CAPITAL REGIONAL DISTRICT

Agenda Item #9

STAFF REPORT TO THE PLANNING & PROTECTIVE SERVICES COMMITTEE
MEETING OF WEDNESDAY, APRIL 26, 2006

SUBJECT: Regional Hospital District capital contributions for residential care projects.

PURPOSE/ISSUE:

The availability of Regional Hospital District capital funding for residential care projects under the Vancouver Island Health Authority's (VIHA) current Request for Proposals.

HISTORY/BACKGROUND:

Since 2003, Regional Hospital Districts have been able to contribute to residential care projects as well as acute (hospital) and extended care projects. The changes introduced in 2003, expanding eligibility of cost shareable projects, were not financially open-ended and did not obligate RHD's to increase their funding beyond historic levels for hospitals and extended care facilities.

On January 31 and February 8, 2006, VIHA issued two separate Requests for Proposals, the first for new capacity and the second for the replacement or major renovation of existing facilities. There is no provincial or Health Authority capital funding attached to these RFP's with the proponents expected to arrange their own capital financing.

Knowing that the District has funded residential care projects in the past, some of the non-profit society proponents have approached the District enquiring of funding availability this time. Proponents have been advised that the District does not have sufficient information from VIHA to review the possibility of being able to afford both residential care and hospital capital demands.

A February 2006 Committee report dealt with VIHA's Draft Ten-Year Capital Plan. The review was based on limited information supplied by VIHA in October 2005. The review anticipates a significant increase in the requisition over the next ten years. The ***medium level 10 year funding scenario*** of $156 million would result in an increase to the peak requisition of $49.[1] That funding scenario is dominated by the Royal Jubilee Inpatient facility then estimated at $167 million. The review also suggested that there could be approximately $53 Million of major acute care projects which had not been prioritized for inclusion in Ten-Year Plan.

In February, VIHA provided a revision to their Draft Ten-Year Capital Plan. Review of that updated plan noted the absence of any future projects for the residential care sector. The cost estimates for the residential care projects are summarized in Attachment One with the new capacity at $47 Million and the affiliate replacements at $90 Million. In addition, there are a number of VIHA facilities which may be replaced or renovated. These facilities are, for the most part, similar or inferior to the affiliate-owned facilities now being proposed for replacement.

VIHA's funding assumption is that all residential care proposals will be privately financed with debt servicing paid out of operating funding. Until the Requests for Proposals are reviewed, it is not clear whether the commercial financing and proponent equity is sufficient to cover all capital costs. If commercial financing and society equity is sufficient, capital funding from the District will not be necessary. Regional Hospital District cost sharing was not mentioned by VIHA in its RFP and discussions

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[1] *$91 peak in 2008 to $140 peak in 2016 – based on the 2006 average assessed residential value of $409,319.*

with senior staff indicate their assumption that District funding would be reserved for hospital projects. VIHA would have no objections to the District participating in these projects which would benefit VIHA through a reduction in the per diem costs making their operating funding go further.

ALTERNATIVES:

The alternatives cannot be fully detailed because of certain unknowns. These unknowns include the status of individual non-profit proposals, the adequacy of private financing and proponent equity to cover capital costs and the impact of potential Regional District contributions on future requisitions.

1. The District make no contributions toward residential care projects. If VIHA has not requested such contributions and private capital financing is adequate to finance them, there is no rationale.

2. The District make 40% contributions to all non-profit proposals. However, if VIHA is able to cover the costs of private capital financing and private capital financing is sufficient to cover project capital costs, there is no need for District contributions.

3. The District will consider applications for capital contributions from individual non-profit proponents on a case by case basis. The District is prepared to make a contribution if private capital financing and society equity are insufficient to cover full capital costs.

FINANCIAL IMPLICATIONS:

There are no financial implications for Alternative 1.

For Alternative 2, if all of the proposals identified in Attachment 2 were to receive a 40% capital contribution, the Region's costs would be an additional $44 Million of capital debt. That additional debt would translate to an increase in the CRHD requisition by $8 starting in 2008 with the peak increase in 2016 of $32 - based on the 2006 average assessed residential value of $409,319. That debt would be in addition to the existing and future debt anticipated in the medium level 10 year funding scenario presented in February 2006 (see Attachment Three).

The financial implications for Alternative 3 cannot be presented until the proposals are approved by VIHA and any capital financing shortfalls revealed. The follow-up report for the April Committee meeting addresses the Sooke proposal which offers an example of one case.

CONCLUSIONS:

The VIHA request for proposals for new and replacement residential care facilities does not have any public funding from VIHA or the province nor does it expect funding from the District. Proponents, whether non–profit or for-profit, are expected to arrange their own capital financing. VIHA has assumed that the District only has sufficient funding for acute care (hospital) projects.

Notwithstanding VIHA's position, four non-profit proponents have enquired of District funding in recognition that a capital grant would reduce their per diem operating costs and thereby advantage their proposals. VIHA likewise has no objection if the District were to contribute capital to these projects making their operating funding go further.

Given that VIHA have not requested District cost sharing of the current round of residential care proposals and assuming they have sufficient operating funding to fund the proposals including their capital debt, Alternative 1, to deny cost sharing, is justifiable.

Alternative 2, to provide full 40% cost sharing for all non–profit proposals, is unjustified for the reasons associated in Alternative 1, in addition to the additional cost factor. A 40% contribution to all known non-profit proposals is estimated to cost the District $44 Million with an additional cost of $32 in 2016 on the 2006 average assessed residential value. This is on top of the estimated increase $49 ($91 to $140) requisition increase to 2016 if all the major hospital projects proceed. That increase would see the peak requisition rise to approximately $172 in 2016. This is illustrated in Attachment Three.

It is important to point out that VIHA does not have a completed 10 Year Capital Plan making it difficult to confirm the capital demand from the hospital sector but every indication is that it will be significant.

Alternative 3, that the District considers applications from non-profit residential care proponents on an individual basis, is the preferred alternative. The District would consider applications only if proponent private capital financing and their equity is insufficient to cover accepted capital costs. No cost implications will be available until proposals are revealed but contributions are expected to be small.

The reason this report is presented with so much missing information is the rapid schedule for the approval and negotiation of residential care proposals (expected in May) and the need to provide context for any quick decisions should they be needed. The Committee will also be receiving related reports. The April Committee meeting will consider the Sooke Elderly Citizens Housing Society case and in May, the issue of the Carey Road land sale to the Baptist Housing Ministries Society.

RECOMMENDATION:

That the Committee accept Alternative 3 as its policy on the funding of residential care facilities, that is the consideration of applications from non-profit proponents only in circumstances where their private capital financing and equity are insufficient to cover approved capital costs.

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COMMENTS: