly subsidized or private pay.</td>
<td>No. Homes are expected to provide individualized care to residents according to their care plans. Homes are expected to have appropriate staff to meet the care needs. Same legislation applies to all types of LTC facilities.</td>
<td>See above</td>
<td>Min. access to 1h nursing care (indicated in regs link above) and 2.45 h personal care time per day (not indicated in regs but was communicated from contact). In past when don't have coverage of RN have to have a plan to provide nursing support. In new facilities funding is through protected envelop- have to give back any money not used for staffing- perhaps decreases the ability to cut staffing- to save money.</td>
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<td>What accountability measures are in place? Reporting to the Ministry? Public Chapter 3 of the BC Home and Community Care Policy Manual, Reportable incidents related to the Long-Term Care Accommodation</td>
<td>Chapter 3 of the BC Home and Community Care Policy Manual, Reportable incidents related to the Long-Term Care Accommodation</td>
<td>Public reporting of facility inspections. Quality of care</td>
<td>Don't have RAI MDS. Reports required for licensing are made</td>
<td>Staffing ratios depend on type of facility. Regs contain examples. For Continuing Care Assistant Full Scope of Practice Model (CCAs include housekeeping and personal care)- ratios approximate: 12%RN, 8% LPN, 79% CCA. For CCA Direct care Funding Model- ratios approximate 15% RN, 10% LPN, 75% CCA.</td>
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<td>reporting?</td>
<td>lays out the general responsibilities for health authorities in applying a performance management approach including monitoring of services (including residential care). (HCC web site: gov.bc.ca/hcc HCC policy manual: <a href="http://www.gov.bc.ca/hccpolicymanual">www.gov.bc.ca/hccpolicymanual</a>) Public reporting for the licensing component, health authorities post summary inspections of routine and follow up inspections on their Community Care Facility Licensing websites.</td>
<td>Standards must be submitted to Alberta Health by an operator or Alberta Health Services within two business days of the incident occurring. A reportable incident can include an event related to the accommodation standards that has occurred causing: * death or serious harm to a resident; * a resident unaccounted for; * extensive damage to the accommodation; or, * an unplanned event causing activation of a contingency plan. Reportable incidents must also be forwarded to Alberta Health for incidents relating to the Continuing Care Health Service Standards.</td>
<td>indicators are reported through Health Quality Ontario.ca. This is used, but probably not enough for decision making. In addition facilities report to CIHI. Ministry inspectors review CIHI data. All homes have RAI MDS electronic reporting system Financial reporting to the Ministry. Homes use OHRS MIS Ontario Healthcare Reporting System/ Management Information system for financial and statistical reporting.</td>
<td>No public reporting on waitlists, facility inspections or licensing process.</td>
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How is data collected? (In provinces please refer to chapter 3 of the) | * Operators collect Resident RAI MDS 2.0 | The home must have an | | | |
Where there is a mix of public and private, is the same reporting system used to monitor quality of care indicators, client health files and financial data? Are these systems electronic or paper based?

Policy manual referenced above

Health Authorities must submit data to the Ministry and other parties as directed by the Ministry

Assessment Instrument (RAI) 2.0 data, which is submitted to AHS. This information is assessed upon a resident’s admission to a facility, quarterly, as well as after any major changes. Operators have their own electronic programs which are able to collect and submit data to AHS electronically. The same method is used in public and private facilities.

* Financial data is collected by the Financial Information Reporting Management System (FIRMS), which collects cost data from AHS operated sites, as well as private operators which receive public funding. Reporting is voluntary, but data is received from the majority of private operators.

How are clients assessed for placement? Who decides where a client is placed? (the Health Authority, Manager of the private facility, client choice?)

For private pay the manager of the facility will need to assess. For publicly subsidized, the Health Authority assesses.

Chapter 2 provides general information about referral, intake and assessment. (HCC policy manual: www.gov.bc.ca/hccpolicymanual)

For-profit operators try to maximize the number of private rooms. Homes have to offer a minimum of 40% basic accommodations.

Challenge- many beds are in old

What have been your overall experiences with managing public private partnerships for the provision of long term care? Can you share information on the strengths and challenges experienced? (recruitment

Best addressed by the Health Authorities

* Overall it has been a positive experience.
* Alberta has partnered with groups that have strong capabilities to deliver the construction of projects.
* Alberta enjoys the mix of public

 Operators try to maximize the number of private rooms. Homes have to offer a minimum of 40% basic accommodations.

Challenge- many beds are in old
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<td>and retention of staff, quality of care, type of client admitted, collaboration among public and private LTC providers, costs, issues dealing with private providers, unplanned closures, bankruptcy?) How have any challenges been addressed?</td>
<td>and private model, as private facilities are often higher quality, and therefore having publically subsidized rooms in the same facility means that rooms also have these higher standard facilities as a spillover effect. * Challenges include limited interest in private facilities operating in some locations, as well as that developers may have limited experiences in project developments (ie. Risks involved include being over-budget/lacking project management skills).</td>
<td>facilities. Ministry committed to funding capital costs and expected the home to redevelop- the money has not been enough to encourage redevelopment</td>
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<td>Any other comments</td>
<td>As per out telephone conversation, here are the links you requested: Continuing Care Health Service Standards: <a href="http://www.health.alberta.ca/documents/Continuing-Care-Standards-2008.pdf">http://www.health.alberta.ca/documents/Continuing-Care-Standards-2008.pdf</a> Long-term Care Facility Public Reporting Information: <a href="http://asalreporting.gov.ab.ca/astral">http://asalreporting.gov.ab.ca/astral</a> Accommodation Standards and Licensing: <a href="http://www.health.alberta.ca/documents/CC-Accommodation-Guide4-2013.pdf">http://www.health.alberta.ca/documents/CC-Accommodation-Guide4-2013.pdf</a></td>
<td>Without the for-profit sector would not be able to meet demand. Some operators of municipal homes want to stop providing this service. Much innovation is driven from the for-profit sector. Issues with recruitment and retention of staff is similar in all types of LTC homes Instead of focusing on what a home must do- the focus is outcome based- LTC homes are given the flexibility to achieve the outcomes.</td>
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Has your government entered into public private partnerships in the provision of Long Term Care (nursing homes that provide 24/7 nursing care)? If no, could you share why not?

Long-term care: In Saskatchewan, regional health authorities may operate SCHs directly or through affiliation/contract. Affiliated/contracted agencies can be either non-profit corporations of for-profit corporations. For example, Extendicare Canada Inc. is a private company that has been contracted by three regional health authorities to provide long-term care services. One long-term care facility is currently proceeding through the P3 model for construction.

Personal Care Homes (PCH)

PCHs are not publicly funded. They provide private accommodation and care options for adults with usually lighter care needs. It is important to note that it is not necessary for PCH residents to demonstrate a need to be admitted. A resident is admitted when he or she chooses this service option. The resident pays for their care in a PCH.

Personal Care Homes are privately owned and operated and provide accommodation and care options in the community.

The Ministry of Health's role
respecting personal care homes is one of licensing and monitoring to ensure that the residents who live in these homes receive safe and appropriate care according to the requirements under The Personal Care Homes Act.

The Ministry of Health does not regulate rates charged in Personal Care Homes.

The type of care provided in personal care homes varies from home to home and personal care home operators may decide who to admit to the home based on the services they are able to provide.

A Personal Care Home Benefit (PCHB) was created in 2012 that provides seniors with monthly financial assistance to help with the cost of living in a licensed personal care home. The benefit supplements the difference between a senior’s monthly income and a threshold of $1950 per month.

What is the nature/terms of the contract? (Is the Ministry or Health Authority a partner? Does Government provide funding for infrastructure, operating costs, or direct client subsidies?)

The Ministry of Health provides global funding to the regional health authorities for operating costs. Regional health authorities are then responsible for the delivery of health programs and services. Regional Health Authorities may operate a SCH directly or through affiliation/contract. They are designated by the Minister under The Regional Health Services Act.
SASKATCHEWAN

New facilities built/under construction are an 80/20 local share partnership (80% government and 20% local share) for capital costs.

The P3 process has a number of contract terms depending on the negotiated scope of the contract. For instance a full scope P3 would consist of a 'Design, Build, Finance, Operate, Maintain' (DBFOM) Contract.

There are a variety of options to the contract and in the case of the only LTC facility in Saskatchewan proceeding under a P3 model it is proceeding under a DBFM, with the health region operating the facility.

The Ministry could be a partner in the Financing portion of the contract to reduce the overall cost of the project.

What is the process for entering partnership? (Request for Proposal, tender, acceptance of unsolicited proposals)

A business case is developed to determine if a P3 is the best procurement method.

Request For Proposals (RFP) are solicited from consortiums interested in the project.

The RFPs are evaluated and Requests for Qualifications (RFQ) are solicited from the top 3 proposals.

The acceptance of one of these submissions is approved to move to development of the project.
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<th>Question</th>
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<td>What are time frames for agreements?</td>
<td>Generally the contracts are for 30 years.</td>
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<td>What is the renewal process?</td>
<td>In most cases the facility is turned back to the owner.</td>
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<td>What is the funding model? (block funding to private provider or individual client subsidy)</td>
<td>The Ministry of Health provides funding to the Regional Health Authorities (RHAs). The RHAs are then responsible for the delivery of health programs and services. Resident’s pay an income tested charge based on annual reported income from Line 150 of the Income Tax Return, which includes earned interest from bank accounts and investments. Personal assets (land, bank accounts, etc) are not taken into account in determining the resident charge. The Government of Saskatchewan covers approximately 80% of the overall cost of LTC.</td>
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<td>How is the rate paid to private provider determined? (Does Government propose the rate, is it negotiated with individual facilities, or do facility owners/managers propose the rate as part of tendering process?)</td>
<td>The rate paid to a P3 provider is determined through RFQ and approval stage. This is the final cost unless there are changes to the contract. Ministry of Health provides RHAs with a global budget to provide programs and services. RHAs work with the individual facilities to determine funding.</td>
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| Can you estimate the average cost of a LTC bed in a private versus public facility? | The average provincial cost of a LTC bed, including resident fees, of providing LTC is estimated to be $87,400 per bed per year (about $7,283 per month on average) based on 2013-14 RHA budget. PCHs are privately owned and operated. In 2014-15, the average monthly cost of PCH in SK ranged between }
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<td>Are there provincial standards, policies or legislation in place governing the provision of LTC services? If yes, could you share these?</td>
<td>The Program Guidelines for Special-care Homes, The Special-care Homes Rates Regulations, 2011, The Housing and Special-care Homes Regulations, The Regional Health Services Act, The Facility Designation Regulations, Personal Care Homes (PCH), Personal Care Homes Act, Personal Care Homes Regulations and Personal Care Home Reporting Regulations, Personal Care Homes Licensee Handbook, For more information about personal care homes</td>
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<td>What processes are in place for licensing, monitoring and regulation of private LTC facilities?</td>
<td>Regional Health Authorities are responsible for the planning, organization, delivery and evaluation of health services it provides. The</td>
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<td>Ministry of Health uses quality indicators (QIs) from Resident Assessment Instrument – Minimum Data Set (RAI-MDS 2.0) to assist in identifying care concerns. Some concerns are brought to the Ministry of Health’s attention directly by the facility manager or RHA.</td>
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<td>How is quality of care monitored in a public facility?</td>
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<td>Are facility inspections completed?</td>
<td>Facility inspections are not conducted by the Ministry of Health; Regional Health Authorities set up their own process regarding this.</td>
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<td>Does the Health authority/Ministry provide staff for oversight of private facilities? If yes, please describe nature of the arrangement and type of staff?</td>
<td>Privately owned and operated facilities have their own staff management and the RHAs Director/Exec. Director provides oversight.</td>
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<td>Are there minimum staffing requirements? (type of provider: RN, LPN, Personal Care Attendant?)</td>
<td>Every home must employ at least one full-time RN/RPN (in the facility minimum 8 hours day and on call when not in the facility). Nursing care by RN/RPN shall be provided on a 24-hour basis.</td>
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<td>Is there a minimum number of hours of care per resident per day mandated in private facilities? How does this compare to public facilities?</td>
<td>Provincially there are no staff/resident ratios. Staffing ratios determined by operator of the home based on resident care needs. Personal Care Homes (PCH) - The Ministry of Health’s role respecting personal care homes is one of licensing and monitoring to ensure that the residents who live in these homes receive safe and appropriate care according to the requirements under The Personal Care Homes Act.</td>
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<td>Inspections of personal care homes are completed on a regular basis by Ministry staff as part of the monitoring process. Inspections occur before initial licensing and at the time of relicensing. Other monitoring tools include follow up phone calls, unannounced drop in visits, request to submit a written report, etc. All complaints are investigated. Personal care home must provide staffing to meet the individual needs of each resident. Personal care homes are staffed 24 hours/day and homes with 31 or more residents must ensure a health care professional (i.e. RN/RPN/LPN) is working in the home on a regular basis. Other staffing requirements include: trained care aides, personal care worker course, medication assistance module, food service sanitation, standard first aid.</td>
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|  | Long-term care facilities complete MDS assessments that the Ministry has access to. Admissions and discharges in long-term care are reported to the Ministry electronically as they occur. Legislation also outlines reporting requirements and expectations: The Program Guidelines for Special-care Homes. The Special-care Homes Rates Regulations, 2011 The Housing and Special-care Homes Regulations The Regional Health Services |  |

<p>| What accountability measures are in place? Reporting to the Ministry? Public reporting How is data collected? (In provinces where there is a mix of public and private, is the same reporting system used to monitor quality of care indicators, client health files and financial data? Are these systems electronic or paper based?) |  |</p>
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<td><strong>Act</strong> The same reporting system is used for public and private special-care homes to monitor quality of care indicators and admissions/discharges from LTC. Both systems are electronic.</td>
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<td><strong>Personal Care Homes (PCH)</strong> Standards are evaluated during the inspection and complaint investigation processes. A standard operational review tool is used to complete all inspections. An outcome of visit report is left for the licensee to follow up and the licensees complete and submit a written report to explain their actions to correct a deficiency and meet the standards. Also, a complaint investigation process is followed that includes a written report. The Personal Care Homes Act and regulations allow for public reporting of inspection results.</td>
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<td><strong>How are clients assessed for placement? Who decides where a client is placed? (the Health Authority, Manager of the private facility, client choice?)</strong> The regional health authority (RHA) has overall responsibility for long-term care services in the region, including managing the special-care home placement process. The assessment of individuals for placement in special-care homes (nursing homes) is the responsibility of the RHA. A provincial assessment tool is used and each RHA has a single point of entry. Personal Care Homes (PCH)</td>
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PCH residents do not need to demonstrate a need to be admitted. A resident is admitted when he or she chooses this service option. PCH licensees are responsible for requesting assessments from the health region upon the resident's admission to the PCH and at least every two years or when care needs change.

What have been your overall experiences with managing public private partnerships for the provision of long term care? Can you share information on the strengths and challenges experienced? (recruitment and retention of staff, quality of care, type of client admitted, collaboration among public and private LTC providers, costs, issues dealing with private providers, unplanned closures, bankruptcy?) How have any challenges been addressed?

Generally speaking, all long-term care facilities face similar challenges whether region owned/operated or contracted i.e.) recruitment/retention issues, aging infrastructure, clients with complex needs etc. We haven't had any bankruptcies or unplanned closures.

Personal Care Homes (PCH) Inspections of personal care homes by Ministry staff are completed on a regular basis as part of the monitoring process. Public reporting of inspection results is available online to provide residents and families with more information to consider when selecting a personal care home.

http://www.health.gov.sk.ca/pch-inspections. These inspection results show some of the challenges in the personal care home sector.

Any other comments