Family Health Teams

Advancing Primary Health Care

Guide to Transitional Funding

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Ontario

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Purpose

This application guide and accompanying appendices are components of the Family Health Team *Guide to Business and Operational Plan Development*, and are part of the Family Health Team (FHT) planning and implementation process. This guide is meant to assist those who are considering establishing a Family Health Team in their community and submitting requests for transitional funding.

Objective of Transitional Funding

Appropriate work space, furnishings and equipment are key enablers for Family Health Teams. Transitional funding provides support to Family Health Team applicants to recognize the additional one-time costs incurred to establish and implement a Family Health Team, such as equipment, furnishings and facility renovations. Transitional funding is intended to supplement, not replace, existing funding sources from community and provider partners. Funding assistance will be provided on a one-time basis, which is separate and distinct from ongoing operating funds.

Family Health Team Funding Principles

Family Health Team funding requests are subject to the following four principles:

1. *Additionality* – Funding is limited to the additional costs incurred by becoming a Family Health Team;

2. *Proportionality* – Funding is proportional to the eligible number of approved Family Health Team members;

3. *Eligibility* – Funding is limited to approved eligible items; and

4. *Reasonableness* – Approved eligible items are funded within the approved benchmark.

Who is Eligible?

Family Health Teams and applicants approved by the Ministry of Health and Long-Term Care (the ministry) to proceed with the implementation of a Family Health Team.

What Expenditures are Eligible?

- Up to 100% (minus any contributions) of clinical and office equipment and furnishings required to provide patient services[1];

- Up to 100% (minus any contributions) of facility improvements to accommodate Family Health Team members, as described in Table 1 below, and illustrated in Appendix M – Facility Improvement Scenarios; and

[1] Support for clinical and office supplies will be considered under operational funding.

- Up to 100% (minus any contributions) of one-time expenses directly related to the provision of approved equipment, furnishings, and facility improvement expenditures (e.g. prime consultant's fees).

In *some* circumstances, supported by a business case, the ministry will consider funding:

- Up to 100% of facility improvement costs, where there is limited or no opportunity for local contributions;

- Up to 100% of practice moving costs[2];

- Up to 100% of lease termination costs[3];

- Up to 100% of facility improvement, furnishings and equipment costs for common space (e.g. waiting room) arising from physician relocation; and

- Up to 50% of facility improvement, furnishings and equipment costs for existing administrative staff (who are paid out-of-pocket by the physician), arising from physician relocation[4].

Table 1 – Transitional Funding Eligibility Matrix[5]

	EXPANSION	NEW LOCATION	IMPROVEMENT OF EXISTING SPACE
	Description: No changes to currently occupied space, and new space is acquired to accommodate new team members	Description: Existing and new team members move to a new building	Description: Significant structural changes (knocking down walls) to existing space to accommodate additional team members
• Existing physicians (blended complement or blended capitation models)	Transitional funding is not eligible – currently occupied space is not going to be improved, thus there is no need for ministry funding	Transitional funding is eligible for common space[6] only; equipment, furnishings, and facility improvements for space exclusively used by these professionals are not eligible (e.g. exam tables, stools, exam rooms)	Subject to ministry approval, facility improvement funding is eligible, up to 100%[7]; equipment and furnishings for space exclusively used by these professionals are not eligible (e.g. exam tables, stools, exam rooms)
• Existing interdisciplinary health care providers (paid by other ministry program, community, other sponsoring organization, etc.)	Transitional funding is not eligible – currently occupied space is not going to be improved, thus there is no need for ministry funding	Transitional funding is eligible for common space[6] only; equipment, furnishings, and facility improvements for space exclusively used by these professionals are not eligible (e.g. exam tables, stools, exam rooms)	Subject to ministry approval, facility improvement funding is eligible, up to 100%[7]; equipment and furnishings for space exclusively used by these professionals are not eligible (e.g. exam tables, stools, exam rooms)

[2] Moving costs include only the costs incurred by practicing family physicians and interdisciplinary health care providers who are joining the Family Health Team by moving their practice, not their personal residence.
[3] A lease buyout/termination penalty is the amount the ministry pays the recipient for terminating an existing lease as a result of relocation.
[4] Applicable if the administrative staff's duties are changed to serve the entire team (instead of just the family physician).
[5] Please see "Appendix M – Facility Improvement Scenarios" for an illustration of facility improvement examples.
[6] Common or shared space such as hallways, working areas in hallways, washrooms, administrative areas, administrative offices, meeting rooms, shared exam rooms, cleaning closets, computer room(s).
[7] In cases where FHTs are seeking ministry funding for a significant portion (e.g. more than 50%) of improvements to space occupied by these professionals, applicants must provide a business case with a compelling rationale.

	EXPANSION	NEW LOCATION	IMPROVEMENT OF EXISTING SPACE
• Existing administrative staff	Transitional funding is not eligible – currently occupied space is not going to be improved, thus there is no need for ministry funding	Transitional funding is eligible for common space[6] only; equipment, furnishings, and facility improvements for space exclusively used by these professionals are not eligible (e.g. exam tables, stools, exam rooms)	Subject to ministry approval, facility improvement funding is eligible, up to 100%[7]; equipment and furnishings for space exclusively used by these professionals are not eligible (e.g. exam tables, stools, exam rooms)
• New Physicians (blended complement or blended capitation)	Transitional funding is eligible for common space only (e.g. reception); equipment, furnishings, and facility improvements for space exclusively used by new physicians are not eligible (e.g. exam tables, stools, exam rooms)	Transitional funding is eligible for common space[6] only; equipment, furnishings, and facility improvements for space exclusively used by these professionals are not eligible (e.g. exam tables, stools, exam rooms)	Subject to ministry approval, facility improvement funding is eligible, up to 100%[7] equipment and furnishings for space exclusively used by these professionals are not eligible (e.g. exam tables, stools, exam rooms)
• Salaried Physicians	Transitional funding is eligible	Transitional funding is eligible	Transitional funding is eligible
• New interdisciplinary health care providers and administrative staff	Transitional funding is eligible	Transitional funding is eligible	Transitional funding is eligible
• Existing interdisciplinary health care providers (paid out-of-pocket by physicians)	Transitional funding is not eligible – currently occupied space is not going to be improved, thus there is no need for ministry funding	Transitional funding is eligible	Transitional funding is eligible

What is Not Eligible?

- Clinical and office equipment, furnishings, facility renovations and related expenses that are covered by private (monetary or in-kind) or public (e.g. other government program) contributions;
- Purchase or construction of real property, such as land or buildings/facilities[8];
- Information technology funded through the Physician IT Program, or other items as specified in the *Guide to Information Technology*;
- New or replacement furnishings, facility improvements, or equipment exclusively for providers currently receiving funding for these items through other funding arrangements;
- Residence moving costs;
- Interior design consultants as an architect/prime consultant;
- Exterior furnishings for residents/clients (e.g. lawn chairs, benches);
- Demolition of existing buildings;

[8] In exceptional cases, where the Family Health Team chooses to purchase or construct/expand a facility, the ministry will consider providing a notional periodic payment equal to the market value of an equivalent facility.

- Contingency budgets;
- Financing charges;
- Gardens, works of art and decorations;
- Construction of parking facilities;
- Construction Management;
- Administration fees (e.g. levied on taxes, utilities, and/or repairs); and
- Any expenditure not authorized by the ministry.

This list is not exhaustive. For questions on specific items not noted in this list, please contact your ministry Family Health Team Coordinator.

Application Submission

Applications for funding are to be submitted as part of the *Business and Operational Plan*, after approval of the Family Health Team's human resource. Transitional funding requests must be reflective of, and proportional to, eligible, approved Family Health Team members.

Application Requirements

Facility Improvements

In order to receive consideration for facility improvement funding, eligible applicants must submit a two-phased proposal, following approval of Family Health Team members[9]:

<u>Phase 1</u>

- Submission of completed "Facility Improvement Phase 1 Checklist" and accompanying appendices (see Appendix A for sample), which includes the following information:
    - The name and contact information of the applicant, and, if applicable, the legal entity or sponsoring organization that will receive funding and who will be accountable to the ministry for the proper use of the funds through a signed legal agreement;
    - A formal assessment/description/schematics of existing facilities and space;
    - Provide facility space requirements for each facility in the Family Health Team *per approved provider* including, but not limited to:
        - Proposed changes to floor plans, in square feet or meters, as per the Space Planning Guidelines (see Appendix B for sample);
        - Area that is to be used by the Family Health Team;

[9] Blended salary physician(s), interdisciplinary health care providers, and administrative professionals

- Useful life of the facility improvements depending on the scope of renovations (e.g. existing facility or new facility space);
- Number of work stations in the reception area;
- Average number of people waiting in the waiting room at peak hours; and
- Estimated cost per square foot/meter.

Phase 2

Upon ministry communication of the approved space, the Family Health Team is to submit a completed “Facility Improvement Phase 2 Checklist” (see Appendix C for sample), which includes the following information:

- Key assumptions used to determine facility space requirements;
- A description of the accessibility of the proposed site, identifying all possible barriers;
- Proposed facility layout (floor plans) of the total space to be improved (including approved Phase 1 space) showing space and room allocation and their dimensions;
- Scope of renovations, including upgrades to building systems – mechanical, electrical, architectural, etc.;
- A completed Lease Agreement Information Schedule (to be provided by your site coordinator);
- If requested by the ministry, a copy of the lease agreement;
- Proof that the applicant, who is also the occupant, has permission [from landlord and tenants (if applicable)] to make the proposed changes;
- Identification of facility ownership and if any are Family Health Team members, including governing body members;
- Details of plans to share the proposed facility space with other providers or organizations that are not part of the proposed Family Health Team; identify the affected facility space area and cost sharing arrangements and rationale;
- Availability or expected source of funds;
- A description of financial and/or in-kind support such as contributions from sponsors, community partners or landlord that will be used to offset one-time expenditures and any conditions attached to each contribution;
- Where total facility improvement cost estimate under $10,000, the Family Health Team must follow the requirements as set out in the Competitive Bidding Requirements (see Appendix D) and must provide the ministry with the following information from the contractor:
    - The scope of work (e.g. painting walls);
    - A detailed cost estimate (e.g. cost of labour, materials); and
    - The completion date;

- Where total facility improvement cost estimates exceed $10,000, the Family Health Team must follow the requirements as set out in the Competitive Bidding Requirements and must provide the ministry with:
    - Confirmation by a qualified professional that all proposed changes are technically feasible and comply with applicable codes, statutes and ordinances;
    - A signed letter to the ministry that the contractor meets the qualifying preconditions as set out in the Competitive Bidding Requirements section;
    - A preliminary cost estimate that includes a breakdown of costs for each element of construction;
    - A schedule update that indicates the estimated start and completion dates for tender of the project;
    - The complete bidding/tendering package;
    - A detailed analysis of the bids, the recommended bid, and the rationale for endorsing it; and
    - Copies of the three lowest bids;
- A signed and completed Final Estimate of Cost (see Appendix H for sample) and completion timeline;
- The Family Health Team governing body's motion indicating their acceptance of the bid;
- A signed and completed Final Capital Cost form (see Appendix I for sample), upon completion of the facility improvement, but before the final payments have been released;
- A signed and completed Final Submission of Disbursements (see Appendix J for sample), after all payments relating to the facility improvement have been made;
- Prime consultant/appropriate professional's appraisal of the impact of the facility improvement on the value of the property for facility improvements that are between $10,000 and $100,000, if deemed necessary by the ministry; and
- An appraisal by a member of the Accredited Appraiser Canadian Institute (AACI) that states the effect of the facility improvements on the value of the property, if facility improvements are over $100,000 or if deemed necessary by the ministry.

Clinical and Office Equipment and Furnishings

In order to receive funding consideration for clinical and office equipment and furnishings, eligible applicants must submit an itemized list (including type, quantity and cost per item, total price, supplier and model number as per Table 2 of proposed eligible expenditures per room, following approval of Family Health Team members[10], and approval of Family Health Team space:

[10] Blended salary physician(s), interdisciplinary health care providers, and administrative professionals

Table 2 – Sample Equipment and Furnishings Request

Room	Item	IHCP*	Qty	Price Per Unit	Price	Supplier	Model
NP Exam Room	Infant Scales	3 NPs	3	200.00	600.00	X Supplies	123-4561
	Exam Table	3 NPs	3	1,600.00	4800.00	X Supplies	123-4562
	Exam Stool	3 NPs	3	350.00	1050.00	X Supplies	123-4563
	Exam Light	3 NPs	3	1,000.00	3000.00	X Supplies	123-4564
	Ophthalmoscope/ Exam Set	3 NPs	3	1,000.00	3000.00	X Supplies	123-4565
	Baby Scale	3 NPs	3	2,000.00	6000.00	X Supplies	123-4566
	Adult Scale	3 NPs	3	500.00	1,500.00	X Supplies	123-4567
Subtotal					19,950.00		
Applicable Taxes					2,992.50		
TOTAL					**22,942.50**		

* Interdisciplinary Health Care Provider

Accessibility

In June 2005, the province passed the *Accessibility for Ontarians with Disabilities Act, 2005*, which launched a 20-year process to make Ontario more accessible in both the public and private sectors to persons with disabilities. As Family Health Teams proceed to start-up (recruiting, designing, equipping and furnishing their space), all Family Health Teams should ensure accessibility from patient and employee perspectives.

Any community-sponsored Family Health Teams that may allow the hospital board to act as the governing body if certain requirements are met, may be affected by the *Ontarians with Disabilities Act, 2001*, which is still in effect for a transitional period. These Family Health Teams should confer with their partner institutions regarding any expectations and responsibilities that may apply.

Family Health Teams are asked to review the *Guide to Accessibility Planning Information and Resources: Addressing the Needs of Ontarians with Disabilities*. This guide has been developed to assist Family Health Teams to become familiar with accessibility issues related to persons with disabilities. It provides information on the changing legislative framework addressing Ontarians with disabilities, resource links and further contact information.

Funding Process

A portion of funding may be provided in advance, once the application has been approved, based on local and justifiable needs. The balance of approved funds will be flowed at a frequency determined between the applicant and the ministry.

Conflict of Interest

The applicant shall ensure that the grant funding is used in a manner that precludes a conflict of interest by any person associated with the funding request in whatever capacity. For clarity, a conflict of interest

includes a situation in which a person associated with the request or any member of his or her family is able to benefit financially from his or her involvement.

Terms and Conditions

Applicants must be willing to sign a grant funding agreement that will specify the purpose of the funding, total amount to be provided, restrictions on the use of the funding and final deliverables. Signatories must have the authority to bind the organization.

Where to Get More Information

All potential Family Health Teams are assigned a Family Health Team Coordinator. This ministry contact is your guide to assist you and work through the details and options of establishing a Family Health Team.

If you have not yet been assigned a Family Health Team Coordinator, please contact the ministry at:

Primary Health Care and Family Health Teams
Ministry of Health and Long-Term Care
1075 Bay Street, 9th Floor
Toronto ON M5S 2B1

Telephone: 416-325-3575
Toll Free Phone: 1-866-766-0266

For more information on Family Health Teams in general, please refer to the Family Health Team Fact Sheets or the Ministry of Health and Long-Term Care website at:
http://www.health.gov.on.ca/familyhealthteams.

Appendix A – Sample Facility Improvement Phase 1 Checklist

This is Phase 1 of two phases to review and approve Family Health Team facility improvement requests. The first phase includes the basic requirements necessary to conduct initial approval for facility improvements. Please provide the information pertaining to your facility improvement request as per the checklist below, including Appendices 1 and 2. Once the Phase 1 Checklist is complete, please send it to your Family Health Team Coordinator.

Facility Improvement Requirements Checklist **PHASE 1**		
Requirements	**Check (/)**	**Comments**
The name and contact information for the applicant, and, if applicable, the legal entity or sponsoring organization that will receive funding and be accountable to the ministry for the proper use of the funds through a signed legal agreement		
A formal assessment/description/schematics of existing facilities and space		
Provide facility space requirements for each facility in the Family Health Team *per approved provider* (as per Appendices 1, and 2) including, but not limited to:		
Proposed changes to floor plans (in square feet or meters)		
Area that is to be used by the Family Health Team		
Useful life of the facility improvements depending on the scope of renovations (e.g., existing facility or new facility space)		
Number of work stations in the reception area		
Average number of people waiting in the waiting room at peak hours		
Estimated cost per square foot/meter		
Key assumptions and rationale for facility improvements – before space approval		

Notes:
1. If there is insufficient information to complete the Checklist, please provide it within a week from the request.
2. Please provide a different Checklist for each location/satellite.
3. Please ensure that space requirements are entered based on the approved salaried physicians, interdisciplinary providers, and administrative staff.

Appendix A – Sample Facility Improvement Phase 1 Checklist – Appendix 1

Staff Changes

Position		Current Staff		Approved Staff		Total
		FTEs		**FTEs**		**FTEs**
Physicians						0
Interdisciplinary Staff						
- Nurse Practitioners						0
- Registered Nurses						0
- Social Worker						0
- Dietitian						0
- Psychologist						0
- Other						0
Administration						0
- Receptionists						0
- Manager/Other personnel						0
Total		0		0		0

Note: In the table above, detail the approved staffing changes as a result of becoming a Family Health Team.

Appendix A – Sample Facility Improvement Phase 1 Checklist – Appendix 2

Facility Space Requirements

Approved FTEs*/ Description of rooms/space	Function of rooms/space	Number	Size in sq. ft.	Estimated % of Use		Space	
				existing practitioners	co-locating practitioners	existing practitioners	co-locating practitioners
[Column 1]	[Column 2]	[Column 3]	[Column 4]				
Physicians:							
- Physician 1	Office						
	Examination room						
- Physician 2	Office						
	Examination room						
- Physician 3	Office						
	Examination room						
- Physician 4	Office						
	Examination room						
Interdisciplinary Staff							
- Nurse Practitioner	Office						
	Examination room						
- Nurse Practitioner	Office/clinical space						
	Examination room						
- Registered nurse	Office/clinical space						
Common functions							
- Reception							
- Administration							
- Storage							
- Waiting area							
- Meeting room							
- Medical records							
- Public washroom							
Sub-total - net space			0.00			0.00	0.00
Gross factor (e.g. 125%)			125.00%			125.00%	125.00%
Total Space Requirements (Gross factor X net space)			**0.00**			**0.00**	**0.00**

***PLEASE ENSURE THAT THE SPACE REQUIREMENTS ABOVE ARE COMPLETED BASED ON THE APPROVED HEALTH AND ADMINISTRATIVE STAFF, AND THAT A DIFFERENT CHART IS COMPLETED FOR EACH LOCATION**

Instructions:

1. Enter the name and position of Family Health Team member
2. Enter the type of room required for that team member
3. Enter the number of rooms required for that team member
4. Enter the size of the room in square feet

Appendix B – Space Planning Guidelines

The purpose of this document is to facilitate the planning and design of Family Health Team facilities.

LISTING OF ROOMS

Table 1.1 lists most of the rooms, normally found in primary health care facilities, which accommodate the users (primary care providers, allied health professionals, administration, support staff, clients/patients, visiting consultants, and others), the functional and operational requirements of the Family Health Team office, and the programs and services that are provided.

The Table cites the floor areas of rooms (in square feet/square meters). These floor areas reflect the functional requirements for rooms in current primary care health facilities and are generally consistent with the floor area standards, including barrier free accessibility standards, established in the Ontario *Building Code*.

In some rooms (e.g. waiting room, meeting rooms, etc), the floor areas may depend upon the number of users of the rooms. Table 1.1 provides an incremental floor area per person, which can be used to calculate the net floor area required to accommodate the ultimate number of users of the rooms.

TABLE 1.1 LIST OF ROOMS

Rooms	Floor Area in SF (SM)	Notes
Offices		
standard offices - private	110 (10.2)	basic office for the facility
standard offices - shared	150 (13.9)	the standard office for use by two persons; this floor area increases by 75 SF for each additional provider and/or allied health professional
special purpose offices		examples of floor areas for rooms required to accommodate special functions; see Section 3.0
executive director	125 (11.6)	
chiropodist	150 (13.9)	
foot care	200 (18.58)	
physiotherapist	200 (18.58)	
occupational therapist	125 (11.6)	
dietitian	125 (11.6)	
social worker	110 (10.2)	basic office with separate or adjacent counselling room; 125 SF as combined office counselling room
other		as required
Exam rooms		
combined office exam room	125 (11.6)	
general purpose exam room	90 (8.36)	adjacent to, in proximity of, or interconnected with a care provider's office
special purpose exam room	125 (11.6)	
large exam room	125 (11.6)	
minor treatment room	125 (11.6)	
Service rooms		
med room/clean utility	100 (9.3)	storage of medications, drug samples and other clean supplies
soiled utility room	100 (9.3)	garbage storage, recycling waste, disposal of expired medications, sharps, etc.
Lab	110 (10.2)	
Support rooms		
janitor's closet	50 (4.64)	
computer server room	80 (7.43)	
reception area	110 (10.2)	basic floor area; floor area increases by 50 SF for each additional work station. (e.g. for a medical secretary)
workroom	150 (13.9)	

Rooms	Floor Area in SF (SM)	Notes
medical records room	200 (18.58)	floor area for the room to accommodate shelving for approximately 3,000 charts; the actual size of the room may vary depending on the amount of shelving, circulation, and other functions (e.g. work station) determined in the detailed design of the facility
waiting room	300 (27.87)	minimum floor area for typical waiting room with a peak period occupancy of 15 persons; floor area increases by 15 SF for each additional adult person
children's area	60 (5.58)	
multi-purpose counselling room	125 (11.6)	minimum floor area for occupancy up to 6 persons; floor area increases by 12 SF for each additional person
small meeting rooms	200-300 (18.58) – (27.87)	groups of up to 15 persons at 20 SF per person
large meeting rooms	300-500 (27.87) – (46.4)	groups of 15 to 25 persons at 20 SF per person
staff lunch room	300 (27.87)	minimum floor area for the room for occupancy up to 12 staff; floor area increases by 12 SF for each additional person.
Storage		
non-medical supplies and equipment (oxygen)		as required
archives		as required
Washrooms		
public washrooms male	125 (11.6)	
public washrooms female	125 (11.6)	
staff washroom	45 (4.2)	wheelchair accessible room
clinical washroom	45 (4.2)	wheelchair accessible room

CALCULATION OF FLOOR AREAS – NET AND GROSS

NET FLOOR AREAS
The net floor area of each room listed in the table (as square feet (SF) or square metres (SM)) is the product of the interior room dimensions (length x width).

Some variance over or under the floor areas cited may be quite appropriate depending on who uses the room and how it is used (for example, a standard exam room may need to be somewhat larger in floor area to permit barrier free access to special purpose examination table).

Wide variations in some or all of the floor areas, however, should be explained.

GROSS FLOOR AREAS
There are rooms, spaces, and elements in a facility (e.g. storage areas, interior corridors, partitions, structural elements [columns], mechanical and electrical service spaces, interior stairs, and functional areas such as the entrance vestibule, foyer, laundry, etc.) which may not be included in the room list but need to be considered to establish the construction cost of the project.

The sum of the floor areas identified in the room list and the floor area of the other rooms and spaces comprise the total gross floor area. The gross floor area is used to calculate the cost of renovation or construction of a project and, in turn, will establish the transitional funding required.

The total gross floor area may not be measurable at the beginning of the space planning and design process (elements such as corridors, duct spaces, structure, etc., are not specifically defined until the design of the space is somewhat advanced).

The gross floor area can be calculated by multiplying the total net floor area (the sum of the net floor areas of all rooms) by a number called a grossing factor. The grossing factor is the ratio of the total net to total gross floor area. It is a measurement of the efficiency of the floor plan for use and is generally not used for leasing purposes.

The efficiency of a floor plan is an expression of how much space is dedicated to habitable use (e.g. offices as opposed to corridors). A Family Health Team facility will vary in efficiency (even if the spaces are well-designed) depending on whether it:

- Occupies a portion of a floor in a commercial office building or retail space (e.g. shopping mall);
- Occupies the whole floor or floors of a commercial office building; or
- Is a self-contained facility in its own building.

The following table illustrates the degree of efficiency by facility type.

TABLE 2.1 FLOOR AREA EFFICIENCY

Floor Area	Efficiency	Grossing Factor	Grossing Elements to be included in the gross floor area
Portion of a floor in an existing commercial office building or retail space (e.g. in shopping mall)	High 80% Most of the floor area in this type of facility would be habitable; limited amount of non-habitable spaces; not included for grossing calculation: elevator shaft, elevator lobby, main building corridor, stairs, exterior walls	1.25	Interior partitions Interior corridors Service spaces
Total floor of commercial office building	Moderate 75% A portion of the floor area is required for corridors, exiting, stairs, service areas, etc., not identified in the list of rooms	1.33	Interior partitions Interior corridors Service spaces, stairs, elevators, lobby
Self-contained building	Low 60% This type of facility contains a significant amount of non-habitable space such as corridors, exits, service areas, etc.	1.67	Interior partitions Interior corridors Service areas, stairs, elevators, lobby, exterior walls

The grossing factor might range from 1.25 to 1.67 x net floor area.

Changes in the size of the operation may necessitate increases in the number of primary facilities (rooms required to accommodate additional staff and programs). Additional ancillary and support facilities may be required to complement (augment) the expansion of the primary facilities (e.g. additional waiting room area, additional medical records space). Ancillary and support facilities can be added in accordance with the floor area increments identified in Table 1.1.

ROOMS AND FUNCTIONS

The following section describes some of the use and occupancy characteristics of the rooms identified in Table 1.1 and some of the required furniture and equipment, which influence room size.

STANDARD OFFICES – PRIVATE
The private office is a standard for most staff including the administration staff, primary care providers, allied health professionals, and support staff. It may be used by individuals for their own professional work purposes – documentation, report writing, phone calling, meetings with colleagues, etc. The office may contain: a desk (or work station), office chair, visitor's chair(s), bookshelf, filing cabinet, credenza, computer return, etc.

STANDARD OFFICES – SHARED
Offices may be provided for individual staff members but shared on a scheduled basis or provided with floor area for two or more persons to accommodate the appropriate number of work stations or desks, chairs, visitors' chairs, bookshelves, filing cabinet(s), credenzas, etc.

The floor area of 75 SF per person should include the space required for each work station as well as the floor area required for common space – circulation, visitors' chairs, filing cabinets, shelving units, etc.

SPECIAL PURPOSE OFFICES
Special purpose offices are included to accommodate the special functional requirements of the staff and users of the rooms. Some of these offices are included in Table 1.1.

An Executive Director's office may be larger than the standard office in order to accommodate a meeting area with table and chairs or a sitting area with sofa and coffee table, etc.

Interdisciplinary health care providers (chiropodist, foot care nurse, physiotherapist, etc.) offices may contain additional floor area required for special furniture and equipment (e.g. chiropody chair, dental chair, massage table, etc.). An orthotics lab may be included as part of foot care program. A physiotherapist may require two or more rooms in a suite of offices or therapy areas. Dietitians, social workers, occupational therapists, and others may require additional floor area to provide counselling or other services within their private offices.

COMBINED OFFICE EXAM ROOMS
According to their requirements, primary care providers may prefer their offices and exam rooms combined to accommodate their administrative work, documentation, reporting, phone calling, meetings with colleagues, etc., as well as patient examinations and treatment. The room should contain: a work station or desk, chair, visitors' chairs, bookshelf, filing cabinet, exam table, stool, sink, base cabinet, upper cupboards, privacy curtain, etc.

GENERAL PURPOSE EXAM ROOM S
General purpose exam rooms for primary care providers to examine and treat patients can be in proximity to, adjacent to or interconnected with a provider's office. The rooms may be assigned for the private use of individuals or may be shared by two or more primary care providers.

All exam rooms should contain: an exam table, stool, sink, base cabinet, upper cupboards, and equipment related to the procedures undertaken.

SPECIAL PURPOSE EXAM ROOMS
Special purpose exam rooms may be provided to accommodate the special needs of clients/patients for wheelchair accessibility, special furniture, etc.

LARGE EXAM ROOM
The room can be shared and used on a scheduled basis for examinations, treatment of clients/patients who are accompanied by family members, translators, others for support.

MINOR TREATMENT ROOM
The room can be used on an as-needed or scheduled basis for minor surgical procedures, sterile dressing applications, pre-exam measurements (blood pressure, height, and weight), patient/client form filling, etc.

SERVICE ROOMS

MED. ROOM/CLEAN UTILITY
The room for the storage of medications, drug samples and other clean supplies may contain counter top, base cabinets, and upper cupboards. Cupboards should be lockable.

SOILED UTILITY ROOM
The room for the temporary storage of garbage, recycling, disposal of expired medications, sharps, etc., may contain bins, a sink, countertop or shelving.

LAB
The room is suggested for those Family Health Teams in which blood and urine specimens are collected and held for pick-up by personnel from medical testing companies. The room may contain a sink, countertop, shelving, a small fridge, etc. The med. room and lab may be combined, with care taken to ensure infection control measures.

SUPPORT ROOMS

JANITOR'S CLOSET
A room(s) may be provided for the storage of cleaning equipment of in-house or contract cleaning services especially in larger facilities. The room(s) generally includes mop sinks, shelving for paper products, room for storage of recycling bins, storage for floor cleaning equipment (mops, vacuum cleaners, etc.).

COMPUTER SERVER ROOM
A room may be provided for server equipment, computer repairs, and servicing. Its design should be confirmed in consultation with IT specialists

RECEPTION AREA
The reception area provided for a receptionist to greet patients/clients, to provide information and directions, and to perform clerical functions and/or for staff (e.g. medical secretary to perform a variety of clerical and clinical functions), should be located to permit good visual surveillance of the people entering and leaving the facility, and sitting in the waiting area.

It should be designed to provide good accessibility for all persons to staff for information, assistance, and directions, to ensure privacy and confidentiality in patient/client and staff interactions, and to establish a comfortable environment in which staff can perform their work.

The area should be designed with: a reception counter (a section of which will facilitate barrier free access to persons in wheelchairs), a desk or built-in work station with drawers for the receptionist and each additional staff member, office chair, filing cabinet, and other equipment (e.g. switchboard, fax machine, etc.) as required.

WORKROOM
A workroom may be provided for the use of reception/clerical staff to support the functions of administration, for storage of paper stock, office supplies, office files, for the operation of the photocopy machine, fax machine, for mail service, etc. The room should contain shelving, a work table, and storage cabinets as required.

The size of the work room is determined by the functions associated with the Family Health Team operation and not dependent upon the size of the patient population.

MEDICAL RECORDS ROOM
This room could be provided to accommodate active patient charts and other files requiring a secure facility. Active patient charts may be located in the reception area as desired by the Family Health Team with an adjustment in the size of the reception area to accommodate the required shelving.

The size of the room is dependent on the patient/client load and on the shelving system employed.

The design of the room should be carefully considered. It may need to accommodate an expansion of the storage of charts and files in the near future. On the other hand, it may not ultimately be required as a self-contained storage room with the introduction of electronic charting. Other uses may be considered for this room in the future.

WAITING ROOM
Patients, clients, and visitors will use this area during office hours while waiting for scheduled appointments. The room should be located to permit staff to monitor the patients/clients and should be designed to preserve staff privacy and confidentiality.

The size of this area is determined by the number of users, the type of practice proposed, and the services provided by the Family Health Team (and not by the number of FTEs in the operation).

The room will contain the appropriate seating (including bariatric chairs as required), and may provide directional information, displays and resource material, a health promotion computer kiosk, or kiosks, etc.

CHILDREN'S AREA
A children's area may be provided depending on the nature of the Family Health Team operation adjacent to and in addition to the waiting room. This is a distinct area (with its own furniture, accessible height-appropriate shelving for toys, etc.) adjacent to and visible from the main waiting area for parental supervision and control.

MULTI-PURPOSE COUNSELLING (GROUP) ROOM
The room used by allied health professionals (psychologists, social workers, dietitians, etc.) for group counselling, self-help groups, family counselling could contain: comfortable chairs, sofas, coffee and end tables, table lamps, etc.

SMALL AND LARGE MEETING ROOMS
The meeting rooms should contain the tables and chairs required for group functions and should permit a variety of arrangements of furniture appropriate to the activities conducted in the rooms.

STAFF LUNCH ROOM
This staff room for socializing, informal communication and work breaks should contain: kitchenette facilities – sink, countertop, cupboards, small appliances – tables, chairs and/or comfortable seating.

STORAGE
This room may be provided for the storage of archival files and records, equipment and medical and non-medical supplies, program materials.

WASHROOMS

PUBLIC – MALE AND FEMALE
The size of the rooms will be determined by the occupant load in the building. The floor areas of the washrooms identified in Table 1.1 can accommodate: in the male washroom – 2 toilets (one wheelchair accessible), one urinal, and 2 sinks recessed in vanity countertops; and in the female washroom – 3 toilets, (one wheelchair accessible), and 3 sinks recessed in vanity countertops.

STAFF
Staff and clinical washrooms are identified as wheelchair accessible, single use rooms with one toilet and one sink.

Appendix C – Sample Facility Improvement Phase 2 Checklist

This document is a control sheet for Family Health Teams to ensure that facility improvement requests fulfill the ministry requirements.

Instructions

This is Phase 2 of two phases to review and approve Family Health Team facility improvement requests. Please provide the information pertaining to the facility improvement request as per the Checklist below. As each piece of information is attained, please send it to your Family Health Team Coordinator.

<table>
<tr><th colspan="3">Facility Improvement Requirements Checklist
PHASE 2</th></tr>
<tr><th>Requirements</th><th>Check
(/×)</th><th>Comments</th></tr>
<tr><td>Key assumptions and rationale for facility improvements – after space approval</td><td></td><td></td></tr>
<tr><td>A description of the accessibility of the proposed site, identifying all possible barriers</td><td></td><td></td></tr>
<tr><td>Proposed facility layout (floor plans) of the total space to be improved (including approved Phase 1 space) showing space and room allocation and their dimensions</td><td></td><td></td></tr>
<tr><td>Scope of renovations, including upgrades to building systems – mechanical, electrical, architectural, etc.</td><td></td><td></td></tr>
<tr><td>• A completed Lease Agreement Information Schedule (see Appendix K for sample)
• If requested by the ministry, a copy of the lease agreement
• Proof that the applicant, who is also the occupant, has permission [of the landlord and tenants (if applicable)] to make the proposed changes using the proposed contractor
• Identification of facility ownership and if any are team members, including governing body members</td><td></td><td></td></tr>
</table>

Facility Improvement Requirements Checklist
PHASE 2

Requirements	Check (/×)	Comments
Details of plans to share the proposed facility space with other providers or organizations that are not part of the proposed team; identify the affected facility space area and cost-sharing arrangements and rationale		
Availability or expected source of funds		
A description of financial and/or in-kind support such as contributions from sponsors, community partners or landlord that will be used to offset one-time expenditures and any conditions attached to each contribution		
Where total facility improvement cost estimate under $10,000, the Family Health Team must follow the requirements as set out in the Competitive Bidding Requirements section in the *Guide to Transitional Funding* (herein *Guide*) and must provide the ministry with the following information from the contractor: • Scope of work (e.g. painting walls) • A detailed cost estimate (e.g. cost of labour, materials) • Completion date		
Where total facility improvement cost estimates exceed $10,000, the Family Health Team must follow the requirements as set out in the *Guide* and must provide the ministry with: • Confirmation by a qualified professional that all proposed changes are technically feasible and comply with applicable codes, statutes and ordinances • A signed letter to the ministry that the contractor meets the qualifying preconditions as set out in the *Guide* • A preliminary cost estimate that includes a breakdown of costs for each element of construction • A schedule update that indicates the estimated start and completion dates for tender of the project • The complete bidding/tendering package • A detailed analysis of the bids, the recommended bid, and the rationale for endorsing it • Copies of the three lowest bids		
A signed and completed Final Estimate of Cost (see Appendix H for sample) and a final completion timeline		
The Family Health Team governing body's motion indicating their acceptance of the bid		
A signed and completed Final Capital Cost form (see Appendix 1 for sample), upon completion of the facility improvement, but before the final payments relating to the facility improvement have been made		
A signed and completed Final Submission of Disbursements (see Appendix J for sample), after all		

Facility Improvement Requirements Checklist PHASE 2		
Requirements	**Check (/×)**	**Comments**
payments relating to the facility improvement have been made		
Prime consultant/appropriate professionals to complete the Value of the Facility Improvements template for facility improvements that are between $10,000 and $100,000 (see Appendix L for sample)		
An appraisal by a member of the Accredited Appraiser Canadian Institute (AACI) that states the effect of the facility improvements on the value of the property (if applicable, as per the *Guide*), if facility improvements are over $100,000 or if deemed necessary		

Appendix D – Competitive Bidding Requirements for Facility Improvements for Family Health Teams

The purpose of this policy is to document the requirements that the Family Health Teams must adhere to when awarding contracts in order to carry out the approved facility improvements.

Preliminary Specifications

Prior to assembling a bidding package, the Family Health Team must provide the Ministry of Health and Long-Term Care (the ministry) with completed specifications, working drawings and other documents that clearly define the project scope of work, for public tendering.

Submission Requirements
The design documentation must include the architectural working drawings, including the full space requirements, and space approved by the ministry.

Preliminary Cost Estimate
The preliminary cost estimate shows a breakdown of costs for each phase of construction. Requests for furniture, equipment, Information Technology, and telecommunications, should be made separately through the *Business and Operational Plan*.

Project Schedule
The schedule should outline the estimated start and completion date for each phase of the project, including tendering of the project, awarding of the contract, and construction.

Requirements

The requirements Family Health Teams must adhere to vary by preliminary cost estimate. Three thresholds have been identified:

- Tier 1: preliminary cost estimate under $10,000
- Tier 2: preliminary cost estimate between $10,000–$100,000
- Tier 3: preliminary cost estimate above $100,000

Tier 1. Requirements for facility improvements with a preliminary cost estimate under $10,000[11]

- Competitive bids are not required.

- The Family Health Team must provide the ministry the following information from the contractor:
  - Scope of work (e.g. painting walls);
  - A detailed cost estimate (e.g. cost of labour, materials); and
  - Completion date.

[11] Please see approval process flowchart in Appendix E for more details.

Tier 2. Requirements for facility improvements with a preliminary cost estimate between $10,000–$100,000[12]

- The Family Health Team must:
  - Place an ad in the *Daily Commercial News* and the local newspaper(s)[13]. The advertisement should specify, as a minimum:
    - Name of project;
    - Location of the project;
    - Name and address of the Family Health Team;
    - Location where bid documents can be picked up and submitted;
    - Contact person;
    - Date and time of tender closing; and
    - The following clause (or a variation) should be included in the advertisement: *"The lowest or any bid will not necessarily be accepted."*

  OR

  - Receive at least three (3) qualified competitive bids[14] from general contractors/vendors. If they fail to provide three bids, a rationale must be provided, and they can seek pre-qualification of contractors as specified on page 24.

- General contractors/vendors must, at a minimum[15]:
  - Be bondable or supply a letter of credit in the amount of the bid;
  - Supply references;
  - Supply a credit check; and
  - Supply proof of construction insurance, if applicable.

- Family Health Teams must also state in a signed letter to the ministry that the general contractor/vendor meets the above preconditions.

- The proponent is required to submit to the ministry the following:
  - Prime consultant's detailed analysis of the bids and recommended bid;
  - Copies of the three lowest bids;
  - Signed and completed Final Estimate of Cost (Appendix H);
  - Family Health Team governing body's motion indicating their acceptance of the prime consultant's recommendations; and
  - Prime consultant's report that provides an analysis of the impact of the facility improvement on the value of the leased property (see the section entitled "Appraisal").

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[12] Please see approval process flowchart in Appendix F for more details.
[13] There is no need to reference the nearest local daily newspaper if there are no daily newspapers in the Family Health Team's location.
[14] The Family Health Team is strongly encouraged to seek help of a prime consultant (typically an architect) who has experience in dealing with bids, planning and the development /tendering process (for projects that exceed $50,000, a prime consultant is mandatory). Where necessary, the prime consultant should provide the Family Health Team with the appropriate approvals (e.g. zoning, fire marshal, building permits and bonds).
[15] This list is not exhaustive. The ministry reserves the right to request additional information and documentation.

Tier 3. Requirements for facility improvements with a preliminary cost estimate over $100,000[16]

A full public tendering process must be followed. Public tendering is the process of obtaining competitive bids from prospective general contractor/vendor to carry out the work identified in the specifications, which may include the architectural working drawings.

The ministry's policies and guidelines for tendering are based on a stipulated price contract as per the Canadian Construction Documents Committee (CCDC) 2 standard forms and documents. The CCDC 2 standard forms are recommended for each aspect of the tendering process, and are available at http://www.ccdc.org.

The tender package must include the tender form and instructions to the bidders. They should reflect the ministry's guidelines on bonds, insurance, permits and the tender acceptance period, and any specific documentation relating to staging, decanting and the ongoing operation and maintenance of the Family Health Team during the construction process.

The tender documents are prepared by the prime consultant who is responsible for the process of calling tenders. Tender calls must be done by public advertisement, to provide for open competitive bidding.

Consideration should be given to the use of the Ontario Bid Depository on projects where the estimated construction cost is more than $2 million. Standard Rules and Procedures are available from local bid depositories.

Information to Bidders

The bid documents should provide bidders with all the available information about the project. This will minimize questions during the tendering process and disputes after the contract has been awarded.

In accordance with the requirements of the CCDC 2, the Instructions to Bidders should include:

General information

- Family Health Team's legal name and address (or name of sponsoring legal entity); and
- Prime consultant's name, address and telephone number.

Project information

- Location where the work is to be carried out;
- Instructions on pricing, e.g. unit price, itemized, alternative and separate prices; and
- Instructions for proposing substitutions or alternatives, so that bidders do not inadvertently modify or limit their bids.

Bid information

- Availability of bid documents to general contractors and sub-contractors;
- Clear instructions about the method, form and completeness of the bid;
- Required bid, performance and payment securities;
- Information and regulations for bid depositories (if used);
- Time and place for receiving bids;
- Required number of copies of the bid (usually one copy is sufficient);
- Details of signing, sealing and witnessing;
- Method of identifying the envelope containing the bid;
- Instructions for amending a bid before the bid closing time;
- Acceptance period for bids (such as 30, 45, 60 or 90 days);
- The following paragraph (or a variation thereof) should be included in the Information to Bidders:

[16] Please see approval process flowchart in Appendix G for more details.

"The right to reject any or all tenders in whole or in part or to accept the tender or parts thereof judged most satisfactory is expressly reserved by the Board of the (insert legal name) Family Health Team without liability on the parts of the Board or the prime consultant. The lowest tender will not necessarily be accepted."

Bonds

The following bonds are used in a construction project:

Bid Bond

The purpose of the bid bond is to guarantee the good faith of the bidder to the Family Health Team. If the bidder's tender is accepted, the bidder is obligated to enter into a formal contract with the Family Health Team within the time specified and to provide bonds or other specified security to secure the performance of the contract.

Performance Bond

A performance bond provides indemnity to the Family Health Team up to the amount of the bond in case the general contractor defaults. A performance bond is not intended to cover payment of labour and materials claims.

Labour and Materials Bond

A labour and materials bond guarantees that all claimants will be paid for the labour and material furnished to the general contractor for use on the project, in the event of a default by the selected contractor.

All facility improvement projects should be covered by performance bonds and labour and material bonds to at least 50% of the construction cost of the project. On some projects, the ministry may require performance and labour and materials bonds of up to 100%.

The general contractor must provide the bonds outlined in the tender package. For additional information on bonds and insurance, refer to Canadian Construction Document Committee guidelines.

Construction Insurance

Large facilities should satisfy themselves that existing insurance policies include construction insurance up to a specified amount. The Family Health Team may want to include construction insurance in the bid form as a separate price and compare the cost of purchasing additional construction insurance directly. If the cost is lower than the bid cost, the Family Health Team can co-insure with the contractor at the lower cost.

Purchasing additional insurance in no way removes the contractor’s risk and liability, but identifying the Family Health Team as co-insured on the policy adds extra protection.

Public Pre-qualification of Bidders

An open tender call with competitive bidding presumes that the finished product will be comparable regardless of which bidder is chosen. Bidders should have previous related experience in construction on similar health care facilities and a proven record of effective time and cost control. The Family Health Team should allow only those contractors to bid who can demonstrate the required experience and financial stability for the type and size of the project.

If a project is sufficiently large and/or complex or if market conditions indicate that pre-qualification would be wise, the Family Health Team may publicly pre-qualify bidders. The public pre-qualification process must comply with the ministry's policies for public tendering and competitive bidding.

Public pre-qualification allows all potential bidders to indicate their interest in a project while enabling the prime consultant to develop an appropriate final bidding list. Only those contractors whose qualifications are acceptable would be permitted to submit bids when tenders are called.

The ministry recommends the use of CCDC 2 (Canadian Standard Form of Contractor's Qualification Statement) as a minimum requirement of facilities who are pre-qualifying bidders. To analyse the pre-qualification applications, the Family Health Team must establish an evaluation committee with the prime consultant. This committee develops the evaluation criteria used to determine the eligibility of prospective bidders. The committee must record their analysis and decisions in case there are appeals or inquiries. The committee should generally choose a minimum of six eligible bidders to ensure fair competitive pricing.

The following guidelines will assist in the public pre-qualification of bidders:

- Place advertisements in the daily local newspapers and in the *Daily Commercial News* at least three days;
- Send copies of these ads to the Family Health Team Coordinator;
- Have the evaluation committee review the applications for pre-qualification and record their analysis and decisions;
- Choose at least three eligible bidders;
- Send the names of the qualified general contractors/vendors to the Family Health Team Coordinator; and
- Encourage all qualified prospective bidders to bid on the project when tenders are called.

Separate, Contractor's Alternative or Unit Prices

On complex projects, it may be in the best interest of the Family Health Team to request either separate, contractor's alternative, or unit prices on the tender form.

Separate Prices

If the Family Health Team or the ministry is concerned that a project may exceed its cost estimate, the Family Health Team can ask bidders to give separate prices for specific items. This allows the Family Health Team to delete or add items at the stated prices. Separate pricing allows the Family Health Team to substitute or delete materials which may improve the cost or quality of the project when awarding a contract to the successful bidder.

Contractor's Alternative Prices

Due to rapid changes in technology, the Family Health Team or its prime consultant may not be aware of new or improved products and/or materials on the market at that time. The Family Health Team can ask a contractor or sub-contractor in the field to recommend alternative products or materials of equal or greater value.

Unit Prices

Unit prices should be used with discretion (e.g. the removal of contaminated soil). In such cases, the quantity of contaminated soil to be removed should be estimated during the tendering process. Any amount over this quantity would be priced through unit prices (i.e., a set price per tonne for removal of contaminated soil). The ministry may consider cost sharing of change orders related to these types of projects on a case-by-case basis.

Cash Allowances

The ministry may approve cash allowances for specific items, such as testing, asbestos removal and hardware. Because Family Health Teams will enter into fixed-price contracts, open ended contingency cash allowances and/or contingency allowances/budgets are not funded by the ministry. The ministry should identify and approve proposed allowances, while the Family Health Team must justify all proposals for cash allowances to the ministry.

The following items may be approved for cash allowances:

- Hardware (e.g. door fasteners);
- Inspection and testing;
- Modifications due to final equipment selection;

- Replacement of existing elements site conditions (contaminated soil, unmarked buried services etc.); and
- Signage/way-making (directional signs).

Hardware

Due to time constraints, the prime consultant can recommend tendering of hardware separately after the construction tender. A cash allowance is then carried in the construction tender. The prime consultant should draw up a detailed hardware list, complete with special requirements, to avoid extra costs for installation.

Inspection and Testing

Inspection and testing allowances are desirable for such items as soil, concrete, building envelope and waterproofing because it is hard to predict the final cost. The Family Health Team must have an independent source verify the amount for each item. For a building with a complicated envelope, the Family Health Team may consider a thermo graphic scan.

Modifications Due to Final Equipment Selection

This type of cash allowance covers the cost of changes to building services to accommodate a justified change in equipment. On a lengthy construction project, equipment models can change or specified models may no longer be available.

Replacement of Existing Elements

This allowance is not intended to make up for a lack of preventative maintenance, but to help the Family Health Team achieve the maximum benefit from facility improvement funds. Therefore, the Family Health Team should use their discretion when deciding to replace elements such as plumbing valves or window seals. This allowance is not intended to cover wholesale replacement of elements.

Site Conditions

This type of allowance is put in place to deal specifically with sub-surface conditions which cannot be determined prior to excavation (contaminated soil, unmarked buried services etc.).

Calling Tender

Calling tender is the method used for securing a general contractor/vendor for a project at a fixed cost by advertising in the open market. Ministry policy requires that all projects be publicly tendered.

Tenders must be prepared based on stipulated price contracts (CCDC 2). Tenders for general contractors must include all the work required to complete the project including specifications and working drawings, if applicable.

Tender calls must be publicly advertised in the *Daily Commercial News* and the daily local newspapers. Advertisements should run for at least three days and copies of the advertisements should be forwarded to the Family Health Team Coordinator. The requirement of public advertising is reinforced by the broader public service procurement agreement. This agreement requires that publicly funded projects with a value greater than $100,000 be advertised in a national publication such as the *Daily Commercial News*.

The advertisement should specify, as a minimum:

- Name and address of project;
- Name and address of the Family Health Team;
- Location where tender documents can be picked up and bids resubmitted;
- Contact person; and
- Date and time of closing.

The following clause (or a variation) should be included in the advertisement:

"The lowest or any tender will not necessarily be accepted."

The ministry recommends that the Family Health Team should not accept bids submitted via fax or telephone. Where possible, tenders should be delivered by hand or registered courier due to the confidentiality of the submission and to avoid potential disputes about the time and/or difficulties encountered in making the submission.

Opening Tenders

The opening of tenders must conform to the protocol set out in CCDC 2 (*A Guideline to Calling Bids and Awarding Contracts*).

The Family Health Team should notify the Family Health Team Coordinator of the date, time and location of the tender opening. If the Family Health Team Coordinator is not able to attend, the ministry may appoint an independent observer to represent the ministry at the tender opening.

The prime consultant must indicate in his/her final report that CCDC 2 procedures were followed when the tenders were opened.

The opening of tenders must be formal, correct and well-documented. Tenders must be opened publicly at a predetermined location, such as the Family Health Team or the prime consultant's (architect's or engineer's) office. Tenders which have been submitted after the specified closing time shall be returned unopened to the bidder.

The following guidelines should be adhered to in the tender opening process. The Family Health Team's prime consultant opens the tenders and records the following information in the tender-opening register:

- Names of tendering authority representatives in attendance;
- Official time of closing receipt of tenders; and
- Names and company affiliation of all persons in attendance.

The same prime consultant announces and records the following information:

- Name of contractor;
- Presence of Consent to Surety and Bid Bond (if required); and
- Tendered price.

Evaluating Tenders

Tenders should be evaluated in accordance with CCDC 2 strictly enforcing the requirements respecting signature, seal, security deposit and bonding. As part of the tender evaluation process, the prime consultant must:

- Analyse all opened tenders for compliance with the specific requirements; and
- Recommend the lowest *bona fide* bid.

Rejecting Tenders

Generally a tender is rejected if:

- It is in any way limited by the addition or omission of information;
- Requirements for tender surety are not satisfied;
- It is not signed by an authorized person or it is not witnessed or sealed;
- It is not submitted on the prescribed bid form; or
- Changes have been made to the bid form.

A tender should be returned to the contractor unopened if:

- It is received after the specified closing time; or
- Only one bid is received.

The ministry may request copies of all bids and related information for review.

Submission Requirements

The proponent is required to submit to the ministry the following:

- Prime consultant's detailed analysis of the tenders and recommendations;
- Copies of the three lowest bids;
- Signed and completed Final Estimate of Cost (see Appendix H);
- Family Health Team board motion indicating their acceptance of the prime consultant's recommendations; and
- Report of the appraiser on the impact of the facility improvement on the value of the property (see the section entitled "Appraisal").

Purchasing: Buy Canadian

To support domestic markets and supplier development, the government offers a price preference of up to 10% on the Canadian content of supplies, equipment and services in bids and proposals of $25,000 or more. The ministry recommends that every consideration be given to Canadian content in the award of tenders.

Budget

The ministry's share of the project cost is calculated when the Final Estimate of Cost (see Appendix H) is approved. It includes:

- General contract price;
- Provincial and federal taxes;
- Prime consultant's fees and disbursements, including building permits;
- Project manager/clerk of the works (if applicable);
- Furnishings and equipment;
- Other allowable costs (such as cash allowances); and
- Shareable costs and non-shareable costs.

The above must also identify the cash available and/or the source of funds for the Family Health Team's share of the project. (See the section *Shareable/Non-shareable Costs* for examples.)

General Contract Price

This item should indicate the name of the successful bidder and amount of the tender. GST must be shown separately.

Provincial and Federal Taxes

The shareable cost of a facility improvement project includes the relevant federal and provincial taxes less the tax rebates that the Family Health Team can claim.

Prime Consultant's Fees and Disbursements

The ministry shares the cost of fees for consultants including the building permit, as determined by ministry policy. If the project involves both renovations and new work, indicate the percentages for each category since the fee structure vary.

Project Manager/Clerk of the Works

The Family Health Team should identify the costs associated with a project manager and/or a clerk of the works. Prior ministry approval is required for cost-sharing in these positions.

Loose Furnishings and Equipment

The ministry shares in the cost of the equipment according to the approved equipment list.

Other Allowable Costs

The ministry may allow cash allowances for items such as hardware, inspection and testing.

Shareable/Non-shareable Costs

Shareable costs are those which the ministry will share with the Family Health Team. These include:

- New construction or renovation of existing buildings to be used as a health care facility;
- Fees paid to the prime consultant;

- Fees for consultants other than those paid through the prime consultant;
- Basic equipment and furniture and their installation;
- Land surveys and soil tests;
- Necessity landscaping;
- Legal fees, building permits; and
- Unforeseeable change orders[17].

The ministry does not cost-share in the following (non-sharable):
- Landlord administration fees;
- Kitchen/dietary consultants;
- Interior design consultants;
- Chapel furnishings;
- Garden areas for residents/clients;
- Exterior furnishings for residents/clients;
- Land acquisition or demolition of existing buildings;
- Paving of parking lots;
- Purchase of replacement equipment;
- Contingency budgets;
- Chapel furnishings in hospitals;
- Financing charges;
- Gardens, works of art and decorations;
- Campaign costs for raising the Family Health Team's share of the approved costs;
- Facilities for ancillary revenue-producing operations;
- Purchase of equipment which is not part of the project;
- Purchase of replacement equipment in hospitals; and
- Parking facilities.

Method of Construction Project Administration

Family Health Teams are encouraged to seek conventional construction project administration methods. Construction Management (CM) and its variations are not an acceptable project administration method. Construction Management is a construction project administration method where the owner/lessee has one direct contract with the construction manager, who seeks sub-contractors to provide the services required to complete the facility improvement.

Awarding Contracts

All tender evaluations, bids and Final Estimate of Cost (see Appendix H for sample) budgets are reviewed by the ministry. Upon review, the ministry will send a letter to the proponent advising them of:
- Approved total project cost;
- Approved facility improvement grant; and
- Approval to sign a contract.

The Family Health Team should not sign a contract before receiving ministry approval. The ministry can withdraw its funding commitment to the project if a contract is awarded before the Family Health Team receives approval.

Acceptance of the contract by the Family Health Team must be done in writing as it is an agreement between the Family Health Team and the selected general contractor/vendor.

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[17] Must be approved by the ministry prior to undertaking work

A Final Capital Cost form (see Appendix I for sample), should be submitted upon completion of the facility improvement, but before the final payments relating to the facility improvement have been made. A Final Submission of Disbursements (see Appendix J for sample), should be submitted after all payments relating to the facility improvement have been made.

The Family Health Team must ensure that they receive a rent-free period while the facility improvement is taking place. The ministry will not pay for vacancy loss.

Appraisal

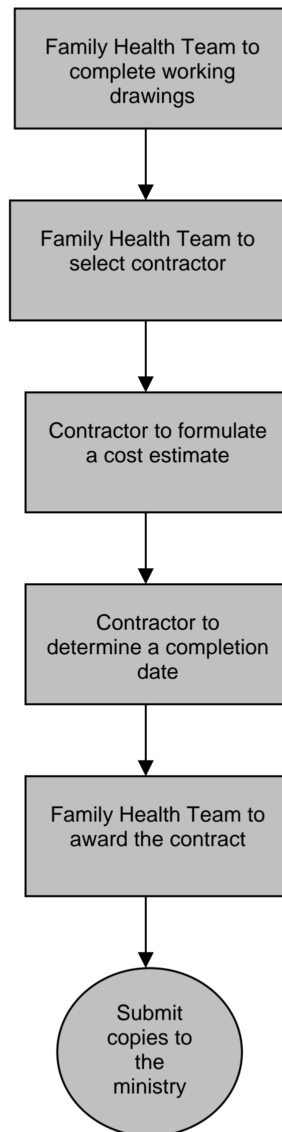
The Family Health Team is expected to negotiate a discount in rent equal to the incremental impact of the ministry's investment on the property value. In order to determine the additional value of the facility improvement, an appraisal must be conducted by:

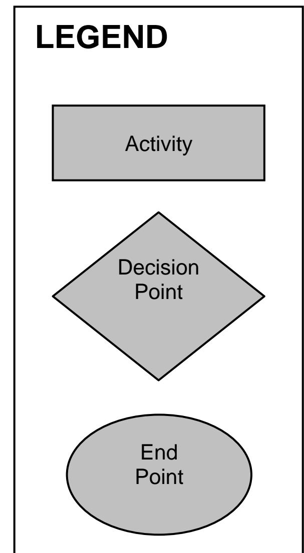
- The prime consultant/appropriate professional for facility improvements between $10,000 and $100,000; or
- An appraiser accredited by the Accredited Appraiser Canadian Institute (AACI) for facility improvements that exceed $100,000.

References

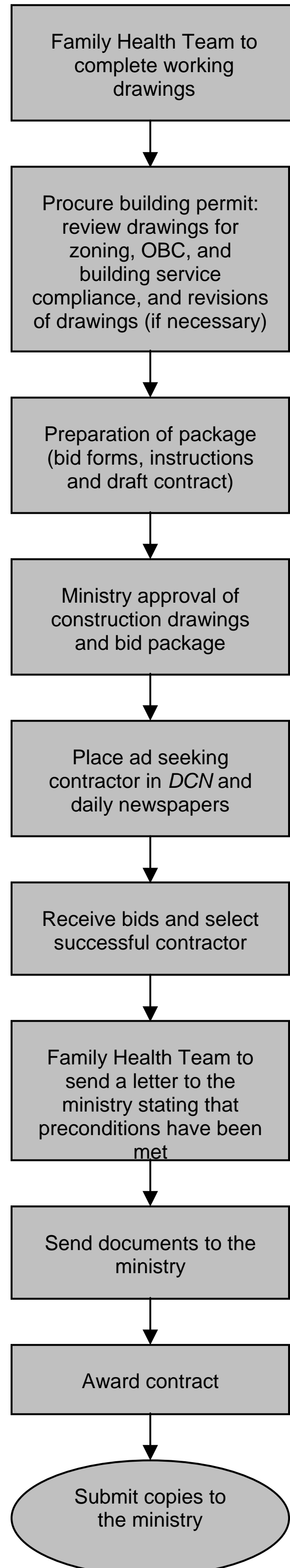
Ontario. Ministry of Health and Long-Term Care. Capital Planning Manual. Toronto, ON: Queen's Printer. 1996.

Appendix E – Tier 1 Requirements Process

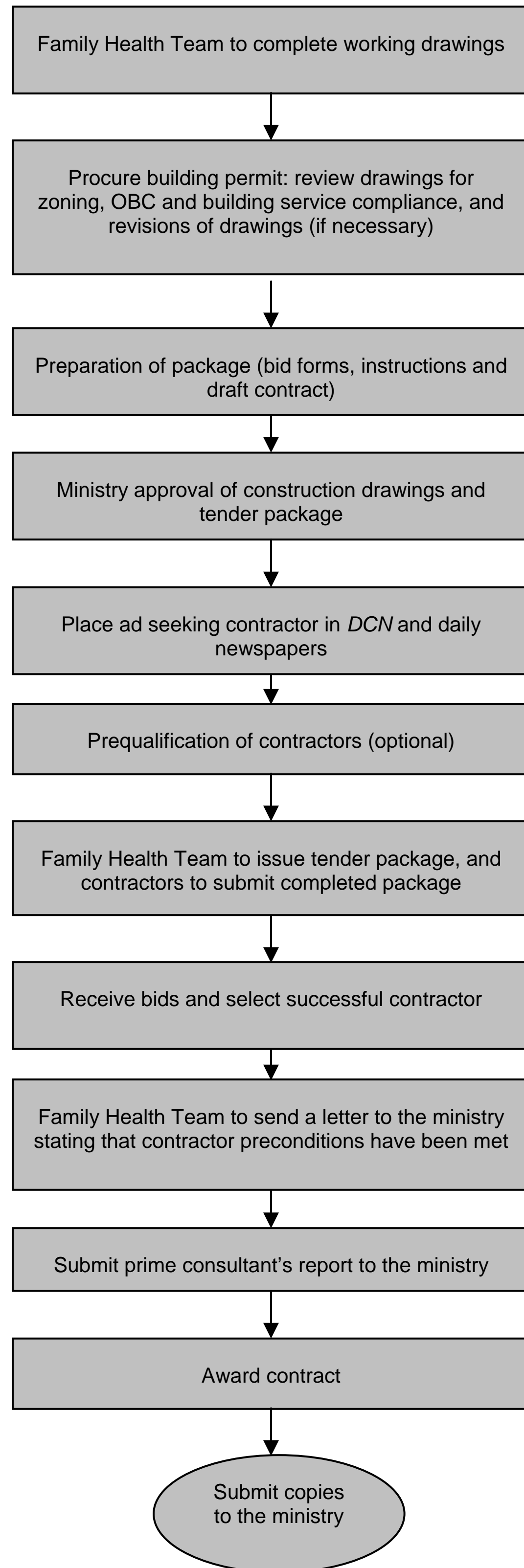


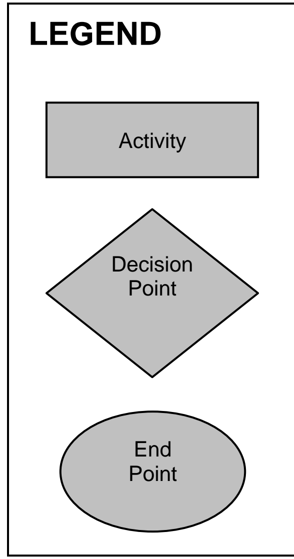


Appendix F - Tier 2 Requirements Process



Appendix G - Tier 3 Requirements Process





Appendix H – Sample Final Estimate of Cost (FEC)

Ontario	Ministry of Health and Long-Term Care	Facility name		City/Town/Township	
		Description of project			Ministry project no.
Final Estimate of Cost (FEC)		Tender expiry date	Est'd no. of months of construction	Construction mix % new	% renovation	Contribution

			Line	Amount	Ministry use
A	**Approved Cost**			**Amount**	**Ministry use**
	General contract price (attach list) (breakdown of actual cost e.g. HVAC System, painting)		1		
	Other contracts (attach list)		2		
		Subtotal - Base cost of contracts	3	$0	
	Add GST		4	$0	
	Less GST rebate		5		
		Subtotal A - Gross cost of contracts	6	$0	
B	**Add Cost of:**				
	Prime consultant's fee		7		
	Disbursements		8		
	Other consultant's fees (attach list)		9		
	Loose furnishings & equipment (attach list)		10		
	Minor equipment allowance (attach list)		11		
	Other allowable costs (attach list)		12		
		Subtotal (Line 7 to Line 12)	13	$0	
	Subtract cost of:				
	Other non-shareable Costs		14		
		Subtotal B (Line 13 minus Line 14)	15	$0	
		Base of contribution (Subtotal A+B: Line 6+15)	16	$0	
C	**Add cost which do not qualify for contribution** (see Guide to Transitional Funding)				
	Other costs (attach list)		17		
	Contingency, change orders, etc. (attach list)		18		
		Subtotal C - Non-shareable cost (Line 17 to Line 18)	19	$0	
		Final estimate of total cost (A+B+C: Line 6+15+19)	20	$0	
		Ministry's share of cost	21		
D	**Facility's share of cost** (Line 20 minus Line 21)		22	$0	
E	**Funds available to facility for this project**				
	Cash Contribution		23		
	Bonds and securities		24		
	Other source (specify)		25		
		Total funds available (Line 23 to Line 25)	26	$0	
	Deficit or surplus on facility's share (state how deficit will be financed)		27		

The governing body/board of directors of the facility hereby accept full responsibility for providing funds to meet their share of the cost, as indicated in **Section D - Facility's share of cost**, and any other unapproved costs.	Signature - Lead/Chair of the Board/Owner	Print Name	Date (dd/mm/yyyy)
		Ministry approval	Date (dd/mm/yyyy)

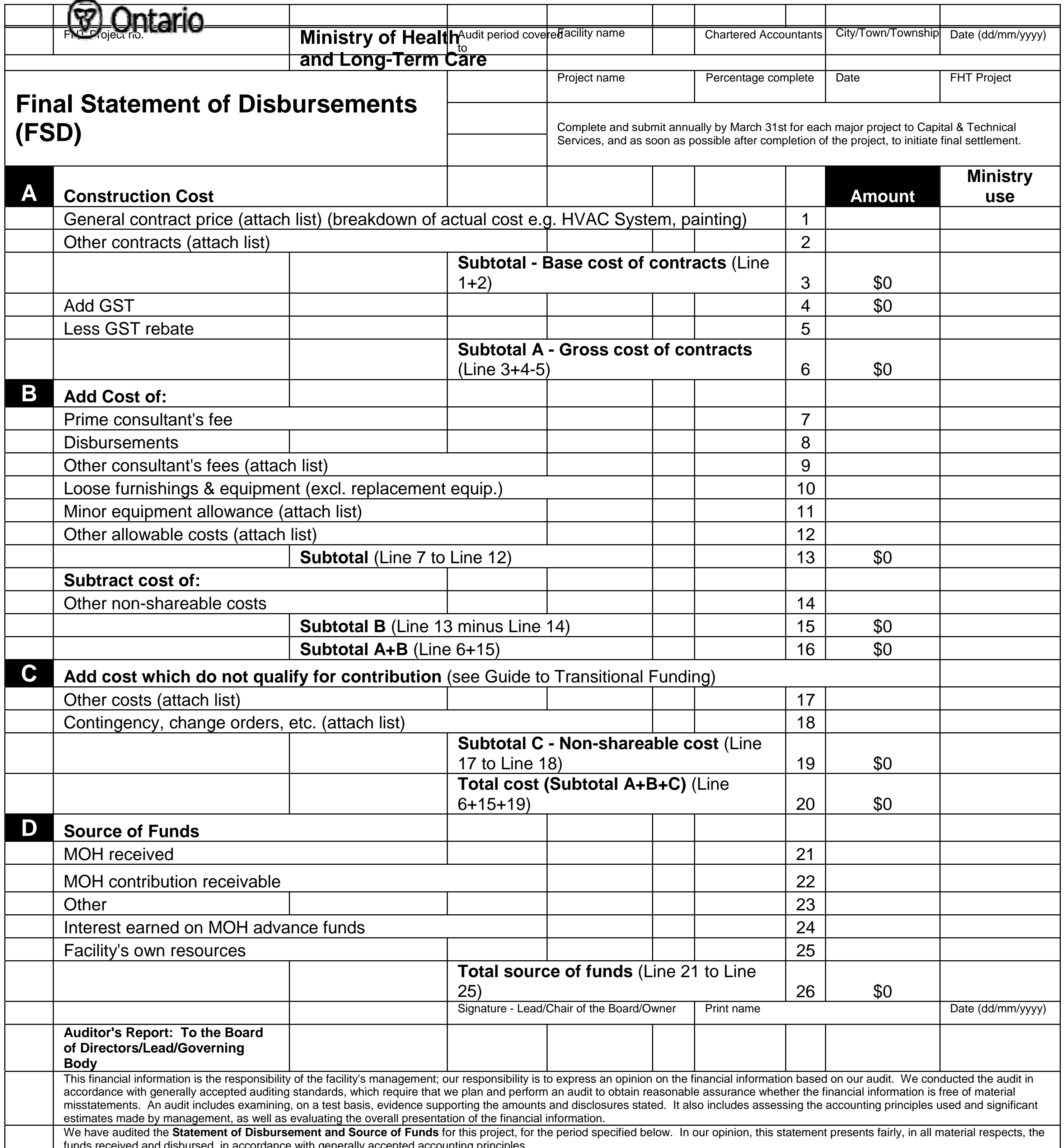
Appendix I – Sample Final Capital Cost (FCC)

Ontario	**Ministry of Health and Long-Term Care**	Facility name			City/Town/Township	
		Description of project				Ministry project no.
Final Capital Cost (FCC)		Tender expiry date	Est'd no. of months of construction	Construction mix % new	% renovation	Contribution

		Line	Amount	Ministry use
A	**Approved Cost**		**Amount**	**Ministry use**
	General contract price (attach list) (breakdown of actual cost e.g.. HVAC System, painting)	1		
	Other contracts (attach list)	2		
	Subtotal - Base cost of contracts	3	$0	
	Add GST	4	$0	
	Less GST rebate	5		
	Subtotal A - Gross cost of contracts	6	$0	
B	**Add Cost of:**			
	Prime consultant's fee	7		
	Disbursements	8		
	Other consultant's fees (attach list)	9		
	Loose furnishings & equipment (attach list)	10		
	Minor equipment allowance (attach list)	11		
	Other allowable costs (attach list)	12		
	Subtotal (Line 7 to Line 12)	13	$0	
	Subtract cost of:			
	Other non-shareable Costs	14		
	Subtotal B (Line 13 minus Line 14)	15	$0	
	Base of contribution (Subtotal A+B: Line 6+15)	16	$0	
C	**Add cost which do not qualify for contribution** (see Guide to Transitional Funding)			
	Other costs (attach list)	17		
	Contingency, change orders, etc. (attach list)	18		
	Subtotal C - Non-shareable cost (Line 17 to Line 18)	19	$0	
	Final estimate of total cost (A+B+C: Line 6+15+19)	20	$0	
	Ministry's share of cost	21		
D	**Facility's share of cost** (Line 20 minus Line 21)	22	$0	
E	**Funds available to facility for this project**			
	Cash Contribution	23		
	Bonds and securities	24		
	Other source (specify)	25		
	Total funds available (Line 23 to Line 25)	26	$0	
	Deficit or surplus on facility's share (state how deficit will be financed)	27		

The board of directors of the facility hereby accept full responsibility for providing funds to meet their share of the cost, as indicated in **Section D - Facility's share of cost**, and any other unapproved costs.	Signature - Lead/Chair of the Board/Owner	Print Name	Date (dd/mm/yyyy)
		Ministry approval	Date (dd/mm/yyyy)

Appendix J – Sample Final Statement of Disbursements (FSD)



Ontario

FHT Project no.	Ministry of Health and Long-Term Care	Audit period covered to	Facility name	Chartered Accountants	City/Town/Township	Date (dd/mm/yyyy)
			Project name	Percentage complete	Date	FHT Project

Final Statement of Disbursements (FSD)

Complete and submit annually by March 31st for each major project to Capital & Technical Services, and as soon as possible after completion of the project, to initiate final settlement.

		Line	Amount	Ministry use
A	**Construction Cost**			
	General contract price (attach list) (breakdown of actual cost e.g. HVAC System, painting)	1		
	Other contracts (attach list)	2		
	Subtotal - Base cost of contracts (Line 1+2)	3	$0	
	Add GST	4	$0	
	Less GST rebate	5		
	Subtotal A - Gross cost of contracts (Line 3+4-5)	6	$0	
B	**Add Cost of:**			
	Prime consultant's fee	7		
	Disbursements	8		
	Other consultant's fees (attach list)	9		
	Loose furnishings & equipment (excl. replacement equip.)	10		
	Minor equipment allowance (attach list)	11		
	Other allowable costs (attach list)	12		
	Subtotal (Line 7 to Line 12)	13	$0	
	Subtract cost of:			
	Other non-shareable costs	14		
	Subtotal B (Line 13 minus Line 14)	15	$0	
	Subtotal A+B (Line 6+15)	16	$0	
C	**Add cost which do not qualify for contribution** (see Guide to Transitional Funding)			
	Other costs (attach list)	17		
	Contingency, change orders, etc. (attach list)	18		
	Subtotal C - Non-shareable cost (Line 17 to Line 18)	19	$0	
	Total cost (Subtotal A+B+C) (Line 6+15+19)	20	$0	
D	**Source of Funds**			
	MOH received	21		
	MOH contribution receivable	22		
	Other	23		
	Interest earned on MOH advance funds	24		
	Facility's own resources	25		
	Total source of funds (Line 21 to Line 25)	26	$0	

Signature - Lead/Chair of the Board/Owner	Print name	Date (dd/mm/yyyy)

Auditor's Report: To the Board of Directors/Lead/Governing Body

This financial information is the responsibility of the facility's management; our responsibility is to express an opinion on the financial information based on our audit. We conducted the audit in accordance with generally accepted auditing standards, which require that we plan and perform an audit to obtain reasonable assurance whether the financial information is free of material misstatements. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures stated. It also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial information.

We have audited the **Statement of Disbursement and Source of Funds** for this project, for the period specified below. In our opinion, this statement presents fairly, in all material respects, the funds received and disbursed, in accordance with generally accepted accounting principles.

Appendix K – Sample of Lease Information Schedule

Ministry of Health and Long-Term Care
Ministère de la Santé et des Soins de longue durée

SCHEDULE 'XX'

This form should be completed by the FHT Proponent

Family Health Team Name: ______________________________

Leased Property Address:

(If there are multiple properties, please complete a form for each location)

Street Name and Number: ______________________________

City/Town: ______________________________

Postal Code: ______________________________

Square Footage: ______________________________

ORIGINAL LEASE PERIOD	DURATION		$ PER SQ FT	PLEASE CHECK IF THE FOLLOWING IS INCLUDED IN GROSS RENT:			
	Start Date	Expiry Date		PROPERTY TAXES	MAINTENANCE FEES	UTILITIES	Comments
Net Rent				NA	NA	NA	
Gross Rent*							
(Add rows if necessary for different rental rates for different time period)							
LEASE OPTIONS (e.g. Renewal, Expansion)	DURATION			PROPERTY TAXES	MAINTENANCE FEES	UTILITIES	Comments
	Start Date	Expiry Date	$ PER SQ FT				
Net Rent				NA	NA	NA	
Gross Rent							
(Add rows if necessary for different rental rates for different time period)							

* Gross rent includes any taxes, and/or utilities, and/or maintenance fees that may be included in the lease rate.

CONDITIONAL CLAUSES	$ AMOUNT	FROM	TO	CONDITION
E.g.: Ministry specified clause: An appraisal by a member of the Accredited Appraiser Canadian Institute (AACI) that states the effect of the facility improvements on the value of the property is to be completed for Ministry funded facility improvements that are over $100,000 (or as requested by the Ministry). The lease rate may be subjected to renegotation if the lease property value has increased as a result of the facility improvements.	TBD	Ministry	AACI appraiser	For ministry funded leasehold improvements that are over $100,000.
E.g.: Ministry specified clause: The value of the facility improvements template is to be completed by a qualified/appropriate professional who is involved in the facility improvements for facility improvements that are between $10,000 and $100,000. The lease rate may be subjected to renegotation if the lease property value has increased as a result of the facility improvements.	TBD	N/A	N/A	For ministry funded leasehold improvements that are between $10,000 and $100,000.
Please list below clauses that may lead to monetary transfers between the landlord, the tenant, or any third parties that are stipulated in the lease agreement or sublease agreements. The following clauses are listed as examples.				
The landlord may provide a cash allowance to the tenant for facility improvements	$20,000	Landlord	Tenant	The landlord is responsible for all base building repairs, such as electrical, mechanical, asbestos removal (anything behind the walls or in the ceiling); the landlord may want the tenant to do the work and the tenant will be reimbursed via a cash allowance based on cost incurred (invoices must be provided to the landlord in order for the tenant to be reimbursed) or the allowance may be applied to the rental fee.
Tenant must inform the landlord based on the specified notice date regarding exercising the option to either renew or terminate the lease upon expiry	$10,000	Tenant	Landlord	Typically, this clause gives the tenant the opportunity to notify the landlord, in writing, their future space requirements. This notice date is usually 1 to 2 years before the lease expiry date and the tenant has to inform the landlord if they will be renewing or terminating the lease. If the landlord does not receive this written notice by the specified date, that deems the lease will be renewed. If the tenant decides that they want to move and missed the notice period, the tenant is committed to pay the penalty until the lease expires for the second term.
(Add rows if necessary.)				

My legal counsel has reviewed the lease agreement and any sub-lease agreements of the abovementioned property and I certify that the above listed information pertaining to the lease agreement and any sub-lease agreements of the abovementioned lease property is accurate and that the Ministry may at any time request supporting documents for audit purposes.

In addition, I acknowledge that the Ministry will not be responsible for any lease conditions for the abovementioned lease property that have not been disclosed in this schedule.

Authorized Signature: ______________________________ **Date:** ______________________________

Print Name: ______________________________ **Tel. Number:** ______________________________

Title: ______________________________

Appendix L – Sample of Value of Facility Improvements Template

Ministry of Health and Long-Term Care
Ministère de la Santé et des Soins de longue durée

Value of the Facility Improvements Schedule

Family Health Team Name	
Address 1: Street/#	
Address 2: City/Town	

This template is to be completed by a qualified professional/expert on the matter of the lease property's facility improvements:

1. Please provide a brief description of the facility improvements:
2. Please input the cost of the facility improvements:
$
3. Please input the potential increase in the lease property's value from the facility improvements:
$
4. Please provide a brief rationale on the impact of the facility improvements on the value of the leased property. Please submit supporting documentation on how the qualified professional/ expert valuation was determined.

I solemnly declare that I do not have a conflict of interest on the matter of the facility improvements and that I have an arms length relationship with the members of the aforementioned Family Health Team and the landlord of the leased property.

Professional Title:	
Prepared by:	
Signature:	

Appendix M – Facility Improvement Scenarios

Expansion Scenario

- Description: Current space is unaltered, but additional space is needed to accommodate new FHT staff.
- Existing Staff:
  - 10 FHN physicians; and
  - 1 registered nurse and 1 administrative assistant (both salaries are paid by the existing physicians).
- New FHT staff: 1 FHN physician, 1 nurse practitioner (NP), 1 administrative assistant (AA), 1 dietitian, 1 mental health worker (MHW).
- Eligible for transitional funding:
  - All transitional funding for new NP, AA, dietitian, and MHW;
  - Facility improvements, equipment and furnishings in common areas; and
  - Facility improvements for existing RN and administrative assistant (whose salaries are paid by the existing physicians).
- Not eligible for transitional funding:
  - Since current space will not be improved, no transitional funding is necessary for the existing space; and
  - Equipment, furnishings and space exclusively used by new FHN physician.

New Location Scenario

- Description: The entire team (existing and new staff) moves to a new establishment.
- Existing Staff:
  - 10 HSO physicians;
  - 1 registered nurse (whose salary is paid by the Institutional Substitution Program); and
  - 1 registered nurse and 1 administrative assistant (both salaries are paid by the existing physicians).
- New FHT staff: 1 HSO physician, 1 nurse practitioner (NP), 1 administrative assistant (AA), 1 dietitian, 1 mental health worker (MHW).
- Eligible for transitional funding:
  - All transitional funding for new NP, AA, dietitian, and MHW;
  - Facility improvements, equipment and furnishings in common areas; and
  - Facility improvements for existing RN and administrative assistant (whose salaries are paid by the existing physicians).
- Not eligible for transitional funding:
  - Equipment, furnishings and space exclusively used by physicians, and by existing staff whose salaries are paid by the Institutional Substitution Program.

Improvement of Existing Space Scenario

- Description: All existing walls are to be torn down to re-design the space to accommodate the entire team.
- Existing Staff:
  - 3 RNPGA physicians;
  - 1 registered nurse (whose salary is paid by the Underserviced Area Program); and
  - 1 registered nurse and 1 administrative assistant (both salaries are paid by the existing physicians).
- New FHT staff: 1 RNPGA physician, 1 nurse practitioner (NP), 1 administrative assistant (AA), 1 dietitian, 1 mental health worker (MHW).
- Eligible for transitional funding:
  - All transitional funding for new NP, AA, dietitian, and MHW;
  - Facility improvements, equipment and furnishings in common areas; and

- Facility improvements for existing RN and administrative assistant (whose salaries are paid by the existing physicians).
- Not eligible for transitional funding:
    - Equipment, furnishings, and space exclusively used by physicians, and by existing staff whose salaries are paid by the Underserviced Area Program.

Glossary

Awarding Tender
Contract is awarded to the board/owner of a registered company/corporation. Award is based on the prime consultant's recommendations and the approval of the Ontario Ministry of Health and Long-Term Care.

Bid Depository
Bid Depository is a method of bid assembly co-ordinated on behalf of contractors to control the bidding process. Tendering documents are held at a designated location for review by sub-contractors who then submit sealed bids to perform work on the project. General contractors that are tendering on the project include these subcontract bid price as part of their total bid on a project.

Bonds – Bid
A Bid Bond is required from a general contractor when responding to a tender. It provides insurance coverage against faulty bids or retraction of a bid after tender opening.

Bonds – Labour and Material
A Labour and Material Bond guarantees that a claim made for labour and material furnished to a contractor will be paid if the contractor defaults.

Bonds – Performance
A Performance Bond is purchased by the general contractor to protect the owner in the event if general contractor fails to complete the specified project.

Call for Tenders
A public advertisement to secure general contractors/vendors to bid on a project.

Canadian Construction Documents Committee (CCDC)
The Canadian Construction Documents Committee (CCDC) is a national joint committee responsible for the development, production and review of standards, Canadian construction contracts, forms and guides. For more information visit the website at http://www.ccdc.org.

Capital Budget Estimate
An estimate of the facility improvement budget developed during the design phase. It includes estimates for:

- Construction costs;
- Architectural/engineering fees and disbursements;
- Building permits;
- Furniture costs;
- Equipment costs; and
- Facility's contribution.

Cash Allowance
An amount carried within the tender package for specifically identified purposes (e.g. hardware allowance).

Cash Flow
Payments made to a facility or Family Health Team to meet payment obligations such as construction costs (e.g. contractor's invoices) based on the contractor's initial estimate – or subsequent updated estimate – and the project schedule.

Change Orders
Changes to the pricing after the contract has been signed.

Change Order (unforeseeable)
Change orders are required after the contract has been signed and unforeseen issues, which may not be reasonably ascertained prior to start of the project or construction (i.e. soil conditions).

Common Space
Common or shared space such as hallways, waiting rooms, reception areas, working areas in hallways, washrooms, administrative areas, administrative offices, meeting rooms, shared exam rooms, cleaning closets, computer room(s).

Contingency Allowance
An allowance to cover unforeseen changes during the development of a project. An allowance for such unidentified, non-specific items is not part of the shareable costs of a project.

Contract Documents
The final specifications, including working drawings and all other necessary information needed for a facility improvement project.

Construction Management
A construction project method where the owner/lessee has one direct contract with the construction manager, who seeks sub-contractors to provide the services required to complete the facility improvement. The ministry does not accept this procurement method for facility improvement purposes. Family Health Teams undertaking facility improvements are encouraged to adopt the Project Management administration method (see definition below).

Costs – Non-Shareable
These are costs incurred in a facility improvement project but which are not eligible for funding by the ministry (i.e. paving of a parking lot, interior designer fees, ancillary revenue producing items such as gift shop, coffee shop, etc.).

Costs – Sharable
These are project costs in which the ministry will consider cost-sharing.

Decanting
Moving of program services and patients during the construction phase of a facility improvement project.

Departmental Gross Area (DGA)
The sum of the net areas calculated for each room in a given department, with an allowance added in for departmental circulation and interior walls.

Facility Improvement Budget
A facility improvement budget is finalized after the bidding and negotiation phase. It itemizes all costs related to a facility improvement project, including, but not limited to:
- Accepted bid amount;
- Total construction cost;
- Consultant fees and disbursements;
- Furniture and equipment; and
- Testing, insurance, permits.

Facility Improvements
Improvements to future or present Family Health Team site. Renovations are facility improvements performed to a property that is owned by a Family Health Team member. Leasehold improvements are facility improvements performed to a leased property.

Family Health Team Coordinator
The ministry liaison person assigned to a specific Family Health Team.

Final Estimate of Cost
A form completed by the facility and forwarded to the ministry listing all costs that will be incurred in the facility improvement project and indicating the source(s) of funds for the facility's share of the project.

General Contractor
The contractor is contractually obligated to a project requestor. The general contractor is responsible for co-ordinating the work at the construction site, including work performed by the sub-contractors.

Gross Floor Area
The total floor area of a project, arrived at by summing department gross area (DGA) and adding an allowance for major circulation routes between departments, exterior walls and all mechanical components such as duct shafts, elevators, fan rooms, and other components.

Net Construction Cost
The tendered price excluding PST and GST. This amount forms the basis for the calculation of professional fees.

Net Area
The sum of the open floor space requirement of a room/department.

Pre-Qualification
A process whereby contractors interested in tendering on a project are invited by public advertisement to submit their qualifications for review by the facility's board/owner and its architect for pre-screening prior to submission of tender bids.

Price – Unit
An amount stated in a contract as the price per unit of measurement for materials or services as described in the contract documents.

Price – Contractor's Alternative
A substitute item or section of the work. The price is added or deducted from the base bid price.

Price – Separate
The price for work to be added or deducted from the base bid price, if selected by the owner. The separate price is not included in the base price.

Prime Consultant
An architect or engineer retained by the facility to prepare contract documents for a facility improvement project on behalf of the Family Health Team.

Professional Fees
The fees and disbursements charged by the prime consultant and any sub-consultant(s) retained by the prime consultant or the facility.

Project Management
A construction project administration method where the owner/lessee has one direct contract with a project manager, or prime consultant, who navigates and protects the interests of the owner/lessee through the entire tendering, construction and delivery process.

Specifications
A part of the contract documents consisting of written description of a technical nature of materials, equipment, construction systems, standards and workmanship.

Statement of Disbursements and Source of Funds Form
A summary of the project costs and revenues (including interest earned on ministry advanced funds) prepared by the facility and verified by the facility's external auditors.

Tender
The process of publicly advertising for bids from general contractors to perform specified work at a given price based on a completed set of specifications.

Total Project Cost
All the various costs associated with a facility improvement project including costs for construction, professional fees, furnishings, equipment, permits, etc.

Total Construction Costs
The cost for the construction phase of a facility improvement project; that is more accurately determined when the tender bids are received including PST and GST.

Transitional Funding
Transitional funding provides support to Family Health Team applicants to recognize the additional one-time costs (equipment, furnishings, facility renovations and related costs) incurred to establish and implement a Family Health Team. Transitional funding is supplemental to contributions from community and provider partners, and is intended to supplement not replace existing funding sources.

Working Drawings
Drawings intended for use by a contractor, sub-contractor or fabrication, which forms part of the contract document for a facility improvement project. Working drawings contain the necessary information to construct or renovate a building.

Questions and Answers

Q1. If Interdisciplinary Health Care Providers need several rooms to be accommodated along with the physicians and the physicians' traditional office layout needs to be demolished, will the ministry provide funding for physician space?

A1. In this case, and in all cases where the Family Health Team (FHT) is seeking ministry funding for a significant portion (e.g. more than 50%) of improvements to space occupied by physicians (remunerated via the blended capitation or the blended complement method), the FHT is to provide a business case supported by a rationale for the ministry to consider its eligibility. Salaried physician space, furnishings and equipment are fully funded by the ministry, because their remuneration does not include any overhead allocation.

Q2. Is a solo physician who co-locates with other interdisciplinary providers expected to contribute to his portion of the facility improvement? If so, is there a specific percentage that they are expected to contribute?

A2. Physicians remunerated via the blended capitation or the blended complement method are expected to contribute 100% of transitional funding costs for the improvements, furnishings and equipment in space occupied exclusively by them. They are also expected to make a contribution towards the costs of shared or common space. While there is no set contribution percentage, these physicians are generally expected to contribute a percentage equal to the ratio of physicians (blended capitation or complement) to interdisciplinary providers, administrators. Salaried physician space, furnishings and equipment are fully funded by the ministry, because their remuneration does not include any overhead allocation.

Q3. Will the ministry provide funding for facility improvements for interdisciplinary providers who were previously paid out of pocket by the physicians?

A3. Yes.

Q4. Why are interior design consultants not eligible for funding?

A4. Because aesthetic goods and services are ineligible. However, the ministry will provide funding for interior designers who are also architects (recognized by their professional organization) and fulfill the role(s) of a prime consultant, as well as those of a designer.

Q5. Tier 2 states that the Family Health Team must state in a signed letter to the ministry that the general contractor/vendor meets the preconditions/requirements. What legal liability do Family Health Teams take on in the declaration about the contractor, how much investigation will the FHT need to do to ensure the validity of the declaration and will this require hiring consultants with sufficient expertise to determine the validity of the declaration? Who signs the letter on behalf of the FHT? Who from the FHT is expected to have the expertise to sit on the evaluation committee?

A5. Family Health Teams undertaking projects of a magnitude that requires such expertise are strongly encouraged (between $50,000 and $100,000) and required (over $100,000) to hire a prime consultant who has the knowledge and expertise necessary to confidently validate that the general contractors/vendors meet the stated requirements. The FHT signing officer(s) should consider the prime consultant's advice prior to signing the declaration. The ministry will consider mitigation options resulting from an erroneous declaration on a case-by-case basis. The membership of the evaluation committee is for the FHT signing officer(s) to decide, acting upon the advice of the prime consultant.

Q6. The eligible expenditures section (see page 4) states: "In *some* circumstances, supported by a business case, the ministry will consider funding … Up to 50% of facility improvement, furnishings and equipment costs for existing administrative staff (who are paid out-of-pocket by the physician), arising from physician relocation … (Applicable if the administrative staff's duties

are changed to serve the entire team (instead of just the family physician)." Does this mean that in most cases the non-salaried physician will be expected to cover 100% of these costs?

A6. Yes.

Q7. Does the ministry expect the family physician to cover the costs of ineligible items on behalf of the team?

A7. The ministry will not fund ineligible items. Other funding sources may be utilized to pay for ineligible items.

Q8. In practice, it is extremely difficult to negotiate a reduction in rent even if the facility improvement increases the value of the property, as the landlord may be unwilling to negotiate or to reduce the rent proportionate to the facility improvement investment. If this is the case, are the family physicians expected to cover the difference?

A8. No they are not. The ministry recognizes that lease negotiations are difficult and yield results with varying degrees of success. If the negotiated terms are not acceptable to the ministry, the ministry may explore alternative acceptable options, safeguarding accountability of ministry funding, as well as successfully implementing the Family Health Team initiative in a timely manner.