MUSKOKA ALGONQUIN
HEALTHCARE

Pre-Capital Submission Form
Capital Development Project

Revised 2015 October 29

MUSKOKA ALGONQUIN HEALTHCARE

October 29, 2015

For more than two years, Muskoka Algonquin Healthcare (MAHC) has been engaged in a planning exercise to identify and develop options for the best future service delivery model and establish the associated long-range facility requirements to best meet the needs of the health care system, the communities we serve, and the staff, physicians and volunteers who deliver care to our patients. This opportunity to comprehensively examine MAHC's current service delivery model has been a valuable exercise that has reinforced the need for the MAHC Board of Directors to identify a vision for the future. MAHC has appreciated the opportunity to lead the community's dialogue on the future and engage feedback. This planning exercise has been an opportunity for MAHC to best position the organization's future focus on acute care priorities, while protecting and strengthening our health care system. More importantly, it has emphasized significant quality and safety issues and challenges that are facing MAHC today.

Impacted by aging and failing infrastructure, significant operating costs that exceed provincial funding, and space constraints that jeopardize infection prevention and control and health and safety, MAHC has embraced the opportunity to envision the future with creativity and innovation, driven by the Ministry of Health and Long-Term Care's transformation of the health care sector to ensure that patients are at the centre of their care. MAHC is prepared and determined to support the Ministry's shift toward a sustainable, efficient and accountable health care system that provides co-ordinated quality care to people in the right place, at the right time, by the right provider.

The future service delivery model that MAHC is proposing in its Pre-Capital Submission recommends a vision for the future that looks very different from the service delivery model of today, yet is a more financially sustainable model that is consistent with evolving to a more efficient health care system that will survive for generations. It is the position of MAHC that the proposed model ensures the best quality, safety and sustainability of acute care services in the region.

Quality and safety continue to be the number one priority of MAHC and the proposed model will enhance program and service development, and address growth opportunities for the MAHC catchment population in the North Simcoe Muskoka LHIN. Providing a stable environment that better enables opportunities to recruit and retain qualified health care providers will sustain and improve the quality of care delivered by MAHC.

MAHC is one piece of a system approach to care in the region. The Board of Directors is committed to fostering collaborative relationships with our partners to be active partners in health integration opportunities locally as well as transportation initiatives that improve access to care for our communities.

Natalie Bubela
Chief Executive Officer

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Pre-Capital Submission Form (PCSF)

Proposing Health Service Provider (HSP) Information

Proposed Project Name:	MAHC Capital Development Proposal	**For LHIN Use Proposal #:**	
HSP Name (Legal):	Muskoka Algonquin Healthcare	**For MOHLTC Use HCIS#:**	
Site Name, Address and Postal Code:	100 Frank Miller Drive, Huntsville, ON P1H 1H7	**LHIN:**	
Submission Date:	October 29, 2015		

Facility Type– Please Select	
Public Hospitals (including own funds projects as per legislation)	☒
Community Health Centres	☐
Community-Based Mental Health Programs	☐
Community-Based Substance Abuse (Addiction) Programs	☐
Long-term Care Supportive Housing Providers (typically supporting programs for the frail elderly, acquired brain injury, physically disabled and HIV/AIDS)	☐

	HSP Primary Contact	**HSP Secondary Contact**
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HSP Approval:		
CEO/ED Name:	Natalie Bubela	
CEO/ED Signature:	Natalie Bubela	

Section 2 – Proposal Overview

Build Type Descriptions

Addition	☐	**Green field**	☒	**Infrastructure**	☒
Renovation	☐	**Remediation**	☐	**Leasehold Improvement**	☐
Brown field	☐	**Decommissioning**	☐	**Property acquisition**	☒
				Other	☐

Service Type Descriptions

Is this a proposal for a single or multi-service project?

Acute	☒	**ELDCAP**	☐	**Mental Health – Longer Term**	☐
Ambulatory	☒	**Emergency**	☒	**Rehab**	☒
CCC	☒	**Neonatal ICU**	☐	**Infrastructure**	☒
Adult Critical Care/ICU	☒	**Provincial Program**	☐	**Mental Health – Acute**	☐
Other Service Type	☒				
Support Service – Please Select					
Laboratory	☒	**CT**	☒	**Food Services**	☒
Pharmacy	☒	**Allied Disciplines**	☒	**Housekeeping**	☒
General DI	☒	**Counselling**	☒	**Maintenance**	☒
MRI	☒ Future	**Staff Facilities**	☒	**Other**	☒

Pre-Capital Submission Form

Completion Guideline: *It is expected that the response to Section 3 (Part A and Part B) will be completed in 15 regularly spaced pages.*

It is important that HSPs ensure their submissions closely follow the format outlined in the guidelines and checklists for each stage, to ensure LHIN and ministry review and to facilitate endorsement /approval.

Section 3 - Proposal

PART A

Program/Service Proposal – LHIN Review

1. Provide a narrative description of the program/service need to be addressed by this initiative. Examples include, but are not limited to:

    a. Need for new program(s)/service(s).
    b. Need for expanded program(s)/service(s).
    c. Need for program redesign or integration.

Located within the North Simcoe Muskoka Local Health Integrated Network (NSM LHIN), Muskoka Algonquin Healthcare (MAHC) is a multi-site health care organization providing 24-hour emergency health care services, acute inpatient care and ambulatory services at the Huntsville District Memorial Hospital in Huntsville and the South Muskoka Memorial Hospital in Bracebridge. In addition, the organization delivers outpatient programs at the Almaguin Highlands Health Centre in Burk's Falls. Situated in rural Ontario's cottage country, MAHC serves the permanent residents of the Muskoka Census Division and East Parry Sound communities, and surging volumes of seasonal residents and transient visitors.

MAHC's South Muskoka Memorial Hospital (SMMH) site, located in a residential neighbourhood of Bracebridge, is a two-storey facility with penthouses and a partial basement. The oldest portions of the structure date from 1964, with major additions built in 1970, 2000 and 2006. Over time, some interiors have been renovated.

MAHC's Huntsville District Memorial Hospital (HDMH) site, located on a treed parcel of land in Huntsville, is a two-storey facility with a penthouse. The original portion of the structure dates from 1978, with minor additions in 1987 and 2003.

As part of the development of a Master Program and Master Plan, a functional and building assessment of each site was undertaken. The assessments rated both sites as poor with significant space and infrastructure challenges, including the following deficiencies:

- lack of separation of patient and public flow and clean and soiled materials flow
- lack of space to support patient-& family-centered practice, current infection control guidelines, patient/staff safety and accessibility, and privacy and confidentiality
- insufficient and undersized patient rooms
- low percentage of private room accommodation
- lack of airborne isolation rooms with ante rooms
- limited facilities for support service departments
- infrastructure that is inadequate for today's equipment and technology
- insufficient infrastructure for organized long-term growth and change
- minimal facilities for on-call study teaching and resource spaces for medical students
- inadequate air handling systems.

SMMH Site VFA Facility Condition Index
The 2012 VFA facility condition index rates the SMMH site at 0.20 (poor). Additional challenges include:

- neighbourhood proximity on two sides of the site

- property size constraints limit future growth
- distance from Highway 11.

HDMH Site VFA Facility Condition Index

The 2012 VFA facility condition index rates the HDMH site as a 0.47 (poor). Additional challenges include:

- aging/inadequate infrastructure
- topography of property
- inadequate sprinkler system.

The current infrastructure significantly challenges MAHC's ability to provide safe, evidence-informed, and high-quality health care. Based on activity projections documented in the MAHC Master Program & Master Plan (summarized in Tables 2 & 3 on page 6), the future service delivery model and recent hospital facility planning guidelines, the space required to provide the necessary services today, let alone into the future, would need to increase by more than 50%. These space constraints pose major clinical implications.

Operational funding is a challenge for health care organizations across Ontario. With the marked surge in MAHC population during the summer months, operating two acute care hospitals with facilities that are fast approaching their "best by" dates presents unique challenges in Muskoka. A new sustainable service model is essential to ensure safe, high-quality health care into the future. Investing in both sites is costly and would not enable MAHC to obtain potential operating savings. As a result, **a single site option** embodying a campus-of-care approach has been identified as the preferred service delivery option to ensure safe, high quality and sustainable health care at MAHC.

While a specific site location has not been identified at this early stage of planning, a location between Huntsville and Bracebridge will be selected in the next stage of planning in order to optimize travel time and access to services for the MAHC catchment population (Refer to Appendix E). The single site option allows for the following:

- maximizes critical volumes, thus ensuring high-quality care and services to patients and their families
- concentrates staff and services at one site, thereby reducing equipment duplication and human resource costs
- least disruptive to care delivery during construction compared to major renovations of existing sites
- presents a single rallying point for foundations and community donations versus distinct sites and catchments
- maximizes clinical and operational adjacencies and provides optimal clinical flow all under one roof with no duplication of services
- supports optimal staffing models
- enhances recruitment and retention of staff and physicians by providing a stable environment that offers optimal working conditions
- protects the viability of core services
- is the least expensive model to build, and is the least expensive model to operate
- offers the potential of siting several partner organizations in a campus of care approach thereby creating the clinical and administrative synergies which would serve not only the interests of all partners but also greatly benefit the patients, their families and the local health system as whole
- meets future growth needs with flexibility and growth potential.

2. Provide a statistical description of the program/service need to be addressed by this initiative: This should include:

    a. Demographic profile (current and projected population for 5, 10 and 20 years).
    b. Utilization profile (current and projected demand for 5, 10 and 20 years).

A. Ontario faces the demographic challenge of an aging population with 14.6% of its residents over the age of 65 years. The number of people 65 and over is expected to double over the next 25 years to 4.1 million. In addition, there are almost 300,000 Aboriginal people, First Nations, Métis and Inuit living in Ontario. This represents 2% of the total population of Ontario. Of note, the percent of aboriginal identity in the Muskoka Census Division is higher than the provincial average. It is known that First Nations peoples have increased health risks due to high rates of obesity, diabetes, and higher than average instances of smoking. First Nations cultural traditions will be accommodated in the service delivery model and supported in facilities that are planned.

Serving the majority of the population of the Muskoka SubLHIN, and situated in rural cottage country, MAHC's services anchor and support the health service system for the Muskoka Census Division and East Parry Sound communities as follows:

- Muskoka - six municipalities (the Towns of Bracebridge, Gravenhurst, and Huntsville, and the Townships of Georgian Bay Lake of Bays and Muskoka Lakes)
- Wahta Mohawk and Moose Deer Point First Nations
- East Parry Sound - patients from communities including Armour, Burk's Falls, Emsdale, Joly, Kearney, MacTier, McMurrich-Monteith, Magnetawan, Novar, Perry, Ryerson, Sundridge, South River, Strong (which are within the catchment area of the North East LHIN)
- seasonal residents (cottagers) - a large influx of summer tourists
- prisoner population from two federal institutions.

Over two thirds of MAHC inpatients reside in Huntsville, Bracebridge, or Gravenhurst. Approximately 8% of MAHC inpatients reside outside of the NSM and NE LHINs. Of note, over 17% of ED visits are for patients outside the NSM and NE LHIN. During peak cottage season, the population served by MAHC rises by an additional 80,000+ people (source: 2013 data, District of Muskoka), therefore broadening the catchment population to approximately 150,000 people. The total population in the Muskoka SubLHIN is expected to increase 13% between 2014 and 2034. If we weight the population by age, the growth rate increases to 51% over the next 20 years, primarily due to the anticipated high growth of residents age 65+. This increased population will bring a higher prevalence of age-related conditions such as circulatory disease, diabetes, arthritis, and dementia. In addition, the NSM LHIN and Muskoka Census Division have significantly larger aboriginal communities compared with the provincial average. Based on current health trends, planning will require a focus on diabetes and the complications arising from late stage diabetes, including on-going multi-system care and rehabilitation. Being able to meet and sustain the needs of these populations in particular will require appropriate facilities to respond to the growing demand for health care and models of care that are effective and operationally efficient.

Table 1: Population Growth (excludes Seasonal Estimates)

	Region	2014	2019	2024	2034	20 Year Change
Unweighted	Muskoka SubLHIN	62,126	63,901	65,986	70,159	13%
	Parry Sound	43,093	43,333	43,556	43,546	1%
	NSM LHIN	471,331	498,249	527,377	585,733	24%
	Province	13,672,718	14,392,871	15,181,617	16,755,443	23%
Weighted	Muskoka SubLHIN	79,948	88,418	98,549	120,591	51%
	Parry Sound	56,489	61,642	67,339	77,310	37%
	NSM LHIN	525,604	591,920	674,386	860,928	64%
	Province	14,135,390	15,707,579	17,715,987	22,138,586	57%

Source: Ministry of Finance Population Projections (Fall 2014), Discharge Abstract Database (DAD) 2011/12

B. MAHC has continued to model its service delivery to best suit the communities' needs. Aligning with the 'right provider, right care, right place, right time' strategy, the model supports an increasingly efficient and sustainable system of care. This approach provides hospital-based services for the acutely ill and shifts services out of the hospital to primary care and other appropriate community services as part of a hub model; thereby strengthening the provision of services in the community and inpatients' homes, where appropriate. Tables 2 and 3 on the following page outline the current and projected volumes for key clinical services over the 20-year planning horizon.

While it is estimated that visit volumes and bed numbers will increase over the 20-year timeframe to accommodate the needs of a growing and aging population, this increase has been tempered by the reduction in some volumes to align with provincial utilization benchmarks, and the relocation of some lower acuity emergency visits and clinical services to the community. Therefore, MAHC will not be substantially changing or increasing clinical services and/or programs in the future. There is no plan for MAHC to divest itself of acute care beds and associated services to neighbouring larger hospitals.

In addition to factoring population growth and aging, the following were considered in the projections of future health service demands on MAHC resources:

- assessing opportunities for repatriation

- adjusting occupancy rates to reflect LHIN and Provincial targets
- reviewing opportunities to reduce use of hospital resources including:
  - reducing the ALC rate from 28% to 9.5% in 20 years
  - identifying and shifting the ambulatory care sensitive conditions from inpatient to outpatient care - currently Muskoka subLHIN residents have high rates of admissions for ambulatory care sensitive conditions
  - reducing the number of low acuity/avoidable ED visits (CTAS 4 and 5)
  - reducing the high number of ICU admissions
  - reducing the current high rate (44%) of C-section deliveries.

Table 2: Bed Projections for the Single Site Option by Time Interval

			Total	MAHC Site		MAHC Single Site		
Program Inpatient Beds	2012-13	2013-14	2014-15	SMMH	HDMH	**2019-20**	**2024-25**	**2034-35**
Total	**111**	**99**	**96**	59	37	**108**	**115**	**139**
Medicine (1) (2)	**69**	**61**	**66**	37	29	**67**	**69**	**86**
Surgical (3)	**-**	**-**	**-**	-	-	**13**	**15**	**18**
Critical Care	**9**	**9**	**9**	4	5	**7**	**8**	**10**
Obstetrics	**5**	**5**	**5**	2	3	**3**	**3**	**3**
Complex Continuing Care	**28**	**24**	**16**	16	0	**18**	**20**	**22**
Nursery (not in total)	**3**	**3**	**3**	1	2	**2**	**2**	**2**

Notes:

(1) In 2014-15 medicine beds consisted of 61 beds plus 5 overflow beds staffed and operated

(2) Reflects equivalent beds currently housed in the Medicine Inpatient Units

(3) Surgical beds are not formally designated in current and historical workload

Table 3: Service Volume Projections for the Single Site Option by Time Interval

			Total	MAHC Site		MAHC Single Site		
	2012-13	2013-14	2014-15	SMMH	HDMH	**2019-20**	**2024-25**	**2034-35**
Emergency Services								
Unscheduled Emergency Visits, Total	**42,764**	**42,855**	**43,505**	**20,077**	**23,428**	**39,318**	**41,378**	**46,026**
- CTAS 1+2	2,473	4,079	4,034	1,721	2,313	4,268	4,518	5,069
- CTAS 3	17,078	18,204	18,317	8,478	9,839	19,136	20,143	22,497
- CTAS 4+5	23,213	20,572	21,154	9,878	11,276	15,914	16,716	18,460
Ambulatory Services								
Surgical Clinic Visits	2,919	2,326	**2,034**	612	1,422	2,184	2,477	3,002
Off-load Clinic Visits/Procedures	1,422	503	**254**	0	254	273	309	375
Fracture Clinic Visits (in ED)	3,108	N/A	N/A			2,713	2,876	3,198
Nutrition Consults	38	38	**30**	5	25	34	42	63
Diabetes Visits	5,035	3,452	**3,058**	808	2,250	3,325	3,885	5,308
Dialysis Annual Treatments	2,689	3,370	**3,405**	0	3,405	3,970	5,353	9,506
Systemic Therapy Treatments	954	1,029	**1,349**	64	1,285	1,548	2,028	3,281
Oncology Clinic Visits	1,837	1,874	**1,798**	765	1,033	2,063	2,703	4,373
Medical Day Care Visits	1,838	1,834	**1,816**	857	959	2,034	2,538	3,802
Pacemaker Visits	597		**N/A**	-	-			
Surgery Cases								
Inpatient Cases	804	855	**812**	534	278	876	941	1,074
Outpatient Cases/SDC	3,292	3,371	**3,015**	1,547	1,468	3,277	3,540	4,060
Cataracts	704	675	**696**	0	696	803	913	1,127
Endoscopy Cases	4,263	4,367	**4,314**	1,996	2,318	4,007	4,229	3,875

Table 3: Service Volume Projections for the Single Site Option by Time Interval…cont'd

			Total	MAHC Site		MAHC Single Site		
	2012-13	2013-14	2014-15	SMMH	HDMH	2019-20	2024-25	2034-35
Allied Health Services								
Rehabilitation Attendances	23,331	24,969	**24,622**	14,527	10,095	27,221	29,732	35,524
Clinical Nutrition Visits	1,375	1,291	**1,054**	622	432	1,186	1,325	1,656
Social Work - Stroke only	-	-	-	-	-	430	515	645
Cardiorespiratory Services								
Cardiology IP Procedures	3,127	3,085	**2,682**	1,506	1,176	3,057	3,932	6,450
Cardiology OP Procedures	833	2,229	**1,218**	337	881	1,313	1,396	1,538
Cardiology ED Procedures	9,334	8,700	**9,574**	4,677	4,897	8,645	9,089	10,098
RT Procedures - IP	40,859	34,431	**22,008**	12,267	9,741	22,299	25,012	30,043
RT Procedures - OP	42,960	42,041	**15,763**	1,688	14,075	16,110	17,010	18,165
Diagnostic Imaging Services								
General Radiolography / IR Exams	38,489	40,438	**41,238**	24,944	16,294	41,581	44,284	49,800
Interventional Exams	405	410	**441**	63	378	460	521	608
Mammography Exams	4,061	4,280	**4,315**	1,085	3,230	4,651	4,946	5,447
OBSP Exams	1,721	N/A	**N/A**			N/A	N/A	N/A
CT Scanning Exams	16,479	16,795	**19,614**	10,788	8,826	20,716	22,091	24,643
Ultrasound / ECHO Exams	17,084	19,918	**24,820**	11,371	13,449	26,255	28,045	31,425
Nuclear Medicine Exams	3,254	2,715	**2,829**		2,829	2,571	2,709	3,024
BMD Exams	2,138	-	**-**			-	-	-
MRI Exams	-	-	-			-	1,200	2,000
Clinical Laboratory Services								
Anatomic Pathology	70,155	13,741	**18,013**	10,448	7,565	19,451	20,770	23,196
Clinical Chemistry	422,486	249,305	**262,709**	152,371	110,338	283,675	302,918	338,294
Clinical Hematology	116,335	60,087	**72,576**	42,094	30,482	78,368	83,684	93,457
Clinical Microbiology	81,003	29,798	**29,481**	17,099	12,382	31,834	33,993	37,963
Cytopathology	4,541	1,104	**1,218**	706	512	1,315	1,404	1,568
Pre & Post Analysis	95,306	99,219	**105,503**	61,192	44,311	113,923	121,651	135,857
Transfusion Medicine	15,842	7,046	**6,110**	3,544	2,566	6,598	7,045	7,868
Pharmacy Services								
Units	688,073	723,047	**711,546**	356,436	336,606	802,138	903,341	1,144,629

3. Describe how this program(s)/service(s) need supports local health system integration and a unified system of care

    a. MOHLTC – Provincial programs (e.g. Cardiac Care and Transplantation)
    b. LHIN – Integrated Health Services Plan, Clinical Services Plan, agreement with Provincial Agencies such as Cancer Care Ontario and Ontario Renal Network, as required
    c. HSP – Strategic Plan, Organizational Goals, Accountability Agreements

In the development of the MAHC Master Program and Master Plan, the proposed single site service delivery model aligns with provincial and local planning frameworks and community needs including key priorities outlined in:

- Ontario's Action Plan for Health Care (MOHLTC)
- Ontario's Priority Programs
- NSM LHIN's Integrated Health Service Plan (IHSP)
- NSM LHIN's Care Connections
- Rural and Northern Health Care Report
- MAHC 2012-2014 and 2015-2018 Strategic Plans

MAHC provides permanent and seasonal residents and visitors with equitable and reasonable access to quality health care services. MAHC continues in its role of improving access to care and of supporting and enhancing a 'healthy community'. It maintains effective linkages with larger centres and with community and primary care providers thereby not duplicating health care services at the community hospital level. Special challenges that face community hospitals where lower visit volumes and challenges in recruiting healthcare professionals may make the provision of some services difficult to sustain. MAHC is constantly working with the NSM LHIN, Orillia Soldiers' Memorial Hospital, Royal Victoria Regional Health Centre, Collingwood General & Marine Hospital, Georgian Bay General Hospital, Waypoint Mental Health Centre, West Parry Sound Health Centre, and other health care partners to develop innovative ways of delivering health care services to their communities now and in the future. These services will continue to meet the future health care needs of Muskoka and East Parry Sound residents and align with the NSM LHIN's IHSP and Ontario's Action Plan to transform health care. A recent example of partnering with the NSM LHIN is the development of a regional stroke rehab program in which initial planning allocated up to 10 beds to MAHC. However, as the planning is still on going, these beds have not been included in MAHC's bed projections.

The objectives of the proposed Service Delivery Model (SDM) include:

- further developing a model of integrated care
- creating a facility that supports and enhances key partnerships and linkages to best meet the health care needs of permanent and seasonal residents of the Muskoka Census Division and East Parry Sound communities in a rural location
- contributing to local health system integration and a unified family/patient-centered system of care
- identifying services to accommodate projected needs based on population health and demographic changes; defining health services and model(s) of service delivery that support the NSM LHIN's IHSP and Care Connections vision, and MOHLTC initiatives
- supporting requirements of Provincial Agencies, such as Cancer Care Ontario and Ontario Renal Network.

The proposed single site SDM will afford MAHC the opportunity to consolidate clinical and other services to achieve evidence-based best practices and critical mass integration. In addition, a single site promotes seamless care with primary care providers. A single site model supports efforts to reduce hospital admissions and ED visits and improves techniques to reduce length of stay. Ensuring sufficient human resource capacity within the LHIN to support these transitions will be fundamental. Strategies for future delivery of MAHC's acute care hospital-based services that align with evidenced-based best practices include:

- patient and family-centered care
- positive patient experience
- care provided close to home
- reduced wait times
- reduced numbers of Alternate Level of Care patients
- integration/collaboration of health care services across the continuum of care
- services moving into the community
- campus of care models
- step-up / step-down medical / surgical care beds
- efficient and effective services
- management of chronic disease
- health promotion and disease prevention.

Linkages & Partnerships with Community Services

During the master programming process, MAHC met with several key Community Services and Partners, such as the District of Muskoka, Emergency Medical Services, Family Health Teams and Nurse Practitioner Clinics, Hospice, community mental health partners and public health. These Services and Partners among others support MAHC in on-going improvements to services and service delivery model, which enables patients to transition from the emergency department and inpatient units to the community. This seamless integration assists in reducing the average length of stay and readmission rates to hospital. In addition, MAHC operates the Seniors Assessment and Support Outreach Team (SASOT) and accommodates the NSM Community Care Access Centre services on site. These Community Services and Partners provide a variety of quality health care services focused on supporting individuals and their families in their homes and other community locations. The goal is to facilitate successful discharges, reduce ED visits and repeat visits and avoid unnecessary hospital admissions.

Currently and into the future the local Community Services and Partners will support the continuum of health care and work with MAHC to:

- increase primary care access
- improve patient and family satisfaction
- increase physician follow-up within seven days of hospital discharge
- reduce the number of unattached (orphan) patients
- provide programming for and management of chronic disease
- contribute prenatal and postnatal programming
- enhance health promotion disease prevention and chronic disease management
- improve care co-ordination and navigation of the health care system at the local level
- provide house calls and children's services
- provide access to specialty services
- provide intensive case management for geriatric and palliative clients
- provide compassionate end-of-life care at home, in hospital and in the community
- participate in hospital-to-home initiatives to improve coordination of post-discharge from primary care.

The MAHC Master Program and Master Plan were developed within the context of MAHC's Strategic Plan 2012-2014 and refreshed 2015-2018 Strategic Plan. These priorities were central to the programming process and form the basis for moving forward with planning development. MAHC has aligned its programs and service delivery model to align and support the MOHLTC Provincial Priority Programs.

NSM LHIN Integrated Health Service Plan

MAHC's high-level goals for redevelopment are consistent with the three strategic priorities of the NSM LHIN's 2013-2016 IHSP:

1. Healthy People - Keeping Ontario healthy and providing support to become healthier.
2. Excellent Care - Faster access and a stronger link to family health care.
3. One System - The right care at the right time in the right place.

4. What discussions have occurred and please describe what level of support has been received from other stakeholders with regard to this initiative? Other stakeholders may include:

    d. Internal staff, physicians and/or Board members
    e. Other HSPs
    f. Neighbouring LHINs
    g. Provincial agencies (e.g. Cancer Care Ontario)
    h. Service partners
    i. Community stakeholders [Local Health System Integration Act, Section 16 (6) Each health service provider shall engage the community of diverse persons and entities in the area where it provides health services when developing plans and setting priorities for the delivery of health services. 2006. c. 4, s. 16 (6)]

The MAHC Board of Directors established a 21 member Ad-Hoc Steering Committee, including nine physicians, to lead the Master Program/Master Plan Development process over the past two years. The Ad-Hoc Committee was responsible for the development of the final recommended model that would best provide safe, high quality, sustainable health care for MAHC's service population in the year 2030 and beyond. The process involved extensive internal and external engagement using more than 20 planning teams with membership (200+ members) representing front-line staff including physicians, management, community providers and the Board of Directors.

Over the past several years, MAHC has continued to establish partnerships with other hospitals and community services in the region to ensure care is provided in the appropriate setting. By working together, the goal is to facilitate

successful discharges, reduce emergency department and repeat visits and avoid unnecessary hospital admissions. These partnerships align with NSM LHIN's priorities in providing a system of hospital- and community-based health care. During the master programming process MAHC met with a specific group representing key community service providers (detailed below) to establish future parameters/assumptions for service provision. These community services (as well as others) provide a variety of health care focused on providing quality care and supporting individuals in their homes and other community locations. These services among others support MAHC in ongoing improvements to service delivery that ensure patient care is provided in the most appropriate location, and also enable patients to flow from the emergency department and inpatient units to the community, thereby reducing the average length of stay and readmission rates to hospital.

During the development of the Master Program and the various Master Plan options, the following stakeholders and partners were consulted:

- Ministry of Health and Long-Term Care – Capital Planning Branch.
- North Simcoe Muskoka Local Health Integration Network.
- MAHC staff, physicians and volunteers.
- Key community service providers including the District of Muskoka, Emergency Medical Services, Emergency Medical Services Dispatch, Family Health Teams and Nurse Practitioner Clinics/Nursing Stations, Midwives, Hospices, Muskoka Parry Sound Community Mental Health Service/Addiction Outreach, Simcoe Muskoka District Health Unit, North Simcoe Muskoka Community Care Access Centre, and Muskoka Victim Services.
- Other Hospital corporations including Royal Victoria Regional Health Centre, Orillia Soldiers' Memorial Hospital, Georgian Bay General Hospital, Collingwood General & Marine Hospital, Waypoint Mental Health Centre, West Parry Sound Health Centre, Trillium Health Partners, and North Bay Regional Health Centre.
- External stakeholders including Muskoka and East Parry Sound community members, municipal, provincial and federal leaders, community special interest/service groups, donors, and cottager/lake associations. The various communication tools utilized included information sessions, Town Halls meetings, internal memos and news releases, CEO Blogs, MAHC Annual General Meetings, and community newsletters. A detailed communication record is available in Appendix A.

Over the course of the project as the various service models were developed and tested, nine separate community information sessions were hosted by MAHC across the catchment area; three in May 2014, three in August 2014, and three in March 2015. Through electronic surveys and written correspondence, more than 350 feedback responses were received. The Steering Committee reviewed this feedback to determine if further considerations should be included in the final evaluation. The overriding theme from the feedback was to carefully consider access, and in particular access to emergency care. The Board of Directors also reviewed all of the collated feedback.

5. Describe any significant operational implications in terms of:
    a. Operating cost
    b. Staffing

The proposed single site service delivery model is better able to operate within the health system funding reform model as one facility could more easily withstand the impacts of funding reform and health system transformation. In essence, one larger facility is more able to adjust service delivery to maintain and retain services and prevent service elimination, and/or potentially add services compared to smaller, fragmented separate sites.

Table 4 below outlines the potential operating savings at the 10-year horizon if all services are consolidated on a single site. The savings were calculated by taking the cost differential between the average cost of running two separate sites (including reduced operating costs for heat, lighting, snow removal, etc.) compared with the efficiencies of a single site using the mid point between the 25th percentile and peer average of comparable facilities. The calculation is based upon achieving improved efficiencies in both direct and indirect costs. A more refined operating cost estimate will be developed in the Stage 1 Proposal.

Table 4: Potential Savings: Single Site Option @ 10-year Horizon

Cost Centre	
Inpatient Nursing	$478,000
Emergency	$109,000
Ambulatory Clinics	$489,000
Surgery	$463,000
Diagnostic and Therapeutic	$3,551,000
Direct Patient Care	**$5,090,000**
Overhead	$2,421,000
Nursing Administration	$37,000
Indirect	**$2,458,000**
Total Potential Savings	$7,548,000

6. Describe any alternative program/service solutions considered to address the need identified in Question 1 and 2 above. Examples may include:
    a. Integration opportunities.
    b. Program /service redesign opportunities.
    c. Alternative service delivery models.

Several options were explored for providing MAHC's clinical services. All options considered balancing the clinical benefits with the patients' needs aligned with operational efficiencies and the organization's strategic directions. At the beginning of the planning exercise nine potential options were explored, which eventually were distilled to three viable options:

A. 2 Full Service Acute Sites - attempting to maintain current services across both sites
B. Centres of Focus (Hybrid) - distributing workload across both sites in a rationalized approach
C. One Hospital, (Centrally Located).

Throughout the entire planning process it was evident that maintaining the current service model across two sites would not be sustainable in the long-term, both operationally and from a capital investment perspective. As a result, variations to the two-site service delivery model were explored extensively with the intent of ensuring appropriate services in each of the communities and at the same time offering access to services that have sufficient volumes to maintain clinical expertise that can also be operated efficiently. As much as possible service integration with other providers was explored and factored into the workload projections. Service redesign in terms of reducing Alternate Level of Care patients, lower admission rates, and shifting to community and outpatient care were all factored into the future service models.

A series of criteria and guiding principles were established to assist the decision makers with the options selection process. The principles addressed operational benefits, access to care, community and government support, sustainability, capital cost, growth potential and opportunities to develop a campus of care service model. The Ad-Hoc Steering Committee outlined the advantages/opportunities, disadvantages/challenges as well as key considerations for each of the final options and shared this overview with internal and external stakeholders during the final engagement sessions in March 2015. All stakeholders were encouraged to provide MAHC with feedback and suggestions as to any further considerations with respect to these final three options. Several issues for further consideration emerged as the models were presented, specifically, access to emergency services and ensuring reasonable drive times and access by the majority of the population served.

The final three options were rated by the Steering Committee based on the guiding principles and criteria developed. The preferred option of a single site was based on the model that would best provide accessible, safe, high quality, cost efficient and sustainable health care in the year 2030 and beyond. An analysis of drive times and access to an emergency department determined that a central location between the Towns of Huntsville and Bracebridge would best serve the entire service population.

PART B

Development Concept – MOHLTC Review

7. What amount of space, based on space benchmarks, is required to meet the program need identified in Part A?

An analysis of the space requirements for all three options was completed. The preferred single site option required the smallest footprint when compared to the other two options. As shown in Table 5 below, an additional 66,107 building gross square feet (BGSF) is required to support the single site model for the 10-year horizon when compared with the total area for both MAHC sites today.

Table 5: Space Requirements (CGSF + BGSF): Single Site Option

	Current			Single Site Option		
Functional Centre	**HDMH**	**SMMH**	**Total**	**2019-20**	**2024-25**	**2034-35**
Clinical Program and Services	41,310	46,270	**87,580**	121,677	127,451	147,283
Clinical Support Services	10,410	12,460	**22,870**	27,320	29,740	32,960
Education and Training Service	n/a	n/a	**0**	5,500	5,500	6,000
Admin and General Support Services	19,580	24,635	**44,215**	49,000	51,700	57,900
Community Services - on-site	650	325	**975**	1,300	1,400	1,700
Component Gross Square Feet (CGSF)	71,950	83,690	**155,640**	204,797	215,791	245,843
Gross up Factor (assumed)				1.40	1.40	1.40
Building Gross Area (BGSF)	**103,000**	**133,000**	**236,000**	**286,716**	**302,107**	**344,180**
% increase over current area				21%	28%	46%

8. Does the HSP have this space available to it now?

Growth space to implement the preferred single site option at the 10- and 20-year horizons is extremely limited. The SMMH site property in Bracebridge is relatively small (approximately 11 acres), which is further compromised by the fact that current hospital occupies much of the developable land. Expansion or redevelopment on the SMMH site will use up all of the existing land assets, leaving limited options for long-term renewal. Furthermore, development will require a building greater in height than the zoning allows, impacting on helicopter flight path and negatively impacting the adjacent residential neighbourhood.

The HDMH site property is larger than the SMMH site. The site is approximately 42 acres. While this increase in area would support redevelopment, the site is characterized by extreme topography. Across the site there is a total of 32-metre grade change from south to north. Expansion or redevelopment on the site would be compromised by the additional effort and cost required to respond to the topography.

In addition to the physical challenges of both sites, use of either site property for the single site option would compromise access to critical services for residents throughout MAHC's service catchment area.

9. Is it practical to renovate the existing space to meet the program need identified in Part A?

It is not practical to renovate the existing space to meet the program need. All models that envisioned an acute care facility on either site would require more space than exists in the current buildings.

While the existing buildings could be considered for part of the redevelopment, the existing spaces are not ideal for current standards for clinical uses. From a structural perspective, renovation to the existing buildings is possible, however, the configurations are not consistent with current practice for clinical hospital use. Both the low floor-to-floor heights and existing dense column spacing make renovation less than ideal. The resultant layout in renovated space would be compromised in its clinical functionality. Furthermore, seismic upgrades would likely be required to the existing structure in order to meet current codes. Finally, based on verbal feedback from the hospital facility representative at the SMMH site, the existing slab is a post-tensioned system. While existing drawings were not available that could confirm the existing structural system, given the likelihood of this system being used, any renovation at the SMMH site would be highly complicated, costly and could present unsafe working conditions, thereby jeopardizing the health and safety of human resources.

Furthermore, renovation of the existing spaces would add complexity, cost and time to the project in order to allow the existing hospital to function while the renovations were on-going. When these factors are considered and the options that consider the existing facility to be renovated are weighed against the evaluation criteria, it was determined that a Greenfield site is the best solution for the MAHC master plan.

10. Does the HSP have physical support and operational support available to serve the existing space, (e.g. pharmacy, food services)?

The consolidation to one site will result in efficiencies and savings that will limit and/or eliminate the need to expand the support services such as food services and pharmacy, as well many associated capital equipment requirements currently duplicated across two sites.

11. Describe the proposed physical infrastructure changes required to support the program/service need identified in Part A. This may include:

    a. Renovation to existing infrastructure.
    b. Development of new infrastructure.
    c. Relationship to any other capital projects (approved or proposed).

In order to support the proposed service model identified in Part A, new infrastructure will need to be developed. It has been determined and noted in questions #8 and #9 above that the existing infrastructure is not suitable to be used for part of this development.

Development of new infrastructure would include land acquisition, servicing land, developing of a new health care facility, development of a new central utility plant to service the facility and parking facilities.

12. Describe the physical infrastructure deficiency related to the program(s)/service(s) need identified in Part A. This may include:

    a. General condition.
    b. Capacity to continue supporting program(s)/service(s) delivery.

The HDMH site was built in 1978 and SMMH site was built 1964. Facility condition assessments conducted by the Ministry for both sites in 2012 determined that both sites are in the poor range. The Building Condition Assessments conducted in 2014 by Stantec Consulting as part of the Hospital's Master Plan reinforced the findings of the 2012 assessment.
Preliminary engineering designs conducted by Stantec Inc. indicates that all options that involve the existing facilities would require a complete replacement of all mechanical and electrical systems in order to support the program needs identified in Part A. The existing building envelope would require upgrading to maintain a reasonable performance level.

Assessing the potential scope of mechanical and electrical systems work for the sites involved the following considerations: building age (some systems and equipment are original to the building construction), equipment age and condition (where equipment has been replaced or original infrastructure supplemented), building condition assessment findings, current minimum code and industry standard servicing requirements, and proposed future usage. Additionally, since this report supports an overall master planning exercise, consideration was given to the fact that implementation of these measures would not be initiated in the immediate future, but could be undertaken in as much as 5-10 years from the date of the publishing of the report.

The conclusion from the above analysis criteria was that the majority of the mechanical and electrical equipment and systems would require replacement due to service life issues or the infrastructure not being capable of supporting the proposed future usage. It was also concluded that site services will also require replacement and upgrade to ensure the facilities can reliably meet the operational needs for the foreseeable future.

The condition of the existing physical infrastructures is one of the reasons that a replacement hospital on a Greenfield site is being proposed.

13. Describe alternative infrastructure solutions considered.

As part of the development of the Master Plan, decisions regarding the long-term redevelopment of existing facilities required careful considered. Four development models were considered:

- 1 acute care facility on one site
- 2 sites, 1 acute, 1 ambulatory care
- 2 sites, both acute
- 2 sites, Centres of Focus.

In total, the following options that were variations of the development potential were explored:

1. Greenfield hospital
2. Renovated ambulatory care centre at HDMH, new acute care facility at SMMH
3. New acute care facility at HDMH, renovated ambulatory care centre at SMMH
4. Renovated acute care facility at HDMH, renovated acute care facility at SMMH
5. New acute care facility at HDMH, new acute care facility at SMMH
6. Renovated acute care facility at HDMH, new acute care facility at new location in Bracebridge
7. Renovated ambulatory care centre at HDMH, new acute care facility at new location in Bracebridge
8. Renovated Centre of Focus at HDMH, renovated Centre of Focus at SMMH.

Consultation and analysis reduced the initial options to three final options:

- 2 Full Service Acute Sites
- Centres of Focus (Hybrid Model)
- 1 Hospital (Central Muskoka Location).

Preliminary cost estimates for these three options were prepared in order to help with the evaluation (refer to Table 6):

Table 6: Master Plan Options Cost Estimate

Model	Square Footage (BGSF)[1]	Total Redevelopment Cost[2]	Approximate Local Share (24%)[3]
2 "Full Service" Acute Care Sites (Not Status Quo)	412,363	$475,479,414	$114,115,059
Centre of Focus (Hybrid)	355,558	$373,301,295	$89,592,311
One Hospital (Central Location)	302,107	$348,985,661	$83,756,559

Notes

(1) Projected BGSF is based on drawn area

(2) Costing is based on 10-year projection horizon

(3) Projected approximate local share includes MOHLTC 10% requirement, plus up to additional 14% for other non-funded capital requirements (ie: furnishings & fittings)

Based on the process outlined above, the various workshops and sessions held with the Steering Committee, internal and external stakeholders and consultants, the steering committee developed criteria (refer to Table 7) based upon Ministry evaluation criteria, along with criteria specific for MAHC's needs and environment to complete the analysis of the options under consideration.

Table 7: Master Plan Options Evaluation Criteria

CRITERIA	SUB-CRITERIA
Patient- and Family- Centered Care	Quality of space Efficient use of space Flow of public, patients & staff
Design	Ability to accommodate future growth & changes Community connection Site & building utilization
Construction	Construction phasing and ease of implementation Impact on ongoing operations Duration of Construction
Financial	Capital cost – building & site Operational cost – initial & ongoing Fundraising capability – Capital needs & redevelopment needs
Approvals	Alignment with MOHLTC / LHIN priorities Municipal support District of Muskoka support
Community Support	Community feedback Travel times Market share Recruitment & retention of staff/physicians/volunteers

The Master Program/Master Plan Ad-Hoc Steering Committee completed an exhaustive evaluation of the final three options. Each Committee member was asked to rate each of the options based on the criteria and sub criteria outlined above. Committee members discussed the results at length and focused discussion on determining the model that would best provide safe, quality, sustainable health care in the year 2030 and beyond.

The result of this process was unanimous Steering Committee support for the single site centrally located option. The results of submissions were collated into a summary, which is found in Appendix B. The Board of Directors subsequently endorsed the single site model as the preferred option for the master plan.

14. Describe any development challenges expected, including:

    a. Site planning
    b. Phasing/decanting

It is expected that a centrally located site will have some challenges. While the new site has not been selected, there are potential options for a preferred area within the District of Muskoka. Preliminary discussions with the District of Muskoka have occurred and there is a strong commitment to continue to work together. A formal site selection process will be part of the Stage 1 proposal. Depending on the site, a new central plant may need to be developed to service the site.

Travel distances and access to emergency services and acute care have also been identified as key issues that need to be addressed as part of the site selection process. The Steering Committee recommended that the site selection target a central location that provides reasonable access for MAHC's service population/catchment area in order to minimize the impact to any particular area. Extensive travel time assessment has been completed to analyze access to hospital services under different planning scenarios (refer to Table 8, Appendix E):

Table 8: Access to Hospital Services Under Different Planning Scenarios

	Percent of region's residents that can reach any hospital within:								
	60 minutes			**45 minutes**			**30 minutes**		
Single siting scenarios	*Muskoka SubLHIN*	*East Parry Sound 1*	*East Parry Sound 2*	*Muskoka SubLHIN*	*East Parry Sound 1*	*East Parry Sound 2*	*Muskoka SubLHIN*	*East Parry Sound 1*	*East Parry Sound 2*
Current State: HDMH and SMMH	**100%**	**88%**	**95%**	**93%**	**80%**	**23%**	**76%**	**26%**	**0%**
Hwy 11 & Hwy 60	98%	100%	95%	88%	88%	32%	55%	52%	0%
Hwy 11 & Taylor Rd	100%	88%	95%	92%	7%	23%	65%	0%	0%
Hwy 11 & Hwy 141	100%	88%	95%	93%	71%	23%	73%	0%	0%
Hwy 11 & Hwy 117	100%	88%	95%	93%	33%	23%	72%	0%	0%
Huntsville District Memorial only	98%	88%	95%	85%	80%	23%	41%	26%	0%
South Muskoka Memorial only	100%	79%	95%	85%	0%	23%	50%	0%	0%

The Board of Directors appreciates that the preferred model is a significant change from the health care delivery model that Muskoka and East Parry Sound areas have grown accustomed to. Throughout the process, the Steering Committee and Board listened to feedback from the community and the concerns that were raised. The Board recognizes that MAHC needs to be an active partner in health integration efforts and transportation initiatives that improve access to care in our communities. The Board also recognizes that MAHC's future planning work is only one piece of a larger health care system design. The Board is committed to working with community partners including Health Hubs, Primary Care Providers, and Health Links among others to further the mandate of the right care in the right place, at the right time, by the right provider.

15. If physical infrastructure will be vacated, what is the intended use of the vacated space?

The intention will be to work with the NSM LHIN, Health Links, the community, and other providers to determine the best use of vacated assets. Community engagement will also be important to help determine the vision for future.

Options could include:

- consider how existing infrastructure could support existing, projected and expanding primary care initiatives
- long Term Care facility development/redevelopment
- community clinic / urgent care needs
- sale of existing land/buildings (all or in part) with proceeds going toward new build capital project
- turnkey office space for new physicians and potentially an urgent care clinic within the building.

16. Provide preliminary capital cost estimate (in current year dollars) noting any assumptions in projecting costs:

Item	Cost	Assumptions (e.g., cost per sq. foot of renovation)
Construction Costs for space required for delivery of services (new construction or renovations)	$230,212,110	
Any premium for renovations to existing conditions		
Any premium for phasing and decanting	$0	Allowance for phasing on major renovation and infrastructure
Any premium for land and/or building acquisition (for community-based agencies)		To be addressed in Stage 1 Proposal
Ancillary Costs	$54,617,700	Allowance of 23.2% on construction and moving costs
Furniture and Equipment (including minor equipment)	$52,645,050	
Post Contract Contingency Allowance	$11,510,800	Allowance of 5% on construction for unforeseeable
Estimated Total Cost	**$348,985,660**	Refer to Appendix C: Hanscomb Report for original estimate. Revised estimate reflects bed/square footage reduction using Hanscomb cost per square foot analysis from July 29, 2015 report.

17. Is this project proposed to be:

Ministry cost shared	☒
Own Funds	☐

18. Explain how your HSP plans to provide for its share of the capital costs by identifying all proposed sources and amounts of funding, including any funding partners.

MAHC has worked closely with its two Foundations (Huntsville Hospital Foundation and South Muskoka Hospital Foundation) throughout the Master Program/Master Planning process. Each Foundation was represented with membership on the Master Program/Master Plan Steering Committee that recommended the single site option as the preferred model for future generations. The Foundations and Auxiliaries understand the estimated project cost and the 10% local share of the capital build responsibility. MAHC has also determined that up to an additional 14% of the project cost will need to be raised by the community to cover the costs associated with land acquisition, servicing, fittings and furnishings. The Foundations are committed to working with MAHC to achieve this goal and recognize the total local share could be up to 24% of the project cost. The Foundations will be conducting a feasibility study in the near future as part of their next steps.

MAHC also has been working with community leaders and the District of Muskoka, ensuring they are aware of the projected needs. There is already a history of the District supporting health care projects. The District is the lead for the Muskoka Health Links initiative and has been instrumental in developing several community health initiatives. In 2009, the District introduced a health tax to property tax bills to support a 10-year, $3M dollar commitment to support the Simcoe Muskoka Regional Cancer Centre in Barrie, ON. This commitment will end in 2019.

MAHC will continue to work collaboratively with the District on mechanisms to support the single site option. An extensive communication plan has been developed to share updated information about this project with both permanent and seasonal residents to garner interest and foster support for the coming years. We believe this cultivation will result in financial support for the local share.

If the HSP has supporting documentation that explains its development concept, please submit this with Part B of the Pre-Capital Submission Form.

APPENDICES

Appendix A: Communications Record

Master Program/Master Plan Communications Record – March 2014 to March 2015

Updated: July 31, 2015 *please note the following chronology does not include individual media inquiries or letters/emails received and responded to by MAHC on this topic

Timeline/ Date	Audience	Tool
March 13, 2014	Internal – Board of Directors	Board Meeting – Verbal Update
April 10, 2014	Internal – Board of Directors	Board Update
April 4, 2014	Internal – Staff, Physicians, Volunteers	Town Hall Meeting Notice
April 17, 2014	Internal – Staff, Physicians, Volunteers	Town Hall Meeting
April 23, 2014	External - NSM LHIN	Briefing/Planning meeting
May 8, 2014	Internal – Board of Directors	Board Update
May 16, 2014	External - Community - (Public/Patients)	Newspaper advertisements
May 21, 2014	External - Community - (Public/Patients)	Dedicated MP/MP Webpage
May 21, 2014	Internal - Board of Directors/Foundations Board of Directors	Key Messages
May 22, 2014	External – Leaders – Mayors, MP, MPP, LHIN CEO & Board Chair	Letter
May 22, 2014	Internal - Staff, Physicians, Volunteers; MP/MP Ad-Hoc Steering Committee	Email Notice of Info Sessions
May 23, 2014	External – Media	Email Notice of Info Sessions
May 26, 2014	External - Community – Huntsville	Community Info Session
May 27, 2014	External - Community - Bracebridge	Community Info Session
May 28, 2014	External - Community - Gravenhurst	Community Info Session
May 30, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting Communication Brief
June 2014	External – Community reps	Create Focus Groups
June 9, 2014	External – Municipal Leaders	Lunch Meeting
June 9, 2014	External – Community	Huntsville Forester
June 26, 2014	External – Community	CEO Blog
June 23, 2014	Internal/External	AGM
June 30, 2014	External – Community Groups	Invitation for Speakers Bureau
July 7, 2014	Internal/External Stakeholders	Workshop #1
July 12, 2014	External – Lake of Bays Association	Speakers Bureau
July 17, 2014	External – Community - (Public/Patients)	Community Health Bulletin
July 18, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
July 20, 2014	External - Donors	Speakers Bureau

Timeline/ Date	Audience	Tool
July 24, 2014	External – Municipal Council Candidates	Information Package
July 29, 2014	Internal – MP/MP Planning Participants	Workshop #2
July 30, 2014	External – Huntsville Rotary Club	Speakers Bureau
August 5, 2014	Internal/External	Key Messages
August 8, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
August 8, 2014	Internal – Staff, Physicians, Volunteers	Update Memo
August 11, 2014	Internal – MP/MP Planning Participants	Workshop #3
August 12, 2014	External – District of Muskoka	Planning Meeting
August 13-14 & 20-21	External - Community - (Public/Patients)	Newspaper advertisements
August 13, 2014	External –Probus Club of Central Muskoka	Speakers Bureau
August 13, 2014	External – Media/Community	Media Release
August 15, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
August 20, 2014	Internal – Staff, Physicians, Volunteers	Town Hall Meeting Memo
August 21, 2014	Internal – Board of Directors	Information Session
August 26, 2014	Internal – Staff, Physicians, Volunteers	Town Hall Meeting
August 26, 2014	External - Community – Huntsville	Community Info Session
August 27-28, 2014	Internal – Physicians	Physicians Forum
August 27, 2014	External - Community – Gravenhurst	Community Info Session
August 28, 2014	External - Community – Bracebridge	Community Info Session
August 28, 2014	External – Community	Webpage update
August 29, 2014	External – Community	CEO Blog
September 2, 2014	Internal – Staff, Physicians, Volunteers	Update Memo
September 2-14, 2014	Internal – Staff, Physicians, Volunteers	Options Display - HDMH
September 5, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
September 8, 2014	External – Leaders – Mayors, MP, MPP, LHIN CEO & Board Chair	Lunch Meeting
September 11, 2014	Internal – Board of Directors	Update
September 15-26, 2014	Internal – Staff, Physicians, Volunteers	Options Display - SMMH
September 18, 2014	External – District of Muskoka	Planning Meeting
September 23, 2014	External – Bracebridge-Muskoka Lakes Rotary Club	Speakers Bureau
September 26, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting

Timeline/ Date	Audience	Tool
September 29, 2014	External – Foundations/Auxiliaries	Key Messages
October 2, 2014	External - Rotary Club of Huntsville/Lake of Bays	Speakers Bureau
October 10, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
October 30, 2014	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting (Evaluation of Models)
November 6, 2014	Internal/External	Key Messages
November 10, 2014	Internal – Steering Committee	Email Update Letter
November 10, 2014	Internal – Proposed Hybrid Workshop Members	Email Letter
November 13, 2014	Internal – Board of Directors	PowerPoint Update
November 14, 2014	Internal – Leadership Team (Managers)	Update Memo
November 14, 2014	Internal – Staff, Physicians, Volunteers	Update Memo
Week of November 17, 2014	External – Leaders – Mayors, MP, MPP, LHIN CEO & Board Chair	Letter/In-person meetings
November 18, 2014	External – Community/Media	Media Release
November 18, 2014	External – Community	Webpage Update
November 25, 2014	Internal – Leadership Team (Managers)	Leadership Forum
November 25, 2014	Internal – Hybrid Model Working Group	Workshop Meeting
December 18, 2014	Internal – Hybrid Model Working Group	Workshop Meeting
January 6, 2015	Internal – Staff, Physicians, Volunteers	Memo re Operational Assessment
January 8, 2015	External – North Muskoka Probus Club	Speaker's Bureau
January 9, 2015	External – Bracebridge Rotary Club	Speaker's Bureau
January 13, 2015	External – Community	CEO Blog
January 14, 2015	External - Leaders – Mayors, MP, MPP	Lunch Meeting
January 28, 2015	Internal – Staff, Physicians, Volunteers	Update Memo
January 29, 2015	Internal – Staff, Physicians, Volunteers	Memo re Petition
February 4, 2015	External – Bracebridge Probus Club	Speaker's Bureau
February 12, 2015	External – Community	Big Ideas Column by Natalie Bubela
February 17, 2015	External - Leaders – Mayors, MP, MPP External – Foundation Boards External – Media (Radio & Newspapers); Website (posted online)	Open Letter from Board Chair
February 25, 2015	Internal – Staff, Physicians, Volunteers	Town Hall Meeting with MP/MP Update
February 26, 2015	Internal – Sub-Hybrid Model Working Group	Workshop Meeting
March 2, 2015	Internal – Staff, Physicians, Volunteers	Letter from Board Chair & Invitation to Info Sessions

Timeline/ Date	Audience	Tool
March 4, 2015	Internal - Hybrid Model Working Group	Workshop Meeting
March 4, 2015	External – Community (Public/Patients) (flyer in What's Up Muskoka)	Letter from Board Chair & Invitation to Info Sessions
March 6, 2015	External – Meeting with District of Muskoka	Planning Meeting
March 5/6, 2015	External – Seasonal Residents via Muskoka Lakes Association	Email NewsBite re: Letter & Invitation to Info Sessions
March 9, 2015	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
March 12, 2015	Internal – Board of Directors	Regular Meeting
March 12, 2015	External – Media, Community	Media Release
March 12, 2015	External – Community (Public/Patients)	Community Health Bulletin
March 13, 2015	External – Leaders - Mayors, MP, MPP, LHIN CEO & Board Chair	Information Luncheon
March 18, 2015	External – Community (Public/Patients)	What's Up Muskoka Advertisement
March 19, 2015	External – Community (Public/Patients)	MuskokaRegion.com Advertisement
March 20, 2015	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
March 23, 2015	Internal – Staff, Physicians, Volunteers	Town Hall Meeting
March 23, 2015	External – Huntsville Town Council	Invitation to Regular Meeting
March 24, 2015	Internal – Leadership Team	Regular Meeting
March 23, 2015	External – Gravenhurst Community	Community Information Session
March 24, 2015	External - Bracebridge Community	Community Information Session
March 25, 2015	External – Huntsville Community	Community Information Sessions
March 25, 2015	External – Community (Public/Patients)	Webpage update – feedback period begins
March 25, 2015	External – Community (Public/Patients)	Muskoka Magazine advertisement – Board Chair letter
March 30, 2015	External – Community (Public/Patients)	CEO Blog
March 30, 2015	External – Gravenhurst Rotary Club	Speaker's Bureau
March 30, 2015	External – Almaguin Highlands Health Centre Committee	Meeting
April 2, 2015	External – NSM LHIN CEO, Vice Chair	Update Meeting
April 8, 2015	Internal – Physicians	Town Hall Meeting
April 15, 2015	External – Community	Feedback period closed
April 20, 2015	Internal - Medical Advisory Committee	Regular Meeting
April 23, 2015	External – District of Muskoka	Meeting with Public Works & Planning, Stantec
April 23, 2015	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting

Timeline/ Date	Audience	Tool
May 1, 2015	Internal – MP/MP Ad-Hoc Steering Committee	Committee Meeting
May 11, 2015	External – Media/Community	News Release re: Board Decision Meeting Date
May 21, 2015	External - Donors	South Muskoka Hospital Foundation Campaign Launch
May 25, 2015	External – NSM LHIN	Update at Board of Directors Meeting
May 27, 2015	Internal – Board of Directors	Meeting
May 27, 2015 – immediately following decision	Internal – MP/MP Ad-Hoc Steering Committee	Email
May 27, 2015 – immediately following decision	Internal – Staff, Physicians, Volunteers	Memo
May 27, 2015 -immediately following decision	Internal – Staff, Physicians, Volunteers	Huddles in all areas/depts
May 27, 2015 – immediately following decision	Internal – Bargaining Units	Letter
May 27, 2015 -immediately following decision	External – Media/Community	Press Conference / Media Release
May 27, 2015-immediately following decision	Internal – Foundations Board of Directors / Auxiliaries Executive	Letter
May 27, 2015 -immediately following decision	External – Muskoka Mayors, District Chair, East Parry Sound Reeves, MPP, MP	Letter
May 28, 2015	Internal - Managers	Leadership Meeting
May 28, 2015	Internal – Staff, Physicians, Volunteers	Huddles in all areas/depts
May 28, 2015	Internal – Staff, Physicians, Volunteers	Town Hall Meeting & OTN webcast
May 28, 2015	External – Partners • North Simcoe Muskoka LHIN • OSMH, RVH, CGMH, GBGH, WPSHC, CCAC, EMS, Hospice, SMDHU • Cottage Country Family Health Team • Algonquin Family Health Team • Burk's Falls Family Health Team • Nurse Practitioner Clinics • Almaguin Highlands Health Centre	Media Release
May 28, 2015	External – Key Donors	Special Letter
May 28, 2015	External – Media, Community, Cottager Associations	Media Release
May 28, 2015	External - Community	Webpage Update
May 29, 2015	Internal – Staff, Physicians, Volunteers	Huddles in all areas/depts
May 29, 2015	Internal – Staff, Physicians, Volunteers	Town Hall Meeting & OTN webcast
June 1, 2015	External - Donors	Dave Ellis Pro/Am (South Muskoka Hospital Foundation)
June 3, 2015	External - Community	CEO Blog

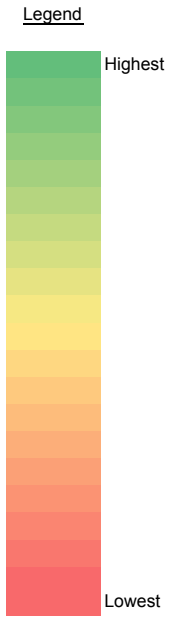
Timeline/ Date	Audience	Tool
June 3, 2015	External - Community	Board Chair Letter (What's Up Muskoka ad)
June 3, 2015	Internal – South Muskoka Hospital Foundation Board of Directors/ South Muskoka Memorial Hospital Auxiliary Executive (or reps)	Meeting
June 3, 2015	External – Town of Bracebridge	CEO/Board Chair Meeting with Mayor & CAO
June 5, 2015	Internal – Huntsville Hospital Foundation Board of Directors / Huntsville Hospital Auxiliary Executive (or reps)	Meeting
June 6, 2015	External – Community	Presentation at Salvation Army Church, Bracebridge
June 10, 2015	Internal – Huntsville Hospital Auxiliary	Annual General Meeting CEO report
June 15, 2015	Internal – Medical Advisory Committee	Meeting
June 16, 2015	External – Community – Muskoka Lakes Probus Club	Presentation
June 17, 2015	External – Community – Muskoka Ratepayers Association	Board Chair Letter (What's Up Muskoka ad)
June 17, 2015	External - Donors	South Muskoka Hospital Foundation Golf Tournament
June 18, 2015	Internal – Huntsville Hospital Foundation Board of Directors	AGM CEO report
June 22, 2015	External – Members of the Corporation	AGM Board Chair report
June 24, 2015	External – Community – Muskoka Lakes Association	e-NewsBites
June 25, 2015	Internal – South Muskoka Memorial Hospital Auxiliary	AGM Speaking Notes
June 25, 2015	External - Donors	Huntsville Hospital Foundation Bigwin Golf Tournament
July 2, 2015	External - Donors	Huntsville Hospital Foundation Docktails Event
July 4, 2015	External – Cottager/Lake Association	Kawagama Lake Cottagers Association AGM, Dorset
July 11, 2015	External – Cottager/Lake Association	Mary Lake Association AGM
July 11, 2015	External – Cottager/Lake Association	Lake of Bays Association AGM, Baysville
July 12, 2015	External - Donors	Beaumaris Community, Milford Bay
July 12, 2015	External – Cottager/Lake Association	Clam Lake Property Owners, Kearney
July 23, 2015	External – Donors	Huntsville Hospital Foundation event

Appendix B: Options Evaluation

Appendix B: Options Evaluation

MAHC Master Plan Options Evaluation Rating
Total Scoring

Option			1	2	3
			Two Full Service Acute Care Sites	Centre of Focus	One Hospital Central & Equitable Access
Evaluation		**points**			
Criteria	**Definition**				
Patient and Family Centered Care		255	149	148	247
Quality of space	light, views, room size	85	50	50	83
Efficient use of space	clinical & operational adjacencies	85	49	53	82
The flow of public, patients and staff	flow of people and materials in and around hospital	85	50	45	82
Design		255	157	138	200
Ability to accommodate future growth and changes	flexibility for future change - land & building	85	42	43	83
Community connection	Scale/presence/impact of development on community	85	67	49	55
Site and building utilization	Capacity of existing infrastructure/systems	85	48	46	62
Construction		255	134	140	234
Construction phasing and ease of implementation	How will the development be accomplished?	85	48	49	74
Impact on ongoing operations	How will the development affect operations?	85	41	41	81
Duration of construction	How long will the development take?	85	45	50	79
Financial		255	134	174	205
Capital cost - Building	Estimated cost to construct	85	36	55	80
Capital cost -Site	Includes land acquisition, civil and infrastructure cost	85	65	68	41
Operational cost - Ongoing	Estimated cost to operate	85	33	51	84
Fundraising		170	119	91	120
Fundraising capability - Capital needs	Ability to support ongoing Capital needs	85	59	44	63
Fundraising capability - Redevelopment needs	Ability to meet 20% Community Share	85	60	47	57
Approvals		255	188	138	159
Alignment with MOHLTC / LHIN priorities	consistent with Ministry's planning & design guidelines	85	30	42	82
Municipal Support	political support	85	80	36	45
District of Muskoka Support	compliance with District Official Plan	85	78	60	32
Community Support		340	294	167	259
Community feedback	Summary of feedback collected	85	78	32	55
Travel times	Length of drive time to access services	85	80	51	60
Market Share	catchment of patient care and referrals	85	77	51	68
Recruitment and retention of staff/physicians/volunteers	Impact of development on program/service critical mass; support partnership opportunities (campus of care)	85	59	33	76
Total		1785	1175	996	1424



Hospital Care for Our Future Generations

Planning for 2030 and Beyond

"FULL SERVICE" ACUTE SITES

(Not Status Quo)

Advantages & Opportunities	Disadvantages & Challenges
+ Public & political support	– Highest cost to build
+ Access	– Highest cost to clinically operate
+ Projects can be phased over time	– Funding – Who/How?
+ Urban Centre presence	– Lack of critical mass
+ Maintains access to Emergency Departments in Bracebridge & Huntsville	– Duplication of services & capital costs
	– Dilution of skills mix
	– Recruitment & Retention of skilled workers (OB, ED, ICU, etc.)
	– SMMH Site limitations
	– Multiple projects require multiple Ministry approvals
	– Potential fundraising confusion and fatigue if multiple projects
	– Long-term sustainability / risk of erosion of services

CENTRES OF FOCUS

(Hybrid)

Advantages & Opportunities	Disadvantages & Challenges
+ Less costly than 2 "Full Service" Acute Sites to clinically operate	– Public & political support
+ Moderately expensive to build	– Potential destabilization – could become ambulatory & acute
+ Urban Centre presence	– Recruitment & Retention of staff / physicians
+ Projects can be phased over time	– Reduced access to some sub-specialty support
+ Reduced duplication compared to 2 "Full Service" Acute Sites	– Duplication of services / costs
+ Maintains access to Emergency Departments in Bracebridge & Huntsville	– More transferring of patients
	– Physician support
	– Access – more single siting
	– Potential fundraising confusion and fatigue if multiple projects
	– Multiple projects require multiple Ministry approvals
	– Travel times increased for some services

ONE HOSPITAL

(Central Muskoka Location)

Advantages & Opportunities	Disadvantages & Challenges
+ Greatest stability to ensure high-quality service	– Building on new site requires land selection
+ Lowest cost to build	– Difficult to phase – big bang project
+ Lowest cost to clinically operate	– Perceived economic impact on Huntsville / Bracebridge
+ Skills and service concentration	– District Official Plan
+ Large enough to be sustained	– Site Servicing (if water / sewer services do not exist at selected site, cost to provide 100% raised locally)
+ Recruitment & Retention of staff/ physicians	– Interim plans required to bridge old facilities while planning for new
+ Opportunity to add sub-specialties	
+ Average travel times maintained	
+ Least disruption to current operation (vs. renovation/ construction projects at existing)	
+ Foundation fundraising focus	

KEY POINTS:

- **Long-term sustainability / risk of erosion of services**
- **Funding – Who / How?**
- **Most expensive to build / clinically operate**

- **Long-term sustainability – destabilization (potential to become acute & ambulatory)**
- **Recruitment & Retention of staff / physicians**
- **Moderately expensive to build / clinically operate**

- **Greatest stability to ensure high-quality service**
- **District Official Plan**
- **Least expensive to build / clinically operate; potential impact of Site Servicing costs**

Appendix C: Capital Cost Report

Appendix C: Capital Cost Report

Preamble

The order-of-magnitude cost estimate that follows was prepared by Hanscomb for the August 2015 Pre-Capital Submission as a means of evaluating the different planning options under review as part of the Master Program and Master Plan study. Additional detail is shown for the preferred single site option. Since the original estimate was prepared (subsequently updated in July 29, 2015), the LHIN requested that MAHC reduce the number of beds projected and associated square footage. RPG and Stantec revised the square footage accordingly and the new costing estimate included in Part B of the Submission was estimated using the Hanscomb cost per square foot analysis of the July 29, 2015 report.

The Stage 1 Proposal will require further analysis by the Cost Consultant to validate the assumptions used to revise the cost estimate included in the attached Pre-Capital Submission, and prepare a new detailed estimate as required.

MUSKOKA ALGONQUIN HEALTHCARE
SMMH and HDMH HOSPITALS
MUSKOKA, ONTARIO

MASTER PLAN ESTIMATES

OCTOBER 21, 2014 (Revised July 29, 2015)

Hanscomb

Table of Contents

1.1 General

These Pre-Capital Submission Estimates are intended to provide an of order of magnitude assessment of the total project costs associated with the proposed Redevelopment of the South Muskoka Memorial Hospital (SMMH) and Huntsville District Memorial Hospital (HDMH) sites in Muskoka, Ontario as outlined in the List of Current Space and Test Fit New Space Charts and Preliminary Floor Plans prepared by Stantec Architecture Ltd..

Accordingly, these Master Plan Estimates should only be considered within the full context of the above noted documentation.

1.2 Methodology

Generally, the areas of work projected by the Space Charts are priced using parametric quantities and unit rates considered appropriate for a project of this scope and nature.

Costs reported in these estimates provide for all building construction and include related site development work, allowances for Hospital Furnishings & Equipment and Professional Fees & Expenses. Separate provision has also been made where appropriate for such things as building demolition, site clearance, etc.

1.3 Construction Phasing

Allowances have been made to cover premiums for phased construction, where applicable.

1.4 Cost Considerations

All costs are estimated on the basis of competitive bids (a minimum of 6 general contractor bids and at least 3 subcontractor bids for each trade) being received in October 2014 from general contractors and all major subcontractors and suppliers based on a stipulated sum form of contract. Pricing shown reflects probable costs obtainable in the Muskoka area on the effective date of this report and is therefore a determination of fair market value for the construction of the work and not a prediction of low bid.

Escalation to tender has been allowed at 2.5% per annum for 5 years. This will be reviewed when the preferred option is developed. Escalation during the construction period is included in the unit rates used in this estimate.

An allowance of 10% has been included to cover design and pricing unknowns. This allowance is not intended to cover any program space or quality modifications but rather to provide some flexibility for the designers and cost planners during the redevelopment design stages.

An allowance of 10% has been included to cover design scope unknowns. This allowance is intended to inform the adequacy of construction costing data through the various stages of the design process, when all items which may impact cost estimates are not identified or known.

An allowance of 5% has been made to cover construction (post contract) unknowns.

1.4 Cost Considerations (continued)

The unit rates in the preparation of these Pre-Capital Submission Order of Magnitude Estimates include labour and material, equipment, subcontractor's overheads and profits.

The following items have been specifically excluded from these estimates:

- owner's staff and management expenses
- land acquisition costs and expenses
- financing and/or fund raising expenses
- all costs associated with an Alternative Financing & Procurement (AFP) method of project delivery

1.5 Ongoing Cost Control

Hanscomb has no control over the cost of labour and materials, the general contractor's or any subcontractor's method of determining prices, or competitive bidding and market conditions. This opinion of probable cost of construction is made on the basis of experience, qualifications and best judgment of the professional consultant familiar with the construction industry. Hanscomb cannot and does not guarantee that proposals, or actual construction costs will not vary from this or subsequent estimates.

Hanscomb recommends that the Owner and the design team carefully review these Master Plan Estimate documents, including line item description, unit price clarifications, exclusions, inclusions and assumptions, contingencies, escalation and mark-ups. If the project is over budget, or if there are unresolved budgeting issues, alternative systems/schemes should be evaluated before proceeding into the bidding phase.

Requests for modifications of any apparent errors or omissions to this document must be made to Hanscomb within ten (10) days of receipt of this estimate. Otherwise, it will be understood that the contents have been concurred with and accepted.

It is recommended that a final updated estimate be produced by Hanscomb using Bid Documents to determine overall cost changes which may have occurred since the preparation of this estimate. The final updated estimate will address changes and additions to the documents, as well as addenda issued during the bidding process. Hanscomb cannot reconcile bid results to any estimate not produced from bid documents including all addenda.

2.0 Total Project Cost Summaries

			Total Redevelopment		Approx. Local Share
2.1 Single Site Option Project Cost Summary					
Total Project Cost	**333,227 SF**	**1,155.18**	**$384,935,900**	**24%**	**$92,416,443**
2.2 Ambulatory / Acute Site Option 3 Project Cost Summary					
Total Project Cost	**353,242 SF**	**1,113.48**	**$393,329,000**	**23%**	**$89,386,127**
2.3 Two Acute Site Option 5 Project Cost Summary					
Total Project Cost	**469,117 SF**	**1,153.06**	**$540,920,200**	**24%**	**$129,044,653**
2.4 Two Acute Site Option 7 Project Cost Summary					
Total Project Cost	**447,648 SF**	**1,135.14**	**$508,141,300**	**23%**	**$117,274,087**
2.5 Ambulatory / Acute Site Option 8 Project Cost Summary					
Total Project Cost	**364,701 SF**	**1,120.77**	**$408,746,200**	**23%**	**$93,613,783**

2.1 Single Site Option Project Cost Summary

				Total Redevelopment		Approx. Local Share
Single Site Option 1, Model 1- Muskoka Algonquin Healthcare						
New Construction	333,227	SF	616.08	$205,294,200	10%	$20,529,420
Renovations	0	SF	-	$0	10%	$0
Existing to Remain		SF	-		10%	$0
Demolition of Existing Buildings		SF	-		10%	$0
Infrastructure Upgrades				$0	10%	$0
Allowance for Surface Parking				$1,440,000	100%	$1,440,000
Allowance for Site Works				$12,420,000	10%	$1,242,000
Allowance for LEED Silver on New				$5,280,000	10%	$528,000
Allowance for Phasing on Major Reno & Infrastructure				$0	10%	$0
Escalation				$29,492,900	10%	$2,949,290
Sub-total Construction Cost	**333,227**	**SF**	**762.03**	**$253,927,100**	**11%**	**$26,688,710**
Construction Contingency				$12,696,500	11%	$1,334,451
Allowance for Moving				$1,332,900	10%	$133,290
Ancillaries				$58,911,200	11%	$6,191,793
FF&E and IT				$58,068,200	100%	$58,068,200
Total Project Cost	**333,227**	**SF**	**1,155.18**	**$384,935,900**	**24%**	**$92,416,443**

APPENDIX A

Single Site Option 1, Model 1- Muskoka Algonquin Healthcare

Single Site Option 1, Model 1- Muskoka Algonquin Healthcare	Constr. Type	Areas		$/SF	Net Construction Cost	Allowance for Asbestos Abatement $15.00	In Contract Equipment Allowance 5.0%	Design & Pricing Allowance 10.0%	Design Scope Allowance 10.0%	Total Construction Cost Excluding Escalation	Potential Impact of Escalation @ 5% p.a. to Construction Start				Total Construction Cost Including Escalation	PCC Construction Contingency 5.0%	Project Ancillaries 23.2%	FF&E / IT Allowance 25% / 15%		Total Project Cost Including Escalation
											Const Start	Yrs	2.5%	Escalation per annum				New Reno	
NEW CONSTUCTION		**333,227**	**bgsf**	**488.95**	**$162,931,800**	**$0**	**$8,146,000**	**$17,108,200**	**$17,108,200**	**$205,294,200**				**$26,977,700**	**$232,271,900**	**$11,613,700**	**$53,887,100**		**$58,068,200**	**$355,840,900**
CLINICAL PROGRAM AND SERVICES		**142,308**	**cgsf**	**551.76**	**$78,520,500**	**$0**	**$3,925,000**	**$8,244,800**	**$8,244,800**	**$98,935,100**	**Oct-19**	**5.0**	**13.1%**	**$13,001,000**	**$111,936,100**	**$5,596,800**	**$25,969,200**		**$27,984,000**	**$171,486,100**
Ambulatory Care	New	21,890	cgsf	550.00	$12,039,500	$0	$602,000	$1,264,200	$1,264,200	$15,169,900	Oct-19	5.0	13.1%	$1,993,400	$17,163,300	$858,200	$3,981,900	25%	$4,290,800	$26,294,200
Emergency	New	14,133	cgsf	660.00	$9,327,800	$0	$466,000	$979,400	$979,400	$11,752,600	Oct-19	5.0	13.1%	$1,544,400	$13,297,000	$664,900	$3,084,900	25%	$3,324,300	$20,371,100
Surgical Services	New	16,295	cgsf	710.00	$11,569,500	$0	$578,000	$1,214,800	$1,214,800	$14,577,100	Oct-19	5.0	13.1%	$1,915,600	$16,492,700	$824,600	$3,826,300	25%	$4,123,200	$25,266,800
Medical / Surgical Inpatient Services	New	53,290	cgsf	500.00	$26,645,000	$0	$1,332,000	$2,797,700	$2,797,700	$33,572,400	Oct-19	5.0	13.1%	$4,411,700	$37,984,100	$1,899,200	$8,812,300	25%	$9,496,000	$58,191,600
Critical Care	New	7,054	cgsf	550.00	$3,879,700	$0	$194,000	$407,400	$407,400	$4,888,500	Oct-19	5.0	13.1%	$642,400	$5,530,900	$276,500	$1,283,200	25%	$1,382,700	$8,473,300
Maternal Child	New	4,719	cgsf	550.00	$2,595,500	$0	$130,000	$272,600	$272,600	$3,270,700	Oct-19	5.0	13.1%	$429,800	$3,700,500	$185,000	$858,500	25%	$925,100	$5,669,100
Complex Continuing Care	New	16,708	cgsf	500.00	$8,354,000	$0	$418,000	$877,200	$877,200	$10,526,400	Oct-19	5.0	13.1%	$1,383,300	$11,909,700	$595,500	$2,763,100	25%	$2,977,400	$18,245,700
Stroke Inpatient Services	New	8,219	cgsf	500.00	$4,109,500	$0	$205,000	$431,500	$431,500	$5,177,500	Oct-19	5.0	13.1%	$680,400	$5,857,900	$292,900	$1,359,000	25%	$1,464,500	$8,974,300
CLINICAL SUPPORT SERVICES		**35,956**	**cgsf**	**633.06**	**$22,762,300**	**$0**	**$1,139,000**	**$2,390,200**	**$2,390,200**	**$28,681,700**	**Oct-19**	**5.0**	**13.1%**	**$3,769,100**	**$32,450,800**	**$1,622,600**	**$7,528,600**		**$8,112,800**	**$49,714,800**
Cardio Respiratory Services	New	6,002	cgsf	550.00	$3,301,100	$0	$165,000	$346,600	$346,600	$4,159,300	Oct-19	5.0	13.1%	$546,600	$4,705,900	$235,300	$1,091,800	25%	$1,176,500	$7,209,500
Clinical Laboratory	New	6,003	cgsf	575.00	$3,451,700	$0	$173,000	$362,500	$362,500	$4,349,700	Oct-19	5.0	13.1%	$571,600	$4,921,300	$246,100	$1,141,700	25%	$1,230,300	$7,539,400
Diagnostic Imaging	New	21,007	cgsf	690.00	$14,494,800	$0	$725,000	$1,522,000	$1,522,000	$18,263,800	Oct-19	5.0	13.1%	$2,400,000	$20,663,800	$1,033,200	$4,794,000	25%	$5,166,000	$31,657,000
Pharmacy Services	New	2,697	cgsf	525.00	$1,415,900	$0	$71,000	$148,700	$148,700	$1,784,300	Oct-19	5.0	13.1%	$234,500	$2,018,800	$100,900	$468,400	25%	$504,700	$3,092,800
Infection Prevention and Control	New	247	cgsf	400.00	$98,800	$0	$5,000	$10,400	$10,400	$124,600	Oct-19	5.0	13.1%	$16,400	$141,000	$7,100	$32,700	25%	$35,300	$216,100
EDUCATION AND TRAINING SERVICES		**5,220**	**cgsf**	**475.00**	**$2,479,500**	**$0**	**$124,000**	**$260,400**	**$260,400**	**$3,124,300**	**Oct-19**	**5.0**	**13.1%**	**$410,600**	**$3,534,900**	**$176,700**	**$820,100**		**$883,700**	**$5,415,400**
Education and Training Services	New	5,220	cgsf	475.00	$2,479,500	$0	$124,000	$260,400	$260,400	$3,124,300	Oct-19	5.0	13.1%	$410,600	$3,534,900	$176,700	$820,100	25%	$883,700	$5,415,400
ADMINISTRATION AND GENERAL SUPPORT SERVICES		**53,118**	**cgsf**	**436.71**	**$23,197,400**	**$0**	**$1,160,000**	**$2,435,800**	**$2,435,800**	**$29,229,000**	**Oct-19**	**5.0**	**13.1%**	**$3,841,000**	**$33,070,000**	**$1,653,600**	**$7,672,200**		**$8,267,700**	**$50,663,500**
Administration	New	5,407	cgsf	400.00	$2,162,800	$0	$108,000	$227,100	$227,100	$2,725,000	Oct-19	5.0	13.1%	$358,100	$3,083,100	$154,200	$715,300	25%	$770,800	$4,723,400
Foundation	New	996	cgsf	400.00	$398,400	$0	$20,000	$41,800	$41,800	$502,000	Oct-19	5.0	13.1%	$66,000	$568,000	$28,400	$131,800	25%	$142,000	$870,200
Auxiliary	New	1,099	cgsf	400.00	$439,600	$0	$22,000	$46,200	$46,200	$554,000	Oct-19	5.0	13.1%	$72,800	$626,800	$31,300	$145,400	25%	$156,700	$960,200
Spiritual Care	New	807	cgsf	500.00	$403,500	$0	$20,000	$42,400	$42,400	$508,300	Oct-19	5.0	13.1%	$66,800	$575,100	$28,800	$133,400	25%	$143,800	$881,100
Health Records	New	2,977	cgsf	375.00	$1,116,400	$0	$56,000	$117,200	$117,200	$1,406,800	Oct-19	5.0	13.1%	$184,900	$1,591,700	$79,600	$369,300	25%	$397,900	$2,438,500
Information and Telecommunications	New	2,524	cgsf	425.00	$1,072,700	$0	$54,000	$112,700	$112,700	$1,352,100	Oct-19	5.0	13.1%	$177,700	$1,529,800	$76,500	$354,900	25%	$382,500	$2,343,700
Plant Operations and Management	New	3,510	cgsf	375.00	$1,316,300	$0	$66,000	$138,200	$138,200	$1,658,700	Oct-19	5.0	13.1%	$218,000	$1,876,700	$93,800	$435,400	25%	$469,200	$2,875,100
Environmental Services	New	1,103	cgsf	400.00	$441,200	$0	$22,000	$46,300	$46,300	$555,800	Oct-19	5.0	13.1%	$73,000	$628,800	$31,400	$145,900	25%	$157,200	$963,300
Materials Management	New	6,779	cgsf	375.00	$2,542,100	$0	$127,000	$266,900	$266,900	$3,202,900	Oct-19	5.0	13.1%	$420,900	$3,623,800	$181,200	$840,700	25%	$906,000	$5,551,700
Medical Devices Reprocessing	New	5,711	cgsf	525.00	$2,998,300	$0	$150,000	$314,800	$314,800	$3,777,900	Oct-19	5.0	13.1%	$496,400	$4,274,300	$213,700	$991,600	25%	$1,068,600	$6,548,200
Nutrition and Food Services	New	8,777	cgsf	500.00	$4,388,500	$0	$219,000	$460,800	$460,800	$5,529,100	Oct-19	5.0	13.1%	$726,600	$6,255,700	$312,800	$1,451,300	25%	$1,563,900	$9,583,700
Main Lobby Services	New	8,428	cgsf	450.00	$3,792,600	$0	$190,000	$398,300	$398,300	$4,779,200	Oct-19	5.0	13.1%	$628,000	$5,407,200	$270,400	$1,254,500	25%	$1,351,800	$8,283,900
Physician and Staff Support	New	5,000	cgsf	425.00	$2,125,000	$0	$106,000	$223,100	$223,100	$2,677,200	Oct-19	5.0	13.1%	$351,800	$3,029,000	$151,500	$702,700	25%	$757,300	$4,640,500
CLINICAL SUPPORT SERVICES		**1,417**	**cgsf**	**400.00**	**$566,800**	**$0**	**$28,000**	**$59,500**	**$59,500**	**$713,800**	**Oct-19**	**5.0**	**13.1%**	**$93,800**	**$807,600**	**$40,300**	**$187,300**		**$201,900**	**$1,237,100**
NSM CCAC	New	903	cgsf	400.00	$361,200	$0	$18,000	$37,900	$37,900	$455,000	Oct-19	5.0	13.1%	$59,800	$514,800	$25,700	$119,400	25%	$128,700	$788,600
SASOT	New	514	cgsf	400.00	$205,600	$0	$10,000	$21,600	$21,600	$258,800	Oct-19	5.0	13.1%	$34,000	$292,800	$14,600	$67,900	25%	$73,200	$448,500
Sub-total Departmental		**238,019**	**cgsf**	**535.78**	**$127,526,500**	**$0**	**$6,376,000**	**$13,390,700**	**$13,390,700**	**$160,683,900**				**$21,115,500**	**$181,799,400**	**$9,090,000**	**$42,177,400**		**$45,450,100**	**$278,516,900**
Building Gross	25% New	59,505	bgsf	400.00	$23,801,900	$0	$1,190,000	$2,499,200	$2,499,200	$29,990,300	Oct-19	5.0	13.1%	$3,941,000	$33,931,300	$1,696,600	$7,872,100	25%	$8,482,800	$51,982,800
Mechanical & Electrical Space	15% New	35,703	bgsf	325.00	$11,603,400	$0	$580,000	$1,218,300	$1,218,300	$14,620,000	Oct-19	5.0	13.1%	$1,921,200	$16,541,200	$827,100	$3,837,600	25%	$4,135,300	$25,341,200
RENOVATIONS		**-**	**cgsf**	**-**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**				**$0**	**$0**	**$0**	**$0**		**$0**	**$0**
Demolition of Existing Buildings	**Reno**	**-**	**bgsf**	**-**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**				**$0**	**$0**	**$0**	**$0**		**$0**	**$0**
Allowance for building demolition	Reno	-	bgsf	25.00	$0	$0	$0	$0	$0	$0	Oct-19	5.0	13.1%	$0	$0	$0	$0		$0	$0
Allowance for Surface Parking	**New**	**800**	**Cars**	**1,500.00**	**$1,200,000**	**$0**	**$0**	**$120,000**	**$120,000**	**$1,440,000**	**Oct-19**	**5.0**	**13.1%**	**$189,200**	**$1,629,200**	**$81,500**	**$378,000**		**$0**	**$2,088,700**
Allowance for Site Works	**New**	**1**	**Sum**	**10,350,000**	**$10,350,000**	**$0**	**$0**	**$1,035,000**	**$1,035,000**	**$12,420,000**				**$1,632,200**	**$14,052,200**	**$702,600**	**$3,260,200**		**$0**	**$18,015,000**
Allowance for site clearing and regrading		1	Sum	800,000	$800,000	$0	$0	$80,000	$80,000	$960,000	Oct-19	5.0	13.1%	$126,200	$1,086,200	$54,300	$252,000		$0	$1,392,500
Allowance for building demolition			SF	8.00	$0	$0	$0	$0	$0	$0	Oct-19	5.0	13.1%	$0	$0	$0	$0		$0	$0
Allowance for potential premiums to foundations		1	Sum	2,500,000	$2,500,000	$0	$0	$250,000	$250,000	$3,000,000	Oct-19	5.0	13.1%	$394,200	$3,394,200	$169,700	$787,500		$0	$4,351,400
Allowance for landscaping		1	Sum	3,300,000	$3,300,000	$0	$0	$330,000	$330,000	$3,960,000	Oct-19	5.0	13.1%	$520,400	$4,480,400	$224,000	$1,039,500		$0	$5,743,900
Allowance for mechanical site services		1	Sum	1,700,000	$1,700,000	$0	$0	$170,000	$170,000	$2,040,000	Oct-19	5.0	13.1%	$268,100	$2,308,100	$115,400	$535,500		$0	$2,959,000
Allowance for electrical site services		1	Sum	1,300,000	$1,300,000	$0	$0	$130,000	$130,000	$1,560,000	Oct-19	5.0	13.1%	$205,000	$1,765,000	$88,300	$409,500		$0	$2,262,800
Helipad at grade		1	Sum	750,000	$750,000	$0	$0	$75,000	$75,000	$900,000	Oct-19	5.0	13.1%	$118,300	$1,018,300	$50,900	$236,200		$0	$1,305,400
Allowance for tunnels/bridge connections		1	Nil	-	$0	$0	$0	$0	$0	$0	Oct-19	5.0	13.1%	$0	$0	$0	$0		$0	$0
Allowance for LEED Silver		**2.5%**		**174,481,800**	**$4,400,000**	**$0**	**$0**	**$440,000**	**$440,000**	**$5,280,000**	**Oct-19**	**5.0**	**13.1%**	**$693,800**	**$5,973,800**	**$298,700**	**$1,385,900**		**$0**	**$7,658,400**
Allowance for Phasing Major Renovation & Infrastructure		**5.0%**		**-**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**Oct-19**	**5.0**	**13.1%**	**$0**	**$0**	**$0**	**$0**		**$0**	**$0**
Allowance for Moving		**333,227**	**bgsf**	**4.00**		**$0**	**$0**	**$0**	**$0**	**$0**	**Oct-19**	**5.0**	**13.1%**	**$0**	**$0**	**$0**	**$1,332,900**		**$0**	**$1,332,900**
Single Site Option 1, Model 1- Muskoka Algonquin Healthcare		**333,227**	**bgsf**	**536.82**	**$178,881,800**	**$0**	**$8,146,000**	**$18,703,200**	**$18,703,200**	**$224,434,200**				**$29,492,900**	**$253,927,100**	**$12,696,500**	**$60,244,100**		**$58,068,200**	**$384,935,900**

Notes:
[1] An allowance of 5% on construction has been included for in-contract equipment. This will require review when more information is available.
[2] An allowance of 10% for design & pricing has been included to provide some further flexibility in design.
[3] An allowance of 10% for design scope contingency has been included to provide further flexibility in design scope.
[4] An allowance of 5% construction contingency has been included for change orders during construction.
[5] An allowance of 23.2% on construction has been included for project ancillaries (soft costs).
[6] An allowance for escalation at 2.5% per annum has been included to cover potential cost increases in labour and material from this current date to the time of construction start.
[7] FF&E / IT have been included at 15% of construction for renovations and 25% of construction for new construction.

Appendix D: Development Concept

Appendix D: Development Concept

Preamble

The preferred development concept for the MAHC master plan is a single site located centrally within the hospital catchment area. This concept would embody a campus-of-care approach to ensure safe, high-quality and sustainable health care at MAHC.

The new full service acute care hospital would be built on a Greenfield site. The building would have one level below ground and three levels above ground including the mechanical penthouse. The new hospital would be constructed with systems and materials typical of current hospital construction. All spaces internally would be designed with current standards for size, location and adjacency to other departments. Site work would need to occur to provide the required vehicular circulation and parking around the buildings on the site.

It is assumed that the facility could be built in one construction stage and would take approximately 3½ years to construct. At this point the development concept is preliminary and will undergo further refinement in the Stage 1 process.

Site Requirements

While a specific site location has not been identified at this early stage of planning, a location between Huntsville and Bracebridge will be selected in the next stage of planning in order to optimize travel time and access to services for the MAHC catchment population.

The following table is a high level summary of requirements for the single site replacement hospital envisioned by the master plan. This data was developed by reviewing the preliminary MAHC Master Program and is used for initial discussion only. Specific requirements will need to be developed as part of the Stage 1 process.

Table D-1: Preliminary Site Requirements

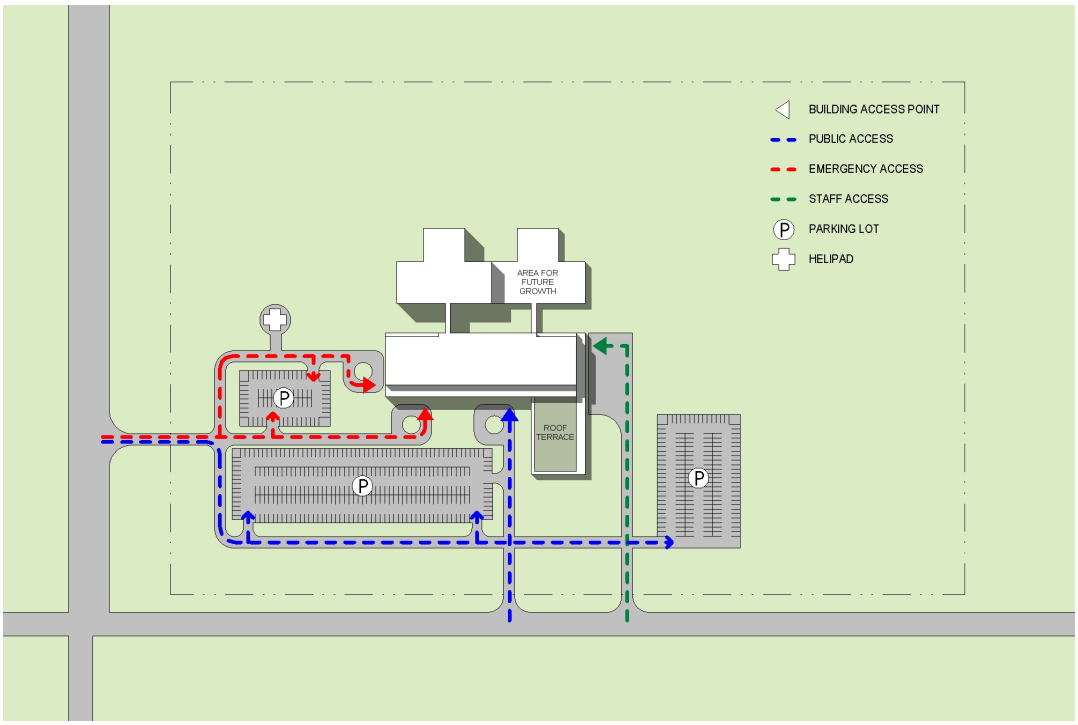
Item	Requirement
Size	50 acres of developable land (i.e. not constrained with environmental features) is ideal
Shape and Geometry	Parcel has a regular shape and is of good proportion
Two Road Frontage	Frontage on at least 2 roads (Established or Potential), one of which is arterial
Helicopter Flight Potential	Minimal restrictions on flight path elevations
Potable Water Services	Fully redundant (2), each line 200 dia
Fire Protection Water Services	Fully redundant (2), each line 200 dia.
Sanitary Drain Service	375 dia
Storm Drain Service	500 dia
Natural Gas Service	30,000 CFH
Power Services	Fully redundant (2), each rated at 3MVA
Telephone and Data Services	Fully redundant, 2 fibre and 2 copper

Site Design

The Development Concept site plan provides frontage on two roads. This allows for a clear separation of onsite circulation via three entrances and distinct site circulation routes based on type of usage. The primary access is for public and staff and provides drop-off at the main entry door and access to the primary parking lot. The secondary access is for the Emergency Department proving access for both public and emergency vehicles to the Emergency Department and dedicated parking lot. These two lots and internal roads are connected to allow circulation between these two entry points. The final access point is the service entry which is dedicated to hospital operational traffic (deliveries, etc.). The service lot and loading dock area accessed via this entry.

The total onsite parking requirements are estimated to be 396 spaces (10 year horizon).

Figure D-1: Development Concept



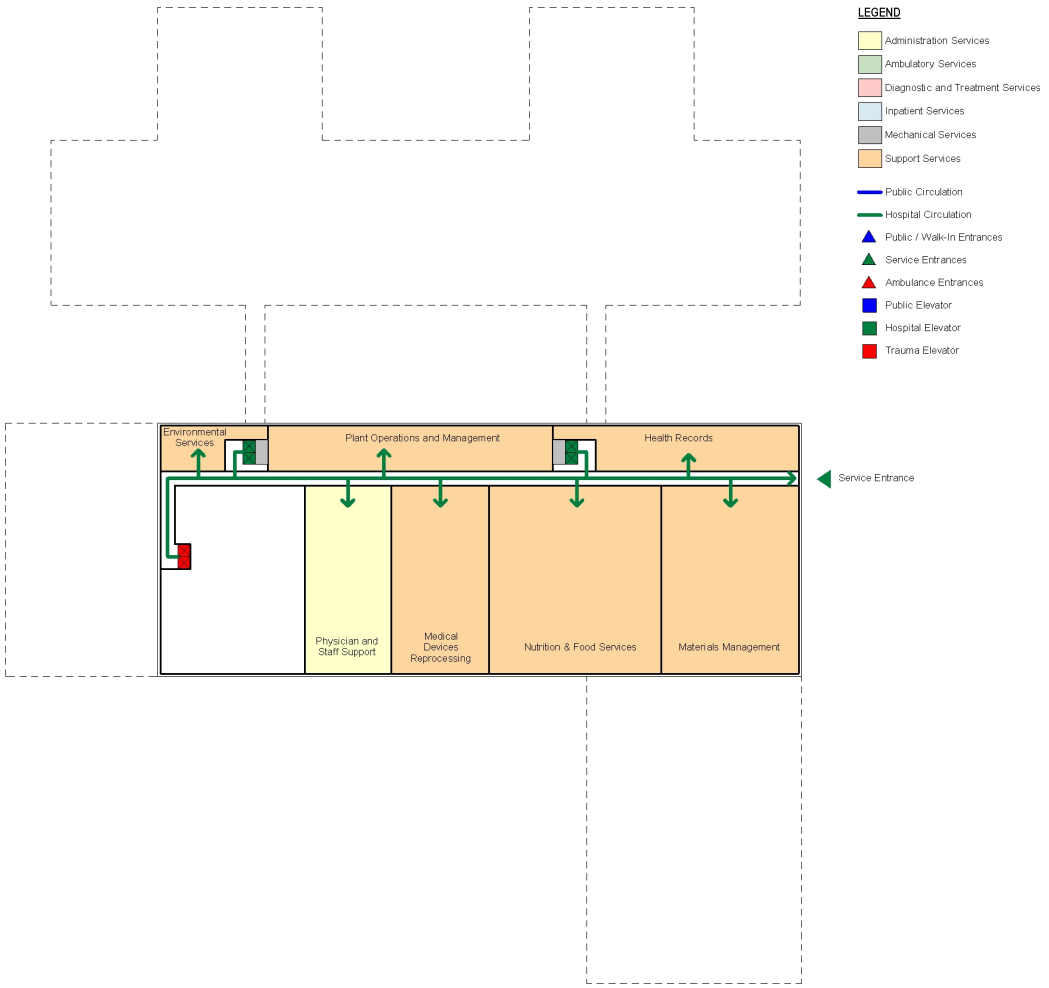
Building Design

The hospital building area is 302,107 BGSF organized into three major components grouped around the entry lobby. The hospital will have one level below ground and three levels above ground including the mechanical penthouse. Levels 1 and 2 will contain the diagnostic and treatment functions. Adjacent to the entry will be a one-story wing containing the ambulatory and outpatient services. The inpatient units will be housed in a separate parallel wing, connected to the facility at various points by corridors off of the main public circulation route. Two smaller units (Complex Continuing Care and Maternal/Child) will be located on the roof of the ambulatory care wing and having access to a rooftop green space.

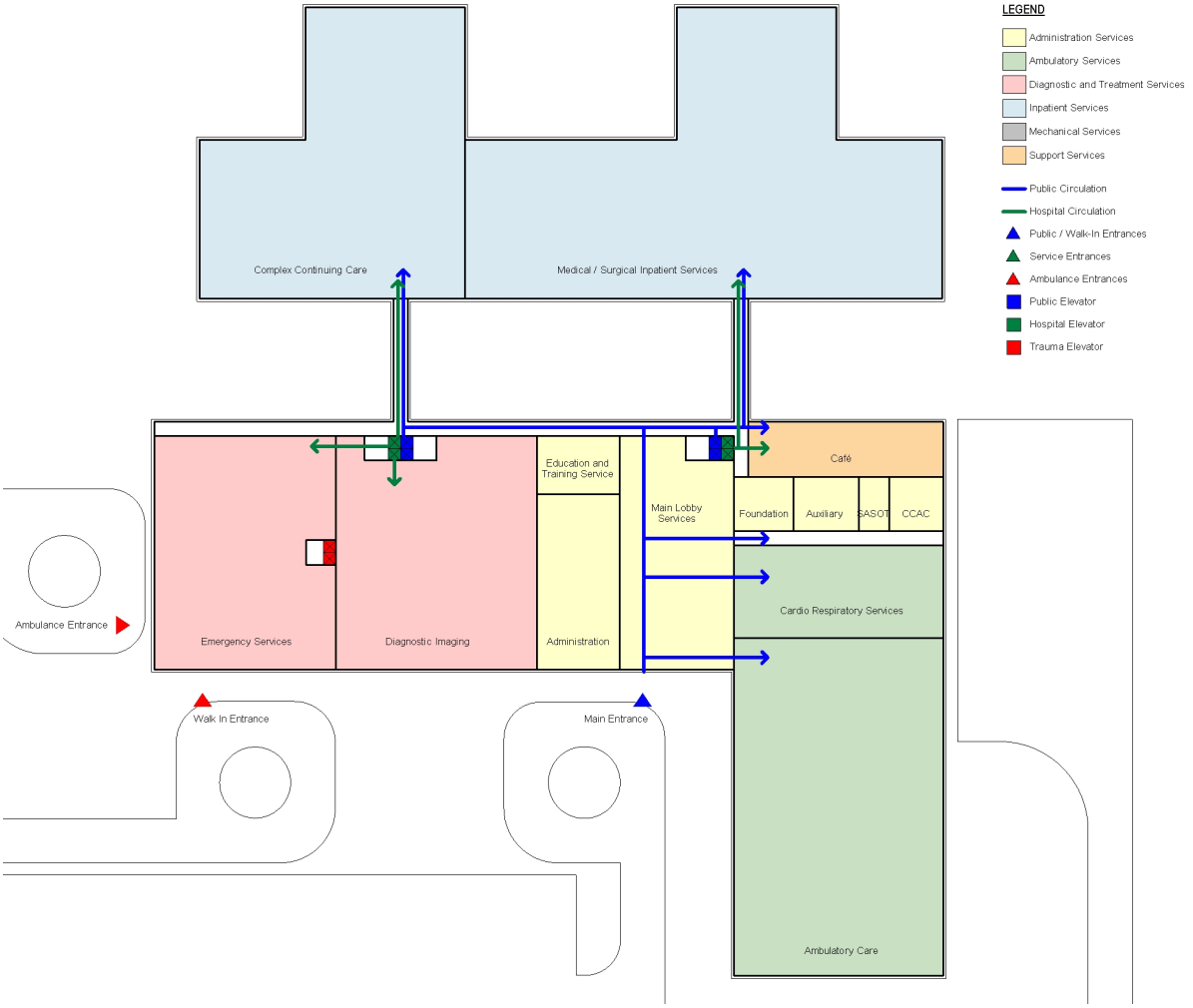
The facility will have the opportunity to maximize light, views and room sizes while providing ideal clinical and operational adjacencies. Public and clinical circulation will be separated. Future growth required for the inpatient unit would be achieved via horizontal expansion at the second floor of the inpatient wing.

An illustration of the Development Concept by floor is included on the following pages.

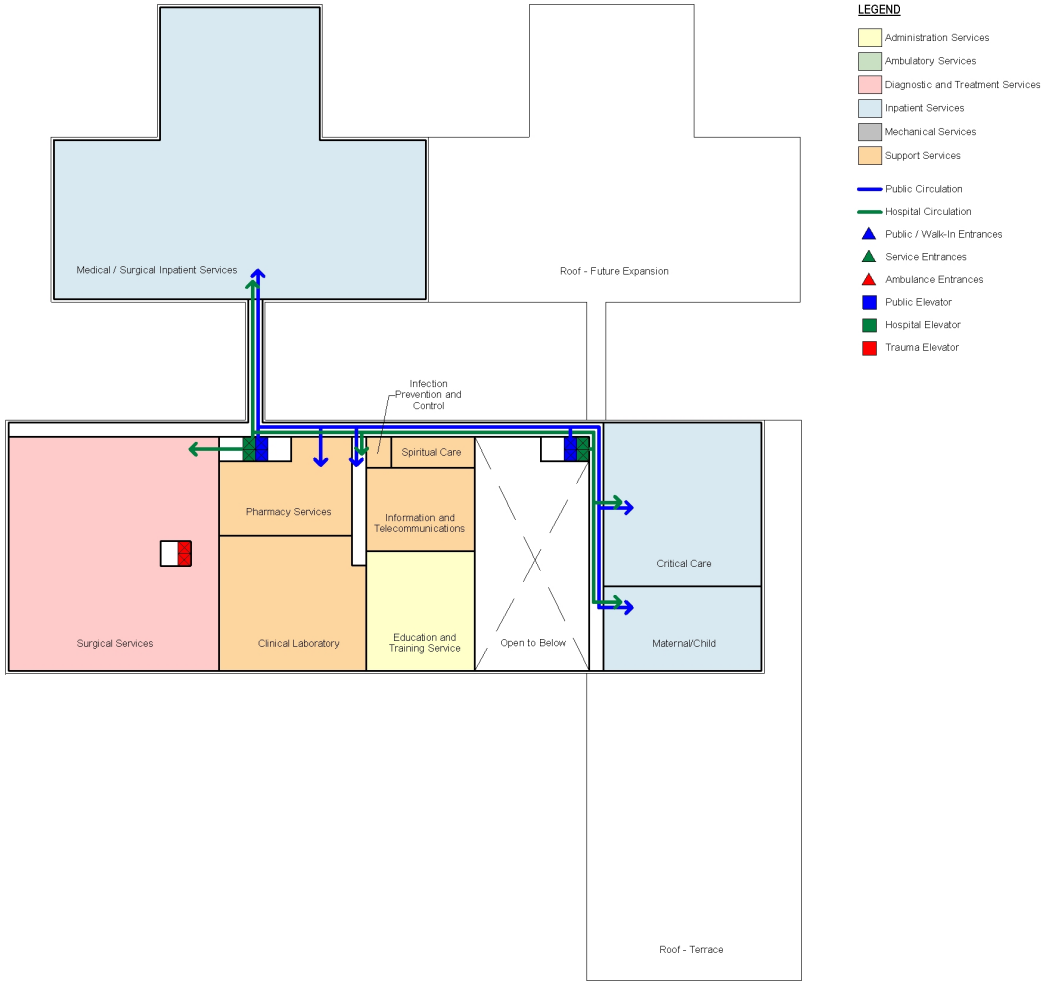
Figure D-2: Development Concept Blocking Plans



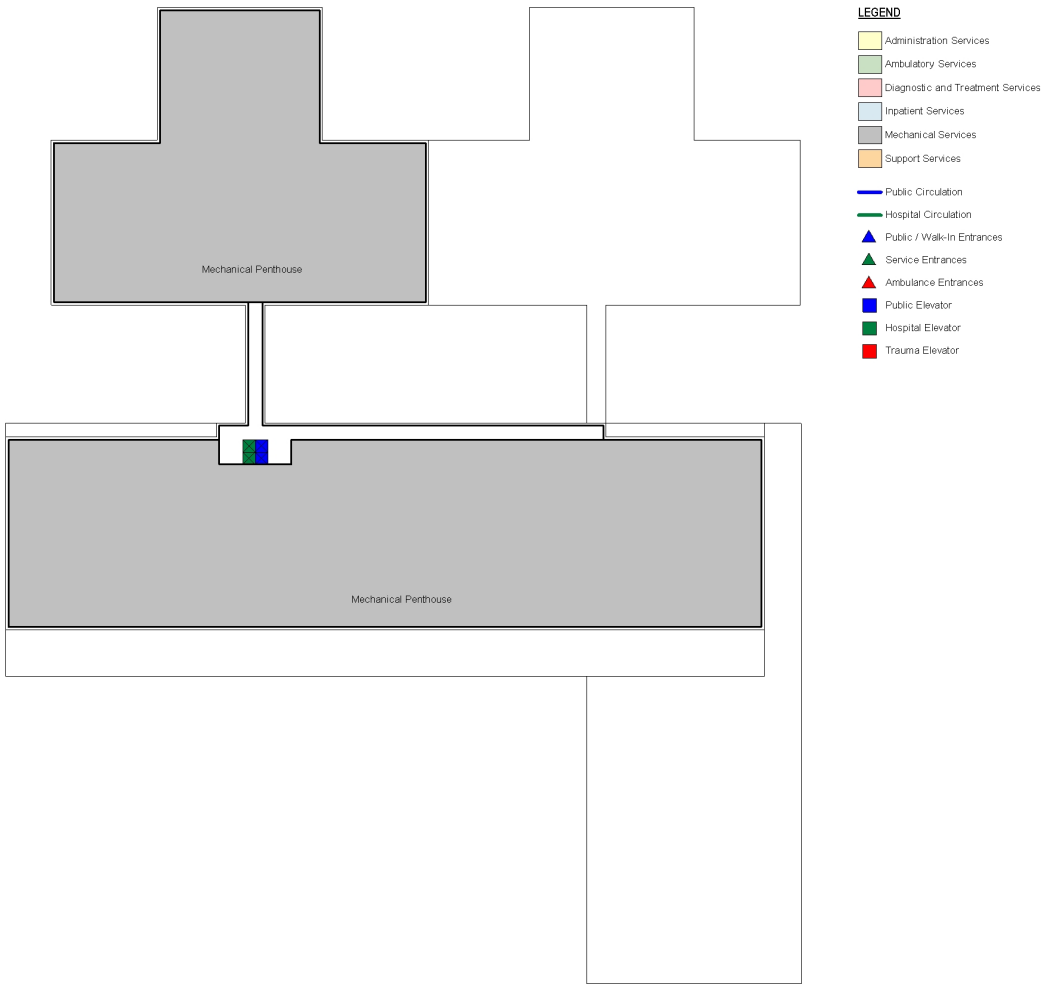
Basement


LEGEND
Administration Services
Ambulatory Services
Diagnostic and Treatment Services
Inpatient Services
Mechanical Services
Support Services
Public Circulation
Hospital Circulation
Public / Walk-In Entrances
Service Entrances
Ambulance Entrances
Public Elevator
Hospital Elevator
Trauma Elevator
Complex Continuing Care
Medical / Surgical Inpatient Services
Education and Training Service
Main Lobby Services
Café
Foundation
Auxiliary
SASOT
CCAC
Cardio Respiratory Services
Ambulatory Care
Ambulance Entrance
Emergency Services
Diagnostic Imaging
Administration
Walk In Entrance
Main Entrance

Level 1


LEGEND
Administration Services
Ambulatory Services
Diagnostic and Treatment Services
Inpatient Services
Mechanical Services
Support Services
Public Circulation
Hospital Circulation
Public / Walk-In Entrances
Service Entrances
Ambulance Entrances
Public Elevator
Hospital Elevator
Trauma Elevator
Medical / Surgical Inpatient Services
Roof - Future Expansion
Infection Prevention and Control
Spiritual Care
Pharmacy Services
Information and Telecommunications
Critical Care
Surgical Services
Clinical Laboratory
Education and Training Service
Open to Below
Maternal/Child
Roof - Terrace

Level 2


Mechanical Penthouse
Mechanical Penthouse
LEGEND
Administration Services
Ambulatory Services
Diagnostic and Treatment Services
Inpatient Services
Mechanical Services
Support Services
Public Circulation
Hospital Circulation
Public / Walk-In Entrances
Service Entrances
Ambulance Entrances
Public Elevator
Hospital Elevator
Trauma Elevator

Level 3

Appendix E: Travel Time Analysis

Access to Hospital Services under Different Planning Scenarios

Percent of region's residents that can reach any hospital within:

Single siting scenarios	**60 minutes**			**45 minutes**			**30 minutes**		
	Muskoka SubLHIN	*East Parry Sound 1*	*East Parry Sound 2*	*Muskoka SubLHIN*	*East Parry Sound 1*	*East Parry Sound 2*	*Muskoka SubLHIN*	*East Parry Sound 1*	*East Parry Sound 2*
Current State: HDMH and SMMH	**100%**	**88%**	**95%**	**93%**	**80%**	**23%**	**76%**	**26%**	**0%**
Hwy 11 & Hwy 60	98%	100%	95%	88%	88%	32%	55%	52%	0%
Hwy 11 & Taylor Rd	100%	88%	95%	92%	7%	23%	65%	0%	0%
Hwy 11 & Hwy 141	100%	88%	95%	93%	71%	23%	73%	0%	0%
Hwy 11 & Hwy 117	100%	88%	95%	93%	33%	23%	72%	0%	0%
Huntsville District Memorial only	98%	88%	95%	85%	80%	23%	41%	26%	0%
South Muskoka Memorial only	100%	79%	95%	85%	0%	23%	50%	0%	0%

East Parry Sound Travel Times

Census Subdivision (CSD)	*Average Travel Time of CSD Residents to:*		
	Parry Sound District	*North Bay Regional Health Centre*	*MAHC Huntsville*
Perry	62	80	29
Burk's Falls	66	64	33
McMurrich/Monteith	49	81	34
Kearney	97	105	63
Armour	72	65	39
Ryerson	69	64	42
East Parry Sound 1	**68**	**77**	**37**
Sundridge	70	50	50
Joly	87	63	67
Strong	70	49	50
Magnetawan	58	63	54
South River	76	44	56
Machar	86	55	67
East Parry Sound 2	**71**	**53**	**56**

In EPS 2 the average travel to NBRHC is 3 minutes less than to MAHC – HDMH

MAHC ED Use by Parry Sound SubLHIN Residents

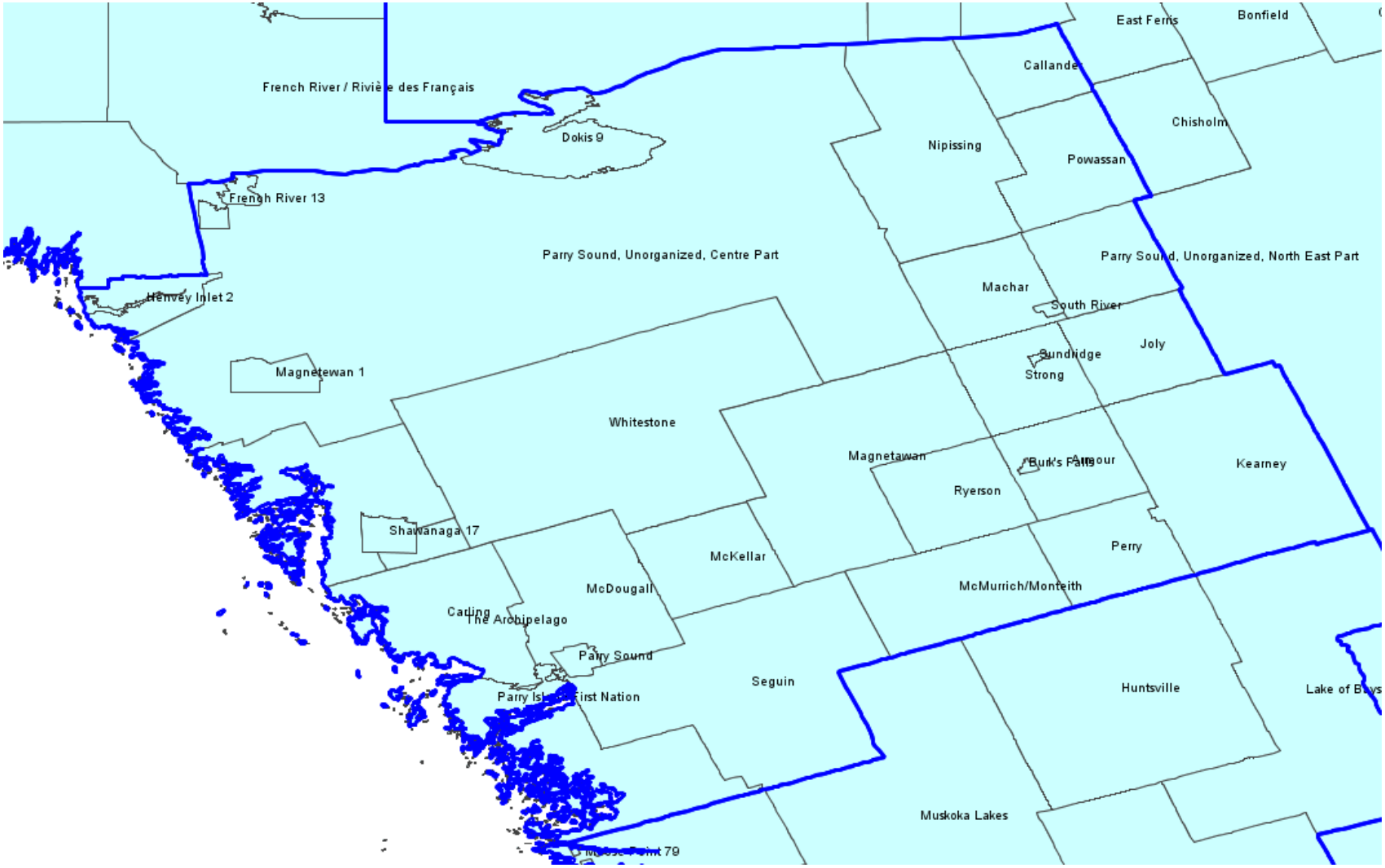
We established two planning regions in the Parry Sound subLHIN based on MAHC's market share of ED visits by the region's residents.

Our planning regions, East Parry Sound 1 and 2, are based on Census Subdivisions

Census Subdivision (CSD)	*Population*	Visits to MAHC ED	Visits to any ED	*MAHC Market Share*
Perry	2,344	1,344	1,440	93%
Burk's Falls	987	440	478	92%
McMurrich/Monteith	796	487	536	91%
Kearney	865	382	426	90%
Armour	1,417	663	740	90%
Ryerson	642	337	388	87%
East Parry Sound 1	**7,050**	**3,653**	**4,008**	**91%**
Sundridge	1,003	285	427	67%
Joly	280	71	108	66%
Strong	1,360	389	605	64%
Magnetawan	1,488	400	690	58%
South River	1,068	204	499	41%
Machar	944	171	437	39%
East Parry Sound 2	**6,143**	**1,520**	**2,766**	**55%**
Other CSDs in Parry Sound SubLHIN		**339**	**20,831**	**2%**

Census Divisions in the Parry Sound SubLHIN

The blue lines mark the Parry Sound SubLHIN boundaries



Travel Time Simulations

Residence of MAHC's Patients	*Average Travel Time*					*MAHC Discharges*				
	Existing sites	*Hwy 11 & Hwy 60*	*Hwy 11 & Taylor Rd*	*Hwy 11 & Hwy 141*	*Hwy 11 & Hwy 117*	*Existing sites*	*Hwy 11 & Hwy 60*	*Hwy 11 & Taylor Rd*	*Hwy 11 & Hwy 141*	*Hwy 11 & Hwy 117*
Muskoka SubLHIN	19	26	24	24	23	32,503	32,503	32,503	32,503	32,503
Acute Inpatient	19	27	23	24	23	3,599	3,599	3,599	3,599	3,599
Emergency Department	19	26	24	23	23	28,904	28,904	28,904	28,904	28,904
NSM LHIN, Not Muskoka	77	85	64	75	66	876	876	876	876	876
Acute Inpatient	71	81	61	71	62	51	51	51	51	51
Emergency Department	78	85	64	75	66	825	825	825	825	825
East Parry Sound 1	37	32	53	42	51	4,028	4,028	4,028	4,028	4,028
Acute Inpatient	39	32	53	43	51	375	375	375	375	375
Emergency Department	37	32	53	42	50	3,653	3,653	3,653	3,653	3,653
East Parry Sound 2	55	50	71	61	69	1,759	1,759	1,759	1,759	1,759
Acute Inpatient	57	52	73	62	70	239	239	239	239	239
Emergency Department	55	50	71	60	69	1,520	1,520	1,520	1,520	1,520
Elsewhere in Ontario	161	163	149	156	150	8,288	8,288	8,288	8,288	8,288
Acute Inpatient	139	140	132	136	133	425	425	425	425	425
Emergency Department	162	165	150	158	151	7,863	7,863	7,863	7,863	7,863

This shows the average travel time of MAHC's 2013/14 patients to alternative locations.

This table includes MAHC's patients, where the previous tables examined all residents of the relevant planning regions. For example:
MAHC had 28,904 ED visits by Muskoka subLHIN residents; on average these 28,904 patients travelled 19 minutes to reach MAHC and they would travel 24 minutes on average to reach a site at Hwy 11 and Taylor Road