1 HOME OXYGEN PROGRAM
2 NEW PROCUREMENT PROCESS
3 MINISTRY OF HEALTH AND LONG-TERM CARE
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6 VENDOR CONSULTATION MEETING #3
7 JULY 31, 2009
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10 APPEARANCES:
11
12 Carol Jones
13 Sara Dobner
14 Maureen Williams
15 Ann Weir
16 Chris Beynon
17 John Campbell - via teleconference
18 Kathleen Powell - via teleconference
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1 VENDORS VIA TELECONFERENCE:
2
3 Catherine Ferguson - Northern Respiratory
4 John Hunter - Vitalaire
5 Jim Crooks - Shoppers Home Health
6 Cathy Chapman - Shoppers Home Health Care

7 Heather Nicholson-Morrison - OHRSA
8 Stephane Plante - Inspiration Medic
9 Kelly O'Donnell - Medigas
10 Randy McFarlane - Medigas
11 Jodie Evans - Home Care Oxygen
12 Tom Greene - Eastern Mobility Specialists
13 John Zgrych - Medigas
14 Missinda Mohring-Westecott - Huronia
15 Bert Richer - Invacare
16 Clair LaFerriere - Inspiration Medic
17 Joe Millage - Shoppers
18 Brian Marshall - ProResp
19 Al Benton - Kingston Oxygen
20 Elsie Chein - Praxia
21 Don Gordon - Praxia
22 Bill Beckett - Medigas
23 Dean Blanchard - Health Care Pharmacy
24
25

1 ---Upon Commencing at 2:05 p.m.
2 MS. JONES: Thank you all for coming.
3 Today's meeting is the third meeting in the second
4 series of consultation sessions with vendors which
5 will focus on the Financial Survey responses. I
6 would like to take this opportunity to thank all of
7 the 22 interested parties who took the time to
8 complete the survey. Your input is very valuable
9 and most appreciated. The results have been
10 reviewed and analyzed by PricewaterhouseCoopers and
11 the key highlights will be shared with you today.

12 As we've discussed in previous
13 meetings, the Ministry is moving to a new
14 procurement process for the Home Oxygen Program and
15 we want to ensure all vendors have full access to
16 all the public documents related to the process.
17 All public documents will be continued to be posted
18 on MERX and on the ADP program's site, including
19 complete records of all the meetings with vendors,
20 the slides and the Qs and As. We'll continue to
21 share these documents with OHRSA so that they can
22 post it on the OHRSA site as well. It's important
23 to understand that throughout the procurement
24 process the Ministry is the sole source of
25 information.

1 I would like to introduce you to the
2 Ministry and other staff who are with me today in
3 support of this project and via teleconference.
4 So here at 5700 Yonge you have myself, Carol Jones,
5 Program Manager at ADP; Maureen Williams, Senior
6 Programmer Coordinator at ADP; Ann Weir, Program
7 Coordinator with ADP; Chris Beynon who is a Program
8 Coordinator also at ADP; Sara Dobner who is the
9 Senior Policy Analyst who's assisting us with this
10 project, with the RFP project; Kathleen Powell is
11 on line, she's the Senior Procurement Advisor,
12 Supply Chain Management, Ministry of Government
13 Services, and she's assisting us as well in making
14 sure that we are following the procurement
15 directive; we have John Campbell who is the
16 Fairness Commissioner; and we have our transcriber
17 Sheila Finlay.

18 I should ask, and I meant to ask
19 earlier, does everybody have a copy of the slides?
20 A collective "yes" would be fine?
21 VENDORS: Yes.
22 MS. JONES: So I will be going through
23 those slides one by one, and if you have looked at
24 them previously there are points during the slides
25 where there are areas that you will be given some

1 opportunity to give us your comments back.
2 We are anticipating it will be about a
3 two-hour session. We'll be providing a high-level
4 preliminary summary of the results of the survey.
5 Obviously we want dialogue, but, as I said, we kind
6 of have to limit it to certain points within this
7 telephone conversation.
8 So our agenda for today will be to
9 reiterate the purpose of this session as part of
10 the pricing schedule development process; provide a
11 bit of background to set the context for the
12 Ministry's approach to the Home Oxygen services; to
13 highlight some constraints and limitations of the
14 data prior to discussing the preliminary findings,
15 and; to report on the summary findings of specific
16 components of the survey responses.
17 The Ministry of Health and Long-Term
18 Care is undertaking a pricing review, as you're
19 aware, of the Assistive Devices Home Oxygen Program
20 in Ontario. The Ministry has retained
21 PricewaterhouseCoopers (PwC) to conduct the Home
22 Oxygen services pricing review. As part of the

23 review, PwC developed the Financial Survey for Home
24 Oxygen Program vendors to collect data from the
25 Home Oxygen vendors to inform the development of

1 the Home Oxygen pricing model.
2 PwC received feedback from interested
3 parties as of June 12th, 2009 on a draft version of
4 the survey. This valuable feedback influenced
5 modifications which were incorporated into the
6 final version of the survey posted online a week
7 later. Two interactive help sessions were held
8 early in July, during which clarification to the
9 survey questions and minor modifications to the
10 survey itself were made.
11 The survey closed on July 16th, and
12 while data valuation and analysis is ongoing, the
13 purpose of this consultation is to provide a
14 high-level summary of the results of the survey and
15 to obtain feedback where responses to the survey
16 varied greatly and/or were incomplete.
17 We have included a slide entitled
18 Discussion Points with each section of this
19 presentation to obtain feedback from the Home
20 Oxygen vendors. This feedback has been sparked
21 either by our preliminary analysis or from feedback
22 obtained from vendors throughout the process.
23 There are two slides here, Setting the
24 Context, and I think I would like to go through the
25 two slides themselves and just give a little

1 comment after that.

2 So the future procurement is an open,
3 fair and transparent competitive process where a
4 Request for Proposal will be issued in order to
5 establish a Vendor of Record arrangement for Home
6 Oxygen services. The VOR arrangement will continue
7 to allow clients to seek Home Oxygen services from
8 the vendor of their choice.
9 The VOR will be open to all Home Oxygen
10 vendors who qualify and meet the program's criteria
11 and agree to the price and conditions of service
12 delivery set by the Ministry. Vendors will be
13 subject to periodic audit reviews for quality
14 assurance. Failure to comply with the VOR
15 requirements may result in action that can include
16 loss of registration.
17 The service model currently in place
18 will remain the same. The current Home Oxygen
19 services will continue to include professional
20 assessment and re-evaluation, training of users and
21 their caregivers, follow-up visits, emergency
22 response, education and consultation with
23 prescribing physicians or other health care
24 providers.
25 Client eligibility or funded benefits

1 with not change. Fair pricing will be set by the
2 program for the RFP, following market research in
3 consultation with the industry, and is likely to
4 include a scaled pricing approach reflecting
5 service intensity.
6 The term of the new Vendor of Record

7 agreement is five years plus two optional years,
8 which will provide the vendors more stability.
9 There will be refreshment periods for the new
10 vendors to register and for price reassessment to
11 be set as required.
12 So the Ministry basically has
13 determined that issuing a Request for Proposal for
14 the establishment of a public Vendor of Record list
15 for qualified vendors will ensure the necessary
16 transparency and fairness, while also ensuring
17 continuity of care to the very vulnerable
18 population served by this program. At the same
19 time, the Ministry will comply with the Procurement
20 Directive of July 2009. All the vendors who
21 qualify will be listed as a Vendor of Record and
22 will be eligible to provide Home Oxygen services.
23 If you all have the slides, there is a
24 chart, New Competitive Model vs. Current Model -
25 Key Differences. I'm not going to go through each

1 of those unless there is someone who does not have
2 the slides. So the slide, basically, is
3 constructed to illustrate the main features of our
4 new approach to the procurement of Home Oxygen
5 services in comparison to the model of procurement
6 which is currently in place.
7 Before we go on, I have to do a
8 disclaimer on behalf of PwC, and I have to read
9 this verbatim.
10 Information presented in the following
11 slides is intended for presentation purposes only
12 and is not legally binding. In the event of

13 inconsistent information between the information in
14 this presentation and the information contained in
15 the future Vendor of Record, the information in the
16 future Vendor of Record will prevail.
17 So the data presented in the slides
18 today reflect the data collected on the vendor
19 Financial Surveys submitted on July 16, 2009.
20 Adjustments have been made, where advised to PwC by
21 the vendors as identified in validation discussions
22 held on or before July 22nd, 2009 at 5 p.m.. PwC
23 is continuing to conduct its due diligence on the
24 data and many of your organizations have already
25 been contacted. Changes are not expected to be

1 material. PwC is primarily dealing with outliers.
2 Because the survey included over 150
3 specific questions, it is not feasible and would
4 not be productive to review each of them during the
5 course of this meeting. Instead, we will be
6 presenting a high-level summary of the findings
7 from the survey.
8 The findings will be grouped based on
9 the cost components that were reflected in the
10 survey. Where there was general agreement by most
11 respondents, we will provide a short description of
12 the findings. Where there was significant
13 variation in the responses, or there were gaps in
14 information collected, we will focus our dialogue
15 with you to better understand the context of this
16 variation and what could be the implications in the
17 development of the pricing model.

18 So I'm moving on to slide 10. You will
19 see there were 22 vendor responses. The survey was
20 designed to accept responses from HOP vendors and
21 non-HOP vendors. Vendors who are currently
22 providing services to HOP were required to provide
23 information on their current cost structure with
24 respect to the provision of HOP services. For the
25 vendor who identified him or herself as a non-HOP

1 vendor, they provided information solely on the key
2 cost drivers and the anticipated impact on these
3 cost drivers in future years.
4 The classification between large and
5 small vendors was based on Home Oxygen revenues. A
6 vendor with HOP revenues greater than $10 million
7 in 2008 was considered to be a large vendor. A
8 vendor with Home Oxygen revenues less than $10
9 million in 2008 was considered small. If a
10 hospital was registered as a vendor, they were
11 asked to self identify as a hospital vendor.
12 Upon initial review of the data, there
13 were four records which were excluded from the
14 preliminary analysis. One record out of the four
15 was a duplicate response. Three responses were
16 obtained with incomplete information. PwC excluded
17 these records from the preliminary analysis on the
18 basis that incomplete information would
19 misrepresent total actual cost. PwC is continuing
20 to perform data validation checks with vendors,
21 these records may be incorporated with the final
22 analysis, if appropriate.
23 Accordingly, as of July 22nd, 18

24 responses were analyzed and the summarized data is
25 presented here. The data collected from the 18

1 vendors whose responses were included in this
2 preliminary analysis represents 14,855 clients and
3 approximately 87% of total ADP HOP expenditures.
4 Slide 11 represents the composition of
5 the cost structure to deliver the Home Oxygen
6 program incurred by a vendor for a typical client.
7 A typical client was defined as one that represents
8 the majority of the clients a vendor serves, based
9 on representative samples of existing cases. The
10 cost components are consistent with those for which
11 data was collected in the survey.
12 The methodology supporting the
13 calculations for the financing cost component
14 mirror that of the Deloitte & Touche report. The
15 top bar represents the cost as determined in the
16 Deloitte & Touche Home Oxygen Program Final Report
17 issued in 1998, which included an independent audit
18 and cost analysis of a sample of HOP vendors. The
19 bottom bar represents the cost as determined
20 through the preliminary analysis conducted by PwC
21 on data collected from year 2008 results.
22 Understanding changes in cost
23 composition through the past ten years will help us
24 establish a fair pricing model for the future, and
25 the trigger points for the Ministry to reopen the

1 VOR and refresh the price over the five- to

2 seven-year term of the contract. These changes are
3 explored in more depth in the next slide.
4 So the percentages reflect averages
5 weighted by the number of clients served by each
6 vendor. Rather than taking a simple average across
7 all vendors, PwC weighted the costs by the number
8 of clients.
9 Key Findings: The share of staffing
10 costs has increased from 33% in 1998 to 44% in
11 2008, an increase of 11%. A small increase in the
12 share of the modality equipment cost, 1%. It
13 showed as a percentage of total costs, oxygen and
14 bulk handling 8%, vehicle 12%, and premises costs
15 5% have remained the same. Some cost categories
16 have decreased. These include other equipment
17 costs at minus 2%, care and support cost at minus
18 2%, and general and administrative costs at minus
19 6%.
20 So that brings us to our first
21 discussion point. We're looking at a high level,
22 are these changes in the cost structure over the
23 past ten years representative? We're asking for
24 your comments to see if this makes sense to you,
25 our findings.

1 If you respond, could you, again, just
2 give us your name and we'll be happy to listen to
3 your response. Any comments? No one has any
4 comment on that? Okay. Can somebody say something
5 so I know you're all out there?
6 MS. WILLIAMS: Heather, are you there?
7 HEATHER NICHOLSON-MORRISON: I'm here.

8 MS. JONES: Okay, good, I was getting a
9 little concerned that I'd done all that and nobody
10 was there.
11 Okay, that's fine, if there's no
12 comments, I think I said this earlier, because
13 there are so many of you, that you can feel free to
14 respond in writing to the questions, these
15 questions, or the ones posted on MERX as well as on
16 the ADP site. So please feel free if you don't
17 want to comment today, you can forward your
18 comments to us by August 10th.
19 So, therefore, we're going to move on
20 to the staffing costs. So the survey collected
21 data which distributed the time required to service
22 a typical client over the identified activities for
23 the initial setup and the maintenance period for a
24 long-term client and for a palliative care client.
25 We wanted to know if there was a difference in the

1 length of time, and thereby costs, it took to
2 service a typical long-term client in the first 90
3 days compared to a palliative care client.
4 Interestingly, total weighted mean number of
5 minutes required to complete activities which take
6 place within the first 90 days for a typical
7 long-term client is 1,193 minutes, whereas this
8 same number for palliative care clients is 1,179
9 minutes. Accordingly, the analysis suggests that
10 the activity time is similar across both types of
11 clients.
12 However, the weighted average duration,

13 the number of months, of a client covered by
14 palliative care funding on the HOP is 1.36 months,
15 while the average duration of a long-term client
16 would be more than the first three months. This
17 information suggestions that palliative clients are
18 more intensively serviced for one month than a
19 long-term funding client over three months.
20 I guess the question there is: Does
21 this make sense? Anyone?
22 So there's a couple of discussion
23 points regarding the staffing here as well. The
24 shares of staffing cost have increased from 33% in
25 1998 to 43% in 2008, an increase of 10%. The

1 question here is: Why do you feel staffing costs
2 increased so dramatically?
3 Discussion Point 2. Responses varied
4 greatly among vendors in response to the question:
5 In 2008, approximately what percentage of your
6 clients, for which you conducted an initial
7 analysis, were not approved for HOP funding? The
8 responses ranged from 1% to 80%. What we are
9 asking here is: What support would the vendors
10 require from the Ministry to help them reduce the
11 number of initial assessments that are performed
12 for ineligible clients?
13 Discussion Point 3. Does the staffing
14 and/or service requirements change from the first
15 90 days to those on maintenance, for example, after
16 90 days and after 1 year, if not, why not?
17 MS. WILLIAMS: No one has any comments?
18 MS. JONES: What we're going to do -

19 because I'm obviously assuming that you're going to
20 be sending in written comments - I'll go through
21 the presentation and then I'll just outline the
22 points and we'll carry on. We're not going to keep
23 asking you if you have comments. If you want to
24 jump in, please feel free.
25 So moving on to care and support costs.

1 Care and support costs include costs of
2 disposables, client education materials,
3 communications, parking associated with service
4 delivery, uniforms, maintaining individual
5 professional certification, accreditation and other
6 care and support costs as identified by vendors
7 themselves. The significant portion of those costs
8 reported as "other" include those which relate to
9 pandemic planning.
10 This chart represents how care and
11 support costs are distributed, weighted by the
12 number of clients, for all vendors. So it appears
13 that disposables, client education materials and
14 the cost of communications together account for
15 approximately 75% of total care and support costs.
16 Components of care and support costs, other than
17 disposables, client education materials and
18 communications, are having a greater impact on the
19 total share of care and support costs.
20 Ten years ago client education
21 materials and communications accounted for 100% of
22 the total care and support costs. It is
23 significant to note that total care and support

24 costs incurred per client are approximately 1.7
25 times higher for a small vendor and approximately

1 1.1 times higher for a hospital vendor than they
2 are for a large vendor. The implication of this is
3 that large companies experience cost savings in
4 care and support costs.
5 The next slide, slide 17, is just a
6 chart. As disposables continue to represent a
7 large component of care and support costs at
8 approximately 30% of the total, which were weighted
9 for the number of clients, the frequency to which
10 disposables are issued were examined. Vehicle
11 costs will also be impacted by the frequency in
12 which disposables are issued. A majority of
13 vendors are issuing disposables at a frequency of
14 no less than once a month. The "other" response
15 includes vendors who distribute weekly and monthly,
16 depending on the disposable to be distributed, or
17 distribute based on client situations.
18 Moving on now to the percentage of
19 clients by modality. Vendors were asked to report
20 the number of clients supported on each type of
21 modality equipment. This chart illustrates the
22 percentage of client population that is served with
23 each type of equipment and is weighted by the
24 number of clients.
25 The majority of clients served by the

1 vendors that were surveyed used stationary
2 concentrators. The majority of stationary

3 concentrator users had cylinder backup, while a
4 smaller percentage had liquid backup or portable
5 systems. Few clients were using both stationary
6 and portable concentrators or other devices, which
7 include home transfill, portable concentrators
8 only, or dual systems.
9 Since 1998 several changes in
10 technology had influenced cost and client use of
11 modalities. Over the past ten years technology in
12 stationary concentrators has improved and more
13 vendors are using them now than ten years ago.
14 Portable concentrator and home transfill systems
15 have emerged, oxygen conserving devices have
16 increased in use, and the use of liquid oxygen as a
17 primary mode of delivery has decreased. As
18 compared to 1998, an increase in the use of
19 stationary concentrators and a decrease in the use
20 of liquid systems is reported. On a per client
21 basis, modality equipment costs have increased
22 slightly.
23 Modality Equipment Costs. The chart
24 shows how modality costs are distributed, weighted
25 by the number of clients for all vendors. Modality

1 equipment costs include cost of owned and leased
2 modality equipment; cost of modality equipment
3 repairs and maintenance.
4 Key Findings: The majority of the
5 equipment is owned. Few vendors reported equipment
6 which was leased. Liquid reservoir, portable and
7 stationary, and stationary concentrators account

8 for approximately two-thirds of the total modality
9 equipment costs. It is significant to note that
10 total modality equipment costs incurred per client
11 are approximately 1.2 times higher for a small
12 vendor than they are for a large vendor.
13 The implications here show that while
14 technology has advanced, total costs incurred for
15 the modality equipment have increased, and that
16 small vendors face challenges as large vendors
17 experience economies of scale.
18 Again, modality equipment costs, we're
19 talking about home transfill systems now. There
20 are several vendors who reported that more than 10%
21 of the total modality is attributed to home
22 transfill. Preliminary analysis indicates that
23 these same vendors report fuel costs that are
24 nearly 35% lower than average.
25 We are at another Discussion Point

1 slide and I'll just put them on the record. Home
2 transfill systems have been identified as a viable
3 modality for northern areas in Ontario. What are
4 the strengths and weaknesses of home transfill
5 systems? Are there opportunities to increase the
6 uses of home transfill while ensuring the same or
7 greater level of care to the client?
8 DEAN BLANCHARD: Dean Blanchard here.
9 MS. JONES: Hi, Dean.
10 DEAN BLANCHARD: I'm not going to
11 address this question specifically right now, but I
12 have a question in terms of where you get the
13 information for northern Ontario. Do you know

14 exactly how many respondents were from northern
15 Ontario that you can look at the data? Do you know
16 which ones, perhaps, may have been outliers or even
17 excluded, would PwC have let those vendors know?
18 MS. JONES: We do not know ourselves,
19 Dean, but we will pass the question along to PwC.
20 DEAN BLANCHARD: For example, the
21 larger companies probably displayed aggregate
22 numbers across the province, so there's only going
23 to be probably me, I know one other small vendor,
24 and perhaps Shoppers in Thunder Bay as being from
25 the north. I know PwC contacted me after the

1 survey because, being a small northern vendor, my
2 cost structure was likely higher. I had to go
3 through some questions and explain some situations.
4 So, I'm only speaking from my own
5 perspective here, but my fuel costs are not
6 significantly down, in fact they're significantly
7 up in northern Ontario. So my question is, when
8 you're asking for feedback on home transfills being
9 a proper modality for the north, being expanded to
10 southern Ontario and saying that fuel costs are
11 nearly 35% lower, that's not what I'm seeing. So,
12 you know, what kind of numbers from the north are
13 giving you that information?
14 MS. JONES: So we will take that, your
15 question, back. As you know, we do not see the
16 surveys. So we'll take this back to PwC and ask,
17 well, we'll take it back to them and ask them to
18 incorporate that into their analysis.

19 DEAN BLANCHARD: Thank you.
20 MS. JONES: Thanks, Dean.
21 Anyone else?
22 So we'll move on to Discussion Point 2.
23 The analysis shows that large vendors benefit from
24 economies of scale. The question to the group is:
25 Are group purchasing opportunities an avenue to

1 explore for smaller vendors, or for all vendors
2 acting as a purchasing consortium?
3 Okay, so we're moving on to Other
4 Equipment Costs. The chart and the slide
5 represents how other equipment costs are
6 distributed, weighted by the number of clients for
7 all vendors. "Other" equipment costs include the
8 cost of carts, oximeters, carrying bags,
9 regulators, storage equipment, measuring equipment,
10 portable analyzers, other and the repairs and
11 maintenance cost which relate to this equipment.
12 What it is showing is that the share of
13 other equipment costs has decreased over the past
14 ten years, a decrease from 2% to 1% of the total
15 cost to provide Home Oxygen service. This is
16 despite the fact that the Deloitte report did not
17 include repairs and maintenance as a component of
18 "other" costs, which today accounts for 21% of the
19 total costs.
20 The cost of oximeters, regulators and
21 repairs and maintenance on the other equipment
22 account for nearly two-thirds of the total share of
23 the equipment. The implication here is that small
24 vendors face challenges as large vendors experience

25 economies of scale.

1 Oxygen and Bulk Handling Costs.
2 Vendors can purchase oxygen in one of the following
3 ways: The oxygen producing or distribution company
4 refills empty cylinders and liquid units, or oxygen
5 is purchased in bulk and then the vendor refills
6 the individual units themselves, or a combination
7 of the two. Accordingly, oxygen and bulk handling
8 cost components vary according to the means in
9 which the vendor purchases the oxygen.
10 The findings here show that
11 approximately 13% of clients represented in the
12 preliminary analysis are serviced by vendors who do
13 not participate in bulk purchasing. This
14 represents 12 vendors.
15 Examining vendors who do not purchase
16 oxygen in bulk, their costs are comprised of oxygen
17 refills and the costs related to demurrage and the
18 rental expense for the gas cylinder. For 2008 this
19 represented approximately 94% and 6%, respectively.
20 Oxygen costs for vendors who do not purchase in
21 bulk are approximately 1.3 times higher than costs
22 for vendors who purchase oxygen in bulk.
23 Slide 24 represents how oxygen and bulk
24 handling costs are distributed, weighted by the
25 number of clients for vendors who participate in

1 bulk purchasing. It shows five vendors reported
2 that they purchased oxygen in bulk, and may also

3 purchase oxygen refills. These five vendors
4 service approximately 87% of the clients
5 represented in the preliminary analysis. The costs
6 associated with the bulk oxygen, tanks and site
7 licensing account for approximately 94% of the
8 costs. The implications here are that the vendors
9 who do not purchase in bulk are at a disadvantage
10 from a cost perspective.
11 So here we have another discussion
12 point: Have your costs of meeting municipal
13 guidelines permitting oxygen gas storage increased
14 in the past two years? Is there any indication of
15 continuing changes in the municipal guidelines?
16 I may need to make a point because it
17 was brought up in our session, probably in both
18 sessions, that we are questioning the municipal
19 guidelines, so when you respond back to that we may
20 be looking at Federal Government licensing
21 guidelines.
22 JOE MILLAGE: At this point there
23 hasn't been a change in those things, but one
24 municipality did say they may not allow for oxygen
25 storage in that area.

1 MS. JONES: Okay, so from one
2 municipality to another it may be different, then.
3 JOE MILLAGE: Yes, I think that after
4 the explosion on Keele Street last year that some
5 places are nervous about any kind of stored gas,
6 that's all it is.
7 MS. JONES: Okay. So if you can make a
8 comment to that when you write into us, that would

9 be great. Thank you.

10 Moving on to Vehicle Costs. The chart
11 represents how vehicles costs are distributed,
12 weighted by the number of clients for all vendors.
13 Vehicle costs include the cost of purchased or
14 leased vehicles, vehicle licensing, vehicle
15 insurance, fuel, cost of reimbursement to staff for
16 use of personal vehicles, cost of vehicle
17 maintenance.

18 We found that the cost of the purchased
19 or leased vehicles accounts for nearly half of the
20 total vehicle costs, while licensing, insurance,
21 fuel and maintenance account for the balance. Per
22 unit monthly lease costs and per unit purchase
23 prices varied greatly between the vendors. The
24 vast majority of vehicles utilized by vendors for
25 the Home Oxygen Program are either leased or owned

1 by the vendor. An immaterial portion of the total
2 cost is attributed to vehicles which are personally
3 owned.

4 Vehicle costs for small northern
5 vendors appear to be significantly less than other
6 vehicle groups. Northern vendors also utilize the
7 highest percentage of home transfill. The
8 implication here is a third of the total costs are
9 dependent upon market swings and the cost of fuel.

10 Moving on to Premise Costs. The
11 premise costs include those costs related to lease
12 and/or depreciation of owned buildings. The vast
13 majority of vendors lease their space. The annual

14 lease cost per square foot range from $7.34 to
15 $35.71, showing that the cost of premise varies
16 greatly among vendors.
17 Just a note: The property taxes
18 related to leased space are recorded in this
19 preliminary analysis as general and administrative
20 costs to maintain comparability with the cost
21 structure reported by Deloitte & Touche in their
22 1998 report.
23 Moving finally on to the General and
24 Administrative Costs. The chart represents how the
25 G&A costs are distributed, weighted by the number

1 of clients for all vendors. The finance and
2 corporate office supplies and G&A costs account for
3 just over half of the G&A costs. Vendors reported
4 no costs associated with fund-raising or loans to
5 staff, the contribution of total costs reported for
6 incorporation and reorganization, provisions for
7 accruals, retainer fees, gifts and honoraria were
8 less than 0%. Accordingly, these components are
9 not listed in the graph presented.
10 So, we are now open to any questions
11 you may have. Questions that we can't answer, we
12 will take back. Questions that you prefer not to
13 ask us, if you could please put it in writing we
14 will ensure that that is forwarded.
15 Okay, thank you for listening to me.
16 We will be posting the session on MERX and the ADP
17 website. I do hope that you do forward us --
18 DEAN BLANCHARD: I just want to

19 reiterate what I originally stated. You've made
20 some conclusions regarding, or at least some
21 statements regarding, northern Ontario. I think
22 you already have a small response rate and then it
23 gets even smaller when you travel north.
24 One of the things I would be interested
25 in is, those that were excluded, the outliers, were

1 they informed of this by PwC?
2 MS. DOBNER: We are not sure.
3 MS. JONES: We are not involved.
4 DEAN BLANCHARD: That's the question
5 you have to ask.
6 MS. JONES: We will.
7 DEAN BLANCHARD: If there's only two or
8 three vendors and I was excluded, then some of
9 these -- like there's only one left, so it might be
10 you're trying to tailor a provincial program on the
11 back of one particular company's model.
12 MS. JONES: Okay.
13 DEAN BLANCHARD: That's a scary
14 proposition, so I think we need some more
15 information.
16 MS. JONES: That's fine. We will
17 definitely bring that to their attention.
18 CATHERINE FERGUSON: We're North Bay,
19 but we're considered north. Again, I replied right
20 away by email to that question because, again, the
21 home fill systems don't work well for us here,
22 we're actually using about 40% portable. The cost
23 of gas has dropped for us using the portable, so I
24 did state that also. I did reply right away to the

25 home fill systems being the answer, because they're

1 definitely not for us.
2 MS. JONES: Okay. We've made that
3 point here.
4 JODIE EVANS: We're also included in
5 the north. We do use home fill systems, but
6 certainly not at high levels. We find that the
7 home fills are used in situations based on a
8 client's needs versus the time travelled. So it's
9 a very, very small group of the clients that we
10 serve that actually can tolerate a system such as
11 the home fill. So it's based more on client
12 tolerance rather than cost savings and fuel.
13 MS. JONES: Okay, thanks, Jodie.
14 Any other comments?
15 Okay, I thank you all very much for
16 attending. As I said, please feel free to put your
17 comments in writing. The more we get the better.
18 So have a lovely long weekend.
19 ---Whereupon Consultation Meeting #3 concluded at
20 2:50 p.m.
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1 REPORTER'S CERTIFICATE
2
3 I, SHEILA M. FINLAY, CSR, Certified

4 Shorthand Reporter and Commissioner of Oaths within
5 and for the Province of Ontario, certify;
6 That the foregoing consultation meeting
7 took place before me at the time and place therein
8 set forth;
9 That the consultation meeting was
10 recorded stenographically by me and thereafter
11 transcribed;
12 That the foregoing is a true and
13 correct transcript of my shorthand notes so taken.
14
15 Dated this 31st day of July 2009.
16
17
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21 ___________________________________
22 NEESON & ASSOCIATES, Court Reporting
23 and Captioning Inc.
24 PER: SHEILA M. FINLAY, CSR
25 CERTIFIED SHORTHAND REPORTER