MUSKOKA ALGONQUIN HEALTHCARE

# 2021 - 2022 ANNUAL REPORT

## Our Mission

Working together to provide outstanding integrated health care to our communities, delivering best patient outcomes with exemplary standards and compassion.

## Our Vision

As a trusted partner, we strive to improve the delivery of health care to our communities and to be known as an outstanding place to work, learn, live and be cared for.


## Contents

AGENDA

# Annual Meeting of the Members of the Corporation of Muskoka Algonquin Healthcare

Monday, June 20, 2022
4:00 PM
Virtual Via Zoom

1. Chair's Welcome/Call To Order — Cameron Renwick

2. Land Acknowledgment — Sally Ashton

   We, Muskoka Algonquin Healthcare, acknowledge that we are situated on the traditional territory of the Anishinaabe. We wish to deepen our understanding of the culture of the local Indigenous communities to develop appropriate culturally safe health care services by building trust through respectful relationships that acknowledge past harms and mistakes to move forward in the spirit of Truth and Reconciliation based on the Seven Grandfather Teachings.

3. Approval of the Minutes of the Previous Meetings♦ — Cameron Renwick

4. Receipt of Reports♦: — Cameron Renwick
   - Board Chair
   - Chief of Staff & Medical Advisory Committee,
   - Quality & Patient Safety Committee
   - Resources & Audit Committee
   - Governance Committee
   - Strategic Planning Committee
   - MAHC Muskoka and Area Ontario Health Team Committee
   - Inclusion, Equity, Diversity and Anti-Racism Working Group

5. Report of the Corporate Auditor — Dave Uffelmann
   - Presentation of the Audited Financial Statements
   - Appointment of Corporate Auditors♦

6. Report of the Nominations Committee — Brenda Gefucia
   - Election of Directors♦

7. Report of the Chief of Staff — Dr. Khaled Abdel-Razek

8. Report of the President and Chief Executive Officer — Cheryl Harrison
   - Stroke Services at MAHC — Amy Gargal
   - Capital Redevelopment — Terry Shields

9. Board Award of Excellence Recipient Announcement — Dave Uffelmann

10. Closing Remarks and Adjournment♦ — Cameron Renwick

♦*Denotes motion required*

# Motions For Resolution

1. Adoption of Minutes

   That the minutes of the Annual General Meeting for the Members of the Corporation held August 23, 2021 be approved.

   That the minutes of the Special Meeting for the Members of the Corporation held February 10, 2022 be approved.

2. Receipt of Reports

   That the following reports presented to the Members June 20, 2022 be received:
   - Chair of the Board of Directors
   - Chief of Staff & Medical Advisory Committee
   - Quality & Patient Safety Committee
   - Resources & Audit Committee
   - Governance Committee
   - Strategic Planning Committee
   - MAHC Muskoka and Area Ontario Health Team Committee
   - Inclusion, Diversity, Equity and Anti-Racism Working Group

3. Appointment of Corporate Auditor

   That KPMG be appointed as the corporate auditor for Muskoka Algonquin Healthcare to hold office until the next annual general meeting.

4. Election of Directors

   That the following be appointed by the Members of the Corporation to the Muskoka Algonquin Healthcare Board of Directors:
   - Tim Ellis for a 3-year term ending 2025
   - Anna Landry for a 3-year term ending 2025
   - Moreen Miller for a 3-year term ending 2025
   - Line Villeneuve for a 3-year term ending 2025
   - Bruce Schouten for a 1-year term ending 2023

# MINUTES OF THE ANNUAL GENERAL MEETING FOR THE MEMBERS OF THE CORPORATION OF MUSKOKA ALGONQUIN HEALTHCARE MONDAY, AUGUST 23, 2021, 4:00 P.M. HELD ELECTRONICALLY BY ZOOM

*Approval Pending*

MEMBERS PRESENT:

| | | |
|---|---|---|
| Cameron Renwick | Roy Stewart | Phil Matthews |
| Brenda Gefucia | Dave Uffelmann | Franke Arnone |
| Beth Goodhew | John Sisson | Natalie Bubela |
| Kathy Newby | Tim Ellis | Dr. Khaled Abdel-Razek |
| Moreen Miller | Evelyn Brown | Janice Raine |

Mr. Cameron Renwick, Chair of the Board of Directors welcomed all participants to the annual general meeting. Participants were also advised that the meeting would be recorded to be made available publicly in a digital format.

The 2021 annual meeting of the Corporation of Muskoka Algonquin Healthcare was called to order at 4:00 pm and the Chair declared the meeting duly constituted with a quorum present for the transaction of business.

1. Land Acknowledgment

   We, Muskoka Algonquin Healthcare, acknowledge that we are situated on the traditional territory of the Anishinaabe. We wish to deepen our understanding of the culture of the local Indigenous communities to develop appropriate culturally safe health care services by building trust through respectful relationships that acknowledge past harms and mistakes to move forward in the spirit of Truth and Reconciliation based on the Seven Grandfather Teachings.

2. Previous Minutes

   The minutes of the previous annual meeting held on August 6, 2020 were circulated by email in advance of the meeting along with the Annual Report. There was no business arising from the minutes of the previous annual meeting.

   It was moved, seconded and carried

   THAT THE MINUTES OF THE JUNE 24, 2019 ANNUAL GENERAL MEETING OF THE CORPORATION OF MUSKOKA ALGONQUIN HEALTHCARE BE APPROVED AS AMENDED.

3. Receipt of Reports

The reports were circulated by email in advance of the meeting along with the Annual Report. The Chair expressed appreciation to all of the Standing Committee Chairs for their leadership and for the outstanding work and milestones achieved throughout the year.

It was moved, seconded and carried

THAT THE FOLLOWING REPORTS PRESENTED TO THE MEMBERS AUGUST 23, 2021 BE RECEIVED:

- CHAIR OF THE BOARD OF DIRECTORS
- PRESIDENT & CHIEF EXECUTIVE OFFICER
- CHIEF OF STAFF & MEDICAL ADVISORY COMMITTEE
- QUALITY & PATIENT SAFETY COMMITTEE
- RESOURCES & AUDIT COMMITTEE
- GOVERNANCE COMMITTEE
- NOMINATIONS COMMITTEE
- MAHC MUSKOKA AND AREA ONTARIO HEALTH TEAM COMMITTEE

4. Presentation of the Audited Financial Statements

Mr. Dave Uffelmann, Resources and Audit Committee Chair presented the audited financial statements highlighted the challenges to manage financially through the pandemic and the impact on the budget. Appreciation was expressed to the members of the Audit Subcommittee for their due diligence. KPMG has provided an unqualified opinion which represents the highest level of assurance that can be received under auditing standards. An overview of the three primary drivers of the financial results was provided. Comments were also provided regarding the excellent performance of the Corporate Auditor within a pandemic environment.

It was moved seconded and carried

THAT KPMG BE APPOINTED AS THE CORPORATE AUDITOR FOR MUSKOKA ALGONQUIN HEALTHCARE TO HOLD OFFICE UNTIL THE NEXT ANNUAL GENERAL MEETING.

5. By-Law & Supplementary Letters Patent

The By-Law amendments were presented to the Membership and the significant time and tremendous efforts of the Governance Committee and the Medical Advisory Committee to modernizing the governing documents were noted. It was also highlighted that the By-Laws have been separated into the Corporate portion and the Credential Staff portion to align with best practice, ensure there is enabling and clear language. The most notable change in this alignment with best practice as it pertains to the Corporate By-Law is that it proposes that the membership in the Corporation is limited to elected Directors only and that membership in the Corporation automatically

ceases when the Member ceases to be a Director. Additionally separating out the Credential Staff portion allows for them to be clean and discrete and a more efficient process for amendments.

It was moved, seconded and carried

WHEREAS on August 5, 2021 the board of directors of the Hospital (the "Board") approved a new corporate by-law (the "Corporate By-Law") and a new credentialed staff by-law (the "Credentialed Staff By-Law"), copies of which have been presented to the meeting, subject to member confirmation.

RESOLVED THAT the Corporate By-law and the Credentialed Staff By-law are confirmed.

The Supplementary Letters Patent that were also reviewed and recommended by the Board. The same principles were applied to these revisions as with the By-Laws and as a result the significant changes are to provide greater flexibility, not specify a fixed number of sites and instead amend paragraph 4(a) to provide that MAHC may operate out of "one or more sites." The document was also updated and modernized to align with recent changes made by the Public Guardian and Trustee of Ontario (the "PGT").

It was moved, seconded and carried

WHEREAS on August 5, 2021 the board of directors of the Hospital (the "Board") approved an application to the Lieutenant Governor of the Province of Ontario for supplementary letters patent, a copy of which has been presented to the meeting (the "Supplementary Letters Patent"), subject to member confirmation by special resolution.

RESOLVED AS A SPECIAL RESOLUTION THAT:

1. the Supplementary Letters Patent are confirmed;
2. the Hospital is authorized to make an Application to the Lieutenant Governor of the Province of Ontario for Supplementary Letters Patent;
3. any two directors of the Hospital (the "Authorized Signatories") are together authorized and directed, for and on behalf of the Hospital, to execute, deliver and file the Supplementary Letters Patent, with such amendments as they may determine necessary or advisable to comply with the requirements of any governmental authority having jurisdiction in respect of the Supplementary Letters Patent and the Hospital, without the need for further approval of the Board or members of the Hospital, and the executed Supplementary Letters Patent shall be conclusive evidence of approval by the Authorized Signatories, and the documents so executed, delivered and filed are the Supplementary Letters Patent authorized by this resolution.

6. Nominations Committee Report

The Committee convened in January 2021, and following review of its responsibilities made a recommendation to the Board for an enhancement to the recruitment process. The revised approach involved including additional data and processes in the evaluation of incumbent Directors along with all applicants. The Board was supportive of this revised approach as it demonstrates our ongoing commitment to continuous improvement, transparency and fairness in the recruitment process. MAHC was extremely fortunate to receive 17 applications including one for an Advisory Member position. The Nominations Committee reviewed all of the applications cross-referencing with the Board Skills & Knowledge Matrix. The Committee was blessed with incredibly strong candidates making their task of selecting the best possible candidates, which included weighing the MAHC experience and accomplishments of the incumbents, that much more challenging. The slate of candidates collectively provide significant skills in several areas that will enhance the Board's matrix and add some skills of key importance to the Board.

It was moved, seconded and carried

THAT the following be appointed by the Members of the Corporation to the Muskoka Algonquin Healthcare Board of Directors:

- Cameron Renwick for a 1 year term ending June 2022
- Sally Ashton for a 2 year term ending June 2023
- Evelyn Bailey for a 3 year term ending June 2024
- Marsha Barnes for a 3 year term ending June 2024
- Carla Clarkson-Ladd for a 3 year term ending June 2024

7. Conclusion

Cameron Renwick announced the conclusion of the business for the 2021 Annual General Meeting.

It was moved

THAT THE MEETING BE ADJOURNED AT 4:21 PM.

MINUTES OF THE GENERAL MEETING
FOR THE MEMBERS OF THE CORPORATION OF
MUSKOKA ALGONQUIN HEALTHCARE
THURSDAY, FEBRUARY 10, 2022 at 6:00 P.M.
HELD ELECTRONICALLY BY ZOOM

*Approval Pending*

MEMBERS PRESENT:

| | |
|---|---|
| Moreen Miller | John Sisson |
| Brenda Gefucia | Tim Ellis |
| Beth Goodhew | Sally Ashton |
| Roy Stewart | Marsha Barnes |
| Dave Uffelmann | Carla Clarkson-Ladd |

Moreen Miller, Acting Chair called the meeting to order at 5:55 pm and acknowledged a quorum was present. The Land Acknowledgement Statement was read aloud.

1. Corporate By-Law Amendment

The By-Law amendment was read aloud and it was confirmed that Members received copies in advance of the meeting. In response to a question it was confirmed that By-Law amendments can be revised at a general or a special meeting and not at an Annual General Meeting.

It was moved, seconded and carried that

WHEREAS on February 10, 2022 the Muskoka Algonquin Healthcare board of directors approved an amendment to Section 8.3 inclusive of the removal of Section 8.3(c. ii) of the corporate by-law, copies of which have been presented to the meeting, subject to member confirmation.

BE IT RESOLVED THAT the amended Corporate By-law is approved.

2. Adjournment

It was moved

THAT THE MEETING BE ADJOURNED.

# REPORTS

ANNUAL REPORT OF THE
**CHAIR OF THE BOARD OF DIRECTORS**
2021-2022

| | |
|---|---|
| SUBMITTED TO: | Members of the Corporation |
| SUBMITTED BY: | Cameron Renwick, Board Chair |

FOR RECEIPT

On behalf of the Board of Directors for Muskoka Algonquin Healthcare, I am pleased to present the 2021-2022 Annual Report.

I think it is fair to say that this time last year I don't think any of us really knew where the pandemic was going to take us next. I'm sure you will all agree that over the past two and half years, this pandemic has interrupted and interfered both our professional and personal lives. No one could have predicted what we have been through together. But I am proud to say that every member of the MAHC Team from staff and credentialed staff to the Leadership Team, our volunteers, Foundations and the Board have met the challenges head on and stepped up in a big way for health care in our communities. As I depart the Board after nine years, I have nothing but faith that you will all continue to face any new challenges as a Team and be stronger than ever with a renewed perspective.

The 2021-2022 fiscal year, despite the most devastating health care crisis that has gripped the world in the past century, has been one of successes and growth for Muskoka Algonquin Healthcare. All of our activities have continued to be guided by our five strategic directions that were established by the Board of Directors in 2019 which collectively are leading us to our Vision:

> "As a trusted partner, we strive to improve the delivery of health care to our communities and to be known as an outstanding place to work, learn, live and be cared for."

Our Strategic Planning Committee met in March and undertook a careful review of our environment, successes and challenges, and re-confirmed our Mission and Vision. A priority that has become even more important in the last year is that of inclusion, diversity, equity and anti-racism. We all need to take action to create an environment where we all see ourselves represented, where individuals know they are in a safe space, and where we ensure we create equality for all. As such, MAHC established special committees at both the Board level and the operational level to provide leadership in promoting and supporting activities that will move us forward in this important journey. In reviewing our Values, the cornerstone of our strategy, there were two distinct revisions that do just that:

> "We will demonstrate LEADERSHIP through encouraging diversity, inclusion, innovation and championing change."

> "We will ENGAGE by including stakeholders representative of diverse perspectives in planning and decision making."

Although we have made an excellent start on this journey, much work remains. I would like to express my appreciation to all of the members of both the operational and governance level Committees for your willingness to spearhead this important work.

There are so many successes over the past year that should be celebrated. Building on our past history of working in collaboration with partners, MAHC is excited to be a signatory partner of the Muskoka and Area Ontario Health Team whose collective efforts will lead to improved integrated care delivery for the benefit of our communities. Our strong financial position has enabled the leadership team to continue to focus on operations delivering excellent patient care with patients and families central to our focus. There were important steps forward in moving towards the targets of our Quality Improvement Plan metrics. As a Board we recognize the importance of strong local governance and have worked hard to ensure that we govern using best practice. A comprehensive policy review resulted in just this - a more streamlined, modernized set of policies based in best practice. And the recent nod from the provincial government for MAHC to proceed to the next stage of our capital redevelopment was so welcomed and appreciated.

All of these successes, and many more, have been achieved during a period of significant change internally while saying farewell to many colleagues including Natalie Bubela who retired after ten years as our President and Chief Executive Officer. We were also very fortunate to have Vickie Kaminski for almost five months as our Interim President and CEO. And while we thank both Natalie and Vickie for their stellar leadership, we welcome our new leader Cheryl Harrison. As we look forward to the future, the Board is excited to be working with Cheryl to continue to build on all of our successes, achieving new successes and continuing to provide outstanding health care to our communities.

As I conclude my tenure on the Board, there are many people to thank and recognize. I have been incredibly fortunate to work with both past and present Board members who are skilled, dedicated, passionate and forward-thinking. The Senior Leadership Team has always impressed me with their will to succeed, enthusiasm and professionalism. To the entire MAHC Team of staff, credentialed staff, volunteers and Foundations, I offer my heartfelt thanks for what you do every day. It has been my honour to get to know so many of you during my time here and I am proud of all that we have accomplished together. And to the broader community thank you, it has been my privilege to serve you through the Board of Muskoka Algonquin Healthcare.

Respectfully submitted,

Cameron Renwick,
Board Chair

# ANNUAL MEDICAL ADVISORY COMMITTEE
# REPORT 2021-2022

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|---|---|
| SUBMITTED TO: | Members of the Corporation |
| SUBMITTED BY: | Dr. Khaled Abdel-Razek |

FOR RECEIPT

The purpose of this report is to summarize the activities and accomplishments of the Medical Advisory Committee during the 2021-2022 Board year.

The Medical Advisory Committee (MAC) is responsible for the overall quality and safety of care delivery at MAHC. The committee receives input from Administration, clinical committees, Quality Council, and the Quality Assurance Committee. In addition, Policy and Procedures, Medical Directives and reports come forward for review and approval.

I am honored to report that over the past year the MAC has duly exercised its duties as it relates to credentialing of medical staff, annual performance reviews, recruitment, quality assurance and quality improvement initiatives.

Accomplishments for the MAC this past year was the advancement of the following:

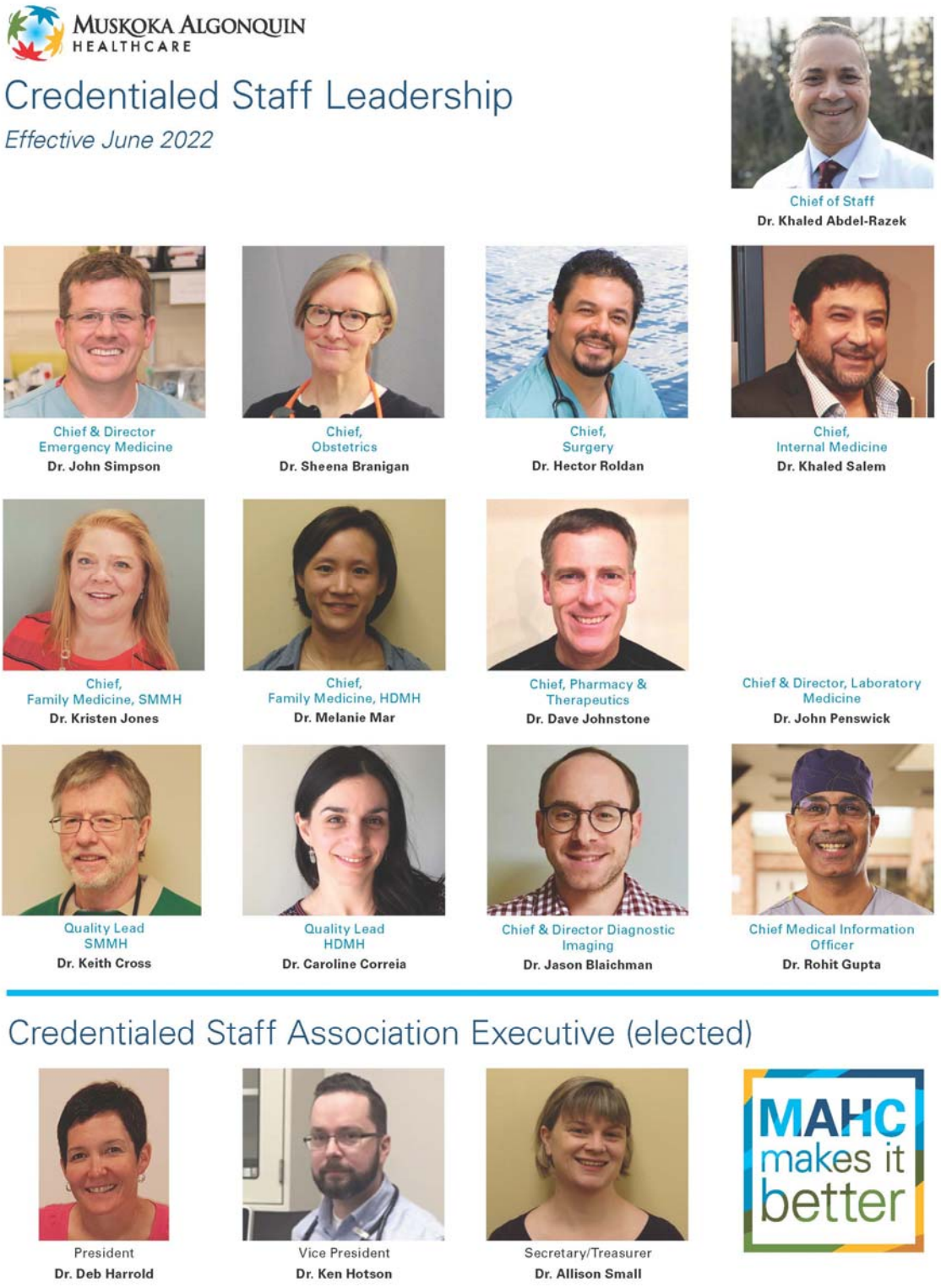
- Quality Improvement Project Charter in partnership with College of Physicians and Surgeons of Ontario and the Muskoka and Area Ontario Healthcare: Medication Reconciliation and Transitioning of Patient care from Hospital to Home.
- Addition of two physician quality lead roles to MAC working closely with administrative quality and safety portfolio.
- Orthopedics at MAHC: suitable orthopedic services now available at the Huntsville Site closer to home in partnership with Orillia Soldiers' Memorial Hospital with plans to expand the service underway.
- More familiarity and effectiveness of the annual credentialed staff performance review through the web based platform that was implemented in September 2020.
- Following the principles of 'Just Culture' for Credentialed Staff assessment and performance.
- Establishing updated stroke protocols across various departments at both Hospital sites.
- Review and approval of drug formulary changes through the Pharmacy and Therapeutics Committee.

I want to acknowledge the commitment of the MAC Credentialed Staff membership and thank them for their leadership in the past year. Their detailed work at the MAC has played an essential role in enabling the MAC to carry out its duties and responsibilities, and has allowed us to provide the Board of Directors with the best possible recommendations for all of the matters reviewed and deliberated at MAC.

I would also like to thank MAHC Credentialed Staff and MAHC Staff, for their collective ability, perseverance and commitment to the delivery of quality safe health care in our hospital and communities. The degree of

collaboration and teamwork among credentialed staff leadership and hospital staff leadership is a cornerstone to our success.

Finally, I would like to take this opportunity to acknowledge and recognize our Board members. I thank them for their confidence in our MAC processes, for the valuable and thoughtful assessment of MAC recommendations and their valuable advice and guidance.



ANNUAL **QUALITY AND PATIENT SAFETY**
COMMITTEE REPORT
2021-2022

| | |
|---|---|
| SUBMITTED TO: | Members of the Corporation |
| SUBMITTED BY: | Moreen Miller, Quality and Patient Safety Committee Chair |

FOR RECEIPT

The purpose of this report is to summarize the activities and accomplishments of the Quality and Patient Safety Committee during the 2021-2022 board year and to identify recommendations for consideration in next year's committee work plan. There were five regular meetings of the Committee this year and one special working group meeting; as per work plan projections the regular meeting of the Committee took place in August, October, January, February and April.

I. Summary list of key accomplishments this year:

- A patient story was shared with the Committee at each meeting that provided the experiences of patients and/or their families for the purpose of further maintaining focus on quality. They also provide an understanding of the impact of the experience on the patient and their perspectives, how management responded and any resulting improvements that may or may not have been identified.
- Through the quarterly Quality and Patient Safety Report, the Committee monitored and reported to the Board on the priorities for quality and patient safety improvement. The following summarizes key topics of discussion and focus over the past year:
  - A specific detailed review of the metrics related to Workplace Violence, Falls & Patient Relations was undertaken for the purpose of improved understanding of the metrics, analysis and the development of mitigation strategies.
  - As a result of the third quarter report, the Committee was provided with the results of an analysis of turnover rates including a comparative review with prior periods identifying that the increase was an anomaly. The Committee was satisfied with the explanation and did not request any further follow up or action on the matter.
  - A list of resources related to adverse events, patient safety issues and incident reporting was prepared for the Committee for the purpose of self-education on these topics. This was subsequently shared forward with the full Board as well.
  - To support analysis and understanding, the Committee made inquiry as to the availability of 'top performer data' for patient satisfaction metrics in addition to the community hospital averages. This information remains pending as a new vendor for patient satisfaction surveying is identified.
  - As it relates to the overall quality of service, management kept the Committee up-to-date on the significant efforts towards addressing the ongoing challenges in the provision of services, especially in light of staffing resource challenges and the ongoing pandemic. The organization experienced high occupancy levels and challenges with the timely transfer of Alternate Level of Care patients throughout the year.
- Reports were presented three times in the past year providing the Committee with an update on Credentialed Staff recruitment. In addition, the annual review of the credentialing process was completed and the Committee was also provided with additional information as it relates to the

disciplinary steps and revocation of privileges. The Credentialed Staff Human Resources Plan was recommended to the Board of Directors for approval.

- In preparation for the Accreditation Survey scheduled for November 2022, Management prepared and presented a milestones checklist document at each Committee meeting. All milestones related to preparations and planning continue to be on track.
    - Additionally, at the request of the Governance Committee, two Governance Standards for Accreditation were reviewed by the Committee for the purpose of identifying improvements as it relates to quality and patient safety. As a result of this work, the Committee made recommendation to the Board of Directors to have a member of the Corporation's Patient and Family Advisory Council become a full member of the Quality and Patient Safety Committee.
- Given the continued focus provincially on the COVID-19 pandemic response, Ontario Health did not require hospitals to submit a Board approved Quality Improvement Plan (QIP) for the 2022/2023. However, MAHC's Quality Improvement Plan specific targets and measures are incorporated into a three-year Quality & Patient Safety Plan. As such, Management undertook an assessment of all targets and measures with a view to identifying Year 2 targets for the Quality & Patient Safety Plan. The Committee considered and supported the recommendation to continue with the QIP metrics; these include:
    1. Number of Workplace Violence Incidents Reported by Hospital Workers
    2. Number of Patients Developing Hospital Acquired Pressure Injuries
    3. Timely and Efficient Transitions – 90th Percentile Time from the Emergency Department to Inpatient Unit/ICU/OR
    4. Patient Flow/Bed Utilization – Acute Care Occupancy
    5. Improve Patient Satisfaction: Receiving enough information at time of discharge
    6. Train and Deploy Patient Partners
- An overview of the activities occurring to further implement a patient and family centered care philosophy at MAHC was provided. Most notably is the increased engagement of the Patient and Family Advisory Council members and the value that they are providing at the operational level given the breadth of experience they are bringing to those tables.
- A quarterly report was prepared for the Committee of any critical incidents that occurred along with the plans developed to address, prevent or remediate such events.
- The review process and approach to complete the three-year review of the Patient Declaration of Values was supported.
- The Committee received an update regarding the approved Quality Improvement Partnership with the College of Physicians and Surgeons of Ontario related to Medication Reconciliation: Transitioning Patients from Hospital to Home. Clarification was garnered during the discussion with respect to the process of ensuring a closed loop feedback with the primary care providers and the community pharmacists. The Committee was also apprised of the work underway internally at MAHC to identify and improve process gaps.

## II. Policy Review:

- In concert with the overall governance policy review process that was undertaken by the Governance Committee, the Quality and Patient Safety Committee reviewed the revised Terms of Reference as recommended by the Governance Committee. Two minor modifications were referred back to the Governance Committee for consideration.

- In reviewing the background related to the Auditing Process for Credentialed Staff Credentialing Policy, it was identified that an audit had been conducted annually for five years and did not identify any concerns or process improvements. Furthermore, all recommendations for appointment to the Credentialed Staff are presented with a signed certificate of integrity that verifies all processes and procedures have been followed. As such, the Committee recommended to the Board that this policy be repealed.
- As part of its regular review cycle, the Committee undertook a review of the Quality of Care Reviews (QCIPA) Policy to better understand its purpose and the Board's role in this process. Following extensive discussions and review of legislation, the Committee was satisfied that implementation of the Quality of Care Information Protection Act is strictly an operational issue and as such recommended to the Board that the policy be repealed as a governance policy and encouraged management to incorporate certain aspects including recognizing a balance between the need for transparency and openness with patients, and the need to sometimes invoke processes provided by QCIPA to have confidential discussions about incidents.
- In support of the Governance Committee's policy review project, the Committee provided comments and revisions as it relates to the new Board Committees and Terms of Reference and Evaluations policies. With respect to the Quality Improvement and Safety policy recommendation the Committee sought clarification regarding and the rationale/justification for the proposed policy given concerns regarding overlap with the Committee's Terms of Reference resulting in the potential for conflict across policies. As a result, it was agreed that the policy would be further reviewed and discussed at the next Committee meeting during the 2022/2023 board cycle.
- The Committee did support the recommendation that the following policies be repealed and relocated to the Corporation's operational policy manual.
    - Accessibility Standards for Customer and Patient Services
    - Definition of Quality
    - Patient- and Family-Centered Care
    - Service Animals
    - Support Person

III. Is the Committee following their work plan and meeting their terms of reference and are there any recommendations for consideration in the upcoming year:

- A work plan for the committee was approved by the Board of Directors in September 2021 based on the Terms of Reference.
- Although some minor modifications were made to the timing of some deliverables throughout the year due to the impact of the pandemic, as of the end of April 2022, all deliverables have been met.
- The following items are identified for follow up in the next work plan:
    - Patient Experience Partner Profiles (for information)
    - Continued oversight of Accreditation preparations
    - Results of Patient Experience Survey vendor identification process
    - Results of the review of the Patient Declaration of Values
    - Quality Improvement and Safety Policy
    - Medication Reconciliation on Discharge Process Review

IV. Are there any emerging risks/issues arising from the Committee's work that the full board should be aware of in preparation for the coming year?

- The Board has been made aware of any specific risks through the Committee's work.

## V. Committee Work Plan

| | | | Q1 | Q2 | Q3 | | Q4 |
|---|---|---|---|---|---|---|---|
| **Deliverable** | **MRP** | **Occurrence** | **Aug 30** | **Oct 28** | **Jan 27** | **Feb 24** | **Apr 28** |
| Land Acknowledgment | Chair | Every Meeting | ✓ | ✓ | ✓ | ✓ | ✓ |
| ***The following reports are brought forward to the Committee as required by legislation (Public Hospitals Act, Excellent Care For All Act, etc.) or Ministry direction:*** | | | | | | | |
| Quality and Patient Safety Report* | Director, Quality | Quarterly | ✓ | ✓ | ✓ | | ✓ |
| Detailed review - workplace violence, falls and patient relations | Director, Quality | One-time | | ✓ | | | |
| Web links for self-education re adverse events, patient safety issues and mitigation strategies | | | | | ✓ | | |
| Top performer data for patient satisfaction (revisit when new survey vendor announced). | | | | | ✓ | A - TBD | |
| Reformatting of QPS Report | | | | | ✓ | | ✓ |
| Follow up request regarding turn over rates | | | | | | A | |
| Credentialed Staff Recruitment Update | Chief of Staff | Quarterly | ✓ | | ✓ | | ✓ |
| Trillium Gift of Life Network Reports | CNE | Quarterly | ✓ | | ✓ | | |
| Credentialing Process review | Chief of Staff | Annually | | ✓ | | | |
| Quality Improvement Plan 22/23 Planning Update | Director, Quality | Quarterly | | | ✓ | | |
| Clinical Services Resources Plan (Recommend Approval) | Chief of Staff | Annually | | | ✓ | | |
| Quality Improvement Plan 22/23 Recommendation to Board | Director, Quality | Annual | | | | ✓ | |
| Patient Declaration of Values | Director, Quality | Every 3 Years | | | | | ✓ |
| ***The following reports are brought forward to the Committee as they assist in meeting an *Accreditation standard*** | | | | | | | |
| Patient Stories | Director, Quality | Every meeting | ✓ | ✓ | ✓ | ✓ | ✓ |
| Quality Council Updates | Director, Quality | Every meeting | | ✓ | | ✓ | |
| Ethics Program Update | CNE | Quarterly | | ✓ | | ☒ | ✓ |
| Accreditation Planning & Preparation | Director, Quality | Every 4 years | | ✓ | ✓ | ✓ | ✓ |
| Patient and Family Centered Care Philosophy Update | CNE | Annually | | | ✓ | | |
| Patient and Family Advisory Council | CNE | Bi – Monthly | | ✓ | | ☒ | ✓ |
| Clinical Research Report | CEO | Annually | | | | ✓ | |
| Accreditation Governance Standard Action Plan Items | CNE | One-Time | | | | ✓ | |
| ***The following reports are brought forward as per MAHC's Board Effectiveness responsibilities.*** | | | | | | | |
| Committee Orientation | Chair | Annually | ✓ | | | | |
| Review 2020/21 Annual Committee Report | Chair | Annually | ✓ | | | | |
| Committee Terms of Reference Review | Chair | Annually | ✓ | | ✓ | | |
| Committee Work Plan for 21/22 | Chair | Every Meeting | ✓ | ✓ | ✓ | ✓ | ✓ |
| Discussion of Board Education Topics | | Ad Hoc | | ✓ | ✓ | | |
| Provide Committee with OHA Quality & Patient Safety Toolkit | | Ad Hoc | | ✓ | | | |
| Policy Review: | | | | | | | |
| – Quality of Care Reviews (QCIPA) | Director, Quality | Every 3 years | ✓ | ✓ | ✓ | ✓ | |
| – Auditing Process for Professional Staff Credentialing | Director, Quality | Every 3 years | | | ✓ | | |
| – Support Person | VP, HR | Every 3 years | | | | | ✓ |
| – Accessibility Standards for Customer and Patient Services | VP, HR | Every 3 years | | | | | ✓ |
| – Service Animals | VP, HR | Every 3 years | | | | | ✓ |
| – Patient- and Family-Centered Care | Director, Quality | Every 3 years | | | | | ✓ |
| Complete Committee Self-Evaluation | Chair | Annually | | | | | ✓ |
| Review Annual Committee Report | Chair | Annually | | | | | ✓ |
| Chair to plan for knowledge transfer to incoming Chair | Chair | Annually | | | | | ✓ |
| ***The following items have been added to the Quality & Patient Safety Committee Terms of Reference over the past few years but are not required for the Quality & Patient Safety Committee due to any governing body.*** | | | | | | | |
| Credentialing Audit Results | Director, Quality | Annually | | ✓ | | | |
| QI Partnership for Hospitals | Chief of Staff | One-Time | | ✓ | | | |

ANNUAL RESOURCES & AUDIT COMMITTEE REPORT
2021-2022

| | |
|---|---|
| SUBMITTED TO: | Members of the Corporation |
| SUBMITTED BY: | Dave Uffelmann, Resources & Audit Committee Chair |

FOR RECEIPT

The purpose of this report is to summarize the activities and accomplishments of the Committee during the 2021-2022 board year and to identify recommendations for consideration in next year's committee work plan. There were seven regular meetings of the Resources & Audit Committee this year; as per work plan projections the regular meeting of the Committee took place in August, September, November, January, February and March. In addition, there were two additional special meetings held in February and April to consider and provide feedback related to the policy revisions from the Governance Committee.

Committee Members included Directors Carla Clarkson-Ladd and Tim Ellis, along with Committee Appointee Member Line Villeneuve.

## I. Summary list of key accomplishments this year:

*Budget Planning and Oversight*

- The Committee achieved its responsibilities as it relates to financial performance oversight by reviewing at each regular meeting the financial results and subsequently recommending approval to the Board of Directors. Key areas of discussion throughout the year included the impact of COVID, occupancy and Alternate Level of Care related challenges and impacts as well as the results of the Broad Based Reconciliation process carried over from the prior year. On several occasions throughout the year, the Committee recognized the consistency of the actual financial results in relation to budget after taking into account the impact of unbudgeted COVID funding received during the year.
- The Committee also conducted a process to confirm that the format and content of the financial information continued to provide the information needed to discharge its duties; there were no revisions made to the information that the Committee receives.
- Work related to establishing the annual Operating Budget began in November with a review of initial assumptions, the timeline and preparation work underway. Similar to prior years during the COVID-19 pandemic, the Ministry of Health once again paused any requirement to complete the Hospital Annual Planning Submission process. However, a budget was developed and presented to the Board for approval. The committee expressed its appreciation to management for its efforts to gain COVID-related funding to protect the hospital against the financial challenges resulting from COVID. Likewise, as it relates to the Hospital Services Accountability Agreement (HSAA), the organization received notification that all terms and schedules would be extended for an additional year ending March 31, 2023.
- MAHC's parking system is beyond normal life expectancy and given ongoing operating challenges, Management presented a proposal to the Committee to consider replacement. Various options and associated analysis were reviewed in detail by the Committee leading to a recommendation to the Board that the systems at both Hospital sites be replaced.
- The Capital Equipment Needs and Funding Plan for fiscal year 2022-2023 was considered by the Committee which was informed through a review of the Capital Equipment planning policy as well as

the full detailed capital equipment listing. The Committee also considered the prioritization process that was undertaken by Management to ensure there is a focus on addressing any patient safety and other risks. The total capital spend of $3.2 million across both sites have been fully supported by both the Huntsville Hospital and South Muskoka Hospital Foundations. They have also committed to support exceptional items in addition to this base commitment that may arise in the coming year.

- As a result of MAHC's positive working capital position, the Committee made recommendation to the Board regarding the establishment of a Business Investment Account to invest in short-term interest bearing options.
- The Committee kept up-to-date as to the progress of two significant capital projects. Muskoka Algonquin Healthcare (MAHC) is seeking the Ministry of Health's approval for Magnetic Resonance Imaging (MRI) scanner for Muskoka and made submission in January 2021. In addition, MAHC has been advocating for the introduction of an Integrated Stoke Unit to improve patient care locally and support MAHC's District Stroke Centre designation.

*Internal Controls and Risk Management*

- The annual Enterprise Risk Management Report was received along with an outline as to how the process was augmented this year through the utilization of the Healthcare Insurance Reciprocal of Canada's (HIROC) ERM Likelihood & Impact Matrix. This has allowed the individual managers and departments to measure the impact and likelihood against HIROC standards. The majority of risks identified were consistent with prior reports and a number of risks were eliminated as the result of facility improvements and capital equipment purchasing.
- Through the Audit Subcommittee, the Committee received a detailed understanding of a new standard with respect to asset retirement obligations which takes effect for the 2023 fiscal year. It has the potential to impact hospitals in different ways and requires organizations to record asset retirement obligations. This is intended to address situations where there is a requirement for hospitals to incur costs to remediate or restore tangible capital assets. KPMG has been engaged to assist the organization with this work and as such the Committee was advised of the mitigations developed to ensure auditor independence.
- A Capital Redevelopment Reserve was presented to the Board of Directors for approval. It is a framework for the Resources & Audit Committee to set funds aside, as they determine appropriate, for capital projects, including Capital Redevelopment. The allocation will be determined on an annual basis when preliminary financial statements are prepared. MAHC may restrict cash and investments as approved by the Board of Directors and these internally restricted amounts will not be available for other purposes without approval by the Board of Directors. This aligns with the work of the Local Share Committee in developing a strategy raise the local share funds collectively with the District of Muskoka, Municipalities and Foundations.
- Oversight for compliance with the Broader Public Sector Accountability Act was achieved through the regular review of the Board and Senior Leadership Team expense reports and Consultant Use reports prior to public posting on the organization's website. Additionally, the year-end attestation was recommended to the Board for approval.
- The annual review of the insurance policy was completed and the Committee received the claims audit report. No actions arose from this review.

*Human Resources*

- The Human Resources Report outlining the progress of identified metrics was presented to the Committee in September, January and March. Throughout the year, discussion ensued with respect to the following key performance indicators specifically:

- Vacancy Rates
- The target for WSIB Lost Time Injuries
- Student placements
- Turnover and Absenteeism

- As it relates to recruitment, the Committee supported in principle a transitional housing strategy with the purpose of improving one of the consistent barriers to recruitment of Health Human Resources to Muskoka. Management continues to explore options and the Committee looks forward to receiving the results of this work.
- Management informed the Committee with respect to a Provincial Benefits Strategy that the Ontario Hospital Association and HIROC are co-designing for the delivery of hospital employee group benefits as well as the potential impact for MAHC.
- Due to pandemic related restrictions, the 2021 Board Award of Excellence process was deferred to the Fall. Following approval by the Board, recipients were presented with their awards in person by a Board Director. The caring nature of the culture and staff was evident by the nominations that were received. The Committee was once again thrilled and honoured to review and recommended to the Board the recipients of the 2022 Board Award of Excellence to be presented at the Annual Meeting in June.

*Information Technology*

- In meeting its obligations for oversight of information technology functions, future planning and processes to safeguard information sources, the Committee received updates with respect to:
  - The Georgian Bay Information Network (GBIN) Clinical Roadmap to understand clinical advancement options, required commitments and how we work with our partners moving forward;
  - Cybersecurity and Management's adoption of HIROC's framework to assess MAHC's activity regarding prevention, monitoring, and incident response;
  - Various project updates relative to IT core activities, the Muskoka & Area Ontario Health Team, the active directory migration project, the integration of *Ocean* into surgical and diagnostic imaging departments and an updated employee onboarding and Cerner training program.

*Audit*

- Early in the year, the Committee appointed the members of an Audit Subcommittee and were delighted to include Phil Matthews as the Subcommittee's Committee Appointee Member.
- Through the Audit Subcommittee, the performance of the Corporate Auditor was considered including the value of a national firm with hospital experience as well as the quality of the work of the Corporate Auditor and any signs of a lack of independence. An updated fee schedule for 2023 through to 2025 was received. As a result of this work, the Committee recommended that the Board appoint KPMG for the 2022-2023 fiscal year.
- Received the Audit Subcommittee Report and recommended approval of the 2021/2022 Audited Financial Statements.

*Policy Review*

- In support of the Governance Committee's policy review project, the Committee provided comments and revisions as it relates to the following policies:
  - Board Committees and Terms of Reference
  - Evaluations

- Financial Objectives
- Financial Planning and Performance
- Insurance and Asset Protection
- Approval and Signing Authority
- Borrowing
- Investments
- Risk Management

- In addition, the Committee carefully considered the recommendation that the Whistleblower policy be relocated to the operational policy manual. Given the significance of such a policy in an organization, the Committee brought the debate forward to the Board of Directors for final decision.

## II. Is the Committee following their work plan and meeting their terms of reference and are there any recommendations for consideration in the upcoming year:

- A work plan for the Committee was approved by the Board in September 2021 based on the Terms of Reference, and as of the end of May 2022, all deliverables will have been met.
- It is recommended that in the upcoming year, the Resources & Audit Committee include the following items for further follow up:
  - Transitional Housing Strategy;
  - Provincial Benefits Strategy;
  - Health Human Resource issues;
  - Additional detail to provide a sense of the range for any future liabilities and the potential plan to accommodate those.

## III. Are there any emerging risks/issues arising from the Committee's work that the full board should be aware of in preparation for the coming year?

- Although current year funding letters (2022/2023) were received and signed off prior to the call for the provincial election and are not at risk, any future anticipated funding is somewhat at risk given the upcoming election and potential change in government.
- Given ongoing recruitment challenges and the number of vacancies, there is an increased reliance on contract services for day-to-day staffing needs.

## IV. 2021/2022 Committee Work Plan

| Deliverable | MRP | Occurrence | Aug 27 | Sept 24 | Nov 26 | Jan 28 | Feb 2 | Feb 25 | Mar 25 | Apr 4 | May 27 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Land Acknowledgement | Chair | Every Meeting | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ |
| *Leadership* | | | | | | | | | | | |
| General Update: VP, Operations & CHRO | VP, HR | Annually | ✓ | | | | | | | | |
| Human Resources Report | VP, HR | Bi-monthly | | ✓ | | ✓ | | | ✓ | | |
| Provincial Hospital Benefits Strategy | VP, HR | One-time | | ✓ | ✓ | | | | | | |
| MAHC's Transitional Housing Strategy | VP, HR | As required | | ✓ | | ✓ | | | | | |
| MRI Updates | VP, HR | As required | | | | ✓ | | | | | |
| **Health Human Resources Update** | **VP, HR** | As required | | | | | | | | | D |
| Potential Collective Agreement Ratification Votes | | | | | | | | | | | |
| – *ONA Expires June 7, 2021 – presented to Board November 11,21* | VP, HR | VP, HR | | | | | | | | | |
| – *SEIU Expires December 31, 2021* | VP, HR | VP, HR | | | | | | | | | |
| – *OPSEU Paramedical Expires March 31, 2022* | VP, HR | VP, HR | | | | | | | | | |
| – *OPSEU Office and Clerical Expires March 31, 2022* | VP, HR | VP, HR | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| ***Program Quality & Effectiveness*** | | | | | | | | | | | |
| Board Award of Excellence Nominations | CEO | Annually | ✓ | | | | | | | | ✓ |
| Information Technology Updates | CFO | Semi-annual | | | ✓ | | | | ✓ | | |
| Notice to HIROC | CFO | Every two years | | ✓ | | | | | | | |
| Enterprise Risk Management Program | CFO | Annually | | | ✓ | | | | | | |
| HIROC Claims Audit Report | CFO | Annually | | | ✓ | | | | | | |
| Program Realignment - Integrated Stroke Unit | CFO | One-Time | | | | | | | ✓ | | ✓ |
| Alternative Hospital Facility – Hospice Muskoka | CFO | | | | | | | | | | ✓ |
| ***Financial and Operational Viability*** | | | | | | | | | | | |
| General Update: VP, Corporate Services, Planning, Risk, CFO | CFO | Annually | ✓ | | | | | | | | |
| Financial Report * | CFO | Monthly | | ✓ | ✓ | ✓ | | ✓ | ✓ | | |
| Compliance Report * | CFO | Monthly | | ✓ | ✓ | ✓ | | ✓ | ✓ | | |
| Receive Expense Reports* | CEO | Every other meeting | | ✓ | | ✓ | | | ✓ | | |
| Business Investment Account | CFO | One-Time | | | | ✓ | | | | | |
| Broad Based Reconciliation Update | CFO | One-Time | | | | ✓ | | | | | |
| Receive Consultant Use Report * | CEO | Every other meeting | ✓ | | ✓ | | | ✓ | | | ✓ |
| Audit Subcommittee Membership Appointment/Confirmation | Chair | Annually | | ✓ | | | | | | | |
| Audit Subcommittee Report | CFO | Annually | | | | | | ✓ | | | ✓ |
| Annual Budget: | | | | | | | | | | | |
| – Process, Assumptions & Development Update | CFO | Annually | | | ✓ | | | | | | |
| – Final Budget to Recommend for Board Approval | CFO | Annually | | | | | | ✓ | | | ✓ |
| Capital Equipment Budget | CFO | Annually | | | | | | | ✓ | | |
| Capital Redevelopment Reserve | CFO | One-Time | | | | | | | ✓ | | |
| Approve annual Board Attestations* | CEO | Annually | | | | | | | | | ✓ |
| Audited Financial Statements | CFO | Annually | | | | | | | | | ✓ |
| Audit Findings Report | Chair | Annually | | | | | | | | | ✓ |
| Determination of Audit RFP Process | Chair | | | ✓ | | | | | | | |
| Annual Appointment of Auditors | Chair | Annually | | | | | | | | | ✓ |
| ***Board Effectiveness*** | | | | | | | | | | | |
| Committee Orientation | | | ✓ | | | | | | | | |
| Review 2020/21 Annual Committee Report | Chair | Annually | ✓ | | | | | | | | |
| Committee Terms of Reference | Chair | Annually | ✓ | | | | ✓ | | | | |
| Committee Work Plan Check Ins | Chair | Monthly | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | ✓ |
| Resources & Audit Committee Policy Review Schedule | Board Liaison | One-Time | | ✓ | | | | | | | |
| Biennial Notice to HIROC | CFO | Every Two Years | | ✓ | | | | | | | |
| Review of financial reporting information | Chair | One-Time | | | | ✓ | | | | | |
| Policy Review: | | | | | | | | | | | |
| – All policies as reviewed by BLG | All | | | | | | | | | ✓ | |
| Evaluations Policy | | | | | | | ✓ | | | | |
| Complete Committee Self-Evaluation | Chair | Annually | | | | | | | | | ✓ |
| Review Annual Committee Report | Chair | Annually | | | | | | | | | ✓ |
| Chair to plan for knowledge transfer to incoming Chair | Chair | Annually | | | | | | | | | ✓ |

# ANNUAL
# GOVERNANCE COMMITTEE REPORT
# 2021-2022

| | |
|---|---|
| SUBMITTED TO: | Members of the Corporation |
| SUBMITTED BY: | Roy Stewart, Governance Committee Chair |

FOR RECEIPT

The purpose of this report is to summarize the activities and accomplishments of the Governance Committee during the 2021-2022 board year and to identify recommendations for consideration in next year's committee work plan. There were six regular meetings of the Governance Committee this year; as per work plan projections the regular meeting of the Committee took place in August, September, November, January, March and May. In addition, two additional special meetings were held in December and February in order to ensure completion of a significant policy review project.

Committee Members included Directors Evelyn Bailey and John Sisson, along with Committee Appointee Member Emanuela Heyninck.

## I. Summary list of key accomplishments this year:

*Policy Review*

- The most notable accomplishment for the Committee this year was that of a complete policy review. MAHC engaged Borden Ladner Gervais LLP (BLG) to undertake a review of its governance policies to ensure alignment with best practices in Ontario public hospital governance and to:
  - update and modernize the policies to reflect the current law and regulatory regime;
  - ensure consistency with the new MAHC Corporate By-Law approved in August 2021; and
  - streamline, consolidate, and eliminate redundancy.
- The review was conducted in four phases with sequencing based on 2021/2022 Governance Committee meeting schedule. Each Phase of the policy review was presented to the Governance Committee along with a Table of Concordance providing the detail relative to the revisions and governance rationale for those revisions. As the Governance Committee completed its review and revision, the policies were then shared forward to Standing Committees, as applicable, for comment. Amendments were finalized and presented to the Board of Directors for approval.
- In total, 87 policies were reviewed. Phases 1 through 3 resulted in 58 policies being streamlined into 24 policies with 7 policies being eliminated. And Phase 4 resulted in 29 policies being condensed into 8 policies, with a recommendation that 13 policies be relocated to the Corporation's operational policy manual. Two policies were deferred to the 2022/2023 Board cycle for further review (Whistleblower policy and Quality Improvement and Safety policy).
- Governance policies provide a framework for sound decision making and accountability. It is through the Board policies that the Board is held accountable for decisions affecting the delivery of quality and safe care and the effective use of resources. This streamlined and modernized set of policies will enable the Board to achieve these objectives.

*Board Goals and Annual Board Work Plan*

- The Committee recommended the following annual Board governance improvement goals to the Board and in doing so considered comments from current Standing Committee Chairs, the 2020/2021 Board evaluation results and prior year goals.

1. Improve board performance in the area of governance role and responsibilities, with specific attention to a better understanding of oversight versus operational issues, included as a component of the continuing education process for the board.
2. Inclusion, Diversity, Equity, and Anti-Racism
3. Governance Policy Review process

- The work of the Board as it relates to inclusion, diversity, equity and anti-racism progressed well with the support of the IDEA working group and the goal to complete the policy review was achieved as noted above. As it relates to education regarding governance roles and responsibilities, a recommendation was made to the Board that this be deferred until the Fall of 2022 to enable the new Board and new President and CEO to partake.
- A Board Work Plan was developed early in the year and recommended to the Board of Directors for approval. Ongoing monitoring occurred to ensure deliverables were met and the Board was receiving appropriate information to support informed policy formulation, decision-making, and oversight.

*Board Orientation and Education*

- The Board Orientation was held in August of 2021 for the six new Directors and Committee Appointees. A review of the results of the evaluations of the program identified improvements including sharing the results with the presenters to take into consideration in developing their information for the 2022 program and cross referencing the presentation slides with the reference manual.
- An ongoing education program for the Board was established ensuring education at each Board of Director through the year.
- As it relates to hosting an education day, the Committee regularly considered the current environment as it related to pandemic restrictions. Given the added value of having this event as an in-person event, there was a recommendation that the event be paused until the Fall of 2022. This would also enable the full new Board and new President and CEO to partake. The recommended topics for the event included:
  - rules of fiduciary conduct and consequences of breaching those rules
  - Ontario's Not-For-Profit Corporations Act (ONCA)
  - Board oversight versus operations.

*Nominations for Board Officers, Committee Chairs and Committee Assignments*

- Following establishing the timeline for the annual nominations process, the Committee initiated the expression of interest process to determine interest in serving on specific Board Committees for the coming year, including interest in assuming responsibilities as a Board Officer or a Committees Chair. The results were received by the Committee enabling an initial draft slate being developed. Follow up occurred with various Directors to confirm interest which culminated in a final recommendation tabled with the Board in June.

*Evaluations*

- Upon review of the responses to the 2021 Exit Interview responses, the Committee agreed to undertake an analysis to compare the results with prior years to determine if there are any recurring themes that can be identified. Upon review of the common themes, the Committee developed a memo to the Board of Directors that summarized the comments and highlighted several quick takeaways that may be useful for the Board in the future. In addition, the Committee agreed to improve the Orientation program with additional information as it relates to the operation of the hospital and the health care sector broadly. Moving forward, the results of exit interviews will be presented to the Board of Directors on the main agenda for full Board discussion.

- The annual evaluation process for the Board as a whole, as well as the peer/self-assessments, was initiated in March. The Committee completed its review of the results and identified remedial actions based on the lowest scored criteria.
- Additionally, it was identified that there is a need to undertake a comprehensive review of these tools as well as all evaluation tools and process for the purpose of ensuring they are effective in improving Board functioning.
- Board meeting evaluation results were reviewed at each regular meeting of the Committee. The following provides a summary of remedial actions identified throughout the year:
    - A memorandum was developed providing the Board of Directors with several observations resulting from the evaluations that included reminders with respect to meeting processes and board functioning.
    - Information was collated and education provided regarding conflict of interest.
    - A new summary report was developed to improve reporting of the meeting evaluation results to the Board.

*Accreditation Preparation*

- In preparation for Accreditation occurring in the Fall of 2022, the Governance Committee began its preparations in August with an in-depth review of the deliverables and the associated timeline with respect to the governance specific requirements.
- The Committee facilitated the completion of the Governance Functioning Tool by all Directors and completed the Governance Self-Assessment. From the results of these two activities, an action plan was developed to address potential gaps in preparation for the survey. Several Standing Committees (Performance Management, Quality & Patient Safety and Strategic Planning) were requested to review the applicable flagged standards specific to their mandates and determine any corrective action required in advance of the Accreditation Survey.
- The result of this work included adding a member of the Patient and Family Advisory Council to the membership of the Quality and Patient Safety Committee. As well, the Strategic Planning Committee recommended to the Board of Directors that a firm timeline be established for the Strategic Plan. An improved process has been established that ensures individual Directors receive better feedback about their contributions to the governing body. The decision support template was updated to include with a section that requests a description of the engagement with patients/families that occurred in arriving at the recommended action

## II. Is the Committee following their work plan and meeting their terms of reference and are there any recommendations for consideration in the upcoming year:

- A work plan for the Committee was approved by the Board of Directors in September 2021. All deliverables were met (see section IV below).
- The following items are recommendations for the 2022/2023 Governance Committee to consider including in their work plan:
    - Ensuring an education session is planned for the Fall 2022 that includes:
        1. rules of fiduciary conduct and consequences of breaching those rules
        2. Ontario's Not-For-Profit Corporations Act (ONCA)
        3. Board oversight versus operations
        4. And any other additional topics as approved by the Board Chair and President and CEO
    - Undertake a review of the evaluation tools utilized to ensure they are effective in terms of improving Board functioning and effectiveness. This review should include the following tools: Board Self-Assessment, Peer/Self-Assessment, Board Meeting Evaluation and Annual Committee Evaluation.

- Review the Board Committee Principles policy to determine if any parameters need to be established with respect to Directors engaging legal counsel.
- Consider if a mechanism or resource is needed to be identified for Directors to discuss potential conflicts of interest in situations where there may be uncertainty.

## III. Are there any emerging risks/issues arising from the Committee's work that the full board should be aware of in preparation for the coming year?

- The Board has been made aware of any risks noted through the Committee's work.

## IV. 2021-2022 Committee Work Plan

| Deliverable | MRP | Occurrence | Aug 25 | Sept 22 | Nov 24 | Dec 1 | Jan 26 | Feb 24 | Mar 23 | May 25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Land Acknowledgement | Chair | Each Meeting | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ***Board Effectiveness*** | | | | | | | | | | |
| Committee Orientation | Chair | Annually | ✓ | | | | | | | |
| – Review 2020/21 Annual Committee Report | Chair | Annually | ✓ | | | | | | | |
| – Committee Terms of Reference | Board Liaison | Annually | ✓ | ✓ | | | | | | |
| Committee Work Plan | Board Liaison | Each Meeting | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ |
| Accreditation 2022 Preparations | Board Liaison | Every 4 years | | | | | | | | |
| – Endorsement of timeline and deliverables | Board Liaison | | ✓ | | | | | | | |
| – Completion of Self-Assessment | Board Liaison | | | ✓ | | | | | | |
| – Development of Action Plan | Board Liaison | | | | ✓ | | | | | |
| – Action Plan Monitoring | Board Liaison | | | | | | ✓ | | ✓ | ✓ |
| Annual Board Governance Goals | Chair | Annually | | | | | | | | |
| – Establish, recommend approval | Chair | Annually | | ✓ | | | | | | |
| – Monitoring | Board Liaison | Every 2 meetings | | | | | ✓ | | | ✓ |
| Board Meeting Evaluation Results | Board Liaison | Each Meeting | | ✓ | ✓ | | ✓ | | ✓ | ✓ |
| Meeting Attendance Review | Board Liaison | Each Meeting | | ✓ | ✓ | | ✓ | | ✓ | ✓ |
| Board Work Plan | Board Liaison | Bi-Monthly | | ✓ | ✓ | | ✓ | | ✓ | ✓ |
| Exit Interview Responses | Board Liaison | Annually | | | ✓ | | ✓ | | | |
| Orientation Evaluation Results & Agenda Development | Board Liaison | Annually | | | ✓ | | | | | ✓ |
| Nominations Committee Membership Recommendation | Chair | Annually | | | ✓ | | | | | |
| Board Education Day Planning | Board Liaison | As required | | | | | ✓ | | ✓ | |
| Annual Board Evaluation | Board Liaison | Annually | | | | | | | | |
| – Timeline Review | Board Liaison | Annually | | | | | ✓ | | | |
| – Results Review, Recommend any remedial action | Board Liaison | Annually | | | | | | | | ✓ |
| Board Officer, Committee Chair, Committee Membership | Board Liaison | Annually | | | | | | | | |
| – Timeline Review | Board Liaison | Annually | | | ✓ | | | | | |
| – Results Review | Board Liaison | Annually | | | | | ✓ | | | |
| – Recommendation of final slate | Chair | Annually | | | | | | | ✓ | ✓ |
| Annual General Meeting | Board Liaison | Annually | | | | | | | | |
| – Planning discussion | Board Liaison | Annually | | | | | | | ✓ | |
| – Update, Agenda review | Board Liaison | Annually | | | | | | | | ✓ |
| Complete Committee Self-Evaluation | Chair | Annually | | | | | | | | ✓ |
| Review Annual Committee Report | Chair | Annually | | | | | | | | ✓ |
| Chair to plan for knowledge transfer to incoming Chair | Chair | Annually | | | | | | | | ✓ |
| Governance Policy Review | Chair | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| *Relationships* | | | | | | | | | | |
| Departing Director Recognition | Board Liaison | Annually | | | | | | | | ✓ |

ANNUAL
STRATEGIC PLANNING COMMITTEE REPORT
2021-2022

| | |
|---|---|
| SUBMITTED TO: | Members of the Corporation |
| SUBMITTED BY: | Beth Goodhew, Committee Chair |

FOR RECEIPT

The purpose of this report is to summarize the activities and accomplishments of the Strategic Planning Committee during the 2021-2022 board year and to identify recommendations for consideration in next year's committee work plan. There was one regular meetings of the Committee held in March 2022. Committee members include Directors Tim Ellis and Evelyn Bailey. As well as the Executive Directors of both Foundations, Leah Walker and Katherine Craine. The Committee is also honoured to have the participation of credentialed staff members Drs Khaled Abdel-Razek, Hector Roldan, Caroline Correia and Kristen Jones.

## I. Summary list of key accomplishments this year:

- The role of the Strategic Planning Committee is to assist the Board in setting the strategic direction and ensuring that the Corporation has a current and relevant Strategic Plan. MAHC's Strategic Plan was approved and implemented June 2019. It was at this time that the Board altered the structure of the Committee to meet annually to review the progress of the Strategic Plan and determine if an update was required.
- A review of the Mission, Vision and Values occurred and the Committee considered recommended revisions from the Inclusion, Diversity, Equity and Anti-Racism Working Group. As a result, recommendation to the Board was made to amend the Values and Behaviours as follows:
  - Leadership: Encouraging diversity, inclusion, innovation and championing change
  - Engagement:
    - Including stakeholders representative of diverse perspectives in planning and decision making.
    - Use systems approaches that incorporate MAHC's health system partners
- Under the direction of the President and CEO, an annual strategic assessment was presented to the Committee that identified significant changes and emerging trends in the operating environment, identified risks and opportunities, and evaluated changes necessary to ensure the continued provision of safe quality care. As a result, the following revisions were recommended to the Board of Directors for approval:

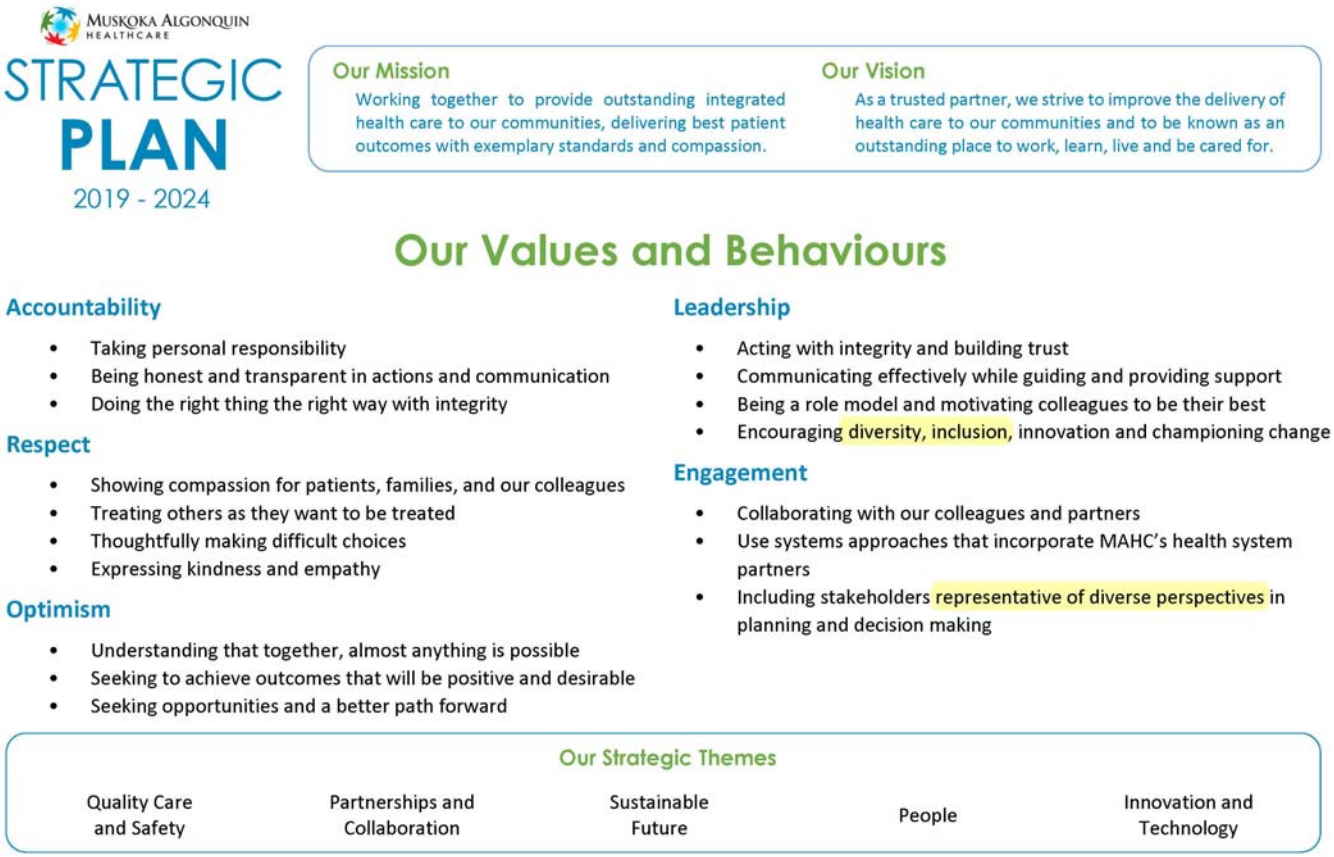
1. That the transitions initiative within the Quality Care & Safety theme be revised to state:
   - Develop a plan to improve patient transitions through the system.
2. That the three Strategic Initiatives within the Partnerships & Collaboration theme be combined to solely focus on MAOHT stating the following:
   - Develop a strategy and plan for building relationships with key service providers through the Muskoka & Area Ontario Health Team
3. That the educational institutions initiative within the People theme be revised to state:
   - Identify initiatives that support transitioning students to staff following education placements.
4. That an additional Strategic Initiative be added to the People theme that states:

- Develop a focused plan to support the four key focus areas outlined in the Equity, Diversity and Inclusion Policy:
  i. Delivering an exemplary patient experience
  ii. Embracing our community
  iii. Empowering our people
  iv. Ensuring health equity

- The Accreditation Governance Standards related to Strategic Planning were reviewed for the purpose of determining if any action is required to meet standards. The discussion focused on the standard that calls for organizations to identify timeframes associated with the Strategic Plan. Following consideration of the standard, the general practice as it relates to identifying timeframes for strategic plans both within the hospital sector as well as other sectors the Committee recommend to the Board that a five year timeframe for the Strategic Plan be applied, identified as 2019-2024.

II. Are there any emerging risks/issues arising from the Committee's work that the full board should be aware of in preparation for the coming year?

- The Board has been made aware of all risks through the Committee's work.



ANNUAL
MAHC MUSKOKA & AREA ONTARIO HEALTH TEAM
COMMITTEE REPORT
2021-2022

| | |
|---|---|
| SUBMITTED TO: | Members of the Corporation |
| SUBMITTED BY: | Brenda Gefucia, Committee Chair |

FOR RECEIPT

The purpose of this report is to summarize the activities and accomplishments of the MAHC Muskoka & Area Ontario Health Team (MAOHT) Committee during the 2021-2022 board year and to identify recommendations for consideration in next year's committee work plan. There were seven meetings of the Committee this year. Committee members included Directors Beth Goodhew, Roy Stewart and Carla Clarkson-Ladd.

## I. Summary list of key accomplishments this year:

- The role of the Committee is to oversee and make recommendations to the Board on MAOHT governance, planning, and decision-making. The Committee provides oversight and direction on the Corporation's involvement in the evolution of the MAOHT, including: the interim through end-state governance structure of the MAOHT; the impact on the Corporation's financial affairs, human resource management, and information technology; and the identification of any risks to the achievement of the Corporation's strategy and compliance with any funding agreements. As such Committee members were kept up-to-date throughout the year as it relates to:
  - The evolution of the MAOHT Governance Structure
  - TPA compliance, given MAHC is the fundholder
  - Core MAOHT activity including programs, services and priority projects
  - Digital projects
  - Overall budget and funding
  - Strategic planning
  - Key risk categories for the MAOHT including resource risk; partnership risk; compliance risk; and patient care risks.
  - Any risks related to MAHC through MAOHT activities
- Ongoing monitoring occurred with respect to the progress of finalizing Partner indemnification of the Fund Holder (MAHC) and the Employer of Record (Cottage Country Family Health Team) should any non-insurable liabilities be incurred. The risk to MAHC remains low given the number of internal controls that are in place however it does remain a high priority to bring to resolution before the programs and services grow and broaden and there is more risks accrued to the Fund Holder and Hiring Partner. The Alliance Council has recommended a tiered, financial capacity-based allocation as the equitable (not equal) methodology which was brought to the committee in May 2022.
- The MAOHT Alliance Council work plan was established based on members' prioritization of the actions embedded in the Council's terms of reference, the Transfer Payment Agreement and any other new Ministry requirements. The Committee provided input and suggestions into this prioritization to assist in finalizing the submission on behalf of MAHC.
- Developing a strategy and strategic plan was prioritized as a key work plan item for the Alliance Council. As part of the data gathering approach, the Committee provided comments and suggestions with respect to validating the Vision, Values and Operating Principles. As well the

Committee identified key focus areas and any further opportunities or risks that the Alliance Council should consider in this work.

- A significant strategy was presented to the Committee that is intended to have a positive impact on MAHC's occupancy and improve the transition of Alternate Level of Care patients from hospital to home. This would involve MAHC applying to be a Health Service Provider under the *Home and Community Care Act* and a request to Ontario Health to provide funding ($2.8 million) to implement a Transitional Care Program at MAHC. Following consideration of the proposal including the benefits to patients and improvements to several quality-of-care performance indicators at MAHC, the Committee made recommendation to the Board of Directors to proceed with this application.
- Reviewed and accepted the Standing Committee policy - Muskoka and Area Ontario Health Team ("MAOHT") Committee

II. Is the Committee following their work plan and meeting their terms of reference and are there any recommendations for consideration in the upcoming year:

- Given the nature of the MAOHT, a formal workplan was not developed for the Committee. Committee activities and timing of those activities follow the activities of the MAOHT.

III. Are there any emerging risks/issues arising from the Committee's work that the full board should be aware of in preparation for the coming year?

- The Committee Chair (who is also the Board Chair's delegate on the Alliance Council and Co-Chair of the Alliance Council) is entering her final year as a member of the Board. Succession consideration should be made to ensure that MAHC continues to be ably represented at MAOHT. As the MAOHT matures, the profile of risks and opportunities and impacts on MAHC will change.

ANNUAL

INCLUSION, DIVERSITY, EQUITY & ANTI-RACISM (IDEA)

WORKING GROUP REPORT

2021-2022

| | |
|---|---|
| SUBMITTED TO: | Members of the Corporation |
| SUBMITTED BY: | Beth Goodhew, Chair, IDEA Working Group |

FOR RECEIPT

The purpose of this report is to summarize the activities and accomplishments of the IDEA Working Group during the 2021-2022 board year and to identify recommendations for consideration in next year's committee work plan. There were 6 regular meetings of the IDEA Working Group this year; as per work plan projections the regular meeting of the working group took place in September, November, January, February, March and May.

I. Summary list of key accomplishments this year:

- The working group started by completing the terms of reference and work plan.
- Operational updates were provided at the beginning of the working group meetings to understand the work that was being done by the MAHC internal IDEA Committee.
- An IDEA Framework to operationalize and align with the 4 pillars of inclusion, diversity, equity and anti-racism was developed for review by the working group.
- The working group coordinated the Board of Director and Senior Staff education sessions conducted by an external vendor that were a good foundation to support the Board moving forward with our commitment to inclusion, diversity, equity and anti-racism.
- Supported the Governance Committee with the Policy review with an IDEA lens.
- Support for MAHC's internal IDEA committee and participation in the Muskoka District IDEA forum.
- The working group provided recommendations to the Strategic Planning Committee for revisions to the Strategic Plan that would better reflect our commitment to IDEA.
- A Board IDEA profile survey was completed to gather data regarding the board diversity, skills and experience. The results were reviewed by the BOD at a summary level.
- The MAHC staff IDEA survey was completed to develop baseline IDEA data.

II. Is the Committee following their work plan and meeting their terms of reference and are there any recommendations for consideration in the upcoming year:

- Review the analysis of the staff survey results to help establish a baseline.
- Further education for the Board
- Complete a community engagement plan with a cross section of representation to advance and inform inclusivity at MAHC
- Based on the Framework develop the BOD IDEA report and key metrics with gathered baseline data.
- Continue with the working group for at least one more year to provide support for the operationalization of the IDEA framework, including the development of a statement, set of principles and/or policy to guide activity at the Board level

III. Are there any emerging risks/issues arising from the Committee's work that the full board should be aware of in preparation for the coming year?

- No risks or issues

## IV. 2021/2022 Working Group Work Plan

| | | | | Q2 | Q3 | | Q4 | | Q1 |
|---|---|---|---|---|---|---|---|---|---|
| **Deliverable** | **TOR Link** | **MRP** | **Occurrence** | **Sept** | **Nov** | **Jan** | **Feb** | **Mar** | **May** |
| Land Acknowledgement | *NA* | Chair | Every Meeting | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ***Contribute to and Establish Strategic Directions*** | | | | | | | | | |
| Board of Directors Education that will promote awareness and understanding of IDEA within MAHC and support the development of IDEA-focused leadership. | | | | | ✓ | | | | |
| Provide recommendations to the Strategic Planning Committee that will support IDEA through changes or additions to the Strategic Plan | | | | | A | ✓ | ✓ | | |
| Provide input and support to the Governance Committee as they complete the review of policies with the lens of IDEA | | | | | A | | ✓ | | |
| ***Provide for Excellent Management*** | | | | | | | | | |
| General update and report on operational IDEA Work | | | | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Review IDEA framework for the operationalization of the key focus areas outlined in the IDEA policy. | | | | | | | | ✓ | |
| Review and support the evolution and application of MAHC's Inclusion, Diversity, Equity and Anti-Racism Strategy, Policy and Framework. | | | | ✓ | ✓ | ✓ | | ✓ | |
| ***Ensure Program Quality & Effectiveness*** | | | | | | | | | |
| Review and identify healthcare industry best practices and barriers to success related to Inclusion, Diversity, Equity, Anti-Racism at MAHC. | | | | | | ✓ | | | |
| Determine Board committee responsible for future reporting | | | | | | | | | ✓ |
| Policy Review | | | | | | | | | |
| • Inclusion, Diversity, Equity & Anti-Racism (IDEA) policy | | | 3 years or Ad Hoc | | | | | | |
| Determine a baseline of current state that will support the development of IDEA reporting | | | | | | ✓ | | | |
| Develop IDEA report that contains key metrics for Board Oversight | | | | | | | | | ~~X~~ |
| ***Financial Viability, In Accordance With The Standards Applicable To The Directors At Law*** | | | | | | | | | |
| | | | | | | | | | |
| ***Foster Relationships*** | | | | | | | | | |
| Support the creation and implementation of engagement plans with a diverse cross section of representation to inform and advance inclusivity in the planning and activities of MAHC | | | | | | | | ~~X~~ | |
| ***Ensure Board Effectiveness*** | | | | | | | | | |
| Committee Orientation | | | Annually | ✓ | | | | | |
| Recommend 21/22 Work Plan to Board of Directors | | | Annually | ✓ | | | | | |
| Committee Work Plan Check Ins | | Chair | Monthly | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Committee Terms of Reference | | Chair | Annually | ✓ | C | | | | |
| Complete Working Group Self-Evaluation | | Chair | Annually | | | | | | ✓ |
| Review Annual Working Group Report | | Chair | Annually | | | | | | ✓ |
| Chair to plan for knowledge transfer to incoming Chair | | Chair | Annually | | | | | | ✓ |

# APPENDIX A
# 2021-2022 Board of Directors

Cameron Renwick

Moreen Miller

Dave Uffelmann

Brenda Gefucia

Beth Goodhew

Tim Ellis

Roy Stewart

John Sisson

Sally Ashton

Evelyn Bailey

Carla Clarkson-Ladd

Marsha Barnes

# APPENDIX B
# 2022 Board Award of Excellence Nominees


# Board Award of Excellence 2022

*and the nominees are...*

**Allison Peace**
Executive Assistant

**Amy Gargal**
Interim Manager of ICU & District Stroke Coordinator

**Bryson Blakelock**
Recruitment & Workforce Planning Specialist

**Cierra Smyth**
Registered Practical Nurse

**Debbie Cattrysse**
Registered Practical Nurse

**Heather Scott**
Lab Transcriptionist

**Jason DeValadares**
Technical Support Specialist

**Jennifer Hall**
Environmental Services Aid

**Julie Jones**
RN, Dialysis Clinical Leader

**Sue Kennedy**
Registered Nurse

**Vraj Patel**
Technical Support Specialist

# APPENDIX C
# Audited Financial Statements

Financial Statements of

# MUSKOKA ALGONQUIN HEALTHCARE

Year ended March 31, 2022

# MUSKOKA ALGONQUIN HEALTHCARE

Financial Statements Index

Year ended March 31, 2022

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KPMG LLP
Claridge Executive Centre
144 Pine Street
Sudbury ON P3C 1X3
Canada
Tel 705-675-8500
Fax 705-675-7586

# INDEPENDENT AUDITORS' REPORT

To the Board of Directors of Muskoka Algonquin Healthcare

## *Opinion*

We have audited the accompanying financial statements of Muskoka Algonquin Healthcare (the "Entity"), which comprise:

- the statement of financial position as at March 31, 2022
- the statement of operations for the year then ended
- the statement of changes in net assets (deficiency) for the year then ended
- the statement of cash flows for the year then ended
- and notes to the financial statements, including a summary of significant accounting policies

(Hereinafter referred to as the "financial statements")

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of Muskoka Algonquin Healthcare as at March 31, 2022, and its results of operations, its changes in net assets and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

## *Basis for Opinion*

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the ***Auditors' Responsibilities for the Audit of the Financial Statements*** section of our report.

We are independent of the Entity in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada and we have fulfilled our other responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

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

Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

## *Auditors' Responsibility for the Audit of the Financial Statements*

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

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit.

We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion.

  The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Entity's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.

- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Entity's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditors' report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditors' report. However, future events or conditions may cause the Entity to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represents the underlying transactions and events in a manner that achieves fair presentation.
- Communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

KPMG LLP

Chartered Professional Accountants, Licensed Public Accountants

Sudbury, Canada

June 9, 2022

# MUSKOKA ALGONQUIN HEALTHCARE

Statement of Operations

Year ended March 31, 2022, with comparative information for 2021

| | 2022 | 2021 |
|---|---|---|
| Revenue: | | |
| Ministry of Health | $ 76,361,499 | $ 74,377,262 |
| Ministry of Health - one-time | 406,431 | 218,568 |
| Ministry of Health pandemic funding (note 13) | 12,316,550 | 9,376,151 |
| Patient charges | 7,505,830 | 6,084,686 |
| Other (note 12) | 4,266,192 | 5,043,615 |
| Amortization of deferred equipment contributions | 2,570,798 | 2,719,203 |
| | 103,427,300 | 97,819,485 |
| Expenses: | | |
| Salaries and wages | 52,854,623 | 49,229,576 |
| Employee benefits | 12,932,604 | 12,873,787 |
| Supplies and other | 15,064,722 | 14,225,506 |
| Medical staff remuneration | 8,205,115 | 7,698,796 |
| Drugs | 3,001,207 | 3,104,388 |
| Medical and surgical supplies | 4,793,009 | 4,432,776 |
| Amortization of equipment | 2,621,784 | 2,278,356 |
| | 99,473,064 | 93,843,185 |
| Excess of revenue over expenses before the undernoted items | 3,954,236 | 3,976,300 |
| Other program: | | |
| Revenue | 13,950 | 13,950 |
| Expenses | (17,117) | (17,066) |
| | (3,167) | (3,116) |
| Excess of revenue over expenses from Hospital operations | 3,951,069 | 3,973,184 |
| Amortization of deferred capital contributions | 1,513,504 | 1,450,482 |
| Amortization of buildings and building service equipment | (1,876,651) | (1,799,134) |
| Excess of revenue over expenses before the undernoted items | 3,587,922 | 3,624,532 |
| Ministry of Health working capital funding | - | 7,712,500 |
| Excess of revenue over expenses | $ 3,587,922 | $ 11,337,032 |

See accompanying notes to financial statements.

# MUSKOKA ALGONQUIN HEALTHCARE

Statement of Financial Position

March 31, 2022, with comparative information for 2021

| | 2022 | 2021 |
|---|---|---|
| **Assets** | | |
| Current assets: | | |
| Cash | $ 22,741,500 | $ 432,518 |
| Restricted cash (note 2) | 2,000,000 | - |
| Accounts receivable (note 3) | 5,220,325 | 18,008,079 |
| Inventories | 670,839 | 561,043 |
| Due from related parties (note 4) | 1,822,729 | 743,627 |
| Prepaid expenses | 695,686 | 488,181 |
| | 33,151,079 | 20,233,448 |
| Capital assets (note 5) | 44,223,519 | 43,558,016 |
| | $ 77,374,598 | $ 63,791,464 |
| **Liabilities, Deferred Contributions and Net Assets (Deficit)** | | |
| Current liabilities: | | |
| Accounts payable and accrued liabilities (note 7) | $ 18,399,455 | $ 15,793,001 |
| Deferred operating contributions (note 8) | 420,697 | 300,837 |
| Current portion of long-term obligations (note 9) | - | 590,000 |
| | 18,820,152 | 16,683,838 |
| Long-term obligations (note 9) | 12,467,218 | 6,446,542 |
| Deferred contributions related to capital assets (note 10) | 43,565,608 | 41,727,386 |
| | 74,852,978 | 64,857,766 |
| Net assets (deficit): | | |
| Unrestricted | 521,620 | (1,066,302) |
| Restricted | 2,000,000 | - |
| | 2,521,620 | (1,066,302) |
| Contingencies (note 14) | | |
| | $ 77,374,598 | $ 63,791,464 |

See accompanying notes to financial statements.

On behalf of the Board:

Director

Director

# MUSKOKA ALONGQUIN HEALTHCARE

Statement of Changes in Net Assets (Deficiency)

Year ended March 31, 2022, with comparative information for 2021

| | Unrestricted | Restricted | 2022 Total | 2021 Total |
|---|---|---|---|---|
| Balance, beginning of year | $ (1,066,302) | $ - | $ (1,066,302) | $ (12,403,334) |
| Transfers | (2,000,000) | 2,000,000 | - | - |
| Excess of revenue over expenses | 3,587,922 | - | 3,587,922 | 11,337,032 |
| Balance, end of year | $ 521,620 | $ 2,000,000 | $ 2,521,620 | $ (1,066,302) |

See accompanying notes to financial statements.

# MUSKOKA ALGONQUIN HEALTHCARE

Statement of Cash Flows

Year ended March 31, 2022, with comparative information for 2021

| | 2022 | 2021 |
|---|---|---|
| Cash flows from operating activities: | | |
| Excess of revenue over expenses | $ 3,587,922 | $ 11,337,032 |
| Adjustments for: | | |
| Amortization of capital assets | 4,498,435 | 4,077,490 |
| Amortization of deferred contributions related to capital assets | (4,084,302) | (4,169,685) |
| Increase in post-retirement benefit obligations | 94,300 | 112,900 |
| | 4,096,355 | 11,357,737 |
| Change in non-cash working capital: | | |
| Accounts receivable | 12,787,754 | (15,975,530) |
| Inventories | (109,796) | (3,996) |
| Due from related parties | (1,079,102) | 633,582 |
| Prepaid expenses | (207,505) | (83,426) |
| Accounts payable and accrued liabilities | 2,606,454 | 2,697,463 |
| Other long-term liabilities | 6,741,755 | 1,185,473 |
| Deferred operating contributions | 119,860 | - |
| | 24,955,775 | (188,697) |
| Cash flows from financing activities: | | |
| Proceeds from issuance of long-term debt | - | 579,328 |
| Principal repayment on long-term debt | (1,405,379) | (340,000) |
| | (1,405,379) | 239,328 |
| Cash flows from capital activities: | | |
| Purchase of capital assets | (5,163,938) | (4,999,936) |
| Deferred contributions related to capital assets | 5,922,524 | 4,586,445 |
| | 758,586 | (413,491) |
| Net increase (decrease) in cash | 24,308,982 | (362,860) |
| Cash, beginning of year | 432,518 | 795,378 |
| Cash, end of year | $ 24,741,500 | $ 432,518 |
| Made up of: | | |
| Cash | 22,741,500 | 432,518 |
| Restricted cash (note 2) | 2,000,000 | - |
| | $ 24,741,500 | $ 432,518 |

See accompanying notes to financial statements.

Muskoka Algonquin Healthcare (the "Hospital") is incorporated without share capital under the laws of the Province of Ontario. Its principal activity is the provision of health care services to the residents of Burk's Falls, Huntsville, Bracebridge, Gravenhurst, Township of Muskoka Lakes, Township of Georgian Bay, Township of Lake of Bays and the surrounding areas. The Hospital is a registered charity and, as such, is exempt from income taxes provided certain requirements under the Income Tax Act are met.

**1. Significant accounting policies:**

The financial statements have been prepared by management in accordance with Canadian public sector accounting standards including the 4200 standards for government not-for-profit organizations. A statement of remeasurement gains and losses has not been included as there are no matters to report therein.

(a) Revenue recognition:

The Hospital accounts for contributions, which include donations and government grants, under the deferral method of accounting.

Under the Health Insurance Act and Regulations thereto, the Hospital is funded primarily by the Province of Ontario in accordance with budget arrangements established by the Ministry of Health (the "Ministry") and Ontario Health Central ("OHC"). Operating grants are recorded as revenue in the period to which they relate. Grants approved but not received at the end of an accounting period are accrued. Where a portion of a grant relates to a future period, it is deferred and recognized in the subsequent period.

Unrestricted contributions are recognized as revenue when received or receivable if the amounts can be reasonably estimated and collection is reasonably assured.

Externally restricted contributions are recognized as revenue in the period in which the related expenses are recognized.

Contributions restricted for the purchase of capital assets are deferred and amortized into revenue on a straight-line basis at rates corresponding to those of the related capital assets.

Revenue from patient and other services is recognized when the service is provided.

(b) Inventories:

Inventories are stated at the lower of average cost and net realizable value. Cost comprises all costs to purchase, convert and any other costs in bringing the inventories to their present location and condition.

(c) Donated assets:

Donated capital assets are recorded at fair value when received.

**1. Significant accounting policies (continued):**

(d) Capital assets:

Purchased capital assets are recorded at cost. The original cost does not reflect replacement cost or market value upon liquidation. Assets acquired under capital leases are amortized over the estimated life of the assets or over the lease term, as appropriate. Repairs and maintenance costs are charged to expense. Betterments which extend the estimated life of an asset are capitalized. When a capital asset no longer contributes to the Hospital's ability to provide services, its carrying amount is written down to its residual value.

Construction in progress is not amortized until construction is complete and the facilities come into use.

Amortization is provided on the straight-line basis at the following range of annual rates:

| | Rate |
|---|---|
| Land improvements | 5% |
| Buildings | 2.5% and 5% |
| Major equipment | 10% - 33% |
| Computer software | 20% - 33% |

Long-lived assets, including capital assets subject to amortization, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability is measured by a comparison of the carrying amount to the estimated undiscounted future cash flows expected to be generated by the asset. If the carrying amount of the asset exceeds its estimated future cash flows, an impairment charge is recognized by the amount by which the carrying amount of the asset exceeds the fair value of the asset. When quoted market prices are not available, the Hospital uses the expected future cash flows discounted at a rate commensurate with the risks associated with the recovery of the asset as an estimate of fair value.

Assets to be disposed of would be separately presented in the statement of financial position and reported at the lower of the carrying amount or fair value less costs to sell, and are no longer amortized. The asset and liabilities of a disposed group classified as held for sale would be presented separately in the appropriate asset and liability sections of the statement of financial position.

**1. Significant accounting policies (continued):**

(e) Employee future benefits:

The Hospital sponsors a defined benefit health and dental plan for certain employees and retirees funded on a pay-as-you-go basis. The Hospital is also a member of a defined benefit pension plan. The Hospital has adopted the following policies:

The Hospital accrues its obligations under the defined benefit plans as the employees render the services necessary to earn the pension, compensated absences and other retirement benefits. The actuarial determination of the accrued benefit obligations for pensions and other retirement benefits uses the projected benefit method prorated on service (which incorporates management's best estimate of future salary levels, other cost escalation, retirement ages of employees and other actuarial factors). The most recent actuarial valuation of the benefit plans for funding purposes was as of March 31, 2021, and the next required valuation will be as of March 31, 2024.

Actuarial gains (losses) on plan assets arise from the difference between the actual return on plan assets for a period and the expected return on plan assets for that period. Actuarial gains (losses) on the accrued benefit obligation arise from differences between actual and expected experience and from changes in the actuarial assumptions used to determine the accrued benefit obligation. The net accumulated actuarial gains (losses) are amortized over the average remaining service period of active employees. The average remaining service period of the active employees covered by the pension plan is 14 years. The average remaining service period of the active employees covered by the other retirement benefits plan is 14 years.

Past service costs arising from plan amendments are recognized immediately in the period the plan amendments occur.

(f) Healthcare of Ontario Pension Plan:

The Hospital is an employer member of the Healthcare of Ontario Pension Plan (the “Plan”), which is a multi-employer, defined benefit pension plan. The Hospital has adopted defined contribution plan accounting principles for this Plan because insufficient information is available to apply defined benefit plan accounting principles. The Hospital records as pension expense the current service cost, amortization of past service costs and interest costs related to the future employer contributions to the Plan for past employee service.

(g) Use of estimates:

The preparation of the financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the periods specified. Significant items subject to such estimates and assumptions include the carrying amount of capital assets; valuation allowances for receivables and inventories; valuation of financial instruments; and assets and obligations related to employee future benefits. Actual results could differ from those estimates. These estimates are reviewed periodically, and, as adjustments become necessary, they are reported in earnings in the year in which they become known.

**1. Significant accounting policies (continued):**

(h) Funding adjustments:

The Hospital receives grants from the OHC and the Ministry for specific services. Pursuant to the related agreements, if the Hospital does not meet specified levels of activity, the Ministry or OHC may be entitled to seek recoveries. Should any amounts become recoverable, the recoveries would be charged to operations in the period in which the recovery is determined to be payable. Should programs and activities incur a deficit, the Hospital records any recoveries thereon when additional funding is received or receivable if the amounts can be reasonably estimated and collection is reasonably assured.

(i) Contributed services:

A substantial number of volunteers contribute a significant amount of their time each year. Given the difficulty of determining the fair market value, contributed services are not recognized in the financial statements.

(j) Financial instruments:

All financial instruments are initially recorded on the statement of financial position at fair value.

All investments, if any, held in equity instruments that trade in an active market are recorded at fair value. Management has elected to record investments at fair value as they are managed and evaluated on a fair value basis. Freestanding derivative instruments that are not equity instruments that are quoted in an active market are subsequently measured at fair value.

Unrealized changes in fair value are recognized in the statement of remeasurement gains and losses until they are realized, when they are transferred to the statement of operations.

Transaction costs incurred on the acquisition of financial instruments measured subsequently at fair value are expensed as incurred.

All financial assets are assessed for impairment on an annual basis. Where a decline in fair value is determined to be other than temporary, the amount of the loss is recognized in the statement of operations and any unrealized gain is adjusted through the statement of remeasurement gains and losses. On sale, the statement of remeasurement gains and losses associated with that instrument are reversed and recognized in the statement of operations.

**2. Restricted cash:**

The Hospital maintains restricted cash as approved by the Board of Directors. These internally restricted amounts are set aside to support future capital redevelopment and are not available for other purposes without approval by the Board of Directors.

**3. Accounts receivable:**

| | 2022 | 2021 |
|---|---|---|
| Insurers and patients | $ 1,416,817 | $ 1,217,625 |
| Ministry of Health | 3,015,087 | 16,325,903 |
| Other | 1,014,797 | 605,526 |
| | 5,446,701 | 18,149,054 |
| Allowance for doubtful accounts | (226,376) | (140,975) |
| | $ 5,220,325 | $ 18,008,079 |

**4. Related party transactions:**

(a) Huntsville District Memorial Hospital Foundation:

The Hospital has an economic interest in the Huntsville District Memorial Hospital Foundation ("HDMHF") in that HDMHF solicits funds on behalf of the Hospital to be used for approved capital projects. During the year, the HDMHF contributed donations of $2,843,217 (2021 - $1,047,844) to fund capital costs.

(b) South Muskoka Hospital Foundation:

The Hospital has an economic interest in the South Muskoka Hospital Foundation ("SMHF") in that SMHF solicits funds on behalf of the Hospital and other organizations in the community with similar objectives. During the year, SMHF contributed donations of $1,718,340 (2021 - $783,723) to fund capital costs.

(c) Due from related parties:

| | 2021 | 2021 |
|---|---|---|
| Huntsville District Memorial Hospital Foundation | $ 946,321 | $ 38,133 |
| South Muskoka Hospital Foundation | 876,408 | 705,494 |
| | $ 1,822,729 | $ 743,627 |

**5. Capital assets:**

| 2022 | Cost | Accumulated amortization | Net book value |
|---|---|---|---|
| Land | $ 669,783 | $ – | $ 669,783 |
| Land improvements | 538,228 | 514,043 | 24,185 |
| Buildings | 65,094,616 | 33,892,389 | 31,202,227 |
| Equipment | 65,475,621 | 53,148,297 | 12,327,324 |
| | $ 131,778,248 | $ 87,554,729 | $ 44,223,519 |

| 2021 | Cost | Accumulated amortization | Net book value |
|---|---|---|---|
| Land | $ 669,783 | $ – | $ 669,783 |
| Land improvements | 538,228 | 511,020 | 27,208 |
| Buildings | 63,575,106 | 32,036,978 | 31,538,128 |
| Equipment | 61,831,193 | 50,508,296 | 11,322,897 |
| | $ 126,614,310 | $ 83,056,294 | $ 43,558,016 |

**6. Short-term demand loans:**

The Hospital has an unutilized demand operating line of credit authorized to a maximum of $7,500,000, which bears interest at a rate of prime plus 0.50%. The line of credit is secured by a general security agreement. As of March 31, 2022 there was $Nil drawn on this line of credit (2021 - $Nil).

**7. Accounts payable and accrued liabilities:**

| | 2022 | 2021 |
|---|---|---|
| Ministry of Health | $ 1,930,724 | $ 1,133,339 |
| Trade payables | 7,646,708 | 6,033,554 |
| Accrued wages and benefits | 8,822,023 | 8,626,108 |
| | $ 18,399,455 | $ 15,793,001 |

**8. Deferred contributions:**

Deferred contributions represent unspent funding externally restricted for specific programs received in the current and/or prior periods that are related to a subsequent period.

| | 2022 | 2021 |
|---|---|---|
| Balance, beginning of year | $ 300,837 | $ 300,837 |
| Add contributions received | 119,860 | – |
| Balance, end of year | $ 420,697 | $ 300,837 |

**9. Long-term obligations:**

| | 2022 | 2021 |
|---|---|---|
| Post-retirement benefit obligation (a) | $ 2,647,000 | $ 2,552,700 |
| Long-term debt | – | 1,405,379 |
| Other | 9,820,218 | 3,078,463 |
| | 12,467,218 | 7,036,542 |
| Less current portion of long-term obligations | – | (590,000) |
| | $ 12,467,218 | $ 6,446,542 |

(a) Post-retirement benefit obligation:

The Hospital sponsors a post-retirement defined benefit plan for medical, life insurance and dental benefits for employees with various cost-sharing arrangements as determined by their collective agreements and conditions of employment. The most recent valuation of the employee future benefits was completed as at March 31, 2021. The next full valuation of the plan will be as of March 31, 2024.

The accrued benefit obligation is recorded in the financial statements as follows:

| | 2022 | 2021 |
|---|---|---|
| Balance, beginning of year | $ 2,552,700 | $ 2,439,800 |
| Add: benefit costs | 401,100 | 360,100 |
| | 2,953,800 | 2,799,900 |
| Less: benefit contributions | (306,800) | (247,200) |
| Balance, end of year | $ 2,647,000 | $ 2,552,700 |

**9. Long-term obligations (continued):**

(a) Post-retirement benefit obligation (continued):

Similar to most post-employment benefit plans (other than pension) in Canada, the Hospital's plan is not pre-funded, resulting in the plan deficit equal to the accrued benefit obligation.

The significant actuarial assumptions adopted in measuring the Hospital's accrued benefit obligation are as follows:

| | 2022 | 2021 |
|---|---|---|
| Discount rate | 3.89% | 3.21% |
| Initial health care cost trend rate | 5.57% | 5.57% |
| Initial dental care cost trend rate | 3.00% | 3.00% |
| Health care cost trend rate decreasing to | 3.57% | 3.57% |
| Dental care cost trend rate increasing to | 3.57% | 3.57% |

**10. Deferred contributions related to capital assets:**

Deferred contributions related to capital assets represent the unamortized or unspent balances of donations and grants received for capital asset acquisitions. The amortization of capital contributions is recorded as revenue in the statement of operations.

| | 2022 | 2021 |
|---|---|---|
| Balance, beginning of year | $ 41,727,386 | $ 41,310,626 |
| Less amount amortized to revenue | (4,084,302) | (4,169,685) |
| Add contributions received: | | |
| Foundations | 4,561,557 | 1,831,567 |
| Ministry of Health | 1,341,786 | 2,606,128 |
| Hospital Auxiliary and other | 19,181 | 148,750 |
| | 5,922,524 | 4,586,445 |
| Balance, end of year | $ 43,565,608 | $ 41,727,386 |

| | 2022 | 2021 |
|---|---|---|
| Unamortized | $ 41,543,910 | $ 37,048,648 |
| Unspent: | | |
| Capital projects | 2,021,698 | 4,678,738 |
| | $ 43,565,608 | $ 41,727,386 |

**11. Pension plan:**

Substantially all of the employees of the Hospital are members of the Healthcare of Ontario Pension Plan (the "Plan"), which is a multi-employer defined benefit plan. Employer contributions made to the Plan during the year by the Hospital amounted to $3,770,622 (2021 - $3,647,291).

**12. Other revenue:**

| | 2022 | 2021 |
|---|---|---|
| Differential and co-payment fees | $ 350,443 | $ 570,655 |
| Parking fees | 482,246 | 324,524 |
| Wages and material recoveries | 1,710,564 | 1,901,184 |
| Laundry recoveries | 626,346 | 595,291 |
| Rental income | 67,969 | 63,966 |
| Interest income | 16,870 | 191 |
| Other | 1,011,754 | 1,587,804 |
| | $ 4,266,192 | $ 5,043,615 |

**13. Ministry of Health pandemic funding:**

In connection with the ongoing coronavirus pandemic ("COVID-19), the MOH has announced a number of funding programs intended to assist hospitals with incremental operating and capital costs and revenue decreases resulting from COVID-19. In addition to these funding programs, the MOH is also permitting hospitals to redirect unused funding from certain programs towards COVID-19 costs, revenue losses and other budgetary pressures through a broad-based funding reconciliation.

While the MOH has provided guidance with respect to the maximum amount of funding potentially available to the Hospital, as well as criteria for eligibility and revenue recognition, this guidance continues to evolve and is subject to revision and clarification subsequent to the time of approval of these financial statements. The MOH has also indicated that all funding related to COVID-19 is subject to review and reconciliation, with the potential for adjustments during the subsequent fiscal year.

Management's estimate of MOH revenue for COVID-19 is based on the most recent guidance provided by MOH and the impacts of COVID-19 on the Hospital's operations, revenues and expenses. As a result of Management's estimation process, the Hospital has determined a range of reasonably possible amounts that are considered by Management to be realistic, supportable and consistent with the guidance provided by the MOH. However, given the potential for future changes to funding programs that could be announced by the MOH, the Hospital has recognized revenue related to COVID-19 based on the lower end of the range. Any adjustments to Management's estimate of MOH revenues will be reflected in the Hospital's financial statements in the year of settlement.

**13. Ministry of Health pandemic funding (continued):**

Details of the MOH funding for COVID-19 recognized as revenue are summarized below:

| | 2022 | 2021 |
|---|---|---|
| Funding for incremental COVID-19 operating expenses | $ 3,131,165 | $ 5,126,800 |
| Funding for bedded capacity | 7,685,320 | – |
| Funding for temporary pandemic pay | – | 1,363,495 |
| Funding for revenue losses resulting from COVID-19 | – | 2,001,900 |
| Broad-based funding reconciliation for other eligible costs and revenue losses | – | 677,005 |
| Funding for CT backlogs resulting from COVID-19 | 850,694 | – |
| COVID swab assessment centre funding losses | 512,354 | 343,502 |
| COVID funding for ICU beds | – | 177,000 |
| Other COVID funding | 137,017 | 228,449 |
| | 12,316,550 | 9,918,151 |
| Less: Provision for measurement uncertainty | – | (542,000) |
| | $ 12,316,550 | $ 9,376,151 |

In addition to the above, the Hospital has also recognized $Nil (2021 - $922,724) in MOH funding for COVID-19 related capital expenditures, which has been recorded as an addition to deferred capital contributions during the year.

**14. Contingencies:**

(a) Legal matters and litigation:

The nature of the Hospital's activities is such that there is usually litigation pending or in process at any given time. With respect to claims at March 31, 2022, management believes the Hospital has valid defenses and appropriate insurance coverage in place. In the event any claims are successful, management believes that such claims are not expected to have a material effect on the Hospital's financial position.

(b) HealthCare Insurance Reciprocal of Canada:

The Hospital is a member of the HealthCare Insurance Reciprocal of Canada ("HIROC"). HIROC is a pooling of the liability insurance risk of its members. All members pay annual deposit premiums which are actuarially determined and are subject to further assessment for losses, if any, experienced by the pool for the years in which they are members. As at March 31, 2022, no assessments have been received by the Hospital.

(c) Employment matters:

During the normal course of business, the Hospital is involved in certain employment related negotiations and has recorded accruals based on management's estimate of potential settlement amounts where these amounts are reasonably determinable. Where amounts are not reasonably determinable, costs, if any, relating to these matters would be recognized when known.

**15. Financial risks and concentration of credit risks:**

(a) Credit risk:

Credit risk refers to the risk that a counterparty may default on its contractual obligations resulting in a financial loss. The Hospital is exposed to credit risk with respect to accounts receivable.

The Hospital assesses, on a continuous basis, accounts receivable and provides for any amounts that are not collectible in the allowance for doubtful accounts. The maximum exposure to credit risk of the Hospital at March 31, 2022 is the carrying value of these assets.

Management considers credit risk to be minimal as most of the accounts receivable balance is collected in a timely fashion.

There have been no significant changes to the credit risk exposure from 2021.

(b) Liquidity risk:

Liquidity risk is the risk that the Hospital will be unable to fulfill its obligations on a timely basis or at a reasonable cost. The Hospital manages its liquidity risk by monitoring its operating requirements. The Hospital prepares budget and cash forecasts to ensure it has sufficient funds to fulfill its obligations.

Accounts payable and accrued liabilities are generally due within 60 days of receipt of an invoice.

There have been no significant changes to the liquidity risk exposure from 2021.

(c) Other risk:

In response to COVID-19 and consistent with guidance provided by the MOH and other government agencies, the Hospital has implemented a number of measures to protect patients and staff from COVID-19. In addition, the Hospital has actively contributed towards the care of COVID-19 patients and the delivery of programs that protect public health.

The Hospital continues to respond to the pandemic and plans for continued operational and financial impacts during the 2023 fiscal year and beyond. Management has assessed the impact of COVID-19 and believes there are no significant financial issues that compromise its ongoing operations. The outcome and timeframe to a recovery from the current pandemic is highly unpredictable, thus it is not practicable to estimate and disclose its effect on future operations at this time.