Capital Regional District

625 Fisgard St.,
Victoria, BC V8W 1R7

Notice of Meeting and Meeting Agenda
Capital Regional Hospital District Board

Wednesday, September 9, 2026 | **12:05 PM** | **6th Floor Boardroom, 625 Fisgard Street, Victoria, BC**

The Capital Regional District strives to be a place where inclusion is paramount and all people are treated with dignity. We pledge to make our meetings a place where all feel welcome and respected.

1. TERRITORIAL ACKNOWLEDGEMENT

2. APPROVAL OF THE AGENDA

3. ADOPTION OF MINUTES

3.1. 26-0948 Minutes of the Capital Regional Hospital District Board meeting of July 8, 2026

Recommendation: That the minutes of the Capital Regional Hospital District Board meeting of July 8, 2026 be adopted as circulated.

Attachments: Minutes - July 8, 2026

4. REPORT OF THE CHAIR

5. PRESENTATIONS/DELEGATIONS

The public are welcome to attend CRD meetings in-person.

Delegations will have the option to participate electronically. Please complete the online application at www.crd.ca/address no later than 4:30 pm two days before the meeting and staff will respond with details.

Alternatively, you may email your comments on an agenda item to the CRD Board at crdboard@crd.bc.ca.

6. CONSENT AGENDA

7. ADMINISTRATION REPORTS

7.1. 26-0863 Reserve Strategy for Health Capital, Long-Term Debt and Requisition Stability

Recommendation: There is no recommendation. This report is for information only.

Attachments:
- Staff Report: Reserve Strategy Health Capital-Long-Term Debt Requisition Stab
- Appendix A: Model Assumptions
- Appendix B: Model Outputs-Detailed
- Appendix C: Reserve History Investment Income
- Appendix D: Sovereign Health Fund (Infographic)
- Presentation: Sovereign Health Fund

8. REPORTS OF COMMITTEES

8.1. 26-0608 Capital Regional Hospital District Capital Contribution Funding Model

Recommendation: [At the June 10, 2026 CRD Board meeting, this report was referred to staff to report back on the sovereign health fund (see Item 7.1. Reserve Strategy for Health Capital, Long-Term Debt and Requisition Stability).]
The Hospitals and Housing Committee recommends to the Capital Regional Hospital District Board:
That the Capital Regional Hospital District maintains the current capital contribution funding model as follows:
* Maintain a 30% contribution for major capital projects;
* Maintain a 40% contribution for minor capital projects; and
* Maintain current annual allocations for medical equipment.
(WP - All)

Attachments:
- Staff Report: CRHD Capital Contribution Funding Model
- Appendix A: May 25, 2026 letter from Island Health

9. BYLAWS

10. NOTICE(S) OF MOTION

11. NEW BUSINESS

12. ADJOURNMENT

Votinq Key:
NWA - Non-weighted vote of all Directors
NWP - Non-weighted vote of participants (as listed)
WA - Weighted vote of all Directors
WP - Weighted vote of participants (as listed)

Making a difference...together

Capital Regional District

625 Fisgard St.,
Victoria, BC V8W 1R7

Meeting Minutes

Capital Regional Hospital District Board

Wednesday, July 8, 2026 **12:10 PM** **6th Floor Boardroom**
625 Fisgard Street
Victoria, BC

PRESENT
DIRECTORS: K. Murdoch (Chair), S. Goodmanson (Acting Chair), S. Brice, J. Brownoff, J. Caradonna, C. Coleman, Z. de Vries, B. Desjardins, G. Holman (EP), S. Kim (for M. Alto) (EP), D. Kobayashi, M. Little, C. McNeil-Smith, D. Murdock, S. Riddell (for R. Windsor), M. Tait, D. Thompson, S. Tobias (EP), Alt. M. Wagner, M. Westhaver (for C. Plant) (EP), A. Wickheim, K. Williams

STAFF: T. Robbins, Chief Administrative Officer; N. Chan, Chief Financial Officer/General Manager, Finance and Technology; L. Hardiman, Acting General Manager, Infrastructure and Water Services; G. Harris, Senior Manager, Environmental Protection; S. Henderson, General Manager, Electoral Area Services; K. Lorette, General Manager, Housing, Planning and Protective Services; K. Morley, Corporate Officer/General Manager, Corporate Services; R. Tooke, Acting General Manager, Parks, Recreation and Environmental Services; M. Barnes, Senior Manager, Health & Capital Planning Strategies; D. Elliott, Senior Manager, Regional Housing; C. Neilson, Senior Manager, People, Safety and Culture; M. Lagoa, Deputy Corporate Officer/Senior Manager, Legislative Services; T. Pillipow, Senior Committee Clerk (Recorder)

EP - Electronic Participation

Regrets: Directors M. Alto, P. Brent, P. Jones, C. Plant, R. Windsor

The meeting was called to order at 2:50 pm.

1. TERRITORIAL ACKNOWLEDGEMENT

A Territorial Acknowledgement was provided in the preceding meeting.

2. APPROVAL OF THE AGENDA

MOVED by Director Goodmanson, SECONDED by Director Thompson,
That the agenda for the Capital Regional Hospital District Board meeting of July 8, 2026 be approved.
CARRIED

3. ADOPTION OF MINUTES

3.1. 26-0810 Minutes of the Capital Regional Hospital District Board meeting of June 10, 2026

MOVED by Director Goodmanson, SECONDED by Director Thompson,
That the minutes of the Capital Regional Hospital District Board meeting of June 10, 2026 be adopted as circulated.
CARRIED

4. REPORT OF THE CHAIR

Chair Murdoch noted that staff are accepting requests for expressions of interest around the Oak Bay Lodge site.

5. PRESENTATIONS/DELEGATIONS

There were no presentations or delegations.

6. CONSENT AGENDA

There were no Consent Agenda items.

7. ADMINISTRATION REPORTS

There were no Administration Reports.

8. REPORTS OF COMMITTEES

There were no Reports of Committees.

9. BYLAWS

There were no bylaws for consideration.

10. NOTICE(S) OF MOTION

There were no notice(s) of motion.

11. NEW BUSINESS

There was no new business.

12. MOTION TO CLOSE THE MEETING

12.1. 26-0809 Motion to Close the Meeting

MOVED by Director Goodmanson, SECONDED by Director Thompson,
1. That the meeting be closed for Land Disposition in accordance with Section 90(1)(e) of the Community Charter.
2. That such disclosures could reasonably be expected to harm the interests of the Regional District.
CARRIED

The meeting moved into closed session at 2:51 pm.

13. RISE AND REPORT

The Capital Regional Hospital District Board rose from the closed session at 3:24 pm without report.

14. ADJOURNMENT

MOVED by Director Caradonna, SECONDED by Director Goodmanson,
That the Capital Regional District Board meeting of July 8, 2026 be adjourned at 3:24 pm.
CARRIED

CHAIR

CERTIFIED CORRECT:

CORPORATE OFFICER

Capital Regional Hospital District

REPORT TO CAPITAL REGIONAL HOSPITAL DISTRICT BOARD
MEETING OF WEDNESDAY, SEPTEMBER 09, 2026

SUBJECT **Reserve Strategy for Health Capital, Long-Term Debt and Requisition Stability**

ISSUE SUMMARY

This report provides the Board with an overview of the Capital Regional Hospital District's (CRHD) reserve fund strategy, with a focus on the Debt Management Reserve (DMR), informally referred to as the "Sovereign Health Fund". The modelled scenarios show how the reserve can help fund capital costs, reduce borrowing and moderate requisition pressures.

BACKGROUND

At the June 2026 Hospitals and Housing Committee meeting, staff committed to report on the CRHD's reserves before this Board term ends. As no further committee meetings were scheduled this report is presented directly to the Board.

Health Capital Funding

In consultation with CRHD staff, Island Health identifies regional major capital projects and prepares a ten-year capital plan for approval by the province and the CRHD Board.

The commonly cited 40% local cost share originates in the 1979 *Hospital District Act*, which generally provided a 60% provincial capital grant while the balance was funded by local sources. The provision was repealed in 2003, but hospital districts continue to contribute at rates that vary by region and project.

The CRHD contributes 30% of eligible major project costs in addition to annual funding for minor capital and equipment. Based on the current 2026-2035 ten-year plan, the CRHD's $281 million major-project contribution represents approximately 30% of the $927 million Island Health program. Including annual minor capital and equipment funding of approximately $7 million, CRHD's ten-year Island Health related capital support rises to approximately $349 million, or about 35%. Major-project contributions are funded from reserves and long-term borrowing through the Municipal Finance Authority of British Columbia[1], while minor capital and equipment grants are funded through the annual operating budget and requisition.

Appendix A summarizes the assumptions, project schedule and anticipated annual cash flows of the current 2026-2035 plan. The *Hospital District Act* permits unspent funds to be carried forward, subject to reporting to the minister. Reserve contributions and draws are approved through the annual budget.

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[1] The Municipal Finance Authority advances 99% of each borrowing request and withholds 1% as a Debt Reserve Fund contribution. The contribution is returned with interest when the loan matures. Borrowing amounts in this report are shown on a gross basis, consistent with the amounts authorized.

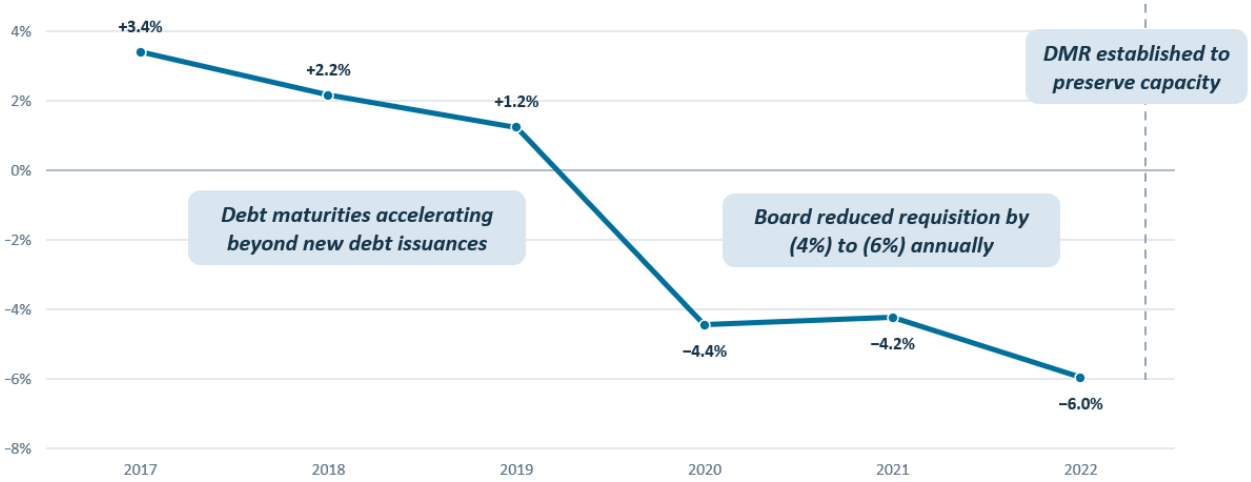
IMPLICATIONS

Financial Implications

Evolution of Requisition and the Debt Management Reserve

From 2017 through 2019, existing debt matured faster than new major capital projects were approved, reducing debt-servicing costs and slowing annual requisition growth from 3.4% to 1.2%. The Board then approved negative requisitions in 2020 (4.4%), 2021 (4.2%) and 2022 (6.0%).

Graph 1: Requisition Capacity Released by Maturing Debt



Although near-term debt costs declined, significant projects remained in the later years of the ten-year capital plan. To preserve this temporary requisition capacity, the DMR, informally called the "Sovereign Health Fund", was established in 2022. As a result, the requisition has remained flat from 2022 through 2026, marking seven consecutive years without an increase (2020-2026).

This approach leverages investment income created by the DMR and flattens the U-shaped requisition curve identified in 2019. Slower-than-planned capital delivery has also deferred borrowing and debt costs compounding the benefits of the DMR.

Why the "Sovereign Health Fund" Analogy is Used

Sovereign wealth funds retain and invest public capital to generate financial returns that support long-term public purposes and future generations. Norway's Government Pension Fund is a well-known example. Canada introduced the Canada Strong Fund in 2026. The CRHD analogy is narrower because the DMR may be used only for CRHD purposes. The shared principle is to preserve financial capacity, earn returns and deploy funds deliberately over time.

Current Reserve Position and Ten-Year Strategy

The 2026 budget includes a $11.6 million transfer to the DMR. Table 1 summarizes the projected 2035 balances of CRHD reserves funds based on the current approved plans.

Table 1: CRHD Reserve Purposes and Year-End Balances ($ million)

Reserve	Purpose	2026	2035
Debt Management	Manage debt servicing and capital funding costs	$33.1	$23.8
All Other Reserves	Studies, grants, minor capital, CRHD properties	$11.4	$10.1
Total Reserves		**$44.5**	**$33.9**

The 2035 DMR balance reflects the continuation of the 2026 final budget – an adopted path of ~3.2% requisition growth. 2035 balances are forecasted based on assumptions detailed in the appendices.

The strategy follows an accumulate-invest-deploy cycle rather than indefinite reserve growth. Subject to annual Board approval, the DMR will fund capital costs, reduce or defer borrowing and moderate future requisition pressures.

To test the strategy's durability, staff modelled the DMR from 2026 to 2035 under three requisition-growth scenarios: continuation of the approved 2026–2030 projection, extended through 2035 at approximately +3.2% annually referred to as the Adopted Path, a Consumer Price Index focused path of +2.0% annually and an affordability focused path of +0.0% annually. These paths are scenarios, not approved future budgets.

Island Health has historically delivered less capital over a longer period than forecast in its ten-year plans. Each scenario still assumes full delivery of the current ten-year plan of which $281 million is CRHD's contribution through 2025. If historical delivery patterns continue, borrowing would be lower and the 2035 reserve balance higher. The table below summarizes results.

Table 2: Debt Management Reserve Modelled Scenarios, 2026 to 2035 ($ million)

	Adopted Path +3.2% annual requisition	CPI-focused +2.0% annual requisition	Affordability-focused +0.0% annual requisition
Transfers to reserve, 2026–2035	**$87.8M**	**$69.6M**	**$41.1M**
Investment income	**$9.4M**	**$8.5M**	**$7.0M**
Closing reserve (2035)	**$23.8M**	**$13.9M**	**$2.1M**
Debt Management Reserve Capital	$100.4M	$91.2M	$73.2M
MFA Long-Term Debt	$181.0M	$190.2M	$208.3M
Net Capital funded	**$281.4M**	**$281.4M**	**$281.4M**
Annual debt service (2035)	**$23.8M**	**$24.6M**	**$26.1M**

In every scenario, the $281 million CRHD commitment is funded without exhausting the reserve, leaving balances between $2.1 million to $23.8 million at year-end. Assumptions are in Appendix A and detailed results in Appendix B.

Compounding Investment Returns

Budget capacity released by declining debt costs is invested in the DMR, reducing the long-term net cost of capital contributions. Investment performance is reported annually in the second quarter to the Board. The reserve earned $1.9 million from 2022 to 2025 and is projected to earn another $7.0 to $9.4 million through 2035 or a total of $8.9 to 11.3 million over the current ten-year plan.

CONCLUSION

The DMR strategy uses temporary capacity from maturing debt to support future health capital, reduce borrowing and moderate requisition pressure. Since 2020, the requisition has been reduced or held flat while reserve transfers have preserved capacity for the CRHD's ten-year capital commitments.

The modelling shows that, under full-delivery assumptions, the CRHD can fund its $281 million major-project share through 2035 without exhausting the reserve or significantly increasing the requisition. The strategy provides meaningful financial flexibility, but it does not eliminate future funding pressure and should be reviewed annually as project schedules, interest rates, operating costs and reserve balances change.

RECOMMENDATION

There is no recommendation. This report is for information only.

Submitted by:	Nelson Chan, MBA, FCPA, FCMA, Chief Financial Officer & General Manager, Finance & Technology
Concurrence:	Ted Robbins, B. Sc., C. Tech., Chief Administrative Officer

ATTACHMENTS

Appendix A: Model Assumptions
Appendix B: Model Outputs - detailed
Appendix C: Reserve Histories and Investment Income
Appendix D: How the CRHD 'Sovereign Health Fund' Works (Infographic)
Presentation: Sovereign Health Fund

Capital Regional Hospital District

APPENDIX A

Model Assumptions

Purpose

This appendix summarizes the assumptions used to model how the Debt Management Reserve (DMR) could support major capital costs from 2026 to 2035 under different requisition-growth and capital-delivery scenarios. The model is a planning tool, not an approved budget.

Key Assumptions

Assumption	Treatment in the Model
Model Period	2026–2035; no results beyond 2035
Opening Debt Management Reserve Balance	$27.1 million at January 1, 2026, based on the final 2026 Capital Regional Hospital District (CRHD) budget
Investment Return	3.0% annually on the average annual reserve balance
Requisition-Growth Paths	Adopted path (approximately 3.2%), CPI-focused path (2%) and affordability-focused path (0%)
Capital Delivery	100%, 75%, 50% or 30% of the ten-year major-project schedule. Undelivered amounts are removed, not deferred
Budgeted DMR draws (2026–2030)	$52.0 million: $7.0 million in 2026, $5.0 million in 2027, $10.0 million in 2028 and 2029, and $20.0 million in 2030 - draws cannot exceed capital delivered
Modelled DMR Draws (2031–2035)	50% of the balance above a $5.0 million minimum, limited to capital delivered. This is a modelling assumption, not Board policy
Existing Debt Payments	Current Municipal Finance Authority (MFA) schedule of CRHD debt-servicing costs
New Borrowing Basis	15-year MFA-style borrowing at a 5.55% re-lending rate, comprising a 4.80% base rate and 0.75% spread, with a 3.40% actuarial rate and 1% Debt Reserve Fund contribution
MFA Debt Reserve Fund Treatment	Borrowing is shown gross before MFA withholds the 1% contribution. Its return with interest at maturity is excluded from the model. MFA also requires a demand note as part of the Debt Reserve Fund. It is a contingent liability rather than a cash cost and is not modelled.
Operating Cost Basis	Approved future budget projections for 2026–2030; 3.2% annual growth for 2031–2035
Model Checks	All sixteen arithmetic and structural checks passed in the V7.1 model dated August 16, 2026

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Annual Model Inputs and Mechanics

Annual Inputs

Table A1: Full-Delivery Model Inputs, 2026–2035 ($ millions)

Year	CRHD Major-Project Capital (100% delivery)	Budgeted DMR Draws	Existing Debt Payments	Other Net Operating Costs
2026	$27.9	$7.0	$11.6	$2.8
2027	$45.0	$5.0	$10.3	$2.6
2028	$43.3	$10.0	$8.1	$2.8
2029	$28.9	$10.0	$6.8	$2.9
2030	$44.9	$20.0	$6.1	$3.0
2031	$44.0	$0.0	$5.6	$3.1
2032	$13.3	$0.0	$4.6	$3.2
2033	$9.6	$0.0	$4.6	$3.3
2034	$18.4	$0.0	$4.5	$3.4
2035	$6.1	$0.0	$4.1	$3.5
Total / average	**$281.4**	**$52.0**	**$66.3**	**$30.5**

Other net operating costs are non-debt costs after deducting non-requisition revenue. Totals may not sum due to rounding.

Requisition-Growth Paths

Table A2: Requisition-Growth Paths ($ millions)

Path	2026	2030	2035	How to Read it
Continued Adopted Path (3.2%)	$26.5	$30.0	$35.2	Approved projection to 2030; 3.2% annual growth thereafter
CPI-Focused Path (2.0%)	$26.5	$28.7	$31.6	2.0% annual growth beginning in 2027
Affordability-Focused Path (0.0%)	$26.5	$26.5	$26.5	Held at the 2026 level through 2035

These are planning scenarios, not approved future budgets.

How the Model Works

- Net DMR transfers equal requisition revenue less debt servicing and other net operating costs
- Capital spending follows the CRHD profile at the tested delivery rate
- DMR draws are applied before borrowing under the 2026–2030 schedule and 2031–2035 rule
- New borrowing funds the balance and includes MFA's 1% Debt Reserve Fund contribution - investment income is based on the average annual reserve balance.

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Model Limits

- The scenarios do not set future requisition levels
- Undelivered capital is not carried beyond 2035; project delays may increase future funding needs
- The model excludes post-2035 debt changes, future MFA rate resets and the return of Debt Reserve Fund contributions at maturity
- For 2031–2035, the model assumes 50% of the reserve balance above $5.0 million may fund capital each year - this is a modelling assumption, not Board policy, and may change under a formal reserve policy.

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APPENDIX B

Model Outputs - Detailed

Purpose

This appendix shows how the Debt Management Reserve (DMR) balance, borrowing and debt service vary under different requisition-growth and capital-delivery assumptions. Amounts are in millions and may not sum due to rounding.

Reading the Results

- **Full delivery:** The full $281.4 million Capital Regional Hospital District (CRHD) major-project share is delivered from 2026 to 2035
- **Reduced delivery:** The 75%, 50% and 30% scenarios remove undelivered capital rather than defer it beyond 2035
- **Debt service avoided:** Savings through 2035 compared with borrowing for all delivered capital

Table B1: Full-Delivery Outcomes, 2026-2035 ($ million)

Measure	Continuation of Adopted Path (~3.2%)	Consumer Price Index Focused Path (2%)	Affordability-Focused Path (0%)
Opening Balance, 2026	$27.1	$27.1	$27.1
Net Operating Transfers	$87.8	$69.6	$41.1
Investment Income	$9.4	$8.5	$7.0
Reserve Funding of Capital	($100.4)	($91.2)	($73.2)
Closing Balance, 2035	$23.8	$13.9	$2.1
Annual Debt-Servicing Cost in 2035	$23.8	$24.6	$26.1
New Borrowing, Gross	$182.8	$192.1	$210.4
Debt Service Avoided Through 2035	$48.8	$46.8	$43.5

All scenarios assume full delivery of the $281.4 million CRHD share. Reserve funding is shown in parentheses.

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Table B2: Detailed Twelve-Scenario Summary ($ million)

Requisition-Growth Path	Capital Delivery Rate	Capital Delivered	DMR Reserve Funding	New Borrowing, Gross	DMR Investment Income	Debt Service Avoided	2035 DMR Reserve Balance
Continuation of Adopted Path (~3.2%)	100%	$281.4	$100.4	$182.8	$9.4	$48.8	$23.8
Continuation of Adopted Path (~3.2%)	75%	$211.1	$106.8	$105.3	$13.3	$50.9	$66.0
Continuation of Adopted Path (~3.2%)	50%	$140.7	$97.7	$43.4	$18.2	$50.0	$121.7
Continuation of Adopted Path (~3.2%)	30%	$84.4	$71.6	$13.0	$24.5	$40.1	$178.3
Consumer Price Index (CPI) Focused Path (2%)	100%	$281.4	$91.2	$192.1	$8.5	$46.8	$13.9
CPI-Focused Path (2%)	75%	$211.1	$105.2	$106.9	$11.9	$50.2	$49.4
CPI Focused Path (2%)	50%	$140.7	$97.7	$43.4	$16.7	$50.0	$104.0
CPI-Focused Path (2%)	30%	$84.4	$71.6	$13.0	$23.0	$40.1	$160.6
Affordability-Focused Path (0%)	100%	$281.4	$73.2	$210.4	$7.0	$43.5	$2.1
Affordability-Focused Path (0%)	75%	$211.1	$99.5	$112.7	$9.9	$48.7	$26.3
Affordability-Focused Path (0%)	50%	$140.7	$95.7	$45.5	$14.4	$49.1	$77.7
Affordability-Focused Path (0%)	30%	$84.4	$71.6	$13.0	$20.5	$40.1	$132.9

Capital delivered, reserve funding, borrowing, investment income and debt-service savings are cumulative for 2026–2035. All scenarios fund delivered capital in full, with no unfunded requirement.

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Scenario Comparison Tables

These tables compare the model's main drivers: requisition growth and capital delivery. Delivery has the greater effect because undelivered capital is removed, not deferred beyond 2035. Lower delivery therefore increases reserve balances and reduces borrowing.

Table B3: 2035 Debt Management Reserve Balance ($ million)

Capital Delivery	Continuation of Adopted Path (~3.2%)	CPI-Focused Path (2%)	Affordability-Focused Path (0%)
100% Delivery	$23.8	$13.9	$2.1
75% Delivery	$66.0	$49.4	$26.3
50% Delivery	$121.7	$104.0	$77.7
30% Delivery	$178.3	$160.6	$132.9

Table B4: New Long-Term Borrowing, 2026–2035 ($ million)

Capital Delivery	Continuation of adopted path (~3.2%)	CPI-focused path (2%)	Affordability-focused path (0%)
100% Delivery	$182.8	$192.1	$210.4
75% Delivery	$105.3	$106.9	$112.7
50% Delivery	$43.4	$43.4	$45.5
30% Delivery	$13.0	$13.0	$13.0

Borrowing is shown gross of Municipal Finance Authority's (MFA) 1% Debt Reserve Fund contribution; MFA advances 99%.

Table B5: DMR Investment Income, 2026–2035 ($ million)

Capital delivery	Continuation of Adopted Path (~3.2%)	CPI-Focused Path (2%)	Affordability-Focused Path (0%)
100% Delivery	$9.4	$8.5	$7.0
75% Delivery	$13.3	$11.9	$9.9
50% Delivery	$18.2	$16.7	$14.4
30% Delivery	$24.5	$23.0	$20.5

Lower delivery leaves funds invested longer, increasing income; it does not represent a better capital-delivery outcome.

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Sensitivity Testing

Table B6 shows the 2035 DMR balance under full delivery when one assumption changes; all others remain at base.

Table B6: 2035 DMR Balance - Full-Delivery Sensitivity Analysis ($ million)

Assumption tested	Continuation of Adopted Path (~3.2%)	CPI-Focused Path (2%)	Affordability-Focused Path (0%)
Investment Return: 1.5%	$21.7	$12.7	$0.7
Investment Return: 2.0%	$22.4	$13.1	$1.2
Base Assumptions: 3.0% Investment Return, 50% Deployment; $5.0 Million Minimum Balance	$23.8	$13.9	$2.1
Investment Return: 4.0%	$25.4	$14.8	$2.8
Investment Return: 4.5%	$26.4	$15.3	$3.1
Investment Return: 5.0%	$27.4	$15.8	$3.5
Investment Return: 5.5%	$28.4	$16.4	$3.9
Investment Return: 6.0%	$29.6	$17.3	$4.3
DMR Deployment Rate: 20%	$37.6	$25.2	$6.5
DMR Deployment Rate: 60%	$21.7	$12.4	$1.5
DMR Deployment Rate: 100%	$17.5	$9.6	$1.3
Minimum Working Balance: $10.0 Million	$27.6	$18.1	$5.8
Higher Operating-Cost Case[1]	$14.2	$6.4	Exhausted

The deployment rate is the share of the DMR above the minimum balance available for annual capital funding. The DMR remains positive under all sensitivities in the continuation and CPI focused paths.

[1] *Under the affordability-focused path with higher operating costs, it is exhausted in 2034, creating a cumulative $9.9 million funding shortfall by 2035. This is a stress test, not a forecast.*

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APPENDIX C

Reserve Histories and Investment Income

Purpose

This appendix summarizes Capital Regional Hospital District (CRHD) reserve histories and uses, explains the allocation of investment income and presents historical and projected interest income for operations and interest-bearing reserves.

Basis of Preparation

Sources include audited financial statements; approved budgets and reserve schedules, including the final 2026 budget; interest-income records from 2002 to 2025; the December 2020 reserve accounts memorandum; information from the CRHD Budget Officer; and the Debt Management Reserve (DMR) model.

Reserve Purposes, History and Treatment

Table C1: Reserve Purposes, History and Operating Treatment

Reserve	Primary Purpose	History and Treatment
Debt Management Reserve	Manage future debt-servicing and capital-funding costs	Available records indicate it was introduced in the 2022 budget and first appeared in the 2023–2027 reserve schedule. It receives operating transfers, year-end surpluses, unspent minor-capital balances after the applicable claim period and investment income. No separate establishing bylaw was found.
Administration and Feasibility Studies Reserve	Fund future studies and other eligible initiatives	In use by December 31, 2020; the establishment year is unknown. Historically funded from unspent budget provisions. It does not receive investment income.
Non-Traditional Projects Reserve	Fund capital grants to eligible non-profit health-care facilities	Established in 2007, with a Board-approved policy adopted in 2012. In 2015, the Board placed the program on hold through 2025. Contributions stopped after funding a $1.0 million hospice commitment, and none are included in the 2026–2030 reserve schedule. It does not receive investment income.
Minor Capital Projects Reserve	Fund annual minor-capital grants to Island Health	Receives approximately $3.75 million annually from operations. Funds are generally available for eligible claims for five years, after which remaining amounts are transferred to the DMR. It does not receive investment income.

Reserve	Primary Purpose	History and Treatment
Land Holdings Management Reserve	Fund the management of CRHD properties	Established in 2018 and separate from the former Land Development Reserve. Transfers fund eligible property-management costs and are adjusted to actual expenditures. It receives investment income.
Summit Management Reserve	Fund lifecycle capital for The Summit	Established in 2020. The final 2026 budget includes an annual lifecycle contribution of $0.26 million. Funds are used for approved lifecycle capital, and the reserve receives investment income.
Regional Housing First Program Reserve — closed	Supported Regional Housing First Program activities	Established in 2019 and closed in 2024 after completion of the Mount Tolmie project. The remaining balance was transferred to the DMR.

Approved Reserve Schedule

Table C2 presents actual 2025 year-end reserve balances, approved 2026–2030 financial plan balances and forecast balances for 2031–2035. Amounts are in millions and may not sum due to rounding.

Table C2: Year-End Reserve Balances — Actual, Approved Financial Plan and Forecast, 2025–2035 ($ millions)

Reserve	2025 Actual	2026	2027	2028	2029	2030	2031F	2032F	2033F	2034F	2035F
Administration and Feasibility Studies	$2.0	$1.6	$1.1	$0.8	$0.5	$0.2	$0.0	$0.0	$0.0	$0.0	$0.0
Non-Traditional Projects	$1.1	$1.1	$1.1	$1.1	$1.1	$1.1	$1.1	$1.1	$1.1	$1.1	$1.1
Minor Capital Projects	$4.4	$4.7	$4.4	$3.3	$3.1	$3.1	$3.1	$3.1	$3.1	$3.1	$3.1
Land Holdings Management	$2.1	$2.0	$2.1	$2.1	$2.2	$2.2	$2.3	$2.4	$2.5	$2.5	$2.6
Summit Management	$1.9	$2.1	$2.2	$2.4	$2.5	$2.6	$2.8	$2.9	$3.1	$3.2	$3.4
Debt Management	$27.1	$33.1	$39.8	$40.5	$39.9	$28.2	$27.3	$22.9	$21.2	$21.4	$23.8
Total Reserves	**$38.5**	**$44.5**	**$50.7**	**$50.1**	**$49.2**	**$37.4**	**$36.5**	**$32.3**	**$30.9**	**$31.2**	**$34.0**

2025 is actual; 2026–2030 balances are from the approved financial plan; 2031–2035 are forecast on the continuation of the adopted path (~3.2%). The approved financial plan balances are separate from the scenario model. The DMR rises from $27.1 million in 2025 to a peak of $40.5 million in 2028, then declines to $23.8 million by 2035 as capital draws increase.

Debt Management Reserve Activity

Table C3: Debt Management Reserve Activity — Actual and Forecast, 2022–2035($ millions)

Activity	2022	2023	2024	2025	2026F	2027F	2028F	2029F	2030F	2031F	2032F	2033F	2034F	2035F
Opening Balance	$0.0	$3.4	$7.2	$15.5	$27.1	$33.1	$41.1	$43.0	$43.4	$33.2	$27.3	$22.9	$21.2	$21.4
Transfers From Operations	$2.8	$3.3	$6.6	$9.8	$12.1	$11.9	$10.6	$9.1	$8.6	$7.3	$6.0	$6.6	$7.6	$7.9
Transfers from Operating Surplus	$0.5	$0.2	$0.9	$1.4	—	—	—	—	—	—	—	—	—	—
Transfer from Regional Housing First Program Reserve	$0.0	$0.0	$2.2	$0.0	—	—	—	—	—	—	—	—	—	—
Investment Income	$0.0	$0.3	$0.6	$0.9	$0.9	$1.1	$1.3	$1.3	$1.1	$0.9	$0.8	$0.7	$0.6	$0.7
Transfers to Fund Capital	$0.0	$0.0	($2.0)	($0.5)	($7.0)	($5.0)	($10.0)	($10.0)	($20.0)	($14.1)	($11.2)	($8.9)	($8.1)	($6.1)
Closing Balance	**$3.4**	**$7.2**	**$15.5**	**$27.1**	**$33.1**	**$41.1**	**$43.0**	**$43.4**	**$33.2**	**$27.3**	**$22.9**	**$21.2**	**$21.4**	**$23.8**

2022–2025 are actual; 2026–2035 are forecast on the continuation of the adopted path (~3.2%) at full capital delivery. The 2025 closing balance of $27.1 million forms the model's opening balance at January 1, 2026. Because this table presents scenario model output, the 2026–2035 balances differ from those shown in Table C2, which presents the approved financial plan for 2026–2030; the difference is expected and reflects the two different presentation methods. On this model basis the balance peaks at $43.4 million in 2029; the approved financial plan basis in Table C2 peaks at $40.5 million in 2028. The modelled 2026 net operating transfer of $12.1 million differs from the approved $11.55 million budget transfer because the model calculates the transfer as requisition less debt service and other net operating costs. Amounts may not sum due to rounding.

Investment Income Allocation

CRHD investment income is recorded in operations and allocated at year-end between operations and the interest-bearing reserves:

- Debt Management,
- Land Holdings Management and
- Summit Management.

Allocation is primarily based on relative average monthly balances, capturing changes during the year, including the August requisition. Adjustments may reflect reserve-specific needs.

The former Regional Housing First Program Reserve received investment income until it closed in 2024. No income is allocated to the Administration and Feasibility Studies, Non-Traditional Projects or Minor Capital Projects reserves.

Historical Investment Income

Table C4 shows CRHD interest income by fund and reserve from 2002 to 2025. The 2002–2016 period is subtotaled, with annual results from 2017 onward. Amounts are in millions to two decimal places.

Table C4: Historical CRHD Interest Income, 2002–2025 ($ millions)

Year / Period	Operating Fund	DMR	Land Holdings	Summit	Former Reserves	Total CRHD Interest Income
2002-2016 Subtotal	$2.13	—	—	—	—	$2.13
2017	$1.10	—	—	—	—	$1.10
2018	$1.28	—	—	—	$0.12	$1.40
2019	$0.97	—	—	—	$0.15	$1.11
2020	$0.19	—	$0.01	$0.00	$0.11	$0.31
2021	$0.09	—	$0.01	$0.00	$0.11	$0.22
2022	$0.30	$0.04	$0.05	$0.02	$0.31	$0.73
2023	$0.23	$0.31	$0.13	$0.08	$0.94	$1.69
2024	$0.30	$0.59	$0.14	$0.12	$0.85	$2.00
2025	$0.25	$0.94	$0.12	$0.11	—	$1.42
Cumulative	**$6.85**	**$1.87**	**$0.45**	**$0.34**	**$2.60**	**$12.11**

2002–2016 is presented as a cumulative subtotal; 2017–2025 are annual actuals. Former reserves comprise the closed Land Development and Regional Housing First Program reserves. Total CRHD interest income includes income earned on operating cash and term investments and is not directly comparable with annual investment performance reports. DMR interest income corresponds to Table C3. Amounts may not sum due to rounding.

Projected Investment Income

Table C5 shows projected income for the current interest-bearing reserves. The 2026–2030 amounts are from the approved reserve schedule. Values marked “F” are DMR forecasts under the continuation of the adopted path (~3.2%) and full capital delivery. Amounts are in millions to two decimal places.

Table C5: Investment Income — Approved Financial Plan and Forecast, 2026–2035 ($ millions)

Year	DMR	Land Holdings	Summit	Total
2026	$1.43	$0.10	$0.10	$1.63
2027	$1.47	$0.08	$0.09	$1.64
2028	$1.34	$0.07	$0.08	$1.49
2029	$1.10	$0.06	$0.07	$1.23
2030	$0.75	$0.05	$0.06	$0.86
2031F	$0.91	—	—	$0.91
2032F	$0.75	—	—	$0.75
2033F	$0.66	—	—	$0.66
2034F	$0.64	—	—	$0.64
2035F	$0.68	—	—	$0.68
2026–2030 total	**$6.10**	**$0.36**	**$0.38**	**$6.84**
2031–2035 total (F)	**$3.64**	**—**	**—**	**$3.64**
Total, 2026–2035	**$9.74**	**$0.36**	**$0.38**	**$10.48**

2026–2030 amounts are from the approved financial plan. F = forecast; 2031–2035 DMR amounts are modelled under the continuation of the adopted path (~3.2%) and full capital delivery. Land Holdings and Summit investment income is not modelled beyond 2030; accordingly, 2031–2035 totals comprise DMR investment income only. Modelled DMR investment income is lower in total over 2026–2030 than the approved financial plan amounts, as shown in Table C3. Amounts may not sum due to rounding.

Investment Income Outlook

The approved plan projects $6.1 million of DMR investment income and $6.8 million across all three interest-bearing reserves from 2026 to 2030. The model projects a further $3.6 million of DMR income from 2031 to 2035.

Requisition and Cost per Average Household

Tables C6 and C7 express the CRHD requisition using a fixed measure: total requisition divided by 197,950 average households. The divisor is derived from the final 2026 budget, which reports a $26,471,813 requisition and a $133.73 cost per average residence based on an average 2026 residential assessment of $1,093,984. Holding it constant isolates requisition changes from assessment changes, and the 2017–2025 history has been rebased on this March 2026 factor so that every year is stated on one basis. This measure covers only the CRHD requisition and is not a property tax bill.

Table C6: Requisition and Cost per Average Household by Scenario, 2026–2035 ($ millions, except $/household)

Year	Continuation Of Adopted Path (~3.2%) Requisition ($M)	$ Per Household	CPI-Focused 2% Requisition ($M)	$ Per Household	Affordability 0% Requisition ($M)	$ Per Household
2026	$26.5	$134	$26.5	$134	$26.5	$134
2027	$27.1	$137	$27.0	$136	$26.5	$134
2028	$28.2	$142	$27.5	$139	$26.5	$134
2029	$29.1	$147	$28.1	$142	$26.5	$134
2030	$30.0	$152	$28.7	$145	$26.5	$134
2031	$31.0	$157	$29.2	$148	$26.5	$134
2032	$32.0	$162	$29.8	$151	$26.5	$134
2033	$33.0	$167	$30.4	$154	$26.5	$134
2034	$34.1	$172	$31.0	$157	$26.5	$134
2035	$35.2	$178	$31.6	$160	$26.5	$134

2026 reflects the approved financial plan; 2027–2035 are planning scenarios, not approved budgets. All scenarios assume full delivery of the $281.4 million CRHD capital share. The 0% affordability path holds the requisition at $26.5 million. Cost per average household equals requisition divided by the fixed 197,950-household measure.

Longer-Term Cost per Average Household

Table C7 and Figure C1 place the current requisition outlook in historical context and compare it with the earlier capital plan outlooks. After annual growth from 2017 to 2019, household cost peaked at $155 in 2019. Board-approved requisition reductions of 4.4%, 4.2% and 6.0% lowered it to $134 by 2022, when the DMR was established. The requisition then remained flat through 2026.

The cost rises from 2027 as capital delivery and borrowing resume, creating a U-shaped path. The 2023 capital-plan comparator peaked at $260 in 2032. The current path is substantially lower, reflecting in part the reduction in the CRHD share of the ten-year plan from $537 million to $349 million.

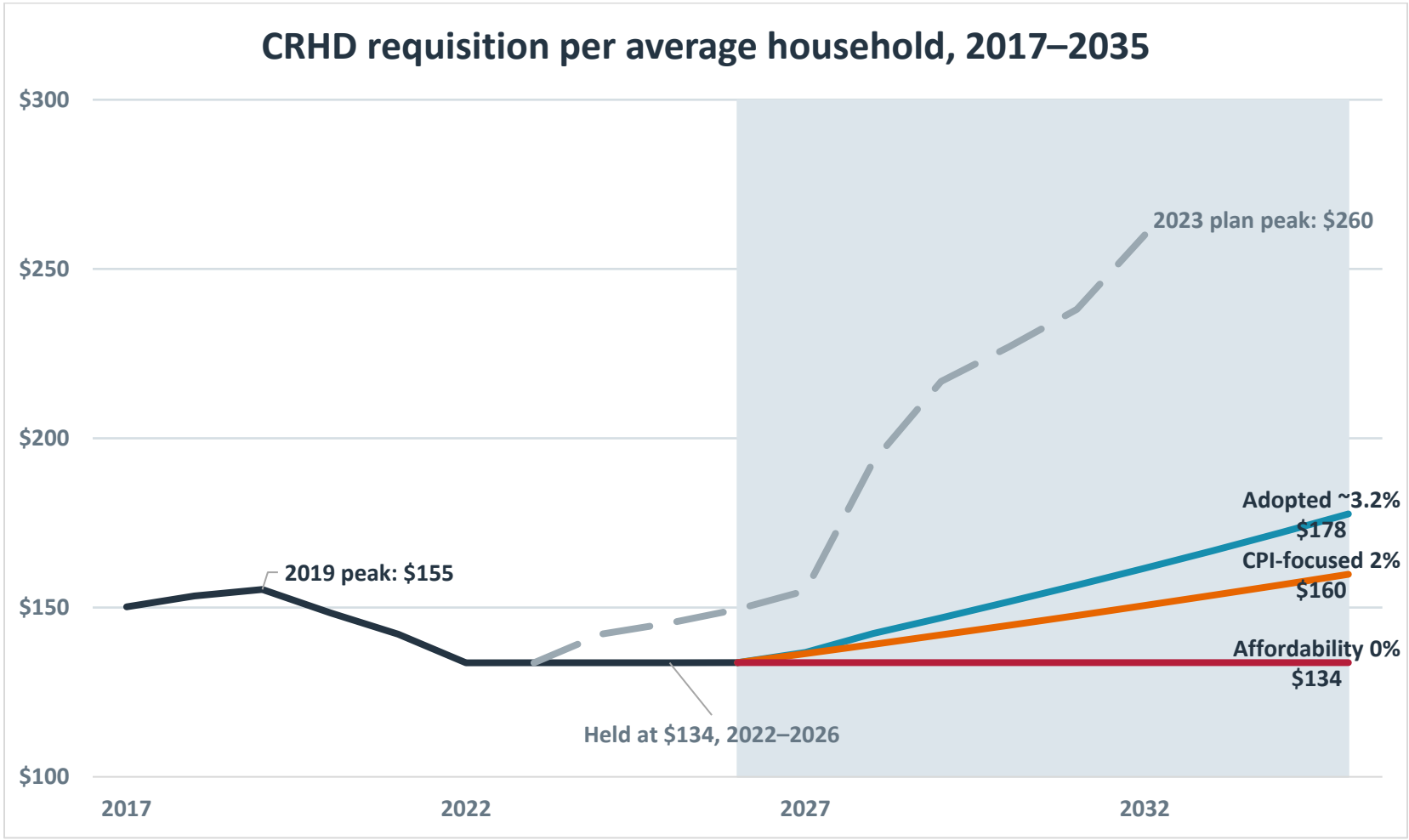
Table C7: Cost per Average Household — Historical, Approved Plan and Forecast, 2017–2035

Year	CRHD Requisition ($ Millions)	Cost Per Average Household ($)	2023 Capital Plan (Projection From 2023 As Published) ($)	2017 Capital Plan (Projection From 2017) ($)	Note
2017	$29.7	$150	—	$168	Requisition growth 3.4%
2018	$30.3	$153	—	$171	Requisition growth 2.2%
2019	$30.7	$155	—	$178	Requisition growth 1.2% — highest point of the historical record
2020	$29.3	$148	—	$174	Board-approved requisition decrease (4.4%)
2021	$28.1	$142	—	$170	Board-approved requisition decrease (4.2%)
2022	$26.5	$134	—	$163	Board-approved requisition decrease (6.0%); cost per average household reaches its lowest point of the record; DMR established
2023	$26.5	$134	$140	$149	Requisition held flat
2024	$26.5	$134	$142	$132	Requisition held flat
2025	$26.5	$134	$145	$123	Requisition held flat — fourth consecutive year

Year	CRHD Requisition ($ Millions)	Cost Per Average Household ($)	2023 Capital Plan (Projection From 2023 As Published) ($)	2017 Capital Plan (Projection From 2017) ($)	Note
2026	$26.5	$134	$149	$126	Requisition flat, fifth consecutive year
2027F	$27.1	$137	$155	$122	
2028F	$28.2	$142	$193	$116	
2029F	$29.1	$147	$217	$113	
2030F	$30.0	$152	$227	$111	
2031F	$31.0	$157	$238	$85	
2032F	$32.0	$162	$260	$84	Highest point of the 2023 capital plan comparator
2033F	$33.0	$167		$84	
2034F	$34.1	$172		$76	
2035F	$35.2	$178		$76	

2017–2025 requisitions are actual; 2026 reflects the approved financial plan; 2027–2035 are modelled under the 3.2% requisition path at full capital delivery. Cost per average household uses the fixed divisor of 197,950; the 2017–2025 history is rebased on the March 2026 assessment factor. The 2023 capital plan comparator uses the debt-servicing requisition and the average 2022 residential assessment of $999,766 and is shown for historical comparison only. The 2017 capital plan comparator is reproduced from the applicable historical capital plan and is not directly comparable with the current fixed-household methodology. The 2023 capital plan column is shown as published; Figure C1 presents this data from 2024 onward for illustrative purposes, with the 2023 point rebased so the series join.

Figure C1: CRHD Cost per Average Household, 2017–2035



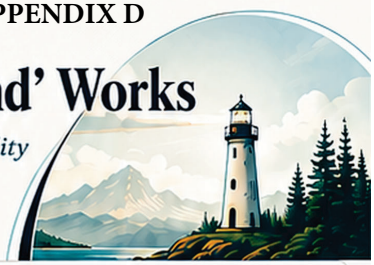
Actual through 2025; modelled 2026–2035 at full capital delivery. The dashed grey line shows the published 2023 capital plan for comparison only. Its values are shown as published from 2024 onward; the 2023 data point is rebased to the March 2026 factor so that the two series join.

Capital Regional Hospital District (CRHD) | Editorial explainer

How the CRHD 'Sovereign Health Fund' Works

Reserve strategy for health capital, long-term debt, and requisition stability

A plain-English view of how temporary debt-service relief is preserved, invested, and redeployed to fund future hospital capital without sharp tax-requisition spikes.



THE STRATEGIC ARC

Three phases to transform the financial landscape into lasting resilience

PHASE 1
BUILD THE FOUNDATION
2016–2022
- Debt maturities
- Requisition reductions
- Summit lease revenue

CURRENT BOARD DISCUSSION

PHASE 2
PRESERVE & COMPOUND
2022–2035
- DMR accumulation
- Leveraging investment income
- Capital deployment

PHASE 3
CREATE PERMANENT CAPACITY
Post–2035
- Summit timing window
- Residual reserve capital
- Income-funded liabilities

TEMPORARY CAPACITY → PERMANENT CAPACITY

WHY THIS MATTERS

$927M
Island Health 2026–2035 major capital program.

$281M
CRHD major-project contribution, about 30% of the total program.

$349M
Total 10-year CRHD support including minor capital and equipment, about 35% of the full health-capital support.

7 years
No requisition increases since 2020.

THE CORE IDEA: HOW THE DMR WORKS

A. Debt matures → Debt-servicing costs fall.

B. Capacity is preserved → Instead of being spent, the capacity is preserved through the DMR.

C. Funds are invested → Investment income compounds over time.

D. Capital is deployed → Reserve dollars reduce or defer borrowing.

E. Requisition is smoother → Less volatility. More predictable tax-requisition path.

WHAT HAPPENED TO THE REQUISITION?

Requisition capacity released by maturing debt

INSIGHT: Near-term debt costs fell first; the reserve was created so that this temporary room could support future capital commitments.

RESERVE POSITION

Debt Management Reserve (DMR)

The strategy is accumulate → invest → deploy, not permanent reserve hoarding.

SCENARIO COMPARISON — 2035 OUTCOMES

	Adopted Path +3.2% annual requisition	CPI-focused +2.0% annual requisition	Affordability-focused +0.0% annual requisition
Transfers to reserve (2026–2035)	$87.8M	$69.6M	$41.1M
Investment income	$9.4M	$8.5M	$7.0M
Closing reserve (2035)	**$23.8M**	**$13.9M**	**$2.1M**
DMR capital contribution	$100.4M	$91.2M	$73.2M
MFA long-term debt	$181.0M	$190.2M	$208.3M
Annual debt service (2035)	$23.8M	$24.6M	$26.1M

In every scenario, the full* $218M capital commitment is funded without exhausting the reserve.

BOTTOM LINE: CRHD is using the DMR to turn temporary debt-service relief into long-term hospital capital capacity — lowering borrowing needs, earning investment income, and smoothing requisition pressure.

- Scenarios are modelling exercises, not approved future budgets.
- Annual review remains necessary as project timing, interest rates, and reserve balances change.

Primary source: CRHD Board report, "Reserve Strategy for Health Capital, Long-Term Debt and Requisition Stability," Sept. 9, 2026.

CAPITAL REGIONAL HOSPITAL DISTRICT BOARD
SEPTEMBER 9, 2026

Reserve Strategy for Health Capital, Long-Term Debt, and Requisition Stability

How the Debt Management Reserve, aka the “Sovereign Health Fund”, helps fund $281M of health capital, reduces borrowing and supports requisition stability

THE STRATEGIC ARC

Three phases to transform the financial landscape into lasting resilience

Key Message: through the Board's leadership and innovation, we are part way through a long journey to sustainable funding

A sovereign wealth fund saves today's capacity and invests it for tomorrow - the same idea, at CRHD scale

A pooled fund whose returns flow outward for public purposes

- **Norway** Government Pension Fund
- **Canada** Canada Strong Fund
- **CRHD** Debt Management Reserve

1 Capacity

Revenue not needed for this year's costs is set aside rather than spent

2 Pooling

Amounts are held together in one fund, not scattered across budgets

3 Investment return

The pooled balance is invested, so it earns income while it waits

4 Purposeful spending

Fund and earnings are deployed to long-term public purposes

Where CRHD's fund is narrower

- Used only for CRHD purposes; approved purpose and permitted uses are unchanged
- "Sovereign Health Fund" is an informal analogy, not a formal designation

Key Message: referring to the "sovereign *health* fund" serves as a way to explain the concept only, it does not alter governance. The Debt Management Reserve (DMR) approved purpose and permitted uses stay as they are, consistent and aligned with legislation.

RESERVE STRATEGY

The strategy is a deliberate accumulate–invest–deploy cycle, not indefinite reserve growth

01

Accumulate

Budget capacity released by maturing debt is transferred to the Debt Management Reserve instead of funding further requisition reductions.

02

Invest

Balances earn investment income at a modelled 3.0% return, lowering the long-term net cost of CRHD's capital contributions.

03

Deploy

Subject to annual Board approval, the reserve funds capital costs, reduces or defers borrowing and moderates requisition pressure.

2022
Debt Management Reserve established to preserve temporary budget capacity

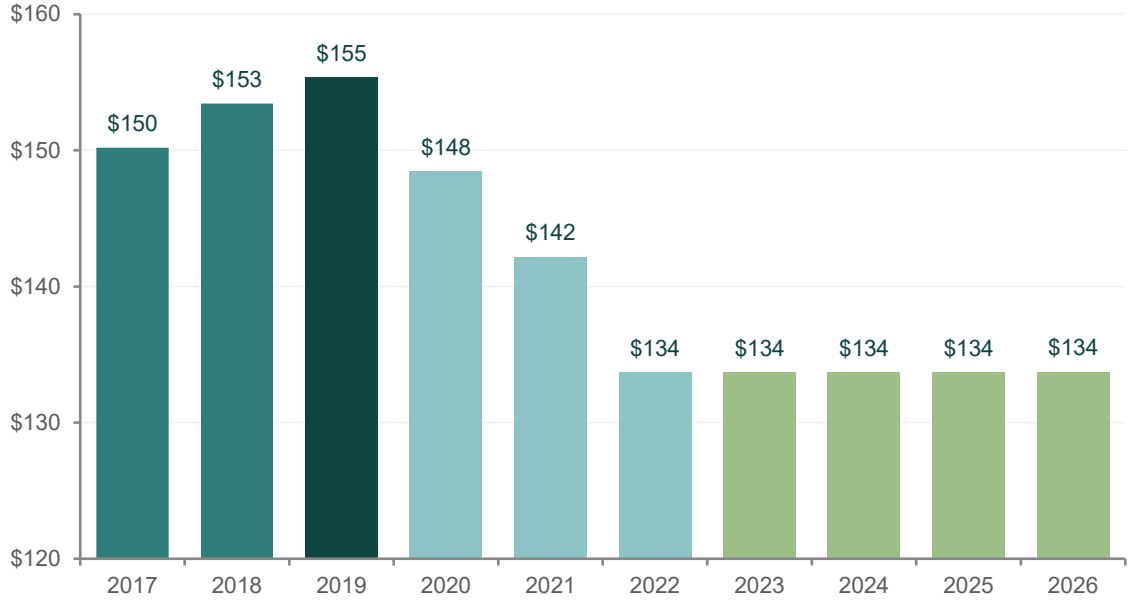
$27M
Debt Management Reserve balance as of the year ended 2025

Annual
Board approval required for every transfer in and every draw out

Key Message: the reserve is designed to be spent - modelled balances grow to a peak of $43M then deployed to an ending balance of $2M–$24M by 2035 aligned to major capital delivery.

REQUISITION HISTORY

Maturing debt released real budget capacity - the Board returned some to taxpayers, then preserved the rest



2017–2019 Capacity identified

Debt maturing faster than new projects were being approved. Requisition growth slowed from 3.4% to 1.2%; household cost peaked at $155.

2020–2022 Returned to taxpayers

Board-approved decreases of (4.4%), (4.2%) and (6.0%) cut household cost to $134 - the reserve was established in 2022.

2022–2026 Held near $134 per average household

2026 is the fifth consecutive year at approximately $134 per average household.

Key Message: five flat years were funded by discipline, not by deferral - the savings were banked in the reserve for the capital commitments wave still ahead.

CAPITAL FUNDING MODEL

CRHD funds 30% of major capital in addition to annual minor capital and equipment - about $349M of support over the ten-year plan

Island Health Plans

Ten-year regional capital, minor capital, and equipment budget plans, approved by the Province and the CRHD Board

›

Regional derived CRHD funding

30% of the 2026–2035 Island Health major capital plan

$7M annual minor and equipment

›

Reserves, borrowing & requisition

Major projects funded from reserves and MFA long-term debt

Minor capital and equipment funded from requisition

›

Requisition repays

Debt servicing, minor capital and equipment reside in the annual operating budget

$281M

CRHD major-project share, 2026–2035

+

$68M

Ten-year minor capital and equipment funding

=

$349M

Total ten-year support

›

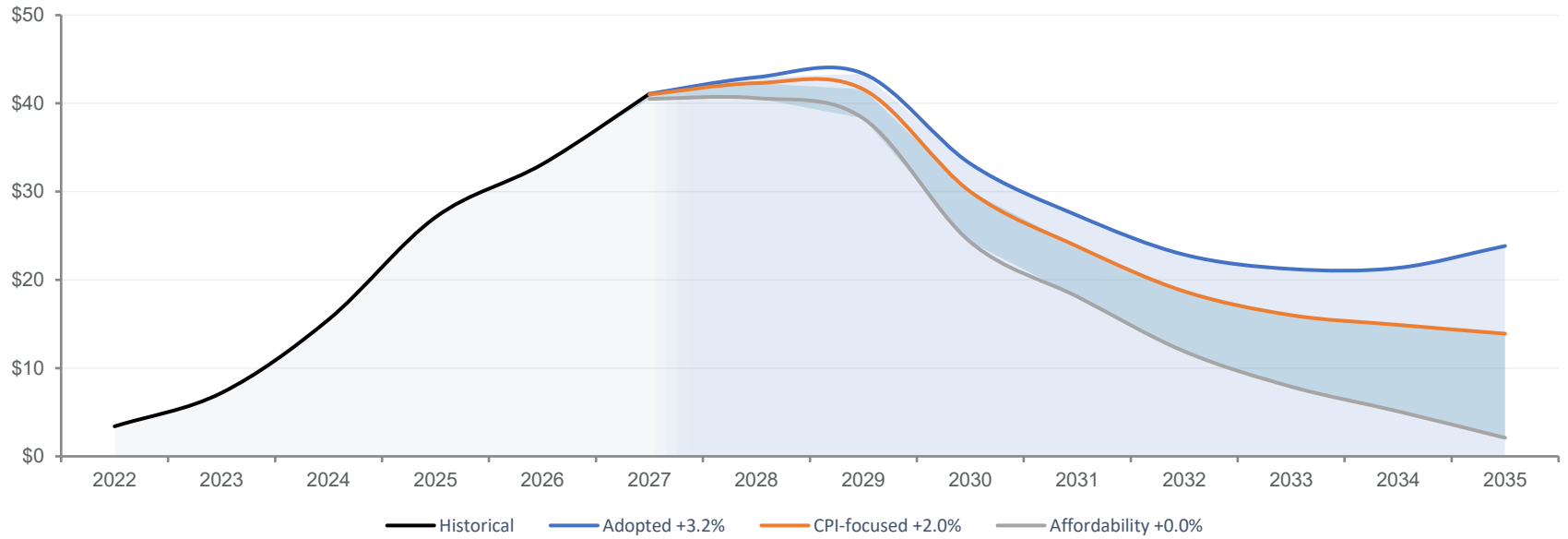
35%

of the ten-year Island Health capital plan

Key Message: the commonly cited 40% local share no longer applies - the 1979 requirement was repealed in 2003. CRHD contributes 30% of eligible major-project costs in addition to annual minor capital & equipment. Hospital district contributions vary across the province.

RESERVE POSITION

Comparison of the Adopted Path (+3.2%) with CPI-Focused (+2.0%) and Affordability-Focused (0.0%)



DMR closing balance, 2022–2035 ($ millions); actual through 2025, modelled 2026 onward

Key Message: the current adopted path leaves the largest reserve in 2035 and adds the least amount of new long-term debt.

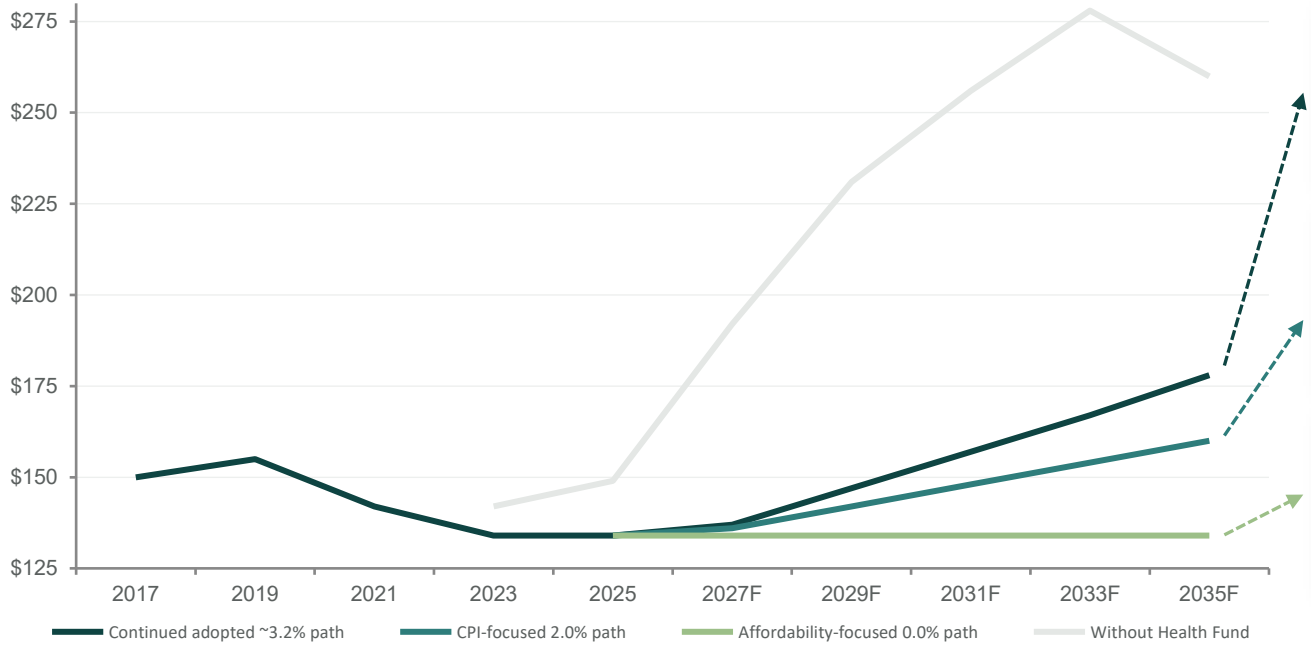
SCENARIO RESULTS

All paths fund $281M - the difference is how much debt and reserve is left behind

	Adopted Path +3.2% annual requisition	CPI-focused +2.0% annual requisition	Affordability-focused +0.0% annual requisition
Transfers to reserve, 2026–2035	**$87.8M**	**$69.6M**	**$41.1M**
Investment income	**$9.4M**	**$8.5M**	**$7.0M**
Closing reserve (2035)	**$23.8M**	**$13.9M**	**$2.1M**
Debt Management Reserve Capital	$100.4M	$91.2M	$73.2M
MFA Long-Term Debt	$181.0M	$190.2M	$208.3M
Net Capital funded	**$281.4M**	**$281.4M**	**$281.4M**
Annual debt service (2035)	**$23.8M**	**$24.6M**	**$26.1M**

Key Message: holding requisitions flat is feasible but requires approximately $27.5M more gross MFA borrowing and leaves only $2.1M in reserve.

Scenarios with three requisition paths modelled to 2035



$178
Continued adopted ~3.2% path

$160
CPI-focused 2.0% path

$134
Affordability-focused 0.0% path

Key message: 2035 costs per household range from $134 to $178 - well below the published 2023 outlook. The Debt Management Reserve helps smooth requisition as Island Health capital spending increases.

INVESTMENT INCOME

Leveraging investment of budget capacity will earn $9 to 11M in real money

$1.9M
Earned by the reserve from 2022 to 2025

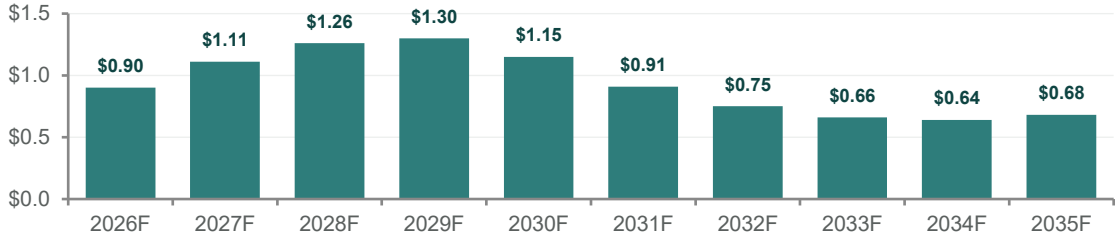
+

$7.0 to 9.4M
Projected 2026–2035, depending on scenario

=

$8.9 to 11.2M
Total return over the full plan period

Projected Debt Management Reserve investment income, 2026–2035 ($ millions)



- Income tracks the balance - it peaks alongside the reserve, then falls as funds are deployed to capital.
- Income is recorded in operations and allocated at year-end on relative average monthly balances.
- Performance is reported to the Board annually in the second quarter.

F = forecast. Every year shown is modelled, including 2026, which is not yet complete. Adopted requisition path, full capital delivery.

Key Message: investment income is a by-product of the strategy - accumulating early and deploying deliberately makes it possible.

FOR THE BOARD

Four things to take away - with no decision required today

1

The strategy works as designed

Temporary capacity from maturing debt has been converted into a reserve that funds capital, defers borrowing, generates investment income and supports requisition stability.

2

The commitment is funded

Under full-delivery assumptions the $281M major-project share is funded through 2035 without exhausting the reserve or a significant requisition increase.

3

Flexibility has limits

The lower the requisition path, the more the CRHD borrows - $208M under a flat requisition versus $181M on the current path.

4

Discipline and consistency matter

Project schedules, interest rates, operating costs and reserve balances change over time. However, the debt management reserve can stabilize the impacts intergenerationally if the strategy is consistently applied or adopted for the long run.

> There is no recommendation. This presentation is for information only.

THANK YOU

Questions and discussion

Capital Regional Hospital District

REPORT TO HOSPITALS AND HOUSING COMMITTEE
MEETING OF WEDNESDAY, JUNE 03, 2026

SUBJECT **Capital Regional Hospital District Capital Contribution Funding Model**

ISSUE SUMMARY

Staff to review the Capital Regional Hospital District (CRHD) capital contribution funding model.

BACKGROUND

On October 29, 2025, the CRHD Board passed the following motion:

> *The Capital Regional Hospital District Board ask staff to review the 30% contribution for major capital and 40% contribution for minor capital and make a recommendation on a potential lower percentage based on a Consolidated Capital Regional District Budget and evolving costs for newly-established services.*

In 2007, the Board completed a comprehensive review of the CRHD funding model and established the current contribution structure. The three categories of CRHD funding are:

1. **Major Capital Projects**
   Projects greater than $2 million (M) generally cost-shared at a 30% contribution level and primarily financed through debt arranged through the Municipal Finance Authority.
2. **Minor Capital Projects**
   Projects valued between $100,000 and $2M where the CRHD contributes 40% of project costs, up to an annual maximum of $3.75M.
3. **Medical Equipment**
   Annual contributions of $2.925M to Island Health and $30,000 to Mount Saint Mary Hospital for medical equipment replacement and acquisition.

The current contribution structure has remained largely unchanged since 2007. During this period, construction costs, population growth, healthcare demand, and broader CRD financial pressures have increased. Staff met with Ministry of Health and the Ministry of Infrastructure staff on February 20 and March 20, 2026, to discuss Hospital District(s) cost shares. Staff were informed that most hospital districts across British Columbia typically contribute up to 40% of eligible capital costs; however, contributions are voluntary and vary based on local circumstances and project funding arrangements. A review of major health capital projects identified in the Province's 2026/27–2028/29 Budget and Fiscal Plan indicates that Regional Hospital District contributions vary significantly between projects. Key observations indicate the historical 40% contribution model is a convention rather than a requirement and funding arrangements increasingly include provincial, foundation, and other funding sources.

Overall, while provincial funding arrangements demonstrate increasing flexibility, discussions with Island Health indicate that existing and planned projects within the CRHD have been developed based on current contribution assumptions and may not readily accommodate further reductions. Island Health advised that the current reduction from the conventional 40% contribution expectation to 30% for major capital projects already represents a significant reduction in CRHD participation.

ALTERNATIVES

Alternative 1
The Hospitals and Housing Committee recommends to the Capital Regional Hospital District Board:
That the Capital Regional Hospital District maintains the current capital contribution funding model as follows:

- Maintain a 30% contribution for major capital projects;
- Maintain a 40% contribution for minor capital projects; and
- Maintain current annual allocations for medical equipment.

Alternative 2
The Hospitals and Housing Committee recommends to the Capital Regional Hospital District Board:
That the Capital Regional Hospital District staff work with Island Health and the Ministry of Health to understand the implications of reducing the major capital percentage contribution from CRHD to 25%.

Alternative 3
That this report be referred back to staff for additional information based on Hospitals and Housing Committee direction.

IMPLICATIONS

Financial Implications
In the current capital environment, increasing construction costs and infrastructure requirements mean that even relatively small contribution changes can create significant funding impacts. Across current Island Health major projects within the existing CRHD Ten-Year Capital Plan, the previous reduction from a 40% to 30% contribution model represents approximately $98M in reduced contributions. A further reduction to 25% would create an estimated additional $49M in funding pressure. Island Health has indicated that additional funding pressures may require reassessment of project scope, timing, viability, and funding strategies (Appendix A).

Maintaining the current contribution model supports assumptions embedded within current and planned capital projects. While reducing contribution rates could improve CRHD financial flexibility, relatively small percentage reductions may create significant funding gaps for major projects. Future impacts would vary depending on the scale and timing of approved capital projects and would require project-specific analysis.

Intergovernmental Implications
Funding arrangements for major capital projects are negotiated and variable. Changes to the CRHD contribution model would require discussions with Island Health and the Province regarding impacts on capital planning and could impact the viability of planned capital projects.

Governance/Legal Implications
The CRHD is established under provincial legislation and letters patent. Authority for establishing, restructuring, or dissolving a regional hospital district rests with the Province through the Lieutenant Governor in Council. A preliminary review of the legislative framework indicates that any restructuring—particularly dissolution—would require provincial approval and would need to address a range of complex considerations, including existing assets and liabilities, debt and long-term financial obligations, taxation authority and requisitioning, ongoing capital funding

responsibilities, and alignment with health authority capital planning. There is no clear mechanism for unilateral dissolution of a regional hospital district by its Board. As such, any consideration of structural changes would represent a significant provincial policy and governance decision requiring coordination with the Province and Island Health. Discussions with Ministry staff indicate a strong opposition to dissolution of the CRHD. While this context is important, it does not directly impact the CRHD's ability to adjust its contribution model within the existing legislative framework.

CONCLUSION

The current reduction from a conventional 40% contribution to 30% for major capital projects already represents a significant reduction in CRHD funding participation. Information provided by Island Health indicates that additional reductions could create material funding pressures that may affect project viability, scope, timing, and overall capital planning assumptions. Maintaining the existing contribution model supports continued partnership with Island Health and the Province and provides stability for current and future healthcare infrastructure planning.

RECOMMENDATION

The Hospitals and Housing Committee recommends to the Capital Regional Hospital District Board:
That the Capital Regional Hospital District maintains the current capital contribution funding model as follows:

- Maintain a 30% contribution for major capital projects;
- Maintain a 40% contribution for minor capital projects; and
- Maintain current annual allocations for medical equipment.

Submitted by:	Michael Barnes, MPP, Senior Manager, Health and Capital Planning Strategies
Concurrence:	Kevin Lorette, P. Eng., MBA, General Manager, Housing, Planning and Protective Services
Concurrence:	Angela Linwood, CMA, Acting Chief Financial Officer
Concurrence:	Ted Robbins, B. Sc., C. Tech., Chief Administrative Officer

ATTACHMENT

Appendix A: May 25, 2026 letter from Island Health

OUR VISION:

Excellent health and care for everyone, everywhere, every time.

Island Health

May 25, 2026

Michael Barnes, MPP
Senior Manager, Health and Capital Planning Strategies
Capital Regional Hospital District
Capital Regional District
625 Fisgard Street
Victoria, BC V8W 0E1

Sent via email: mbarnes@crd.bc.ca

Dear Michael:

Re: CRHD Cost-Share Contributions and Health Infrastructure Delivery

Thank you for your May 12, 2026, correspondence regarding Regional Hospital District cost-share contributions and potential changes to the Capital Regional Hospital District's (CRHD) funding approach.

Island Health recognizes the pressures local and regional governments face regarding supporting growing need for health infrastructure, escalating costs for this infrastructure, multiple competing priorities across sectors, and the increasingly limited capacity of tax payers to absorb tax increases.

I am responding in my capacity of being responsible for identifying, planning and advancing priority health infrastructure projects in the South Island. This letter is intended to speak to the practical implications of changes to CRHD cost-share contributions and should not be read as legal advice or as a definitive interpretation of provincial policy. Questions regarding provincial policy, legislative requirements, or Regional Hospital District cost-share expectations should be directed to the Ministry of Health and the Ministry of Infrastructure, as appropriate.

As you are aware, the current 30% CRHD contribution assumption for major capital projects is already materially lower than the historic 40% regional contribution reference point. The practical effect of this change in contribution is significant: a lower regional contribution reduces the funding available to advance priority health infrastructure in the CRD region. The move from a 40% reference point to a 30% CRHD contribution for major capital projects already has a substantive impact on Island Health's ability to deliver health care infrastructure in the CRD region. A further reduction would compound that impact.

This is particularly significant in the current capital environment. Project budgets are not carrying large margins, and costs continue to escalate across construction, equipment, infrastructure renewal, consultant fees and contingency. In that context, even relatively small percentage changes translate into material funding gaps.

Health infrastructure is integral to care delivery. Clinical buildings, electrical capacity, medical equipment, diagnostic and treatment space, infection prevention requirements, accessibility, and building renewal form the foundation required to enable the delivery of safe and effective health services. When capital funding is reduced, the impact extends beyond buildings and equipment; over time, it constrains Island Health's maintain, modernize, and expand the service capacity required to support patient care needs.

Island Health and the CRHD are critical partners in delivering health care infrastructure for the region. From Island Health's perspective, the cost-share model is not simply a financial arrangement – it is fundamental to advancing projects from planning through to approval, funding and delivery. When regional contributions are reduced, it impacts on the project scope, the project schedule, and project viability. Ultimately it delays the delivery of need infrastructure for the community requiring care.

Contribution shifts also create pressure across Island Health's broader capital plan, as provincial and health authority capital funding must be managed across a portfolio of priorities in Island Health's service area. Reduced or less predictable regional contributions in one area may affect the ability to advance priorities in other regions and can create broader uncertainty for capital planning, particularly where multiple Regional Hospital Districts are supporting major projects at the same time. The practical consequence is reduced capacity to renew, replace and expand the health infrastructure that supports care delivery in the Capital Region. Over time, which means fewer projects advancing, projects taking longer to deliver, projects being reduced in scope, or projects not proceeding at all. While the effect may not always be visible immediately as a direct service reduction, the long-term result is a lower level of health care service capacity than would otherwise be possible in the CRHD region.

Island Health is committed to continued collaboration with the CRHD and the Province to advance priority health infrastructure for the region. As noted earlier, should there be interest in changing the current relationship between the CRHD and Island Health, next steps most likely require legal review and clarifying existing legislative expectations.

We recognize the pressures for infrastructure funding within the current environment. For Island Health, maintaining a stable and predictable cost-share framework is critical to ensure that residents of the Capital Region continue to have access to the health infrastructure and services they need.

Sincerely,

Jesse Tarbotton, RPP
Director, Capital Planning, Real Estate & Leasing

cc: Ted Robbins, Chief Administrative Officer, Capital Regional District
Kevin Lorette, General Manager, Housing, Planning & Protective Services, Capital Regional District
Kathy MacNeil, President & CEO
James Hanson, Vice President, Community Clinical Operations and Support Programs
Bobi Plecas, Deputy Minister, Ministry of Infrastructure
Cynthia Johansen, Deputy Minister, Ministry of Health
Amy Miller, Assistant Deputy Minister, Ministry of Infrastructure
Mark Bell, Director, Ministry of Infrastructure