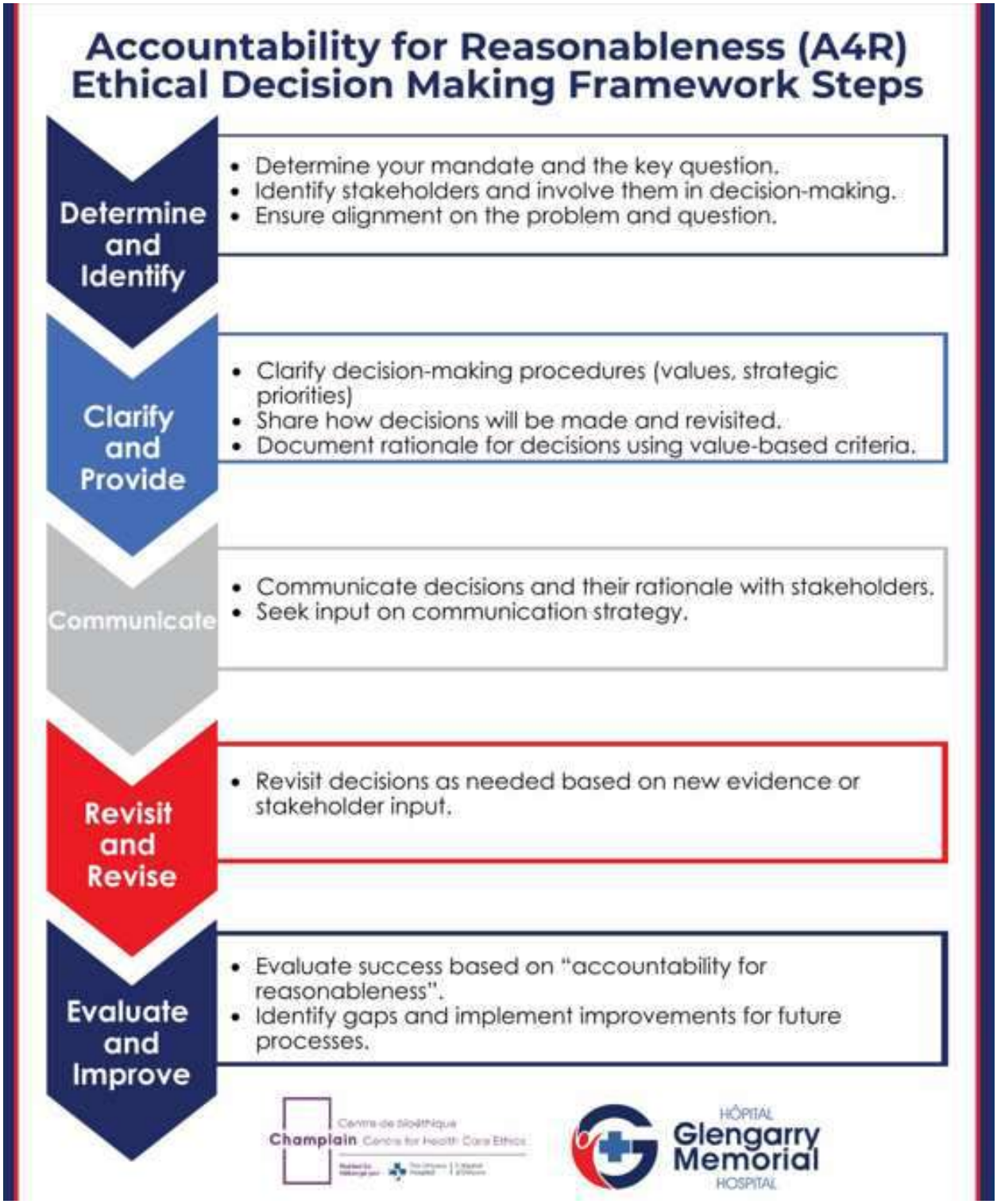
Board of Directors Meeting Agenda

Date: Thursday, April 24, 2025
Time: 9:00am – 12:00pm
Location: Boardroom / Microsoft Teams

Time	Agenda Item	Attachment
9:00	**1. Call to Order** (Dr. S. Robertson)	
(1 min)	1.1 Confirmation of Quorum	
(1 min)	1.2 Land Acknowledgment	
(1 min)	1.3 Adoption of the agenda	P. 1-2
(1 min)	1.4 Declaration of Conflict of Interest (Policy BOD.01.013.X.XX)	
9:04	**2. Minutes** (Dr. S. Robertson)	
(1 min)	2.1 Approval of previous meeting minutes – March 27, 2025	P. 3-7
(1 min)	2.2 Business arising from minutes	
9:06	**3. Equity, Diversity & Inclusion**	
(5 min)	3.1 Creating an Inclusive Workplace (K. MacGillivray)	
9:11	**4. Education**	
(15 min)	4.1 Best Practice Spotlight Organization – End of Life Care (C. Auger)	
9:26	**5. Matters for Discussion/Decision**	
(5 min)	5.1 Report of the Board Chair (Dr. S. Robertson)	P. 8
(5 min)	5.2 Report of the President & CEO (R. Alldred-Hughes)	P. 9-10
(5 min)	5.3 Report of the Chief of Staff (Dr. L. MacKinnon)	P. 11
(5 min)	5.4 Report of the Patient and Family Advisory Committee (J. Shackleton)	
(10 min)	5.5 Feedback – Visioning Session (R. Alldred-Hughes)	
(5 min)	5.6 Strategic Actions 2025-2026 (R. Alldred-Hughes) **THAT the Board of Directors approve the 2025/2026 strategic actions as presented.**	P. 12-14
(5 min)	5.7 Governance Accreditation Standard Review (R. Alldred-Hughes) **THAT the Board of Directors approve the new policy entitled "Framework for Board Accountability & Transparency" as presented.**	P. 15-18
(5 min)	5.8 Equity, Diversity & Inclusion Update (K. MacGillivray)	P. 19-21
(5 min)	5.9 Governing Body Assessment Survey Results	P. 22-24
(5 min)	5.10 Personal Business Commitments Results for 2024-2025 (Dr. S. Robertson) 5.10.1 CEO Personal Business Commitments Results 5.10.2 COS Personal Business Commitments Results **THAT the Board of Directors review and receive the results of Personal Business Commitments for 2024-2025 of the CEO and COS.**	P. 25-30
(5 min)	5.11 Personal Business Commitments 2025-2026 (Dr. S. Robertson) 5.11.1 CEO Personal Business Commitments 5.11.2 COS Personal Business Commitments **THAT the Board of Directors approve the Personal Business Commitments of the CEO and COS for 2025-2026 as presented.**	P. 31-35
10:26	**6. Consent Agenda** (a formal request is to be made with the Board Chair to move an item out of the consent agenda for it to be discussed)	
	6.1 Draft Finance, HR, and Audit Committee Report of April 9, 2025	P. 36
	6.2 Audit Plan Review	P. 37-75
	6.3 Draft Governance and Nominating Committee Report of April 9, 2025	P. 76-77
	6.4 Board Application for Membership Process Policy	P. 78-80
	6.5 Appointment of Auditor Policy	P. 81
	6.6 Draft Executive Committee Report of April 9, 2025	P. 82-83
10:27	**7. Correspondence (Dr. S. Robertson)**	P. 84
	8. Date of Next Meeting – May 22, 2025, 9:00am	
10:28	**9. Closing Remarks & Adjournment (Dr. S. Robertson)**	

**Meeting Moves to In Camera*


Accountability for Reasonableness (A4R)
Ethical Decision Making Framework Steps
Determine and Identify
• Determine your mandate and the key question.
• Identify stakeholders and involve them in decision-making.
• Ensure alignment on the problem and question.
Clarify and Provide
• Clarify decision-making procedures (values, strategic priorities)
• Share how decisions will be made and revisited.
• Document rationale for decisions using value-based criteria.
Communicate
• Communicate decisions and their rationale with stakeholders.
• Seek input on communication strategy.
Revisit and Revise
• Revisit decisions as needed based on new evidence or stakeholder input.
Evaluate and Improve
• Evaluate success based on "accountability for reasonableness".
• Identify gaps and implement improvements for future processes.
Centre de bioéthique
Champlain Centre for Health Care Ethics
HÔPITAL Glengarry Memorial HOSPITAL

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS

Date	Thursday, March 27, 2025		
Time	8:45am-10:00am		
Location	Boardroom / Microsoft Teams		
Present:	Dr. S. Robertson, Chair	L. Boyling, Vice-Chair	Dr. R. Cardinal
	F. Wetering	G. McDonald	G. Peters
	H. Salib	F. Desjardins	Dr. G. Raby
	C. Nagy	C. Larocque	W. Rozon
	R. Alldred-Hughes, CEO	K. MacGillivray, CHRO	J. Shackleton (PFAC)
	R. Romany, CNE		
Regrets:	Dr. L. MacKinnon	L. Ramsay	

1. Call to Order

Dr. S. Robertson, Chair, called the meeting to order at 8:47.

1.1 Quorum

A quorum was present.

1.2 Land Acknowledgment

Dr. R. Cardinal read the land acknowledgment.

1.3 Adoption of the Agenda

The agenda was reviewed.

Moved By: F. Desjardins
Seconded By: W. Rozon
THAT the agenda be adopted as presented.

CARRIED

1.4 Declaration of Conflict of Interest

There were no conflicts of interest declared at this time.

2 Minutes

2.3 Approval of the Minutes

The minutes of the last meetings held on February 27, 2025, were presented.

Moved By: Dr. R. Cardinal
Seconded By: H. Salib
THAT the minutes of the February 27, 2025, meeting be approved as presented.

CARRIED

2.2 Business Arising from the Minutes

There was no business arising from the minutes.

3 Equity, Diversity & Inclusion

The mini training for EDI was assigned, titled Unconscious Bias. The Board discussed their thoughts on the training.

4 Matters for Discussion/Decision

4.1 Report of the Board Chair

Dr. S. Robertson reminded the Board that the Foundation Washer Toss tournament is taking place on April 5th. 2025.

It was also mentioned that the Donor Recognition board has been installed.

4.2 Report of the President & CEO

R. Alldred-Hughes reported on a meeting that took place with Supply Ontario in which all hospitals are to develop a list of their suppliers of services and equipment and anything that comes from the US is to have a Canadian alternative if possible.

Going forward, stakeholder engagement activities will be outlined in the CEO report to serve as a reminder regarding engagement being done.

4.3 Report of the Chief Human Resources Officer

K. MacGillivray updated on some initiatives that recently took place for staff including a new initiative for Valentines Day in which staff could send candygrams to their colleagues and proceeds raised were donated to the Foundation as well as the breakfast for staff to celebrate staff appreciation day.

It was noted that there were 29 new hires over the past year with 27 of those hires still employed by the hospital.

4.4 Report of the Chief of Staff

Deferred

4.5 Report of the Patient and Family Advisory Committee

Deferred

4.6 Board Peer-to-Peer Survey Questionnaire

The Board Peer-to-Peer survey was reviewed with changes recommended by the Governance & Nominating Committee.

Moved By: C. Nagy
Seconded By: G. Peters
THAT the Board of Directors approve the Board Peer-to-Peer Survey Questionnaire as presented.

The Governance & Nominating Committee worked on updating the survey to better reflect its purpose. Appreciation was shared for the work done on this survey.

CARRIED

4.7 Board Committee Meeting Schedule

A draft meeting schedule for 2025/2026 was presented.

Moved By: C. Larocque
Seconded By: W. Rozon
THAT the Board of Directors approve the proposed adjustments to the committee meeting schedule as presented.

The Board would like to see meetings return to evenings to allow those who work the opportunity to attend meetings.

The frequency of meetings will be adjusted to allow equal focus for all committees. Currently, Quality only meets four (4) times, Governance meets six (6) times, and Finance meets eight (8) times per Board cycle. The agenda for Quality meetings are usually overloaded with information and little time to fully discuss items, and the Finance meetings often have months with very little to discuss. By having every committee meet six (6) times per year, agendas will be more balanced. This will also allow for more discussions on Quality which currently do not happen often.

The Committee Workplans were provided as examples of what the meeting schedules would look like. The workplans will be approved by committees at the first meeting of the next board cycle.

CARRIED

4.8 Financial Statements – January 2025
The financial statements for January 2025 were shared.

Moved By: W. Rozon
Seconded By: H. Salib
THAT the Board of Directors review and receive the financial statements for January 2025 as presented.

The Hospital received $469,833 of global funding in January, which was 10 months of the remaining total of the Bill 124 current year funding, announced in late December. With this, January ended in a year-to-date surplus of $ 371, 543. There has been a decrease in out of province visits, however work is being done to provide services to residents of Akwesasne who have a RAMQ card. This is an opportunity to secure more out of province volume while providing equitable access to care.

CARRIED

Moved By: W. Rozon
Seconded By: H. Salib
THAT the Board of Directors approve the transfer of up to $ 125,000 of parking income into capital reserves should the Hospital finish in a surplus or more than $ 150,000.

Capital reserves are self managed in which a year's worth of amortization is generally kept.

CARRIED

4.9 HSAA Extending Agreement
The letter from Ontario Health around the extension of the Hospital Service Accountability Agreement was shared.

Moved By: F. Desjardins
Seconded By: W. Rozon
THAT the Board of Directors approve the signing of the HSAA Extending Agreement as presented.

This is the second extension of this specific HSAA given the financial uncertainty. Once funding letters are received, Ontario Health would advise whether an improvement plan is needed to get finances in order.

CARRIED

4.10 Capital Plan 2025-2026
The Capital Plan for 2025-2026 was shared.

Moved By: F. Desjardins
Seconded By: H. Salib
THAT the Board of Directors approve the Capital Plan for 2025-2026 as presented.

The process on how the capital plan is created was explained. This list went through extensive work to ensure we are purchasing items that need replacement and that enhance quality and safety of both the patients and staff.

CARRIED

Moved By: F. Desjardins
Seconded By: H. Salib
THAT the Board of Directors approve the use of the Endowment Fund to purchase up to $ 107,621 of capital expenses.

As there is an unfunded amount on the capital plan, the transfer of funds was proposed to allow the purchase of all items on the list. Capital expenses will be monitored throughout the year to ensure that endowment fund usage is at a minimum.

CARRIED

5 Consent Agenda

The following were included in the meeting package under consent agenda and reviewed by members prior to the meeting:
6.1 Draft Governance & Nominating Committee Report
6.2 Roles and Responsibilities of the Board Policy (BOD.01.005)
6.3 Nomination and Election Policy (BOD.01.016)
6.4 Roles of a Director and Code of Conduct Policy (BOD.01.017)
6.5 Roles and Responsibilities of the Board Chair, Vice Chair and Treasurer (BOD.01.018)
6.6 Framework for Ethical Decision-Making Policy (BOD.03.001)
6.7 Board Mentorship Policy (BOD.01.012)
6.8 Draft Finance, HR and Audit Committee Report

Moved By: C. Larocque
Seconded By: G. Peters
THAT the Board of Directors approve and receive all documents as presented in the consent agenda.

CARRIED

6 Correspondence

Correspondence was shared.

7 Date of Next Meeting

Thursday, April 24, 2025, at 9:00am

8 Closing Remarks & Adjournment

The meeting adjourned at 9:38.

K-L. Massia, Recording Secretary

Report of the Board Chair

April 2025 Board Meeting

Monthly donation to the Foundation

Many of the hospital staff give a monthly donation to the Foundation. This money contributes to the fundraising of the Foundation. In light of the CT scanner project, it would be wonderful to have Board members contribute on this way. $100 monthly gift would certainly make a difference. Consider giving what you can afford to help the Foundation reach its yearly goal of one million dollars.

New board members

We have several applicants for the Board. But with minimal media outlets in our region now, it is more difficult to get the word out. Fortunately our Board only requires one new member currently. But that could certainly change in the future. If you recall, we had four new members join us last year. Current Board members are an excellent source of potentially useful members. Please keep trying to recruit suitable friends and acquaintances. The quality of future Boards depends on this.

Dr Stuart Robertson
Chair, Board of Directors
Hôpital Glengarry Memorial Hospital

Report of the President & CEO

April 24, 2025 Board Meeting

New Procurement Restriction Policy to Restrict Procurement from U.S. Businesses

A new Procurement Restriction Policy, part of the Ontario government's response to the tariffs imposed on Canada by the United States (U.S.) has been put in place. This policy is designed to restrict U.S. businesses from accessing public sector procurements in Ontario by restricting public sector buyers from procuring from U.S. businesses.

As of March 4, 2025, the Procurement Restriction Policy is in effect for Ontario government entities (ministries, provincial agencies) and designated Broader Public Sector organizations, including hospitals.

Existing procurement policies continue to apply, including the Broader Public Sector Procurement Directive and rules to support the Building Ontario Businesses Initiative.

This Procurement Restriction Policy applies to all new procurements beginning after March 4, 2025, and does not apply to procurements already in progress or through existing Vendor of Record arrangements.

A U.S. business means a supplier, manufacturer or distributor of any business structure (includes a sole proprietorship, partnership, corporation or other business structure) that:

1. has its headquarters or main office located in the U.S., and
2. has fewer than 250 full-time employees in Canada at the time of the applicable procurement process.

To ensure critical goods and services can still be obtained, the policy allows procurement from U.S. businesses in some limited situations: where the U.S. business is the only viable source and the procurement cannot be delayed (for example, delays may result in risks to public health and safety). Both criteria must be met.

As part of procurement documentation, hospitals will be required to document that these criteria have been met and must secure Chief Executive Officer approval.

EPIC Kicks Off

We are pleased to share that our EPIC implementation project has officially kicked off. This marks a significant milestone for our organization as we move forward with the adoption of a new, integrated digital health information system. The journey began with an EPIC Day held on April 2, 2025, in Ottawa, where all third wave partners came together to launch the initiative in collaboration and shared purpose. The energy and momentum from this joint event set a strong foundation for the work ahead.

Building on that momentum, we held a local kickoff at Hôpital Glengarry Memorial Hospital on April 3, 2025. This event brought together key members of our internal teams to begin preparations and align on early deliverables. The project remains on track, with staff actively engaged in gathering and validating all pertinent information needed for the successful execution of the plan.

Further details regarding the project rollout and implementation timelines will be brought forward to the Finance, Human Resources, and Audit Committee once the final project plan is delivered. The first draw on financing is scheduled for June 2025, and a comprehensive cash flow projection will also be reviewed through this committee and subsequently shared with the Board. We look forward to keeping you informed as the project progresses and will continue to work diligently to ensure a smooth and successful transition to the EPIC system.

60 Year Anniversary with Community Engagement Session

MARK YOUR CALENDAR: MAY 9th, 2025 from 6pm-9pm: As part of our 60th anniversary celebrations, Hôpital Glengarry Memorial Hospital is proud to host a special community engagement event titled *"The Perfect Pairing: 60 Years of Care & Community."* This event will showcase the deep connection between the hospital and the communities we serve, offering an opportunity to reflect on our history while looking ahead to our future. The evening will feature a series of information booths highlighting the breadth of services we offer—from frontline care to essential back-office operations. Our valued partners from the Hospital Auxiliary and the HGMH Foundation will also be present to share their contributions and ongoing support.

Live music will be provided by the talented local band *Two for the Road*, with intermissions dedicated to sharing stories from the hospital's past and insights into our vision for the years to come. To foster meaningful dialogue, a community poll has been launched inviting residents to submit their questions in advance, which we will respond to throughout the evening. Invitations have been extended to local dignitaries and past members of the Board of Directors, ensuring a rich gathering of individuals who have played a role in shaping our journey. We look forward to celebrating this milestone with our community and engaging in thoughtful conversations about our shared future.

Patient Experience Week -Senior Team Launches Leader Patient Rounding

As part of our commitment to enhancing the patient experience, HGMH will be launching senior leader rounding with patients during Patient Experience Week. This new initiative will see members of the senior leadership team engaging directly with patients at the bedside to listen to their feedback, better understand their care journey, and identify opportunities for improvement. Rounding will continue on a weekly basis moving forward, with a focus on addressing concerns in real time and reinforcing our culture of compassionate, person and family centered care. This proactive approach will support continuous quality improvement and strengthen trust between patients, families, and our care teams.

Stakeholder Engagement Activities

To strengthen relationships and foster collaboration, key meetings have been held with external partners and stakeholders. These engagements are essential for sharing information about our hospital's performance, discussing future plans, and aligning efforts to better support the needs of our patients and community. Building strong partnerships in this way helps ensure transparency, trust, and coordinated progress toward shared healthcare goals. This past month, I had the opportunity to conduct the following stakeholder meetings:

- *Meeting with Gordon Kubanek – Political Candidate for SD&G, Green Party (Board chair in attendance)*
- *Meeting with Sarah Good – Political Candidate for SD&G, Liberal Party (Board chair in attendance)*
- *Meeting with Eric Duncan – Political Candidate for SD&G, Conservative Party (Board chair in attendance)*
- *Meeting with Jeff Hohenkerk – CEO of Campbellford Memorial Hospital*
- *Meeting with Dennis Garvin – New CEO of Eastern Ontario Regional Laboratory Association*

Upcoming Events/Special Dates

- April 28-May 2: Patient Experience Week
- April 28: World Day for Health and Safety at Work
- May 1: National Physicians Day
- May 5: Hand Hygiene Day
- May 12-18: National Nursing Week
- May 13th: National PTA/OTA Day
- May 18th: National Speech Language Pathologist Day

Report of the Chief of Staff
April 2025

Physician Recruitment
We have engaged in discussions with representatives from the Rural Ontario Medical Program (ROMP) and the Township regarding a potential partnership to host first and second-year medical students during their annual Rural Medicine Week. Depending on the medical school, these placements would take place either May 19–23 or June 2–6, 2025 and would entail arranging student accommodations, organizing hospital placement experiences, and planning community activities to help the students feel welcomed into our rural community and hospital.

Suzanne and I also attended a Recruitment Campaign Project meeting, initiated by the Great River Ontario Health Team. We will continue participating in this working group, which is exploring physician and healthcare recruitment opportunities—including outreach to physicians currently practicing in the U.S. who may be interested in relocating to Canada.

Active recruitment continues for one Emergency Medicine physician and two Inpatient Medicine physicians. Our vacant positions are posted on the Health Force Ontario website as well as other educational institutions in the region.

Scheduling
The Emergency Department Physician schedule is complete until the end of July 2025, despite concerns regarding a possible physician shortage with the end of the Temporary Summer Locum Program funding.

The new Physicians Service Agreement is underway and further contract details from the Ontario Medical Association and the Ministry of Health should be available over the next month.

Epic
Dr. Farmer, Chief of Emergency participated in the Epic Strategic Roadshow and Epic Third Wave Kick-Off held in Ottawa earlier this month.

Education
April 7-9, I attended the Emergency Medicine Update in Toronto representing HGMH. This conference is the largest Community Emergency Medicine Conference in North America. The focus is on uptodate practical clinical medicine learning, taught by practicing Emergency Medicine Physicians. Additional Symposium topics included Women in Emergency Medicine and Ways to Improve ED Flow & Efficiency.

Upcoming, May 23-28, Dr. Farmer will be attending the International Conference on Emergency Medicine representing HGMH.

DECISION SUPPORT DOCUMENT FOR

☒ Board of Directors ☐ Board Committee – ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: April 15, 2025 Meeting Date Prepared for: April 24, 2025

Subject: Strategic Actions 2025/2026

Prepared by: Robert Alldred-Hughes, President & CEO

☒ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

The purpose of this briefing note is to outline the strategic actions planned by Hôpital Glengarry Memorial Hospital (HGMH) for the upcoming fiscal year, which are aimed at advancing our strategic plan and achieving our vision of "*providing your care, your way, with seamless integration, innovation, and equitable access for our communities*." These actions have been developed through planning workshops and the identification of system opportunities to address the priorities outlined in our strategic plan: Quality & Safety, People & Culture, Integration & Standardization, and Future Planning.

RECOMMENDATION / MOTION

That the Board of Directors approve the strategic actions for 2025/2026 as presented.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☐ *No* ☒ *Yes, please specify:*

- Quality Committee of the Board
- Finance & Human Resources Committee of the Board

SITUATION & BACKGROUND

A brief description of the background to the issue.

HGMH recognizes the importance of aligning our operational activities with our strategic priorities to ensure that we continue to deliver high-quality healthcare services to our communities. Through planning workshops, meetings, and ongoing analysis of system opportunities, we have identified specific actions that will enable us to make meaningful progress in each priority area of our strategic plan.

The process of identifying strategic actions annually helps shape the organizations commitments for the year. A few notable achievements on our prior fiscal year include: Implementing at least two actions from the Inclusion, Diversity, Equity, and Anti-Racism framework that support equitable access and/or culturally safe care; Implementing two Best Practice Guidelines aligned with the RNAO, BPSO; PFAC developing and implementing two initiatives to continue advancing person and family centred care; Developing a recruitment brand that markets the hospital to prospective talent in a meaningful way; Developing and implementing a standardized retirement recognition program that celebrates staff members who are retiring from the hospital in a meaningful way; and Beginning the capital redevelopment planning process to name a few.

These plans provide focus for the leadership team and support our ability to remain steadfast on our organizations vision.

OPTIONS CONSIDERED & ANALYSIS

Outline alternatives that were contemplated in coming to a recommendation. If no viable alternatives exist, include that information as well.

The strategic actions for the 2025/2026 fiscal year have been carefully considered and selected based on their potential to drive positive outcomes in our priority areas. These actions include:

1. Quality & Safety:
    - Through our participation in the Best Practice Spotlight Organization (BPSO) initiative, we will implement Best Practice Guidelines to strengthen the tools and resources available to our palliative care team. This includes introducing assessment tools and reference sheets to support consistent, high-quality care across all touchpoints.
    - Increase the use of medical directives for nursing staff, allowing for faster initiation of diagnostic tests and treatments before physician assessment. Undertake facility enhancements to support patient care and operational efficiency
    - Enhance patient involvement in care decisions by implementing Leader and Patient and Family Advisory Committee (PFAC) patient rounding to engage directly with patients and assess their level of involvement in their care before discharge.

2. People & Culture:
    - HGMH is initiating a Medical Student and Resident Program to provide hands-on learning experiences within our medical community. By collaborating with the Rural Ontario Medical Program (ROMP) and other academic partners, we will support initiatives such as Discovery Week for medical students and structured resident placements
    - As part of our ongoing commitment to health and safety, we are enhancing leadership training with a dedicated focus on psychological safety in addition to management responsibilities.
    - Redesign our performance evaluation process to create a more meaningful, transparent, and development-focused experience for our employees.

3. Integration & Standardization:
    - Continue the transition to a new Electronic Medical Record (EMR) system by joining the Atlas Alliance and implementing the EPIC EMR platform in the Fall of 2026.
    - As part of our commitment to business continuity, IT performance, and cybersecurity, HGMH is investing in critical upgrades to our information technology infrastructure. This year, we are enhancing system reliability and security by purchasing backup servers and an uninterruptible power supply (UPS) for our server environment.

4. Future Planning:
    - Submit pre-capital submission to support the future redevelopment and revitalization of the hospital
    - Actively work with and support the HGMH Foundation in their efforts to fund our ability to bring CT to HGMH.

The strategic actions outlined in this briefing note represent our commitment to advancing our strategic plan and fulfilling our vision of delivering patient-centered care with excellence. By focusing on quality, safety, people, integration, and future planning, we will continue to meet the evolving needs of our community and position HGMH as a leader in healthcare provision.

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.

The implementation of these strategic actions is expected to have a significant impact on our organization, including:

- Improved patient outcomes and experiences.

- Enhanced staff engagement and retention.
- Increased operational efficiency and effectiveness.
- Strengthened partnerships and collaborations with community stakeholders.
- Positioned HGMH as a leader in rural healthcare innovation and excellence.

IMPLEMENTATION & COMMUNICATION PLAN

Consider how the recommendation will be rolled-out and communicated to all key stakeholders.

Effective communication will be essential to ensure that all stakeholders are informed and engaged throughout the implementation of these strategic actions. To facilitate this, we will:

- Provide regular updates and progress reports to the Board of Directors, senior leadership team, and staff.
- Engage with frontline staff and solicit feedback through town hall meetings, leader rounding, CEO Round Table
- Communicate with our community partners and stakeholders to ensure alignment and collaboration on shared goals.
- Utilize various communication channels, including email, newsletters, intranet, and social media, to disseminate information and engage with our broader community.

DECISION SUPPORT DOCUMENT FOR

☒ Board of Directors ☐ Board Committee - ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared:	March 28, 2025	Meeting Date Prepared for:	April 9, 2025 – Governance April 24, 2025 - Board
Subject:	Accreditation Standard Feature		
Prepared by:	Robert Alldred-Hughes, President & CEO		

☒ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- As part of the hospital's efforts to embrace the new continuous model for Accreditation and embed it into our daily work, committees will feature 1-2 criteria from an Accreditation standard that applies to their committee's work at each meeting
- These features will provide an opportunity for the committee to discuss the standard and how HGMH achieves compliance, identifies opportunities for improvement, while ensuring the committee is well-equipped to make informed decisions and recommendations related to quality

MOTION

THAT the Board of Directors approve the new policy entitled "Framework for *Board Accountability & Transparency*" as presented.

STANDARD / CRITERIA FEATURED

Include the standard name, number(s), statement(s), guideline text, and other information if applicable

Priority High Priority Guidelines Quality Dimension: Efficiency

3.1.3 The governing body applies the organization's accountability framework to ensure the organization is well-managed and accountable to its stakeholders.

Guidelines

An accountability framework specifies the evidence-informed approach and mechanisms (e.g., criteria, guidelines, plans, procedures) that the governing body can use to set expectations for strong organizational management practices and performance. The governing body uses the framework to oversee and guide the organization's achievement of its strategic goals and objectives and establish the organization's accountability to its stakeholders, including workforce, volunteers, clients, and families. The framework aligns with the organization's ethics and values. It may be developed in collaboration with stakeholders or may be adopted from existing frameworks.

Based on the above, HGMH does not currently have an Accountability Framework, however, our orientation materials do speak to who the Board of Directors is Accountable to.

To support the Board in ensuring we have a documented framework that demonstrates our accountability and transparency practices, the attached policy has been developed for consideration, and recommendation to the Board of Directors for adoption. If approved, this policy will be added to the list of policies to be reviewed on a rotational basis.

DISCUSSION QUESTIONS

Choose 1-2 questions from the list below to guide discussion at your meeting, or create your own question(s)

Does the new policy meet the Accreditation Standard from your perspective?
Are there opportunities for enhancement, or elements you believe should be added or removed?

FRAMEWORK FOR BOARD ACCOUNTABILITY & TRANSPARENCY

Document Name:	Framework for Board Accountability & Transparency	
Document Number:	BOD.01.XXX.0.25	
Review Period:	☒3 years ☐1 year	**Manual: Governance**
Classification: Board of Directors		**Section:**
Owner: President & CEO		**Signing Authority:** Board of Directors

POLICY STATEMENT:

This Policy sets out the accountability of the Board of Directors of Hôpital Glengarry Memorial Hospital (HGMH).

The duty of the board is to make decisions that are in the best interests of the corporation. Decisions that are in the best interests of the corporation will be decisions that further the hospital's mission, move it towards its vision, are consistent with its values, but also discharge its accountabilities.

PROCEDURE:

The Board governs the Corporation through the direction and supervision of the business and affairs of the Corporation in accordance with its By-Laws, vision, mission and core values, governance policies and applicable laws and regulations.

The Board adheres to a model of governance through which it provides strategic leadership and direction to the Corporation by establishing policies, making governance decisions, monitoring performance related to the key dimensions of the Corporation's mission, as well as evaluating its own effectiveness and by building relationships within the health system.

To guide the board in making decisions in the best interests of the corporation, the board has confirmed the following accountabilities of the corporation:

To patients and families	*For quality services, patient safety, patient and family-centered care and best practices.*
To the community we serve	*For efficient utilization of resources, clear communication, transparent processes, advocacy, and expectation management.*
To the Ministry of Health	*For compliance with applicable legislation, regulation and policies, including funding policies for capital.*
To the Ontario Health	*For performance of HSAA, participation in OH-led initiatives, expenditure management and performance management.*
To donors	*For financial stewardship.*
To staff and volunteers	*For establishing and communicating expectations and providing a safe work environment.*
To health system partners	*For cooperation and collaboration.*
To members of the corporation	*For complying with the by-laws and applicable legislation as it governs the corporation, and for the achievement of its mission and vision in a manner consistent with its values and accountabilities.*

Through the provision of outstanding healthcare and demonstrating our commitment to operate in a medically, socially and financially responsible manner HGMH shares our performance in an open and transparent manner.

To maintain HGMH's commitment to accountability and transparency, the Board adopts the framework below to earn the trust of those it is accountable.

Process or Action Required by Legislation	***Contributes to or Demonstrates***		
	Accountability	**Transparency**	**Engagement**
Entering into a Hospital Service Accountability Agreement (HSAA)	*X*		
Post HSAA in a conspicuous place and on website	*X*	*X*	
Public Reporting of Quality-of-Care Indicators (as required under the Public Hospitals Act, Regulation 965)	*X*	*X*	
Annual Audited Financial Statements	*X*	*X*	
Engage community of diverse persons and entities when setting plans and priorities (required under Local Health System Integration Act)	*X*	*X*	*X*
Public Sector Salary Disclosure Act compliance	*X*	*X*	
Quality Improvement Plans (required under Excellent Care for All Act)	*X*	*X*	
Quality Improvement Plan available to the public, and Ontario Health (Excellent Care for All Act)	*X*	*X*	*X*
Executive Compensation linked to Performance Improvement Targets in Quality Improvement Plan (Excellent Care for All Act) (pay for performance) and described in the Quality Improvement Plan	*X*	*X*	
Patient Declaration of Values/Rights and Responsibilities (Excellent Care for All Act) developed after consultation with the public and make publicly available	*X*	*X*	*X*
Patient Relations Process (Excellent Care for All Act) to reflect Patient Declaration Values and to be publicly available	*X*	*X*	*X*
Patient Satisfaction Surveys (Excellent Care for All Act)	*X*	*X*	*X*
Employee/Staff Satisfaction Surveys (Excellent Care for All Act)	*X*		*X*
Critical Incident Reporting (Public Hospitals Act, Regulation 965)	*X*	*X*	
Appointing investigator or supervisor under Public Hospitals Act	*X*	*X*	
Value for money audits by Auditor General	*X*	*X*	
Broader Public Sector Accountability Act and Directives requirements			
• *Not using public funds to engage lobbyists*	*X*		
• *Reporting on use of consultants*	*X*	*X*	
• *Managing expense claim reporting*	*X*	*X*	
• *Setting expense claim rules*	*X*	*X*	
• *Setting procurement standards*	*X*	*X*	
• *Establishing allowable perquisites rules*	*X*		
• *Creating compliance reports*	*X*	*X*	

Freedom of Information and Protection of Privacy Act		*X*	
Voluntary Processes			
Annual Reports	*X*	*X*	
Town Hall Forums or Targeted Focus Groups	*X*	*X*	*X*
Open Recruitment Process for Board	*X*	*X*	*X*
Open Board Meetings	*X*	*X*	*X*
Open Annual Meetings of Members	*X*	*X*	*X*
Policies for Responding to Media Enquiries	*X*	*X*	*X*
Website	*X*	*X*	*X*
Relationship-building with stakeholders (foundation, volunteers, Ontario Health, Ministry, local government, academic, partners, provincial and federal elected members of government)	*X*	*X*	*X*
Publications (such as information booklets, pamphlets, newsletters, including those issued by a hospital's foundation or volunteer organization)	*X*	*X*	
Community Advisory Councils or Committees (including community liaison committees or advisory committees for input from broader community or input based on stakeholders, services or special interest groups)	*X*	*X*	*X*
Patient & Family Advisory Committee member on Board of Directors	*X*	*X*	*X*
Presentations to Community and/or Stakeholder Groups	*X*	*X*	*X*
Accreditation Process through Accreditation Canada	*X*		

REFERENCES:

1. OHA Guide to Good Governance

DECISION SUPPORT DOCUMENT FOR

☒ Board of Directors ☐ Board Committee – ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: March 31, 2025 Meeting Date Prepared for: April 9, 2025 – Governance
April 24, 2025 – Board

Subject: Inclusion, Equity, Diveristy & Anti-Racism (IDEA) - Update

Prepared by: Robert Alldred-Hughes, President & CEO

☐ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☒ FOR INFORMATION ONLY

PURPOSE

- The purpose of this briefing note is to remind the Governance and Nominating Committee of the requirements of Accreditation Canada Standards that are being overseen by this committee, in addition to provide an update on actions taken to date which support our policy on Inclusion, Diversity, Equity and Anti-Racism at HGMH.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☐ *No* ☒ *Yes, please specify:*

- All Board Committees

SITUATION & BACKGROUND

A brief description of the background to the issue.

- In the Fall of 2023, the Board of Directors approved the recommendation that the Governance Committee take on a proactive role in leading, coordinating, and monitoring IDEA-related activities within HGMH. This includes ensuring compliance with Accreditation Canada Standards for IDEA and fostering a culture of inclusion, diversity, equity, and anti-racism throughout the organization.
- Since this recommendation was approved, there has been much work completed by the team at HGMH related to IDEA activities.
- HGMH, as a prominent organization and employer in our community, is committed to promoting an environment that is inclusive, diverse, and equitable, while actively combatting racism.
- In the winter/spring of 2024 an Inclusion, Diversity, Equity, and Anti-Racism Framework was developed by HGMH, which focuses our efforts on achieving meaningful actions to increase inclusion and celebrate diversity, while creating an overall sense of belonging.
- The advent of this framework helped kick off significant work that has been completed over the spring and summer, whereby:
  - an IDEA Committee has been formed consisting of leaders and staff with a passion for IDEA and lived experience.
  - A policy related to Land Acknowledgement has been created along with an official Land Acknowledgement statement for our hospital. The Land Acknowledgement has been endorsed by the senior leadership team and reviewed by the Native North American Travelling College.
  - September 30th is National Truth and Reconciliation Day, and HGMH will be holding a series during the month of September to support Truth and Reconciliation, including a special on-site ceremony and social on September 17th from 1-3. All Board Members are encouraged to attend, and invitations to MP's and MPP, including municipal officials have been issued.
- In October 2024 HGMH rolled out an education program for all leaders and Board Members at HGMH to complete through Culture Ally. To date the following education topics have been delivered:
  - *Foundations of Diversity, Equity, and Inclusion*

- *Truth and Reconciliation*
- *Anti-Sexual Harassment*
- *LGBTQ+ Awareness*
- *Unconscious Bias*
- *Microaggressions*
- *Inclusive Hiring*
- *Allyship*
- *Cultural Competency*

- The hospital has commissioned artwork by indigenous artist Dawn Iehstoseranonnha from Akwesasne to be installed at our hospital. The art is a symbol for indigenous patients and family who access our services that we care deeply about the whole person and providing care that is culturally safe and supportive.
- HGMH Update Job Description Template now includes and IDEA values statement: "*We recognize the intrinsic value of every individual and the diversity they bring to our community. We are committed to fostering a sense of belonging and an environment that upholds principles of equity, diversity, inclusion and anti-racism in every facet of our operations. Our commitment is unwavering, rooted in our belief that healthcare should be equitable, accessible and inclusive for all*".
- The IDEA Committee has selected cultural celebration days to be recognized through communication and special events. Recently those included Black History Month, and Pink Shirt Day.
- Looking ahead, adding an IDEA corner to the bi-weekly blitz.
- IDEA committee found inclusive spiritual care contacts from the broader community willing to provide care for our patients, for inclusion in the new Palliative and End of Life Care handbook.
- IDEA committee partnering with PFAC to co-design the new Family and Spiritual Care Room.
- Ongoing review of policies, recently involved in a review of the following policies with a IDEA lens, Pastoral Care, and Unidentified Patients
- Review results and feedback from Patient Satisfaction Survey data regarding patients who self-identify as Indigenous and Gender-diverse.
- There are 10 new Governance related standards for IDEA and HGMH will be assessed against these standards in our next accreditation survey cycle of 2026. (*Attached*)

CONSULTED WITH:

Indicate those bodies and individuals who have been consulted with in the development of this decision support document

- Kayla MacGillivray, Chief Human Resources Officer

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Listing of Accreditation Canada Standards related to Governance

HÔPITAL Glengarry Memorial HOSPITAL

Accreditation Canada Standards Related to Inclusion, Diversity, Equity, and Anti-Racism

The governing body uses a recognized framework for acknowledging systemic racism.
The governing body implements an action plan, in partnership with community partners, to address systemic racism in the organization.
The governing body provides its members with education and continuous learning on cultural safety and humility and systemic racism.
The governing body ensures the organization's policies reflect cultural safety and humility practices and encompass the culture and rights of the communities receiving services from the organization.
The governing body monitors its action plan for addressing systemic racism.
The governing body uses a recognized framework for acknowledging Indigenous-specific systemic racism.
The governing body implements an action plan, in partnership with Indigenous partners, to address Indigenous-specific systemic racism in the organization.
The governing body provides its members with education and continuous learning on cultural safety and humility and Indigenous-specific systemic racism.
The governing body ensures the organization's policies reflect cultural safety and humility practices and encompass the culture and rights of the Indigenous peoples and communities receiving services from the organization.
The governing body monitors its action plan for addressing Indigenous-specific systemic racism.

HÔPITAL Glengarry Memorial HOSPITAL

BRIEFING NOTE FOR

☒ Board of Directors ☐ Board Committee – Governance ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: March 4, 2025 Meeting Date Prepared for: April 9, 2025 – Governance
April 24, 2025 - Board

Subject: HSO Governing Body Assessment Results

Prepared by: Robert Alldred-Hughes, President & CEO

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- To review the results of the Health Standards Organization (HSO) Governing Body Assessment as part of the hospital's Accreditation process and to outline key findings and next steps for review and improvement.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☐ *No* ☒ *Yes, please specify:*

- Board of Directors

SITUATION & BACKGROUND

A brief description of the background to the issue.

- As part of the Accreditation process, the Board was asked to complete the HSO Governing Body Assessment to evaluate its governance practices, effectiveness, and alignment with accreditation standards. This assessment serves as a critical tool for identifying strengths and areas requiring improvement to ensure the hospital continues to uphold high standards of governance and accountability.

Key Findings:

The assessment results highlight the following key areas:

- **Strengths:** The Board demonstrated strong governance practices in some of the following areas which all received 100% positive responses:
    - Clear understanding of roles and responsibilities.
    - Confidence in raising difficult issues.
    - Access to necessary information for decision-making.
    - Alignment with the hospital's mission and vision.
    - Clear understanding of what quality means for the organization.
    - Ability to monitor the organization's actions to improve the quality of care and services for patients/residents/clients.
    - Received education or participated in continuous learning sessions
    - Meetings are conducted in the spirit of open, constructive discussions.
    - Strong collaboration with executive leadership and respect amongst each other.

- **Opportunities for Improvement:** While the results were generally positive, some areas showed lower confidence:
    - **Supporting the organization to reduce its carbon footprint** (54.60%) – Improving knowledge and training in these areas.
    - **% of governing body's meeting time spent on the organization's quality performance** (27.3%) – increasing meeting frequency for Quality & Patient Safety to allow for more discussions around quality to take place at the Board level.

- **Actively engage external stakeholders in reviewing the organization's performance and ensure that the quality-of-care action plan is co-developed with internal and external stakeholders** (81.8%) – increase communication around efforts to engage external stakeholders.

Next Steps:

- **Ongoing Monitoring:** Regular progress updates will be provided to the Board to ensure continuous improvement in governance practices.
- **Integration with Accreditation Preparation:** The insights gained from this assessment will be integrated into our broader Accreditation readiness efforts to strengthen compliance with HSO standards.

OPTIONS CONSIDERED & ANALYSIS

Outline alternatives that were contemplated in coming to a recommendation. If no viable alternatives exist, include that information as well.

- Based on the results of the survey overall, the committee is satisfied with the current performance level, both from an individual and committee perspective.
- There appears to be some opportunity to increase the comfort level of the committee members and improve overall performance levels in the following areas:
    - Increasing communication efforts
    - Increase discussions around quality

Questions for consideration:

- Based on the results of the survey, are there areas the Committee would like to explore alternate ways of accomplishing its work?
- Are there other areas the Committee would like to develop actions to support the Committees effectiveness?

IMPLEMENTATION & COMMUNICATION PLAN

Consider how the recommendation will be rolled-out and communicated to all key stakeholders.

- Results to be shared with HGMH Board in April 2025

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- HSO Governing Body Assessment Results

HSO Governing Body Assessment Results

Questions - How much do you agree or disagree with the following statements about your role on the governing body?	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Positive	Neutral	Negative
01. I have a clear understanding of my role on the governing body.	90.9%	9.1%				100%		
02. I am confident in raising difficult issues during governing body meetings.	81.8%	18.2%				100%		
03. I can get the information I need to make informed decisions at governing body meetings.	90.9%	9.1%				100%		
04. I fully understand the organization's mission, vision, and values.	90.9%	9.1%				100%		
05. I have a clear understanding of what quality means for the organization.	100%	0.0%				100%		
06. I can monitor the organization's actions to improve the quality of care and services for patients/residents/clients.	63.6%	36.4%				100%		
07. I was provided with comprehensive new member orientation when I joined this governing body.	63.6%	27.3%	9.1%			90.9%	9.1%	

Questions - In the past 12 months have you received education or participated in continuous learning on any of the following topics as a member of this governing body? If a statement does not apply to you select 'Not Applicable (N/A)' or 'Don't Know'.	Yes	No	Don't Know	Not Applicable		Positive	Neutral	Negative
08. How this organization is addressing systemic racism.	90.9%		9.1%			90.9%	9.1%	
09. The importance of the cultural safety in the organization's approach to addressing Indigenous-specific systemic racism.	90.9%		9.1%			90.9%	9.1%	
10. How to interpret quality and patient/resident/client safety performance information.	90.9%		9.1%			90.9%	9.1%	
11. How to be an effective member of this governing body.	90.9%		9.1%			90.9%	9.1%	
12. How the organization takes a people-centered care approach to providing care and services.	90.9%		9.1%			90.9%	9.1%	
13. Have you received constructive feedback from the chair on your contributions as a governing body member in the past 12 months?	72.7%	9.10%		18.20%		72.7%	18.2%	9.1%

Questions - How much do you agree or disagree with the following statements about the organization and the governing body you participate on? If a statement does not apply to you select 'Not Applicable (N/A)' or 'Don't Know'.	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Not applicable	Don't Know	Positive	Neutral	Negative
14. Our meetings are conducted in the spirit of open, constructive discussions.	90.9%	9.1%					100%		
15. At our meetings, governing body members show respect to each other.	90.9%	9.1%					100%		
16. We ensure that all governing body members participate in decision making.	72.7%	27.3%					100%		
17. We have an effective quality sub-committee.	72.7%	18.2%			9.1%		90.9%	9.1%	
18. We ensure that the organization's executive leader(s) who report to the governing body have accountability for the quality of care in their performance objectives.	81.8%	18.2%					100%		
19. We actively engage internal stakeholders in reviewing the organization's performance.	72.7%	18.2%				9.1%	90.9%	9.1%	
20. We actively engage external stakeholders in reviewing the organization's performance.	36.4%	45.5%				18.2%	81.8%	18.2%	
21. We ensure that the organization's quality-of-care action plan is co-developed with internal and external stakeholders.	63.6%	18.2%				18.2%	81.8%	18.2%	
22. We support the organization's executive leader(s) to develop a strategy for improving cultural safety for Indigenous patients/clients/residents.	81.8%	18.2%					100%		
23. We support the organization's executive leader(s) on a strategy to address Indigenous-specific racism.	72.7%	27.3%					100%		
24. We support the organization's executive leader(s) to publicly review the organization's quality and safety performance annually.	81.8%	18.2%					100%		
25. We support the organization to reduce its carbon footprint.	36.4%	18.2%	9.1%			34.4%	54.60%	43.5%	
26. We regularly review data documenting the experiences of patients/residents/clients and their families.	90.9%	9.1%					100%		
27. We regularly review data from the organization's workforce documenting their health, safety, and overall work experiences.	54.5%	27.3%				18.2%	81.8%	18.2%	
28. We regularly review data showing the organization's performance.	72.7%	18.2%				9.1%	90.9%	9.1%	
29. We regularly evaluate how we can improve our effectiveness as a governing body.	36.4%	54.5%				9.1%	90.9%	9.1%	
30. We do not become directly involved in the day-to-day operations of the organization.	90.9%	9.1%					100%		
31. We have a collaborative relationship with the organization's senior leaders.	90.9%	9.1%					100%		
32. We have a collaborative relationship with the organization's clinical management.	72.7%	27.3%					100%		

Question - This question asks for your assessment of the governing body's focus on the organization's quality performance over the past 12 months. If a statement does not apply to you select 'Not Applicable (N/A)' or 'Don't Know'.	In Evey Meeting	In Most Meetings	Not Applicable			Positive	Neutral	Negative
33. How frequently was the organization's quality performance on the governing body's agenda?	45.5%	45.5%	9.0%			91%	9.0%	

Question - This question asks for your assessment of the governing body's focus on the organization's quality performance over the past 12 months. If a statement does not apply to you select 'Not Applicable (N/A)' or 'Don't Know'.	More than 40%	31-40%	21-30%	10-20%		Positive	Neutral	Negative
34. Approximately what percentage of the governing body's meeting time was spent on the organization's quality performance?	18.2%	9.1%	36.4%	36.4%		27.3%	36.4%	36.4%

Questions - How would you rate the governing body's impact on the following? If a statement does not apply to you select 'Not Applicable (N/A)' or 'Don't Know'.	Excellent	Very Good	Good	Don't Know		Positive	Neutral	Negative
35. Improving the quality of care?	18.2%	63.6%	18.2%			100%		
36. Improving patient/resident/client safety?	18.2%	63.6%	18.2%			100%		
37. Improving occupational health and safety?	18.2%	63.6%	18.2%			100%		
38. Addressing systemic racism in the organization?	18.2%	63.6%	18.20%			100%		
39. Addressing Indigenous-specific systemic racism in the organization?	18.2%	63.6%	18.2%			100%		
40. Ensuring the security of the organization's information management systems?	27.3%	63.6%	9.10%			100%		
41. Improving the sharing of patient/resident/client information with them and their care providers?	9.10%	54.50%	18.20%	18.20%		81.8%	18.2%	

Year End Update
Personal Business Commitments (2024 - 2025)

Robert Alldred-Hughes, President & Chief Executive Officer

Introduction

The Ontario Government passed the Excellent Care For All Act (ECFAA) and Bill 16 in 2010 which required Hospital Boards to establish a pay for performance component of executive compensation and achieve targets tied to a Quality Improvement Plan.

My Personal Business Commitments are tied to Hôpital Glengarry Memorial Hospital's (HGMH) Quality Improvement Plan (QIP), the HGMG Board Strategic Plan, our Accreditation, directive from the Ontario Health and Ministry of Health and any impacting factors that have been identified through an environmental scan. These form the context that has shaped the 2024-2025 Personal Business Commitments. Clearly, health funding and its emphasis on cost efficiency and quality outcomes (value for money), the focus on clinical performance, the patient experience, patient and family centered care and the need for integration and partnerships are key drivers to positioning, not only HGMH, but the health system as a whole for continued high performance and success.

In order to ensure that expected levels of performance are clearly articulated and understood, measures have been aligned with three performance assessment categories (PAC) – Quality, Financial and Strategic / Significant Initiatives as per HGMH's Executive Compensation Philosophy, Strategy and Policy. The performance assessment categories will be rated on the following scale:

Quality: 50% weighting
Financial: 30% weighting
Strategic: 20% weighting

Although selected commitments have been identified in this document for the performance pay component of executive compensation determination, it is important to note that an unrelenting focus will also be placed on other areas such as those identified in the QIP, the Patient Safety Plan, the Strategic Plan, Enterprise Risk Management and so forth.

Finally, my Personal Business Commitments serve as the framework and the priorities for all leaders within HGMH. Each senior leader is expected to develop their Personal Business Commitments to align with the Chief Executive Officer's, support the Strategic Plan, the Quality Improvement Plan as well as align with corporate metrics/balanced scorecard.

	Goal	2023/2024 Performance	2024/25 Target	Current Performance	Quality Improvement Plan	Strategic Plan	Accreditation	OH/ MOH
QUALITY	Implement a ~~virtual~~ care model to support reduced wait times and enhance physician initial assessment times in the emergency department during peak periods.	N/A	~~Virtual~~ Care model in ED Implemented	**Complete** Implemented 3 Physician shifts during peak periods beginning July 1, 2024. **LWBS (pre-post action):** From: 10.7% To: 7.3% **ED Wait (Pre-post action):** From 7.3 To: 6.8		✓	✓	✓
	Provide leadership training related to Diversity, Equity, Inclusion & Anti-Racism.	*0% of leaders currently trained.*	100% of Leaders Trained	**Complete and ongoing** Rolled out comprehensive EDI training for leaders, this training included 8 individual learning modules. 100% of leaders at HGMH have completed all 8 modules.	✓	✓	✓	✓
	Develop a business case for Surgical Services at HGMH to support care close to home and wait time reduction in the region.	N/A	Business Case Developed	**Complete.** Options Analysis has been completed, with short-, medium- and long-term plan. This work will move forward next fiscal year given the implantation of EPIC, which will have the surgical services module. Overview to be presented to Quality in May.		✓		✓
	Support the Patient & Family Advisory Committee to develop and implement two initiatives that continue advancing person and family centred care.	Committee has not been tasked with this in the past.	Two initiatives implemented	**Complete** Library program set to launch October 2024, led by PFAC. PFAC provided feedback for the training of ECPs.		✓	✓	

FINANCIAL	Develop an operational efficiencies plan that that reduces cost and does not impact the quality & safety of the programs and services currently offered.	*Implemented efficiencies that reduced cost by $200K in 2023/2024*	Develop a plan	**Complete** Leadership developed opportunities to reduce operating costs by $400K. Currently being implemented with full savings being realized in 2025/2026.				✓
	Advocate with Ontario Health & Ministry of Health to support funding to support Bill 124 pressures and other operating pressures.	*Projected deficit of $1.7 Million*	Balanced Budget	**Complete** Worked with OHA, MOH, and OH in multiple sessions. Met with local MPP's to describe impacts regularly. Invited to attend meeting with Deputy minister to represent small hospitals. Full based funding received for Bill 124. Budget projects a small surplus.				✓

STRATEGIC	Explore the viability of a Health Hub in Alexandria in collaboration with the Great River Ontario Health Team, to support Primary Care, Emergency Department diversion, and sustainable physician recruitment and retention.	N/A	Develop a collaborative plan with GROHT and Physicians	**Complete** 2 meetings occurred with GROHT, CMHA, Alexandria FHO, EOHU. This concept will be explored in our capital redevelopment planning, and ongoing.		✓	✓	✓
	Develop a creative recruitment brand that markets the hospital to prospective talent in a meaningful way.	N/A	Recruitment brand completed to reduce vacancy rate.	**Complete** Recruitment brand developed, and currently in use.		✓		
	Begin the capital redevelopment planning process that supports the development of a plan that meets the needs of the communities we serve.	N/A	Have initiated to work to develop a capital redevelopment plan.	**Complete and ongoing.** Work has begun for a pre-capital submission early summer 2025. Senior leadership, and Board involvement. In addition to meetings with external partner stakeholders to update on hospital planning and discuss opportunities for future partnerships.		✓	✓	✓

	Continue to work collaboratively the Ministry of Health and the HGMH Foundation to bring Computerized Tomography (CT) to HGMH, with the goal of obtaining approval for implementation.	Business case submitted.	Obtain approval for CT from MOH	**Complete** Approval received in May of 2024. HGMH Foundation motion to fund $3.2M cost of CT/Renos. And HGMH Foundation rebranding and reorganizing to meet enhance fundraising targets.		✓		✓

Personal Business Commitments (2024 - 2025)

Dr. Lisa MacKinnon, Chief of Staff

Introduction

The Ontario Government passed the Excellent Care For All Act (ECFAA) and Bill 16 in 2010 which required Hospital Boards to establish a pay for performance component of executive compensation and achieve targets tied to a Quality Improvement Plan.

My Personal Business Commitments are tied to Hôpital Glengarry Memorial Hospital's (HGMH) Quality Improvement Plan (QIP), the HGMG Board Strategic Plan, our Accreditation, directive from the Ontario Health and Ministry of Health and any impacting factors that have been identified through an environmental scan. These form the context that has shaped the 2023-2024 Personal Business Commitments. Clearly, health funding and its emphasis on cost efficiency and quality outcomes (value for money), the focus on clinical performance, the patient experience, patient and family centered care and the need for integration and partnerships are key drivers to positioning, not only HGMH, but the health system as a whole for continued high performance and success.

In order to ensure that expected levels of performance are clearly articulated and understood, measures have been aligned with three performance assessment categories (PAC) – Quality, Financial and Strategic / Significant Initiatives as per HGMH's Executive Compensation Philosophy, Strategy and Policy. The performance assessment categories will be rated on the following scale:

Quality: 50% weighting
Financial: 30% weighting
Strategic: 20% weighting

Although selected commitments have been identified in this document for the performance pay component of executive compensation determination, it is important to note that an unrelenting focus will also be placed on other areas such as those identified in the QIP, the Patient Safety Plan, the Strategic Plan, Enterprise Risk Management and so forth.

	Goal	2023/2024 Performance	2024/25 Target	Current Performance	Quality Improvement Plan	Strategic Plan	Accreditation	OH/ MOH
QUALITY	90th percentile emergency department wait time to inpatient bed	6.63 hours	6 hours	**Complete & on-going** 3.4 (*missing March data*)	✓	✓	✓	
FINANCIAL	Ensure ~~at least 50~~ 40 chart reviews are completed annually from the Emergency Department to maintain Emergency Department pay For Results (ED P4R) funding levels	N/A	~~50~~ annually	**Complete & On-going** 8 chart reviews completed **The ED P4R-chart review requirement for funding is effective April 2025. We will be provided lists of return visits to audit from.* There is a plan in place to meet the new requirement of 40 chart reviews for 2025-26.	✓	✓		
STRATEGIC	Explore the viability of a Health Hub in Alexandria in collaboration with the Great River Ontario Health Team, to support Primary Care, Emergency Department diversion, and sustainable physician recruitment and retention.	N/A	Develop a collaborative plan with GROHT and Physicians	**Complete and ongoing** This concept will be explored in our capital redevelopment planning, and ongoing.		✓	✓	✓

DRAFT
Personal Business Commitments (2025 - 2026)

Robert Alldred-Hughes, President & Chief Executive Officer

Introduction

The Ontario Government passed the Excellent Care For All Act (ECFAA) and Bill 16 in 2010 which required Hospital Boards to establish a pay for performance component of executive compensation and achieve targets tied to a Quality Improvement Plan.

My Personal Business Commitments are tied to Hôpital Glengarry Memorial Hospital's (HGMH) Quality Improvement Plan (QIP), the HGMG Board Strategic Plan, our Accreditation, directive from the Ontario Health and Ministry of Health and any impacting factors that have been identified through an environmental scan. These form the context that has shaped the 2024-2025 Personal Business Commitments. Clearly, health funding and its emphasis on cost efficiency and quality outcomes (value for money), the focus on clinical performance, the patient experience, patient and family centered care and the need for integration and partnerships are key drivers to positioning, not only HGMH, but the health system as a whole for continued high performance and success.

In order to ensure that expected levels of performance are clearly articulated and understood, measures have been aligned with three performance assessment categories (PAC) – Quality, Financial and Strategic / Significant Initiatives as per HGMH's Executive Compensation Philosophy, Strategy and Policy. The performance assessment categories will be rated on the following scale:

Quality: 50% weighting
Financial: 30% weighting
Strategic: 20% weighting

Although selected commitments have been identified in this document for the performance pay component of executive compensation determination, it is important to note that an unrelenting focus will also be placed on other areas such as those identified in the QIP, the Patient Safety Plan, the Strategic Plan, Enterprise Risk Management and so forth.

Finally, my Personal Business Commitments serve as the framework and the priorities for all leaders within HGMH. Each senior leader is expected to develop their Personal Business Commitments to align with the Chief Executive Officer's, support the Strategic Plan, the Quality Improvement Plan as well as align with corporate metrics/balanced scorecard.

	Goal	2024/2025 Performance	2025/26 Target	Current Performance	Quality Improvement Plan	Strategic Plan	Accreditation	OH/ MOH
QUALITY	Accreditation standards will be embedded into daily operations through enhanced staff training, policy improvements, and readiness initiatives, driving measurable gains in quality and patient care.	2022 Accreditation – Accredited with Commendation	Accreditation with Exemplary Status		✓		✓	
	Patient involvement in care decisions will be strengthened through Leader and PFAC patient rounding, ensuring real-time feedback is gathered and acted upon to enhance communication, patient satisfaction, and person- and family-centered care.	*Percent positive score on the question – related involvement in care: 87%*	89% positive score		✓	✓	✓	✓
	Strengthen relationships with the Mohawk Nation of Akwesasne to advance equitable access to care and foster collaboration in meeting community healthcare needs.	-	Implement one partnership action			✓		✓
FINANCIAL	Ensure financial stability by proactively engaging with Ontario Health and government stakeholders to secure funding, advocate for sustainable reimbursement models, and align resources with HGMH's strategic priorities to support high-quality, sustainable care.	*$150K Surplus*	Balanced Budget					✓
	Assess and explore feasible revenue generation opportunities within the constraints of Ontario's hospital funding model, identifying sustainable strategies to enhance HGMH's financial resilience while maintaining alignment with our mission and regulatory requirements.	-	Increase non-ministry revenue growth					✓

STRATEGIC	Drive the pre-capital submission and visioning process for HGMH's redevelopment, ensuring that our hospital's infrastructure aligns with evolving healthcare needs and supports the delivery of innovative, high-quality, and accessible rural healthcare.	-	Submit Pre-Capital Proposal to MOH			✓	✓	✓
	Healthcare capacity will be strengthened through a Medical Student and Resident Program, leveraging partnerships with ROMP and academic institutions to provide hands-on learning, enhance recruitment, and promote rural healthcare careers.	-	Participate in Discovery Week. Bring at least one Medical Resident to Learn at HGMH			✓		
	Cultural safety will be advanced through organization-wide DEI training, equipping staff with the knowledge and tools to provide equitable, patient-centered care and foster an inclusive, respectful workplace.	100% of Leaders Trained	25% of Staff Trained			✓	✓	✓
	Lead the launch of the EPIC EMR system by ensuring staff readiness, optimizing clinical workflows, and strengthening regional collaboration to enhance patient care and interoperability, maintaining key milestones.	-	100% of project milestones completed on schedule that are within HGMH's control			✓		✓

Personal Business Commitments (2025 - 2026)

Dr. Lisa MacKinnon, Chief of Staff

Introduction

The Ontario Government passed the Excellent Care For All Act (ECFAA) and Bill 16 in 2010 which required Hospital Boards to establish a pay for performance component of executive compensation and achieve targets tied to a Quality Improvement Plan.

My Personal Business Commitments are tied to Hôpital Glengarry Memorial Hospital's (HGMH) Quality Improvement Plan (QIP), the HGMG Board Strategic Plan, our Accreditation, directive from the Ontario Health and Ministry of Health and any impacting factors that have been identified through an environmental scan. These form the context that has shaped the 2023-2024 Personal Business Commitments. Clearly, health funding and its emphasis on cost efficiency and quality outcomes (value for money), the focus on clinical performance, the patient experience, patient and family centered care and the need for integration and partnerships are key drivers to positioning, not only HGMH, but the health system as a whole for continued high performance and success.

In order to ensure that expected levels of performance are clearly articulated and understood, measures have been aligned with three performance assessment categories (PAC) – Quality, Financial and Strategic / Significant Initiatives as per HGMH's Executive Compensation Philosophy, Strategy and Policy. The performance assessment categories will be rated on the following scale:

Quality: 50% weighting
Financial: 30% weighting
Strategic: 20% weighting

Although selected commitments have been identified in this document for the performance pay component of executive compensation determination, it is important to note that an unrelenting focus will also be placed on other areas such as those identified in the QIP, the Patient Safety Plan, the Strategic Plan, Enterprise Risk Management and so forth.

	Goal	2023/2024 Performance	2024/25 Target	Current Performance	Quality Improvement Plan	Strategic Plan	Accreditation	OH/ MOH
QUALITY	% of patients who left without being seen (LWBS) **Regional Provincial Avg = 8.2%* **Provincial Avg = 5%*	7.6%	7.4%		✓	✓	✓	
FINANCIAL	Ensure 40 return visit chart reviews are completed annually from the Emergency Department to maintain Emergency Department pay For Results (ED P4R) funding levels.	N/A	40 annually		✓	✓		
STRATEGIC	Expand medical professional staff recruitment efforts by developing relationships with ROMP and other educational institutions, while also motivating our current physician group to embrace mentoring more students.	-	Participate in Rural Week. Bring at least one Medical Resident to Learn at HGMH			✓		

REPORT OF THE MEETING OF THE FINANCE, HR, AND AUDIT COMMITTEE

April 9, 2025 at 4:30PM via MS Teams

Present:	C. Nagy, Chair	Dr. S. Robertson	F. Desjardins
	Dr. G. Raby	R. Alldred-Hughes, CEO	S. Bussiere
Regrets:	L. Ramsay	K. MacGillivray, CHRO	L. Boyling
Guest:	M. Pharand (MNP Auditor)		

Summary of Discussion

1.0 Approval of Agenda

Agenda: The agenda was reviewed.

Moved By: F. Desjardins
Seconded By: Dr. S. Robertson
THAT the agenda be approved as amended.

CARRIED

Declaration of Conflict of Interest: there were no conflicts declared.

2.0 Minutes

Report from the Previous Meeting: The report of the meeting of March 12, 2025, was shared.

Moved By: F. Desjardins
Seconded By: Dr. G. Raby
THAT the report of the meeting of March 12, 2025, be approved as presented.

CARRIED

Business Arising:
There was no business arising from the minutes.

3.0 Matters for Discussion/Decisions

3.1 Audit Plan Review
The audit plan was presented by M. Pharand from MNP.

Moved By: Dr. S. Robertson
Seconded By: F. Desjardins
THAT the Finance, HR, and Audit Committee recommend to the Board of Directors the audit plan for 2024-2025 as presented.

The audit plan was discussed with no recommended changes. The suggested materiality for audit planning purposes is $800,000 which is higher than the $640,000 last year, however there are no concerns this year with this adjustment.

CARRIED

4.0 Date of Next Meeting

Next meeting: May 14, 2025

K-L. Massia, Recorder

Hôpital Glengarry Memorial Hospital

2025 Audit Service Plan

Report to the Finance Committee

March 31, 2025

Marc Pharand, CPA, CA
T: 613.636.6039
E: Marc.Pharand@mnp.ca

March 12, 2025

Dear members of the Finance Committee of
Hôpital Glengarry Memorial Hospital

We are pleased to present our Audit Service Plan for Hôpital Glengarry Memorial Hospital (the "Hospital"). In this plan we describe MNP's audit approach, our engagement team, the scope of our audit and a timeline of anticipated deliverables. We are providing this Audit Service Plan to the Finance Committee on a confidential basis. It is intended solely for the use of the Finance Committee and is not intended for any other purpose. Accordingly, we disclaim any responsibility to any other party who may rely on this report.

Our audit will include an audit of the Hospital's financial statements for the year ended March 31, 2025, prepared in accordance with Canadian public sector accounting standards. Our audit will be conducted in accordance with Canadian generally accepted auditing standards.

At MNP, our objective is to perform an efficient, high-quality audit which focuses on those areas that are considered higher risk. We adhere to the highest level of integrity and professionalism. We are dedicated to maintaining open channels of communication throughout this engagement and will work with management to coordinate the effective performance of the engagement. Our goal is to exceed the Finance Committee's expectations and ensure you receive outstanding service.

Additional materials provided along with this report includes our Engagement Letter. Our Engagement Letter is the formal written agreement of the terms of our audit engagement as negotiated with management and outlines our responsibilities under Canadian generally accepted auditing standards.

We look forward to discussing our Audit Service Plan with you and look forward to responding to any questions you may have.

Sincerely,

MNP LLP

Chartered Professional Accountants
Licensed Public Accountants

Encls.

Table of Contents

MNP's Client Service Commitment

To make informed business decisions with confidence, management and the Finance Committee of the Hospital need relevant, reliable and independently audited financial information. Our audit strategy is risk-based, and considers the limitations and opportunities you encounter each day. Committed to your success, MNP delivers meaningful, reliable financial information to not only help you fulfill your compliance obligations, but also to achieve your key strategic goals.

Our Audit Service Plan outlines the strategy we will follow to provide the Hospital's Finance Committee with our Independent Auditor's Report on the financial statements for the year ended March 31, 2025.

Topics for Discussion

We are committed to providing superior client service by maintaining effective two-way communication. Topics for discussion include, but are not limited to:

- Changes to your business operations and developments in the financial reporting and regulatory environment.
- Business plans and strategies.
- Any other issues and/or concerns.
- Fraud, including how fraud could occur, the risk of fraud and misstatement, and any actual, suspected or alleged fraud.
- The management oversight process.
- Your specific needs and expectations.

A summary of required communications with those charged with governance, as outlined by Canadian Auditing Standards (CAS), is included in Appendix A.

Key Changes and Developments

Based on our knowledge of the Hospital and our discussions with management, we have noted the recent developments set out below. Our audit strategy has been developed considering these factors.

	Key Issues and Developments	Summary
	**New Reporting Developments**	• Concepts Underlying Financial Performance (New Conceptual Framework for Financial Reporting in the Public Sector). • Concepts Underlying Financial Performance (New Section PS 1202). • Narrow Scope Amendments: GAAP Designation of PSA Handbook Appendices (Exposure Draft). These changes are effective for fiscal years beginning on or after April 1st, 2026, with earlier adoption permitted.

Issues and Developments	Summary
New Assurance Developments	• CAS 500 Audit Evidence (Appendix: Joint Policy Statement Concerning Communications between Actuaries Involved in the Preparation of Financial Statements and Auditors). This change is effective for communications between the auditor and the actuary initiated on or after March 31, 2023.

Detailed information on Key Changes and Developments are included in Appendix B.

Risk Assessment

Risk Assessment

Based on the preliminary risk assessment procedures performed, we have identified the following significant risk areas which will be addressed during our audit. We have also outlined the proposed audit response to address those risks. We will update our risk assessment as the audit progresses for additional risks identified and will inform management of any additional significant risks identified.

Significant Risk Area	Proposed Audit Response
Management override of controls • Under CAS, it is the responsibility of management, with the oversight of those charged with governance, to place a strong emphasis on fraud prevention and detection. Oversight by those charged with governance includes considering the potential for override of controls or other inappropriate influence over the financial reporting process. • Management override of controls is present in all entities. It is a risk of material misstatement resulting from fraud and therefore is considered as a significant risk.	• We will discuss fraud with management, the Finance Committee, and others. • We will test the appropriateness of journal entries recorded in the general ledger and other adjustments made in the preparation of the financial statements. • We will evaluate the business rationale for any significant unusual transactions. • We will determine whether the judgments and decisions related to management estimates indicate a possible bias, which will include performing retrospective analysis of significant accounting estimates.
Cut-off of revenues • Cut-off of revenues is inappropriate.	• We will evaluate the design and implementation of the internal controls that address this risk. • We will perform detailed testing of accounts receivable, accounts payable and accrued liabilities as well as deferred revenues. • We will audit subsequent cash receipts and disbursements.

Significant Risk Area	Proposed Audit Response
Reserves and reserve funds • Transfers are not approved or approved transfers are not accounted for.	• We will evaluate the design and implementation of the internal controls that address this risk. • We will perform substantive testing of the reserves and reserve funds continuity schedule and of material transactions, to determine if transfers are in accordance with the Board approvals and/or legislative requirements.
Management estimates • Management estimates are not realistic or justified.	• We will evaluate the design and implementation of the internal controls that address this risk. • We will review calculations and estimates. • We will compare last year's actual to estimate to ensure the estimates are reasonable. • We will discuss with management regarding assumptions. • We will perform analytical review of related accounts. We will obtain an understanding of the Hospital's relationships and transactions with its related parties.
Recent economic events • Events such as pandemics, staffing difficulties, change in government and inflation may create economic challenges and pressures for the Hospital which in turn can have an impact on audit risk.	• We will evaluate the design and implementation of the internal controls that address this risk. • We will inquire of management about the impact of the recent events on its current and future financial results. • We will assess the impact of recent events on the financial results to determine whether that affects our planned materiality. • We will consider the effect of the recent events on our risk assessment and planned audit procedures, including reviewing management estimates and the scope of testing.

Key Milestones

Based on the audit planning performed and areas of audit risks identified, the following timelines for key deliverables have been discussed and agreed upon with management:

Key Deliverable	Expected Date
Presentation of March 31, 2025 Audit Service Plan to the Finance Committee	March 13, 2025
Year-end fieldwork procedures	May 16, 2025 to May 30, 2025

Key Deliverable	Expected Date
Draft year-end financial statements to be discussed with management	June 4, 2025
Presentation of March 31, 2025 Audit Findings Report to the Finance Committee	June 4, 2025
Issuance of Independent Auditor's Report	June 4, 2025

Audit Materiality

Materiality is an important audit concept. It is used to assess the significance of misstatements or omissions that are identified during the audit and is used to determine the level of audit testing that is carried out. Specifically, a misstatement or the aggregate of all misstatements in the financial statements as a whole (and, if applicable, for particular classes of transactions, account balances or disclosures) is considered to be material if it is probable that the decision of the party relying on the financial statements, who has reasonable understanding of business and economic activities, will be changed or influenced by such a misstatement or the aggregate of all misstatements.

The scope of our audit work is tailored to reflect the relative size of operations of the Hospital and our assessment of the potential for material misstatements in the Hospital's financial statements as a whole (and, if applicable, for particular classes of transactions, account balances or disclosures). In determining the scope, we emphasize relative audit risk and materiality, and consider a number of factors, including:

- The size, complexity, and growth of the Hospital;
- Changes within the organization, management or accounting systems; and
- Concerns expressed by management.

The scope of our audit work is tailored to reflect the relative size of operations of the Hospital and our assessment of the potential for material misstatements in the Hospital's financial statements as a whole.

Judgment is applied separately to the determination of materiality in the audit of each set of financial statements (and, if applicable, for particular classes of transactions, account balances or disclosures) and is affected by our perception of the financial information needs of users of the financial statements. In this context, it is reasonable to assume that users understand that financial statements are prepared, presented and audited to levels of materiality; recognize uncertainties inherent in the measurement of amounts based on the use of estimates, judgment and consideration of future events; and make reasonable economic decisions based on the financial statements. The foregoing factors are taken into account in establishing the materiality level.

We propose to use $800,000 ($640,000 in 2024) as overall materiality for audit planning purposes.

Audit Team

In order to ensure effective communication between the Finance Committee and MNP, we outline below the key members of our audit team that will be responsible for the audit of the Hospital and the role they will play:

Team Members	Contact Information
Marc Pharand, CPA, CA, Partner	E: Marc.Pharand@mnp.ca
Patricia Hernandez, CPA, Manager	E: Patricia.Hernandez@mnp.ca
Kelly Kaneza, Accounting Technician	E: Kelly.Kaneza@mnp.ca
Nazneen Ali, Accounting Technician	E: Nazneen.Ali@mnp.ca

In order to serve you better and meet our professional responsibilities, we may find it necessary to expand our audit team to include other MNP professionals whose consultation will assist us to evaluate and resolve complex, difficult and/or contentious matters identified during the course of our audit.

Any changes to the audit team will be discussed with you to ensure a seamless process and that all concerned parties' needs are met.

Fees and Assumptions

DESCRIPTION	2025 ESTIMATE
Base audit fee as per our fee quote	$ 26,100

If any significant issues arise during the course of our audit work which indicate a possibility of increased procedures or a change in the audit timetable, these will be discussed with management by the engagement partner, so a mutually agreeable solution can be reached.

Appendix A – Communication Requirements

Required Communication with Those Charged with Governance

Recognizing the importance of effective two-way communication in an audit of financial statements, we wish to highlight the following areas of required communication between our audit team and those charged with governance.

Required Communication	Reference
AUDIT SERVICE PLAN	
• How the firm's system of quality management supports the consistent performance of quality audit engagements.	CSQM 1.34(e)
• Our responsibilities in relation to the financial statement audit, including forming and expressing an opinion on the financial statements.	CAS 260.14
• An overview of the planned scope and timing of the audit, including communication of significant risks identified by the audit team.	CAS 260.15
INQUIRY IN THE COURSE OF THE AUDIT	
• How those charged with governance exercise oversight of management's processes for identifying and responding to the risks of fraud and the controls that management has established to mitigate these risks.	CAS 240.21
• Knowledge of any actual, suspected or alleged fraud affecting the Hospital.	CAS 240.22
• Whether the Hospital is in compliance with laws and regulations.	CAS 250.15
• Whether any subsequent events have occurred which might affect the financial statements.	CAS 560.7(b)
AUDIT FINDINGS AND FINALIZATION	
• Any modification to our audit plan and strategy.	CAS 260.A26
• Fraud or suspected fraud identified through the audit process.	CAS 240.40 - .42
• Matters involving non-compliance with laws and regulations identified through the audit process, unless prohibited by law or regulation.	CAS 250.23

Appendix A – Communication Requirements (continued from previous page)

Required Communication	Reference
• Our views about significant qualitative aspects of the Hospital's accounting practices, including accounting policies, accounting estimates and financial statement disclosures. • When applicable, an explanation of why we consider a significant accounting practice that is acceptable under the applicable financial reporting framework, not to be most appropriate in the particular circumstances of your Hospital.	CAS 260.16(a), CAS 260 Appendix 2
• Significant difficulties, if any, encountered during the audit.	CAS 260.16(b)
• Significant matters arising during the audit that were discussed or subject to correspondence, with management and the associated written representations requested of management.	CAS 260.16(c)

• Circumstances that affect the form and content of the auditor's report. This includes:
  • Modifications to our opinion(s), if any.
  • The wording of an expected Emphasis of Matter or Other Matter paragraph.
  • If an uncorrected material misstatement of other information exists.
	CAS 260.16(d)
	CAS 705.30
	CAS 706.12
	CAS 720.17 - .18

• Any other significant matters arising during the audit that, in our professional judgment, are relevant to the oversight of the financial reporting process.	CAS 260.16(e)

• A statement of our compliance with relevant ethical requirements regarding independence, including disclosure of:
  • All relationships or matters that in the auditor's professional judgment, may reasonably be thought to bear on independence, and
  • The related safeguards that have been applied to eliminate identified threats to independence or reduce them to an acceptable level.
	CAS 260.C17, .A32

• Significant deficiencies in internal control identified during the audit.	CAS 265.9
• Uncorrected misstatements and the effect that they, individually or in aggregate, may have on the opinion in the auditor's report.	CAS 450.12 - .13
• Significant matters arising during the audit in connection with the Hospital's related parties.	CAS 550.27

Appendix A – Communication Requirements (continued from previous page)

Required Communication	Reference
• Events or conditions that may cast significant doubt on the Hospital's ability to continue as a going concern.	CAS 570.25

This list is not exhaustive. In addition to the communication requirements discussed above, other requirements exist which are contingent on specific circumstances arising in the course of an audit. The audit team applies professional judgment in determining areas of additional communication with those charged with governance outside of the requirements identified above.

Appendix B – Key Changes and Developments

We would like to bring to your attention the following accounting and auditing developments, which may have some impact on your financial reporting.

Issues and Developments Summary

New Reporting Developments

Concepts Underlying Financial Performance (New Conceptual Framework for Financial Reporting in the Public Sector)
In December 2022, the Public Sector Accounting Board (PSAB) issued *The Conceptual Framework for Financial Reporting in the Public Sector* (the Conceptual Framework) which replaces conceptual aspects of Section PS 1000 *Financial Statement Concepts* and Section PS 1100 *Financial Statement Objectives*.

The Conceptual Framework outlines:

- Characteristics of public sector entities;
- The objective of financial reporting;
- Primary users of financial reporting and their expectations;
- The role, foundations and objectives of financial statements;
- Qualitative characteristics of information in financial statements and related considerations;
- Definitions of elements;
- Criteria of general recognition and derecognition; and
- Concepts of general measurement and presentation.

The Conceptual Framework applies for fiscal years beginning on or after April 1st, 2026, with earlier adoption permitted.

As a result of the issuance of the Conceptual Framework, various Sections and Guidelines of the PSA Handbook have been withdrawn or amended. Most notably, Section PS 1000 and Section PS 1100 have been withdrawn and replaced with the Conceptual Framework. Other consequential amendments include updates to:

- References to the Conceptual Framework
- The Introduction to the Public Sector Accounting Handbook
- Section PS 1150 *Generally Accepted Accounting Principles*
- Section PS 1201 *Financial Statement Presentation*
- Section PS 1300 *Government Reporting Entity*
- Section PS 2100 *Disclosure of Accounting Policies*
- Section PS 2120 *Accounting Changes*
- Section PS 2130 *Measurement Uncertainty*
- Section PS 2200 *Related Party Disclosures*
- Section PS 3150 *Tangible Capital Assets*
- Section PS 3200 *Liabilities*
- Section PS 3210 *Assets*

Appendix B – Key Changes and Developments (continued from previous page)

- Section PS 3400 *Revenue*
- Section PS 3430 *Restructuring Transactions*
- Section PS 3450 *Financial Instruments*
- Section PS 4230 *Capital Assets Held by Not-for-Profit Organizations*

Concepts Underlying Financial Performance (New Section PS 1202)
In October 2023, the PSAB issued Section PS 1202 *Financial Statement Presentation* which replaces PS 1201 *Financial Statement Presentation.*

The new Section PS 1202:

- Discusses going concern that builds on the discussion in *The Conceptual Framework for Financial Reporting in the Public Sector;*
- Changes the statement of financial position by:
  - Relocating the calculation of the net financial liabilities (formerly known as "net debt") or net financial assets indicator, to its own statement;
  - Introducing two categories of liabilities: financial and non-financial;
  - Adding a third component of net assets or net liabilities: "accumulated other";
  - Updating the definition of "non-financial assets";
  - Restructuring the statement to present assets, followed by liabilities, followed by net assets or net liabilities; and
  - Providing an option to show the net financial assets or net financial liabilities indicator below the indicator of financial position, with reference to the statement of net financial assets or net financial liabilities;
- Adds a statement of net financial assets or net financial liabilities that presents the revised net financial assets or net financial liabilities calculation;
- Provides the option to present the change in net financial assets or net financial liabilities on the statement of net financial assets or net financial liabilities;
- Includes a statement of operations similar to the one in superseded Section PS 1201;
- Permits presenting an amended budget only when there is an election or when the majority of the governing body of a government organization has been newly elected or appointed;
- Adds the statement of changes in net assets or net liabilities that includes a reconciliation of each component of net assets or net liabilities and incorporates what is required in superseded Section PS 1201 to be included in the statement of remeasurement of gains and losses;
- Isolates financing activities in the statement of cash flow; and
- Includes guidance in various appendices in the form of application guidance, decision trees, illustrative examples and illustrative financial statements.

Section PS 1202 applies to fiscal years beginning on or after April 1st, 2026. Earlier adoption is permitted only if the Conceptual Framework is also adopted at the same time. Prior period amounts would need to be restated to conform to the presentation requirements for comparative financial information in Section PS 1202.

Appendix B – Key Changes and Developments (continued from previous page)

Various consequential amendments resulting from the issuance of Section PS 1202 have also been issued. These include various Sections and Guidelines of the PSA Handbook that have been withdrawn or amended.

Narrow Scope Amendments: GAAP Designation of PSA Handbook Appendices (Exposure Draft)
In February 2024, the PSAB issued an Exposure Draft (ED) proposing narrow-scope amendments to elevate the level of generally accepted accounting principles (GAAP) designation for four Public Sector Accounting (PSA) appendices:

- Appendix A to Section PS 3400 *Revenue;*
- Appendix B to Section PS 3410 *Government Transfers;*
- Appendix A to Section PS 3450 *Financial Instruments;* and
- Appendix A to Section PS 4270 *Disclosures of Allocated Expenses by Not-for-Profit Organizations.*

In addition, the ED also proposes a narrow-scope amendment to remove an outdated cross-reference in the decision tree in Appendix B to Public Sector Guidance (PSG) 2 *Leased Tangible Capital Asset*. The ED proposes consequential amendments to Section PS 1150 *Generally Accepted Accounting Principles* and Section PS 2120 *Accounting Changes* for any required change in accounting policy for operating leases. The proposed amendments would be effective for fiscal years beginning on or after April 1st, 2026.

Further information on the proposal can be found on the PSAB's project page.

New Assurance Developments

CAS 500 Audit Evidence (Appendix: Joint Policy Statement Concerning Communications between Actuaries Involved in the Preparation of Financial Statements and Auditors)
In March 2023, the Auditing and Assurance Standards Board (AASB) appended the *Joint Policy Statement Concerning Communications between Actuaries Involved in the Preparation of Financial Statements and Auditors* (Statement) to Canadian Auditing Standard (CAS) 500 *Audit Evidence* in the CPA Canada Handbook – Assurance. The Statement replaces the existing Statement with the same title. The AASB and the Canadian Actuarial Standards Board (ASB) uploaded the revised Statement on the AASB and Canadian institute of Actuaries websites in February 2023. The Statement applies when:

- An auditor is engaged to carry out an audit of financial statements in accordance with generally accepted auditing standards where the financial statements prepared by management include amounts determined by or with the assistance of an actuary; or
- An actuary uses the work of an auditor in connection with conducting the actuarial valuation to determine amounts to be included in the financial statements prepared by management.

Appendix B – Key Changes and Developments (continued from previous page)

The revised Statement includes:

- Clarifications to its scope;
- Clarifications to the use of the other professional's work and addresses potential inappropriate use of that work;
- Enhancements to the discussions between auditors and actuaries, including the written response from the responding professional to the inquiring professional; and
- Other enhancements to clarify the Statement.

The revised Statement is effective for communications between the auditor and the actuary initiated on or after March 31, 2023. Early application is permitted.

Appendix C – The Audit Process

Our Plan

Our audit process focuses on significant risks identified during the pre-planning and planning and risk assessment stage, ensuring that audit procedures are tailored to your specific circumstances and appropriately address those risks.

The Finance Committee is responsible for approval of the financial statements and Hospital policies, and for monitoring management's performance. The Finance Committee should consider the potential for management override of controls or other inappropriate influences, such as earnings management, over the financial reporting process. The Finance Committee, together with management, is also responsible for the integrity of the accounting and financial reporting systems, including controls to prevent and detect fraud and misstatement, and to monitor compliance with relevant laws and regulations.

Effective discharge of these respective responsibilities is directed toward a common duty to provide appropriate and adequate financial accountability, and quality financial disclosure.

Key responsibilities of MNP and management are outlined in the Engagement Letter (see attached).

Our overall audit strategy is risk-based and controls-oriented. Assessment and identification of risk are performed continuously throughout the audit process. We focus on the risks that have a potential impact on the financial accounting systems and subsequent financial reporting.

Our overall audit strategy does not, and is not intended to involve the authentication of documents, nor are our team members trained or expected to be experts in such authentication. Unless we have reason to believe otherwise, we accept records and documents as genuine. The subsequent discovery of a material misstatement resulting from fraud does not, in and of itself, indicate a failure to comply with Canadian generally accepted auditing standards.

Audit Procedures

To meet our responsibilities in accordance with Canadian generally accepted auditing standards, our audit examination includes:

- Obtaining an understanding of the entity and its environment, including its controls, in order to identify and assess the risk that the financial statements contain material misstatements due to fraud or misstatement;
- Assessing the adequacy of and examining, on a test basis, the key controls over significant transaction streams and over the general organizational and computer environments;
- Assessing the systems used to ensure compliance with applicable legislative and related authorities pertaining to financial reporting, revenue raising, borrowing, and investing activities;
- Examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements;
- Assessing the appropriateness and consistency of accounting principles used and their application;

Appendix C – The Audit Process

(continued from previous page)

- Assessing the significant estimates used by management; and
- Assessing the entity's use of the going concern basis of accounting in the preparation of the financial statements.

As part of our planning process, we will also undertake to inform the Finance Committee of concerns relating to management's implementation and maintenance of controls, and the effects of any such concerns on the overall strategy and scope of the audit. These concerns might arise from the nature, extent and frequency of management's assessments of controls in place to detect fraud and misstatement, and of the risk that the financial statements may be misstated; from a failure by management to appropriately address significant deficiencies in controls identified in prior audits; and, from our evaluation of the Hospital's control environment, and management's competence and integrity.

Overall Reliance

Control Reliance Level	Low/None	Moderate	High
Description	Where we cannot rely on controls because they are weak or absent, or where it is deemed to be more efficient to carry out a high level of direct substantive tests of details. Audit evidence is primarily obtained through detailed verification procedures and sufficient substantive tests of details.	Where there are some deficiencies in systems application or procedural controls, or where it is deemed to be inefficient to test systems application controls, but where we can test and rely on the management monitoring systems in place to detect and correct material misstatements in the financial reporting systems. Testing of controls is supplemented with a moderate level of substantive tests of details.	Where a high degree of control is in place in the areas of management monitoring controls AND systems application and procedural controls. Our audit work focuses on testing both management monitoring and systems application and procedural controls, and is supplemented with a low level of substantive tests of details.
Planned Reliance		–	–

Appendix C – The Audit Process

(continued from previous page)

For the March 31, 2025 audit, we are planning to place low reliance on the Hospital's controls. This level of reliance is consistent with the prior year, and will involve mainly substantive tests of details.

As part of our audit work, we will update our understanding of the entity and its environment, including the controls relevant to our audit of the principal transaction cycles, sufficient to identify and assess the risks of material misstatement of the financial statements resulting from fraud or misstatement. This will be accomplished through inquiries with management and others within the entity, analytical procedures and observation and inspection. Furthermore, we will consider whether effective controls have been established to adequately respond to the risks arising from the use of IT or manual systems and test the operation of those controls to an extent sufficient to enable us to reduce our substantive work. Our review of the Hospital's controls will not be sufficient to express an opinion as to their effectiveness or efficiency.

Although we will provide the Finance Committee with any information about significant deficiencies in internal control that have come to our attention, we may not be aware of all the significant deficiencies in internal control that do, in fact, exist.

Use of Specialists

To obtain sufficient appropriate audit evidence to support our opinion, we intend to solicit the assistance of the acturial valuation of retirement benefits.

We have sole responsibility for the audit opinion being expressed, and that responsibility is not reduced by our use of a specialist. We will, in accordance with Canadian generally accepted auditing standards, evaluate the competence, capabilities and independence of any specialists we employ to ensure their work is adequate for our purposes.

Inherent Limitations in the Auditing Process

An auditor cannot obtain absolute assurance that material misstatements in the financial statements will be detected due to factors such as the use of significant judgment regarding the gathering of evidence and the drawing of conclusions based on the audit evidence acquired; the use of testing of the data underlying the financial statements; inherent limitations of controls; and, the fact that much of the audit evidence available to the auditor is persuasive, rather than conclusive in nature.

Because of the nature of fraud, including attempts at concealment through collusion and forgery, an audit designed and executed in accordance with Canadian generally accepted auditing standards may not detect a material fraud. While effective controls reduce the likelihood that misstatements will occur and remain undetected, they do not eliminate that possibility. Therefore, the auditor cannot guarantee that fraud, misstatements and non-compliance with laws and regulations, if present, will be detected when conducting an audit in accordance with

Appendix C – The Audit Process

(continued from previous page)

Canadian generally accepted auditing standards.

The likelihood of not detecting material misstatements resulting from management fraud is greater than for employee fraud, because management is in a position to manipulate records, present fraudulent information or override controls.

We will inform the appropriate level of management or the Finance Committee with respect to identified:

- Misstatements resulting from errors, other than clearly trivial misstatements;
- Fraud, or any information obtained that indicates that fraud may exist;
- Evidence obtained that indicates non-compliance or possible non-compliance with laws and regulations, other than that considered inconsequential;
- Significant deficiencies in the design or implementation of controls to prevent and detect fraud or misstatement; and
- Related party transactions that are not in the normal course of operations and that involve significant judgments made by management concerning measurement or disclosure.

Our concern as auditors is with material misstatements, and thus, we are not responsible for the detection of misstatements that are not material to the financial statements taken as a whole.

Appendix D – Auditor Independence

Auditor Independence

An essential aspect of all our services to the Hospital is an independent viewpoint, which recognizes that our responsibilities are to the members. While the concept of independence demands a questioning and objective attitude in conducting our audit, it also requires the absence of financial or other interests in the Hospital. In accordance with our firm's policy, and the Code of Professional Conduct, which govern our profession, neither MNP nor any of its team members assigned to the engagement or any of its partners, are permitted to have any involvement in or relationship with the Hospital that would impair independence or give that appearance. As auditors, we subscribe to the highest standards and are required to discuss the auditor's independence with the Finance Committee on an annual basis. Under the standard an auditor shall:

- Disclose, to the Finance Committee in writing, all relationships between the auditor and the Hospital that in the auditor's professional judgment may reasonably be thought to bear on our independence;
- Confirm in writing that, in its professional judgment, MNP is independent within the meaning of the Code of Professional Conduct; and,
- Discuss the auditor's independence with the Finance Committee.

During the course of the audit, we will communicate any significant new matters that come to our attention that, in our professional judgment, may reasonably be thought to bear on our independence.

Independence Communication

(See Attached)

Engagement Letter

(See Attached)

MADE IN CANADA

And proud of it!

At MNP we're proud to be the national accounting, consulting and tax firm that is 100% Made in Canada.

Our history defines who we are and our approach to business. Being a Canadian firm has helped shape our values, our collaborative approach, and the way we work with our clients, engaging them every step of the way.

We have a unique perspective. Our decisions are made here – decisions that drive Canadian business and help us all achieve success — and we know the impact that our choices have on the cities and towns we call home.

Throughout our six decades of work, we've seen our communities are more than just a place we do business in. They're a place where our families live, play, and thrive, and we work to make them the best places they can be.

Being 100% Canadian is something we wear proudly. This country provides us with great opportunities, and we're here to help our clients seize the opportunities so we can create a brighter future for the generations to come.

PRAXITY

MNP

Wherever business takes you

MNP.ca

March 12, 2025

Dr. Stuart Robertson
Hôpital Glengarry Memorial Hospital
20260 County Road 43
Alexandria ON K0C 1A0

Dear Sir:

This letter will confirm the arrangements discussed with you regarding the services MNP LLP ("we" or "MNP") will render to Hôpital Glengarry Memorial Hospital (the "Hospital") commencing with the fiscal year ending March 31, 2025.

Our responsibilities

We will audit the financial statements of Hôpital Glengarry Memorial Hospital for the year ended March 31, 2025.

Our audit will be conducted in accordance with Canadian generally accepted auditing standards. Accordingly, we will plan and perform our audit to obtain reasonable, but not absolute, assurance that the financial statements taken as a whole are free of material misstatement, whether caused by fraud or error.

Our responsibilities, objective, scope, independence and the inherent limitations of an audit conducted in accordance with Canadian generally accepted auditing standards are detailed in Appendix A, which forms part of our mutual understanding of the terms of this engagement.

Management's responsibilities

The operations of the Hospital are under the control of management, which has responsibility for the accurate recording of transactions and the preparation and fair presentation of the financial statements in accordance with Canadian public sector accounting standards. This includes the design, implementation and maintenance of internal controls relating to the preparation and presentation of the financial statements.
Appendix B, which describes in detail management's responsibilities with respect to this engagement, forms part of our mutual understanding of the terms of this engagement.

Reporting

Unless unanticipated difficulties are encountered, our report will be substantially in the form illustrated in Appendix C.

Fees and expenses

Our fees and expenses are discussed in detail in Appendix D.

Other matters

We will, as permitted by the Code of Professional Conduct, provide additional services upon request, in areas such as taxation, leadership and human resource management, communication, marketing, strategic planning, financial management and technology consulting.

Our standard terms and conditions, included as Appendix, form part of our mutual understanding of the terms of this engagement. In the event that you choose to terminate this engagement based on the terms outlined in Appendix, we reserve the right to notify all financial statement users of the change.

These terms will continue in effect from year to year, unless changed in writing.

We believe the foregoing correctly sets forth our understanding, but if you have any questions, please let us know. If you find the arrangements acceptable, please acknowledge your agreement to the understanding by signing and returning the engagement letter to us.

It is a pleasure for us to be of service to you. We look forward to many years of association with you and Hôpital Glengarry Memorial Hospital.

Sincerely,

MNP LLP

Chartered Professional Accountants
Licensed Public Accountants

encls.

RESPONSE:

This letter correctly sets forth the understanding of Hôpital Glengarry Memorial Hospital.

		March 12, 2025
Management's Signature	President	Date
		March 12, 2025
Management's Signature	VP of Corporate Services and Chief Financial Officer	Date

cc: Board of Directors

Appendix A: Our Audit Responsibilities, Objective, Scope and Limitations

The following details our responsibilities as auditors and the objective, scope, independence and inherent limitations of an audit conducted in accordance with Canadian generally accepted auditing standards.

Our responsibilities, objective and scope

Our audit will be planned and performed to obtain reasonable assurance that the financial statements taken as a whole are free of material misstatement, whether caused by fraud or error. If any of the following matters are identified, they will be communicated to the appropriate level of management:

- Misstatements, resulting from error, other than immaterial misstatements;
- Fraud or any information obtained that indicates that a fraud may exist;
- Material uncertainties related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern;
- Any evidence obtained that indicates non-compliance or possible non-compliance with laws and regulations has occurred;
- Significant deficiencies in the design or implementation of controls to prevent and detect fraud or misstatements; and
- Related party transactions identified that are not in the normal course of operations and that involve significant judgments made by management concerning measurement or disclosure.

The matters communicated will be those that we identify during the course of our audit. Audits do not usually identify all matters that may be of interest to management in discharging its responsibilities. The type and significance of the matter to be communicated will determine the level of management to which the communication is directed.

Furthermore, we will consider the Hospital's controls over financial reporting for the purpose of identifying types of potential misstatement, considering factors that affect the risks of material misstatement, and determining the nature, timing and extent of auditing procedures necessary for expressing our opinion on the financial statements. This consideration will not be sufficient to enable us to render an opinion on the effectiveness of controls over financial reporting nor to identify all significant deficiencies in the Hospital's system of financial controls.

Independence

The Code of Professional Conduct require that we are independent when conducting this engagement. We will communicate to the Board of Directors any relationships between the Hospital (including related entities) and MNP that, in our professional judgment, may reasonably be thought to bear on our independence.

If matters should arise during this engagement that can reasonably be assumed to have impaired our independence, we may need to withdraw from this engagement.

Audit limitations

An audit involves performing procedures to obtain audit evidence regarding the amounts and disclosures in the financial statements. This includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation, structure and content of the financial statements, including disclosures.

Appendix A: Our Audit Responsibilities, Objective, Scope and Limitations *(continued from previous page)*

It is important to recognize that an auditor cannot obtain absolute assurance that material misstatements in the financial statements will be detected because of factors such as the use of judgment, selective testing of data, inherent limitations of controls, and the fact that much of the audit evidence available is persuasive rather than conclusive in nature.

Furthermore, because of the nature of fraud, including attempts at concealment through collusion and forgery, an audit designed and executed in accordance with Canadian generally accepted auditing standards may not detect a material misstatement due to fraud.

While effective controls reduce the likelihood that misstatements will occur and remain undetected, they do not eliminate that possibility. Therefore, we cannot guarantee that fraud, misstatements and non-compliance with laws and regulations, if present, will be detected when conducting an audit in accordance with Canadian generally accepted auditing standards.

The audit of the financial statements and the issuance of our audit opinion are solely for the use of the Hospital and those to whom our report is specifically addressed. We make no representations of any kind to any third party in respect of these financial statements and we accept no responsibility for their use by any third party. If our name is to be used in connection with the financial statements, you will attach our independent audit report when distributing the financial statements to third parties.

We ask that our names be used only with our consent and that any information to which we have attached a communication be issued with that communication unless otherwise agreed to by us.

Appendix B: Management Responsibilities

During the course of our audit, you will be required to provide and make available complete information that is relevant to the preparation and presentation of the financial statements, including:

- Financial records and related data, including data relevant to disclosures made in the financial statements;
- Copies of all minutes of meetings of Board of directors;
- Access to personnel to whom we may direct our inquiries;
- Information relating to any known or possible instances of non-compliance with laws, legislative or regulatory requirements (including financial reporting requirements);
- Information relating to all related parties and related party transactions; and
- Allowing access to those within the entity from whom the auditor determines it necessary to obtain audit evidence.

Management's responsibility with respect to fraud and misstatement includes:

- The design and implementation of controls for its prevention and detection;
- An assessment of the risk that the financial statements may be materially misstated;
- Disclosure of situations where fraud or suspected fraud involving management, employees who have significant roles in controls, or others, where the fraud could have a material effect on the financial statements, have been identified or allegations have been made; and
- Communicating your belief that the effects of any uncorrected financial statement misstatements aggregated during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

In accordance with Canadian generally accepted auditing standards, we will request a letter of representation from management at the close of our audit in order to confirm oral representations given to us and reduce the possibility of misunderstanding concerning matters that are the subject of the representations. These representations are used as evidence to assist us in deriving reasonable conclusions upon which our audit opinion is based.

If the Hospital plans any reproduction or publication of our report, or a portion thereof, printer's proofs of the complete documents should be submitted to us in sufficient time for our review, prior to making such documents publicly available. It will also be necessary for you to furnish us with a copy of the printed report. Further, it is agreed that in any electronic distribution, for example on Hôpital Glengarry Memorial Hospital's website, management is solely responsible for the accurate and complete reproduction of our report and the subject matter on which we reported, and for informing us of any subsequent changes to such documents. However, we are responsible to read the documents to ensure accuracy, and consider the appropriateness of other information accompanying the audited financial statements, upon initial posting.

Appendix C: Illustrative Independent Auditor's Report

To the Board of Directors of
Hôpital Glengarry Memorial Hospital:

Opinion

We have audited the financial statements of Hôpital Glengarry Memorial Hospital (the "Hospital"), which comprise the balance sheet as at March 31, 2025, and the statements of operations, changes in net assets and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Hospital as at March 31, 2025, and the results of its operations, changes in its net assets and its cash flows for the year then ended in accordance with Canadian public sector accounting standards (PSAS).

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards (Canadian GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are independent of the Hospital in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

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

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Hospital's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Hospital to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Hawkesbury ON

Chartered Professional Accountants
Licensed Public Accountants

Appendix D: Fees and Expenses

Our fees are determined on the basis of time spent on the engagement at the tariff rates of various members of our team. Any disbursements will be added to the billing.

Our estimated fees are based on our past experience and our knowledge of the Hospital. This estimate relies on the following assumptions:

- No significant deficiencies in the system of internal control which cause procedures to be extended;
- No major unadjusted misstatement(s) or un-reconciled balances;
- Significantly all adjusting entries are completed prior to the trial balance and journal entries being provided to the audit team;
- All management and required staff are available as needed;
- Information and working papers required, as outlined in our letter of fiscal year-end requirements, are provided in the mutually agreed form and timing; and
- There are no changes to the agreed upon engagement timetable and reporting requirements.

We will ask that your personnel, to the extent possible, prepare various schedules and analysis, and make various invoices and other documents available to our team. This assistance will facilitate the progress of our work and minimize the cost of our service to you.

If any significant issues arise during the course of our audit work which indicate a possibility of increased procedures or a change in the audit timetable, these will be discussed with management by the practitioner leading your engagement so a mutually agreeable solution can be reached. In accordance with our standard terms and conditions, included as Appendix E, if significant changes to the arrangements set forth in this engagement letter are required, any change in scope of the engagement will need to be agreed in writing.

Appendix E: Standard Terms and Conditions

The following standard terms and conditions and engagement letter to which they are attached form one agreement (the "Agreement") and set out the terms and conditions upon which MNP LLP ("MNP") will provide services to you (the "Hospital").

1. **Timely Performance** - MNP will use all reasonable efforts to complete, within any agreed-upon time frame, the performance of the services described in the engagement letter to which these terms and conditions are attached. However, MNP shall not be liable for failures or delays in performance that arise from causes beyond our control, including the untimely performance by the Hospital of its obligations as set out in the engagement letter.

2. **Right to Terminate Services** - The Hospital may terminate the engagement upon 30 days written notice. If this occurs, the Hospital shall pay for time and expenses incurred by MNP up to the termination date, together with reasonable time and expenses incurred to bring the services to a close in a prompt and orderly manner. Should the Hospital not fulfil its obligations as set out herein and in the engagement letter, and in the event that the Hospital fails to remedy such default within 30 days following receipt of notice from MNP to that effect, MNP may, upon written notification and without prejudice to its other rights and resources, terminate provision of our services as described in the engagement letter. In such case, MNP shall not be responsible for any loss, costs, expenses, or damages resulting from such termination.

3. **Change Order** - If, subsequent to the date of this engagement letter, the Hospital requires significant changes to the arrangements set forth in this engagement letter, the Hospital will be required to agree to the change in scope of the engagement in writing, in a "Change Order" agreement. The "Change Order" agreement will set forth the revised arrangements and scope of services to be performed and any related additional fees associated.

4. **Fees** - Any fee estimates by MNP take into account the agreed-upon level of preparation and assistance from the Hospital's personnel. MNP undertakes to advise the Hospital's management on a timely basis should this preparation and assistance not be provided, or should any other circumstances arise which cause actual time to exceed the estimate.

5. **Administrative Expenses** - A non-reimbursable administrative expense fee (the "Administrative Fee") equal to 5% of the professional fees charged will be levied for administrative expenses. The administrative fee will be added to the professional fees and will be payable at the same time. Out-of-pocket expenses, including travel and accommodation expenses, incurred in connection with and necessary to the provision of our Services will be charged to the client.

6. **Billing** - Bills will be rendered on a regular basis as the assignment progresses. Accounts are due and payable upon receipt. Interest may be charged on the balance of any accounts remaining unpaid for more than 30 days, at a rate of 1.5% per month (19.56% per annum).

7. **Taxes** - All fees and other charges do not include any applicable federal, provincial, or other goods and services or sales taxes, or any other taxes or duties whether presently in force or imposed in the future. The Hospital shall assume and pay any such taxes or duties, without deduction from the fees and charges hereunder.

Appendix E: Standard Terms and Conditions *(continued from previous page)*

8. **Governing Law** - The engagement will be governed and construed in accordance with the laws of the Province of Ontario, and shall be deemed in all respects to be an Ontario contract. The Hospital and MNP submit to the courts of that jurisdiction with respect to all matters arising under or by virtue of this Agreement.

9. **Working Papers** - MNP owns all working papers and files, other materials, reports and work created, developed or performed during the course of the engagement, including intellectual property used in the preparation thereof. We will provide management with a copy of all practitioner-prepared working papers necessary for the Hospital's accounting records. MNP may develop software, including spreadsheets, documents, databases, and other electronic tools, to assist us with our assignment. As these tools and working papers were developed specifically for our purposes and without consideration of any purpose for which the Hospital might use them, any such tools which may be provided to the Hospital, will be made available on an "as is" basis only, at our discretion, and should not be distributed to or shared with any third party. Except as indicated in the Code of Professional Conduct or by any legal proceeding, we have no responsibility to share our working papers with you or with any other parties.

10. **Personal Information** - Except to the extent necessary for the performance of the services, the Hospital shall not provide any personal information, as defined in Canadian federal and provincial privacy legislation, to MNP in connection with this engagement. If personal information is disclosed to or by MNP, or is accessed, collected, used, or disclosed by MNP, the Hospital consents to the same and represents and warrants that it has or will collect all necessary consents, provide any necessary notices, and do all such other things as are required under applicable law in respect of such personal information. Any collection, use or disclosure of personal information will be subject to MNP's privacy policy (available for review at www.mnp.ca/privacy) and will comply with applicable Canadian federal and provincial laws.

11. **Confidentiality** - To the extent that, in connection with this engagement, MNP comes into possession of any proprietary or confidential information of the Hospital, MNP will not disclose such information to any third party without the Hospital's consent, except: (a) when properly acting in the course of providing the Services (including to such of MNP's subcontractors, affiliates and advisors as may have a need to know), (b) as may be required by applicable law, or as may be permitted by applicable professional standards; or (c) to the extent such information: (i) shall have otherwise become publicly available (including, without limitation, any information filed with any governmental agency and available to the public) other than as the result of a disclosure by MNP in breach hereof; (ii) is disclosed by the Hospital to a third party without substantially the same restrictions as set forth herein; (iii) becomes available to MNP on a non-confidential basis from a source other than the Hospital whom MNP believes is not prohibited from disclosing such information to MNP by obligation to the Hospital; (iv) is known by MNP prior to its receipt from the Hospital without any obligation of confidentiality with respect thereto; or (v) is developed by MNP independently of any disclosures made by the Hospital to MNP of such information. The Hospital acknowledges that our client files may be periodically reviewed by provincial or national practice inspectors as required by law, including for reporting-issuers by the Canadian Public Accountability Board, the Public Company Accounting Board, or other regulators, and by other MNP personnel that may be located extra-provincially to ensure we are adhering to professional and MNP standards.

12. **Data Analytics** - The Hospital agrees that MNP may use relevant portions of the Hospital information disclosed to MNP in the course of the Engagement, which may include Confidential information and Personal information (the "Client Data") for the purpose of performing individualized (using your data only, for your eyes only) and aggregated benchmarking and industry models and reports (using de-identified data from a variety of sources). Aggregated benchmarking and industry reporting services will be performed to provide valuable insights on financial and other trends either (a) within your specific business organization over time, or (b) on an aggregated basis across an entire industry or sector. MNP may use such information to provide services to its clients or for other business purposes. None of the aggregated reporting will contain any information that would allow a third party to identify you. The data will not be re-identified or removed following the aggregation process.

13. **Nature of the Limited Liability Partnership (LLP)** - MNP is a registered limited liability partnership, as permitted by legislation enacted in our governing jurisdiction of the Province of Alberta. This legislation provides that a partner of an LLP is not personally liable for any of the debts, obligations, or liabilities of the LLP or any of the other partners which may arise as a result of any negligent act or omission of another partner of the LLP, or by any employee of the partnership, unless such act or omission is committed by the partner him or herself or by a person under the partner's direct supervision and control. All partners of an LLP remain personally liable for any acts or omissions arising as a result of their own negligence, and for the acts or omissions of those directly under their supervision or control, and shall continue to be subject to unlimited personal liability for all of the other liabilities of the partnership. The legislation does not reduce or limit in any way the liability of the partnership itself, and all of the partnership's assets and insurance coverage remain at risk.

14. **Release and Limitation of Liability** - The Hospital and MNP agree to the following with respect to MNP's liability to the Hospital:

    a. In any action, claim, loss or damage arising out of the engagement, the Hospital agrees that MNP's liability will be several and not joint and the Hospital may only claim payment from MNP of MNP's proportionate share of the total liability based on the degree of fault of MNP as finally determined by a court of competent jurisdiction.

    b. Other than for matters finally determined to have resulted from the gross negligence, fraud or willful misconduct of MNP, whether the claim be in tort, contract, or otherwise:

        i. MNP shall not be liable to the Hospital and the Hospital releases MNP for all claims, damages, costs, charges and expenses (including legal fees and disbursements) incurred or suffered by the Hospital related to, arising out of, or in any way associated with the engagement to the extent that the aggregate of such amounts is in excess of the total professional fees paid by the Hospital to MNP in connection with this engagement during the 12 month period commencing from the date of the engagement letter to which these terms and conditions are attached; and,

        ii. MNP shall not be liable to the Hospital for any consequential, indirect, lost profit or similar damages, or failure to realize expected savings, relating to MNP's services provided under the engagement letter to which these terms and conditions are attached.

Appendix E: Standard Terms and Conditions *(continued from previous page)*

15. **Indemnity** - The Hospital agrees to jointly and severally indemnify and hold harmless MNP against:

    a. All claims, damages, costs, charges and expenses (including legal fees and disbursements) which are related to, arise out of, or are in any way associated with the engagement, whether the claims are civil, penal, regulatory, or administrative in nature, other than those finally determined by a court of competent jurisdiction to have resulted from MNP's gross negligence, fraud or willful misconduct; and,

    b. Notwithstanding "a.," all claims, damages, costs, charges and expenses (including legal fees and disbursements) which are related to, arise out of, or are in any way associated with the engagement, whether the claims are civil, penal, regulatory, or administrative in nature, that arise from or are based on any deliberate misstatement or omission in any material, information or representation supplied or approved by any officer or member of the Board of Directors of the Hospital.

    For the purposes of paragraph 14. and 15., "MNP" shall mean MNP LLP and its directors, officers, partners, professional corporations, employees, subsidiaries and affiliates and to the extent providing services under the engagement letter to which these terms are attached, MNP LLP, its member firms, and all of their partners, principals, members, owners, directors, staff and agents; and in all cases any successor or assignee.

16. **Survival of Terms** - The Hospital and MNP agree that clauses 14. and 15. will survive termination of the engagement.

17. **Electronic Communications** - Unless the Hospital prefers we use a particular manner of communication and specifies as much in writing, MNP will use whatever form of communication it deems most efficient in the circumstances. In many instances, this will involve the use of internet e-mail. With respect to internet e-mail, MNP and the Hospital both acknowledge that neither party has control over the performance, reliability, availability, or security of internet e-mail. Additionally, MNP staff may be required or requested to work from your offices during which visits access to and use of and reliance upon your electronic environment (including but not limited to, your network, Internet, and extranet resources) is necessitated. The Hospital accepts that MNP shall not be liable for any loss, damage, expense, harm or inconvenience resulting from any loss, delay, interception, corruption, security breach, delivery failure, incompatibility, incompleteness or alteration of any document or transmission arising from the use of e-mail or the transmission of any document outside of MNP's electronic environment.

18. **Third Party Services** - In connection with this engagement, MNP may use certain third parties to provide professional, administrative, and analytical services and other clerical support. As a result, Client Data may transit or be used, stored or accessed in jurisdictions outside your province of residence or outside of Canada, and may be subject to disclosure in accordance with the laws applicable in such jurisdiction, which laws may not provide the same level of protection as Canadian federal and provincial privacy laws. MNP will require such third parties to undertake confidentiality obligations that are equivalent to those contained in this Agreement. For clarity, MNP does not warrant and is not responsible for any third-party product or service obtained independently by the Hospital notwithstanding any participation or involvement by MNP in the procurement of such services.

Appendix E: Standard Terms and Conditions *(continued from previous page)*

19. **Praxity** - We are an independent accounting firm allowed to use the name "PRAXITY" in relation to our practice. We are not connected by ownership to any other firm using the name "PRAXITY" and we will be solely responsible for all work carried out by us on your behalf. In deciding to instruct us you acknowledge that we have not represented to you that any other firm using the name "PRAXITY" will in any way be responsible for the work we do.

20. **Solicitation** - The Hospital agrees that for a period of one year after completion of the services, it shall not, directly or indirectly, for itself or for any third party, solicit the services of, hire, contract for the services of, or otherwise entice away from their partnership, employment or contract of services with MNP or any MNP Person. In the event of a breach of this section by the Hospital, the Hospital shall be obliged to pay to MNP liquidated damages in the amount of one hundred fifty (150%) percent of the total compensation the Hospital or third party offered to pay the individual in their first year of service to such party, or one hundred fifty (150%) percent of total compensation the Hospital or third party actually paid to the individual in their first year of service to such party, whichever is greater. The Hospital further understands that any breach by the Hospital of this provision may result in a threat to our independence which may prevent us from accepting or continuing any engagement to provide assurance services to the Hospital. "MNP Person" means any and all partners, employees and contractors providing services to MNP, whether for a defined or indefinite period or on a part-time or full-time basis, and with whom the Hospital had contact during the term of this engagement.

March 12, 2025

Hôpital Glengarry Memorial Hospital
20260 County Road 43
Alexandria ON K0C 1A0

Madam, Sir:

We have been engaged to audit the financial statements of Hôpital Glengarry Memorial Hospital (the "Hospital") as at March 31, 2025 and for the year then ended.

CAS 260 *Communication With Those Charged With Governance* requires that we communicate with you matters that are significant to our engagement. One such matter is relationships between the Hospital and its related entities or persons in financial reporting oversight roles at the Hospital and MNP LLP and any affiliates ("MNP") that, in our professional judgment, may reasonably be thought to bear on our independence. In determining which relationships to report, the Standard requires us to consider relevant rules and related interpretations prescribed by the appropriate professional accounting body and applicable legislation, covering such matters as:

(a) Holding a financial interest, either directly or indirectly, in a client;
(b) Holding a position, either directly or indirectly, that gives the right or responsibility to exert significant influence over the financial or accounting policies of a client or a related entity;
(c) Personal or business relationships of immediate family, close relatives, partners or retired partners, either directly or indirectly, with a client or a related entity;
(d) Economic dependence on a client; and
(e) Provision of non-assurance services in addition to the audit engagement.

We are not aware of any relationship between the Hospital and MNP that, in our professional judgment, may reasonably be thought to bear on our independence, which have occurred from April 1, 2024 to March 12, 2025.

We hereby confirm that MNP is independent with respect to the Hospital within the meaning of the Code of Professional Conduct of the Chartered Professional Accountants of Ontario as of March 12, 2025.

This report is intended solely for the use of management and others within the Hospital and should not be used for any other purposes.

We look forward to discussing with you the matters addressed in this letter as well as other matters that may be of interest to you at our upcoming meeting. We will be prepared to answer any questions you may have regarding our independence as well as other matters.

Sincerely,

MNP LLP

Chartered Professional Accountants
Licensed Public Accountants

REPORT OF THE GOVERNANCE AND NOMINATING COMMITTEE

April 9, 2025 at 5:00PM Boardroom/MS Teams

Present:	L. Boyling, Chair	G. Peters	Dr. S. Robertson
	G. McDonald	C. Larocque	R. Alldred-Hughes, CEO
Regrets:	None		

Summary of Discussion

Approval of the Agenda
The agenda was reviewed.

Moved By: C. Larocque
Seconded By: G. McDonald
THAT the agenda be approved as presented.

CARRIED

Declaration of Conflict of Interest
There were no conflicts declared.

Approval of Previous Meeting Report
The meeting report from March 12, 2025, was shared.

Moved By: Dr. S. Robertson
Seconded By: G. Peters
THAT the meeting report be approved as presented.

CARRIED

Business Arising from Report
There was no business arising from the report.

Committee Workplan Review
There were no changes to the committee workplan, and things are on track.

Matters for Discussion/Decision

Governance Accreditation Standard Review
The Accreditation standard was reviewed in which a new policy was presented.

Moved By: C. Larocque
Seconded By: G. McDonald
THAT the Governance and Nominating Committee recommend to the Board of Directors the new policy entitled “Framework for Board Accountability & Transparency” as amended.

While doing Accreditation work, it was brought to our attention that we don’t have a framework for Board accountability. As such, a policy was created formed from legislation and the Guide to Good Governance. The website is going to be updated to ensure transparency components are all outlined on our website and is publicly available. For the most part, it is all there, however there are a couple of things to be added.

It was suggested that the policy is the what and the procedure is the how and it seems to be the reverse here. He also suggested that there are X’s missing or in the wrong place. This will

be adjusted. The first paragraph under procedure should be under the second paragraph of policy and moving the rest of policy under procedure.

The changes will be made to the policy and brought to the board as amended.

CARRIED

Equity, Diversity & Inclusion Update
R. Alldred-Hughes gave an update on Equity, Diversity & Inclusion in which the Auxiliary will be sponsoring the Spiritual and Family Room. Survey responses are being pulled from diverse groups to analyze their responses and see what can be done to improve their experience at the hospital.

The committee would like to see a plan of what is being done and where we want to go with this.

Review Governing Body Assessment Results
The Governing Body Assessment results were reviewed. Overall, the results are positive. Adjustments will be made based on these results in terms of the amount of time meetings are spent reviewing quality. This will take place with the Quality committee meeting 6 times per year as of next Board cycle.

Based on these results, it was questioned whether there were areas the committee would like to improve in order to enhance the work. The only area was around education in which it was agreed that education sessions be done at every board meeting to allow the board to learn about the hospital environment.

Documents for Review
Board Application for Membership Process Policy and Appointment of Auditor Policy
These policies were due for regular review.

Moved By: C. Larocque
Seconded By: G. Peters
THAT the Governance & Nominating committee recommend to the Board of Directors the approval of the following policies as presented: Board Membership Application Process and Appointment of Auditor.

There were no changes proposed to the policies.

CARRIED

Fraud Prevention
This policy was suggested to be archived.

Moved By: C. Larocque
Seconded By: G. McDonald
THAT the Governance & Nominating committee recommend to the Board of Directors the retirement of the Fraud Prevention Policy.

The recommendation for archiving this policy is due to the Whistleblower Policy being implemented and to eliminate duplicate policies. The Whistleblower Policy delineates who is responsible for what. It was agreed that the Whistleblower policy be renamed to include fraud prevention. The policy will be brought back to the next meeting with some revisions including title change. **CARRIED**

Next meeting: Wednesday, May 14, 2025

K-L. Massia, Recorder

DECISION SUPPORT DOCUMENT FOR

☒ Board of Directors ☐ Board Committee – ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: March 31, 2025 Meeting Date Prepared for: April 9, 2025 – Governance April 24, 2025 - Board

Subject: Policy Reviews

Prepared by: Robert Alldred-Hughes, President & CEO

☒ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

The purpose of this briefing note is to provide an overview of the three policies up for review and highlight any material changes to each policy.

RECOMMENDATION / MOTION

That the Governance and Nominating Committee recommend to the Board of Directors the approval of the following policies as amended: Board Membership Application Process, and Appointment of Auditor.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ *No* ☐ *Yes, please specify:*

SITUATION & BACKGROUND

A brief description of the background to the issue.

Summary of amendments:

Board Membership Application Process

- The policy was reviewed and revised to clearly articulate its focus on the application process for prospective Board members.
- A Diversity, Equity, and Inclusion (DEI) lens was applied to emphasize the Board's commitment to recruiting members who reflect the diversity of the community it serves. The policy now explicitly encourages applications from diverse candidates, reinforcing this commitment. Codifying this language ensures consistency in recruitment practices across the organization.

Appointment of Auditor

- Since the HGMH Corporate By-laws include provisions regarding the appointment of the auditor, this policy and procedure serve as a supplementary requirement of the Board of Directors. Accordingly, a cross-reference to the By-laws is included to ensure the Board adheres to its prescribed duties in this matter.

IMPLEMENTATION & COMMUNICATION PLAN

Consider how the recommendation will be rolled-out and communicated to all key stakeholders.

- Obtain Board Approval – April 24, 2025
- Update Board Policy Online
- Include updates in Board Orientation Material

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Board Member Application Process Policy
- Appointment of Auditor Policy

BOARD MEMBERSHIP APPLICATION PROCESS

Document Name:	Board Membership Application Process	
Document Number:	BOD.01.XXX.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** N/A
Classification: Board of Directors	**Section:** Governance	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Board is a skills/knowledge-based Board with a passion to serve. Directors are chosen for their skill, competency, knowledge and experience, which will support the mission of HGMH. While in keeping with the objective of maintaining a skills/knowledge-based Board, Board membership should reflect the diversity of the Corporation's catchment area.

This policy outlines the application process members of the community use to apply to become a member of the Board of Directors.

PROCEDURE:

1. To apply for membership on the HGMH Board of Directors, the applicant must secure an application package from the HGMH website www.hgmh.on.ca or through administration which contains/requires the following:
    i) Covering letter
    ii) Conflict of interest disclosure
    iii) Skill matrix form
    iv) Vulnerable Sector check
    v) Updated resume
    vi) Interview (with panel to include CEO or delegate as non-voting member)

    Applications that are completed via an electronic submission process. Applicants that do not have access to electronic devises may submit hardcopy through the Board Liaison.

2. The application form will also include:
    a) Eligibility Criteria and Conditions of Appointment
    b) Duties and Expectations of a Director

3. If selected by the nominating committee, the applicant will be notified to be present at the Annual Meeting when/if voting is to take place. The applicant will also be notified if not selected, and applications will remain on file for one year at the candidate's request.

4. The Board of Directors continually strives to represent the diversity of voices and experiences in our community and strongly encourages Indigenous peoples, members of visible minorities, persons with disabilities, and people who identify as 2SLGBTQ+, to apply.

APPOINTMENT OF AUDITOR

5Document Name:	Appointment of Auditor	
Document Number:	BOD.01.XXX.0.25	
Review Period:	☒3 years ☐1 year	**Manual: Governance**
Classification: Board of Directors		**Section:**
Owner: President & CEO		**Signing Authority:** Board of Directors

POLICY STATEMENT:

The Corporation will appoint an Auditor every year at the Annual Meeting. The Corporation will consider the recommendation of the Board.

PROCEDURE:

In addition to HGMH Corporate By-law 9.5, the Board of Directors will ensure the following actions related to the appointment of the auditor.

1. Every five years, tenders will be sought for auditors and reviewed by the Finance and Human Resources Committee who will recommend the auditor to the Board.

2. Every year, at the annual meeting, the membership of the Corporation will appoint the auditor as recommended.

MINUTES OF THE MEETING OF THE EXECUTIVE COMMITTEE

Date	Wednesday, April 9, 2025		
Time	6:00PM		
Location	Boardroom / Microsoft Teams		
Present:	Dr. S. Robertson, Chair	L. Boyling	C. Nagy
	R. Alldred-Hughes, CEO	Dr. L. MacKinnon	
Regrets:	None		

1. Call to Order

Dr. S. Robertson, Chair, called the meeting to order at 18:00.

1.1. Quorum

1.2. A quorum was present.

1.3. Adoption of the Agenda

The agenda was reviewed and approved.

Moved By: C. Nagy
Seconded By: L. Boyling
THAT the agenda be adopted as presented.

CARRIED

1.4. Declaration of Conflict of Interest

There were no conflicts of interest declared at this time.

2. Minutes

2.1. Approval of the Minutes

The minutes from the meeting held on October 9, 2024, were reviewed.

Moved By: C. Nagy
Seconded By: L. Boyling
THAT the minutes of the meeting of October 9, 2024, be approved as presented.

CARRIED

3. Matters for Discussion/Decision

3.1 Review Personal Business Commitments Results 2024-2025 (Dr. S. Robertson)

3.1.1 Personal Business Commitments of the CEO

The results of the personal business commitments of the CEO were reviewed and discussed in which all items were completed. These results will be tied in with the evaluation which will be conducted in May.

3.1.2 Personal Business Commitments of the COS (Dr. S. Robertson)

3.1.3 The results of the personal business commitments of the COS were reviewed and discussed in which all items were completed. These results will be tied in with the evaluation which will be conducted in May.

3.2 Personal Business Commitments of the CEO and COS 2025-2026 (Dr. S. Robertson)

3.2.1 Personal Business Commitments of the CEO

R. Alldred-Hughes explained the personal business commitments he chose for 2025-2026. It was questioned if a balanced budget is attainable with the tariffs in place. This will remain a target to achieve and reviewed next year if it is an issue.

Moved By: C. Nagy
Seconded By: L. Boyling
THAT the Executive Committee recommend to the Board of Directors the approval of the personal business commitments of the CEO for 2025-2026 as presented.

CARRIED

3.2.2 Personal Business Commitments of the COS

Dr. L. MacKinnon explained the personal business commitments she chose for 2025-2026.

Moved By: L. Boyling
Seconded By: C. Nagy
THAT the Executive Committee recommend to the Board of Directors the approval of the personal business commitments of the COS for 2025-2026 as presented.

CARRIED

4. Date of Next Meeting

October 2025

Correspondence

April 8, 2025 – Seaway News – Things are going Epic at HGMH

April 11, 2025 – The Review – Washer Tournament for Glengarry Hospital