



BOARD OF DIRECTORS MEETING - OPEN Wednesday October 7, 2026

1700-1745

Virtual via Teams / C.1.229

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AGENDA

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
1. CALL TO ORDER				
1.1 Territorial Acknowledgement		1700	D. Wilkinson	
1.2 Welcome		1702	D. Wilkinson	
1.3 Confirmation of Quorum (7)		1703	D. Wilkinson	Confirmation
1.4 Declarations of Conflict of Interest		1704	D. Wilkinson	Declaration
1.5 Consent Agenda <i>(Any Board member may request that any item be removed from this consent agenda and moved to the regular agenda)</i>		1705	D. Wilkinson	Motion
1.5.1 Minutes of June 24, 2026 and Open (2)*	4			
1.5.2 2026/27 Board of Directors Action Log*	13			
1.5.3 Board Attendance*	14			
1.5.4 Board Work Plan*	15			
1.5.5 Events Calendar*	23			
1.5.6 Committee Reports to the Board of Directors				
1.5.6.1 Audit Committee (Next Meeting Nov 16, 2026)				
1.5.6.2 Digital Health Strategy Committee* (Sep 17, 2026)	25			
1.5.6.3 Executive Committee (Next Meeting Nov 17, 2026)				
1.5.6.4 Governance and Nominating Committee (Next Meeting Oct 15, 2026)				
1.5.6.5 Medical Advisory Committee* (Sep 9, 2026)	26			
1.5.6.5.1 New Credentialed Physicians – <i>No Credentialed Physicians This Meeting</i>				
1.5.6.6 Resources Committee* (Sep 28, 2026)	28			
1.5.7 Governance Policy Approvals <i>No Policies for Approval this Meeting</i>				
1.5.8 Strategic Priorities Tracker Update Q1*	29			
1.5.8.1 Quality Monitoring Scorecard*	45			
1.5.9 CEO Certificate of Compliance* (June 20, 2026 – October 2, 2026)	73			
1.5.10 2024-25 and 2025-26 Ministry of Health Child and Youth Mental Health Program Transfer Payment Annual Reconciliation (TPAR) Submissions *	74			
1.6 Confirmation of Agenda		1709	D. Wilkinson	Motion
2. PRESENTATIONS				
2.1 DEI Plan Annual Update*	110	1710	M. Iromoto	Information

Board Members: Diane Wilkinson (Chair), Abdul-Qayum Ali, Sara Alvarado, Tom Barker, Paulo Brasil, William Conway, Julia Goyal, Stephanie Kessler, Jayne Herring, Miles Lauzon, Dr. Margaret McKinnon, Lynn Woeller

Ex officio Members: Patrick Gaskin, Dr. Winnie Lee, Dr. Vlad Miropolsky, Dr. Minta Patel, Stephanie Pearsall

Agenda Item * indicates attachment / TBC – to be circulated	Page #	Time	Responsibility	Purpose
3. BUSINESS ARISING				
3.1 No Open Matters for Discussion				
4. NEW BUSINESS				
4.1 Chairs Update				
4.1.1 Board Chairs Report*	120	1720	D. Wilkinson	Information
4.1.2 Board “Thank You Week” Participation*	128	1725	D. Wilkinson	Information
4.2 Resources Committee (Sep 28, 2026)				
4.2.1 Financial Statements – August 2026*	129	1730	P. Brasil	Motion
4.3 Quality Committee (Sep 16, 2026)				
4.3.1 Report to the Board of Directors*	135	1735	B. Conway	Discussion
4.4 Patient & Family Advisory Council (PFAC) Update* (Sep 8 & Oct 6, 2026)		1740	D. Wilkinson	Information
4.5 CEO Update				
4.5.1 No Open Matters for Discussion				
5. UPCOMING EVENTS <i>Visit GovHub for the most current listing of all upcoming events</i>		1744	D. Wilkinson	Information
5.1 Grand Rounds: October 22, 2026 – 8:00-9:00am, virtual – Details to follow				
5.2 CMH Thank-You Week Event: October 28, 2026 – Details TBD				
5.3 Celebration of Champions: November 2, 2026 – 4:30pm-8:30pm Hamilton Family Theatre				
5.4 Good Morning Cambridge Breakfast with Darshpreet Bhatti: November 4, 2026 – 7:45am – 9:30am, Galt Country Club				
5.5 Cambridge and North Dumfries Community Awards: November 23, 2026 – 5:00pm – 7:00pm, Hamilton Family Theatre				
5.6 Grand Rounds: November 26, 2026 – 8:00-9:00am, virtual – Details to follow				
5.7 Giving Tuesday – December 1, 2026 – CMHF Working Towards a \$50,000 Goal for 2026 – Watch your inbox for ways to get involved and help spread the word.				
6. DATE OF NEXT MEETING	Wednesday December 2, 2026 Location: Virtual			
7. END OF MEETING		1745	D. Wilkinson	Motion
Link: Board/Committee Evaluation Survey	Following the meeting, please complete within one week.			

Board Members: Diane Wilkinson (Chair), Abdul-Qayum Ali, Sara Alvarado, Tom Barker, Paulo Brasil, William Conway, Julia Goyal, Stephanie Kessler, Jayne Herring, Miles Lauzon, Dr. Margaret McKinnon, Lynn Woeller

Ex officio Members: Patrick Gaskin, Dr. Winnie Lee, Dr. Vlad Miropolsky, Dr. Minta Patel, Stephanie Pearsall



CMH Board of Directors Motions Page

Agenda Item	Motions Being Brought Forward for Approval	
1.5	Consent Agenda 1.5.10	- That, the CMH Board of Directors approves the Consent Agenda as presented/amended <i>The following motions are contained in the Consent Agenda:</i> - That, The Board of Directors, having reviewed the information presented and considered the recommendation of the Resources Committee arising from its meeting on September 28, 2026, approves the 2024–25 and 2025–26 Ministry of Health Child and Youth Mental Health Program Transfer Payment Annual Reconciliation (TPAR) submissions, as presented/amended.
1.6	Confirmation of Agenda	That, the CMH Board of Directors approves the agenda as presented/amended
4.2.1	Financial Statements	That, The Board of Directors, having reviewed the information presented and considered the recommendation of the Resources Committee arising from its meeting on September 28, 2026, accepts the August 2026 financial statements as presented/amended.

Board Members: Diane Wilkinson (Chair), Abdul-Qayum Ali, Sara Alvarado, Tom Barker, Paulo Brasil, William Conway, Julia Goyal, Stephanie Kessler, Jayne Herring, Miles Lauzon, Dr. Margaret McKinnon, Lynn Woeller

Ex officio Members: Patrick Gaskin, Dr. Winnie Lee, Dr. Vlad Miropolsky, Dr. Minta Patel, Stephanie Pearsall

Cambridge Memorial Hospital
BOARD OF DIRECTORS MEETING
Wednesday, June 24, 2026
OPEN Session

Minutes of the open session of the Board of Directors meeting, held via a hybrid model (video conference and at Cambridge Memorial Hospital, C.1.229) on Wednesday, June 24, 2026.

Present:

L. Woeller, Chair	Dr. W. Lee
S. Alvarado	P. Brasil
B. Conway	M. Hempel
J. Herring	D. Wilkinson
P. Gaskin	T. Barker
M. Lauzon	J. Tulsani

Regrets: J. Goyal, M. McKinnon, Dr. V. Miropolsky, Dr. M. Patel

Staff Present: Dr. K. Rhee, T. Clark

Guests: A. Ali, S. Kessler

Recorder: S. Fitzgerald

1. **CALL TO ORDER**

The Chair called the meeting to order at 1715h.

1.1. **Territorial Acknowledgement**

The Chair presented the Territorial Acknowledgement. This acknowledgement was offered in keeping with the Hospital's commitment to reconciliation.

1.2. **Welcome**

The Chair welcomed Board members and guests to the meeting.

1.3. **Confirmation of Quorum (7)**

Quorum was confirmed, and the meeting proceeded, as per the agenda.

1.4. **Declarations of Conflict of Interest**

Board members were asked to declare any known conflicts of interest related to the open session of the meeting. No conflicts were declared.

1.5. **Consent Agenda**

The consent agenda was presented to approve routine Board materials that had been reviewed in advance of the meeting and did not require further discussion.

Board members were asked whether they wished to remove any items from the consent agenda for separate discussion. No items were removed.

The following motion was duly made, seconded and **CARRIED** with no members opposed:

MOTION: That, the CMH Board of Directors approves the consent agenda as presented.

- 1.5.1 Minutes of June 3, 2026
- 1.5.2 2025/26 Board of Directors Action Log

- 1.5.3 Board Attendance
- 1.5.4 Board Work Plan
- 1.5.5 Events Calendar
- 1.5.6 Committee Reports to the Board of Directors
 - Digital Health Strategy Committee (June 18, 2026)
 - Medical Advisory Committee (June 10, 2026)
 - Resources Committee (June 22, 2026)
- 1.5.8 Quality Monitoring Scorecard
- 1.5.9 CEO Certificate of Compliance (May 30, 2026-June 19, 2026)

1.6. Confirmation of Agenda

The meeting agenda was presented for approval. Board members were given the opportunity to raise questions or propose amendments to the agenda as circulated. The following items were added to the agenda for discussion:

Agenda item 4.5 Volunteer Association Annual Meeting Update

The following motion was duly made, seconded, and **CARRIED** with no members opposed:

MOTION: That, the agenda be approved as amended.

2. PRESENTATIONS

2.1. Accessibility Plan Annual Update

The Board received an overview of the Accessibility Plan annual update. It was noted that the work has transitioned from a primary focus on facilities and redevelopment to a broader patient experience lens, emphasizing how patients, staff, and the public access and interact with the environment.

Highlights under the physical environment included parking consultations conducted with the Patient and Family Advisory Council and the Accessibility Committee, along with a space audit of Lot 2 involving community members who use wheelchairs. Feedback was provided on the location and slope of accessible parking spaces. It was also noted that Wing B shower remediation has been completed.

Under information and communications, it was reported that the organization transitioned to new language translation tablets after the previous vendor exited the Canadian market, with minimal disruption to staff and patients.

With respect to training, a CMH-specific accessibility training module was launched in April 2026. It was noted that this training supplements the required AODA training and focuses on practical, organization-specific applications, including duty to accommodate and available equipment and supports.

In employment, the continuation of Project SEARCH in partnership with the Waterloo Catholic District School Board was highlighted, along with the successful placement of one intern into a position within the organization. Discovery Day was also noted as an initiative to provide students with exposure to the hospital environment.

Under community engagement, it was reported that CMH participated in the National Accessibility Trade Show, where the organization showcased its initiatives and received positive feedback. It was also noted that CMH was the only hospital represented.

3. BUSINESS ARISING

There were no open matters for discussion.

4. NEW BUSINESS

4.1. Chair's Report

4.1.1. The Chair thanked the Directors for their continued participation in hospital events.

4.2. Resources Committee

4.2.1. Financial Statements – May 2026

The Board received an update on the May 2026 financial statements. The Chair of the Resources Committee highlighted that CMH is currently reflecting a year-to-date deficit of \$685,000, primarily driven by \$1.1 million in IT equipment that was sourced in 2025–2026 but received and realized in 2026–2027. Additional pressures included \$276,000 in contracted services related to Clear Vision for cataract surgeries, while the Tri-City Endo contract remains frozen and is expected to be discontinued.

Accounts receivable variance was attributed to higher billing rates and increased cancer care drug costs. It was confirmed that the Revised Final Estimate of Costs (4) from the CRP is included within long-term liabilities as deferred capital grants on the balance sheet. Revenues were positively impacted by QBP funding, which is favorable by \$585,000 year to date, along with billable patient services, although it was noted that the regional targets associated with these revenues may be a stretch.

Ongoing expense pressures were identified in salaries and wages, medical and surgical supplies, and drug expenditures. The balance sheet reflects a current ratio of 1.48, and a cash flow deficit is projected for March 2027, with anticipated use of debt remaining within the \$20 million forecast.

Management noted that this is early in the fiscal year and that adjustments will be made, particularly regarding timing of equipment spend and delivery. It was indicated that a balanced budget is still forecast; however, the year is expected to be tighter given the evolving operating environment.

The Board had no questions with the information presented.

The following motion was duly made, seconded, and **CARRIED** with no members opposed:

MOTION: That, the CMH Board of Directors receives the May 2026 financial statements as presented by management and upon recommendation of the Resources Committee at the meeting of June 22, 2026.

4.3. Quality Committee

4.3.1. Report to the Board of Directors

The Chair of the Quality Committee provided an overview of the Committee's recent work, highlighting discussions from the June meeting. It was reported that the Diagnostic Imaging program completed 127,403 exams in 2025–2026, with volumes primarily across x-ray, ultrasound, CT, and MRI. Staffing levels were outlined, and it was noted that the program supports outpatient, emergency department, and inpatient activity. Median reporting turnaround times were identified for inpatient, emergency, and overall exams. Patient feedback highlighted support during booking and rebooking, guidance through the process, and reassurance from staff. Clinical growth areas were noted, including ultrasound volumes and the MRI project planned for fall 2026, along with participation in the abdominal aortic aneurysm screening program. Members who attended in person toured the department and viewed the new MRI space.

The Laboratory Medicine program update noted over one million chemistry and hematology tests annually, representing an increase from prior years. Staffing levels were outlined. Patient feedback referenced staff skill and care, including successful single-attempt venipuncture. It was noted that the program uses incident reporting to support quality and safety monitoring and achieved a 98.3% accreditation score.

Draft goals for 2026–2027 were reviewed, with a focus on supporting quality and patient safety during implementation of the new hospital information system. It was noted that program presentations will be paused until early 2027, with regular reporting and critical updates to continue. Potential disruption to data and reporting timelines during the transition was acknowledged.

The Committee reviewed the quality monitoring scorecard, the Medical Advisory Committee update, and the results of the annual self-assessment survey, which indicated strong agreement on committee effectiveness.

In Board discussion, questions were raised regarding whether Diagnostic Imaging operates on a 24/7 basis and staffing levels during overnight hours. It was confirmed that the department operates 24/7 with reduced staffing overnight. Questions were also raised regarding the introduction of the new MRI, including whether there is any difference in patient assignment between the existing and new machines, and it was confirmed that both are appropriate for patient use, with the new MRI serving as the primary magnet and the existing unit supporting outpatient flow. It was noted that the addition of the new MRI is expected to increase access and reduce wait times. Further discussion addressed the impact on patient flow, operating room utilization, and system capacity.

Discussion also included funding limitations, noting that imaging volumes must align with funded levels. It was noted that advocacy for additional funding is ongoing, and that flexibility exists to support other hospitals where capacity allows, subject to provincial coordination. The Board discussed the provincial e-referral program and its role in balancing wait times across regions, with early implementation underway and full impact expected over time.

No further questions were raised.

4.4. **Patient & Family Advisory Council (PFAC) Update**

The Board received the PFAC Committee update from its June 9, 2026 meeting. It was reported that an update was provided on the hospital information system, with discussion focused on the patient and family communication strategy. Feedback emphasized the need for communications to be patient- and family-centred, with a multimedia approach to support understanding. It was noted that communications should address both short-term changes and long-term benefits, support hospital visitors who may encounter new processes, and include volunteers as a source of information sharing.

An update was also provided on the DEI policy. It was noted that the policy is in development and outlines CMH's commitment and expectations related to equity, diversity, inclusion, and anti-racism. It was reported that 13 groups across the organization were consulted, with PFAC being the final group to provide input, and that the policy is expected to return in a formal format in the fall.

The Committee received the semi-annual patient experience update and plan. It was noted that PFAC members continue to participate broadly across committees

and initiatives within the organization, contributing feedback and perspectives based on their involvement.

No questions were raised by the Board.

4.5. **CMH Volunteer Association Annual Meeting Update**

The Board received the Volunteer Association update following its Annual General Meeting held on June 18, 2026.

It was reported that the AM featured a presentation from the Vice President of Philanthropy from YMCA of Three Rivers. Leadership appointments were confirmed, including Mark Squire as President, Yvonne King as Vice President, Catherine Patten as Business Manager, Sandra Highgate as Finance Director, and Jennifer Horton as a new Director. It was noted that the Volunteer Association has been working closely with Finance following the retirement of its bookkeeper. An update was provided on governance, noting that bylaw revisions have been completed and will be brought forward for review by the membership in the fall.

Operational updates were shared, including fundraising activities and revenue generation. It was reported that the Cambridge Gaming and Bingo Hall generated over \$70,000 in profit. Additional revenue was generated through retail operations, including the thrift store, Tim Hortons, and the gift shop. A total contribution of \$110,000 was presented to the CMH Foundation.

Volunteer recognition was highlighted, including long-service awards, with one individual recognized for over 25 years of service. A total of 117 volunteers were recognized.

No questions were raised.

5. **UPCOMING EVENTS**

The Chair reviewed the upcoming events.

6. **DATE OF NEXT MEETING**

The next scheduled Board of Directors meeting will be held on October 7, 2026.

7. **TERMINATION**

MOTION: That the meeting be terminated at 1754hrs.
None opposed, **CARRIED.**

Cambridge Memorial Hospital
BOARD OF DIRECTORS MEETING
Wednesday, June 24, 2026
OPEN SESSION (2)
(After Annual Meeting)

Minutes of the open session of the Board of Directors meeting, held via hybrid model (video conference and within Cambridge Memorial Hospital, C.1.229) on June 24, 2026.

Present:

D. Wilkinson, Chair (from 4.2 on)	Dr. W. Lee
S. Alvarado	A. Ali
B. Conway	S. Kessler
T. Barker	S. Pearsall
P. Gaskin	D. Wilkinson
L. Woeller, Chair (up to and including 4.1)	J. Herring
M. Lauzon	P. Brasil

Regrets: J. Goyal, Dr. M. McKinnon, Dr. V. Miropolsky, Dr. M. Patel

Staff Present: M. Iromoto, T. Clark, Dr. K. Rhee

Guests: None

Recorder: S. Fitzgerald

1. CALL TO ORDER

The Chair called the meeting to order at 2006 hours.

1.1. Confirmation of Quorum

Quorum requirements having been met, the meeting proceeded, as per the agenda.

1.2. Declarations of Conflict

Board members were asked to declare any known conflicts of interest regarding this meeting. There were none.

1.3. Confirmation of Agenda

MOTION: That, the agenda be approved as amended.

None opposed. **CARRIED.**

2. PRESENTATIONS

No open presentations for discussion.

3. BUSINESS ARISING

No open matters for discussion.

4. NEW BUSINESS

4.1. Election of the Officers

The following motion was duly made, seconded and **CARRIED** with no members opposed:

MOTION: That, the Board of Directors elects Diane Wilkinson as Chair of the Board and Bill Conway as Vice Chair of the Board None opposed,

4.2. Appointment of Chairs, Directors, and Non-Director Committee

The following motions were duly made, seconded and **CARRIED** with no members opposed:

That, the CMH Board of Directors appoints the following Committee Chairs for a one-year term and upon recommendation of the Governance and Nominating Committee at its meeting of May 14, 2026:

Lynn Woeller – Chair of Audit Committee
Paulo Brasil – Chair of Resources Committee
Sara Alvarado – Chair of Digital Health Strategy Committee
Bill Conway – Chair of Quality Committee
Julia Goyal – Chair of Governance and Nominating Committee
Diane Wilkinson – Chair of Executive Committee

That, the CMH Board of Directors appoints the following non-Director committee members and Directors to CMH Board committees for a one-year term upon recommendation of the Governance and Nominating Committee at its meeting of May 14, 2026:

Committee	Chair	Directors	Non-Directors
Audit	Lynn Woeller	Abdul-Qayum Ali Julia Goyal Miles Lauzon Margaret McKinnon	Bonita Bonn Brian Quigley Taariq Shaikh Helene St-Amand Chris Whiteley
Digital Health Strategy	Sara Alvarado	Tom Barker Lynn Woeller	Joel Campbell Masood Darr Paul Martinello Richard Neidert Gloria Ringwood Suzanne Sarrazin (PFAC)
Executive	Diane Wilkinson (ex officio)	Paulo Brasil Bill Conway (ex officio) Julia Goyal Jayne Herring	
Governance and Nominating	Julia Goyal	Paulo Brasil Jayne Herring Stephanie Kessler	Roger Ma Milena Protich Alana Russell
Quality	Bill Conway	Jayne Herring Stephanie Kessler Miles Lauzon Margaret McKinnon	Kellen Baldock (staff, selected) Nalini Gandhi Patrick Gaskin (ex officio) Dilys Haughton (PFAC) Winnie Lee (MAC member, selected) Alison McCarthy Tooba Mohtsham Stephanie Pearsall (ex officio) Angela Schrum (staff, selected)

Committee	Chair	Directors	Non-Directors
Resources	Paulo Brasil	Abdul-Qayum Ali Sara Alvarado Bill Conway	Amanda Forrest Shannon Maier Janet Richter

That, the CMH Board of Directors appoints the following Directors to non-CMH Board committees for a one-year term and upon recommendation of the Governance and Nominating Committee at its meeting of May 14, 2026:

- Tom Barker – CMH Foundation Board
- Jayne Herring – CMH Volunteer Association
- Bill Conway – Medical Advisory Committee
- Diane Wilkinson – Patient and Family Advisory Council
- Diane Wilkinson – WRHN Redevelopment Committee

5. **Notice of 2025-26 Board meetings and the Annual Meeting of the Corporation**
Meeting dates and Annual Meeting dates were circulated for review.

The following motion was duly made, seconded and **CARRIED** with no members opposed:

MOTION: That, the CMH Board of Directors approves the following proposed meeting dates for the 2026/27 Board cycle;

- Wednesday, October 7, 2026
- Wednesday, November 4, 2026
- Wednesday, December 2, 2026
- Wednesday, February 3, 2027
- Wednesday, March 3, 2027
- Wednesday, May 5, 2027
- Wednesday, June 2, 2027
- Wednesday, June 23, 2027

The Annual meeting will take place on Wednesday, June 23, 2027.

All meetings take place on the 1st Wednesday of each month following with one exception. Meetings will start at 5:00 pm and will be held in either hybrid or virtual format.

6. **ABCDE Goals Review for 2025/26 and Planning for 2026/27**
The Chair reminded Directors to update their 2025/26 ABCDE Goals and to begin considering goals for 2026/27, as outlined in the briefing note pre-circulated with the meeting agenda package. Directors were advised that a sign-up sheet is available to schedule one-to-one meetings with the Board Chair to review the past year's accomplishments and establish goals for the year ahead.

5. **DATE OF NEXT MEETING**
The next scheduled Board meeting is October 7, 2026.

6. **TERMINATION**
MOTION: That, the meeting terminated at 2011h.
None opposed, **CARRIED**.

-
- 6. DISCUSSION OF INDEPENDENT DIRECTORS AND MANAGEMENT
 - 7. DISCUSSION OF INDEPENDENT DIRECTORS
-

DRAFT



2026/27 Board of Directors Action Log

Meeting Date	Agenda # / Item Description	Action Item	Owner	Status
No Open Action Items				



Board of Directors Attendance Report 2025/2026

Consent Agenda Item 1.5.3

	75%	100%	100%	100%	75%	63%	100%	100%	100%	88%	100%	100%
Meeting Dates	Lynn Woeller	Bill Conway	Diane Wilkinson	Jayne Herring	Julia Goyal	Margaret McKinnon	Miles Lauzon	Paulo Brasil	Sara Alvarado	Tom Barker	Stephanie Kessler	Abdul-Qayum Ali
01-Oct-25	P	P	P	P	P	P	P	P	P	P	NA	NA
05-Nov-25	R	P	P	P	R	P	P	P	P	P	NA	NA
03-Dec-25	P	P	P	P	P	R	P	P	P	P	NA	NA
04-Feb-26	P	P	P	P	P	P	P	P	P	P	NA	NA
04-Mar-26	P	P	P	P	P	R	P	P	P	P	NA	NA
06-May-26	P	P	P	P	R	P	P	P	P	R	NA	NA
03-Jun-26	P	P	P	P	P	P	P	P	P	P	NA	NA
12-Aug-26	R	P	P	P	P	R	P	P	P	P	P	P

Cambridge Memorial Hospital Board of Directors - 2026-27 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors is responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
07-Oct-26	4a Corporate Culture					
	i	setting the tone for a culture throughout the Corporation that is consistent with the mission, vision and values and supports the Corporation's strategy	1-A-05		➤ share, measure and improve culture by setting ABCDE goals a) Attend – attend Board/committee meetings b) Be engaged – be an active contributor to the committee and Board work c) Connect – attend staff huddles, events d) Donate – support the CMH Foundation e) Educate – undertake education, courses	Due
	4b Strategic Planning					
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality / Resources	➤ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	Due
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➤ review critical incident reports (as per the Excellent Care for all Act)	Due
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➤ receive and review the Quality Monitoring Metrics ➤ receive and review the Strategic Priorities Tracker	Due
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➤ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	Due
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➤ make the final appointment, reappointment, and privilege decisions ➤ ensure the effectiveness and fairness of the credentialing process	Due
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➤ receive the MAC Report to the Board of Directors	Due
	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➤ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	Due
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➤ review and approve Board policies as recommended by Governance and Nominating Committee	Due
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➤ review upcoming events ➤ reported through Directors ABCDE Goals ➤ receive CMH Board Giving Activity	Due
4a Corporate Culture						

Cambridge Memorial Hospital Board of Directors - 2026-27 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors is responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
02-Dec-26	ii	overseeing the establishment and monitoring of such a culture through appropriate mechanisms, including assessing the Chief Executive Officer, and Chief of Staff of the Corporation against this expectation	2-B-25 2-B-26	Executive	➤ receive and review the mid-year CEO and COS report and provide input	
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality Audit / Quality / Resources	➤ review critical incident reports (as per the Excellent Care for all Act) ➤ receive mid-year IRM report	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➤ receive and review the Quality Monitoring Metrics	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➤ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements ➤ receive and approve Certificate of Compliance – Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding (semi-annual)	
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➤ make the final appointment, reappointment, and privilege decisions ➤ ensure the effectiveness and fairness of the credentialing process	
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➤ receive the MAC Report to the Board of Directors	
	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➤ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➤ review and approve Board policies as recommended by Governance and Nominating Committee	
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➤ review upcoming events ➤ reported through Directors ABCDE Goals ➤ receive CMH Board Giving Activity	
	4l Programs Required under the <i>Public Hospitals Act</i>					
	ii	ensure that policies are in place to encourage and facilitate organ procurement and donation		Quality	➤ receive the annual Trillium Gift of Life Update	
	iii	ensure that the Chief Executive Officer, Chief of Staff, nursing management, Medical/Professional Staff, and employees of the Hospital develop plans to deal with emergency situations and the failure to provide services in the Hospital		Quality	➤ receive the annual Emergency Preparedness update	

Cambridge Memorial Hospital Board of Directors - 2026-27 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors is responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
03-Feb-27 (Organizational Priorities Update & Education Session)	4n Director Recruitment, Orientation, and Evaluation					
		The Board shall ensure there is an appropriate, objective, and formal process for the recruitment of Directors, and the evaluation of the Board, the Board Chair, its committees, committee Chairs and individual Directors.	2-D-20		➤ approve the members of the Nominating Sub-Committee & Interview Team	
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➤ review critical incident reports (as per the Excellent Care for all Act)	
03-Mar-27	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➤ make the final appointment, reappointment, and privilege decisions ➤ ensure the effectiveness and fairness of the credentialing process	
	4i Board Effectiveness					
	4b Strategic Planning					
	iv	ensuring that key corporate priorities are formulated that help the Corporation accomplish its mission and actualize its vision in accordance with the strategic plan. The corporate priorities shall be reflective of the Board's primary accountability to the Ministry of Health ("MOH") and Ontario Health and any applicable accountability agreements with the MOH or Ontario Health		Quality Resources	➤ review and approve Annual Quality Improvement Plan (QIP) ➤ review and approve Hospital Service Accountability Agreement (HSAA) ➤ review and approve Multi-Sector Service Accountability Agreement (MSAA) ➤ review and approve Community Accountability Planning Submission (CAPS) ➤ review and approve Hospital Accountability Planning Submission (HAPS)	
	v	approving operating and capital plans	2-C-31	Resources	➤ review and approve the annual Operating Plan ➤ review and approve the Annual Capital Plan	
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➤ review critical incident reports (as per the Excellent Care for all Act)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➤ receive and review the Quality Monitoring Metrics	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➤ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	
	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➤ make the final appointment, reappointment, and privilege decisions ➤ ensure the effectiveness and fairness of the credentialing process	
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➤ receive the MAC Report to the Board of Directors	

Cambridge Memorial Hospital Board of Directors - 2026-27 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors is responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
05 Mar 27	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➤ receive monthly reports/updates from: CND OHT ➤ CMH Foundation ➤ CMH Volunteer Association ➤ CMH Patient & Family Advisory Council ➤ Others as needed	
	4h Financial Viability					
	i	establish key financial objectives that support the Corporation's financial needs		Resources / Quality	➤ review and approve Annual Operating & Capital Plans - service changes, operating plan, capital plan, salary increases, material amendments to benefit plans, programs and policies	
	4i Board Effectiveness					
	i	monitor Board members' adherence to corporate governance principles and guidelines		Governance	➤ Declaration of Conflict Agreement signed by Directors ➤ Directors' Consent to Act ➤ Governance and Nominating Committee Report to the Board of Directors	
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➤ review and approve Board policies as recommended by Governance and Nominating Committee	
	4k Fundraising					
		The Board supports fundraising initiatives of the Foundation	2-A-30		➤ review upcoming events ➤ reported through Directors ABCDE Goals ➤ receive CMH Board Giving Activity	
	4c Corporate Performance					
	i	identify principal risks to the Corporation in line with the Board's Integrated Risk Management policy	2-C-20	Audit Quality Resources	➤ review and approve the IRM process undertaken by management to identify and develop the in-year IRM risks and associated mitigation strategies	
	ii	monitor, mitigate and respond to the principal risks		Quality	➤ review critical incident reports (as per the Excellent Care for all Act)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➤ receive and review the Quality Monitoring Metrics ➤ receive and review the Strategic Priorities Tracker	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➤ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	
	4e Succession Planning					
	i	provide for a Chief Executive Officer succession plan and process	2-B-10	Executive	➤ receive confirmation that succession plans are in place through the Executive Committee Report to the Board of Directors	
	ii	provide for a Chief of Staff succession plan and process	2-B-12	Executive	➤ receive confirmation that succession plans are in place through the Executive Committee Report to the Board of Directors	
	iii	ensure that the Chief Executive Officer and Chief of Staff establish an appropriate succession plan for both executive management and Medical/Professional Staff leadership	2-B-10 2-B-12	Executive	➤ receive confirmation that succession plans are in place through the Executive Committee Report to the Board of Directors	

Cambridge Memorial Hospital Board of Directors - 2026-27 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors is responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
05-May-27	4f Oversight of Medical/Professional Staff					
	i	credential Medical/Professional Staff	1-C-13	MAC	➤ make the final appointment, reappointment, and privilege decisions ➤ ensure the effectiveness and fairness of the credentialing process	
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➤ receive the MAC Report to the Board of Directors	
	4g Relationships					
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Medical Association			➤ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	
	4i Board Effectiveness					
	iv	periodically review and revise governance policies, processes, and structures as appropriate		Governance	➤ review and approve Board policies as recommended by Governance Committee	
	4k Fundraising					
02-Jun-27 (Organizational Priorities Update & Education Session)		The Board supports fundraising initiatives of the Foundation	2-A-30		➤ review upcoming events ➤ reported through Directors ABCDE Goals ➤ receive CMH Board Giving Activity	
	4n Director Recruitment, Orientation, and Evaluation					
		The Board shall ensure there is an appropriate, objective, and formal process for the recruitment of Directors, and the evaluation of the Board, the Board Chair, its committees, committee Chairs and individual Directors.	2-D-20		➤ review recommendations for new Directors, non-Director committee members	
	4a Corporate Culture					
	ii	overseeing the establishment and monitoring of such a culture through appropriate mechanisms, including assessing the Chief Executive Officer, and Chief of Staff of the Corporation against this expectation	2-B-25 2-B-26	Executive	➤ receive and review the annual CEO and COS survey results & self-appraisal and provide input (Meeting of Independent Directors)	
	4c Corporate Performance					
	ii	monitor, mitigate and respond to the principal risks		Quality	➤ review critical incident reports (as per the Excellent Care for all Act)	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources Audit	➤ receive and approve Declaration of Compliance with MSAA Schedule F ➤ receive and approve Declaration of Compliance with BPSAA Schedule A ➤ receive and approve Certificate of Compliance – Semi-Annual Distribution of Psychiatric Sessional and Stipend Funding (semi-annual) ➤ receive the legislative compliance review ➤ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	

Cambridge Memorial Hospital Board of Directors - 2026-27 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors is responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
23-Jun-27		4f Oversight of Medical/Professional Staff				
	i	credential Medical/Professional Staff	1-C-13	MAC	➤ make the final appointment, reappointment, and privilege decisions ➤ ensure the effectiveness and fairness of the credentialing process	
		4h Financial Viability				
	ii	ensure that the organization undertakes the necessary financial planning activities so that resources are allocated effectively and within the parameters of the financial performance indicators		Resources	➤ receive updates on how the budget is being developed through the Resources Committee Report to the Board of Directors ➤ receive and approve the year-end financial statements	
		4b Strategic Planning				
	ii	measuring and monitoring the implementation and achievement of the Corporation's strategic plans and performance targets	2-C-50	Quality Resources	➤ progress report on Strategic Plan - received quarterly through Strategic Priorities tracker	
		4c Corporate Performance				
	ii	monitor, mitigate and respond to the principal risks		Quality	➤ review critical incident reports (as per the Excellent Care for all Act)	
	v	ensure processes are in place to monitor and continuously improve upon the performance targets	2-C-50	Quality	➤ receive and review the Quality Monitoring Metrics ➤ receive and review the Strategic Priorities Tracker	
	vi	regularly review the functioning of the Corporation in relation to the objects of the Corporation as stated in the Letters Patent, the By-Laws, legislation, and any applicable accountability agreements with the MOH or Ontario Health	1-C-02 1-C-20	Resources	➤ receive and approve the CEO Certificate of Compliance regarding the obligation for payments of salaries, wages, benefits, statutory declarations and financial statements	
		4f Oversight of Medical/Professional Staff				
	i	credential Medical/Professional Staff	1-C-13	MAC	➤ make the final appointment, reappointment, and privilege decisions ➤ ensure the effectiveness and fairness of the credentialing process	
	iii	provide oversight of the Medical/Professional Staff through and with the Medical Advisory Committee and Chief of Staff		MAC	➤ receive the MAC Report to the Board of Directors	
		4g Relationships				
		The Board shall build and maintain good relationships with the Corporation's key stakeholders including, without limitation, MOH, Ontario Health, Cambridge North Dumfries Ontario Health Team (CND OHT), community leaders, patients, employees, families, caregivers, other health service providers and other key stakeholders, donors, Cambridge Memorial Hospital Foundation ("CMH Foundation") and the Cambridge Memorial Hospital Volunteers Association			➤ receive monthly reports/updates from: CND OHT CMH Foundation CMH Volunteer Association CMH Patient & Family Advisory Council Others as needed	
		4i Board Effectiveness				
	iii	ensure ethical behaviour and compliance with laws and regulations, audit and accounting principles, accreditation requirements and the By-Laws		Audit	➤ receive and review the annual Audit Findings Report ➤ review and approve the year-end financial statements	
		4k Fundraising				
		The Board supports fundraising initiatives of the Foundation	2-A-30		➤ review upcoming events ➤ reported through Directors ABCDE Goals ➤ receive CMH Board Giving Activity	

Cambridge Memorial Hospital Board of Directors - 2026-27 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors is responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
As Needed	4l Programs Required under the Public Hospitals Act					
	i	(i) Ensure that an occupational health and safety program and a health surveillance program are established and regularly reviewed			➤ reported through annual attestations	
	4n Director Recruitment, Orientation, and Evaluation					
		The Board shall ensure there is an appropriate, objective, and formal process for the recruitment of Directors, and the evaluation of the Board, the Board Chair, its committees, committee Chairs and individual Directors.	2-D-20		➤ conduct the election of officers ➤ review Board annual survey results ➤ review the results of the annual evaluation surveys through the Governance and Nominating Committee Report to the Board of Directors	
	4a Corporate Culture					
	iii	overseeing policies in respect of the Corporation's code of conduct	1-A-04		➤ review the organization's code of conduct policy every three years (last approved May 9, 2024)	
	4b Strategic Planning					
	i	ensuring that a strategic planning process is undertaken with Board, employees and Medical/Professional Staff involvement and approved by the Board from time to time			➤ Strategic Plan: approve process, participate in development, approve plan - (last completed in 2022, will begin in fall 2027 - timetable approved by CMH Board on June 3, 2026)	
	iii	contributing to the development of and approving the mission, vision, values, and strategic plan of the Corporation				
	4d Chief Executive Officer and Chief of Staff					
	i	select the Chief Executive Officer in accordance with the relevant Board policies	2-B-15	Executive	➤ recruit, select, and hire an individual with the requisite skills, abilities, and competencies to effectively perform the role of President and Chief Executive Officer (CEO) of the organization	
	ii	delegate responsibility for the management of the Corporation to the Chief Executive Officer and require accountability to the Board	2-B-05	Executive		
	iii	establish a Board policy for the performance evaluation and compensation of the Chief Executive Officer & Chief of Staff	2-B-20 2-B-25	Executive / Governance	➤ review and approve the Board's policies 2-B-20 CMH Executive Compensation Policy (last approved Dec 3, 2025) 2-B-25 CEO Performance Review Policy (last approved Dec 3, 2025)	
	iv	select the Chief of Staff in accordance with the relevant Board policies	2-B-16	Executive	➤ recruit, select, and hire an individual with the requisite skills, abilities, and competencies to effectively perform the role of Chief of Staff (COS) of the organization	
	v	delegate responsibility for the management of the Corporation to the Chief of Staff and require accountability to the Board	2-B-06	Executive		
	4j Effective Communication and Community Relationships					
	i	establish processes for community engagement to receive public input on material issues	1-A-05 2-D-09		➤ Post meeting agenda packages and minutes publicly on the CMH website ➤ review and approve Board policy 2-D-09 (last approved June 3, 2026)	

Cambridge Memorial Hospital Board of Directors - 2026-27 Annual Work Plan

Meeting Date	Ref. #	Board of Directors Terms of Reference The Board of Directors is responsible for:	Relevant Policy	Relevant Committee	Action Arising	Work Planned / Completed
	ii	promote effective collaboration and engagement between the Corporation and its community, particularly as it relates to organizational planning, mission, and vision			➤ Strategic Plan	
	4m Communications Policy					
		The Board shall establish a communications policy for the Corporation and oversee the maintenance of effective relations with stakeholders (e.g. MOH, Ontario Health, CND OHT, other health service providers, clients, patients, employees, volunteers, Medical/Professional Staff, CMH Foundation, CMH Volunteer Association, federal, provincial, regional and city politicians) through the Corporation's communications policy and programs	2-D-11	Governance	➤ review and approve Board policy 2-D-11 every three years (last approved April 22, 2022 - deferred update to align with amendments made to the corporate policy)	
	General					
		On behalf of the Board, the Governance Committee shall review and assess the adequacy of the Board terms of reference at least every 3 years and submit proposed changes to the Board for consideration		Governance	➤ review and approve the Board of Directors Terms of Reference (last approved June 28, 2023)	

DELAYED

Date	ref #	Item	Rationale	

2026–27 BOARD MEETING & EVENTS CALENDAR

Annual schedule of board meetings, committees, events, and education sessions

Board/Committee Meetings and Event Dates	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep (2027)
Board of Directors Regular Meetings 5:00pm - 8:00pm		7		2			3		5	23			
Board Organization Priorities Update & Education Session													
Emergency Preparedness						3							
Overtime & Sick Time: A Deeper Dive (Education)										2			
Board Committee Meetings													
Audit Committee 5:00pm - 7:00pm			16		18			26	25				
Digital Health Strategy Committee 5:00pm - 7:00pm	17		19			18		15	20	17			
Executive Committee 5:00pm - 7:00pm			17				16		18				
Governance and Nominating Committee 5:00pm - 7:30pm		15	12	10		11		8	13				
Quality Committee 7:00 am - 9:00am	16	21	18		20	17		15	20	17			
Quality Committee QIP Meeting 7:00 am - 9:00am						4		21	19				
Quality Committee Joins Resources - Budget Review 5:00pm - 6:00pm						22							
Resources Committee 5:00pm - 7:00pm	28		23			22		26	25	21			
Medical Advisory Committee (MAC) 4:30pm - 7:00pm	9	14	2	9	13	10	10	14	12	9			
CMHVA Board Meetings 9:30am - 11:15am - In Person / Hybrid	3	1	5 20 AGM	3	7	4	4	1	6	3 18 AGM			
CMHF Board Meetings 4:30pm - 6:30 - In Person / Hybrid		6	24			2	30			1 22 AGM			

Board/Committee Meetings and Event Dates	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep (2027)
Patient Family Advisory Council (PFAC)	8	6	3	1	5	2	2		4	1			
<i>5:00pm - 7:00pm In Person / Hybrid</i>													
2026-27 Events													
Staff Holiday Lunch 11:00am-2:00pm & 9:00pm-10:00pm				3									
Cambridge & North Dumfries Community Awards - Hamilton Family Theatre 5:00pm - 7:00pm			23										
Cambridge City Council Workshop - Meeting with City Council and CMH Board of Directors - TBD													
CMH Celebration of Champions, Hamilton Family Theatre - 4:30pm - 7:30pm			2										
CMH Staff BBQ - June 10 (11:00am-2:00pm / 9:00-10:00pm)										10			
Career Achievement June 10 (11:00am-2:00pm / 9:00-10:00pm)										10			
CMH Thank You Week - October 28 - Details to Follow - Board Led Event		28											
CMH Celebrate the Values - TBD						TBD							
CMH Golf Classic - TBD										TBD			
CMHF Reveal 2027						26							
Board Social - TBD								TBD					
Board Education Opportunities													
Governors Education Sessions													
Governance Essentials Program for New Directors (OHA)													
7:00am-9:00am Virtual													
<i>Hospital Legal Framework</i>		8											
<i>Hospital Accountability Within the Health System</i>		13											
<i>Hospital Funding and Accountability</i>		22											
<i>Governance and Management Partnership</i>		29											
<i>Current Issues and Emerging Themes: Bringing It All Together</i>			5										



BRIEFING NOTE

Date: September 18, 2026
Issue: Digital Health Strategy Committee Report to Board of Directors – September 17, 2026 – OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kristen Hoch – Administrative Assistant
Approved by: Mari Iromoto – VP, People & Strategy

Attachments/Related Documents: None

A meeting of the Digital Health Strategy Committee took place on Thursday, September 17, 2026, at 1700h.

- Present: S. Alvarado (Chair), J. Campbell, M. Darr, P. Martinello, R. Neidert, G. Ringwood, S. Sarrazin, L. Woeller
- Regrets: T. Barker, T.Clark
- Staff: J. Backler, P. Gaskin, M. Iromoto, Dr. W. Lee (ex-officio), K. Leslie, S. Pearsall
- Guests: D. Crawford, M. Kazar, Dr. K. Rhee, J. Short

The Digital Health Strategy Committee completed its scheduled work for the September 17, 2026 reporting period. Key matters reviewed, discussed, and advanced by the committee are summarized below for Board awareness.

Committee Matters – For information only

1. **Digital Health Strategy Committee Work Plan 2026-27:** As aligned with the terms of reference, the committee approved the 2026-27 work plan.



BRIEFING NOTE

Date: September 9, 2026
Issue: MAC Report to the Board of Directors – September 2026 OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Dr. Winnie Lee, Chief of Staff
Approved by: Dr. Winnie Lee, Chief of Staff

Attachments/Related Documents: None

A meeting of the Medical Advisory Committee took place on Wednesday September 9, 2026, at 1700h.	
Present:	Dr. W. Lee, Dr. J. Legassie, Dr. A. Sharma, Dr. B. Courteau, Dr. A. Nguyen, Dr. T. Holling, Dr. L. Green, Dr. A. Mendlowitz, C. Witteveen, Dr. I. Isupov, Dr. A. Unger, Dr. E. Thompson, Dr. J. Bourgeois, Dr. Yu Ming Wang, Dr. M. Hindle,
Regrets:	Dr. M. Rajguru, Dr. J. Gill, Dr. D. Kolev, Dr. V. Miropolsky, Dr. M. Patel
Staff:	P. Gaskin, S. Pearsall, M. Iromoto, Dr. K. Rhee, Dr. R. Taseen, J. Backler, J. Visocchi
Guests:	B. Conway

This briefing note highlights the key updates in patient safety, medical quality, and organizational excellence from the Medical Advisory Committee (MAC) meeting held on September 9, 2026.

Committee Matters – For information only

- Emergency Department Leadership Transition:** MAC welcomed Dr. Andrea Unger as the new Chief of the Emergency Department. Dr. Unger brings 25 years of emergency medicine experience, including administrative leadership at Brantford General Hospital, and first-hand experience at other community hospitals, including Joseph Brant Hospital and Trillium Health Partners, where she worked in an ED department, seeing approximately 350 visits per day. To support continuity through the transition, there will be a team-based ED leadership model in which Dr. Jas Gill, the outgoing Chief, and Dr. Dimitar Kolev will serve as co-deputies for the next six months.
- Digital Transformation & Project Quantum:** The transition to the Oracle/Cerner Health Information System is a fundamental redesign of CMH’s clinical safety architecture. Crucially, this transformation is being executed in regional alignment with our partner, WRHN (Waterloo Regional Health Network). This partnership encourages local and regional standardization but relies on strong governance to manage approvals for clinical modifications at both sites.

A key shift in clinical practice at CMH is the implementation of Computerized Provider Order Entry (CPOE), which mandates a transition away from verbal and telephone orders typical of paper-based system. While legacy workflows relied on implicit trust and verbal communication, the new digital standard requires physician-led entry to

eliminate transcription errors at the source. MAC reviewed and endorsed a guiding principle document on verbal and telephone orders to guide forthcoming policy jointly developed by CMH and WHRN.

Led by the Pharmacy Informatics and Pharmacy and Therapeutics (M&T) committee completed an extensive and comprehensive evaluation of "Power Plans" (standardized order sets) against CMH's clinical context and WHRN's current Power Plans. Power Plans were categorized and addressed by category, ensuring safety of the CMH Power Plans in the new HIS. These categories of Power Plans included those that were:

1. *Adopted as is*: Utilizing standardized regional Best Practice templates.
2. *Minor modifications*: Localized adjustments for CMH-specific resources
3. *Hidden/Inactive*: Disabling procedures not performed at CMH to reduce digital "noise" and prevent selection errors.

This digital transformation requires a robust suite of Power Plans to authorize nursing and allied health activities under the directive of physicians within the new HIS system. Additional changes were also advanced as a result of this work, including establishing continuous 24/7 clinical validation; mandatory nurse witnessing for physician-administered medications, such as topical cocaine in the Emergency Department; enforcing closed-loop management on the electronic Medication Administration Record (eMAR); automated stop dates to orders entered outside standard Power Plans, reducing order clutter and aligning medication durations with regulatory safety standards. Together these changes move bedside practice from paper-based workflows toward electronically documented, auditable verification – a prerequisite for safe digital ordering.

3. **Medical Directive Comprehensive Update**: To support the November go-live, MAC approved revisions to a substantial number of medical directives. This update follows a recent 2026-2027 reappointment cycle. This work is critical to ensure clinical protocols remain valid within the integrated digital environment of the new Oracle/Cerner HIS. Because these directives define the practice authority for nurses/allied health to act on protocols under a physician's directive, department Chiefs and the Medical Affairs office are leading the work to ensure 100% compliance by the Cerner/Oracle go-live date. While many changes are related to documentation in the new HIS, several key medical directives have also been updated to reflect current best practices/guidelines.
4. **Chief's Compass – Medical Quality Oversight**: As we move into a data-rich environment, the strategic challenge for medical leadership is avoiding "metric fatigue" and focusing on surfaced intelligence. The Chief of Staff has introduced the "**Chief's Compass**" dashboard to provide this high-level visibility, which the "Chief's Compass" focuses on four critical areas of accountability by the MAC:
 1. **Quality Metrics**: Distilling the data into the most relevant clinical indicators, including quality of care review themes.
 2. **Operational Health**: Monitoring health human resource gaps and incomplete charts, which will become even more prevalent in the new HIS.
 3. **Credentialing/Privileging**: Reappointment/credentialing tracking
 4. **Professional Development**: Ensuring compliance with E-learning, Grand Rounds, and QI projects.



BRIEFING NOTE

Date: September 30, 2026
Issue: Resources Committee Report to Board of Directors October 7, 2026 – Open
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Bonnie Collins, Administrative Assistant
Approved by: Trevor Clark, VP Finance & Corporate Services, CFO

Attachments/Related Documents: None

A meeting of the Resources Committee took place on Monday, September 28, 2026 at 1700h.	
Present:	P. Brasil (Chair), A. Ali, S. Alvarado, B. Conway, A. Forrest, J. Richter
Regrets:	S. Maier
Staff:	T. Clark, M. D’Souza, A. Foster, P. Gaskin, S. Ogston, Dr. K. Rhee, J. Short
Guests:	None

The Resources Committee completed its scheduled work for the September 28, 2026 reporting period in accordance with its terms of reference and workplan. Key matters reviewed, discussed, and advanced by the committee are summarized below for Board awareness.

Committee Matters – For information only

- Financial Statements – August 2026:** The Committee reviewed and discussed the August 2026 financial statements, reflecting a \$79K surplus (YTD results \$1M negative to budget), unrestricted working capital at \$23.6M and a working capital ratio of 1.35. The Committee inquired whether government funding could be reduced because CMH is performing better than other hospitals. Management identified the more immediate risk of government scrutiny of efficiency rather than removal of funding solely due to a surplus. CMH’s Finance department is shifting from transactional reporting to business partnership, with analysts helping leaders understand and manage budgets. Leaders will be expected to identify pressures earlier, establish realistic future budgets, and reduce reliance on contingency to cover operating results. *(Further information will be discussed during agenda item 4.2.1)*



BRIEFING NOTE

Date: September 18, 2026
Issue: Strategic Priorities Tracker Update Q1
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Kyle Leslie – Director, Analytics and Innovation & CIO
Approved by: Mari Iromoto – VP, People & Strategy; Executive Sponsor, Project Quantum – Health Information System

Attachments/Related Documents: Strategic Priorities Tracker Q1

Alignment with 2026/27 CMH Priorities:

2022-2027 Strategic Plan No ☐	2026/27 CMH Priorities No ☐	2026/27 Integrated Risk Management Priorities No ☐
☒ Elevate Partnerships in Care	☒ Improve Patient Flow (CBD, PIA, ED Admits)	☒ Organizational Flow
☒ Reimagine Community Health	☒ Prepare for Digital Health Transformation	☒ Project Quantum
☒ Increase Joy in Work	☒ Increase Staff Engagement Through Improved Staffing (Med, ICU, ED, Physicians)	☒ Management/Medical Staff Partnership
☒ Sustain Financial Health	☒ Achieve a Balanced 2026/27 Operating Position	☒ Financial Sustainability
☒ Advance Health Equity	☒ Embrace Diversity, Build a Culture of Inclusion	☒ Change Management

Alignment with 2026/27 CMH Corporate Plans: Quality and Safety Plan

Executive Summary

This briefing note provides the Quarter 1 (Q1) update on CMH's 2026/27 strategic priorities. The refreshed tracker introduces a focused set of measures tied to patient flow, workforce stability, Project Quantum readiness, fiscal sustainability, health equity and emerging priorities such as Master Planning and Strategic Partnerships.

Q1 progress demonstrates substantive advancement in patient flow stabilization, discharge management, workforce actions, HIS readiness, equity initiatives, and foundational planning for patient flow improvements and leadership stabilization.

Performance pressures remain concentrated in Emergency Department access, Medicine conservable bed days, HIS readiness confidence, and the overall Project Quantum risk score.

Management action plans for Q2 focus on stabilizing ED staffing and front-end flow, strengthening Medicine discharge practices, sustaining overtime control, advancing physician recruitment, executing HIS training and cutover readiness, maintaining balanced-budget delivery, and progressing the DEI, Truth and Reconciliation, Master Planning and WRHN partnership work plans.

Background

The Strategic Priorities Tracker aligns annual organizational objectives with CMH's 2022-2027 Strategic Plan, Quality Improvement Plan, Integrated Risk Management priorities, and aligned corporate plans. For 2026/27, the tracker has been

refreshed to reflect five strategic pillars and two emerging priorities: Master Planning and Strategic Partnerships.

The tracker combines quarterly performance results with actions taken, upcoming-quarter plans, and identified risks and mitigations. This creates a reporting structure for Board and management oversight.

Analysis
Q1 Corporate Performance Measures

Elevate Partnerships in Care (Quality Committee)
Overall status: Mixed, with CTAS 1 meeting target and material pressure in all-CTAS PIA and conservable bed days. For conservable bed days, please note that this indicator is using the target set for Cambridge Memorial Hospital by Ontario Health for this fiscal year. This metric reflects the total patient days over and above benchmark length of stay.

- Q1 Achievements**
- Recruited and onboarded a new Director, Emergency Department & Patient Flow; recruited a new Emergency Department Chief with a September 2026 start; completed an ED current-state assessment; established a Four-Lever ED Transformation Framework; initiated staffing, resource allocation, and front-end flow reviews.
 - Medicine completed electronic discharge-board education and the first PDSA cycle, established physician-supported discharge rounds and daily charge-nurse flow meetings, and implemented the electronic board with full physician attendance before mandatory use.

- Q2 Action Plan**
- Implement the ED RN master schedule; complete a demand- and acuity-informed staffing review; redesign rapid assessment zone (RAZ) and front-end streaming; strengthen Chief-Director dyad ownership; implement the Corporate Surge Policy; extend the discharge board to Medicine B3; provide the Welcome to Medicine brochure at admission; and translate estimated discharge dates to patient whiteboards.

- Key Risks and Mitigations**
- Risk: Sustained ED demand, inpatient access block, and workforce pressure may limit near-term PIA improvement. Mitigation: Stabilize staffing, optimize resources, redesign front-end flow, and use corporate surge escalation.
 - Risk: Late discharges and front-line resistance may slow discharge improvement. Mitigation: Use physician-supported discharge boards and targeted coaching, drop-ins, and user guides.

Reimagine Community Health (Digital Health Strategy Committee)
Overall status: At heightened delivery risk, with the Project Quantum risk score above target as the organization approaches go-live.

- Q1 Achievements**
- Advanced Oracle build, workflow design, and validation; operationalized cross-partner governance and risk forums; initiated cutover, data migration and EMPI planning; progressed interfaces, device connectivity, cybersecurity, and infrastructure readiness; and developed end-user training, super-user and change-readiness plans.

- Q2 Action Plan**
- Complete Integration Testing #2 and critical defect resolution; deliver end-user and super-user training; finalize cutover, service-slowdown, staffing and command-

centre support plans; complete remaining PowerPlan, device, interface, production, cybersecurity, data migration and reporting readiness work; and support 90-day and 60-day readiness and go/no-go decisions.

Key Risks and Mitigations

- Risk: Clinical build, PowerPlan, ambulatory workflow and SME constraints may compress timelines. Mitigation: Risk-based prioritization added resources, and escalation through clinical governance.
- Risk: Lab/Blood Bank, OLIS, OCINet, LMDI, BMDI and nurse-mobility dependencies may affect testing. Mitigation: Dedicated working groups, vendor escalation, and weekly milestone tracking.
- Risk: Wireless remediation, real-time reporting, and specialized informatics resourcing remain critical dependencies. Mitigation: Complete network upgrades, secure Oracle development/backend access, obtain third-party coverage and protect SME time.
- Risk: Interdependent workstreams create cumulative schedule pressure on November 8, 2026 go-live. Mitigation: Enhanced executive oversight, readiness assessments, critical-path monitoring, and formal go/no-go governance.

Increase Joy in Work (Resources Committee)

Overall status: Mixed, with quarterly overtime near target but continued recruitment, retention, and readiness pressures. Note overtime target and actuals have been adjusted to reflect complete pay periods within the Quarter for greater accuracy.

Q1 Achievements

- Deployed Nursing Resource Team (NRT) capacity to no-bed-admit and sick-call coverage; established an ICU overtime working group; expanded Medicine cross-coverage; introduced daily review of one-to-one staffing; increased RN and RPN recruitment targets; assessed ED staffing and initiated the new RN master schedule and resource-allocation review.
- Medical Affairs revalidated the vacancy baseline, recruited the ED Chief and Medical Director, added courtesy paediatricians, planned Medical Director roles, and developed EMPP simulation.
- HIS change work established targeted physician and unit strategies, monthly pulse surveys, Change and Wellness Champion engagement, and phased awareness and personal-impact campaigns.

Q2 Action Plan

- Establish flexible ICU lines; standardize one-to-one criteria; continue NRT/overtime reviews; automate NRT PSW assignment; implement the ED RN master schedule; complete current recruitment; advance shortlisted physician candidates and academic relationships; execute physician and unit readiness strategies; continue monthly pulse surveys; and launch countdown-to-go-live communications.

Key Risks and Mitigations

- Risk: NRT recruitment and retention may limit sustainable overtime reduction. Mitigation: Standardize deployment and preserve start-of-shift flexibility.
- Risk: Sick calls, vacancies, and implementation pressures may continue to drive overtime. Mitigation: Improve baseline schedules, complete recruitment, optimize skill mix, and monitor trends.
- Risk: A competitive physician market may impede recruitment and retention. Mitigation: Specialty-specific recruitment, targeted retention, and pipeline planning.

Sustain Financial Health (Resources Committee)

Overall status: Q1 actions support balanced-budget delivery; Q1 total budget variance was -\$1,088K.

Q1 Achievements

- Supported overtime taskforce and float-pool initiatives. MRI and HIS projects remained on track and on budget.

Q2 Action Plan

- Validate EY sustainability initiatives with Directors and initiate projects; establish the Transformation Management Office; and maintain MRI and HIS delivery on schedule and budget.

Key Risks and Mitigations

- Risk: Year-end forecasting may identify pressures extending into 2027/28. Mitigation: Complete the 2026/27 forecast and roll forward early enough to address pressures in the 2027/28 budget cycle.

Advance Health Equity

Overall status: On track, with both DEI and Truth & ReconciliACTION milestone measures reported at 100% for Q1.

Q1 Achievements

- DEI Launched Asian and Indigenous Employee Resource Groups; delivered Asian Heritage Month and Pride programming, including CMH's first Cambridge Pride booth; completed consultation on the DEI-AR Policy and Inclusive Communications Guide; and secured Diversity Council endorsement of the DEI Foundations Huddle Series.
- Truth & ReconciliACTION Delivered National Indigenous History Month programming; expanded Red Dress Day engagement; co-delivered the first Indigenous Advisory Council retreat with WRHN; activated the Crow Shield Lodge agreement; advanced the Smudging Policy, Territorial Acknowledgement and micro-education content; and launched the Indigenous Art Video Series.

Q2 Action Plan

- Complete the ERG pilot evaluation; refresh DEI Council governance and recruitment; launch the DEI-AR Policy, Inclusive Communications Guide and DEI Foundations Huddles; plan Islamic History Month and revise the Days of Significance framework.
- Advance Orange Shirt Day and National Day for Truth and Reconciliation activities; progress the HEC Cultural Safety Pathway application; finalize the Smudging Policy and resources; engage SOAHAC and Nursing Advisory Circle; begin MOU discussions; and re-scope Women & Children's education with alternative partners.

Key Risks and Mitigations

- Risk: HIS readiness may reduce staff and leadership capacity. Mitigation: Sequence work with Organizational Effectiveness, Culture & Transformation to avoid critical HIS periods.
- Risk: Staffing and partner changes may delay Orange Shirt Day, Smudging Policy, and Women & Children's education work. Mitigation: Use co-op support, adjust timelines and re-plan with the SOAHAC Indigenous Patient Navigator and Regional Indigenous Cancer Program.

Emerging Priorities (Board)

Overall status: Foundational work is underway for Master Planning and Strategic Partnerships.

Q1 Achievements

- Master Planning Engaged Agnew Peckham for Stage 1.2 Master Programming; established Decision Support collaboration for service-volume validation; drafted the architect RFP; and advanced Steering Committee membership.

- Strategic Partnerships Continued work with WRHN on the MSA and shared operating model for HIS oversight, joint planning, and sustainable support. Continued innovation partnerships with MACcelerate and Communitex to connect emerging health-technology companies with CMH clinicians and teams.

Q2 Action Plan

- Master Planning Launch the Steering Committee and governance structure; conduct visioning and clinical user-group sessions; and issue and award the architect RFP.
- Strategic Partnerships Support a safe Project Quantum go-live with WRHN; operationalize the joint operating model, support structures, escalation, and decision pathways; and transition toward post-go-live optimization, analytics, privacy, digital operations, and clinical optimization accountability.

Key Risks and Mitigations

- Risk: Master Plan engagement overlaps with HIS implementation. Mitigation: Prioritize director-level input and shorter, more frequent sessions around HIS commitments.
- Risk: Transition from project delivery to optimization may strain capacity. Mitigation: Align existing and future structures and begin the transition in September and October 2026.

Consultation

The Q1 update consolidates performance, action-plan and risk-mitigation commentary from Executive Sponsors and operational leads responsible for the 2026/27 Strategic Priorities Tracker. Monitoring and escalation continue through Directors' Council, Operations Huddles, project governance forums, and program-level Quality and Operations Councils.

Next Steps

- Continue quarterly reporting against 2026/27 measures, actions, risks, and mitigations.
- Execute Q2 action plans, with focused escalation of patient flow, workforce, and HIS critical-path risks.
- Daily HIS review of HIS action items and escalation as needed.
- Advance Master Planning governance and architect procurement while scheduling engagement around HIS commitments.
- Operationalize the WRHN-CMH shared operating model and prepare the transition from implementation to post-go-live optimization and sustainment.

Strategic Priorities 26/27
"Creating Healthier Communities, Together"

Aligned Corporate Plans

Metric		Target	Q1	Q2	Q3	Q4
 Elevate Partnerships in Care	90th Percentile All CTAS Triage to Provider Initial Assessment in the ED (hours) (QIP/IRM)	<4.5	8.2			
	90th Percentile CTAS 1 Triage to Provider Initial Assessment in the ED (hours) (QIP/IRM)	<0.5	0.4			
	Conservable Bed Days OH Methodology (Acute LOS-CIHI ELOS) (QIP/IRM)	<2450	3052.7			
	Adequate Discharge Information	>74.27	71.6			
 Increase Joy in Work	Over Time Hours Per Quarter (IRM)	Q1/Q3 Target:22,210 Q2/Q4 Target:25,911	22.7K			
	Fill targeted Core Medical Professional Staff Vacancies for 26/27 (IRM)	0	20			
	HIS Readiness: Leader, Staff, Physician Confidence Score (IRM)	>3.7	3.38			
 Reimagine Community Health	HIS Project Risk Score	<2.4	2.48			
 Sustain Financial Health	Total Hospital Budget Variance in Dollars (K)- 2026/27	0	-\$1,088K			
 Advance Health Equity	% On Track with DEI Action Plan	100	100			
	% On Track with Truth and ReconciliACTION Plan	100	100			

Clinical Services
Growth Plan

HR Plan

Digital Health Plan

Multi-year
Financial Plan

DEI Plan
Truth & ReconciliACTION
Plan



Executive Sponsor(s):
Dr. Winnie Lee, Stephanie Pearsall

Physician Liaison(s):
Dr. Kunuk Rhee

Director Lead(s):
Faisal Khan

Project Manager(s):
Jennifer Woo

In Year Measures of Success

90th%tile Provider Initial Assessment Hours

90th%tile Urgent (CTAS-1) Provider Initial Assessment Hours

Target

<4.5 hours

<0.5 hours

Q1

8.2

0.4

Q2

Q3

Q4

Trailing 12 Month Trend

Measure	Start	Mid	End
90th%tile Provider Initial Assessment Hours	7.43	7.43	7.53
90th%tile Urgent (CTAS-1) Provider Initial Assessment Hours	0.45	0.44	0.44

In Year Objectives	Actions / Taken	Next Quarter's Plan	Risks and Mitigations
90th %ile Triage to Provider Initial Assessment in Hours (All CTAS)	- Recruited new Director, Emergency Department & Patient Flow, with successful onboarding in June 2026. - Successfully recruited new Chief, Emergency Department, with September 2026 start date, establishing the Chief–Director leadership dyad. - Completed initial ED current-state assessment, including review of performance, patient flow, staffing, capacity and front-end processes. - Established a Four-Lever ED Transformation Framework and phased two-year roadmap to guide improvement. - Initiated staffing, resource allocation and front-end flow reviews to address key contributors to PIA performance.	- Implement the new RN master schedule to stabilize baseline staffing, skill mix and shift distribution. - Complete resource allocation review and develop a sustainable, demand- and acuity-informed staffing model. - Redesign RAZ/front-end flow, including patient streaming, zone utilization, workflows and role clarity. - Strengthen shared physician–nursing ownership of PIA and flow through the Chief–Director leadership dyad. - Implement the Corporate Surge Policy to establish proactive, organization-wide response and accountability for emerging capacity and flow pressures. - Advance priority ED transformation work and Project Quantum readiness, supported by operational performance - Engage staff and physicians throught the August 11 ED Transformation Town Hall and establish multidisciplinary working group to support implementation of priority front-end flow and operational redesign initiatives	Risk 1: Sustained ED demand, inpatient access block and workforce pressures may limit near-term PIA improvement. Mitigation 1: Stabilize staffing, optimize existing resources, redesign front-end flow and implement proactive corporate surge escalation and accountability. Risk : Project Quantum go-live may temporarily disrupt workflows and performance. Mitigation 2: Complete priority stabilization and redesign work before go-live, supported by workflow preparation, education and post-go-live monitoring.
90th %ile Triage to Provider Initial Assessment in Hours (CTAS 1)	- Established new ED operational leadership and successfully recruited the incoming ED Medical Chief and ED Director - Included CTAS 1 access and high-acuity care requirements within the broader ED current-state assessment. - Reviewed staffing, skill mix, capacity and operational processes supporting high-acuity/resuscitation care. - Identified role clarity, reliable high-acuity coverage and rapid physician access as priorities within ED redesign.	- Implement staffing and skill-mix changes to support reliable high-acuity/resuscitation coverage. - Clarify physician, nursing and flow responsibilities supporting immediate CTAS 1 assessment and care. - Monitor CTAS 1 PIA performance and case-level variation through the developing ED performance framework. - Incorporate high-acuity workflows into front-end redesign and Project Quantum readiness planning.	Risk 1: Low CTAS 1 volumes and individual case complexity may create significant variation in the 90th percentile measure. Mitigation 1: Monitor aggregate performance alongside case-level review to identify actionable delays and process opportunities. Risk 2: Competing ED demand and capacity pressures may affect timely access to high-acuity resources. Mitigation 2: Stabilize staffing and skill mix, maintain clear resuscitation coverage and incorporate high-acuity capacity into operational escalation processes.



Executive Sponsor(s):
Dr. Winnie Lee, Stephanie Pearsall

Physician Liaison(s):
Dr. Augustin Nguyen

Director Lead(s):
Andrea Brissette

Project Manager(s):
Jennifer Woo

In Year Measures of Success

Conservable Bed Days OH
Methodology (Acute LOS-
CIHI ELOS)

Adequate Discharge
Information

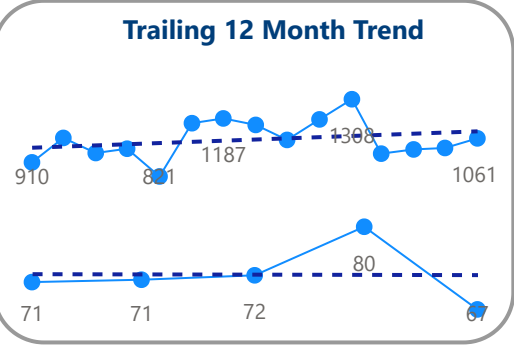
Target
<2450
74.27

Q1
3052.7
71.6

Q2

Q3

Q4



In Year Objectives

Conservable Bed Days Rate
Medicine (Conservable days / Acute
Days)

Actions / Taken

- Completed Electronic Patient Discharge Board education, training with PMO drop-in sessions.
- Implemented the electronic discharge board with 100% physician attendance before the mandatory start.
- Completed the first PDSA cycle of the new discharge model and identified role-clarity needs.
- Established physician-supported discharge rounds and daily Medicine charge-nurse flow meetings.
- Advanced patient transportation information and the "Welcome to Medicine" brochure.

Next Quarter's Plan

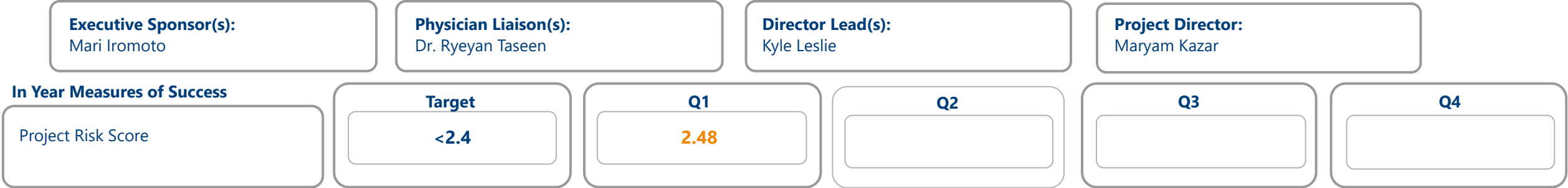
- Spread the electronic patient discharge board to Medicine B3 with three reviews per week.
- Provide the "Welcome to Medicine" brochure at admission to patients and families.
- Assign a responsible multidisciplinary team member at discharge rounds to update estimated discharge dates on patient whiteboards.

Risks and Mitigations

Risk 1: Discharges continue to occur late in the day.
Mitigation 1: Use the electronic discharge board with physician participation to drive earlier planning.
Risk 2: Front-line resistance may slow adoption of improved discharge practices.
Mitigation 2: Deliver targeted change support through drop-ins, user guides and one-to-one coaching.



Digital Health Plan (IRM- Digital Health / Resource Committee)



In Year Objectives	Actions / Taken	Next Quarter's Plan	Risks and Mitigations
HIS Project Risk Score	- Advanced Oracle build, workflow design and validation across clinical, corporate and technical workstreams. - Operationalized cross-partner governance, escalation and project risk-management forums. - Initiated cutover, data-migration and Enterprise Master Patient Index planning. - Progressed integration, device connectivity, cybersecurity and infrastructure readiness. - Developed end-user training, super-user and change-readiness plans while maintaining alignment to the November 8, 2026 Go-Live.	- Complete Integration Testing #2, resolve critical defects and finalize remaining build. - Deliver end-user and super-user training and monitor readiness across all user groups. - Finalize cutover, service-slowdown, staffing and go-live support plans. - Complete PowerPlan decisions, device/interface testing, production rebuild, cybersecurity validation, data migration and reporting readiness. - Conduct 90-day and 60-day readiness assessments and support executive go/no-go decisions.	Risk 1: Clinical build and validation: PowerPlan, ambulatory workflow and clinical-resource constraints may compress readiness timelines. Mitigation 1: Apply risk-based prioritization, add resources and escalate unresolved decisions through clinical governance. Risk 2: Integration and testing: Lab/Blood Bank, OLIS, OCINet, LMDI, BMDI and nurse-mobility dependencies may affect testing completion. Mitigation 2: Use dedicated working groups and SMEs, escalate vendor timelines and track integration milestones weekly. Risk 3: Infrastructure and analytics: Wireless remediation and access to real-time reporting remain critical dependencies. Mitigation 3: Complete network upgrades and secure Oracle development/backend access for localized reporting. Risk 4: Specialized resourcing: Informatics contracts and limited clinical SME availability extend through the go-live period. Mitigation 4: Secure third-party coverage and schedule protected SME capacity for validation and support. Risk 5: Schedule: Multiple interdependent workstreams create cumulative pressure on the November 8, 2026 Go-Live. Mitigation 5: Maintain enhanced executive oversight, readiness assessments, critical-path monitoring and formal go/no-go governance.



Human Resources Plan (Resource Committee)

[Click Here to Input Action Plans](#)

Executive Sponsor(s): Dr. Winnie Lee, Mari Iromoto	Physician Liaison(s): Dr. Kunuk Rhee	Director Lead(s): Melissa Duguid, Kim Towes, Andrea Brissette	Project Manager(s): Jennifer Woo
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In Year Measures of Success	Target	Q1	Q2	Q3	Q4	Trailing 12 - OT												
Fill targeted Core Medical Professional Staff Vacancies	0	20				<table><caption>Trailing 12 - OT Data</caption><tr><th>Month</th><th>OT (K)</th></tr><tr><td>Jan 2026</td><td>48.4K</td></tr><tr><td>Feb 2026</td><td>47.9K</td></tr><tr><td>Mar 2026</td><td>51.9K</td></tr><tr><td>Apr 2026</td><td>51.2K</td></tr><tr><td>May 2026</td><td>50.9K</td></tr></table>	Month	OT (K)	Jan 2026	48.4K	Feb 2026	47.9K	Mar 2026	51.9K	Apr 2026	51.2K	May 2026	50.9K
Month	OT (K)																	
Jan 2026	48.4K																	
Feb 2026	47.9K																	
Mar 2026	51.9K																	
Apr 2026	51.2K																	
May 2026	50.9K																	
HIS Readiness Confidence Score	>3.7	3.38																
Overtime Hours per Quarter	Q1/Q3 Target:22,210 Q2/Q4 Target:25,911	22682.92																

In Year Objectives	Actions / Taken	Next Quarter's Plan	Risks and Mitigations
HIS Readiness: Leaders, staff, physician confidence score	- Established a targeted change and communications strategy for physicians in partnership with VP, Medical, HIS Physician Lead, and COS - Developed and executed ongoing unit-specific change and comms strategies for high-impact units aligned to readiness and risk - Implemented a monthly change readiness pulse survey to generate actionable insights and continuously refine change strategies, messaging, and support at the unit level - Developed a Change x Wellness Champion Engagement and Recognition strategy to strnegthen change networks across the organization - Executed engagement campaigns to build understanding, reinforce trust, and sustain project momentum - Executed Engagement Campaign #1 (Theme: Awareness: "Why We're Changing") - Planned and executed Engagement Campaign #2 aligned with the Best Practice Fair (Theme: Personal Impact: "What This Means for Me") - Began planning for Engagement Campaign #3 aligned with the Staff BBQ (Theme: "Feedback Loop: You Said, We Did") - Partnered with the HIS Training and Testing Coordinator to align change and communications with training and testing strategy - Continued to keep staff, physicians, and leaders informed through estavlished two-way communications channels	- Develop, in partnership with Patient Experience, a comprehensive, safety-focused patient and family communication strategy to support consistent messaging before, during, and after go-live - Execute key deliverables in the physician change and communications strategy - Continue developing and executing unit-specific change and comms strategies for high-impact units aligned to readiness and risk - Continue conducting monthly readiness pulse surveys to generate insights and continuously refine change strategies, messaging, and support at the unit level - Execute engagement campaigns to build understanding, reinforce trust, and sustain project momentum - Plan and execute Engagement Campaign #4 (Theme: Normalize Learning: "Getting Ready, Together") - Begin planning for Engagement Campaign #5 (Theme: "Go Live with Care") - Continue partnering with Training and Testing Coordinator to align change and communications with training and testing strategy - Develop and execute "Countdown to Go-Live" campaigns tied to 90, 60, 30, 10 days to go-live	



Human Resources Plan - Cont. - (IRM- Resource Committee)

[Click Here to Input Action Plans](#)

Executive Sponsor(s):
Dr. Winnie Lee, Mari Iromoto

Physician Liaison(s):
Dr. Kunuk Rhee

Director Lead(s):
Melissa Duguid, Kim Towes, Andrea Brissette

Project Manager(s):
Jennifer Woo

In Year Objectives	Actions / Taken	Next Quarter's Plan	Risks and Mitigations
Overtime Hours Per Pay Period	(Medicine, Nursing Resource Team (NRT), ICU) • Deployed two NRT staff to support no-bed-admit coverage and used additional NRT capacity for sick-call coverage. • Established an ICU working group focused on surge- and flu-related overtime. • Expanded additional Medicine A2 staff to provide cross-coverage across Medicine portfolio • Introduced daily review of one-to-one staffing requirements. • Increased recruitment targets by five full-time RN and five full-time RPN positions, supported by monthly overtime, sick-time and modified-hours reviews. (Emergency) • Recruited new Director, Emergency Department & Patient Flow, with onboarding in June 2026, to provide dedicated operational leadership. • Completed initial assessment of ED staffing, vacancies, skill mix, scheduling variation and workforce pressures. • Advanced recruitment of existing ED RN/RPN vacancies. • Initiated redesign of the ED RN master schedule to improve baseline staffing consistency and optimize existing resources. • Initiated resource allocation review to better align staffing with demand, acuity and operational requirements.	(Medicine, Nursing Resource Team, ICU) • Establish four unmastered full-time ICU lines to cover long-term absences and advance recruitment. • Launch a multidisciplinary Medicine task force to standardize criteria for initiating and discontinuing 1:1 care. • Continue biweekly NRT/OT Task Force meetings and assess the full-time/part-time NRT complement. • Automate assignment of available NRT PSWs to 1:1s and finalize PSW float-pool scheduling guidelines with the Organizational Scheduling Office. (Emergency) • Implement the new ED RN master schedule in September 2026, level-setting baseline staffing and skill mix across shifts. • Complete recruitment for all current ED RN/RPN vacancies, with onboarding/start dates by September 2026. • Complete the resource allocation and staffing-model review to establish a sustainable, demand- and acuity-informed staffing model. • Continue resource realignment work to maximize existing organizational resources supporting ED and non-bed-admit demand. • Advance ED transformation initiatives to improve patient flow, workload distribution, role clarity and workforce sustainability. • Monitor overtime, sick time, vacancies and staffing utilization to evaluate impact and guide further adjustments.	(Medicine, Nursing Resource Team, ICU) Risk 1: Continued recruitment and retention pressure within the NRT may limit sustainable overtime reduction. Mitigation 1: Standardize NRT staff engagement, optimize the geographic placement of admitted patients, and assign NRT work locations at the start of each shift to retain deployment flexibility. (Emergency Department) Risk 2: Sick calls, vacancies, sustained demand and implementation pressures may continue to drive overtime during the stabilization period. Mitigation 2: Improve baseline schedule reliability, complete current recruitment, optimize skill mix and resource utilization, and monitor overtime trends following implementation of the new master schedule. Risk 3: The resource allocation review may identify additional staffing requirements, or resource realignment may create additional recruitment needs. Mitigation 3: Quantify requirements through the staffing-model review and align future recruitment/resource decisions with demonstrated demand and operational need.



Human Resources Plan - Cont. - (IRM- Resource Committee)

[Click Here to Input Action Plans](#)

Executive Sponsor(s):
Dr. Winnie Lee, Mari Iromoto

Physician Liaison(s):
Dr. Kunuk Rhee

Director Lead(s):
Melissa Duguid, Kim Towes, Andrea Brissette

Project Manager(s):
Jennifer Woo

In Year Objectives	Actions / Taken	Next Quarter's Plan	Risks and Mitigations
Achieve and fill targeted Medical Professional Staff Positions	• Revised the vacancy baseline with the Chief of Staff and Medical Affairs and aligned recruitment and retention tactics. • Recruited the Emergency Department Chief and Medical Director. • Added courtesy paediatricians to improve coverage stability. • Planned additional Medical Director roles and developed EMPP simulation for Emergency and Medicine/hospitalist teams.	• Confirm the Q2 baseline with Medical Affairs and Chiefs • Open new recruitment pathways and progress shortlisted candidates through credentialing. • Secure on-call coverage and optimize shift coverage across departments. • Extend offers for priority roles and strengthen academic relationships, including WOAHSN, SickKids and TAHSN-m.	Risk 1: A highly competitive physician market may impede recruitment and retention. Mitigation 2: Use specialty-specific recruitment, targeted retention, close Medical Affairs partnership and ongoing pipeline/workforce planning.



Multi-Year Financial Plan (Resource Committee)

[Click Here to Input Action Plans](#)

Executive Sponsor(s):
Trevor Clark

Physician Liaison(s):
Dr. Augustin Nguyen

Director Lead(s):
Kyle Leslie

Project Manager(s):
Jennifer Woo

In Year Measures of Success	Target	Q1	Q2	Q3	Q4
Total Hospital Budget Variance in dollars x 000	0	-\$1,088K			

In Year Objectives	Actions / Taken	Next Quarter's Plan	Risks and Mitigations
Total hospital budget variance	- Supported overtime task-force and float-pool initiatives. - MRI and HIS projects remain on track and on budget.	- Validate EY sustainability initiatives with Directors and initiate project planning. - Establish the Transformation Management Office. - Maintain MRI and HIS delivery on schedule and budget.	Risk 1: Year-end forecasting may identify pressures that extend into 2027/28. Mitigation 1: Complete the 2026/27 forecast and roll-forward early enough to address pressures in the 2027/28 budget cycle.

*Please note Actual QBP Revenue will be capped at the Funding Available for each category (Total Funding=\$28.2M: \$20.8M for OH QBP, \$2.9M for Cancer Surgery QBPs; \$2.0M for GI Endo QBP, \$2.5M for Systemic Treatment QBP)



DEI Plan (Board)

[Click Here to Input Action Plans](#)

Executive Sponsor(s):
Mari Iromoto

Physician Liaison(s):
TBD

Director Lead(s):
Diana Crawford

Project Manager(s):
Jennifer Woo

In Year Measures of Success

% on track with DEI Action Plan

Target

100

Q1

100

Q2

Q3

Q4

In Year Objectives

DEI Action Plan - % achievement of identified milestones for 26/27

Actions / Taken

- Launched the Asian and Indigenous Employee Resource Groups.
- Delivered Asian Heritage Month and Pride programming, including CMH’s first booth at Cambridge Pride.
- Completed final consultation on the DEI-AR Policy and Inclusive Communications Guide.
- Secured Diversity Council endorsement of the DEI Foundations Huddle Series framework.

Next Quarter's Plan

- Complete the ERG pilot evaluation and refresh DEI Council governance and recruitment.
- Finalize and launch the DEI-AR Policy and Inclusive Communications Guide.
- Launch DEI Foundations Huddles and update Hospital-Wide Orientation materials.
- Plan Islamic History Month and propose a revised Days of Significance framework.

Risks and Mitigations

Risk 1: HIS readiness work may reduce leader and staff capacity for DEI deliverables.
Mitigation 1: Coordinate sequencing with Organizational Effectiveness, Culture & Transformation to avoid critical HIS periods and minimize added demands.



Truth and ReconciliAction Plan (Board)

[Click Here to Input Action Plans](#)

Executive Sponsor(s):
Patrick Gaskin

Physician Liaison(s):
TBD

Director Lead(s):
Diana Crawford

Project Manager(s):
Jennifer Woo

In Year Measures of Success

	Target	Q1	Q2	Q3	Q4
% on track Truth & ReconciliAction	100	100			

In Year Objectives

Actions / Taken

Next Quarter's Plan

Risks and Mitigations

Truth & ReconciliACTION Plan- % achievement of identified milestones for 26/27

- Delivered National Indigenous History Month programming and launched the Indigenous ERG.
- Expanded Red Dress Day engagement, including 111 pins sold.
- Co-delivered the first Indigenous Advisory Council retreat with WRHN.
- Activated the Crow Shield Lodge agreement and advanced the Smudging Policy, Territorial Acknowledgement and micro-education content.
- Obtained Indigenous Council endorsement of the 2026/27 work plan and launched the Indigenous Art Video Series.

- Deliver Orange Shirt Day/National Day for Truth and Reconciliation activities and reenergize the Eagle Feather.
- Advance the HEC Cultural Safety Pathway application with WRHN and IAC support.
- Finalize the Smudging Policy, supporting resources and Q3 micro-education huddles.
- Engage SOAHAC and Nursing Advisory Circle on smudging and traditional healing; begin MOU discussions.
- Re-scope the Women & Children’s education series with alternative partners.

Risk 1: Staffing gaps may constrain Orange Shirt Day planning and the Smudging Policy launch.
Mitigation 1: Use co-op support and adjust the policy timeline.
Risk 2: The SOAHAC Midwifery Program closure and Professional Practice gaps may delay the Women & Children’s education series.
Mitigation 2: Re-plan with the SOAHAC Indigenous Patient Navigator and Regional Indigenous Cancer Program.



Emerging Priorities Plan (Board)

[Click Here to Input Action Plans](#)

Executive Sponsor(s):
Patrick Gaskin

Physician Liaison(s):

Director Lead(s):
Kyle Leslie, Amanda Foster

Project Manager(s):
Jennifer Woo

In Year Objectives	Actions / Taken	Next Quarter's Plan	Risks and Mitigations
Master Planning Advance the hospital's Master Program and Master Plan in accordance with Stage 1.2 Proposal Development requirements, establishing the planning foundation and stakeholder governance structure needed to support the Major Hospital Project business case.	- Engaged Agnew Peckham to lead Stage 1.2 Master Programming. - Established a working relationship with Decision Support to validate projected service volumes. - Drafted the architect RFP and advanced Steering Committee membership.	- Launch the Steering Committee and governance structure. - Conduct visioning and clinical user-group sessions. - Issue and award the architect RFP to begin Master Plan development.	Risk 1: Master Plan engagement overlaps with HIS implementation, limiting clinical and operational leaders' capacity. Mitigation 1: Prioritize director-level input and use shorter, more frequent sessions scheduled around HIS commitments.
Strategic Partnerships	Strengthening CMH's partnership with WRHN through a formal MSA and shared operating model that enables coordinated HIS Oversight Model, joint planning, and sustainable support, while positioning both organizations to expand collaboration across future digital platforms and services. Continued collaboration with MACcelerate and Communitech to bring emerging health technology companies into CMH, providing opportunities for clinicians and hospital teams to evaluate innovations and provide real-world healthcare feedback. This work supports CMH's innovation ecosystem and pipeline for future pilots and partnerships.	Support a safe and successful Project Quantum HIS go-live in partnership with WRHN. Stand up and operationalize the new joint WRHN-CMH operating model, including shared oversight model, support structures, escalation pathways, and decision-making processes. Transition from project implementation to post-go-live optimization and sustainment, ensuring accountability for continuous improvement, change prioritization, analytics, privacy, digital operations, and clinical optimization activities.	Risk 1: Transitioning from Project phase to optimization phase and creating capacity to make the transition and establish the new models and structures Mitigation 1: Coordinated transition- aligning existing structures with new structures and begin transition in September / October



Quality Monitoring Scorecard

Meeting Target ● 9 29%
Within 10% of Target ▲ 10 32%
Exceeding Target ◆ 12 39%

CTRL+click here to follow link

Quality Dimension		Unit of Measure	Target	YTD	Status (Last 3 periods)	Period
Efficient	Conservable Bed Days(Typical/Atypical Long Stay)	Sum	817.0	4,106.7	◆	Jul-26
	Overtime Hours - Average per pay period	hours	3,662.3	3,931.5	◆	Aug-26
	Sick Hours - Average per pay period	hours	2,895.9	4,128.9	◆	Aug-26
Integrated & Equitable	ALC Throughput	Ratio	1.0	0.8	◆	Jul-26
	Percent ALC Days (closed cases)	%	20.0	24.7	◆	Jul-26
	Repeat emergency department visits for Mental Health Care	Patients	11.0	11.0	▲	Jul-26
Patient & People Focused	Adequate Discharge Info	%	74.3	72.2	▲	Aug-26
	Organization Wide Vacancy Rate	%	12.0	4.4	●	Aug-26
Safe, Effective & Accessible	30 Day CHF Readmission Rate	%	14.0	10.7	▲	Jun-26
	30 Day COPD Readmission Rate	%	15.5	20.0	▲	Jun-26
	30 Day In-Hospital Mortality Following Major Surgery	%	1.9	1.5	▲	Jun-26
	30 Day Overall Readmission Rate	%	8.8	2.8	●	Jun-26
	Ambulance Offload Time (90% Spent Less, in Minutes)	minutes	30.0	50.0	◆	Jul-26
	Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.	Average	10.0	15.5	◆	Jul-26
	ED Length of Stay for Admitted Patients (90% Spent Less, in Hours)	hours	33.0	61.9	◆	Jul-26
	ED Length of Stay for Non-Admitted Complex Patients (90% Spent Less, in Hours)	hours	8.0	10.9	◆	Jul-26
	ED Wait Time for Inpatient Bed (90% Spent Less, in Hours)	hours	25.0	51.6	◆	Jul-26
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours)	hours	4.5	8.4	◆	Jul-26
	ED Wait Time for Physician Initial Assessment (90% Spent Less, in Hours) CTAS 1	hours	0.5	0.4	●	Jul-26
	Hip Fracture Surgery Within 48 Hours	%	83.1	96.5	●	Jun-26
	Hospital Standardized Mortality Ratio (HSMR)	Ratio	100.0	67.8	●	Jun-26
	In-Hospital Sepsis	per 1000 D/C	3.2	3.7	▲	Jun-26
	Long Waiters Waiting For All Surgical Procedures	%	20.0	10.2	●	Aug-26
	Low-Risk Caesarean Sections	%	17.3	19.9	◆	Jul-26
	Medication Reconciliation at Admit	%	95.0	91.2	▲	Aug-26
	Medication Reconciliation at Discharge	%	95.0	91.4	▲	Aug-26
	Obstetric Trauma (With Instrument)	%	14.4	13.7	▲	Jun-26
	Patient Safety Event - Falls with Harm	per 1000 PD	0.0	0.1	▲	Aug-26
	Patient Safety Event - Medication Events with Harm	per 1000 PD	0.0	0.0	●	Aug-26
	Revenue - Achieve budgeted PCOP growth (IRM)	\$	2,238,908.8	6,858,353.7	●	Jul-26
	Revenue - Achieve Quality Based Procedure Funding (IRM)	\$	6,708,544.0	10,157,196.7	●	Jul-26



Conservable Bed Days



Description

The total patient days over the benchmark LOS (conservable days) as a percentage of the total acute patient days for patients discharged from MEDA/MEDB. The benchmark LOS is determined by case mix group, age, and resource intensity level of a discharge.

Data Source

Discharge Abstract Database (DAD)

Target

817.0

Previous YE

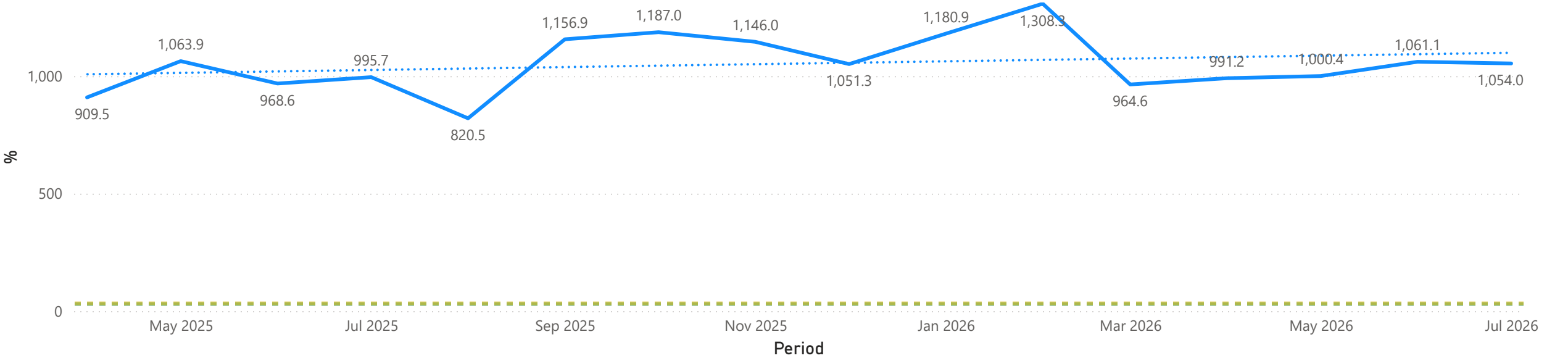
12.8K

YTD

4,106.7

Status (Last 3 periods)

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	909.5	1,063.9	968.6	995.7	820.5	1,156.9	1,187.0	1,146.0	1,051.3	1,180.9	1,308.3	964.6
2026/2027	991.2	1,000.4	1,061.1	1,054.0								



Overtime, Average per pay period



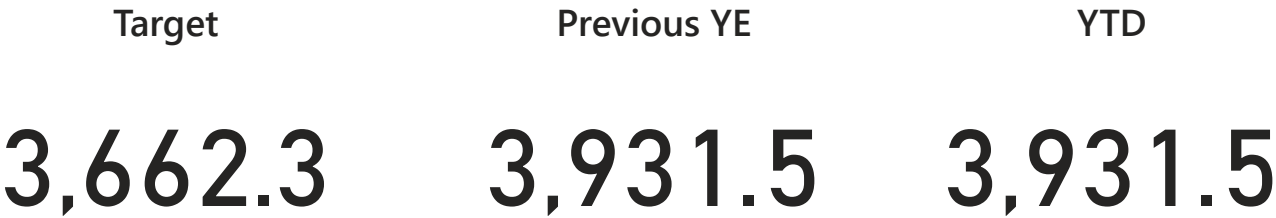
Description

The total sum of overtime hours per pay period ending in a month, divided by the number of pay periods in a month

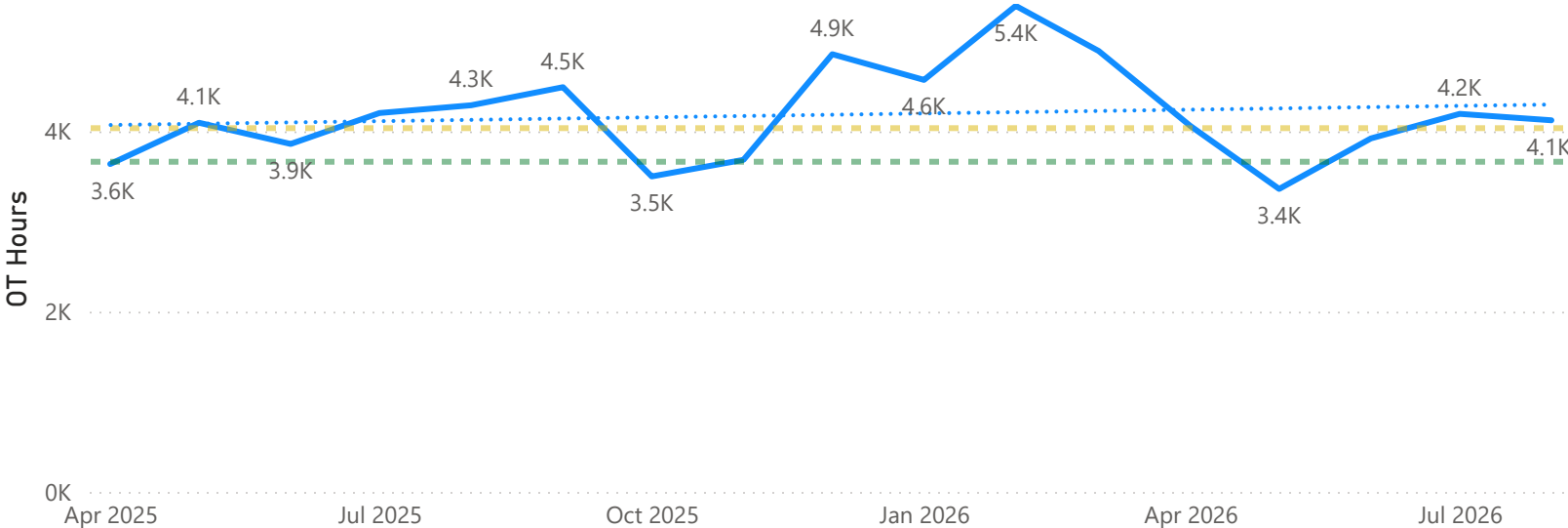
Data Source

Meditech Payroll

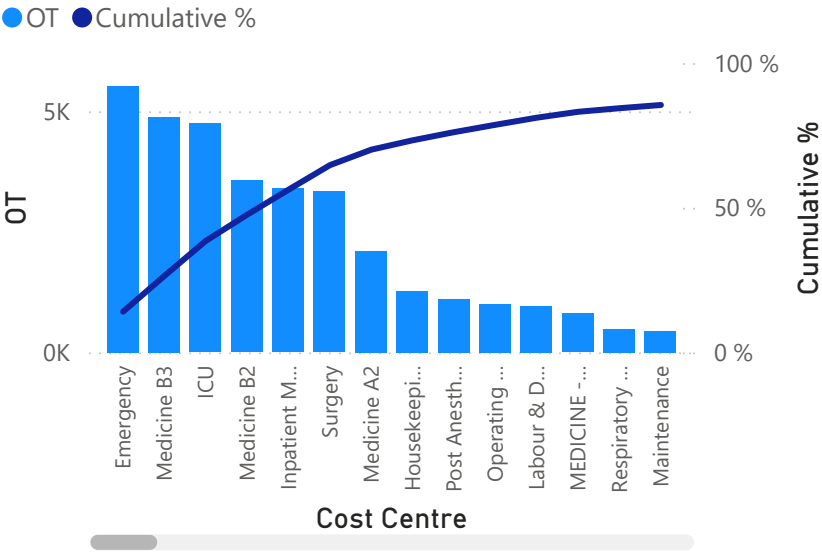
Status (Last 3 periods)



Average OT Hours per pay period, Trend



Total OT Hours, by Cost Centre



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	3,637.0	4,094.9	3,859.9	4,202.9	4,289.1	4,489.6	3,499.6	3,683.6	4,855.3	4,570.2	5,391.8	4,891.4
2026/2027	4,059.6	3,360.9	3,921.1	4,193.6	4,122.5							



Sick Time, Average per pay period



Description

The total sum of sick hours per pay period ending in a month, divided by the number of pay periods in a month

Data Source

Meditech Payroll

Target

Previous YE

YTD

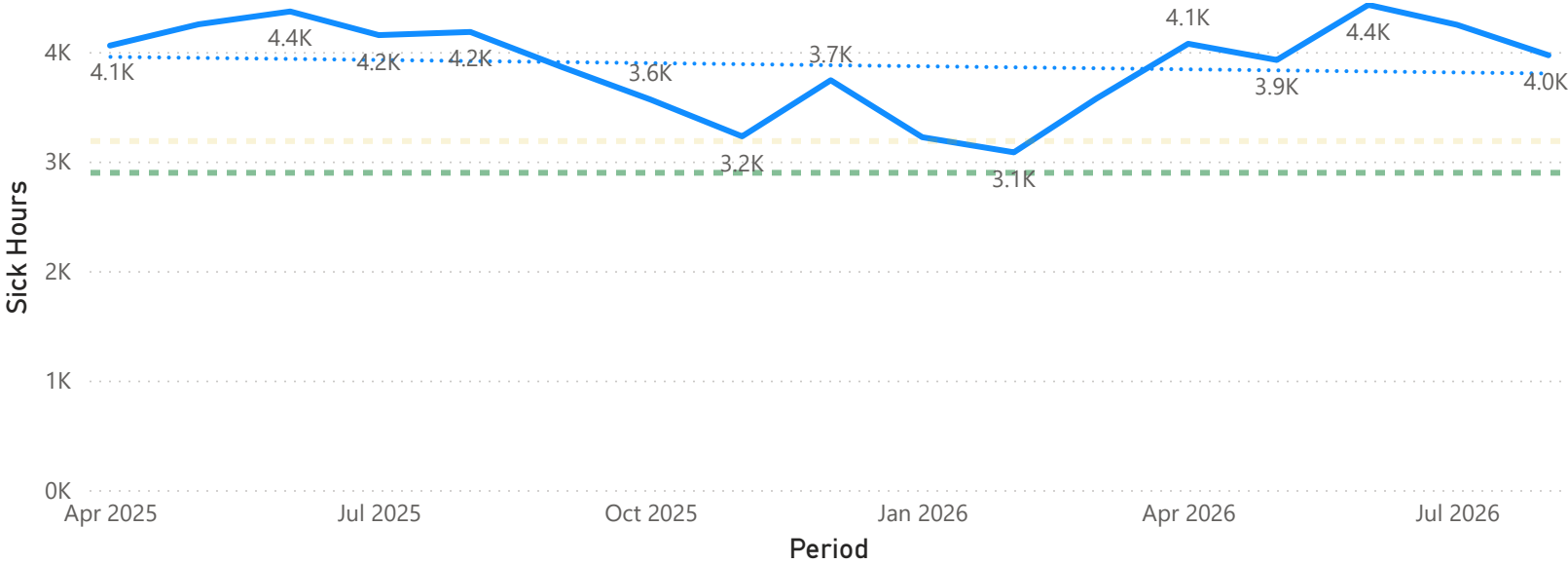
Status (Last 3 periods)

2,895.9

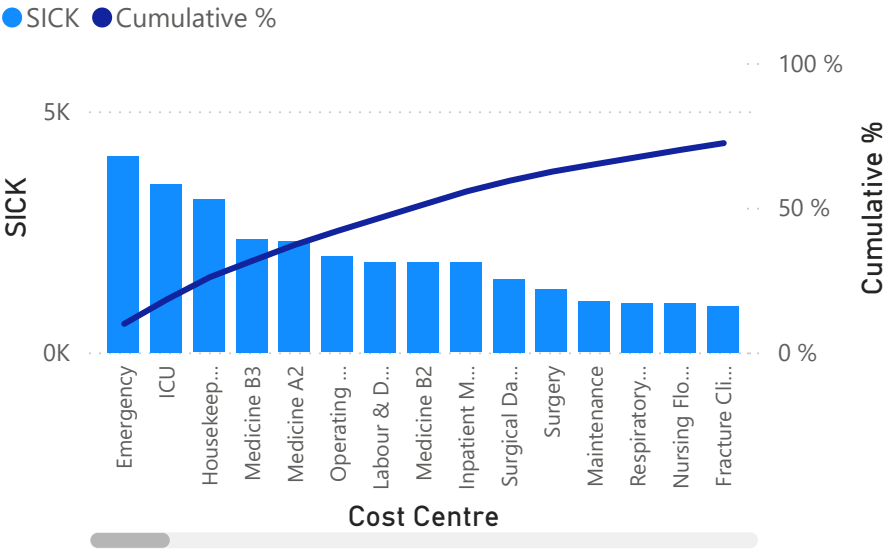
3,768.0

4,128.9

Average Sick Hours per pay period, Trend



Total Sick Hours, by Cost Centre



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	4,057.1	4,251.5	4,368.5	4,152.8	4,181.5	3,861.3	3,564.2	3,228.3	3,740.7	3,220.6	3,082.6	3,574.6
2026/2027	4,073.7	3,925.8	4,428.9	4,247.1	3,968.9							



Alternate Level of Care



ALC Throughput

Description

ALC Throughput is the ratio of the number of discharged ALC cases to the number of newly added and redesignated ALC cases

Data Source

WTIS

Target

Previous YE

YTD

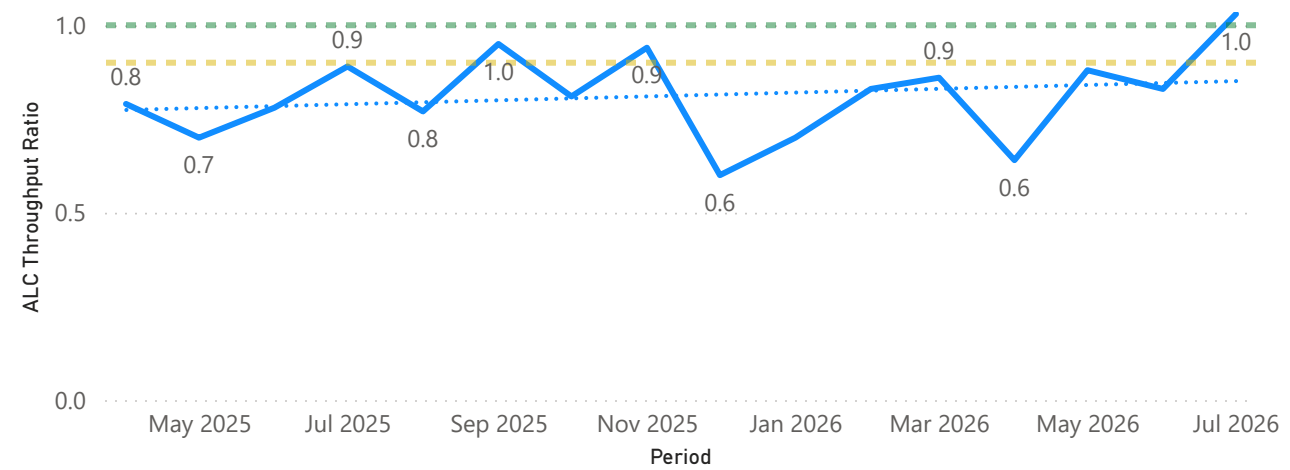
Status (Last 3 periods)

1.0

0.8

0.8

ALC Throughput Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	0.8	0.7	0.8	0.9	0.8	1.0	0.8	0.9	0.6	0.7	0.8	0.9
2026/2027	0.6	0.9	0.8	1.0								

ALC Rate

Description

The proportion of total days that a patient was assigned to the alternate level of care (ALC) service. ALC patients are those who no longer need acute care services but continue to occupy an acute care bed or use acute care services.

Data Source

Discharge Abstract Database (DAD)

Target

Previous YE

YTD

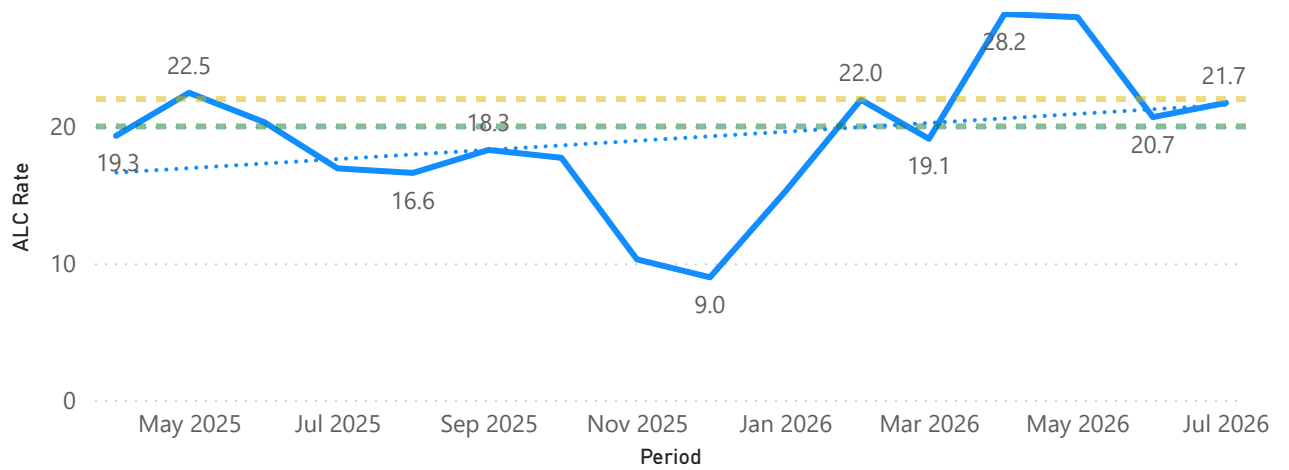
Status (Last 3 periods)

20.0

17.3

24.7

ALC Rate Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	19.3	22.5	20.3	16.9	16.6	18.3	17.7	10.3	9.0	15.3	22.0	19.1
2026/2027	28.2	28.0	20.7	21.7								



Repeat ED Visits for Mental Health Care



Description

Number of patients who have four or more repeat unscheduled visits to the emergency department in the last 12 months for mental health or substance abuse condition

Data Source

National Ambulatory Care Reporting System (NACRS)

Target

11.0

Previous YE

10.5

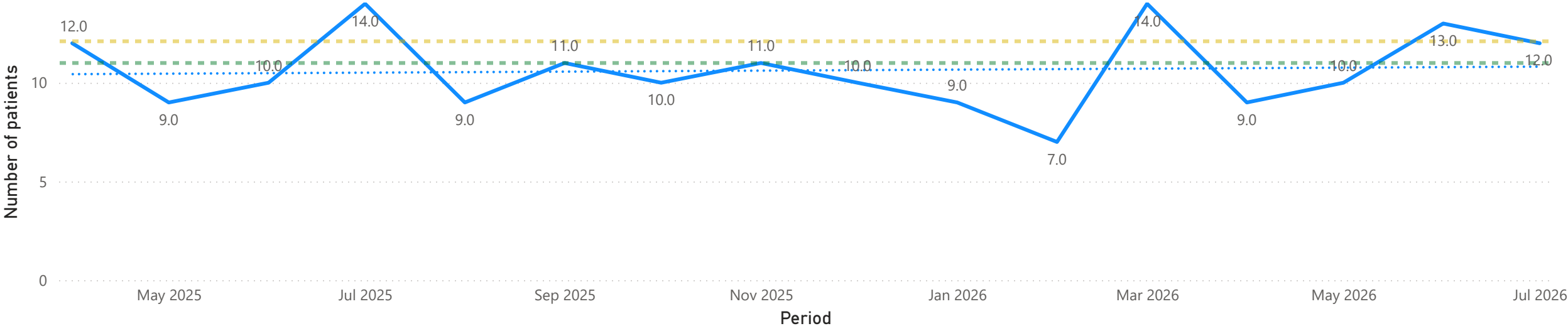
YTD

11.0

Status (Last 3 periods)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	12.0	9.0	10.0	14.0	9.0	11.0	10.0	11.0	10.0	9.0	7.0	14.0
2026/2027	9.0	10.0	13.0	12.0								



Organizational Vacancy Rate



Description

This indicator measures the organization wide vacancy rate for permanent full time and part time staff

Data Source

ICIMs Vacancy Report and Meditech Payroll

Target

12.0

Previous YE

5.4

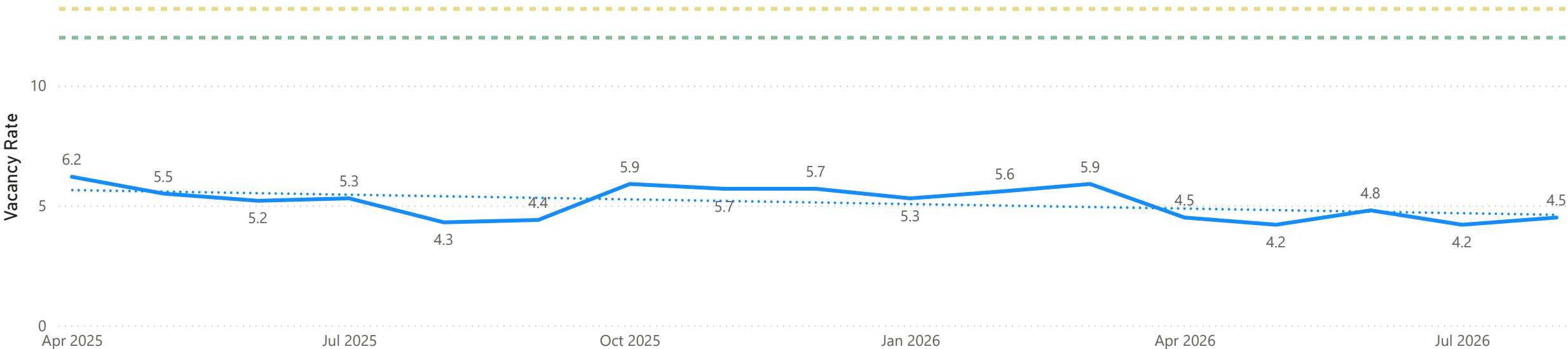
YTD

4.4

Status (Last 3 periods)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	6.2	5.5	5.2	5.3	4.3	4.4	5.9	5.7	5.7	5.3	5.6	5.9
2026/2027	4.5	4.2	4.8	4.2	4.5							



Readmissions within 30 Days: Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD)

CHF Readmissions

Description

Rate of urgent readmission for any reason within 30 days of discharge for Congestive Heart Failure (CHF) at CMH

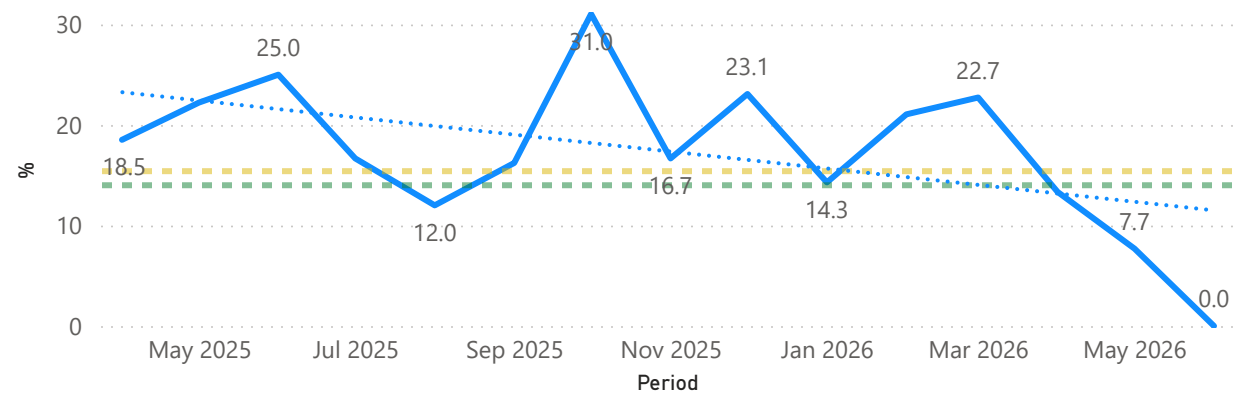
Data Source

Discharge Abstract Database (DAD)

Target Previous YE YTD Status (Last 3 periods)

14.0 20.1 10.7

CHF Readmission Rate, Trend



Fiscal Year		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	Rate	18.5	22.2	25.0	16.7	12.0	16.2	31.0	16.7	23.1	14.3	21.1	22.7
	Readmits	5	6	9	4	3	6	9	3	6	4	4	5
2026/2027	Rate	13.3	7.7	0.0									
	Readmits	4	2	0	0	0							

COPD Readmissions

Description

Rate of urgent readmission for any reason within 30 days of discharge for Chronic Obstructive Pulmonary Disease (COPD) at CMH

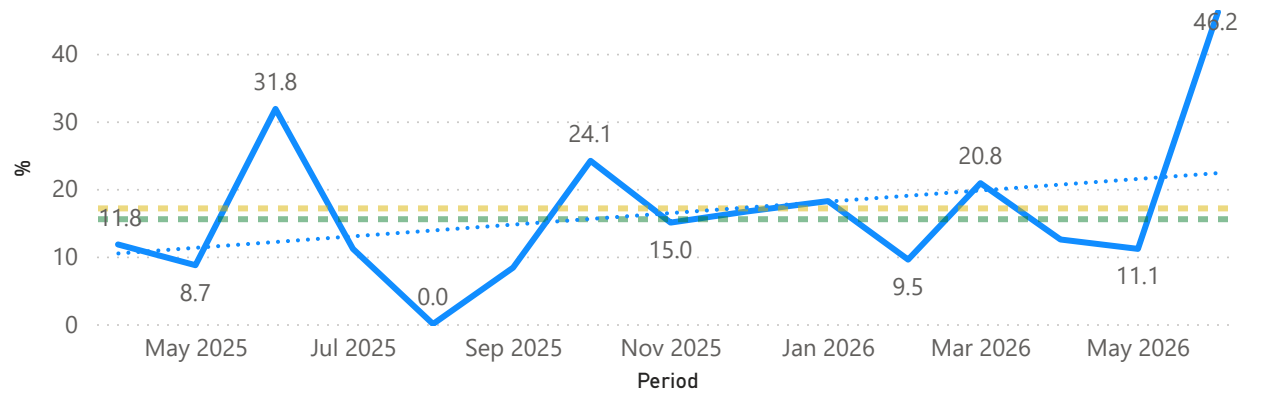
Data Source

Discharge Abstract Database (DAD)

Target Previous YE YTD Status (Last 3 periods)

15.5 16.5 20.0

COPD Readmission Rate, Trend



Fiscal Year		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	Rate	11.8	8.7	31.8	11.1	0.0	8.3	24.1	15.0	16.7	18.2	9.5	20.8
	Readmits	9	8	16	6	3	7	16	6	13	10	6	10
2026/2027	Rate	12.5	11.1	46.2									
	Readmits	7	4	6	0	0							



30 Day In-Hospital Mortality Following Major Surgery Rate



Description

Risk-adjusted rate of in-hospital deaths due to all causes occurring within 30 days of major surgery (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

Target

1.9

Previous YE

0.1

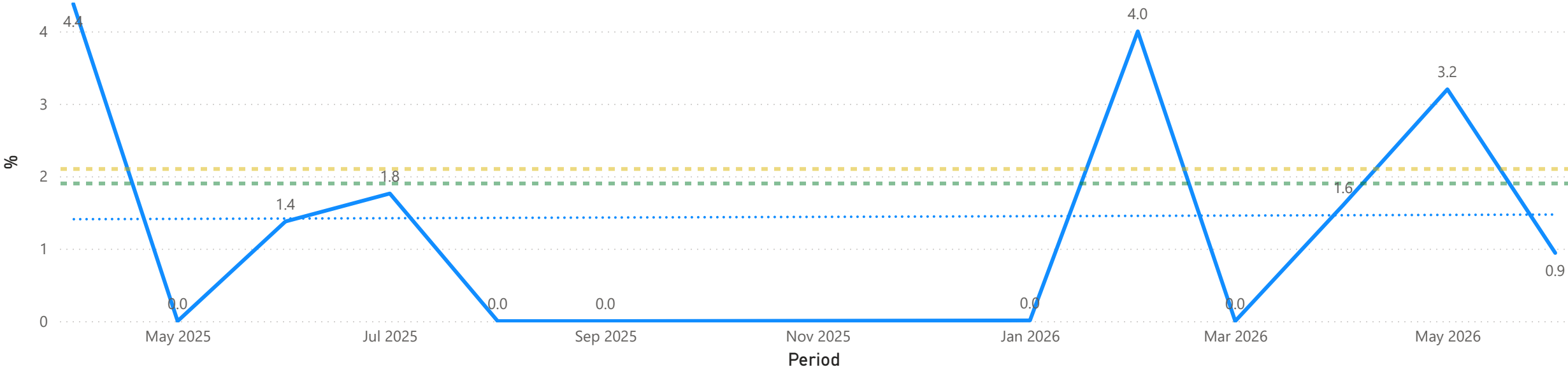
YTD

1.5

Status (Last 3 periods)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Jan	Feb	Mar
2025/2026	4.4	0.0	1.4	1.8	0.0	0.0	0.0	4.0	0.0
2026/2027	1.6	3.2	0.9						



30 Day Overall Readmission Rate



Description

The rate of urgent readmissions within 30 days of discharge for episodes of care for the following patient groups: medical, obstetric, paediatric, and surgical. Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average

Data Source

Discharge Abstract Database (DAD)

Target

8.8

Previous YE

6.7

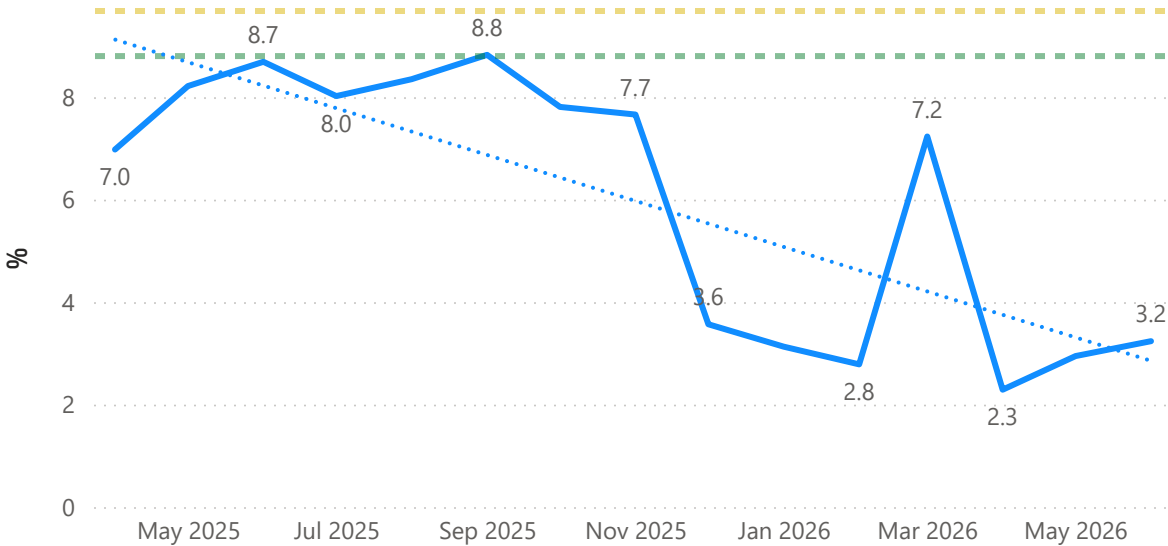
YTD

2.8

Status (Last 3 periods)



Trend

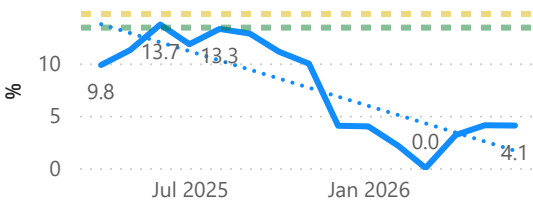


Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	7.0	8.2	8.7	8.0	8.3	8.8	7.8	7.7	3.6	3.1	2.8	7.2
2026/2027	2.3	2.9	3.2									

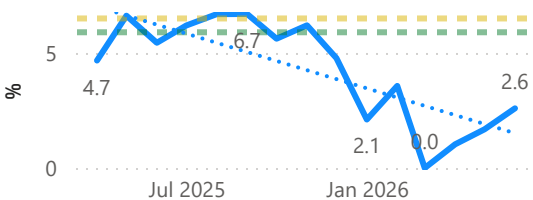
Readmissions, by Patient Group

IndicatorName	Target	YTD	Status (Last 3 periods)
30 Day Medical Readmission Rate	13.4	3.8	●
30 Day Obstetric Readmission Rate	1.4	0.8	▲
30 Day Paediatric Readmission Rate	6.7	4.4	●
30 Day Surgical Readmission Rate	5.9	1.8	●

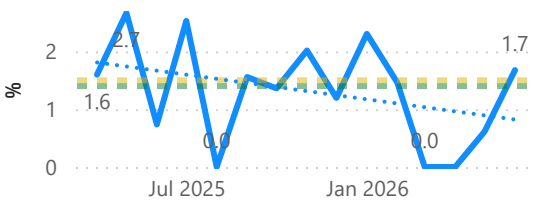
Medical Readmissions Trend



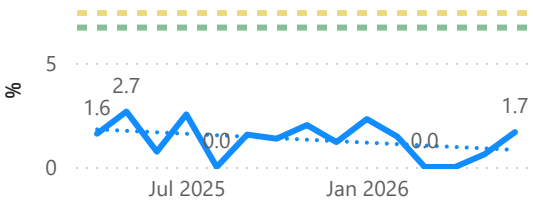
Surgical Readmissions Trend



Obstetric Readmissions Trend



Paediatric Readmissions Trend





Ambulance Offload Time, minutes, 90th percentile



Description

The total time, in minutes, within which 9 out of 10 patients who arrived via ambulance waited for transfer of care process to be completed, calculated as the total time elapsed from ambulance arrival to completion of transfer of care process.

Data Source

National Ambulatory Care Reporting System (NACRS)

Target

30.0

Previous YE

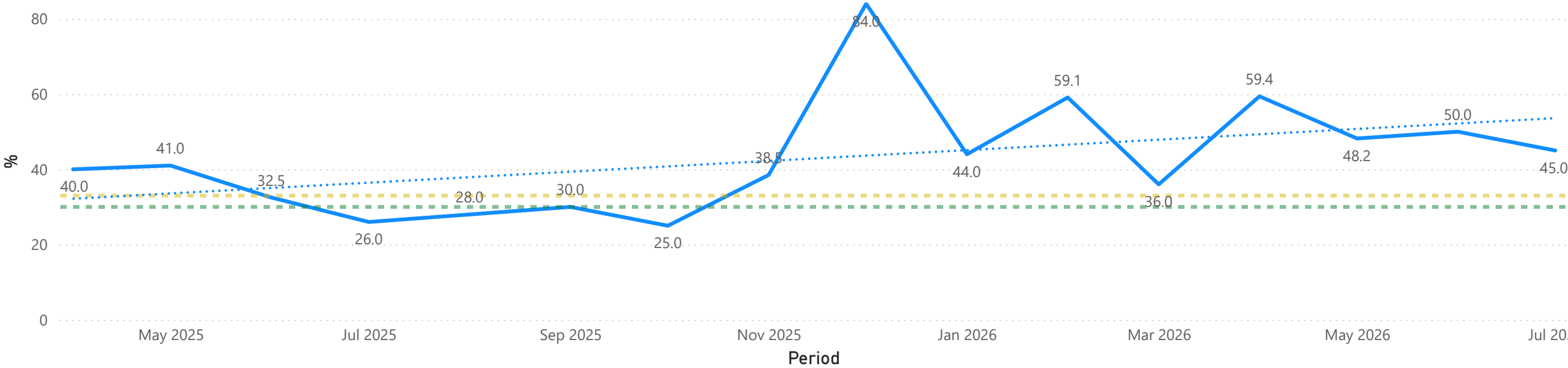
39.0

YTD

50.0

Status (Last 3 periods)

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	40.0	41.0	32.5	26.0	28.0	30.0	25.0	38.5	84.0	44.0	59.1	36.0
2026/2027	59.4	48.2	50.0	45.0								

55



AVG Patients in ED at 8AM waiting for IP bed



Description

The number of patients in the emergency department waiting for an inpatient bed at 8 a.m. who have been waiting at least 2 hours since disposition. Average number of patients per day

Data Source

NACRS

Target

9.2

Previous YE

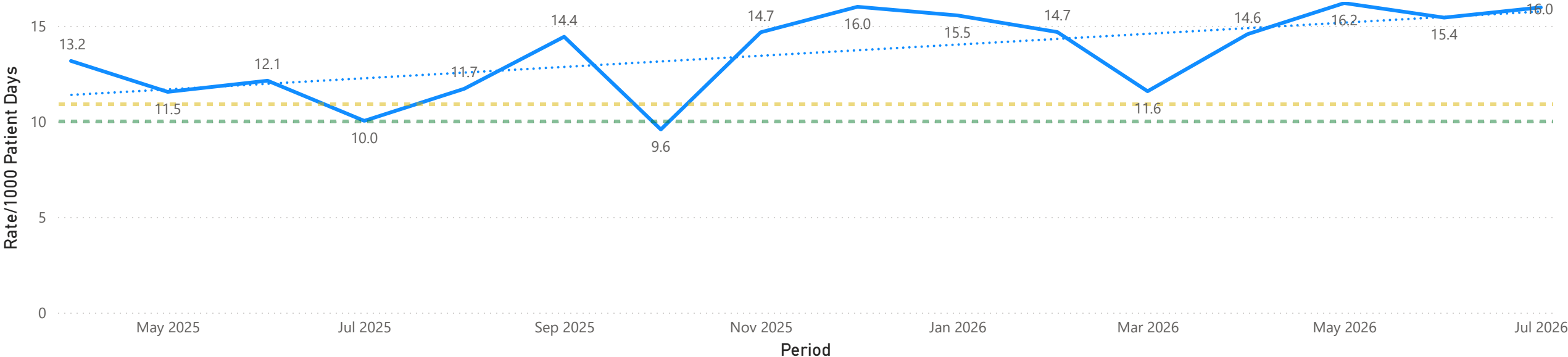
12.9

YTD

15.5

Status (Last 3 periods)

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	13.2	11.5	12.1	10.0	11.7	14.4	9.6	14.7	16.0	15.5	14.7	11.6
2026/2027	14.6	16.2	15.4	16.0								



ED LOS for Admitted Patients, hours, 90th percentile



Total ED LOS for Admitted Patients

Description

The total time, within which hours, that 9 out of 10 admitted patients spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target

Previous YE

YTD

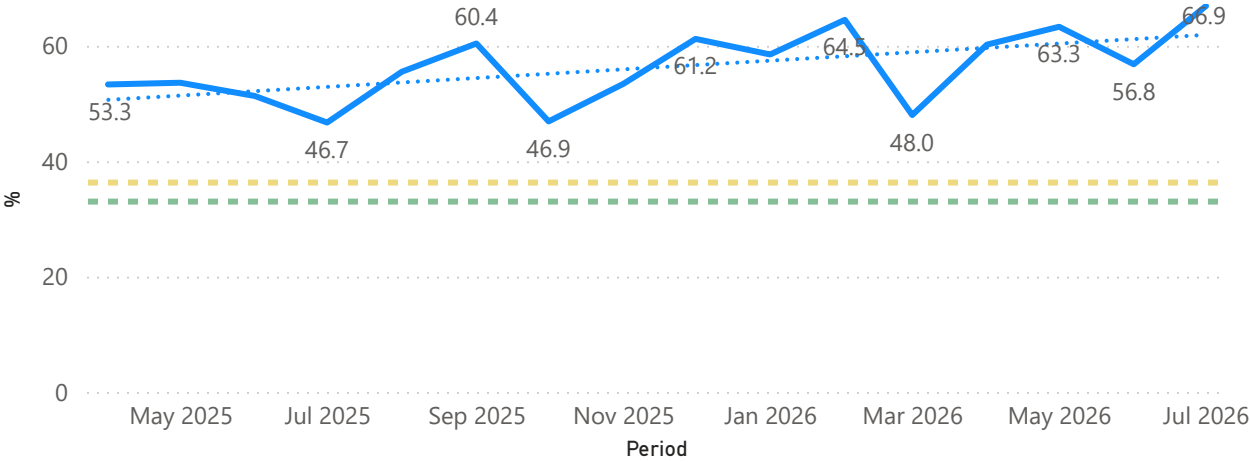
Status (Last 3 periods)

33.0

54.4

61.9

ED LOS for Admitted Patients, Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	53.3	53.6	51.3	46.7	55.5	60.4	46.9	53.4	61.2	58.5	64.5	48.0
2026/2027	60.2	63.3	56.8	66.9								

Time to Inpatient Bed

Description

The total time, in hours, within 9 out of 10 admitted patients spent waiting in the emergency department (ED) for a bed, calculated as the total time elapsed from disposition decision to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target

Previous YE

YTD

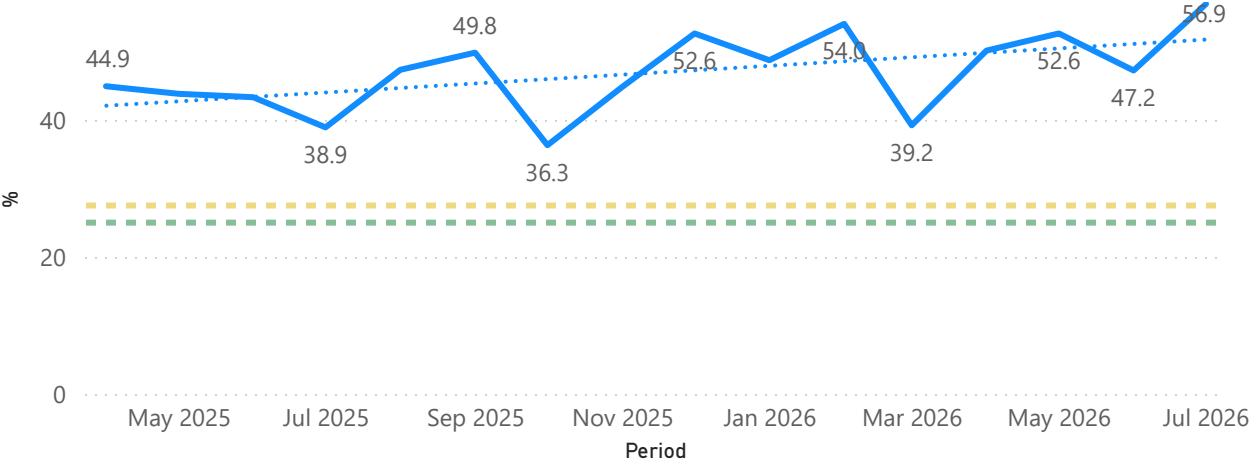
Status (Last 3 periods)

25.0

45.8

51.6

Time to Inpatient Bed, Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	44.9	43.8	43.3	38.9	47.3	49.8	36.3	44.8	52.6	48.7	54.0	39.2
2026/2027	50.1	52.6	47.2	56.9								



ED LOS for Non-Admitted, Complex Patients, hours, 90th percentile



Description

The total time, within which hours, that 9 out of 10 high-urgency patients (CTAS 1-3) who were not admitted spent in the emergency department (ED), calculated as the total time elapsed from triage to when the patient left the ED

Data Source

National Ambulatory Care Reporting System (NACRS)

Target

8.0

Previous YE

10.0

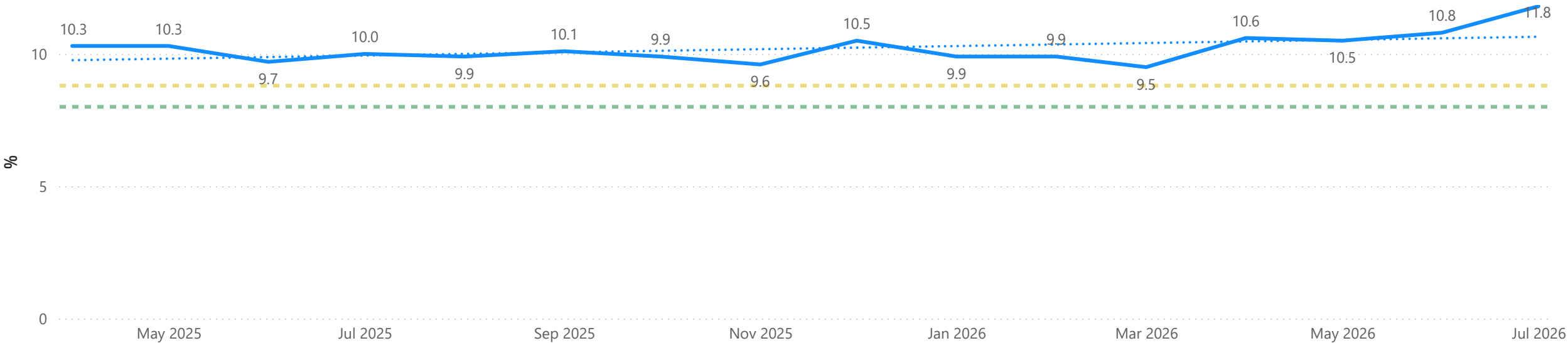
YTD

10.9

Status (Last 3 periods)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	10.3	10.3	9.7	10.0	9.9	10.1	9.9	9.6	10.5	9.9	9.9	9.5
2026/2027	10.6	10.5	10.8	11.8								



Provider Initial Assessment Time, hours, 90th percentile



Description

The total time, in hours, within which 9 out of 10 patients spent waiting for their first assessment by a doctor or nurse practitioner in the emergency department (ED), calculated as the total time elapsed from triage to time of initial assessment

Data Source

National Ambulatory Care Reporting System (NACRS)

Target

4.5

Previous YE

7.4

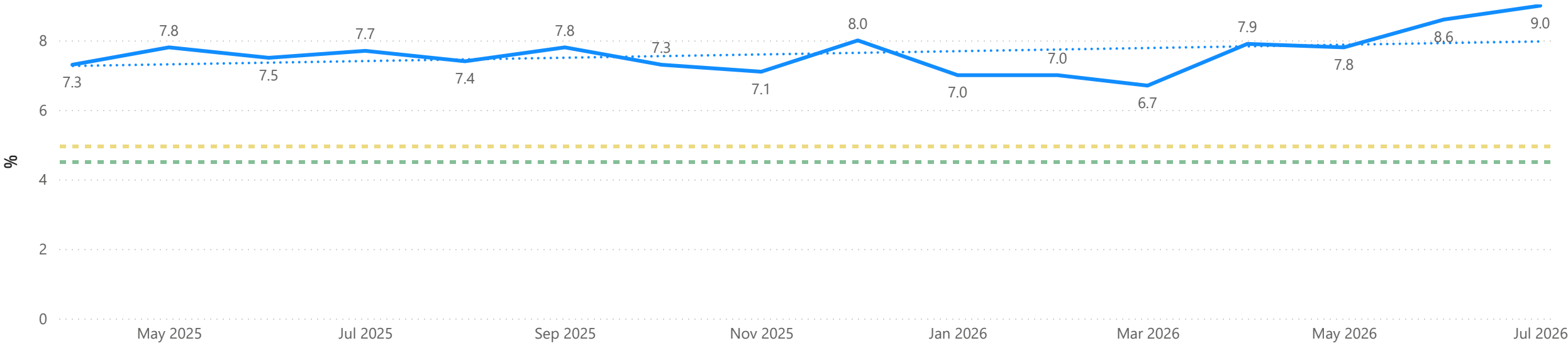
YTD

8.4

Status (Last 3 periods)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	7.3	7.8	7.5	7.7	7.4	7.8	7.3	7.1	8.0	7.0	7.0	6.7
2026/2027	7.9	7.8	8.6	9.0								



Urgent Provider Initial Assessment Time, hours, 90th percentile



Description
In total time, in hours, within which 9 out of 10 CTAS 1 patients spent waiting for their first assessment by a doctor or nurse practitioner in the emergency department (ED), calculated as the total time elapsed from triage to time of initial assessment.

Data Source
National Ambulatory Care Reporting System (NACRS)

Target

0.5

Previous YE

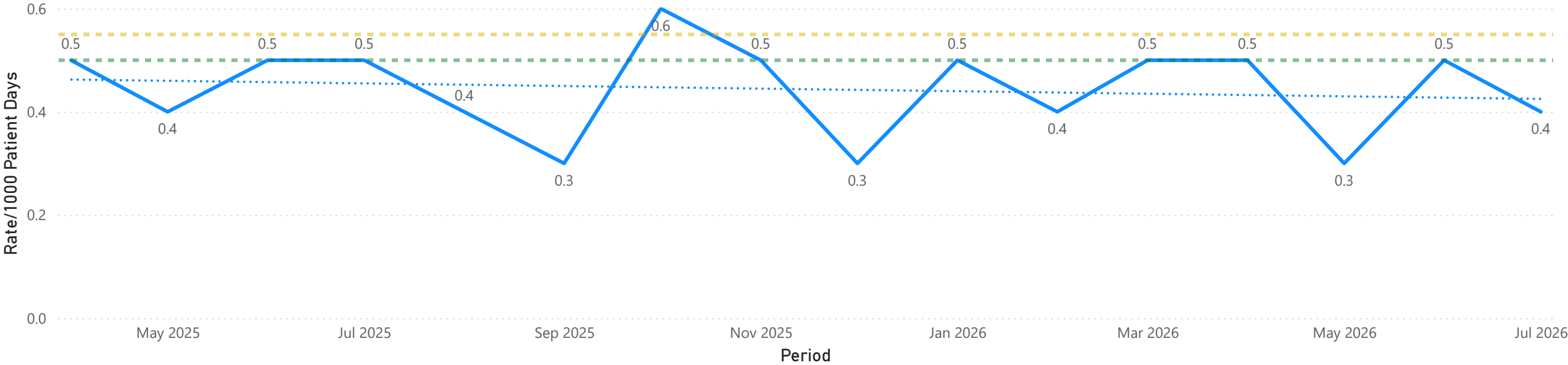
0.4

YTD

0.4

Status (Last 3 periods)

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	0.5	0.4	0.5	0.5	0.4	0.3	0.6	0.5	0.3	0.5	0.4	0.5
2026/2027	0.5	0.3	0.5	0.4								



Hip Fracture Surgery within 48 Hours, %



Description

Risk-adjusted proportion of hip fractures that were surgically treated within 48 hours of initial admission (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

Target

83.1

Previous YE

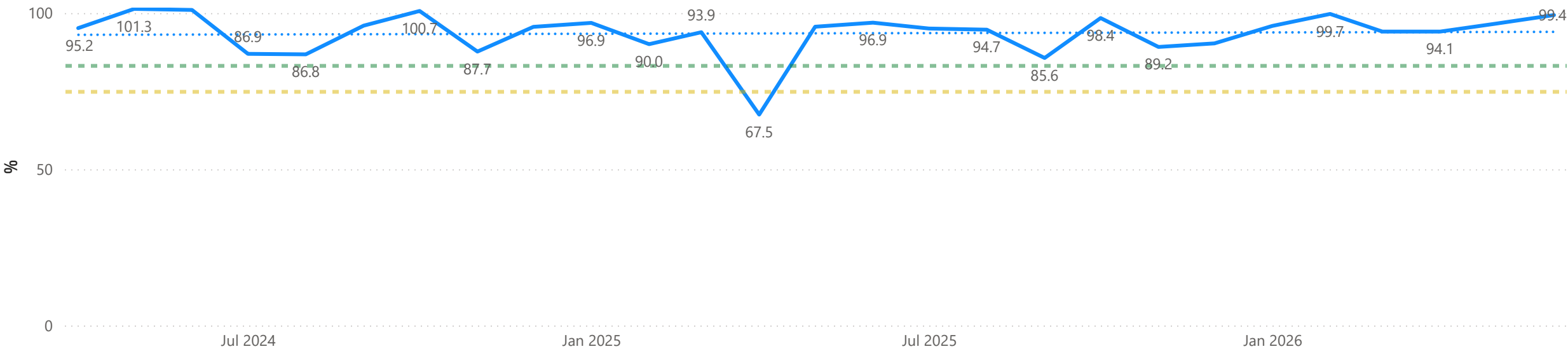
94.2

YTD

92.3

Status (Last 3 periods)

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/2025	95.2	101.3	101.0	86.9	86.8	96.0	100.7	87.7	95.6	96.9	90.0	93.9
2025/2026	67.5	95.6	96.9	95.1	94.7	85.6	98.4	89.2	90.3	95.9	99.7	94.1
2026/2027	94.1	96.6	99.4									



Hospital Standardized Mortality Ratio (HSMR)



Description

The ratio of the actual number of in-hospital deaths to the expected number of in-hospital deaths, for conditions accounting for about 80% of inpatient mortality

Data Source

Discharge Abstract Database (DAD)

Target

100.0

Previous YE

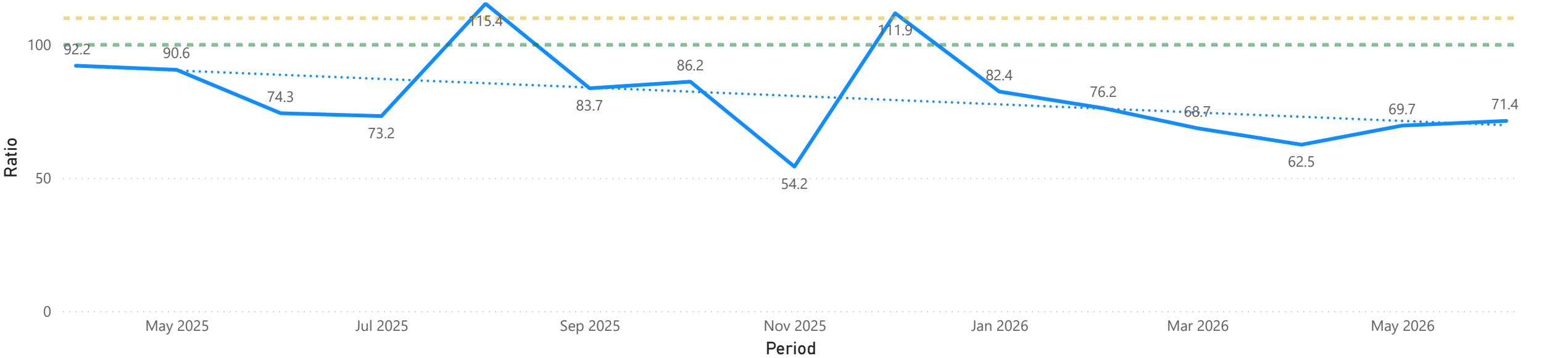
84.7

YTD

67.8

Status (Last 3 periods)

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	92.2	90.6	74.3	73.2	115.4	83.7	86.2	54.2	111.9	82.4	76.2	68.7
2026/2027	62.5	69.7	71.4									

62



In-Hospital Sepsis



Description

Risk-adjusted rate of sepsis that is identified after admission, per 1,000 discharges (Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average)

Data Source

Discharge Abstract Database (DAD)

Target

3.2

Previous YE

2.6

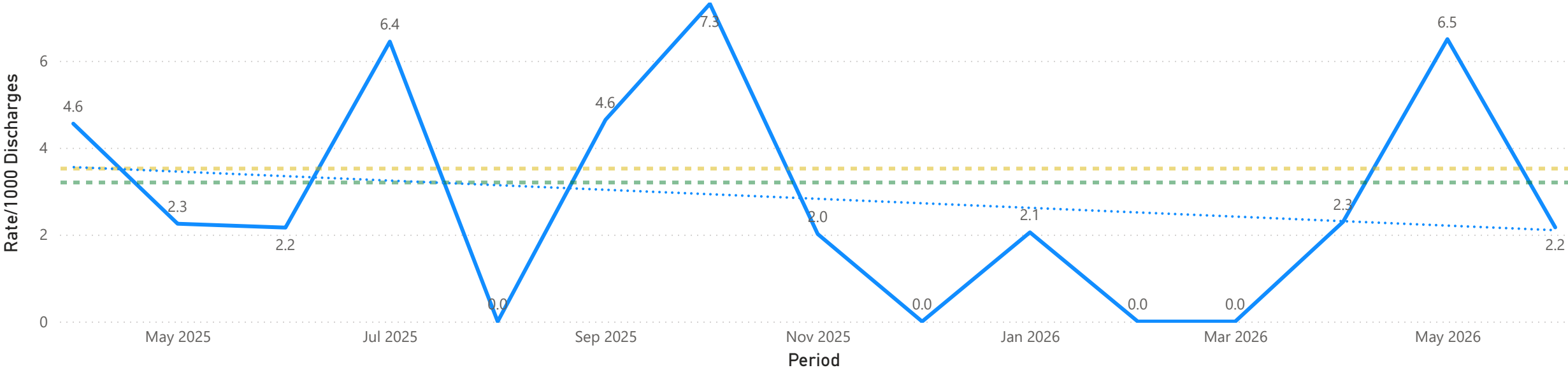
YTD

3.7

Status (Last 3 periods)

▲

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	4.6	2.3	2.2	6.4	0.0	4.6	7.3	2.0	0.0	2.1	0.0	0.0
2026/2027	2.3	6.5	2.2									



Long Waiters Waiting for Surgical Procedures



Description

This indicator measures the percentage of patients waiting for a surgical procedure whose wait has exceeded the associated Priority Level Access Target (excludes DART days)

Data Source

WTIS

Target

20.0

Previous YE

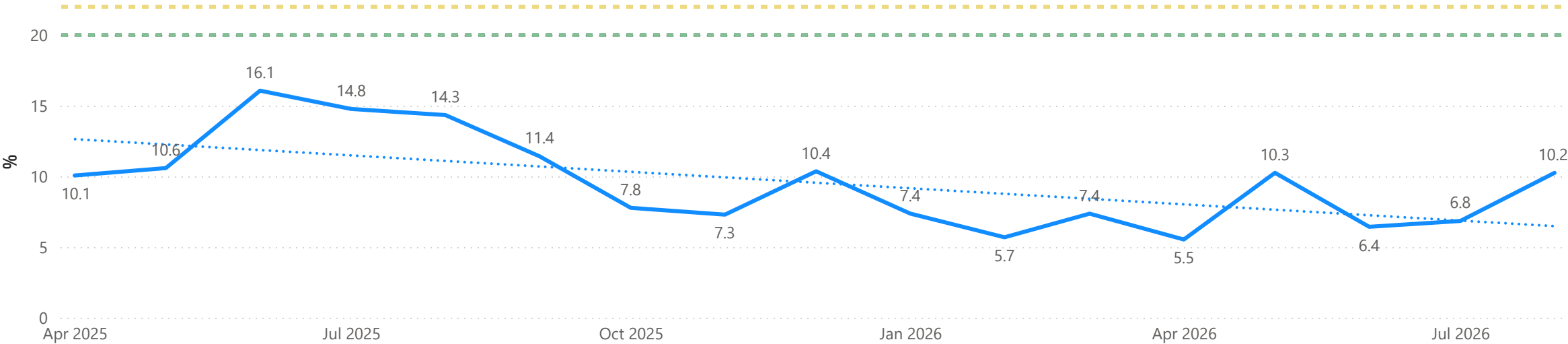
7.4

YTD

10.2

Status (Last 3 periods)

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	10.1	10.6	16.1	14.8	14.3	11.4	7.8	7.3	10.4	7.4	5.7	7.4
2026/2027	5.5	10.3	6.4	6.8	10.2							



Low-Risk Caesarean Section Rate



Description

This indicator measures the rate of deliveries via Caesarean section among singleton term cephalic pregnancies for low-risk nulliparous women in spontaneous labour

Data Source

Discharge Abstract Database (DAD)

Target

17.3

Previous YE

17.7

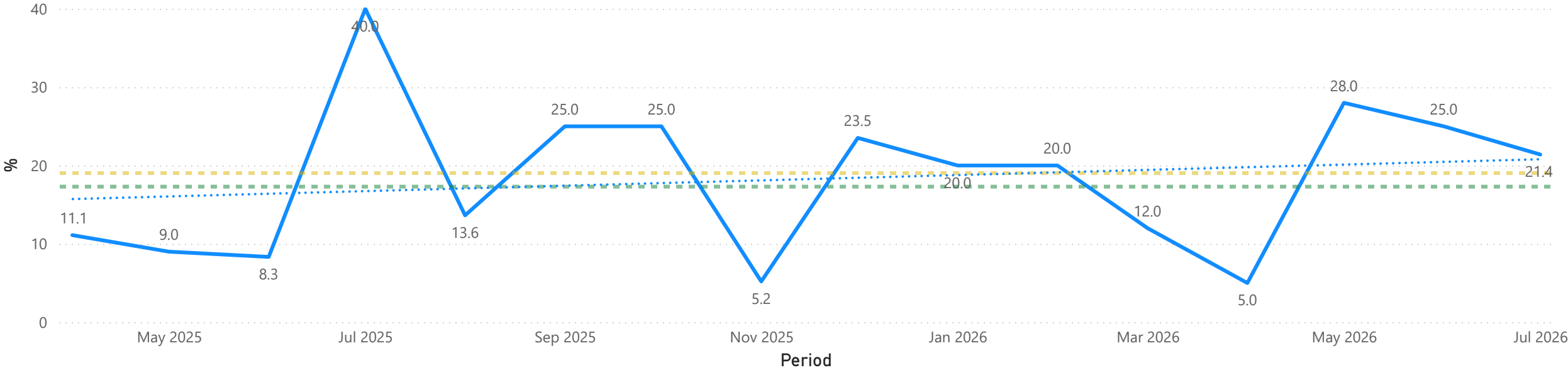
YTD

19.9

Status (Last 3 periods)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	11.1	9.0	8.3	40.0	13.6	25.0	25.0	5.2	23.5	20.0	20.0	12.0
2026/2027	5.0	28.0	25.0	21.4								



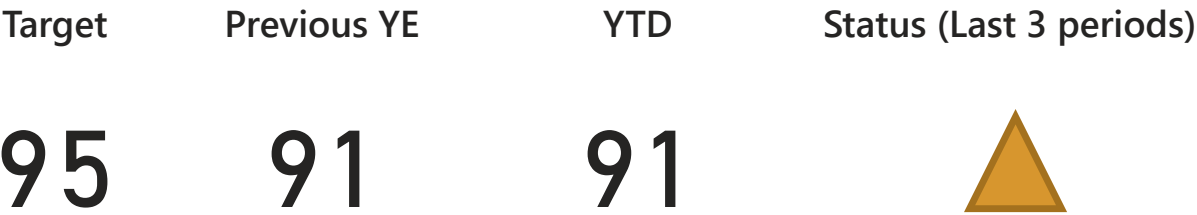
Medication Reconciliation



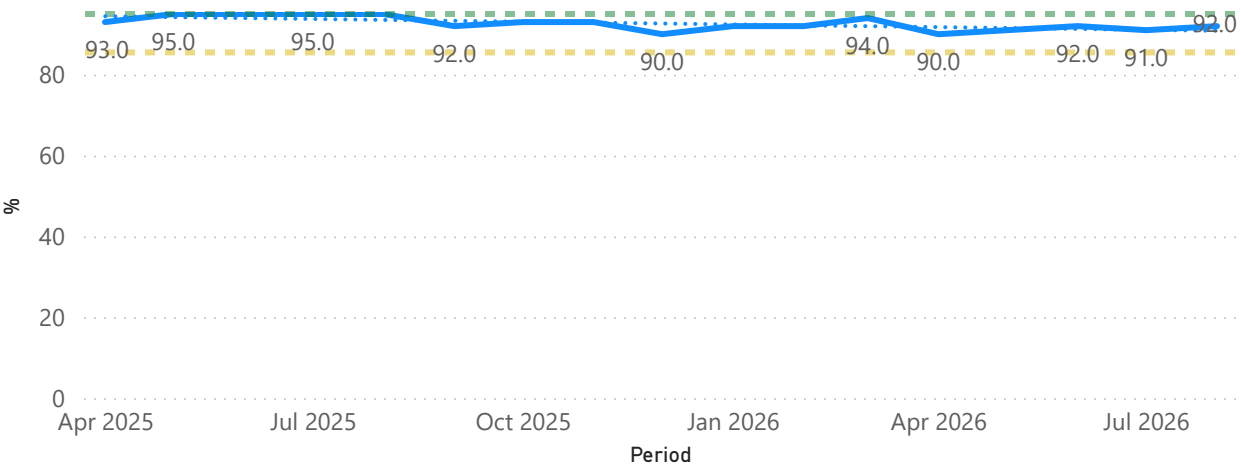
Admission

Description
The total number of patients who were discharged who had a Best Possible Medication History (BPMH) completed divided by the total number of patients who were discharged home

Data Source
Meditech Pharmacy Patient Profile



Trend

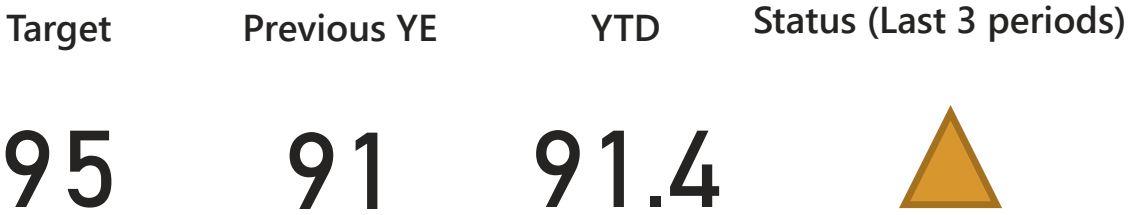


Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	93.0	95.0	95.0	95.0	95.0	92.0	93.0	93.0	90.0	92.0	92.0	94.0
2026/2027	90.0	91.0	92.0	91.0	92.0							

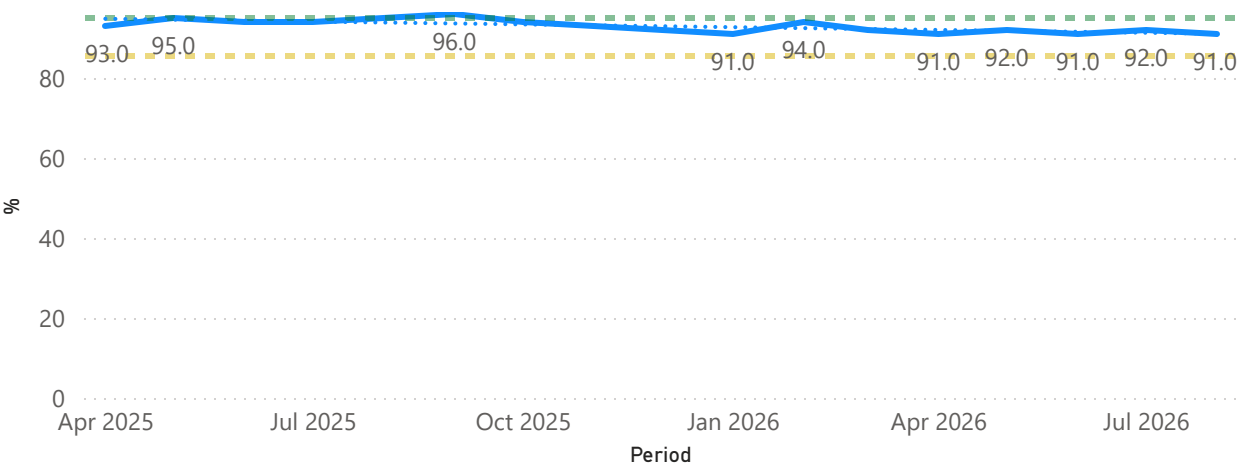
Discharge

Description
The percentage of Yes responses to the question "Was the CMH community pharmacy prescription completed? " for all inpatient locations participating in medication reconciliation at discharge

Data Source
Meditech



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	93.0	95.0	94.0	94.0	95.0	96.0	94.0	93.0	92.0	91.0	94.0	92.0
2026/2027	91.0	92.0	91.0	92.0	91.0							



Obstetric Trauma (with Instrument)



Description

Risk-adjusted rate of obstetric trauma (lacerations that are third degree or greater in severity) for instrument-assisted vaginal deliveries
(Risk-adjusted rate = Observed cases ÷ Expected cases × Canadian average,18.4)

Data Source

Discharge Abstract Database (DAD)

Target

14.4

Previous YE

3.9

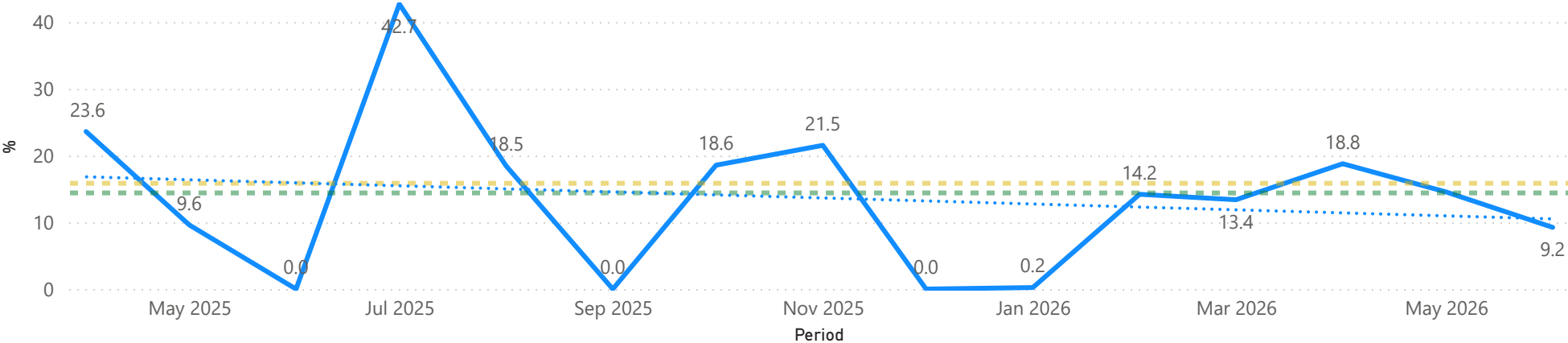
YTD

14.2

Status (Last 3 periods)



Trend



Month	Observed
Jun-26	2.00
May-26	3.00
Apr-26	3.00
Mar-26	2.00
Feb-26	3.00
Jan-26	1.00
Dec-25	0.00
Nov-25	3.00
Oct-25	2.00
Sep-25	0.00
Aug-25	4.00
Jul-25	4.00
Jun-25	0.00
Mav-25	1.00

Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	23.6	9.6	0.0	42.7	18.5	0.0	18.6	21.5	0.0	0.2	14.2	13.4
2026/2027	18.8	14.6	9.2									



Patient Safety Event - Falls with Harm Rate



Description

The number of falls with harm per 1,000 inpatient days. This includes events where after review, the severity is deemed to have incurred moderate or severe harm, or a critical incident involving death.

Data Source

ReportLink, Meditech

Target

0.0

Previous YTD

0.15

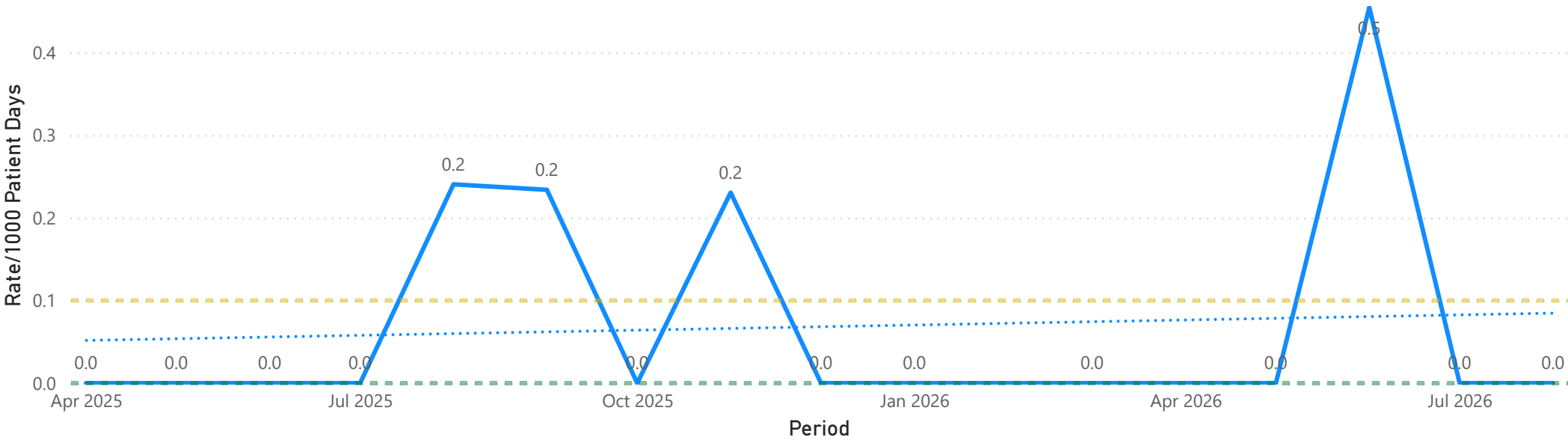
YTD

0.1

Status (Last 3 periods)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	0.0	0.0	0.0	0.0	0.2	0.2	0.0	0.2	0.0	0.0	0.0	0.0
2026/2027	0.0	0.0	0.5	0.0	0.0							



Patient Safety Event - Medication Events with Harm Rate



Description

The number of medication events with harm per 1,000 inpatient days. This includes events where after review, the severity is deemed to have incurred moderate or severe harm, or a critical incident involving death.

Data Source

ReportLink, Meditech

Target

0.0

Previous YTD

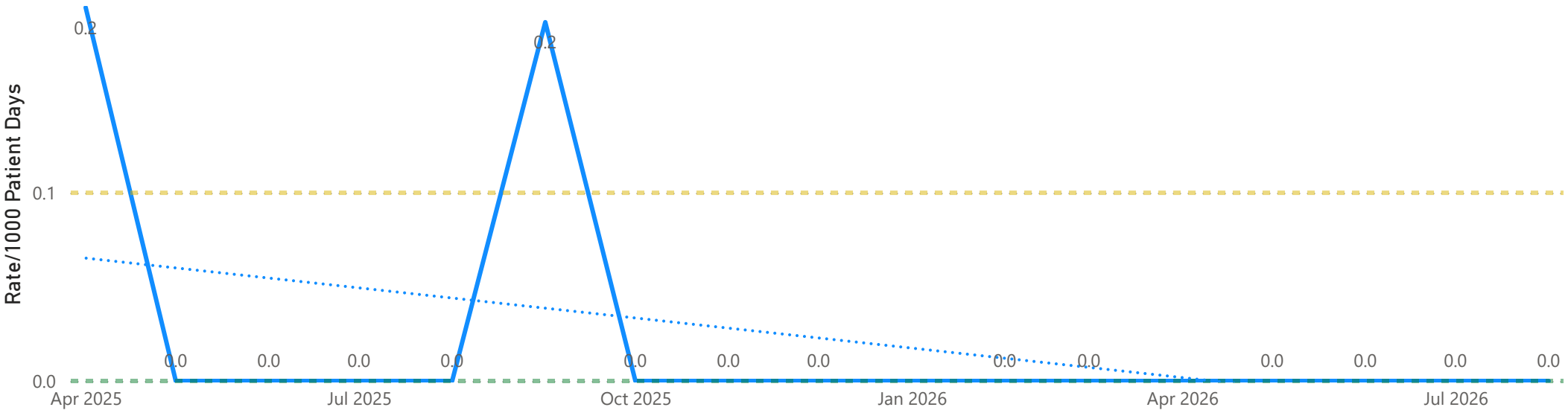
0.03

YTD

0.0

Status (Last 3 periods)

Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	0.2	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0
2026/2027	0.0	0.0	0.0	0.0	0.0							



Post-Construction Operating Plan (PCOP) Revenue



Description

The revenue achieved through all PCOP service areas, including Acute Inpatient, ED, Day Surgery, Mental Health Day Hospital, Mental Health Inpatient, ECT, and Ambulatory Clinics (Mental Health, Paediatric, Fracture, Surgery)

Data Source

Discharge Abstract Database, National Ambulatory Care Reporting System, Meditech

Monthly Target

746.3K

YTD Target

3.0M

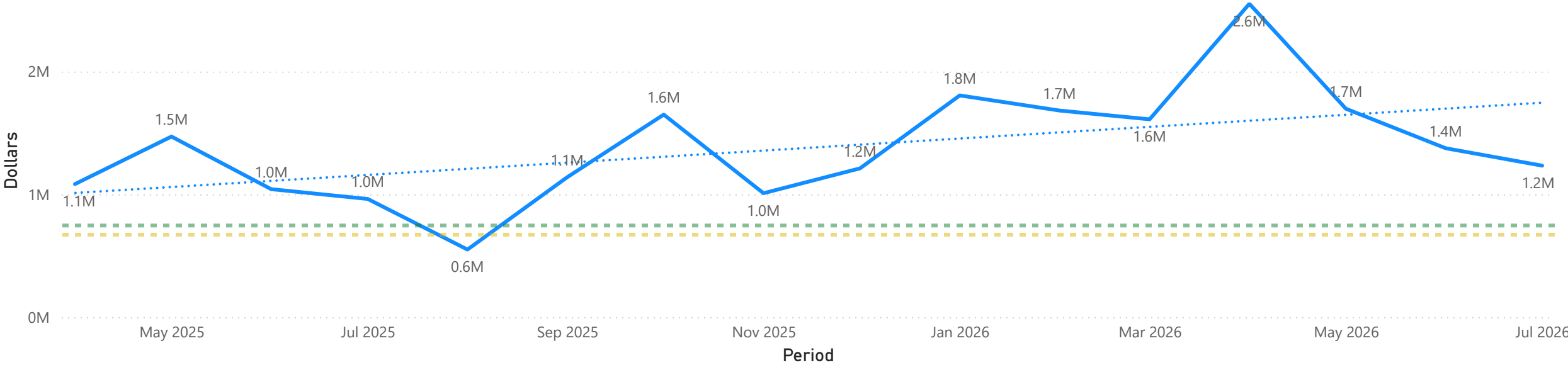
YTD

6.86M

Status (Last 3 periods)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	1,083,669	1,470,565	1,042,128	962,599	550,654	1,139,702	1,649,398	1,009,308	1,211,689	1,805,534	1,682,466	1,611,008
2026/2027	2,551,763	1,697,153	1,375,631	1,233,807								



Quality Based Procedure (QBP) Revenue



Description

The revenue achieved through all Quality Based Procedures, including Urgent QBPs & Non-Urgent Surgical QBPs (OH), Systemic Treatment (CCO), GI Endoscopy (CCO), and Cancer Surgery (CCO).

Data Source

Discharge Abstract Database, National Ambulatory Care Reporting System

Monthly Target

2.2M

YTD Target

8.9M

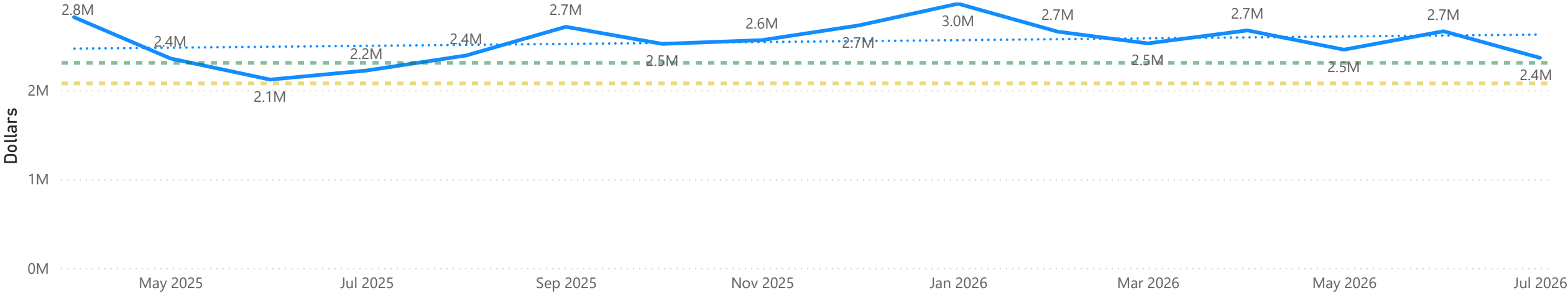
YTD

10.16M

Status (Last 3 periods)



Trend



Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	2,821,780	2,357,760	2,119,923	2,221,794	2,391,002	2,713,363	2,521,351	2,563,415	2,728,391	2,972,779	2,658,835	2,527,071
2026/2027	2,672,825	2,456,505	2,663,473	2,364,394								

*Please note Actual QBP Revenue will be capped at the Funding Available for each category (Total Funding=\$28.2M: \$20.8M for OH Urgent & Elective QBPs; \$2.9M for Cancer Surgery QBPs; \$2.0M for GI Endo QBP, \$2.5M for Systemic Treatment QBP)



Adequate Discharge Information

Data Source
Quality Metrics Survey



YTD Target

74.3

Previous YE

74.7

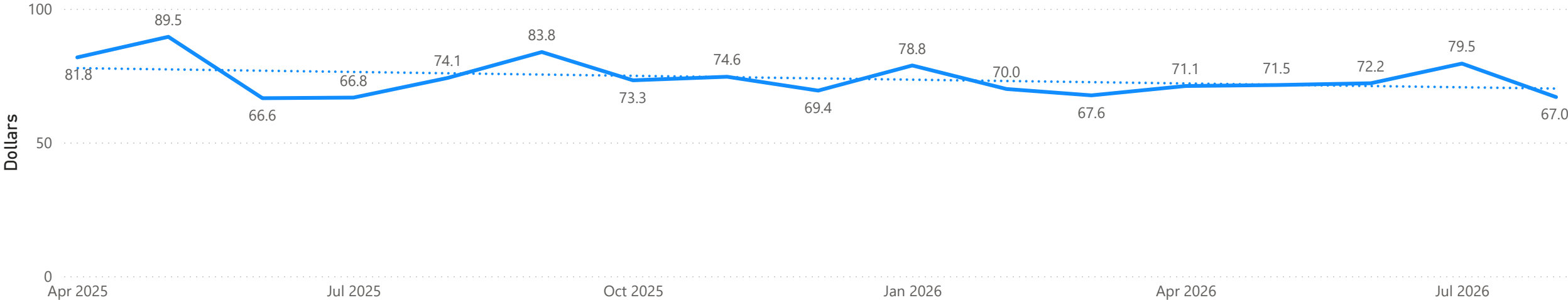
YTD

72.2

Status (Last 3 periods)



Trend



Fiscal Year	Period											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025/2026	82	90	67	67	74	84	73	75	69	79	70	68
2026/2027	71	71	72	80	67							

72



Patrick Gaskin
President and CEO
Phone: (519) 621-2333, Ext. 2301
Fax: (519) 740-4953
Email: pgaskin@cmh.org

MEMORANDUM

TO: Board of Directors, Cambridge Memorial Hospital

DATE: October 2, 2026

REPORTING PERIOD: June 20, 2026 to October 2, 2026

FROM: Patrick Gaskin
President and CEO

RE: CEO Certificate of Compliance

I have reviewed, or caused to be reviewed, such files, books of account and records of CMH and have made, or caused to be made, such enquiries of the financial, accounting and other personnel of CMH as I have determined necessary for the purpose of this certificate.

In my capacity of President and CEO, and for the reporting period identified above, I hereby attest that to the best of my knowledge, except as set out below:

- a) Salaries, Wages and Benefits – CMH has met all of its obligations in respect of the payment of all employee salaries and wages, vacation pay, holiday pay, termination pay, severance pay and benefits.
- b) Statutory Deductions – CMH has met all of its obligations in respect of the deduction, withholding and/or remittance of funds under the Income Tax Act (Canada), the Income Tax Act (Ontario), the Employer Health Tax Act (Ontario) (EHT), the Excise Tax Act (Canada) (HST), Workplace Safety and Insurance Act (Ontario) (WSIB), the Employment Insurance Act (Canada) (EI), the Canada Pension Plan Act (Canada) (CPP), and if applicable, remittances for required deductions for payments to non-residents.
- c) Financial Statements – the CMH financial statements, as at the date of their preparation were accurate and complete in all material respects.

Exceptions: NIL

A handwritten signature in black ink, appearing to read "Patrick M. Gaskin", with a horizontal line extending from the end.

Patrick Gaskin
President and CEO



BRIEFING NOTE

Date: September 23, 2026
Issue: 2024-25 and 2025-26 Ministry of Health Child and Youth Mental Health Transfer Payment Annual Reconciliation (TPAR) Submissions
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Spencer Ogston, Senior Financial Analyst
Michelle D’Souza, Manager, Finance
Approved by: Janet Short, Senior Financial Advisor, Finance
Trevor Clark, VP Finance & Corporate Services, CFO

- Attachments/Related Documents:**
- 1. 2024-25 Ministry of Health Child and Youth Mental Health Transfer Payment Annual Reconciliation (TPAR) Submission
 - 2. 2025-26 Ministry of Health Child and Youth Mental Health Transfer Payment Annual Reconciliation (TPAR) Submission

Alignment with 2026/27 CMH Priorities:

2022-2027 Strategic Plan No ☐	2026/27 CMH Priorities No ☐	2026/27 Integrated Risk Management Priorities No ☐
☐ Elevate Partnerships in Care	☐ Improve Patient Flow (CBD, PIA, ED Admits)	☐ Organizational Flow
☐ Reimagine Community Health	☐ Prepare for Digital Health Transformation	☐ Project Quantum
☐ Increase Joy in Work	☐ Increase Staff Engagement Through Improved Staffing (Med, ICU, ED, Physicians)	☐ Management/Medical Staff Partnership
☒ Sustain Financial Health	☒ Achieve a Balanced 2026/27 Operating Position	☒ Financial Sustainability
☐ Advance Health Equity	☐ Embrace Diversity, Build a Culture of Inclusion	☐ Change Management

Alignment with 2026/27 CMH Corporate Plans: Multi-Year Financial Plan

Recommendation/Motion
Board

That, The Board of Directors, having reviewed the information presented and considered the recommendation of the Resources Committee arising from its meeting on September 28, 2026, approves the 2024–25 and 2025–26 Ministry of Health Child and Youth Mental Health Program Transfer Payment Annual Reconciliation (TPAR) submissions, as presented/amended.

Resources Committee
Following review of the information provided, the Resources Committee recommends to the Board of Directors the approval of the 2024-25 and 2025-26 Ministry of Health - Child and Youth Mental Health Program Transfer Payment Annual Reconciliation (TPAR) submissions. *CARRIED.*

Executive Summary
Management is proactively requesting Board approval of the fiscal 2024-25 and 2025-26 Ministry of Health – Child and Youth Mental Health Program Transfer Payment Annual

Reconciliation (TPAR) submissions in advance of the Ministry of Health (MOH) request to submit these reports. The MOH is currently reviewing the 2023-24 TPAR submission and expected to catch-up on prior year reconciliations in fiscal 2026-27.

Background

TPAR submissions are completed each fiscal year-end and audited by Cambridge Memorial Hospital’s (CMH) external auditor before submission to the MOH. The reports summarize how the hospital has spent funding provided by the MOH on Child and Youth Mental Health programs during the year.

Analysis

Historically, there has been misalignment with the timing of CMH Board meetings and the due date of the Ministry of Health - Child and Youth Mental Health Transfer Payment Annual Reconciliation (TPAR) submissions. These submissions require Board approval and the signature of the Board Chair. In future years, management will continue to submit to the MOH subject to Board approval. The TPAR submission will be brought to the first Board meeting after the summer break period for approval and then resubmitted to the MOH.

KPMG has audited the 2024-25 and 2025-26 TPAR submissions. Most of the funding was spent on salaries and wages for staff and a psychiatrist working in the program. CMH has used all the funding provided in both 2024-25 (\$430K) and 2025-26 (\$479K).

Ministry of Health - Child and Youth Mental Health	
2024-25 Transfer Payment Annual Reconciliation (TPAR) submission	
SECTION I: CERTIFICATION AND VERIFICATION	
I hereby certify that, to the best of my knowledge, the financial data in the Transfer Payment Annual Reconciliation to which this certification is attached, is true, correct, agrees with the books and records of the organization and has been prepared in accordance with the Technical Instructions and ministry financial policies provided by the Ministry of Health.	
CERTIFICATION BY TRANSFER PAYMENT RECIPIENT	
Cambridge Memorial Hospital	
Legal Name of Transfer Payment Recipient	
	Signature of Service Provider / Delivery Agent Authority
	Patrick Gaskin
	Name of Service Provider/Delivery Agent Authority
	President & Chief Executive Officer
	Title
	Date (dd/mm/yy)
VERIFICATION BY THE BOARD OF DIRECTORS	
The above certification, together with the Transfer Payment Annual Reconciliation, was received and approved by:	
the Board of Directors on the day of , .	
Chairperson of the Board of Directors:	
	Signature
	Diane Wilkinson
	Name of Chairperson or Designate
	Chair, Board of Directors
	Title

Annual Final Report

**CAMBRIDGE MEMORIAL
HOSPITAL**

**Ministry of Health Child and Youth Mental
Health Program**

And Independent Auditor's Report thereon

For the period from April 1, 2024 to March 31, 2025



KPMG LLP
 120 Victoria Street South
 Suite 600
 Kitchener, ON N2G 0E1
 Canada
 Telephone 519 747 8800
 Fax 519 747 8811

INDEPENDENT AUDITOR'S REPORT

To Cambridge Memorial Hospital and the Ontario Ministry of Health:

Opinion

We have audited the financial information in the accompanying schedules "F Year End Actuals" and "G Final Report Summary" of the Ministry of Health Child and Youth Mental Health Program Annual Final Report (excluding statistics, FTE's and Interim Actuals) of Cambridge Memorial Hospital (the "Hospital"), for the period from April 1, 2024 to March 31, 2025, including a summary of significant accounting policies and other explanatory information (Hereinafter referred to as the "Schedule").

In our opinion, the accompanying Schedule for the period from April 1, 2024 to March 31, 2025, of the Hospital is prepared, in all material respects, in accordance with financial reporting provisions of the Ministry of Health Child and Youth Mental Health Transfer Payment Financial Policies issued by the Ontario Ministry of Health.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the "**Auditor's Responsibilities for the Audit of the Schedule**" section of our auditor's report.

We are independent of the Hospital in accordance with the ethical requirements that are relevant to our audit of the Schedule 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.

Emphasis of Matter – Financial Reporting Framework

We draw attention to Note 2 to the Schedule which describe the applicable financial reporting framework and the purpose of the Schedule. The Schedule is prepared to assist the Hospital to meet the requirements of reporting provisions issued by the Ontario Ministry of Health.

As a result, the Schedule may not be suitable for another purpose.

Our opinion is not modified in respect of this matter.



Page 2

Responsibilities of Management for the Schedule

Management is responsible for the preparation of the Schedule in accordance with financial reporting provisions of the Ministry of Health Child and Youth Mental Health Transfer Payment Financial Policies issued by the Ontario Ministry of Health, and for such internal control as management determines is necessary to enable the preparation of the Schedule that is free from material misstatement, whether due to fraud or error.

Auditor's Responsibilities for the Audit of the Schedule

Our objectives are to obtain reasonable assurance about whether the Schedule as a whole is 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 the Schedule.

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 Schedule, 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.



Page 3

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



Chartered Professional Accountants, Licensed Public Accountants

Kitchener, Canada

July 31, 2025



MOH - Child and Youth Mental Health 2024-25

Reporting Period: 04/01/2024 to 03/31/2025

Saved: 07/22/2025 13:58

Expand

Validate

A) Instructions	B) Organization Information	C) Organization Address Information
D) Organization Contact Information	E) Report Contact Information	F) Year End Actuals
G) Final Report Summary	H) TPAR Instructions	I) TPAR
J) Declaration / Signing		

A) Instructions

PLEASE DO NOT WORK ON COMPLETING THIS FORM UNTIL THE FINAL REPORT HAS BEEN SUBMITTED SUCCESSFULLY IN TRANSFER PAYMENT ONTARIO.

How to Use and Submit the Transfer Payment Annual Reconciliation (TPAR) Form:

- Save this form to your hard drive (note the file name so that you can upload the form to TP Ontario upon completion). Please do not change the format of this PDF Document. TP Ontario will not accept a flat or scanned copy of this form.
- Organizational information has been pre-populated based on information supplied during the TP Ontario registration process. Please ensure the accuracy of pre-populated organizational information prior to proceeding.
- Input the information required for each section. IMPORTANT NOTE: The form does not save automatically. Press “CTRL+S” on your keyboard to save.
- We recommend the Report be reviewed and completed in sequential order (from section “B” through to “J”) given that section “F) Year-End Actuals” of the form has been pre-populated with information collected in the Final Report Submission and populates into “I) TPAR”).
- Validate the report form by selecting the Validate button (top right corner of the pdf form) and making corrections as prompted.
- In Section “J) Declaration / Signing”, the form must be signed digitally by a person from your organization with signing authority.
- Upload your completed form, along with all the required supplementary reports and documentation, to Transfer Payment Ontario.

Additional Important Information:

- The financial details reported in the Transfer Payment Annual Reconciliation (TPAR) report will be used to create to reconcile your organization’s actual expenditures with ministry funding for accountability purposes. The reconciliation is done to enable the ministry to identify funds that have to be recovered. Please ensure that the financial information provided in this section reflect the audited year end results.
- Kindly review the prepopulated information. Should any details be incorrect, please contact your Program Supervisor to amend the Final Report in TPON, as it is not editable in the TPAR. Once the revised final report has been resubmitted in TPON, you will need to redownload a new TPAR for completion.
- The TPAR Report will be assessed based on the information provided within this form and additional assessments as determined by ministry staff.

TPON Technical Support

For technical support related to Transfer Payment Ontario, please contact Transfer Payment Ontario Client Care at 416-325-6691 or 1-855-216-3090 or TPONCC@ontario.ca

Monday to Friday from 8:30 a.m. to 5:00 p.m. Eastern Standard Time.

TTY/Teletypewriter (for the hearing impaired): 416-325-3408 / Toll-free: 1-800-268-7095

B) Organization Information

This section displays general information about your organization that was submitted during the Transfer Payment Ontario registration process. Please ensure this information is correct. **You will not be able to update the information displayed here within the form.** If this information needs to be updated, please update your organization information by logging into your TP Ontario account and selecting the “View/Update Organization” menu card displayed on the Home Page and re-download a new version of the form.

For more information visit: [How to View/Update Organization information.](#)

Organization Information

Organization Name:
Cambridge Memorial Hospital

Organization Legal Name:
Cambridge Memorial Hospital

Website URL:

Type of Organization:
Hospital

Date Incorporated:

Region:

C) Organization Address Information

This section displays your organization’s address information that was submitted during the Transfer Payment Ontario registration process. Please ensure this information is correct. **You will not be able to update the information displayed here within the form.** If this information needs to be updated, please update your organization address information through logging into your TP Ontario account and selecting the “View/Update Organization” menu card displayed on the Home Page and re-download a new version of the form.

For more information visit: [How to View/Update Organization information.](#)

Business Address

Street Address 1:
700 Coronation Boulevard

Street Address 2:

City/Town:
Cambridge

Province:
ON

Postal Code:
N1R3G2

Country:
Canada

Mailing Address

Street Address 1:
700 Coronation Boulevard

Street Address 2:

City/Town:
Cambridge

Province:
ON

Postal Code:
N1R3G2

Country:
Canada

D) Organization Contact Information

This section displays general contact information about your organization’s primary staff. This information is pre-populated based on information submitted during the Transfer Payment Ontario enrolment process. The contacts listed in this section are not necessarily specific to this submission.

To edit contacts within the TP Ontario System, log into your TP Ontario account and select the “View/Update Organization” menu card displayed on the Home Page and re-download the budget form to reflect the changes made in the TP Ontario system.

For more information visit: [How to View/Update Organization information.](#)

Organization Contact Information

Agenda

First Name: Patrick	Last Name: Gaskin
Job Title: President/CEO	
Primary Phone Number: --	Secondary Phone Number: --
Email Address: pgaskin@cmh.org	

E) Report Contact Information

The fields in this section are prepopulated from the budget submission. Please review the contact information and provide updates where the contact information is out of date. Please do not use any abbreviations when providing the contact information.

At least one representative within your organization must have attestation authority for this report. Any representatives outside your organization (i.e. project management/consulting staff) will not be considered as signing authorities.

The individual listed as the primary contact for this submission may be contacted by the ministry for further information regarding the elements within this form.

1. The “Primary” box should be checked off if the contact is considered the main contact for all information within this report.
2. The “Signing Authority” box should be checked if the contact has the authority to commit your organization to a binding agreement. More than one person can be a “Signing Authority”.
3. The “Primary” and “Signing Authority” contact can be the same person.
4. Use the “Add” button to provide additional contacts if needed.

The contacts listed in this section will receive all communications from the Transfer Payment Ontario System regarding agreements, and any changes related to the final report.

Report Contact information	Add	Remove
Primary: ☒		
First Name: * Valerie	Last Name: * Smith-Sellers	
Title: * Director, Finance	Primary Phone Number: * 5196212333	
Secondary Phone Number:	Email Address * vsmith-sellers@cmh.org	
Signing Authority ☒		

F) Year End Actuals

THE DATA IN THIS SECTION IS PRE-POPULATED FROM YOUR FINAL REPORT SUBMISSION AND CANNOT BE EDITED.

This section of the form, “Section F – Year-End Actuals”, reflects financial information for all expenses and revenues at the Component Level. The funding amount by service delivery area and program in this form has been pre-populated with information that is specific to your organization, for all the funding you received in the current fiscal year and has been reconciled to your final Ministry of Health remittance for Child and Youth Mental Health programs. If it appears to be incorrect, please contact your Program Supervisor or the contact person/s below. Information pre-populated in this section will be summarized in “Section G -Final Report Summary”.

IMPORTANT! The financial details reported in the Final Report back populates the Transfer Payment Annual Reconciliation (TPAR) Report that will be used to reconcile your organization’s actual expenditures with ministry funding for accountability purposes. The reconciliation is done to enable the ministry to identify funds that have to be recovered. Please ensure that the financial information provided in this section reflect the audited year end results.

The Component, Ministry Allocation, and Service Delivery Area is indicated at the top of each table.

Definitions:

- “Ministry Allocation for Component” is pre-populated with the funding you received from the Ministry of Health in the fiscal year for the specific program component and has been reconciled to your final remittance.
- “Budget Item” indicates categories and sub-categories of expenses and revenue.
- “Definition” provides a brief description of the budget item.

“Year End Actuals” is pre-populated with information you have submitted to the ministry as part of your Final Report and is not editable in the TPAR. Kindly review the information. Should any details be incorrect, please contact your program supervisor to amend the Final Report in TPON. Once the revised Final Report has been resubmitted in TPON, you will need to download a new TPAR for completion.

Component:

2 - CYMH Case Management and Service Coordination

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Budget : CYMH Case Management and Service Coordination 2024-25 (Waterloo)

Ministry Allocation for Component: \$18356

Budget Item	Definition	Year End Actuals
Budget		
Total Ministry Allocation	Sum of all Ministry of Health Allocation amounts	\$18,356.00
Annualized (Rollover from previous fiscal year)	Base/ongoing funding amount as approved at the end of the previous fiscal year	\$18,356.00
In-year base adjustment	Base/ongoing funding amount approved in the current fiscal year	\$0.00
In-year one-time funding adjustment (fiscal funding)	One-time funding approved for the current fiscal year	\$0.00
Total Ministry Program Expenditures	Expenditures net of non-ministry offsetting revenue	\$18,356.00
Total Expenditures	Sum of all expenditure lines	\$18,465.00
* Salaries	Salary and Wages paid to all full-time, part-time, temporary, occasional, summer or other employees. Includes pay for: regularly scheduled hours, overtime, statutory holidays, vacation, sick leave and education leave	\$15,305.00
* Benefits	Includes mandatory benefits such as Canada Pension Plan (CPP), Employment Insurance (EI), Employer Health Tax (EHT), etc. and other non-mandatory benefits such as pension contributions, group life coverage, etc. paid by the employer.	\$3,160.00
* # of FTEs	Number of full time service/program staff.	0.16
* Staff Training	All service costs incurred by the service provider in the recruitment and education of Volunteers, Board Members and Staff.	\$0.00
* Travel and Communication	Total travel and communication expenses incurred conducting activities for all services/programs	\$0.00
* Mortgage Principal	Costs incurred for mortgage principal (eligible expenditure only if the ministry has a financial interest in the property)	\$0.00
* Other Building occupancy Costs	Total building occupancy expenditures, other than mortgage principal, directly associated with the service/prigram (e.g. rent, property tax, insurance, repairs and maintenance on buildings/grounds/ structures etc.)	\$0.00
* Professional/Contracted-out Services	Professional or contracted out services for which the service provider itself does not employ staff including: Accounting, Audit, and Legal fees; Bank payroll services; Architectural and engineering fees; and Medical and related consultants fees.	\$0.00
* Supplies and Equipment	Expenditures directly related to supplies and equipment for all service/ program delivery.	\$0.00

Agenda

* Other Program/Service Expenditures	Any services that cannot be classified elsewhere above. Can include: rental/lease of equipment; bank service charges; dues or fees paid to professional associations or other organizations; etc.	\$0.00
* Allocated Central Administration	General operating costs associated with governing and operating an organization. Do not include cost for service/program administrative expenses that directly supports clients.	\$0.00
Allocated Central Administration Percentage	Allocated Central Administration expressed as a percentage of the ministry allocation	0.00%
* Adjustments (+/-)	Transactions (+/-) against ministry allocation amount for program/services (e.g. one-time funds [+], or reductions [-]). Ministry approval required prior to adjustments between components.	\$0.00
NON-MINISTRY FISCAL REVENUE (OFFSETTING REVENUE)		\$109.00
* Other Provincial Government Funding	"Revenue received from the Government of Ontario (other than MOH) for all services/programs."	\$0.00
* Federal Government Funding	"Revenue received from the Government of Canada for all services/ programs."	\$0.00
* Municipal Government Funding	Revenue received from the Municipality for all services/programs.	\$0.00
* Client Contribution Payments	Revenue received from clients for all services/ programs.	\$0.00
* Other Revenue	"Other revenue received, from sources not captured above, for all programs/ services."	\$109.00
Variance Notes and Adjustments Itemization		

G) Final Report Summary

THE DATA IN THIS SECTION IS PRE-POPULATED FROM YOUR FINAL REPORT SUBMISSION AND CANNOT BE EDITED.

The "Final Report Summary" tab is prepopulated with financial data summarized at the component level. It requires no action other than reviewing the information for accuracy.

Component+Service Area	Total Ministry Revenue	Total Year-End Actual Ministry Program Expenditure (excludes Non-Ministry Offsetting Revenue)	Variance (\$)	% Variance
CYMH Case Management and Service Coordination 2024-25 Waterloo	\$18,356.00	\$18,356.00	\$0.00	0.00%
CYMH Coordinated Access and Intake 2024-25 Waterloo	\$36,612.00	\$36,612.00	\$0.00	0.00%
CYMH Counselling/Therapy Services 2024-25 Waterloo	\$318,443.00	\$318,443.00	\$0.00	0.00%
CYMH Specialized Consultation Assessment 2024-25 Waterloo	\$56,992.00	\$56,992.00	\$0.00	0.00%
TOTAL:	\$430,403.00	\$430,403.00	\$0.00	0.00%
Allocated Central Admin				\$0.00
Actual Allocated Central Admin as a Percentage of Ministry Revenue (Should not exceed 10%, or 10.5% for Northern agencies, of the overall allocation)				0.00%
Actual Allocated Central Admin as a Percentage of Year-End Expenditures				0.00%
Overall Variance Explanation				

H) TPAR Instructions

Complete each section on the TPAR Template.

1. REVENUE, EXCLUSIONS AND INCLUSIONS FROM THE SUBSIDY CALCULATION (LINES 400 to 445)

a. Ministry Revenue: All funding received from the ministry for a program/service for the current fiscal year. Includes previous year annualized funding and any in-year adjustments.

- (401 - 411) Revenue received from the Ministry of Health (MOH) must only be used for the services that the Transfer Payment Recipient (TPR) is approved to deliver.
- Complete Line 401 and 402 as per the Ministry of Health (MOH) remittance report; Line 401 should be all the base/annualized funding and repeating one time funding utilized for operating purposes; and Line 402 should reflect the total funding received for time-limited projects (for example minor capital improvements funding).
- Line 402 should equal the sum of all one-time funding for which the Ministry will require a project sub-report to be completed.
- Line 405 is the sum of Line 401 and 402, no input required.
- Line 410 is linked to section "F) Year-End Actuals", which represents the TOTAL funding received from MOH for CYMH services in the current Fiscal Year. No input required.
- Line 411 is the variance between the total input by the TPR in line 401 & 402 and the auto populated line 410. This variance should be zero, or an explanation must be provided.

b. Non-Retainable Revenue: If produced from ministry funded resources, the excess revenue is subtracted from the gross expenditures, which reduces the expenditures eligible for ministry funding.

- Lines 415-421 add in any revenue generated from MOH-CYMH funded resources that were not used for admissible CYMH program expenditures (reported in Line 425). These non-retainable revenues must be returned to the Ministry and included in the subsidy calculation as part of the TOTAL TPAR RECOVERY. Examples of non-retainable revenues include interest revenue from investing ministry funds, expenditure recoveries, refunds or recoveries of previous expenditures; specific CYMH program operating donations, net revenue arising from the sale of goods and/or the provision of services provided by the TPR, parental contributions and inter-agency chargebacks, etc.). For more information refer to the CYMH Transfer Payment Financial Policies, "Retainable and Non-Retainable Revenue".

c. Non-Ministry Fiscal Revenue (Offsetting Revenue): All non-ministry revenue sources that provides funding for a program

- Line 425 is linked to section "F) Year-End Actuals". Which represents the Total of NON-MINISTRY FISCAL REVENUE (OFFSETTING REVENUE), no input required.
- Lines 426 - 428 Enter other revenue adjustments, such as unspent recoverable funds or reporting of prior year carry over of funds, revenue generated from charges levied for the use of ministry subsidized resources, such as parking fees, staff or visitor accommodation or meals, space or equipment rentals, transportation charges, etc. This also encompasses rental income generated from leasing ministry-funded space to other organizations, as well as revenue received from other ministries, government bodies or community agencies (for example Lead Agencies) for costs that are typically subsidizable. These revenues are not recorded or accounted for separately and are used to offset CYMH expenses. Detailed comments are required.
- Line 429 is the sum of Lines 425 to 428 related to all non-ministry revenue sources that are used to offset CYMH program expenses.

d. Total CYMH funding for settlement purposes (Line 430) is the sum of Lines 405 + Line 421 + Line 429. No input is required.

e. The next section reflects accounting adjustments required to reconcile the TPAR to the Audited Financial Statements (AFS):

- Line 431 Funding used to purchase capitalized items in the current year must be deducted from the total subsidy to align with the Audited Financial Statements (enter as negative amount).
- Line 432 Amortization of MOH-CYMH funding and donation revenue in the current fiscal year.
- Line 435 is the sum of Lines 431 to 434 related to all other adjustments needed to reconcile the TPAR to the audited financial statements.

f. Retainable Revenue: generated from non-ministry funded resources is applied to meet the TPRs legislated share of approved expenditures (referred to as Revenue [Legislated Share] in the Budget Schedule). Excess retainable revenue not legislatively assigned is available for the TPRs other costs or deficits.

- Line 433 & 434 Enter other revenue adjustments, such as general donations, any monies received for capital purposes (e.g. specific donations, endowments, bequests), fundraising where the revenue is generated through activities not involving the use of ministry resources, interest revenue arising from the investment of retainable revenue; and other grants or subsidies received for activities not ordinarily funded by the ministry. Detailed comments are required.

g. Line 445 Enter Other Revenue that relates to Other Grants or Subsidies (non-MOH-CYMH), revenue received from other ministries, government bodies or community agencies for costs ordinarily subsidizable. These revenues are reported in the same statement of operation as CYMH but need to be accounted for separately.

h. Line 400 is the sum of Line 430 + Line 435 + Line 445 and reflects the Total Revenue for the TPR on the AFS for the Funding Year. No input required.

2. FUNDED AND NON-FUNDED EXPENSES (LINES 450 to 485)

a. Expenditures that are deemed reasonable and necessary for the provision of services are usually admissible for calculation of the operating subsidy. These expenditures must be authorized in accordance with the policies of the TPR, consistent with government policies, approved by the ministry, and supported by documentation as requested.

- Line 451 to 456 Listed below are funded expenses (i.e., admissible for calculation of the operating subsidy) and are linked to section "F) Year-End Actuals". If changes to these amounts are required, the Final Report submission will have to be resubmitted in TPON.
 - Line 451 Add: Salaries (Sum of All components except ACA)
 - Line 452 Add: Benefit (Sum of All components except ACA)
 - Line 453 Add: Other Direct Operating and Service Costs [Sum of (Staff Training - Travel and Communication - Mortgage Principal - Other Building occupancy Costs - Professional/Contracted-out Services - Supplies and Equipment) - Sum of All components except ACA]
 - Line 454 Add: Other Transactions [Sum of (Other Program/Service Expenditures - Adjustments (+/-) - Small Water Works - Pay Equity) - Sum of All components except ACA]
 - Line 455 Add: Allocated Central Administration (Sum of All components except ACA)

b. Inadmissible Expenditures: The modified accrual basis of accounting, as defined by the ministry, does not recognize non-cash transactions such as charges/appropriations to reserves or allowances, as these expenses do not represent an actual cash expenditure related to the current period; as well any expenses are not consistent with government policies and approved by the Ministry.

- Lines 457 - 463 to report inadmissible expenditures that were already included in lines 451-456; such as amortization, Provisions for Unused Vacation/Sick Leave, Wage Settlements, Contributions or Donations to Political Organizations, Fines, Loans to Clients or Staff, etc.. For more details, please refer to the MOH CYMH Transfer Payment Financial Policies "Admissible and Inadmissible Expenditures".

c. The next section reflects accounting adjustments required to reconcile the TPAR to AFS:

- Lines 464 - 466 are reconciling items to match the TPAR to the AFS, these items are One Time Capitalized purchases, Amortization on Major Equipment and Building amortization.

d. Total CYMH Expenses to for settlement purposes (Line 480) is the calculation of Line 456 - Line 463. No input is required.

e. Line 485 Enter all other expenditures (excluding MOH-CYMH) related services not associated with CYMH services. These expenditures are reported in the same statement of operation as CYMH but must be accounted for separately.

f. Line 450 is auto calculated: Line 456 - Line 464 + Line 465 + Line 466 + Line 485. No input required. Note that the Total Expenses must match the Total Expenses in the AFS.

g. Total surplus/(deficit) reported in the AFS (Line 490) should match the Statement of Operations, auto calculated: Line 400 - Line 450. No input required.

h. Ministry approved carryover (Line 495) is the unspent funding amount previously approved by the Ministry to carryover into the following Fiscal Year. If applicable, this will be pre-populated, no input required.

i. Final TPAR Recovery amount (Line 500) auto calculated: Line 430 - Line 480 - Line 495. No input required.

3. Manual Input Required from Audited Financial Statements:

- 510 - Liquid Assets - is an asset that can be easily converted into cash in a short amount of time.
- 511 - Total Assets - refer to the total amount of assets (Current and non-current assets) owned by an organization, total assets represent the economic value owned by an organization.
- 512 - Total Debt - is the sum of money due to be paid includes the values of long-term liabilities (loans) and current liabilities.
- 513 - Total Liabilities - are the combined debts and obligations that an organization owes to outside parties.
- 514 - Current Assets - short-term assets that are expected to be used up or spent within 12 months.
- 515 - Current Liabilities - financial obligations of an organization that are due and payable within a year.
- 516 - Total Revenue - is money received from donations from individuals, foundations, and companies, grants from government entities, investments, and/or membership fees.

Agenda

- 517 - Total Expenses - for a given period refer to the sum of all the total gross cash expenditures plus any subsidiary pending, such as operating expenses, incentive fees, interest, and taxes. This refers to the total expenses as per the Financial Statements in a given year.
- 518 - Total Government Revenue - is money received from all areas of the Provincial government.

4. Ratios: Calculated fields. No input required.

- Current Ratio (Line 514 / Line 515) - is used to measure the overall liquidity of a nonprofit organization.
- Program Expense Ratio (Line 480 / Line 517) - measures the percentage of expenses that a nonprofit organization is spending on this program. If ratio is less than 50% means this is not the main program of the organization.
- Administrative Expense Ratio (Line 455 / Line 480) - measures the percentage of an organization's expenses that are being allocated to administrative costs in specific program.
- Government Reliance Ratio (Line 518 / Line 516) - measures a nonprofit organization's reliance on governmental funding.
- Leverage Ratio (Line 513 / Line 511) - measures how heavily leveraged an organization is. This nonprofit ratio also is an indicator of how sustainable an organization is. An increasing leverage ratio could be a sign of financial trouble for an organization. Under .5 or 50% is better.
- Net Margin Ratio (Line 516 - Line 517 / Line 516) - Nonprofits should not be expected to not make a profit. However, continued negative trends in the net margin ratio can be an indicator of poor financial management.
- Liquidity Ratio (Line 510 / Line 515) - assess a nonprofit's ability to meet short-term obligations, ensuring smooth operations. A quick ratio of 1 or higher is generally satisfactory.
- Debt Ratio (Line 512 / Line 511) - debt ratio refers to a financial ratio that measures the extent of an organization's leverage. It can be interpreted as the proportion of a organization's assets that are financed by debt. A lower debt ratio signifies that the nonprofit is more financially solid and lowers the chance of insolvency. Ratio less than 1.

I) TPAR

PLEASE DO NOT WORK ON COMPLETING THIS FORM UNTIL THE FINAL REPORT HAS BEEN SUBMITTED SUCCESSFULLY IN TRANSFER PAYMENT ONTARIO. THERE ARE SECTIONS IN THE FORM THAT ARE PRE-POPULATED FROM YOUR FINAL REPORT SUBMISSION AND CANNOT BE EDITED.

LINE	Description	2024-25 Final	Comments
400	TOTAL GROSS REVENUES PER AUDITED FINANCIAL STATEMENTS (Line 430 + Line 435 + Line 445)	\$432,720.00	
401	Funding - MOH-CYMH -Operational	\$430,403.00	
402	Funding - MOH-CYMH- One-Time Projects		
405	TOTAL Approved Ministry Funding as per cash flow (Line 401 + Line 402)	\$430,403.00	
410	TOTAL of Funding Received - Current Year	\$430,403.00	
411	Variance (Line 405 - Line 410 = 0) must equal to zero or provide an explanation	\$0.00	
	Adjustments for Revenues from Ministry(ies) Funding calculation		
415	Add: Non Retainable Revenues (not included in Line 405)		
416	Add: e.g. donation for a specific operating purpose		
417	Add: e.g. Rebates, Credits and Refunds		
418	Add: e.g. Interest Revenue from MOH-CYMH Funds		
419	Add: Other (specify)		
420	Add: Other (specify)		
421	Sub-Total	\$0.00	
425	Add: Offsetting Revenue (Provide Detail Breakdown)	\$2,317.00	

Agenda

426	Add: Other revenue adjustments (detailed comments required)		
427	Add:		
428	Add:		
429	Sub-Total	\$2,317.00	
430	TOTAL CYMH funding for settlement purposes (Line 405 + Line 421 + Line 429)	\$432,720.00	
	Other Adjustments for AFS reconciliation purposes		
431	Add: Deferred MOH-CYMH funding used to purchase capitalized items in the current year (Enter as Negative Amount)		
432	Add: Amortization of MOH-CYMH funding and donation revenue in the current fiscal year		
	(*): Enter as negative amount if needed to reduce and positive if needed to add to revenue		
433	Add (*): Other revenue adjustments (detailed comments required)		
434	Add (*):		
435	Sub-Total	\$0.00	
445	ADD: Other Revenue (excluding MOH-CYMH) (i.e. funding from other sources not related to CYMH ministry services)		
450	TOTAL GROSS EXPENDITURES PER AUDITED FINANCIAL STATEMENTS (Line 456 - Line 464 + Line 465 + Line 466 + Line 485)	\$432,720.00	
451	Add: Salaries	\$324,445.00	
452	Add: Benefit	\$66,989.00	
453	Add: Other Direct Operating and Service Costs	\$41,286.00	
454	Add: Other Transactions	\$0.00	
455	Add: Allocated Central Administration	\$0.00	
456	Sub-Total	\$432,720.00	
	Adjustments for Inadmissible Expenditures related to Ministry Funded Programs (Included in lines 451-455)		
457	Less: e.g. Contingent Liabilities		
458	Less: e.g. Provisions for Bad Debt		
459	Less:		
460	Less:		
461	Less:		
462	Less:		
463	Sub-Total	\$0.00	
	Adjustments for AFS Reconciliation purposes		
464	One-Time Capitalized Purchases and Services in current year		
465	Amortization on Major Equip and Software License and Fees (as per AFS)		
466	Building Amortization (as per AFS)		

Agenda

480	Total CYMH Expenses for Settlement Purposes (Line 456 - Line 463)	\$432,720.00	
485	Other Expenditures (excluding MOH-CYMH) (i.e. expenditures from other services not related to CYMH ministry services)		
490	Total Surplus/(Deficit) reported in Audited Financial Statements (Line 400 - Line 450), must match AFS	\$0.00	
495	TOTAL Ministry Approved Carry Over	\$0.00	
500	TOTAL TPAR RECOVERY (Line 430 - Line 480 - Line 495)	\$0.00	
	Financial Insight for Risk Assessment (Below data must align with Audited Financial Statements)		
510	Liquid Assets	\$98,651,000.00	
511	Total Assets	\$414,911,000.00	
512	Total Debt	\$49,728,000.00	
513	Total Liabilities	\$350,991,000.00	
514	Current Assets	\$90,487,000.00	
515	Current Liabilities	\$68,155,000.00	
516	Total Revenue	\$231,223,000.00	
517	Total Expenditure	\$220,265,000.00	
518	Total Other Government Grants	\$214,905,000.00	
	Ratios		
	Current Ratio (Line 514 / Line 515)	1.33	
	Program Expense Ratio (Line 480 / Line 517)	0.00	
	Administrative Expense Ratio (Line 455 / Line 480)	0.00	
	Government Reliance Ratio (Line 518 / Line 516)	0.93	
	Leverage Ratio (Line 513 / Line 511)	0.85	
	Net Margin Ratio (Line 516 - Line 517 / Line 516)	0.05	
	Liquidity Ratio (Line 510 / Line 515)	1.45	
	Debt ratio (Line 512 / Line 511)	0.12	

J) Declaration / Signing

Declaration

The Applicant hereby certifies as follows:

1. That to the best of my knowledge, the financial data in the Transfer Payment Annual Reconciliation to which this certification is attached, is true, correct, agrees with the books and records of the organization and has been prepared in accordance with the technical instructions and ministry financial policies provided by the Ministry of Health.
2. understand that the information contained in this submission is subject to disclosure under the Freedom of Information and Protection of Privacy Act.
3. I am an authorized signing officer for the Applicant.

Applicant

Valerie Smith-Sellers
Director, Finance
(w): 5196212333
Email: vsmith-sellers@cmh.org

Sign Document

By clicking the "I Agree" button, I Agree with the Declaration and Statement Above

I Agree

I Disagree

Signature Valerie Smith-Sellers

Date/Time 07/08/2025 15:16:06

Please validate your form by clicking the validate button before submitting the form back to Transfer Payment Ontario.

CAMBRIDGE MEMORIAL HOSPITAL

Ministry of Health Child and Youth Mental Health Program
Notes to Schedule

For the period from April 1, 2024 to March 31, 2025

1. Program description:

Cambridge Memorial Hospital (“Hospital”) entered into an agreement with the Ontario Ministry of Health to administer the Child and Youth Community Mental Health Program (“Program”).

The Schedule presents Hospital’s eligible expenditures incurred, and the contributions received, for this Program.

2. Basis of accounting:

The Schedule has been prepared in accordance with the financial reporting provisions as follows:

- (a) The Child and Youth Mental Health Transfer Payment Financial Policies issued by the Ontario Ministry of Health; and
- (b) Additional funding reference, the funding approval letters may provide details and specifications or restrictions on specific funding arrangements.

3. Significant accounting policies:

- (a) Revenue:

Revenue is recognized on an accrual basis.

- (b) Expenditures:

Expenditures are eligible under the Program if they were incurred in the period of the Program and are directly related to the completion of the Program.

- (c) Budget:

The Budget lines reflect the approved Ontario Ministry of Health amounts.

Ministry of Health - Child and Youth Mental Health	
2025-26 Transfer Payment Annual Reconciliation (TPAR) submission	
SECTION I: CERTIFICATION AND VERIFICATION	
I hereby certify that, to the best of my knowledge, the financial data in the Transfer Payment Annual Reconciliation to which this certification is attached, is true, correct, agrees with the books and records of the organization and has been prepared in accordance with the Technical Instructions and ministry financial policies provided by the Ministry of Health.	
CERTIFICATION BY TRANSFER PAYMENT RECIPIENT	
Cambridge Memorial Hospital	
Legal Name of Transfer Payment Recipient	
	Signature of Service Provider / Delivery Agent Authority Patrick Gaskin Name of Service Provider/Delivery Agent Authority President & Chief Executive Officer Title Date (dd/mm/yy)
VERIFICATION BY THE BOARD OF DIRECTORS	
The above certification, together with the Transfer Payment Annual Reconciliation, was received and approved by:	
the Board of Directors on the	day of , .
Chairperson of the Board of Directors:	Signature Diane Wilkonson Name of Chairperson or Designate Chair, Board of Directors Title

Annual Final Report

**CAMBRIDGE MEMORIAL
HOSPITAL**

**Ministry of Health Child and Youth Mental
Health Program**

And Independent Auditor's Report thereon

For the period from April 1, 2025 to March 31, 2026



KPMG LLP
120 Victoria Street South
Suite 600
Kitchener, ON N2G 0E1
Canada
Telephone 519 747 8800
Fax 519 747 8811

INDEPENDENT AUDITOR'S REPORT

To Cambridge Memorial Hospital and the Ontario Ministry of Health:

Opinion

We have audited the financial information in the accompanying schedules "F Year End Actuals" and "G Final Report Summary" of the Ministry of Health Child and Youth Mental Health Program Annual Final Report (excluding statistics, FTE's and Interim Actuals) of Cambridge Memorial Hospital (the "Hospital"), for the period from April 1, 2025 to March 31, 2026, including a summary of significant accounting policies and other explanatory information (Hereinafter referred to as the "Schedule").

In our opinion, the accompanying Schedule for the period from April 1, 2025 to March 31, 2026, of the Hospital is prepared, in all material respects, in accordance with financial reporting provisions of the Ministry of Health Child and Youth Mental Health Transfer Payment Financial Policies issued by the Ontario Ministry of Health.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the "***Auditor's Responsibilities for the Audit of the Schedule***" section of our auditor's report.

We are independent of the Hospital in accordance with the ethical requirements that are relevant to our audit of the Schedule 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.



Emphasis of Matter – Financial Reporting Framework

We draw attention to Note 2 to the Schedule which describe the applicable financial reporting framework and the purpose of the Schedule. The Schedule is prepared to assist the Hospital to meet the requirements of reporting provisions issued by the Ontario Ministry of Health.

As a result, the Schedule may not be suitable for another purpose.

Our opinion is not modified in respect of this matter.

Responsibilities of Management for the Schedule

Management is responsible for the preparation of the Schedule in accordance with financial reporting provisions of the Ministry of Health Child and Youth Mental Health Transfer Payment Financial Policies issued by the Ontario Ministry of Health, and for such internal control as management determines is necessary to enable the preparation of the Schedule that is free from material misstatement, whether due to fraud or error.

Auditor's Responsibilities for the Audit of the Schedule

Our objectives are to obtain reasonable assurance about whether the Schedule as a whole is 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 the Schedule.

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 Schedule, 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.



Page 3

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

A handwritten signature in black ink that reads 'KPMG LLP'. The signature is written in a cursive, stylized font. Below the signature is a single, long, horizontal, slightly wavy line.

Chartered Professional Accountants, Licensed Public Accountants

Kitchener, Canada

June 25, 2026

MOH - Child and Youth Mental Health 2025-26

Reporting Period: 04/01/2025 to 03/31/2026

Saved: 06/24/2026 11:36

Expand

Validate

A) Instructions	B) Organization Information	C) Organization Address Information
D) Organization Contact Information	E) Report Contact Information	F) Year End Actuals
G) Final Report Summary	H) TPAR Instructions	I) TPAR
J) Declaration / Signing		

A) Instructions

PLEASE DO NOT WORK ON COMPLETING THIS FORM UNTIL THE FINAL REPORT HAS BEEN SUBMITTED SUCCESSFULLY IN TRANSFER PAYMENT ONTARIO.

How to Use and Submit the Transfer Payment Annual Reconciliation (TPAR) Form:

- Save this form to your hard drive (note the file name so that you can upload the form to TP Ontario upon completion). Please do not change the format of this PDF Document. TP Ontario will not accept a flat or scanned copy of this form.
- Organizational information has been pre-populated based on information supplied during the TP Ontario registration process. Please ensure the accuracy of pre-populated organizational information prior to proceeding.
- Input the information required for each section. IMPORTANT NOTE: The form does not save automatically. Press “CTRL+S” on your keyboard to save.
- We recommend the Report be reviewed and completed in sequential order (from section “B” through to “J”) given that section “F) Year-End Actuals” of the form has been pre-populated with information collected in the Final Report Submission and populates into “I) TPAR”).
- Validate the report form by selecting the Validate button (top right corner of the PDF form) and making corrections as prompted.
- In Section “J) Declaration / Signing”, the form must be signed digitally by a person from your organization with signing authority.
- Upload your completed form, along with all the required supplementary reports and documentation, to Transfer Payment Ontario.

Additional Important Information:

- The financial details reported in the Transfer Payment Annual Reconciliation (TPAR) report will be used to reconcile your organization’s actual expenditures with ministry funding for accountability purposes. The reconciliation is done to enable the ministry to identify funds that have to be recovered. Please ensure that the financial information provided in this section reflects your organization’s audited year end results.
- Kindly review the prepopulated information. Should any details be incorrect, please contact your Program Supervisor to amend the Final Report in TPON, as it is not editable in the TPAR. Once the revised final report has been resubmitted in TPON, you will need to redownload a new TPAR for completion.
- The TPAR Report will be assessed based on the information provided within this form and additional assessments as determined by ministry staff.

TPON Technical Support

For technical support related to Transfer Payment Ontario, please contact Transfer Payment Ontario Client Care at 416-325-6691 or 1-855-216-3090 or TPONCC@ontario.ca

Monday to Friday from 8:30 a.m. to 5:00 p.m. Eastern Standard Time.

TTY/Teletypewriter (for the hearing impaired): 416-325-3408 / Toll-free: 1-800-268-7095

B) Organization Information

This section displays general information about your organization that was submitted during the Transfer Payment Ontario registration process. Please ensure this information is correct. **You will not be able to update the information displayed here within the form.** If this information needs to be updated, please update your organization information by logging into your TP Ontario account and selecting the “View/Update Organization” menu card displayed on the Home Page and re-download a new version of the form.

For more information visit: [How to View/Update Organization information.](#)

Organization Information

Organization Name:
Cambridge Memorial Hospital

Organization Legal Name:
Cambridge Memorial Hospital

Website URL:

Type of Organization:
Hospital

Date Incorporated:

Region:
Central

C) Organization Address Information

This section displays your organization's address information that was submitted during the Transfer Payment Ontario registration process. Please ensure this information is correct. **You will not be able to update the information displayed here within the form.** If this information needs to be updated, please update your organization address information through logging into your TP Ontario account and selecting the “View/Update Organization” menu card displayed on the Home Page and re-download a new version of the form.

For more information visit: [How to View/Update Organization information.](#)

Business Address

Street Address 1: 700 Coronation Boulevard	Street Address 2:
City/Town: Cambridge	Province: ON
Postal Code: N1R3G2	Country: Canada

Mailing Address

Street Address 1: 700 Coronation Boulevard	Street Address 2:
City/Town: Cambridge	Province: ON
Postal Code: N1R3G2	Country: Canada

D) Organization Contact Information

This section displays general contact information about your organization's primary staff. This information is pre-populated based on information submitted during the Transfer Payment Ontario enrolment process. The contacts listed in this section are not necessarily specific to this submission.

To edit contacts within the TP Ontario System, log into your TP Ontario account and select the “View/Update Organization” menu card displayed on the Home Page and re-download the budget form to reflect the changes made in the TP Ontario system.

For more information visit: [How to View/Update Organization information.](#)

Organization Contact Information

Agenda

First Name: Patrick	Last Name: Gaskin
Job Title: President/CEO	
Primary Phone Number: --	Secondary Phone Number: --
Email Address: pgaskin@cmh.org	

E) Report Contact Information

The fields in this section are prepopulated from the budget submission. Please review the contact information and provide updates where the contact information is out of date. Please do not use any abbreviations when providing the contact information.

At least one representative within your organization must have attestation authority for this report. Any representatives outside your organization (i.e. project management/consulting staff) will not be considered as signing authorities.

The individual listed as the primary contact for this submission may be contacted by the ministry for further information regarding the elements within this form.

- 1. The "Primary" box should be checked off if the contact is considered the main contact for all information within this report.
- 2. The "Signing Authority" box should be checked if the contact has the authority to commit your organization to a binding agreement. More than one person can be a "Signing Authority".
- 3. The "Primary" and "Signing Authority" contact can be the same person.
- 4. Use the "Add" button to provide additional contacts if needed.

The contacts listed in this section will receive all communications from the Transfer Payment Ontario System regarding agreements, and any changes related to this report.

Report Contact information		Add	Remove
Primary: ☒			
First Name: * Michelle	Last Name: * D'Souza		
Title: * Manager, Finance	Primary Phone Number: * 5196212333		
Secondary Phone Number:	Email Address * mdsouza@cmh.org		
Signing Authority ☒			

F) Year End Actuals

THE DATA IN THIS SECTION IS PRE-POPULATED FROM YOUR FINAL REPORT SUBMISSION AND CANNOT BE EDITED.

This section of the form, "Section F – Year-End Actuals", reflects financial information for all expenses and revenues at the Component Level. The funding amount by service delivery area and program in this form has been pre-populated with information that is specific to your organization, for all the funding you received in the current fiscal year and has been reconciled to your final Ministry of Health remittance for Child and Youth Mental Health programs. If it appears to be incorrect, please contact your Program Supervisor. Information pre-populated in this section will be summarized in "Section G -Final Report Summary".

IMPORTANT! The financial details reported in the Final Report back populates the Transfer Payment Annual Reconciliation (TPAR) Report that will be used to reconcile your organization's actual expenditures with ministry funding for accountability purposes. The reconciliation is done to enable the ministry to identify funds that have to be recovered. Please ensure that the financial information provided in this section reflects your organization's audited year end results.

The Component, Ministry Allocation, and Service Delivery Area is indicated at the top of each table.

Definitions:

- “Ministry Allocation for Component” is pre-populated with the funding you received from the Ministry of Health in the fiscal year for the specific program component and has been reconciled to your final remittance.
- “Budget Item” indicates categories and sub-categories of expenses and revenue.
- “Definition” provides a brief description of the budget item.
- “Year End Actuals” is pre-populated with information you have submitted to the ministry as part of your Final Report and is not editable in the TPAR. Kindly review the information. Should any details be incorrect, please contact your program supervisor to push back the Final Report in TPON for amendment. Once the revised Final Report has been resubmitted in TPON, you will need to download a new TPAR for completion.

Component:		4 - CYMH Counselling/Therapy Services 2025-26 (Waterloo)		<<	<	>	>>
Budget : CYMH Counselling/Therapy Services 2025-26 (Waterloo)							
Ministry Allocation for Component: \$331143							
Budget Item		Definition				Year End Actuals	
Budget							
Total Ministry Allocation		Sum of all Ministry of Health Allocation amounts				\$331,143.00	
Annualized (Rollover from previous fiscal year)		Base/ongoing funding amount as approved at the end of the previous fiscal year				\$318,443.00	
In-year base adjustment		Base/ongoing funding amount approved in the current fiscal year				\$12,700.00	
In-year one-time funding adjustment (fiscal funding)		One-time funding approved for the current fiscal year				\$0.00	
Total Ministry Program Expenditures		Expenditures net of non-ministry offsetting revenue				\$331,143.00	
Total Expenditures		Sum of all expenditure lines				\$357,123.00	
* Salaries		Salary and Wages paid to all full-time, part-time, temporary, occasional, summer or other employees. Includes pay for: regularly scheduled hours, overtime, statutory holidays, vacation, sick leave and education leave				\$285,544.00	
* Benefits		Includes mandatory benefits such as Canada Pension Plan (CPP), Employment Insurance (EI), Employer Health Tax (EHT), etc. and other non-mandatory benefits such as pension contributions, group life coverage, etc. paid by the employer.				\$67,129.00	
* # of FTEs		Number of full time service/program staff.				2.67	
* Staff Training		All service costs incurred by the service provider in the recruitment and education of Volunteers, Board Members and Staff.				\$0.00	
* Travel and Communication		Total travel and communication expenses incurred conducting activities for all services/programs				\$0.00	
* Mortgage Principal		Costs incurred for mortgage principal (eligible expenditure only if the ministry has a financial interest in the property)				\$0.00	
* Other Building occupancy Costs		Total building occupancy expenditures, other than mortgage principal, directly associated with the service/prigram (e.g. rent, property tax, insurance, repairs and maintenance on buildings/grounds/ structures etc.)				\$0.00	
* Professional/Contracted-out Services		Professional or contracted out services for which the service provider itself does not employ staff including: Accounting, Audit, and Legal fees; Bank payroll services; Architectural and engineering fees; and Medical and related consultants fees.				\$0.00	
* Supplies and Equipment		Expenditures directly related to supplies and equipment for all service/ program delivery.				\$4,450.00	

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* Other Program/Service Expenditures	Any services that cannot be classified elsewhere above. Can include: rental/lease of equipment; bank service charges; dues or fees paid to professional associations or other organizations; etc.	\$0.00
* Allocated Central Administration	General operating costs associated with governing and operating an organization. Do not include cost for service/program administrative expenses that directly supports clients.	\$0.00
Allocated Central Administration Percentage	Allocated Central Administration expressed as a percentage of the ministry allocation	0.00%
* Adjustments (+/-)	Transactions (+/-) against ministry allocation amount for program/services (e.g. one-time funds [+], or reductions [-]). Ministry approval required prior to adjustments between components.	\$0.00
NON-MINISTRY FISCAL REVENUE (OFFSETTING REVENUE)		\$25,980.00
* Other Provincial Government Funding	"Revenue received from the Government of Ontario (other than MOH) for all services/programs."	\$0.00
* Federal Government Funding	"Revenue received from the Government of Canada for all services/ programs."	\$0.00
* Municipal Government Funding	Revenue received from the Municipality for all services/programs.	\$0.00
* Client Contribution Payments	Revenue received from clients for all services/ programs.	\$0.00
* Other Revenue	"Other revenue received, from sources not captured above, for all programs/ services."	\$25,980.00

Variance Notes and Adjustments Itemization
Other Provincial Government Funding: Anticipated funding adjustment
Other Revenue: CMH using 2025-26 surplus funds generated to cover the the inflationary wage increases gap between funding and actual expenses.

G) Final Report Summary

THE DATA IN THIS SECTION IS PRE-POPULATED FROM YOUR FINAL REPORT SUBMISSION AND CANNOT BE EDITED.

The "Final Report Summary" tab is prepopulated with financial data summarized at the component level. It requires no action other than reviewing the information for accuracy.

Component+Service Area	Total Ministry Revenue	Total Year-End Actual Ministry Program Expenditure (excludes Non-Ministry Offsetting Revenue)	Variance (\$)	% Variance
CYMH Case Management and Service Coordination 2025-26 Waterloo	\$19,156.00	\$19,156.00	\$0.00	0.00%
CYMH Coordinated Access and Intake 2025-26 Waterloo	\$38,112.00	\$38,112.00	\$0.00	0.00%
CYMH Counselling/Therapy Services 2025-26 Waterloo	\$331,143.00	\$331,143.00	\$0.00	0.00%
CYMH Specialized Consultation Assessment 2025-26 Waterloo	\$90,678.00	\$90,678.00	\$0.00	0.00%
TOTAL:	\$479,089.00	\$479,089.00	\$0.00	0.00%
Allocated Central Admin				\$0.00
Actual Allocated Central Admin as a Percentage of Ministry Revenue (Should not exceed 10%, or 10.5% for Northern agencies, of the overall allocation)				0.00%
Actual Allocated Central Admin as a Percentage of Year-End Expenditures				0.00%
Overall Variance Explanation				

H) TPAR Instructions

Complete each section on the TPAR Template

1. REVENUE, EXCLUSIONS AND INCLUSIONS FROM THE SUBSIDY CALCULATION (LINES 400 to 445)

- a. Ministry Revenue: All funding received from the ministry for a program/service for the current fiscal year. Includes previous year annualized funding and any in-year adjustments.
 - o (401 - 411) Revenue received from the Ministry of Health (MOH) must only be used for the services that the Transfer Payment Recipient (TPR) is approved to deliver.
 - o Complete Line 401 and 402 as per the Ministry of Health (MOH) remittance report; Line 401 should be all the base/ annualized funding and repeating one time funding utilized for operating purposes; and Line 402 should reflect the total funding received for time-limited projects (for example minor capital improvements funding).
 - o Line 402 should equal the sum of all one-time funding for which the Ministry will require a project sub-report to be completed.
 - o Line 405 is the sum of Line 401 and 402, no input required.
 - o Line 410 is linked to **section "F) Year-End Actuals"**, which represents the TOTAL funding received from MOH for CYMH services in the current Fiscal Year. No input required.

Line 411 is the variance between the total input by the TPR in line 401 & 402 and the auto populated line 410. This variance should be zero, or an explanation must be provided.

- b. Non-Retainable Revenue: If produced from ministry funded resources, the excess revenue is subtracted from the gross expenditures, which reduces the expenditures eligible for ministry funding.
 - o Lines 415-421 add in any revenue generated from MOH-CYMH funded resources that were not used for admissible CYMH program expenditures (reported in Line 425). These non-retainable revenues must be returned to the Ministry and included in the subsidy calculation as part of the TOTAL TPAR RECOVERY. Examples of non-retainable revenues include interest revenue from investing ministry funds, expenditure recoveries, refunds or recoveries of previous expenditures; specific CYMH program operating donations, net revenue arising from the sale of goods and/or the provision of services provided by the TPR, parental contributions and inter-agency chargebacks, etc.). For more information refer to the CYMH Transfer Payment Financial Policies, "Retainable and Non-Retainable Revenue".
- c. Non-Ministry Fiscal Revenue (Offsetting Revenue): All non-ministry revenue sources that provides funding for a program.
 - o Line 425 is linked to section "F) Year-End Actuals". Which represents the Total of NON-MINISTRY FISCAL REVENUE (OFFSETTING REVENUE), no input required.
 - o Lines 426 - 428 Enter other revenue adjustments, such as unspent recoverable funds or reporting of prior year carry over of funds, revenue generated from charges levied for the use of ministry subsidized resources, such as parking fees, staff or visitor accommodation or meals, space or equipment rentals, transportation charges, etc. This also encompasses rental income generated from leasing ministry-funded space to other organizations, as well as revenue received from other ministries, government bodies or community agencies (for example Lead Agencies) for costs that are typically subsidizable. These revenues are not recorded or accounted for separately and are used to offset CYMH expenses. Detailed comments are required.
 - o Line 429 is the sum of Lines 425 to 428 related to all non-ministry revenue sources that are used to offset CYMH program expenses
- d. Total CYMH funding for settlement purposes (Line 430) is the sum of Lines 405 + Line 421 + Line 429. No input is require
- e. The next section reflects accounting adjustments required to reconcile the TPAR to the Audited Financial Statements (AFS):
 - o Line 431 Funding used to purchase capitalized items in the current year must be deducted from the total subsidy to align with the Audited Financial Statements (enter as negative amount).
 - o Line 432 Amortization of MOH-CYMH funding and donation revenue in the current fiscal year.
 - o Line 435 is the sum of Lines 431 to 434 related to all other adjustments needed to reconcile the TPAR to the audited financial statements.
- f. Retainable Revenue: generated from non-ministry funded resources is applied to meet the TPRs legislated share of approved expenditures (referred to as Revenue [Legislated Share] in the Budget Schedule). Excess retainable revenue not legislatively assigned is available for the TPRs other costs or deficits.
 - o Line 433 & 434 Enter other revenue adjustments, such as general donations, any monies received for capital purposes (e.g. specific donations, endowments, bequests), fundraising where the revenue is generated through activities not involving the use of ministry resources, interest revenue arising from the investment of retainable revenue; and other grants or subsidies received for activities not ordinarily funded by the ministry. Detailed comments are required.
- g. Line 445 Enter Other Revenue that relates to Other Grants or Subsidies (non-MOH-CYMH), revenue received from other ministries, government bodies or community agencies for costs ordinarily subsidizable. These revenues are reported in the same statement of operation as CYMH but need to be accounted for separately.

- ... Line 400 is the sum of Line 430 + Line 435 + Line 445 and reflects the Total Revenue for the TPR on the AFS for the Funding Year. No input required.

2. FUNDED AND NON-FUNDED EXPENSES (LINES 450 to 485)

- a. Expenditures that are deemed reasonable and necessary for the provision of services are usually admissible for calculation of the operating subsidy. These expenditures must be authorized in accordance with the policies of the TPR, consistent with government policies, approved by the ministry, and supported by documentation as requested.
 - o Line 451 to 456 Listed below are funded expenses (i.e., admissible for calculation of the operating subsidy) and are linked to section "F) Year-End Actuals". If changes to these amounts are required, the Final Report submission will have to be resubmitted in TPON.
 - Line 451 Add: Salaries (Sum of All components except ACA)
 - Line 452 Add: Benefit (Sum of All components except ACA) Line 453 Add: Other Direct Operating and Service Costs [Sum of (Staff Training - Travel and Communication - Mortgage Principal - Other Building occupancy Costs - Professional/Contracted-out Services - Supplies and Equipment) - Sum of All components except ACA]
 - Line 454 Add: Other Transactions [Sum of (Other Program/Service Expenditures - Adjustments (+1-) - Small Water Works - Pay Equity) - Sum of All components except ACA]
 - Line 455 Add: Allocated Central Administration (Sum of All components except ACA)
- b. Inadmissible Expenditures: The modified accrual basis of accounting, as defined by the ministry, does not recognize non-cash transactions such as charges/appropriations to reserves or allowances, as these expenses do not represent an actual cash expenditure related to the current period; as well any expenses are not consistent with government policies and approved by the Ministry
 - o Lines 457 - 463 to report inadmissible expenditures that were already included in lines 451-456; such as amortization, Provisions for Unused Vacation/Sick Leave, Wage Settlements, Contributions or Donations to Political Organizations, Fines, Loans to Clients or Staff, etc.. For more details, please refer to the MOH CYMH Transfer Payment Financial Policies "Admissible and Inadmissible Expenditures".
- c. The next section reflects accounting adjustments required to reconcile the TPAR to AFS:
 - o Lines 464 - 466 are reconciling items to match the TPAR to the AFS, these items are One Time Capitalized purchases, Amortization on Major Equipment and Building amortization.
- d. Total CYMH Expenses to for settlement purposes (Line 480) is the calculation of Line 456 - Line 463. No input is require
- e. Line 485 Enter all other expenditures (excluding MOH-CYMH) related services not associated with CYMH services. These expenditures are reported in the same statement of operation as CYMH but must be accounted for separately.
- f. Line 450 is auto calculated: Line 456 - Line 464 + Line 465 + Line 466 + Line 485. No input required. Note that the Total Expenses must match the Total Expenses in the AFS.
- g. Total surplus/(deficit) reported in the AFS (Line 490) should match the Statement of Operations, auto calculated: Line 400 - Line 450. No input required.
- h. Ministry approved carryover (Line 495) is the unspent funding amount previously approved by the Ministry to carryover into the following Fiscal Year. If applicable, this will be pre-populated, no input required.
- i. Final TPAR Recovery amount (Line 500) auto calculated: Line 430 - Line 480 - Line 495. No input required.

3. MANUAL INPUT REQUIRED FROM AUDITED FINANCIAL STATEMENTS:

- a. 510 – Liquid Assets - is an asset that can be easily converted into cash in a short amount of time.
- b. 511 – Total Assets - refer to the total amount of assets (Current and non-current assets) owned by an organization, total assets represent the economic value owned by an organization.
- c. 512 - Total Debt - is the sum of money due to be paid includes the values of long-term liabilities (loans) and current liabilities.
- d. 513 – Total Liabilities - are the combined debts and obligations that an organization owes to outside parties.
- e. 514 - Current Assets - short-term assets that are expected to be used up or spent within 12 months.
- f. 515 - Current Liabilities - financial obligations of an organization that are due and payable within a year.
- g. 516 - Total Revenue - is money received from donations from individuals, foundations, and companies, grants from government entities, investments, and/or membership fees.
- h. 517 - Total Expenses – for a given period refer to the sum of all the total gross cash expenditures plus any subsidiary pending, such as operating expenses, incentive fees, interest, and taxes. This refers to the total expenses as per the Financial Statements in a given year.
- i. 518 - Total Government Revenue - is money received from all areas of the Provincial government.

4. RATIOS: CALCULATED FIELDS. NO INPUT REQUIRED.

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- a. Current Ratio (Line 514 / Line 515) - is used to measure the overall liquidity of a nonprofit organization.
- b. Program Expense Ratio (Line 517 / Line 480) - measures the percentage of expenses that a nonprofit organization is spending on this program. If ratio is less than 50% means this is not the main program of the organization.
- c. Administrative Expense Ratio (Line 455 / Line 480) - measures the percentage of an organization's expenses that are being allocated to administrative costs in specific program.
- d. Government Reliance Ratio (Line 518 / Line 516) - measures a nonprofit organization's reliance on governmental funding.
- e. Leverage Ratio (Line 513 / Line 511) - measures how heavily leveraged an organization is. This nonprofit ratio also is an indicator of how sustainable an organization is. An increasing leverage ratio could be a sign of financial trouble for an organization. Under .5 or 50% is better.
- f. Net Margin Ratio (Line 516 - Line 517 / Line 516) - Nonprofits should not be expected to not make a profit. However, continued negative trends in the net margin ratio can be an indicator of poor financial management.
- g. Liquidity Ratio (Line 510 / Line 515) - assess a nonprofit's ability to meet short-term obligations, ensuring smooth operations. A quick ratio of 1 or higher is generally satisfactory.
- h. Debt ratio (Line 512 / Line 511) - debt ratio refers to a financial ratio that measures the extent of an organization's leverage. It can be interpreted as the proportion of a organization's assets that are financed by debt. A lower debt ratio signifies that the nonprofit is more financially solid and lowers the chance of insolvency. Ratio less than 1.

I) TPAR

PLEASE DO NOT WORK ON COMPLETING THIS FORM UNTIL THE FINAL REPORT HAS BEEN SUBMITTED SUCCESSFULLY IN TRANSFER PAYMENT ONTARIO. THERE ARE SECTIONS IN THE FORM THAT ARE PRE-POPULATED FROM YOUR FINAL REPORT SUBMISSION AND CANNOT BE EDITED.

LINE	Description	2025-26 Final	Comments
400	TOTAL GROSS REVENUES PER AUDITED FINANCIAL STATEMENTS (Line 430 + Line 435 + Line 445)	\$509,854.00	
401	Funding - MOH-CYMH -Operational	\$479,089.00	
402	Funding - MOH-CYMH- One-Time Projects	\$0.00	
405	TOTAL Approved Ministry Funding as per cash flow (Line 401 + Line 402)	\$479,089.00	
410	TOTAL of Funding Received - Current Year	\$479,089.00	
411	<i>Variance (Line 405 - Line 410 = 0) must equal to zero or provide an explanation</i>	\$0.00	
	Adjustments for Revenues from Ministry(ies) Funding calculation		
415	Add: Non Retainable Revenues (not included in Line 405)	\$0.00	
416	Add: e.g. donation for a specific operating purpose	\$0.00	
417	Add: e.g. Rebates, Credits and Refunds	\$0.00	
418	Add: e.g. Interest Revenue from MOH-CYMH Funds	\$0.00	
419	Add: Other (specify)	\$0.00	
420	Add: Other (specify)	\$0.00	
421	Sub-Total	\$0.00	
425	Add: Offsetting Revenue (Provide Detail Breakdown)	\$30,765.00	
426	Add: Other revenue adjustments (detailed comments required)	\$0.00	
427	Add:	\$0.00	
428	Add:	\$0.00	

Agenda

429	Sub-Total	\$30,765.00	
430	TOTAL CYMH funding for settlement purposes (Line 405 + Line 421 + Line 429)	\$509,854.00	
	Other Adjustments for AFS reconciliation purposes		
431	Add: Deferred MOH-CYMH funding used to purchase capitalized items in the current year (Enter as Negative Amount)	\$0.00	
432	Add: Amortization of MOH-CYMH funding and donation revenue in the current fiscal year	\$0.00	
	(*): Enter as negative amount if needed to reduce and positive if needed to add to revenue		
433	Add (*): Other revenue adjustments (detailed comments required)	\$0.00	
434	Add (*):	\$0.00	
435	Sub-Total	\$0.00	
445	ADD: Other Revenue (excluding MOH-CYMH) (i.e. funding from other sources not related to CYMH ministry services)	\$0.00	
450	TOTAL GROSS EXPENDITURES PER AUDITED FINANCIAL STATEMENTS (Line 456 - Line 464 + Line 465 + Line 466 + Line 485)	\$509,854.00	
451	Add: Salaries	\$353,967.00	
452	Add: Benefit	\$83,215.00	
453	Add: Other Direct Operating and Service Costs	\$72,672.00	
454	Add: Other Transactions	\$0.00	
455	Add: Allocated Central Administration	\$0.00	
456	Sub-Total	\$509,854.00	
	Adjustments for Inadmissible Expenditures related to Ministry Funded Programs (Included in lines 451-455)		
457	Less: e.g. Contingent Liabilities	\$0.00	
458	Less: e.g. Provisions for Bad Debt	\$0.00	
459	Less:	\$0.00	
460	Less:	\$0.00	
461	Less:	\$0.00	
462	Less:	\$0.00	
463	Sub-Total	\$0.00	
	Adjustments for AFS Reconciliation purposes		
464	One-Time Capitalized Purchases and Services in current year	\$0.00	
465	Amortization on Major Equip and Software License and Fees (as per AFS)	\$0.00	
466	Building Amortization (as per AFS)	\$0.00	
480	Total CYMH Expenses for Settlement Purposes (Line 456 - Line 463)	\$509,854.00	
485	Other Expenditures (excluding MOH-CYMH) (i.e. expenditures from other services not related to CYMH ministry services)	\$0.00	

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490	Total Surplus/(Deficit) reported in Audited Financial Statements (Line 400 - Line 450), must match AFS	\$0.00	
495	TOTAL Ministry Approved Carry Over	\$0.00	
500	TOTAL TPAR RECOVERY (Line 430 - Line 480 - Line 495)	\$0.00	
	Financial Insight for Risk Assessment (Below data must align with Audited Financial Statements)		
510	Liquid Assets	\$92,659,000.00	
511	Total Assets	\$410,184,000.00	
512	Total Debt	\$49,031,000.00	
513	Total Liabilities	\$334,161,000.00	
514	Current Assets	\$81,961,000.00	
515	Current Liabilities	\$54,012,000.00	
516	Total Revenue	\$254,132,000.00	
517	Total Expenditure	\$239,708,000.00	
518	Total Other Government Grants	\$239,081,000.00	
	Ratios		
	Current Ratio (Line 514 / Line 515)	1.52	
	Program Expense Ratio (Line 480 / Line 517)	0.00	
	Administrative Expense Ratio (Line 455 / Line 480)	0.00	
	Government Reliance Ratio (Line 518 / Line 516)	0.94	
	Leverage Ratio (Line 513 / Line 511)	0.81	
	Net Margin Ratio (Line 516 - Line 517 / Line 516)	0.06	
	Liquidity Ratio (Line 510 / Line 515)	1.72	
	Debt ratio (Line 512 / Line 511)	0.12	

J) Declaration / Signing

Declaration

The Applicant hereby certifies as follows:

1. That to the best of my knowledge, the financial data in the Transfer Payment Annual Reconciliation to which this certification is attached, is true, correct, agrees with the books and records of the organization and has been prepared in accordance with the technical instructions and ministry financial policies provided by the Ministry of Health.
2. I understand that the information contained in this submission is subject to disclosure under the Freedom of Information and Protection of Privacy Act.
3. I am an authorized signing officer for the Applicant.

Applicant

Michelle D'Souza
Manager, Finance
(w): 5196212333
Email: mdsouza@cmh.org

Sign Document

By clicking the "I Agree" button, I Agree with the Declaration and Statement Above

I Agree

I Disagree

Signature Michelle D'Souza Date/Time 06/24/2026 11:25:25

Please validate your form by clicking the validate button before submitting the form back to Transfer Payment Ontario.

CAMBRIDGE MEMORIAL HOSPITAL

Ministry of Health Child and Youth Mental Health Program
Notes to Schedule

For the period from April 1, 2025 to March 31, 2026

1. Program description:

Cambridge Memorial Hospital (“Hospital”) entered into an agreement with the Ontario Ministry of Health to administer the Child and Youth Community Mental Health Program (“Program”).

The Schedule presents Hospital's eligible expenditures incurred, and the contributions received, for this Program.

2. Basis of accounting:

The Schedule has been prepared in accordance with the financial reporting provisions as follows:

- (a) The Child and Youth Mental Health Transfer Payment Financial Policies issued by the Ontario Ministry of Health; and
- (b) Additional funding reference, the funding approval letters may provide details and specifications or restrictions on specific funding arrangements.

3. Significant accounting policies:

(a) Revenue:

Revenue is recognized on an accrual basis.

(b) Expenditures:

Expenditures are eligible under the Program if they were incurred in the period of the Program and are directly related to the completion of the Program.

(c) Budget:

The Budget lines reflect the approved Ontario Ministry of Health amounts.



Diversity, Equity, & Inclusion Plan

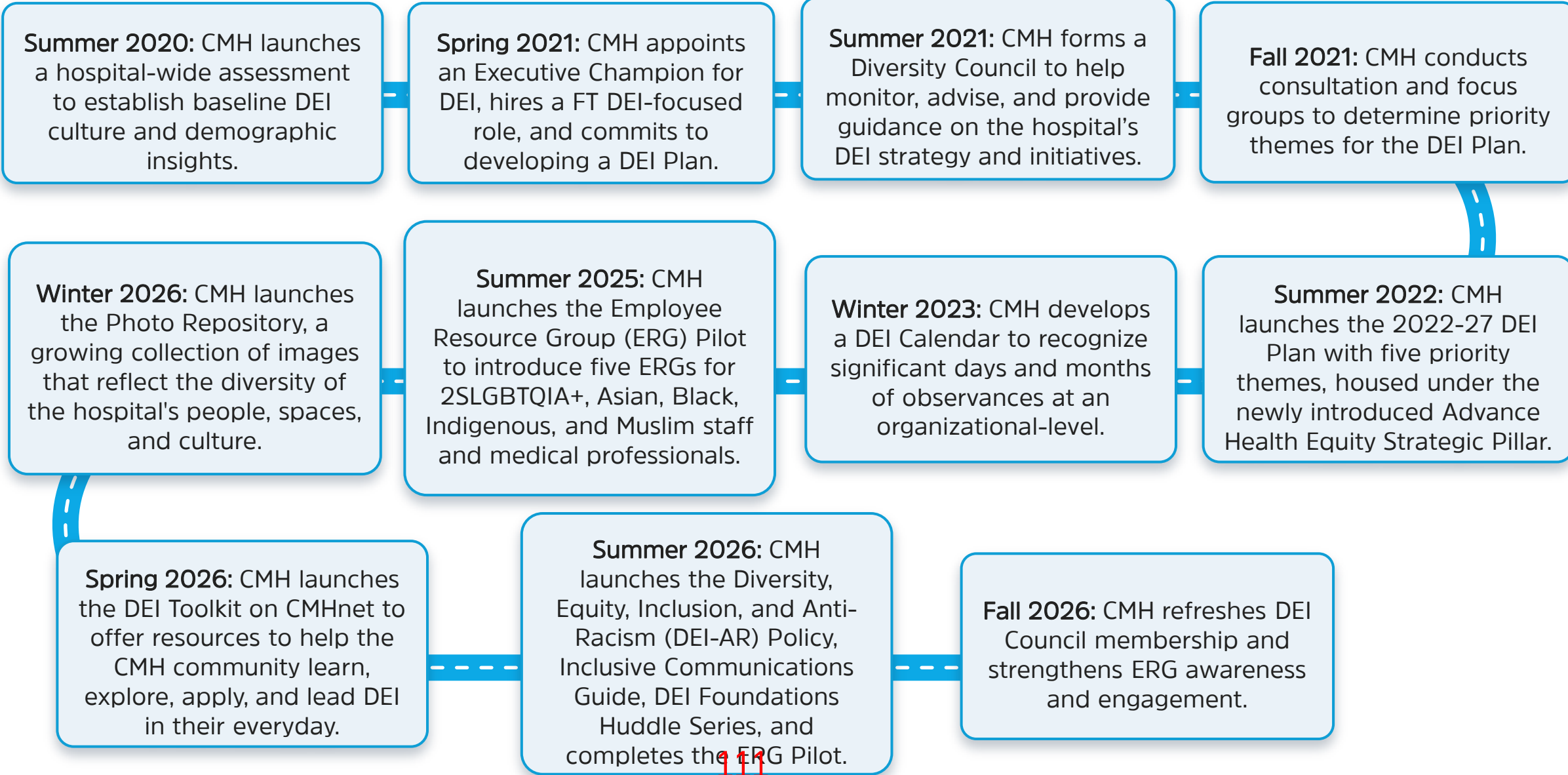
2026-27 Status Update

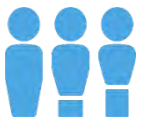
Mari Iromoto – VP, People & Strategy; Executive Champion, DEI
Diana Crawford – Director, Organizational Effectiveness, Culture & Transformation
Joy Braga – Diversity, Equity, & Inclusion Specialist



CMH's DEI Journey

CMH advances its DEI Plan with Council input and provides quarterly and annual progress updates to ensure transparency and drive continuous improvement.





Plan Overview & Priority Themes

5-Year Success Goal

Make meaningful change to our culture to establish CMH as a safe space where all individuals can access the care they need and team members are empowered to perform to the best of their ability.

Be more deliberate with inclusive language and images depicted in CMH communications.

Inclusive Language & Images

Provide education and tools to heighten awareness, better understand bias, and equip people in their role in allyship.

Education & Tools

People & Processes

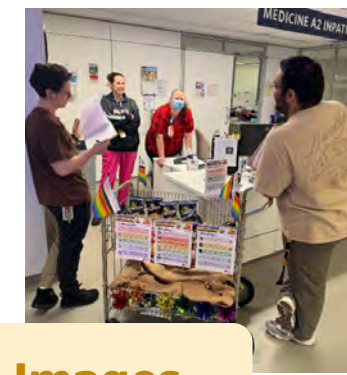
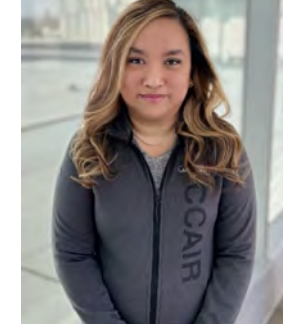
Strengthen and establish key HR processes and policies to reinforce behaviours and practice for recruitment and retention.

Creating Safe Spaces

Develop safe spaces to set the right tone for our environments and where staff can feel safe and turn to when needed.

Key Objectives

- Increase engagement in Diversity Calendar events and activities
- Develop practical tools and resources to promote inclusive communication across the organization



Inclusive Language & Images

2025-26 Achievements

- Launched the practical, easy-to-use **Inclusive Communications Guide** grounded in staff realities and patient experiences
- Completed first full year of **Quarterly CEO DEI & T&R Updates** with 500+ views across all reports to date
- Elevated **Asian Heritage Month (AHM)** by launching the Asian Employee Resource Group (ERG), three diverse Voices of CMH stories (515 total interactions), and introducing the first AHM L.E.A.R.N Challenge, Cultural Snack Cart, and Trivia Activity
- Celebrated **Pride Month** by engaging with 250+ staff through a Lunch & Learn with OK2BME; Show Your Pride cart rounding; Myth or Fact Trivia; Wear Your Pride Day; and DEI Table at the Staff BBQ
- Participated in the **Cambridge Pride Street Party**, engaging 200+ community members and sparking meaningful staff connection, including a new Voices of CMH story on queer visibility in healthcare (204 interactions)

113

Work Ahead

- **Inclusive Communications Guide (ICG) Roll-out:** Promote the ICG and its content across CMH through initiatives such as the DEI Foundations Huddle Series, "Communication with Impact" Leader Lunch & Learn (March 2027), and practical training sessions with frequent communicators
- **ICG Companion Checklist:** Develop a simple one-page check-list to support everyday application of the best practices and key tips from the guide. Test with key departments and frequent communicators, then refine based on feedback. Launch on CMHnet and promote alongside the ICG.
- **Days of Significance Acknowledgement Framework:** Conduct an environmental scan to develop a revised framework for standardizing organization-wide acknowledgement of DEI-related observances.

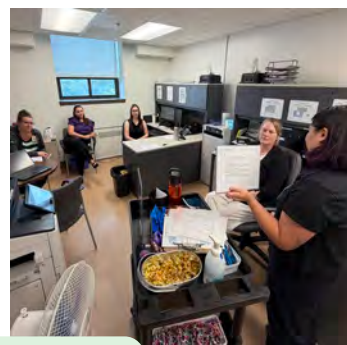


Key Objectives

- Refresh Hospital Wide Orientation (HWO) to improve DEI awareness and engagement amongst new hires
- Increase organizational awareness and engagement with DEI tools, resources, and events



"One thing I'm taking away is that small changes can lead to big impact."
- Staff reflection after their first DEI Huddle



Education & Tools

2025-26 Achievements

- Published the **DEI Toolkit** as a living resource to support everyday DEI education and application for CMH staff and medical professionals
- Hosted a **Lunch & Learn with OK2BME**, offering practical strategies and resources to strengthen culturally safe, trauma-informed care for 2SLGBTQIA+ patients and families
- Created **L.E.A.R.N Challenges** for Asian Heritage Month (May) and Pride Month (June)
- Launched the **DEI Foundations Huddle Series**, delivering tangible, organization-wide micro-learning across five core DEI topics, with a 95% favourable rating on session clarity and relevance thus far.

Work Ahead

- **Socialization of DEI Tools & Resources:** Promote the DEI Council, Indigenous Council, ERGs, DEI & Anti-Racism Policy, DEI Toolkit, Inclusive Communications Guide, and CCDI Employee Partner Benefits as part of the DEI Foundations Huddle Series roll-out.
- **DEI Foundations CMHnet Page:** Create a central spot for huddle series material, including printable quick reference sheets for each of the five topics
- **CCDI Community of Practice Events (October):** Recruit a diverse group of individuals across various departments, councils/committees, and leadership roles to attend

Key Objectives

- Develop a policy to reflect CMH's commitment to DEI and establish shared standards
- Refresh Hospital Wide Orientation (HWO) to improve DEI awareness and engagement amongst new hires

The screenshot shows the 'poli-C-cast' website header with the tagline 'Exceptional Healthcare, Exceptional People'. Below the header, a welcome message states: 'Welcome to poli-C-cast – your quick guide to CMH's latest policy updates. For your convenience, policy changes that have an impact on your practice are colour-coded red and hyperlinked.' It also provides contact information for Jennifer Theis at ext. 3250 or jtheis@cmh.org. The date 'July/August 2026' and a link to the 'Corporate Manual' are displayed. A table lists policy updates:

Policy Name	Policy #	Changes	Practice Change?
1-400 Diversity, Equity, Inclusion, and Anti-Racism (DEI-AR) Policy	1-400	New: This is a new policy. The Diversity, Equity, Inclusion, and Anti-Racism (DEI-AR) Policy outlines CMH's commitment to embedding DEI-AR principles into all aspects of the organization, ensuring these values guide behaviour, decision-making, and care delivery. It establishes shared responsibility across CMH to advance equity, foster an inclusive and anti-racist environment, and align efforts with key organizational plans and provincial frameworks. The policy also reinforces CMH's legal and ethical obligations, including accessibility and the duty to accommodate, to create a safe, welcoming, and equitable environment for everyone.	Yes

People & Processes

2025-26 Achievements

- Published the **Diversity, Equity, Inclusion, and Anti-Racism (DEI-AR) Policy** to reflect the CMH's commitment and shared responsibility to advance this work by embedding it into all aspects of the hospital

Work Ahead

- **DEI-AR Policy Socialization:** Create a CMHnet landing page for the policy and promote the policy through the DEI Foundations Huddle Series.
- **Hospital Wide Orientation (HWO):** Update DEI orientation material by incorporating information about newly launched DEI resources and initiatives and refreshing the presentation to make it more engaging for new hires.
- **Practice Policy Review:** Guide policy updates to strengthen DEI alignment and embed inclusive language in CMH policies as a member of the HIS Practice Policy Approval Committee.

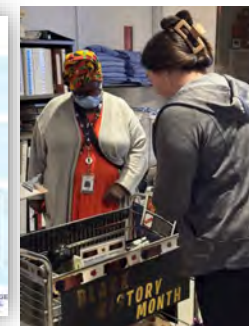
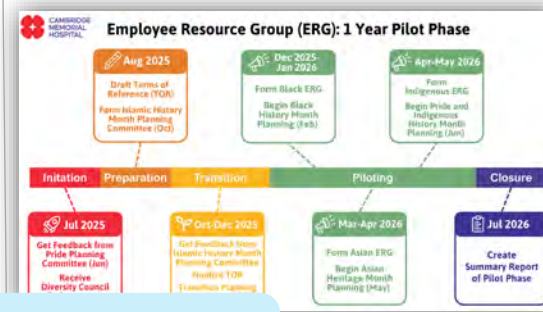
Key Objectives

- Strengthen Diversity Council's impact by more deeply integrating their insights into organizational DEI planning and decision-making
- Develop foundational infrastructure to help foster a culture of inclusion and belonging

2025-26 Achievements

- Revised the **DEI Council Terms of Reference** and refreshed the application process to improve accessibility and encourage a diverse applicant pool
- Completed the **Employee Resource Group (ERG) Pilot Phase** by introducing five pilot ERGs (Black, Asian, Indigenous, 2SLGBTQIA+, Muslim), including the transition of existing planning committees into ERGs
- Partnered with ERGs (including former planning committees) to co-create more authentic and meaningful **staff-led cultural celebrations** for Black History, Asian Heritage, Pride, Indigenous History, and Islamic History Months

Creating Safe Spaces



Work Ahead

- **DEI Council Recruitment Campaign:** Develop member spotlights and promotional communications to grow and diversify the applicant pool
- **Refresh DEI Council Membership:** Transition members completing their term, onboard new members, and work toward a full Council with diverse, representative membership.
- **ERG Pilot Summary Report:** Complete pilot evaluation by using staff insights to inform the next phase for sustainable, staff-led ERG development.
- **Building ERG Structure:** Transition ERGs from observance-focused activity to building foundational structure through kick-off meetings and establishing group governance

Employee Resource Groups (ERGs) at CMH

WE ARE HERE

Phase 1: Launch Pilot to lay foundation for ERG roll-out

- ✓ Complete environmental scan and consultation with the DEI Council and CMH leadership
- ✓ Develop ERG Terms of Reference (TOR)
- ✓ Launch ERG Landing Page on CMHnet
- ✓ Transition existing planning committees into ERGs
- ✓ Form five pilot ERGs: 2SLGBTQIA+, Asian, Black, Indigenous, and Muslim

Phase 2: Fully establish ERG structure and processes

- Host ERG kick-off meetings to review TOR and establish governance
- Support ERG-led delivery of Level 4 Observances: Black History, Asian Heritage, Pride, Indigenous History, and Islamic History Months
- Evaluate pilot to determine early findings and outline strengths and opportunities for ERG growth and sustainability
- Launch campaign to increase awareness and engagement (e.g., promotion through DEI Foundations Huddle series, focused communications, and ERG spotlights)

Phase 3: Promote long-term ERG Growth and Sustainability

- Focus on enhancing member recruitment and retention
- Evaluate ERG impact on belonging and connection with current members
- Measure inclusion culture and sense of belonging across the organization through the Global Workforce Survey (2027)

Numbers to Date:

- 2SLGBTQIA+ ERG: 6 members
- Asian ERG: 7 members
- Black ERG: 8 members
- Indigenous ERG: 2 members
- Muslim ERG: 7 members
- Total ERG Members: 30

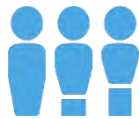
- # Formal Expressions of Interest (MS Form): 12
- # Informal Expressions of Interest (direct invitations to join via in-person conversations or email outreach): 18

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Member Feedback:

- "I **appreciated** the opportunity to **get involved and contribute** to celebration of this month."
- "I felt **safe** to share my ideas and felt **heard**."
- "I enjoyed being able to **connect with others** and support in this capacity."

Diversity, Equity & Inclusion Plan: 2026/27 KPMs



Lead(s):
Diana Crawford
Joy Braga

Exec Sponsor(s):
Mari Iromoto

Overall Status



Updated: September 2026

#	Key Performance Measure (KPM)	Target	Actual	Comments
1	Achieve DEI Work Plan Milestones	100%	86%	Hospital Wide Orientation (HWO) Presentation Updates (Q1 Milestone) forecasted to achieve by the end of Q2 along with HR's revamp of HWO.
2	Number of DEI Foundations Huddles (Topic 1: DEI & Allyship in Healthcare) Scheduled	25	26	As of Thursday, September 3, 2026
3	Number of Staff Engaged in DEI Foundations Huddles (Topic 1: DEI & Allyship in Healthcare)	N/A	284	23/26 huddles completed. As of Tuesday, September 29, 2026.
4	Number of Lunch & Learn Attendees (FY 2026/27)	N/A	35	Attendance across two Lunch & Learn Events to date: Keira Lewis Black History Month L&L (February) and OK2BME Pride L&L (June)

Overall Status Legend:

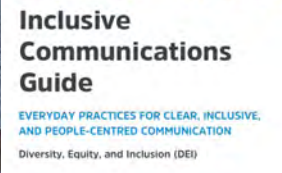
Achieved/Forecasted to achieve
> 50% of all KPMs

Achieved/Forecasted to achieve
> 25%-50% of KPMs

118

Achieved/Forecasted to achieve
< 25% of KPMs





poli-C-cast

Exceptional Healthcare
Exceptional People

Welcome to poli-C-cast – your quick guide to CMH's latest policy updates. For your convenience, policy changes that have an impact on your practice are colour-coded red and hyperlinked.

If you have any questions regarding these policy updates, please contact Jennifer Theis at ext. 3250 or jtheis@cmh.org

July/August 2026

Corporate Manual

Policy Name	Policy #	Changes	Practice Change?
1-400 Diversity, Equity, Inclusion, and Anti-Racism (DEI-AR) Policy	1-400	New: This is a new policy. The Diversity, Equity, Inclusion, and Anti-Racism (DEI-AR) Policy outlines CMH's commitment to embedding DEI-AR principles into all aspects of the organization, ensuring these values guide behaviour, decision-making, and care delivery. It establishes shared responsibility across CMH to	Yes



CMH Introducing the DEI Foundations Huddle Series

Build small, meaningful habits and explore practical tools that help us better support one another and provide more inclusive care.

10-min Huddles	Monthly Sessions	Open to All Staff	DEI Tools & Supports
In-person micro-learning	A new topic each month	Team sessions booked by leaders	Resources for ongoing learning

Five Core Topics

- DEI & Allyship in Healthcare
- Indigenous Ways of Healing
- Dimensions of Diversity
- Everyday Equity
- Inclusion in Action

Questions? Contact diversity@cmh.org



New! Employee Resource Group (ERG) Pilot Phase

Want to connect with others who share similar identity, interests, or lived experiences?

Want to help foster an inclusive workplace or shape meaningful events and activities that reflect our hospital's diversity?

Join an ERG!

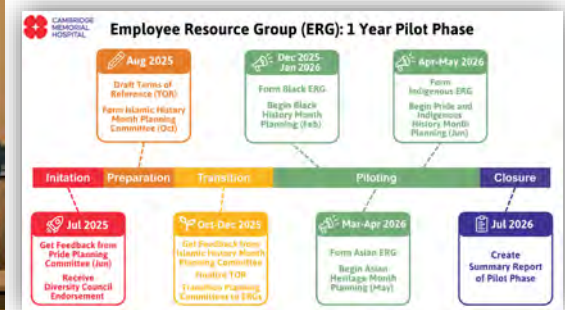
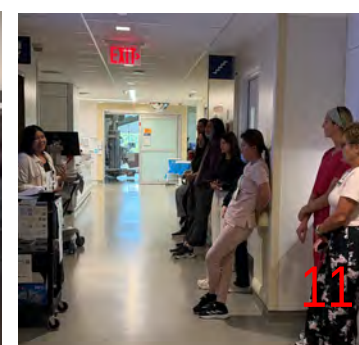
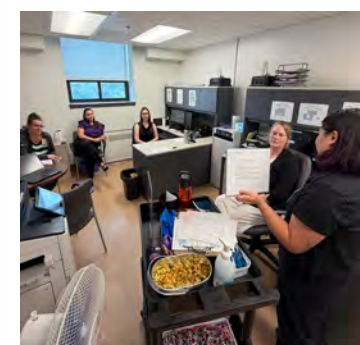
Help plan upcoming events:

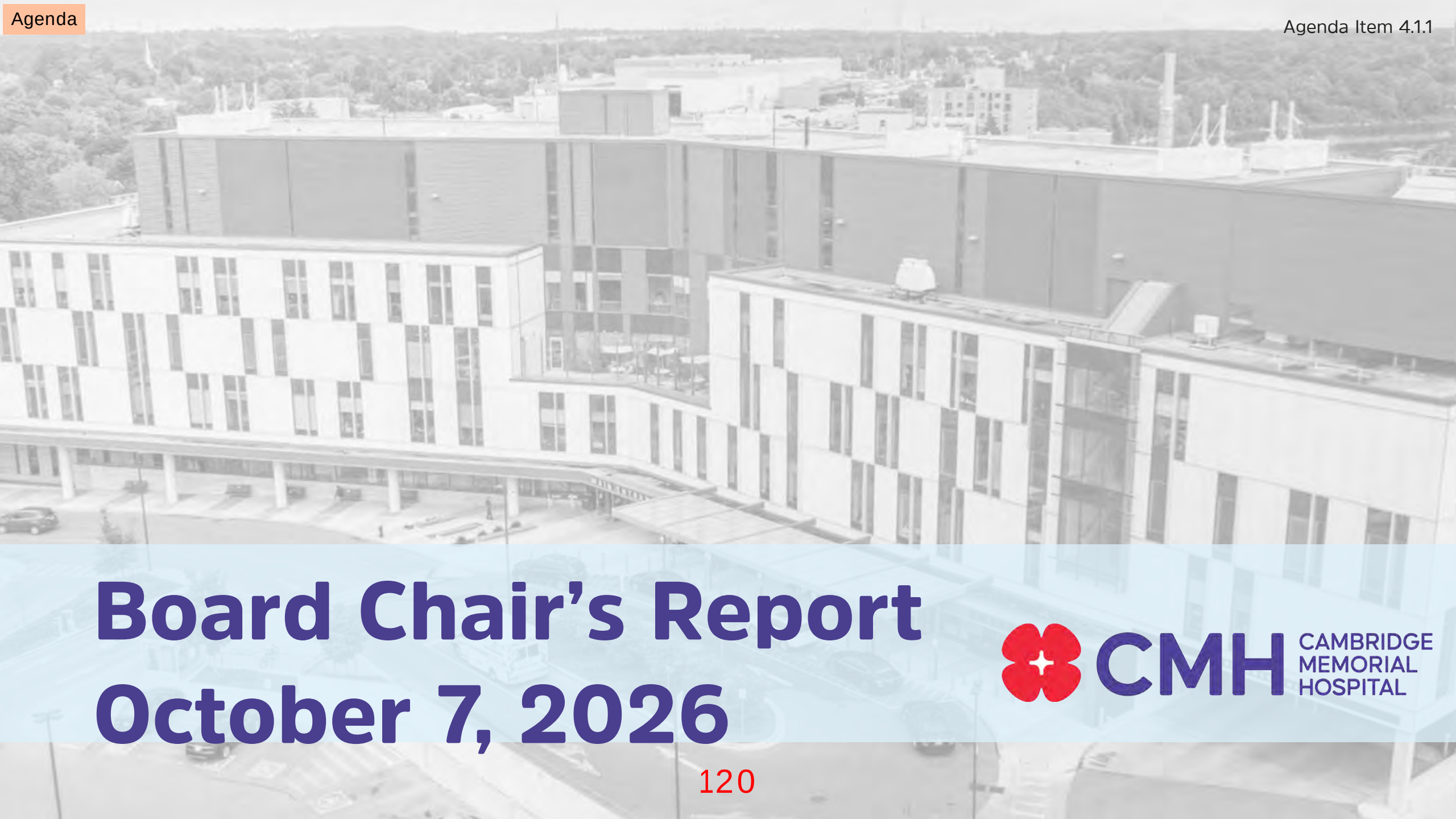
- Asian Heritage Month (May)
- Pride (June)
- National Indigenous History Month (June)

Pilot ERGs include:

- 2SLGBTQIA+
- Muslim
- Black
- Asian
- Indigenous

CMH logo





Board Chair's Report October 7, 2026



Board Chair's Report



Diane Wilkinson

Board Chair

Cambridge Memorial Hospital

Message From the Chair

Welcome back, everyone. I hope the summer brought you a good break and that you are returning with fresh energy for the year ahead. It is a pleasure to be together again around the Board table, with familiar faces returning and new ones joining us.

I am grateful for how this Board stayed connected over the summer. Your engagement at our August meeting, your questions on Project Quantum readiness, and your governance through the season kept our oversight steady when it mattered most.

The year ahead asks much of us, and I believe we are ready. Three organizational priorities will hold our attention: the November 8 Project Quantum go-live, our ED and patient flow transformation, and a balanced budget as we plan for the pressures of 2027/28.

What gives me confidence is the depth of experience around this table and the perspective each of you offers. Thank you for the governance and commitment you bring to CMH and to the community we serve. I look forward to the work ahead with you.

Board Chair's Report

JULY – SEPTEMBER 2026



Members of the CMH community gathered for the Eagle Feather Re-Energizing Ceremony, guided by Clarence Cachagee of Crow Shield Lodge

CMH Eagle Feather Re-Energizing Ceremony

July 17, 2026 — Miles Lauzon, Paulo Brasil, Sara Avlarado, Stephanie Kessler, Bill Conway, Diane Wilkinson, attended CMH's Annual Eagle Feather Re-Energizing Ceremony held in the courtyard at CMH.

The ceremony renewed the spirit of the Eagle Feather that rests at CMH, marked by smudging, song and prayer, and a shared moment of reflection for everyone gathered.

A meaningful moment in our Truth and ReconciliACTION journey, and a reminder of the relationships we continue to build with Indigenous partners and our community.

Board Chair's Report

JULY – SEPTEMBER 2026

Board Chair & Vice Chair Connect with the MPSA Executive

July 23, 2026: Diane Wilkinson and Bill Conway met with Dr. Miropolsky and Dr. Patel to open the door to ongoing dialogue. We heard HIS concerns and everyday frustrations. We've since added a Board welcome letter for new physicians and will show our appreciation at the Fall Thank You event. We'll meet quarterly over coffee, next in December or January after HIS go-live.



MOH Webinar: Initial Allocations & Hospital Sector Stabilization Plans

July 23, 2026 — Diane Wilkinson joined the Ministry of Health webinar on Ontario's initial hospital funding allocations and Hospital Sector Stabilization Plans, which highlighted demand, workforce and inflationary pressures facing hospitals.



New Director and Non-Director Orientations – Signing on to CMH Values

August 13 & 18, 2026 — Alana Russell, Stephanie Kessler, Abdul-Qayum Ali and Helene St. Amand completed orientation, meeting our leaders and learning how governance works at CMH. The August 13 session was virtual for non-Directors; August 18 was in person for Directors, with non-Directors joining at the end for a guided tour of CMH.



Board Chair's Report

JULY – SEPTEMBER 2026

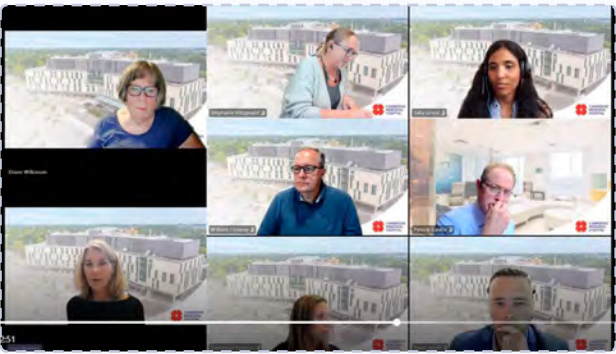
WRHN Redevelopment Orientation

August 25, 2026 – The Board Chair attended orientation for the WRHN Redevelopment Committee, strengthening the regional planning work we share with our partners. An update on the WRHN redevelopment is included in the agenda package.



Annual CMH Chairs Meeting

September 10, 2026 – Committee Chairs gathered virtually for the annual CMH Chairs meeting to align on the year ahead. A main focus of the meeting was providing input on the new Chairs Resource Guide and a modified tips sheet for all Directors for meetings. Stay tuned, you will see the new version soon!



Chair & CEO Check-Ins

The Board Chair and CEO met regularly through the summer and will continue to meet throughout the year. These standing check-ins keep the Board current on HIS implementation, flow and finance, support a strong Board–CEO partnership, and surface issues early so Board agendas stay focused on strategy and oversight.



Board Chair's Report

JULY – SEPTEMBER 2026

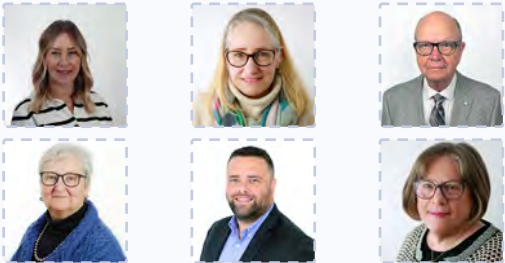
Julia Goyal Nominated for a Chamber Community Award

Julia Goyal has been nominated for a Board Member Award at the 2026 Cambridge Chamber Community Awards for her role with the Canadian Mental Health Association. Congratulations, Julia!



Grand Rounds: From Information to Impact

September 24, 2026 — Jennifer Backler (Professional Practice & Clinical Informatics, Clinical Lead HIS) and Kyle Leslie (Data Analytics & Innovation, CIO) presented Grand Rounds on how our new Health Information System will improve quality, flow and coordination and use data to drive better decisions, ahead of the November 8 go-live. Sara Alvarado, Diane Wilkinson, Miles Lauzon, Paulo Brasil, Jayne Herring and Stephanie Kessler participated.



A Gift in Honour of the CMH Board and Staff

Monika Hempel made a generous gift in honour of the CMH Board and staff

“Thank you for the care that you have given, continue to give and will give to our community. It has been a pleasure working on the Board and its committees”

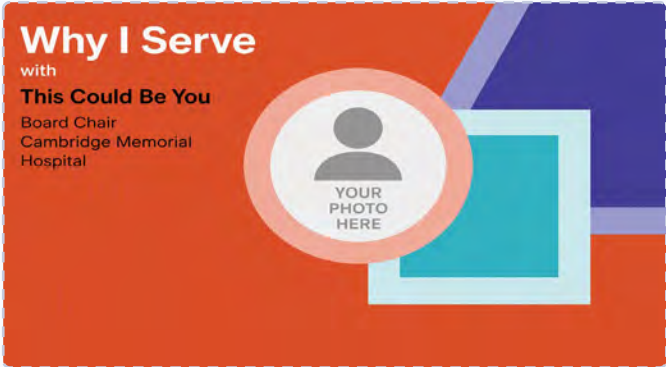


Board Chair's Report

JULY – SEPTEMBER 2026

CMH Governance Featured in OHA Spotlight Still Time to Participate

The OHA has launched “Why I Serve,” a governance profile series featuring volunteer hospital board members from across Ontario. Diane Wilkinson invited CMH Directors to take part and share what inspired them to serve and what they have learned at the Board table. Participation involves a short questionnaire that the OHA will use to develop a feature article for Health System News – a chance to showcase CMH's governance, innovation and community partnerships provincially. Directors interested in participating can connect with Stephanie for next steps.



Director 1:1s with the Board Chair

Thank you to the Directors for taking time out of their summers to meet one-on-one with the Board Chair and set their ABCDE goals for 2026/27 as a commitment to supporting the CMH Culture and Values

OUR BOARD ABCDE GOALS
Our commitments. Our impact.

A	ATTEND attend Board/committee meetings	
B	BE ENGAGED be an active contributor to the committee and Board work	
C	CONNECT attend staff huddles, be present at CMH events	
D	DONATE support the CMH Foundation	
E	EDUCATE undertake education, courses etc.	

Board Chair's Report

JULY – SEPTEMBER 2026

Indigenous Women's Health & Allyship Lunch and Learn

September 24, 2026 — Paulo Brasil, Sara Alvarado, Julia Goyal and Miles Lauzon joined virtually as CMH hosted an Indigenous Women's Health and Allyship Lunch and Learn. The session examined how colonization and systemic racism continue to shape health inequities and erode trust in care.

Participants left with practical trauma-informed and culturally safe care principles they can apply to create more respectful, equitable patient experiences.



Project SEARCH Graduation

June 26, 2026 — Members of the Board joined CMH leaders, families and our partners at KW Habilitation and the Waterloo Catholic District School Board to celebrate the Project SEARCH interns who completed their placements at CMH, building job skills and workplace experience alongside our teams.





BRIEFING NOTE

Date: September 23, 2026
Issue: Board Participation in CMH Thank You Event
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Stephanie Fitzgerald, Executive Assistant to the President & CEO
Approved by: Diane Wilkinson, Board Chair

Attachments/Related Documents: None

Executive Summary

Each fall, CMH holds a staff appreciation event to recognize the commitment and contributions of our staff. This year, the Board of Directors has been invited to take a more active role in the event as a meaningful way to offer its support and appreciation to staff and physicians as they prepare for the Health Information System (HIS) go-live.

The event will take place on October 28 and will combine the traditional appreciation gathering with Board-led rounding throughout the hospital. Staff and physicians will be invited to drop in at the MEC for hot apple cider, apples and tarts from 10:00 a.m. to 12:00 p.m., with an additional evening drop-in from 8:00 p.m. to 9:00 p.m. Throughout the day, Directors will be paired with a CMH leader to visit departments with wellness carts, share treats, deliver Board-signed thank-you posters and personally acknowledge staff. This approach will extend the Board’s appreciation to teams that may be unable to leave their work areas, while giving Directors a meaningful opportunity to connect with staff and hospital leaders in their own environments. Physicians will also be specifically included through direct communication and a planned visit to the physicians’ lounge.

Participation will be flexible. The rounding schedule will be developed around Directors’ availability, and Directors may participate for as little as one hour or for a longer block during the day. Stephanie Fitzgerald will assist with the coordination of the location, schedule, carts, refreshments, departmental communications and other event logistics.

Next Steps

Directors are asked to confirm whether they can participate in the October 28 event and identify all times they are available that day. Even a limited window of availability is helpful, as the schedule will be built to accommodate Directors’ commitments and maximize participation across the hospital.

Requested response: Please email Stephanie Fitzgerald by October 9 to confirm your willingness to participate and indicate all times you are available on October 28.



BRIEFING NOTE

Date: September 29, 2026
Issue: Financial Statements – August 2026
Prepared for: Board of Directors
Purpose: ☒ Approval ☐ Discussion ☐ Information ☐ Seeking Direction
Prepared by: Spencer Ogston, Senior Financial Analyst
Michelle D’Souza, Manager, Finance
Approved by: Janet Short, Senior Financial Advisor, Finance
Trevor Clark, VP Finance & Corporate Services, CFO

Attachments/Related Documents: Financial Statements – August 2026

Alignment with 2026/27 CMH Priorities:

2022-2027 Strategic Plan No ☐	2026/27 CMH Priorities No ☐	2026/27 Integrated Risk Management Priorities No ☐
☐ Elevate Partnerships in Care	☐ Improve Patient Flow (CBD, PIA, ED Admits)	☐ Organizational Flow
☒ Reimagine Community Health	☐ Prepare for Digital Health Transformation	☒ Project Quantum
☐ Increase Joy in Work	☐ Increase Staff Engagement Through Improved Staffing (Med, ICU, ED, Physicians)	☐ Management/Medical Staff Partnership
☒ Sustain Financial Health	☒ Achieve a Balanced 2026/27 Operating Position	☐ Financial Sustainability
☐ Advance Health Equity	☐ Embrace Diversity, Build a Culture of Inclusion	☐ Change Management

Alignment with 2026/27 CMH Corporate Plans: Multi-Year Financial Plan

Recommendation/Motion

Board

That, The Board of Directors, having reviewed the information presented and considered the recommendation of the Resources Committee arising from its meeting on September 28, 2026, accepts the August 2026 financial statements as presented/amended.

Resource Committee

Following review and discussion of the information provided, the Resources Committee of the Board recommends that the Board of Directors receives the August 2026 financial statements as presented by management. **CARRIED.**

Executive Summary

Cambridge Memorial Hospital (CMH) is in a \$0.1M net surplus position at the end of August 2026. This is primarily due to one-time items including budgeted contingency (\$1.6M). This is partially offset by a negative variance in minor equipment (\$1.4M) driven by Project Quantum purchases (\$1.1M) which were budgeted in 2025-26 but not completed until 2026-27, and one-time purchases in the Information Technology department (\$0.2M).

Analysis

CMH is in a \$0.1M year-to-date net surplus position at the end of August 2026. Actual results are \$1.0M unfavourable to budget.

The unfavourable variance is driven by:

- \$1.4M in minor equipment expenses driven by purchasing equipment for the HIS project (\$1.1M) and Information Technology department (\$0.2M). This was budgeted in the prior year.
- \$0.8M in electricity costs which were due to high Cogen downtime.
- \$0.6M in contracted out expenses driven by contracting out to Clearvision (cataract surgery) which was budgeted to be discontinued in 2026/27.
- \$0.4M in salaries and wages and benefits driven by sick time, constant care (one-to-one), overtime, and payments in lieu of benefits to part-time staff.

The unfavourable variance is partially offset by the following favourable variances:

- \$1.6M in budgeted contingency.
- \$0.5M in recoveries driven primarily by recoveries for Cogen downtime.
- \$0.5M in equipment depreciation expense, driven by delays in capital equipment purchases.

Revenue Highlights

- QBPs are \$0.1M favourable to budget year to date due to higher bundled care and surgical volumes (\$0.8M). This is partially offset by a negative variance in non-elective QBP volumes (\$0.7M).
- Billable patient services is \$0.4M favourable to budget year to date. The variance is driven by a positive variance in self pay revenue (\$0.6M), which is partially offset by a negative variance in preferred accommodations revenue (\$0.1M).
- The hospital has budgeted \$23.7M in PCOP funding for 2026/27, representing 100% of the total available allocation. Recognition of this funding is contingent upon the achievement of volume targets. There is no year-to-date variance, as revenue is being recognized in accordance with budget. Actual PCOP procedure volumes completed to date have exceeded budgeted levels, which provides assurance that the full funding allocation will be achieved. However, careful monitoring is being done to ensure the excess volumes are maintained within a reasonable range to avoid operational pressure.
- Base funding is \$0.4M negative to budget due to an unanticipated claw back of 2025/26 NICU Incremental funding. It has been determined that the hospital is ineligible for this additional funding in 2026-27. It has been removed from the 2026/27 budget.

Expense Highlights

- Salaries and wages are slightly unfavourable to budget year to date. There are negative variances due to higher overtime (\$0.3M), training time (\$0.3M), constant care (one-to-one) (\$0.2M), and sick time (\$0.2M), partially offset by a positive variance in worked salaries. Strategies to address these pressures include hiring efforts to staff to full complement, assessment of part-time staffing requirements and procedures to address replacement for sick/leaves and use of constant care.
- Employee benefits are \$0.3M unfavourable to budget year to date. The variance is driven by higher in lieu of benefits payments to part-time staff, due to a higher number of hours worked by part-time staff compared to budget (\$0.1M) and higher maternity leave top-ups (\$0.1M).
- Medical remuneration costs are slightly favourable to budget year to date. There is a small positive variance generated by savings from a pathologist vacancy.
- Medical and surgical supplies costs are \$0.1M unfavourable to budget year to date. This is driven by a negative variance in Endoscopy, ICU, and Emergency due to high patient volume.
- Drug expenses are \$0.1M favourable year to date. Presently, there is a favourable variance in drugs for the Oncology Program (\$0.3M). 98% of oncology drug costs are reimbursed by Ontario Health. This favourable variance is partially offset by increased costs of other drugs used throughout the hospital.

- Other supplies and expenses are \$1.8M unfavourable to budget year to date. The variance is primarily due to minor equipment costs (\$1.4M) to purchase equipment for the HIS program (\$1.1M) and Information Technology department (\$0.2M). These costs were budgeted last fiscal year, but purchasing and delivery was not completed until June 2026. There is also an unfavourable budget in contracted-out expenses (\$0.6M) driven by cases contracted out to Clearvision and Tri-City Endo for cataract surgeries and endoscopies respectively. CMH has stopped contracting out cases to Tri-City Endo but is still sending both unilateral and bilateral cases to Clearvision. Review of these services is underway. Additionally there is a negative variance in electricity expenses (\$0.8M) driven by Cogen downtime. These negative variances are partially offset by budgeted contingency (\$1.6M).
- \$1.2M of expenses related to Project Quantum are included in the YTD financial statements. As noted, these costs include IT equipment for the HIS project that did not meet the threshold for capitalization.

Balance Sheet and Statement of Cash

CMH's current cash position is \$73.1M, consisting of \$57.1M of unrestricted cash and \$16M of restricted cash. The working capital ratio is 1.35 and meets the requirements of the Hospital Service Accountability Agreement (H-SAA) target range of 0.8 to 2.0.

Unrestricted working capital available at the end of August was \$23.6M, which is summarized below.

	\$M
Unrestricted Bank Balance – August 31, 2026	57.2
Add: Other Current Assets	13.1
Less: Current Liabilities (\$3.8M due to MOH)	(52.0)
Subtotal – Net Current Assets	18.3
Add: Vacation Bank Accrual (consistent with MOH working capital calculation)	5.3
Working Capital Available – August 31, 2026	23.6
Add:	
CMHF & Third Party Funding for Approved Equipment	7.6
2026-27 Hospital Infrastructure Renewal Fund (Estimate)	3.9
Less:	
Outstanding Health Information System Commitments	(17.1)
Outstanding 2026-27 Capital Budget Commitments	(11.7)
Outstanding Approved POs	(11.3)
Forecast Unrestricted Working Capital – March 31, 2027	(5.0)
Anticipated Debt Draw – 2026-27	-
Working Capital Available – March 31, 2027	(5.0)

A cashflow deficit is forecast for the end of March 31, 2027, which will require debt financing. The maximum debt anticipated is \$20M. Management will continue to monitor cashflow to ensure there is adequate cash on hand, while also minimizing the extent of debt required.

**Cambridge Memorial Hospital
Statement of Financial Position
As at August 31, 2026**

(Expressed in Thousands of Dollars)

	August 2026	March 2026
ASSETS		
Current Assets		
Cash and Short-term Investments	\$ 57,155	\$ 64,648
Due from Ministry of Health / Ontario Health	1,577	5,949
Other Receivables	5,755	5,981
Inventories	2,724	2,733
Prepaid Expenses	3,077	2,605
	70,288	81,916
Non-Current Assets		
Cash and Investments Restricted - Capital	15,966	15,811
Due from Ministry of Health - Capital Redevelopment	8,199	8,199
Due from CMH Foundation	59	45
Endowment and Special Purpose Fund Cash & Investments	228	225
Capital Assets	308,991	303,988
Total Assets	\$ 403,731	\$ 410,184
LIABILITIES & NET ASSETS		
Current Liabilities		
Due to Ministry of Health / Ontario Health	3,778	3,778
Accounts Payable and Accrued Liabilities	39,031	41,071
Deferred Revenue	9,161	9,161
	51,970	54,010
Long Term Liabilities		
Capital Redevelopment Construction Payable	-	317
Employee Future Benefits	3,972	3,864
Deferred Capital Grants and Donations	268,555	272,838
Asset Retirement Obligation	3,130	3,130
	275,657	280,149
Net Assets:		
Unrestricted	14,347	24,043
Externally Restricted Special Purpose Funds	228	225
Invested in Capital Assets	61,529	51,757
	76,104	76,025
Total Liabilities and Net Assets	\$ 403,731	\$ 410,184
Working Capital Balance	18,318	27,906
Current Ratio	1.35	1.52

Cambridge Memorial Hospital
Statement of Operations
For the period ending August 31, 2026

Confidential
(Expressed in Thousands of Dollars)

Month of August 2026					Year to Date				2026-27	2025-26 Prior Year Actuals	
Actual	Budget	Variance	% Variance		YTD Actual	YTD Budget	YTD Variance	% Variance	Budget	August 2025	2025-26 YE
Revenue:											
MOH Funding											
\$ 11,123	\$ 11,123	\$ -	0%	MOH - Base	\$ 54,480	\$ 54,896	\$ (416)	(1%)	\$ 131,378	\$ 10,559	\$ 126,166
2,063	2,341	(278)	(12%)	MOH - Quality Based Procedures	12,362	12,233	129	1%	29,132	2,461	30,484
1,833	1,833	-	0%	MOH - Post Construction Operating Plan	9,166	9,166	-	0%	23,729	1,293	15,107
941	952	(11)	(1%)	MOH - One Time / Other	5,020	4,776	244	5%	10,092	986	32,859
15,960	16,249	(289)	(2%)	Total MOH Funding	81,028	81,071	(43)	(0%)	194,331	15,299	204,616
1,653	1,599	54	3%	Billable Patient Services	8,304	7,899	405	5%	18,840	1,428	17,913
1,677	1,772	(95)	(5%)	Recoveries and Other Revenue	9,246	8,795	451	5%	21,820	1,902	23,232
269	290	(21)	(7%)	Amortization of Deferred Equipment Capital Grants	1,348	1,432	(84)	(6%)	3,417	255	3,112
369	424	(55)	(13%)	MOH Special Votes Revenue	1,908	2,094	(186)	(9%)	5,022	321	5,063
19,928	20,334	(406)	(2%)	Total Revenue	101,834	101,291	543	1%	243,430	19,205	253,936
Operating Expenses:											
9,124	9,298	174	2%	Salaries & Wages	45,935	45,901	(34)	(0%)	111,410	8,940	109,037
2,694	2,545	(149)	(6%)	Employee Benefits	13,549	13,228	(321)	(2%)	30,893	2,507	29,899
2,086	2,068	(18)	(1%)	Medical Remuneration	10,189	10,228	39	0%	24,414	1,933	24,519
1,077	1,278	201	16%	Medical & Surgical Supplies	6,415	6,309	(106)	(2%)	15,051	1,206	16,751
1,128	1,266	138	11%	Drug Expense	6,116	6,247	131	2%	14,903	1,065	15,080
2,760	2,449	(311)	(13%)	Other Supplies & Expenses	14,225	12,398	(1,827)	(15%)	32,599	2,654	33,615
479	583	104	18%	Equipment Depreciation	2,349	2,875	526	18%	6,859	449	5,389
342	424	82	19%	MOH Special Votes Expense	1,926	2,094	168	8%	5,022	321	5,222
19,690	19,911	221	1%	Total Operating Expenses	100,704	99,280	(1,424)	(1%)	241,151	19,075	239,512
238	423	(185)	(44%)	MOH Surplus / (Deficit)	1,130	2,011	(881)	(44%)	2,279	130	14,424
(831)	(869)	38	(4%)	Building Depreciation	(4,154)	(4,288)	134	(3%)	(10,231)	(812)	(9,772)
621	675	(54)	(8%)	Amortization of Deferred Building Capital Grants	3,103	3,333	(230)	(7%)	7,952	621	7,451
\$ 28	\$ 229	\$ (201)		Net Surplus / (Deficit)	\$ 79	\$ 1,056	\$ (977)		\$ -	\$ (61)	\$ 12,103

Cambridge Memorial Hospital
Statement of Cash Flows
For the period ending August 31, 2026

(Expressed in Thousands of Dollars)

	August 2026	March 2025
Cash Provided By (Used In) Operations:		
Excess (Deficiency) of Revenue over Expenses	\$ 79	\$ 12,104
Items not Involving Cash:		
Amortization of Capital Assets	6,503	15,161
Amortization of Deferred Grants and Donations	(4,451)	(10,563)
Change in Non-Cash Operating Working Capital	2,075	(14,419)
Change in Employee Future Benefits	108	(222)
	4,314	2,061
Investing:		
Acquisition of Capital Assets & Capital Redevelopment Project	(11,506)	(16,739)
Capital Redevelopment Project Construction Payable	(317)	149
	(11,823)	(16,590)
Financing:		
Change in Non-Cash Capital Accounts Receivable	-	(508)
Capital Donations and Grants & Capital Redevelopment Project	168	7,703
	168	7,195
Increase (Decrease) In Cash for the Period	(7,341)	(7,333)
Cash & Investments - Beginning of Year	80,462	87,795
Cash & Investments - End Of Period	\$ 73,121	\$ 80,462
Cash & Investments Consist of:		
Unrestricted Endowment and Special Purpose Investments	30	30
Cash & Investments Operating	57,125	64,621
Cash & Investments Restricted	15,966	15,811
Total	\$ 73,121	\$ 80,462



BRIEFING NOTE

Date: September 17, 2026
Issue: Quality Committee Report to the Board of Directors, September 16, 2026- OPEN
Prepared for: Board of Directors
Purpose: ☐ Approval ☐ Discussion ☒ Information ☐ Seeking Direction
Prepared by: Jennifer Morgan, Administrative Assistant to Clinical Programs
Approved by: William Conway, Quality Committee Chair

Attachments/Related Documents: None

A meeting of the CMH Quality Committee of the Board took place on Wednesday, September 16, 2026, at 0700h.

- Present:** W. Conway (Chair), Dr. W. Lee, N. Gandhi, A. Schrum, J. Herring, S. Pearsall, D. Haughton, S. Kessler, M. Lauzon, A. McCarthy, M. McKinnon, K. Baldock
- Regrets:** P. Gaskin
- Staff:** Dr. J. Legassie, M. Iromoto, Dr. K. Rhee, L. Barefoot
- Guests:** J. Backler, D. Pereira

The Quality Committee completed its scheduled work for the September 16, 2026 reporting period. Key matters reviewed, discussed, and advanced by the committee are summarized below for Board awareness.

Committee Matters – For information only

- Quarterly Strategic Priorities Tracker for 2026/27:** The Committee received an overview of the updated Strategic Priorities Tracker and quarterly reporting framework for the first quarter of the fiscal year. Management advised that the revised reporting format is intended to provide a governance-level view of organizational performance by connecting key performance indicators to strategic priorities, current initiatives, future actions, risks, and mitigation strategies. The updated approach was developed in response to stakeholder feedback and is designed to provide greater context regarding organizational progress and performance outcomes. Members heard that the Strategic Priorities Tracker aligns the organization's Strategic Plan, Quality Improvement Plan, Integrated Risk Management framework, and supporting corporate plans, creating a clear link between strategy, performance, and risk. While the Board receives an enterprise-wide view of all strategic measures, the Quality Committee's reporting remains focused on indicators within its oversight mandate.

Management highlighted that the Quality Committee's key areas of focus for 2026-2027 include patient access, patient flow, and discharge performance measures within the Elevate Partnerships in Care pillar and Clinical Services Growth Plan. Priority

indicators include CTAS triage-to-provider assessment times, CTAS 1 assessment times, conservable bed days, and adequacy of discharge information. Members were reminded that these measures are closely aligned with the organization's broader patient flow initiatives and strategic risk priorities. The Committee was advised that each measure includes detailed reporting on objectives, actions completed, upcoming priorities, and associated risks and mitigation strategies. Members were encouraged to focus on performance trends, underlying drivers, and the effectiveness of mitigation efforts, while exercising their governance role through oversight, inquiry, and the escalation of emerging quality, patient safety, and organizational risks as appropriate.

A Committee member noted the importance of ensuring that the Committee's focus on patient flow and operational challenges remains balanced with recognition of areas of strong organizational performance. Members commended the organization's achievement of its health equity and diversity, equity, and inclusion (DEI) targets and discussed ongoing physician recruitment challenges. Management advised that approximately 20 physician vacancies exist across several clinical areas, with particular needs in perioperative services, including anesthesia, as well as programs supporting Emergency Department operations and the Clinical Services Growth Plan. Physician recruitment remains a key organizational priority, and management expressed confidence that focused recruitment efforts will help address vacancies and support future growth objectives.

Members also discussed the Committee's governance role in overseeing strategic performance and organizational risk. A Committee member expressed appreciation for the reporting framework presented by management, noting that it clearly distinguishes governance oversight responsibilities from operational management functions and provides valuable guidance for Committee members, particularly those new to the role. Management will circulate the key governance oversight principles to Committee members and include the framework within the meeting minutes as a reference tool to support ongoing Committee governance and oversight activities. *(Further information found in consent agenda item 1.5.8)*

2. **Review Quality Terms of Reference:** The Committee reviewed the Quality Committee Terms of Reference. Members were advised that no changes have been made to the Terms of Reference and that they remain current. The Chair noted that the document was last reviewed by the Governance Committee in December 2024 and continues to be reviewed in accordance with the organization's regular governance review cycle.
3. **Approval of Draft 2026/27 Quality Workplan:** The Committee reviewed and approved the proposed Quality Committee Workplan for 2026/27 and was advised that it incorporates feedback received through summer member consultations while maintaining the Committee's established annual meeting cadence. In addition to its regular quality oversight responsibilities, the Committee will receive monthly updates regarding the implementation and progress of the Health Information System (HIS).
4. **HIS Implementation Progress Update:** The Committee received a comprehensive update on the Health Information System (HIS) implementation, which is intended to support safer, higher-quality care through the transition from fragmented paper and electronic processes to a fully integrated electronic health record environment. Management advised that the HIS will provide a single source of patient information, standardized clinical workflows, and real-time access to data, enabling more consistent clinical decision-making, improved care coordination, and enhanced operational performance across the organization.

Members heard that the current environment relies on a combination of paper documentation and multiple electronic systems, resulting in fragmented information and variable processes. The future-state HIS will allow clinicians to access comprehensive patient information from any clinical workstation, support standardized documentation and ordering practices, and improve consistency across departments and care settings. The system is expected to strengthen continuity of care and facilitate safer patient transitions through improved information sharing across the Waterloo Regional Health Network and partner organizations.

Management highlighted several anticipated patient safety and quality benefits associated with the HIS, including standardized electronic order sets (PowerPlans), clinical decision support tools, automated alerts, and digital patient identification processes. These features are designed to reduce variation in care, support evidence-based clinical decision-making, identify patient deterioration earlier, and help ensure that patients receive appropriate and timely treatment. Enhanced medication safety will be supported through standardized ordering workflows, improved visibility of medication and allergy information, and closed-loop medication administration processes using barcode verification technology.

The Committee was advised that the HIS will create a longitudinal electronic medication record that follows patients across encounters and partner organizations, improving continuity of care and reducing the need for repetitive medication history collection. Embedded clinical safeguards and automated alerts for conditions such as sepsis and other indicators of deterioration will support timely reassessment and escalation of care, while standardized workflows will help reduce process-related errors and strengthen organizational quality and patient safety outcomes.

Members also heard that the HIS will support the organization's Just Culture framework by providing improved access to data, enhanced monitoring of quality outcomes, and better identification of system-level issues requiring improvement. In addition, the system incorporates several patient experience and health equity enhancements, including the collection of preferred names, pronouns, gender identity, sexual orientation, and other socio-demographic information to support more inclusive and patient-centred care. Management noted that the comprehensive longitudinal patient record will reduce the need for patients to repeatedly provide the same information throughout their care journey, improving both the patient experience and care coordination.

The Committee received further information on Health Information System (HIS) enhancements related to health equity, patient experience, quality improvement, and system integration. Management highlighted new socio-demographic data collection capabilities, including preferred names, pronouns, gender identity, and other patient-specific information, to support respectful, inclusive, and patient-centred care. Preferred names will be displayed prominently throughout the system, including on patient identification armbands, while allowing patients the option to decline providing this information.

Members heard that the HIS will strengthen information sharing and continuity of care through enhanced integration with regional partner organizations, including the Waterloo Regional Health Network (WRHN). The system will also improve the patient experience by providing clear discharge information, including medication changes, follow-up appointments, and care instructions, supporting safer transitions from hospital to home. Management advised that the HIS will provide a strong foundation for ongoing quality improvement through structured data collection, reporting, auditing, and performance monitoring. Enhanced access to real-time clinical and operational data will support the identification of trends, monitoring of adherence to standardized practices, and advancement of continuous quality improvement initiatives. The Committee was also informed that extensive monitoring activities will

occur during and following HIS go-live, including daily safety rounds and ongoing review of key performance indicators such as turnaround times, electronic order entry utilization, barcode medication administration compliance, and duplicate orders. These measures are intended to support implementation stabilization and ensure the anticipated patient safety and quality benefits are achieved.

The Committee engaged in a discussion regarding Health Information System (HIS) integration, data management, privacy, and organizational readiness. Members sought clarification on the future role of ClinicalConnect, record retention practices, system architecture, and the long-term implications of data growth. Management advised that significant work has been undertaken to develop a comprehensive data strategy to support data storage, governance, analytics, research, and innovation needs. Planning has also focused on managing information within a shared regional environment and ensuring the necessary infrastructure, governance, and reporting capabilities are in place to support both go-live and future organizational requirements.

Members discussed privacy considerations and patient access to information within the new HIS environment, particularly in relation to shared regional records. Management advised that access to patient information will continue to be governed by the circle of care principle, supported by enhanced privacy education and increased auditing. The Committee also received an update on patient portal access and was advised that Connect My Health will remain available following HIS implementation, with an additional regional HIS patient portal planned for future implementation to provide patients and families with expanded access to their health information.

The Committee also discussed organizational readiness for go-live, including staff training, technical support, and overall employee preparedness. Management outlined a comprehensive training and support strategy that includes classroom education, micro-learning sessions, job aids, super users, at-the-elbow support, workflow practice opportunities, and 24/7 IT support during the early stages of implementation. Members heard that staff feedback has become increasingly positive as implementation approaches, with many employees expressing enthusiasm about transitioning to a modern electronic health record system. Previous experience with similar systems among staff is expected to support adoption and peer learning, while the implementation of a digital health record is also anticipated to strengthen physician and staff recruitment efforts. *(Further information is included in Package 2.)*

5. **Quality Monitoring Scorecard:** The Committee was provided a detailed monthly review of quality, safety, operational, and workforce indicators across the organization. Management noted that while there is some overlap with the Strategic Priorities Tracker, the scorecard offers a broader and more detailed view of organizational performance and is reviewed regularly by the Committee to support quality oversight.

The Committee discussed workforce-related indicators and the impact of Health Information System (HIS) implementation activities on staffing metrics. Management advised that HIS training costs and associated overtime are being tracked separately from regular operational overtime and that future reporting will allow implementation-related overtime to be identified independently. Members noted the importance of understanding the effect of HIS-related activities on workforce measures while recognizing the additional workload pressures experienced by staff during implementation.

Committee members also sought clarification regarding the analysis and reporting of workforce indicators, including sick time, overtime, and benchmarking practices. Management advised that workforce data is reviewed in detail and includes comparisons against industry benchmarks and peer organizations, as well as analysis by job classification, staffing complement, employment status, replacement hours, and

other workforce variables. Additional considerations, such as vacancies and maternity leaves in high-demand clinical areas, are also incorporated into workforce monitoring and planning. In response to questions regarding employee benefit practices, management confirmed that personal days and sick time are tracked and reported separately. Members were advised that more detailed workforce and human resource metrics are generally reviewed through the appropriate human resources and resource committees rather than through the Quality Committee.

Members were advised that ten indicators had remained in red status for three consecutive reporting periods; however, management noted that overtime should also have been included, bringing the total to eleven indicators. Most indicators trending below target were related to patient flow and access, reflecting ongoing pressures across the organization. Sick time and overtime were also identified as areas of concern, highlighting the workforce challenges associated with sustained operational demands. *(Further information found in consent agenda item 1.5.8.1)*

6. **Medical Advisory Committee Update:** The Committee received an update from the Medical Advisory Committee (MAC), including the introduction of the new Chief and Medical Director of the Emergency Department. Management highlighted her extensive clinical and leadership experience and advised that she will be supported during the transition by the outgoing Chief and Emergency Department physician leaders. This collaborative leadership approach is intended to support key organizational priorities, including Emergency Department flow improvement and Health Information System (HIS) implementation.

Members heard that HIS implementation was a major focus of the recent MAC meeting. Management emphasized that the HIS is a patient safety and workflow transformation initiative, rather than solely a technology project. Discussion focused on computerized provider order entry (CPOE), which is expected to reduce reliance on verbal and telephone orders and minimize transcription-related errors. MAC endorsed guiding principles for verbal and telephone orders to support the development of a joint policy with the Waterloo Regional Health Network and reviewed and approved a comprehensive suite of electronic order sets (PowerPlans) that will be implemented at go-live. The Committee was also advised that MAC is developing a quality oversight framework to strengthen monitoring of key medical quality domains. The framework will provide oversight of organizational quality indicators, quality review trends, human resource gaps, incomplete charting, credentialing activities, and physician professional development, supporting MAC's governance role in advancing medical quality, patient safety, and continuous improvement. *(Further information found in consent agenda item 1.5.6.5)*

7. **OHT Quarterly Update:** The Committee received an update on Ontario Health Team (OHT) initiatives. Members heard that improving access to primary care and specialist services remains a key strategy for reducing avoidable Emergency Department visits and hospital admissions. Management advised that enhanced coordination between primary care providers and specialists will support timely follow-up care, improve community-based management of patients, and reduce unnecessary hospital utilization.

The Committee was advised that work is underway to implement the Specialist Consultation and Optimization Program (SCOPE), led by the Director, Medical Programs and the Chief, Community & Family Medicine, with a soft launch planned for October. The initiative is designed to provide primary care providers with timely access to specialist advice and expedited consultations, helping patients receive appropriate care

in the community and reducing pressure on acute care services. Management noted that further updates on OHT initiatives will be provided in the coming months.

Committee members commended the breadth of system improvement initiatives underway and noted the positive impact of Ontario Health Team partnerships on system integration, access to care, and patient outcomes. Members expressed encouragement regarding the progress being made to strengthen coordination across the healthcare system and improve access to primary and specialty care services.
(Further information is included in Package 2.)