# *Advocating for LTC reform in the name of Robert C. Pinto: A practical guide*

## What this guide contains and how to use it

What does this guide contain? Probably too much information! However, some will want to be informed about the background of Dr. Pinto's situation, as well as the reasons that the family is recommending action and certain types of reform.

The guide begins with who you might contact and how to reach them – so you don't have to look up CEOs or anything.

Next, the document contains a summary of Dr. Pinto's experiences, followed by context, and the problems that Dr. Pinto's family believes should be addressed.

Dr. Pinto's family encourages you to copy and paste whatever information or statements resonate with you in order to create a unique letter (form letters are ineffective).

Dr. Pinto would be impressed and grateful if you took the time to advocate on his behalf.

## Where to send acerbic letters

Christine Elliott, Minister of Health and Long-Term Care, christine.elliott@pc.ola, christine.elliott@ontario.ca

Doug Ford, Premier of Ontario, premier@ontario.ca

France Gélinas, Opposition Critic, Healthcare, fgelinas-qp@ndp.on.ca

Your own MPP

Auditor General of Ontario, comments@auditor.on.ca

Dr. Michael Guerriere, President and Chief Executive Officer, Extendicare, communications@extendicare.com, 3000 Steeles Avenue East, Suite 103, Markham, ON L3R 4T9

Lois Cormack, President and Chief Executive Officer, Sienna Living, investors@siennaliving.ca, 302 Town Centre Blvd, Ste 300, Markham, Ontario L3R 0E8

Thomas Wellner, CEO, Revera Living, 5015 Spectrum Way, Suite 600, Mississauga, ON, L4W 0E4 (you can also CC Larry Roberts, Senior Manager, Corporate Affairs, Larry.Roberts@reveraliving.com)

## Start by explaining why you are writing

I am writing to you to express my outrage after hearing about the horrific an un-necessary abuse that my FRIEND/COLLEAGUE/HERO/MENTOR, Dr. Robert Charles Pinto, experienced in Ontario's for-profit

Long-Term Care system. As a voting-age citizen of Ontario, and a potential future victim of the current system, I demand changes at the corporate level, which most likely can only be remedied by massive legislative reform and improved oversight by the province.

Secondly, as a citizen, I am expressing my concern the misuse of taxpayer OHIP dollars which should go to direct care, but instead is channeled into private profits. All governments talk about efficient use of funds, but I have learned that the current structure of LTC billing merely results in billions of Ontario taxpayer dollars earmarked for healthcare services paid out to shareholders and CEOs. This is unacceptable, and certainly contradicts the promises made by elected officials on all sides of the aisle.

## Before you write: Some Additional Context: How Long-term Care (LTC) Works

The roughly 77,000 beds[1] in Ontario's 627 long-term care (LTC) facilities are subsidized by the province's Ministry of Health and Long-Term Care (MOHLTC). The MOHLTC pays for personal and nursing care, support services and food, and the resident pays a capped "co-payment" for the accommodation and other fees (television, pharmacy dispensing, etc.). In 2018, the monthly accommodation co-payment for a private room was about $2,600. The provincial portion was $149.95 per resident, per day or $54,730 per year, amounting to a **total provincial expenditure of $4.28 billion or 7% of Ontario's total health budget** (Ontario Long Term Care Association, 2018).[2]

For-profit LTC facilities have a history of staffing at lower levels than their not-for-profit counterparts (McGregor, Cohen, McGrail, Broemeling, Adler, Schulzer, Ronald, Cvitkovich & Beck, 2005[3]). In Dr. Pinto's LTC, a ward of 28 residents only had 2 PSWs on duty most of the time, and regardless of time/day, 1 RPN for two wards, and 1 Charge Nurse for the entire facility of 4 wards. As a point of comparison, when he was in the hospital, the acute care ward had 2 RNs assigned to care for 4 patients. Most of Ontario's nursing home wards have staff-to-patient ratios similar to Dr. Pinto's facility – ward sizes of 32 residents per unit were arbitrarily selected decades ago, and never updated (Welsh, 2018[4]). On occasion, Dr. Pinto's LTC's PSW staffing levels were slightly higher during daytime shifts – presumably due to the increase in duties that would include feeding residents their meals, medication schedules, and the fact that more residents are awake and have demands. Yet, he was routinely left helpless on a toilet for sometimes over an hour at a time, despite family members repeatedly asking for help to move him.

While Ontario no longer sets minimum staffing requirements for caregivers (Banjaree & Armstrong, 2015; Harrington et al., 2017), the Auditor General (2017[5]) found that inadequate staffing and training were identified as reasons for persistent regulatory noncompliance. Reg. 97/10 of the *LTC*

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[1] Ontario Long Term Care Association (2018). *This is Long-Term Care 2018*. Retrieved: https://www.oltca.com/OLTCA/Documents/Reports/ThisIsLongTermCare2018.pdf.
[2] Ontario Long Term Care Association (2018). *This is Long-Term Care 2018*. Retrieved: https://www.oltca.com/OLTCA/Documents/Reports/ThisIsLongTermCare2018.pdf.
[3] McGregor, M. J., Cohen, M., McGrail, K., Broemeling, A. M., Adler, R. N., Schulzer, M., Ronald, L., Cvitkovich, Y. & Beck, M. (2005). Staffing levels in not-for-profit and for-profit long-term care facilities: Does type of ownership matter? *Canadian Medical Association Journal, 172*(5), 645-649.
[4] Welsh, M. (2018, June 20). The fix. *Toronto Star*. Retrieved: http://projects.thestar.com/dementia-program/
[5] Auditor General of Ontario. (2017). 2017 Annual report volume 2. Retrieved: http://www.auditor.on.ca/en/content/annualreports/arbyyear/ar2017.html

*Homes Act* (2007) does, however, set minimum standards for non-caregiving staff. For example, Sec. 76(1) requires a cook for a minimum of 35 hours per week, and Sec. 77(1) provides a formula for the minimum number of food service workers: Occupancy × 7 × 0.45. Minimum hours for an Administrator and a Director of Nursing and Personal Care (based on number of resident) are stipulated in Sec. 213(1). LTC facilities set their own staffing levels for frontline caregivers in the form of a Staffing Plan required by Sec. 41 of Reg. 97/10 (*LTC Homes Act*, 2007). The regulation requires that the Staffing Plan be followed (which is part of annual inspections, described later), and evaluated and revised annually. For example, in the spring of 2018, **Dr. Pinto's nursing home was cited for a shortfall of 181 hours of frontline staff over the course of a month** (where minimum staffing is set out in the facility's own Staffing Plan), identified during an annual inspection.[6]

## Types of abuse and neglect in Dr. Pinto's LTC

Dr. Pinto was the victim of various forms of abuse and neglect, but he and his family also witnessed horrific situations and events in the LTC. Dr. Pinto's wife was at the LTC every single day except for a few brief periods of illness where she could not attend. As a result of her constant presence, she witnessed and reported many instances of horrific treatment of her husband and others. A summary of issues (with some documentation – because the LTC was caught in violation by inspectors[7]) include (but are not limited to):

- The LTC was cited for "non-compliance" in Inspection Report #2018_538144_0019 (2018) and # 2019_674610_0010 (2019) for failing to report repeated sexual abuse Dr. Pinto's co-residents (p. 9 of MOHLTC report). While this did not impact Dr. Pinto directly, this was the environment he was in. It was an environment where residents experienced abuse by other residents, and neglect by staff.
- The nursing home failed to respond to inquiries and complaints by Dr. Pinto's family (including a request to know what happened to him in October 2018 and why the family was not informed when he fell ill, which led to his hospitalization). That complaint is detailed in Inspection Report #2019_674610_0010. The family has a right to know.
- While Dr. Pinto was there, the LTC was cited by the Inspectors for short-staffing 181 PSW hours over the course of a month (Inspection Report 2018-538144-0020 dated July 5, 2018), and Dr. Pinto's family have evidence to suggest this was not an isolated incident. Despite documented short-staffing the LTC continued to take both public (OHIP) and private (resident co-pay) dollars that did not go to required front-line care. Where did the funds go? Why were residents or the province not reimbursed?
- Dr. Pinto's basic needs were routinely neglected – for instance, documented instances where he was left on a toilet for an hour at a time, despite his family calling for help repeatedly to help

[6] MOHLTC. (2018, July 5). Inspection No.2018_538144_0020. Retrieved: http://publicreporting.ltchomes.net/en-ca

[7] You can view Inspection Reports here – there are far too many violations to list: http://publicreporting.ltchomes.net/en-ca/homeprofile.aspx?Home=2842&tab=1

him up. For example, The *Toronto Star* reported, around that same time period, that residents in a Peel nursing home had wait times as long as 2 hours[8] for help with similar things. Dr. Pinto's wife routinely helped other residents eat meals when inadequate staffing left them starving, and if the meals were not consumed in a certain amount of time food was taken away.

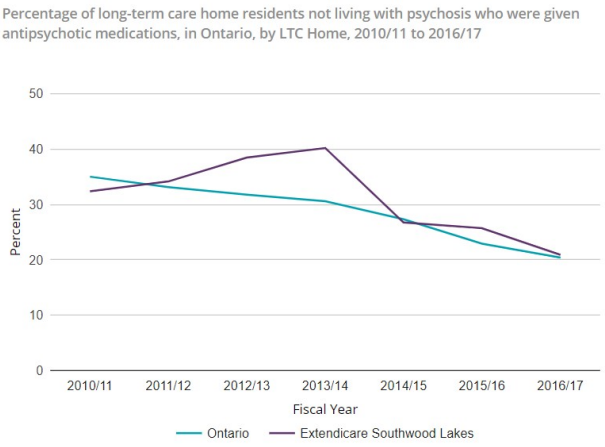
- When Dr. Pinto was unable to stand up without assistance, and had several falls out of his wheelchair, instead of putting safety measures in place the LTC would keep him in a wheelchair, 24 hours a day, spending multiple nights in a row in a nurse's station. At times (and we have photographic evidence of this) Dr. Pinto, alongside others, was tilted back at a 45-degree angle in his wheelchair, making it impossible to sit up. The family observed multiple residents in this state, all squirming like turtles to escape.
- Dr. Pinto, along with other residents, was subject to a "chemical straightjacket[9]" – a well-documented and common practice of sedating LTC residents to make them placid and controllable. He fluctuated between a dangerously unresponsive state, and periods of feistiness when he roused. Ultimately, two physicians (the attending ER physician on May 12, 2018 and a geriatric psychiatrist on May 24, 2018) were of the clinical opinion that he was over-medicated. Once he moved from LTC to the hospital and was not heavily sedated, his demeanor improved and he was able to enjoy life a little bit more.

## Problem 1: Profits (and more profits) over people –and our OHIP funds in private pockets

**LTCs represent a total provincial expenditure of $4.28 billion or 7% of Ontario's total health budget**[10], with nearly 60% of that going to private, for-profit entities.[11] The number of chain-owned nursing homes in the province rose from 7% in 1971 to 43% in 1999 (Baum, 1999), to well over 60% in

[8] Welsh, M. (2018, June 20). The fix. *Toronto Star*. Retrieved: http://projects.thestar.com/dementia-program/

[9] Percentage of LTC residents not living with psychosis who were given antipsychotic medications 2010/2011-2016/2017




Source: https://www.hqontario.ca/System-Performance/Long-Term-Care-Home-Performance/Antipsychotic-Medication-Use

[10] Ontario Long Term Care Association (2018). *This is Long-Term Care 2018*. Retrieved: https://www.oltca.com/OLTCA/Documents/Reports/ThisIsLongTermCare2018.pdf.

[11] Ontario Long Term Care Association (2018). This is Long-Term Care 2018. Retrieved: https://www.oltca.com/OLTCA/Documents/Reports/ThisIsLongTermCare2018.pdf.

2017 (Ontario Long Term Care Association, 2018). In Canada, the largest 5 corporate chains (Extendicare, Sienna, Rivera, Schlegel and Chartwell) control 23.8% of beds and 18.9% of facilities (Harrington et al., 2017), making **Ontario the most privatized jurisdiction in Canada, Germany and Norway** (Daly, Struthers, Müller, Taylor, Goldmann, Doupe & Jacobsen, 2016[12]).

In 2017, Sienna Senior Living paid its CEO a little over $1.2 million and over $36 million in shareholder dividends to shareholder, while Extendicare paid its president and CEO just under $4 million and paid out more than $37 million in dividends.[13] Others do not report financial data.

The problem of LTC profits over people is not news. In 1984, the Social Planning Council of Toronto published an influential report titled "Caring for Profit" that focused on tensions between public services and profits (Baum, 1999). That same year, the Canadian Medical Association's task force called for the elimination of for-profit elder care "when an institution becomes the only answer for care," it must be "run on a principle of loving care, not tender loving greed" (Baum, 1999, p. 549). Despite repeated calls to eliminate a profit motive, Ontario feared that the elimination of a profit motive would result in too many closures in a system already lacking sufficient beds for the population (Baum, 1999). The 2003 bankruptcy of the Royal Crest Group for-profit chain (the largest nursing-home failure in Canada) proved to be costly to governments and other stakeholders (McKie, 2009[14]), which may lead to additional reluctance to dismantle private ownership structures in the future.

Ontario's privatization-friendly Harris government introduced measures during the 1990s that favoured the growth of chains, including lower bids for contracts, publicly financed capital funding, the elimination of minimum staffing standards, and a new payment system that allowed companies to maintain their profits without returning excess funds to governments (Banjaree & Armstrong, 2015; Harrington, et al., 2017). It appears that during the late 1990s, when the Harris government was awarding bed licenses, non-profits including the Salvation Army and the Sisters of Charity were passed over in favour of private corporations such as Extendicare and others (CBC News, 2001[15]). **News surfaced that Extendicare donated $37,000 to the Ontario Tories between 1995 and 1999 (within the legal limit), then was awarded a $700 million contract** for 900 beds (CBC News, 2001). While no direct link has been established, critics often call for a ban on political donations by healthcare providers, which exists in other provinces (CBC News, 2001).

Privatization most certainly does not imply better quality of care. Interestingly, **Canadian for-profit-chains have significantly higher rates of resident complaints compared with non-profit and public facilities** (Harrington et al., 2017; McGregor, Cohen, Stocks-Rankin, Cox, Salomons, McGrail,

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[12] Daly, T., Struthers, J., Müller, B., Taylor, D., Goldmann, M., Doupe, M., & Jacobsen, F. F. (2016). Prescriptive or Interpretive Regulation at the Frontlines of Care Work in the "Three Worlds" of Canada, Germany and Norway. *Labour, 77*, 37-71.

[13] CTV News, https://www.ctvnews.ca/w5/groundbreaking-legal-action-alleges-nursing-home-chains-put-profit-ahead-of-care-1.4155852

[14] McKie, D. (2009, March 23). Advocates demand inquiry into Ontario's costly handling of Royal Crest nursing-home failure. *CBC News*. Retrieved: http://www.cbc.ca/news/canada/advocates-demand-inquiry-into-ontario-s-costly-handling-of-royal-crest-nursing-home-failure-1.791359

[15] CBC News. (2001, March 19). Relationship between nursing homes, Ontario government questioned. Retrieved: https://www.cbc.ca/news/canada/relationship-between-nursing-homes-ontario-government-questioned-1.289052

Spencer, Ronald & Schulzer, 2011[16]). Ontario for-profit nursing homes, especially chains, provided significantly fewer hours of RN and RPM care than their non-profit counterparts, after controlling for resident care needs (Harrington et al., 2017; Hsu, Berta, Coyte & Laporte, 2016[17]) and have been known to evade regulations that interfere with profits (Banjaree & Armstrong, 2015; Lloyd, Banjaree, Harrington, Jacobsen & Szebehely,2014[18]). For-profit nursing homes in Ontario are more likely to use anti-psychotic medication for residents without any psychosis (Wodchis, Walker, Bai & Shearkhani, 2015[19]).

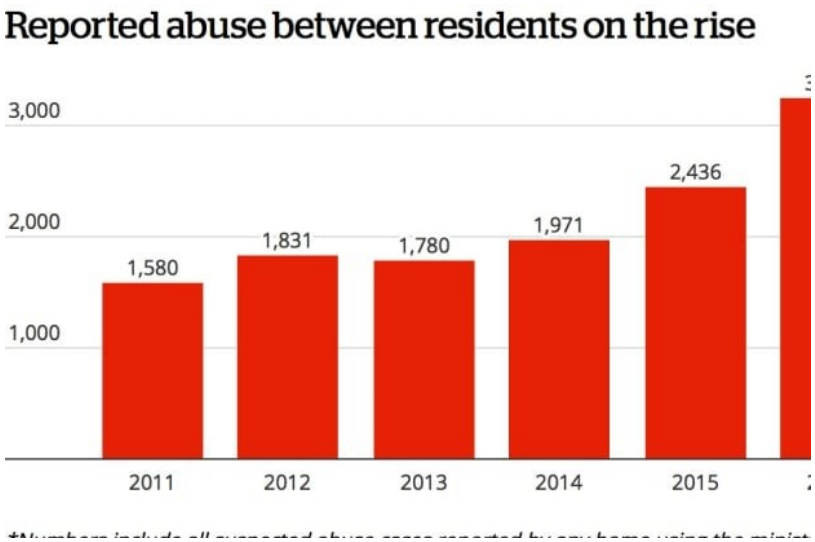
## Problem 2: Abuse and Neglect are Features of the System, Not Bugs

Section 19 of the *LTC Homes Act* (2007) requires that nursing homes protect residents from abuse by anyone. To prevent altercations, staff must be proactive in identifying triggers and must deal with potentially harmful interactions before they escalate into a harmful situation. Abuse and neglect ought to be dealt with by MOHLTC inspectors.

Yet, abuse and neglect occur routinely – whether abuse staff or other residents. The CBC[20] reports that about 9 reports per day of resident-on-resident abuse occur in Ontario, totalling 78,000 incidents in 2016 alone (Mancine & Pedersen, 2018). In Dr. Pinto's world, it was not just "in the paper," but literally at his dining room table.

**Figure OO: Reported abuse between residents, 2011-2016 (CBC)**

[16] McGregor, M. J., Cohen, M., Stocks-Rankin, C. R., Cox, M. B., Salomons, K., McGrail, K. M., Spencer, C., Ronald, L.A. & Schulzer, M. (2011). Complaints in for-profit, non-profit and public nursing homes in two Canadian provinces. *Open Medicine, 5*(4), e183.
[17] Hsu, A. T., Berta, W., Coyte, P. C., & Laporte, A. (2016). Staffing in Ontario's long-term care homes: differences by profit status and chain ownership. *Canadian Journal on Aging/La Revue canadienne du vieillissement, 35*(2), 175-189.
[18] Lloyd, L., Banjaree, A., Harrington, C., Jacobsen, F.F., Szebehely, M. (2014). It's a scandal. *International Journal of Sociology and Social Policy, 34*(1/2), 2-18.
[19] Wodchis, W., Walker, K., Bai, Y. Q., & Shearkhani, S. (2015). Impacts of Residents First, Public Reporting and Long-Term Care Homes Act on Restraint and Antipsychotic Use in Ontario Long-Term Care Homes. Paper presented at: "This is Long Term Care 2015" Conference held by the Ontario Long-Term Care Home Association.
[20] Mancini, M. & Pederson, K. (2018, January 26). 'It's a horror movie': Nursing home security footage provides raw picture of resident violence problem. *CBC*. Retrieved: http://www.cbc.ca/news/health/long-term-care-marketplace-1.4501795




## Problem 3: MOHLTC Inspections and Reporting Ineffective

Ontario's MOHLTC has regulatory practices in place for nursing homes. All undergo annual Resident Quality Inspections (RQI), but also are subject to unscheduled inspections when complaints are filed by members of the public or families under The LTC Home Quality Inspection Program (LQIP), usually through a call to the MOHLTC Action Line. Critical Incident Reports, which are mandatory for certain types of events such as fire, neglect or abuse, improper care, unlawful conduct, unexpected/sudden death, etc., filed by the nursing home also trigger an inspection. All RQI and LQIP results are publicly available, though the public website[21] has been criticized for lacking user-friendliness by the Auditor General of Ontario (2017) and others (Payne & Fenton, 2018). Making matters worse, inspections are not conducted or posted in a timely manner – the Auditor General (2017[22]) found that the 2017 backlog of complaints and critical incidents requiring inspections increased to 3,370 from 2,800 in 2015. Moreover, many complaints and critical incident cases were closed without inspection, and the majority of those lacked sufficient documentation to show why an inspection was not required (Auditor General, 2017). Finally, the Auditor General (2017) concluded that inspection results are not consistent from one region to another, or among facilities in the same region, and recommended that the Ministry take steps to ensure high quality and consistency of inspectors' work.

The Auditor General (2017) also identified an absence of sufficient enforcement procedures to address repeated noncompliance. To address that observation, MOHLTC amended the legislation. Effective January 1, 2019, Reg. 263/18 of the *LTC Homes Act* (2007) (amending Reg. 79/10) institutes

[21] Every report issued can be reviewed at http://publicreporting.ltchomes.net
[22] Auditor General of Ontario. (2017). 2017 Annual report volume 2. Retrieved: http://www.auditor.on.ca/en/content/annualreports/arbyyear/ar2017.html

fees for inspections and noncompliance. Penalties for noncompliance under that regulation range between $1,000 and $10,000, and vary depending upon the type of infraction. A multiplier is applied to each fee for repeat offenses. After the first inspection at no cost, subsequent inspections are subject to a $500 surcharge.

Canada's Extendicare was, until relatively recently, operating internationally. It owned and operated over 200 LTC facilities in the United States that were eliminated in 2015. The circumstances immediately preceding the corporation's exodus from the US are interesting. Extendicare Health Services Inc. (EHSI) agreed to pay $38 million various US governments to settle allegations that it improperly billed Medicare and Medicaid for substandard nursing services and unnecessary rehabilitation therapy (Sullivan, 2015), in the largest Medicare/Medicaid fraud in US history at that point, involving 33 nursing homes across 8 states.[23] The US Department of Justice (DOJ) (2014[24]) press release stated that between 2007 and 2013,

> Extendicare billed Medicare and Medicaid for materially substandard skilled nursing services and failed to provide care to its residents that met federal and state standards of care and regulatory requirements. The government alleges, for example, that Extendicare failed to have a sufficient number of skilled nurses to adequately care for its skilled nursing residents; failed to provide adequate catheter care to some of the residents and failed to follow the appropriate protocols to prevent pressure ulcers or falls.[25]

Now operating only in Canada, Extendicare continues to pay shareholder dividends (a total of over $42 million in 2017, a yield of 5.25% annually which they have maintained for 5 years running), on the backs of residents like Dr. Pinto who do not receive adequate care, and out of citizens' pockets based on the proportion of provincial healthcare funding that directly results in their healthy revenue and margins. Top-level management receives generous compensation packages – in fact, in 2010, Ontario's Finance Minister argued in Parliament that executives at for-profit long-term-care homes should adopt the province's fiscal austerity measures by freezing their own pay[26] (Howlett & Perkins, 2010[27]). However, Ontario has not taken any concrete steps to curb profitability, nor did the Liberal government elected in 2002 roll back the 1990s legislation that was eliminated the paying back of excess funds.

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[23] Sullivan, J. (2015). False Claim Act Liability for Worthless or Substandard Care in Long Term Care. *CE Law*. Retrieved: http://www.celaw.com/blog/false-claim-act-liability-for-worthless-or-substandard-care-in-long-term-care

[24] Department of Justice. (2014, October 10). Extendicare Health Services Inc. Agrees to Pay $38 Million to Settle False Claims Act Allegations Relating to the Provision of Substandard Nursing Care and Medically Unnecessary Rehabilitation Therapy. Retrieved: https://www.justice.gov/opa/pr/extendicare-health-services-inc-agrees-pay-38-million-settle-false-claims-act-allegations

[25] Extendicare, in their 2014 Annual Report, stated that the corporation "has denied engaging in any illegal conduct and has agreed to the terms of the settlement without any admission of wrongdoing in order to resolve the investigations and ancillary claims" (p. 15).

[26] Howlett and Perkins (2010) report that Extendicare CEO Tim Lukenda was compensated with $1.5 million salary in 2010, and on November 3W5 reported that his 2017 compensation had nearly doubled to $3,961,352.00.

[27] Howlett, K. & Perkins, T. (2010, September 15). Ontario considers freezing pay of bosses at for-profit care homes. *Globe & Mail*. Retrieved: https://www.theglobeandmail.com/news/national/ontario-considers-freezing-pay-of-bosses-at-for-profit-care-homes/article4189996/

## What I Demand of Corporations

Identifying action on the part of corporations to rectify the LTC situation may be a pointless exercise. Corporations exist for one purpose: to maximize shareholder profits. Thus, diverting public funds into the pockets of shareholders is the goal. Payouts to victims are made by insurance companies, and therefore do not impact the bottom line – thus it is in a corporation's best interest to allow abuse and neglect to happen, and any liability is the "cost of doing business" out of their pockets.

Nonetheless, to remedy the situation, Corporations must:

- Realize that abuse, neglect, poor service quality and fraud, while profitable, may ultimately contribute to the industry's demise and potentially result in revocation of licenses.
- Realize that nobody is "too big to fail."
- Self-audit to identify and eliminate fraud.
- Significantly increase staff to resident/patient ratios, despite the impact on profits
- Hold their own staff accountable for abuse and neglect

## What I Demand of my MPPs and the Province of Ontario

MPPs must:

- Acknowledge that profits paid out to CEOs and Shareholders funnel public money into private hands, and that money therefore is not used for direct services or care
- Establish legislation that would ensure ALL public funds (and user co-pays by LTC residents) go to direct care. This would obviously pose an existential threat to corporations – so a plan to replace corporate entities with non-profits must be established (e.g., municipally-owned LTCs such as Huron Lodge in Windsor, Ontario)
- Legislate limits to private, for-profit management companies who come in and offer management services thus diverting public funds from direct service
- Legislate staff to resident ratios. It is appalling that the MOHLTC LTC Act legislates kitchen staff numbers, but not direct care ratios.
- Empower MOHLTC Inspectors to do their jobs effectively and establish more meaningful consequences for noncompliance, especially abuse. Today, it's a pittance and a small cost of doing business – and not a deterrent.
- Improve public access to MOHLTC inspection reports: including a more user-friendly translation of results.
- Establish patient advocates that can assist those who encounter persistent abuse and neglect, as Robert Pinto and others in his LTC did. Such advocates must have the authority to make meaningful change.
- Heed the advice of the Auditor General of Ontario, who has repeatedly offered sound recommendations for over a decade.
- Hold individual CEOs and management accountable for failing to prevent abuse and neglect in LTC environments.

- Actively monitor LTCs for fraudulent activity by (a) encouraging whistleblowing; and (b) frequent and detailed audits to identify activity such as the practices that led to 2014's record-setting $38 million settlement that Canada's Extendicare paid to the US Department of Justice for Medicare/Medicaid fraud, and led to Extendicare's departure from US markets.[28] The whistleblower who called attention Extendicare's fraudulent billing was awarded nearly $3 million for unlawful retaliation and legal fee reimbursement.[29]
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## What I Will Do

I, along with friends, colleagues, and acquaintances of the late Dr. Robert Pinto will continue to raise awareness of the horrors of LTC in this province, and the failure of elected officials from all three parties to do anything meaningful to remedy the situation over decades when they were each in power.

I will advocate to elected officials to make LTC reform a priority: as Rosario Marchese (a former MPP) astutely pointed out, MPPs cannot take on all issues; the ones with the most constituent currency are addressed, the others, however laudable, fall to the wayside. I will encourage my networks to do the same.

# Final Context: An example of how a private LTC achieves billions in revenue

Extendicare was the largest privately-owned chain operating in Canada, with 116 facilities, accommodating 15,004 residents in 2017 (Extendicare website[30]). In Ontario, they owned or leased 34 LTC facilities with 5,206 beds, and managed an additional 40 facilities with 5,165 beds. According to their annual report, Extendicare's 2017 revenue from continuing operations grew to $1.1 billion, 3.4% higher than the previous year. Fifty-five percent of revenues are from LTC operations (North Channel Investments, 2018[31]).

Extendicare relies on a number of common organizational and financial structures common designed to maximize profits. One such strategy structuring the company as a real estate investment trust (REIT), which allows the company to separate nursing operations homes from their property, allowing leaseback arrangements (Harrington et al., 2017). REITs are attractive because they offer tax advantages, and rental rates can be artificially inflated in leasebacks (Harrington et al., 2017). While Extendicare was structured as an REIT, this structure was converted to a publicly-traded company on the Toronto Stock Exchange in 2012.

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[28] https://www.justice.gov/opa/pr/extendicare-health-services-inc-agrees-pay-38-million-settle-false-claims-act-allegations
[29] *United States ex rel. Lovvorn v. Extendicare Health Services Inc., et. al.*, C.A. 10-1580 (E.D. Pa.)
[30] Retrieved: https://www.extendicare.com/care-and-services/long-term-care/long-term-care/
[31] (2018, May 18). Canadian Long-Term Care: Too Big Of A Headache For Low Profits. Retrieved: https://seekingalpha.com/article/4172045-canadian-long-term-care-big-headache-low-profits

Second, Extendicare has been involved in diversification through horizontal ownership, in which they operate related healthcare companies to enhance profit-taking (Harrington et al., 2017). The profits are generated when one company within the corporation purchases services from another company within that same corporation (Harrington et al., 2017). An example of this is Extendicare's Paramed Home Health Care, which provides various healthcare and medical services at home or other institutions. Extendicare's home health care services account for 38% (or about $400 million) of their revenue (Extendicare, 2017[32]).

LTCs also earn additional revenue from related fees collected from other corporate entities. A common practice in Ontario is charging pharmacies "bed fees" ranging from $10 to $70 per resident annually for the rights to dispense publicly funded drugs to residents (Walsh, 2016[33]). Extendicare, who collects such fees, said that the money generated is used for staff training (Walsh, 2016). Across all LTC facilities in Ontario, an estimated $20 million in bed fees is collected (Walsh, 2016). For example, all of Dr. Pinto's medications were dispensed to his LTC by a corporation called Medical Pharmacies, which charge residents dispensing fees. By only dispensing 30 days of medication at a time, the fees multiply quickly, contributing to LTC industry profits.

Third, a related diversification strategy is the creation of separate management companies within the corporation, which allows the management company to charge the individual nursing homes at rates set by the parent company (Harrington et al., 2017). Extendicare operates Extendicare Assist, a management company, and Group Purchasing Services, which offers purchasing contracts to other senior care providers for food, capital equipment, furnishings, and supplies. Together, those companies provided Extendicare with approximately $20 million (2%) in revenues (Extendicare, 2017).

[32] Extendicare. (2017). *2017 Annual Report*. Retrieved: https://www.extendicare.com/investors/financial-reports/
[33] Welsh, M. (2016, October 17). Pharmacies Pay Millions in 'bed Fees' to Ontario Nursing Homes. Toronto Star. Retrieved: https://www.thestar.com/news/canada/2016/10/17/pharmacies-pay-millions-in-bed-fees-to-ontario-nursing-homes.html