2016-17

Alberta Health Services
Annual Report

Alberta Health Services

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or call HEALTHLink at 811

MESSAGE FROM THE BOARD CHAIR AND THE PRESIDENT & CEO

We are pleased to present the Annual Report for Alberta Health Services (AHS) for the fiscal year ended March 31, 2017. This report summarizes AHS progress and accomplishments over the past 12 months as we continue our progress as a high-performing, learning healthcare organization.

AHS was widely recognized for our prompt and effective response to the Fort McMurray wildfire in May 2016. AHS staff, physicians and volunteers safely evacuated more than 100 patients and clients from the Northern Lights Regional Health Centre in two hours, transported patients and clients to safety, ensured continuity of care for patients with chronic conditions and serious illnesses, supported evacuees throughout Alberta, and restored most hospital services just one month after the biggest evacuation in Alberta history.

AHS focused on its community engagement work in 2016-17. Our Health Advisory Councils around the province were revitalized and grew to nearly 190 members after a robust recruitment effort. Meetings with community leaders occurred across the province addressing area-specific concerns in communities such as Fort McMurray, Red Deer, Beaver Lodge, Slave Lake, Sylvan Lake and Sundre.

During 2016-17, we continued to work with our partners to address the opioid crisis. We opened new and upgraded facilities and units, and continued to drive research, innovation implement programs that are improving patient outcomes and experiences.

You can learn more about these highlights, and more, in this report.

The 2016-17 AHS Annual Report was prepared in accordance with the *Fiscal Management Act, Regional Health Authorities Ac*t and instructions as provided by Alberta Health. All material economic and fiscal implications known as of June 1, 2017 have been considered in preparing the Report.

Respectfully submitted on behalf of Alberta Health Services.

[Original Signed By]

Linda Hughes
Chair, Alberta Health Services Board

[Original Signed By]

Dr. Verna Yiu
President and CEO, Alberta Health Services

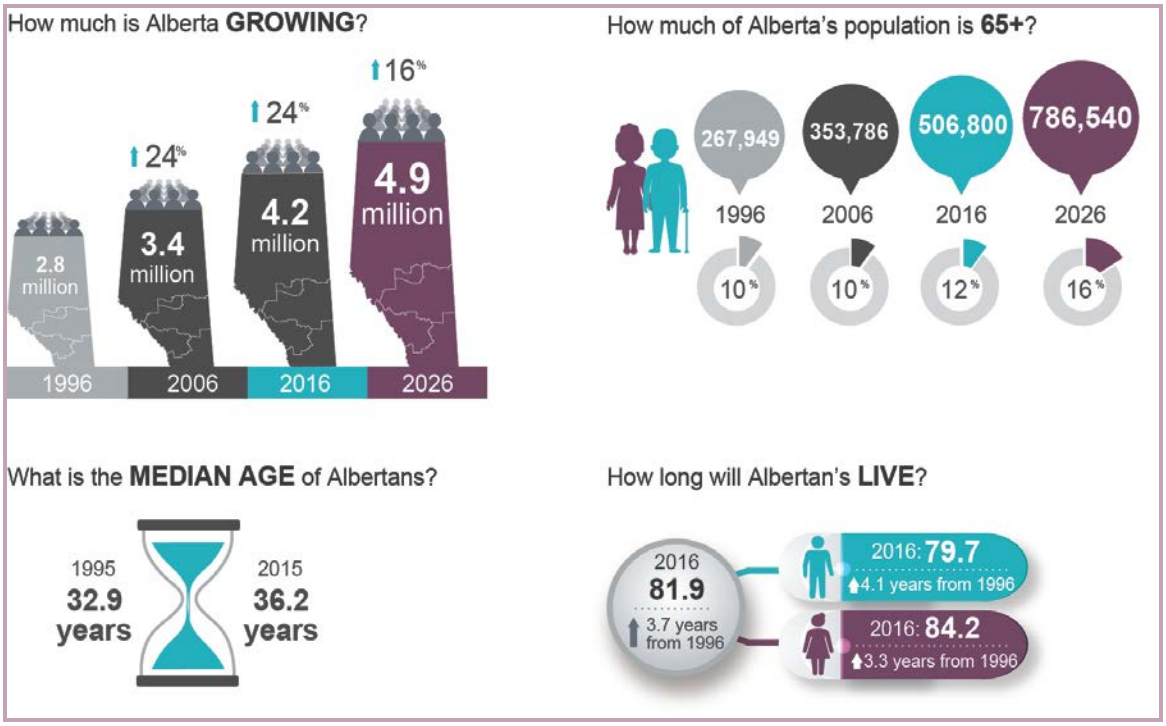
WHO WE ARE

AHS is Canada's first and largest provincewide, fully integrated health system, responsible for delivering health services to more than 4.2 million people living in Alberta, as well as to some residents of Saskatchewan, British Columbia and the Northwest Territories.

Being a provincewide integrated healthcare system allows us to share information, work seamlessly and provide standardized care to Albertans.

AHS cares for a growing and aging population with diverse needs. Alberta is one of the fastest-growing provinces in Canada. Alberta's population growth remains ahead of the national average.

Alberta has urban, rural and remote populations. Certain geographical areas within our province are home to different population structures and unique health needs requiring tailored approaches to healthcare delivery.



AHS has more than 109,000 employees, including over 101,000 direct AHS employees (excluding Covenant Health staff). Over 8,300 staff work in AHS' wholly-owned subsidiaries, such as Carewest, CapitalCare Group and Calgary Laboratory Services. We have 13,900 volunteers who have contributed over one million volunteer hours this past year. We are also supported by more than 10,000 physicians, more than 8,100 of whom are members of the AHS medical staff (physicians, dentists, podiatrists, oral and maxillofacial surgeons). Students from Alberta's universities and colleges, as well as from educational institutions outside of Alberta, receive clinical education in AHS facilities and community locations.

AHS programs and services are offered at more than 650 facilities throughout the province, including hospitals, clinics, continuing care facilities, cancer centres, mental health facilities and community health sites. We also have community-based services designed to help Albertans maintain and/or improve their health status. All facilities and programs are operated in compliance with specific sections of program legislation.

VISION, MISSION, VALUES AND FOUNDATIONAL STRATEGIES

AHS refreshed its vision, mission and values and rolled out four foundational strategies that help us reach our goals. Our vision tells us where we need to go and where we want to be. Our mission is our reason for being; it defines our purpose, who we serve and how we serve them. Our five values are at the heart of everything that we do; they inspire, empower and guide how we work together with patients, clients, families and each other.

Vision: Healthy Albertans. Healthy Communities. Together.

Mission: To provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

Values: Compassion, Accountability, Respect, Excellence, and Safety (CARES)

AHS has developed four foundational strategies that guide our efforts to sustain safe, high-quality healthcare delivery for the benefit of all Albertans.

Patient First Strategy puts patients and families at the centre of all healthcare activities, decisions and teams.

Our People Strategy creates a culture in which AHS staff, physicians, and volunteers feel safe, healthy and valued.

Clinical Health Research, Innovation and Analytics Strategy drives research and innovation to improve patient outcomes and health system performance.

Information Management/Information Technology Strategy puts information at the fingertips of patients, clinicians and researchers in an effort to inform and to improve decision-making.

Volunteers – Our Most Valuable Resource

Volunteers are a central part of building environments that support patient- and family-centred care.

Over the course of a year, more than 13,900 volunteers dedicated over one million hours of their time to help keep Albertans safe and healthy.

In honour of the important roles our volunteers play, this year, members of the AHS Executive and Senior Leadership Teams shadowed a volunteer and learned the ropes of various volunteer roles.

Among their many contributions, volunteers manage patient visits, give input to improve the quality and safety of healthcare, play wayfinding roles and tend our retail shops to raise funds.

PROVINCIAL QUICK FACTS

The numbers below provide a snapshot of AHS' activity and demonstrate the change in services provided in the last few years.

Alberta Health Services	2013-14	2014-15	2015-16	2016-17	% Change 2015-16 to 2016-17
Primary Care / Population Health					
Ambulatory Care Visits	5,909,207	6,238,749	6,421,309	n/a	2.9%
Number of Unique Home Care Clients	112,062	114,990	116,462	118,834	2.0%
Number of People Placed in Continuing Care	7,694	7,810	7,879	8,002	1.6%
Health Link Calls	778,353	813,471	755,334	744,278	-1.5%
Poison & Drug Information Service (PADIS) Calls	34,174	35,080	36,375	39,467	8.5%
Seasonal Influenza Immunizations	1,157,550	1,254,950	1,146,569	1,171,728	2.2%
EMS Events	461,813	503,769	517,640	512,167	-1.1%
Food Safety Inspections	95,389	92,723	92,857	82,482	-11.2%*
Acute Care					
Emergency Department Visits (all sites)	2,142,633	2,181,369	2,134,945	2,079,280	-2.6%
Urgent Care Visits	205,354	195,312	189,775	187,798	-1.0%
Hospital Discharges	393,764	401,331	404,514	403,908	-0.1%
Births	52,323	54,203	55,283	53,650	-3.0%
Total Hospital Days	2,670,814	2,808,990	2,812,244	2,837,673	0.9%
Average Length of Stay (in days)	6.8	7.0	7.0	7.0	0.0%
Diagnostic / Specific Procedures					
Total Hip Replacements (scheduled and emergency)	5,243	5,397	5,564	6,003	7.9%
Total Knee Replacements (scheduled and emergency)	6,224	6,377	6,645	6,690	0.7%
Cataract Surgery	36,785	36,583	36,807	37,904	3.0%
Main Operating Room Activity	272,708	275,925	281,401	287,991	2.3%
MRI Exams	190,024	199,928	195,419	192,375	-1.6%
CT Exams	365,181	387,116	391,600	405,332	3.5%
X-rays	1,848,122	1,868,044	1,874,879	1,843,076	-1.7%
Lab Tests	70,911,298	73,994,032	75,512,771	76,282,777	1.0%
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	560,340	578,005	616,237	641,856	4.2%
Unique Cancer Patients	51,105	52,288	55,020	57,549	4.6%
Addiction & Mental Health					
Mental Health Hospital Discharges (acute care sites)	21,008	21,429	22,810	24,307	6.6%
Community Treatment Orders (CTOs) Issued	361	443	452	444	-1.8%
Addiction Residential Treatment & Detoxification Admissions	9,978	11,180	11,976	11,726	-2.1%

n/a = data not available at time of report

* Food inspections in all zones decreased in 2016-17 to support emergency response and recovery for the Fort McMurray wildfire which required reprioritization of service delivery.

BED NUMBERS

AHS is committed to providing more community-based options for Albertans, including long-term care, supportive living, palliative care and home care. A key objective in healthcare is to shift services from acute care hospital and facility living to the community – bringing care closer to home for patients.

In 2016-17, AHS opened 376 continuing care beds for a total of 25,323 community-based spaces. Since April 2010, AHS has opened 5,623 community-based beds/spaces.

Number of Beds/Spaces	March 31, 2016	March 31, 2017	Difference	% Change
Acute & Sub-Acute Care				
Acute Care	8,479	8,430	-49	-0.6%
Sub-acute in Auxiliary Hospital	490	510	20	4.1%
TOTAL ACUTE AND SUB-ACUTE CARE	**8,969**	**8,940**	**-29**	**0%**
Continuing Care				
Auxiliary Hospital (includes 50 restorative beds)	5,610	5,606	-4	-0.1%
Nursing Home	9,158	9,139	-19	-0.2%
Long-Term Care (LTC) Subtotal	**14,768**	**14,745**	**-23**	**-0.2%**
Supportive Living Level 4 – Dementia	2,659	2,904	245	9.2%
Supportive Living Level 4 (includes 5 restorative beds)	5,739	5,914	175	3.0%
Supportive Living Level 3	1,538	1,517	-21	-1.4%
Supportive Living (SL) Subtotal	**9,936**	**10,335**	**399**	**4.0%**
LONG-TERM CARE & SUPPORTIVE LIVING SUBTOTAL	**24,704**	**25,080**	**376**	**1.5%**
Community Palliative and Hospice (out of hospital)	**243**	**243**	**0**	**0.0%**
TOTAL CONTINUING CARE (LTC, SL and palliative)	**24,947**	**25,323**	**376**	**1.5%**
Addiction & Mental Health				
Psychiatric (standalone facilities)	955	955	0	0.0%
Addiction Treatment	955	968	13	1.4%
Community Mental Health	625	736	111	17.8%
TOTAL ADDICTION & MENTAL HEALTH	**2,535**	**2,659**	**124**	**4.9%**
ALBERTA TOTAL	**36,451**	**36,922**	**471**	**1.3%**

Refer to appendix for more information on beds.

GOVERNANCE

The eight-member AHS Board is responsible for the governance of AHS, working in partnership with Alberta Health to ensure all Albertans have access to high-quality health services across the province. The Board is accountable to the Minister of Health.

The AHS Board has established the following committees to assist in governing AHS and overseeing the management of AHS' business and affairs: Audit & Risk Committee, Community Engagement Committee (established April 2016), Finance Committee, Governance Committee, Human Resources Committee, and Quality & Safety Committee.

The Board Chair is a member of each committee, and the President and Chief Executive Officer is a non-voting ex-officio member of each committee. The purpose and scope of each committee is in accordance with good governance practices and is consistent with the governing legislation of AHS.

AHS Board Members

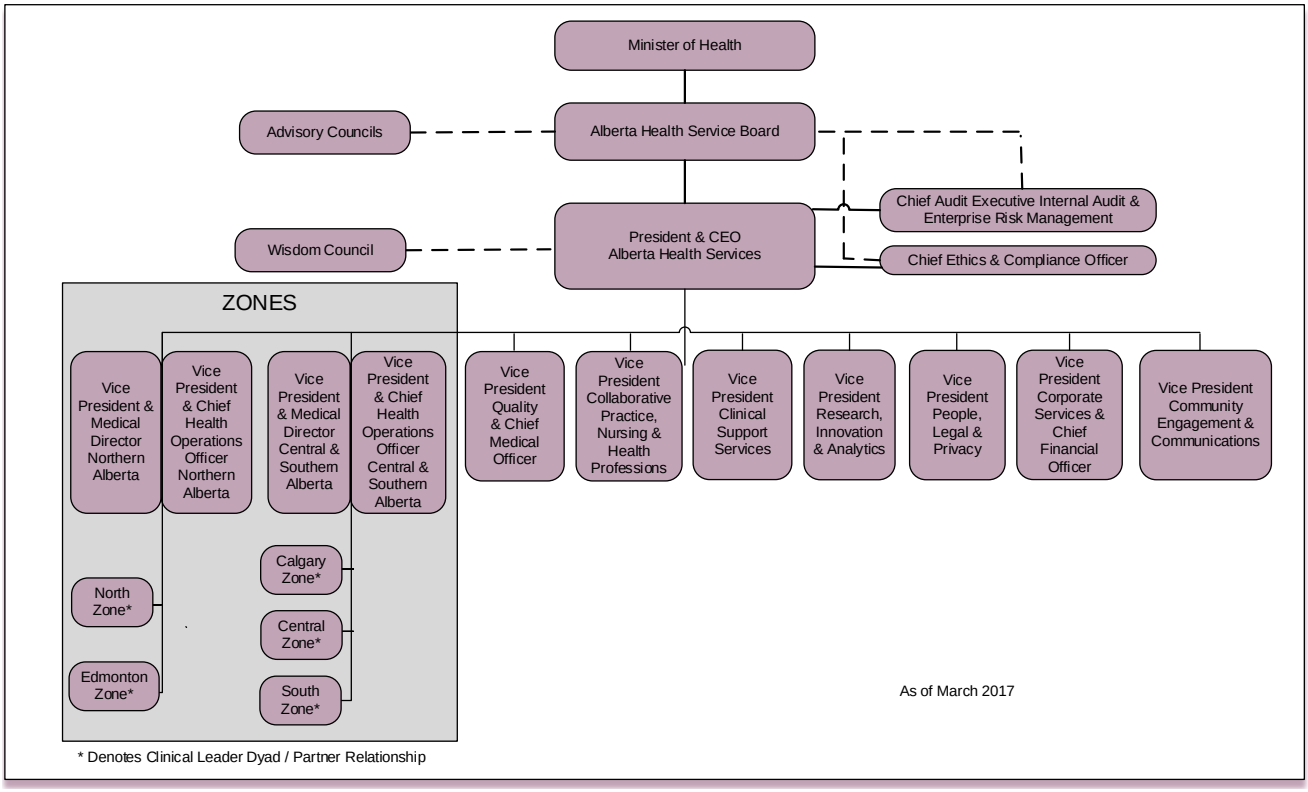
Linda Hughes – Board Chair
Dr. Brenda Hemmelgarn – Vice Chair
Heather Hirsch
Hugh D. Sommerville
David Carpenter
Marliss Taylor
Glenda Yeates
Richard Dicerni

ORGANIZATIONAL STRUCTURE

Dr. Verna Yiu is President and Chief Executive Officer (CEO) of AHS. Dr. Yiu leads a staff of over 109,000 caring and dedicated individuals who make up the AHS workforce. In this role, she is leading health services through transformational change, shaping the future for AHS to allow achievement of our strategic directions.

With leaders and staff in the organization, AHS will build a culture that exemplifies our values, takes a provincial perspective on issues and ensures good ideas developed in one part of the province are shared across the province.

The AHS organizational structure is arranged under the AHS Executive Leadership Team reporting directly to the President and CEO.



ADVISORY COUNCILS

Advisory councils help bring the voice of Alberta's communities to healthcare services. Community input allows us to better address the health needs of Albertans and brings decision-making to the local level. AHS is committed to engaging the public in a respectful, open and accountable manner to support our strategic directions. AHS has established the following councils to support ongoing collaboration and engagement. In 2016-17, more than 80 new volunteer members were added to the councils, with a total of over 190 members on these councils.

Health Advisory Councils (HACs) engage members of the public in communities throughout Alberta and provide advice and feedback from a local perspective on what is working well in the healthcare system and where there are areas in need of improvement. Each of the 12 HACs was established in 2009-10 and represents a different geographical area within the province. The HACs report to the AHS Board Chair.

1. True North – La Crete, High Level & Area
2. Peace – Peace River, Grande Prairie & Area
3. Lesser Slave Lake – Slave Lake, High Prairie & Area
4. Wood Buffalo – Fort McMurray & Area
5. Lakeland Communities – Lac LaBiche, Redwater, Cold Lake & Area
6. Tamarack – Hinton, Edson, Whitecourt & Area
7. Oldman River – Lethbridge & Area
8. Greater Edmonton – Edmonton & Area
9. Yellowhead East – Camrose, Lloydminster & Area
10. David Thompson – Red Deer & Area
11. Prairie Mountain – Calgary & Area
12. Palliser Triangle – Medicine Hat & Area

Wisdom Council provides guidance and recommendations to ensure AHS develops and implements culturally appropriate and innovative health service delivery for Indigenous Peoples. It is comprised of Indigenous People who provide their time on the council. Their backgrounds are wide-ranging, including traditional knowledge-holders (ceremonial leaders), contemporary trained physicians, nursing professionals and health consultants, all equally important when discussing challenges to inform AHS on Indigenous health and well-being.

Provincial Advisory Council on Addiction and Mental Health advises AHS on programs and services for provincewide addiction and mental health treatment. Its members provide evidence-based suggestions that improve quality of services and patient satisfaction through effective service planning.

Provincial Advisory Council on Cancer advises AHS on programs and service for provincewide cancer care. Its members provide evidence-based suggestions on prevention and screening, diagnosis, treatment and care, and research.

Alberta Clinician Council is an organization-wide forum comprised of front-line clinicians from a variety of disciplines and zones. Applying their collective knowledge, experience and expertise, the council advises senior leadership on issues and opportunities to improve quality, access and patient safety across Alberta.

Patient and Family Advisory Group continues to be an important avenue for bringing patient and family voices into AHS. The group partners with senior leaders to review policy and strategies and share insights from patients' perspectives for the planning and delivery of healthcare services. In 2016-17, this group consulted and advised on a number of organizational priorities such as the AHS vision, medical assistance in dying, family presence and visitation, and the clinical information system. For more information, refer to the Patient and Family Advisory Group Annual Report.

Patient Engagement Reference Group brings together Strategic Clinical Network™ (SCN) patient and family advisors and Patient and Community Engagement Researchers (PaCERs). Members ensure patients' voices are heard and incorporated in the SCNs by sitting on committees and contributing to projects with leadership, researchers, healthcare providers and decision-makers. The group meets quarterly to provide an opportunity for consultation with a larger group of advisors and PaCERs. Meetings also consist of updates, networking opportunities, specific advisor learning and promoting partnerships between advisors and SCN leaders.

The creation of a ***Provincial Advisory Council for Seniors and Continuing Care*** *was approved by AHS Executive Leadership Team in August 2016. The Terms of Reference and Bylaws have been developed and are pending approval.*

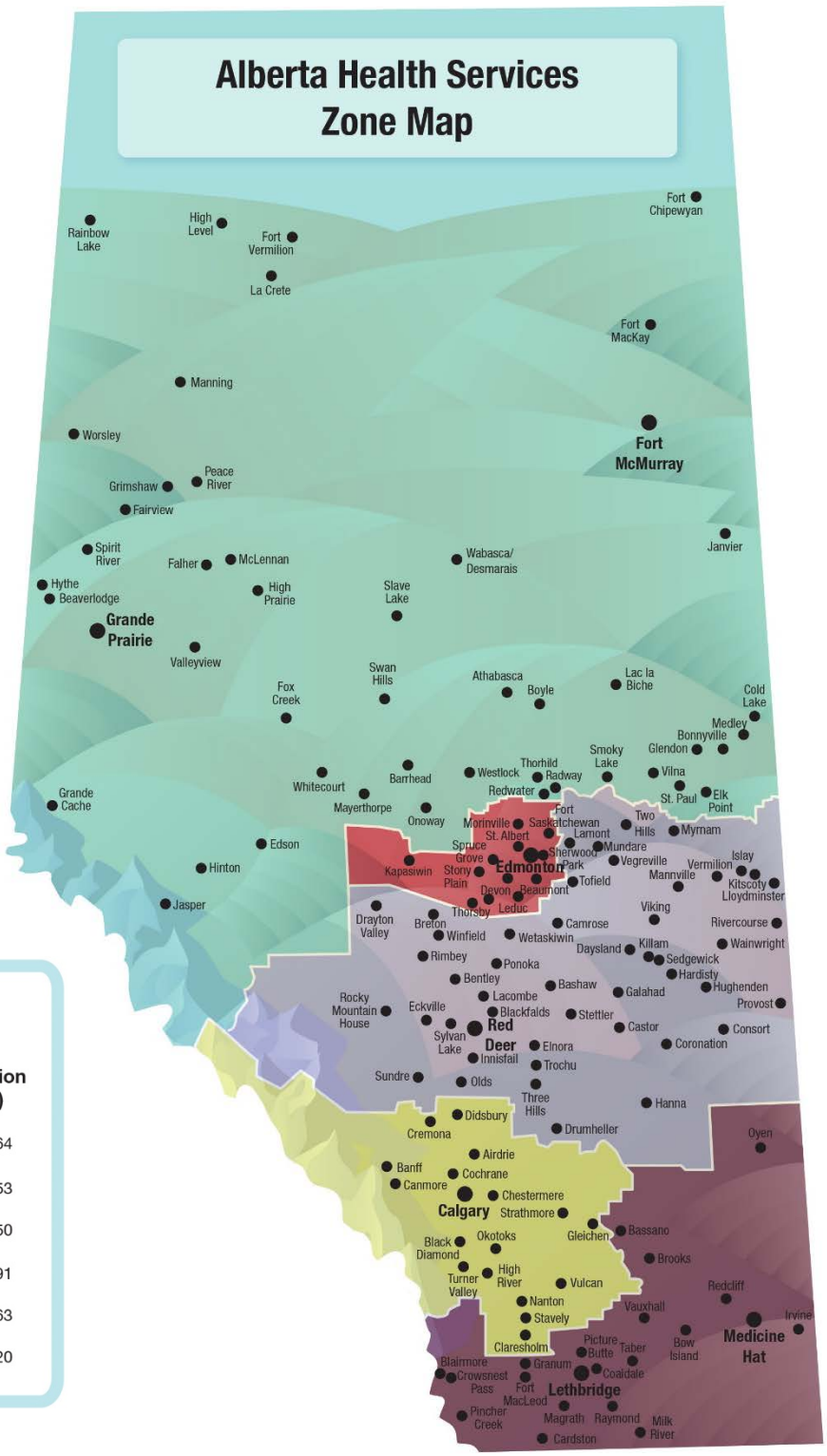
AHS Map and Zone Overview

AHS is organized into five geographic zones – South, Calgary, Central, Edmonton and North.

Our zones are invaluable in terms of providing decision-making at a local level, and listening to and responding to local communities, local staff members, and our patients and clients.

Provincewide services, such as emergency medical services; population, public and Indigenous health; diagnostic imaging; quality and safety; and so on, work in co-operation with the zones to deliver care.

The next section includes an overview, highlights and Quick Facts about each zone.



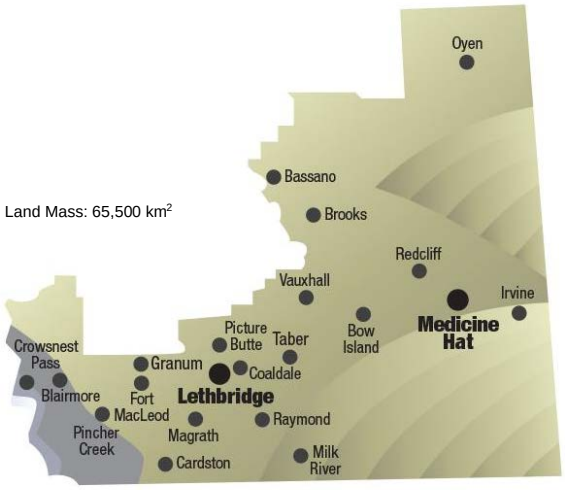
South Zone

Population Statistics (2016)

Overall Population: 303,663
Aging Population (over 65 years): 45,546
Life Expectancy: 79.8 years
Median Age: 36.4 years (2015)

Facts at your Fingertips

29% are obese
14% smoke daily
51% are active or moderately active
39% eat 5 or more servings of fruit/vegetables daily
17% are heavy drinkers (≥ 5 drinks on one occasion, at least once a month)
Source: Canadian Community Health Survey 2014



South Zone Highlights

Lethbridge and its surrounding area have increased access to outpatient services, specialized care and emergency services thanks to the redevelopment of Chinook Regional Hospital. The redevelopment added a new five-story wing to the hospital and includes expansions and renovations to several departments, including emergency department, day surgery and neonatal intensive care. The new wing also includes a Ceremonial Room for use by people of various faiths.

The first phase of the expansion and renovation of the Medicine Hat Regional Hospital is complete. The project includes a six-story wing with added space for surgical services, ambulatory (outpatient) care, cardio-respiratory services, a renal program, a cancer clinic, sterile processing, and maternal newborn services. In addition, the building features a rooftop heliport, diagnostic imaging, an expanded day procedures department, and physiotherapy and occupational therapy. The next phase of the project started in spring 2017 and will include a major expansion of the emergency department.

Individuals in Medicine Hat who experience mental health, addiction or psychosocial crises and are at risk will now be identified for treatment by a Police and Crisis Team (PACT). PACT, a partnership between AHS and the Medicine Hat Police Service, pairs a mental health clinician and a police officer who attend emergency calls to assist individuals in crisis and diverts individuals toward the most appropriate community services and resources to stabilize them.

AHS ID Program was expanded to Medicine Hat for homeless and at-risk patients to store their newly obtained identification and/or healthcare card until they have the ability to secure these documents independently. Based on their consent, client information can be shared with healthcare providers to initiate referrals to followup programs and services. The program currently runs in Edmonton, Lethbridge and Calgary, where it launched in 2013. Since then, more than 2,470 homeless, at-risk and recently-housed patients have acquired identification through the program.

Patients and families at Chinook and Medicine Hat Regional Hospitals can refer to patient-friendly placemats located at their bedside tables for concise and basic information on what to expect while in hospital and the services and amenities available. It also serves as a tool for staff when providing face-to-face orientation to the patients. This initiative is in support of providing patient- and family-centred care by bringing the patient and family into the conversation about their care.

After much work with the Town of Cardston, the Kainai First Nation, local physicians and pharmacists, South Zone opened an Opioid Dependency Treatment Clinic in the Cardston Health Centre in May 2016. The Cardston Clinic's voluntary Recovery and Wellness Program is open to all people with opioid addictions in southwest Alberta. In the first year, the clinic saw approximately 120 patients, and more are added each week. The clinic is open five days a week. Physician services are provided three days a week via Telehealth by the Metro City Medical Clinic located in Edmonton. Other staffing includes a registered nurse, an addiction counsellor, and administrative support.

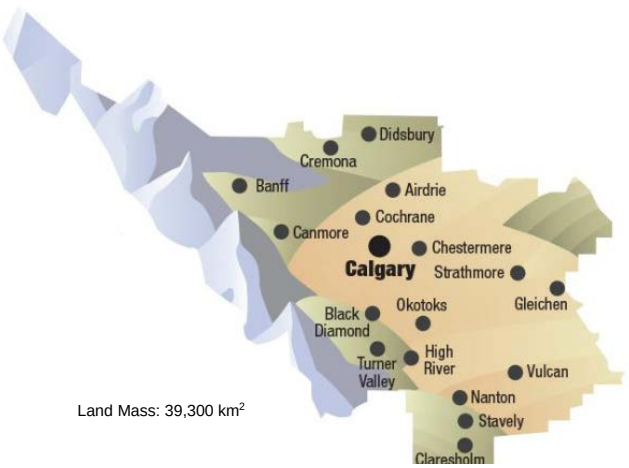
SOUTH ZONE QUICK FACTS	2013-14	2014-15	2015-16	2016-17	% Change 2015-16 to 2016-17
Primary Care / Population Health					
Ambulatory Visits	358,836	365,293	376,743	n/a	3.1%
Number of Unique Home Care Clients	11,577	12,044	12,060	12,381	2.7%
Number of People Placed in Continuing Care	868	866	887	930	4.8%
Health Link Calls	32,186	32,108	34,773	34,061	-2.0%
Seasonal Influenza Immunizations	89,634	96,663	88,172	90,273	2.4%
Food Safety Inspections	8,402	8,609	7,866	7,707	-2.0%
Acute Care					
Emergency Department Visits (all sites)	196,576	194,352	194,257	192,083	-1.1%
Hospital Discharges	31,093	31,125	30,485	30,521	0.1%
Births	3,973	4,156	4,217	3,940	-6.6%
Total Hospital Days	199,672	212,020	219,218	228,311	4.1%
Average Length of Stay (in days)	6.4	6.8	7.2	7.5	4.2%
Diagnostic / Specific Procedures					
Total Hip Replacements (scheduled and emergency)	526	571	578	591	2.2%
Total Knee Replacements (scheduled and emergency)	804	822	838	784	-6.4%
Cataract Surgery	2,653	2,878	2,847	2,955	3.8%
Main Operating Room Activity	23,049	23,501	23,209	23,352	0.6%
MRI Exams	13,380	14,227	14,288	13,809	-3.4%
CT Exams	24,906	26,185	26,964	28,926	7.3%
X-rays	156,503	163,095	166,251	165,091	-0.7%
Lab Tests	4,843,124	5,085,305	5,263,114	5,195,905	-1.3%
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	31,529	30,277	32,144	34,055	5.9%
Unique Cancer Patients	4,522	4,349	4,273	4,379	2.5%
Addiction & Mental Health					
Mental Health Hospital Discharges (acute care sites)	2,019	2,026	2,058	2,169	5.4%
Staffing					
Head Count	6,947	7,238	7,280	7,431	2.1%
Volunteers*	2,130	1,933	1,746	1,632	-6.5%
AHS Physicians	n/a	704	569	578	1.6%

*Decrease in volunteers is attributed to removing duplications and inactive volunteers in the database.

Calgary Zone

Population Statistics (2016)
Overall Population: 1,622,391
Aging Population (over 65 years): 180,327
Life Expectancy: 83.3 years
Median Age: 36.5 years (2015)

Facts at your Fingertips
20% are obese
12% smoke daily
61% are active or moderately active
44% eat 5 or more servings of fruit/vegetables daily
20% are heavy drinkers (≥ 5 drinks on one occasion, at least once a month)
Source: Canadian Community Health Survey 2014



Land Mass: 39,300 km^2

Calgary Zone Highlights

Cancer patients have access to a larger space and new treatment areas with the opening of the newly renovated and expanded High River Community Cancer Clinic. With the exception of radiation, a full treatment plan is followed (chemotherapy, symptom management, transfusions, monitoring blood levels, followup visits and intravenous fluids). The cancer clinic, part of the original pilot for rural Alberta, considers the expansion a step forward in the patient-friendly philosophy.

A new AHS Improvement Way (AIW) project is helping clinicians discuss and document Advance Care Planning and Goals of Care Designations (ACP/GCD) with their patients. The project began in September in four clinical areas (Bowmont Medical Clinic, Foothills Medical Centre's Unit 81 and Heart Function Outpatient Clinic, and Calgary Zone's Heart Failure Home Care team). ACP empowers clinicians to help patients document their wishes for healthcare in the event that they become incapable to consent. The GCD is a medical order used to describe and communicate the focus of care, including the preferred location of care. Printed resources and training are available to ensure the care team is prepared to discuss ACP/GCD with their patients, and to improve the quality of these conversations.

Oilfields General Hospital in Black Diamond is piloting a Telehealth project that allows patients to stay in their rural communities while receiving videoconference care from specialists in Calgary. With this system, the patient has the entire care team engaged in the appointment. It also reduces stress, saves time and eliminates tying up patient transport that may be better used for a more critical situation.

A home-based primary care project was developed in conjunction with the West Central Primary Care Network (PCN) to include support for clients of home care – allowing them to remain in their homes and receive appropriate care as required. This is a partnership that includes physicians, case managers, and specialized professional staff who work together to determine the needs of specific clients of the PCN and care for them in their homes.

Work continues in partnership with current operations to assist with creating a community-based unit to quickly move alternate level of care (ALC) patients from acute care to community beds in advance of their placement to allow for more time to achieve optimal functioning. This initiative will expand in the coming year to include non-ALC patients who may require more time before being assessed for an alternative level of care.

Alberta Children's Hospital's neonatal intensive care unit (NICU) went live with e-critical implementation in December 2016. Staff were trained and the new system has been integrated well into practice. The NICU will be able to use the data generated by the e-critical system to make improvements in care for patients and families, and to benchmark across sites and zones to inform improved use of resources.

CALGARY ZONE QUICK FACTS	2013-14	2014-15	2015-16	2016-17	% Change 2015-16 to 2016-17
Primary Care / Population Health					
Ambulatory Visits	2,298,894	2,573,583	2,646,960	n/a	2.9%
Number of Unique Home Care Clients	32,648	33,548	34,690	35,892	3.5%
Number of People Placed in Continuing Care	2,164	2,548	2,722	2,450	-10.0%
Health Link Calls	325,215	325,566	318,422	310,333	-2.5%
Seasonal Influenza Immunizations	461,442	511,151	467,942	491,931	5.1%
Food Safety Inspections	31,805	31,121	30,496	27,093	-11.2%
Acute Care					
Emergency Department Visits (all sites)	485,803	493,861	487,862	475,415	-2.6%
Urgent Care Visits	181,377	183,230	179,832	176,131	-2.1%
Hospital Discharges	136,598	140,563	143,063	143,633	0.4%
Births	18,865	19,554	19,720	19,395	-1.6%
Total Hospital Days	959,949	1,025,776	1,030,612	1,024,250	-0.6%
Average Length of Stay (in days)	7.0	7.3	7.2	7.1	1.4%
Diagnostic / Specific Procedures					
Total Hip Replacements (scheduled and emergency)	1,897	1,960	2,099	2,184	4.0%
Total Knee Replacements (scheduled and emergency)	2,185	2,388	2,511	2,490	-0.8%
Cataract Surgery	13,799	13,378	13,578	13,489	-0.7%
Main Operating Room Activity	94,403	97,177	99,697	101,659	2.0%
MRI Exams	75,273	78,175	76,850	77,116	0.3%
CT Exams	134,515	143,496	142,863	145,678	2.0%
X-rays	539,337	541,087	546,546	537,800	-1.6%
Lab Tests	26,521,983	28,407,412	28,800,108	29,212,267	1.4%
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	176,552	180,811	200,599	213,828	6.6%
Unique Cancer Patients	20,926	21,717	22,934	23,792	3.7%
Addiction & Mental Health					
Mental Health Hospital Discharges (acute care sites)	7,798	8,150	9,067	9,513	4.9%
Staffing					
Head Count	35,909	37,000	37,023	36,887	-0.4%
Volunteers*	4,165	4,623	5,100	4,206	-17.5%
AHS Physicians	n/a	3,076	3,326	3,439	3.4%

*Decrease in volunteers is attributed to removing duplications and inactive volunteers in the database.

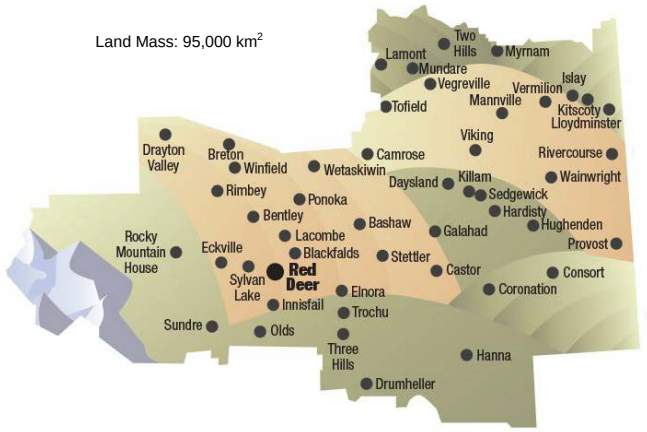
Central Zone

Population Statistics (2016)

Overall Population: 478,050
Aging Population (over 65 years): 69,778
Life Expectancy: 80.7 years
Median Age: 37.3 years (2015)

Facts at your Fingertips

27% are obese
18% smoke daily
57% are active or moderately active
39% eat 5 or more servings of fruit/vegetables daily
19% are heavy drinkers (≥ 5 drinks on one occasion, at least once a month)
Source: Canadian Community Health Survey 2014



Central Zone Highlights

Terminally ill residents located in Sundre and surrounding rural communities are provided support enabling them to die at home. A new, one-of-a kind palliative program was created in partnership with AHS that helps patients remain in their homes by maximizing local resources, as well as using a multidisciplinary team approach. Local physicians and nurses provide 24/7 access (via phone or house visits) to manage crises. Local pharmacists provide access to medications needed by patients in expedited fashion, including after-hours and weekends. An interdisciplinary team works together to provide care and assistance/advice, allowing patients to have the journey that they desire at the end of their days.

To help transition the care of patients between nursing shifts, the postpartum unit at Red Deer Regional Hospital Centre (RDRHC) introduced the Patient Handover At Bedside (PHAB) initiative. PHAB helps staff transition the care of patients between nursing shifts while ensuring patients are included in the process.

Staff and physicians at RDRHC worked diligently to accommodate patients who were scheduled for surgical procedures after a flood forced shutdown of five out of the nine operating rooms. Dedicated staff and physicians offered longer operating room hours at RDRHC and were able to leverage resources at other hospitals in Olds, Innisfail and Stettler during flood remediation. All patients were accommodated in a timely manner through effective use of existing resources and good crisis management practices.

Residents of Lloydminster received enhanced Emergency Medical Services (EMS) through the introduction of an advanced life support (ALS) service, ensuring a broader range of cardiac interventions, breathing supports, and medicines are available in emergency situations. ALS allows EMS to perform lifesaving protocols and skills performed by paramedics and other medical professionals. Previously, EMS was only able to perform basic life support in Lloydminster.

Didsbury and Viking and surrounding areas receive increased access to EMS through new hospital helipads at each location. Local ambulance services are now connected directly to STARS air ambulance services. The new heliports are able to accommodate the new, larger STARS helicopters ensuring emergency transport of local residents.

Cardiac patients awaiting treatment or diagnosis can expect shorter wait times thanks to the new central referral system at Foothills Medical Centre developed jointly between South, Central and Calgary Zones. This new system has helped decrease wait times and ensures urgent cases are prioritized. With the new system, all referrals go to a single location and are triaged by a nurse. For patients, it means improved access to care, and for clinicians, it streamlines the referral process. The project also included implementation of a new information technology system that provides better tracking of each referral and measuring key points in the patient journey.

CENTRAL ZONE QUICK FACTS	2013-14	2014-15	2015-16	2016-17	% Change 2015-16 to 2016-17
Primary Care / Population Health					
Ambulatory Visits	450,619	471,522	479,723	n/a	1.7%
Number Of Unique Home Care Clients	17,483	18,245	18,370	18,770	2.2%
Number of People Placed in Continuing Care	1,189	1,259	1,060	1,365	28.8%
Health Link Calls	57,847	62,035	68,388	61,431	-10.2%
Seasonal Influenza Immunizations	109,014	115,539	105,872	106,934	1.0%
Food Safety Inspections	10,626	11,234	11,390	9.944	-12.7%
Acute Care					
Emergency Department Visits (all sites)	372,122	380,367	360,966	344,643	-4.5%
Hospital Discharges	44,589	45,691	45,577	45,242	-0.7%
Births	4,812	4,926	5,037	4,765	-5.4%
Total Hospital Days	322,478	330,752	323,983	338,113	4.4%
Average Length of Stay (in days)	7.2	7.2	7.1	7.5	5.6%
Diagnostic / Specific Procedures					
Total Hip Replacements (scheduled and emergency)	574	569	585	632	8.0%
Total Knee Replacements (scheduled and emergency)	669	654	616	678	10.1%
Cataract Surgery	3,495	3,722	3,782	3,711	-1.9%
Main Operating Room Activity	27,847	29,330	29,999	30,930	3.1%
MRI Exams	13,137	12,610	12,406	11,034	-11.1%
CT Exams	33,708	36,143	37,485	38,679	3.2%
X-rays	259,979	256,595	255,147	251,374	-1.5%
Lab Tests	6,088,885	6,187,163	6,374,514	6,426,497	0.8%
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	18,686	27,298	32,098	33,366	4.0%
Unique Cancer Patients	2,172	2,461	2,762	2,970	7.5%
Addiction & Mental Health					
Mental Health Hospital Discharges (acute care sites)	2,169	2,281	2,514	2,636	4.9%
Staffing					
Head Count	12,361	12,631	12,772	12,813	0.3%
Volunteers*	3,297	3,292	3,409	2,852	-16.3%
AHS Physicians	n/a	707	710	725	2.1%

*Decrease in volunteers is attributed to removing duplications and inactive volunteers in the database.

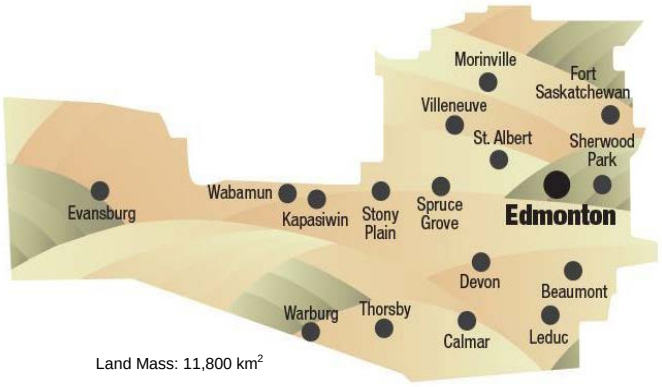
Edmonton Zone

Population Statistics (2016)

Overall Population: 1,363,653
Aging Population (over 65 years): 164,827
Life Expectancy: 82.1 years
Median Age: 36.2 years (2015)

Facts at your Fingertips

21% are obese
15% smoke daily
55% are active or moderately active
35% eat 5 or more servings of fruit/vegetables daily
18% are heavy drinkers (≥ 5 drinks on one occasion, at least once a month)
Source: Canadian Community Health Survey 2014



Edmonton Zone Highlights

Stollery Children's Hospital celebrated the opening of its redeveloped operating room suite. The redeveloped space features five operating rooms and two procedure rooms along with modern infrastructure and equipment. Roughly 10,000 surgeries are performed in the Stollery operating room suite each year. This redesigned operating suite will enable our health providers to deliver quality, patient- and family-centred care that will ease anxieties and improve both patient outcomes and patient experiences.

Canada's first nurse practitioner-led outpatient trauma clinic, which supports trauma patients from emergency and hospital bedside to post-discharge followups opened at the University of Alberta Hospital's Kaye Edmonton Clinic. This clinic focuses on seamless transitions in care, which is especially important for populations vulnerable to poor health outcomes, including those who live with domestic abuse, drug or alcohol abuse, mental health issues and post-traumatic stress disorder, many of whom do not have a family physician.

Teams work together with emergency medical services (EMS) to deliver care in the community for specific patient populations with a goal of decreasing EMS usage and subsequent emergency department presentations:

- Edmonton Continuing Care Urgent Response team provides community-based medical interventions typically received in the emergency department such as lab analysis, diagnostic imaging, suturing, casting, intravenous antibiotic treatment of infections, wound management and other diagnostic and treatment pathways. The focus of the team is to stabilize onsite, develop a treatment plan with nursing staff, reconnect the patient with their physician, and provide followup when required. The program operates 17 hours per day with a team of community paramedics and nurse practitioners.

- Crisis Response EMS (CREMS) team works with mental health therapists to respond to clients in mental health crisis and has the ability to use primary care and existing community supports, addiction and mental health clinics and inpatient beds to best meet a client's immediate needs.

- City Centre Paramedic Response Unit (CC-PRU) responds to calls in the core of Edmonton with a focus on events that involve inner-city support sites and their clients. CC-PRU's goal is to foster strengthened relationships with these sites and to build trust with inner-city clients by improving access to primary care and other community supports as alternatives to EDs and EMS.

Northern Alberta Renal Program (NARP) serves northern and central Alberta, northwestern Saskatchewan, northeastern British Columbia and the Northwest Territories. A multidisciplinary approach to care is utilized for patients with end-stage renal disease. NARP has expanded its efforts in providing patients with education and opportunities to choose treatment modalities. Recent initiatives include the introduction of a modality nurse who meets with all new patients, and patient/family educational events such as the 'Home Sweet Home' educational day.

EDMONTON ZONE QUICK FACTS	2013-14	2014-15	2015-16	2016-17	% Change 2015-16 to 2016-17
Primary Care / Population Health					
Ambulatory Visits	2,383,476	2,410,006	2,490,807	n/a	3.4%
Number of Unique Home Care Clients	38,011	38,183	37,554	38,013	1.2%
Number of People Placed in Continuing Care	2,742	2,443	2,506	2,582	3.0%
Health Link Calls	296,362	325,440	269,205	278,755	3.5%
Seasonal Influenza Immunizations	387,959	417,388	384,723	389,918	1.4%
Food Safety Inspections	29,678	26,170	27,788	23,188	-16.6%
Acute Care					
Emergency Department Visits (all sites)	502,838	535,146	541,451	545,146	0.7%
Urgent Care Visits	23,977	12,082	9,943	11,667	17.3%
Hospital Discharges	135,969	139,052	141,279	142,582	0.9%
Births	18,374	19,258	19,751	19,849	0.5%
Total Hospital Days	940,956	984,395	975,054	995,660	2.1%
Average Length of Stay (in days)	6.9	7.1	6.9	7.0	1.4%
Diagnostic / Specific Procedures					
Total Hip Replacements (scheduled and emergency)	1,936	1,957	1,987	2,269	14.2%
Total Knee Replacements (scheduled and emergency)	2,156	2,068	2,166	2,191	1.2%
Cataract Surgery	14,525	14,411	14,458	15,751	8.9%
Main Operating Room Activity	104,219	102,467	102,463	106,999	4.4%
MRI Exams	75,665	81,945	78,254	77,523	-0.9%
CT Exams	139,743	147,226	149,237	157,225	5.4%
X-rays	597,028	609,179	613,135	603,962	-1.5%
Lab Tests	26,734,776	27,278,431	27,781,396	28,233,276	1.6%
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	319,104	325,538	337,234	344,170	2.1%
Unique Cancer Patients	23,507	23,868	25,074	26,442	5.5%
Addiction & Mental Health					
Mental Health Hospital Discharges (acute care sites)	6,061	5,978	6,188	6,929	12.0%
Staffing					
Head Count	31,497	32,657	32,921	33,473	1.7%
Volunteers*	2,522	2,680	2,903	2,771	-4.5%
AHS Physicians	n/a	2,659	2,714	2,824	4.1%

*Decrease in volunteers is attributed to removing duplications and inactive volunteers in the database.

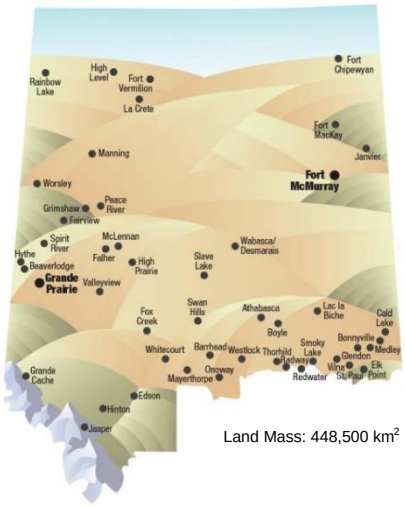
North Zone

Population Statistics (2016)

Overall Population: 484,964
Aging Population (over 65 years): 46,322
Life Expectancy: 79.9 years
Median Age: 33.9 years (2015)

Facts at your Fingertips

31% are obese
21% smoke daily
54% are active or moderately active
31% eat 5 or more servings of fruit/vegetables daily
21% are heavy drinkers (≥ 5 drinks on one occasion, at least once a month)
Source: Canadian Community Health Survey 2014



Land Mass: 448,500 km^2

North Zone Highlights

In early May 2016, nearly 90,000 Albertans were forced to leave their homes and communities when a wildfire swept through Fort McMurray in what would become Canada's largest natural disaster. AHS staff, physicians and volunteers in the Wood Buffalo area were faced with immense challenges as they assisted in evacuating affected sites, including the Northern Lights Regional Health Centre, relocating 73 patients and 32 continuing care clients to safety. At the same time, AHS teams around the province also responded. Thousands of people worked to keep patients safe, arrange for health services in makeshift locations, and provide care and support to those displaced from their homes. Response to the Fort McMurray wildfires required a provincewide effort co-ordinated by North Zone Addiction and Mental Health, First Responder Support Team.

Nursing staff at the Northwest Health Centre worked with the AHS Human Factors team to redesign crash carts to improve quality and patient safety. A crash cart is a mobile unit that holds a collection of emergency equipment, such as a defibrillator, medications and intubation supplies. Changes include arranging medication by order of use and removing supplies not needed during a code. These changes reduce the potential for medication errors, and improve accessibility to all items on the cart.

The new Edson Healthcare Centre opened in November 2016 and provides new continuing care beds, and expanded staffing in emergency and acute care. Many health services in the community are provided at the new facility including acute care, emergency, obstetrics, public health, mental health, and home care as well as primary care through the Community Health and Wellness Clinic. Services are supported by pharmacy, rehabilitation, ultrasound, X-ray and laboratory.

The High Prairie enhanced primary care clinic is operational and focuses on comprehensive, interdisciplinary primary care in communities with higher Indigenous populations, including enhanced mobile chronic disease management screening services.

Integrated Crisis and Access Team in Grande Prairie was launched to provide seven-days-a-week, 10-hour access to an intake assessment for addiction and mental health. The objectives are to increase ease of access to addiction and mental health services and decrease presentation to the emergency department.

Early Hearing Detection and Intervention program was implemented at Queen Elizabeth II Hospital (QEII) in November 2016. Phase I focused on screening of neonatal intensive care infants and Phase II focused on testing of well babies. The program builds on the previous Newborn Hearing Screening Program in place at the QEII and former Peace Country Health Region since 2000.

QEII was flooded as a result of a rain storm in August 2016. Flood remediation work was completed in December 2016. All staff worked together to support continued patient service. Despite the widespread extent of flood damage, work was completed with minimal interruptions to patient care activities.

NORTH ZONE QUICK FACTS	2013-14	2014-15	2015-16	2016-17	% Change 2015-16 to 2016-17
Primary Care / Population Health					
Ambulatory Visits	417,382	418,345	427,076	n/a	2.1%
Number of Unique Home Care Clients	12,343	12,970	13,788	13,778	-0.1%
Number of People Placed in Continuing Care	731	694	704	675	-4.1%
Health Link Calls	66,743	68,322	64,546	59,698	-7.5%
Seasonal Influenza Immunizations	109,501	114,209	99,860	92,672	-7.2%
Food Safety Inspections	14,878	15,589	15,317	14,550	-5.0%
Acute Care					
Emergency Department Visits (all sites)	585,294	577,643	550,409	521,993	-5.2%
Hospital Discharges	45,515	44,900	44,110	41,930	-4.9%
Births	6,299	6,309	6,558	5,701	-13.1%
Total Hospital Days	247,759	256,047	263,377	251,339	-4.6%
Average Length of Stay (in days)	5.4	5.7	6.0	6.0	0.0%
Diagnostic / Specific Procedures					
Total Hip Replacements (scheduled and emergency)	310	340	315	327	3.8%
Total Knee Replacements (scheduled and emergency)	410	445	514	547	6.4%
Cataract Surgery	2,313	2,194	2,142	1,998	-6.7%
Main Operating Room Activity	23,190	23,450	26,033	25,051	-3.8%
MRI Exams	12,569	12,971	13,621	12,893	-5.3%
CT Exams	32,309	34,066	35,051	34,824	-0.6%
X-rays	295,275	298,088	293,800	284,849	-3.0%
Lab Tests	4,774,459	4,883,055	5,038,109	4,937,068	-2.0%
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	14,469	14,081	14,162	16,437	16.1%
Unique Cancer Patients	2,272	2,199	2,318	2,378	2.6%
Addiction & Mental Health					
Mental Health Hospital Discharges (acute care sites)	2,961	2,994	2,983	3,060	2.6%
Staffing					
Head Count	9,987	10,411	10,403	10,574	1.6%
Volunteers*	3,356	3,083	2,774	1,626	-41.4%
AHS Physicians	n/a	579	607	594	-2.1%

*Decrease in volunteers is attributed to removing duplications and inactive volunteers in the database.

2016-17 Health Plan Results

AHS is working to improve the quality of care we provide to Albertans. Across the province, significant progress is being made toward building a patient-focused, quality health system that is accessible and sustainable for all Albertans.

Over the past year, we have undertaken many actions which are helping us to advance our mission. These actions align to our four goals and are organized by our 12 strategic objectives. The following section fulfils AHS' legislated accountability requirements to report on the year-end results of the actions stated in the 2016-17 Health Plan and Action Plan. Examples of actions are provided for each of the 12 objectives.

Build a Culture of Patient-Centred Care to Improve Experience

Patients, families and communities are the centre of everything we do and every decision we make. AHS is committed to the needs of Albertans and has developed a Patient First Strategy to help build a culture that organizes care around patients and their families. This strategy enables us to advance healthcare in Alberta by empowering and enabling Albertans to be at the centre of their healthcare team, improving their own health and wellness.

Improve the experience

Embed Patient First Strategy across the province.

Patient satisfaction is important to measure because it relates directly to the work we do. AHS conducts patient experience surveys in various areas, including experience related to hospital care, emergency medical services, family care clinics and addiction and mental health. These surveys help us improve care and services, better understand healthcare needs of Albertans and develop future programs and policies in response to what Albertans say.

Initiatives related to patient- and family-centred care (PFCC) in non-acute care settings are underway across the province. South Zone is working in partnership with primary care to involve patients in developing programs for vulnerable populations. Edmonton Zone's home care children's team engaged patients and children to redesign brochures and information sheets to be more client-oriented. In addition, provincial ambulatory community rehabilitation teams created a patient advisory panel for redesign work.

AHS welcomes patients and their families as full partners in their care and as essential members of the healthcare team. The new Visitation with a Family Presence Focus Policy and Visitor Management Appeal Procedure will be implemented in spring of 2017.

The annual Patient- and Family-Centred Care Week was held across the province in October 2016 and focused on building partnerships between care providers, patients and families. There were also contributions made to the PFCC website including the creation of digital stories.

To support patient- and family-centred care for Albertans who do not speak English as their first language, AHS provides interpretation and translation services provincewide. Accurate, two-way communication between patients and healthcare teams is essential in delivering high quality healthcare. Professional interpretation and translation support helps reduce misunderstandings, enabling patients to get the care they need and helping them understand their diagnosis and treatment. In 2016-17, AHS used over one million minutes of professional over-the-phone interpretation compared to 770,400 in 2015-16, a 30% increase. This service is available 24/7 in over 240 different languages. In 2016-17, professional telephone interpretation was used for approximately 110 languages.

AHS is ensuring there are sufficient policies and procedures, supported by educational resources and discussion guides, for physicians and staff to access in the event patients or their families ask about medical assistance in dying (MAID). Resources and statistics are now available online at www.ahs.ca/maid for both patients and their families and healthcare providers.

Zone committees and engagement consultants continue to support PFCC initiatives. Examples include implementing the family presence policy, recruiting patient advisors, and continuing implementation of CoACT elements such as discharge planning; Name, Occupation and Duty (NOD); care hubs, comfort rounds; and delivering culturally competent care. In the Calgary Zone, each urban acute care site has a formal PFCC committee that meets on a monthly basis and includes membership from at least five patient and family advisors. Zones also participate in leader rounding, which are planned and purposeful conversations between leaders, patients and families to learn about experiences and identify improvement opportunities.

AHS has processes in place to review and respond to feedback from patients and families regarding care and services. The provincial team works to resolve concerns with patients, families and staff. If a resolution is not possible, a concern will be forwarded to the Patient Concerns Officer (PCO) for review. All concerns and commendations reported are tracked in the Feedback and Concerns Tracking (FACT) database and monitored to identify areas for broader improvement. The table below displays the types of feedback provided to the provincial Patient Relations team and the number of concerns escalated to the PCO.

Concerns and Commendations	2015-16	2016-17
Total Number of Commendations	1,845	1,847
Total Number of Concerns	9,845	10,596
Total Number of Concerns reviewed by PCO	9	14
% of actions arising from concerns resolved in 30 days or less	59%	62%

Improve resident experience in long-term care.

Publicly accessible tools and resources are available on the AHS website to help clients understand the continuing care system and to provide clients and families with information to assist them with choosing the most appropriate living option.

Improvement strategies and action plans for sites with lower satisfaction levels were implemented. For example, staff practice compassionate communication and active listening to better tailor interventions for residents in Central Zone facilities.

Continuing Care Quality Indicator Working Group meets regularly to provide expertise and advice to support continuous improvement of continuing care measures for quality assurance and quality improvement. Sharing information about health service quality and success stories are ways that quality of care can be reviewed, monitored and improved. The Alberta Long-Term Care Quality Indicators report is available on the AHS website and complements Canadian Institute for Health Information (CIHI) data. It illustrates how Alberta is doing compared to national averages, shows comparisons between zones and describes actions undertaken or underway to improve care for residents in the zones. Ongoing public reporting raises awareness of good, quality care and flags areas for improvement.

Provide better transitions in care

Increase addiction and mental health capacity in primary care and the community to address recommendations in the "Valuing Mental Health Review."

Protection of Children Abusing Drugs Act (PChAD) is an Alberta law that helps children under 18 whose use of alcohol or drugs is likely to cause significant psychological or physical harm. AHS offers the PChAD program and currently has four safe houses in Calgary, Edmonton, Red Deer and Grande Prairie which provide a secure and supportive home-like setting for these children and give them direct access to addiction counselors and other health professionals to help them address their alcohol, substance abuse or concurrent disorders.

As of March 31, 2017, AHS opened 13 addiction spaces (including three new PChAD beds) and 111 community mental health spaces. With a provincial total of 25 PChAD beds, approximately 600 youth were admitted to PChAD in 2016-17.

A new local clinic will open in Edmonton in April 2017 that will offer a centralized option for addiction and mental health services and supports for local and area residents ages 11 to 25. Clinicians at the Access Open Minds clinic will screen clients to determine what services are needed and then co-ordinate those services.

Online training modules were developed to support community-based agencies and Primary Care Networks to expand the InRoads Drug Treatment Funding Program. The program's goal is to develop capacity to increase access to sustainable, evidence-informed, early intervention treatment services for children and youth in Alberta with addiction and mental health concerns.

AHS continues to support communities to prevent and reduce the harms associated with alcohol and other drug use under the umbrella of the Alberta Alcohol Strategy. Thirty-two community coalitions across the province were supported to implement promotion and prevention activities.

AHS is committed to addressing the increased misuse and effects of fentanyl use. Information and resources are provided on the AHS website to support staff and community agencies working with individuals using fentanyl. Free Take Home Naloxone kits were made available for all Albertans at pharmacies, mental health and addiction offices, harm reduction agencies and other walk-in clinics across the province. As of March 31, 2017, nearly 15,000 were dispensed to Albertans with a reported 1,130 reversals, through 1,095 registered sites including local pharmacies.

New opioid dependency treatment services were opened in Cardston, Ponoka and surrounding communities, Fort McMurray, and soon to open in Grande Prairie. These services provide patients with methadone treatment in an outpatient setting where they are stabilized under close medical supervision.

In response to the wildfire disaster in Fort McMurray, AHS developed nine disaster and emergency resources. Over 80,000 resources were distributed and more than 1,700 participants were trained with a focus on addiction and mental health preparedness, response and recovery.

Telemental health uses technology to ensure clients receive help without leaving their community by linking them to mental health professionals. The utilization of telemental health events increased by 36% from 2015-16 to over 10,000 events.

Expand access to cancer care.

The Community Paramedic program and Tom Baker Cancer Centre (TBCC) partnered to deliver supportive care interventions such as hydration, electrolyte replacement and transfusions to cancer patients outside of acute care. This partnership resulted in over 1,500 patients receiving care at home rather than going to the hospital. This program has enhanced the patient experience, supported better symptom management, decreased TBCC and emergency department visits, and increased emergency medical services job satisfaction.

Number of curative radiation therapy techniques and palliative radiation oncology clinics that improve treatment quality, efficiency and patient experience increased by 9.4% to over 124,000 treatments compared to 2015-16.

Total number of cancer patient visits increased to over 640,000 visits in 2016-17, representing a 3.9% increase from 2015-16.

An electronic Putting Patient First form was completed to support how providers respond to priority issues identified by patients. It includes a newly developed dashboard to help identify patients who have significant symptoms.

Other actions that support patient outcomes include the development of fatigue management and patient transition videos to support self-management, and a systemic therapy (chemotherapy) treatment series that enables patients to understand what is being prescribed, what to expect and how to self-manage so that they are partners in care and optimize their well-being throughout the treatment.

Investments were made in community and regional cancer centres to enhance patient access to care closer to home. This included expanding clinic hours and opening the newly renovated High River, Hinton, and Barrhead Community Cancer Centres.

Implement integrated service delivery models in rural and urban communities, with particular focus on seamless transitions of care and support for complex patients.

The planning phase of a new Primary Health Care Integration Network has been created to help Albertans access healthcare. The network focuses on improving transitions of care between primary care providers and acute care, emergency departments, specialized services and other community-based services.

Integrated care partnership (ICP) is an approach that helps primary care providers, zones and community partners to collaboratively develop and implement models of care to address care co-ordination challenges. Three ICPs were launched for chronic obstructive pulmonary disease (COPD) and heart failure, foot care and community geriatric service planning to enhance integrated care for patients with complex health needs.

AHS completed a report to better understand populations in Alberta that do not have primary care physicians. The report revealed that 12% of Albertans did not have a single visit with a primary care provider and 27% had low attachment and/ or low continuity. Findings from this report will be used to support physicians and teams, AHS programs, Primary Care Networks, Alberta Health and other stakeholders to improve attachment to primary care.

Edmonton Zone is working on an initiative to address the health of people with complex high needs and compromised social determinants of health. The objectives are to improve the experience of care for the individual, improve the health of this population and reduce the overall cost of care. The seven teams involved in this work are the Addictions and Mental Health Inner City Support Team working with adults experiencing homelessness and mental health and addictions issues, the Women and Addictions Team working with young women of child-bearing age with addictions, the Boyle McCauley Health Centre, the East Edmonton Health Centre, Home Care, Inner City Palliative Care and EMS community services. The learnings and approach will be leveraged to support developmental work in other zones.

A Provincial Community & Rural Maternity Care Plan was completed and approved for implementation. The plan focuses on keeping maternity care closer to home while maintaining principles of safety and best practice. It provides direction to address current service planning needs for maternal patients as well as a stepping stone to support future primary healthcare and acute care health service planning activities.

Web pages were launched on AHS Insite to support midwives with staff appointments and admitting privileges. The web pages help build understanding about the midwifery profession and the role midwives play as primary care providers for maternal and newborn care in Alberta.

Midwifery services are funded through the “Course of Care” model, which encompasses antepartum care, labour, and birth support to women with low-risk pregnancies and postpartum care to women and infants. Midwifery Services added 3,174 courses of care in 2016-17, an increase of 15% from 2015-16.

Address access and culturally appropriate care for underserved populations.

Alberta Screening and Prevention (ASaP) Program supports primary care providers in offering screening and prevention to patients who do not present for screening care. In September 2016, ASaP was launched in the Elbow River Healing Lodge located at the Sheldon M. Chumir Health Centre in Calgary. This facility offers a full range of primary care services to First Nations, Métis, and Inuit people and their families.

Three Indigenous communities (First Nations, Inuit and Métis) recruited community prevention practitioners to support communities to apply evidence-based comprehensive cancer prevention and screening plans and to increase awareness of prevention and screening.

The Improving Cultural Safety with Indigenous Patients, Families and Communities at Wetaskiwin Hospital and Care Centre (WHCC) project is under progress. This project aims to improve Indigenous patient and provider experiences at WHCC and establish culturally-safe delivery of care for Indigenous people.

A new initiative is underway to improve access and quality of maternal healthcare of Indigenous women in Edmonton, Maskwacis and Little Red River Cree Nation. The three communities will benefit through enhanced quality of prenatal care closer to home, culturally grounded education and peer support before and after birth as well as improved care coordination and evaluation.

Enhance community-based options

Offer more continuing care living options.

In 2016-17, AHS opened 376 net new continuing care spaces including 245 for seniors with dementia for a total of 25,323 community-based beds/spaces (including palliative). Since April 2010, AHS has added 5,623 spaces in the continuing care system to support individuals who need community-based housing, care and supports. Details on continuing care bed capacity can be found in the Appendix.

Home care helps people remain well, safe and independent in their home for as long as possible. Home care promotes client independence, and supplements care and supports provided by families and community services. Nearly 118,834 clients with unique needs received home care in 2016-17, an increase of 2% from 2015-16.

The Emergency Medical Services (EMS) Palliative End-of-Life Care Assess, Treat, and Refer program expanded in October 2016, increasing access to community clinicians and EMS. This program provides services across the province to help manage patients' palliative emergencies in their homes when they do not wish to go to the hospital.

To support palliative and end-of-life care, a provincial bereavement package and White Rose program were developed and launched. The White Rose program provides tools and supports for staff to help families in times of grief. In addition, a resource guide was developed and is available online to help communities build local supports and services in Alberta.

Improve system flow

Continue implementation of collaborative practice through CoACT and TeamCARE.

CoACT is an innovative model of care in which care providers collaborate with patients. Elements of CoACT include integrated plans of care, transition rounds, patient scheduling, standard transition process, right bed first time, home team, home unit and partnerships with support services. Overall implementation of the project is 73%.

TeamCARE is a team-based training program that seeks to improve the reliability of care and enhance patient safety by empowering staff with teamwork, communication and quality improvement skills and techniques. TeamCARE refresh training programs were designed to increase the number of trainees per team to reduce the impact of turnover, align with AHS content, and provide more opportunities for teams to practice key techniques in a safe environment. In 2016-17, nine teams with over 70 staff and supports participated in refresh training.

Address patient flow, emergency department throughput and capacity.

Zones continue to implement initiatives to improve emergency department (ED) flow. Real-time Emergency Department Patient Access & Co-ordination (REPAC) was implemented in the South Zone to provide information on patient volumes, incoming EMS volumes and information on capacity to improve ED workload balance between hospitals. Calgary Zone completed a rural ED satisfaction survey and created plans to improve care and flow. Central Zone's Red Deer Regional Hospital Centre developed daily RAPID discharge rounds on inpatient units, trialed use of recliner chairs for patients waiting to be discharged, and began work on improving bed turnaround. Edmonton Zone conducted process improvements in consult times for general surgery and mental health, implemented a Rapid Transfer Unit at the University of Alberta Hospital and provided new mental health space at the Royal Alexandra Hospital. Mental health teams are working to improve community services by opening a clinic to reduce usage of the Queen Elizabeth II ED in the North Zone.

Dementia Advice was launched in Calgary and Edmonton Zones in May 2016 and is now available in all five zones through Health Link and can be accessed by dialing 811. Dementia Advice nurses help support anyone living with or caring for someone who has dementia, including those with Alzheimer's disease.

AHS launched the Health, Education and Learning (HEAL) website in September 2016, a resource aimed at providing families across Alberta with easily accessible, reliable information about common minor illness and injuries in children. The content was developed by Pediatric Emergency Medicine experts at the Alberta Children's Hospital and Stollery Children's Hospital.

The Provincial Patient Repatriation Policy and Procedure was revised to facilitate proactive planning and timely transfer of patients from hospitals to healthcare facilities closer to the patient's home community.

Health Outcomes and Clinical Best Practice

AHS encourages Albertans to be partners in health to achieve better health outcomes for themselves, their families and their communities. Through collaboration with various stakeholders, we are building a health system that gives patients control over factors that affect their health, improves service quality, promotes leading practices, consistently applies standards and increases local decision-making.

Ensure a quality and safety focus in patient care

Focus on accreditation standards that address patient safety areas.

Hand hygiene is the most-effective way to prevent the spread of communicable diseases and infections. At the provincial level, hand hygiene reviews were performed by 521 reviewers, including 510 site-based reviewers, at 155 sites.

Hand hygiene compliance was 82.2%, an improvement of 3% from last year. At the zone level, hand hygiene compliance varied from 77.6% (Central Zone) to 88.0% (North Zone); a total of 382,993 observations were collected. AHS is in the process of redesigning the Hand Hygiene Reviewer Training to be more efficient and effective.

AHS continues to hold accredited status based on the Accreditation Canada on-site survey, which demonstrates our commitment to meeting national standards for quality and safety in providing healthcare services. The results capture the successes and challenges of our provincewide, integrated health system. In the report, Accreditation Canada surveyors recognized AHS' passionate and caring staff who work collaboratively in interdisciplinary teams to meet the needs of patients, both within the organization and with community partners. Surveyors also acknowledged additional strengths contributing to AHS' ability to provide safe, quality patient care such as a committed executive leadership and front-line managers; positive interactions between staff, patients and families at the point of care; continued progress and dedication to quality improvement; and significantly improved medication reconciliation practice from the last survey.

With the incorporation of the Pharmacy Good Catch program into AHS' Reporting and Learning System for Patient Safety (RLS), the process for entering and reviewing parenteral nutrition-related events has become more intuitive and accessible for both front-lines and administrators. These changes improve patient safety and meet Health Quality Council of Alberta (HQCA) recommendations.

Antimicrobial Stewardship committees continue to implement *Clostridium difficile* Infection (CDI) toolkits. These include pre-printed care orders, environmental cleaning protocols, nursing checklist and a management flow map. Cases of CDI are reviewed by AHS Infection, Prevention & Control and AHS Pharmacy for proper treatment, order set use, precautions, cleaning, and appropriate antibiotic and proton pump inhibitor de-escalation to evaluate the use of the CDI toolkit components.

Overall, antimicrobial usage of the 16 sites for the 14 antimicrobials highly associated with CDI decreased in the last two years. This is due in part to AHS implementing targeted initiatives, such as education and awareness campaigns, aimed at reducing the use of antimicrobials highly associated with CDI.

Proper cleaning and disinfection of the healthcare environment can prevent cross-transmission of microbes, thereby preventing healthcare-acquired infections. AHS implemented the standardized clinical equipment cleaning program at four Edmonton Zone sites: Royal Alexandra Hospital, Glenrose Rehabilitation Hospital, University of Alberta Hospital, and Sturgeon Community Hospital; remaining AHS sites will be completed in 2017-18.

Implement business continuity and disaster recovery plans.

A Provincial Framework for Emergency/Disaster Management was completed in October 2016 with a business plan completed in April 2017. This framework is a health-focused, comprehensive, integrated document that provides a context for co-ordination of emergencies/disasters.

The Business Continuity Management Program serves as a treatment of risk associated with the loss or interruption of any of the requirements for healthcare delivery. The program began implementation of business continuity and disaster recovery plans across AHS to ensure effective readiness. This work will continue in 2017-18.

Ensure appropriate clinical practice through innovation.

Strategic Clinical Networks (SCNs) are bringing new models of care, along with evidence-based care pathways, to improve clinical care and utilization by removing barriers that lead to variation in practice. Below is a sample of key SCN highlights:

- Two new SCNs were launched – Population, Public & Indigenous Health SCN (May 2016) and Digestive Health (November 2016).
- The Appropriate Use of Antipsychotics (AUA) project started at 11 early adopter sites, then spread to 170 long-term care facilities and now is spreading to over 80 supportive living sites. The project aims to reduce antipsychotic medication use for continuing care residents. The Resident Assessment Instrument quality indicator for AUA improved from 26.8% in 2015-16 to 17.5% in 2016-17. Alberta is leading Canada in this indicator.
- Four High Risk Foot Teams in Brooks, Slave Lake, Westview and Calgary were mobilized to support primary care teams to provide treatment for diabetic foot ulcers – thereby decreasing the need for emergency care or amputations.
- Eight early adopter sites implemented basal bolus insulin therapy to allow clinicians to customize insulin based on unique needs of patients.
- Quality Improvement & Clinical Research (QuICR) initiative, which focuses on reducing median door-to-needle (DTN) time to improve stroke outcomes, was completed. Results show that the median DTN time improved from 45 minutes with 65% treated in 60 minutes or less (October 2015) to 36 minutes with 82% treated in 60 minutes or less (February 2017).
- Endovascular Reperfusion Alberta project was implemented in the zones to improve endovascular therapy access for patients with acute ischemic stroke to reduce mortality and disability.
- All 50 acute care sites that provide obstetrical services have implemented the new Postpartum and Newborn Clinical Pathways developed in 2016.
- Zones continue to reduce emergency department stat toxicology in rural areas and to ensure appropriate use of antipsychotics and benzodiazepines in addiction and mental health patients (Choosing Wisely).

Clinical care pathways outline a sequence of activities for specific diagnosis groups or patient populations to maximize quality of care, efficient use of resources and improve transitions of care.

The following pathways were developed in 2016-17:

- Diabetic Foot Care
- Inpatient Diabetes Management
- Repetitive Transcranial Magnetic Stimulation
- Breast Health
- Provincial Delirium Initiative
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)
- Conservative Kidney Management
- Provincial Perinatal

Continue to implement and spread AHS Improvement Way (AIW) initiatives.

AIW provides training and application support in principles, knowledge and tools necessary to help make positive changes. The number of staff and medical staff receiving AIW training in 2016-17 was 2,345, a 6.2% increase from 2015-16. Over 15,000 people have received AIW training. There were 14 large AIW initiatives with 10 initiatives showing a more than 20% improvement and over 100,000 patients positively impacted.

Examples of AIW projects include:

- Neonatal intensive care unit program at the Stollery Children's Hospital made improvements that led to freeing up staff time and improved patient experience.
- Gastro-Intestinal Bleed initiative was conducted in partnership with the Emergency Strategic Clinical Network at seven sites that impacts over 10,000 patients. A clinical pathway was created to reduce unnecessary admissions to the medicine units as well as unnecessary blood transfusions.

Improve surgical capacity management

Improve outcomes for patients after surgery.

The Enhanced Recovery After Surgery (ERAS) program, and SCN initiative, standardizes care before, during and after surgery to get patients back on their feet quicker while shortening hospital stays and reducing complications after surgery. The program started with one pathway (colon/rectal cancer) at two sites, then 10 pathways at 16 sites and is now spreading to over 50 sites. The implementation of the ERAS colorectal pathway has generated 3,024 days of bed capacity, as well as patients returning home 2.3 days sooner with 11% fewer complications.

The National Surgery Quality Improvement Program (NSQIP) uses clinical data to improve performance by reducing rate of preventable surgical complications at five hospitals in Lethbridge, Calgary, Red Deer, Edmonton and Grande Prairie. The readmission rate for 2016-17 showed an improvement since previous year (4.5% compared to 5.2%).

The emergent and urgent coding project was launched to standardize wait time measurement and processes around emergent and urgent surgeries. This project will enable AHS to have a full measurement of surgical access/demand across the province.

Improve co-ordination of emergency medical services in rural and remote communities

Implement the Emergency Medical Services (EMS) Plan.

The AHS Emergency Medical Dispatch system was recognized by the International Academies of Emergency Dispatch as an Accredited Centre of Excellence (ACE). Recognition as a medical ACE service is one of the highest achievements in the medical dispatch community and is an acknowledgment of the skill and dedication demonstrated by the nearly 250 EMS dispatch professionals.

Fort McMurray was consolidated into the EMS Dispatch Model, including the roll-out of the Alberta First Responder Radio Communications System to all EMS units in the province. This dispatch model ensures all patients have access to the closest ambulance in an emergency.

Six centres – Northern Communication Centre, Central Communication Centre, Southern Communication Centre, Red Deer, Fort McMurray and City of Lethbridge – are utilizing the collaborative computer-aided dispatch system.

AHS EMS played a significant role in the successful response to the Fort McMurray wildfire disaster in patient evacuation by air ambulance, support (first responders during the event), and recovery. To support the region's fire and EMS services, AHS EMS provided additional ambulances for the duration of the disaster to ensure medical support was available, deployed a portable isolation containment system to establish a temporary field hospital, and provided continual logistical support until it was demobilized.

AHS EMS continues to support the implementation of the new stroke ambulance in Edmonton which is a specially built and equipped ambulance that travels to stroke patients in central and northern Alberta. With the new vehicle, stroke diagnosis and treatment that was previously only available in hospitals is brought directly to the patient.

A fentanyl training package for Medical First Responder agencies was established for those interested in providing treatment for opioid overdose patients.

Education modules for registered midwives with privileges and EMS were developed to gain a better understanding of how they can collaborate to provide effective care to Albertans and to improve neonatal and maternal outcomes. This was a joint project between AHS Provincial Midwifery Services and AHS Emergency Medical Services.

In support of the EMS Strategic Framework, four communities with ambulance stations were engaged with service planning. Plans are underway to continue engagement with communities in 2017-18.

Based on the EMS patient experience survey, 96% of surveyed patients agreed or strongly agreed with the statement "overall, I was satisfied with my experience with EMS." AHS publicly posts six EMS-specific performance measures in the form of a performance dashboard on its website.

Integrate research, innovation and analytics in the delivery of care

Integrate research, innovation and analytics to guide decision-making, improve performance and deliver quality care.

AHS continues to strengthen health research innovations, new technologies and new knowledge to apply to clinical settings. A total of 91 projects were funded through formal, peer-reviewed processes. There were a total of 66 requests submitted by the SCNs for review of technologies under the Health Technology Assessment process.

Examples of research and innovation highlights from the past year:

- Alberta's 17 stroke treatment centres are among the fastest in the world in giving patients the clot-busting drug tPA (tissue Plasminogen Activator). The average time it takes from a patient's arrival at hospital to being diagnosed with stroke and treated has been halved from 70 minutes to 36 minutes.
- A new approach is used to treat recurrent *Clostridium difficile* Infection (CDI). Fecal Microbiota Transplantation (FMT) is the process of transplanting fecal bacteria from a healthy individual into a recipient with CDI. FMT has an overall treatment success rate of 93%. Timely FMT can prevent subsequent emergency room visits and hospitalization, and improve quality of life for patients.
- Alberta Children's Hospital offers a new surgical procedure to ease the pressure of hydrocephalus. The minimally invasive procedure creates new channels for cerebrospinal fluid to drain and circulate normally. Standard practice has been to place a shunt to drain the fluid, which can have complications.
- A new high-tech heart-valve fix heals seniors who are too weak for open-heart surgery. The minimally invasive procedure provides patients with a rapid recovery time and improved quality of life.
- Stroke patients at risk of choking can benefit from a new assessment tool, Fiberoptic Endoscopic Evaluation of Swallowing, offered at the Brooks Health Centre and Medicine Hat Regional Hospital. The new tool means a reduction in wait times and helps patients, families and care teams make decisions about nutrition.
- Work continues on a research project that provides a complete and accurate measurement of immunization coverage in children in two Alberta First Nation communities and identifies barriers and supports to childhood immunizations in these communities. The project will help guide policy and practices to improve immunization access and uptake through development of culturally appropriate solutions.
- AHS is engaged in a national research project that identifies tests, treatments and procedures to avoid in Emergency Medicine. The Emergency Strategic Clinical Network has implemented strategies to improve efficiency of evidence-based care by avoiding unnecessary tests, improve safety of care, and improve stewardship of healthcare resources.

Promote and support wellness for our communities

Reduce communicable disease through preventative measures.

Immunizations, also known as vaccinations, help protect against infectious disease. Vaccines are safe and they are important for two key reasons: vaccinations protect you and protect those around you. For more information, visit the website at immunizealberta.ca.

Immunization	2015-16	2016-17
Influenza:		
Children	36%	34%
Long-Term Care Resident	90%	89%
Health Care Worker	61%	63%
Childhood Immunization by age 2:		
Diphtheria / Tetanus /Acellular Pertussis, Polio, Hib (DTPP)	78%	78%
Measles / Mumps / Rubella (MMR)	87%	87%
Rotavirus immunization coverage in infants (completion rate of 2-dose series)	56%	80%
Sexually transmitted infections (STI) screening rates for 20-24 year olds	23% (2015)	24% (2016)

In response to the mumps outbreak declared in the South and Edmonton Zones, AHS Communicable Disease Control (CDC) worked closely with Alberta Health, Medical Officers of Health and senior management on reporting number of cases, vaccine supplies and updating policies (i.e., a new policy for adult immunization is planned to go into effect in June 2017). CDC also opened a virtual Emergency Co-ordination Centre to ensure a co-ordinated provincial response. For more current information, visit www.ahs.ca/mumps.

Promote healthy social and physical environments and focus on health promotion, wellness, and disease and injury prevention.

The Better Health, Better Business website outlines steps and provides tools on how workplaces can create sustainable changes to health culture and employee health practices that influence cancer and chronic disease. For 2016-17, eight workplaces completed the workplace health assessment, 14 completed action plans, and 11 completed evaluation plans.

To support recovery operations in communities impacted by the Fort McMurray wildfire, there were 40 rental/public inspections, 106 private home inspections, 138 housing inspections, 785 demand inspections, 116 risk management inspections, and 659 service requests completed in 2016-17.

Several safe and healthy environment initiatives were conducted across the zones. For example, Calgary Zone responded to residential properties contaminated with fentanyl and created an interim solution to ensure properties were assessed and remediated without exposing public health inspectors to fentanyl contamination.

Work continues with school boards to implement comprehensive school health and healthy public policy related to nutrition, physical activity and positive mental health. For 2016-17, 90% of school jurisdictions implemented comprehensive school health and 79% of school jurisdictions have a healthy public policy in place.

A Million Messages standardizes child injury prevention messages given to parents and caregivers. In 2016-17, 770 AHS staff (compared to 466 in 2015-16) completed the module which is an electronic self-learning tool for staff working with parents and caregivers to learn about the burden of injury.

Applied Suicide Intervention Skills Training (ASIST) is a workshop in suicide first aid that teaches participants to recognize when someone may have thoughts of suicide and work with them to create a plan that will support their immediate safety. In 2016-17, 834 AHS staff completed ASIST and other suicide prevention training courses.

AHS is developing the Early Hearing Detection and Intervention program which offers screening to newborns in Alberta for hearing loss prior to hospital discharge. Infants not passing the screening receive diagnostic evaluation and, when necessary, are enrolled in early intervention programs. Three neonatal intensive care units - Medicine Hat Regional Hospital, Queen Elizabeth II Hospital (Grande Prairie) and Grey Nun's Hospital (Edmonton) – implemented the program in 2016-17. This program will continue implementation into 2017-18.

Reduce risk factors for cancer and chronic disease through direct intervention.

Alberta's cancer incidence rates have declined by about 0.6% annually between 2001 and 2014. Mortality rates have also decreased over the past 20 years, falling on average by 2.1% annually between 2004 and 2014. The data in the 2014 Report on Cancer Statistics in Alberta – released February 2017 – shows the significant impact early detection and cancer screening can have on a rate of survival and years lived. AHS continues to support a number of effective screening and prevention programs, and expand these services every year.

Alberta cancer screening programs (breast, cervical and colorectal cancers) continue to provide education and awareness across the province. For example, collaborative work is underway with Primary Care Networks to understand diverse populations and address access to services.

Screen Test celebrated 25 years of mobile breast cancer screening services, reaching over 117 communities, including 26 Indigenous communities (New Sarepta, Fort McMurray First Nation, Kehewin Cree Nations and Alexander First Nation added this year). Screen Test has seen a 67% increase in First Nations clients since 2013. This year, Screen Test sent approximately 800,000 letters to Albertans and their healthcare providers on cancer screening status and recommended actions; as well, 135,260 visits to www.screeningforlife.ca were recorded.

Twelve communities completed the community health assessment for cancer prevention and screening, and 14 implemented action plans. Five additional communities were recruited – two rural Alberta and three Métis Settlements.

Total number of visitors to AlbertaPreventsCancer.ca was 114,859, a 23% increase from 2015-16. New content and enhancements made to the website to improve user experience include:

AlbertaPreventsCancer.ca connects Albertans to useful resources and strategies they can use to reduce the risk of cancer or detect cancer earlier. It provides online tools and resources to support cancer prevention, screening and research.

- Upgrade to the Human Papilloma Virus (HPV) vaccine decision tool, a tool for parents of children who are eligible for the HPV vaccine, resulting in an increase in the number of site visits (2,017 compared to 47,564) and completion rates (15.5% compared to 18.1%) from 2015-16.
- BeSunsible website was optimized to better support employers of outdoor workers to incorporate sun safety into their occupational health and safety practices; site visits increased 70% from 2015-16.
- Online community cancer prevention and screening dashboard was launched, and Albertans can access information on how to reduce cancer risk in their communities and see how their community is performing compared to other communities.

Chronic diseases, including some cancers, cardiovascular diseases, chronic respiratory disease and diabetes are leading causes of death in the province. As Alberta's population increases and gets proportionately older, the rising burden of chronic disease on the healthcare system will also become unsustainable. There are strong associations with four risk factors (tobacco, alcohol consumption, physical inactivity and unhealthy eating) and the most common chronic diseases. Examples of AHS activities related to chronic disease management in 2016-17:

- AlbertaQuits connects people to support services, such as counselling, to help quit smoking. There were a total of 2,900 registrations and 2,752 quit attempts at AlbertaQuits.ca in 2016-17, a significant increase from 2015-16.
- The Find Your Stride program, which targets smokers to increase physical activity was piloted and evaluated.
- Four new communities (including one Indigenous community) are engaged in WalkABle Alberta. There are a total of 19 communities participating in WalkABle Alberta.
- Resources related to healthy drinks, vegetable and fruit consumption, and sodium were completed and posted on healthyeatingstartshere.ca, including a Community Gardens Handbook.
- A Collective Kitchens toolkit was developed and disseminated to community groups across Alberta.
- Ten alcohol and health educational resources to improve the health and safety of groups at high risk of alcohol misuses were developed.

Our People

AHS is committed to supporting our people as we work together to deliver patient- and family-centred care. This commitment is reflected in Our People Strategy, which guides how we put our people first, so they can put patients and families first.

Engage staff, physicians and volunteers in a culture of patient- and family-centred care

Implement Our People Strategy across the province.

Our People Survey is a comprehensive workforce engagement and patient safety culture survey conducted at AHS. AHS' leadership will use the survey results to lead a change management effort and to support engaging discussions within teams. The scores were based on a five-point scale, with one being 'strongly disagree' and five being 'strongly agree'. The survey results give us valuable information and a starting point to have local team discussions that will guide our engagement efforts and continually improve our patient safety culture.

Employees	Volunteers	Physicians
57% were positive about the work they do at AHS and chose a 4 or 5 for overall satisfaction.	90% were positive about the work they do at AHS and chose a 4 or 5 for overall satisfaction.	48% were positive about the work they do at AHS and chose a 4 or 5 for overall satisfaction.

The New Manager Preparation Program was launched across AHS after successful pilots in the Edmonton and Central Zones. This program is aligned with Our People Strategy's priority of building excellent leaders by focusing on foundational management skills and gaining an early understanding of manager accountabilities. The program provides new managers access to education, tools and resources as they prepare for their new role.

LEADS in a Caring Environment Capabilities Framework has become a foundation for health leadership in Canada. The LEADS framework represents the key skills, behaviours, abilities, and knowledge necessary to lead across the health system. Work is progressing to align AHS leadership competencies with the LEADS education module.

Ensure a safe and healthy workforce and manage workplace communicable disease exposures and outbreaks.

The health and safety commitments under Our People Strategy for 2016-17 were completed, including the launch of a comprehensive safety training program for leaders (Leading Health and Safety in the Workplace - Fundamentals) and the formation of an AHS Psychological Health and Safety Steering Committee in the workplace.

The Psychological Health and Safety Steering Committee outlined an organization-wide strategy to improve and maintain psychological health and safety within AHS. Emergency Medical Services launched Road to Mental Readiness (R2MR) training for all staff to improve workers' resilience to the psychological hazards they face in the workplace.

AHS was formally recognized by the Mental Health Commission of Canada as one of 40 organizations helping to foster psychologically healthy and safe workplaces. There were 125 compensable psychological injuries reported in 2016-17 compared to 107 in 2015-16. AHS Workplace Health & Safety continues to actively partner with several internal and external partners to create awareness and mitigation strategies for this type of injury in AHS. As the stigma lessens and the work continues, AHS expects to see a rise in employees reporting psychological injuries.

AHS implemented the mandatory communicable disease assessment (CDA) policy and program for all new hires which provides access to staff immunization history and records in the event of an outbreak or exposure to a patient who has a communicable disease. By the end of fiscal year 2016-17, 84% of new hires completed the communicable disease assessment.

As of March 31, 2017, there were 186 wellness champions across the province compared to 165 in 2015-16. The network builds on the idea that everyone at AHS can act to protect the health, safety and wellness of themselves and those they work with.

Financial Health and Operational Best Practice

AHS continues to address challenges through fiscal management, a focus on sustainability, development of our workforce, implementation of leading practices, process improvement and preparing for the future health needs of Albertans.

Ensure investment in new technology and/or information management systems supports care delivery

Use information for front-line automated clinical decision support and provincial electronic health records.

AHS co-ordinates provision of access to the Alberta Netcare Portal to staff and physicians. The number of active provider accounts within Netcare increased by 5.5% compared to last year. Netcare usage increased in part due to significant enhancements in Netcare in 2016, such as the addition of immunization history for all Albertans and the Best Possible Medication History report.

Alberta Netcare is a secure and confidential electronic system of Alberta patients' health information, collected through point-of-service systems in hospitals, laboratories, testing facilities, pharmacies, and clinics.

MyHealth.Alberta.ca provides trusted health and wellness information to Albertans and is also the access point to Albertans' personal health records. There was a 20% increase in the number of visits to MyHealth.Alberta.ca in 2016-17 compared to 2015-16. Other highlights to MyHealth.Alberta.ca include:

- Home page feature carousel was used to support emerging events such as measles, mumps, World Cancer Day, Alzheimer's disease, oral health, fentanyl awareness, and Fort McMurray wildfire mental health support.
- "Help4Me" website launched in May 2016 in collaboration with Alberta Health and Human Services to improve access to youth addictions and mental health resources.
- Two new learning modules were added on weight management for adults and insulin pump education.
- Over 550 pages of new content were added to the website, including drug monographs, health information, videos and patient care handouts.

Enhance clinical information systems in ambulatory and acute care settings.

A key focus for the past fiscal year has been the AHS Provincial Clinical Information Systems (CIS) Request for Proposal (RFP). AHS is reviewing proposals and a final decision will be made early in the new fiscal year. A provincial CIS will ensure that healthcare providers have access to accurate patient information. With a single comprehensive record and care plan for every patient, quality and safety of care is improved, and patients and their families across the healthcare system will have a better experience.

Supporting the Provincial CIS, 18 new clinical guidance knowledge topics (i.e., emergency, cancer, maternal and seniors' health topics) were released which provide standardized guidance to clinicians on a particular disease or condition. In addition, 25 new order/service catalogues (i.e., pharmacy medications, diagnostic imaging reporting, special chemistry (lab), and respiratory) were released which standardizes orders and clinical services provincially.

Optimize service delivery through needs-based service planning and operational best practices

Focus on operational best practices, identifying where we vary from other jurisdictions.

Senior leaders continue to implement business efficiency initiatives through an attrition model based on direction from the Government of Alberta. While this resulted in delays in implementation of initiatives as the natural attrition rates have slowed within AHS, cumulative savings of $135 million and a reduction of 833,000 in worked hours have been realized to the end of March 31, 2017.

In addition to identifying business efficiencies, opportunities were identified for data quality improvement. These improvements provide AHS leaders with increased levels of consistent, relevant and comparable information to improve operational decision-making, peer comparison and consultation.

Create comprehensive health service delivery models to achieve optimal health outcomes for Albertans.

Long-range planning is underway in both the Calgary and Central Zones with a focus on a 15-year vision for healthcare, as well as assessing potential options for transforming care into the community. Community and staff engagement sessions and online opportunities for providing input begin in November 2016 and continues. These inputs will contribute to informing a high-level health system strategy, which will be further developed in 2017. Long-range plans for North and South Zones will follow.

Access to service guidelines are part of a comprehensive, provincial, community-based planning approach to health system/service planning. They provide consistency and transparency in service planning and decision-making, while considering access, quality and sustainability as well as improved patient outcomes, improved patient experience, lower cost of care, and improved provider experience. They will ensure local population needs and unique community characteristics are considered in service planning and delivery. Guideline development for three priority planning areas were identified to be further advanced in 2017.

The following are examples of service plans completed in 2016-17: South Zone Aboriginal Health and Action Plan, Airdrie Urgent Care Service Plan, Calgary Zone Child and Adolescent Mental Health Program Brain Health Service Plan, Edmonton Zone Trauma Plan, Sylvan Lake Enhanced Services Plan, and Beaverlodge Health Service Plan in the North Zone.

A Guide to Community Engagement was developed and shared across AHS to help build understanding of and support for practicing meaningful engagement. The guide has been applied to various engagement activities and feedback has been positive.

Continue implementation of a consolidated Laboratory Service Delivery Model.

AHS continues to work with Alberta Health to finalize the new laboratory service model for Alberta. A new model will focus on patient needs, safety and quality by addressing challenges of increasingly sophisticated testing and increased demand for services, and also by providing a cost-effective solution.

PERFORMANCE RESULTS

- Leading in Health
- Performance Measures
- Monitoring Measures

Measuring and Monitoring our Progress

AHS continues to monitor a number of measures that help inform us about the performance of our health system and support priority setting and local decision-making.

The measures track our performance using a broad range of indicators that span the continuum of care. They include population and public health, primary care, continuing care, cancer care, emergency department and surgery.

Some of these measures do not have targets or national benchmarks across the country for comparison. However, these measures are familiar and of interest to Albertans. These measures are updated quarterly and posted on the AHS website.

Leading in Health

The following indicators were developed by the Canadian Institute for Health Information (CIHI) that measure the health of Canadians and health system performance in Canada. These indicators help inform AHS and Albertans on how we perform nationally but may not align with the measures developed by AHS and Alberta Health to measure performance in Alberta. While AHS is always striving to improve and address challenges in healthcare, these examples highlight where Alberta already excels in the country.

AHS is a national leader in many areas of healthcare, according to the latest statistics from the CIHI, including having administration costs that are among the lowest in the country as a percentage of total spending. We want to make sure we maintain or further improve this level of performance and the excellent clinical care that is already being provided.

First in country for:	Second in country for:	Third in country for:
❖ Lowest total time spent in emergency department for admitted patients (all sites) ❖ Fewest repeat hospital stays for mental illness ❖ Lowest hospital deaths following major surgery (tied) ❖ Lowest potentially inappropriate use of antipsychotics in long-term care ❖ Lowest administrative expense ❖ Best perceived health	❖ Lowest number of obstetric patients readmitted to hospital (tied) ❖ Lowest restraint use in long-term care ❖ Highest improved physical functioning in long-term care ❖ Fewest patients experiencing pain in long-term care ❖ Highest physical activity during leisure time	❖ Fewest low-risk caesarean sections ❖ Highest life expectancy at age 65 ❖ Fewest hospitalized heart attacks ❖ Fewest self-injury hospitalizations

Source: CIHI 2014-15

Performance Measures

The following 17 AHS performance measures were established in collaboration with Alberta Health. These measures reflect a balance across the spectrum of healthcare and accurately reflect health system performance. They were developed to enable us to compare AHS performance nationally. The performance measures are aligned to the Alberta Quality Matrix for Health, developed by the Health Quality Council of Alberta (HQCA), which describes six dimensions of quality: acceptability, accessibility, appropriateness, effectiveness, efficiency and safety.

The measures play a key role in advising staff and physicians about our progress and where we may need to adjust actions to achieve the identified targets; they also help in communicating with Albertans about the value provided by health funding expenditures.

The 2016-17 targets were established in the AHS 2016-17 Health Plan and Business Plan. These performance targets help us measure our progress and improve the health system.

In many areas, AHS continues to see increases in volume and demand for services. Initiatives within AHS are being put in place in an effort to not only move measures toward their targets, but also to compensate for these increases.

The chart on the following page represents the full fiscal period ending March 31, 2017. These results are produced by AHS Analytics with national comparisons from Canadian Institute for Health Information (CIHI), where applicable. There are 15 measures that are reported quarterly; of these, nine measures include the most current data available (2016-17) and six measures are updated to the end of the third quarter. These latter measures either rely on patient followup after a patient's discharge date and require additional information to become available after discharge (e.g., readmission rates) or require longer periods of time for verification (hospital-acquired infections and mortality rates). The reporting cycles for two measures, Early Detection of Cancer (source: Alberta Cancer Registry Data) and Satisfaction with Long-Term Care (source: HQCA), do not align with AHS' reporting cycle.

Performance trending is done by comparing current reporting period (2016-17) to the same period last year (2015-16). Further analysis and explanation of variances can be found in the Q4 year-to-date 2016-17 performance measure report – available on the AHS website.

- Three performance measures *achieved 2016-17 target* regardless of performance comparison (★).
- Five performance measures *are better than the same time period as last year* but have not met target (✓).
- Six performance measures are stable, within 3% from the same time period as last year (⇔).
- Two measures have deteriorated from the same period as last year (✗).

Continuing care placement: To address the rate of spending in 2016-17, a decision was made to defer the opening of some continuing care and addiction and mental health community care spaces and minimize growth of home care program spending. These changes are driving longer waits and higher waitlists for placement into continuing care living options. The average wait time for continuing care placement in acute /subacute care is 46 days (compared to 44 days for the same period last year). The number of people waiting in acute/sub-acute care has increased to 846 as of March 31, 2017 (compared with more than 628 people waiting in 2015-16). It is important to note that not all of these patients are waiting in an acute care hospital bed in a busy urban hospital. Many are staying in transition beds, sub-acute beds, restorative/rehabilitation care beds, and rural hospitals where system flow pressures and patient acuity are not as intense. In 2016-17, there were 8,002 people placed into continuing care compared to 7,879 for the same period last year. Work continues across the province to implement the Seniors Health Continuing Care Capacity Plan. In 2016-17, AHS opened 376 net new continuing care spaces including 245 for seniors with dementia for a total of 25,323 community-based beds/spaces (including palliative). Since April 2010, AHS has added 5,623 spaces in the continuing care system to support individuals who need community-based housing, care and supports. All delayed/deferred care spaces are planned to open in the 2017-18 fiscal year.

Access to Children's Mental Health: Overall, there has been an improvement in access to children's mental health services from quarter to quarter this fiscal year; however, year-to-date results have been impacted by increased demand for children's mental health services combined with staff vacancies/leaves that impact the availability of services and wait-times. Strategies to improve efficiency include: process improvement and service innovation, parenting programs and walk-in sessions, successful recruitment into long-standing vacancies, implementation of regional collaborative school delivery projects as well as children and youth mental health projects via child and family services and primary care networks, expanded in-reach into high schools and improved access to care for families in south Edmonton through the newly opened Rutherford Clinic.

AHS Performance Measure	2012-13	2013-14	2014-15	2015-16	2016-17	Target 2016-17	Trend	2015-16 National Comparison*
Acceptability: *Health services are respectful and responsive to user needs, preferences and expectations.*								
Satisfaction with Hospital Care: Percentage of adult patients who rated their overall care in hospital as 8, 9 or 10, where zero is the lowest level of satisfaction possible and 10 is the best.	81%	82%	82%	82%	83% Q3 YTD	85%	✓	Not available
Satisfaction with Long-Term Care: Percentage of families of long-term care residents who rated the overall care as 8, 9 or 10; zero is the lowest level of satisfaction possible and 10 is the best.	2007 = 71% 2010 = 73% 2014 = 72%			Reported by HQCA				Not available
Safety: *Mitigate risks to avoid unintended or harmful results.*								
Hospital-Acquired Clostridium difficile Infections: Number of Clostridium difficile infections (C-diff) acquired for every 10,000 patient days. A rate of 4.0 means approximately 100 patients per month acquire C-diff infections in Alberta.	4.1	4.4	3.5	3.5	3.4 Q3 YTD	3.3	✓	Better than national results based on surveillance data
Hand Hygiene: Percentage of opportunities for which healthcare workers clean their hands during the course of patient care.	58.6%	66.4%	75.0%	79.8%	82.2%	90%	✓	Not available
Hospital Mortality: Actual number of deaths compared to the expected number of deaths in hospital. Values less than 100 mean fewer than expected deaths In Alberta.	95	95	93	93	93	90	⇔	5th out of 9 provinces
Accessibility: *Health services are obtained in the most suitable setting in a reasonable time and distance.*								
Emergency Department (ED) Wait to see a Physician: Average patient's length of time in ED before being seen by a physician at the busiest EDs.	1.3 hours	1.3 hours	1.4 hours	1.3 hours	1.3 hours	1.2 hours	⇔	4th out of 5 provinces
ED Length of Stay for Admitted Patients: Average patient's length of time in the ED before being admitted to a hospital bed at the busiest EDs.	8.7 hours	8.6 hours	9.9 hours	9.4 hours	9.5 hours	9.3 hours	⇔	2nd out of 5 provinces (busiest sites)
ED Length of Stay for Discharged Patients: Average patient's length of time in the ED before being discharged at the busiest EDs.	3.1 hours	3.0 hours	3.2 hours	3.2 hours	3.2 hours	3.1 hours	⇔	4th out of 5 provinces
Access to Radiation Therapy: Length of time that 9 out of 10 patients wait to receive radiation therapy.	3.0 weeks	3.0 weeks	3.1 weeks	2.9 weeks	2.7 weeks	2.6 weeks	✓	4th out of 9 provinces (Q2 2016-17)
Children's Mental Health Access: Percentage of children (age 0-17 years) offered scheduled community mental health treatment within 30 days from referral.	n/a	87%	89%	85%	81%	90%	✗	Not available

AHS Performance Measure	2012-13	2013-14	2014-15	2015-16	2016-17	Target 2016-17	Trend	2015-16 National Comparison*
Appropriateness: *Health services are relevant to user needs and are based on accepted or evidence-based practice.*								
Continuing Care Placement: Percentage of people placed into continuing care within 30 days of being referred.	67%	69%	60%	60%	56%	62%	✗	Not available
Efficiency: *Resources are optimally used in achieving desired outcomes.*								
Acute (Actual) Length of Hospital Stay Compared to Expected Stay: Actual length of stay in hospital compared to the expected length of stay in hospital. Every .01 drop in this ratio means we can treat over 3,200 more patients in hospital every year.	1.04	1.03	1.02	1.00	0.98	0.98	★	3rd out of 9 provinces
Effectiveness: *Health services are based on scientific knowledge to achieve desired outcomes.*								
Early Detection of Cancer: Percentage of patients with breast, cervical and colorectal cancers who are diagnosed at early stages.	66% (2011) 67% (2012) 68% (2013) 69% (2014) 70% (2015)					70% (2015-16 target)	★	2nd for breast cancer and 8th for colorectal cancer out of 9 provinces (2010)
Mental Health Readmissions: Percentage of mental health patients with unplanned readmission to hospital within 30 days of leaving hospital.	9.6%	8.9%	8.8%	8.6%	8.6% Q3 YTD	8.5%	⇔	2nd out of 10 provinces (2014-15)
Surgical Readmissions: Percentage of surgical patients with unplanned readmission to hospital within 30 days of leaving hospital.	6.6%	6.7%	6.5%	6.5%	6.7% Q3 YTD	6.3%	⇔	5th out of 10 provinces (2014-15)
Heart Attack Mortality: Percentage of patients dying in hospital within 30 days of being admitted for a heart attack.	5.9%	7.2%	6.2%	6.3%	5.8% Q3 YTD	5.9%	★	4th out of 10 provinces (2014-15)
Stroke Mortality: Percentage of patients dying in hospital within 30 days of being admitted for a stroke.	15.0%	14.1%	13.9%	14.1%	13.5% Q3 YTD	13.2%	✓	4th out of 10 provinces (2014-15)

*National comparison is based on data and information provided by the Canadian Institute for Health Information (CIHI). However, the analyses, conclusions, opinions and statements expressed herein are those of the author, and not necessarily those of the CIHI.

Monitoring Measures

There are a number of measures that AHS monitors internally to help inform us about other areas of the health system. These monitoring measures do not have targets, and some of these measures do not have benchmarks across the country for comparison. However, these measures are familiar and of interest to Albertans. These measures are updated quarterly and posted on the AHS website.

The following measures contribute to balanced performance monitoring and reporting that have been tracked over many years. These measures are tactical as they inform the performance of an operational area or reflect the performance of key drivers of a performance measure. The measures represent a broad range of indicators that span the continuum of care.

The trend column indicates comparison of the most recent available data over the earliest data available for each measure: an upward arrow (⇧) indicates improvement; a horizontal arrow (⇔) indicates stability and a downward arrow (⇩) indicates areas that require additional focus.

LIFE EXPECTANCY	2012	2013	2014	2015	2016	Trend
The number of years a person would be expected to live, starting at birth, on the basis of mortality statistics. Both sexes combined.						
Provincial	81.7	81.7	81.8	81.8	81.9	⇧
Females	83.9	83.7	83.9	84.1	84.2	⇧
Males	79.4	79.6	79.7	79.5	79.7	⇧
First Nations	72.2	72.5	71.6	70.4	n/a	⇩
Non-First Nations	82.0	82.1	82.2	82.3	n/a	⇧
POTENTIAL YEARS OF LIFE LOST	**2012**	**2013**	**2014**	**2015**	**2016**	**Trend**
The total number of years not lived (per 1,000 population) by an individual who died before their 75th birthday.						
Both	48.4	48.2	49.5	50.1	48.9	⇧
Females	37.5	38.3	38.7	38.1	37.8	⇧
Males	58.9	57.7	59.7	61.5	59.5	⇧
CANCER SCREENING PARTICIPATION RATES	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**Trend**
Breast	n/a	62.2%	62.7%	62.8%	n/a	⇧
Colorectal	n/a	n/a	39.2%	38.0%	n/a	⇩
Cervical	64.2% (2011-13)	62.7% (2012-14)	62.0% (2013-15)	61.5% (2014-16)	n/a	⇔
INFLUENZA IMMUNIZATION	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**Trend**
Rates of seasonal influenza immunization by age group.						
Adults aged 65 years and older	60.0%	63.6%	60.5%	62.7%	62.4%	⇔
Children aged six to 23 months	30.2%	35.7%	35.6%	35.9%	34.4%	⇩
AHS Healthcare Workers	n/a	60.0%	63.9%	60.9%	62.5%	⇧
CHILDHOOD IMMUNIZATION	**2012**	**2013**	**2014**	**2015**	**2016**	**Trend**
Rates of childhood immunization by two years of age.						
Diphtheria/ tetanus/ acellular pertussis, polio, Hib	75.0%	74.8%	75.8%	75.6%	77.0%	⇧
Measles/ mumps/ rubella	85.9%	86.1%	88.1%	87.4%	87.9%	⇧
PRIMARY CARE	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**Trend**
Albertans Enrolled in a Primary Care Network (%)	76%	78%	79%	80%	81%	⇧
Ambulatory Care Sensitive Conditions: Rate of hospital admissions for health conditions that may be prevented or managed by appropriate primary healthcare.	293	291	288	281	269	⇧
Family Practice Sensitive Conditions: Percentage of emergency department or urgent care visits for health conditions that may be appropriately managed at a family physician's office.	26.0%	25.1%	24.3%	23.0%	22.1%	⇧
HEALTH INFORMATION	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**Trend**
Health Link: Percentage of calls to Health Link that are answered within two minutes.	78%	79%	77%	76%	74%	⇩

CHILDREN'S MENTAL HEALTH SERVICES	2012-13	2013-14	2014-15	2015-16	2016-17	Trend
Percentage of children aged 0 to 17 years receiving scheduled mental health treatment within 30 days.	80%	81%	82%	73%	73%	⇔
EMERGENCY DEPARTMENT WAIT TIME in hours	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**Trend**
Percentage of patients treated and discharged from the Emergency Department within 4 hours.						
Busiest 16 sites	65%	66%	63%	63%	62%	⇔
All sites	80%	80%	78%	78%	78%	⇔
Percentage of patients treated and admitted to hospital from the Emergency Department within 8 hours.						
Busiest 15 sites	45%	46%	39%	41%	41%	⇔
All sites	55%	54%	48%	49%	49%	⇔
ACUTE CARE	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**Trend**
Acute Care Occupancy – Busiest Hospitals (Percentage of patient days in hospital compared to available bed days in the reporting period for top 16 AHS sites).	n/a	97.4%	97.1%	95.6%	96.5%	⇩
Alternate Level of Care (ALC) days – Percentage of Total Hospital Days classified as ALC.	n/a	10.1%	12.2%	13.5%	15.1%	⇩
CANCER WAIT TIME in weeks (90th percentile)	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**Trend**
Radiation Oncology Access – referral to first consult (from referral to the time of their first appointment with a radiation oncologist).	4.9	4.9	4.9	5.0	5.0	⇔
Medical Oncology Access – referral to first consult (from referral to the time of their first appointment with a medical oncologist).	4.9	5.6	5.6	5.6	5.1	⇧
SURGERY WAIT TIME in weeks	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**Trend**
CABG (Coronary Artery Bypass Graft) Urgency III – Scheduled	25.9	21.5	23.7	19.8	15.5	⇧
CABG RTT Urgency III – Scheduled	n/a	13.3	14.9	12.1	10.7	⇧
Cataract Surgery DTT	31.6	31.6	33.3	35.9	36.9	⇔
Cataract Surgery RTT	n/a	27.9	29.9	33.0	34.0	⇩
Hip Replacement Surgery DTT	36.3	36.7	36.3	38.0	38.3	⇔
Hip Replacement Surgery RTT	n/a	27.9	28.7	31.4	32.9	⇩
Knee Replacement Surgery DTT	40.9	41.9	44.9	43.9	47.0	⇩
Knee Replacement Surgery RTT	n/a	31.4	33.0	34.7	37.1	⇩
Hip Fracture Repair: Percentage within 48 hours	84.9%	88.4%	86.2%	90.0%	91.9%	⇧
CONTINUING CARE	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**Trend**
Total Number of People Placed into Continuing Care	7,761	7,694	7,810	7,879	7,963*	⇧
Number of patients placed from acute / subacute hospital bed into continuing care.	5,561	5,522	5,548	5,405	5,395	⇔
Number of clients placed from community (at home) into continuing care.	2,200	2,172	2,262	2,474	2,568	⇧
Average wait time in acute / subacute care hospital bed for continuing care placement (in days).	34	31	42	44	46	⇩
Total Number Waiting For Continuing Care Placement:	1,154	1,193	1,544	1,411	1,873	⇩
Number of persons waiting in acute / subacute hospital bed for continuing care placement.	453	512	690	628	846	⇩
Number of persons waiting in community (at home) for continuing care placement.	701	681	854	783	1,027	⇩
Number of unique home care clients	109,184	112,062	114,990	116,462	118,834	⇧

Data updated as of May 18, 2017
Surgery Wait Time: RTT (Ready to Treat to Treatment); DTT (Decision to Treat to Treatment)
* Number Placed amended Aug. 10, 2017 from 8,002 to 7,963.

FINANCIAL INFORMATION

- Financial Statement Discussion and Analysis
- Consolidated Financial Statements
- Compensational Analysis and Discussion

FINANCIAL STATEMENT DISCUSSION AND ANALYSIS For the year ended March 31, 2017

This Financial Statement Discussion and Analysis (FSD&A) is provided to enable readers to assess the results of Alberta Health Services' (AHS) operations and financial condition for the year ended March 31, 2017. In particular, the FSD&A reports to stakeholders how financial resources are being managed to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans. It serves as an opportunity to communicate with stakeholders and other report users regarding AHS' 2016-17 financial performance, as well as significant financial policies, cost drivers, strategies and plans to address financial risk and sustainability.

This FSD&A has been prepared by management and should be read in conjunction with the March 31, 2017 audited consolidated financial statements, notes, and schedules. The consolidated financial statements are prepared in accordance with Canadian Public Sector Accounting Standards (PSAS) and the Financial Directives issued by Alberta Health (AH). All amounts are presented in millions of dollars unless otherwise specified.

Additional information about AHS including financial reports from prior periods is available on the AHS website at **www.albertahealthservices.ca**.

2016-17 FINANCIAL HIGHLIGHTS

Recognizing the overall provincial fiscal climate and the economic challenges facing the Province of Alberta (Province), AHS continued its efforts to manage costs and maximize benefits within available resources. AHS has continued its efforts in supporting health services to meet the healthcare needs of Albertans, enhance effective service delivery, and develop business efficiency initiatives.

The demands on the healthcare system continue to increase in Alberta, resulting in the need for new and different approaches to delivering healthcare at a time when AHS must continue to manage limited available resources. AHS has continued to focus on strengthening public health and primary care, improving access and flow, and enhancing community-based options. While expenses continued to increase, driven by a growing and aging population, and healthcare inflation, the current growth rate of expenses has decreased significantly compared to the average rate seen historically.

The AHS 2016-17 budget was approved by the Minister of Health on June 29, 2016. The overall goal has been consistent: to ensure AHS' resources are used to maximize benefits and to achieve the best results – timely, high quality, patient-centred, and effective health services and patient outcomes.

AHS finished the year with a $67 annual operating surplus, reflecting 0.5% of total revenues primarily due to additional funding received at the end of the year. The strategic deferral of certain initiatives throughout the year, and an ongoing effort to find cost savings and efficiencies also contributed in enabling AHS to finish the year in a small surplus position. While expenses increased as a result of increasing demand for healthcare services and increasing costs to deliver those services, AHS has begun to slow the rate of increased spending while maintaining a focus on delivering high quality services. Faced with a challenging fiscal climate and limited resources, AHS continued to support current programs and services levels, while managing expenses.

Did You Know?

- Alberta's population grew by 1.5% in 2016-17, which contributed to the growing need for healthcare services.
- Historically, AHS' expenses have grown by over 6.0% per year.
- In 2016-17, expenses increased by 2.1% as compared to the prior year. For the next three years, expenses are budgeted to increase by an average of 1.8% per year.
- Health represents 40% of the provincial budget in Alberta and AHS accounts for 70% of this amount.

AHS continued to work internally and with external stakeholders, including AH, to implement and realize ongoing operational efficiencies. The identification and implementation of Operational Best Practices (OBP) in 2016-17 has led to marked improvements in the cost of delivering healthcare services, and will continue to be instrumental in supporting the long-term sustainability of the Alberta healthcare system.

ALIGNMENT TO THE 2016-17 HEALTH PLAN AND BUSINESS PLAN

The 2016-17 Health Plan and Business Plan support the four AHS goals of building a culture of patient, family, and community-centred care to improve patient experience, improving health outcomes through clinical best practices, ensuring our people feel safe, healthy, and valued, and achieving financial sustainability through operational best practices. AHS continued to support current services to meet the healthcare needs of Albertans, while strategically delaying some targeted new investments in order to focus on addressing service pressures, strategic priorities, and enterprise risks.

AHS is facing challenging times, operating in an environment of limited resources, rising healthcare costs and increasing demand and expectations for services. As a result, AHS has had to find cost savings and efficiencies in order to be financially sustainable, now and in the long-term. Focusing on how care is provided to patients and working to ensure clinical best practices and clinical appropriateness, AHS has had to reallocate resources to where care is needed most and make strategic investments within the limitations described above.

Build a Culture of Patient-Centred Care to Improve Experience

- AHS continued to respond to the demand for continuing care by building and contracting new spaces across Alberta, opening 376 net new continuing care spaces in 2016-17. Creating community capacity has positive impacts for clients who need continuing care, and also improves system flow for individuals who need emergency and acute care services by freeing up capacity in these areas.
- Additional home care visits and an increase of 2.0% in the number of home care clients further supported Albertans remaining within their homes and local communities, avoiding hospital admissions, and reducing the demand on acute care services.
- AHS increased addiction and mental health capacity in the community.
- AHS made additional investments in cancer care, including the purchase of high-tech equipment such as linear accelerators as part of a continuing multi-year purchase plan, and through expanding access to cancer care in the community, as patients received cancer care at home and in cancer centres.
- AHS increased the number of courses of care delivered by midwives by over 400, increasing access to this maternity service.
- AHS and community partners took action together to increase support for opioid dependency treatment services throughout the province.

Health Outcomes and Clinical Best Practices

- As part of AHS' continued efforts to improve patient experience, facility openings, enhancements and upgrades were carried out to ensure that quality and safe care continued to be provided to Albertans in clean and healthy environments.
- AHS continued to invest in Infrastructure Maintenance Program projects, as well as the procurement of equipment under the Medical Equipment Replacement and Upgrade Program.
- Increased surgical volumes of 2.3% resulted from a focus on surgical capacity management.
- There was increased focus on ensuring appropriate clinical practice and innovation in various pathways including Enhanced Recovery after Surgery, Inpatient Diabetes Management, Heart Failure, Chronic Obstructive Pulmonary Disease and Conservative Kidney Management.
- There was continued focus on finding new, efficient and innovative ways of delivering healthcare in order to improve the healthcare system through Strategic Clinical Networks, Primary Care Networks (PCNs), various clinical pathways, research, and education.

Our People

- AHS continued to focus on leadership development and learning initiatives.
- The implementation of the Manager Preparation and Leadership Development Program enhanced the capability of, and support to, frontline managers.
- The successful rollout of a comprehensive workforce engagement and patient safety culture survey, with increased organization-wide participation rates, took place in 2016-17. Survey results provided valuable feedback on what staff, physicians and volunteers need to feel safe, healthy, and valued.

Financial Health and Operational Best Practice

- With a focus on achieving operational efficiencies and continuing to reduce costs, AHS began the implementation of OBP in late 2015-16, which led to efficiencies in operations and will be expanded upon in 2017-18 and beyond.
    - OBP is the practice of comparing AHS' cost of providing healthcare services within Alberta, as well as externally, to ensure overall efficiency and quality care. Where necessary, changes will continue to be made to improve practices and reduce costs. Quality and patient safety are paramount while implementing OBP initiatives.
    - The implementation of OBP operates under the principles of no reduction in core front-line services, an attrition only strategy, adherence to union collective agreements, and the commitment to quality and continuous improvement in the healthcare system.
- AHS implemented various information technology initiatives including increasing access to the Personal Health and Alberta Netcare web portals (part of the provincial electronic health record). Investments were also made in anticipation of the Provincial Clinical Information System (CIS) program, including development of wireless technology, data centres, and modernizing technological infrastructure, applications and end user devices.
- AHS continued to address and invest in services to meet clinical needs, while managing spending growth related to workforce compensation, clinical contract inflation, healthcare support, and physician fees.

As detailed throughout the annual report, these goals guided AHS in its delivery of health services throughout Alberta. As AHS enters its next planning cycle, there will be continued focus on strengthening public health and wellness while improving access, flow and community-based options. AHS will continue to focus on transforming the delivery of healthcare in a way that improves quality and, at the same time, save costs by enhancing care in the community and reducing the need for hospital admissions. Further discussion on the future outlook can be found at the end of the FSD&A.

FINANCIAL OVERVIEW

Operations

2016-17 Highlights

- Total revenue exceeded budget by 1.1% and increased by 3.7% over 2015-16, with Alberta Health transfers accounting for 90% of total revenue.
- Total expenses were 0.6% higher than budget and increased by 2.1% over 2015-16. With a number of efficiencies implemented, AHS has reduced the rate of spending.
- There was increased investment in continuing care, community care, and home care - a 3.4% increase over 2015-16.
- Inpatient and outpatient acute care expenses continued to increase, albeit at a lower growth rate - a 1.5% increase over 2015-16.
- At 3.3%, administration expense as a percentage of total expense remains amongst the lowest of all provinces and territories in Canada, according to the Canadian Institute for Health Information (CIHI).

AHS' consolidated revenues in 2016-17 were $14,470, an increase of $515 as compared to 2015-16. The change was a result of increased funding received from AH and other government transfers, partially offset by lower fees and charges. Relative to the budget, revenues were higher due to increased investment and other income, and government funding, offset by lower fees and charges.

AHS' consolidated expenses in 2016-17 were $14,403, an increase of $303 as compared to 2015-16. The change was a result of increased activity resulting from an increased demand for services, continued implementation of priority initiatives, collective bargaining increases, and inflation, partially offset by the implementation of savings initiatives, including OBP, and a decrease in amortization expense. When compared to the budget, expenses were $85 higher largely due to increased activity and compensation costs. As AHS continued to find cost savings, while addressing the growing demand for healthcare services, there were delays in the implementation of planned savings initiatives, which are expected to be realized through the continued implementation of OBP. The overall variance was partially offset by vacancies, timing delays of initiatives, and cost mitigation strategies.

In 2016-17, the provision of healthcare services for Albertans cost AHS an average of $39 per day (2015-16 – $39 per day).

Financial Position

AHS' net debt position at March 31, 2017 was $35, a decrease of $66 from the prior year.

Facilities, medical equipment, and information technology are integral to AHS' clinical and business processes and are key enablers for innovation and transformation. AHS continued to invest in new facilities, various information technologies, as well as equipment purchases and upgrades in areas such as cancer care, emergency medical services (EMS), and surgical services.

The AHS accumulated surplus at March 31, 2017 was $1,226 and consists of four main components: unrestricted surplus, internally restricted surplus for future purposes, invested in tangible capital assets, and endowments.

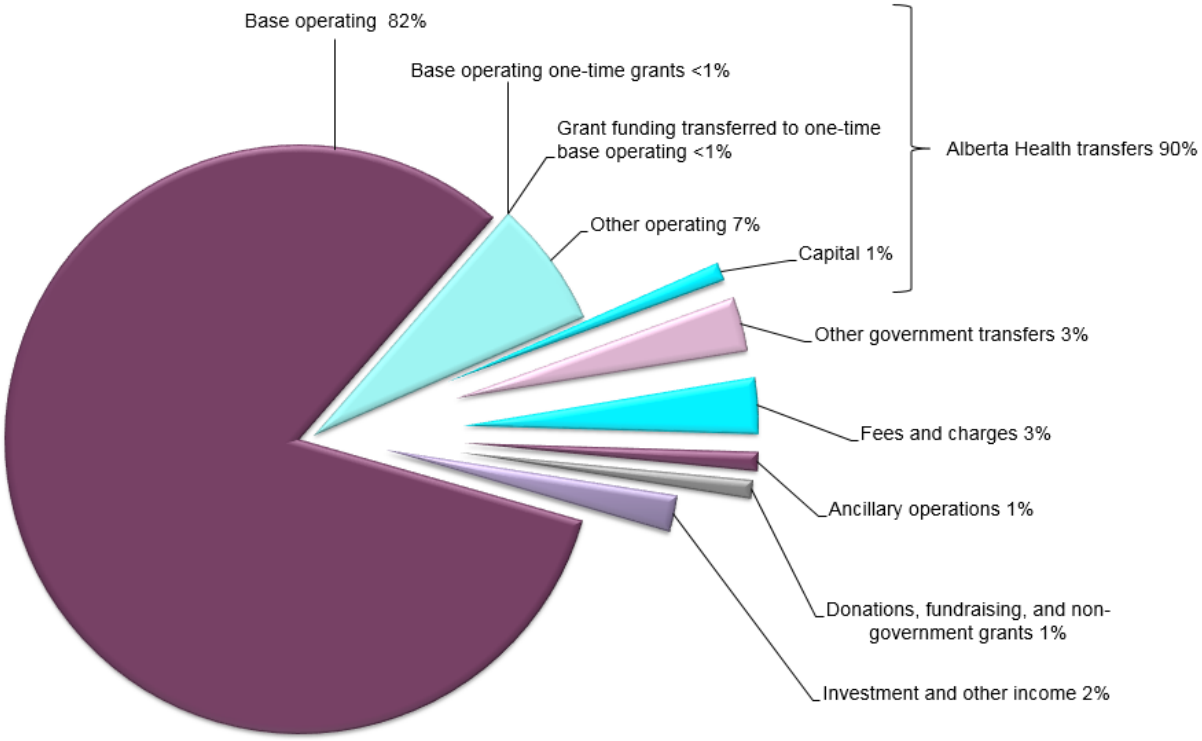
The unrestricted surplus at March 31, 2017 of $212 does not have any restrictions attached to its future use. Internally restricted surplus for future purposes of $225 has been restricted internally by AHS for specific purposes, as approved by the Board. Invested in tangible capital assets of $714 represents tangible capital assets purchased with internal funds, and endowments of $75 are externally restricted and must be maintained in perpetuity.

FINANCIAL ANALYSIS

STATEMENT OF OPERATIONS

The Consolidated Statement of Operations shows the revenue earned by AHS and its application to provide health services.

Revenue



Total 2016-17 revenues increased by $515 or 3.7% from 2015-16 and were higher by $152 or 1.1% compared to the budget. The overall increase in revenue from 2015-16 was primarily due to increased base operating transfers from AH, which is AHS' primary source of funding. The AH funding comprised 90% (2015-16 – 89%) of total revenue in 2016-17.

Revenues	Budget 2017	Actual 2017	Variance 2017		Actual 2016	Increase (Decrease)	
Alberta Health transfers	$ 12,909	$ 12,965	$ 56	0.4%	$ 12,480	$ 485	3.9%
Other government transfers	408	456	48	11.8%	417	39	9.4%
Fees and charges	513	479	(34)	(6.6%)	491	(12)	(2.4%)
Ancillary operations	133	136	3	2.3%	133	3	2.3%
Donations, fundraising and non-government contributions	150	164	14	9.3%	166	(2)	(1.2%)
Investment and other income	205	270	65	31.7%	268	2	0.7%
Total revenues	**$ 14,318**	**$ 14,470**	**$ 152**	**1.1%**	**$ 13,955**	**$ 515**	**3.7%**

Significant variances and changes are explained as follows:

Alberta Health transfers are comprised of all funding received from AH – unrestricted, restricted operating, and capital. Unrestricted AH transfers are the main source of operating funding to provide health-care services to the population of Alberta. Restricted operating and capital funding can only be used for specific purposes and are recognized when the related expenses are incurred. Consequently, the variances for restricted funding discussed below are directly attributed to the recognition of the related expense.

Alberta Health Transfers	Budget 2017	Actual 2017	Variance 2017		Actual 2016	Increase (Decrease)	
Base operating	$ 11,860	$ 11,860	$ -	0%	$ 11,330	$530	4.7%
One-time base operating	-	50	50	-	-	50	-
Grant funding transferred to one-time base operating	-	15	15	-	-	15	-
Other operating	968	953	(15)	(1.5%)	1,065	(112)	(10.5%)
Recognition of expended deferred capital revenue	81	87	6	7.4%	85	2	2.4%
Total AH transfers	**$12,909**	**$ 12,965**	**$56**	**0.4%**	**$ 12,480**	**$485**	**3.9%**

Base operating transfers amounted to $11,860, which is consistent with the budget.

Compared to the prior year, base operating transfers increased by $530 or 4.7% mainly due to base funding increases received in 2016-17 for the delivery of health services across Alberta, as well as the transition of various restricted grants into base operating funding.

One-time base operating and grant funding transferred to one-time base operating totalled $65, which was $65 higher compared to both the budget and the prior year amount of $nil mainly due to one-time base operating funding, and recognition of unexpended funds from restricted grants in prior years, which transitioned into base funding as unrestricted revenue.

Other operating transfers amounted to $953, which was $15 or 1.5% lower than the budget of $968 mainly due to vacancies in physician services programs, delayed implementation of various community, seniors, addiction and mental health initiatives, and reduced prices of certain specialized high cost drugs, all funded from restricted grants. The overall variance was partially offset by higher revenue resulting from increased physician remuneration paid under the Academic Alternate Relationship Plan programs, and the increased volume of outpatient drugs provided at no cost to patients, all of which are funded on a restricted basis.

Compared to the prior year, other operating transfers decreased by $112 or 10.5% primarily due to the transition of various restricted grants into base operating funding, and a decline in specialized high cost drug prices. The overall decrease was partially offset by increased revenue resulting from a higher volume of outpatient drugs provided at no cost to patients, increased activity in various Academic Alternative Relationship Plan programs, and increases in physician compensation rates, all of which are funded on a restricted basis.

Recognition of expended deferred capital revenue was consistent with the budget and the prior fiscal year.

Other government transfers are comprised of funding from federal, provincial (other than AH), and municipal governments that can be unrestricted or restricted for operating or capital purposes. Restricted amounts received are recognized as revenue when the related stipulations are met.

Revenues from other government transfers amounted to $456, which was $48 or $11.8% higher than the budget of $408 primarily due to revenue recognized in relation to the expense portion of infrastructure maintenance programs being higher than planned and, unbudgeted revenue recognized for the reimbursement of Fort McMurray wildfire costs.

Compared to the prior year, other government transfers increased by $39 or 9.4% primarily due to an increased number of operating projects implemented for infrastructure maintenance, incremental revenue recognized for the amortization of externally funded tangible capital asset additions, partially offset by reductions related to externally funded tangible capital assets that were fully amortized in 2016-17, and revenue recognized for the reimbursement of Fort McMurray wildfire costs.

Fees and charges consist of patient revenue for health services provided at rates set by the Minister of Health, and collected by AHS from individuals, Workers' Compensation Board (WCB), federal and provincial governments, and other parties, such as Alberta Blue Cross and other insurance companies.

Revenues from fees and charges amounted to $479, which was $34 or 6.6% lower than the budget of $513 mainly due to the economic downturn in Alberta which resulted in fewer temporary workers (non-residents of Alberta or Canada) requiring healthcare services, as well as reduced acuity, and healthcare insurance coverage retroactively granted by AH to patients previously classified as non-residents of Canada.

Compared to the prior year, revenue from fees and charges decreased by $12 or 2.4% mainly due to lower activity and acuity involving services billable to other Canadian jurisdictions, non-residents of Canada, and WCB, and healthcare insurance coverage retroactively granted by AH to patients previously classified as non-residents of Canada. The overall decrease was partially offset by increased reciprocal billing rates, long-term care accommodation fees, and higher activity and acuity involving services billable to the federal government.

Ancillary operations consist of revenue from the sale of goods and services that are unrelated to the direct provision of health services, and include parking, non-patient food services, and rental operations.

Revenue from ancillary operations were consistent with the budget and the prior year.

Donations, fundraising and non-government contributions are comprised of revenue that can be unrestricted or restricted for operating or capital purposes.

Revenue from donations, fundraising and non-government contributions amounted to $164, which was $14 or 9.3% higher than the budget of $150 mainly due to higher than anticipated revenue related to spending for various research studies and clinical trials. The overall variance was partially offset by lower revenue recognized due to lower than budgeted amortization expense for major equipment, which are restricted due to being funded by donations and non-government contributions.

Revenue from donations, fundraising and non-government contributions were consistent with the prior year.

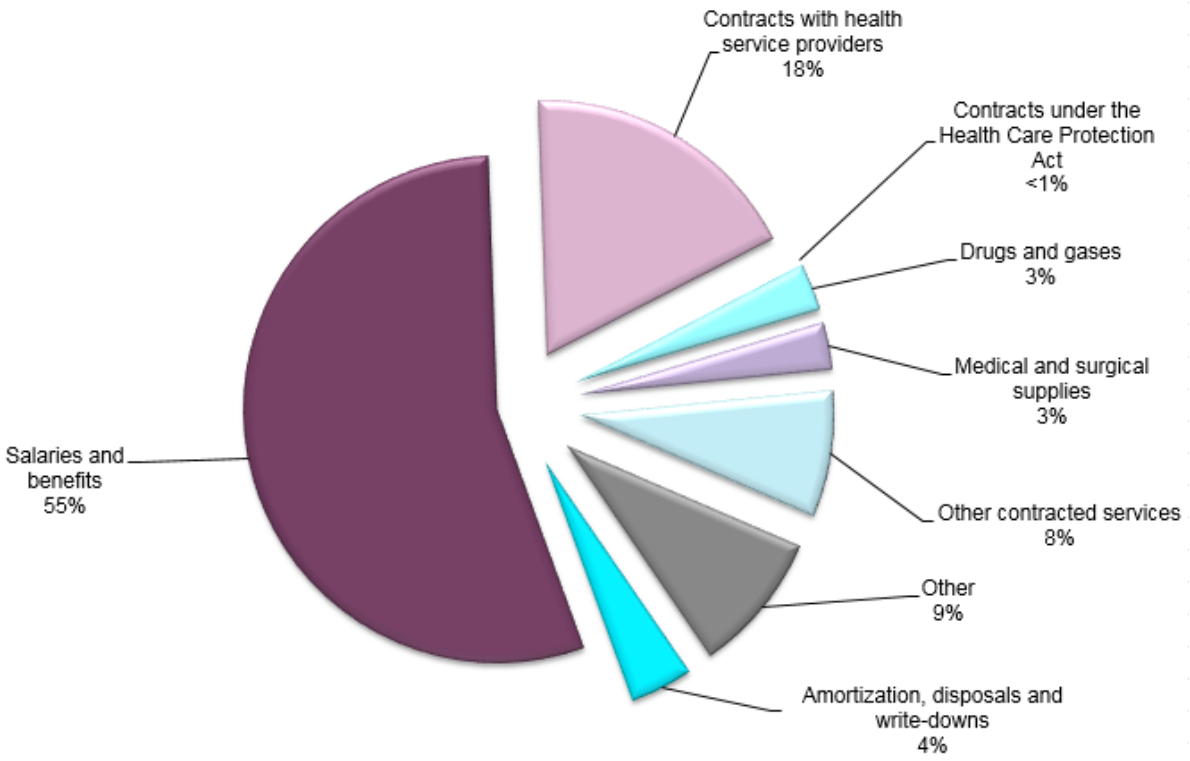
Investment and other income is comprised of interest income, dividends, net realized gains and losses on disposal of investments, and recoveries from external sources other than ancillary operations. Included are revenues from third parties, such as drug and medical supply companies, and universities (for purposes other than research).

Investment and other income amounted to $270, which was $65 or 31.7% higher than the budget of $205 mainly due to higher than budgeted recoveries for services provided to external entities, unbudgeted other income including a WCB surplus distribution, outpatient cancer drugs received at no cost from suppliers, and accrued Fort McMurray wildfire insurance proceeds.

Investment and other income was consistent with the prior year.

Expenses – By Object

AHS reviews and reports expenses by object and by function in order to fully describe the results of current operations, strategic priorities, and new investments.



The overall distribution of expenses by object remained consistent with prior years, with salaries and benefits making up more than half of total expenses (2015-16 – 55%). Expenses continued to be driven higher by salaries and benefits both within AHS, and within contracts with health service providers, resulting from increased demand for healthcare services. Rate increases in union wages and benefits, as well as clinical contract inflation increases have also contributed to the variance.

Expenses	Budget 2017	Actual 2017	Variance 2017		Actual 2016	Increase (Decrease)	
Salaries and benefits	$ 7,760	$ 7,983	$ (223)	(2.9%)	$ 7,742	$ 241	3.1%
Contracts with health service providers	2,635	2,540	95	3.6%	2,451	89	3.6%
Contracts under the Health Care Protection Act	18	20	(2)	(11.1%)	19	1	5.3%
Drugs and gases	425	450	(25)	(5.9%)	417	33	7.9%
Medical and surgical supplies	390	385	5	1.3%	414	(29)	(7.0%)
Other contracted services	1,173	1,107	66	5.6%	1,134	(27)	(2.4%)
Other expenses	1,330	1,367	(37)	(2.8%)	1,334	33	2.5%
Amortization, disposals and write-downs	587	551	36	6.1%	589	(38)	(6.5%)
Total expenses	**$ 14,318**	**$ 14,403**	**$ (85)**	**(0.6%)**	**$ 14,100**	**$ 303**	**2.1%**

Significant variances and changes are explained as follows:

Salaries and benefits are comprised of compensation for hours worked, vacation and sick leave, other cash benefits (which includes overtime), employer benefit contributions made on behalf of employees, and severance.

Salaries and benefits amounted to $7,983, which was $223 or 2.9% higher than the budget of $7,760 mainly due to increased activity resulting in the need for higher worked hours. While AHS strived to make the best use of compensation related costs through sound leadership and implementation of OBP initiatives, low attrition rates limited the progress required to meet the budgeted savings plan. Compensation rate variances including shift differentials and weekend premium rate differences, as well as the insourcing of certain contracted positions also contributed to the variance. The overall increase was partially offset by vacant positions throughout AHS, the mediated contract for auxiliary nursing, and delayed initiatives resulting in hiring delays.

Compared to the prior year, salaries and benefits increased by $241 or 3.1% mainly due to compensation rate variances and higher costs resulting from collective agreement settlements. AHS' management, non-union and exempt employees continued to be included in the provincial government salary freeze. Increased activity also contributed to the variance as AHS continued to invest in priority new investments, resulting in an increase of 1.2% in worked hours, which includes overtime and relief hours. While the number of clinical operations and clinical support employees increased compared to the prior year, vacancies continued to persist throughout AHS resulting in increased costs for casual relief and overtime, which increased by 4.2% and 0.6%, respectively. Further contributing to the overall increase were compensation costs resulting from the insourcing of certain contracted positions, and additional costs arising from the Fort McMurray wildfire. The overall increase was partially offset by the achievement of cost containment strategies, including OBP.

Calculated Full Time Equivalents (FTE) amounted to 78,434 FTE compared to the prior year of 77,007 FTE, resulting in an increase of 1,427 or 1.9%. Calculated FTEs are determined by actual hours earned divided by 2,022.75 annual base hours for fiscal 2017. This is a decrease from the previous 2,030.50 annual base hours used in fiscal 2016. The decrease in the annual base hours was due to 2016 being a leap year, resulting in one additional day in the prior fiscal year. The overall increase in FTEs was primarily due to increased worked hours. Clinical positions, including medical doctors, regulated nurses, health technical and professional staff, and unregulated health service providers account for 48,977 FTEs, which was an increase of 1.8% compared to the prior year. Other Staff, which include support services such as food services, facilities and maintenance, clerical staff, and secretarial support, account for 26,383 FTEs, which was an increase of 2.1% compared to the prior year, primarily due to insourcing. Total management accounts for 3,052 FTEs, which was an increase of 0.9% compared to the prior year.

Contracts with health service providers include voluntary and private health service providers with whom AHS contracts for health services, such as long-term care facilities, acute care providers, home care providers and lab service providers.

Contracts with health service providers amounted to $2,540, which was $95 or 3.6% lower than the budget of $2,635 mainly due to timing delays of budgeted initiatives, lower than anticipated clinical contract inflation due to the implementation of a revised methodology based on the Consumer Price Index, and mitigation strategies to reduce spending. The overall variance was partially offset by higher than budgeted activity, due in part to the continued expansion of home care services in response to increased home care clients, resulting in increased vendor hours.

Compared to the prior year, contracts with health service providers increased by $89 or 3.6% mainly due to increased activity, particularly in community-based care, facility-based care and home care, with the addition of 376 net new beds as a result of planned initiatives including Continuing Care Capacity Plan and supportive living initiatives. Further contributing to the increased costs were collective agreement costs and clinical contract inflation.

Contracts under the Health Care Protection Act relates to contracts with surgical facilities pursuant to the *Health Care Protection Act* which ensures quality while promoting the delivery of publicly funded services by allowing contracting out to profit-orientated surgical facilities.

Costs associated with Contracts under the Health Care Protection Act were consistent with budget and the prior fiscal year.

Drugs and gases include all drugs used by AHS, including medicines, certain chemicals, anaesthetic gas, oxygen, and other medical gases used for patient treatment. Drugs used for purposes other than patient treatment such as diagnostic reagents, are not included in this category, and are reported in other expenses.

Drugs and gases amounted to $450, which was $25 or 5.9% higher than the budget of $425 mainly due to higher drug utilization due to new cancer drugs added to the cancer grant, as approved by the Minister of Health. The overall variance was partially offset by price changes and higher than budgeted drug rebates.

Compared to the prior year, drugs and gases increased by $33 or 7.9% mainly due to higher drug utilization due to new cancer drugs added to the cancer grant as noted above, as well as increased demand for specialized drugs. The overall variance was partially offset by price changes on certain specialized high cost drugs as well as higher drug rebates.

Medical and surgical supplies include prostheses, instruments used in surgical procedures and in treating and examining patients, sutures, and other supplies.

Costs associated with medical and surgical supplies were consistent with the budget.

Compared to the prior year, medical and surgical supplies decreased by $29 or 7.0% mainly due to a decision during the year, in which AHS decided to treat value added benefits as a reduction to the cost of the contract the benefits are associated with. The achievement of cost containment strategies, including OBP also contributed to the variance. The overall decrease was partially offset by increased activity in surgical procedures.

Other contracted services are payments to those under contract that are not considered to be employees. This category includes payments to physicians for referred-out services and purchased services, as well as home support contracts and various self-managed care contracts.

Other contracted services amounted to $1,107, which was $66 or 5.6% lower than the budget of $1,173 mainly due to hard-to-recruit physician vacancies and the insourcing of certain contracted positions. Timing variances associated with the implementation of various budgeted initiatives further contributed to the variance, as well as the continued achievement of cost control strategies implemented by AHS. The overall positive variance was partially offset by increased activity relating to the Academic Alternative Relationship Plan, and in the areas of genetic testing within lab services, as well as diagnostic imaging.

Compared to the prior year, other contracted services decreased by $27 or 2.4% mainly due to performing more functions in house which were previously contracted out. The overall decrease over the prior year is partially offset by increased activity, in particular, resulting from the Academic Alternative Relationship Plan, and contract inflation mainly relating to the areas of diagnostic and therapeutic services and home care.

Other expenses relate to those expenses not classified elsewhere.

Other expenses amounted to $1,367, which was $37 or 2.8% higher than the budget of $1,330 mainly due to additional Infrastructure Maintenance Program projects, higher one-time information technology hardware and infrastructure costs, as well as increased activity. An insurance deductible relating to an overland flood, costs relating to the Fort McMurray fire, and delays in the implementation of savings initiatives also contributed to the variance. The overall variance was partially offset by mitigation strategies relating to general supplies, travel, minor equipment purchases, reduced operating parking projects, and delays in budgeted initiatives.

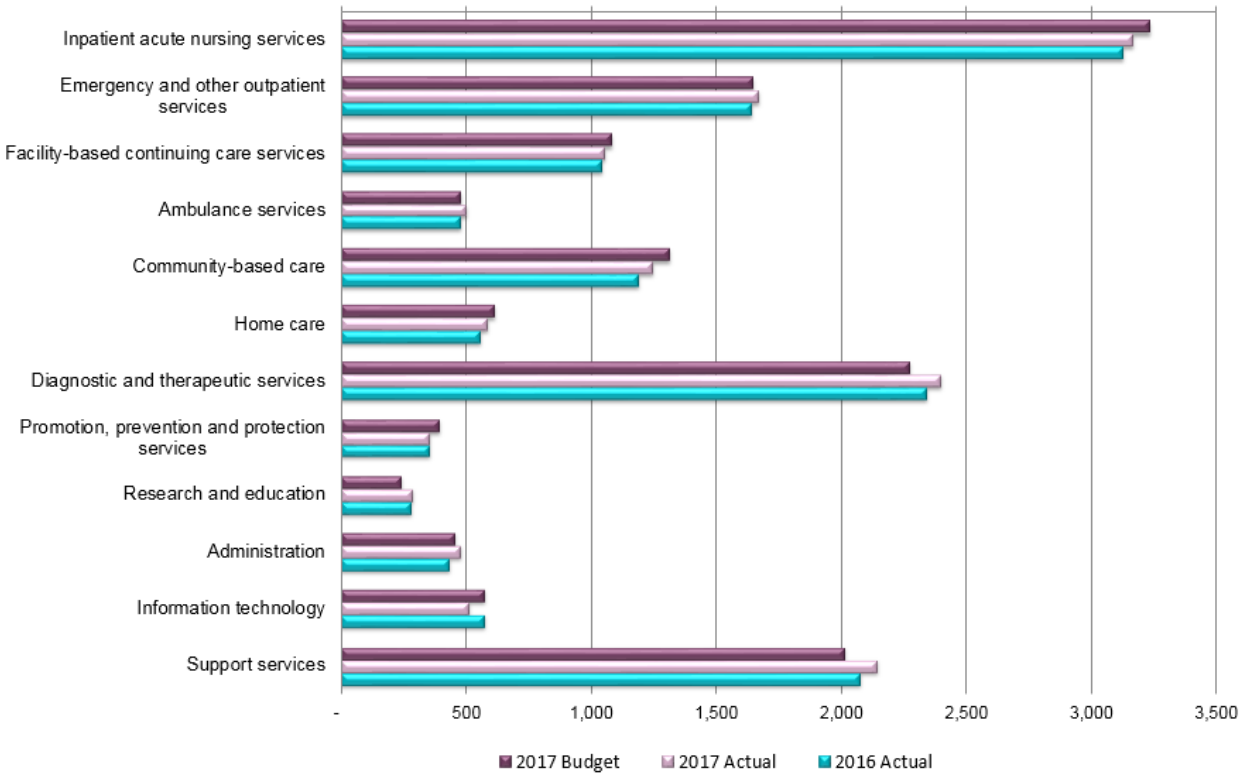
Compared to the prior year, other expenses increased by $33 or 2.5% mainly due to increased costs due to higher activity, including infrastructure and equipment maintenance costs, leases, and costs related to the Fort McMurray wildfire. The overall increase was partially offset by achieved savings initiatives including decreased spending on general costs, such as travel and supply costs, minor equipment purchases and reduced project costs, such as parking related initiatives.

Amortization, disposals and write-downs relates to the periodic charges to expenses representing the estimated portion of the cost of the respective tangible capital asset that expired through use and age during the period.

Amortization, disposal and write-downs amounted to $551, which was $36 or 6.1% lower than the budget of $587, mainly due to both timing differences between anticipated and actual purchases and lower capitalized costs, particularly with respect to information technology systems and equipment. In addition, changes to the expected completion costs and deployment date of system and facilities projects further contributed to the variance.

Compared to the prior year, amortization, disposal and write-downs decreased by $38 or 6.5%, mainly due to the impact realized from assets that were fully amortized over the course of the current and prior year, particularly within facilities, information technology systems, and equipment. The overall decrease was partially offset by increased deployment of facilities and building service equipment compared to the prior year.

Expenses – By Function



The overall 2.1% increase in 2016-17 expenses was primarily due to increased salary and benefit costs, and contracts with health service provider costs, offset by a decrease in medical and surgical supplies, other contracted services and amortization expense. AHS' overall distribution of expenses has remained consistent with prior years, with inpatient acute nursing services and diagnostic and therapeutic expenses making up 39% of total expenses (2015-16 – 39%).

Focusing on community-based care and capacity, there were higher relative increases in these areas, as compared to inpatient acute nursing services. Enhancing the care in communities should ease the pressures on hospitals, while ensuring the right services are offered to support the growing and aging population of Alberta.

Total expenses have increased annually due to continued cost pressures such as, salary rate increases related to collective agreement settlements, increased activity, planned initiatives, and inflation.

Expenses	Budget 2017	Actual 2017	Variance 2017		Actual 2016	Increase (Decrease)	
Inpatient acute nursing services *	$ 3,235	$ 3,169	$ 66	2.0%	$ 3,130	$ 39	1.2%
Emergency and other outpatient services	1,646	1,672	(26)	(1.6%)	1,641	31	1.9%
Facility-based continuing care services	1,080	1,053	27	2.5%	1,043	10	1.0%
Ambulance services	479	498	(19)	(4.0%)	479	19	4.0%
Community-based care	1,317	1,249	68	5.2%	1,192	57	4.8%
Home care *	611	585	26	4.3%	556	29	5.2%
Diagnostic and therapeutic services *	2,273	2,400	(127)	(5.6%)	2,344	56	2.4%
Promotion, prevention and protection Services *	393	355	38	9.7%	353	2	0.6%
Research and education *	240	285	(45)	(18.8%)	278	7	2.5%
Administration	458	478	(20)	(4.4%)	434	44	10.1%
Information technology	572	513	59	10.3%	572	(59)	(10.3%)
Support services *	2,014	2,146	(132)	(6.6%)	2,078	68	3.3%
Total expenses	**$ 14,318**	**$ 14,403**	**$(85)**	**(0.6%)**	**$ 14,100**	**$303**	**2.1%**

* During the year, certain costs were reclassified within the expenses by function categories to better align with the Canadian Institute of Health Information (CIHI) standards and definitions. This allowed AHS to improve comparability with other health entities across Canada, and enable better discussions to identify operational differences and efficiencies. Reclassifications were made for the years ended March 31, 2017, and the March 31, 2016 comparative financial statements. The 2016-17 budget however, was not adjusted and reflects the original Board approved budget at the start of the fiscal year. This significantly impacts the budget to actual variances for some functions, which are identified below. The reclassifications did not impact expenses by object, or the annual surplus on the Statement of Operations.

Significant variances and changes are explained as follows:

Inpatient acute nursing services are comprised predominantly of patient care units such as medical, surgical, intensive care, obstetrics, pediatrics, and mental health. This category also includes operating and recovery rooms.

Inpatient acute nursing services amounted to $3,169, which was $66 or 2.0% lower than the budget of $3,235 mainly due to the unbudgeted reclassification of $141 out of inpatient acute nursing services, to better align with CIHI standards and definitions, as noted above. Excluding this reclassification, inpatient acute nursing services would have been higher than budget by $75, mainly due to delayed implementation of savings initiatives, zone activity including increased elapsed patient days and surgical activity, as well as activity levels related to unfunded transition beds and units. Increased activity also resulted in compensation rate variances due to shift premiums and the incurrence of overtime and relief coverage. The variance was partially offset by vacancies related to physician and staff positions, settlement of union agreements, lower contract inflation, timing delays of new investments, and the achievement of cost containment strategies.

Compared to the prior year, inpatient acute nursing services increased by $39 or 1.2% mainly due to increased compensation costs related to collective agreements, which also resulted in increased contract costs for health service providers. While elapsed patient days remained relatively constant compared to the prior year, there were increases in various other activities, including surgical activity, in line with the planned increase in procedural access, as well as increased activity under the Academic Alternative Relationship Plan and the Alternative Relationship Plan. Increased activity also resulted in increased staffing costs. The overall increase was partially offset by savings due to the achievement of OBP initiatives.

Emergency and other outpatient services are comprised primarily of emergency, day/night care, clinics, day surgery, and contracted surgical services.

Emergency and other outpatient services amounted to $1,672, which was $26 or 1.6% higher than the budget of $1,646 mainly due to delayed implementation of savings initiatives, increased cancer drug utilization, and increased activity, particularly within clinics and to a lesser extent, emergency visits. Further contributing to the variance were compensation rate variances due to shift premiums. The overall variance was partially offset by staff and physician vacancies, various cost containment strategies, union settlements, some timing delays in new investments and initiatives, and market rate fluctuations for high cost drugs.

Compared to the prior year, emergency and other outpatient services increased by $31 or 1.9% mainly due to increased drug utilization as additional new cancer drugs were made available in the current year. The increase in activity within various areas including surgical, cardiac sciences, and day/night clinics, also contributed to the increase in drug usage and overall costs. While emergency visits decreased year-over-year, this was offset by an increase in the number of urgent visits as compared to non-urgent visits. Increased compensation costs related to collective agreements, and increased activity, particularly in the area of surgical cases, also contributed to the increase. The overall increase was partially offset by cost mitigation strategies and OBP savings implemented during the year as well as drug price reductions and rebates.

Facility-based continuing care services are comprised of long-term care including chronic and psychiatric care in facilities operated by AHS and contracted providers.

Facility-based continuing care services amounted to $1,053, which was $27 or 2.5% lower than the budget of $1,080 mainly due to lower contract inflation, union settlements, and vacancies. The overall variance was partially offset by compensation rate variances due to shift premiums.

Compared to the prior year, facility-based continuing care services increased by $10 or 1.0% mainly due to increased long-term care capacity.

Ambulance services are comprised of ground ambulance, air ambulance, patient transport, and Emergency Medical Services (EMS) central dispatch. AHS also supports community paramedic programs, as well as other programs that support the learning, development, quality and safety of EMS professionals.

Ambulance services amounted to $498, which was $19 or 4.0% higher than the budget of $479 mainly due to increased activity resulting in higher relief coverage and overtime, as well as the extension of dispatch contracts, which were budgeted to be partial year contracts. Compensation costs relating to the Fort McMurray wildfire also contributed to the variance. The overall variance was partially offset by vacancies.

Compared to the prior year, ambulance services increased by $19, or 4.0% mainly due to union settlements, contract inflation, and salaries and benefit costs related to additional front-line responders as a result of the Fort McMurray wildfire.

Community-based care refers to the services provided to those who need care and support in their living environments including supportive living, and palliative and hospice care, but excludes community-based dialysis, oncology, and surgical services. This category also consists of community programs including Primary Care Networks, Family Care Clinics, urgent care centres, and community mental health.

Community-based care amounted to $1,249, which was $68 or 5.2% lower than the budget of $1,317 mainly due to delays in budgeted initiatives, in particular the Continuing Care Capacity Plan, and vacancies. Further contributing to the variance was a reduction in costs relating to travel, hiring and administrative costs, and reduced clinical contract inflation. The overall decrease was partially offset by the delayed implementation of savings initiatives and increased activity resulting from higher demand in areas such as, adult housing initiatives and correctional facilities.

Compared to the prior year, community-based care increased by $57 or 4.8% mainly due to increased capacity under the Continuing Care Capacity Plan and supportive living initiatives. Further contributing to the variance were higher compensation costs related to collective agreements. The overall variance was partially offset by mitigation of costs related to supplies and travel.

Home care is comprised of home nursing and support.

Home care amounted to $585, which was $26 or 4.3% lower than the budget of $611 mainly due to delayed initiatives and the unbudgeted reclassification of $12 out of home care, to better align with CIHI standards and definitions, as noted above. Reduced administrative, travel, relief and overtime costs, in addition to vacancies, further contributed to the variance. The overall variance was partially offset by higher activity stemming from increased demand which resulted in increased home care hours and costs.

Compared to the prior year, home care increased by $29 or 5.2% mainly due to increased activity resulting from increased home care clients and unique client visits, as well as increased contract inflation costs.

Diagnostic and therapeutic services support and provide care for patients through clinical lab (both in the community and acute), diagnostic imaging, pharmacy, acute and therapeutic services such as physiotherapy, occupational therapy, respiratory therapy, and speech language pathology.

Diagnostic and therapeutic services amounted to $2,400, which was $127 or 5.6% higher than the budget of $2,273 mainly due to the unbudgeted reclassification of $64 in to diagnostic and therapeutic services to better align with CIHI standards and definitions, as noted above. Excluding this reclassification, diagnostic and therapeutic services would have continued to exceed budget, but to a lesser extent, of $63, due to delays in the implementation of savings initiatives, and higher compensation benefit and rate variances. Increased activity throughout AHS such as, increased referred-out specialized testing, changes in the mix of exams resulting in higher cost procedures, and staff premiums also contributed to the variance. The overall variance was partially offset by vacancies, reduced relief and overtime costs, and decreases in minor purchases and office supplies. Delayed initiatives and reduced amortization expense resulting from timing differences between anticipated and actual purchases also offset the overall variance.

Compared to the prior year, diagnostic and therapeutic services increased by $56 or 2.4% mainly due to compensation increases related to collective agreements, increased activity throughout the organization, and contract inflation particularly within laboratory services. Further contributing to the variance is higher activity resulting from new facilities, and from initiatives such as the Continuing Care Capacity Plan, cancer care, and surgical initiatives. The overall increase was partially offset by reduced amortization expense resulting from a declining diagnostic and therapeutic capital asset base, achieved savings initiatives and reduced contract pricing for cardiac devices.

Promotion, prevention and protection services are comprised primarily of health promotion, disease and injury prevention, and health protection.

Promotion, prevention and protection services amounted to $355, which was $38 or 9.7% lower than the budget of $393 mainly due to the unbudgeted reclassification of $12 out of promotion, prevention and protection services to better align with CIHI standards and definitions, as noted above. Vacancies, the reduction of general expenses such as travel, supply and hiring costs, and delays in hiring for various budgeted initiatives also contributed to the variance.

Promotion, prevention and protection services were consistent with the prior fiscal year.

Research and education is comprised primarily of costs pertaining to formally organized health research and graduate medical education, primarily funded by donations, and third party contributions.

Research and education amounted to $285, which was $45 or 18.8% higher than the budget of $240 mainly due to the unbudgeted reclassification of $51 in to research and education to better align with CIHI standards and definitions, as noted above. Excluding this reclassification, research and education would have been consistent with the budget.

Research and education costs were consistent with the prior year.

Administration is comprised of human resources, finance, communications and general administration, as well as a share of administration of certain contracted health service providers. General administration includes senior executives and many functions such as planning and development, infection control, quality assurance, patient safety, insurance, privacy, risk management, internal audit, and legal. Activities and costs directly supporting clinical activities are excluded.

In 2016-17 AHS' administration expense was $478 which represents 3.3% (2015-16 – 3.1%) of total expenses.

The Canadian Institute for Health Information (CIHI) reports administration expense as a financial performance indicator calculated based on administration expense, net of recoveries, and total expenses, net of recoveries and inclusive of bad debt expense. For 2016-17 AHS' indicator was 3.3% (2015-16 – 3.1%).

Administration amounted to $478, which was $20 or 4.4% higher than the budget of $458 mainly due to an insurance deductible for an overland flood, higher legal and arbitration costs, and increased information technology costs. Also contributing to the variance were higher liability insurance claims and higher compensation and benefit rate variances. The overall increase was partially offset by vacancies and the mitigation of costs related to recruitment, travel, and supplies.

Compared to the prior year, administration increased by $44 or 10.1% mainly due to higher insurance expenses resulting from higher liability claims and property settlements, and increased legal and reinsurance expense. A higher provision for unpaid claims, including increased insurance deductibles, also contributed to the variance. The overall variance was partially offset by achieved savings initiatives and reduced office costs.

Information technology is comprised of costs pertaining to the provision of services to design, develop, implement, and maintain effective and efficient management support systems in the areas of data processing, systems engineering, technical support, and systems research and development. This includes clinical and corporate enterprise systems and infrastructure, as well as support of provincial systems such as, Alberta Netcare.

Information technology amounted to $513, which was $59 or 10.3% lower than the budget of $572 mainly due to lower amortization resulting from changes in system project completion costs, deployment dates, and timing differences between anticipated and actual purchases. Lower project expenditures, timing delays with budgeted initiatives, and vacancies also contributed to the variance. Reduced travel, education and purchased service costs further contributed to the variance. The overall decrease was partially offset by unbudgeted contract growth, inflation, market rate fluctuations, and minor equipment purchases.

Compared to the prior year, information technology decreased by $59 or 10.3% mainly due to reduced amortization expense resulting from a declining information technology capital asset base arising from a slowdown in the reinvestment of related assets, and increased savings due to the insourcing of several information technology services. Reduced spending on projects due to prioritization in order to align with organizational objectives and human resource capacity also contributed to the variance. The overall decrease was partially offset by reduced vacancies resulting from increased staffing levels required to support the organization, which also resulted in higher minor equipment purchases.

Support services are comprised of building maintenance operations (including utilities), materials management (including purchasing, central warehousing, distribution and sterilization), housekeeping, patient registration, health records, food services, and emergency preparedness.

Support services amounted to $2,146, which was $132 or 6.6% higher than the budget of $2,014 mainly due to the unbudgeted reclassification of $25 in to support services to better align with CIHI standards and definitions, as noted above. Excluding this reclassification, support services would have continued to exceed budget, but to a lesser extent, of $107 mainly due to higher compensation and benefit rate variances, and increased activity including the completion of projects, particularly with respect to the Infrastructure Maintenance Program. Further contributing to the variance are higher amortization expenses resulting from timing differences related to capital expenditures, higher equipment purchases relating to Alberta Infrastructure (AI) projects, continued work resulting from the Fort McMurray wildfire and delayed implementation of savings initiatives. The overall increase was partially offset by vacancies, cost mitigation strategies, including reduced travel and supply costs, delayed initiatives, and general hiring delays.

Compared to the prior year, support services increased by $68 or 3.3% mainly due to increased Infrastructure Maintenance Program costs, higher benefit and compensation rate variances, and increased amortization costs due to the deployment of facilities. Further contributing to the variance were costs for new and upcoming facility openings, implementation of strategic new initiatives, as well as continued work resulting from the Fort McMurray wildfire. The overall increase was partially offset by cost mitigation strategies, including reduced parking projects and lower general purchases.

STATEMENT OF FINANCIAL POSITION

Consolidated Statement of Financial Position	Actual 2017	Actual 2016	Increase (Decrease)
Cash	$ 46	$ 80	$ (34)
Investments	2,265	2,188	77
Total cash and investments	2,311	2,268	43
Accounts receivable	386	393	(7)
Total financial assets	**2,697**	**2,661**	**36**
Accounts payable and accrued liabilities	1,210	1,236	(26)
Employee future benefits	653	621	32
Unexpended deferred operating revenue	411	430	(19)
Unexpended deferred capital revenue	138	148	(10)
Debt	320	327	(7)
Total liabilities	**2,732**	**2,762**	**(30)**
Net debt	**(35)**	**(101)**	**(66)**
Tangible capital assets	7,619	7,573	46
Inventories for consumption	92	94	(2)
Prepaid expenses and other non-financial assets	128	128	-
Total non-financial assets	**7,839**	**7,795**	**44**
Expended deferred capital revenue	6,549	6,530	19
Net assets	**$ 1,255**	**$ 1,164**	**$ 91**
Accumulated surplus	$ 1,226	$ 1,159	$ 67
Accumulated remeasurement gains	29	5	24

AHS prepares its financial statements using the net debt presentation which emphasizes financial vs. non-financial assets on the Consolidated Statement of Financial Position. Net debt provides a measure of the future revenues required by AHS to pay for past transactions and services. It provides information regarding the extent to which the expenditures of the accounting period are met by the revenues recognized in the Consolidated Statement of Operations during the period.

Financial Assets

Financial assets are the financial resources available to AHS for settling its liabilities or to finance future activities.

Cash and Investments

AHS receives its base operating funding from AH on a semi-monthly basis. The arrangement allows AHS to manage its operating cash balances effectively to meet its immediate and ongoing liabilities as they become due. AHS' investment portfolio employs a conservative strategy and is highly liquid in nature, enabling AHS to respond to cash flow requirements quickly and efficiently. Focusing on prudent stewardship of funds, AHS monitors its bank balances closely and transfers cash to or from its investment portfolio to ensure that cash balances earn maximum returns until they need to be utilized.

Cash and investments increased during the year by $43 due to higher operating and restricted funding received, offset by slightly higher expense growth year over year. AHS' investment portfolio generated a return of 2.9% during 2016-17 (2015-16 - 3.7%). AHS' investment portfolio benefited from growth returns from its equity investments offset by lower yielding fixed income investments.

The cash and investment balance of $2,311 will be used to cover future liabilities including accounts payable and accrued liabilities, unexpended deferred operating revenue, unexpended deferred capital revenue, and debt.

AHS has an investment philosophy designed to ensure that its funds are invested in a way that promotes the short and long-term sustainability of AHS' operations. The investment philosophy assures preservation of capital by minimizing exposure to undue risk of loss or impairment, while maintaining a reasonable expectation of fair return or appreciation while offsetting the effects of inflation. This strategy protects the original capital while providing reasonable returns with a conservative exposure to more volatile equity markets.

As at March 31, 2017, management believes that the current balance is appropriate to cover immediate and upcoming obligations as they become due.

Accounts Receivable

Accounts receivable decreased by $7 during the year mainly as a result of a decline in patients' receivables of $13 offset by a net increase in operating and capital transfers receivable from AH and AI respectively, amounting to $6.

Liabilities

Liabilities are existing financial obligations at the date of the financial statements.

Accounts Payable and Accrued Liabilities

Accounts payable and accrued liabilities decreased by $26 compared to prior year. The decrease is mainly attributed to earlier remittances of statutory payroll deductions compared to prior year as well as retroactive payments related to the ratification of collective bargaining agreements which resulted in the related payables and accruals declining by $128. This was offset by an increase of $102 in trade accounts payable and other liabilities mainly due to timing of payments.

Employee Future Benefits

Employee future benefits, which is comprised of vacation and accumulated non-vesting sick leave liability, increased by $32, mainly due to the vacation liability, which increased by $26 due to salary rate increases related to collective agreement ratifications which occurred in the year.

Unexpended Deferred Operating Revenue

Unexpended deferred operating revenue is comprised of unspent operating funds that have been received by AHS for which spending restrictions, imposed by a funder or donor, exist. During the year, AHS received or accrued, net of repayments, interest income, and unrealized gains/losses, $1,151 in restricted funding. An additional $47 was transferred from unexpended deferred capital revenue to fund operating initiatives. AHS recognized $1,217 of offsetting revenue, reflecting the amount spent in related expenses.

Unexpended Deferred Capital Revenue

Unexpended deferred capital revenue is comprised of unspent capital funds that have been received by AHS for which spending restrictions, imposed by donors, exist. During the year, AHS received or accrued, net of repayments, $459 in restricted capital funding of which $216 comprised a transfer of tangible capital assets from AI. AHS incurred $422 in offsetting capital expenditures and transferred $47 to unexpended deferred operating revenue to fund operating initiatives.

Debt

AHS issues debentures to Alberta Capital Financing Authority (ACFA) to finance the construction of parking facilities and for Energy Savings initiatives. AHS pledges the revenue derived from all parking facilities as security for the debentures, while for Energy Savings initiatives, land at the respective sites has been pledged as security. During the year, a $52 debenture was issued of which $5 in debt proceeds was received to begin financing the construction of a parking facility at the Foothills Medical Centre in Calgary. The remainder will be drawn by March 2018. A second debenture totalling $26 was issued in the year. Of this amount, $5 in debt proceeds was received in the year to begin financing Energy Savings initiatives at the Royal Alexandra Hospital and Alberta Hospital in Edmonton. The remainder is expected to be drawn by December 2017. The net principal repayments in the year on all outstanding debt amounted to $17.

AHS has access to a $220 revolving demand loan facility with a Canadian chartered bank, which may be used for operating purposes. This facility was not utilized during the year. Additionally, AHS has access to a $33 revolving demand letter of credit facility of which $3 in letters of credit was outstanding as at March 31, 2017 (March 31, 2016 - $3).

Non-Financial Assets

Non-financial assets are assets that AHS uses when providing services to the public and are not intended to be monetized for settling its liabilities with external parties.

Tangible Capital Assets

	Actual 2017	Actual 2016	Increase
Cost	$ 14,606	$ 14,054	$ 552
Accumulated amortization	6,987	6,481	506
Net book value	**$ 7,619**	**$ 7,573**	**$ 46**

Over the course of the year, several capital projects totalling $590 previously included in work in progress (WIP), were brought into service. Notable projects included the Medicine Hat Regional Hospital Renovation and Redevelopment Facility, High Prairie Health Complex, Royal Alexandra Hospital – Concurrent Disorders Capable Treatment Continuum Facility, Edson Healthcare Centre – Continuing Care Centre and The Stollery Pediatric Surgical Suite Expansion Facility.

The remaining WIP balance of $914 includes infrastructure and information technology capital projects at the following sites:

- Grande Prairie Regional Hospital
- University of Alberta Hospital
- Red Deer Regional Hospital Centre
- Lethbridge Chinook Regional Hospital
- Northern Lights Regional Health Centre
- Foothills Medical Centre
- Taber Health Centres Renovation
- Peter Lougheed Centre
- Northern Alberta Urology Centre

At March 31, 2017, AHS had approved capital commitments to purchase tangible capital assets of $157 for facilities and improvements, $10 for information systems, and $58 for equipment.

Financing of Tangible Capital Assets

AHS primarily relies on transfers from AI for funding the acquisition of tangible capital assets. Facilities and building service equipment were 90% externally funded (2015-16 – 94%), equipment purchases were 52% externally funded (2015-16 – 69%) and information technology equipment purchases were 20% externally funded (2015-16 – 51%). The general decline in the percentage of externally funded tangible capital assets in the current year is mainly the result of increased capital financing from AHS' accumulated surplus compared to the prior year.

Expended Deferred Capital Revenue

Expended deferred capital revenue represents funding received from donors which has been spent on the acquisition of tangible capital assets but has not yet been recognized in the Consolidated Statement of Operations through matching with the related amortization expense. Tangible capital assets acquired with donor funding are utilized for the duration of their economic useful lives, and on the same basis, AHS recognizes revenue equivalent to the amortization expense charged as the assets are utilized. The assets include hospitals and other related facilities, equipment and information systems. Funding from the GOA, mainly AI, represents $6,368 (97%) of the $6,549 total balance

Accumulated Surplus

	Actual 2017	Actual 2016	Increase (Decrease)
Accumulated surplus	$ 1,226	$ 1,159	$ 67
Less: Invested in tangible capital assets	(714)	(677)	(37)
Less: Internally restricted surplus for future purposes	(225)	(284)	59
Less: Endowments	(75)	(73)	(2)
Unrestricted surplus	**$ 212**	**$ 125**	**$ 87**

The unrestricted surplus of $212 at March 31, 2017 does not have any restrictions attached to its future use and may be used at AHS' discretion for operating or capital purposes.

The accumulated surplus invested in tangible capital assets at March 31, 2017 of $714 represents the net book value of tangible capital assets that have previously been purchased with AHS' unrestricted surplus. AHS has no plans to monetize these assets to cover future operations

The internally restricted surplus for future purposes at March 31, 2017 of $225 has been approved by the Board for future purposes. The reduction in the internally restricted surplus is primarily due to the Clinical Information System capital reserve having been collapsed as AH is now funding this project through a multiyear funding program and, as such AHS no longer has the requirement for this specific reserve.

The endowments of $75 are comprised of financial resources received by AHS where the principal amount is maintained in perpetuity and investment income earned on the principal is available for use as stipulated by the endowment donors. Endowment contributions in the year amounted to $2.

HISTORICAL 5-YEAR INFORMATION

Select Annual Financial Information Years Ended March 31					
	Actual 2017	Actual 2016	Actual 2015	Actual 2014	Actual 2013
Revenue	$ 14,470	$ 13,955	$ 13,828	$ 13,221	$ 12,685
Expenses	14,403	14,100	13,827	13,062	12,578
Annual surplus (deficit)	**$ 67**	**$ (145)**	**$ 1**	**$ 159**	**$ 107**
Accumulated surplus	$ 1,226	$ 1,159	$ 1,304	$ 1,303	$ 1,144

FINANCIAL REPORTING, CONTROL AND ACCOUNTABILITY

Alberta Health Services was established under the *Regional Health Authorities Act* (Alberta), effective April 1, 2009, as a result of the amalgamation of 12 formerly separate health entities in Alberta.

The AHS consolidated financial statements have been prepared in accordance with Canadian Public Sector Accounting Standards and the financial directives issued by Alberta Health. The chart of accounts that AHS uses to report expenses by function and by object is based on the national standard of CIHI. Detailed site-based results are submitted to CIHI annually for analysis and reporting on Canada's health system and the health of Canadians. AHS' annual financial reports are available at **www.ahs.ca** under data, statistics, and reporting.

An effective, integrated governance model is an essential component in support of improving:

- the delivery of care and services to Albertans;
- support for people who deliver care and services; and
- the way the organization operates.

AHS performance measures are aligned with the Alberta Quality Matrix for Health, a framework that provides a common language, understanding and approach for thinking about quality among health-care organizations, professionals and other stakeholders.

The Board provides oversight and carries out its risk management mandate primarily through sub committees, which include the Audit & Risk Committee, Finance Committee, Quality & Safety Committee, Governance Committee, Human Resources Committee, and Community Engagement Committee.

The Audit & Risk Committee has the responsibility to assist in fulfilling the oversight responsibilities of the Board with respect to management and compliance, external financial reporting, internal controls over financial reporting, internal audit, and the external audit. The Finance Committee has responsibility to assist in fulfilling the financial oversight responsibilities of the Board such as including those pertaining to the Health Plan, Business Plan, budget, and its investment portfolio.

AHS has established an Internal Audit function with the mandate of providing independent advisory and assurance services to management and the Board on AHS operations. The scope of Internal Audit's work is to determine whether AHS' risk management, control and governance processes are adequate and functioning effectively. The Chief Audit Executive is also responsible for coordinating AHS' Enterprise Risk Management function including development and implementation of policies and processes for identifying, monitoring, and reporting risks within the organization.

As a component of the Internal Audit function, AHS has an Internal Controls over Financial Reporting (ICOFR) group, which is tasked with ensuring that the financial reporting environment mitigates the risk of material misstatements by establishing a sustainable framework of internal controls over financial reporting. In fulfilling its mandate, ICOFR continues to work on the implementation of its plan to ensure that appropriate internal controls are designed, implemented, and documented within AHS.

The Auditor General of Alberta is the appointed external auditor of AHS. In addition to expressing an audit opinion on the AHS annual consolidated financial statements, the Auditor General of Alberta also reports to the legislature recommendations related to AHS along with other government entities. The Auditor General of Alberta's reports are available at **www.oag.ab.ca** under public reports.

FORWARD-LOOKING STATEMENTS DISCLOSURE

The FSD&A includes forward-looking statements and information about the organization's outlook, direction, operations, and future financial results that are subject to risks, uncertainties, and assumptions. As a consequence, actual results in the future may differ materially from any conclusion, forecast or projection in such forward-looking statements. Therefore, forward-looking statements should be considered carefully and undue reliance should not be placed on them.

Outlook

Over the next 3 years, AHS must operate within the budget approved by the Minister of Health while also meeting the priorities of Albertans. Starting in 2017-18, funding will be provided for enhancing community and home care, and will allow patients and families to have more responsibility for their healthcare. The plan will also include the funding needed to delivery our current programs and services and will take into account the budget challenges we face as an organization in the current provincial fiscal environment.

AHS must continue to maximize every dollar we invest in order to deal with the cost drivers described in the previous sections. AHS must continue to improve how we work so that we can offset the costs of a growing and aging population, reallocate resources to where they are most needed, and make strategic investments within the infrastructure and programs of the health system.

For 2017-20, expenses are budgeted to grow by less than 2% per year. While AHS has seen a decrease in the growth of expenses, we must continue to focus on using resources more efficiently and appropriately and provide better care in more effective ways. AHS will continue to achieve business efficiencies through Operational Best Practices and we will also work to ensure clinical best practices and appropriateness. As mentioned, by enhancing care in the community and focusing on the health and wellness of Albertans rather than on treating disease and illness, we will be more sustainable over time.

Cost Pressures

The following pressures are specific to the outlook and include:

Population and demand: the population of Alberta continues to increase and is aging and living longer. On average, we are using more healthcare per person compared to previous generations, creating increased demand in all areas of the healthcare system.

Costs: healthcare costs have been rising more rapidly than general inflation and costs per unit of service are also increasing. AHS' salaries and benefits expenses comprise approximately 55% of total expenses.

Workforce: to support a transition from "hospital to community" there is a need for trained healthcare workers to also shift from a hospital setting to community and home care settings. AHS respects staff preferences and is committed to using a voluntary attrition-based approach to allocate staff where they are needed most. This means though that the transition will take longer and it will take time before savings will be realized and the growth of expenses decreases.

Multiple priorities: AHS must continue to work with AH to find the right balance of programs and services to ensure that the needs of Albertans are met while working efficiently. One of the priorities for 2017-18 is to enhance community and home care options for Albertans. To do this successfully, there must be a reduction in reliance on acute care and resulting costs so that resources can be redeployed to areas that will build better health long-term for Albertans.

Engagement: enhancing the care that's provided requires engagement from multiple stakeholders, including Albertans, AHS employees, physicians, other healthcare providers, and the Government of Alberta. AHS will need to work with key stakeholders to determine how to successfully transition the focus to placing more resources in our communities.

AHS also has an Enterprise Risk Management (ERM) program which actively supports management in identifying, analyzing, and monitoring risks that may impact the achievement of its strategic objectives. Priority strategic risks for AHS for future years is updated annually and where needed, risk mitigation strategies are developed and monitored to guide management decision-making and actions.

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2017

Management's Responsibility for Financial Reporting

Independent Auditor's Report

Consolidated Statement of Operations

Consolidated Statement of Financial Position

Consolidated Statement of Change in Net Debt

Consolidated Statement of Remeasurement Gains and Losses

Consolidated Statement of Cash Flows

Notes to the Consolidated Financial Statements

Schedule 1 – Consolidated Schedule of Expenses by Object

Schedule 2 – Consolidated Schedule of Salaries and Benefits

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying consolidated financial statements for the year ended March 31, 2017 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Public Sector Accounting Standards and the financial directives issued by Alberta Health, and of necessity include some amounts based on estimates and judgment.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains systems of financial management and internal control which give consideration to costs, benefits and risks that are designed to:

- provide reasonable assurance that transactions are properly authorized, executed in accordance with prescribed legislation and regulations, and properly recorded so as to maintain accountability of public money;
- safeguard the assets and properties of the "Province of Alberta" under Alberta Health Services' administration

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Audit & Risk Committee (the Committee). The Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the consolidated financial statements to the Alberta Health Services Board for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Committee.

The Auditor General of Alberta provides an independent audit of the consolidated financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures which allow him to report on the fairness of the consolidated financial statements prepared by management.

[Original Signed By]

Dr. Verna Yiu, MD, FRCPC
President and Chief Executive Officer
Alberta Health Services

[Original Signed By]

Deborah Rhodes, CPA, CA
Vice President Corporate Services and Chief Financial Officer
Alberta Health Services

June 1, 2017

Independent Auditor's Report

To the Minister of Health

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of Alberta Health Services, which comprise the consolidated statement of financial position as at March 31, 2017, and the consolidated statements of operations, remeasurement gains and losses, change in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these consolidated financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Alberta Health Services as at March 31, 2017, and the results of its operations, its remeasurement gains and losses, its changes in net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

[Original signed by Merwan N. Saher FCPA, FCA]

Auditor General

June 1, 2017

Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS
YEAR ENDED MARCH 31

	2017		2016
	Budget (Note 3)	Actual	Actual
Revenues:			
Alberta Health transfers			
Base operating	$ 11,860,000	$ 11,859,923	$ 11,329,851
One-time base operating	-	50,000	-
Grant funding transferred to one-time base operating	-	14,515	-
Other operating	968,000	953,328	1,064,739
Recognition of expended deferred capital revenue	81,000	86,784	84,716
Other government transfers (Note 4)	408,000	456,152	416,554
Fees and charges	513,000	479,180	491,487
Ancillary operations	133,000	135,660	133,220
Donations, fundraising, and non-government contributions (Note 5)	150,000	164,016	166,806
Investment and other income (Note 6)	205,000	270,410	267,931
TOTAL REVENUE	**14,318,000**	**14,469,968**	**13,955,304**
Expenses:			
Inpatient acute nursing services	3,235,000	3,169,177	3,129,520
Emergency and other outpatient services	1,646,000	1,671,830	1,641,261
Facility-based continuing care services	1,080,000	1,053,118	1,043,410
Ambulance services	479,000	497,686	479,031
Community-based care	1,317,000	1,249,031	1,191,605
Home care	611,000	585,313	555,831
Diagnostic and therapeutic services	2,273,000	2,400,242	2,343,794
Promotion, prevention, and protection services	393,000	354,700	353,028
Research and education	240,000	285,300	277,908
Administration (Note 7)	458,000	478,074	434,426
Information technology	572,000	513,420	572,545
Support services (Note 8)	2,014,000	2,145,541	2,077,504
TOTAL EXPENSES (Schedule 1)	**14,318,000**	**14,403,432**	**14,099,863**
ANNUAL OPERATING SURPLUS (DEFICIT)	**-**	**66,536**	**(144,559)**
Accumulated surplus, beginning of year	1,159,000	1,159,123	1,303,682
Accumulated surplus, end of year (Note 19)	**$ 1,159,000**	**$ 1,225,659**	**$ 1,159,123**

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31

	2017 Actual	2016 Actual
Financial Assets:		
Cash	$ 46,103	$ 79,867
Investments (Note 10)	2,264,866	2,187,506
Accounts receivable (Note 11)	386,292	393,493
	2,697,261	2,660,866
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,209,974	1,236,312
Employee future benefits (Note 13)	653,037	620,687
Unexpended deferred operating revenue (Note 14)	411,079	429,515
Unexpended deferred capital revenue (Note 15)	137,806	148,319
Debt (Note 17)	320,087	326,909
	2,731,983	2,761,742
NET DEBT	**(34,722)**	**(100,876)**
Non-Financial Assets:		
Tangible capital assets (Note 18)	7,619,077	7,573,071
Inventories for consumption	91,882	94,439
Prepaid expenses and other non-financial assets	128,058	127,943
	7,839,017	7,795,453
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	7,804,295	7,694,577
Expended deferred capital revenue (Note 16)	6,549,770	6,530,432
NET ASSETS	**1,254,525**	**1,164,145**
Net Assets is comprised of:		
Accumulated surplus (Note 19)	1,225,659	1,159,123
Accumulated remeasurement gains	28,866	5,022
	$ 1,254,525	**$ 1,164,145**

Contractual Obligations and Contingent Liabilities (Note 20)

The accompanying notes and schedules are part of these consolidated financial statements.

Approved by the Board of Directors:

[Original Signed By]

Linda Hughes
Board Chair

[Original Signed By]

David Carpenter, FCPA, FCA
Audit & Risk Committee Chair

CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT
YEAR ENDED MARCH 31

	2017		2016
	Budget (Note 3)	Actual	Actual
Annual operating surplus (deficit)	$ -	$ 66,536	$ (144,559)
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets (Note 18)	(402,000)	(597,021)	(650,785)
Amortization and disposals of tangible capital assets (Note 18)	587,000	551,015	588,851
Effect of other changes:			
Net increase (decrease) in expended deferred capital revenue	(217,000)	19,338	166,733
Net (increase) decrease in inventories for consumption	1,000	2,557	2,144
Net (increase) decrease in prepaid expenses and other non-financial assets	(5,000)	(115)	10,846
Net remeasurement gains (losses) for the year	(19,000)	23,844	(33,753)
(Increase) decrease in net debt for the year	**(55,000)**	**66,154**	**(60,523)**
Net debt, beginning of year	(101,000)	(100,876)	(40,353)
Net debt, end of year	**$ (156,000)**	**$ (34,722)**	**$ (100,876)**

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES
YEAR ENDED MARCH 31

	2017 Actual	2016 Actual
Unrestricted unrealized gains (losses) attributable to:		
Derivatives	$ 643	$ (2,451)
Portfolio investments		
Equity instruments quoted in an active market	14,456	(12,894)
Financial instruments designated to the fair value category	(786)	(3,360)
Amounts reclassified to the Consolidated Statement of Operations:		
Portfolio investments		
Equity instruments quoted in an active market	555	783
Financial instruments designated to the fair value category	8,976	(15,831)
Net remeasurement gains (losses) for the year	**23,844**	**(33,753)**
Accumulated remeasurement gains, beginning of year	5,022	38,775
Accumulated remeasurement gains, end of year (Note 10)	**$ 28,866**	**$ 5,022**

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS
YEAR ENDED MARCH 31

	2017 Actual	2016 Actual
Operating transactions:		
Annual operating surplus (deficit)	$ 66,536	$ (144,559)
Non-cash items:		
Amortization and disposals of tangible capital assets	551,015	588,851
Recognition of expended deferred capital revenue	(402,887)	(394,294)
Revenue recognized for acquisition of land	(687)	-
Decrease (increase) in:		
Accounts receivable related to operating transactions	(26,890)	(49,250)
Inventories for consumption	2,557	2,144
Prepaid expenses and other non-financial assets	(115)	10,846
Increase (decrease) in:		
Accounts payable and accrued liabilities related to operating transactions	(51,771)	(39,564)
Employee future benefits	32,350	26,084
Unexpended deferred operating revenue	(70,148)	(80,367)
Cash provided by (applied to) operating transactions	99,960	(80,109)
Capital transactions:		
Acquisition of tangible capital assets	(380,401)	(233,213)
Increase (decrease) in accounts payable and accrued liabilities related to capital transactions	25,433	(6,434)
Cash applied to capital transactions	(354,968)	(239,647)
Investing transactions:		
Purchase of investments	(3,339,338)	(4,230,911)
Proceeds on disposals of investments	3,290,394	4,133,948
Cash applied to investing transactions	(48,944)	(96,963)
Financing transactions:		
Restricted capital contributions received	278,230	164,359
Unexpended deferred capital revenue returned	(1,220)	(4,698)
Proceeds from debt	10,000	20,300
Principal payments on debt	(16,822)	(15,222)
Cash provided by financing transactions	270,188	164,739
Decrease in cash	**(33,764)**	**(251,980)**
Cash, beginning of year	79,867	331,847
Cash, end of year	**$ 46,103**	**$ 79,867**

The accompanying notes and schedules are part of these consolidated financial statements.

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS MARCH 31, 2017

Note 1 Authority, Purpose and Operations

Alberta Health Services (AHS) was established under the *Regional Health Authorities Act* (Alberta), effective April 1, 2009, as a result of the merger of 12 formerly separate health entities in Alberta.

Pursuant to Section 5 of the *Regional Health Authorities Act* (Alberta), AHS is responsible in Alberta to:

- promote and protect the health of the population in the health region and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the health region;
- determine priorities in the provision of health services in the health region and allocate resources accordingly;
- ensure that reasonable access to quality health services is provided in and through the health region; and
- promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.

Additionally, AHS is accountable to the Minister of Health (the Minister) for the delivery and operation of the public health system.

The AHS consolidated financial statements include the revenue and expenses associated with its responsibilities. These consolidated financial statements do not reflect the complete costs of provincial health care. For a complete picture of the costs of provincial health care, readers should consult the consolidated financial statements of the Government of Alberta (GOA).

AHS and its contracted health service providers deliver health services at facilities and sites grouped in the following areas: addiction treatment, community mental health, standalone psychiatric facilities, acute care hospitals, sub-acute care in auxiliary hospitals, long-term care, palliative care, supportive living, cancer care, community ambulatory care centres, and urgent care centres.

Under the *Income Tax Act (Canada)*, AHS is a registered charity.

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

These consolidated financial statements have been prepared in accordance with Canadian Public Sector Accounting Standards (PSAS) and the financial directives issued by Alberta Health (AH). AHS is a Government Not-for-Profit Organization under PSAS.

These financial statements have been prepared on a consolidated basis and include the following entities:

(i) Controlled Entities

The consolidated financial statements reflect the assets, liabilities, revenues, and expenses of the reporting entity, which is comprised of the organizations controlled by AHS as noted below:

AHS owns 100% of the Class A voting shares in the following three entities:

- Calgary Laboratory Services Ltd. (CLS) - provides medical diagnostic services in Calgary and southern Alberta.
- Capital Care Group Inc. (CCGI) - manages continuing care programs and facilities in the Edmonton area.
- Carewest - manages continuing care programs and facilities in the Calgary area.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHS has the majority representation indicating control of the following entities and therefore constitute part of the consolidated reporting entity:

- Foundations:

Airdrie Health Foundation
Alberta Cancer Foundation (ACF)
American Friends of the Calgary Health Trust Foundation
Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Calgary Health Trust (CHT)
Canmore and Area Health Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Trust (*inactive)*
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation (*inactive)*
Grimshaw/Berwyn and District Hospital Foundation
Jasper Health Care Foundation
Lac La Biche Regional Health Foundation
Lacombe Health Trust
Medicine Hat and District Health Foundation
Mental Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Peace River and District Health Foundation
Ponoka and District Health Foundation
Stettler Health Services Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Two Hills Health Centre Foundation
Vermillion and Region Health and Wellness Foundation (*inactive)*
Viking Health Foundation
Vulcan County Health and Wellness Foundation
Windy Slopes Health Foundation

- Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP) **-** AHS has the majority of representation on the LPIP's governance board and is therefore considered to control the LPIP. The main purpose of the LPIP is to share the risks of general and professional liability to lessen the impact on any one subscriber.

- Queen Elizabeth II Hospital Child Care Centre

(ii) Government Partnerships

AHS uses the proportionate consolidation method to account for its 50% interest in the Primary Care Network (PCN) government partnerships with physician groups, and its 50% interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta (Note 22).

AHS has joint control with various physician groups over PCNs. AHS entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services, to achieve the PCN business plan objectives, and to contract and hold property interests required in the delivery of PCN services.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

The following PCNs are included in these consolidated financial statements on a proportionate basis:

Alberta Heartland Primary Care Network
Aspen (Athabasca/Westlock) Primary Care Network
Big Country Primary Care Network
Bighorn Primary Care Network (previously Grande Cache)
Bonnyville Primary Care Network
Bow Valley Primary Care Network
Calgary Foothills Primary Care Network
Calgary Rural Primary Care Network
Calgary West Central Primary Care Network
Camrose Primary Care Network
Chinook Primary Care Network
Cold Lake Primary Care Network
Drayton Valley Primary Care Network
Edmonton North Primary Care Network
Edmonton Oliver Primary Care Network
Edmonton Southside Primary Care Network
Edmonton West Primary Care Network
Grande Prairie Primary Care Network
Highland Primary Care Network
Kalyna Country Primary Care Network
Lakeland (St. Paul/Aspen) Primary Care Network
Leduc Beaumont Devon Primary Care Network
Lloydminster Primary Care Network
McLeod River Primary Care Network
Mosaic Primary Care Network
Northwest Primary Care Network
Palliser Primary Care Network
Peace Region Primary Care Network
Peaks to Prairies Primary Care Network
Provost Primary Care Network
Red Deer Primary Care Network
Rocky Mountain House Primary Care Network
Sexsmith/Spirit River Primary Care Network
Sherwood Park/Strathcona County Primary Care Network
South Calgary Primary Care Network
St. Albert & Sturgeon Primary Care Network
Wainwright Primary Care Network
West Peace Primary Care Network
WestView Primary Care Network
Wetaskiwin Primary Care Network
Wolf Creek Primary Care Network
Wood Buffalo Primary Care Network

(iii) Other

These consolidated financial statements do not include trusts administered on behalf of others (Note 23).

All inter-entity accounts and transactions between these organizations are eliminated upon consolidation.

Adjustments are made for consolidated entities whose fiscal year-ends are different from AHS' fiscal year end. This only consists of LPIP with a fiscal year-end of December 31, 2016.

(b) Revenue Recognition

Revenue is recognized in the period in which the transactions or events that give rise to the revenue as described below occur. All revenue is recorded on an accrual basis, except when the accrual cannot be determined within a reasonable degree of certainty or when estimation is impracticable.

(i) Government Transfers

Transfers from AH, other GOA ministries and agencies, and other government entities are referred to as government transfers.

Government transfers and the associated externally restricted investment income are recorded as deferred revenue if the eligibility criteria for the use of the transfer, or the stipulations together with AHS' actions and communications as to the use of the transfer, create a liability. These transfers are recognized as revenue as the stipulations are met and, when applicable, AHS complies with its communicated use of the transfer.

All other government transfers, without stipulations for the use of the transfer, are recorded as revenue when the transfer is authorized and AHS meets the eligibility criteria.

Deferred revenue consists of unexpended deferred operating revenue, unexpended deferred capital revenue, and expended deferred capital revenue. The term deferred revenue in these consolidated financial statements refers to the components of deferred revenue as described.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(ii) Donations, Fundraising, and Non-Government Contributions

Donations, fundraising, and non-government contributions are received from individuals, corporations, and other not-for-profit organizations. Donations, fundraising, and non-government contributions may be unrestricted or externally restricted for operating or capital purposes.

Unrestricted donations, fundraising, and non-government contributions are recorded as revenue in the year received or in the year the funds are committed to AHS if the amount can be reasonably estimated and collection is reasonably assured.

Externally restricted donations, fundraising, non-government contributions, and realized and unrealized gains and losses for the associated externally restricted investment income are recorded as deferred revenue if the terms for their use, or the terms along with AHS' actions and communications as to their use create a liability. These resources are recognized as revenue as the terms are met and, when applicable, AHS complies with its communicated use.

Endowment contributions are recognized in the Consolidated Statement of Operations in the period they are received. Donors have placed restrictions on these contributions. Realized and unrealized gains and losses attributable to endowments are recorded as deferred revenue and only recognized as revenue when the terms of use are met, as stipulated by the donors.

In-kind donations of services and materials are recorded at fair value when such value can reasonably be determined. While volunteers contribute a significant amount of time each year to assist AHS, the value of their services is not recognized as revenue and expenses in the consolidated financial statements because fair value cannot be reasonably determined.

(iii) Transfers and Donations of or for Land

AHS records transfers and donations to buy land as a liability when received and recognizes as revenue when AHS buys the land. AHS recognizes in-kind contributions of land as revenue at the fair value of the land when a fair value can be reasonably determined. When AHS cannot determine the fair value, it records such in-kind contributions at nominal value.

(iv) Fees and Charges, Ancillary Operations, and Other Income

Fees and charges, ancillary operations, and other income are recognized in the period that goods are delivered or services are provided. Amounts received for which goods or services have not been provided by year end are recorded as deferred revenue.

(v) Investment Income

Investment income includes dividend income, interest income, and realized gains or losses on the sale of portfolio investments. Unrealized gains and losses on portfolio investments exclusive of restricted transfers or donations are recognized in the Consolidated Statement of Remeasurement Gains and Losses until the related investments are sold. When realized, these gains or losses are recognized in the Consolidated Statement of Operations. Investment income and unrealized gains and losses from restricted transfers or donations are allocated to their respective balances according to the provisions within the individual agreements.

(c) Expenses

Expenses are reported on an accrual basis. The cost of all goods consumed and services received during the year are expensed. Interest expense includes debt servicing costs.

Expenses include grants and transfers under shared cost agreements. Grants and transfers are recorded as expenses when the transfer is authorized and eligibility criteria have been met by the recipient.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(d) Financial Instruments

All of AHS' financial assets and liabilities are initially recorded at their fair value. The following table identifies AHS' financial assets and liabilities and identifies how they are subsequently measured:

Financial Assets and Liabilities	Subsequent Measurement and Recognition
Cash and investments	Measured at fair value with changes in fair values recognized in the Consolidated Statement of Remeasurement Gains and Losses or deferred revenue until realized, at which time the cumulative changes in fair value are recognized in the Consolidated Statement of Operations.
Accounts receivable, accounts payable and accrued liabilities and debt	Measured at amortized cost.

PSAS requires portfolio investments in equity instruments quoted in an active market to be recorded under the fair value category and AHS may choose to record other financial assets under the fair value category if there is an investment strategy to evaluate the performance of a group of these financial assets on a fair value basis. AHS has elected to record its money market securities, fixed income securities, and certain other equity investments at fair value. The three levels of information that may be used to measure fair value are:

- Level 1 – Unadjusted quoted market prices in active markets for identical assets or liabilities;
- Level 2 – Observable or corroborated inputs, other than level 1, such as quoted prices for similar assets or liabilities in inactive markets or market data for substantially the full term of the assets or liabilities; and
- Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets and liabilities.

AHS measures and recognizes embedded derivatives separately from the host contract when the economic characteristics and risk of the embedded derivative are not closely related to those of the host contract, when it meets the definition of a derivative and, when the entire contract is not measured at fair value. Embedded derivatives are recorded at fair value. For the year ended March 31, 2017, AHS has no embedded derivatives that require separation from the host contract.

Derivatives are recorded at fair value in the Consolidated Statement of Financial Position. Derivatives with a positive or negative fair value are recognized as increases or decreases to investments. Unrealized gains and losses from changes in the fair value of derivatives are recognized in the Consolidated Statement of Remeasurement Gains and Losses.

All financial assets are assessed for impairment on an annual basis. When a decline is determined to be other than temporary, the amount of the loss is reported as a realized loss on the Consolidated Statement of Operations.

Transaction costs associated with the acquisition and disposal of investments are expensed as incurred. Investment management fees are expensed as incurred. The purchase and sale of investments are accounted for using trade date accounting.

(e) Cash

Cash is comprised of cash on hand.

(f) Inventories For Consumption

Inventories for consumption or distribution at no charge are valued at lower of cost (defined as moving average cost) and replacement cost.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(g) Tangible Capital Assets

Tangible capital assets and work in progress are recorded at cost, which includes amounts that are directly related to the acquisition, design, construction, development, improvement, or betterment of the assets. Cost includes overhead directly attributable to construction and development as well as interest costs that are directly attributable to the acquisition or construction of the asset. Contributed tangible capital assets and work in progress acquired from other government organizations and other entities are recorded at their fair value on the date of the transfer. Costs incurred by Alberta Infrastructure (AI) to build tangible capital assets on behalf of AHS are recorded by AHS as work in progress as AI incurs costs.

Works of art, historical treasures, and collections are not recognized in tangible capital assets.

The costs less residual values of tangible capital assets, excluding land, are amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Facilities and improvements	10-40 years
Equipment	3-20 years
Information systems	3-5 years
Building service equipment	5-40 years
Land improvements	5-40 years

Work in progress, which includes facility and improvement projects and development of information systems, is not amortized until after a project is substantially complete and the tangible capital assets are put into service.

Leases transferring substantially all benefits and risks of tangible capital asset ownership are classified as capital leases and reported as tangible capital assets. Capital leases and leasehold improvements are amortized over the term of the lease. The capital lease obligations associated with these capital leases are recorded at the present value of the minimum lease payments excluding executory costs (e.g. insurance, maintenance costs, etc.) and reported as obligations under capital leases. The discount rate used to determine the present value of the lease payments is the lower of AHS' rate for incremental borrowing and the interest rate implicit in the lease.

Tangible capital assets are written down when conditions indicate that they no longer contribute to AHS' ability to provide goods and services or when the value of future economic benefits associated with the tangible capital assets are less than their net book value. The net write-downs are accounted for as expenses in the Consolidated Statement of Operations. Write-downs are not reversed.

(h) Employee Future Benefits

(i) Registered Benefit Pension Plans

AHS participates in the following registered defined benefit pension plans: the Local Authorities Pension Plan (LAPP) and the Management Employees Pension Plan (MEPP). These multi-employer public sector defined benefit plans provide pensions for participants for each year of pensionable service based on the average salary of the highest five consecutive years, up to the average Canada Pension Plan's Year's Maximum Pensionable Earnings (YMPE), over the same five consecutive year period. Benefits for post-1991 service payable under these plans are limited by the *Income Tax Act* (Canada). The President of Alberta Treasury Board and Minister of Finance is the legal trustee and administrator of the plans. The Department of Treasury Board and Finance accounts for its share of obligations for these pension plans relating to former and current employees of all of the organizations included in the GOA consolidated reporting entity on a defined benefit basis. As a participating government organization, AHS accounts for these plans on a defined contribution basis. Accordingly, the pension expense recorded for these plans in these consolidated financial statements is comprised of the employer contributions that AHS is required to pay for its employees during the fiscal year, which are calculated based on actuarially pre-determined amounts that are expected to provide the plan's future benefits.

(ii) Other Defined Contribution Pension Plans

AHS sponsors Group Registered Retirement Savings Plans (GRRSPs) for certain employee groups. Under the GRRSPs, AHS matches a certain percentage of any contribution made by plan participants up to certain limits. AHS also sponsors a defined contribution pension plan for certain employee groups where the employee and employer each contribute specified percentages of pensionable earnings.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(iii) Supplemental Retirement Plan for Designated Employees (SERP)

Previously, AHS sponsored multiple SERPs, with assets held in three Retirement Compensation Arrangements (RCA). Since March 31, 2016, amendments were made to consolidate the SERPs into a single plan with assets consolidated under one RCA arrangement. The consolidation did not affect SERP members' accrued benefit entitlements, which continue to be funded. The SERP covers certain employees and supplement the benefits under AHS' registered plans that are limited by the *Income Tax Act* (Canada). Prior to consolidation, the SERPs were closed and continue to be closed to new entrants since April 1, 2009. The SERP provides future pension benefits to participants based on years of service and earnings.

Due to *Income Tax Act* (Canada) requirements, the SERP is subject to the RCA rules; therefore, approximately half of the assets are held in a non-interest bearing Refundable Tax Account with the Canada Revenue Agency. The remaining assets of the SERP are invested in a combination of Canadian equities and Canadian fixed income securities.

The obligations and costs of SERP benefits are determined annually through an actuarial valuation as at March 31 using the projected benefit method pro-rated on service. AHS uses a discount rate based on plan asset earnings to calculate the accrued benefit obligation.

The net SERP retirement benefit cost reported in these consolidated financial statements is comprised of the retirement benefits expense and the retirement benefits interest expense. Costs shown reflect the total estimated cost to provide annual pension income over an actuarially determined post employment period. The key components of retirement benefits expense include the cost of any plan amendments including related net actuarial gains or losses incurred in the period, gains and losses from any plan settlements or curtailments incurred in the period, and amortization of actuarial gains and losses. Retirement benefit costs are not cash payments in the period but are the period expense for rights to future compensation. The retirement benefits interest expense is net of the interest cost on the accrued benefit obligation and the expected return on plan assets.

The actuarial gains and losses that arise are accounted for in accordance with PSAS whereby AHS amortizes actuarial gains and losses from the liability or asset over the average remaining service life of the related employee group.

Prior period service costs arising from plan amendments are recognized in the period of the plan amendment. When an employee's accrued benefit obligation is fully discharged, all unrecognized amounts associated with that employee are fully recognized in the net retirement benefit cost in the following year.

(iv) Supplemental Pension Plan (SPP)

Subsequent to April 1, 2009, staff eligible for SERP are enrolled in a defined contribution SPP. Similar to the SERP, the SPP supplements the benefits under AHS registered plans that are limited by the *Income Tax Act* (Canada). AHS contributes a certain percentage of an eligible employee's pensionable earnings, in excess of the limits of the *Income Tax Act* (Canada). This plan provides participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participant.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(v) Sick Leave Liability

Sick leave benefits accumulate with employees' service and are provided by AHS to certain employee groups of AHS, as defined by employment agreements, to cover illness related absences that are outside of short-term and long-term disability coverage. Benefit amounts are determined and accumulate with reference to employees' final earnings at the time they are paid out. The cost of the accumulating non-vesting sick leave benefits is expensed as the benefits are earned.

AHS accrues its liabilities for accumulating non-vesting sick leave benefits but does not record a liability for sick leave benefits that do not accumulate beyond the current reporting period as these are renewed annually.

The accumulating non-vesting sick leave liability is actuarially determined using the projected benefit method pro-rated for service and management's best estimates of expected discount rate, inflation, rate of compensation increase, termination and retirement rates, and mortality. The liability associated with these benefits is calculated as the present value of expected future payments pro-rated for service.

Any resulting net actuarial gain (loss) is deferred and amortized on a straight-line basis over the expected average remaining service life of the related employee groups.

(vi) Other Benefits

AHS provides its employees with basic life, accidental death and dismemberment, short-term disability, long-term disability, extended health, dental, and vision benefits through benefits carriers. AHS fully accrues its obligations for employee non-pension future benefits.

(i) Liability for Contaminated Sites

Contaminated sites are a result of contamination being introduced into air, soil, water, or sediment of a chemical, organic or radioactive material or live organism that exceeds an environmental standard. The liability is recognized net of any expected recoveries. A liability for remediation of contaminated sites normally results from operations that are no longer in productive use and is recognized when all of the following criteria are met:

(i) an environmental standard exists;
(ii) contamination exceeds the environmental standard;
(iii) AHS is directly responsible or accepts responsibility;
(iv) it is expected that future economic benefits will be given up; and
(v) a reasonable estimate of the amount can be made.

(j) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a difference between the recognized or disclosed amount and another reasonably possible amount. The amount recorded for amortization of tangible capital assets is based on the estimated useful life of the related tangible capital assets while the recognition of expended deferred capital revenue depends on when the terms for the use of the funding are met and, when applicable, AHS complies with its communicated use of the funding. The amounts recorded for employee future benefits are based on estimated future cash flows. The provision for unpaid claims, allowance for doubtful accounts and accrued liabilities are subject to significant management estimates and assumptions. The establishment of the provision for unpaid claims relies on the judgment and opinions of many individuals; historical precedent and trends; prevailing legal, economic, social, and regulatory trends; and expectation as to future developments. The process of determining the provision necessarily involves risks that the actual results will deviate perhaps materially from the best estimates made. These estimates and assumptions are reviewed at least annually. Actual results could differ from the estimates determined by management in these consolidated financial statements, and these differences, which may be material, could require adjustment in subsequent reporting periods.

(k) Internally Restricted Surplus for Future Purposes

Certain amounts, as approved by the AHS Board, are set aside in accumulated surplus for use by AHS for future operating and capital purposes, to restrict amounts for legislatively required restricted equity and donation amounts restricted by 3rd parties. Transfers to or from internally restricted surplus for future purposes are recorded to the respective reserved surplus when approved.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(l) Foreign Currency Translation

Transaction amounts denominated in foreign currencies are translated into their Canadian dollar equivalents at exchange rates prevailing at the transaction dates. Carrying values of monetary assets and liabilities and non-monetary items included in the fair value category reflect the exchange rates at the Consolidated Statement of Financial Position date. Unrealized foreign exchange gains and losses are recognized in the Consolidated Statement of Remeasurement Gains and Losses.

In the period of settlement, foreign exchange gains and losses are reclassified to the Consolidated Statement of Operations, and the cumulative amount of remeasurement gains and losses are reversed in the Consolidated Statement of Remeasurement Gains and Losses.

(m) Future Accounting Changes

The Public Sector Accounting Board has issued the following accounting standards in recent years:

- **PS 2200 – Related Party Disclosures (effective April 1, 2017)**
  PS 2200 defines a related party and establishes disclosures required for related party transactions.
- **PS 3420 – Inter-Entity Transactions (effective April 1, 2017)**
  PS 3420 establishes standards on how to account for and report transactions between public sector entities that comprise a government's reporting entity from both a provider and recipient perspective.
- **PS 3210 – Assets (effective April 1, 2017)**
  PS 3210 provides guidance for applying the definition of assets set out in PS 1000 – Financial Statement Concepts and establishes general disclosure standards for assets.
- **PS 3320 – Contingent Assets (effective April 1, 2017)**
  PS 3320 defines and establishes disclosure standards on contingent assets.
- **PS 3380 – Contractual Rights (effective April 1, 2017)**
  PS 3380 defines and establishes disclosure standards on contractual rights.
- **PS 3430 – Restructuring Transactions (effective April 1, 2018)**
  PS 3430 provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related programs or operating responsibilities.

AHS' management is currently assessing what the impact of these new standards will be on future consolidated financial statements.

Note 3 Budget

The AHS Health Plan and Business Plan 2016-17, which included the 2016-17 annual budget, was approved by the Minister of Health on June 29, 2016.

Note 4 Other Government Transfers

	2017	2016
Unrestricted operating	$ 59,737	$ 60,272
Restricted operating (Note 14)	118,303	88,192
Recognition of expended deferred capital revenue (Note 16)	278,112	268,090
	$ 456,152	**$ 416,554**

Other government transfers include $449,067 (2016 – $409,882) transferred from the GOA and $7,085 (2016 – $6,672) from the federal government, and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

Note 5 Donations, Fundraising, and Non-Government Contributions

	2017	2016
Unrestricted operating	$ 4,597	$ 2,622
Restricted operating	120,120	119,111
Recognition of expended deferred capital revenue	37,991	41,488
Endowment contributions and reinvested income	1,308	3,585
	$ 164,016	**$ 166,806**

Note 6 Investment and Other Income

	2017	2016
Investment income	$ 65,552	$ 84,900
Other income:		
GOA (Note 21)	37,422	31,118
AH	19,166	20,371
Other[a]	148,270	131,542
	$ 270,410	**$ 267,931**

(a) Other includes revenue related to administrative services provided to other organizations of $15,547 (2016 – $10,906).

Note 7 Administration

	2017	2016
General administration[a]	$ 251,703	$ 221,472
Human resources[b]	92,695	91,370
Finance[c]	73,394	61,872
Communications[d]	21,354	22,078
Administration expense of full-spectrum contracted health service providers[e]	38,928	37,634
	$ 478,074	**$ 434,426**

(a) General administration includes senior leaders' expenses, the former Official Administrator expenses, Board expenses, and other administrative functions such as planning and development, privacy, risk management, internal audit, infection control, quality assurance, insurance, patient safety, and legal.

(b) Human resources includes personnel services, staff recruitment and selection, orientation, labour relations, employee health, and employee record keeping.

(c) Finance includes the recording, monitoring, and reporting of the financial and statistical aspects of AHS' planned and actual activities.

(d) Communications includes the receipt and transmission of AHS' communications including electronic communication, visitor information, and mail services. It also includes personnel dedicated to maintenance and repair of communication systems and devices.

(e) Administration expense of full spectrum contracted health service providers is AHS' estimate of the portion that AHS funds of the general administration, human resources, finance, and communication expenses incurred by service providers with whom AHS contracts for a full spectrum of health services.

Note 8 Support Services

	2017	2016
Facilities operations	$ 869,181	$ 816,608
Patient: health records, food services, and transportation	385,444	373,682
Materials management	207,661	198,116
Housekeeping, laundry, and linen	208,380	192,342
Support services expense of full-spectrum contracted health service providers[(a)]	149,941	143,701
Ancillary operations	105,078	104,867
Fundraising expenses and grants awarded	42,866	48,028
Emergency preparedness services	6,808	4,353
Other	170,182	195,807
	$ 2,145,541	**$ 2,077,504**

(a) Support services expense of full spectrum contracted health service providers is AHS' estimate of the portion that AHS funds of the support services incurred by service providers with whom AHS contracts for a full spectrum of health services.

Note 9 Financial Instruments

AHS is exposed to a variety of financial risks associated with its financial instruments. These financial risks include market risk, credit risk, and liquidity risk.

(a) Market Risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises three types of risk: price risk, interest rate risk, and foreign currency risk.

In order to earn financial returns at an acceptable level of market risk, each of the investment policies have established a targeted asset mix. The AHS Investment Bylaw & Policy has established asset mix ranges of 0% to 100% for cash and money market securities, 0% to 80% for fixed income securities, and 0% to 40% for equities.

The ACF Investment Policy has established an asset mix policy of 0% to 10% for money market securities, 30% to 60% for fixed income securities, and 30% to 70% for equities.

The LPIP Investment Policy has established an asset mix policy of 78% to 89% for cash and fixed income securities, 8% to 17% for equities, and 3% to 5% for real estate fund.

The CHT Statement of Investment Policies and Goals has established an asset mix policy of 30% to 70% for fixed income securities and 30% to 70% for equities.

Risk is reduced under all of the investment policies through asset class diversification, diversification within each asset class, and portfolio quality constraints.

AHS assesses the sensitivity of its portfolio to market risk based on historical volatility of equity and fixed income markets. The volatility is determined using a ten year average based on fixed income and equity market fluctuations and is applied to the total portfolio. Based on the volatility average of 2.76% (2016 – 2.69%) increase or decrease, with all other variables held constant, the increase or decrease in accumulated remeasurement gains and losses and unrealized net gains and losses attributable to deferred revenue and endowments would be $48,779 (2016 – $45,939).

(i) Price Risk

Price risk relates to the possibility that equity investments will change in fair value due to future fluctuations in market prices caused by factors specific to an individual equity investment or other factors affecting all equities traded in the market. AHS is exposed to price risk associated with the underlying equity investments held in pooled funds. If equity market indices (S&P/TSX, S&P1500 and MSCI ACWI and their sectors) declined by 10%, and all other variables are held constant, the potential loss in fair value to AHS would be approximately $51,363 or 2.27% of total investments (March 31, 2016 – $46,236 or 2.11%).

Note 9 Financial Instruments (continued)

(ii) Interest Rate Risk

Interest rate risk is the risk that the value of a financial instrument might be adversely affected by a change in market interest rates. Changes in market interest rates may have an effect on the cash flows associated with some financial assets and liabilities, known as cash flow risk, and on the fair value of other financial assets or liabilities, known as price risk. AHS manages the interest rate risk exposure of its fixed income investments by management of average duration and laddered maturity dates.

AHS is exposed to interest rate risk through its investments in fixed income securities with both fixed and floating interest rates. AHS has fixed interest rate loans for all debt, thereby mitigating interest rate risk from rate fluctuations over the term of the outstanding debt. The fair value of fixed rate debt fluctuates with changes in market interest rates but the related future cash flows will not change.

In general, investment returns for bonds and mortgage funds are sensitive to changes in the level of interest rates, with longer term interest bearing securities being more sensitive to interest rate changes than shorter term bonds.

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $68,009 (March 31, 2016 – $65,654).

Fixed income securities include bonds and money market securities. The fixed income securities have the following average maturity structure ranging from 2017 and 2067.:

	2017	2016
0 – 5 years	78%	76%
6 – 10 years	13%	13%
Over 10 years	9%	11%

	Effective Market Yield			Average Effective Market Yield
Asset Class	< 1 year	1-5 years	> 5 years	
Interest bearing securities	1.28%	1.31%	2.69%	1.76%

(iii) Foreign Currency Risk

Foreign currency risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates. The fair value of cash and investments denominated in foreign currencies is translated into Canadian dollars on a daily basis using the reporting date exchange rate. AHS is exposed to foreign exchange fluctuations on its cash denominated in foreign currencies. At March 31, 2017, no investment balances were denominated in foreign currency (2016 – $nil).

Foreign currency risk is managed by the fact that the investment policies limit non-Canadian equities to a maximum of 10% to 45% of the total investment portfolio, depending on the policy. At March 31, 2017, investments in non-Canadian equities represented 15.7% (March 31, 2016 – 13.40%) of total portfolio investments.

Foreign exchange fluctuations on cash balances are mitigated by forward contracts and holding minimal foreign currency cash balances. At March 31, 2017, AHS held US dollar forward contracts with ATB Financial to manage currency fluctuations relating to its US dollar accounts payable requirements. As at March 31, 2017, AHS held derivatives in the form of forward contracts for future settlement of $18,000 (2016 – $24,000). The fair value of these forward contracts as at March 31, 2017 was a gain of $501 (2016 – loss of $141) and is included in investments (Note 10).

Note 9 Financial Instruments (continued)

(b) Credit Risk

Credit risk is the risk of loss arising from the failure of a counterparty to fully honour its financial obligations. The credit quality of financial assets is generally assessed by reference to external credit ratings. Credit risk can also lead to losses when issuers and debtors are downgraded by credit rating agencies. All of the investment policies restrict the types and proportions of eligible investments, thus mitigating AHS' exposure to credit risk.

Accounts receivable primarily consists of amounts receivable from AH, other Alberta government reporting entities, patients, other provinces and territories, Workers' Compensation Board, and the federal government. AHS periodically reviews the collectability of its accounts receivable and establishes an allowance based on its best estimate of potentially uncollectible amounts.

Under the AHS Investment Bylaw, money market securities are limited to a rating of R1 or equivalent or higher, and no more than 10% may be invested in any one issuer. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total fixed income securities. Investments in debt and equity of any one issuer are limited to 5% of the issuer's total debt and equity. AHS holds unrated mortgage fund investments. Short selling is not permitted.

The ACF Investment Policy limits the overall rating of all fixed income instruments to at least an A rating, and no more than 10% of publicly traded equities may be invested in any one issuer.

The LPIP Investment Policy limits money market securities to a rating of R1 or equivalent or higher, and no more than 10% may be invested in any one issuer, unless guaranteed by the Government of Canada or a Canadian province. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher. Investments in debt and equity of any one issuer are limited to 10% of total equities. LPIP holds unrated mortgage fund investments.

The CHT Statement of Investment Policies and Goals limits the overall rating of fixed income securities to BBB or equivalent or higher, and no more than 10% of fixed income securities or equities may be invested in any one issuer.

The following table summarizes AHS' investment in debt securities by counterparty credit rating at March 31, 2017.

Credit Rating	2017	2016
Investment Grade (AAA to BBB-)	90%	90%
Unrated	10%	10%
	100%	**100%**

(c) Liquidity Risk

Liquidity risk is the risk that AHS will encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivery of cash or another financial asset. Liquidity requirements of AHS are met through funding in advance by AH, income generated from investments, and by investing in liquid assets, such as money market investments, equities, and bonds traded in an active market that are easily sold and converted to cash.

Note 10 Investments

	2017		2016	
	Fair Value	Cost	Fair Value	Cost
Cash held for investments	**$ 106,666**	**$ 106,666**	$ **108,650**	**$ 108,650**
Interest bearing securities:				
Money market securities	101,113	101,113	139,986	139,986
Fixed income securities	1,543,462	1,546,500	1,476,511	1,466,168
	1,644,575	**1,647,613**	**1,616,497**	**1,606,154**
Equities:				
Canadian public pooled equity funds	157,446	136,403	169,064	155,830
Global public pooled equity funds	356,179	312,159	293,295	283,265
	513,625	**448,562**	**462,359**	**439,095**
	$ 2,264,866	**$ 2,202,841**	**$ 2,187,506**	**$ 2,153,899**

	2017	2016
Items at Fair Value		
Financial instruments designated to the fair value category	$ 1,750,740	$ 1,725,288
Portfolio investments in equity instruments that are quoted in an active market	513,625	462,359
Derivatives	501	(141)
	$ 2,264,866	**$ 2,187,506**

Included in the investments is $161,134 (March 31, 2016 – $147,572) that is restricted for use as per the requirements in Sections 99 and 100 of the Insurance Act of Alberta. Endowments included in investments amount to $74,710 (March 31, 2016 – $73,402).

As AHS is comprised of multiple entities as described in Note 2(a), investments are governed independently under multiple investment policies and procedures. The fair value of investments governed under each investment policy is as follows:

	2017	2016
AHS Investment Bylaw & Policy	$ 1,801,679	$ 1,752,970
ACF Investment Policy	160,219	153,158
LPIP Investment Policy	184,000	176,610
CHT Statement of Investment Policies and Goals	118,968	104,768
	$ 2,264,866	**$ 2,187,506**

Investments are measured at fair value with the differences between cost and fair value being recorded as a remeasurement gain or loss or recorded as deferred revenue.

The following are the total net remeasurement gains on investments:

	2017	2016
Accumulated remeasurement gains	$ 28,866	$ 5,022
Restricted unrealized net gains attributable to unexpended deferred operating revenue and endowments (Note 14(b))	32,811	28,558
Restricted unrealized net gains attributable to unexpended deferred capital revenue (Note 15(b))	348	27
	$ 62,025	**$ 33,607**

Note 10 Investments (continued)

Fair Value Hierarchy

	2017			
	Level 1	Level 2	Level 3	Total
Cash held for investments	$ 106,666	$ -	$ -	$ 106,666
Interest bearing securities:				
Money market securities	-	101,113	-	101,113
Fixed income securities	-	1,406,541	136,921	1,543,462
Equities:				
Canadian public pooled equity funds	156,154	1,292	-	157,446
Global public pooled equity funds	254,321	101,858	-	356,179
	$ 517,141	**$ 1,610,804**	**$ 136,921**	**$ 2,264,866**
Percent of total	23%	71%	6%	100%

	2016			
	Level 1	Level 2	Level 3	Total
Cash held for investments	$ 108,650	$ -	$ -	$ 108,650
Interest bearing securities:				
Money market securities	-	139,986	-	139,986
Fixed income securities	-	1,351,309	125,202	1,476,511
Equities:				
Canadian public pooled equity funds	167,817	1,247	-	169,064
Global public pooled equity funds	193,722	99,573	-	293,295
	$ 470,189	**$ 1,592,115**	**$ 125,202**	**$ 2,187,506**
Percent of total	21%	73%	6%	100%

Note 11 Accounts Receivable

	2017			2016
	Gross	Allowance for Doubtful Accounts	Net	Net
Patient accounts receivable	$ 109,658	$ 24,301	$ 85,357	$ 98,632
AH operating transfers receivable	89,247	-	89,247	72,387
Other operating transfers receivable	45,810	-	45,810	20,984
Other capital transfers receivable	82,797	-	82,797	116,888
Other accounts receivable	83,103	22	83,081	84,602
	$ 410,615	**$ 24,323**	**$ 386,292**	**$ 393,493**

At March 31, 2016, the total allowance for doubtful accounts was $29,199.

Note 12 Accounts Payable and Accrued Liabilities

	2017	2016
Payroll remittances payable and related accrued liabilities	$ 523,543	$ 651,578
Trade accounts payable and accrued liabilities[(a)]	470,126	371,670
Provision for unpaid claims[(b)]	141,233	136,378
Other liabilities	43,431	42,496
Obligations under capital leases[(c)]	31,641	34,190
	$ 1,209,974	**$ 1,236,312**

(a) Trade Accounts Payable and Accrued Liabilities

Trade accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $82,878 (2016 – $57,445).

(b) Provision for Unpaid Claims

Provision for Unpaid Claims is an estimate of liability claims within AHS. It is influenced by factors such as historical trends involving claim payment patterns, pending levels of unpaid claims, claims severity and claim frequency patterns.

The provision has been estimated using the discounted value of claim liabilities using a discount rate of 2.20% (2016 – 1.95%) plus a provision for adverse deviation, based on actuarial estimates.

(c) Obligations under Capital Leases

Capital leases include a site lease with the University of Calgary, a site lease for the Northern Communications Centre in Peace River, and vehicle leases.

The University of Calgary lease expires January 2028. The implicit interest rate payable on this lease is 6.50% (2016 – 6.50%). There are no renewal options, purchase options or escalation clauses related to this capital lease.

The Northern Communications Centre site lease expires May 2036. The implicit interest rate payable on this lease is 3.40% (2016 – 3.40%). The lease has an option to renew for two additional terms of 5 years each.

AHS is committed to making payments for obligations under capital leases as follows:

Year ended March 31	Minimum Lease Payments
2018	$ 3,889
2019	3,388
2020	2,909
2021	2,731
2022	2,754
Thereafter	27,772
	43,443
Less: interest	(11,802)
	$ 31,641

(d) Liability for Contaminated Sites

At March 31, 2017, AHS has not identified or accepted any liability for contaminated sites (2016 – $nil).

Note 13 Employee Future Benefits

	2017	2016
Accrued vacation pay	$ 540,547	$ 514,672
Accumulating non-vesting sick leave liability[(a)]	112,490	106,015
Registered defined benefit pension plans[(b) (c)]	-	-
	$ 653,037	**$ 620,687**

(a) Accumulating Non-Vesting Sick Leave Liability

Sick leave benefits are paid by AHS; there are no employee contributions and no assets set aside to support the obligation.

The AHS sick leave liability is based on an actuarial valuation as at March 31, 2015, and extrapolated to March 31, 2017 by AHS. The next actuarial valuation will be performed as at March 31, 2018.

The following table summarizes the accumulating non-vesting sick leave liability.

	2017	2016
Change in accrued benefit obligation and funded status		
Accrued benefit obligation and funded status, beginning of year	$ 118,969	$ 114,979
Current service cost	10,262	9,939
Interest cost	3,621	3,486
Benefits paid	(8,675)	(9,435)
Actuarial gain	(9,000)	-
Accrued benefit obligation and funded status, end of year	**$ 115,177**	**$ 118,969**
Reconciliation to accrued benefit liability		
Funded status – deficit	$ 115,177	$ 118,969
Unamortized net actuarial loss	(2,687)	(12,954)
Accrued benefit liability	**$ 112,490**	**$ 106,015**
Components of expense		
Current service cost	$ 10,262	$ 9,939
Interest cost	3,621	3,486
Amortization of net actuarial loss	1,267	1,267
Net expense	**$ 15,150**	**$ 14,692**
Assumptions		
Discount rate – beginning of year	2.90%	2.90%
Discount rate – end of year	2.02%	2.90%
Rate of compensation increase per year	2016-2017 2.43% 2017-2018 0.75% Thereafter 2.75%	2015-2016 3.21% 2016-2017 2.43% Thereafter 3.25%

Note 13 Employee Future Benefits (continued)

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP. AHS is not responsible for future funding of the plan deficit other than through contribution increases. As AHS is exposed to the risk of contribution rate increases, the following disclosure is provided to explain this risk.

The LAPP provides for a pension of 1.4% for each year of pensionable service based on the average salary of the highest five consecutive years up to the average Canada Pension Plan's Year's Maximum Pensionable Earnings (YMPE), over the same five consecutive year period and 2.0% on the excess, subject to the maximum pension benefit limit allowed under the *Income Tax Act* (Canada). The maximum pensionable service allowable under the plan is 35 years.

(ii) LAPP Deficit

An actuarial valuation of the LAPP was carried out as at December 31, 2015 by Mercer (Canada) Limited and these results were then extrapolated to December 31, 2016 for use in the LAPP 2016 audited financial statements. LAPP's December 31, 2016 net assets available for benefits divided by LAPP's pension obligation shows that the LAPP is 98% (2015 – 97%) funded.

	December 31, 2016	December 31, 2015
LAPP net assets available for benefits	$ 37,722,943	$ 34,419,584
LAPP pension obligation	38,360,300	35,343,000
LAPP deficiency	**$ (637,357)**	**$ (923,416)**

The 2016 and 2017 LAPP contribution rates are as follows:

Calendar 2017		Calendar 2016	
Employer	**Employees**	**Employer**	**Employees**
11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess	11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess

(c) Pension Expense

	2017	2016
Local Authorities Pension Plan	$ 595,795	$ 570,438
Defined contribution pension plans and group RRSPs	48,397	46,763
Supplemental Pension Plan	2,230	1,882
Supplemental Executive Retirement Plans	2,240	(788)
Management Employees Pension Plan	585	668
	$ 649,247	**$ 618,963**

Note 14 Unexpended Deferred Operating Revenue

(a) Changes in the unexpended deferred operating revenue balance are as follows:

	2017				2016
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 153,253	$ 25,055	$ 251,207	$ 429,515	$ 491,254
Received or receivable during the year, net of repayments	927,960	76,747	134,360	1,139,067	1,210,987
Restricted investment income	253	1,645	5,818	7,716	6,579
Transferred from (to) unexpended deferred capital revenue	3,696	60,529	(16,764)	47,461	48,395
Recognized as revenue	(953,328)	(118,303)	(120,120)	(1,191,751)	(1,272,042)
Miscellaneous other revenue recognized	(196)	(5)	(24,981)	(25,182)	(25,891)
	131,638	**45,668**	**229,520**	**406,826**	**459,282**
Changes in unrealized net gains attributable to portfolio investments related to endowments and unexpended deferred operating revenue	(1,783)	18	6,018	4,253	(29,767)
Balance, end of year	**$ 129,855**	**$ 45,686**	**$ 235,538**	**$ 411,079**	**$ 429,515**

[(i)] The balance at March 31, 2017 for other government includes $582 of unexpended deferred operating revenue received from the federal government (March 31, 2016 – $549). The remaining balance in other government all relates to the GOA, see Note 21.

(b) The unexpended deferred operating revenue balance at the end of the year is externally restricted for the following purposes:

	2017				2016
	AH	Other Government	Donors and Non-Government	Total	Total
Research and education	$ 19,263	$ 3,080	$ 134,835	$ 157,178	$ 158,148
Cancer prevention, screening and treatment	27,454	-	711	28,165	18,861
Physician revenue and alternate relationship plans	26,129	1,112	-	27,241	21,660
Promotion, prevention and community	6,748	19,486	605	26,839	14,120
Addiction and mental health	20,912	-	-	20,912	19,330
Primary Care Networks	19,372	-	-	19,372	44,146
Long term care partnerships	-	17,227	-	17,227	15,479
Emergency and outpatient services	2,297	305	1,413	4,015	11,033
Administration and support services	4,852	3,361	51,161	59,374	67,240
Others less than $10,000	4,588	1,095	12,262	17,945	30,940
	131,615	**45,666**	**200,987**	**378,268**	**400,957**
Unrealized net gain (loss) attributable to portfolio investments related to endowments and unexpended deferred operating revenue (Note 10)	(1,760)	20	34,551	32,811	28,558
	$ 129,855	**$ 45,686**	**$ 235,538**	**$ 411,079**	**$ 429,515**

Note 15 Unexpended Deferred Capital Revenue

(a) Changes in the unexpended deferred capital revenue balance are as follows:

	2017				2016
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 57,916	$ 9,175	$ 81,228	$ 148,319	$ 178,078
Received or receivable during the year	30,300	184,468	29,371	244,139	194,567
Transferred tangible capital assets (Note 18(a))	-	215,933	-	215,933	399,992
Restricted investment income	-	-	-	-	63
Unexpended deferred capital revenue returned	-	-	(1,220)	(1,220)	(4,698)
Transfer to expended deferred capital revenue	(45,285)	(332,402)	(43,851)	(421,538)	(561,027)
Used for the acquisition of land	-	(687)	-	(687)	-
Transferred (to) from unexpended deferred operating revenue	(3,696)	(60,529)	16,764	(47,461)	(48,395)
	39,235	**15,958**	**82,292**	**137,485**	**158,580**
Changes in unrealized net gain on portfolio investments related to unexpended deferred capital revenue	321	-	-	321	(10,261)
Balance, end of year	**$ 39,556**	**$ 15,958**	**$ 82,292**	**$ 137,806**	**$ 148,319**

[(i)] The balance at March 31, 2017 for other government all relates to the GOA, see Note 21.

(b) The unexpended deferred capital revenue balance at the end of the year is externally restricted for the following purposes:

	2017	2016
AH		
Information systems less than $10,000	$ 32,504	$ 38,741
Medical Equipment Replacement Upgrade Program	18	11,367
Equipment less than $10,000	6,686	7,781
Total AH	**39,208**	**57,889**
Other government		
Facilities and improvements less than $10,000	15,958	9,176
Total other government	**15,958**	**9,176**
Donors and non-government		
Equipment less than $10,000	80,482	73,918
Facilities and improvements less than $10,000	1,810	7,309
Total donors and non-government	**82,292**	**81,227**
Unrealized net gain on portfolio investments related to unexpended deferred capital revenue (Note 10)	348	27
	$ 137,806	**$ 148,319**

Note 16 Expended Deferred Capital Revenue

Changes in the expended deferred capital revenue balance are as follows:

	2017				2016
	AH	Other Government[i]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 297,812	$ 6,056,411	$ 176,209	$ 6,530,432	$ 6,363,699
Transferred from unexpended deferred capital revenue	45,285	332,402	43,851	421,538	561,027
Used for the acquisition of land	-	687	-	687	-
Less: amounts recognized as revenue	(86,784)	(278,112)	(37,991)	(402,887)	(394,294)
Balance, end of year	**$ 256,313**	**$ 6,111,388**	**$ 182,069**	**$ 6,549,770**	**$ 6,530,432**

[i] The balance at March 31, 2017 for other government includes $78 of expended deferred capital revenue received from the federal government (March 31, 2016 – $nil). The remaining balance in other government all relates to the GOA, see Note 21.

Note 17 Debt

	2017	2016
Debentures payable[a]:		
Parkade loan #1	$ 32,223	$ 34,903
Parkade loan #2	30,278	32,505
Parkade loan #3	39,089	41,432
Parkade loan #4	147,262	154,086
Parkade loan #5	35,605	37,204
Parkade loan #6	24,418	25,300
Parkade loan #7[b]	51,500	-
Energy savings initiative loan[b]	25,800	-
Other	1,212	1,479
	387,387	326,909
Loan proceeds to be received[b]	(67,300)	-
	$ 320,087	**$ 326,909**

(a) AHS issued debentures to Alberta Capital Financing Authority (ACFA), a related party, to finance the construction of parkades. AHS has pledged revenue derived directly or indirectly from the operations of all parking facilities being built, renovated, owned, and operated by AHS as security for these debentures.

AHS issued a debenture to ACFA relating to an energy savings initiative. AHS has pledged the mortgage on the Royal Alexandra Lands and Alberta Hospital Lands as security for this debenture.

The maturity dates and interest rates for the debentures are as follows:

	Maturity Date	Fixed Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Parkade loan #6	December 2035	3.6090%
Parkade loan #7	March 2038	2.6400%
Energy savings initiative loan	December 2030	2.4160%
Other	March 2021	4.6000%

(b) At March 31, 2017, $5,000 of $51,500 had been advanced to AHS relating to the Foothills Medical Centre Lot 1 parkade debenture with the remainder to be drawn by March 2018. Semi-annual principal and interest payments of $1,665 will commence September 2018. At March 31, 2017, $5,000 of $25,800 had been advanced to AHS relating to the Energy Savings initiative with the remainder to be drawn by December 2017. Semi-annual principal and interest payments of $1,162 will commence June 2018.

Note 17 Debt (continued)

AHS is committed to making payments as follows:

Year ended March 31	Debentures Payable, Term/Other Loan and Mortgages Payable Principal Payments
2018	$ 17,612
2019	22,133
2020	23,091
2021	24,092
2022	24,800
Thereafter	275,659
	$ 387,387

During the year, the amount of total interest expensed, including interest related to obligations under capital leases, was $16,221 (2016 – $15,249).

(c) As at March 31, 2017, AHS has access to a $220,000 (March 31, 2016 – $220,000) revolving demand facility with a Canadian chartered bank which may be used for operating purposes. Draws on the facility bear interest at the bank's prime rate less 0.50% per annum. As at March 31, 2017, AHS has $nil (March 31, 2016 – $nil) draws against this facility.

AHS also has access to a $33,000 (March 31, 2016 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2017, AHS has $3,469 (March 31, 2016 – $3,664) in a letter of credit outstanding against this facility. AHS is in compliance with the terms of the agreement relating to the letter of credit, therefore no liability has been recorded.

Note 18 Tangible Capital Assets

Cost	2016	Additions[a]	Transfers out of Work in Progress	Disposals	2017
Facilities and improvements	$ 8,488,610	$ -	$ 510,770	$ (2,625)	$ 8,996,755
Work in progress	1,086,124	418,267	(590,285)	-	914,106
Equipment[b]	2,179,617	153,429	1,256	(31,483)	2,302,819
Information systems	1,331,861	24,391	17,754	(11,350)	1,362,656
Building service equipment	567,261	-	43,815	(55)	611,021
Land[c]	110,069	687	-	(167)	110,589
Leased facilities and improvements	219,937	247	4,784	-	224,968
Land improvements	70,919	-	11,906	(61)	82,764
	$ 14,054,398	**$ 597,021**	**$ -**	**$ (45,741)**	**$ 14,605,678**

Accumulated Amortization	2016	Amortization Expense	Effect of Transfers	Disposals	2017
Facilities and improvements	$ 3,179,295	$ 236,203	$ -	$ (2,626)	$ 3,412,872
Work in progress	-	-	-	-	-
Equipment[b]	1,678,226	155,393	-	(31,084)	1,802,535
Information systems	1,081,472	110,696	-	(11,350)	1,180,818
Building service equipment	332,616	32,449	-	(49)	365,016
Land[c]	-	-	-	-	-
Leased facilities and improvements	149,431	12,891	-	-	162,322
Land improvements	60,287	2,812	-	(61)	63,038
	$ 6,481,327	**$ 550,444**	**$ -**	**$ (45,170)**	**$ 6,986,601**

	Net Book Value	
	2017	2016
Facilities and improvements	$ 5,583,883	$ 5,309,315
Work in progress	914,106	1,086,124
Equipment	500,284	501,391
Information systems	181,838	250,389
Building service equipment	246,005	234,645
Land	110,589	110,069
Leased facilities and improvements	62,646	70,506
Land improvements	19,726	10,632
	$ 7,619,077	**$ 7,573,071**

Note 18 Tangible Capital Assets (continued)

Cost	2015	Additions[a]	Transfers out of Work in Progress	Disposals	2016
Facilities and improvements	$ 8,287,500	$ -	$ 201,923	$ (813)	$ 8,488,610
Work in progress	834,328	524,033	(272,237)	-	1,086,124
Equipment[b]	2,185,995	104,390	4,985	(115,753)	2,179,617
Information systems	1,349,427	4,420	25,595	(47,581)	1,331,861
Building service equipment	539,452	-	27,834	(25)	567,261
Land[c]	110,069	-	-	-	110,069
Leased facilities and improvements	191,866	17,942	10,129	-	219,937
Land improvements	69,148	-	1,771	-	70,919
	$ 13,567,785	**$ 650,785**	**$ -**	**$ (164,172)**	**$ 14,054,398**

Accumulated Amortization	2015	Amortization Expense	Effect of Transfers	Disposals	2016
Facilities and improvements	$ 2,955,848	$ 224,212	$ -	$ (765)	$ 3,179,295
Work in progress	-	-	-	-	-
Equipment[b]	1,602,510	191,046	-	(115,330)	1,678,226
Information systems	1,000,609	128,444	-	(47,581)	1,081,472
Building service equipment	304,910	27,731	-	(25)	332,616
Land[c]	-	-	-	-	-
Leased facilities and improvements	134,819	14,612	-	-	149,431
Land improvements	57,952	2,335	-	-	60,287
	$ 6,056,648	**$ 588,380**	**$ -**	**$ (163,701)**	**$ 6,481,327**

	Net Book Value	
	2016	2015
Facilities and improvements	$ 5,309,315	$ 5,331,652
Work in progress	1,086,124	834,328
Equipment	501,391	583,485
Information systems	250,389	348,818
Building service equipment	234,645	234,542
Land	110,069	110,069
Leased facilities and improvements	70,506	57,047
Land improvements	10,632	11,196
	$ 7,573,071	**$ 7,511,137**

(a) Transferred Tangible Capital Assets

Additions include total transferred tangible capital assets of $215,933 (2016 – $399,992) consisting of $215,933 from AI (2016 – $399,927) and $nil from other sources (2016 – $65).

(b) Leased Equipment

Equipment includes tangible capital assets acquired through capital leases at a cost of $13,417 (2016 – $15,694) with accumulated amortization of $11,266 (March 31, 2016 – $11,859). For the year ended March 31, 2017, leased equipment included a net decrease of $1,137 related to vehicles under capital leases (2016 – net decrease of $362).

Note 18 Tangible Capital Assets (continued)

(c) Leased Land

Land at the following sites has been leased to AHS at nominal values:

Site	Leased from	Lease Expiry
Cross Cancer Institute Parkade	University of Alberta	2019
Evansburg Community Health Centre	Yellowhead County	2031
Myrnam Land	Eagle Hill Foundation	2038
Two Hills Helipad	Stella Stefiuk	2041
McConnell Place North	City of Edmonton	2044
Northeast Community Health Centre	City of Edmonton	2047
Foothills Medical Centre Parkade	University of Calgary	2054
Alberta Children's Hospital	University of Calgary	2103

Note 19 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2017					2016
	Unrestricted Surplus[a]	Internally Restricted Surplus for Future Purposes[b]	Invested in Tangible Capital Assets[c]	Endowments[d]	Total	Total
Balance, beginning of year	$ 125,480	$ 283,814	$ 676,427	$ 73,402	$ 1,159,123	$ 1,303,682
Annual operating surplus (deficit)	66,536	-	-	-	66,536	(144,559)
Tangible capital assets purchased with internal funds	(166,783)	-	166,783	-	-	-
Amortization of internally funded tangible capital assets	148,128	-	(148,128)	-	-	-
Repayment of debt used to fund tangible capital assets	(16,822)	-	16,822	-	-	-
Payments on obligations under capital leases	(1,655)	-	1,655	-	-	-
Net repayment of life lease deposits	(59)	-	59	-	-	-
Transfer of revenue for acquisition of land	(687)	-	687	-	-	-
Transfer of internally restricted	58,885	(58,885)	-	-	-	-
Transfer of endowment contributions	(1,308)	-	-	1,308	-	-
Balance, end of year	**$ 211,715**	**$ 224,929**	**$ 714,305**	**$ 74,710**	**$ 1,225,659**	**$ 1,159,123**

(a) Unrestricted Surplus

Unrestricted surplus represents the portion of accumulated surplus that has not been internally restricted for future purposes, invested in tangible capital assets, or endowments.

Note 19 Accumulated Surplus (continued)

(b) Internally Restricted Surplus for Future Purposes

The Board has approved the restriction of accumulated surplus for future purposes as follows:

	2017	2016
Ancillary services [(i)]	$ 112,718	$ 92,842
Insurance equity requirements [(ii)]	42,224	41,431
Foundations [(iii)]	39,987	34,545
Other [(iv)]	30,000	114,996
Internally restricted surplus for future purposes	**$ 224,929**	**$ 283,814**

(i) Restriction of ancillary operation surpluses from parking, retail food services, and controlled entities' (2015-16 Restriction of ancillary operation surpluses for parking and retail food services).
(ii) Restriction of surplus related to equity of the LPIP (2015-16 Restriction of surplus related to equity of the LPIP).
(iii) Restriction of surplus related to AHS Controlled Foundations (2015-16 Restriction of surplus for specific local initiatives as a result of local fundraising, and to fund cancer research).
(iv) Restriction of surplus to address funding of expenses for certain initiatives spanning multiple fiscal years (2015-16 Restriction of surplus related to future capital purposes and the Provincial Clinical Information Systems Initiative (CIS)).

(c) Invested in Tangible Capital Assets

The restriction of accumulated surplus is equal to the net book value of internally funded tangible capital assets as these amounts are only available to AHS for its health care mandate.

(d) Endowments

Endowments represent the portion of accumulated surplus that is restricted and must be maintained in perpetuity.

Note 20 Contractual Obligations and Contingent Liabilities

Contractual obligations are AHS' obligations to others that will become liabilities in the future when the terms of current or existing contracts or agreements are met.

(a) Leases

AHS is contractually committed to future operating lease payments as follows:

Year ended March 31	Total Lease Payments
2018	$ 53,243
2019	45,999
2020	38,259
2021	32,055
2022	29,679
Thereafter	69,215
	$ 268,450

Note 20 Contractual Obligations and Contingent Liabilities (continued)

(b) Contingent Liabilities

AHS is subject to legal claims during its normal course of business. AHS records a liability when the assessment of a claim indicates that a future event is likely to confirm that an asset had been impaired or a liability incurred at the date of the financial statements and the amount of the contingent loss can be reasonably estimated.

Accruals have been made in specific instances where it is likely that losses will be incurred based on a reasonable estimate. As at March 31, 2017, accruals have been recorded as part of the provision for unpaid claims and other liabilities (Note 12). Included in this accrual are claims in which AHS has been jointly named with the Minister. The accrual provided for these claims under the provision for unpaid claims represents AHS' portion of the liability.

AHS has been named in 186 legal claims (2016 – 176 claims) related to conditions in existence at March 31, 2017 where the likelihood of the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 179 claims have $310,941 in specified amounts and 7 have no specified amounts (2016 – 162 claims with $240,665 of specified claims and 14 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that is different than the claimed amount.

AHS has been named as a co-defendant, along with the GOA, in a certified Class Action (the Claim) arising from increases to long-term accommodation charges implemented by Alberta Government regulations enacted on and after August 1, 2003, and paid by residents of long-term care facilities. The likelihood of the Claim is considered by AHS to be indeterminable, and the amount of the Claim has not yet been specified.

Note 21 Related Parties

Transactions with the following related parties are considered to be undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length. Amounts due to or from the related parties and the recorded amounts of the transactions are included within these consolidated financial statements, unless otherwise stated.

AH appoints all members of the AHS Board. The viability of AHS' operations depends on transfers from AH. Transactions between AHS and AH are reported and disclosed in the Consolidated Statement of Operations, the Consolidated Statement of Financial Position, and the Notes to the Consolidated Financial Statements, and are therefore excluded from the table below.

Related parties also include key management personnel of AHS. Related party transactions with key management personnel primarily consist of compensation related payments to employees and senior management and are considered to be undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length.

AHS is considered to be a related party with those entities consolidated or included on a modified equity basis in the GOA consolidated financial statements. Transactions between AHS and the other ministries that are undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length are recorded at their exchange amount as follows:

Note 21 Related Parties (continued)

	Revenues[a]		Expenses	
	2017	2016	2017	2016
Ministry of Advanced Education[b]	$ 52,621	$ 52,564	$ 122,527	$ 120,194
Ministry of Infrastructure[c]	373,253	340,028	24,538	24,796
Other ministries[d]	60,865	49,096	29,341	29,814
Total for the year	**$ 486,739**	**$ 441,688**	**$ 176,406**	**$ 174,804**

	Receivable from		Payable to	
	2017	2016	2017	2016
Ministry of Advanced Education [b]	$ 5,536	$ 5,131	$ 26,449	$ 19,009
Ministry of Infrastructure [c]	23,623	49,688	-	-
Other ministries [d]	30,412	11,318	322,157	329,757
Balance, end of year	**$ 59,571**	**$ 66,137**	**$ 348,606**	**$ 348,766**

(a) Revenues with GOA ministries include other government transfers of $449,067 (2016 – $409,882), (Note 4), other income of $37,422 (2016 – $31,118), (Note 6), and fees and charges of $250 (2016 – $688).

(b) Most of AHS transactions with the Ministry of Advanced Education relate to initiatives with the University of Alberta and the University of Calgary. These initiatives include teaching, research, and program delivery. A number of physicians are employed by either AHS or the universities but perform services for both. Due to proximity of locations, some initiatives result in sharing physical space and support services. The revenue and expense transactions are a result of grants provided from one to the other and recoveries of shared costs.

(c) The transactions with the Ministry of Infrastructure relate to the construction and funding of tangible capital assets. These transactions include operating transfers of $71,225 (2016 – $47,634) and recognition of expended deferred capital revenue of $277,660 (2016 – $268,090) relating to tangible capital assets with stipulations or external restrictions to utilize over their remaining useful lives. AHS has also recorded an in-kind transfer and expense of $24,368 (2016 – $24,304) for space that is provided by AI rent free. Not included in the table above but included in total amounts disclosed in Note 18(a) is the transfer of tangible capital assets from AI of $215,933 (2016 – $399,927).

(d) The payable transactions with other ministries include the debt payable to ACFA (Note 17(a)).

At March 31, 2017, AHS has recorded deferred revenue from other ministries within the GOA, excluding AH, of $45,104 (March 31, 2016 – $24,506) related to unexpended deferred operating revenue (Note 14), $15,958 (March 31, 2016 – $9,176) related to unexpended deferred capital revenue (Note 15) and $6,111,310 (March 31, 2016 – $6,056,411) related to expended deferred capital revenue (Note 16).

Contingent liabilities in which AHS has been jointly named with other government entities within the GOA are disclosed in Note 20.

Note 22 Government Partnerships

The following is 100% of the financial position and results of operations for AHS' government partnerships.

	2017	2016
Financial assets	$ 57,950	$ 122,784
Liabilities	57,950	122,784
Accumulated surplus	$ -	$ -
Total revenues	$ 231,097	$ 229,955
Total expenses	231,097	229,955
Annual surplus	**$ -**	**$ -**

AHS has proportionately consolidated 50% of the results of the PCNs and NACTRC.

Note 23 Trusts under Administration

(a) Health Benefit Trust of Alberta (HBTA)

AHS is one of more than 30 participants in the HBTA and has a majority of representation on the HBTA governance board. The HBTA is a formal health and welfare trust established under a Trust Agreement effective January 1, 2000. The HBTA provides health and other related employee benefits pursuant to the authorizing Trust Agreement.

The HBTA maintains various reserves to adequately provide for all current obligations and reported fund balances of $78,183 as at December 31, 2016 (December 31, 2015 – $97,502). AHS has included in prepaid expenses $64,317 (March 31, 2016 – $71,664) as a share of the HBTA's fund balances representing in substance a prepayment of future premiums. These consolidated financial statements do not include the HBTA other than the premiums paid by AHS. For the fiscal year ended March 31, 2017, AHS paid premiums of $340,947 (2016 – $315,103).

(b) Other Trust Funds

AHS receives funds in trust for research and development, education, and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2017, the balance of funds held in trust by AHS for research and development is $514 (March 31, 2016 – $3,762).

AHS receives funds in trust from continuing care residents for personal expenses. As at March 31, 2017, the balance of these funds is $1,717 (March 31, 2016 – $1,780). These amounts are not included in the consolidated financial statements.

Note 24 Corresponding Amounts

Certain amounts have been reclassified to conform to 2017 presentation.

Note 25 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on June 1, 2017.

SCHEDULE 1 – CONSOLIDATED SCHEDULE OF EXPENSES BY OBJECT
YEAR ENDED MARCH 31

	2017		2016
	Budget (Note 3)	Actual	Actual
Salaries and benefits (Schedule 2)	$ 7,760,000	$ 7,983,182	$ 7,741,667
Contracts with health service providers	2,635,000	2,539,854	2,451,216
Contracts under the Health Care Protection Act	18,000	20,198	19,300
Drugs and gases	425,000	449,620	417,110
Medical and surgical supplies	390,000	385,213	414,053
Other contracted services	1,173,000	1,106,722	1,134,353
Other[a]	1,330,000	1,367,628	1,333,313
Amortization and disposals of tangible capital assets (Note 18)	587,000	551,015	588,851
	$ 14,318,000	**$ 14,403,432**	**$ 14,099,863**
(a) Significant amounts included in Other are:			
Equipment expense		$ 223,364	$ 208,119
Other clinical supplies		152,312	149,183
Building rent		132,080	126,825
Building and ground expenses		121,044	107,011
Utilities		105,159	107,608
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies		90,259	87,497
Food and dietary supplies		81,985	80,078
Office supplies		54,040	58,506
Fundraising and grants awarded		50,859	54,426
Insurance and liability claims		49,639	24,199
Minor equipment purchases		45,831	69,436
Travel		41,734	39,462
Telecommunications		39,397	42,070
Licenses, fees and memberships		28,477	24,803
Education		12,107	13,628
Other		139,341	140,462
		$ 1,367,628	**$ 1,333,313**

SCHEDULE 2 - CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2017

	2017								2016	
						Severance [e]				
	FTE[a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Number of Individuals	Amount	Total	FTE [a]	Total
Total Board (Sub-Schedule 2A)	9.21	$ -	$ 310	$ -	$ 310	-	$ -	$ 310	4.42	$ 147
Total Former Official Administrator / Former Advisory Committees	-	-	-	-	-	-	-	-	4.62	248
Total Executive (Sub-Schedule 2B)	13.86	4,927	34	961	5,922	1	219	6,141	14.38	6,566
Management Reporting to CEO Direct Reports	66.06	15,176	364	2,937	18,477	2	214	18,691	54.81	15,598
Other Management	2,985.79	355,981	3,893	85,522	445,396	18	1,314	446,710	2,971.65	440,242
Medical Doctors not included above[f]	150.06	46,937	380	3,672	50,989	-	-	50,989	156.89	53,126
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	18,966.63	1,807,350	248,976	405,990	2,462,316	2	88	2,462,404	18,773.62	2,386,246
LPNs	4,836.11	315,465	34,991	72,503	422,959	-	-	422,959	4,691.76	417,040
Other Health Technical & Professional	16,307.58	1,458,289	83,499	338,966	1,880,754	7	60	1,880,814	15,964.01	1,824,007
Unregulated Health Service Providers	8,716.34	442,343	43,373	107,204	592,920	3	35	592,955	8,542.13	585,336
Other Staff	26,382.57	1,667,727	55,831	376,998	2,100,556	37	653	2,101,209	25,829.17	2,013,111
Total	**78,434.21**	**$ 6,114,195**	**$ 471,651**	**$ 1,394,753**	**$ 7,980,599**	**70**	**$ 2,583**	**$ 7,983,182**	**77,007.46**	**$ 7,741,667**

The accompanying footnotes and sub-schedules are part of this schedule.

SUB-SCHEDULE 2A – BOARD REMUNERATION FOR THE YEAR ENDED MARCH 31, 2017

	Term	2017 Committees	2017 Remuneration	2016 Remuneration
Board Chair				
Linda Hughes[g]	Since Nov 27, 2015	ARC, CEC, FC, GC, HRC, QSC	$ 71	$ 26
Board Members				
Dr. Brenda Hemmelgarn (Vice Chair)	Since Nov 27, 2015	CEC (Chair), QSC	51	19
David Carpenter	Since Nov 27, 2015	ARC (Chair), CEC, FC (Chair)	38	14
Richard Dicerni[h]	Since Nov 27, 2015	FC, HRC (Chair)	30	-
Heather Hirsch	Since Nov 3, 2016	CEC, QSC	9	-
Hugh Sommerville	Since Nov 27, 2015	ARC, GC (Chair)	37	13
Marliss Taylor	Since Nov 27, 2015	CEC, GC, HRC	36	12
Glenda Yeates	Since Nov 27, 2015	ARC, FC, QSC (Chair)	33	13
Board Committee Participants[i]				
Barbara Burton	Nov 27, 2015 to Mar 31, 2016	-	-	12
Dr. Thomas Feasby	Nov 27, 2015 to Jan 18, 2017	QSC	2	2
Martin Harvey	Nov 27, 2015 to Mar 31, 2016	-	-	1
Don Sieben	Nov 27, 2015 to Mar 31, 2016	-	-	17
Doug Tupper	Nov 27, 2015 to Mar 31, 2016	-	-	17
Gord Winkel	Since Nov 27, 2015	QSC	3	1
Total Board			**$ 310**	**$ 147**

Board members were remunerated with monthly honoraria. In addition, they receive remuneration for attendance at Board and committee meetings.

Board committees were established by the Board to assist in governing AHS and overseeing the management of AHS' business and affairs. Board committee participants are eligible to receive remuneration for meetings attended, and in addition Board committee chairs also receive a monthly honorarium.

Committee legend: ARC = Audit and Risk Committee, CEC = Community Engagement Committee, FC = Finance Committee, GC = Governance Committee, HRC = Human Resources Committee, QSC = Quality and Safety Committee

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2017

	2017						
For the Current Fiscal Year	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board Direct Reports							
Dr. Verna Yiu – President and Chief Executive Officer[j,u]	1.00	$ 565	$ 16	$ 163	$ 744	$ -	$ 744
Ronda White – Chief Audit Executive [v]	1.00	240	-	39	279	-	279
CEO Direct Reports							
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta[k,w]	1.00	370	-	44	414	-	414
Dr. Ted Braun – VP and Medical Director, Central and Southern Alberta[l, w]	1.00	383	5	69	457	-	457
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta[w]	1.00	370	-	104	474	-	474
Dr. David Mador – VP and Medical Director, Northern Alberta[x]	1.00	450	-	104	554	-	554
Sean Chilton – VP, Collaborative Practice, Nursing and Health Professions[m, w]	0.27	89	-	14	103	-	103
Dave Bilan – Interim VP, Collaborative Practice, Nursing and Health Professions[n]	0.77	130	-	2	132	-	132
Dr. Francois Belanger – VP, Quality and Chief Medical Officer[o, w]	1.00	456	-	93	549	-	549
Karen Horon – Acting VP, Clinical Support Services[p, w]	0.02	5	-	1	6	-	6
Mauro Chies – VP, Clinical Support Services[q, w]	0.80	245	-	40	285	-	285
Dr. Kathryn Todd – VP, Research, Innovation and Analytics[r,y]	1.00	264	13	32	309	-	309
Todd Gilchrist – VP, People, Legal and Privacy[w]	1.00	450	-	78	528	-	528
Colleen Turner – VP, Community Engagement and Communications[s, w]	1.00	314	-	81	395	-	395
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer[w]	1.00	370	-	65	435	-	435
Noela Inions – Chief Ethics and Compliance Officer[t]	1.00	226	-	32	258	219	477
Total Executive	**13.86**	**$ 4,927**	**$ 34**	**$ 961**	**$ 5,922**	**$ 219**	**$ 6,141**

SUB-SCHEDULE 2B - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2017 (CONTINUED)

	2016						
For the Prior Fiscal Year	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board / Official Administrator Direct Reports							
Dr. Verna Yiu – Interim President and Chief Executive Officer	0.23	$ 120	$ 22	$ 8	$ 150	$ -	$ 150
Vickie Kaminski – President and Chief Executive Officer	0.85	462	31	32	525	-	525
Ronda White – Chief Audit Executive	1.00	241	-	36	277	-	277
CEO Direct Reports							
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta	1.00	372	-	50	422	-	422
Dr. Ted Braun – Acting VP and Medical Director, Central and Southern Alberta	0.23	88	1	13	102	-	102
Dr. Francois Belanger – VP and Medical Director, Central and Southern Alberta	0.77	348	-	66	414	-	414
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta	1.00	372	-	32	404	-	404
Dr. David Mador – VP and Medical Director, Northern Alberta	1.00	452	-	70	522	-	522
Dave Bilan – Interim VP Collaborative Practice, Nursing and Health Professions	0.34	57	-	9	66	-	66
Linda Dempster – VP Collaborative Practice, Nursing and Health Professions	0.66	172	-	23	195	-	195
Dr. Francois Belanger – Interim VP, Quality and Chief Medical Officer	0.23	104	-	20	124	-	124
Dr. Verna Yiu – VP, Quality and Chief Medical Officer	0.77	402	36	26	464	-	464
Dr. Kathryn Todd – VP, Research, Innovation and Analytics	1.00	264	15	29	308	-	308
Todd Gilchrist – VP, Human Resources	0.91	406	-	123	529	-	529
Robert Armstrong – Acting VP, Human Resources	0.09	22	3	6	31	-	31
Colleen Turner – Interim VP, Community Engagement and Communications	0.23	61	-	13	74	-	74
Carmel Turpin – VP, Community Engagement and Communications	0.78	237	-	30	267	293	560
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer	1.00	372	-	48	420	-	420
Noela Inions – Chief Ethics and Compliance Officer	1.00	227	-	45	272	-	272
Vivian Simpkin – Interim General Counsel, Legal and Privacy	0.22	48	5	9	62	-	62
Salimah Walji-Shivji – General Counsel, Legal and Privacy	0.46	111	-	21	132	266	398
Sharon Lehr – Chief Program Officer, Operational Benchmarking and Efficiency	0.61	188	-	59	247	-	247
Total Executive	**14.38**	**$ 5,126**	**$ 113**	**$ 768**	**$ 6,007**	**$ 559**	**$ 6,566**

SUB-SCHEDULE 2C - EXECUTIVE SUPPLEMENTAL PENSION PLAN AND SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN

Certain employees will receive retirement benefits that supplement the benefits limited under the registered plans for service. The Supplemental Pension Plan (SPP) is a defined contribution plan and the Supplemental Executive Retirement Plan (SERP) is a defined benefit plan. The SERP is disclosed in Note 2(h)(iii). The amounts in this table represent the total SPP and SERP benefits earned by the individual during the fiscal year. The current period benefit costs for SPP and the other costs for SERP included in other non-cash benefits disclosed in Sub-Schedule 2B are prorated for the period of time the individual was in their position directly reporting to the Board or directly reporting to the President and Chief Executive Officer. Only individuals holding a position directly reporting to the Board or President and Chief Executive Officer during the current fiscal year are disclosed.

	2017			2016			
	SPP	SERP					
	Current period benefit costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2016	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2017
Dr. Verna Yiu - President and Chief Executive Officer	$ 41	$ -	$ 41	$ -	$ -	$ 41	$ 41
Ronda White - Chief Audit Executive	9	-	9	10	51	12	63
Brenda Huband - VP and Chief Health Operations Officer, Central and Southern Alberta							
SERP	-	23	23	(8)	422	(42)	380
SPP	25	-	25	25	95	30	125
Dr. Ted Braun - VP and Medical Director, Central and Southern Alberta							
SERP	-	12	12	(4)	217	(8)	209
SPP	27	-	27	16	58	27	85
Deb Gordon - VP and Chief Health Operations Officer, Northern Alberta							
SERP	-	35	35	(11)	626	23	649
SPP	25	-	25	25	85	31	116
Dr. David Mador - VP and Medical Director, Northern Alberta	35	-	35	35	106	38	144
Sean Chilton - VP, Collaborative Practice, Nursing and Health Professions	18	-	18	18	94	21	115
Dr. Francois Belanger - VP, Quality and Chief Medical Officer	35	-	35	35	127	45	172
Karen Horon - Acting VP, Clinical Support Services	4	-	4	4	12	4	16
Mauro Chies - VP, Clinical Support Services	16	-	16	12	49	18	67
Dr. Kathryn Todd - VP, Research, Innovation and Analytics [f]	-	-	-	-	-	-	-
Todd Gilchrist - VP, People, Legal and Privacy	35	-	35	31	31	36	67
Colleen Turner - VP, Community Engagement and Communications	18	-	18	10	48	22	70

SUB-SCHEDULE 2C - EXECUTIVE SUPPLEMENTAL PENSION PLAN AND SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (CONTINUED)

	2017			2016			
	SPP	SERP					
	Current period benefit costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2016	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2017
Deborah Rhodes - VP, Corporate Services and Chief Financial Officer	$ 25	$ -	$ 25	$ 25	$ 138	$ 32	$ 170
Noela Inions - Chief Ethics and Compliance Officer	8	-	8	8	64	12	76

(1) The SPP current period benefit costs are AHS contributions earned in the period.
(2) Other SERP costs include retirement benefits, interest expense on the obligations, and amortization of actuarial gains and losses, offset by the expected return on the plans' assets. AHS uses the straight line method to amortize actuarial gains and losses over the expected average remaining service life of the plan members.
(3) The account balance represents the total cumulative earned contributions to the SPP as well as cumulative investment gains or losses on the contributions.
(4) Changes in the accrued benefit obligation include current period benefit cost, interest accruing on the obligations and the amortization of any actuarial gains or losses in the period. Changes in the account balance include the current benefit costs and investment gains or losses related to the account.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2017

Definitions

a. For this schedule, full time equivalents (FTE) are determined by actual hours earned divided by 2,022.75 annual base hours. FTE for the Board and Board committee members are prorated using the number of days in the fiscal year between either the date of appointment and the end of the year, the date of appointment and the termination date, or the beginning of the year and the termination date.

b. Base salary is regular salary and includes all payments earned related to actual hours earned other than those reported as other cash benefits.

   Vacation accruals are included in base salary except for direct reports of the Board or President and Chief Executive Officer whose vacation accruals are included in other non-cash benefits.

c. Other cash benefits include, as applicable, honoraria, overtime, acting pay, travel and automobile allowances, lump sum payments and an allowance for professional development. Relocation expenses are excluded from compensation disclosure as they are considered to be recruiting costs to AHS and not part of compensation unless related to severance. Expense reimbursements are also excluded from compensation disclosure except where the expenses meet the definition of the other cash benefits listed above.

d. Other non-cash benefits include:
   - Employer's current period benefit costs and other costs of supplemental pension plan and supplemental executive retirement plans as defined in Sub-Schedule 2C
   - Employer's share of employee benefit contributions and payments made on behalf of employees including pension, health care, dental and vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, and long and short-term disability plans, and
   - Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

e. Severance includes direct or indirect payments to individuals upon termination which are not included in other cash benefits or other non-cash benefits.

f. Compensation provided by AHS for medical doctors included in salaries and benefits expense includes medical doctors paid through AHS payroll. The compensation provided by AHS for the remaining medical doctors is included in other contracted services.

Board and Board Committee Participants

g. The Board Chair is an Ex-Officio member on all committees.

h. This individual started claiming honoraria on April 16, 2016.

i. These individuals were participants of Board committees, but are not Board members or AHS employees.

Executive

j. The incumbent held the position of Interim President and Chief Executive Officer and received acting pay until June 3, 2016 when the incumbent was appointed to President and Chief Executive Officer. The incumbent received an increase in compensation for the new position. The contract term ends June 2, 2021. The incumbent was on secondment from the University of Alberta until June 3, 2016. During this time, the incumbent's total remuneration was comprised of salary amounts from both AHS and the University of Alberta, and AHS reimbursed the University for the incumbent's base salary and benefits. In lieu of enrollment into the AHS SPP, the incumbent received an annual lump sum supplemental payment equivalent to the amount the incumbent would have received as a member of the SPP and payable from AHS. The lump sum has been included in Other Cash Benefits. Effective June 3, 2016, the incumbent began a leave of absence from the University of Alberta and entered into an employment relationship with AHS.

k. The incumbent received a vacation payout of $29 during the year for unused accrued vacation earned in prior periods; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

l. The incumbent held the position of Acting Vice President and Medical Director, Central and Southern Alberta and received an increase in base salary until February 13, 2017 at which time the incumbent was appointed to Vice President and Medical Director, Central and Southern Alberta. The incumbent received an increase in compensation for the new position.

m. The incumbent held the position of Chief Zone Officer, South Zone until December 26, 2016 at which time the incumbent was appointed to Vice President, Collaborative Practice, Nursing and Health Professions and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in compensation for the new position.

n. The incumbent held the position of Interim Vice President, Collaborative Practice, Nursing and Health Professions and received an increase in base salary until January 9, 2017 at which time the incumbent resumed the role of Executive Director, Health Professions – Strategy and Practice and is no longer a direct report to the President and Chief Executive Officer.

o. The incumbent held the position of Interim Vice President, Quality and Chief Medical Officer until November 1, 2016 when the incumbent was appointed to Vice President, Quality and Chief Medical Officer. The incumbent received an increase in compensation for the new position.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2017 (CONTINUED)

p. The incumbent held the position of Senior Operating Officer, Pharmacy Services until March 28, 2017 at which time the incumbent was appointed to Acting Vice President, Clinical Support Services and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in base salary for the Acting Vice President, Clinical Support Services position.

q. The incumbent held the position of Chief Program Officer, Clinical Support Services until June 13, 2016 at which time the incumbent was appointed to Vice President, Clinical Support Services and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in compensation for the new position. In addition, the incumbent received a vacation payout of $6 during the year for unused accrued vacation earned in prior periods; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned. The incumbent began a leave of absence on March 28, 2017.

r. The incumbent is on secondment from the University of Alberta. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Alberta, and AHS reimburses the University for the incumbent's base salary and benefits. In lieu of enrollment into the AHS SPP, the incumbent will receive an annual lump sum supplemental payment equivalent to the amount the incumbent would have received as a member of the SPP and payable from AHS. The lump sum has been included in Other Cash Benefits.

s. The incumbent held the position of Interim Vice President, Community Engagement and Communications and received an increase in base salary until July 4, 2016 when the incumbent was appointed to Vice President, Community Engagement and Communications. The incumbent received an increase in compensation for the new position.

t. The incumbent held the position until April 21, 2017, at which time the accountability and scope of the position was expanded. The employer and employee negotiated a separation agreement which resulted in the incumbent resigning her position in exchange for a severance payment. The employer allowed this resignation to be communicated as a retirement. The incumbent received salary and other accrued entitlements to the date of resignation. The reported severance included 44 weeks of base salary at the rate in effect at the date of retirement and an additional 15% of the severance in lieu of benefits. This severance was expensed in the current year.

Termination Obligations

u. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to one month base salary for each completed month of service during the first year of the term or, after completion of one year of service of the term, 12 months base salary.

v. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to 12 months base salary. The severance payment will be reduced by any employment earnings received from a new employer within the 12 month period.

w. The incumbent's termination benefits have not been predetermined.

x. In the case of termination without just cause by AHS, the incumbent shall receive severance pay to a maximum of 12 months base salary plus market supplement. Such severance will be paid in 12 equal monthly instalments. The severance payment will be reduced by any employment earnings received from a new employer within the 12 month period.

y. There is no severance associated with the secondment agreement. Upon termination of the secondment agreement, the incumbent would return to the incumbent's regular position at the University of Alberta.

Compensation Analysis and Discussion
(Non-Union/Exempt Employees)

A total compensation strategy is the blueprint for an organization's total compensation program. It includes the mix of direct and indirect compensation to be provided to employees and the means through which it will be provided in order to support an organization's goals. It is important that total compensation in a publicly-funded organization such as AHS has a governance-approved strategy or "blueprint" that is properly aligned with its direction, goals and values.

Total Compensation Philosophy

AHS reinforces outstanding patient care for all Albertans by attracting, retaining and engaging talented and committed employees. We do this with competitive and fair total compensation that motivates and rewards performance while demonstrating sound fiscal management and sustainability. Principles set out in the total compensation policy guided by AHS' total compensation philosophy reflect:

- Competitive market positioning
- Internal equity
- Performance orientation
- Affordability
- Individual flexibility
- Shared employee/employer responsibility

Total Compensation Strategy

AHS ensures the process used to set total compensation, establish and maintain good governance, and incorporate best practices is transparent. The job rates for Executive and Senior Leadership salary ranges are representative of the median of the national healthcare and Alberta public sector market. To ensure total compensation remains market competitive, AHS reviews its market positioning on a regular basis and, in any event, no less than once every second year. Salary ranges are published on the AHS website. AHS is currently under a salary freeze that applies to all government agencies, boards and commissions until March 31, 2018 and consequently has not conducted a regular review of its market positioning.

AHS' Total Compensation programs and practices encourage behaviours that will promote a patient-focused, quality health system that is accessible and sustainable for all Albertans.

Total Compensation Plan Structure

AHS is committed to providing a comprehensive total compensation package including salary, benefits, pension and other programs and services that support attracting, retaining and engaging talented and committed employees. AHS' total compensation is comprised of direct and indirect compensation. Elements within direct and indirect compensation fit the overall total compensation strategy by driving accountability and performance, demonstrating sound fiscal management, and promoting a sense of integrity and equity.

Direct Compensation includes pay received as wages and salaries. It integrates with the AHS Performance Management Program. AHS has no incentive, variable pay or pay at risk of any kind. Base salary ranges are intended to be competitive compared to the median (50th percentile) of the national healthcare market and the Alberta public sector market. An employee's individual base salary is set based on individual performance and salary range adjustments within AHS market comparators.

Indirect Compensation includes benefits and pension (including supplemental pension plan), terms and conditions, and employee appreciation. AHS' benefits and pension plans support the health and well-being of our employees and financial security upon retirement. AHS provides a competitive benefits program that includes pension, health and dental-care benefits, life insurance, illness and long-term disability coverage and professional memberships.
All AHS employees are eligible to participate in the Local Authorities Pension Plan (LAPP). This is a defined benefit pension plan. It provides for a pension of 1.4% for each year of pensionable service based on the average salary of the highest five consecutive years up to the Year's Maximum Pensionable Earnings under the Canada Pension Plan and 2.0% on the excess. Benefits under this plan are capped at the maximum pension benefit limit allowed under the federal Income Tax Act, a salary of $162,312 in 2017.

As pensionable earnings are limited under LAPP, AHS provides a Supplemental Pension Plan (SPP). Unlike the Local Authorities Pension, the SPP is a Defined Contribution plan that provides annual notional contributions that are allocated to and invested as directed by each member. The SPP allows AHS to maintain a competitive position, but at less cost and risk to the organization. AHS does not provide car allowances or perquisite allowances to its executives or employees.

Total Compensation Governance

The Human Resources Committee of the Board monitors, oversees and advises the Board on total compensation matters related to AHS including:

- Determining the overall strategic approach to compensation.
- Reviewing substantive changes to total compensation programs to ensure they support the organization's mission, strategic directions and values.
- Reviewing the compensation of the President and Chief Executive Officer (CEO) and Vice Presidents.
- Reviewing the compensation philosophy recommended by the President and CEO for non-executive staff of AHS.

Total Compensation Reporting

The Schedule 2 – Consolidated Schedule of Salaries and Benefits in the annual audited consolidated financial statements for the year ended March 31, 2017, provides complete disclosure of salary, benefits, and all other compensation earned for years ended March 31, 2017 and March 31, 2016 by the direct reports to the Board and direct reports to the President & CEO. The Board's compensation is disclosed in Schedule 2 – Consolidated Schedule of Salaries and Benefits in the annual audited consolidated financial statements for the year ended March 31, 2017.

The Schedule 2 Information on total compensation philosophy and practices can be found on the AHS website.

Total Compensation 2016-17 Information Updates

The Public Service Compensation Transparency Act increased transparency by requiring compensation disclosure from Alberta agencies, boards and commissions including AHS. AHS was required to disclose the names and compensation of employees whose earnings were over $125,000 per year. The first AHS disclosure under the Act was required by June 24, 2016, and was posted on AHS' external website. For 2016-17, AHS will be disclosing the names and compensation of employees whose earnings are over $126,375. The Alberta government has frozen salaries for all non-union and exempt employees at provincial agencies, boards and commissions as part of the province's ongoing restraint measures to reduce government operating costs. AHS is among the organizations affected by the freeze. The freeze will be in effect for two years, beginning April 1, 2016 and expiring March 31, 2018.

A compensation regulation under the Reform of Agencies, Boards, and Commissions Act (RABCA) established total compensation, including salary and benefits, for Chief Executive Officers or equivalent in 23 provincial agencies that are part of the Alberta Public Agencies Governance Act (APAGA). This regulation came into effect on March 16, 2017 and applied to 23 provincial agencies identified in APAGA.

AHS is exempt from this regulation and the executive compensation structure developed by the Government. Alternatively, AHS will be submitting an executive compensation plan annually to Government. This compensation plan will demonstrate how AHS aligns to the key compensation principles outlined in the Regulation and help ensure scrutiny of its compensation practices. Transparency will continue to be provided through mandated salary disclosure.

APPENDIX

- **Public Interest Disclosure (Whistleblower Protection) Act**
- **Non-Hospital Surgical Facility Contracts Under the *Health Care Protection Act* (Alberta)**
- **AHS-Funded Facilities**
- **Zone Overview of Beds and Spaces**

PUBLIC INTEREST DISCLOSURE (WHISTLEBLOWER PROTECTION) ACT

On June 1, 2013, the provincial government enacted legislation surrounding the Public Interest Disclosure (Whistleblower Protection) Act (PIDA) and Regulations (the Act). The Act protects employees when making disclosures of certain kinds of wrongdoing they observe in the AHS workplace.

The purpose of the Act includes:

- Facilitating the disclosure of wrongdoing.
- Protecting those who make a disclosure from reprisal.
- Implementing recommendations arising from investigations.
- Promoting confidence in the public sector.

In 2009, AHS established a solid foundation for leading this work across the organization by approving the AHS Safe Disclosure/Whistleblower Policy and appointing a Chief Ethics & Compliance Officer who, under the Act, is also the AHS Designated Officer for PIDA.

Over the past year, AHS has:

- Implemented the internal processes and procedures to manage reports of wrongdoing in the new Ethical Conduct Governance Documents Policy Suite (as in the PIDA Procedures and the Safe Disclosure/ Whistleblower Policy Frequently Asked Questions).
- Updated additional resources and ongoing training to managers and staff about PIDA and the internal disclosure process.
- Monitored the legislative review of PIDA.

In compliance with legislated reporting requirements, from April 1, 2016 to March 31, 2017, there have been no disclosures under PIDA to the AHS Designated Officer; as such, no AHS investigations are underway and no actions have been taken.

Of note: the AHS Designated Officer co-ordinates all PIDA disclosures pertaining to AHS, including those that may originate externally via the provincial PIDA Commissioner/Office of the Ombudsman.

NON-HOSPITAL SURGICAL FACILITY CONTRACTS UNDER THE *HEALTH CARE PROTECTION ACT* (ALBERTA)

AHS contracts services with multiple Non-Hospital Surgical Facilities (NHSF) to provide insured surgical services for dermatology, ophthalmology, oral maxillofacial, otolaryngology, plastic surgery and pregnancy terminations. The use of NHSFs enables AHS to obtain quality services to enhance surgical access and alleviate capacity pressures within AHS main operating rooms.

AHS works with Alberta Health and the College of Physicians and Surgeons of Alberta to coordinate activities addressing quality, safety and compliance with the *Health Care Protection Act* and regulations.

A provincial framework was developed including governance, quality measurement, incident reporting, and monitoring. Contracts with non-hospital surgical facilities provide increased choice of service provider for patients and supplement the resources available in hospitals, while providing good value for public dollars. In 2016-17, there was a 1.8% increase in the total number of procedures performed compared to 2015-16.

The following table summarizes surgical contracts by service area for 2016-17:

Non-Hospital Surgical Facilities Activity		
Contracted Service Area	**Number of Contracted Operators**	**Number of Contracted Procedures Performed**
Dermatology - Edmonton Zone	1	23
Ophthalmology - Calgary Zone	5	16,997*
Ophthalmology - Edmonton Zone	6	4,090*
Ophthalmology - North Zone	1	895
Oral and Maxillofacial Surgery - Calgary Zone	8	854
Oral and Maxillofacial Surgery - Edmonton Zone	9	2,516
Otolaryngology (ENT) - Edmonton Zone	2	193
Plastic Surgery - Edmonton Zone	3	355
Pregnancy Termination - Calgary	1	5,004
Pregnancy Termination - Edmonton	1	6,159
There are no surgical contracts with Non-Hospital Surgical Facilities in the South and Central Zones that fall under the *Health Care Protection Act* (Alberta).		

*Calgary Zone contracts more ophthalmology procedures outside AHS hospitals compared to Edmonton Zone where more ophthalmology procedures are performed within AHS hospitals.

AHS Funded Facilities

Facility Definitions

Facility	Definition
Addiction	Addiction treatment facilities with beds and mats for clients with substance use and gambling problems. Includes detoxification, nursing care, assessment, counselling and treatment. Direct services provided by AHS as well as funded and contracted services. This also includes beds for Protection of Children Abusing Drugs (PChAD) program clients and residential beds funded through the Safe Communities Initiative.
Comm. MH	Community Mental Health support home programs, Canadian Mental Health Association community beds and other mental health community beds/spaces.
Standalone Psych	Standalone psychiatric facilities: Alberta Hospital Edmonton (Edmonton), Southern Alberta Forensic Psychiatric Centre (Calgary), Centennial Centre for Mental Health and Brain Injury (CCMHBI) (Ponoka), Claresholm Centre for Mental Health and Addictions (Claresholm) and Villa Caritas (Edmonton)
Hospital	Acute Care Hospitals are where active treatment is provided. They include medical, surgery, obstetrics, pediatrics, acute care psychiatric, NICU (neonatal intensive care level II and III), ICU (includes intensive care unit, coronary care unit, special care unit, etc.), sub-acute, restorative and palliative beds located in the hospital. ***Urban*** hospitals are located in large, densely populated cities and may provide access to tertiary and secondary level care. Some examples of tertiary level care include head and neck oncology, high risk perinatology and neonatology, organ transplantation, trauma surgery, high dose (cancer) radiation and chemotherapy, growth and puberty disorders, advanced diagnostics (i.e., MRI, PET, CT, Nuclear Medicine, Interventional Radiology) and tertiary level specialty clinic services. ***Regional*** hospitals provide access to secondary level care medical specialists who do not have first contact with patients, for example, cardiologists, urologists, and orthopedic surgeons. In addition to providing general surgery services, these facilities provide specialist surgical services (e.g. orthopedics, otolaryngology, plastic surgery, gynecology) and advanced diagnostics (i.e., MRI, CT). ***Community*** hospitals provide access to rural clinical services – ambulatory, emergency, inpatient medicine, obstetrics and surgery (includes endoscopy). ***Standalone Emergency Departments (ED)*** reflect facilities with an ED and access to lab, diagnostic imaging, outpatient and specialty clinics. They do not have acute care beds or inpatient services. ***Ambulatory Endoscopy / Surgical Centre Hospitals (OP)*** reflect facilities providing ambulatory services including endoscopy and outpatient specialty clinics.
Sub-acute Care (SAC)	Sub-acute care is provided in an auxiliary hospital for the purpose of receiving convalescent and/or rehabilitation services, where it is anticipated that the patient will achieve functional potential to enable them to improve their health status and to successfully return to the community.
Restorative Care (RC)	Restorative Care is a multi-disciplinary, client-centred rehabilitation service that supports frail, complex, or at-risk individuals to retain their independence following debilitating effects of illness or injury. RC aims to promote independence and keeps individuals in the community (home) and to reduce the need for higher levels of care (long-term care).
Palliative (PEOLC)	Palliative and End-of-Life Care (PEOLC) facilities are where a designated program or bed for the purpose of receiving palliative care services, including end-of-life and symptom alleviation, but are not located in an acute care facility. This includes community hospice beds.
Long-Term Care (LTC)	Long-term care is provided in nursing homes and auxiliary hospitals. It is reserved for those with unpredictable and complex health needs, usually multiple chronic and/or unstable medical conditions. Long-term care includes health and personal care services, such as 24-hour nursing care provided by registered nurses or licensed practical nurses.
Supportive Living (SL)	Supportive living includes comprehensive services, such as the availability of 24-hour nursing care (levels 3 or 4). Supportive Living 4-Dementia and Supportive Living Mental Health is also available for those individuals living with moderate to severe dementia or cognitive impairment. Albertans accessing supportive living services generally reside in lodges, retirement communities, or supportive living centres.
Cancer (Ca)	Cancer Care Services include assessments and examinations, supportive care, pain management, prescription of cancer- related medications, education, resource and support counselling and referrals to other cancer centres.
Ambulatory	***Urgent Care Centre (UCC)*** is a community-based service delivery site (non-hospital setting) where higher level assessment, diagnostic and treatment services are provided for unscheduled clients who require immediate medical attention for injuries /illnesses that require human and technical resources more intensive than what is available in a physicians' office or AACC unit. ***Advanced Ambulatory Care Centre (AACC)*** is a community-based service delivery site (non-hospital setting) where assessment, diagnostic and treatment services are provided for unscheduled patients seeking immediate medical attention for non-life threatening illnesses, typically patients of lower acuity than those treated in a UCC or ED. ***Community Ambulatory Care Centre (CACC)*** is a community-based service delivery site (non-hospital setting) primarily engaged in the provision of ambulatory care diagnostic and treatment services. This includes typically scheduled primary care for clients who do not require hospital outpatient emergency care or inpatient treatment. ***Family Care Clinic (FCC)*** provides primary healthcare to people and their families in under-serviced areas of Alberta. ***Public Health Centres*** include community health centres, community health clinics, district offices, public health, and public health centres. They provide services that are offered by public health nurses, including immunization, health education/counselling/support for parents, health assessment and screening to identify health concerns, and referral to appropriate healthcare providers such as physicians, and community resources.

Facility by Zone

This section contains an overview of facilities that support healthcare throughout the province and the beds or spaces within them, broken down provincially and/or by zone.

Number of Facilities	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
Community Ambulatory Care						
Urgent Care Centres		5		1		**6**
Ambulatory Care Centres	2	1	2		2	**7**
Family Care Clinics		1		1	1	**3**
Primary Care Networks	2	7	12	9	12	**42**
Public Health Centres	17	22	34	21	45	**139**
Addiction and Mental Health						
Addiction	5	13	5	9	7	**39**
Community Mental Health	3	10	2	10	1	**26**
Standalone Psychiatric		2	1	2		**5**
Acute Care						
Urban		5		5		**10**
Regional	2		1		2	**5**
Community	10	8	29	7	31	**85**
Standalone Emergency Departments	1			2	1	**4**
Ambulatory Endoscopy or Surgical Centre Hospital	1	1				**2**
TOTAL DESIGNATED HOSPITALS	**14**	**14**	**30**	**14**	**34**	**106**
Cancer Care						
Cancer Centres	2	3	5	1	6	**17**
Community-Based Care						
Long-Term Care & Supportive Living (3, 4, Dementia, Mental Health and Restorative Care)	47	68	76	85	55	**331**
Additional contracted care sites not included in above number reflect the number of personal care, special care and family care homes		*53*		*55*		***108***
Community Hospice, Palliative & End-of-Life Care	2	8	1	5	4	**20**

Refer to definition and explanation of facilities on previous page.

Provincial Overview of Community-Based Capacity

Seniors and other Albertans living with disability and chronic conditions deserve the best care and support possible, and to live with dignity and respect. Since March 2010, 5,623 net new continuing care beds have been added to the system. Continued growth in community and home care capacity is the key to efficient system flow in emergency departments, acute care and community; it also allows patients to receive the most appropriate care in the most appropriate setting by the most appropriate care provider.

As of…	Long-Term Care (LTC)	Supportive Living (SL)	Total Continuing Care	Net New LTC & SL Beds	Net New Palliative Beds	Total Net New Continuing Care Beds
March 2010	14,429	5,089	19,518			
March 2011	14,569	6,104	20,673	1,155		**1,155**
March 2012	14,734	6,941	21,675	1,002		**1,002**
March 2013	14,553	7,979	22,532	857	20	**877**
March 2014	14,370	8,497	22,867	335		**335**
March 2015	14,523	9,219	23,742	875	6	**881**
March 2016	14,768	9,936	24,704	962	35	**997**
March 2017	14,745	10,335	25,080	376		**376**
Total Net New Beds	**316**	**5,246**	**5,562**	**5,562**	**61**	**5,623**

Number of Continuing Care Facilities by Provider

As of March 31, 2017, there were 25,080 Designated Long Term Care (LTC) and Designated Supportive Living (SL) spaces staffed and in operation in the province in over 300 facilities. These facilities encompass AHS, AHS subsidiaries (Carewest and CapitalCare), voluntary (non-profit includes Covenant, Good Samaritan, etc.), private (Extendicare, Agecare, etc.) and Regional Health Authority (RHA) ownership. AHS will continue to improve the system and access to care and supports in the community. Collaboration with our valued service providers is integral to this effort.

Continuing Care Facilities by Operator	Number of Facilities as of March 31, 2017								
	LTC (Facilities)	LTC (Spaces)	SL (Facilities)	SL (Spaces)	Campus of Care (Facilities)	Campus of Care (LTC Spaces)	Campus of Care (SL Spaces)	Total Facilities	Total Spaces
AHS Operated / Subsidiaries	81	4,386	11	397	3	236	87	95	5,106
Private	38	4,803	80	4,721	9	584	907	127	11,015
Voluntary (non-profit)	31	3,787	65	3,745	11	839	478	107	8,849
Prairie North RHA - Lloydminster	2	110	0	0	0	0	0	2	110
Total	**152**	**13,086**	**156**	**8,863**	**23**	**1,659**	**1,472**	**331**	**25,080**

Zone Overview of Bed Numbers

Summary of Bed Numbers by Zone

Number of Beds/Spaces as of March 31, 2017	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
Hospital & Sub-Acute Care						
Hospital Acute Care	543	2,156	935	2,396	835	6,865
Psychiatric in Acute Care	72	277	50	212	34	645
Neonatal Intensive Care (NICU Level II and III)	23	126	17	130	10	306
Intensive Care (includes ICU, SCU, CCU, CVICU and PICU)	24	136	21	189	14	384
Sub-acute in Acute Care	9	32	32	22	0	95
Palliative beds in acute care	10	29	49	23	24	135
HOSPITAL ACUTE CARE SUBTOTAL	**681**	**2,756**	**1,104**	**2,972**	**917**	**8,430**
Sub-acute in Auxiliary Hospital (includes transition, rehab, community support beds, etc.)*	24	280	0	168	38	510
TOTAL HOSPITAL ACUTE AND SUB-ACUTE CARE	**705**	**3,036**	**1,104**	**3,140**	**955**	**8,940**
Continuing Care						
Auxiliary Hospital	248	1,072	1,413	2,234	639	5,606
Nursing Home	601	4,286	891	2,747	614	9,139
Long-Term Care (LTC) Subtotal	**849**	**5,358**	**2,304**	**4,981**	**1,253**	**14,745**
Supportive Living Level 4 - Dementia	513	678	401	1,118	194	2,904
Supportive Living Level 4	1,023	1,555	811	2,131	394	5,914
Supportive Living Level 3	299	233	395	392	198	1,517
Supportive Living (SL) Subtotal	**1,835**	**2,466**	**1,607**	**3,641**	**786**	**10,335**
LONG-TERM CARE & SUPPORTIVE LIVING SUBTOTAL	**2,684**	**7,824**	**3,911**	**8,622**	**2,039**	**25,080**
Community Palliative and Hospice (out of hospital) PEOLC	20	121	10	79	13	243
TOTAL CONTINUING CARE (includes LTC, SL and PEOLC)	**2,704**	**7,945**	**3,921**	**8,701**	**2,052**	**25,323**
Addiction and Mental Health						
Psychiatric (standalone facilities)	0	141	330	484	0	955
Addiction Treatment	74	296	66	389	143	968
Community Mental Health	37	418	31	245	5	736
TOTAL ADDICTION & MENTAL HEALTH	**111**	**855**	**427**	**1,118**	**148**	**2,659**
Alberta Total	**3,520**	**11,836**	**5,452**	**12,959**	**3,155**	**36,922**

* This includes restorative beds located in long-term care. Restorative beds are reported where they are located (auxiliary hospital, nursing home and supportive living).

SOUTH ZONE: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Bassano Health Centre	X	Bassano				4			8		12		
Crowsnest Pass Health Centre	X	Blairmore				16			58		74		
York Creek Lodge		Blairmore								20	20		
Bow Island Health Centre	X	Bow Island				10			20		30		
Pleasant View Lodge		Bow Island								20	20		
Brooks Health Centre	X	Brooks				37			15		52		
Orchard Manor		Brooks								25	25		
Sunrise Gardens		Brooks								84	84		
Cardston Health Centre	X	Cardston				19			12		31		
Chinook Lodge		Cardston								20	20		
Good Samaritan Lee Crest		Cardston								95	95		
Coaldale Health Centre	X	Coaldale				OP			44		44		
Sunny South Lodge		Coaldale								45	45		
Extendicare Fort Macleod		Fort Macleod							50		50		
Foothills Detox Centre		Fort Macleod	14								14		
Fort Macleod Health Centre	X	Fort Macleod				4					4		
Chinook Regional Hospital	X	Lethbridge				288					288		
Jack Ady Cancer Centre	X	Lethbridge	Co-located on same campus as Chinook Regional Hospital									Ca	
CMHA Crisis Beds		Lethbridge		5							5		
CMHA Laura House		Lethbridge		7							7		
Columbia Assisted Living		Lethbridge								50	50		
Edith Cavell Care Centre		Lethbridge							120		120		
Extendicare Fairmont Park		Lethbridge								140	140		
Golden Acres Lodge		Lethbridge								45	45		
Good Samaritan Park Meadows Village		Lethbridge								121	121		
Good Samaritan West Highlands		Lethbridge								100	100		
Legacy Lodge		Lethbridge								104	104		
SASHA Group Homes		Lethbridge		25							25		
South Country Treatment Centre		Lethbridge	21								21		
Southern Alcare Manor		Lethbridge	13								13		
St Michael's Health Centre		Lethbridge					24	10	72	72	178		
St. Therese Villa		Lethbridge								200	200		
Youth Residential Services	X	Lethbridge	8								8		

South Zone: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Good Samaritan Garden Vista		Magrath								35	35		
Magrath Health Centre	X	Magrath											CACC
Club Sierra		Medicine Hat							50	36	86		
Cypress View		Medicine Hat								45	45		
Good Samaritan South Ridge Village		Medicine Hat							80	48	128		
Leisure Way		Medicine Hat								17	17		
Meadow Lands		Medicine Hat								10	10		
Meadow Ridge Seniors Village		Medicine Hat								84	84		
Medicine Hat Recovery Centre	X	Medicine Hat	18								1		
Medicine Hat Regional Hospital	X	Medicine Hat				246					246		
Margery E. Yuill Cancer Centre	X	Medicine Hat	Co-located same campus Medicine Hat Regional Hospital									Ca	
Riverview Care Centre		Medicine Hat							118		118		
St. Joseph's Home		Medicine Hat						10		10	20		
Sunnyside Care Centre		Medicine Hat							100	24	124		
The Wellington Retirement Residence		Medicine Hat								50	50		
Valleyview		Medicine Hat							30	5	35		
Milk River Health Centre	X	Milk River				ED			24		24		
Prairie Rose Lodge		Milk River								10	10		
Big Country Hospital	X	Oyen				10			30		40		
Piyami Health Centre	X	Picture Butte											CACC
Piyami Lodge		Picture Butte								20	20		
Piyami Place		Picture Butte								15	15		
Good Samaritan Vista Village		Pincher Creek								75	75		
Pincher Creek Health Centre	X	Pincher Creek				16			3		19		
Good Samaritan Prairie Ridge		Raymond								85	85		
Raymond Health Centre	X	Raymond				12			5		17		
Clearview Lodge		Taber								20	20		
Good Samaritan Linden View		Taber								105	105		
Taber Health Centre	X	Taber				19			10		29		
Total South Zone			**74**	**37**	**0**	**681**	**24**	**20**	**849**	**1,835**	**3,520**		

Calgary Zone: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Airdrie Regional Community Health Centre	X	Airdrie											UCC
Bethany Airdrie		Airdrie							74		74		
Mineral Springs Hospital		Banff				22			25		47		
Oilfields General Hospital	X	Black Diamond				15			30		45		
Agape Hospice		Calgary						20			20		
Alberta Children's Hospital	X	Calgary				141					141		
Alpha House		Calgary	40								40		
Approved Homes - Mental Health		Calgary		117							117		
Aspen Family and Community Network		Calgary	3	3							6		
Aventa Addiction Treatment for Women		Calgary	48								48		
Bethany Calgary		Calgary							446		446		
Bethany Harvest Hills		Calgary							60		60		
Beverly Centre Glenmore		Calgary							208		208		
Beverly Centre Lake Midnapore		Calgary							270		270		
Bow Crest Care Centre		Calgary							150		150		
Bow View Manor		Calgary							231		231		
Calgary Community Rehab Program		Calgary		6							6		
Canadian Mental Health Association		Calgary		123							123		
Calgary Homeless Foundation		Calgary		26							26		
Canadian Mental Health Association (Hamilton House)		Calgary		8							8		
Canadian Mental Health Association (Robert's House)		Calgary		9							9		
Carewest Colonel Belcher	X	Calgary							175	30	205		
Carewest Dr. Vernon Fanning Centre	X	Calgary					98		191		289		
Carewest Garrison Green	X	Calgary							200		200		
Carewest George Boyack	X	Calgary							221		221		
Carewest Glenmore Park	X	Calgary					147				147		
Carewest Nickle House	X	Calgary								10	10		
Carewest Rouleau Manor	X	Calgary							77		77		
Carewest Royal Park	X	Calgary							50		50		
Carewest Sarcee	X	Calgary					35	15	85		135		
Carewest Signal Pointe	X	Calgary							54		54		
Centre of Hope - Salvation Army		Calgary	30								30		
Clifton Manor		Calgary							250		250		
Community Living Alternative Services Ltd.		Calgary		1							1		

Calgary Zone: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Community Living Alternatives for the Mentally Disabled Association (Community LAMDA)		Calgary		62							62		
East Calgary Health Centre	X	Calgary											FCC
Eau Claire Retirement Residence		Calgary								73	73		
Edgemont Retirement Residence		Calgary								31	31		
Enviros Wilderness School Association		Calgary	10								10		
Evanston Grand Village		Calgary								102	102		
Extendicare Cedars Villa		Calgary							248		248		
Extendicare Hillcrest		Calgary							112		112		
Father Lacombe Care Centre		Calgary							114		114		
Foothills Medical Centre	X	Calgary				1081					1081		
Fresh Start Recovery Centre		Calgary	1								1		
Glamorgan Care Centre		Calgary							52		52		
Holy Cross Manor		Calgary								100	100		
Hull Homes Detox/PChaD		Calgary	15								15		
Retirement Concepts Millrise		Calgary							51		51		
Intercare Brentwood Care Centre		Calgary							224		224		
Intercare Chinook Care Centre		Calgary						14	220		234		
Intercare Southwood Care Centre		Calgary						24	231		255		
Kerby Centre		Calgary		10							10		
Kingsland Terrace		Calgary								24	24		
Mayfair Care Centre		Calgary							142		142		
McKenzie Towne Continuing Care Centre		Calgary							150		150		
McKenzie Towne Retirement Residence		Calgary								42	42		
Millrise Place		Calgary								40	40		
Monterey Place		Calgary								107	107		
Mount Royal Care Centre		Calgary							93		93		
Newport Harbour Care Centre		Calgary							127		127		
Oxford House		Calgary	23								23		
Personal Care Homes - Continuing Care		Calgary								223	223		
Peter Lougheed Centre	X	Calgary				509					509		
Prince of Peace Harbour		Calgary								32	32		
Prince of Peace Manor		Calgary								30	30		
Providence Care Centre		Calgary							94	56	150		
Recovery Acres		Calgary	13								13		

Calgary Zone: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Renfrew Recovery Centre	X	Calgary	40								40		
Richmond Road Diagnostic & Treatment Centre	X	Calgary				OP							
Rocky Ridge Retirement Community		Calgary								29	29		
Rockyview General Hospital	X	Calgary				605					605		
Rosedale Hospice		Calgary						7			7		
Rotary Flames House	X	Calgary						7			7		
Sage Hill Retirement Residence		Calgary								72	72		
Scenic Acres Retirement Residence		Calgary								26	26		
SCOPE Hunterview House		Calgary		1							1		
Seton Seniors Community		Calgary							59	252	311		
Sheldon M. Chumir Health Centre	X	Calgary											UCC
South Calgary Health Centre	X	Calgary											UCC
South Health Campus	X	Calgary				272					272		
Southern Alberta Foresenic Psychiatric Centre	X	Calgary			33						33		
St. Marguerite Manor		Calgary						26		102	128		
Sunridge Medical Gallery	X	Calgary											CACC
Sunrise Native Addiction Services Society		Calgary	24								24		
Swan Evergreen		Calgary								48	48		
Trinity Foundation		Calgary		30							30		
Tom Baker Cancer Centre	X	Calgary										Ca	
Walden Heights Seniors Community		Calgary							58	234	292		
Wentworth Manor/The Residence and The Court		Calgary							73	57	130		
Whitehorn Village		Calgary								53	53		
Wing Kei Care Centre		Calgary							145		145		
Wing Kei Greenview		Calgary								95	95		
Woods Homes		Calgary		22							22		
Youville Women's Residence		Calgary	1								1		
Canmore General Hospital	X	Canmore				21			23		44		
Bow Valley Community Cancer Centre	X	Canmore	Co-located on same campus as Canmore General Hospital									Ca	
Claresholm Centre for Mental Health and Addictions	X	Claresholm			108						108		
Claresholm General Hospital	X	Claresholm				16					16		
Lander Treatment Centre	X	Claresholm	48								48		
Willow Creek Continuing Care Centre	X	Claresholm							100		100		
Bethany Cochrane		Cochrane							78		78		

Calgary Zone: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Cochrane Community Health Centre	X	Cochrane											UCC
Aspen Ridge Lodge		Didsbury								30	30		
Bethany Didsbury		Didsbury								100	100		
Didsbury District Health Services	X	Didsbury				16			21		37		
High River General Hospital	X	High River				27			50		77		
High River Community Cancer Centre	X	High River	Co-located on same campus as High River General Hospital									Ca	
Sunrise Village High River		High River								108	108		
Silver Willow Lodge		Nanton								38	38		
Foothills Country Hospice		Okotoks						8			8		
Okotoks Health and Wellness Centre	X	Okotoks											UCC
Revera Heartland		Okotoks								40	40		
Strafford Foundation Tudor Manor		Okotoks								152	152		
Agecare Sagewood Seniors Community		Strathmore							35	130	165		
Strathmore District Health Services	X	Strathmore				23					23		
Extendicare Vulcan		Vulcan							46		46		
Vulcan Community Health Centre	X	Vulcan				8			15		23		
Total Calgary Zone			**296**	**418**	**141**	**2,756**	**280**	**121**	**5,358**	**2,466**	**11,836**		

Central Zone: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Bashaw Care Centre	X	Bashaw											CACC
Bashaw Meadows		Bashaw								30	30		
Bentley Care Centre	X	Bentley							16		16		
Slim Thorpe Recovery Centre		Blackfoot	6								6		
Breton Health Centre	X	Breton							23		23		
Bethany Meadows		Camrose							65	30	95		
Faith House		Camrose								20	20		
Louise Jensen Care Centre		Camrose							65		65		
Memory Lane		Camrose								25	25		
Rosehaven Care Centre		Camrose							75		75		
St Mary's Hospital		Camrose				76					76		
St Mary's Hospital		Camrose	Co-located on same campus as St. Mary's Hospital									Ca	
Sunrise Village Camrose		Camrose								82	82		
Viewpoint		Camrose								20	20		
Our Lady of the Rosary Hospital		Castor				5			22		27		
Consort Hospital and Care Centre	X	Consort				5			15		20		
Coronation Hospital and Care Centre	X	Coronation				10			23	19	52		
Daysland Health Centre	X	Daysland				26					26		
Providence Place		Daysland								16	16		
Drayton Valley Hospital and Care Centre	X	Drayton Valley				36			50		86		
Drayton Valley Community Cancer Centre	X	Drayton Valley	Co-located on same campus as Drayton Valley Hospital and Care Centre									Ca	
Serenity House	X	Drayton Valley								12	12		
Sunrise Village Drayton Valley		Drayton Valley								16	16		
Drumheller Health Centre	X	Drumheller				37			96		133		
Drumheller Community Cancer Centre	X	Drumheller	Co-located on same campus as Drumheller Health Centre									Ca	
Grace House		Drumheller	5								5		
Hillview Lodge		Drumheller								36	36		
Eckville Manor House		Eckville								15	15		
Galahad Care Centre	X	Galahad							20		20		
Hanna Health Centre	X	Hanna				17			61		78		
Hardisty Health Centre	X	Hardisty				5			15		20		
Innisfail Health Centre	X	Innisfail				28			78		106		
Sunset Manor		Innisfail								102	102		
Islay Assisted Living	X	Islay								20	20		

Central Zone: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Killam Health Care Centre		Killam				5			45		50		
Royal Oak Manor		Lacombe								111	111		
Lacombe Hospital and Care Centre	X	Lacombe				35			75		110		
Lamont Health Care Centre		Lamont				15			105		120		
Westview Care Community		Linden							37		37		
Points West Living Lloydminster		Lloydminster								60	60		
Dr Cooke Extended Care Centre		Lloydminster							50		50		
Lloydminster Continuing Care Centre		Lloydminster							60		60		
Lloydminster Hospital		Lloydminster (Sask)				39					39		
Lloydminster Hospital		Lloydminster (Sask)	Co-located on same campus as Lloydminster Hospital									Ca	
Mannville Care Centre	X	Mannville							23		23		
Mary Immaculate Hospital		Mundare							30		30		
Eagle View Lodge		Myrnam								9	9		
Enviros Wilderness School (Shunda Creek)		Nordegg	10								10		
Olds Hospital and Care Centre	X	Olds				33			50		83		
Sunrise Encore Olds		Olds								60	60		
Sunrise Village Olds		Olds								20	20		
Centennial Centre for Mental Health & Brain Injury	X	Ponoka			330						330		
Northcott Care Centre (Ponoka)		Ponoka							73		73		
Ponoka Hospital and Care Centre	X	Ponoka				29			28		57		
Sunrise Village Ponoka		Ponoka								20	20		
Provost Health Centre	X	Provost				15			47		62		
Addiction Counselling & Prevention Services	X	Red Deer	5								5		
Bethany CollegeSide (Red Deer)		Red Deer							112		112		
Extendicare Michener Hill		Red Deer							220	60	280		
Kentwood Place	X	Red Deer		25							25		
Pines Lodge		Red Deer								20	20		
Points West Living Red Deer		Red Deer								114	114		
Red Deer Hospice		Red Deer						10			10		
Red Deer Regional Hospital Centre	X	Red Deer				370					370		
Central Alberta Cancer Centre	X	Red Deer	Co-located on same campus as Red Deer Regional Hospital									Ca	
Safe Harbour Society		Red Deer	40								40		
Villa Marie		Red Deer								100	100		

Central Zone: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
West Park Lodge		Red Deer								36	36		
Rimbey Hospital and Care Centre	X	Rimbey				23			84		107		
Clearwater Centre		Rocky Mtn House							40	39	79		
Park Avenue at Creekside		Rocky Mtn House								40	40		
Rocky Mountain House Health Centre	X	Rocky Mtn House				31					31		
Stettler Hospital and Care Centre	X	Stettler				26			50		76		
Points West Living Stettler		Stettler								88	88		
Sundre Hospital and Care Centre	X	Sundre				14			9		23		
Sundre Seniors Supportive Living		Sundre								40	40		
Bethany Sylvan Lake		Sylvan Lake							40	21	61		
Sylvan Lake Community Health Centre	X	Sylvan Lake											CACC
Chateau Three Hills		Three Hills								15	15		
Three Hills Health Centre	X	Three Hills				21			24		45		
Tofield Health Centre	X	Tofield				16			50		66		
St. Mary's Health Care Centre		Trochu							28		28		
Two Hills Health Centre	X	Two Hills				27			56		83		
Heritage House		Vegreville								42	42		
Points West Living Century Park		Vegreville								40	40		
St Joseph's General Hospital		Vegreville				25					25		
Vegreville Care Centre	X	Vegreville							60		60		
Vegreville Manor		Vegreville								15	15		
Vermilion Health Centre	X	Vermilion				25			48		73		
Vermilion Valley Lodge		Vermilion								40	40		
Extendicare Viking		Viking							60		60		
Viking Health Centre	X	Viking				16					16		
Points West Living Wainwright		Wainwright								59	59		
Wainwright Health Centre	X	Wainwright				25			69		94		
Good Samaritan Good Shepherd Lutheran Home		Wetaskiwin								69	69		
Sunrise Village Wetaskiwin		Wetaskiwin								20	20		
Wetaskiwin Hospital and Care Centre	X	Wetaskiwin				69			107		176		
Wetaskiwin Meadows		Wetaskiwin								26	26		
Wetaskiwin Serenity House (Bosco)		Wetaskiwin		6							6		
Total Central Zone			**66**	**31**	**330**	**1,104**	**0**	**10**	**2,304**	**1,607**	**5,452**		

EDMONTON ZONE: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Kipohtakawmik Elders Lodge		Alexander Reserve								13	13		
Chateau Vitaline		Beaumont								46	46		
Devon General Hospital	X	Devon				10			14		24		
Addiction Recovery Centre	X	Edmonton	42								42		
Alberta Hospital Edmonton	X	Edmonton			334						334		
Allen Gray Continuing Care Centre		Edmonton							156		156		
Allendale House		Edmonton		10							10		
Ambrose Place		Edmonton		42							42		
Anderson Hall	X	Edmonton		16							16		
Aspire Homes	X	Edmonton		10							10		
Balwin Villa (Excel Society)		Edmonton								104	104		
CapitalCare Dickinsfield	X	Edmonton							275		275		
CapitalCare Dickinsfield Duplexes	X	Edmonton								14	14		
CapitalCare Grandview	X	Edmonton					34		147		181		
CapitalCare Kipnes Centre for Veterans	X	Edmonton							120		120		
CapitalCare Laurier House Lynnwood	X	Edmonton								80	80		
CapitalCare Lynnwood	X	Edmonton							284		284		
CapitalCare McConnell Place North	X	Edmonton								36	36		
CapitalCare McConnell Place West	X	Edmonton								36	36		
CapitalCare Norwood	X	Edmonton					114	23	68		205		
Churchill Retirement Community		Edmonton								35	35		
Cross Cancer Institute	X	Edmonton				55					55	Ca	
Devonshire Care Centre		Edmonton							132		132		
Devonshire Manor		Edmonton								59	59		
Donnelly House		Edmonton		8							8		
Diverse City Housing		Edmonton		15							15		
E4C Meadows Place		Edmonton		16							16		
E4C Inner Ways		Edmonton		10							10		
E4C Our Place		Edmonton		10							10		
East Edmonton Health Centre	X	Edmonton											FCC
Edmonton Chinatown Care Centre		Edmonton							80	15	95		
Edmonton General Continuing Care Centre		Edmonton					20	26	449		495		
Edmonton People in Need #2 (SCH)		Edmonton								34	34		
Edmonton People In Need Batoma House		Edmonton								85	85		
Emmanuel Home		Edmonton								15	15		
Extendicare Eaux Claires		Edmonton							180		180		

Edmonton Zone: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Extendicare Holyrood		Edmonton							74		74		
Garneau Hall		Edmonton								37	37		
George Spady Centre Society		Edmonton	73								73		
Glastonbury Village		Edmonton								49	49		
Glenrose Rehabilitation Hospital	X	Edmonton				244					244		
Good Sam. Dr. Gerald Zetter Care Centre		Edmonton							200		200		
Good Samaritan Millwoods Care Centre		Edmonton							60		60		
Good Samaritan Southgate Care Centre		Edmonton							226		226		
Good Samaritan Wedman House		Edmonton								30	30		
Good Samaritan Wedman Village Homes		Edmonton								30	30		
Grand Manor		Edmonton								102	102		
Grey Nuns Community Hospital		Edmonton				354					354		
Hardisty Care Centre		Edmonton							175		175		
Health First Strathcona	X	Edmonton											UCC
Henwood Treatment Centre	X	Edmonton	72								72		
House Next Door #1, 2, 3		Edmonton		24							24		
Innovative Housing – Spucewood Place		Edmonton								93	93		
Innovative Housing - Villa Marguerite		Edmonton								242	242		
Jasper Place Continuing Care Centre		Edmonton							100		100		
Jellinek House		Edmonton	15								15		
Jubilee Lodge Nursing Home		Edmonton							154		154		
Laurel Heights		Edmonton								70	70		
Lewis Estates Retirement Residence		Edmonton								87	87		
Lifestyle Options Riverbend		Edmonton								18	18		
Lifestyle Options Terra Losa		Edmonton								77	77		
Lifestyle Options Whitemud		Edmonton								77	77		
McDougall House		Edmonton	11								11		
Miller Crossing Care Centre		Edmonton							155		155		
Misericordia Community Hospital		Edmonton				309					309		
Northeast Community Health Centre	X	Edmonton				ED							
Ottewell Lodge		Edmonton		38							38		
Our House		Edmonton	70								70		
Our Parents' Home		Edmonton								50	50		
Recovery Acres Edmonton		Edmonton	34								34		

Edmonton Zone: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Riverbend Retirement Residence		Edmonton								38	38		
Rosedale at Griesbach		Edmonton								165	165		
Rosedale Estates		Edmonton								50	50		
Royal Alexandra Hospital	X	Edmonton				858					858		
Rutherford Heights Retirement Residence		Edmonton								89	89		
Saint Thomas Assisted Living Centre		Edmonton								138	138		
Salvation Army Grace Manor		Edmonton								87	87		
Salvation Army Stepping Stone Supportive Residence		Edmonton								50	50		
Shepherd's Care Ashbourne		Edmonton								0	0		
Shepherd's Care Greenfield		Edmonton								30	30		
Shepherd's Care Kensington		Edmonton							69	86	155		
Shepherd's Care Millwoods		Edmonton							147		147		
Shepherd's Care Vanguard		Edmonton								93	93		
Shepherd's Garden		Edmonton								45	45		
South Terrace Continuing Care Centre		Edmonton							107		107		
St. Joseph's Auxiliary Hospital		Edmonton						14	188		202		
St. Michael's Long Term Care Centre		Edmonton							153		153		
Stollery Children's Hospital	X	Edmonton				155					155		
Touchmark at Wedgewood		Edmonton							64		64		
Tuoi Hac - Golden Age Manor		Edmonton								91	91		
University of Alberta Hospital	X	Edmonton				691					691		
Venta Care Centre		Edmonton							148		148		
Villa Caritas		Edmonton			150						150		
Wild Rose Cottage		Edmonton								27	27		
Youth Stabilization & Residential Services	X	Edmonton	21								21		
Good Samaritan Society Pembina Village		Evansburg							40		40		
Fort Saskatchewan Health Centre	X	Fort Saskatchewan				36					36		
Rivercrest Care Centre		Fort Saskatchewan							85		85		
Extendicare Leduc		Leduc							79		79		
Leduc Community Hospital	X	Leduc				74					74		
Lifestyle Options Leduc		Leduc								74	74		
Salem Manor Nursing Home		Leduc							102		102		

Edmonton Zone: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Aspen House	X	Morinville								74	74		
CapitalCare Strathcona	X	Sherwood							111		111		
CapitalCare Laurier House Strathcona	X	Sherwood								42	42		
CASA House		Sherwood		20							20		
Country Cottage Seniors Residence		Sherwood								26	26		
Sherwood Care		Sherwood							100		100		
Strathacona Community Hospital	X	Sherwood				ED							
Summerwood Village Retirement Residence		Sherwood								79	79		
Copper Sky Lodge		Spruce								131	131		
Good Samaritan Spruce Grove Centre		Spruce								30	30		
Citadel Care Centre		St. Albert							129		129		
Foyer Lacombe		St. Albert						10	12		22		
Citadel Mews West		St. Albert								67	67		
Poundmaker's Lodge Treatment Centre - Youth Addiction (Safe-Com)		St. Albert	51								51		
Rosedale St Albert		St. Albert								70	70		
St. Albert Retirement Residence		St. Albert								92	92		
Sturgeon Community Hospital	X	St. Albert				163					163		
Youville Auxiliary Hospital (Grey Nuns) of St. Albert		St. Albert							232		232		
Good Samaritan George Hennig Place		Stony Plain								30	30		
Good Samaritan Stony Plain Care Centre		Stony Plain							126	30	156		
WestView Health Centre - Stony Plain Care Centre	X	Stony Plain				23		6	40		69		
Family Care Homes		Various								2	2		
Approved Mental Health Care Homes		Various		26							26		
Personal Care Homes		Various								247	247		
Special Care Homes		Various								92	92		
West Country Hearth		Villeneuve								32	32		
Total Edmonton Zone			**389**	**245**	**484**	**2,972**	**168**	**79**	**4,981**	**3,641**	**12,959**		

North Zone: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Athabasca Healthcare Centre	X	Athabasca				27			23		50		
Extendicare Athabasca		Athabasca							50		50		
Barrhead Healthcare Centre	X	Barrhead				34					34		
Barrhead Community Cancer Centre	X	Barrhead	Co-located on same campus as Barrhead Healthcare Centre									Ca	
Dr. W.R. Keir - Barrhead Continuing Care Centre	X	Barrhead							100		100		
Mental Health Spaces		Barrhead											
Shepherd's Care Barrhead		Barrhead								42	42		
Beaverlodge Municipal Hospital	X	Beaverlodge				18					18		
Bonnyville Healthcare Centre		Bonnyville				33			30		63		
Bonnyville Community Cancer Centre		Bonnyville	Co-located same campus as Bonnyville Healthcare Centre									Ca	
Bonnyville Indian Metis Rehab Centre		Bonnyville	20								20		
Extendicare Bonnyville		Bonnyville							50		50		
Boyle Healthcare Centre	X	Boyle				20					20		
Cold Lake Healthcare Centre	X	Cold Lake				24			31		55		
Points West Living Cold Lake		Cold Lake								42	42		
Ridgevalley Seniors Home		Crooked Creek								15	15		
Wabasca/Desmarais Healthcare Centre	X	Desmarais				10					10		
Edson Healthcare Centre	X	Edson				22			38	38	98		
Parkland Lodge		Edson								10	10		
Elk Point Healthcare Centre	X	Elk Point				12			30		42		
Elk Point Heritage Lodge		Elk Point								10	10		
Fairview Health Complex	X	Fairview				25		1	66		92		
Fort McMurray Recovery Centre	X	Fort McMurray	16								16		
Northern Lights Regional Health Centre	X	Fort McMurray				105			31		136	Ca	
Pastew Place Detox Centre		Fort McMurray	11								11		
St. Theresa General Hospital	X	Fort Vermilion				26			8		34		
Fox Creek Healthcare Centre	X	Fox Creek				4					4		
Grande Cache Community Health Complex	X	Grande Cache				12					12		
Whispering Pines Seniors Lodge		Grande Cache								15	15		
Grande Prairie Care Centre		Grande Prairie							60	60	120		
Northern Addiction Centre	X	Grande Prairie	63								63		
Points West Living Grand Prairie		Grande Prairie						10	50	95	155		
Queen Elizabeth II Hospital	X	Grande Prairie				161	30			27	218		
Grande Prairie Care Centre	X	Grande Prairie	Co located same campus as QEII Hospital									Ca	

North Zone Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
The Gardens at Emerald Park		Grande Prairie								15	15		
Youth Detoxification Services	X	Grande Prairie	4								4		
Grimshaw/Berwyn and District Community Health Centre	X	Grimshaw				ED		1	19		20		
Stone Brook		Grimshaw								56	56		
Action North Recovery Centre		High Level	13								13		
Northwest Health Centre	X	High Level				21			11		32		
High Prairie Health Complex	X	High Prairie				25					25		
J.B. Wood Continuing Care Centre	X	High Prairie							37		37		
Metis Indian Town Alcohol Association (MITAA Centre)		High Prairie	16								16		
Hinton Healthcare Centre	X	Hinton				23					23		
Hinton Community Cancer Centre	X	Hinton	Co-located same campus as Hinton Healthcare Centre									Ca	
Mountain View Centre		Hinton								52	52		
Hythe Continuing Care Centre	X	Hythe							31		31		
Jasper Alpine Summit Seniors Lodge		Jasper								16	16		
Seton - Jasper Healthcare Centre	X	Jasper				11					11		
Heimstaed Lodge		La Crete								54	54		
La Crete Continuing Care Centre	X	La Crete						1	22		23		
La Crete Health Centre	X	La Crete											AACC
William J. Cadzow - Lac La Biche Healthcare Centre	X	Lac La Biche				23			41		64		
Manning Community Health Centre	X	Manning				11			16		27		
Extendicare Mayerthorpe		Mayerthorpe							50		50		
Mayerthorpe Healthcare Centre	X	Mayerthorpe				25			30		55		
Pleasant View Lodge		Mayerthorpe								15	15		
Manoir du Lac		McLennan							22	35	57		
Sacred Heart Community Health Centre	X	McLennan				20					20		
Chateau Lac St. Anne		Onoway								15	15		
Peace River Community Health Centre	X	Peace River				31			40		71		
Peace River Community Cancer Centre	X	Peace River	Co-located same campus as Peace River Comm. Health Centre									Ca	
Points West Living Peace River		Peace River								42	42		
Radway Continuing Care Centre	X	Radway							30		30		
Rainbow Lake Health Centre		Rainbow Lake											CACC
Redwater Healthcare Centre	X	Redwater				14			7		21		
Points West Living Slave Lake		Slave Lake								45	45		

North Zone: Beds by Facility (refer to definitions page)

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Slave Lake Family Care Clinic	X	Slave Lake											FCC
Slave Lake Healthcare Centre	X	Slave Lake				24			20		44		
Vanderwell Lodge		Slave Lake								8	8		
George McDougall - Smoky Lake Healthcare Centre	X	Smoky Lake				12			23		35		
Smoky Lake Continuing Care Centre	X	Smoky Lake							28		28		
Central Peace Health Complex	X	Spirit River				12			16		28		
Extendicare St. Paul		St Paul							76		76		
St. Therese - St. Paul Healthcare Centre	X	St Paul				40			30		70		
St. Paul Abilities Network		St. Paul		5						6	11		
Swan Hills Healthcare Centre	X	Swan Hills				4					4		
Valleyview Health Centre	X	Valleyview				20			25		45		
Vilna Villa		Vilna								12	12		
Smithfield Lodge	X	Westlock								46	46		
Westlock Healthcare Centre	X	Westlock				46	8		112		166		
Spruce View Lodge		Whitecourt								15	15		
Whitecourt Healthcare Centre	X	Whitecourt				22					22		
Total North Zone			**143**	**5**	**0**	**917**	**38**	**13**	**1,253**	**786**	**3,155**		

Change in Bed Numbers by Zone from 2015-16 to 2016-17

ALBERTA HEALTH SERVICES — Updated as of May 16 2017

REPORTED BEDS STAFFED & IN OPERATION SUMMARY AS OF March 31, 2017

	Addiction and Mental Health			Acute Care			Continuing Care - Facility Living			Supportive Living						
Zone	Addiction	Community Mental Health	Psychiatric (Standalone Facility)	Acute Care	Sub-Acute (Non Acute Care Facility)	Community Palliative & End of Life Care (PEOLC)	Auxiliary Hospital	Nursing Home	LONG TERM CARE SUBTOTAL (auxiliary + nursing home)	Level 3 (includes mental health)	Level 4 (includes mental health)	Level 4 Dementia	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)	TOTAL CONTINUING CARE (LTC + SL)	TOTAL COMMUNITY BASED CARE (includes PEOLC)	Total Beds
South Zone	74	37	0	681	24	20	248	601	849	299	1,023	513	1,835	2,684	2,704	3,520
Calgary Zone	296	418	141	2,756	280	121	1,072	4,286	5,358	233	1,555	678	2,466	7,824	7,945	11,836
Central Zone	66	31	330	1,104	0	10	1,413	891	2,304	395	811	401	1,607	3,911	3,921	5,452
Edmonton Zone	389	245	484	2,972	168	79	2,234	2,747	4,981	392	2,131	1,118	3,641	8,622	8,701	12,959
North Zone	143	5	0	917	38	13	639	614	1,253	198	394	194	786	2,039	2,052	3,155
ALBERTA HEALTH SERVICES TOTAL:	**968**	**736**	**955**	**8,430**	**510**	**243**	**5,606**	**9,139**	**14,745**	**1,517**	**5,914**	**2,904**	**10,335**	**25,080**	**25,323**	**36,922**

REPORTED BEDS STAFFED & IN OPERATION SUMMARY AS OF March 31, 2016

	Addiction and Mental Health			Acute Care			Continuing Care - Facility Living			Supportive Living						
Zone	Addiction	Community Mental Health	Psychiatric (Standalone Facility)	Acute Care	Sub-Acute (Non Acute Care Facility)	Community Palliative & End of Life Care (PEOLC)	Auxiliary Hospital	Nursing Home	LONG TERM CARE SUBTOTAL (auxiliary + nursing home)	Level 3 (includes mental health)	Level 4	Level 4 Dementia*	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)	TOTAL CONTINUING CARE (LTC + SL)	TOTAL COMMUNITY BASED CARE (includes PEOLC)	Total Beds
South Zone	64	37	0	675	24	20	248	601	849	309	1,009	513	1,831	2,680	2,700	3,500
Calgary Zone	293	352	141	2,798	280	121	1,072	4,286	5,358	233	1,487	626	2,346	7,704	7,825	11,689
Central Zone	66	31	330	1,105	0	10	1,419	891	2,310	396	748	268	1,412	3,722	3,732	5,264
Edmonton Zone	389	200	484	2,984	168	79	2,232	2,754	4,986	402	2,111	1,086	3,599	8,585	8,664	12,889
North Zone	143	5	0	917	18	13	639	626	1,265	198	384	166	748	2,013	2,026	3,109
ALBERTA HEALTH SERVICES TOTAL:	**955**	**625**	**955**	**8,479**	**490**	**243**	**5,610**	**9,158**	**14,768**	**1,538**	**5,739**	**2,659**	**9,936**	**24,704**	**24,947**	**36,451**

Change from March 31, 2016 to March 31, 2017

	Addiction and Mental Health			Acute Care			Continuing Care - Facility Living			Supportive Living						
Zone	Addiction	Community Mental Health	Psychiatric (Standalone Facility)	Acute Care	Sub-Acute (Non Acute Care Facility)	Community Palliative & End of Life Care (PEOLC)	Auxiliary Hospital	Nursing Home	LONG TERM CARE SUBTOTAL	Level 3 (includes mental health)	Level 4	Level 4 Dementia	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)	TOTAL CONTINUING CARE (LTC + SL)	TOTAL COMMUNITY BASED CARE (includes PEOLC)	Total Beds
South Zone	10	0	0	6	0	0	0	0	0	-10	14	0	4	4	4	20
Calgary Zone	3	66	0	-42	0	0	0	0	0	0	68	52	120	120	120	147
Central Zone	0	0	0	-1	0	0	-6	0	-6	-1	63	133	195	189	189	188
Edmonton Zone	0	45	0	-12	0	0	2	-7	-5	-10	20	32	42	37	37	70
North Zone	0	0	0	0	20	0	0	-12	-12	0	10	28	38	26	26	46
ALBERTA HEALTH SERVICES TOTAL:	**13**	**111**	**-**	**(49)**	**20**	**-**	**(4)**	**(19)**	**(23)**	**(21)**	**175**	**245**	**399**	**376**	**376**	**471**

Our many thanks to the hundreds of people who contributed to the completion of AHS' 2016-17 Annual Report.