Ref #	Subject Matter	Question	Background / Context
1.	**Functional Plan – Bed Count and Population Statistics**	(a) What data and modelling did MAHC rely on to determine the distribution of acute care beds between the South Muskoka and Huntsville sites, and how were South Muskoka's population size, projected growth, and aging demographics accounted for? (b) How was the significant seasonal population of South Muskoka included in the MAHC population statistics? (c) Will MAHC release or cite the provincial statistical information that it was required to rely upon in the development of the Stage 1.3 Functional Plan?	The Ministry of Health's Capital Planning and Policy manual states that hospital redevelopment projects are required to plan for the future demographics and population growth of the community. The recently completed District of Muskoka Growth Study indicates that the vast majority of permanent and seasonal residents will be in South Muskoka by 2051 (close to 100,000 persons) whereas North Muskoka will be significantly less than that. The community will also be, on the whole, older. MAHC has advised previously that it was required to use provincial statistics and therefore could not rely upon the District of Muskoka information. SSMHC remains concerned that the allocation of longer-term beds and the overall number of beds at the proposed SMMH will be grossly insufficient to meet population and demographic projections. Currently SSMH has sixty-seven (67) beds and the hospital routinely runs at 110-140% capacity. By reducing beds at SMMH by 30% to forty-six (46) beds, this proposal does not meet current need that, based on local usage/demand and population, ought to be in the range of seventy-seven (77) and ninety-three (93) beds in South Muskoka.
2.	**Equitable Healthcare Access**	(a) How does MAHC define "equitable access to care" within the Muskoka region? (b) What proportion of South Muskoka admissions are expected to receive acute care in Huntsville under the proposed model? (c) What happens should beds at the Huntsville site reach capacity—what is the overflow plan? Do South Muskoka residents have equal access to acute care beds in Huntsville as Huntsville residents?	Equitable healthcare refers to ensuring that patients have fair access to appropriate care based on need, regardless of where they live or their ability to travel. In a geographically large and rural region such as Muskoka, this includes consideration of travel times, demographics, and access barriers such as age and transportation. The Made in Muskoka model raises serious questions about how equity is defined and measured across different communities in future hospital healthcare delivery. Reliance on transfers out of the South Muskoka community for healthcare, without established and planned related supports, indicates that equity is not being appropriately considered in the Made in Muskoka model.

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		(d) If disparities in access are identified over time across the MAHC catchment, what actions will MAHC take to address them?	
3.	**Functional Plan – Patient Transfer Requirements**	(a) How will patients that are transferred from the South Muskoka site to the Huntsville site receive continuity of care from their regular physician? If that physician does not attend to the Huntsville site, who is the responsible physician? (b) Did MAHC evaluate whether transferring patients away from their local hospital and regular providers affects patient outcomes, and if so, what data or studies informed that analysis? (c) As the plan does not contain a defined transportation plan, does MAHC have a plan to support patients and families by making transportation assistance available?	MAHC's Stage 1.3 Functional Plan mandates transferring patients expected to stay six days or longer to the Huntsville hospital site soon after admission. This creates potential disruption for patients and families and may introduce added clinical and logistical complexity. It raises concern about how transfer practices align with patient-centred care and continuity of treatment.
4.	**Functional Plan – Alternate Level of Care (ALC) Beds**	(a) What analysis supports locating all Transition/Alternate Level of Care (ALC) beds at the Huntsville site rather than distributing them between both hospital sites (as is done currently)? (b) What factors were considered in determining the geographic placement of ALC beds, including patient origin, access to transportation, and family support? (c) What would be the operational and cost implications of distributing ALC beds between the South Muskoka and Huntsville sites?	MAHC's Made in Muskoka plan places all Transition/Activation/Alternate Level of Care (ALC) beds (approximately 64 beds) at the Huntsville site with no capacity in South Muskoka. ALC patients are typically awaiting placement in more appropriate community or long-term care settings, meaning the Made in Muskoka model will systematically relocate longer-stay and recovering patients outside of South Muskoka. This centralization raises material concerns about whether the model aligns with patient origin, access to family/caregiver support, and the transportation realities across the region. While MAHC's approach appears to assume that ALC demand can increasingly be met through community-based or non-hospital settings- thereby freeing up acute care capacity - there is no equivalent provision within

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		(d) What are the identified benefits for residents of South Muskoka through the centralization of ALC recovery at the Huntsville site? Correspondingly, has MAHC identified any risks associated with this approach for South Muskoka residents? (e) What alternatives to hospital-based ALC beds were evaluated, including community-based or long-term care solutions? (f) How does the inclusion of ALC recovery beds within the hospital align with provincial policy and best practices for managing non-acute patients?	South Muskoka to support these transitions. The absence of any ALC or longer-stay beds at the South Muskoka site effectively removes local capacity for extended recovery, system flexibility, and future program development. Taken together, this raises fundamental questions about the equity, resilience, and long-term sustainability of a model that concentrates post-acute care in a single location while reducing South Muskoka to a predominantly short-stay acute care site.
5.	**Functional Plan - Responsibility for Transfers**	(a) Who is ensuring that there is sufficient care available during a 40 km non-urgent transfer between hospital sites? (b) What contingency plans will be in place to address circumstances should a patient materially destabilize during transfer? (c) Who is responsible for determining transportation need and safety?	There is practical and legal uncertainty in the current Stage 1.3 Functional Plan around responsibility for patient transfers. If MAHC seeks to centralize many services, including longer stay acute care and OB services at one regional hospital, moving away from two balanced sites and a "Care Close to Home" delivery model, the public requires assurance that healthcare contingencies and risk mitigations are adequately addressed in the planning.
6.	**MAHC Community Engagement and Communication**	(a) Does MAHC assert that it has performed appropriate consultation with the community to support its Made in Muskoka Functional Plan approach? If so, on what basis?	MAHC's "Made in Muskoka" plan introduces significant changes to healthcare delivery in the region, yet questions remain about the level of meaningful public consultation behind it and reasons for ongoing opposition. Particular concerns have been raised as to whether residents were adequately informed, including changes from MAHC's prior public commitments (e.g. two acute care hospitals) or given a clear opportunity to engage on key decisions. This has

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		(b) How does MAHC intend to continue to engage with the community to ensure understanding and support for its Made in Muskoka Functional Plan approach? (c) What specific efforts has MAHC made to communicate with community advocacy groups, including the Save South Muskoka Hospital Committee to address public concern with its Made in Muskoka Functional Plan? (d) What steps has MAHC taken to ensure that it is being sufficiently transparent with the community about its Made in Muskoka Functional Plan? (e) Will MAHC release further information concerning the Stage 1.3 planning process to the public, including materials concerning the site selection process, absent a Freedom of Information request, given the community concern on this issue?	implications for public confidence in the planning process, the legitimacy of the proposed model, and undermines fundraising support for the local share portions (e.g. hospital foundations). SSMHC asserts that MAHC opted to only meet with selected small groups and offered only limited public engagement. MAHC did not disclose the Stage 1.3 Functional plan or the site selection reports (i.e. Stantec report) to the community or local leaders, despite repeated requests for transparency and accountability in its decision making. To underscore the challenges on this subject, broader questions concerning MAHC Board accountability, community representation and Board-member selection processes have also emerged from the Made in Muskoka roll-out, including in public statements from the Mayor of Bracebridge and in Town consultations with provincial representatives.
7.	**Functional Plan - Family Burden / Social Cost**	(a) What assessment has MAHC done to ensure that its Made in Muskoka plan is suitable for the local full-time population, including current physician access, age, employment status, family status and income demographics? (b) Has MAHC considered performing a “Social Impact Study” to calculate the cost to the patient/family (e.g. support loss, costs of travel, time off work, parking, etc.) for this split-service model between two hospital sites?	The proposed Made in Muskoka Functional Plan will result in patients and families travelling greater distances for care, with associated time, financial, and social costs. These impacts can be particularly significant for seniors, those without reliable transportation, and individuals requiring frequent or ongoing care. This raises questions about how social and indirect economic costs have been assessed alongside project budgets. SSMHC is particularly concerned that the “realities of life in Muskoka” are omitted from the Made in Muskoka plan, including harsh winter weather, rural communities with limited public transit, and income/poverty demographics.

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8.	**Functional Plan – Obstetrical (OB) Unit**	(a) How will decisions be made regarding where expectant mothers from South Muskoka are directed for labour and delivery care? (b) Related to the above, how is relative travel times to either Huntsville or Orillia and a potential impact on Muskoka Paramedic Services factored into this assessment process, if at all? (c) How will MAHC ensure that the birthing room at South Muskoka Hospital, as planned, will be adequately supported when the main unit is based in Huntsville? (d) Will mothers and babies that are born at the South Muskoka site be transferred to Huntsville following delivery? (e) Have any plans been developed to provide obstetrical care beyond birthing at the South Muskoka site? If so, please provide details. (f) What mitigations will be in place to address gaps in safety and care between a full Level 1 obstetrical unit in Huntsville and a labour and birthing room at the South Muskoka site?	A nesting bed is not a maternity ward. It is a room for a crisis not a plan for a community. Expecting mothers in South Muskoka were promised a full program, but what was submitted in November 2024 was effectively an emergency stop-gap. Humanizes the risk: 'Having a baby is easy until it's not.'

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9.	**Functional Plan – Community Expectations for an OB Unit in South Muskoka**	(a) How does MAHC justify that a labour and birthing room at the South Muskoka hospital site meets MAHC's public promise of April 2024 that the South Muskoka hospital would have obstetrical services? (b) Why does MAHC assert that a labour and birthing room at the South Muskoka site would be sufficient to address community concern about locating OB services in Bracebridge or concern that the birthing room may not be adequate for complications? (c) Does MAHC have any evidence to suggest that the clear gap between community expectations for OB services and the Stage 1.3 Functional Plan will nonetheless instill confidence in local mothers and families to rely on South Muskoka as a local birthing option?	The Stage 1.3 Functional Plan submitted to the province does not include a staffed OB unit at the future South Muskoka Hospital site. All cesarian births will be Huntsville. The Bracebridge obstetrical labour/birth room will be located adjacent to the ER, suggesting that the services will be staffed by ER doctors and staff in only limited circumstances where transfer is not possible. All other obstetrical care will be delivered out of the Huntsville hospital site. This model is inconsistent with public assurances and community expectation that OB services will remain intact at the South Muskoka hospital site.
10.	**Current "Temporary Closure" of OB Unit at South Muskoka Hospital**	(a) If the OB ward closed in March 2025 due to 'unforeseen' issues, why was it already reduced in the November 2024 Stage 1.3 Functional Plan submission to the province? (b) What is the current timeline to reopen the unit at the current hospital? (c) When can the public expect a further update from MAHC on its efforts to reopen the OB unit in South Muskoka?	The submission date of the Stage 1.3 Functional Plan (November 2024) precedes the 'temporary' closure of the OB unit – now closed for over a year, since March 2025. The plan, as submitted, did not include a full obstetrical program at the South Muskoka site. This timing raises questions about whether the subsequent closure due to staffing was aligned with Stage 1.3 service planning decisions and calls into question MAHC's credibility on the issue.

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11.	**Local Share Contribution**	(a) What will happen to the redevelopment plans if MAHC is unable to secure public support, including municipal contributions, for the Made in Muskoka model? (b) Is MAHC aware that the Town of Bracebridge's contribution of $10M to the Local Share commitment is contingent on the South Muskoka hospital offering full obstetrical services? (c) Does MAHC identify challenges with fundraising for local share contributions locally (i.e. through hospital foundation) given the gap between public expectations based on prior public commitments and the details of the Stage 1.3 Functional Plan?	The Town of Bracebridge committed $10M in local share funding for the hospital redevelopment with the understanding that certain services, including obstetrical care, would be maintained at the South Muskoka site. This was also a condition of the local doctors. The absence of a full obstetrical program in redevelopment plans prompts questions about how the Town's expectations and conditions have been addressed. There are broader considerations regarding alignment between municipal funding commitments and the conditions for such funding. The Town and the community supported a local ratepayer contribution based upon MAHC's commitment of having full OB services at the future South Muskoka hospital site – as this is now not part of the plan, significant questions about the viability of ongoing Town support should be considered.
12.	**Functional Plan-Transportation**	(a) What assumptions, if any, concerning transportation between hospital sites are part of the Stage 1.3 Functional Plan? Please provide clarity. (b) What steps has MAHC taken to prepare a transportation plan to support (i) routine transfers between hospital sites; and (ii) transportation between South Muskoka communities and the Huntsville site to support patients and families for those, for example, in longer term care (i.e. >6 days). (c) Will local ambulances be pulled off the 911-grid to perform 'shuttle' transfers between sites? (d) Who pays for the transfer of a stable patient to the Huntsville site for continuing care?	The Stage 1.3 Functional Plan contains no details about a required transportation plan. SSMHC notes that local transit options currently in operation, such as the Corridor 11 bus, have limited operational hours (i.e. no weekend, holiday or evening/overnight hours). Additionally, paramedic offload delays are already at record highs. It is also unclear that MAHC isn't otherwise expecting private operators to charge patients for such transfers – this concern should be addressed openly, now. "Care by Courier" is not a healthcare model that the community should be required to accept without legitimate consultation and acceptance.

Ref #	Subject Matter	Question	Background / Context
13.	**Site Selection - Site Engineering**	(a) At the time of the site selection process for 300 Pine Street, was MAHC aware of the need to perform 15m of fill and earthworks to make a useable building site? (b) When compared to other potential available hospital sites, how much weight did MAHC place on the cost and effort to prepare each site? Did MAHC specifically consider the 15m of fill and massive earthworks required to make 300 Pine Street a level buildable site?	The engineering reports obtained by MAHC concerning 300 Pine Street identify a 30m elevation drop across the parcel with significant site remediation costs to prepare a level building site. SSMHC is concerned that the location is a poor choice when these topographical challenges are considered. The engineering solutions required to support 300 Pine Street as the hospital site are unreasonably expensive and do not overcome permanent limitations on the site's functionality, including constrained future growth without significant additional investment.
14.	**Site Selection - Transparency / Public Trust**	(a) Will the MAHC release the full, unredacted GHD Infrastructure Report so the public can see the true anticipated cost of the Pine Street remediation?	The site evaluation work prepared by GHD for the 300 Pine Street location plays a key role in informing decisions related to site suitability, constraints, and long-term expansion potential. GHD identified fire flow deficiencies and grading issues that contradict the 'low-cost' narrative. As this analysis underpins major planning and investment decisions in the hospital redevelopment, questions have been raised about the extent to which the full report has been made publicly available. Releasing the complete report would support transparency and allow stakeholders to better understand the technical basis for site selection and associated risks.
15.	**Site Selection – Alternative Sites**	(a) Why was Highway 118 West dismissed for 'access costs' that the Salmon Ave extension has now largely resolved? (b) What site challenges were specifically relied upon by MAHC to bypass the top-ranked site, Muskoka Beach Road, for a lower-scoring site?	Salmon Ave. in Bracebridge now ends at the property line of the Hwy 118W site that had been under consideration – and partially discounted due to servicing challenges. It appears that circumstances have now materially changed since the site selection review in 2023. During the site selection review, Muskoka Beach Road scored 131.55 vs. Pine Street's 117.20.

Ref #	Subject Matter	Question	Background / Context
16.	**Site Selection – 300 Pine Street – Future Growth**	(a) What risks, if any, does MAHC identify with the selection of 300 Pine Street for the future South Muskoka hospital? (b) Has MAHC considered the costs associated with future building at the 300 Pine Street site as part of the site selection process?	MAHC assured the community that the 300 Pine Street site allows for growth, but the technical maps show the site is “boxed in” by an old quarry pit and steep slopes. We are at risk of building a "new" hospital that is landlocked from day one, repeating the mistakes of the past at the current site.
17.	**Site Selection – 300 Pine Street**	(a) What is the total usable, buildable area of the 300 Pine Street site after accounting for slopes, setbacks, and the former aggregate pit? (b) What assumptions were used to define “buildable land,” and can MAHC provide the full record of supporting geotechnical and planning analysis? (c) What detailed analysis has been done to identify the volume of fill required to remediate the former aggregate pit to a condition suitable for hospital construction? (d) What are the estimated costs, timelines, and technical risks associated with that remediation? (e) What level of geotechnical uncertainty remains regarding subsurface conditions at the site? (f) Has MAHC performed a comparative analysis of building costs at the 300 Pine Street site relative to other sites, including the 118W site or Muskoka Beach Road sites?	The Stantec Stage 1.3 Site Selection Report does not state a precise acreage or percentage of the 300 Pine Street site that requires 15 meters of fill, but it does describe the specific technical necessity and the physical area affected by these requirements: - Necessity for Gravity Drainage: The report specifies that up to 15 meters of fill is required specifically to "receive flows by gravity" for the sanitary sewer system. - Affected Area: This massive fill requirement is concentrated in the areas extending outwards from the core of the site (approximately halfway to the back of the property). - Topographical Context: The report notes that these areas must be "raised considerably" due to an "extreme drop in site elevation" as one moves away from the central portion of the property. - Site Preparation Risk: Because of these requirements, the site received a very low score (0.25 out of 1.0) for "Site Preparation," with the report citing "extensive earthworks within site" as a major capital cost challenge.

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18.	**Site Selection – 300 Pine Street – Additional Land Acquisition**	(a) What is the maximum practical expansion capacity of 300 Pine Street under current constraints? (b) What is the purpose of additional land acquisition? (c) Were additional land acquisition needs considered during the site selection process for the Stage 1.3 Functional Plan? (d) Could you please advise on the status of the additional land acquisition activity?	Due to deficiencies of the site and land availability, MAHC previously informed members of the SSMHC that it was engaged in activity to acquire land adjacent to 300 Pine Street. SSMHC identifies that MAHC has yet to inform the public of this activity. MAHC advised that they are trying to acquire lands owned by the Catholic District School Board, other parcels that are privately owned and other land that is currently part of the Bracebridge Fairgrounds.
19.	**Site Selection – 300 Pine Street - Water Servicing and Fire Safety**	(a) Why has the public not been made aware that Pine Street lacks municipal water capacity to handle a fire emergency without additional private storage facilitates? (b) What consultation has MAHC performed with the local fires services to ensure appropriate access for fire suppression / emergency response? (c) What consultation has MAHC undertaken with the local and regional municipalities to address water servicing needs for the 300 Pine Street site? (d) Will any “off hospital site” water facility upgrades (i.e. new pumping station or pumping station capacity upgrades) be paid by MAHC/Province as part of the redevelopment capital cost?	Water servicing and fire protection capacity are critical considerations for a hospital development, particularly for emergency response and life safety systems. For the 300 Pine Street site, questions have been raised regarding the availability, reliability, and required upgrades to municipal water infrastructure needed to support a full-service hospital in Bracebridge. This includes whether existing supply and fire flow capacity meet applicable standards, and what additional costs or risks may be associated with servicing the site. Basic fire safety shouldn't be an "add-on". The SSMHC asserts that MAHC’s selection of a site that lacks the municipal infrastructure to put out a fire is a massive red flag that a thorough analysis wasn’t undertaken about the site and that ancillary development costs were not properly represented in budgets to local ratepayers.

Ref #	Subject Matter	Question	Background / Context
20.	**Doctor Recruitment/ Retention**	(a) What doctor recruitment challenges has MAHC experienced historically, and how does the Stage 1.3 Functional Plan model address them? (b) What evidence does MAHC have that physicians are willing to relocate to or practice primarily at the South Muskoka site in the Stage 1.3 Functional Plan versus the Huntsville site? (c) How does MAHC plan to retain current physicians who rely on access to higher-acuity services at the South Muskoka site that will be relocated to Huntsville? (d) How will the South Muskoka site support medical learners (students, residents), and in particular, support the growth of primary and specialist care delivery situated in South Muskoka? (e) Has MAHC considered that the operational differences between hospital sites may impact recruitment of primary or specialist care in South Muskoka? (f) Does MAHC intend to distinguish recruitment efforts for South Muskoka from Huntsville? If so, what will the priority be for each site in terms of recruitment?	MAHC continues to experience chronic staffing shortages, increasing demand for care, and persistent burnout that has become the norm. When deciding on joining an organization, physicians and healthcare professionals often base their choices on available scope of services, workload/call burden, medical infrastructure (hospital and ancillary community supports) and lifestyle. MAHC has included an intentional division of services between hospital sites in the Made in Muskoka model which will necessarily impact recruitment. Huntsville will have specialized acute care services whereas the South Muskoka site, by plan design, is merely a short stay facility. SSMHC is concerned that this will materially impact the ability of the community to have local access to specialized care and will, as a result, also impact the ability to recruit and retain general practitioners who need access to specialized support for their patients.

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21.	**Capital Redevelopment Process**	(a) As there remains a 14-bed differential between the Made in Muskoka model and the "Care Close to Home V2 Model", could MAHC clarify its rationale for dismissing the need for these additional beds in South Muskoka? (b) Further, could MAHC outline what data, assumptions, or constraints has informed any decision on this issue, and whether there remains flexibility within the capital plan to revisit this capacity in light of current and projected needs?	Adjustments have been made: i. **January 2024:** MAHC's functional plan for South Muskoka had **14 inpatient beds** and no OB. ii. **Spring 2024:** After community outcry, MAHC revised the plan to include **36 acute care beds in South Muskoka** and OB. iii. **October 2024:** After sustained advocacy from physicians, healthcare providers, municipalities, and community groups, MAHC revised the plan with **an additional 10 acute care beds in South Muskoka.** Community groups (SSMHC included) continue to advocate that **46 beds remain insufficient** and that the "minimum" **60-bed Care Close to Home model** should be used to ensure equitable and sustainable healthcare in South Muskoka, consistent with the "Care Close to Home V2" model prepared by local physicians in August 2024.