MEMORANDUM OF UNDERSTANDING

BETWEEN:

GROVES MEMORIAL COMMUNITY HOSPITAL

AND

NORTH WELLINGTON HEALTH CARE CORPORATION

1. Purpose of this Memorandum of Understanding

   A. Groves Memorial Community Hospital ("GMCH") and North Wellington Health Care Corporation ("NWHC") are each designated as public hospitals under the *Public Hospitals Act* (Ontario) and are each a party to the Wellington Health Care Alliance Agreement dated October 10, 2013 (the "Alliance Agreement").

   B. GMCH and NWHC (each sometimes referred to herein as a "hospital" or collectively the "hospitals", and for certainty reference to the term "hospital" or "hospitals" means hospital corporation or hospital corporations, as the case may be) have determined that it is in their mutual interest and in furtherance of their respective missions, visions and values to achieve the further integration of their hospitals through a joint executive committee governance model, the composition and responsibilities of which are described below (the "Integration").

   C. The Integration is being facilitated by Mark Rochon of KPMG LLP (the "Facilitator") who was appointed as facilitator by the Waterloo Wellington Local Health Integration Network by resolution on August 13, 2015 (the "LHIN") and requires LHIN approval prior to implementation.

   D. This Memorandum of Understanding ("MOU") summarizes the key terms developed by a joint steering committee comprised of directors of each hospital (the "Joint Steering Committee") with the assistance of the Facilitator, and is intended to provide a framework for terminating and replacing the Alliance Agreement with a new alliance agreement that implements and codifies the Integration set out herein (the "New Alliance Agreement") following approval of this MOU by the boards of directors of each hospital and the LHIN.

2. Non-Binding Nature of this MOU

   This MOU is not legally binding on the parties. However, the intention of each hospital is to fully and unreservedly accept the concepts set forth in this MOU once approved by the LHIN, and to not attempt to renegotiate or substantially modify any such concepts when they are more fully articulated in the New Alliance Agreement.

3. Guiding Principles of Integration

a. *Goals of Integration*: Each hospital acknowledges, affirms and accepts the following nine goals developed by the Joint Steering Committee, as goals of this Integration:

1. To bring stability to the governance of the three hospital sites;
2. To better position the organization for long term stability of hospital operations;
3. To facilitate planning, decision making, and resource allocation to meet the needs of patients;
4. To strengthen the organization's ability to attract and retain talent, including physicians, specialists, and leadership;
5. To allow for the continued achievement of the objectives set out in the Alliance Agreement;
6. To support the achievement of a robust, integrated model of care in Wellington as contemplated in the Rural Wellington Plan;
7. To contribute to the advancement of rural health care in Wellington County;
8. To create a stronger voice to advance health care issues in the Wellington County; and,
9. To eliminate duplication of board and other activities.

b. *Commitment to Joint Communication*: Each hospital is committed to the process established by the Facilitator and agrees the Joint Steering Committee shall establish a joint communication strategy in respect of the MOU and the New Alliance Agreement. Each hospital further affirms its commitment to the principle of joint community and stakeholder communication.

c. *Commitment to Good Governance*: Each hospital is committed to ensuring the conditions for good governance are in place at each hospital at all times, which conditions include but are not limited to a commitment to continuing director education and the ongoing recruitment of skills-based boards comprised of independent directors.

d. *Solidarity and One Voice*: Despite the continuing existence of two separate legal entities, the Integration will result in shared governance responsibilities for certain activities of both hospitals. For such shared oversight to be effective, each hospital acknowledges that it is imperative for both corporations to speak with one voice on matters within the jurisdiction of the Joint Executive Committee

(defined below) unless and until the joint governance arrangements described in this MOU are unwound and the New Alliance Agreement is terminated.

e. *Respectful Dispute Resolution*: The parties acknowledge that disputes will arise from time to time but all such disputes shall be exclusively addressed using an escalated dispute resolution process.

4. Joint Executive Committee

The board of directors of each hospital shall delegate decision-making authority related to the matters set forth on Schedule "A" to an executive committee comprised of hospital directors, and the executive committees of each hospital will at all times meet jointly and function as one governance body (the "Joint Executive Committee" or "JEC"). For certainty, all matters not expressly referenced on Schedule "A" shall be reserved to and shall remain the powers of the board of directors of each respective hospital, until such time as both hospital boards delegate, by resolution, additional powers to the JEC. The JEC is expected to function collectively and make decisions considering the needs of all residents serviced by the hospitals, recognizing the uniqueness of each hospital site and its associated communities. Without limiting the foregoing but for certainty, the intention of the hospitals is that the JEC will consider and discuss all issues jointly and openly and collectively (rather than having each hospital's representatives to JEC predetermine positions on issues). The JEC shall have the following governance attributes:

(a) *Size and Composition*: Each hospital board shall appoint 5 independent elected directors to the JEC, all of whom shall have one vote on matters properly brought before the JEC. Each hospital shall determine its appointees to the JEC annually using its own process, but the chair of each hospital board shall be appointees to the JEC at all times, to ensure governance alignment between the boards and JEC.

The hospitals shall work together to ensure a balance of skills and expertise and independence are at all times reflected on the JEC. For certainty, independence means directors are free from outside influences that could impact their ability to make impartial and objective decisions. Individuals who are sitting as elected members of a municipal council shall not be considered independent and shall not qualify to sit on JEC. To ensure the independent functioning of JEC, the by-laws of each hospital shall be revised to ensure the chair of each hospital board meets the independence criteria contemplated herein.

The JEC shall direct the joint governance committee to develop an appropriate skills matrix for JEC and shall direct the joint nominating committee to identify potential

candidates for appointment to JEC. For certainty, no recommendation from the joint nominating committee shall restrict a hospital board's ability to appoint qualified directors to JEC.

In addition, the following persons shall have a standing invitation to attend JEC meetings, but shall not have any right to vote at JEC meetings: the chief executive officer, the chief of staff of each hospital, and the chief nursing executive. From time to time JEC may invite others to attend all or a portion of JEC meetings, including, for example only, the presidents of the medical staff associations, the chief financial officer, etc.

(b) *Quorum and Term*: 6 independent elected directors, including at least 3 directors from each hospital. The term of appointment to JEC shall be annual. No directors may vote by proxy at JEC meetings.

(c) *JEC Chair and Vice-Chair*: The first chair of the JEC shall be the current chair of one of the hospitals, and the first vice-chair of the JEC shall be the current chair of the other hospital, decided by lot. Subsequently, the chair of JEC shall rotate between the individuals who are the then-chair of each hospital on an annual basis (a "Term"), and when a chair of one of the hospitals is not acting as JEC Chair, he or she shall be JEC Vice-Chair. No individual shall serve as chair or vice-chair of the JEC, collectively, for more than four (4) years; provided, however, that an exception to this term limit shall be available to the founding Chair and Vice-Chair to accommodate existing term lengths as hospital chair if required. The JEC chair shall be entitled to vote at JEC meetings. The duties of the JEC chair shall include (a) setting JEC agendas and chairing JEC meetings; (b) acting as sole public spokesperson (internal and external) for both hospitals on matters delegated to JEC (but the chairs of each hospital board shall continue to retain spokesperson authority for matters not delegated to JEC or the chief executive officer); and (c) acting as the primary contact between the JEC and the chief executive officer and chief(s) of staff for those matters delegated to JEC (but the chairs of each hospital board shall continue to retain a direct contact to the chief executive officer and chief(s) of staff for matters not delegated to JEC). The JEC shall be

entitled to meet by telephone or other means that permit instantaneous and simultaneous communication.

(d) *Decision Making Power*: Decisions of the JEC require approval by a majority of appointees of each hospital in attendance and voting to be effective. In other words, a hospital shall not be bound by a decision of the JEC unless a majority of independent directors appointed by that hospital vote in favor of the decision. For certainty, if a matter within the authority of the JEC is not agreed to by both hospitals, neither hospital will proceed on the issue unless the JEC expressly permits different courses of action by each hospital or different courses of action are expressly permitted in this MOU or the New Alliance Agreement. Nothing in the proceeding sentence shall limit the authority of each hospital board on matters reserved to the hospital board.

(e) *Reporting and Supervision:* Matters delegated to the JEC do not require ratification or approval by the boards of either hospital to be legally binding, however JEC-approved written reports shall be regularly made to the boards of both hospitals for information purposes. Directors of each hospital shall also be entitled to review minutes of all JEC meetings.

5. Chief Executive Officer and Chief(s) of Staff

(a) Without limiting the decision making power of the JEC set forth above, but for certainty, both hospitals are committed to immediately commencing a joint search for a new chief executive officer ("CEO") who will assume the role as soon as practicable. If interim leadership is required, both hospital boards are committed to taking all steps necessary or desirable to ensure appropriate actions are taken to engage an appropriate person to provide interim leadership to both hospitals. A majority vote of the JEC appointees of each hospital is required in order to hire a new CEO.

(b) In the event the appointees to JEC of one hospital lose confidence in the CEO or a chief of staff at any time for bona fide reasons linked to performance expectations, whether quantifiable or otherwise specified, both hospitals agree to respect the decision of the other alliance participant and shall jointly undertake appropriate progressive remedial action or, if required, jointly terminate the engagement with the CEO or chief(s) of staff and recruit a replacement CEO or chief(s) of staff, as the case may be, out of respect for and a commitment to the joint governance arrangement set forth in this MOU.

(c) Each hospital expressly acknowledges and reaffirms the principle that a chief executive officer reporting primarily to JEC, and chief(s) of staff reporting primarily to JEC, furthers the goals of the Integration.

(d) JEC shall establish performance expectations, conduct annual performance reviews of the CEO and chief(s) of staff, and shall at all times be responsible for monitoring and supervising the CEO and chief(s) of staff at all times. All decisions of the JEC related to the performance of the CEO or a chief of staff shall require the support of a majority vote of the JEC appointees of each hospital.

(e) The hospitals acknowledge that in Year 1 following the New Alliance Agreement, there will be 2 chiefs of staff who will work together with JEC and the two MACs and make recommendations on how to further integrate the medical staff and chief of staff role. For Year 2, recommendations on further integration shall be considered by JEC and implemented as appropriate.

6. Transition of Board Committees to JEC Committees

a. *Committees Generally*: The current committee structure of each hospital shall be replaced by joint committees reporting to the JEC if the committee deals with matters delegated to JEC. JEC shall have the power, from time to time, to establish, modify the terms of reference of, and disband committees that deal with matters within the authority of JEC, in its discretion, subject to applicable laws. Each hospital board shall retain the power to strike, modify the terms of reference of, and disband committees that deal with matters not subject to the delegated authority of the JEC. Both hospital boards shall retain the right to access all committee meeting minutes, and committees shall be required to report to each hospital board in respect of any matter not delegated to JEC. The JEC committees that will be operational as at the date the New Alliance Agreement is effective are: (i) governance; (ii) nominating; (iii) resources and risk; (iv) quality; (v) medical advisory committees. The Joint Steering Committee shall develop terms of reference for each committee, to be effective upon adoption by the JEC, which is expected to be at the first meeting of the JEC following the effective date of the New Alliance Agreement. Without limiting the foregoing but for certainty, the building sub-committees of each hospital shall be maintained as separate committees and the existing terms of reference and composition of each building sub-committee shall be maintained until: (i) the integrated health facility at GMCH; and (ii) the emergency room at the Louise Marshall site of NWHC are complete.

b. *Medical Advisory Committees*: Each hospital shall maintain separate medical advisory committees. The JEC and each hospital board shall direct each medical advisory committee to hold joint meetings as necessary to develop joint policies and to consider the future integration of the medical advisory committees into a single committee and such other business that will further the integration of the 2 hospitals.

c. *Quality Committees*: To comply with the *Excellent Care for All Act, 2010* and the regulations made thereunder, each hospital will be required to maintain its

own quality committee, and both quality committees will meet jointly and function as one committee in practice. The composition of each quality committee is mandated by law, and requires that at least 1/3 of each quality committee to be comprised of voting members of that hospital's board, plus, one member of each hospital's MAC, the chief nursing executive of each hospital, one person who works in each hospital who is not a doctor or nurse, and the CEO. The joint quality committee shall be co-chaired by independent voting directors from each hospital.

7. Committee Chairs and Composition

Directors serving on JEC shall chair the various committees of the JEC. For certainty, only one director appointed to JEC (as opposed to one director from each hospital) will be required to sit on each JEC committee, to respect the limited time available to volunteer directors to serve in these capacities. The JEC shall take appropriate steps to ensure there is equitable representation of both hospitals in terms of committee chairs and the composition of each committee.

8. Consequential Governance Changes to Implement New Alliance Agreement

Each hospital shall take all steps necessary or desirable to amend its by-laws, governance policies and committee terms of reference to enable the Integration described in this MOU and the New Alliance Agreement.

For certainty, this Integration does not require either hospital to amend the composition of its board of directors, however it is anticipated that over time additional governance steps may be taken on the recommendation of the JEC or a joint governance committee, to further integrate the hospitals at the governance level, including by way of example only, by cross appointing some or all independent directors, simplifying corporate membership such that directors are the only members of each hospital corporation, continuing GMC as a letters patent corporation, etc.

9. Foundations and Auxiliary Associations

The expectation of each hospital is that their strong relationships with their respective communities and their separate foundations and auxiliary organizations shall remain as presently structured. For certainty, the hospitals do not intend that this Integration will have any impact whatsoever on any relationship between a hospital and its foundations or auxiliary associations or other similar organizations, and in particular each hospital affirms and accepts the autonomy of each foundation, including with respect to decisions regarding capital expenditures.

10. Dispute Resolution Mechanics

All disputes between hospitals shall be exclusively addressed using the escalating dispute resolution process set forth below:

i. *Voluntary Negotiation*: The appointees to JEC will use their best efforts to resolve issues and disputes in a collaborative manner. This includes avoiding disputes by clearly articulating expectations, establishing clear lines of communication, respecting each hospital's interests, involving persons previously uninvolved in the dispute as appropriate, and promptly meeting in good faith to jointly develop options to resolve disputes informally to the extent possible.

ii. *Non-Binding Mediation – JEC Selects Mediator*: If an issue remains in dispute sixty (60) days following the first good faith meeting to informally resolve a dispute, the JEC shall appoint a neutral third party mediator of appropriate skill and experience to assist in resolving the dispute on such terms and timeline as established by the mediator, provided mediation shall in no event exceed ninety (90) days in duration, unless the JEC agrees to a shorter or longer period.

iii. *Non-Binding Mediation – Mediator Decided by Lot*: If a neutral third party mediator is not jointly selected by the JEC on the date the JEC convenes to make such selection, a mediator shall be determined by lot from the individuals listed on the roster of mediators last approved by the JEC. The hospitals agree a roster of mediators of appropriate skill and experience shall be determined by the JEC annually. Each hospital shall accept the mediator determined by lot, who shall assist in resolving the dispute on such terms and timeline as established by the mediator, provided mediation shall in no event exceed ninety (90) days in duration, unless the JEC agrees to a shorter or longer period.

iv. *LHIN Report*: The hospitals shall each report any dispute that is not successfully resolved through mediation to the LHIN within thirty (30) days of the conclusion of said mediation, such report to be in writing and to include the materials prepared and used in mediation, and a report of the mediator, if available.

v. *Termination*: Provided a hospital participates, in good faith, in mediation, and files a report with the LHIN, such hospital may unilaterally terminate the New Alliance Agreement on at least twelve (12) months' written notice to the other hospital. Without limiting the foregoing but for greater certainty, each hospital shall not revoke its delegation of authority to the Joint Executive Committee (defined below) without first engaging in mandatory good faith mediation.

11. Corporate Approvals

Each hospital acknowledges and agrees that the MOU and the New Alliance Agreement each requires the approval by the board of directors of each hospital, and both hospitals, on approval of the MOU, shall delegate authority to approve the final form of the New Alliance Agreement to its directors appointed to the Joint Steering Committee. In addition, to the extent consequential changes to the by-laws of each hospital are required, both directors and members approval will be required to take the corporate steps necessary to confirm those changes.

12. LHIN Approval

The Integration is a facilitated integration requiring LHIN approval pursuant to the *Local Health System Integration Act, 2006*. KPMG shall file a copy of this MOU with the LHIN forthwith following its execution and delivery by duly authorized representatives of each hospital.

13. Timing and Key Dates

The hospitals will work diligently to complete the Integration on the following timetable:

A. Approval of MOU by Joint Steering Committee: **Nov. 4, 2015**

B. Approval of MOU by boards of each hospital: Meeting: **Nov. 17, 2015**
Approval by **Nov. 27, 2015**

C. LHIN approval **TBD**

D. Joint Steering Committee approval of New Alliance Agreement: **Late January 2016**

E. Initiate community engagement: **February 2016**

F. Approval of New Alliance Agreement by hospital boards: **Mid-February 2016**

G. Approval of consequential changes to existing governance documents (by-laws of each hospital, creation of terms of reference for each committee, etc.) by boards and members of each hospital, as required **March 2016**

H. Effective Date of New Alliance Agreement **April 1, 2016**

In the event work assigned to the Joint Steering Committee is not completed by the time the JEC is constituted, it shall automatically be assumed by the JEC.

[*Signature Page Follows*]

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Each hospital confirms that the foregoing statements accurately set out its understanding of the key terms of the Integration.

DATED this day of November, 2015.

GROVES MEMORIAL COMMUNITY HOSPITAL

Per: _____
Print Name:
Print Title:

Per: _____
Print Name:
Print Title:

NORTH WELLINGTON HEALTH CARE CORPORATION

Per: _____
Print Name:
Print Title:

Per: _____
Print Name:
Print Title:

Schedule "A"

Matters Delegated to Joint Executive Committee
(Effective Date of New Alliance Agreement)

1. **Select, manage, and evaluate the performance of CEO**
2. **Strategic plan development and approval following consultation with each hospital board**
3. **Medical and non-medical human resources planning** (including harmonization of credentialing processes, adoption of joint medical HR plans)
4. **Fiscal oversight and planning and allocation of resources** (information sharing related to budgets and joint operating plan development with site specific elements, but no approval. Allocations consistent with Strategic Plan)
5. **Quality oversight** (one program, respecting 3 unique sites)
6. **Government relations**
7. **Public relations** (development of coordinated public relations strategy, but not approvals and JEC not spokesperson year 1)
8. **Management of existing integrations**
9. **Effective hospital governance practices**
10. **Capital planning** (sharing of information and coordination and development of plans only in year 1)
11. **Manage, and evaluate the performance of Chiefs of Staff**

Matters Delegated to Joint Executive Committee
(To be Delegated by Hospital Boards by Resolution in Year 2)

1. **Decision to move (or not to move) to a single Chief of Staff** (approval, and related management of various stakeholder relationships related to transition)
2. **Select Chief(s) of Staff**
3. **Fiscal oversight and planning and allocation of resources** (approval of budgets and joint operating plans with site specific elements; and all allocations consistent with Strategic Plan)
4. **Capital planning** (approvals)
5. **Public relations** (approvals and JEC is spokesperson, subject to MOU limitations)
6. **Brand management**

NOTE: a failure of either hospital to enact a resolution delegating all of the foregoing matters by the end of Year 1 shall immediately and automatically trigger the dispute resolution process.

(Matters Reserved to Boards of Directors of Each Hospital)

If a matter is not expressly enumerated above, the matter is reserved to the board of directors of each hospital unless further expressly delegated by board resolution, and such reserve powers shall include but shall not be limited to:

1. **Appointment and reappointment of medical staff per *Public Hospitals Act***
2. **Fiscal oversight** (approvals of plans – year 1 only)
3. **Public relations** (approvals, year 1 only, subject to MOU limitations)
4. **Capital planning** (approvals, year 1 only)
5. **Material clinical changes**
6. **Relationship with foundations and volunteer auxiliary organizations**
7. **Amendments to New Alliance Agreement**
8. **Approval of new integration opportunities (**with other organizations)
9. **Approval of fundamental corporate changes that require member confirmation** (by-law changes, legal name changes, sale or lease of all or substantially all assets, dissolution, etc.)
10. **Approval of the issuance of debt obligations** (other than debt obligations related to operations, which for certainty shall be a JEC delegated power in Year 2 within the scope of fiscal oversight and resource allocation)