OFFICE OF THE
SENIORS ADVOCATE

A BILLION REASONS TO CARE:

A Funding Review of Contracted Long-Term Care in B.C.

2020

OFFICE OF THE
SENIORS ADVOCATE
BRITISH COLUMBIA

February 4, 2020

B.C. seniors who live in long-term care deserve the best possible care and taxpayers need to know the money they are investing in seniors care is well spent.

As the Seniors Advocate, I have examined many issues related to public long-term care over the years and have found that our system has some aspects that work well and others that need to be improved. For the most part, most seniors appear to be receiving the appropriate care from a group of incredibly dedicated people who have chosen careers in the demanding but rewarding field of seniors care. However, I also know that the system is not working for everyone all of the time and there are cases of unmet need within our long-term care sector. We are also experiencing challenges in the recruitment of care staff as the tight labour market, especially in B.C., puts upward pressure on wages.

In British Columbia the majority of long-term care is delivered by contracted care providers who receive over $1.3 billion of public funding annually. Knowing how contracted care providers are spending the public money they receive is an important part of monitoring the effectiveness of the system.

My office undertook a systemic review of the funding and expenditures in the contracted long-term care sector, and the results have produced some surprise findings. You will read in the attached report of a funding and monitoring system that lacks the type of accountability, openness and transparency that both B.C. seniors and B.C. taxpayers deserve. The review also illustrates some marked differences in spending between contracted providers who are private businesses and those who are not-for-profit care societies.

Despite some shortcomings in our current system, we have a solid foundation to build on. I am confident that, together, health authorities and contracted providers can bring increased fairness, equity, openness, and transparency to the contracted long-term care sector and improve the lives of many residents along the way.

This report would not have been possible without the contributions of many people. In addition to the dedicated staff at my office, I want to thank the health authorities and the many contracted care providers who assisted in the information gathering for this report.

Sincerely,

Isobel Mackenzie
Seniors Advocate
Province of British Columbia

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EXECUTIVE SUMMARY

A Billion Reasons to Care is a review of the contracts, audited financial statements and expense reports (2017/18) for 174 contracted long-term care homes in B.C. The review examined these documents to determine levels of accountability, monitoring and financial oversight in one of the largest contracted sectors within government.

Currently in B.C. 33% of publicly funded long-term-care beds are operated directly by health authorities. The remaining 18,000 beds are delivered by for-profit companies (35%) and not-for-profit societies (32%) who have been contracted by one of the five regional health authorities in B.C. In total, long term care services in B.C. cost $2 billion per year, with the majority, $1.3 billion, spent in the contracted sector.

An overall review of the contracts that exist between care home operators and health authorities found a variety of different contracts both within and between health authorities with different language related to care standards and expectations. Notwithstanding this, the review found almost all contracts allow the health authority to set annual funding levels and no contracts make commitments to any specific amount.

The review examined most, but not all, audited financial statements. Those examined were all prepared by external auditors using generally accepted accounting principles. The review found these statements to be of limited value given the level of detail did not address expenditures on direct care and many of the statements examined were prepared as one statement that covered several care homes.

The review focused mostly on the detailed Expense Reports that are submitted to health authorities by each care home. Expense Reports are unaudited and prepared by the care home operator but provide the most detail on care home revenues and expenses. The Expense Reports varied between health authorities but were consistent for each care home within a health authority.

The review found that expense statements overall were not collecting sufficient details for large expenditures such as management fees, head office allocations, administrative costs and payment to related parties. The review found the treatment of capital building costs significantly different between health authorities and significant discrepancies were found to exist between operators, particularly between operators in the for-profit sector and the not-for-profit sector on the amount expensed for capital building costs. There was no attempt to establish fair market value for building costs evident from the review and as such no ability to determine if the public is receiving good value for money.

The review found monitoring of direct hours was not sufficiently robust. The current reporting system relies on the operators unaudited self reported worked hours for direct care staff. This system can lead to the miscalculation of care staff worked hours to include the time care staff spend performing other duties such as housekeeping, food services or administration. The review also found that not all health authorities were counting the co-located private beds in the calculation of delivered care hours and some health authorities used occupancy rates of less than 100% to calculate delivered care hours.

Overall, the contracted care sector generated $1.4 billion in revenue, of which $1.3 billion came from the publicly funded per diem. The sector spent 97% of its revenues generating a 3% ($37 million) profit/surplus. The biggest expenditure was for staffing at 72%, with the majority spent on direct care. The second largest expenditure was building costs at 15% ($209 million of expenditures).

The review found, however, that expenditures were not evenly distributed across all care homes and that there was a pattern of significant differences between the for-profit and not-for-profit sectors. The review examined these differences.

The public funding and funded direct care hour amounts were almost proportionately identical between the sectors. The for-profit sector was found however to produce significantly more revenue from co-located private beds than the not-for-profit sector ($59 million versus $5 million).

While the review found differences in revenue were limited to co-located private beds, the review found very significant differences in several expenditures and these include:

- The not-for-profit sector spends 59% of its revenue on direct care compared to 49% in the for-profit sector; this equals almost $10,000 or 24% more per resident, per year spent on care in the not-for-profit sector.

- The for-profit sector failed to deliver 207,000 hours of funded care and the not-for-profit sector provided 80,000 more hours of direct care than they were funded to deliver.

- The for-profit sector generated 12 times the amount of profit/surplus generated by the not-for-profit sector ($34.4 million versus $2.8 million)

- The for-profit sector had high building expenses at 20% of revenues compared to the not-for-profit sector at 9%.

- There were 18 care homes with an annual profit in excess of $1 million and all but one was in the for-profit sector. These 18 care homes also expensed $23 million in capital building costs.

- The not-for-profit sector may not be receiving adequate compensation for its building capital given its low rate of both capital building costs and profit/surplus.

- The for-profit sector spends an average of 17% less per worked hour, and wages paid to care aide staff in the for-profit sector can be as much as 28% below the industry standard.

The report highlights concern for fairness and equity between the for-profit and not-for-profit sectors in addition to the issues related to the accuracy of direct care hour reporting and the impact of low wages on the recruitment and retention of care staff. The report produced five recommendations to address the issues raised in the review.

INTRODUCTION

On any given day in British Columbia, there are over 27,000 seniors living in one of 293 publicly funded long-term care homes.

One hundred and eighty-two, or 62%, of these care homes are operated by private sector contractors that are a combination of for-profit businesses and not-for-profit societies[i]. In B.C., the contracted long-term care sector is a $1.4 billion per year business, making it one of the largest financial transactions between government and the private sector. Given the magnitude of the public expenditure and the vulnerability of the population served, it is reasonable to ask whether sufficient financial oversight is in place to ensure that B.C. seniors are receiving the best possible care for the money invested.

For the most part, those who operate care homes in B.C.—whether they are health authorities, for-profit companies or not-for-profit societies—want to provide the best possible experience for their residents. However, it must be acknowledged that, for many operators, the long-term care home is also a business. For-profit care homes, by the nature of their business, expect to demonstrate a profit/surplus; this underlying fact sets in motion incentives that may, at times, conflict with the best interests of the resident. For this reason, it is important that those who regulate and oversee publicly funded care homes ensure that care

and service standards are met, and contracted care homes spend the public's money in areas that will have the biggest positive impact on those who live there. The right financial incentives combined with robust and transparent oversight can allow contracting with the for-profit and not-for-profit sector to be an effective and good value-for-money method of providing public long-term care. In order to ensure this objective is achieved, we need a funding and oversight model that provides:

- appropriate and targeted financial incentives that result in the best possible care for residents;
- a robust, open and transparent process to monitor and report on how care homes are spending the money they receive; and
- a timely, effective, and transparent response to address care homes that do not deliver the quality of care that is required by contract language and/or regulation.

This review demonstrates the current system has some of the required elements but is lacking in others. However, working together, contracted care home providers and health authorities can build on the current system, make it better, and improve the lives of many residents along the way.

CONTEXT

Currently in B.C., 38% of care homes are owned-and-operated by health authorities, with the remaining 62% of care homes and 67% of beds owned-and-operated by contracted providers[ii]. The contracted sector is divided evenly between for-profit companies and not-for-profit societies.

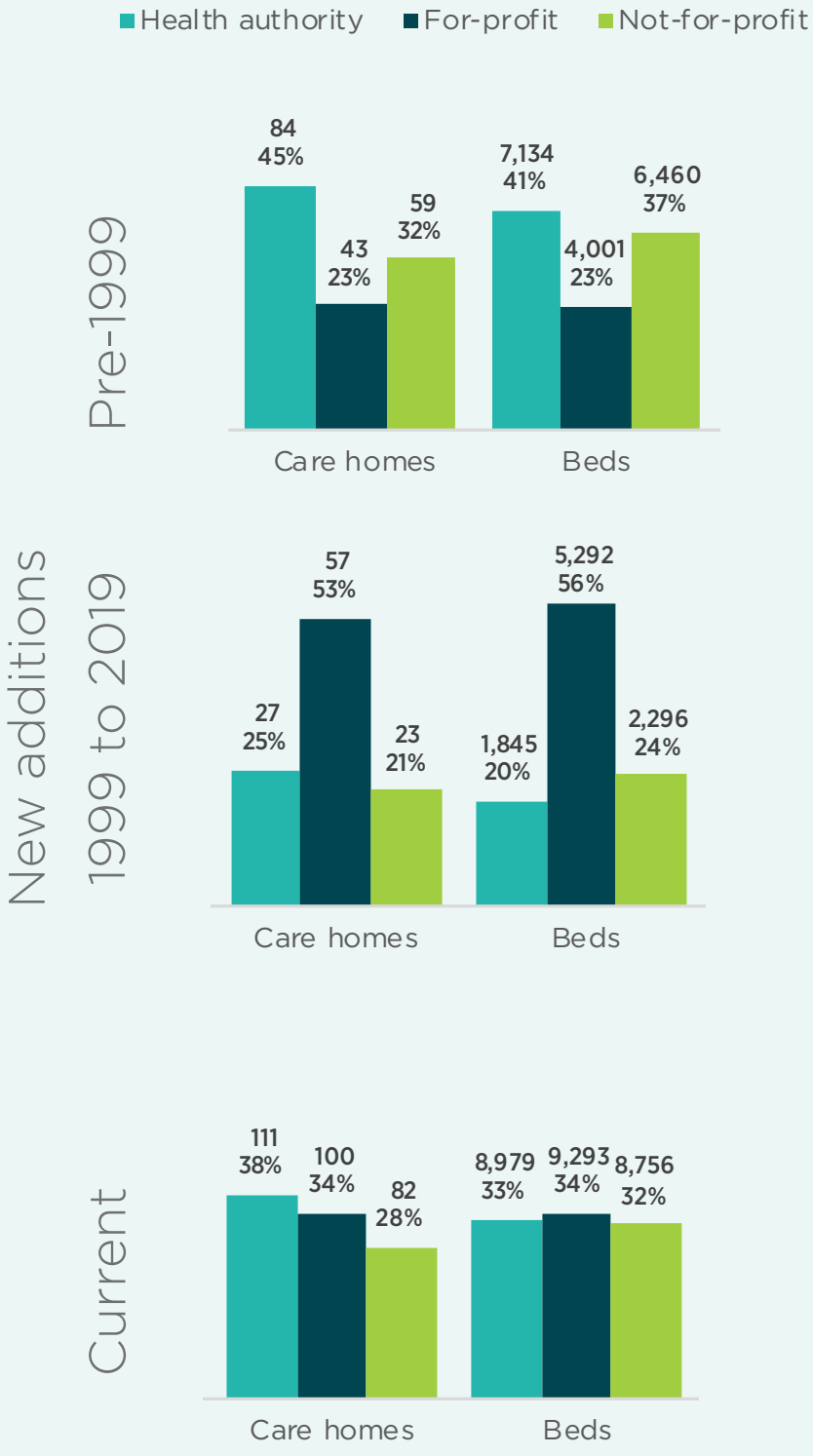
Contracted care home providers have been selected through a variety of means. Some were chosen through an open, competitive process based on a health authority issuing a Request for Proposal (RFP) for interested parties to bid. Some operators were selected through a non-competitive process where a health authority, through an internal process, chose a specific operator to provide subsidized long-term care beds (usually for unique care requirements or a specific location). Others were part of the block of care homes that opted in to the public system in the late 1970s and early 1980s[iii].

Approximately 38% of care homes and 36% of public beds have been built in the last 20 years[iv]. During this time, there was a shift in the distribution of ownership type in the long-term care sector. Prior to 1999:

- 45% of care homes were owned and operated by health authorities;
- 33% were owned and operated by not-for-profit societies; and
- 23% were operated by for-profit companies.

During the period of 1999 to 2019, these numbers shifted as an additional 107 new care homes with 9,433 new public beds were added to the long-term care system in B.C. resulting in a decreased share of care homes owned and operated by health authorities and not-for-profit societies and an increase in the share of care homes owned and operated by the for-profit sector.

Care homes and beds over time



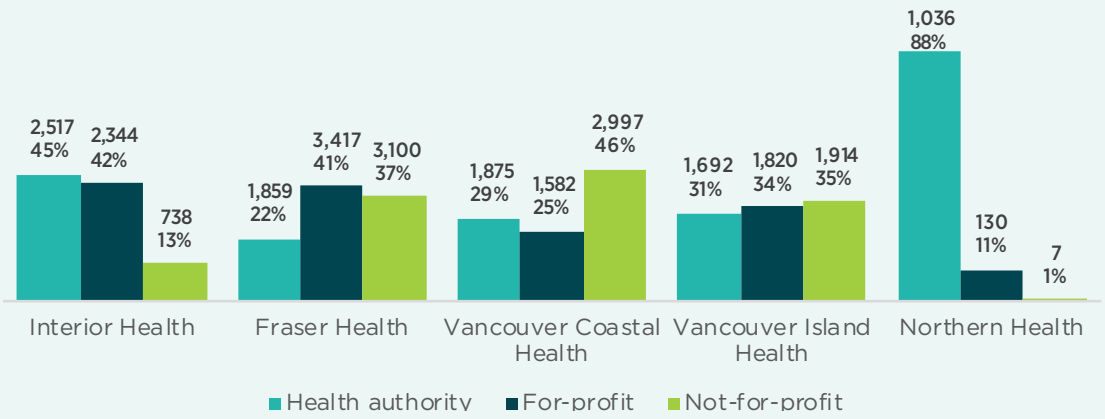
The current overall complement of long-term care homes by ownership type is[v]:

- 38% owned and operated by regional health authorities;
- 34% owned and operated by for-profit companies; and
- 28% owned and operated by not-for-profit societies.

However, the current mix of long-term care home ownership is not consistent across all health authorities. Northern Health Authority's care homes are almost exclusively owned-and-operated by Northern Health. Only two care homes are operated by contractors, leaving 92% of care homes in the region owned and operated by the health authority.

Of the remaining four health authorities, Interior Health has the most even balance between health authority owned-and-operated and contracted care homes, although its contracted sector has the highest proportion of for-profit operators. Fraser Health directly owns and operates less than a quarter of its long-term care beds but has a more even balance between those operated by the for-profit sector and those operated by the not-for-profit sector. Vancouver Coastal has almost three-quarters of its beds owned and operated by a contracted provider and it has the highest proportion of contracted beds operated by the not-for-profit sector.

Beds by operator type across B.C.



Current Funding Framework

Health authority funding for contracted care homes to provide long-term care services is based on a business model of block funding. The health authority provides a care home operator with a total fixed amount of money for the year and assumes the operator will allocate those funds within its care home to achieve the deliverables set out in the health authority contract for services. The block funding amount is unique to each care home and it is determined through individual negotiations between a health authority and each operator. Within this framework, health authorities specify the number of direct care hours an operator is expected to deliver, and operators are funded a specific amount of money through their block funding to deliver these hours.

Health authorities report their block funding as a per diem. The per diem is calculated by dividing the total block funding by the number of beds in a care home and then further dividing that by 365 days. This produces a number that represents the amount of daily funding for each bed. Expressing the funding as a per diem allows an accurate comparison of funding between operators by recognizing and accounting for the variation in the number of beds operated by care homes. Given that contracted care homes are expected to deliver the same complex care services to similar types of residents, one would expect to find that per diems between care homes are similar. Some minor variation would be expected to exist as issues of scale, location, the age of the building, and delivery of specialized services would impact the per diem in different care homes.

The Office of the Seniors Advocate (OSA) first reported on care home per diems in our 2017/18 release of the *British Columbia Long-Term Care Facilities Quick Facts Directory* and significant variations in care home per diems were immediately evident (ranging from $171 to $282). The OSA sought to understand the underlying reason for the vastness of these differences given they are greater than issues related to scale, location, building age, and specialized services would support. This work triggered questions about the systems that are in place to monitor care home expenditures in general, which in turn led to the analysis of existing funding formulas and financial oversight that has resulted in this report.

OUR REVIEW

All contracted long-term care home operators that receive annual per diem funding from a health authority have a legal contract with their respective health authority. About half of the care homes use their health authority's most recent standardized form of contract. This form is the same within each heath authority but is different between health authorities. The other half of care homes have contracts that are unique to their particular care home in terms of the language and structure of the contract. Almost all contracts, whether standard form or unique, have multiple attachments (schedules) that are again similar within a health authority but different between health authorities. Notwithstanding these differences, almost all contracts refer to the requirement of operators to deliver services that meet licensing and regulation standards and to comply with other legal obligations. While almost all contracts refer to care services, the specificity used to describe these services varies greatly. Almost all contracts contain language related to funding that allows a health authority to unilaterally set funding levels and none identify any specific amount. Most contracts identify notice periods that allow either the operator or health authority to terminate the contract without cause and provides the health authority with the ability to terminate the contract with cause on a shorter notice period.

The reason for the variety of contracts is historical. Most care homes built in the last 20 years have been built in response to an open, competitive procurement process managed by BC Bid on behalf of a health authority. These care homes use more standardized and detailed contract language. Care homes built prior to 1999 were built and funded before the existence of the five regional health authorities. A few of these care home operators have transitioned to a standard contract over time but many have not. There have been past attempts by government and the contracted sector to produce a standard long-term care contract for the Province; however, these efforts have been unsuccessful.

Contracted care homes are required to provide their health authority with annual audited financial statements[vi]. These statements are available to the public if the care home is operated by a not-for-profit society, but for-profit operators are not obliged to make their audited financial statements available to the public. The OSA reviewed the audited financial statements for most contracted care home operators (both not-for-profit and for-profit) for the fiscal years 2016/17 and 2017/18. While all audited financial statements conform to generally accepted accounting principles (GAAP), they have slightly different formats (hence, details differed) depending on the auditing firm retained. Some of the statements for chains (67% of care homes are part of a chain of two or more care homes[vii]) aggregate the chain's multiple care homes together into a single statement. These factors combine to make a comparative analysis of the audited financial statements very difficult. In addition, while an important aspect of overall due diligence, the audited financial statements lack the needed detail (as this is not their designed purpose) to meaningfully inform health authorities and the public on an individual care home's spending on direct care or other potential quality initiatives.

In addition to the annual audited financial statements, health authorities do require a more detailed financial reporting from each care home on a quarterly or semi-annual basis, through reports we will refer to as Expense Reports. These reports detail an operator's expenditures (and, in three of four health authorities, revenues) that can provide meaningful information on how a care home is spending the money it receives. The Expense Reports are prepared directly by the care home operator and are not audited by a third party. Each health authority uses a different template; however, the template is consistent for all care homes within a given health authority.

Notwithstanding that Expense Reports are consistent within a single health authority, there are significant differences between health authorities in the type of financial information contracted care home providers are required to submit. Examples of these differences include:

- not all health authorities require operators to report revenues, with some requiring only expenses;

- not all health authorities require operators to report revenue and expenses for co-located private-pay beds;

- some health authorities allow operators to expense both mortgage principal and interest while others allow only the interest;
- some health authorities report rent and mortgage interest together;
- some health authorities require paid hours as well as worked hours to be reported, while others require only worked hours;
- details on compensation costs vary between health authorities both in terms of wages and benefits and cost allocations outside of direct care;
- specific details on what services are subcontracted and to whom vary greatly between health authorities; and
- expenses for head office allocation and/or management fees and administration are treated differently both within and between health authorities and they have little to no detail on the expenses covered.

Despite these differences, the Expense Reports are the most detailed and presumably accurate accounting we have of how care homes are spending the public dollars they receive.

The OSA compared two years of Expense Reports to ensure data quality at the provincial and health authority level and found no material differences between the two years. Northern Health was excluded from the review because with only two contracted care homes (137 public beds and 14 co-located private beds), there is a risk the individual care home could be identified if data were presented at the health authority level.

The OSA examined Expense Reports for a total of 174 care homes covering over 95% of publicly subsidized beds in the contracted long-term care sector. In addition to Northern Health, the most notable exclusion is the five care homes (609 beds) operated by Providence Health Care, which receives global funding for all five care homes and does not report separately for each care home.

A review of the Expense Reports reinforced the finding of significant variations in funding that are reflected in the per diem rates reported in the *British Columbia Long-Term Care Facilities Quick Facts Directory*. The reason for these differences is less clear; however, an examination of the history of the sector in combination with the incremental approach that led to the creation of our current five regional health authorities offers some insight. Those care homes built prior to 1999 for the most part predate the current health authorities and the current procurement process. Their funding developed in a piecemeal fashion and many were simply rolled in with the wave of not-for-profit and for-profit care homes that opted into the public long-term system when it was created in the 1970s. The period from 1999 to 2019 employed a Request for Proposal (RFP) process to price-seek (as opposed to price-set) in the purchase of new long-term care beds. RFPs invited operators to effectively put forward (bid) the per diem amount they needed in order to deliver the required care beds. Each RFP call would produce a different per diem rate and this rate was then used to establish what would become the block funding for that particular care home. Currently, there is as much as a 49% difference in the per diem rates.

Differences in per diems are reinforced by the current approach to annual funding, which is to effectively roll over the previous year's funding with an across the board funding lift to address increases in wages, supplies, utilities, taxes and other cost pressures. Generally, this is the same per centage for all care homes within a health authority, with each health authority determining its own annual lift.

The challenge of this funding framework is that it will provide the care home with an annual profit/surplus of $1 million with the same relative annual funding lift as the care home with a loss/deficit of $100,000. This result is further compounded by the application of the per centage increase to different base amounts, thereby cementing the funding inequities in perpetuity.

REVENUES AND EXPENDITURES

Care home revenue can be allocated to one of four main sources:

- **Heath authority grant funding** This is the amount of money a care home receives directly from the health authority. This amount varies depending on the negotiated funding between the care home and the health authority and the amount collected from each resident (this varies based on the resident's income). Together the health authority funding and the residents' contributions create the block funding from which the per diem is calculated. Because residents' incomes will vary over time, the relative proportion derived from grant funding and client contributions will fluctuate.

- **Client contribution** Every resident will contribute to the cost of their long-term care. The amount of contribution is based on income. Residents are charged 80% of their after-tax income to a maximum of $3,278.80 (2018)[viii]. Notwithstanding the 80% rule, residents must be left with at least $325 per month after the client contribution has been deducted from their income and this may result in very low-income seniors paying less than 80% of their income.

- **Private beds** Just over half of the contracted care homes have private-pay beds co-located in the same care home as subsidized public beds. These private beds share the same care staff and common amenities, such as dining rooms, with the residents in public beds.

- **Other sources of income** Care homes can create revenue from a variety of ancillary services and functions. These activities can include fundraisers, payments from third parties for out patient services such as activation therapy or bathing, additional charges to residents for services and supplies not covered by the per diem, and commercial activities such as room rentals.

There are five broad categories that capture the expenditures of care homes:

- **Compensation for direct care staff** This captures the wages and benefits for staff (directly employed or subcontracted) who provide direct care to residents. All health authorities define direct care hours to include Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Health Care Aides (HCAs) and allied health disciplines (e.g., occupational therapists, physical therapists, speech therapists). There are some minor differences between health authorities in terms of the activities allowed within the definition of allied health (for example, pastoral care, music therapy and work by activity aides are included in some health authorities, but the impact is so small as to be immaterial to the overall numbers). In aggregate, 67% of direct care is provided by HCAs, 17% by LPNs, 8% by RNs, and 8% by allied health disciplines.

- **Compensation for non-direct care staff** This category captures all remaining staff who provide non-direct care services. Examples of staff included in this would be those who prepare and serve food, clean the rooms, maintain the building and grounds, work in payroll, management, and senior executives. Between "compensation for direct care" and "compensation for non-direct care staff," the total payroll for the care home is captured.

- **Building expenses** This category includes capital items such as mortgage costs depreciation/replacement reserves, major building capital expenditures, minor repairs and maintenance.

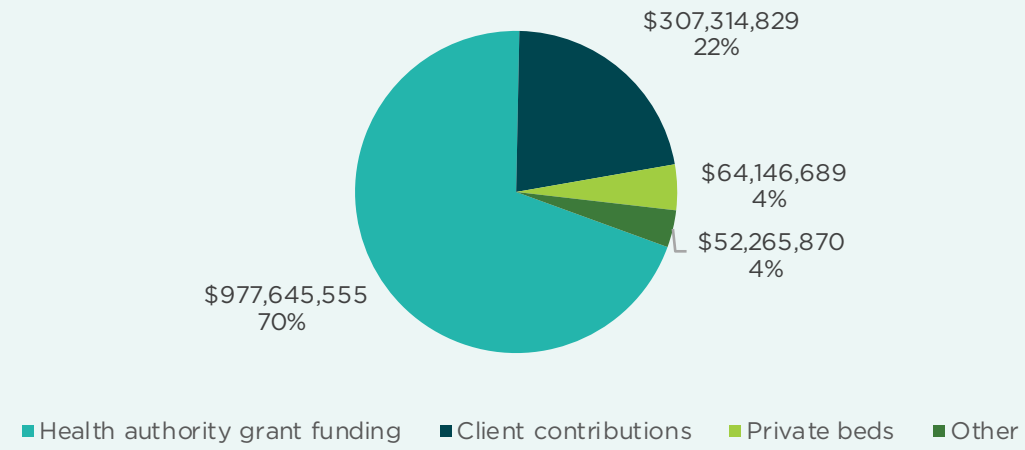
- **Supplies/other** This category captures all other expenditures. Supplies such as food (but not the labour to prepare and serve), incontinence pads, and equipment such as wheelchairs are some examples. In addition, various administrative non-wage expenditures, such as head office allocation, insurance and industry association dues are captured here. Any expense not captured in the above-three categories is captured here.

- **Profit/surplus** This is the amount of revenue that remains once all expenses have been subtracted. In the for-profit sector this is generally referred to as profit and in the not-for-profit sector this is generally referred to as surplus.

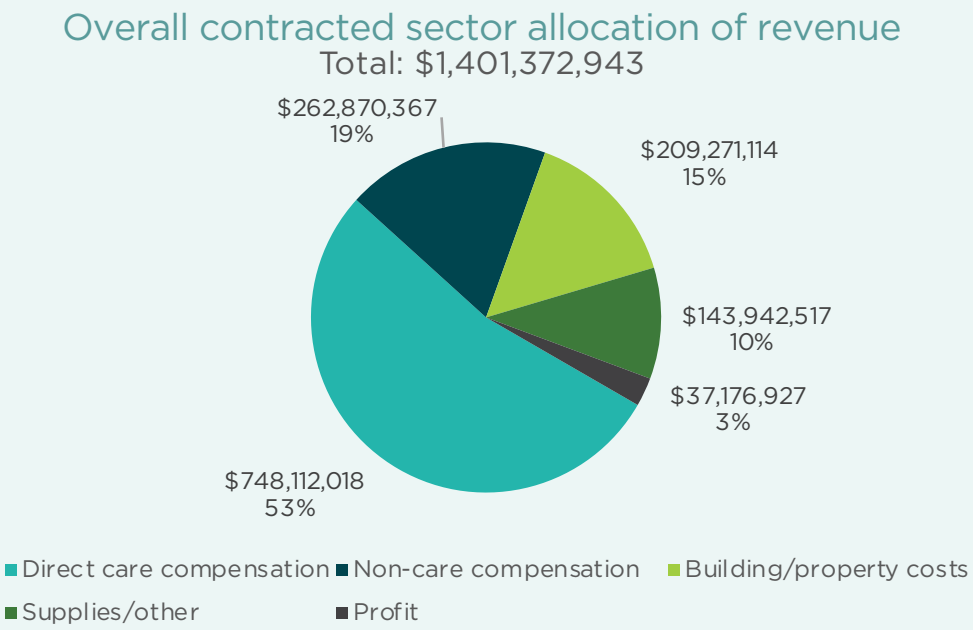
Overall, in 2017/18, contracted care homes generated $1.4 billion in revenue. The majority of this ($1.3 billion) comes from the combination of health authority funding and client contributions, which are collectively referred to as the per diem. Income from co-located private-pay beds was 4% of revenue and another 4% was found from sources of revenue such as charges to residents for services not covered by the health authority, commercial rentals, fund raising and gaming revenue.

Overall contracted sector revenue sources

Total: $1,401,372,943



Together, contracted care homes spent 97% of revenues on various and sundry expenses and produced a self-reported profit/surplus[ix] of just over $37 million.



Most of the expenses are directed at paying staff, with most going to direct care staff. After staffing costs, the next largest expenditure is for buildings, followed by supplies and, lastly, profit/surplus.

However, revenues, expenditures and profit/surplus are not evenly distributed across all care homes.

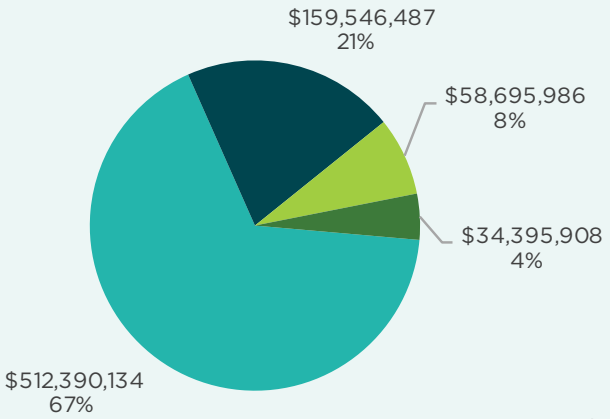
Revenues generated by private co-located beds range from 0% to 60%. The amount of revenue spent on direct care for residents ranges from 40% to 70%. Building expenses ranged from 2% to 38% of expenditures. Overall, we found there are care homes with high profit/surplus and care homes that produce a deficit.

We looked for a pattern that would explain the type of revenue and expenditure variations found given their lack of correlation to per diem rates. The most pronounced pattern that produced meaningful differences was whether a contracted care home was owned and operated by a for-profit company or by a not-for-profit society.

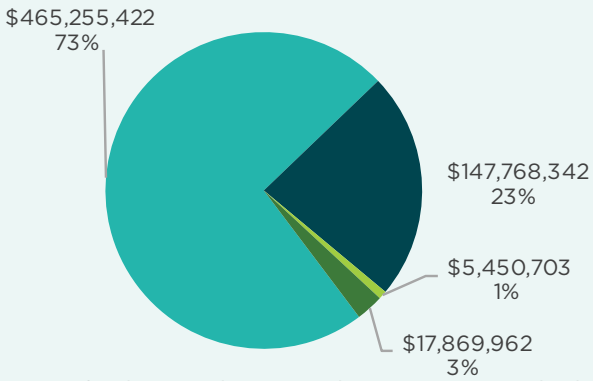
For revenue, the major difference is the amount of revenue produced from co-located private beds. The for-profit operators generated 8% of revenue ($59 million) from private beds versus the not- for-profit sector where only 1% ($5 million) was generated through private beds. This is to be expected given that 90% of the co-located private beds are in the for-profit sector.

Revenue

For-profit revenue sources
Total: $765,028,514



Not-for-profit revenue sources
Total: $636,344,429

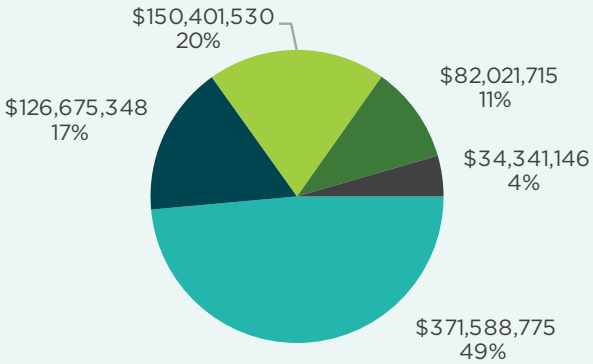


Health authority grant funding | Client contributions | Private beds | Other

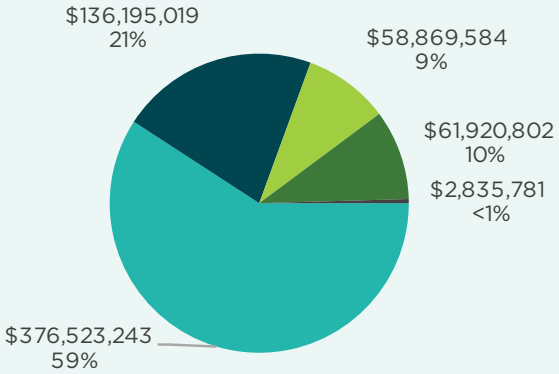
On the expense side, we find that not-for-profit operators spent 59% of their revenue on direct care versus 49% in the for-profit sector.

Expenses

For-profit allocation of revenue
Total:$765,028,514



Not-for-profit allocation of revenue
Total: $636,344,429



Direct care compensation | Non-care compensation | Building/property costs | Supplies/other | Profit

The for-profit sector allocates more than twice as much of their revenue to fund building costs as does the not-for-profit sector (20% compared to 9%), with most of this difference attributed to mortgage costs and depreciation.

The for-profit sector also allocated 12 times the amount to profit/surplus that the not-for-profit sector allocated ($34.4 million versus $2.8 million).

The degree to which these differences exist given almost identical levels of public funding raises a number of questions; fairness and equity amongst the operators is among them. However, for the OSA, the most significant issue raised by this review is the disproportionately lower spending on direct care compensation in the for-profit sector versus the not-for-profit sector.

HOW WE CALCULATE AND FUND DIRECT CARE COSTS

In 2016/17, the OSA conducted a survey of all publicly funded care homes throughout B.C. and heard from over 20,000 residents and family members one unifying message: "we need more staff and we need more consistent staff"[x]. Results from the survey were released following a public commitment from the Province to raise care standards to, on average, 3.36 hours of care per resident, per day. Each year, the OSA reports on the funded direct care hours for each care home and indeed we have seen improvement. However, this only reports on the hours that are funded. We do not have standardized monitoring and public reporting of the number of direct care hours that are delivered. Nor do we report on how the money that is allocated to provide these direct care hours is spent by the care home operator.

The funding to care homes for direct care hours is based on two numbers. The first is the number of direct care hours that each resident is to receive, on average, each day in that particular care home. The second number is the cost to deliver each of those hours of care. The current approach assigns a dollar value to the cost of a direct care hour. This is called the "cost per worked hour."

All health authorities calculate a cost per worked hour for each of the various classifications of direct care jobs: RN, LPN, HCA, and various professional and non-professional allied health disciplines. The cost per worked hour calculation starts with the wage rate, adds the cost of benefits, adds the cost of replacing staff when they are sick, on vacation or other paid leaves such as training, and factors in costs for overtime and statutory holidays. In three of four health authorities, this calculation is based on the wage rate and benefits in the HEABC Health Services and Support Facilities Collective Agreement (sometimes referred to as the Master Collective Agreement or the "industry standard") and the allowance for replacement hours and overtime is generally experience rated from employers who fully participate in the Master Collective Agreement. One health authority uses a lower assumed rate for benefits and relief costs, resulting in their relatively lower cost per worked hour funding.

For the 2017/18 fiscal year used in this review, the following cost per worked hour for direct care funded rates[xi] were:

	RN	LPN	HCA	PROFESSIONAL ALLIED HEALTH	NON-PROFESSIONAL ALLIED HEALTH
HA A	$67.66	$41.52	$32.09	$44.17	$32.73
HA B	$71.89	$46.14	$38.40	$62.69	$41.46
HA C	$71.84	$46.68	$39.39	$66.15	$39.50
HA D	$76.28	$46.98	$39.08	$62.71	$37.31

A typical health authority would calculate direct care hour funding by taking the above wage rates and weighting them to the expected per centage of hours to be delivered by each job classification to produce one blended cost per worked hour rate and then apply that blended rate to the expected hours of care to be delivered multiplied by the number of beds. The amount produced is the funding envelope for direct care that is folded into the block funding.

To illustrate, we will use a hypothetical care home with 100 beds and a hypothetical health authority with a blended cost per worked hour rate of $44.40/hour. The health authority would take $44.40 and multiply by the number of care hours the care home is expected deliver. In this case, we will assume 3.36 and then multiply that by the number of beds (100), and again multiply by 365 days. This creates the direct care funding which rolls into the block funding and becomes part of the per diem.

EXAMPLE

$44.40 X 3.36 = $149.18 X 100= $14,918 X 365 = $5,445,216

Total Funding = $8,066,500 = $221 per diem

Direct care funding is $149.18 or 67% of this hypothetical care home per diem

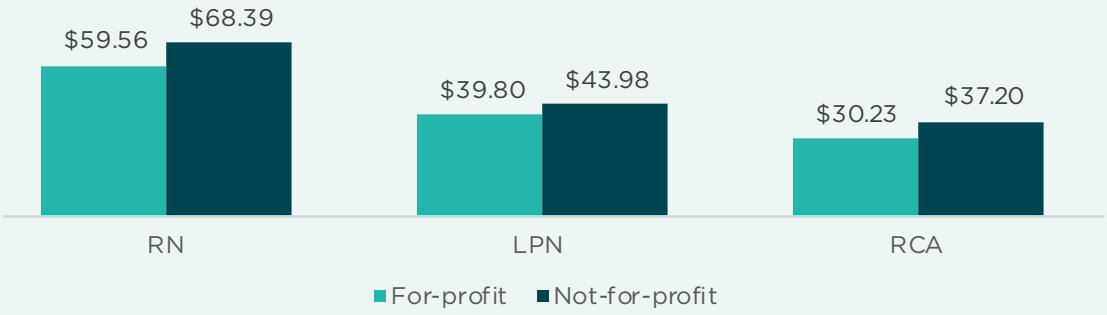
In terms of the number of funded direct care hours, there was almost no difference between the for-profit and not-for-profit sector. The not-for-profit sector was funded an average of 3.03 direct care hours, a 1% difference from the 3.00 average for funded direct care hours in the for-profit sector. This is somewhat reflected in the per diem funding, with the for-profit sector receiving an average per diem of $211.33 and the not-for-profit sector receiving an average per diem of $212.47.

The per worked hour funding provided to deliver direct care hours was the same for all contracted care homes within each health authority, regardless of whether they were not-for-profit or for-profit.

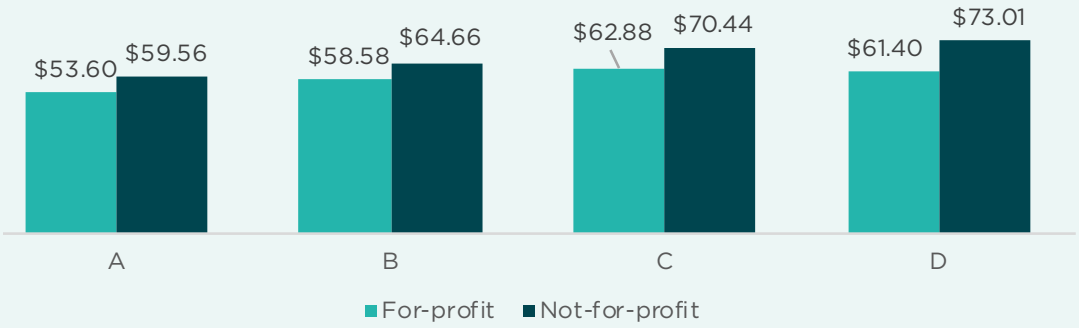
Although there is only a 1% difference in the average number of funded care hours between the for-profit and not-for-profit sectors and a similar difference in the average per diem, we find the not-for-profit sector spent 24% more (almost $10,000) per resident, per year.

The difference in direct care expenditures is not materially related to differences in funding, which leaves differences in costs as the next most logical explanation. This would mean that, all things being equal, it is costing the not-for-profit sector more money than it is costing the for-profit sector to deliver the same level of care. The main cost driver for direct care is the amount an operator pays in wages and benefits to the direct care staff, which are referred to as the cost per worked hour. We analyzed the cost per worked hour between the for-profit and not-for-profit sectors to test for differences. We found the for-profit sector paid less per worked hour than the not-for-profit sector in each staffing classification. This pattern held within each health authority except in a single case (one health authority's for-profit care homes pay slightly more for LPNs than do their not-for-profit care homes).

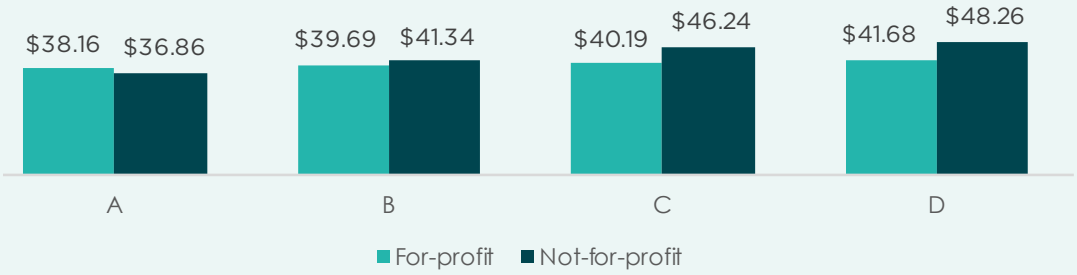
Average cost per worked hour



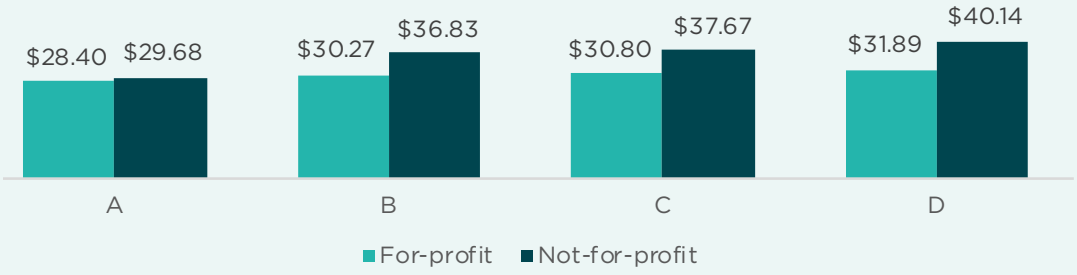
Registered Nurses - Average cost per worked hour



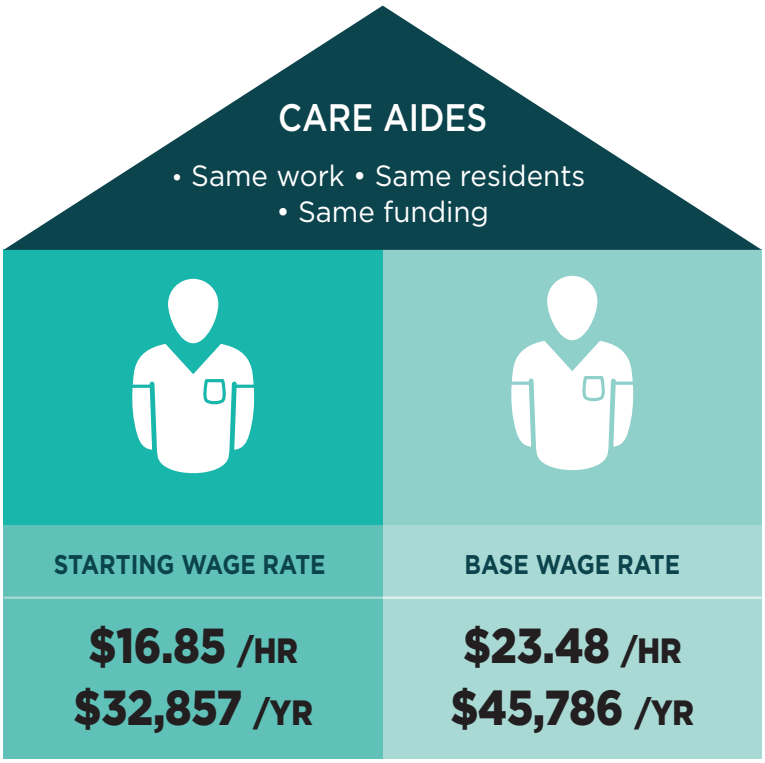
Licensed Practical Nurses - Average cost per worked hour



Health Care Aides - Average cost per worked hour



Within the average cost per worked hour, however, there is also a significant range, driven to a large extent by differences in base wage rates. In 2017/18, the industry standard base wage rate for a care aide was $23.48/hour[xii]. Some care aides were paid as much as 28% less based on the lowest confirmed wage rate of $16.85/hour[xiii], which was found in a for-profit care home.



It could be argued that for-profit care operators are doing exactly what they are expected to do...look for areas where they can be efficient and achieve cost savings. In this case, if an operator can find staff who will provide the same service for less cost, should they not be allowed to keep the money they have saved? In effect, the low wage operator has been more efficient at delivering direct care and if they are not rewarded for this, they will lose the incentive to be efficient. This is a compelling argument and is the guiding principal behind why governments engage

in a competitive process to contract with the private sector to produce and deliver public goods and services. The question in this case is whether the delivery of direct care hours in publicly funded long-term care homes is where we want operators to find efficiency based on lower wages given current labour market conditions.

For example, the current funding model could result in some care homes (those that pay lower wages and provide fewer benefits) attracting, on average, less experienced staff who will leave for a higher paying job as soon as one becomes available. This could leave the lower wage paying care home with less experienced staff, higher rates of staff turnover and a large pool of casual staff. More significantly, it could leave the lower wage paying care home unable to recruit enough staff to meet their care hour obligations. None of these situations is going to provide the staffing continuity residents and their family members are asking for and that public regulators and funders should be incentivizing operators to deliver.

The long-term care sector, like many sectors in British Columbia, is currently experiencing staffing challenges. Part of the challenge relates to the overall low unemployment rate in B.C., which is pushing up wages overall and putting more pressure on low and moderate wage jobs. Within the health care sector, research and evidence shows there is a relationship between paying industry standard wages and benefits and more successful recruitment and retention for staff, particularly care aides. The Health Employers Association of British Columbia maintains a human resource database[xiv] for those care homes that employ care aides through the master collective agreement (the majority of which are owned-and-operated by health authorities) and it shows that employers who fully participate in the wage and benefit scales of the master collective agreement see relatively high rates of overall retention and successful recruitment of new care aides.

HOW WE MONITOR DELIVERED CARE HOURS

In addition to whether care home operators are spending all of their direct care funding on direct care, there is the question of whether they are actually delivering the number of direct care hours they are funded to deliver.

An operator could spend all the direct care hour funding they received from the health authority yet fail to deliver the actual number of care hours they are funded to deliver. This could happen if an operator pays above industry standard wages and benefits and/or if the amount they pay for things such as training, overtime, and vacation/sick relief are excessive.

An operator could deliver all care hours that they were funded to deliver yet not spend all the money they received to deliver these required direct care hours. This can happen if the operator pays below industry standard wages and benefits, and/or has training, overtime, and vacation/sick relief costs that are very low.

An operator could fail to deliver the direct care hours required and not spend all the money that was provided to them to deliver these required direct care hours. This would happen if an operator either failed to fully staff the care home to the required level or did not replace some or all of the care staff when they were absent due to illness, vacation, training or other types of leave.

In the past few years, B.C. has paid significant attention to the number of direct care hours that care homes are funded to deliver. Much of this resulted from reports that highlighted the failure of health authorities to fund care homes to deliver the average of 3.36 hours of care per day per resident that is recommended in B.C. Ministry of Health Guidelines. Each year since 2015, the *British Columbia Long-Term Care Facilities Quick Facts Directory* reports on how many direct care hours each care home is funded to deliver. Reports show the number of funded care hours has been increasing over the last few years.

What is not reported is the number of funded care hours that are actually delivered by each care home. Part of the challenge to providing this information is the lack of a single cohesive approach to calculating the number of direct care hours delivered, although health authorities all use reported worked hours to equal an hour of delivered direct care.

Another challenge is whether the health authority includes co-located private pay beds in their calculation of delivered care hours. Some health authorities, it would appear, accept the argument put forward by operators that state they can deliver fewer hours of direct care to their co-located private beds without any impact on the hours of care for the public beds. We argue this is not logical.

For example, assume a care home is funded for 3.20 hours of direct care per resident per day and has 100 public beds and 10 private beds for a total of 110 beds. The operator creates one staffing plan for the entire 110 bed care home. When the operator is determining how many care staff they need, their calculation will be based on 3.20 hours of direct care for the 100 public beds and 2.0 hours per resident for the 10 private beds resulting in a staffing plan based on 3.09 hours per bed per day for the 110 beds. Of the 174 care homes within our review, 93 (53%) have private-pay beds co-located with publicly subsidized beds. There is a total of 1,501 co-located private beds and 90% of these are in for-profit care homes.

Some health authorities use a care home occupancy rate of less than 100% as the base for calculating delivered care hours. For example, if a care home has 100 beds and over the year there are sometimes vacant beds for a few days as the bed turns over to a new resident, this care home may experience 98% occupancy for the year. Some health authorities then apply the direct care hours to only 98 of the 100 beds. This means that on any day when the care home has 99 or 100 residents, the prescribed number of direct care hours are not delivered.

In addition to the above challenges, there is no verification of the accuracy of the reported *worked hours*, which is the measure used by all health authorities to equal a delivered care hour. Some health authorities do require operators to identify the number of paid hours and the number of worked hours. Paid hours should exceed worked hours by a margin of 15-20%. This will indicate the operator is reasonably providing replacement hours. For those health authorities who only require the reporting of worked hours, this analysis is not possible. While some health authorities report relief hours separately from worked hours, our review found a wide variation in the numbers and it was not clear how the health authority was monitoring the sufficiency of reported relief hours.

The financial information in the Expense Reports, which is relied upon to determine how many care hours are delivered, is self-reported by the care home and unaudited. This creates opportunities for potential miscalculation of worked hours for direct care.

If a care aide is on a training program or involved in orientation, they are working and they are paid, but they are not delivering direct care hours. If this time is recorded as a worked hour, it will be counted as a direct care hour delivered. Complications can also arise if care aides are pulled from direct care duties to perform other duties such as preparing and serving food or housekeeping. If they are classified as a care aide, all their hours, including those spent on non-direct care, could be counted as worked hours and could count as delivered direct care hours.

Similarly, nursing staff who are serving in administrative roles as well as providing direct care could potentially have all worked hours, including those spent on administrative duties, counted as direct care.

Notwithstanding its challenges, the current system is the only process used to verify the number of direct care hours each care home delivers and while it might overstate the actual number of delivered care hours it is not likely to understate the number of care hours that are delivered.

Using the current reporting, we sought to confirm the number of direct care hours delivered in 2017/18 relative to the number funded[xv]. There was a significant difference between for-profit providers and not-for-profit providers. For-profit care homes failed to deliver 207,000 hours of funded direct care hours while not-for-profit care homes over-delivered by providing an additional 80,000 hours of direct care beyond what they were funded to deliver. While the shortfall of 207,000 hours in the for-profit care homes represents only 2% of their funded hours, these hours would be enough to fully staff a 168-bed care home at 3.36 hours of direct care per resident, per day for one year.

CHALLENGES WITH BUILDING COSTS

In addition to a discrepancy between not-for-profit operators and for-profit operators in the amount allocated to direct care, there was also a significant difference between sectors in the amount allocated to building expenses.

Within the overall contracted sector, 15% of revenue ($209 million) is spent on buildings; however, only 9% of revenue is allocated to buildings in the not-for-profit sector and this more than doubles to 20% of revenue allocated to buildings in the for-profit sector.

While there is a common definition of direct care hours for all health authorities, the treatment of building costs varies between health authorities, particularly capital building costs.

The issues related to reported building costs arise from the following practices:

- some health authorities allow depreciation, mortgage interest, amortization, and replacement reserves to be expensed, while others allow mortgage principal but not depreciation;
- there is no uniform approach either within or between health authorities to set standard amortization periods for purposes of calculating depreciation or mortgage payments;
- some health authorities do not allow not-for-profit operators to expense depreciation, but it is allowed for for-profit operators, while both are allowed mortgage interest and replacement reserves;
- use of amortization appears random, and its application as an expense versus revenue is inconsistent between and within health authorities;

- there is no method to evaluate reported capital costs for buildings relative to the current value of the building;

- there is no method to uniformly address single sites with multiple buildings that mix public long-term care with private independent living and assisted living in terms of allocated joint costs and the financial impact, if any, of cross subsidization; and

- where rent is paid to the owner of the building where the owner is a related party, there is no documentation on how the rental amount was calculated or confirmation of who is the related party.

The physical building that is the care home and the land it sits on are an asset that is owned by the care home operator. This asset can be bought and sold and leveraged through a mortgage to raise capital. It is also an asset that has the potential to increase in value over time. The money to pay for this asset, for the most part, comes through the publicly funded per diem payment. When capital buildings costs such as mortgages and depreciation are funded it is a form of rent paid to the operator for the use of their building. Paying rent to an operator for the use of their building is reasonable and to be expected. However, the current funding system is not equitable across the contracted sector as a whole and may or may not reflect fair market value. This is apparent when we analyze the swings in building costs across the entire contracted sector that can range from 2% to 38% of overall expenses and we find care homes in both the for-profit and not-for-profit sector paying mortgage interest rates that are double the rates paid for public borrowing.

There are significant building cost differences between the for-profit and the not-for-profit sector. As the chart below illustrates, the for-profit sector is funded for much higher rates of building capital relative to the not-for-profit sector while also generating higher rates of profit/surplus. Normally, one would expect to find high funding of building capital to be offset by lower profit/surplus or low funding of building capital to be offset with a higher profit/surplus. In this case, we find the opposite situation.

These are annual per bed calculations:

	FOR-PROFIT	NOT-FOR-PROFIT
Mortgage interest	$5,270	$2,034
Mortgage principal	$3,149	$1,333
Depreciation	$4,477	$1,748
Replacement reserves	$296	$237
Profit/surplus	$3,399	$348

With no common approach on how to report and fund the capital expenditures in contracted long-term care, there is a lack of consistency across the province, a lack of fairness within the contracted sector between for-profit and not-for-profit operators, and an overall inability to determine if the public is receiving good value for their money.

In the United States of America, where public nursing homes are funded through the national Medicare program, we find cost of capital averaging about 8% of revenues in markets such as California[xvi]. This is significantly less than the 20% of revenue the B.C. for-profit sector allocates to building costs, although it is fairly consistent with allocations in the not-for-profit sector.

CHALLENGES WITH PROFIT/LOSS CALCULATIONS

When government contracted with the private sector to deliver long-term care services, it was reasonably expected by government that operators would, on average, collect more money than they spent and would retain this surplus as their profit. Contractual relationships between health authorities and operators were established with this good faith understanding.

It also possible that, while the not-for-profit sector does not exist for the purpose of creating profit, not-for-profits can also achieve a surplus of funds between what they receive to deliver public long-term care services and what it costs them to deliver these services.

There will obviously be a difference between how the for-profit sector and not-for-profit sector choose to spend their excess funds, but they should be treated equally in terms of funding, expenses and the ability to retain their surplus dollars. Our review found this was not always the case.

There are many ways in which profits/surpluses are generated by care home operators, with some more transparent than others. These differences can make it difficult sometimes to understand the true overall profit or surplus generated by a particular care home or chain of care homes.

While profit/surplus is the difference between revenue and expenses, what is counted as revenue and what is counted as an expense can impact how much profit/surplus a care home operator generates.

If a care home operator does not report income from their private co-located beds but reports some of the expenses related to those beds (for example, mortgage costs and/or depreciation for the building that houses the private beds), that care home will effectively have

understated their revenue, which will impact their reported profit/surplus. The operator may also generate profit from related businesses the care home operator owns that supply goods and/or services to their publicly funded care home. If this profit/surplus is not counted as part of the overall profits generated by the care home, the total profit/surplus generated by the operation of the care home could be understated.

In addition to issues with the clarity and transparency of revenue, a care home has many expenses that can be deducted where, it might be argued, they are not a cash expense, or they are funding equity within the business.

Capital building expenses

Operators reasonably need to be paid for the use of their care home. However, the current approach has no method to determine the fair market value that should be paid.

Instead, the current system funds a series of different capital building costs. What is funded varies greatly between health authorities and even within health authorities there is inconsistent treatment between operators.

Examples include:

- All health authorities allow mortgage payments as an expense. Some allow only interest as an expense and others allow interest and principal. There is no examination of the reasonableness of the total mortgage amount, the interest rate paid, the amortization period used to determine the mortgage payments or whether the mortgage has been advanced by a related party.

- Health authorities that allow only mortgage interest also allow depreciation expense. Depreciation is not a cash expense. It is an amount of money the operator effectively puts into a "savings account" and it sits on their balance sheet. Operators would be expected to use this account to pay for capital upgrades. However, there does not appear to be a systematic approach to ensure that operators are using their depreciation account to fund capital replacements and it is also not clear what happens to money in the depreciation account when an operator sells their care home to another operator.

Without a more uniform and disciplined approach to funding building capital we have no way to determine if the public is receiving good value for money.

Management fees/head office allocation/administration

Most health authorities allow operators to report lump sum payments labelled as head office allocation, management fee, or administration. There is no detail on what expenses these are intended to cover, and amounts can run into the hundreds of thousands of dollars. Our review found that some operators are reporting large management fees or head office allocations in addition to significant administrative expenses and some operators are using administration to capture interest expense paid to related parties. The lack of detail on these expenditures make it impossible to determine if they are appropriate, in part or in whole, as an expense.

Executive compensation

None of the health authorities require care home operators to report if company owners are also receiving a salary from the care home. A care home owner can pay him or herself a salary that would count as an expense under compensation. The income they receive as a salary would be in addition to the remuneration derived through any profits generated by the care home.

Contracts with related businesses

There is no requirement for care home operators to disclose if they have a financial interest or receive other types of financial remuneration from the companies with whom they subcontract for care services and other supplies. Currently, over one-third of care home operators contract with another company to provide some or all of their direct care and some care homes subcontract for other services such as grounds maintenance and administration. The amount paid to these subcontractors is generally reported as a lump sum with little to no detail or breakdown on the services purchased. It is possible for a care home operator to enjoy a profit/surplus from the related business they contract with in addition to the profit/surplus they generate from the care home.

Operators with multiple care homes

Most care homes are part of a chain, yet there is no system in place to examine the entire financial picture for the chain relative to the care homes they own and operate in B.C.

The 174 care homes reviewed for this report produce a pattern that speaks to inequities within the system between the for-profit and not-for-profit sectors. Within this pattern, however, there is great variation, which was one of the most significant findings. To provide a sense of the variation, we examined four care homes—two in the for-profit sector and two in the not-for-profit sector—to compare the experience of a larger sized care home and a medium sized care home. Here is what we found.

Large Care Home #1 – For-Profit

The care home reported:

Total revenue	$17,768,604
Total expenses	$15,807,574
Profit/loss	**$1,961,030**

In addition to paying for direct care staffing, food, housekeeping, plant services, and laundry, the care home was also paid for the following:

Mortgage principal and interest	$2,601,017
Maintenance and repairs	$542,067
Administrative expenses	$202,389
Audit/insurance/association dues	$114,373
Managers (support/food services, finance, etc.)	$202,479
Administrative support (book keeper, reception, etc.)	$407,354
Management fee	$446,040

This care home is not untypical of a larger care home in the for-profit sector. We see a large self-reported profit along with high capital expenses, and a management fee that is in addition to expenditures for management and administration.

Large Care Home #2 – Not-For-Profit

Total revenue	$18,186,645
Total expense	$18,675,419
Surplus/deficit	**($486,774)**

In addition to paying for the same items as outlined for Care Home #1, this care home reported the following expenses:

Mortgage interest and principal	$99,999
CMHC Replacement Reserves	$73,826
Maintenance and repairs	$231,896
Administrative expenses	$370,148
Audit/insurance/association dues	$80,217
Managers (support/food services, finance, etc.)	$447,867
Administrative support (bookkeeper, reception etc.)	$796,332

This care home, which is a not-for-profit, has generated a deficit of $486,774. They have been paid only $99,999 toward their mortgage, and $73,826 to their CMHC Replacement Reserves for a total capital building cost of $173,825.

While they have not claimed any management fees, they have robust administration expenses that appear related to wage rates versus FTEs[xvii]. More significantly, their revenue includes a transfer of almost $1 million dollars from their charitable foundation, without which they their deficit would have risen to almost $1.5 million

In 2017/18, there were 18 care homes reporting over $1 million dollars in annual profit/surplus, with a total of $28 million in reported profit/surplus amongst them. In addition to their profit/surplus, these operators were funded $23 million in capital costs. All but one of these care homes was in the for-profit sector.

Mid-Size Care Home #3 – For-Profit

Total revenue	$7,826,486
Total expenses	$7,063,767
Profit/loss	**$762,719**

In addition to paying for staffing, food, housekeeping, and laundry, this care home was also paid for the following:

Mortgage principal	$519,961
Mortgage interest	$695,819
Capital replacement reserves	$52,000
Other capital expenditures	$195,654
Administrative costs	$463,879
Management fee	$211,400

Here again we see an example of a healthy self-reported profit with relatively high funded capital building costs. This operator reported $463,879 for administrative costs including auditing and an additional $211,400 management fee. This particular care home had additional private beds for which there was no reported net revenue and it is part of a chain of care homes, all of which claim varying amounts for a management fee.

Mid-Size Care Home #4 – Not-For-Profit

Total revenue	$7,304,074
Total expenses	$7,327,260
Surplus/deficit	**($23,186)**

In addition to paying for care services, food, housekeeping, and maintenance, the following was charged:

Mortgage interest	$0
Depreciation	$0
Amortization (capital building)	$0
Administration	$454,746
Head office allocation	$216,205

Here we see an example of a care home typically found in the not-for-profit sector. There is a small profit/surplus or deficit with a low to non-existent payment for capital. While this particular care did claim head office allocation expense, they still incurred a deficit.

While there are many challenges with the self reported profit/surplus on the Expense Reports, they are the only measure we currently have to measure the profit/surplus generated within the contracted long-term care sector. While current Expense Reports may understate true profit/surplus, they do not lend themselves to overstating them.

Using self reported profits/surplus from the Expense Reports, 66% of care homes reported a profit or surplus with an overall net reported profit of $37 million. The proportion of care homes reporting a profit/surplus was almost identical between the for-profit and not-for-profit sectors. However, there was a significant difference in the amount of profit/surplus reported. The for-profit sector generated 92% of the overall profit at $34.4 million, while the not-for-profit sector generated $2.8 million in surplus.

The profit/surplus produced by the 66% of care homes that report profit/surplus is $59 million. However, the amount of profit/surplus reported varies greatly between care homes in the for-profit sector and care homes in the not-for-profit sector.

	FOR-PROFIT	NOT-FOR-PROFIT
Care homes showing profit	69	45
Total profit among these care homes	$49,528,790	$9,024,337
Total beds (incl. co-located private beds)	6,985	4,438
Minimum profit/surplus	$7,446	$4,494
Maximum profit/surplus	$2,750,976	$1,431,332
Average profit/surplus	$717,809	$200,541
Average profit/surplus per bed	$7,091	$2,033

Other than being operated by a for-profit business versus a not-for-profit society, the strongest driver generating profit is wages and benefits paid to staff. The review did not find strong correlations between profit and funded care hours or per diems in general. What the review did highlight, however, were several examples of care homes with high profits and above-average per diems and care homes with smaller profits or deficits and below-average per diems. The average per diem in the sector is $211.87 ($211.33 in the for-profit sector and $212.47 in the not-for-profit sector). Measured against this, we found the following example:

Above-average per diem

	PROFIT	PER DIEM
Care Home A	$1,262,238	$220
Care Home B	$2,098,264	$231
Care Home C	$1,262,257	$227
Care Home D	$2,750,976	$232

Below-average per diem

	PROFIT	PER DIEM
Care Home A	$38,345	$187
Care Home B	($23,186)	$198
Care Home C	($128,422)	$191
Care Home D	($145,030)	$192

The care homes that received above-average per diems were in the for-profit sector and the care homes that received below-average per diems were in the not-for-profit sector.

CONCLUSION AND RECOMMENDATIONS

This review provides the first in-depth look at how the contracted long-term care sector in B.C. is spending the public money it receives, and we can see there are shortcomings in our current funding and monitoring approach.

Current practices for funding in long-term care have evolved over time along with an expansion of the contracted sector. Health authorities are not experts in the management of large private sector contracts; they are experts in the delivery of care. To some extent, the challenges we see with our current funding and reporting system reflects this. Contracted long-term care operators, both not-for-profit and for-profit, have followed the rules and guidelines that have been established. However, the financial incentives of our current system may be producing some unintended consequences and our funding and financial reporting is disjointed, unfair to the not-for-profit sector, and unaccountable to the public. It is not clear that we have a sufficiently firm grip on an annual expenditure of $1.3 billion of taxpayers' money. It is the job of regulators and funders to put in place monitoring and reporting systems based on a "trust but verify" relationship.

There will be some challenging and difficult work ahead. We need to develop a funding model that recognizes the legitimate financial needs of all operators, regardless of whether they are for-profit or not-for-profit, and that puts the interests of residents first. Those who live in our publicly funded long-term care homes and their family members need the confidence to know that, regardless of who is running their care home, consistent and sufficient staff will be there to meet their needs.

The taxpayer also needs to have confidence the annual investment of $1.3 billion of public money invested in the contracted long-term care sector is spent in a way that is resident-focused, that is fair and equitable, and that represents good value.

However challenging and difficult the conversations and negotiations will be, we must change from our current practice or the problems will only compound in the future as the need for long-term care beds increases.

The steps we need to take are outlined in the following recommendations.

1. Funding for direct care must be spent on direct care

We must remove the financial incentive for operators to do anything other than provide as many care hours as possible with the public money they receive to deliver direct care. If an operator can find staff who will work for lower wages than their funded rate, they should use their surplus funds to provide more hours of care or return the funding. Anything short of this will not provide operators with the incentives we need in today's labour market to ensure residents have consistent and sufficient care staff to meet their needs.

2. Monitoring for compliance with funded care hours must be more accurate

We need tighter standardized reporting for direct care hours. All beds need to be counted at 100% occupancy and we need to verify self-reported worked hours. Consideration needs to be given to regulation changes that will empower licensing to monitor staffing levels similar to the current regulatory and licensing practices in licensed day care.

3. Define profit

There are a number of reported expenses that may or may not be fair and appropriate. There needs to be a decision about how to treat building capital along with management fees, head office allocations, administrative expenses, and subcontracts with related parties. The decisions made need to be uniformly applied to all care homes in the province and need to transparently demonstrate value for money to the taxpayer.

4. Standardize reporting for all care homes throughout B.C.

We need to be collecting the same information, using the same calculations and the same measurements, for all care homes regardless of health authority and we should report this at the provincial level.

5. Revenues and expenditures for publicly funded care homes should be available to the public.

The public is entitled to know how their money is spent, in detail, and residents and families are entitled to know how many care hours are delivered by their care home.

ENDNOTES

i Source: Office of the Seniors Advocate – British Columbia Long-Term Care Facilities Quick Facts Directory (2017/18). Hereafter referred to as Quick Facts Directory.

ii ibid.

iii Source: Bainbridge, J. (1980). British Columbia's long-term care program: the first two years. *Health management forum* 1(2), 28-36.

iv Source: Construction date based on information provided by health authorities, care homes, and collected by the OSA for the Quick Facts Directory. Information in the Quick Facts Directory is provided annually to each care home for their review, ensuring the accuracy of the information.

v Source: Quick Facts Directory

vi These are statements prepared by an independent auditor retained by the care home operator and reported under generally accepted accounting principles as set out in the CPA Canada Handbook - Accounting.

vii Source: Quick Facts Directory

viii Source: Office of the Seniors Advocate – Monitoring Seniors Services (2018 edition).

ix Profit is calculated as total revenue minus total expenditures, which is reported as profit/loss in three health authorities. In the fourth health authority, the OSA obtained health authority funding and subtracted reported expenditures for each care home in this health authority.

x Source: Office of the Seniors Advocate - Every Voice Counts (Provincial Results).

xi These funded rates were provided by each health authority via a direct request from the OSA.

xii From 2017 Facilities Subsector Wage schedule for April 1, 2017 for Grid 22 (Nursing Assistant I).

xiii Source: Direct request to Hospital Employees' Union

xiv Source: Direct request to Health Employers Association of British Columbia

xv Total worked direct care hours as reported by operators across all beds and checked against the health authority-reported funded direct care hours.

xvi Source: Kaiser Family Foundation – Improving the Financial Accountability of Nursing Facilities

xvii FTEs: full-time equivalents

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