ALBERTA HEALTH SERVICES

Annual Report

2013-2014

Alberta Health Services

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LETTER OF ACCOUNTABILITY

I am pleased to present the Annual Report for Alberta Health Services for the fiscal year ended March 31, 2014.

The 12 months summarized in this report represent a period of transition in the governance and organizational structures of AHS. The AHS Board was dissolved, replaced by an Official Administrator; and the number of management levels reduced. This resulted in eliminating duplication and creating a clearer line of sight between front-line staff and management. As part of the new governance structure, the Official Administrator is supported by three governance advisory committees: the Audit and Finance advisory committee, the Human Resources advisory committee and the Quality Assurance and Patient Safety advisory committee. Equally important, the Alberta Quality Matrix of Health – with its four areas of need and six dimensions of quality – now guides everything we do. As a result, AHS is more keenly focused on patient needs and better positioned to deliver high-quality, patient-centred care for four million Albertans.

To achieve our goals, we are building a senior leadership team poised to guide our organization now and into the future.

Vickie Kaminski – who joined AHS as its President and Chief Executive Officer on May 26, 2014 – has demonstrated a values-driven commitment to health care during her career. Her personal belief system is aligned with the goals of our organization.

Ms. Kaminski is supported by a leadership team that stepped up in the months leading up to her arrival. I would like to personally thank Brenda Huband and Rick Trimp, who took on roles as interim presidents and CEOs, and enabled AHS to keep moving forward during a time of transition.

I'd also like to thank all of our staff, physicians and volunteers for their patience during our search for a permanent CEO and, most of all, for their commitment to health care in Alberta.

Finally, I'd like to thank former AHS President and CEO Dr. Chris Eagle for his long-term dedication to improving health care delivery in Alberta. Many of the accomplishments outlined in this Annual Report were initiated and achieved under his steady leadership.

This Annual Report was prepared under my direction, in accordance with the Fiscal Management Act, Regional Health Authorities Act and instructions as provided by Alberta Health. All material economic and fiscal implications known as of June 5, 2014, have been considered in preparing this Annual Report.

Respectfully submitted on behalf of the Official Administrator of AHS.

[Original Signed by]

Dr. John Cowell
Official Administrator

WELCOME TO THE 2013-14 ANNUAL REPORT

Many Albertans will remember 2013 as the year of the devastating floods that displaced and distressed hundreds of thousands of southern Albertans. When reviewing the accomplishments of AHS in the 2013-14 fiscal year, we need to start with this once-in-a-century natural disaster.

Staff, physicians and volunteers responded quickly and nimbly to the needs of southern Albertans as floodwaters put lives at risk and destroyed or damaged homes, buildings and infrastructure. With the help of foundations, as well as community and business partners, AHS established field hospitals and reception centres to ensure displaced Albertans received shelter, food, medical care and emotional support. Emergency Medical Services personnel provided medical care and helped to move Albertans to safety. Public health inspectors ensured home and business owners had the information they needed to get safely back on their feet. In short, when Albertans needed AHS, AHS was there.

Through it all, AHS still moved forward with its day-to-day business, which you can read about in this report. More Albertans than ever were vaccinated for seasonal influenza in 2013-14, and additional measles immunization clinics were established in communities where high numbers of confirmed cases were reported. AHS added significant new capacity with the opening of the South Health Campus in Calgary, and making radiation therapy available in Red Deer for the first time with the opening of the new Central Alberta Cancer Centre. You can also read stories that exemplify the caring, compassion, ingenuity and dedication demonstrated every day by the 104,900 men and women who serve Alberta's health system – stories about the six-year-old girl whose life was saved by a revolutionary cardiac procedure; or about a Calgary man who was able to once again spend quality time with his wife of 60 years thanks to new guidelines around administering behaviour-modifying dementia medications.

AHS now looks to the future, focused on our ongoing work of building a high-quality, patient-centred health system.

[Original Signed by]

Brenda Huband,
Interim President and Chief Executive Officer
for Zone and Health Operations

[Original Signed by]

Rick Trimp,
Interim President and Chief Executive Officer
for Population Health and Province-Wide Services

WHO WE ARE

We are skilled and dedicated health professionals, support staff, volunteers and physicians who promote wellness and provide health care everyday to more than four million adults and children living in Alberta, as well as to many residents of southwestern Saskatchewan, southeastern British Columbia and the Northwest Territories.

Alberta Health Services has more than 104,900 employees (excluding Covenant Health staff), including approximately 96,700 direct AHS employees and more than 8,200 staff working in AHS wholly-owned subsidiaries such as Carewest, CapitalCare Group and Calgary Laboratory Services, as well as 15,470 volunteers. Of the 8,800 physicians practising in Alberta, more than 7,500 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 universities and colleges outside of Alberta, receive clinical education in AHS facilities. Covenant Health works with AHS and is Canada's largest Catholic health care organization, with almost 15,000 staff, physicians, and volunteers in 12 communities.

We offer health care programs and services at more than 450 facilities across the province including hospitals, clinics, continuing care facilities, mental health facilities and community health sites. The province also has an extensive network of community-based services designed to help Albertans maintain or improve their health.

AHS is required to prepare and submit an Annual Report to the Minister of Health, in compliance with legislation, reporting how AHS has discharged its legislated responsibilities, and any other responsibility delegated by the Minister. The Annual Report is approved by the AHS Official Administrator and then submitted to the Minister who then tables the report in the Legislative Assembly.

All programs and facilities, whether owned and operated by AHS, non-profit organizations or private groups, are operated in compliance with specific sections of program legislation.

Under Section 5 of the **Regional Health Authorities Act**, AHS is required to:

i. promote and protect the health of the population in the health region and work toward the prevention of disease and injury,

ii. assess on an ongoing basis the health needs of the health region,

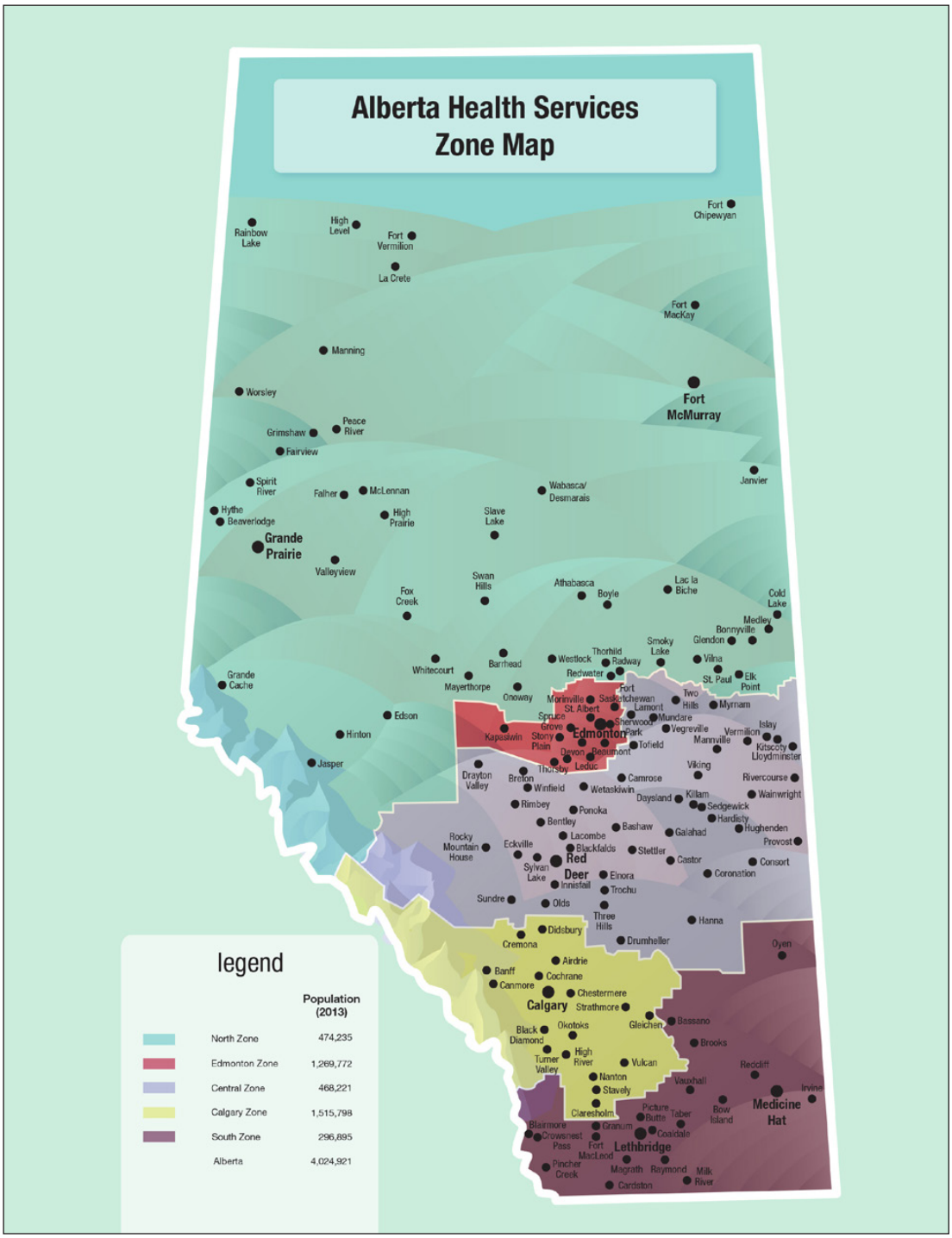
iii. determine priorities in the provision of health services in the health region and allocate resources accordingly,

iv. ensure that reasonable access to quality health services is provided in and through the health region and

v. 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.

ALBERTA HEALTH SERVICES MAP

AHS is organized by five zone geographic areas which are designed to better focus our attention on providing high quality health care to Albertans. Our zones — South, Calgary, Central, Edmonton and North — enable local decision-making and engagement with local communities, local staff members, and our patients and clients.



OUR MISSION AND STRATEGIC DIRECTIONS

The **Mission** of Alberta Health Services is to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

In collaboration with Alberta Health (AH), AHS identified strategic directions and goals that focus our work over the next three years. To support the AHS 2013-2016 Health Plan and Business Plan, AHS developed actions to achieve the goals outlined in the Health Plan. These strategic directions and goals are supported by priorities and actions which allow us to include them in every decision we make in our day-to-day operations. In addition, we measure how we are doing through performance measures.

Strategic Direction – Bringing Appropriate Care to the Community

AHS' goal is to build a strong, integrated community and primary health care foundation to deliver appropriate, accessible and seamless care.

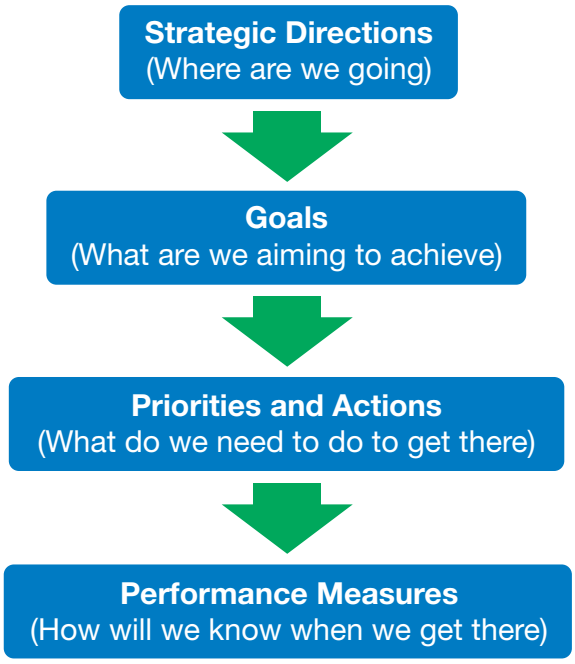
Strategic Direction – Partnering for Better Health Outcomes

AHS' goal is to actively engage Albertans as partners and provide them with the support they need to enhance control over the factors that affect their health and the health of their families.

AHS' goal is to advance the adoption of evidence-informed practices in the delivery of quality services across the continuum through partnerships with providers, academic institutions, physicians and others.

Strategic Direction – Achieving Health System Sustainability

AHS' goal is to continue to build a sustainable, quality health system that is patient-centred, driven by outcomes and informed by evidence.



VALUES

Our work is grounded in our **Values**. Our values make us who we are. They drive us and are the essence of our culture. Our values define what we believe in and what we stand for. They provide us with a common understanding of what is important and anchor our thinking. We use our values to lead our work, our actions and our decisions.

Respect	We demonstrate respect for one another, our patients, clients, communities and partners as we lead the evolution of health care.
Accountability	We display integrity; act honestly; and evaluate and improve the quality, safety and effectiveness of our services and the outcomes of our decisions. We use best practice to promote excellence, innovation and continuous improvement.
Transparency	We value open, honest and timely communication. We disclose information to learn from our mistakes; make available easy-to-understand information about system and financial performance; and clearly lay out our expectations and decision-making processes.
Engagement	We collaborate with patients and their families, health care providers, research and education institutions, government and communities, and involve them in meaningful ways in decision-making processes.
Safety	We actively promote the safety and wellness of our communities, clients and patients. We can only achieve long-term success if we promote the workplace safety and well-being of our staff, physicians and volunteers.
Learning	We seek the best information available and find ways to employ it in our daily work. Learning to be the best also means supporting and promoting the development of new knowledge.
Performance	We perform at our highest potential when every person in AHS has a clear and well-understood responsibility to improve their areas of performance every day.

PROVINCIAL QUICK FACTS

The numbers below provide a brief snapshot of Alberta Health Services' activity and demonstrate the growth in services provided in the last few years.

Alberta Health Services	2011-12	2012-13	2013-14	% Change 2012-13 to 2013-14
Primary Care / Population Health				
Home Care Clients (unique)	104,516	109,184	112,227	3%
Number of People Placed in Continuing Care	7,700	7,761	7,694	-1%
Health Link Calls	766,146	755,980	778,353	3%
EMS Calls / Events	393,964	416,160	461,813	11%
Number of Vaccinations Administered	875,984	919,348	1,157,550	26%
Public Health Inspections – All Programs[2]	148,301	160,793	175,122	9%
Food Safety Inspections	88,413	94,856	95,389	1%
Acute Care				
Emergency Department Visits (all sites)[1]	2,029,225	2,116,946	2,141,984	1%
Urgent Care Visits[1]	196,268	204,602	204,889	0%
Hospital Discharges[1]	376,118	385,536	397,766	2%
Births[1]	50,097	51,540	52,324	2%
Total Hospital Days[1]	2,602,408	2,640,537	2,670,682	1%
Average Length of Stay (in days)	6.9	6.8	6.8	0%
Diagnostic / Specific Procedures				
Total Hip Replacements (scheduled and emergency)	4,912	5,216	5,243	1%
Total Knee Replacements (scheduled and emergency)[1]	5,836	6,116	6,223	2%
Cataract Surgery	36,559	35,716	36,693	3%
Main Operating Room Activity[1]	266,603	268,380	274,552	2%
MRI exams[3]	166,645	176,705	190,024	8%
CT exams	334,614	344,667	365,181	6%
X-rays[3]	1,869,309	1,815,295	1,847,641	2%
Lab Tests[4]	65,407,292	68,571,727	70,926,262	3%
Cancer Care				
Cancer Patient Visits (patients may have multiple visits)	547,093	560,927	560,340	0%
Unique Cancer Patients	48,421	50,107	51,105	2%
Addiction & Mental Health				
Mental Health Hospital Discharges (acute care sites)[1]	19,278	19,955	20,977	5%
Community Treatment Orders (CTO) Issued[1]	204	271	359	32%
Addiction Residential Treatment & Detoxification Discharges[1]	9,848	10,056	9,957	-1%

[1] Number revised for previous years.

[2] Environmental Public Health delivers inspections and interventions in seven program areas (Safe Food, Safe Drinking Water, Safe Built Environments, Safe Indoor Air, Healthy Environments, Safe Recreational Water and Disease and Injury Control).

[3] MRI exam (in 2011-12) and X-ray (in 2012-13) count converted to new methodology from the Common Procedures Exam List (CPEL) to the Canadian Institute for Health Information (CIHI).

[4] Lab volumes include zones, genetics, Provincial Lab for Public Health (PLPH), and referred out.

CIHI INTERESTING FACTS

The Canadian Institute for Health Information (CIHI) is a not-for-profit organization that helps to improve the Canadian health system and the well-being of Canadians by being a leading source in the development and maintenance of comprehensive and integrated health information that enables health leaders to make better-informed decisions.

In May 2013, CIHI released its annual Health Indicators report. Alberta performed among the top two provinces in six of the 20 health system performance indicators for the most recent year of tracking (2010-11 or 2011-12, depending on the indicator).

Alberta is top performing (first) in Canada in:

- 30-Day Heart Attack In-Hospital Mortality
- 30-Day Stroke In-Hospital Mortality
- Patients with Repeat Hospitalizations for Mental Illness

Alberta ranks second on:

- 30-Day Readmission Rate for Pregnant Women and New Mothers Following Childbirth
- Self-Injury Hospitalization
- 30-Day Readmission for Mental Illness

The Hospital Standardized Mortality Ratio (HSMR) is a ratio that indicates how successful hospitals have been in reducing inpatient deaths – leading to improved patient care. In November 2013, CIHI released HSMR data for large acute care hospitals across Canada, including nine Alberta hospitals. In Alberta, HSMR improved from 88 in 2011-12 to 84 in 2012-13, well below the weighted national average of 100, and steady improvement has been seen over the past four years. Values less than 100 mean fewer than expected deaths in Alberta, a rate of 84 means 850 fewer deaths in hospital than expected each year.

In March 2014, CIHI released its Annual Report Wait Times for Priority Procedures in Canada. The report tracks the per cent of procedures performed within national benchmarks. In 2013, Alberta ranks second in:

- Per cent of hip fracture repairs performed within the 48-hour benchmark
- Per cent of radiation therapy performed within the four-week benchmark

AHS (including Covenant Health) is spending more on patient care and less on administration than any other province in Canada.

AHS (including Covenant Health) is spending more on patient care and less on administration than any other province in Canada. As calculated by CIHI in the May 2014 CIHI Financial Indicators report, for the 2012-13 fiscal year, Alberta was tied with British Columbia for lowest percentage of expenses spent on administration at 3.6 per cent.

BED NUMBERS

While the following chart illustrates that overall capacity has increased by almost one per cent, it is apparent that growth is not keeping pace with the population growth of three per cent. This is challenging throughout the system. Several long-term care beds were lost this year due to flooding and contract issues, but more than 500 supportive living beds were opened. A key objective in health care is to shift services from acute care hospitals and facility living to the community, bringing care closer to home for patients.

Number of Beds/Spaces as of:	March 31, 2013	March 31, 2014	Difference	% Change
Primary Care / Population Health				
Acute Care	8,226	8,311	85	1.0%
Sub-acute in Auxiliary Hospital	511	507	-4	-0.8%
TOTAL ACUTE & SUB-ACUTE CARE	**8,737**	**8,818**	**81**	**0.9%**
Continuing Care				
Auxiliary Hospital	5,617	5,527	-90	-1.6%
Nursing Home	8,936	8,843	-93	-1.0%
Subtotal Long-Term Care	**14,553**	**14,370**	**-183**	**-1.3%**
Supportive Living Level 3	1,552	1,565	13	0.8%
Supportive Living Level 4	4,576	4,889	313	6.8%
Supportive Living Level 4 - Dementia	1,851	2,043	192	10%
Subtotal Supportive Living	**7,979**	**8,497**	**518**	**6.5%**
SUBTOTAL LONG-TERM CARE & SUPPORTIVE LIVING	**22,532**	**22,867**	**335**	**1.5%**
Community Palliative and Hospice (outside a hospital)	202	202	0	0.0%
TOTAL CONTINUING CARE	**22,734**	**23,069**	**335**	**1.5%**
Addiction and Mental Health				
Psychiatric (standalone facilities)	987	967	-20	-2.0%
Addiction Treatment	855	855	0	0.0%
Community Mental Health	582	579	-3	-0.5%
TOTAL ADDICTION & MENTAL HEALTH	**2,424**	**2,401**	**-23**	**-0.9%**
ALBERTA TOTAL	**33,895**	**34,288**	**393**	**1.2%**

Notes:

The baseline bed numbers for March 31, 2013 have been revised due to previous incorrectly reported beds: acute care by four beds; continuing care by one bed; standalone psychiatric by nine beds; addiction by 45 beds and community mental health by 43 beds. The majority of these corrections are due to standardized provincial definitions as well as improved reporting and tracking of beds on a regular basis.

GOVERNANCE

In June 2013, the Minister of Health dismissed the members of the AHS Board and appointed an Official Administrator in place of the AHS Board. In accordance with Section 11 of the Regional Health Authorities Act, the Official Administrator has the responsibility 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 Official Administrator is accountable to the Minister of Health. In September 2013, Dr. John Cowell was appointed Official Administrator of AHS.

To support the role of the Official Administrator, the governance advisory committees specified below have been established to aid in governing AHS and overseeing the managment of AHS' business and affairs. The purpose and scope of each committee is in accordance with good governance practices and is consistent with the governing legislation of AHS.

- Audit and Finance Advisory Committee (AFAC)
- Human Resources Advisory Committee (HRAC)
- Quality Assurance and Patient Safety Advisory Committee (QAPSAC)

Below is a list of the current advisory committee members. The Official Administrator is a member of each advisory committee and the Chief Executive Officer is an *ex officio* member of each advisory committee.

AHS Advisory Committee Member	Committee Membership
Barbara Burton	HRAC
Dr. Tom Feasby	QAPSAC
Martin Harvey	HRAC
Gregory Henders	HRAC
Brian Olson	AFAC HRAC (Chair)
Don Sieben	AFAC (Chair)
Douglas Tupper	QAPSAC (Chair)
Gord Winkel	QAPSAC

The Official Administrator has a duty to the public as the governor of the organization to ensure that the community understands and trusts the organization and has ample opportunity to provide meaningful input into the way AHS functions and performs. The Official Administrator, along with the CEO, is accountable to the government for the organization's overall performance.

Accreditation is a requirement for AHS based on a three-year rotating accreditation schedule. AHS governance is one of the standards being accredited in 2014.

COUNCILS

Everything we do at Alberta Health Services is about improving the health of Albertans. Community input and engagement furthers our ability to provide quality, patient-focused health care that is accessible and sustainable. AHS is committed to engaging the public in a respectful, open and accountable manner to support the strategic direction of the organization. Community input and feedback allows us to better address the health needs of communities. AHS has established several councils to support engagement.

Health Advisory Councils

Health Advisory Councils

The Health Advisory Councils (HACs) support AHS in achieving its strategies by engaging members of the public in communities throughout Alberta, and providing advice and feedback from a local perspective on what is working well in the health care system and where there are areas in need of improvement. Each of the 12 HACs was established in 2009-10. Every HAC represents a different geographical area within the province. The term of office for all HAC Chairs was April 1, 2013 to March 31, 2014.

Health Advisory Councils	Geographical Area	HAC Chair
1. True North Health Advisory Council	La Crete, High Level & Area	Michael Osborn
2. Peace Health Advisory Council	Peace River, Grande Prairie & Area	Michael Ouellette
3. Lesser Slave Lake Health Advisory Council	Slave Lake, High Prairie & Area	Ken Matthews
4. Wood Buffalo Health Advisory Council	Fort McMurray & Area	Iris Kirschner
5. Lakeland Communities Health Advisory Council	Lac La Biche, Redwater, Cold Lake & Area	Patricia Palechuck
6. Tamarack Health Advisory Council	Hinton, Edson, Whitecourt & Area	Ruth Martin-Williams
7. Greater Edmonton Health Advisory Council	Edmonton & Area	Lawrence Tymko
8. Yellowhead East Health Advisory Council	Camrose, Lloydminster & Area	Don Whittaker
9. David Thompson Health Advisory Council	Red Deer & Area	Gerald Ingeveld
10. Prairie Mountain Health Advisory Council	Calgary & Area	Larry Albrecht
11. Palliser Triangle Health Advisory Council	Medicine Hat & Area	Dr. Kenneth Sauer
12. Oldman River Health Advisory Council	Lethbridge & Area	Dr. Barbara Lacey

AHS has worked with the 12 HACs and two Provincial Advisory Councils (Provincial Advisory Council on Cancer and Provincial Advisory Council on Addiction & Mental Health) to establish a Council of Chairs. The Council provides advice and feedback to the Official Administrator, helping to bring the voice of Albertans to decision-making at a provincial level at AHS.

Provincial Advisory Council Cancer

Provincial Advisory Council on Cancer

The Provincial Advisory Council on Cancer acts as an advisory body to AHS and provides evidence-based suggestions on cancer care for Albertans. The Council is composed of 15 volunteers, including members who are experts in their cancer-related field as well as public members who have been touched by cancer, diagnosed with cancer or are cancer survivors.

Provincial Advisory Council Addiction & Mental Health

Provincial Advisory Council on Addiction & Mental Health

The Provincial Advisory Council on Addiction & Mental Health (AMH) acts as an advisory body to AHS to enhance the delivery of addiction and mental health services. The Council is composed of volunteer members (three members per AHS zone). There may be AHS service providers or members of the public who have been touched by addiction and/or mental health, either as a patient, or through the experience of a family member, close associate or are AMH service providers.

Patient and Family Advisory Council

The Patient and Family Advisory Group works with the vision that patients and families are partners with their health care providers. This means that patients and families need to be engaged in all aspects of health care. The Patient and Family Advisory Group works to help identify areas for improvement in the delivery of patient-and family-centred care. The group does this by partnering with senior leaders to review policy and strategies and to share insights from a patient's perspective for the planning and delivery of health care services.

Alberta Clinician Council

The Alberta Clinician Council is a forum made up of approximately 40 front-line clinicians from a variety of disciplines and zones across the province. Applying their collective knowledge, experience and expertise, the council advises senior leadership on issues and opportunities to improve quality, access and patient safety across the province.

The Alberta Clinician Council is a multidisciplinary forum that addresses organization-wide issues of quality and patient safety. It has direct access to the Alberta Health Services leadership team and advises on significant strategic clinical issues and organizational priorities. As such, the council is accountable to both the AHS Chief Executive Officer and front-line clinicians.

Wisdom Council

The Wisdom Council also provides guidance and recommendations to ensure AHS develops and implements culturally appropriate and innovative health service delivery for Aboriginal Peoples. The Wisdom Council is responsible for reviewing AHS provincewide priorities and strategies to improve the health and wellness for First Nations, Métis and Inuit within Alberta.

The Wisdom Council is comprised of 19 aboriginal volunteers ranging from traditional knowledge holders (ceremonial leaders) to contemporary trained physicians, each equally important when discussing challenges to aboriginal health and well-being. Other members include a former chief, nursing professionals, a professor, health consultants and a number of elders. This diverse composition has served council members well over the last two years as they advocate for improving aboriginal health and wellness, recognizing this important feedback is used to support the overall strategic direction of AHS and more specifically the Aboriginal Health Program.

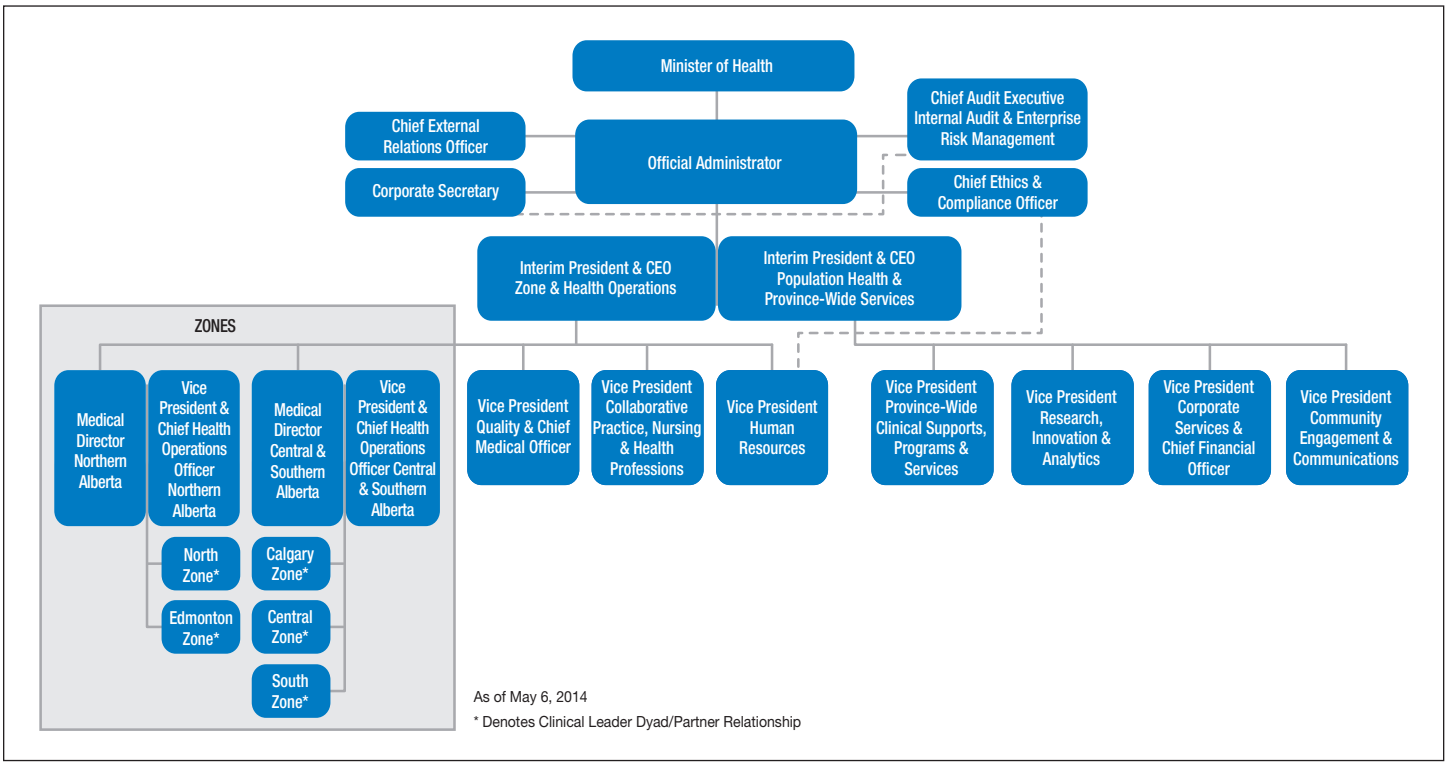
2013-14 ORGANIZATIONAL STRUCTURE

AHS is responsible for delivering health services to the four million people living in Alberta. AHS is Canada's first and largest provincewide, fully-integrated health system. The creation of AHS supports consistent access to health services and standards, and better coordination of services across the province.

In 2008, the AHS Board became the common governance board responsible for the delivery of health services previously provided by nine regional health authorities, the Alberta Cancer Board, Alberta Alcohol and Drug Abuse Commission (AADAC) and Alberta Mental Health Board. The provision of Emergency Medical Services (Ground Ambulance Service) has also transitioned from former municipal responsibility, to become a part of this provincial health care service.

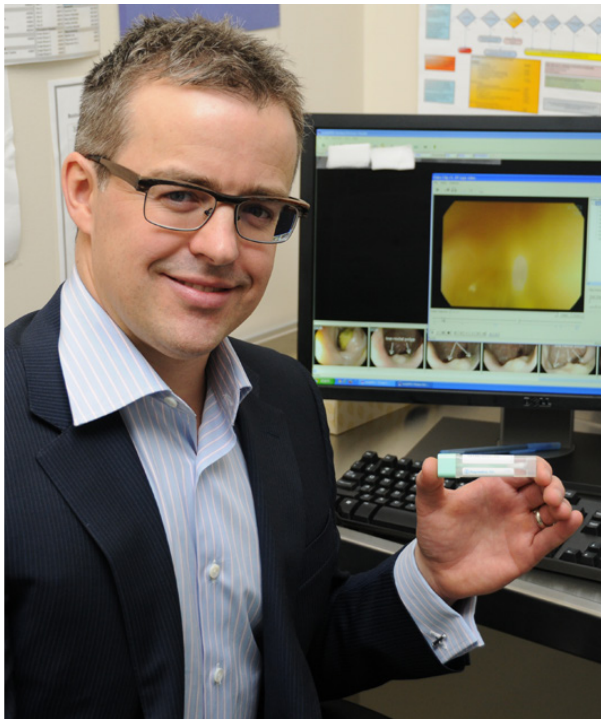
In October 2013, Dr. Chris Eagle stepped down as the President and Chief Executive Officer of AHS, and Duncan Campbell was appointed Acting President and CEO. Mr. Campbell had been serving as the Vice President, Administration and Chief Financial Officer. In November 2013, Brenda Huband was appointed Interim President and Chief Executive Officer for Zone and Health Operations and Rick Trimp was appointed Interim President and Chief Executive Officer for Population Health and Province-Wide Services. They are accountable for the organization's day-to-day operations and report directly to the Official Administrator.

In January 2014, our organizational structure was arranged under the following AHS Executive Leadership Team, reporting directly to the President and Chief Executive Officer.



In March 2014, AHS announced the appointment of a new President and Chief Executive Officer, Vickie Kaminski, who started on May 26, 2014.

HIGHLIGHTS FOR 2013-14



STORIES AND HIGHLIGHTS

The stories profiled in this Annual Report are just a small sampling of the accomplishments we have celebrated this past year (April 1, 2013 to March 31, 2014) and the initiatives that are making a difference in the way health care is being delivered in Alberta.

We have highlighted stories from the following areas within AHS:

The **Provincial Highlights** section of this report helps to demonstrate how AHS is working together as one organization to deliver high-quality health care across this province. As a provincial organization, AHS is able to respond to crises and provide more consistent support throughout the province. We saw this in the devastating flooding in the south, a wildfire in the north and the coordinated team effort to protect thousands from influenza. Staff and physicians have been able to mobilize to respond to these crises effectively and quickly, drawing on expertise and resources from across the organization

AHS is organized into **five geographic zones** — South, Calgary, Central, Edmonton and North — so that communities are more directly connected to their local health systems and decisions can be made closer to where care is provided. In this report, we have shared some of the stories of the fantastic work that is happening in each of these areas of Alberta – health care that is close to home and making a difference in the lives of Albertans.

AHS recognizes **Research and Innovation** as a critical strategic priority. The evidence that research provides leads to more informed decision-making in both policy and practice and ultimately leads to better health outcomes for Albertans. This is vital to advance the health care system and to ensure the effective use of funds. AHS is working to coordinate tremendous research talent across the province and to use that research to become a health services organization which uses research to provide care that is evidence-informed and patient-focused.

Strategic Clinical Networks (SCNs) are creating improvements within focused areas of health care. To get the most out of our health care system, AHS has developed networks of people who are passionate and knowledgeable about specific areas of health, challenging them to find new and innovative ways of delivering care that will provide better quality, better outcomes and better value for every Albertan. Great work is happening in our SCNs and we've included some examples of how this work is improving the quality of health care in our province.

Every day in health care, we are privileged to witness and take part in amazing stories like these —stories that embody a spirit of innovation, collaboration and caring for the community that benefit Albertans. They demonstrate how we are working to delivery high-quality health care across this province, putting patients and families at the forefront of everything we do.

PROVINCIAL HIGHLIGHTS FOR 2013-14 »

From left: Both High River evacuees who moved to Vulcan General Hospital, AHS care attendant Linda Gibbs offers tea and cake to long-term care resident Charlotte Colbow; Hayley Shepherd, an RN at Foothills Medical Centre, and fellow volunteer Devin Wanamaker distribute bottled water at a flood relief centre in Calgary; and AHS off-duty staff and volunteers get dirty helping seniors clean up in High River.

Floods devastate southern Alberta

Natural disaster sees Alberta Health Services medical staff, leadership and volunteers embrace the challenge of providing uninterrupted care with enthusiasm, creativity and resolve. The resilience of southern Albertans shines through as AHS partners with civic, military and government emergency agencies to set up evacuation and urgent care centres — and a field hospital — in under four hours.

When rivers overflowed and floods wreaked havoc in Calgary, High River, Canmore, Medicine Hat and neighboring communities last June, the swift and comprehensive response from AHS demonstrated how amazing, resilient, and generous Albertans can be in the face of disaster.

It meant not only caring for the tens of thousands of people evacuated from their homes, but ensuring all Albertans continued to have access to the health services they needed.

When rising waters threated to close bridges and cut off 20,000 people from medical care in Medicine Hat, AHS opened a field hospital there within four hours. At the field hospital, city staff, volunteers and businesses supported AHS without hesitation.

Across southern Alberta, AHS opened and staffed urgent care clinics, and provided teams including health inspectors, and mental health and public health professionals to help local residents and business owners cope when they got their first closeup look at the damage flood waters left behind.

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Police, fire, EMS, military — both British and Canadian — plus physicians, nurses, support staff within the health sector including administration, emergency disaster management, security, and many others were crucial to all the efforts.

In Lethbridge, AHS staff joined even more volunteers, the City of Lethbridge, the University of Lethbridge and the Red Cross — among many others — to prepare and provide care for more than 200 evacuees relocated there from hardest-hit High River.

On their days off, teams of AHS staff donned plastic suits and rubber boots to help affected residents haul water-damaged furniture and shovel muck from their homes.

At the height of the southern Alberta flood disaster, road closures made the relocation of patients and continuing care residents challenging, and the delivery of medications to AHS facilities especially difficult.

Whether helping the many or the one — such as the out-of-country patient visiting Banff who urgently needed more anti-rejection medication after a transplant — AHS got the job done.

"I shouldn't have been surprised by the teamwork and the dedication of our staff because I've seen it before in other crises," says Dr. Vanessa Maclean, South Zone Medical Director. "But I was once again blown away by how everyone came together to make this happen."

ASIST deters Aboriginal suicides

Four AHS staff members in the Aboriginal Health Program now deliver the Applied Suicide Intervention Skills Training (ASIST) program — an internationally recognized initiative for people who live and work with individuals at risk of self-harm. Since late 2011, these ASIST-certified staff members have led two-day workshops for 36 aboriginal groups in First Nations and Métis communities.

Continuing care access improves

Lethbridge-area seniors with dementia now have additional supports with the opening of supportive living dementia beds. To the north, new facilities increased supportive living access in Peace River and Grimshaw for seniors. Within the Calgary and Central Zones, supportive living beds opened in areas such as Bashaw, Calgary, Lacombe, Red Deer, Strathmore and Stettler. In 2012-13, Edmonton Zone opened more than 225 continuing care spaces, continuing to bring care closer to home.

Paramedics boost care in lodges

Specially trained paramedics are treating Calgary and Lethbridge residents in local supportive living facilities and community lodges as part of a new AHS-Emergency Medical Services program that delivers additional primary health care. The Community Paramedic Program provides additional support to the multidisciplinary health care teams based in supportive living facilities and community lodges.

Workplace Wellness Program on job

AHS helps employers tailor plans to forge a healthier workforce through the new Workplace Wellness Program. So far, the AHS Mental Health Promotion team has engaged eight sites across the province, and Alberta Environment Water and Sustainable Resource Development (GOA), Calgary Police Service, Husky Energy and Canadian Tire in Grande Prairie.

Canadian Tire staff member Tracy Davis, and general manager Ron Regnier, stand in Canadian Tire's renovated lunch room in Grande Prairie. The renovation was completed to help improve the health of staff.

Health Link talks diet, medication

Newly-added services at call centres in Edmonton and Calgary mean that Albertans can now call Health Link Alberta to talk to medication specialists and registered dietitians about their nutrition and prescription concerns. Both services offer better access to information and advice that will improve the health of Albertans.

PROVINCIAL HIGHLIGHTS FOR 2013-14 »

A youngster receives a nasal spray vaccine for her annual influenza vaccination. The 2013-14 AHS campaign was the most successful in Alberta's history. Increased use of television, online and social media helped to get the word out.

Record 1.1 million immunized in flu vaccine program

Alberta Health Services' timely and effective use of television advertising, web and online resources, and social media, as well as an increased incidence of influenza, encouraged Albertans to get immunized. Progress was made towards immunizing more high-risk groups such as children, seniors, expectant mothers and health care workers.

The 2013-14 Influenza Immunization Program was the most successful in Alberta's history, with more Albertans receiving vaccine this season than in any previous regular influenza season.

Together with more than 1,780 community partners, AHS administered 1,157,150 doses of influenza vaccine; more than 27 per cent of Albertans were immunized this year compared to 23 per cent last year. Increased partnerships between public health and immunization providers in the community improved access for the general public and contributed to influenza vaccine uptake this season.

Progress was also made towards improving immunization coverage rates for higher-risk groups.

- 36 per cent of children six to 23 months of age were immunized this season, compared to 30 per cent last season; 24 per cent of children two years to five years of age were immunized this season, compared to 18 per cent last season.
- 64 per cent of seniors were immunized this season, compared to 60 per cent last season.
- 16 per cent of pregnant women were immunized this season, compared to 13 per cent last season.

Just as uptake of influenza vaccine increased this season over last, so too did the avenues through which Albertans were provided, and accessed, influenza information.

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Not only did AHS expand its use of TV and online advertising this season, it increased its use of social media (e.g., Twitter), providing Albertans with daily updates.

The revamped AHS influenza website also provided Albertans with frequently updated information on the provincial response. The web activity was well received by Albertans. From October 1st to April 30th, the AHS influenza webpage received more than 350,000 visits: 153 per cent more visits than in the 2012-13 season.

The key message this year to all AHS health care workers was: *No patient should get influenza from our staff while in our care*.

AHS' target for staff influenza immunization was 50 per cent. More than 54 per cent of AHS health care workers reported being immunized this season, compared to 41 per cent last season; 72 per cent of long-term care staff were immunized this season, compared to 67 per cent last season.

As planning for the 2014-15 influenza season commences, AHS continues to build on the successes and learnings of the 2013-14 program, focusing on protecting the health of all Albertans.

AEDs: the shock that saves lives

Automated External Defibrillators (AEDs) have been distributed across the province by AHS and the Heart & Stroke Foundation. The devices can tell if the heart has stopped beating and deliver an electric shock to restart the heart. One Edmonton man, Bob Chomyn, credits access to the device with saving his life, after he went into cardiac arrest during a hotel brunch.

Stopping tobacco use

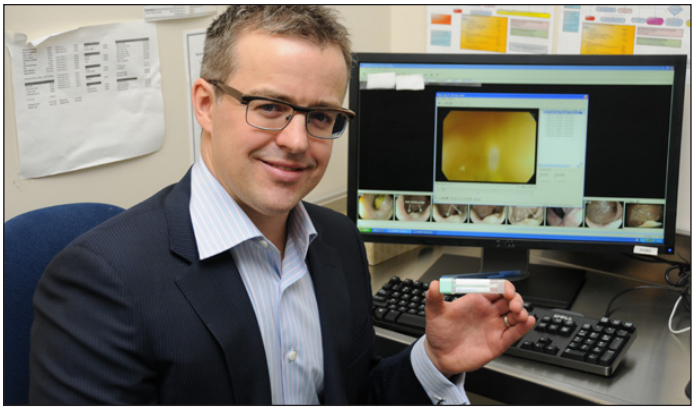
The Tobacco Reduction Program continues to generate awareness and education to diverse audiences including a new provincial marketing campaign that encouraged tobacco users to keep trying to quit. Other examples include the creation of new resources on spit tobacco, as well as materials designed for pregnant and postpartum women and their families and First Nations.

'Operation Strange Brew' exercise

A Saturday morning emergency exercise at Edmonton Remand Centre gave AHS staff a chance to practise their Mass Casualty Plan for Correctional Health. The event, "Operation Strange Brew" employed a scenario where inmates were poisoned by a botulism-tainted homemade alcohol. More than 20 staff and students volunteered to play the roles of inmates and patients in the simulated event.

New colorectal test a lifesaver

Alberta has a new colorectal cancer screening test that could save hundreds of lives by detecting the potentially deadly disease earlier. Every year, about 1,900 Albertans are diagnosed with colorectal cancer and about 600 die of the disease. Nearly one million Albertans may be eligible to take the FIT, a home stool test that is now the primary screening test for average-risk Albertans between the ages of 50 to 74.



Dr. Steve Heitman of the Forzani & MacPhail Colon Cancer Screening Centre holds a Fecal Immunochemical Test kit.

Teen beats hereditary pancreatitis

A Medicine Hat girl is healthy and pain-free two years after becoming the youngest Canadian to be cured of a rare form of hereditary pancreatitis. Lauren Miner, 13, received an auto islet cell transplant, pioneered by Edmonton's Clinical Islet Cell Transplant Program.

SOUTH ZONE HIGHLIGHTS FOR 2013-14 »

A portable isolation tent outside Chinook Regional Hospital helped keep patients with suspected measles away from emergency departments and doctors' offices.

Planning paved way for swift measles response

To the public, it may have seemed like it came out of nowhere, but when a case of measles was confirmed in Lethbridge in mid-October last year, health officials were prepared.

Measures that had been implemented ahead of the outbreak enabled Alberta Health Services staff to mobilize quickly to contain the contagious virus.

"It highlights how important our work in emergency preparedness is in our day-to-day business," says Dr. Vivien Suttorp, Medical Officer of Health, South Zone. "The planning phase was integral to the success of rapid containment."

Key strategies during the planning phase included immunization of AHS health care workers and health care providers in community physician offices, development of negative pressure rooms at Chinook Regional Hospital, and the development of a measles assessment centre operational plan.

With confirmation of the first measles case, an outbreak was declared and containment measures implemented, including:

- Mass immunization clinics for children and health care workers.
- A dedicated measles hotline.
- The creation of Mobile Measles Assessment Teams.
- The opening of a portable Measles Assessment and Treatment Centre at Chinook Regional Hospital, in order to minimize possible exposures at physicians' offices and emergency departments.

The strategies developed for this outbreak have recently been implemented – rapidly and effectively – in the Calgary, Central and Edmonton zones, following declaration of measles outbreaks in these three zones on April 29, 2014.

New procedure fixes bones

Southern Albertans with severe skeletal problems, including bowed legs and limbs of different lengths, are now able to have these conditions fixed at Chinook Regional Hospital. Patients undergo orthopedic surgery to cut through the bone that needs fixing and a circular, metal frame is placed around the limb. Called the Taylor Spatial Frame, the device can be adjusted daily to gradually lengthen or straighten bones.

Art empowers patients

Dozens of southern Alberta residents are getting a reprieve from the stress of chronic illness and injury through an AHS program. Expressive Arts is a 10-week program for individuals recovering from a stroke, living with a brain injury or chronic illness, or struggling with social isolation. Participants, who must be referred by a physician or other health care professional, explore art using a variety of materials.

Go-kart simulates impaired driving

Southern Albertans are getting an opportunity to better understand the dangers of impaired and distracted driving with a specialized go-kart that's touring communities. The battery-powered vehicle simulates what happens when people drive while impaired by alcohol or drugs, or drive when distracted by texting or talking on a cellphone. It's the latest of several programs developed by AHS and the Southeastern Alberta Traffic Safety Coalition.

Cycling promotes mental well-being

Bicycles built for two are lifting the spirits of long-term care residents in the South Zone. Ten wheelchair bikes — or "duet bikes" — are being used at several care centres in the region. The bikes are for seniors who experience mild to moderate depression or are at risk of depression, such as those suffering from chronic illness, bereavement and loss, or those who are socially isolated.

NAT vans come to South Zone

Four specially equipped minivans are now moving medically stable patients between health care facilities in the South Zone for specialist consults, diagnostics and procedures.

The new patient transfer service is helping free up significant ground ambulance resources throughout the zone.

Known as non-ambulance transfer vans, or NAT vans for short, the vehicles are staffed by emergency medical responders and equipped with automated electronic defibrillators, first-aid kits, and sophisticated GPS and communications equipment.

"The NAT vans provide an appropriate level of care and service for thousands of patients every year," says Sandy Halldorson, Executive Director of EMS for AHS South Zone.

The vans are expected to perform as many as 3,600 trips annually, which represent about 16 per cent of all ground ambulance calls in the South Zone.

Two vans are based in Raymond and have been operating since mid-January. The other two are based in Brooks. Nineteen other NAT vans are in service throughout the province.

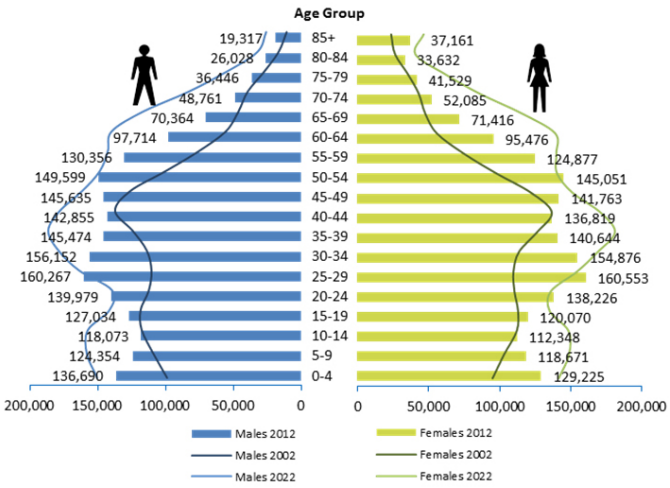
Ron 'Lewy' Lewison, Team Lead, Milk River EMS, with one of the NAT vans in Raymond.

SOUTH ZONE *At a Glance* »

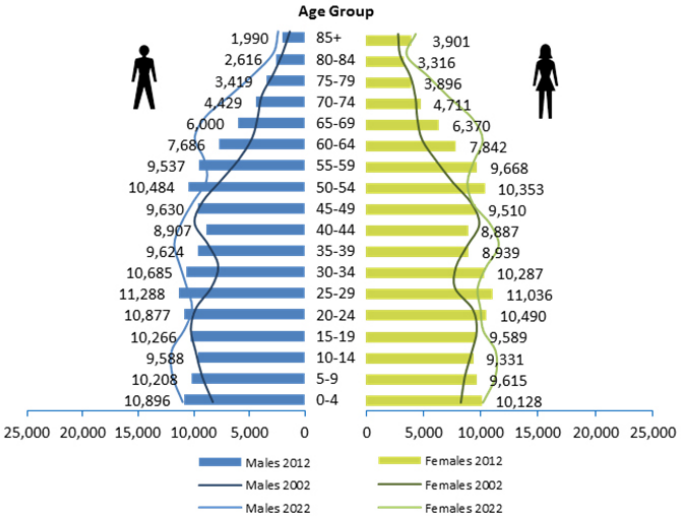
South Zone Facts

Population: 296,895 (2013) • **Land Mass:** 65,500 km²
Life Expectancy: 80.3 years (2013) • **Median Age:** 36 years (2013)
Seniors Population: 13.7% of zone is 65 years old and older (2012)
Births: 3,973 • **Hospitals:** 14 • **Physicians:** 481
Employees: 6,947 • **Volunteers:** 2,130
Meals Served: 750,000 per year

Projected Provincial Growth to 2021



Projected South Zone Growth to 2021



Facilities and Beds

South Zone	Community Ambulatory Care	Addiction & Mental Health	Acute Care	Cancer Care	Continuing Care (long-term care, supportive living & palliative)	TOTAL
# of Facilities	2 Ambulatory Care Centres 18 Public Health Centres	4 addiction facilities	2 regional hospitals 12 community hospitals	2 cancer centres (Jack Ady Cancer Centre, Margery E. Yuill Cancer Centre)	48 continuing care facilities	**88**
# of Beds	not applicable	90	668 acute & subacute		2,553	**3,311**

Note: The above facility counts are based on physical building structures in Alberta. To avoid double counting, it is important to note that programs/services related to the above areas (i.e. addiction, mental health, hospice, etc.) reside within multiple facilities.

For more detail, please see Appendix (Reported Beds Staffed and in Operation Summary as of March 31, 2014).

South Zone Quick Facts	2012-13	2013-14	% Change 2012-13 to 2013-14	% of Province
Primary Care / Population Health				
Home Care Clients	11,144	11,576	4%	10%
Number of People Placed in Continuing Care	930	868	-7%	11%
Health Link Calls	28,077	32,186	15%	4%
Seasonal Influenza Immunizations	75,488	89,634	19%	8%
Food Safety Inspections	9,014	8,402	-7%	9%
Acute Care				
Emergency Department Visits (all sites)	202,797	196,577	-3%	9%
Hospital Discharges	31,641	31,093	-2%	8%
Births	4,125	3,973	-4%	8%
Total Hospital Days	197,447	199,677	1%	7%
Average Length of Stay (in days)	6.2	6.4	3%	not applicable
Diagnostic / Specific Procedures				
Total Hip Replacements (scheduled and emergency)	513	526	3%	10%
Total Knee Replacements (scheduled and emergency)	832	804	-3%	13%
Cataract Surgery	2,514	2,653	6%	7%
Main Operating Room Activity	22,596	23,049	2%	8%
MRI exams[1]	13,875	13,380	-4%	7%
CT exams	22,724	24,906	10%	7%
X-rays[1]	151,898	156,503	3%	8%
Lab Tests	4,598,753	4,843,124	5%	7%
Cancer Care				
Cancer Patient Visits (patients may have multiple visits)	32,645	31,529	-3%	6%
Unique Cancer Patients	4,775	4,522	-5%	9%
Addiction & Mental Health				
Mental Health Hospital Discharges (acute care sites)	2,038	2,004	-2%	10%
Addiction Residential Treatment & Detoxification Discharges	28	33	18%	0%
Staffing				
Head Count[2]	6,874	6,947	1%	7%
Volunteers[3]	2,433	2,130	-12%	14%
AHS Physicians	474	481	1%	5%
Per Cent of Healthcare Workers Immunized	35.4	36.3	3%	not applicable

[1]MRI exam (in 2011-12) and X-ray (in 2012-13) count converted to new methodology from the Common Procedures Exam List (CPEL) to CIHI.
[2]Head Count excludes Covenant Health, United Church of Canada and wholly-owned subsidiaries such as Carewest, CapitalCare Group and Calgary Laboratory Services.
[3]The overall numbers have decreased due to the elimination of duplicate volunteer records.

CALGARY ZONE HIGHLIGHTS FOR 2013-14 »

One-quarter of Emergency Department visitors at South Health Campus are pediatric patients.

Up and running at South Health Campus

South Health Campus had a remarkable year with the successful opening of all its inpatient beds, programs and services.

SHC has about 3,000 staff and 180 physicians who provide care for more than 200,000 outpatient visits annually. The 269-bed campus serves Calgary and surrounding areas, and is also a referral centre for southern Alberta.

"We knew SHC was going to help with delivery of health care in the Calgary Zone, but we didn't expect the impact to be so immediate," says Lori Anderson, Senior Operating Officer, SHC. For example, opening adult and adolescent mental health inpatient beds has improved access to mental health services and been welcomed by patients and families.

SHC also opened its Child & Women's Health program, which includes single-room maternity care, an array of women's and pediatric outpatient clinics, as well as an Intensive Care Unit for infants. To date, SHC has delivered almost 1,000 babies and has the capacity to accommodate up to 2,400 deliveries annually.

During 2013-14, more than 109,500 diagnostic imaging exams were performed, improving overall access and wait times in the Calgary Zone.

The SHC Emergency Department (ED), which opened in January 2013, has approximately 166 visits a day, a quarter of which are pediatric patients. Like Alberta Children's Hospital, SHC has physicians with specialized pediatric emergency expertise.

A new SORCe for help

A new hub of service and support aimed at helping the most vulnerable populations is now available in Calgary. SORCe, the Safe Communities Opportunity and Resource Centre, is a partnership between Alberta Health Services, the Government of Alberta, the Calgary Police Service, and more than 20 social service agencies and non-profit organizations. The centre connects people to resources for housing, mental health, addictions, training and employment.

Toxicology Clinic opens

The Poison and Drug Information Service (PADIS) Medical Toxicology Clinic is a monthly outpatient clinic that provides evaluation, diagnosis and management of patients who have been exposed to potentially toxic substances such as lead, arsenic, mercury, carbon monoxide, pharmaceuticals and herbal preparations. Opened in September 2013, it is the only clinic of its kind in western Canada.

New NICU at Alberta Children's Hospital

The Alberta Children's Hospital is now home to a new 14-bed Neonatal Intensive Care Unit (NICU), named after donor Murray and Heather Edwards. The Level 3 NICU cares for some of the most critically-ill newborn babies in southern Alberta. It provides specialized care for preterm and term newborns requiring cardiac and surgical care.

Surgery telecast sparks interest

In a first for Western Canada, a new program offers local junior high and high school students the chance to watch a knee surgery as it happens and ask questions of the surgical team. 'Direct from the Operating Room' broadcasts from Rockyview General Hospital to between 100 and 166 students in TELUS Spark's Presentation Theatre. The program is a partnership between TELUS Spark and AHS.

After a stroke, seconds count

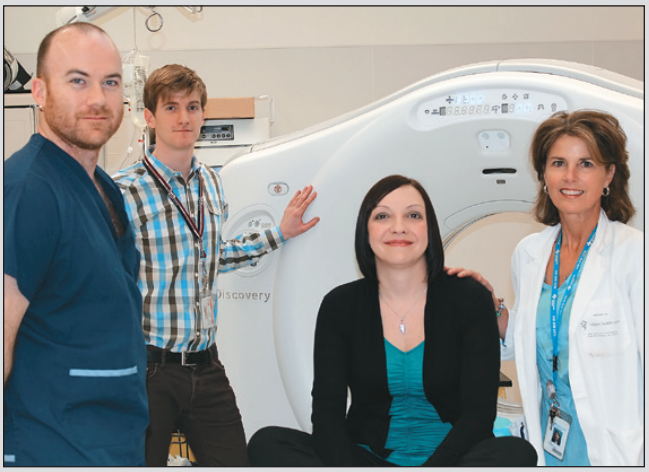
When Amy Houghton started feeling dizzy and nauseous at work, she knew it was more than just a stomach bug.

"My vision was blurred and I was seeing stars. I blacked out and I don't remember anything until two days later in the ICU when I was told I had had a stroke," recalls the 35-year-old.

Houghton's recovery was made possible by a newly created team of specialists at the Foothills Medical Centre who jump into action when a stroke occurs. The team includes paramedics, nurses, computed tomography (CT) technologists and physicians.

"With strokes, there is a sense of urgency because brain cells are dying extremely quickly. We need to reopen the blocked blood vessel as soon as possible," says Dr. Mayank Goyal, Interventional Neuroradiologist with AHS.

The specialized interventional team is another notable achievement for the Calgary Stroke Program, which was the first comprehensive stroke service in Canada to receive the Stroke Service of Distinction Award from Accreditation Canada, an honour it has held since 2010.



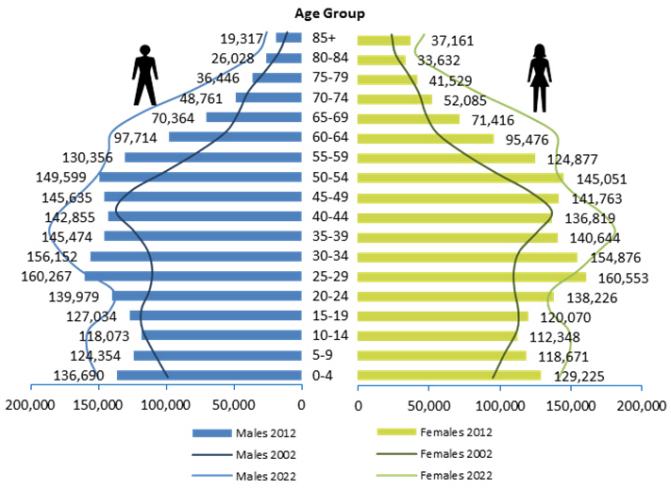
Stroke patient Amy Houghton, second from right, poses with, from left, CT technologist Steve Thompson, radiologist Dr. Brendan Diederichs and registered nurse Leslie Zimmel.

CALGARY ZONE *At a Glance* »

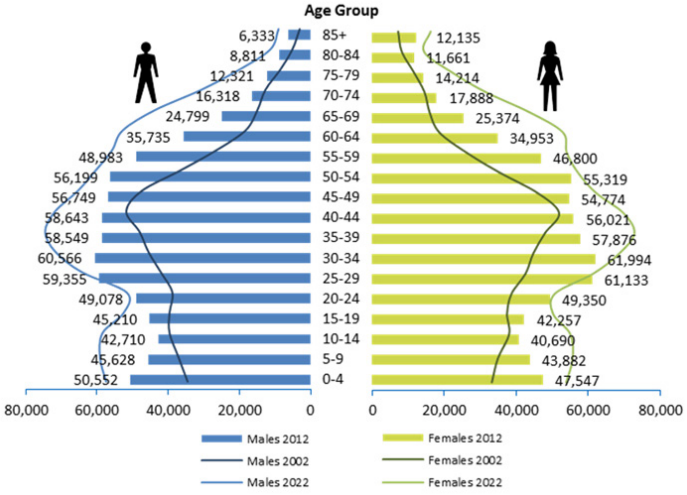
Calgary Zone Facts

Population: 1,515,798 (2013) • **Land Mass:** 39,300 km²
Life Expectancy: 82.9 years (2013) • **Median Age:** 36.3 years (2013)
Seniors Population: 10.2% of zone is 65 years old and older (2012)
Births: 18,865 • **Hospitals:** 14 • **Physicians:** 3,827
Employees: 35,909 • **Volunteers:** 4,165
Meals Served: More than 3 million per year

Projected Provincial Growth to 2021



Projected Calgary Zone Growth to 2021



Facilities and Beds

Calgary Zone	Community Ambulatory Care	Addiction & Mental Health	Acute Care	Cancer Care	Continuing Care (long-term care, supportive living & palliative)	TOTAL
# of Facilities	5 urgent care centres 1 Family Care Clinic 21 Public Health Centres	2 standalone psychiatric 13 addiction facilities 9 community mental health facilities	5 urban hospitals 8 community hospitals 1 ambulatory surgical centre hospital (Richmond Road Diagnostic & Treatment Centre)	3 cancer centres (Tom Baker Community Cancer Centre, Canmore Community Cancer Centre and High River Community Cancer Centre)	56 continuing care facilities 52 contracted care homes 4 hospice	**180**
# of Beds	not applicable	791	3,064 acute & subacute		6,529	**10,384**

Note: The above facility counts are based on physical building structures in Alberta. To avoid double counting, it is important to note that programs/services related to the above areas (i.e. addiction, mental health, hospice, etc.) reside within multiple facilities.

For more detail, please see Appendix (Reported Beds Staffed and in Operation Summary as of March 31, 2014).

Calgary Zone Quick Facts	2012-13	2013-14	% Change 2012-13 to 2013-14	% of Province
Primary Care / Population Health				
Home Care Clients	31,832	32,813	3%	29%
Number of People Placed in Continuing Care	2,301	2,164	-6%	28%
Health Link Calls	319,859	325,215	2%	42%
Seasonal Influenza Immunizations	372,337	461,442	24%	40%
Food Safety Inspections	30,372	31,805	5%	33%
Acute Care				
Emergency Department Visits (all sites)	450,901	485,715	8%	23%
Urgent Care Visits	185,706	181,352	-2%	89%
Hospital Discharges	130,846	136,599	4%	35%
Births	18,453	18,865	2%	36%
Total Hospital Days	938,624	959,950	2%	36%
Average Length of Stay (in days)	7.2	7.0	-2%	not applicable
Diagnostic / Specific Procedures				
Total Hip Replacements (scheduled and emergency)	1,815	1,896	4%	36%
Total Knee Replacements (scheduled and emergency)	1,934	2,186	13%	35%
Cataract Surgery	13,131	13,799	5%	38%
Main Operating Room Activity	90,363	94,403	4%	34%
MRI exams[1]	64,061	75,273	18%	40%
CT exams	125,906	134,515	7%	37%
X-rays[1]	519,601	538,856	4%	29%
Lab Tests	25,541,717	26,796,267	5%	38%
Cancer Care				
Cancer Patient Visits (patients may have multiple visits)	179,172	176,552	-1%	32%
Unique Cancer Patients	20,646	20,926	1%	41%
Addiction & Mental Health				
Mental Health Hospital Discharges (acute care sites)	7,052	7,794	11%	37%
Addiction Residential Treatment & Detoxification Discharges	3,913	3,866	-1%	39%
Staffing				
Head Count[2]	35,839	35,909	0%	37%
Volunteers[3]	4,686	4,165	-11%	27%
AHS Physicians	3,616	3,827	6%	44%
Per Cent of Healthcare Workers Immunized	40.1	43.8	9%	not applicable

[1]MRI exam (in 2011-12) and X-ray (in 2012-13) count converted to new methodology from the Common Procedures Exam List (CPEL) to CIHI.
[2]Head Count excludes Covenant Health, United Church of Canada and wholly-owned subsidiaries such as Carewest, CapitalCare Group and Calgary Laboratory Services.
[3]The overall numbers have decreased due to the elimination of duplicate volunteer records.

CENTRAL ZONE HIGHLIGHTS FOR 2013-14 »

Myrna Kelley, Nurse Manager at the Central Alberta Cancer Centre, which officially opened in Red Deer November 25, 2013, bringing radiation therapy to the area for the first time. With the opening of the new centre, Red Deer became the fourth city in the province to offer radiation therapy as part of a provincewide strategy to open a corridor of cancer care treatment centres across Alberta.

Central Alberta Cancer Centre opens

Care options increase as radiation therapy comes to Red Deer along with additional outpatient clinics and a medical day unit with treatment areas for chemotherapy.

Radiation therapy has a new home in Red Deer with the opening last November of the Central Alberta Cancer Centre, next to the Red Deer Regional Hospital Centre.

By bringing radiation therapy to the city for the first time, the new Alberta Health Services facility expands the scope of cancer care available for central Alberta residents and eliminates the need to travel as it offers more options closer to home.

The new facility will offer treatment for multiple cancers, including lung, breast, gastrointestinal and prostate.

With the opening, Red Deer becomes the fourth city in the province to offer radiation therapy, joining Edmonton, Calgary and Lethbridge. With the two radiation vaults in the facility — and room for a third in the future — radiation therapy will be provided to about 600 new cancer patients.

"This is a wonderful addition to central Alberta," says Red Deer resident Morris Flewwelling. Diagnosed with prostate cancer in 2009, he underwent radiation treatments in 2010 and had to drive to Edmonton for 39 consecutive weekdays for treatment.

"It was a long drive every time I had to go, and it was tiring and stressful," adds Flewwelling.

The new centre also offers additional outpatient clinics and a medical day unit with treatment areas for chemotherapy.

Move Your Mood helps kids cope

Move Your Mood is a program that helps children aged 17 and under and their families cope with mental health challenges by promoting a positive outlook and physical activity. “Move Your Mood helps children adopt or rekindle healthy, active lifestyles — and that leads them to look outward to people for help,” says Joe Bower, a Child and Adolescent Mental Health Unit teacher in Red Deer.

One-stop referrals ease access

The Continuing Care Access Centre establishes a single point of contact for new referrals to continuing care services, including home care, supportive living and long-term care. Registered nurses trained in case management will run the call centre and complete the intake and screening functions using an internationally standardized tool, known as the InterRAI-Contact Assessment.

Continuing care guides the way

Instead of a map for seniors and their families, a Continuing Care counsellor — a personal guide — can help them find their way. Across the Central Zone, a 17-member team of care counsellors drawn from many disciplines is helping people to find their way every day. Offered to clients in home care, hospital and continuing Care settings, counsellors can become invaluable navigation tools.

Physician assistants top up team

Physician assistants are now part of the health care team at Red Deer Regional Hospital Centre. As physicians rotate shifts every week, the physician assistants will continue to work with their patients. The physician assistant project will bring about a dozen physician assistants on board with AHS facilities, in a variety of settings, to improve health care access, safety and quality.

Stroke Action Plan extends reach

Stroke survivors in central Alberta now get better care in hospital and can receive expert and timely access to stroke rehab in their homes thanks to the recent launch of a provincewide project designed to improve stroke care in rural and small urban areas.

The Stroke Action Plan uses provincial standards to ensure stroke care in these settings matches the care available in larger centres, both during and after a stay in hospital.

Small urban sites will offer improved options for outpatient rehabilitation in the community, such as Early Supported Discharge, which brings therapy into the home of stroke survivors.

Red Deer is the first urban centre outside of Calgary and Edmonton to implement the initiative, which can reduce by half the average length of hospital stay for stroke patients.

As part of the Stroke Action Plan, Grande Prairie, Camrose, Lethbridge and Medicine Hat will receive enhancements to inpatient and outpatient services, plus the addition of Early Supported Discharge teams.

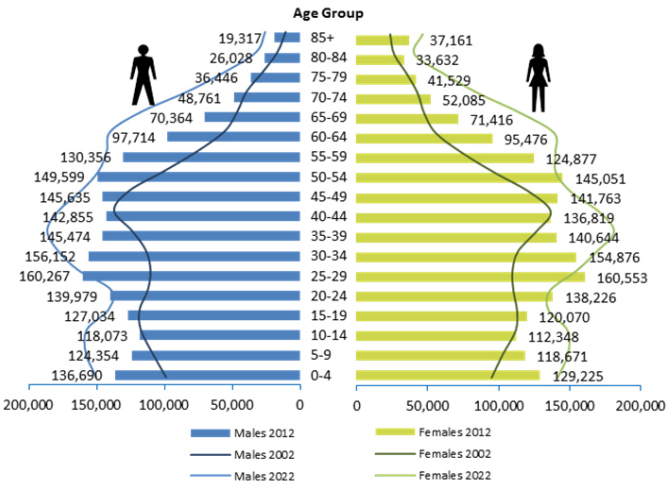
Stroke survivor Elwood Kirkpatrick performs a motor skills test as therapy assistant Jolene Boutin observes. Boutin is part of the multidisciplinary Early Supported Discharge team that does in-home rehab with Red Deer stroke patients.

CENTRAL ZONE *At a Glance* »

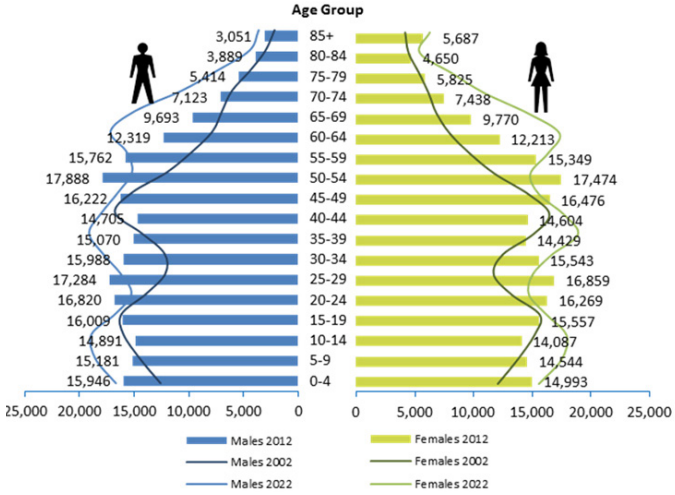
Central Zone Facts

Population: 468,221 (2013) • **Land Mass:** 95,000 km^2
Life Expectancy: 80.7 years (2013) • **Median Age:** 37.1 years (2013)
Seniors Population: 13.5% of zone is 65 years old and older (2012)
Births: 4,812 • **Hospitals:** 30 • **Physicians:** 621
Employees: 12,361 • **Volunteers:** 3,297
Meals Served: Approximately 2.5 million per year

Projected Provincial Growth to 2021



Projected Central Zone Growth to 2021



Facilities and Beds

Central Zone	Community Ambulatory Care	Addiction & Mental Health	Acute Care	Cancer Care	Continuing Care (long-term care, supportive living & palliative)	TOTAL
# of Facilities	2 Ambulatory Care Centres 34 Public Health Centres	1 standalone psychiatric 3 addiction facilities 2 community mental health facilities	1 regional hospital 29 community hospitals	1 cancer centre and 4 clinics (Camrose, Drayton Valley, Drumheller, Lloydminster and the newly opened Central Alberta Cancer Centre)	71 continuing care facilities	**148**
# of Beds	not applicable	428	1,091 acute		3,647	**5,166**

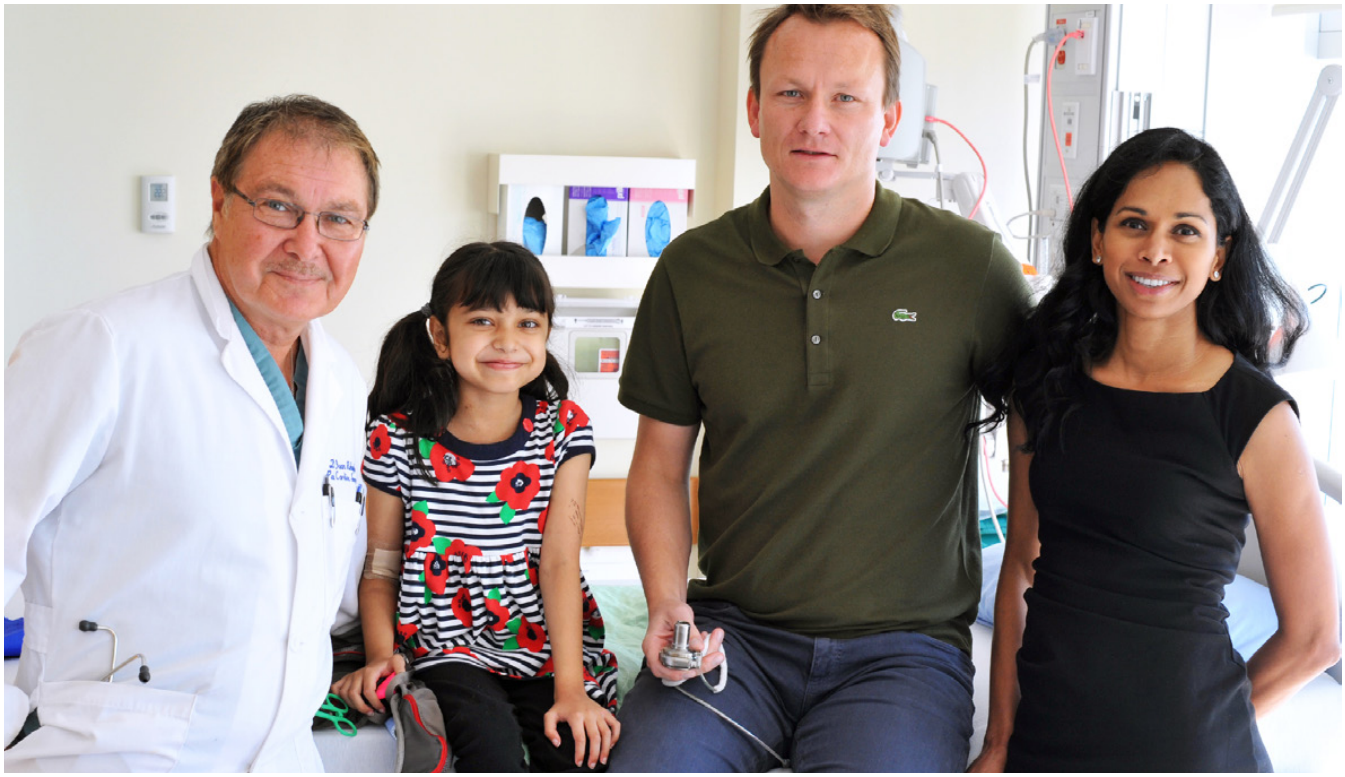
Note: The above facility counts are based on physical building structures in Alberta. To avoid double counting, it is important to note that programs/services related to the above areas (i.e. addiction, mental health, hospice, etc.) reside within multiple facilities.

For more detail, please see Appendix (Reported Beds Staffed and in Operation Summary as of March 31, 2014).

Central Zone Quick Facts	2012-13	2013-14	% Change 2012-13 to 2013-14	% of Province
Primary Care / Population Health				
Home Care Clients	16,962	17,495	3%	16%
Number of People Placed in Continuing Care	1,281	1,189	-7%	15%
Health Link Calls	58,686	57,847	-1%	7%
Seasonal Influenza Immunizations	86,453	109,014	26%	9%
Food Safety Inspections	12,443	10,626	-15%	11%
Acute Care				
Emergency Department Visits (all sites)	379,557	371,558	-2%	17%
Hospital Discharges	45,619	44,587	-2%	11%
Births	4,869	4,812	-1%	9%
Total Hospital Days	319,977	322,382	1%	12%
Average Length of Stay (in days)	7.0	7.2	3%	not applicable
Diagnostic / Specific Procedures				
Total Hip Replacements (scheduled and emergency)	566	574	1%	11%
Total Knee Replacements (scheduled and emergency)	649	669	3%	11%
Cataract Surgery	3,489	3,403	-8%	9%
Main Operating Room Activity	27,965	28,012	0%	10%
MRI exams[1]	12,204	13,137	8%	7%
CT exams	31,575	33,708	7%	9%
X-rays[1]	261,541	259,979	-1%	14%
Lab Tests	6,012,138	6,088,885	1%	9%
Cancer Care				
Cancer Patient Visits (patients may have multiple visits)	15,508	18,686	20%	3%
Unique Cancer Patients	2,001	2,172	9%	4%
Addiction & Mental Health				
Mental Health Hospital Discharges (acute care sites)	2,342	2,153	-8%	11%
Addiction Residential Treatment & Detoxification Discharges	144	150	4%	1%
Staffing				
Head Count[2]	12,210	12,361	1%	13%
Volunteers[3]	3,296	3,297	0%	21%
AHS Physicians	606	621	2%	7%
Per Cent of Healthcare Workers Immunized	32.1	37.2	16%	not applicable

[1]MRI exam (in 2011-12) and X-ray (in 2012-13) count converted to new methodology from the Common Procedures Exam List (CPEL) to CIHI.
[2]Head Count excludes Covenant Health, United Church of Canada and wholly-owned subsidiaries such as Carewest, CapitalCare Group and Calgary Laboratory Services.
[3]The overall numbers have decreased due to the elimination of duplicate volunteer records.

EDMONTON ZONE HIGHLIGHTS FOR 2013-14 »



Muskaan Grewal beams after her heart transplant with, from left: Dr. Ivan Rebeyka, Chief of Pediatric Cardiac Surgery; Dr. Holger Buchholz, Director, Pediatric Artificial Heart Program; and Selvi Sinnadurai, VAD Program Co-ordinator.

Girl youngest in world to get artificial heart

Ten months after having revolutionary pump surgically implanted in her chest, six-year-old receives heart transplant at Stollery Children's Hospital.

A six-year-old girl has received a heart transplant 10 months after becoming the youngest patient in the world to have a revolutionary heart pump surgically implanted inside her chest at the Stollery Children's Hospital in Edmonton.

In September 2012, then five-year-old Muskaan Grewal received a HeartWare pump, a ventricular assist device (VAD) which took over the pumping function of her heart. The VAD, roughly the size of a golf ball, was designed for adults, but has been used in a small number of pediatric cases around the globe.

Inside the chest, the pump was connected directly to the patient's heart and powered by a small controller, outside the body, which Muskaan carried over her shoulders in a backpack.

"Unlike other artificial heart machines which require patients to stay in hospital, this device did allow Muskaan and her family to return home until a heart became available for transplant," says Dr. Holger Buchholz, Director, Pediatric Artificial Heart Program, Stollery Children's Hospital.

After 10 months with the pump, Muskaan developed an infection, which required hospitalization. During her stay at the Stollery, a heart became available and she received a heart transplant in July 2013.

The Pediatric VAD Program at the Stollery is one of the largest such pediatric programs in North America.

Hip, hip hooray for shorter wait

Patients seeking pre- and post-operative care at Edmonton's only hip and knee clinic have seen wait times cut by 80 per cent thanks to a wait-time reduction initiative supported by AHS and other partners. In a one-year period, the wait time between referral to the Edmonton Musculoskeletal Centre (hip and knee clinic) and initial consult has been cut to less than two months from 10 months.

New hope for lung transplants

Edmonton is now home to the country's only portable Ex-Vivo lung perfusion device — a technology that strengthens and repairs donor lungs prior to surgery — which gives new hope to approximately 60 Albertans currently awaiting a lung transplant. The Ex-Vivo program was established through a partnership between AHS, the University of Alberta and the University Hospital Foundation.

EMS brings palliative care home

The new Palliative Care and Treat in Place program in Edmonton Zone sees Emergency Medical Services (EMS), Continuing Care and family physicians collaborate in palliative care for patients at home, reducing the need for emergency department admissions. The initiative allows a health care professional to contact EMS and have a paramedic unit dispatched to help in a symptom crisis.

NeuroGym patients make big strides

The arrival of two NeuroGym Bungee Mobility Trainers at WestView Health Centre in Stony Plain is helping patients to retrain their brain as they relearn walking ability and stability. The body-weight support device allows for the safe retraining of gait and natural protective reactions that prevent falls, such as side-stepping, by helping patients recover their sense of balance.

moveEZ inspires elderly to get up, be active

Vienna-raised and PhD educated, Joseph Richter enjoys lively conversation and keeping up on current events. When the 93-year-old came to the Glenrose Rehabilitation Hospital after breaking his hip in a fall, he soon found himself spending time with bright students who not only helped him get back on his feet, but who provided engaging companionship for the journey.

This Edmontonian is one of many elderly patients at the Glenrose who are getting up and moving around more often as part of a new AHS program designed to prevent the functional decline of elderly patients during their stay.

The moveEZ program — the only initiative of its kind in Western Canada — employs university student volunteers to visit patients after-hours and on weekends and encourage them to move around as they share quality social time. Up to 24 patients take advantage of moveEZ visits weekly.

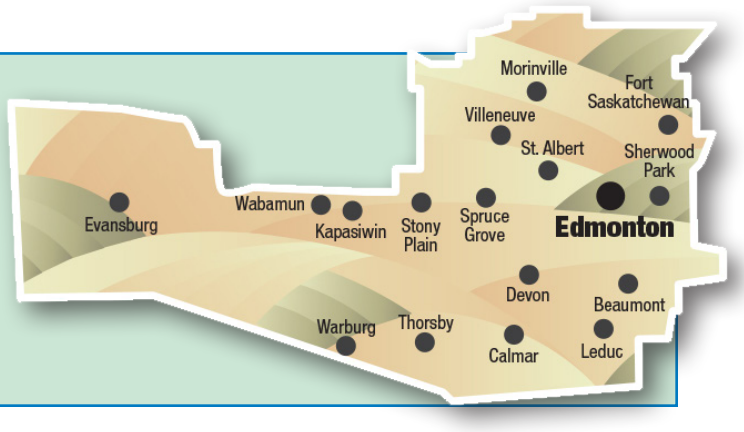
"I really enjoy the program and the students," says Richter. "I'm very grateful for all that they do."

Joseph Richter, 93, enjoys a walk with moveEZ volunteers Alyssa Gummer, left, and Lin Yuan at Glenrose Rehabilitation Hospital in Edmonton.

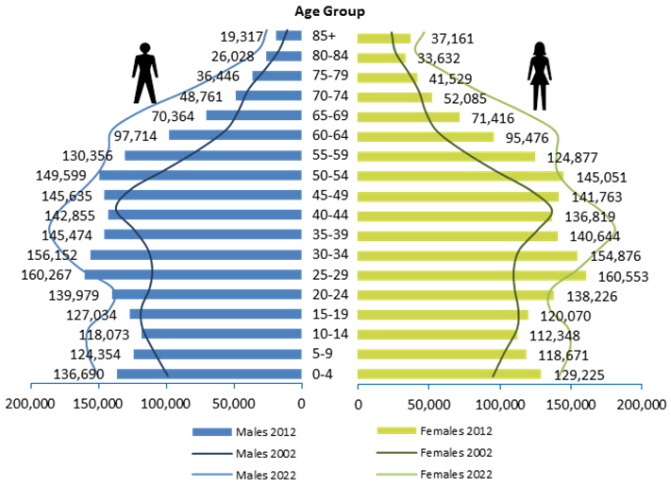
EDMONTON ZONE *At a Glance* »

Edmonton Zone Facts

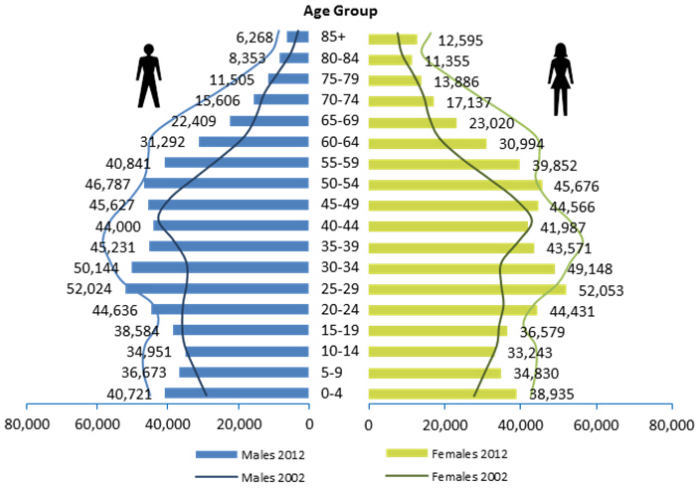
Population: 1,269,772 (2013) • **Land Mass:** 11,800 km²
Life Expectancy: 81.9 years (2013) • **Median Age:** 36.2 years (2013)
Seniors Population: 11.5% of zone is 65 years old and older (2012)
Births: 18,375 • **Hospitals:** 13 • **Physicians:** 3,342
Employees: 31,497 • **Volunteers:** 2,522
Meals Served: More than 3.5 million per year



Projected Provincial Growth to 2021



Projected Edmonton Zone Growth to 2021



Facilities and Beds

Edmonton Zone	Community Ambulatory Care	Addiction & Mental Health	Acute Care	Cancer Care	Continuing Care (long-term care, supportive living & palliative)	TOTAL
# of Facilities	1 urgent care centres 1 Family Care Clinic 22 Public Health Centres	2 standalone psychiatric 9 addiction facilities 9 community mental health facilities	5 urban hospitals 7 community hospitals 1 standalone emergency departments	1 cancer centre (Cross Cancer Institute)	82 continuing care facilities 60 contracted care homes	**200**
# of Beds	not applicable	960	3,078 acute & subacute		8,390	**12,428**

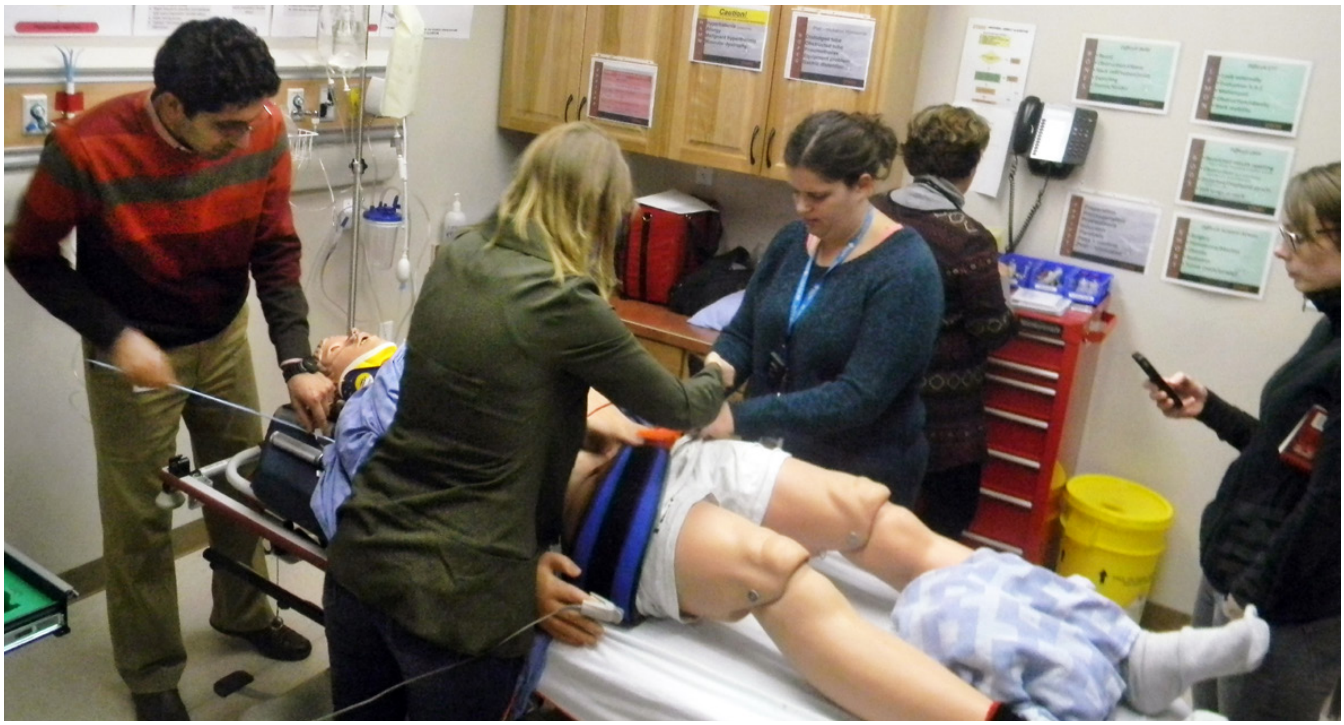
Note: The above facility counts are based on physical building structures in Alberta. To avoid double counting, it is important to note that programs/services related to the above areas (i.e. addiction, mental health, hospice, etc.) reside within multiple facilities.

For more detail, please see Appendix (Reported Beds Staffed and in Operation Summary as of March 31, 2014).

Edmonton Zone Quick Facts	2012-13	2013-14	% Change 2012-13 to 2013-14	% of Province
Primary Care / Population Health				
Home Care Clients	37,604	38,011	1%	34%
Number of People Placed in Continuing Care	2,620	2,742	5%	36%
Health Link Calls	283,410	296,362	5%	38%
Seasonal Influenza Immunizations	298,712	387,959	30%	34%
Food Safety Inspections	28,234	29,678	5%	31%
Acute Care				
Emergency Department Visits (all sites)	492,014	502,839	2%	23%
Urgent Care Visits	18,896	23,537	25%	11%
Hospital Discharges	132,343	135,974	3%	35%
Births	17,849	18,375	3%	35%
Total Hospital Days	933,814	940,915	1%	35%
Average Length of Stay (in days)	7.1	6.9	-2%	not applicable
Diagnostic / Specific Procedures				
Total Hip Replacements (scheduled and emergency)	2,040	1,937	-5%	37%
Total Knee Replacements (scheduled and emergency)	2,305	2,154	-7%	35%
Cataract Surgery	14,480	14,525	0%	40%
Main Operating Room Activity	99,691	105,610	6%	39%
MRI exams[1]	73,570	75,665	3%	40%
CT exams	133,007	139,743	5%	38%
X-rays[1]	585,759	597,028	2%	32%
Lab Tests	25,730,945	26,753,478	4%	38%
Cancer Care				
Cancer Patient Visits (patients may have multiple visits)	320,344	319,104	0%	57%
Unique Cancer Patients	22,769	23,507	3%	46%
Addiction & Mental Health				
Mental Health Hospital Discharges (acute care sites)	5,861	6,064	3%	29%
Addiction Residential Treatment & Detoxification Discharges	4,364	4,285	-2%	43%
Staffing				
Head Count[2]	31,380	31,497	0%	33%
Volunteers[3]	3,052	2,522	-17%	16%
AHS Physicians	3,241	3,342	3%	38%
Per Cent of Healthcare Workers Immunized	35.7	39.1	10%	not applicable

[1]MRI exam (in 2011-12) and X-ray (in 2012-13) count converted to new methodology from the Common Procedures Exam List (CPEL) to CIHI.*
[2]Head Count excludes Covenant Health, United Church of Canada and wholly-owned subsidiaries such as Carewest, CapitalCare Group and Calgary Laboratory Services.
[3]The overall numbers have decreased due to the elimination of duplicate volunteer records.

NORTH ZONE HIGHLIGHTS FOR 2013-14 »



Family medicine residents, including Ali Adbalvand, left, work to save a 'patient' from a drug overdose while, in a control room behind a one-way mirror, STARS Mobile Education Leaders Chris Larose and Manpreet Uppal control the lifelike mannequin.

Simulator sharpens future physicians' skills

High-tech patient mannequin keeps family medicine residents on their toes as Rural Alberta North program at Queen Elizabeth II (QEII) Hospital gets a big lift from the mobile educators of STARS Air Ambulance.

Family medicine residents from the University of Alberta's Rural Alberta North (RAN) program at the QEII Hospital in Grande Prairie are thinking faster on their feet thanks to a high-tech patient simulator and a new partnership with the mobile educators of STARS Air Ambulance.

"Simulation training helps rural family medicine residents maintain and improve their abilities to deal with acute life-threatening situations," says Dr. Valentine Duta, a family physician and co-director of the RAN program.

"Because of this training, our residents are better prepared for working in rural and remote locations, where they don't have the same backup found in large hospitals."

The mannequin breathes, has heart and lung sounds, vital signs, reactive eyes, an airway and more. Its real-life resemblance allows residents to apply their skills in more realistic emergency situations staged monthly at the STARS Air Ambulance headquarters in Grande Prairie.

Manpreet Uppal, a flight paramedic and mobile education leader with STARS, creates lifelike emergency scenarios. He and his co-worker Chris Larose control the patient's symptoms and reactions from a control room hidden behind a one-way mirror.

"We are very lucky to be able to experience this type of training," says Ali Adbalvand, a second-year medical resident with RAN.

Better connected, better care

Along with a blood-pressure cuff and a stethoscope, nurse care managers in Grande Prairie now tote a laptop on home care visits. This allows remote access to patients' electronic medical records for a timely review of their most recent, accurate health information and findings from ED and acute care. A home care case manager in the QEII Hospital also ensures consistent care.

I Am a Person First helps homeless

Local government, business and community leaders in Fort McMurray have joined forces with Alberta Health Services for I Am a Person First — a campaign launched in November that aims to reduce the social stigma surrounding the homeless population and mental health and addiction issues. Seeing the homeless as people first reduces internalized stigma they often face and can boost their self-esteem.

Website promotes healthy employees

Employers have a new resource that describes the supports they can access to help employees who are experiencing serious difficulties resulting from alcohol and drug use. AHS has launched a new website — www.businessindustryclinic.ca — that outlines services available at the Business and Industry Clinic, in Grande Prairie's specialized Northern Addictions Centre.

Crayons inspire snowmobile safety

Kids can have fun learning how to help out in times of emergency thanks to *Nolan and the Snowmobile Crash Colouring Book*, a 12-page publication created by AHS Emergency Medical Services in Grande Prairie and funded, in part, by the Regional EMS Foundation. The book tells the story of a boy and his father on a snowmobile trip in a mountainous region of northern Alberta. Nolan takes action with a call to 911.

AIM makes immunization easier

Being on hand at kindergarten registration to book children for their immunizations is just one of the ideas Grande Prairie Public Health staff adopted to give quicker and easier access to immunization services.

Jason Arlint says he's glad it only took one stop to register his son Mitchell for both school and his AHS immunization.

"Anything that saves time when you have young children is a good thing," says Arlint.

It's all part of the Alberta Access, Improvement, Measures (AIM) project — an initiative to improve quality by supporting health-care teams to become more efficient. It focuses on improving access through quicker appointments and less waiting at appointments.

Prior to the start of the AIM project in June 2012, people were waiting upwards of 28 days to get an immunization appointment.

Since the project started, the wait time to get an appointment has dropped to as low as 14 days, with improvement continuing.

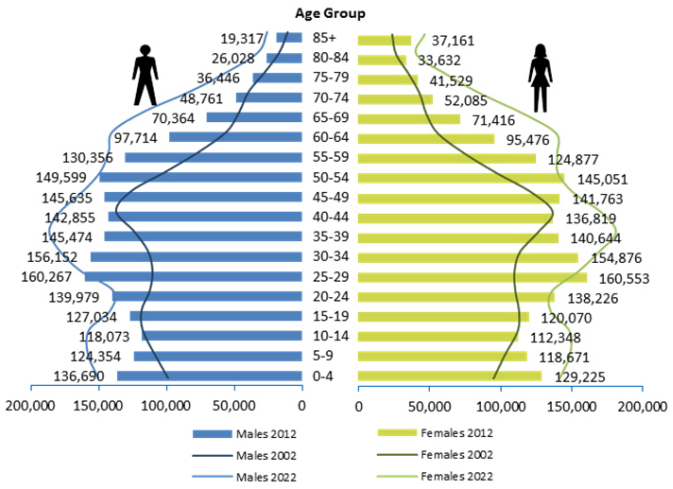
Public health nurse Caitlin Rathburn gets set to immunize Jason Arlint's son Mitchell.

NORTH ZONE *At a Glance* »

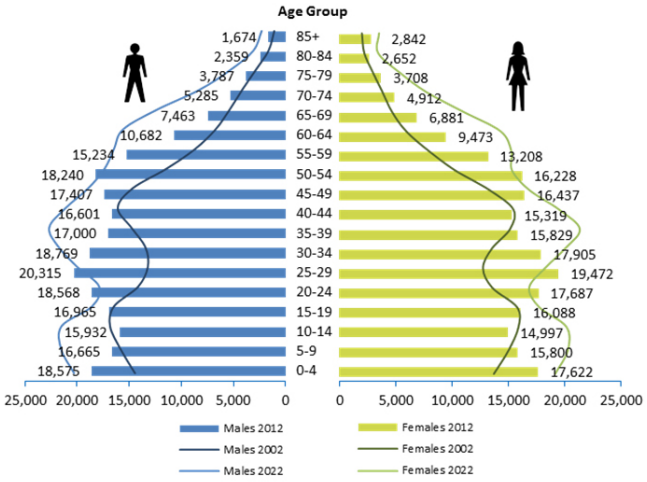
North Zone Facts

Population: 474,235 (2013) • **Land Mass:** 448,500 km²
Life Expectancy: 79.8 years (2013) • **Median Age:** 33.5 years (2013)
Seniors Population: 8.9% of zone is 65 years old and older (2012)
Births: 6,299 • **Hospitals:** 34 • **Physicians:** 477
Employees: 9,987 • **Volunteers:** 3,356
Meals Served: More than 1.6 million per year

Projected Provincial Growth to 2021



Projected North Zone Growth to 2021



Facilities and Beds

North Zone	Community Ambulatory Care	Addiction & Mental Health	Acute Care	Cancer Care	Continuing Care (long-term care, supportive living & palliative)	TOTAL
# of Facilities	2 Ambulatory Care Centres 1 Family Care Clinic 37 Public Health Centres	7 addiction facilities 2 community mental health facilities	2 regional hospital 32 community hospitals	6 cancer centres (Barrhead, Bonnyville, Fort McMurray, Grande Prairie, Hinton and Peace River)	53 continuing care facilities	**142**
# of Beds	not applicable	132	920 acute & subacute		1,947	**2,999**

Note: The above facility counts are based on physical building structures in Alberta. To avoid double counting, it is important to note that programs/services related to the above areas (i.e. addiction, mental health, hospice, etc.) reside within multiple facilities.

For more detail, please see Appendix (Reported Beds Staffed and in Operation Summary as of March 31, 2014).

North Zone Quick Facts	2012-13	2013-14	% Change 2012-13 to 2013-14	% of Province
Primary Care / Population Health				
Home Care Clients	11,642	12,332	6%	11%
Number of People Placed in Continuing Care	629	731	16%	10%
Health Link Calls	65,948	66,743	1%	9%
Seasonal Influenza Immunizations	86,358	109,501	27%	9%
Food Safety Inspections	14,793	14,878	1%	16%
Acute Care				
Emergency Department Visits (all sites)	591,677	585,295	-1%	27%
Hospital Discharges	45,098	45,513	1%	12%
Births	6,247	6,299	1%	12%
Total Hospital Days	250,804	247,758	-1%	9%
Average Length of Stay (in days)	5.6	5.4	-3%	not applicable
Diagnostic / Specific Procedures				
Total Hip Replacements (scheduled and emergency)	282	310	10%	6%
Total Knee Replacements (scheduled and emergency)	396	410	4%	7%
Cataract Surgery	2,102	2,313	10%	6%
Main Operating Room Activity	22,581	23,478	4%	9%
MRI exams[1]	12,995	12,569	-3%	7%
CT exams	31,455	32,309	3%	9%
X-rays[1]	296,496	295,275	0%	16%
Lab Tests	4,672,572	4,774,459	2%	7%
Cancer Care				
Cancer Patient Visits (patients may have multiple visits)	13,956	14,469	4%	3%
Unique Cancer Patients	2,121	2,272	7%	4%
Addiction & Mental Health				
Mental Health Hospital Discharges (acute care sites)	2,662	2,962	11%	14%
Addiction Residential Treatment & Detoxification Discharges	1,607	1,623	1%	16%
Staffing				
Head Count[2]	9,804	9,987	2%	10%
Volunteers[3]	4,482	3,356	-25%	22%
AHS Physicians	462	477	3%	5%
Per Cent of Healthcare Workers Immunized	26.9	30.2	12%	not applicable

[1]MRI exam (in 2011-12) and X-ray (in 2012-13) count converted to new methodology from the Common Procedures Exam List (CPEL) to CIHI.
[2]Head Count excludes Covenant Health, United Church of Canada and wholly-owned subsidiaries such as Carewest, CapitalCare Group and Calgary Laboratory Services.
[3]The overall numbers have decreased due to the elimination of duplicate volunteer records.

RESEARCH AND INNOVATION HIGHLIGHTS FOR 2013-14 »

Lawna Hurl and her son Deacon took part in a pertussis vaccine study, led at the Alberta Children's Hospital in Calgary by Dr. Otto Vanderkooi.

Enhancing whooping cough protection

Calgarian Lawna Hurl says she "signed up on the spot" when a researcher approached her at a maternity clinic about participating in a study related to the pertussis vaccine.

Moms-to-be in both Calgary and Edmonton have been helping researchers determine whether giving pregnant women the pertussis vaccine will protect their newborns for the first few months of life.

Babies are particularly vulnerable to the potentially fatal respiratory infection — more commonly known as whooping cough — until at least partial immunity develops following immunization at two months of age.

"I know that pertussis is something the really little ones can get and so I thought it was worth helping out with this," says Hurl.

Whooping cough starts as a mild cold but rapidly progresses to a severe cough that can include a gasping intake of breath. Very young children may develop significant distress and require hospitalization. Recovery can take months.

"Most people think of whooping cough as a disease of the past but we still have many cases of pertussis in Canada each year," says Dr. Wendy Vaudry, a pediatric infectious disease specialist with Stollery Children's Hospital.

Dr. Otto Vanderkooi, a pediatric infectious disease specialist with Alberta Children's Hospital, says the study could result in another tool for prevention.

"Depending on the findings, it could be an effective strategy to eliminate or lessen the severity of the illness in the youngest and most vulnerable age group."

Wii tested for rehab

Calgary researchers are studying the use of a popular gaming system in stroke rehabilitation as part of a nationwide study that could lead to improved outcomes for patients. The study examines the effectiveness of using Nintendo Wii – a virtual reality gaming system – in rehabilitating stroke patients who have limited mobility. The study involves 160 stroke patients across Canada, including about 20 at two sites in Calgary.

Dangers of herbal shisha

Researchers with Alberta Health Services and the University of Alberta found that samples of some herbal shisha products sold in Alberta contain similar levels of toxic trace metals and cancer-causing chemicals found in cigarette tobacco. The Government of Alberta referenced the research study, which was funded by AHS and Health Canada, when it announced in November its support for a bill calling for a ban on flavoured tobacco products, such as herbal shisha.

Radioactive seeds

Oncologists at the Tom Baker Cancer Centre in Calgary are now performing an innovative breast cancer treatment that uses implanted radioactive seeds, each the size of a grain of rice, to eradicate remaining cancer cells weeks after the removal of a tumour. It's a first in Alberta where about 20 low-risk patients will be part of a national study on a one-day procedure, called breast brachytherapy, which could provide another option for treatment.

New methods for treating clubfoot

Parents of babies born with the deformity of the foot and ankle known as clubfoot can now access a new clinic at the Stollery Children's Hospital in Edmonton. The new Clubfoot Clinic offers a rehabilitation program that corrects the condition without major surgery, and reduces the possibility of relapse. Clubfoot affects the muscles, ligaments, bones and joints of the developing foot and ankle, causing one or both feet to curl in and down.

Refining the use of heart technology

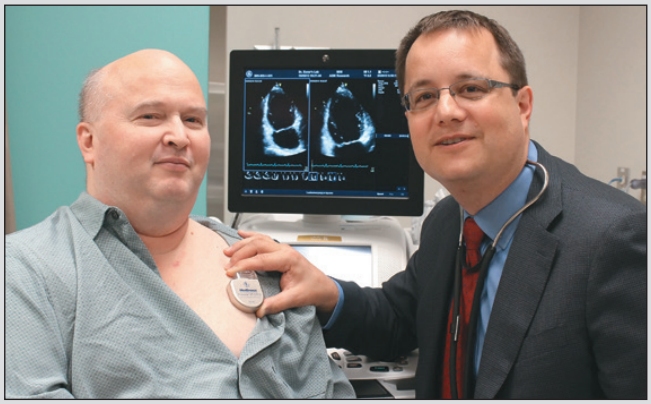
Lethbridge resident Gordon Skidmore woke up one October night in 2011 with the feeling something was sitting on his chest.

He was having a heart attack. Living in Calgary at the time, he wound up in the intensive care unit at Foothills Medical Centre and subsequently had bypass surgery. Today, Skidmore is taking part in research aimed at saving the lives of more cardiac patients.

As part of the study, he has an implantable cardioverter defibrillator, or ICD, which is a small device implanted under the skin that monitors heart rhythm and automatically corrects heart rhythm abnormalities.

"Our present approach to prescribing ICD therapy identifies only one in four people at risk," says cardiologist Dr. Derek Exner, principal investigator of the study. "The goal of this research is to better identify those at risk in order to save more lives."

Researchers are recruiting participants from Foothills Medical Centre in Calgary, the Royal Alexandra Hospital and the Mazankowski Alberta Heart Institute in Edmonton, and the Chinook Regional Hospital in Lethbridge.



Calgary cardiologist and researcher Dr. Derek Exner places an implantable cardioverter defibrillator on the chest of Gordon Skidmore, who had a similar device implanted following a heart attack in 2011.

STRATEGIC CLINICAL NETWORKS HIGHLIGHTS FOR 2013-14 »

Marshall Bye says the sparkle came back in his wife Evelyn's eyes, thanks to an innovative project led by Seniors Health and Addiction and Mental Health Strategic Clinical Networks.

Finding alternatives to antipsychotic medications

Marshall and Evelyn Bye have made the most of their 60 years of marriage, enjoying dancing, travelling the world and sharing more than a few laughs.

But in the year before her death in May 2014, 93-year-old Evelyn began to deteriorate. The dementia she had struggled with for the past decade worsened and she spent most of her days sleeping. At times she could barely recognize Marshall.

When he learned about a new approach taken by Alberta Health Services (AHS) to better manage the anxiety and behavioral challenges of dementia by reducing the use of antipsychotic medications, he was quick to sign up Evelyn.

"I have always had faith in the staff and felt that we had little to lose and lots to gain," says Marshall. "Her eyes sparkled sometimes, which was not the case eight to 10 months before."

Led by the Seniors Health Strategic Clinical Network (SCN) and the Addiction and Mental Health SCN, 11 long-term care sites across the province are helping to research, review and implement new guidelines around the appropriate use of antipsychotic medications.

The project is looking at alternative treatments, such as music, exercise and art. It ensures residents, families or other decision-makers, physicians, and staff work together to investigate and trial innovative approaches.

Preliminary data is positive, showing more than 35 per cent of those residents are no longer using an antipsychotic medication. On completion, the SCNs will review findings and implement new approaches across the province.

New procedure fixes bones

For Joan Poplawski, recovering from surgery last spring was much smoother than she expected, thanks to a new Strategic Clinical Network (SCN) initiative.

The Enhanced Recovery After Surgery (ERAS) project standardizes care before, during and after surgery, in an effort to get patients back on their feet sooner while shortening hospital stays and reducing complications.

Drawing from best practices around the world, the project improves protocols related to nutrition, mobility after surgery, and anesthetics and pain control.

Poplawski was one of the first patients to benefit from the protocols when she had colorectal surgery at the Grey Nuns Community Hospital in Edmonton.

"Everything went very, very smoothly," says Poplawski. "The pre-op education by both the surgeon and nurse was unbelievably helpful."

ERAS reduces complications by up to 50 per cent and decreases hospital stays by 30 per cent.

ERAS is led by the Obesity, Diabetes and Nutrition SCN and supported by the Surgery SCN. AHS is one of the first organizations in Canada to introduce ERAS protocols.

SCNs – driving innovation to improve health care

Strategic Clinical Networks (SCNs) are engines of innovation, bringing together people who are passionate and knowledgeable about specific areas of health to find new and creative ways of delivering evidence-based care.

By the end of 2013-14, there were 10 SCNs, made up of patients and families, physicians, clinicians, community partners, researchers and staff:

- Addiction and Mental Health
- Bone and Joint Health
- Cancer
- Cardiovascular Health and Stroke
- Critical Care
- Emergency
- Obesity, Diabetes and Nutrition
- Respiratory
- Seniors' Health
- Surgery

Over the last year, the SCNs have continued working on improving the health care system and are currently focused on nine projects, including:

- Access for referral & triage eReferral
- Adult coding access target for surgery
- Appropriate use of antipsychotics in long-term care
- Enhanced recovery after surgery
- Fragility and stability program
- Insulin pump therapy
- Safe surgery checklist
- Stroke action plan
- Vascular risk reduction

In addition to those projects, nine research grants were awarded in early 2014 by the newly created Partnership for Research and Innovation in the Health System (PRIHS) fund, which was created by AHS and Alberta Innovates – Health Solutions. Worth a total of $7.5 million, the three-year projects include:

- Researching strain on intensive care units
- Creating a seniors surgery unit
- Improving care for people suffering back pain
- Developing a rectal cancer school for clinicians
- Improving prevention, outcomes and access to care for those with heart rhythm disorders
- Standardizing the use of CT scans in emergency departments
- Expanding the Enhanced Recovery After Surgery (ERAS) program
- Improving specialized hospital care for obese patients
- Creating a centralized way of caring for arthritis patients
- Improving care for critically ill patients in intensive care

2013-14 HEALTH ACTION PLAN RESULTS

Alberta Health Services is working to continually improve the quality of care we provide to Albertans. In all areas of 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 course of the past year, we have undertaken many activities and monitored our progress every step of the way.

We've come a long way since the former health regions were amalgamated into AHS, and we will keep working to improve health services in this province, while we continue to update you on our progress.

The following summarizes the key actions which were identified in the *AHS 2013-14 Action Plan: Supplement to Health Plan and Business Plan 2013-2016*. These actions are provincial in nature, represent innovation and/or will significantly impact how services are delivered. The actions align with the three strategic directions outlined earlier in this report as follows:

1. Bringing Appropriate Care to the Community

a. Primary and Community Care
b. Health Link
c. Emergency Medical Services
d. Continuing Care
e. Population and Public Health

2. Partnering for Better Health Outcomes

a. Mental Health
b. Cancer
c. Patient Flow and Access
d. Strategic Clinical Networks
e. Research and Innovation

3. Achieving Health System Sustainability

a. Workforce
b. Financial
c. Information Technology
d. Quality Improvement

PERFORMANCE MEASURES

In collaboration with Alberta Health, Alberta Health Services established 16 performance measures in January 2014 to help us continue to build and strengthen our health care system. We will continue to monitor other measures to help support the health and well-being of all Albertans and the support of our front-line health care providers.

We've streamlined performance measures to ensure they represent the broad spectrum of health care, including targets for community-based care and patient outcomes. We've added measures that align with national standards where possible, so Albertans can easily compare the performance of our health system with other health systems across Canada. Having measures aligned with national and Western Canadian benchmarks improves the transparency of our reporting by putting our accomplishments into a broader context.

The Alberta Quality Matrix for Health provides a way of organizing information and thinking around the complexity of the health system.

The matrix has two components:

1. Dimensions of quality, which focus on aspects of the patient/client experience

2. Areas of need, which divides the range of services offered by the health system into four distinct, but related, categories.

    i. Being Healthy: Achieving health and preventing occurrence of injuries, illness, chronic conditions and resulting disabilities.

    ii. Getting Better: Care related to acute illness or injury.

    iii. Living with Illness or Disability: Care and support related to chronic or recurrent illness or disability.

    iv. End of Life: Care and support that aims to relieve suffering and improve quality of living with or dying from advanced illness or bereavement.

The Quality Matrix allows the public, patients, providers, and organizations to see how levels of quality and areas of need might intersect. It has been used in numerous ways, including policy development, strategic planning, and as a way to educate the public about quality in healthcare.

Our performance measures are organized by the Alberta Quality Matrix for Health, which describes six dimensions of quality.

Acceptability	Health services are respectful and responsive to user needs, preferences and expectations.
Accessibility	Health services are obtained in the most suitable setting in a reasonable time and distance.
Appropriateness	Health services are relevant to user needs and are based on accepted or evidence-based practice.
Effectiveness	Health services are provided based on scientific knowledge to achieve desired outcomes.
Efficiency	Resources are optimally used in achieving desired outcomes.
Safety	Mitigate risks to avoid unintended or harmful results.

Targets have been created for the new 16 performance measures for 2014-15 and 2015-16; since the new measures were released near the end of 2013-14, targets were not established for 2013-14. The performance targets for 2014-15 and 2015-16 are challenging but achievable. At present, we are on track to achieve the targets set for 2014-15. These performance targets will help us measure our progress and improve the health system.

PERFORMANCE MEASURES (continued)

The following chart demonstrates trending of Alberta Health Services' system performance measures. Six out of 16 measures have 2013-14 data. Seven measures reflect the third quarter year-to-date data (April 1, 2013 to December 31, 2013); once 2013-14 data is available for these seven measures; the chart below will be refreshed and published. Two measures are only reported annually (i.e., satisfaction with long-term care and early detection of cancer). One other measure – "Emergency Department Wait to See a Physician", is currently under development.

The trend column indicates comparison of the most recent 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.

Performance Measures	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	Trend
Early Detection of Cancer: Are we diagnosing cancer in its early stages? *The percentage of patients with breast, cervical and colorectal cancers who are diagnosed at early stages.*	64.9% (2007)	64.6% (2008)	65.4% (2009)	66.6% (2010)	66.3% (2011)	pending	pending	↑
Mental Health Readmissions: Are mental health patients returning to hospital unexpectedly? *The percentage of mental health patients with unplanned readmission to hospital within 30 days of leaving hospital.*	not available	9.4%	9.2%	9.5%	9.4%	9.8%	9.3% (Q3 YTD)	→
Access to Radiation Therapy: How long do most patients wait for radiation therapy? *The length of time or less that 9 out of 10 patients wait to receive radiation therapy (in weeks).*	not available	5.0	5.3	3.6	3.1	3.0	3.0	↑
Emergency Department Length of Stay for Admitted Patients (hours): How long does a patient stay in the emergency department before moving to a hospital bed? *The average patient's length of time in the emergency department before being admitted to a hospital bed at the 16 busiest emergency departments.*	not available	10.8	10.3	9.8	8.8	8.7	8.9	↑
Emergency Department Length of Stay for Discharged Patients (hours): How long does a patient stay in emergency department before going home if they don't need to stay in hospital? *The average patient's length of time in the emergency department before being discharged at the 17 busiest emergency departments.*	not available	3.2	3.1	3.1	3.1	3.1	3.0	↑
Satisfaction with Hospital Care: Are patients satisfied with their hospital care? *The 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.*	not available			81%	84%	81%	81% (Q3 YTD)	→

Performance Measures	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	Trend
Actual Length of Stay Compared to Expected Stay: Are patients in hospitals longer than needed? *The 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 more than 3,200 more patients in hospital every year.*	not available	1.04	1.02	1.01	1.00	0.98	0.97	↑
Surgery Readmissions: Are surgery patients returning to hospital unexpectedly? *The percentage of surgical patients with unplanned readmission to hospital within 30 days of leaving hospital.*	not available	5.8%	5.9%	6.0%	6.3%	6.5%	6.6% (Q3 YTD)	↓
Satisfaction with Long-Term Care: Are families satisfied with the long-term care their loved ones received? *The percentage of families of long-term care residents who rated the overall care as 8, 9 or 10, where zero is the lowest level of satisfaction possible and 10 is the best.*	71%	This measure is updated every two years.		73%	This measure is updated every two years.		pending	↑
Continuing Care Placement: How many people are placed in continuing care within 30 days? *The percentage of people placed into continuing care within 30 days of being referred.*	not available			55%	64%	67%	69%	↑
Stroke Mortality: Are patients dying in the hospital following a stroke? *The percentage of patients dying in hospital within 30 days of being admitted for a stroke.*	16.1%	12.6%	11.7%	13.2%	13.5%	15.0%	14.3% (Q3 YTD)	↓
Heart Attack Mortality: Are patients dying in the hospital following a heart attack? *The percentage of patients dying in hospital within 30 days of being admitted for a heart attack.*	7.1%	6.5%	6.3%	6.2%	6.5%	5.9%	7.2% (Q3 YTD)	→
Hospital Mortality: Are more patients dying in the hospital than expected? *The actual number of deaths compared to the expected number of deaths in hospital. Values less than 100 mean fewer than expected deaths. In Alberta, a rate of 84 means 850 fewer deaths in hospital than expected each year.*	104	104	99	93	88	84	85 (Q3 YTD)	↑
Hand Hygiene: Are health care workers cleaning their hands to avoid spreading infections? *The percentage of times health care workers clean their hands during the course of patient care.*	not available				50%	59%	66%	↑
Hospital Acquired Infections: Are patients acquiring infections while in the hospital? *The number of Clostridium difficile infections (C-diff) acquired in hospital every 10,000 days of care. A rate of 4.1 means approximately 100 patients per month acquires C-diff infections in Alberta.*	not available				4.3	4.1	4.4 (Q3 YTD)	↓

Under development: **Emergency Department Wait to See a Physician:** How long are patients waiting to see a physician in the Emergency Department? The average patient's length of time in emergency department before being seen by a physician at the 17 busiest emergency departments.

PRIMARY AND COMMUNITY CARE

Alberta Health Services supports all Albertans in having access to a primary health care team with a range of providers no matter where patients enter the system. AHS is:

- Working with Alberta Health (AH) to increase the number of Family Care Clinics and enhance the services provided by primary care networks.
- Redesigning how we deliver care more appropriately to specific complex, high-needs populations.
- Developing an integrated primary health care service model, which will focus on linking many existing services to provide support to identified population groups.
- Developing collaborative team care models for populations with similar needs. Those groups will include the frail elderly, the vulnerable, complex high-needs children and youth, and those at the end of life.

With an aging population and the prevalence of chronic disease on the rise, it is imperative that we offer Albertans access to the best primary care system, and in turn, the best opportunity to maintain good health and access to the services they need, when they need them.

PRIORITY ACTIONS	PROGRESS/RESULTS
Complex High Needs Population: Develop innovative community-based service model(s) to address complex, high needs individuals/ populations.	• Edmonton Zone currently has five projects underway to address the health of complex high needs populations to improve their care, with a focus on: the inner-city team, addictions and reproductive health, Boyle McAuley Home Care team, high risk pre/ post-natal care, and EMS community-level services. The learning and approach used in Edmonton will be leveraged to support developmental work in other zones. • Calgary Zone has identified users of emergency department and inpatient services at the Peter Lougheed Centre that might benefit from integrated services at the Calgary East Family Care Clinic. • North Zone is working in Grande Prairie to assess utilization of complex, high needs populations with mental health issues.
Family Care Clinics (FCC): Further develop AHS FCCs and work with AH to increase the number of FCCs within the province.	• AHS continues to work with AH to increase the number of Family Care Clinics (FCCs) within the province. FCC's provide comprehensive primary health care services and connections to social/community services that align with the health needs of those areas. • 24 communities have been identified where there is a need for better access to primary health care. Three pilot projects were implemented in 2012 in Calgary, Edmonton and Slave Lake. • Albertans and community groups have been engaged to support the development of FCCs in targeted areas. • Business planning process is currently underway, but Alberta Health has extended the timeframe for FCC setup, business planning, and grant agreement development to allow FCC proponents time to undertake all the required work. • Work is also underway with the Complex High Needs Patients initiative to ensure needs for those populations within communities can be met through the development of new service models such as FCCs.
Primary Care Networks (PCN): Work with AH to enhance the work of PCNs through further development of common standards and expansion of the range of services where needed.	• The Primary Care Alliance (PCA) of the Alberta Medical Association (AMA) completed a draft blueprint for an enhanced Primary Care Network Program in Alberta (PCN Evolution). The blueprint incorporates input from PCA, AMA, Alberta Health, AHS and Alberta College of Family Physicians. • The Primary Health Care Evaluation Expert Advisory Group, led by AH, released the evaluation framework in November 2013 for the primary health care system. The evaluation framework focused on measures that lead to improved access, greater attachment, higher quality patient-centred care, better health outcomes and patient experiences, healthier choices, efficiency and accountability. • Thirteen PCNs are engaged in the Measurement Capacity Initiative, to build capacity for collaborative development of common quality and outcome measures in primary care. • Work continues with the Complex High Needs Patients initiative to define complex high needs population to ensure needs for those populations within communities are met through integration between AHS and PCNs. • Currently, there are a total of 42 primary care networks: South Zone - 2; Calgary Zone - 7; Central Zone - 12; Edmonton Zone - 9; North Zone - 12.

PRIORITY ACTIONS	PROGRESS/RESULTS

Community Service Delivery Alignment: Develop transformation plans to support the implementation of integrated community and primary care services, enhancing primary care, chronic disease management and other community based options.	• Worked with zones and communities to assess service needs and develop plans to address those needs, taking into account services that are available locally and within the surrounding area.
	• Developed Rural Service Access Guidelines including educational presentations; map guidebooks and interactive maps were posted on the AHS internal website.
	• Established the Rural Surgical & Obstetrical Guideline Advisory Committee with key zone and strategic partner membership. Final guideline documentation is currently in development.
	• Initiated other provincial chronic disease management activities including:
	  • Better Choices Better Health™ Online (self-management) License Agreement between AHS and the National Council on Aging.
	  • Working with Strategic Clinical Networks on clinical decision support tools to support standards in the supervised exercise program.
	  • Completed emotional eating patient education resource facilitator training in the South Zone.
	  • Formed provincial MEND (Mind, Exercise, Nutrition… Do-it!) working group with representation from all zones.
	  • Completed diversity workshop facilitator training in the Edmonton Zone.

In Summary: Alberta Health Services continues to work on improving the health and wellness of Albertans by improving access to and the quality of primary health care services. We are:

- Strengthening integration and collaboration across community-based services and primary health care providers by developing appropriate service delivery models to address the specific health needs of Albertans.
- Delivering innovative service delivery models to address the complex, high needs populations.

MyHealthAlberta and HEALTHLink Alberta

Significant work is underway to enhance access for all Albertans to health information and advice through MyHealthAlberta and Health Link Alberta. The staff, physicians and volunteers of AHS are also key partners in health and their voices will help us build a system that makes best use of their talents and improves the quality, outcomes and value of our health system.

PRIORITY ACTIONS	PROGRESS/RESULTS
Personal Health Portal (PHP): Work with Alberta Health to support the development of a personal health record for Albertans that can contain both self-entered and clinical reports from the provincial electronic health record, Alberta Netcare.	• The Personal Health Portal program is a collaborative provincial health system initiative that provides online personalized health information and services to Albertans through the MyHealth.Alberta.ca (MHA) portal. • On-line visits to the MyHealth.Alberta.ca website increased significantly over the year, reaching just under 1 million visits in 2013-14. • In 2013-14, the portal added a video library and search, a "Health and Alberta" library, learning modules with quiz tools, patient care information handouts on more than 3,000 different topics, Medication Safety pages, as well as consumer appropriate drug monographs for all prescribed, over the counter and herbal drugs available in Canada. • The portal also provided emerging content during the Southern Alberta floods and Alberta Influenza. • The Organ Tissue Donor Registry has been developed, and is made available through MHA. The registry allows Albertans to register their intent to become and organ and tissue donor. • MHA continues to form new partnerships with other AHS departments for subject matter and expert review of clinical content. Recent partnerships include the Pelvic Floor Clinic, Medication Reconciliation, Goals of Care, Physiotherapy, Chronic Kidney Disease, Enhanced Recovery After Surgery, Acute Pain Service and Fall Prevention.

PRIORITY ACTIONS	PROGRESS/RESULTS
Health Link Alberta (HLA)	• Health Link Alberta (HLA) has added two new services through partnerships with the Poison & Drug Information Service and AHS Nutrition Services, enabling convenient access to medication information and nutrition advice for callers. • HLA supported the development, posting and highlighting of flood related health information on MyHealth.Alberta.ca during the flooding in Calgary and Southern Alberta to enable easy access to accurate and timely information for the volunteers at the Flood Welcome Centres and the public. • HLA is partnering with the Bone and Joint Strategic Clinical Network to implement a new program called "Catch-a-Break", which identifies patients who have suffered a low impact fracture and are at risk for osteoporosis. HLA follows up with the patient and their physician to support appropriate screening, diagnosis and intervention. • HLA participated in the Calgary Zone Surge Capacity committee to plan for the diversion of appropriate patients who present to the emergency departments to Primary Care Network clinics. HLA support included the use of expanded triage criteria to the After-Hours Primary Care Network Clinics. • HLA experienced significant call volume related to influenza beginning in December and peaking in January 2014. HLA added information on the Influenza Immunization Clinic "look up tool" which provided accurate and up-to-date information to the public on immunization clinic locations across the province for the duration of the influenza season.

In Summary: MyHealth.Alberta.ca, Health Link Alberta and InformAlberta are growing by adding new content and functions that will help more Albertans to manage their own health. In January 2014, Alberta Health Services launched the "Know Your Options" campaign to help Albertans understand what their health care options are and when to use them, so that they get the right care, in the right place. This multimedia, multilingual campaign helps provide direction to the public to call HealthLink Alberta, or visit their family doctor as the starting point for health advice, or to visit the AHS website for more information about health care options.

EMERGENCY MEDICAL SERVICES

When Alberta was hit by historic flooding in June 2013, AHS Emergency Medical Services (EMS) was on the front lines of flood relief efforts. From sending its Multi Patient Unit – a big bus capable of transporting multiple patients at a time – to relocating patients in High River and Drumheller, to using community paramedics to assist patients access basic health care needs such as medication, minor wound care, prescriptions and housing – AHS EMS was there to ensure Albertans received the care they needed.

FOCUS	PROGRESS/RESULTS
EMS: Develop a provincial EMS system fully integrated within the overall health system.	• EMS is involved in an ongoing study with the University of Calgary's Ward of the 21st Century in the Ambulance Design Research Project, the first of its kind in Canada. Its findings on how to best use the limited space in the back of an ambulance could influence the safety, layout and functionality of future ambulances in AHS and across the country. • In May 2013, EMS announced the innovative Community Paramedic Program, which has teams of paramedics and EMTs dedicated to providing community care to patients. Focusing mainly on seniors, these health care professionals provide care in the patient's residence. The program is currently operating in Lethbridge and Calgary. It is estimated that this program has prevented about 700 emergency department visits in its first year of operation. • Critical Care Medical Control Protocols to support air medical personnel in treating patients were completed. This will ensure safe, consistent care for patients across the province as well as enhancing training and safety for staff. • EMS has worked on ways to improve processes for third-party and out of province patient billings for air ambulance. It is using a Patient Care Record database to identify billable clients and also engaging with providers to assist in identifying billable parties/patients. • To make sure service plan strategies are more connected at the local community level, EMS initiated a more proactive approach to engaging communities regarding service plan modeling. • The development of electronic Patient Care Record (ePCR) specific to the air ambulance environment will improve accuracy and completeness of clinical information during transport, facilitate data collection, reporting, medical review and oversight. The ePCR system design and clinical content was completed. ePCR implementation is scheduled for early Summer 2014 for all contracted Air Ambulance providers.

In Summary: Saving lives and improving care is a vital goal for Alberta Health Services. Whenever EMS is called upon, lives are potentially on the line. Ensuring we are providing the right care, at the right time, by the right provider, will save lives. As we strive to improve overall system performance, we have implemented a co-ordinated series of initiatives across the province to improve patient care. Protocols to support EMS personnel in treating patients and avoiding hospitalization will continue to be implemented.

CONTINUING CARE

It is estimated, that by 2030, one out of five Albertans will be more than 65 years old and the average age of Alberta's population will continue to increase. Many seniors will be more independent and healthier than in previous generations. Others, including those with multiple chronic illness and disabilities, will need health care and will want options that allow them to receive care while continuing to live in their own homes and communities. With more options available and better access to caregivers, seniors will be able to live independently as long as possible.

PRIORITY ACTIONS	PROGRESS/RESULTS
Home Care Standardization: Streamline and standardize home care services.	• A Request for Proposals (RFP) was issued and concluded in Edmonton and Calgary Zones which resulted in a significant reduction in both the number of contracts and cost of services. All operators are now on standard contract terms with consistent accountabilities and funded rates. • Planning began in the zones to address equity between urban and rural zones, particularly with respect to personal care, respite care and caregiver support and Adult Day Program access. • Work is underway to expand existing adult day programs and to launch new adult day programs in both Calgary and Edmonton in early 2014-15. This will benefit more than 500 additional seniors.
Continuing Care Options and Capacity: Further development of continuing care spaces, options and capacity.	• A total of 335 net spaces were staffed and placed into operation in the 2013-14 fiscal year. • From April 1, 2010 to March 31, 2014, 3,369 net new continuing care and palliative spaces have been staffed and placed into operation. • As anticipated, 2013-14 has been a challenging year for net capacity increases. The unavoidable loss of space related to the southern Alberta flood and contract issues further decreased net new capacity. • Work continued to expand implementation of the Advance Care Planning Goals of Care across the province.

In Summary: Seniors have told us they want to remain safe and independent in their own homes, for as long as possible. In response, AHS is expanding services, and providing more home care to Alberta's seniors than ever before.

AHS continues to expand home care by adding more hours for those requiring short-term care, in order to prevent hospitalization or an emergency situation. There is a 2.8 per cent increase (3,043 clients) between 2012-13 and 2013-14 volume of home care clients served. In total for 2013-14, AHS had 112,227 home care clients across the province. All zones will continue to implement the new service guidelines and to educate staff to the new guidelines. In order to manage increased referrals from acute care, AHS implemented enhanced home care capacity to seven days a week with evening access to home care. Destination Home continues to increase home care services to clients with complex needs in Calgary and Edmonton.

AHS continues to expand seniors' health options to respond to our changing demographics and to provide quality care and support to Albertans and their families and caregivers. In 2013-14, 335 beds were added to the system which now totals 3,369 additional beds since 2010. Home care and adult day programs expanded in 2013-14 with 95 new adult day program spaces to meet the needs of Albertans. AHS has increased the unique number of home care clients by 12 per cent since 2010-11.

Unexpected or sudden medical events can leave us unable to communicate our wishes. Other medical conditions can slowly take away our ability to communicate or make decisions about our health care. Goals of Care and Advanced Care Planning are two initiatives which recognize the importance of understanding an individual's values regarding care choices and serves as a communication tool for individuals and health care professionals. In times of crisis, health care providers are enabled to provide timely care that is medically appropriate and meets the family's personal values and wishes. AHS will continue to ensure Albertans have an opportunity to document an at-a-glance summary of the focus of care and what the patient and family will and will not permit, preventing unwanted interventions especially during a medical crisis.

POPULATION HEALTH

In working to improve the health of all Albertans, we also recognize the need to promote better health and reduce health inequities. Enabling people to stay well and to minimize their need to access health services will improve both the quality of life for Albertans and enable the system to be more sustainable. This focus on health promotion and wellness underlies all of what we do across the continuum of care within AHS and requires full partnership with the public, government and a variety of stakeholders. This year, AHS worked with partners across Government of Alberta Ministries including Health, Education and Human Services to deliver greater coordination and integration for initiatives such as the Early Childhood Development Strategy.

PRIORITY ACTIONS	PROGRESS/RESULTS
Children and Youth – Nutrition, Activity and Mental Health: Partner with schools, school jurisdictions and community organizations to plan and carry out initiatives that increase availability of healthy foods and beverages, expand opportunities to be physically active, and improve mental health for children and youth.	• Comprehensive School Health (CSH) is an evidence-based approach to building healthy school communities. AHS collaborates with schools, school jurisdictions and community organizations to develop knowledge and skills; create supportive environments; and facilitate healthy policy development to support healthy eating, active living and positive mental health. • Completed report summarizing work between AHS, education sectors and community organizations to achieve the goals of promoting healthy eating, active living, and positive well-being to support healthy weights in school-aged children and youth. The report highlights that 90 per cent (target was 75 per cent) of school jurisdictions are partnering with AHS. • An external website **www.everactive.org/shaping-the-future** was established. Fifteen new CSH educational resources were added to the website which was further promoted through emails to AHS staff, schools, school jurisdictions and submissions to relevant school health newsletters.
Early Childhood Development: Work with the Ministries of Health, Education, Justice and Solicitor General, and Human Services to implement the Regional Collaborative Service Delivery Model (RCSDM) in support of early childhood development.	• AHS collaborated with the Ministries of Health, Education, Justice and Solicitor General, and Human Services to better integrate programs, services and supports for children and youth. This is an Alberta Education led initiative supported by AHS Primary and Community Care, Addiction and Mental Health. This initiative is intended to improve supports for children and youth in schools, including early childhood programs, and those between the ages of 0-20 years with complex needs and/or requiring extraordinary care. • Regional Collaborative Service Delivery merged the Student Health Partnerships, Children and Youth with Complex Needs and Regional Educational Consulting Services programs into 17 regional groups. Strategic plans were developed and approved by the 17 regional groups. • Implementation of the Regional Collaborative Service Delivery model is underway.
Infant and Pre-School Screening and Follow-Up: Work with AH to implement the Infant and Preschool Screening and Follow-Up Services Framework and the Early Childhood Development Priority Initiative.	• The Newborn Metabolic Screening (NMS) Program Initiative (2010-2015) will ensure all infants born in Alberta receive timely access to safe and effective newborn blood spot screening to support Newborn Metabolic Screening. • AHS completed NMS Program clinical policy suite implementation and evaluation plans. • 99.4 per cent of all newborns in the province are currently screened. Planning underway with Alberta Health regarding the implementation of the Infant and Preschool Screening and Follow-up Services Framework.
Child Injury Prevention: Develop guidelines and training resources and implement A Million Messages for child injury prevention (aimed to prevent abuse and injury for that age group).	• A Million Messages (AMM) standardizes the child injury prevention messages given to parents and caregivers and is designed to provide simple, consistent and targeted messaging to parents and caregivers as part of the core business of AHS health care professionals. • The AMM Online Learning Module went live on My Learning Link in January 2014 for provincewide use by AHS staff. It supports staff orientation to AMM program content and delivery. The module remains available to non-AHS health providers on the AHS public website at **www.albertahealthservices.ca/7607.asp**.
Healthy Parents and Children: Disseminate and begin evaluation of Healthy Parents, Healthy Children resources.	• Alberta Health and AHS media launch of Healthy Parents Healthy Children resources took place in November 2013, including the launch of the nine week Social Media campaign. • There have been a total of 56,867 visits to the website and distribution of printed material includes 91,100 redemption cards, 469,400 promotional cards and 40,420 book sets. • An evaluation plan for the Healthy Parents, Healthy Children initiative was developed.
Tobacco Reduction Strategy: Work with Alberta Health and other Ministries to implement the Alberta Tobacco Reduction Strategy.	• AHS worked with Alberta Health and other organizations to implement the Alberta Tobacco Reduction Strategy. • Tobacco Free Futures, an integrated health systems tobacco cessation model was implemented at 29 sites across AHS with continued expansion planned for 2014. Planned and proposed expansions include clients of Addictions & Mental Health and Cancer Control services. • The AHS Tobacco and Smoke free policy (site-based) was established and a tool to measure AHS compliance was implemented. • The "Keep Trying" marketing campaign targeting female smokers, 25-44 years of age, was launched. • The Nicotine Replacement Therapy research project has been implemented at four mental health and addiction sites across three zones.

PRIORITY ACTIONS	PROGRESS/RESULTS
Suicide Prevention: Work in partnership with the AHS Provincial Steering Committee on suicide prevention to increase the availability of prevention programs.	• Developed a system to track the number of partnerships that Aboriginal Youth and Community Empowerment Strategy (AYCES) communities establish with surrounding non-AYCES communities. • Nearly 650 people have received training to prevent suicide in Aboriginal communities through an AHS initiative. Four AHS staff members from the Aboriginal Health Program are certified to deliver Applied Suicide Intervention Skills Training (ASIST), an internationally recognized program for people who live and work with individuals at risk of self-harm. Since the AHS initiative was launched in late 2011, these ASIST-certified staff members have led two-day workshops for 36 aboriginal groups in First Nations and Métis communities across the province. ASIST participants learn how to discuss suicide with a person who might be at risk, identify risks and signs of self-harm, and develop a safe plan to address them, develop skills required to intervene with a person at risk, connect people to available resources and improve community resources and networking to better prevent suicide.
Alberta Alcohol Strategy (AAS): Work with Alberta Health and other Ministries in support of the Alberta Alcohol Strategy.	• AHS worked with Alberta Health, other Ministries and non-government stakeholders in support of the Alberta Alcohol Strategy to build shared leadership commitment to the strategy and build capacity to reduce alcohol-related harm. • Governance and leadership structures were put in place with Alberta Health, AHS and Alberta Gaming and Liquor Commission. In addition, the development of Alberta Alcohol Strategy Shared Action Plan for 2013-14 was completed and implementation of the actions is underway. • Consultation with 25 community coalitions to support local efforts to reduce alcohol-related harm (i.e. knowledge exchange strategy implementation for community coalitions, webinars, social network forums, formal learning events and individual consultation) is ongoing; 37 Community Coalitions participated at the March 2014 Coalitions Connect. • Canada's Low Risk Drinking Guidelines (LRDG) communication plan was approved. LRDG was promoted in AHS staff and public communications (i.e. National Addiction Awareness Week, social media feeds, myhealth.alberta.ca, Chief Medical Officer of Health blog). As well, seven education events and 30 consultations were delivered.
Environmental Public Health: AHS continues its efforts in support of environmental public health, including inspections of restaurants. The goal of the Safe Food Program is to contribute to the reduction of the incidence of food-borne illness. This is accomplished by inspecting food establishments, by education and enforcement.	• In June 2013, the investigative work by AHS with the 2012 E. coli outbreak associated with mechanically tenderized Costco beef steak traced to XL Foods was commended in the report of an Independent Expert Advisory Panel appointed by the Government of Canada. An excerpt from the Expert Advisory Panel's report: *"The investigation team at Alberta Health Services (AHS) quickly identified the link between human cases and the [mechanical beef tenderization] process at the North Costco store near Edmonton. With the collaboration of company management, AHS staff was able to take rapid action to minimize further exposure of the public to the threat, as well as bring the [mechanical beef tenderization] issue to the attention of CFIA and other provinces and territories."* AHS Environmental Public Health's identification of mechanical beef tenderization as a public health risk in Canada elicited a high profile, national-level discussion on the issue. • In September 2013, AHS Environmental Public Health officers identified an outbreak of E. coli illnesses associated with unpasteurized gouda cheese produced. AHS Environmental Public Health was the first agency in the country to link outbreak cases to cheese produced at the implicated facility, which eventually included 28 cases among five provinces. Identification of the outbreak elicited national-level discussion on requirements for raw milk gouda cheese production in Canada.

In Summary: AHS is working with Alberta Health (AH) to implement a long-term plan to promote wellness. However, the health system alone cannot make people healthier. We must partner with Albertans, other government departments, health service providers, communities, businesses and others to support individuals in taking personal responsibility for their health and Albertans in turn need to understand how to manage their own health and that of their families.

In 2013-14, AHS conducted more than 95,000 food safety inspections which is an increase of 10 per cent (9,064) from 2010-11. Also, AHS conducted more than 175,000 public health inspections which is a nine per cent increase from 2012-13. AHS delivers inspections and interventions in seven program areas: Safe Food, Safe Drinking Water, Safe Built Environments, Safe Indoor Air, Healthy Environments, Safe Recreational Water and Disease and Injury Control. The increase was largely due to AHS quick response to businesses and rental housing during the flooding in southern Alberta.

AHS annual seasonal influenza immunization program contributes to individual and population-level influenza prevention, including prevention of outbreaks in our facilities. AHS aimed to immunize half of its workforce in 2013-14. Health care worker immunization rates increased from 41 per cent in 2012-13 to 54 per cent in 2013-14. AHS continues to develop new strategies to provide enhanced communication and service delivery initiatives.

We helped prevent further spread of measles by undertaking a coordinated approach to assessment and immunization through Zone Emergency Operations Centres, and by activating the Provincial Emergency Coordination Centre. Thousands of individuals around Alberta were assessed, immunized and advised.

MENTAL HEALTH

The provincial Addiction and Mental Health Strategy is supported through the development of innovative community-based service models to address individuals with complex addiction and mental health needs and the further development of coordinated and consistent access for children and adolescents to addiction and mental health services.

PRIORITY ACTIONS	PROGRESS/RESULTS
Children's Mental Health Plan Implementation: Further development of coordinated and consistent access for children and adolescents to addiction and mental health services.	• Supported implementation of the provincial Addiction and Mental Health Strategy through further development of coordinated and consistent referral and access for children and youth to Addiction and Mental Health Services across the continuum. • Developed an inventory of the types of services provided locally, regionally (zone) and provincially. • AHS continues to participate in a cross-ministerial strategic planning process for "Children, Youth and Families Addiction and Mental Health" led by Alberta Health with Government of Alberta (GOA) Ministries of Education, Human Services, Justice and Solicitor General, as well as the Chief Medical Officer and community partners. • Completed a work plan for the Integrated and Collaborative Care Model for Complex Youth Project that was announced January 2014 in the Calgary Zone. The project will build on previous and current shared cross-ministerial services and will provide recommendations for a best practice model. • Shared support, tools and information with the GOA Ministry of Human services as it relates to planning and preparation for their new grant-funded children's mental health projects. • As part of the Children's Bed Plan Initiative, work continues to advance a Community of Practice that will create support and information to improve access for children and youth moving between programs and across health care sectors.

In Summary: Over the past year, significant work has been implemented to improve addiction and mental health delivery systems for all age groups. AHS has begun work on a care model for the support of seniors in continuing care environments who have been diagnosed with an addiction and/or mental health condition.

Examples of future work in mental health include the development and implementation of a sustainable model for addiction and mental health service delivery for Family Care Clinics throughout Alberta, to allow for provincial standardization with local adaptation to meet community needs.

CANCER

AHS worked with Alberta Health to implement the new provincial cancer strategy. This strategy focuses on accelerating the implementation of evidence-informed clinical pathways (how patients optimally flow through the system), best practices and standards in cancer surgery (beginning with lung cancer); prevention and early detection through breast, cervical and colorectal cancers screening; and support for cancer survivors and provision of palliative care.

PRIORITY ACTIONS	PROGRESS/RESULTS
Cancer Plan Implementation: Begin actions in support of the phased implementation of "Alberta's Cancer Plan to 2030".	• CancerControl Alberta brings together cancer facilities and programs under one umbrella to create a comprehensive and coordinated system of cancer prevention, screening, care and research for Alberta. • The provincial accountability framework that addresses alignment and integration to support provincial operational standards and equity of care is in place and aligns with AHS Health Plan, CancerControl Alberta Operations Plan and Changing Our Future: Alberta's Cancer Plan to 2030. • A comprehensive health information cancer-specific management unit, C-MORE was developed and implemented. • Three provincial councils (Radiation Medicine, Systemic Therapy and Supportive Care) and 12 tumour teams were created to support quality improvement and integration of services across the province. Significant quality improvement initiatives were initiated including a 10-year replacement plan. • In November 2013, the Red Deer Cancer Centre opened and offers radiation therapy and dedicated dietician and nutritional counselling. This complements the existing chemotherapy program. There have been more than 25 new staff hired or in the process of being hired to support the centre. As of the end of March, more than 140 patients have been treated with radiation therapy and have completed nearly 1,772 treatment sessions. Red Deer is the latest addition after Lethbridge, with Grande Prairie to follow in 2017. • In 2013-14, AHS launched the Enhanced Access to Cancer Screening Project. This project is sponsored by federal, provincial, zone and community partners to increase access to cancer screening for rural and remote communities. • The Alberta Breast Cancer Screening Program (ABCSP) initiated a trial to support women in rural and remote areas in having timely knowledge of their ability to access mobile screening services close to home or fixed site service (usually at a greater distance). The ABCSP will work to address any gaps which may result in inaccurate estimation of both breast cancer screening participation rates, and wait time for resolution of abnormal screening results. The Screen Test Program continued to provide mobile mammography services without disruption despite the displacement of the Screen Test south office. In addition, despite the closure due to flooding of the Screen Test fixed mammography clinic in Calgary, the Screen Test Program continued to provide screening mammography services to Calgary clients through the use of the south mobile unit which has been set up in Calgary. • The Alberta Cervical Cancer Screening Program made the following key accomplishments in the past year: Completed initial phase of development and testing of the Colposcopy electronic synoptic reporting system that includes all the essential data elements for this clinical procedure, as approved by a provincial committee and the Canadian Partnership against Cancer. Achieved 100 per cent implementation of all client correspondence for eligible women in Alberta (including invitation letters, results letters, and screening reminder letters). • Fecal Immunochemical Test (FIT) was implemented provincewide in November 2013. FIT is a new screening test targeting colorectal cancer, it is an easy, at-home test that can eliminate the need for average-risk Albertans to have a colonoscopy. Initial utilization of FIT is being closely monitored. An Alberta Colorectal Cancer Screening Program performance management framework including FIT related indicators is currently being developed.

In Summary: The long-term, strategic plan for cancer control in the province outlines a vision for 2030, where more cancers are prevented, more cases of cancer are cured and the suffering from cancer is greatly reduced. Changing Our Future will make better use of existing facilities and staff, and build or expand cancer facilities in Edmonton, Calgary, Red Deer and Grande Prairie.

PATIENT FLOW AND ACCESS

When it comes to health care, three key ingredients come into play: patients, their health care professionals and the system that supports them. Collaborative care happens when these three components work in unison, and AHS is focused on working as a team with patients and families. We call it CoACT – "to act or bring together". CoACT is a project aimed at ensuring all team members know what's involved in the patient journey, from arrival at the hospital, day by day, until discharge home.

For patients, it means a partnership with their health care team in planning care, including their return to the community and follow-up needed to return to health. It offers patients a clear view on where they are, and where they're going in their journey through the health system. CoACT also helps ensure the right staff are doing the work they're best at doing, to meet the individual needs of patients. This not only helps our health system get the most value for every dollar spent, but also ensures a stable workforce of health professionals in years to come.

PRIORITY ACTIONS	PROGRESS/RESULTS
CoAct: Implement and spread this Model of Care Innovation by integrating multiple projects into one initiative: Workforce Model Transformation, Care Transformation, Path to Home and transition projects; and expedite roll-out plans for two additional sites. Ensure that all staff are working collaboratively and to the full scope of their roles, while bringing the patient and family into the care planning process, and increasing time spent on care.	• CoACT (previously called Model of Care Transformation) brings three legacy projects together as one cohesive model: Care Transformation, Workforce Model Transformation and Path to Home (discharge planning). • Collaborative practice team-based model of care was launched in four units in September 2013 at two sites in Edmonton (Royal Alexandra Hospital and University of Alberta Hospital) and two units in Medicine Hat. Processes of care are being implemented on five units at the University of Alberta Hospital. Staff mix and processes of care have been implemented on one unit at Royal Alexandra Hospital. • All zones and Covenant Health have committed to proceed with CoACT implementation.

In Summary: CoACT is building on all the successes and lessons learned from legacy projects, including: Path to Home, Workforce Model Transformation and Care Transformation. In addition, components of CoACT are well underway throughout the province as other facilities come onboard in the months ahead. We look forward to collaborating with our patients and working together to improve their care and our health system.

STRATEGIC CLINICAL NETWORKS

Strategic Clinical Networks (SCN) are engines of innovation, bringing together physicians, clinicians, patients, researchers, staff and partners across Alberta to develop strategies, which are based on evidence, to improve patient outcomes and satisfaction. The SCNs work to improve access to health care and the long-term sustainability of the health care system.

PRIORITY ACTIONS	PROGRESS/RESULTS
SCN – CARDIOVASCULAR HEALTH AND STROKE	
Rural Stroke Action Plan: Develop and implement best practice recommendations for "stroke unit equivalent care" and a community-based stroke rehabilitation service that includes Early Supported Discharge (ESD).	• Implemented the Stroke Action Plan to address the quality of, and access to, stroke care in rural and small urban stroke centres across Alberta. • Developed and implemented best practice recommendations for "stroke unit equivalent care" (SUEC) in a small urban and rural setting. • Launched Early Supported Discharge/SUEC teams in Red Deer, Camrose, Grande Prairie, and Medicine Hat. Start-up and training provided with teams seeing patients and collecting data in Red Deer, Camrose and Grande Prairie. • Two Learning Collaborative sessions were conducted in January and March 2014 with more than 70 participants representing all project sites. • Balanced scorecards developed by each site to establish baselines for monitoring planned quality improvements.
Vascular Risk Reduction Project: Phased in vascular risk factor screening and early management project in primary care setting and pharmacies.	• 24 primary care organizations with more than 1,000 physicians and 119 providers have implemented systematic and vascular disease prevention processes. • Staff training and education for pharmacies completed - more than 100 pharmacists participated in training. • Initiated implementation of integration model in Medicine Hat in December 2013.
SCN – OBESITY, DIABETES AND NUTRITION	
Enhancing Recovery After Surgery (ERAS): Develop surgical care pathway (integrating best practices in nutrition and physical functioning) starting with colorectal and pancreatic surgeries.	• ERAS will improve surgical care of patients before, during and after surgery through adoption of best practices (protocols) that include preoperative nutrition risk screening and improved patient education; shorter preoperative fasts and preoperative oral carbohydrate; improved anaesthetic and post-operative analgesic techniques; and earlier post-operative feeding and ambulation. • ERAS is currently being piloted in colorectal surgery at the Grey Nuns Hospital in Edmonton and the Peter Lougheed Centre in Calgary and is planned for the Royal Alexandra Hospital and University of Alberta Hospital in Edmonton and Foothills Medical Centre in Calgary; with the hope of spreading to other sites and other areas of surgery in the near future.
Insulin Pump Therapy (IPT): Development of IPT clinical eligibility/ineligibility criteria for children, youth and adults with Type 1 diabetes (TD1) and identification of required AHS infrastructure across the province.	• Alberta Health officially launched the Insulin Pump Therapy (IPT) Program in June 2013. This program funds an insulin pump and supplies for adults and children with Type 1 diabetes who meet the eligibility criteria developed by AHS. This SCN led the development of the clinical criteria and the evaluation framework. • The 11 approved diabetes clinics have implemented the new eligibility criteria in determining the most appropriate patient for IPT. • The Health Technology & Policy Unit (University of Alberta) developed a Project Charter and defined the metrics for the Access with Evidence Development evaluation of insulin pump therapy in pediatric and adult patients with Type 1 diabetes in Alberta. This plan identifies the approach to develop evidence for the use of insulin pump therapy in Alberta.
SCN - CANCER	
Access for Referral and Triage eReferral Project: One component of a larger provincial eReferral project, which will focus on the development of a web portal to support referrals provincially for breast and lung cancer.	• The eReferral project aims to be innovative in its approach to patient and provider access, making it easier for people to work together, and to focus on providing a quality health system that is accessible and sustainable for all Albertans. The eReferral platform will be a new component of the Alberta Netcare Electronic Health Record Portal, which is currently used by more than 40,000 staff in the province, to look at patient medical information such as blood results and current medication. For Albertans, this means that the referral process becomes more predictable, transparent and personal. They will be able to make informed choices and know what's happening throughout the process. • eReferral will start accepting electronic referrals to cancer centres for patients with lung and breast cancer and to hip and knee clinics for patients who may require hip or knee replacement surgery. • The Alberta Thoracic Oncology Program, a provincial initiative of the Cancer SCN, is a collaborative effort of health professionals in Edmonton and Calgary Zones and CancerControl Alberta to improve the efficiency and effectiveness of the process for suspected lung cancer patients, from initial symptom or suspicious x-ray to definitive surgery or initial chemotherapy. Developed Rapid Access Clinics in both Edmonton and Calgary to dramatically reducing the wait times for suspected lung cancer patients.

PRIORITY ACTIONS	PROGRESS/RESULTS
SCN – SURGERY	
Adult Coding Access Target for Surgery (aCATS) Sustain and Spread: Develop and implement a standardized diagnosis-based surgical benchmark for all surgeries in Alberta.	• Completed provincial diagnosis and urgency access targets for surgical services based on best practice evidence. • Surgical wait list duplications have been removed and maintained. • Completed pilot phase of evaluation to inform aCATS provincial spread and sustain strategy and plan. • Implemented aCATS at 11 pilot sites and 15 additional surgical sites. • Work will begin to monitor data on the numbers of patients having their surgery within or out of the acceptable wait times so that improvements can be made.
Safe Surgery Checklist: Implementation and standardized measurement of compliance in AHS facilities and contracted non-hospital surgical facilities throughout the province.	• AHS introduced the Safe Surgery Checklist across the province. This tool is used by surgical teams, and enhances existing safety checks before, during and after a surgical procedure. Developed by the World Health Organization, the checklist has been shown to reduce the number of preventable complications associated with surgery. • The Safe Surgery Checklist has been identified as an Accreditation Canada Requirement of Practice, a requirement which will be met under this project. • Across the province, there was 90 per cent compliance using the Safe Surgery Checklist in all surgical sites.
SCN – SENIORS HEALTH	
Appropriate Use of Antipsychotics in Long-term Care: Development of best practice guidelines in the management of responsive behaviour with dementia in long-term care residents.	• Implemented draft Appropriate Use of Antipsychotics guidelines and a toolkit for management of responsive behaviours at pilot sites. • Completed evaluation of implementation of guideline and toolkit. • Developed strategy for provincial spread and implementation is underway. • In 2013-14, 85 per cent of residents on antipsychotics had their medications reviewed monthly by an inter-professional team which is an increase from 36 per cent last year. Prevalence of antipsychotic use in pilot sites has decreased from 41 per cent last year to 26 per cent in 2013-14.
SCN – BONE AND JOINT	
Bone and Joint Fragility and Stability: Design a Fracture Prevention Program. Develop inventory of osteoporosis resources.	• Developed "Catch a Break" (secondary fracture prevention program) materials. • Reviewed and updated inventory of osteoporosis resources and services. • Initiated planning session and working group to develop material for discharge criteria project for both acute and post-acute sites. • The re-fracture rate has decreased from 6.6 per cent last year to 5.3 per cent in 2013-14.

In Summary: SCNs are provincial, clinically led teams that are designed to improve quality and clinical outcomes. Given AHS' position as Canada's only provincewide health delivery organization, AHS has the ability to create novel approaches to high-quality, sustainable health care delivery, prevention and wellness for every Albertan. SCNs support clinical operations and clinicians to continuously improve quality and to lead health innovation across the care continuum. Also, SCNs enhance teamwork between academic organizations and AHS.

RESEARCH AND INNOVATION

PRIORITY ACTIONS	PROGRESS/RESULTS
Research and Innovation – Funding Criteria and Processes: Establish a funding framework, cycle and process, select projects and announce funding in support of research and innovation projects that target high-impact activities associated with any part of the continuum of care.	• Alberta Innovates Health Solutions (AIHS) and AHS partnered to launch the inaugural 2013 Partnership for Research and Innovation in the Health System (PRIHS) competition. This opportunity supports networks of health researchers and clinical practitioners across the continuum of care, with an emphasis on population health and community and primary care, that can (re)assess technologies, services and /or processes within the health system and identify sustainable solutions to improve the overall quality of care and value for money in Alberta's health system. • AIHS completed an external review of all applications in November 2013. Members of the review panel were drawn from across Canada. The review panel identified several projects that satisfied the scientific and health system criteria for funding. • AIHS posted the results publically on its website on January 2014. Additional communication to the public about the PRIHS project on reducing wait time for sufferers of back pain was delivered in February 2014.
Research and Innovation – Ethics: Contribute to streamlining ethics for health research and clinical trials towards provincial harmonization of research ethics boards.	• Health Research Ethics Harmonization is vital to Alberta's Health Research and Innovation Strategy. In Alberta, health research involving humans is reviewed by the Alberta Cancer Research Ethics Committee, one of six Health Information Act designated research ethics committees/boards. • In 2009, the six designated boards worked towards a more aligned and coordinated provincial research ethics review system that would improve efficiencies, multi-site communications, and facilitate additional research investment. A Research Ethics Reciprocity Agreement was signed in February 2011. Alberta is the first in Canada to reach such an agreement. Once fully implemented, ethics review for multi-site health research studies will be streamlined.
Provincial Health Analytics Network (PHAN)	• The Provincial Health Analytics Network (PHAN) is a three-year joint initiative between Alberta Health and AHS to develop an integrated health analytics network for the province. The PHAN will be a single window into authoritative sources of comprehensive health information of mutual interest to stakeholders and to the health system. • There are 35 identified PHAN projects, with 16 projects led by AHS, and the remainder led by AH. PHAN data model and architecture were completed.
Health Technologies Assessment (HTA) and Reassessment	• This joint initiative with AH means that Albertans will receive access to the most clinically and cost effective health care technologies and services. • Developed and implemented criteria for the Alberta Advisory Committee on Health Technologies screening committee to guide the triaging of promising technologies and reassessments. The committee continues to trial the draft criteria/ prioritization plan developed by the University of Alberta. • Collaboration is underway with the University of Calgary to incorporate an operational and financial impact analysis into the social, technology, economic review process for the Repetitive Transcranial Magnetic Stimulation; and with the Institute of Health Economics for the review of Low-Dose CT for Lung Cancer Screening.
Patient Engagement Researchers (PERs)	• Strategic Clinical Networks (SCNs) are the collaborative strategy groups that bring the perspectives of all stakeholders together to achieve improvement in patient outcomes and satisfaction, access to health care and sustainability of the health care system. An important voice in this work is that of the patient and the consumer of health services. Patient Engagement Researchers (PERs) are citizens living with various health conditions who are trained to design and conduct health research, using specific adapted methods of qualitative inquiry. • Patients are fully engaged in all phases of research from setting agendas, funding and implementation through to the uptake of research suggestions. PERs are trained to collaborate with health professionals and researchers, engage other patients, capture and articulate perspectives and ideas through valid research methods, and offer the findings to support collaborative, interdisciplinary decision-making. • Exciting research led to the development of a Patient and Community Engagement Research Program, housed in the Faculty of Medicine as part of the Institute for Public Health at the University of Calgary. AHS, through the SCNs, are full partners in this program by ensuring PERs are involved with the networks' core committees, working groups and research networks.

In Summary: Embedding research within the Strategic Clinical Networks (SCNs) is a critical provincial platform to bring academics and clinicians together to create new solutions for problems of value to AHS and Albertans. In turn, this has created the need for Research, Innovation and Analytics to focus its resources to enable the achievement of the goals established by AHS. Critical to the sustained long-term success of research and innovation in the province is a sustainable research funding model and robust evaluation criteria. The AHS Research portfolio is working with SCNs, AHS departments and external health care partners to achieve this. Success within the SCNs will strengthen the competitiveness and deepen the impact of health researchers within Alberta's academic institutions. The SCNs will provide more effective platforms to demonstrate to funders the ability to apply new knowledge to the benefit of patients.

ACHIEVING HEALTH SYSTEM SUSTAINABILITY

The performance of our health care system is directly related to the people who provide care and services to the patients, families and communities we serve. Improvements in the productivity of our workforce will be supported through adopting care models that make the best use of the skills of our physicians and staff, providing greater opportunities for full-time work for our nurses, and continuing to improve our processes, procedures and flow of patients through our system. The productivity of our workforce will be supported through ongoing initiatives to improve workplace health and safety.

PRIORITY ACTIONS	PROGRESS/RESULTS
Scheduling and Rotations: Implement and spread the standardized scheduling and rotation management initiative to increase the number of full-time staff, streamline staffing processes and reduce costs.	• To build a sustainable workforce and ensure patients experience a consistent level of care, we are improving how we schedule staff. This includes increasing the number of full-time employees and creating a stable supply of relief staff. Standardized scheduling processes will ensure staff have more predictable shifts and access to online scheduling technology. These changes allow us to operate more efficiently so that resources are focused on patient care. • Staff scheduling transformation has aligned rotation scheduling work with the CoACT initiative. This will enable rotations to be built that support the collaborative model of care-provider mix. • Rotation management and optimization has increased full-time positions in the master rotations schedule. A tactical guide for front-line managers was created to optimize rotation through attrition to increase full-time positions. • Standardized scheduling processes have been developed with staff being trained to use the new standard tools and processes for rotation management. • Built optimized regular and relief rotations for a total of 253 units.
Workforce Actions: Implement the following workforce actions: • Compensation freeze for management and out of scope staff. • Implement vacancy management.	• AHS implemented a three-year salary range freeze for all management and out-of-scope employees, including senior leaders. • The Official Administrator completed the Executive compensation review and is posted on AHS' external website. The review has been fully implemented as outlined in the report. • AHS implemented a hiring freeze on all administrative positions that are not mission-critical. Any hiring is tightly focused on clinical care. • The vacancy management process helped ensure AHS increased the number of nurses, while the number of management and out-of-scope individuals decreased. • Negotiations with United Nurses of Alberta (UNA) are ongoing.
Workplace Health & Safety: Create a healthy, safe and supportive work environment to enable staff to provide quality patient care.	• Several accomplishments were made through the Safe Client Handling program to reduce occupational injury and strengthen the health and safety culture of a health workplace. Since 2010, 94 per cent of ceiling lifts have been installed. In addition, 58 per cent of AHS staff have been trained in "It's Your Move", which provides training and specialized equipment to help move clients safely and avoid potential injury. The Move Safe manual material handling program trained provincewide almost 200 program champions as well as more than 650 front-line staff. • Portfolio Health and Safety Improvement Plans were completed and included key measures such as injury reduction targets, immunization rates and an "It's Your Move" training rate that are regularly reviewed by operational leaders.
Workplace Mental Health: Identify, implement and evaluate various best and promising practices to address workplace mental health and addiction in Alberta.	• Developed the Psychological Safety and Mental Health Strategy which is composed of three parts: (1) increase awareness of psychological safety within the workplace and implementation of the Canadian Standards Association Standard for Psychological Health and Safety in the Workplace within AHS; (2) support leaders to identify and address psychological safety risks in the workplace; and (3) provide employees with resources and supports to facilitate psychological wellness. • Minding the Workplace pilot project is funded by a grant from Alberta Health to inform the development of an employee mental health strategy that fosters and supports psychological safety and flourishing, reduces stigma and discrimination in the workplace and promotes workplace mental health. An assessment of the psychological health and safety of employee groups has been conducted. This project has received an approved extension to July 2014. • AHS Prevention of Workplace Violence Program is now available to support all AHS staff.

In Summary: Ensuring the AHS workforce is supported, and their skills are utilized in the most appropriate and efficient way, is important to AHS. Continued efforts have resulted in increased full-time positions. Occupational injury and illness reduction plans are focusing on mitigating workplace hazards and building employee resilience to cope with workplace demands. In 2013-14, 12 per cent of AHS staff participated in workplace wellness programs, an increase of 50 per cent from the previous year (eight per cent). Continued work is also required to ensure we have the right workforce to meet the needs of our health system, and that staff injuries are reduced. AHS values safety and accountability. Each employee is responsible for the quality of patient care and the safety of our work environment.

AHS is committed to providing a safe and healthy work environment to ensure all workers are protected from harm and can focus on providing the highest quality of care to those we serve.

BUILDING ONE SYSTEM

AHS is committed to developing models and allocating funding for programs and service providers across the continuum of care based on the needs of the patient and/or the needs of the population group. The delivery of quality, safe health care services depends on fiscal responsibility and good stewardship of resources, reducing duplication and streamlining processes to improve efficiencies.

PRIORITY ACTIONS	PROGRESS/RESULTS
Results-Based Budgeting: Work with AH to complete the results-based budgeting review process for Addiction and Mental Health.	• AHS has participated in the Cycle 1 review of Primary Health Care, including Addiction and Mental Health (AMH). Individual units of review were identified and comprehensive assessment of the current state for these units was completed, along with assessment of the relevancy, effectiveness and efficiency value for each unit of review. • Recommendations for future state and specific AMH actions have been identified and the results of this review have been compiled in a draft final report that was submitted to AH outlining the overall assessment completed and future state improvement initiatives and recommendations.
Patient-Care-Based-Funding – Acute and Continuing Care:	• Work on the current state and draft desired strategic shifts have been completed and first collaborative review workshops have been held to discuss a desired state for both acute and continuing care. • For the second workshop, the acute and continuing care reviews will be combined, and a workshop was scheduled for early May 2014, to continue to the Health System Dialogue discussions.
Patient-Care-Based-Funding – Long-Term Care: Continue the new patient-based funding for long-term care.	• The Continuing Care Business Model and Funding Steering Committee includes representatives from AH, AHS and long-term care and supportive living providers. • The committee is reviewing priorities for a business model and funding for the future, and will develop a work plan and priorities for activities in 2014-15, along with recommendations on funding allocations for continuing care.
Patient-Based Funding – Acute Services: Implement patient-based funding for acute services.	• Extensive work has been completed under the leadership of the Bone and Joint Strategic Clinical Network to plan for implementation of patient-based funding for hip and knee replacements at acute care sites across the province. Implementation was deferred to 2014-15. • The Diagnostic Imaging Leadership Team has been working with the patient-based funding team to plan for implementation of activity-based funding for CT scans. Implementation in 2013-14 was deferred to 2014-15. • Preliminary discussions are underway to identify other opportunities to implement activity-based funding for acute care. Opportunities will be explored in consultation with acute care leads for programs.
Revenue Generation: Identify revenue generation initiatives.	• Obtained approval from AH for cost recovery of services provided to out-of-province patients for services such as islet cell transplants, cardiac interventions - transcatheter aortic valve intervention (TAVI) and ventricular assist device (VAD) program; and diagnostic imaging PET/CT scans. • Implemented preferred accommodation rate increase implemented April 1, 2014 (phase 2). • Implemented policy on patient billings for medical supplies and consumables.
Alternate Service Delivery: Develop alternative service models.	• AHS has many services provided by external third-party providers. Developed project plan to ensure sufficient resources and limited burden on front-line operations. This approach will ensure development of consistent service delivery models, transition to standardized contracts that can be used to monitor service levels as well as allow AHS to generate savings while maintaining or enhancing quality of care and service.
Third-Party Contracts: Conduct a review of third-party contracts.	• Established the Major Contract Oversight Committee to explore alternate strategies for completing third-party agreements with a focus on engagement and level of risk by community.

Overhead Costs: Reduce overhead costs by 10 per cent in 2013-14.	• Overhead costs were reduced by 11 per cent in 2013-14. Various corporate service areas developed initiatives to reduce overhead costs across the organization including:
	  • Improving efficiencies and reducing costs associated with printers, long distance and cell phones as well as software maintenance and contracts.
	  • Reducing in the use of consultants, contractors and temporary staff.
	  • Reducing in travel expenditures within the organization.

Optimizing Support Services: Optimize the support service areas in relation to zones and operating units.	• Implemented Lean improvements by standardizing and optimizing processes and workflows, delivering projects that improve efficiencies and reduce waste, and embedding a culture of front-line empowerment and decision-making. The following are some examples of work underway.
	  • Bed rental analysis at the University of Alberta Hospital.
	  • 30 per cent less usage for patient watch security following patient safety watch review in the South Zone.
	  • Centennial Centre for Mental Health and Brain Institute projects include energy savings, work flow re-organization, and administrative efficiency improvements.

PRIORITY ACTIONS	PROGRESS/RESULTS
Laboratory Services: New model development and implementation.	• A new 'hub and spoke' service delivery model ensures high quality care that is accessible and sustainable for all Albertans. Hub facilities will provide latest automated technologies and testing, best in class quality, and consistent access to expert medical consultative services provincewide.
Provincial Clinical Information System (CIS):	• Planning for a new integrated Clinical Information System (CIS) for the Edmonton Zone to replace current legacy systems, including VAX, Tandem, and others, is underway. • The Edmonton Zone CIS Program will help to support and enable care transformation in the Edmonton Zone and enable more patient-focused care by providing a new integrated CIS for all primary care, acute and ambulatory sites, and will include provincial services like Mental Health, Corrections, and Cancer Care. • The project will use and leverage evidence-informed clinical decision support being developed by provincial SCNs such as Emergency, Bone & Joint (hip fracture pathway), Addictions & Mental Health (alcohol addiction pathway) to build provincial knowledge and content, but deliver that solution locally within the Edmonton Zone.
Support Services – Value: Harvest the value from systems.	• e-Accounts is working to consolidate numerous Finance and Contracting, Procurement and Supply Management initiatives. The e-Accounts program includes accurate, timely and responsive processes for procurement, budgeting, forecasting and payables. It impacts every area and department within AHS and supports our goal to provide high-quality patient care to Albertans by reducing duplication of systems. • The e-Facilities project has been established by the Capital Management group to improve the management of AHS facilities across the province. This project integrates several systems across the province to manage project delivery, real estate, planning and design, and facility operations and maintenance.

Zone Planning: Identify productivity and sustainability initiatives by working with the zones.	• Developed five draft 2014-2017 Zone Operational Plans that informed the AHS 2014-2017 Health Plan and Business Plan. Utilized the five Zone Operational Plans, as well as the 35 operational plans from corporate, provincewide and other support areas, to create the 2014-2015 AHS Action Plan, which is a supplement to the Health Plan and Business Plan.
	• Completed Phase 1 of Edmonton Zone 2030 Plan which focused on optimizing existing space (primarily in acute care) to address service pressures. Between August 2012 and June 2013, 18 health care facilities in the Edmonton Zone were reviewed with a view to understanding service and space pressures. Highlights of this work were:
	  ◦ Strengths, issues and opportunities for each site and program area were documented relating to space, workflow and safety - more than 180 strengths and opportunities were identified.
	  ◦ Tours covered 1 million square metres of space across the 18 sites.
	  ◦ 42,000 square meters of vacant space was identified (including shelled in or under-utilized) that could be repurposed for inpatient or ambulatory services.
	• Edmonton Zone 2030 Phase 2 work involves projecting the health needs of the population served and developing a zone-wide health service plan and supporting infrastructure plan in five year increments from 2015 to 2030.

Measurement and Reporting: Work with Alberta Health to implement outcomes-based framework to standardize measurement and reporting.	• Published the 16 new measures, which reflect a better balance across the spectrum of health care and show health system performance, on the AHS website at **www.albertahealthservices.ca/performance.asp**. • ·The newly revised measures are also designed to be more balanced and include measures for acute care, community-based care, and patient outcomes in the areas of seniors care, mental health and cancer care. Indicators focus on long-term care, continuing care placement, early cancer detection and mental health readmissions, emergency department wait times, emergency room wait times, and incidences of strokes and heart attacks. • Many of the new measures are aligned with national standards and benchmarks, so that Albertans can see how their health system is performing compared to the rest of Canada. Each measure has an associated target.

In Summary: Since AHS became one organization, there has been significant effort to implement common financial, procurement, planning and reporting systems. These systems have brought together nine former health regions and three provincial health entities and all of their existing systems into a single platform, in a relatively short timeframe. This furthers our goal to enable one health system.

The results from the Results-Based Budgeting reviews will be reviewed by the Government of Alberta and decisions related to this work are subject to next steps in the provincial Results-Based Budgeting review.

The financial summary can be found in the Financial Statements section of this document.

QUALITY IMPROVEMENT

AHS is on a continuous journey of quality improvement, utilizing new evidence-based practices so that we can continue to provide the highest quality of care for our patients and their families. Across AHS, health care providers, medical staff, managers, staff and leaders are committed to provide quality and safe patient care. Together we are working to develop a just culture where our commitment is visibly demonstrated.

It is imperative that the voice of Albertans be embedded into the valuable work done every day to enhance and maintain the quality of all care within AHS. Quality, including a focus on patient safety, is a critical area where the patient voice is vital.

The Just Culture philosophy supports an environment where everyone feels safe, encouraged, and enabled to discuss quality and safety issues where reporting and learning are key elements. Everyone can trust that those within the organization will demonstrate, through their behaviours and decisions, a fair and consistent approach to responding to issues raised.

FOCUS	PROGRESS/RESULTS
Quality	• Developed a standardized improvement methodology that is based on Lean, Six Sigma and other leading improvement methodologies. This approach is now known as the AHS Improvement Way (AIW) and more than 8,000 staff and medical staff have received introductory or advanced training to date. • Initiated TeamCARE, a demonstration initiative that combines learning and skill development for effective teamwork with clinical improvement approaches to provide safe and reliable care. • Developed and published Medication Reconciliation (MedRec) information materials for health care providers, patients and families, and the public to increase awareness and knowledge of this important partnership for medication management. • Finalized an integrated ethics framework - a guide to support and spread ethics reflection and action into all aspects of health care and services across the organization. In 2013-14, 500 clinical ethics consultations were provided to support patients, families, staff and physicians through the resolution of ethical concerns.
Patient Safety	• Let's Talk Leadership Safety Rounds were launched to help leaders to learn from front-line staff, physicians, patients and family about near misses, adverse events and hazards that impact staff and patient safety. • Collected 250 reports on average per day via the Reporting and Learning System (RLS) for Patient Safety and a toll-free phone line to provide physicians and front-line staff easier access for submitting reports was also launched. • Safety Alerts and Safer Practice Notices are disseminated to support timely learning following the identification of a key patient safety risk. In 2013-14, ten Alerts and one Safer Practice Notice were issued. • Patient Safety Culture Survey launched in March 2014 to obtain a better understanding of the safety culture at a unit-level across AHS and inform targeted strategies for improving patient safety. • The just culture initiative integrates a consistent set of principles with organizational policies and practices to reduce inconsistency in reporting and responding when 'things go wrong' within AHS. The application of just culture in all AHS practice is reinforced through various engagement activities including internal messaging, communication strategies (such as video, webinars) and senior leaders' endorsement.
Infection Prevention and Control (IPC)	• AHS has a provincewide Infection Prevention & Control (IPC) team dedicated to preventing infections acquired within health care facilities. • IPC monitors hospital-acquired infection rates to improve patient safety, including Clostridium difficile Infection (CDI), the most frequent cause of health care associated infectious diarrhea. • Control and reduce the spread of CDI with effective protocols including: early identification and isolation of all patients with CDI, enhanced hand hygiene, cleaning of shared equipment, staff and physician training, and, in some cases, temporary closure of the unit to transfers and new admissions. • Cleaning hands before every patient interaction is the single most effective way to prevent the spread of communicable diseases and infections. More AHS staff and physicians are cleaning their hands consistently and properly, which protects our patients by reducing the risk of infection. • Hand hygiene compliance rates have improved by 32 per cent over the past two years. The current 2013-14 compliance rate is 66 per cent, up from 59 per cent in 2012-13 and 50 per cent in 2011-12. • Continues to move forward with local actions and activities to engage staff and raise the profile of hand hygiene including: the ongoing work of site and zone based hand hygiene committees, improved access to alcohol-based hand rub products and continual monitoring and reporting of hand hygiene compliance rates.

FOCUS	PROGRESS/RESULTS
Accreditation AHS undertakes accreditation activities in compliance with the Minister's directive on mandatory accreditation.	• Following the 2012 onsite Accreditation Survey, AHS transitioned to a four-year cycle with Accreditation Canada. AHS focused on follow-up from the 2012 onsite survey, planning the 2014-2017 cycle, and preparations for the May 2014 onsite survey. The 2014 survey included assessment against Accreditation Canada's Governance, Leadership, Infection Prevention and Control, Medication Management, Reprocessing and Sterilization of Medical Devices, Telehealth, and Provincial Corrections Standards. • College of Physicians and Surgeons of Alberta (CPSA) provides accreditation services for Laboratory Services, Diagnostic Imaging Services, Neurophysiology and Pulmonary Function Test Labs for AHS, Covenant Health and Lamont Health Care Centre. Accreditation status for these sites is posted on the AHS and CPSA websites. • Worked with AH to add four additional accrediting bodies to the list of accepted accrediting organizations. In October 2013, AH accepted Canadian Accreditation Council, Council on Accreditation, College of American Pathologists, and Ontario Laboratory Accreditation as satisfactory accrediting organizations for Alberta's health system. The addition of these accrediting organizations allows more options for contracted providers to pursue accreditation. • Compiles information on the accreditation status of contracted providers and provides an Annual Report to AH. • The Provincial Medication Management Committee is responsible for providing direction and decision-making to improve medication management across the province. It oversees the work of the Provincial Accreditation Medication Management Committee which supports the implementation of the Medication Management Standards, to be surveyed as part of Accreditation Canada's May 2014 on-site visits. • Several provincial teams from Pharmacy Services and Health Professions Strategy & Practice manage the medication management required organizational practices, including high alert medication safety, narcotic safety, heparin safety, concentrated electrolyte safety, antimicrobial stewardship, and dangerous abbreviations.
ENGAGEMENT: EFFECTIVE COMMUNITY ENGAGEMENT AND PUBLIC CONSULTATION SUPPORTS EFFECTIVE PLANNING, DELIVERY AND EVALUATION OF HEALTH SERVICES.	
Patient and Family Advisory Group	The AHS Patient and Family Advisory Group includes individuals who volunteer their time to assist AHS to incorporate the voice and perspective of patients in the design and delivery of health care services. • The group of 21 Patient/Family Advisors met six times in 2013-14, consulted on 24 items and sat on many committees across AHS to share their unique perspectives and valuable advice. • Members determined priorities on a dynamic and flexible yearly work plan, and incorporated 2013-14 key themes of improving patient experience and quality of care, patient- and family-centred care, supporting organizational priorities, continuous quality improvement of the group and emerging issues. • Members were provided with education on quality and patient safety through participation in the Alberta Improvement Way Fundamentals training and a Systems Analysis Methodology simulation. • Members provided feedback and recommendations on how to embed the patient and family voice and improve quality, safety and the patient experience through consultations on initiatives such as CoACT, Patient-Centred Care, Medication Reconciliation Public Engagement and Education Campaign, Provincial Clinical Telehealth Services and Clinical Information Systems. Feedback was also provided on various policies, procedures and frameworks including the Palliative and End of Life Care Framework, the Clinical Ethics Framework, Continuing Care Waitlist: Access to Living Option, Alternate Level of Care Accommodation Charges – Patients Waiting for Continuing Care, Searching Patients at Risk of Harming Themselves or Others, QAR: Sexual Misconduct in Continuing Care Recommendations, and the Continuing Care Quality Management Framework. • A collaborative initiative with Volunteer Resources, Engagement and Patient Experience, and IT was formed to create a Patient and Family Advisor Registry program whereby 130 advisors created profiles and were matched with more than 34 quality improvement initiatives in advisory capacities.
Alberta Clinician Council (ACC)	• At each quarterly meeting, council members met with the CEO of AHS and were informed about organizational priorities, direction and leadership. There was also an opportunity for an informal discussion to discuss front-line clinical/operational concerns and local innovation ideas. • ACC was consulted on high priority AHS initiatives and frameworks such as: CoACT, AHS Quality Management Framework, Medication Reconciliation, Patient First Strategy, Provincial Ethics Service Framework, Information Technology Risk Assessment, Integrated Patient Safety Curriculum, Patient Safety Strategic Plan, 2013-2016 Health Plan and Business Plan, and AHS Performance Measures. For most initiatives, ACC members participated in facilitated breakout discussion groups to provide in-depth input into these priority areas. • ACC members were provided with detailed background information and local examples of promising and leading practices on the front-line such as disclosure of hospital-acquired infections, serving complex high-needs populations, and improving emergency department flow. • ACC members were offered learning opportunities on quality improvement, safety and leadership development.

FOCUS	PROGRESS/RESULTS
Health Advisory Councils	• The fourth annual Advisory Council provincewide meeting provided an opportunity for members to provide input to the Minister and AHS about the importance of engagement and the opportunities to promote wellness. The members were able to network and share engagement strategies as well as awareness techniques. • Each Advisory Council completed an Annual Report of activities and accomplishments achieved from their work plans. A broad range of work was highlighted in their Annual Reports. • Health Advisory Councils hosted presentations from chronic disease management staff and further promoted awareness to local communities as well as mass audiences. For example, Lesser Slave Lake Health Advisory Council engaged local citizens at the Land of Opportunity Expo in Wabasca, which provided an opportunity to promote awareness and gather feedback on creating better access to primary care and seniors care in their community. The Wood Buffalo Health Advisory Council met with key community stakeholders and AHS to provide quality integrated services to the community. The True North Health Advisory Council solicited feedback from the residents, which provided the basis of the recommendation for an Aboriginal Liaison position at the St. Theresa Hospital in Fort Vermilion, to mitigate barriers to health, including language, culture and transportation. • A Council of Chairs, including Chairs from the Health Advisory Councils and Provincial Advisory Councils, was developed to provide advice and feedback to the Official Administrator. The Council provided feedback on topics such as EMS dispatch and mental health.
Provincial Advisory Council on Cancer	Over the past year, the Provincial Advisory Council on Cancer advised and provided feedback to cancer services such as: • Participation in the Cancer Strategic Clinical Network, Engagement & Patient Experience, and Alberta Valued Health workshop. • Providing a work plan that links the Council, CancerControl Alberta and Alberta Health cancer services. • Providing feedback to enrich the development of the Tobacco Reduction Strategy for AHS, the Survivorship Strategy, the Cancer Prevention Social Marketing Campaign (in development by Alberta Cancer Prevention Legacy Fund), CancerControl Alberta and Screening, Population and Public Health that led to the development of the FIT in Alberta, and cancer clinical trials in Alberta.
Provincial Advisory Council on Addiction and Mental Health	Over the past year, the Provincial Advisory Council on Addiction and Mental Health advised and provided feedback to mental health services such as: • Acting in an advisory capacity in various sub-committees, such as the Improving Safety in Mental Health Units and Facilities sub-committee, Patient Safety, Quality and Policy Committee sub-committee, AMH Strategic Clinical Network, AMH Data sub-committee, AMH Electronic Health Records sub-committee, Patient Engagement Reference Group sub-committee, Alberta Health, Addiction Awareness Campaign sub-committee and the Patient and Community Engagement Research sub-committee (PACER). • Developing an AMH work plan that links the Council with AMH services in AHS and Alberta Health. • Presenting to the Council of Chairs on the need for 24/7 access to AMH services in Alberta. • Providing feedback and consultation on the Recommendations to Improve Mental Health Promotion: Addiction and Mental Illness Prevention and Early Intervention for Albertans Report, the Tobacco Free Futures Initiative for AMH program, the Provincial Health Case Summary; Video Surveillance on In-Patient Health Units and the educational tool 'What We Wish You Knew About Us' with Patient Engagement. • Maintaining linkages with the Canadian Mental Health Association, Mental Health Patient Advocate, and Health Advocate.

In Summary: Each day, staff and physicians deliver health care services to thousands of Albertans across the continuum of care and make a positive difference in their lives. We acknowledge and appreciate what is going well but also know that there is room for improvement in the quality and safety of our care.

In early 2013, AHS initiated the process of integrating the quality dimensions and areas of need into a broader AHS Quality Management Framework (QMF) to ensure seamless, reliable and evidence-informed care. This work is helping us to clarify, formalize and coordinate the internal structures and processes that will most effectively help us to address key gaps and issues in our care processes. Partnering with patients and families is an example of a key enabler within the QMF. We have realigned our resources to better engage patients and families on the improvement journey.

Community input and feedback allows us to better address the health needs of Albertans and bring decision-making to the local level. AHS continues to employ various channels to involve stakeholders early on in the decision-making process so their opinions can be considered when health care planning decisions are being made.

FINANCIAL STATEMENT DISCUSSION AND ANALYSIS

For the year ended March 31, 2014
(in millions of dollars)

Purpose

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, 2014 compared to budget and to the preceding year. In particular, the FSD&A reports to stakeholders on how financial resources are being managed to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

This FSD&A has been prepared by management and should be read in conjunction with the March 31, 2014 audited consolidated financial statements, notes and schedules. The consolidated financial statements are prepared in accordance with Canadian Public Sector Accounting Standards (PSAS) and Financial Directives issued by Alberta Health (AH). All amounts are in millions of dollars unless otherwise specified.

AHS financial statements are prepared on a consolidated basis and include the following:

- 3 wholly owned subsidiaries: Calgary Laboratory Services Ltd., Capital Care Group Inc., and Carewest;
- 30 controlled foundations and trusts;
- Provincial Health Authorities of Alberta Liability and Property and Insurance Plan (LPIP) and the Queen Elizabeth II Hospital Child Care Centre; and
- 50 per cent interest in the 42 Primary Care Networks (PCNs), 50 per cent interest in the Northern Alberta Clinical Trials Centre joint venture and 30 per cent interest in the HUTV limited partnership.

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

OVERVIEW OF 2013-14

The following table summarizes the Consolidated Statement of Operations:

Consolidated Statement of Operations	Budget 2014	Actual 2014	Variance 2014	Actual 2013	Increase (Decrease)
Revenue	$13,355	$13,224	$(131)	$12,674	$550
Expenses	13,355	13,068	287	12,568	500
Operating Surplus	**$ -**	**$156**	**$156**	**$106**	**$50**

2013-14 Highlights

2013-14 key strategic areas highlighted throughout “Who We Are” include:

- Bringing care to the community;
- Partnering for better outcomes; and
- Achieving health system sustainability.

2013-14 saw the realization of several long-established commitments, including:

- Opening of the Central Alberta Cancer Care Centre in Red Deer;
- Renovation and expansion of the Northern Lights Regional Health Centre in Fort McMurray;
- Full implementation of various programs and services at the South Health Campus in Calgary; and
- Opening of 335 net new continuing care and palliative beds.

Operational highlights:

- Increased activity experienced across the organization including 2.1% increase in hospital discharges, 1.1% increase in emergency department visits and 2.8% increase in home care clients.
- Cost management in place throughout 2013-14 illustrated through only a 4.0% increase in expenses from 2012-13. Administration expense remained unchanged from 2012-13.
- Focus on community-based care shown through increased costs incurred in this area.

2013-14 Results

Operating Surplus:

The AHS operating surplus for the year ended March 31, 2014 is $156 compared to a budget of $nil. The overall positive variance of $156 is comprised of $287 positive expense variance and $131 negative revenue variance. The majority of the revenue and expense variances offset as they are related to restricted funding.

The $287 positive expense variance is primarily due to lower than budgeted expenses resulting from unused contingency, vacancies related to recruiting physician and staff positions, timing delays in the implementation of new and ongoing initiatives, cost control strategies and the later than planned implementation of various programs and services at the South Health Campus during 2013-14. Offsetting the overall positive variance is higher than expected expenses related to increased activity levels throughout the province, including demand for acute care and continuing care services, delays in achieving planned cost savings initiatives, additional positions not anticipated in the budget and compensation rate increases.

The $131 negative revenue variance is primarily due to lower revenue recognized from AH transfers caused by the phased implementation of various programs at the South Health Campus, lower activity and vacancies in physician services programs, delays in the implementation of various initiatives funded by AH, and an unbudgeted reduction in AH base funding. The overall negative variance was partially offset by higher than budgeted investment income from the diversification of AHS' portfolio, higher than anticipated recoveries for services provided to external entities, and increased revenue recognized from donations, non-government grants, purchase incentive rebates and miscellaneous income.

Included in the total unused contingency positive variance is $128 that was set aside in the 2013-14 approved budget for additional strategic and new investments. This balance was not utilized and remained unallocated at year-end as part of unused contingency due to waiting for expected savings to be realized, governance and leadership changes during the year, and anticipating reduced funding in 2014-15.

In the days leading up to June 20, 2013, significant rainfall, as well as rapid snow melt, triggered floods which caused damage throughout Southern Alberta, including AHS facilities. The Province's flood recovery initiatives, through its Disaster Recovery Program (DRP), provides financial assistance to impacted government organizations including AHS for uninsurable loss and damage. The DRP is administered and funded by the Alberta Emergency Management Agency of the Department of Municipal Affairs through the authority of the Disaster Recovery Regulation. AHS flood related costs are reported by Municipal Affairs.

The operating surplus is added to the total unrestricted net assets balance within accumulated surplus at March 31, 2014.

Accumulated Surplus:

The AHS accumulated surplus for the year ended March 31, 2014 is $1,234 compared to the prior year of $1,078 representing an increase of $156 primarily related to the operating surplus generated in 2013-14. Accumulated surplus consists of three main components: unrestricted net assets, reserves for future purposes and net assets invested in tangible capital assets.

The unrestricted net assets at March 31, 2014 of $266 does not have any restrictions attached to its future use and may be used at AHS' discretion for operating purposes, capital purposes or the creation of new reserves. Future plans to use the unrestricted net asset balance include consideration towards major information technology investments, such as clinical information systems, further investing in deferred capital maintenance, and future principal payments on non-ancillary related debt.

	Actual 2014	Actual 2013	Increase (Decrease)
Accumulated surplus	$1,234	$1,078	$156
Less: Net assets invested in tangible capital assets	(881)	(916)	35
Less: Reserves for future purposes	(87)	(79)	(8)
Unrestricted net assets	**$266**	**$83**	**$183**

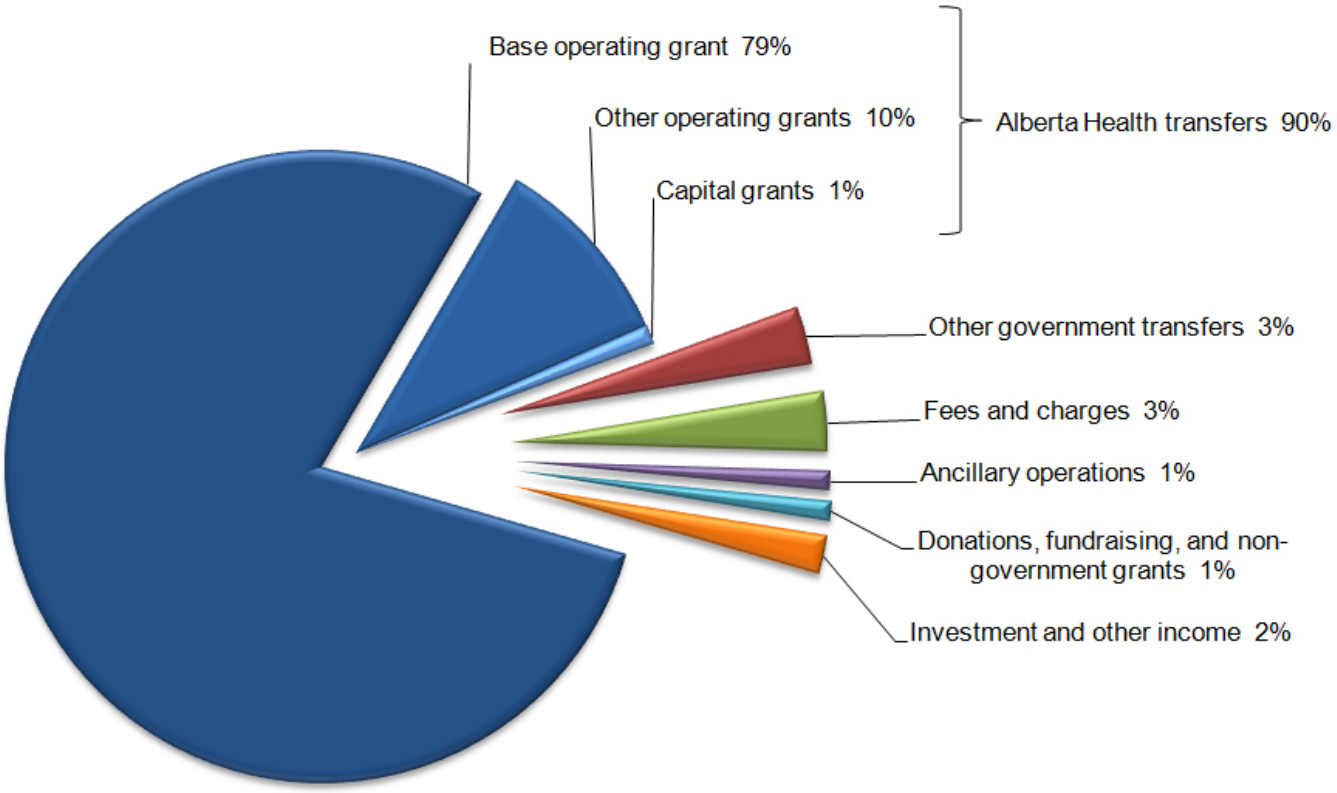
Net assets invested in tangible capital assets and reserves for future purposes have been restricted internally by AHS, as approved by the Official Administrator for use in specific activities, and are therefore not available for any other purpose.

- The net assets invested in tangible capital assets at March 31, 2014 of $881 represents the restricted net book value of tangible capital assets that have previously been purchased with AHS unrestricted net assets.
- The reserves for future purposes at March 31, 2014 of $87 have been set aside for future operating and capital purposes related to South Health Campus, cancer research, parkade infrastructure, special local initiatives and retail food services infrastructure.

AHS' annual expenditures of $13,068 equates to approximately $36 per day, hence the operating surplus of $156 represents approximately 4.3 days of expenses, or 1.2% of total expenses, and the unrestricted net assets of $266 represents approximately 7.4 days of expenses, or 2.0% of total expenses.

STATEMENT OF OPERATIONS

Revenue



Total 2013-14 revenues increased by $550 or 4.3% from 2012-13 and were lower than budgeted amounts by $131. The overall increase in revenue from 2012-13 was primarily due to increased base operating funding from AH, which is AHS' primary source of funding. AH funding coverage indicator is 91% (2013 – 91%), representing the percent of total expenses being funded by AH in 2013-14.

Revenue	Budget 2014	Actual 2014	Variance 2014	Actual 2013	Increase (Decrease)
Alberta Health transfers	$12,055	$11,840	$(215)	$11,388	$452
Other government transfers	389	387	(2)	393	(6)
Fees and charges	456	432	(24)	412	20
Ancillary operations	129	126	(3)	118	8
Donations, fundraising and non-government grants	131	155	24	144	11
Investment and other income	195	284	89	219	65
Total revenue	**$13,355**	**$13,224**	**$(131)**	**$12,674**	**$550**

Significant variances and changes are explained as follows:

- **Alberta Health Transfers** is comprised of all AH grants – 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 is revenue that can only be used for specific projects and is recognized when the related expenses are incurred.

Alberta Health Transfers	Budget 2014	Actual 2014	Variance 2014	Actual 2013	Increase (Decrease)
Base operating grant	$10,521	$10,496	$(25)	$10,214	$282
Other operating grants	1,436	1,257	(179)	1,068	189
Capital grants	98	87	(11)	106	(19)
Total AH Transfers	**$12,055**	**$11,840**	**$(215)**	**$11,388**	**$452**

Base operating grants amounted to $10,496 compared to a budget of $10,521 resulting in a negative variance of $25 or 0.2% due to an unbudgeted reduction in base funding.

Compared to the prior year, base operating grants increased by $282 or 2.8% due to additional base funding in 2013-14 received for the delivery of health services across Alberta.

Other operating grants amounted to $1,257 compared to a budget of $1,436 resulting in a negative variance of $179 or 12.5% mainly due to the phased implementation of various programs at the South Health Campus, delays in the implementation of various initiatives such as the Strathcona Community Hospital, Addiction & Mental Health initiatives and other smaller initiatives funded by AH, and lower activity and vacancies in physician services programs. The overall negative variance was partially offset by some additional grant revenue and higher activity in pharmacy programs.

Compared to the prior year, other operating grants increased by $189 or 17.7% primarily due to increased operations at the South Health Campus and Kaye Edmonton Clinic, higher usage of specialized high cost drugs and outpatient cancer drugs provided at no cost to patients, and increased number of medical residents providing services to AHS through the postgraduate medical residency training program.

Capital grants amounted to $87 compared to a budget of $98 resulting in a negative variance of $11 or 11.2% mainly due to delays in the completion of various capital projects.

Compared to the prior year, capital grants decreased by $19 or 17.9% due to lower expended deferred capital revenue recognized for various capital assets that became fully amortized in 2013-14; partly offset by incremental revenue associated with new capital asset additions.

- **Other government transfers** are ongoing and one-time transfers for operating and capital purposes from federal, provincial (other than AH) and municipal governments.

Other government transfers amounted to $387 compared to a budget of $389 resulting in a negative variance of $2 or 0.5%.

Compared to prior year, other government transfers decreased by $6 or 1.5% mainly due to reduced minor equipment purchases for the clinical commissioning of the South Health Campus and Kaye Edmonton Clinic and fewer operating projects implemented for infrastructure maintenance. The overall decrease was partly offset by revenue recognized from new grant funding and increased revenue recognized from expended deferred capital revenue mainly due to new tangible capital assets put into service.

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

  Fees and charges revenue amounted to $432 compared to a budget of $456 resulting in a negative variance of $24 or 5.3% mainly due to less than budgeted patient fees and charges from residents of AHS operated long-term care facilities, out-of-country patients, the federal government and other responsible parties caused by lower than expected activity or patient volumes. The overall negative variance was partially offset by an increase in fees and charges from WCB.

  Compared to prior year, fees and charges revenue increased by $20 or 4.9% primarily due to improved monitoring and collection of overdue accounts receivable, increased volume of services provided to out-of-province patients, and higher recoveries from WCB. The overall increase was partially offset by a decrease in fees and charges from out-of-country patient billings, other responsible parties and the federal government.

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

  Ancillary operations revenue amounted to $126 compared to a budget of $129 resulting in a negative variance of $3 or 2.3%.

  Compared to the prior year, ancillary operations increased by $8 or 6.8% mainly due to staff and visitor parking fee increases, and higher demand for visitor parking due to influenza and colder than normal winter. Additionally, parking lots at Kaye Edmonton Clinic and South Health Campus experienced their first full year of operations in 2013-14.

- **Donations, fundraising and non-government grants** is comprised of revenue that can be any of unrestricted, restricted, operating and capital. Restricted amounts received are recognized when the restrictions are met.

  Donations, fundraising and non-government grants revenue amounted to $155 compared to a budget of $131 resulting in a positive variance of $24 or 18.3% mainly due to higher than anticipated revenue recognized from restricted research and education grants, unbudgeted one-time revenue from unrestricted donations and special purpose funds, and unbudgeted revenue recognized for minor equipment purchases funded by various foundations.

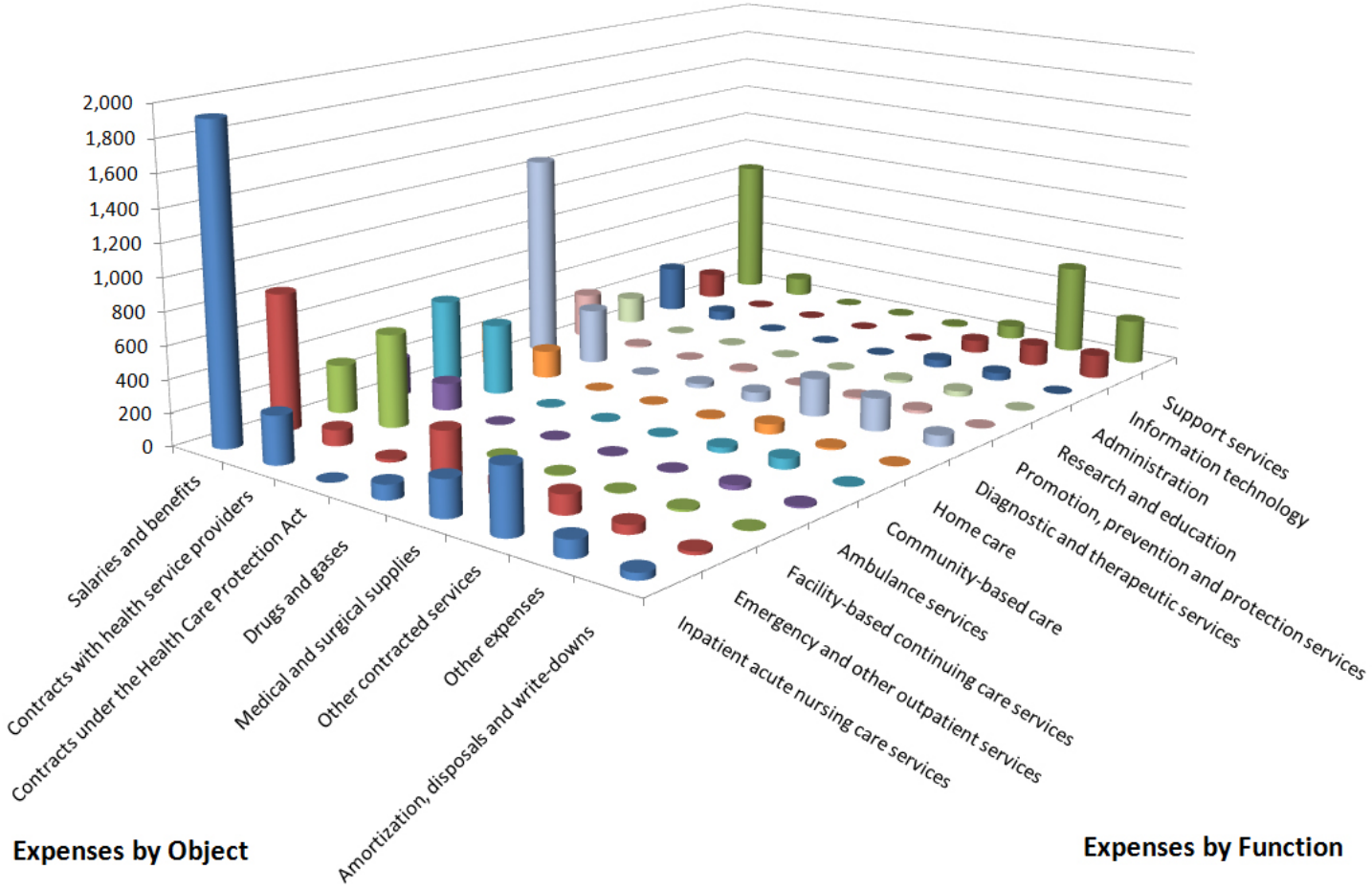
  Compared to prior year, donations, fundraising and non-government grants increased by $11 or 7.6% mainly due to more revenue recognized from restricted research grants, one-time revenue from unrestricted donations and special purpose funds, and higher revenue recognized from expended deferred capital revenue as a result of tangible capital assets put into service.

- **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 $284 compared to a budget of $195 resulting in a positive variance of $89 or 45.6% mainly due to the diversification of AHS' portfolio which resulted in higher yields from the Canadian and global equity markets while maintaining a conservative risk profile, higher than anticipated recoveries for the compensation expense component of services provided to external entities, increased purchase incentive rebates, and higher than budgeted revenue recognized for minor equipment purchases and physician fees assigned to AHS in relation to physician income guarantee agreements. Further contributing to the positive variance is the increase in miscellaneous income from tenant improvement allowance, sale of drugs and surplus items, and WCB surplus distribution.

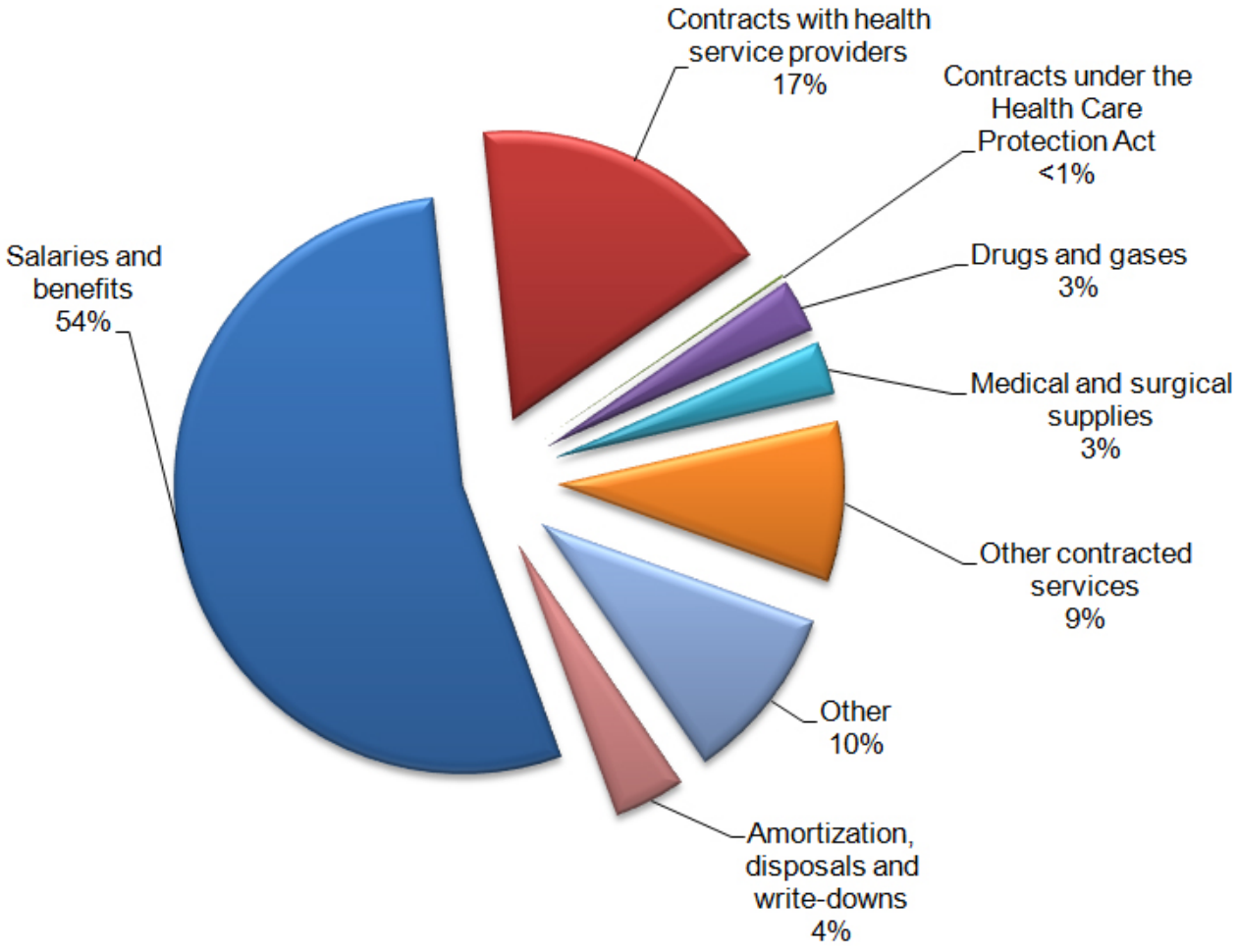
  Compared to prior year, investment and other income increased by $65 or 29.7% mainly due to the diversification of AHS' portfolio which resulted in higher yields from the Canadian and global equity markets, higher recoveries for the compensation expense component of services provided to external entities, increased activity in programs with physician income guarantee agreements, higher purchase incentive rebates, and an increase in miscellaneous income from sources such as tenant improvement allowance and minor equipment funding.

EXPENSES – BY FUNCTION AND OBJECT



AHS reviews and reports operating expenses by function and by object in order to fully understand and present the results of current operations, strategic priorities and new investments. Operating expenses increased to $13,068 in 2013-14, representing 4.0% growth from the prior year, with the largest increase related to salaries and benefits. Expenses growth includes support for continuing existing operations, strategic priorities and new initiatives, including the operating requirements of new programs and services. The graph above highlights the most significant areas of operational spending, by function and related objects. A significant portion of the program expenses occurs in inpatient acute nursing services (within which salaries and benefits and other contracted services are the highest objects), emergency and outpatient services (within which salaries and benefits is the highest object), facility-based and continuing care services (within which salaries and benefits and contracts with health service providers are the highest objects), community-based care (within which salaries and benefits is the highest object), diagnostic and therapeutic services (within which salaries and benefits and contracts with health service providers are the highest objects) and support services (within which salaries and benefits, other expenses and amortization are the highest objects).

EXPENSES – BY OBJECT



The overall distribution of expenses by object has remained consistent with prior years, with salaries and benefits making up more than half of total expenses. While AHS continues to focus on priority areas such as reducing wait times in emergency departments, expanding continuing care operations and improving access to high-demand surgeries, expenses continue to be driven by salaries and benefits and contracts with health service providers, whose costs would also be driven by salaries and benefits.

During 2013-14, AHS continued to experience challenges in recruiting physicians and staff at the pace anticipated within the 2013-14 operating budget. There were also some delays in implementing certain priority initiatives this year including the Continuing Care Capacity Plan, Strathcona Community Hospital and Addictions & Mental Health initiatives. The overall positive variance was partially offset by increased activity, patient volumes and delayed savings initiatives.

Expenses	Budget 2014	Actual 2014	Variance 2014	Actual 2013	Increase (Decrease)
Salaries and benefits	$7,101	$7,049	$52	$6,753	$296
Contracts with health service providers	2,314	2,258	56	2,166	92
Contracts under the Health Care Protection Act	18	19	(1)	17	2
Drugs and gases	412	427	(15)	388	39
Medical and surgical supplies	385	399	(14)	392	7
Other contracted services	1,212	1,090	122	1,099	(9)
Other expenses	1,353	1,261	92	1,220	41
Amortization, disposals and write-downs	560	565	(5)	533	32
Total expenses	**$13,355**	**$13,068**	**$287**	**$12,568**	**$500**

The 2013-14 approved budget included specific and general contingencies to handle unexpected events and potential risks that could arise during the course of the year. Included in the total unused contingency positive variance is $128 that was set aside in the 2013-14 approved budget for additional strategic and new investments. This balance was not utilized and remained unallocated at year-end as part of unused contingency due to waiting for expected savings to be realized, governance and leadership changes during the year, and anticipating reduced funding in 2014-15. The majority of the contingency was not required. As a result, the unused contingency is contributing to positive variances across both expenses by function and by object.

Significant variances and changes are explained as follows:

- **Salaries and benefits** is composed 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 $7,049 compared to a budget of $7,101 resulting in a positive variance of $52 or 0.7%. Included in this variance is an unused contingency of $80. The offsetting $28 negative variance is primarily due to the budget assuming higher savings initiatives than realized and an additional number of positions required to support the South Health Campus than what was assumed in preliminary implementation plans. Higher costs compared to budget were also incurred related to increased activity in the zones, leading to increased overtime and additional positions not anticipated in the budget, as well as the use of overtime and relief to cover vacancies. The overall variance also includes savings due to vacant positions throughout the organization including both hard-to-recruit positions and regular recurring vacancies. Further contributing were various delays in initiatives relative to when originally budgeted resulting in delayed hiring. There was also a cash credit recognized from net surpluses held by benefit plans. Cost control strategies, including a vacancy management process that reviewed vacancies without impacting front line services, were also in place during the year to help reduce the impact of recruitment issues.

  There is an increase of $296 over prior year mainly due to the increasing number of employees for new initiatives, salary and benefit rate increases (including increases under collective agreements and Local Authority Pension Plan which are impacted by the increase in employees, hours and rates). New and existing positions were filled to manage increased activity and capacity, particularly related to the phased implementation of services at the South Health Campus which became fully operational in 2013-14. Although the number of clinical employees increased slightly compared to prior year, vacancies persisted throughout the organization which increased capacity pressures resulting in the need for increased standby, call backs and casual relief. The overall increase was partially offset by the achievement of various savings initiatives and vacancies.

- **Contracts with health service providers** include voluntary and private health service providers with whom AHS contracts for health services.

  Contracts with health service providers amounted to $2,258 compared to a budget of $2,314 resulting in a positive variance of $56 or 2.4%. Included in this variance is an unused contingency of $32. The remaining $24 positive variance is mainly due to fewer contracts required than originally anticipated in the budget and timing variances associated with the implementation of various budgeted initiatives including Community Treatment Orders, Corrections, Continuing Care Capacity Plan, Capital Bed Initiative, Children's Mental Health Plan, and Safe Communities. The overall positive variance is partially offset by various delayed savings initiatives.

  There is an increase of $92 over prior year mainly due to increased activity, including opening new supportive livings sites, addition of 335 net new continuing care beds, creating Community Care Teams, implementation of Community Care Capacity Plan initiatives and increased ground ambulance transportation. Further contributing to the increased costs is operating contract rate increases due to inflation. The overall increase was partially offset by achieved savings initiatives primarily related to home care and community-based care.

- **Contracts under the Health Care Protection Act** relates to contracts with surgical facilities pursuant to the *Health Care Protection Act* which is about ensuring quality, while ensuring more efficient delivery of publically funded services by allowing contracting out to profit-orientated surgical facilities.

  Contracts under the Health Care Protection Act amounted to $19 compared to a budget of $18 resulting in a negative variance of only $1 or 5.6%.

  Contracts under the Health Care Protection Act costs increased by only $2 compared to the prior 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 other than patient treatment such as diagnostic reagents are not considered to be part of this category, but rather included in other expenses.

  Drugs and gases amounted to $427 compared to a budget of $412 resulting in a negative variance of $15 or 3.6%. The negative variance is mainly due to increased activity related to cancer treatments and immunization programs, as well as a shortfall of budget for costs related to high cost emerging drugs and specialized high cost drugs. The overall negative variance is partially offset by the phased implementation of various programs and services at the South Health Campus. Included in this variance is an unused contingency of $7.

  There is an increase of $39 over prior year mainly due to increased activity related to high cost emerging drugs, cancer treatments, rare disease and specialized high cost drugs.

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

  Medical and surgical supplies amounted to $399 compared to a budget of $385 resulting in a negative variance of $14 or 3.6%. The negative variance is mainly due to increased activity within the zones primarily related to surgical activity, operating rooms including increased supply and instrument costs, emergency department visits and outpatient services, as well as increases in highly specialized provincial services for renal runs. The overall negative variance is partially offset by the phased implementation of various programs at the South Health Campus and various delayed initiatives. Included in this variance is an unused contingency of $5.

There is an increase of $7 over prior year mainly due to the phased implementation of various programs and services at the South Health Campus which included opening additional surgical suites and medical units, as well as increased activity related to patient volumes, emergency department visits and surgical volumes.

- **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.

  Other contracted services amounted to $1,090 compared to a budget of $1,212 resulting in a positive variance of $122 or 10.1%. Included in this variance is an unused contingency of $39. The remaining $83 positive variance is mainly due to physician recruitment issues resulting in vacancies and delays in various initiatives, including the purchase of pandemic supplies, lab and diagnostic imaging quality assurance plans and the staff rotation review and optimization initiative. Further contributing to the overall positive variance is the achievement of cost control strategies and reduced activity related to various contracted services. The overall positive variance is partially offset by inflation, higher operating contract costs and additional positions not anticipated in the budget.

  There is a decrease of $9 over prior year mainly due to successful cost control strategies to reduce contract costs primarily related to the use of agency nurses and information technology related contracts. The overall decrease was partially offset by increased activity due to the phased implementation of programs at the South Health Campus which fully opened in 2013-14 and contract inflation.

- **Other expenses** relate to those not classified elsewhere.

  Other expenses amounted to $1,261 compared to a budget of $1,353 resulting in a positive variance of $92 or 6.8%. Included in this variance is an unused contingency of $23. The remaining $69 positive variance is mainly due to more savings initiatives achieved than budgeted and fewer costs required to support the South Health Campus than what was assumed in preliminary implementation plans. Further contributing to the variance are other savings initiatives and cost mitigation efforts related to managing overhead expenses, various delays in initiatives, including the phased implementation of various programs at the South Health Campus, and lower research activity than budgeted. The overall positive variance is partially offset by inflation costs for utilities due to higher natural gas prices, vendor contract inflation related to information technology services and higher than expected legal and liability expenses and an increase in actuarial estimates for past and future unreported liability claims.

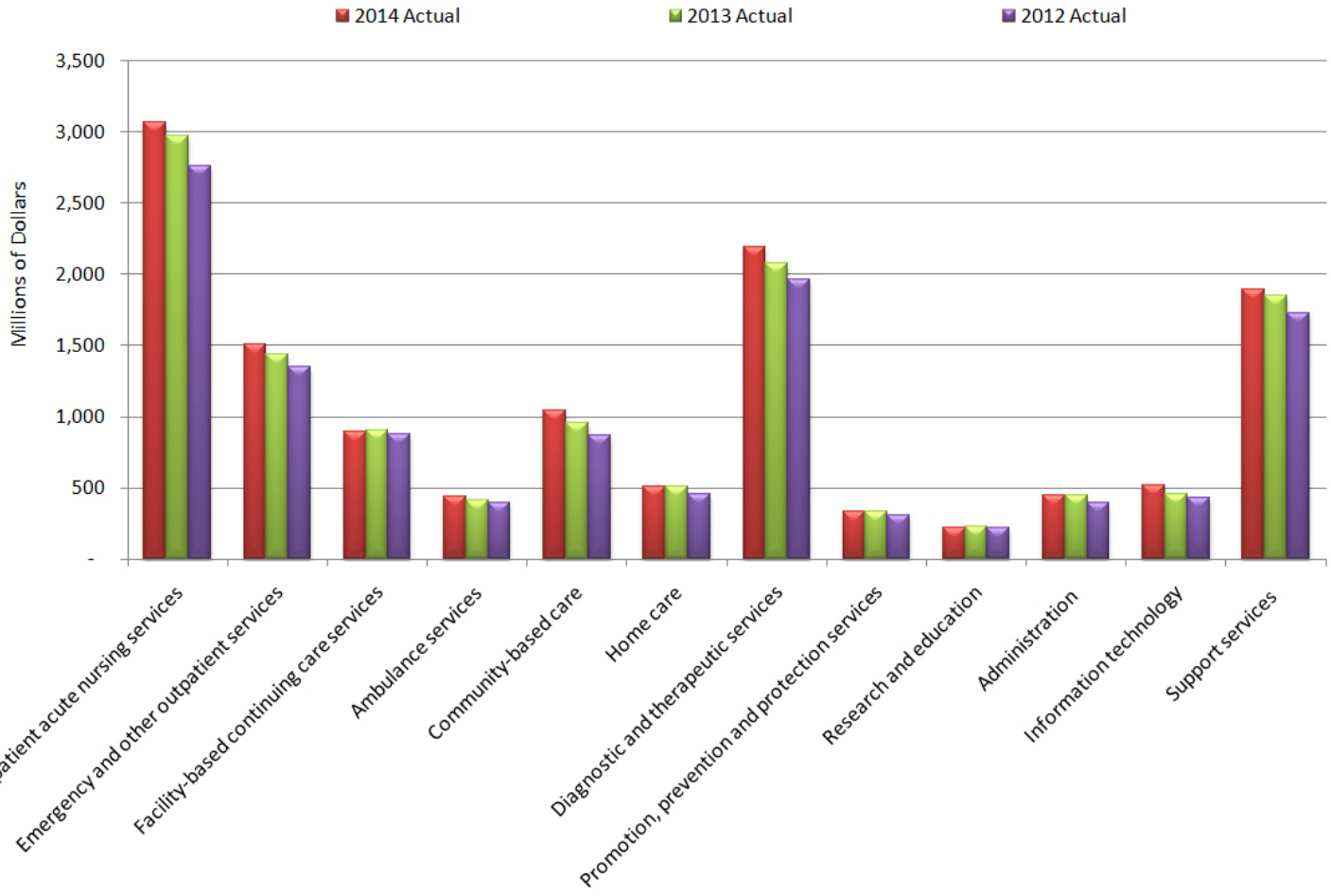
  There is an increase of $41 over prior year mainly due to increased costs related to information technology purchases for the replacement of diagnostic imaging workstations and other end user devices, increased utility costs resulting from higher natural gas prices, and increased insurance costs. Further contributing was increased costs related to operations at the South Health Campus moving to being fully operational in 2013-14. The overall increase was partially offset by achieved savings initiatives, including reduced equipment maintenance, service contracts, and travel costs.

- **Amortization expenses** relate to the periodic charges to expense representing the estimated portion of the cost of the respective tangible capital asset that expired through use and age during the period.

  Amortization expenses amounted to $565 compared to a budget of $560 resulting in a negative variance of $5 or 0.9%. The negative variance is mainly due to higher capital asset additions than planned and cost adjustments to existing projects for facility improvements and information systems; partially offset by delays in project capitalization.

  There is an increase of $32 over prior year mainly due to the addition of information technology assets during the year, which were put into service and therefore increased the amortization expense.

EXPENSES – BY FUNCTION



Total expenses in 2013-14 increased by 4.0% from 2012-13 and were lower than budgeted amounts by 2.1%, illustrating achieved cost control strategies. This represents a 3.0% reduction in annual expense growth as compared to the 2012-13 increase of 7.0% from 2011-12. The reduced growth in expenses was primarily achieved in inpatient acute nursing services, facility-based continuing care services, home care, promotion, prevention and protection services, and support services. There was no growth in administration expenses between 2013-14 and 2012-13.

The overall 4.0% increase in 2013-14 expenses was primarily due to increased salary and benefit costs, increased contracts with health service provider costs and increased patient volumes. AHS' overall distribution of expenses has remained consistent with the previous year, with inpatient acute nursing services and diagnostic and therapeutic expenses making up 40% of total expenses. Almost all areas experienced an increase from the prior year, with the exception of facility-based continuing care services, home care, research and education, and administration.

Total expenses over the three years have increased annually due to items such as compensation rate and benefit increases, new investments, inflation, new facilities and changes to restricted grants. AHS is using new investments to shift delivery of care from acute care settings into non-acute settings. The 2013-14 budget reflected this shift by increasing new investments at a higher rate for non-acute settings (such as community-based care) compared to acute care settings (such as inpatient acute nursing services). The actual results also reflect this shift in focus, as shown in the graph above, through the reduction in annual expense growth in inpatient acute nursing services, compared to the steady annual expense growth in community-based care.

Expenses	Budget 2014	Actual 2014	Variance 2014	Actual 2013	Increase (Decrease)
Inpatient acute nursing services	$3,004	$3,069	$(65)	$2,972	$97
Emergency and other outpatient services	1,530	1,510	20	1,440	70
Facility-based continuing care services	929	896	33	906	(10)
Ambulance services	421	443	(22)	409	34
Community-based care	1,164	1,040	124	955	85
Home care	501	506	(5)	507	(1)
Diagnostic and therapeutic services	2,234	2,193	41	2,075	118
Promotion, prevention and protection services	361	333	28	331	2
Research and education	252	222	30	225	(3)
Administration	481	444	37	444	-
Information technology	479	517	(38)	455	62
Support services	1,999	1,895	104	1,849	46
Total expenses	**$13,355**	**$13,068**	**$287**	**$12,568**	**$500**

Significant variances and changes are explained as follows:

- **Inpatient acute nursing services** are composed predominantly of nursing units such as: medical, surgical, intensive care, obstetrics, paediatrics and mental health. This category also includes operating and recovery rooms.

  Inpatient acute nursing services amounted to $3,069 compared to a budget of $3,004 resulting in a negative variance of $65 or 2.2%. Included in this variance is an unused contingency of $38. The offsetting $103 negative variance is mainly due to increased activity levels, including increased surgical activity and patient days. The increased activity levels have resulted in higher salaries, benefits, and medical and surgical supplies costs. Higher costs compared to budget were also incurred related to increased overtime, as well as the hiring of additional staff to respond to the increase in activity. Further contributing was an additional number of positions required to support the South Health Campus than what was assumed in preliminary implementation plans. The overall negative variance is partially offset by vacancies and the phased implementation of various programs and services at the South Health Campus.

  There is an increase of $97 over prior year mainly due to the phased opening of programs and services at the South Health Campus which included the opening of additional surgical suites, addictions and mental health services and various medical clinics and increased physician positions. Further contributing is inflationary and compensation cost increases, as well as increased labour. The overall increase was partially offset by achieved savings initiatives and cost control strategies.

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

  Emergency and other outpatient services amounted to $1,510 compared to a budget of $1,530 resulting in a positive variance of $20 or 1.3%. Included in this variance is an unused contingency of $22. Increased activity levels, particularly in emergency, cancer treatments, and renal runs are offset by vacancies and the phased implementation of programs and services at the South Health Campus.

  There is an increase of $70 over prior year mainly due to increased activity primarily for drugs and gases related to high cost emerging drugs, rare disease, and specialized high-cost drugs. Further increased costs were incurred related to operations at the South Health Campus moving to being fully operational in 2013-14, particularly in salaries and benefits.

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

  Facility-based continuing care services amounted to $896 compared to a budget of $929 resulting in a positive variance of $33 or 3.6%. The positive variance is mainly due to the budget being higher than required. Part of the positive variance is also due to the implementation of cost control strategies and vacancies. Included in this variance is an unused contingency of $9.

  There is a decrease of $10 over prior year mainly due to the achievement of targeted savings initiatives, including reduced drugs and gases costs, and vacancies. The overall decrease was partially offset by contract inflation and increased activity at many AHS facilities.

- **Ambulance services** are composed of EMS ambulance, patient transport, and EMS central dispatch.

  Ambulance services amounted to $443 compared to a budget of $421 resulting in a negative variance of $22 or 5.2%. Included in this variance is an unused contingency of $10. The offsetting $32 negative variance is mainly due to the budget being lower than required. The overall negative variance is partially offset by vacancies and unsettled ground ambulance contracts.

  There is an increase of $34 over prior year mainly due to increased activity primarily related to ground ambulance transportation at the Edmonton International Airport and a new restricted grant for improved Medevac services with STARS. Further contributing to the increase was the phased opening of programs at the South Health Campus which includes emergency medical services now in full operation, compensation rate increases and inflation.

- **Community-based care** is composed primarily of supportive living, and palliative and hospice care, but excludes community-based dialysis, oncology and surgical services. This category also consists of community programs: Primary Care Networks, Family Care Clinics, urgent care centres, and community mental health.

  Community-based care amounted to $1,040 compared to a budget of $1,164 resulting in a positive variance of $124 or 10.7%. Included in this variance is an unused contingency of $24. The remaining $100 positive variance is mainly due to vacancies and lower underlying costs related to drugs used in community-based care compared to the budget. Further contributing is timing variances associated with the implementation of various budgeted initiatives, including facilities not operating at full capacity and the timing of opening beds. Delayed initiatives also led to lower costs compared to budget and include the Continuing Care Capacity Plan, Community Treatment Orders, Corrections, Capital Bed Initiative, Children's Mental Health Plan, and Safe Communities.

There is an increase of $85 over prior year mainly due to increased activity in the zones primarily resulting from the Edmonton Remand Centre being open for the full year in 2013-14, creating Community Care Teams, implementing Community Care Capacity Plan initiatives and increased supportive living capacity at various facilities. Further increased costs were incurred related to contract inflation and increased salaries and benefits costs due to compensation rate increases.

- **Home care** is composed of home nursing and support.

  Home care amounted to $506 compared to a budget of $501 resulting in a negative variance of $5 or 1.0%. The negative variance is mainly due to an increase in home care activity across the zones stemming from increased demand, home care hours, unique clients and home care visits, as well as delays in the implementation of various saving initiatives. Included in this variance is an unused contingency of $5.

  Home care costs were relatively unchanged, with a decrease of only $1 compared to the prior year.

- **Diagnostic and therapeutic services** is composed primarily of 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 $2,193 compared to a budget of $2,234 resulting in a positive variance of $41 or 1.8%. Included in this variance is an unused contingency of $37. The remaining $4 positive variance is mainly due to vacancies including some hard-to-recruit positions, various delays in initiatives including the Anatomic Pathology Quality Assurance implementation, as well as the phased implementation of various programs at the South Health Campus. The positive variance also includes the amortization of capital equipment, which was less than budgeted mainly due to less than anticipated major capital equipment purchases. The overall positive variance is partially offset by the budget assuming higher savings initiatives than were actually realized and higher than anticipated costs required to support the South Health Campus than what was assumed in preliminary implementation plans.

  There is an increase of $118 over prior year mainly due to the phased implementation of programs and services at the South Health Campus which fully opened during 2013-14, increased activity including Kaye Edmonton Clinic now operating at full capacity, and increased diagnostic testing. Increased costs were also incurred for compensation rate increases and various increased contract costs.

- **Promotion, prevention and protection services** are composed primarily of health promotion, disease and injury prevention, and health protection.

  Promotion, prevention and protection services amounted to $333 compared to a budget of $361 resulting in a positive variance of $28 or 7.8%. The positive variance is mainly due to vacancies and various delays in initiatives, including the Pandemic Supplies grant, Alberta Cancer Prevention Legacy Fund grant, Sexually Transmitted Infections, Blood Borne Pathogens and Continuing Care Innovations grant.

  Promotion, prevention and protection services costs were relatively unchanged with an increase of only $2 compared to the prior year.

- **Research and education** pertains to formally organized health research and graduate medical education, primarily funded by donations and third party contributions.

  Research and education amounted to $222 compared to a budget of $252 resulting in a positive variance of $30 or 11.9%. The positive variance is mainly due to lower grant funded research activity compared to budget. The overall positive variance is partially offset by a decrease in special purpose funds. Included in this variance is an unused contingency of $7.

  Research and education costs were relatively unchanged, with a decrease of only $3 compared to the prior year.

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

  For 2013-14 AHS' administration expense was $444 which represents 3.4% of total expenses of $13,068.

  The Canadian Institute for Health Information (CIHI) reports an administration expense financial performance indicator. For 2013-14 AHS' indicator was 3.4% calculated based on administration expense, net of recoveries, of $432 and total expenses, net of recoveries and inclusive of bad debt expense, of $12,838.

  Administration amounted to $444 compared to a budget of $481 resulting in a positive variance of $37 or 7.7%. Included in this variance is an unused contingency of $8. The remaining $29 positive variance is mainly due to vacancies throughout the organization, including some hard-to-recruit positions and cost minimization efforts related to travel, supplies and materials. Further contributing to the overall positive variance are various delays in initiatives, including the staff rotation review and optimization initiative. The overall positive variance is partially offset by higher than expected legal and liability expenses and an increase in actuarial estimates for past and future unreported liability claims.

  Administration costs are unchanged compared to prior year.

- **Information technology** are 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 Netcare.

  Information technology amounted to $517 compared to a budget of $479 resulting in a negative variance of $38 or 7.9%. The negative variance is mainly due to the replacement of obsolete diagnostic imaging workstations and other end user devices. Included in information technology is the amortization of information systems, which further contributed to the negative variance due mainly to assets having been put into use earlier than anticipated in the budget. Further contributing is the write-down of various projects in progress to focus on fewer priority projects. The overall negative variance is partially offset by lower project costs due to delayed prioritization decisions, cost control strategies, and vacancies.

There is an increase of $62 over prior year mainly due to increased costs related to the replacement of obsolete diagnostic imaging workstations and other end user devices, write-down of various projects in progress to focus on fewer priority projects and increased contract rates, including licensing and software maintenance. Further contributing is the increased amortization expense related to the information technology tangible capital asset purchases in the year. The overall increase in costs is partially offset by the achievement of savings initiatives and cost control strategies.

- **Support services** is composed of building maintenance operations (including utilities), materials management (including purchasing, central warehousing, distribution and sterilization), housekeeping, laundry and linen services, patient registration, health records, food services, and emergency preparedness.

  Support services amounted to $1,895 compared to a budget of $1,999 resulting in a positive variance of $104 or 5.2%. Included in this variance is an unused contingency of $22. The remaining $82 positive variance is mainly due to the budget being higher than required. Further contributing to the overall positive variance is staff vacancies and decreased spending on AI funded Infrastructure Maintenance Projects (IMP). The overall positive variance was partially offset by increased utility costs, building and ground maintenance, and minor equipment purchases. Included in support services is the amortization of facilities and improvements, further offsetting the overall positive variance due mainly to additional costs added to existing AI managed projects including South Health Campus, Foothills Medical Centre, McCaig Tower, and Fort Saskatchewan Hospital.

  There is an increase of $46 over prior year mainly due to the phased implementation of programs and services at the South Health Campus which fully opened in 2013-14, increased utility costs due to higher natural gas prices, and compensation rate of pay and benefit increases. Further contributing to the overall increase in costs is higher amortization expense associated with higher capitalized asset balances. The overall increase in costs is partially offset by achieved savings initiatives, including reduced minor renovation work, equipment maintenance costs and service contracts compared to the prior year.

FINANCIAL POSITION

The following table summarizes the Consolidated Statement of Financial Position:

Consolidated Statement of Financial Position	Actual 2014	Actual 2013	Increase (Decrease)
Cash and portfolio investments	$2,335	$2,100	$235
Tangible capital assets	7,502	7,516	(14)
All other assets	596	555	41
Total assets	**$10,433**	**$10,171**	**$262**
Deferred revenue			
Unexpended deferred operating revenue	$499	$484	$15
Unexpended deferred capital revenue	230	241	(11)
Expended deferred capital revenue	6,277	6,235	42
Debt	350	375	(25)
All other liabilities	1,750	1,682	68
Total liabilities	**$9,106**	**$9,017**	**$89**
Accumulated surplus	$1,234	$1,078	$156
Accumulated remeasurement gains and losses	25	10	15
Endowments	68	66	2
Total net assets	**$1,327**	**$1,154**	**$173**

Accumulated Surplus	Actual 2014	Actual 2013	Increase (Decrease)
Unrestricted net assets	$266	$83	$183
Reserves for future purposes	87	79	8
Net assets invested in tangible capital assets	881	916	(35)
Accumulated surplus	**$1,234**	**$1,078**	**$156**

Cash & Portfolio Investments

The Consolidated Statement of Cash Flows summarizes the sources and uses of cash in 2013-14.

AHS receives its base operating funding from AH twice per month. The arrangement allows AHS to manage its operating cash balances effectively to meet its immediate and ongoing liabilities as they become due. The AHS investment portfolio is conservative and highly liquid in nature and allows AHS to react to expected and unexpected cash requirements quickly and efficiently. Focusing on prudent stewardship of funds, AHS monitors its bank balances closely and transfers cash to, or from, the investment portfolio to ensure that cash balances will earn maximum returns until they need to be utilized. The net increase of $235 in the overall cash and portfolio investment balance as compared to the prior year was comprised of a cash outflow of $78 offset by an increase in portfolio investments of $313.

Portfolio Composition and Risk Analysis

AHS has a responsibility to ensure its funds are invested in a way that promotes the short and long-term sustainability of the organization's operations. The investment philosophy assures the 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.

AHS manages its investment portfolio risk through diversification in various investment vehicles such as treasury bills, federal, provincial and corporate fixed income, and equity pooled funds. The short-term investment strategy is designed to focus on safety and liquidity, while capturing reasonable rates of return. The longer term strategy balances federal and provincial bonds, high quality corporate fixed income holdings and Canadian and Global equity income funds. This strategy protects the original capital while providing reasonable returns with a conservative exposure to more volatile equity markets. The majority of cash and portfolio investments are used to fund operations in the short and medium term.

Restrictions

The total cash and portfolio investment balance of $2,335 will be used to cover liabilities including accounts payable, deferred operating and capital costs and long-term borrowing obligations, with the exception of $266 representing unrestricted net assets.

AHS manages its cash and portfolio investments prudently so that funds are available to meet current and long-term commitments. As at March 31, 2014, the balance is adequate to cover immediate and upcoming obligations as they become due.

Tangible Capital Assets

Tangible Capital Assets	Actual 2014	Actual 2013	Increase (Decrease)
Cost	$12,992	$12,569	$423
Accumulated amortization	5,490	5,053	437
Net book value	**$7,502**	**$7,516**	**$(14)**

The total net book value of tangible capital assets as at March 31, 2014 consists of $5,412 of facilities, $858 of equipment and building service equipment, $725 of work in progress (WIP), $334 of information systems, $122 of land and land improvements, and $51 of leased facilities and improvements.

Over the course of the year, several capital projects totalling $383 in WIP were brought into service and capitalized. Notable projects included South Health Campus, Strathcona County Hospital, AHS/Human Resources Pay Consolidation, AH Equipment Upgrades, Chinook Regional Hospital Parking, Grey Nun's Hospital, Bed Reclamation, and Electronic Facilities initiative.

The WIP balance includes infrastructure and information technology capital projects at:

Grande Prairie Regional Health Centre	Diagnostic Imaging Initiative	Provincial Patient Lifts Initiative
South Health Campus	High Prairie Hospital	Access to Health Services Initiative
Chinook Regional Hospital	Emergency Room/Ambulatory Care Expansion Project	eClinician Initiative
Medicine Hat Regional Hospital	Lloydminster Dr Cooke Continuing Care Centre	Personal Health Portal
Edson Health Care Centre	eCRITICAL Alberta Project	Foothills Medical Centre
Strathcona Community Hospital	Provincial Communicable Diseases Initiative	Peter Lougheed Centre
Alberta Hospital Edmonton	Fort McMurray General Hospital	

At March 31, 2014, AHS has approved capital commitments for purchases of tangible capital assets of $37 for facilities and improvements, $17 for information systems, and $61 for equipment.

The capital purchases compared to the annual amortization expense indicates the rate of reinvestment. The reinvestment rate for equipment and information systems was 75% in 2013-14 (2012-13 – 146%). As a result, the estimated remaining useful life for equipment and information systems decreased from 3.7 years in 2012-13 to 3.4 years in 2013-14 (2011-12 – 3.5 years).

Financing of Tangible Capital Assets

AHS primarily relies on external sources for funding capital expenditures. Except for parkades, new facility purchases, including WIP, of $326 were primarily funded by the Alberta Government. Equipment purchases, including WIP, of $130 were externally funded approximately two-thirds (2012-13 – two-thirds), whereas information system purchases, including WIP, are only externally funded approximately one-third (2012-13 – one-half).

A greater portion of information systems purchases were externally funded in 2012-13 due to their inclusion in the South Health Campus and Kaye Edmonton Clinic projects.

Expended deferred capital revenue balance represents tangible capital assets purchased for which AHS has an obligation to utilize these for the duration of their economic useful lives. Funding from other government organizations, mainly AI, makes up $5,678 of the $6,277 total balance, while facilities makes up a similar proportion of the total tangible capital assets.

Net assets invested in tangible capital assets included in accumulated surplus is $881, representing the amount of unrestricted net assets already used to fund tangible capital assets internally or required to repay debt used to fund tangible capital assets. The majority of the outstanding $350 of debt was used to fund parkades.

Resources Available for Future Use

Transfers, donations, and fundraising are key sources of revenue for AHS. Through these funds, AHS is able to implement various operating and capital initiatives intended to improve the quality of health care in Alberta. Restricted funding subject to timing and purpose restrictions imposed by funding agencies, is deferred and recognized as revenue when the terms for the use of the funding is met and, when applicable, AHS complies with its communicated use.

Unexpended deferred operating revenue

During the year, AHS received or accrued $1,426 in restricted funding and spent $1,481 in related expenses. The amounts received or accrued and spent by AHS during the fiscal year pertain primarily to initiatives funded by AH grants related to physician compensation, incremental operating costs of new health facilities, and provision of various drugs at no cost to patients. AHS has $499 available at March 31, 2014 for future use.

Unexpended deferred capital revenue

During the year, AHS received or accrued $456 in restricted capital funding, including $271 of in-kind revenue from AI transitioned projects, $52 from IMP projects, $38 from AI equipment and systems projects, and $44 from AH projects. The remaining $51 in funding was received from other foundations. AHS incurred $416 in expenditures, including AI expenditures of $310 ($271 of which is in-kind transitioned WIP), $60 was incurred for AH Medical Equipment Replacement Upgrade Program and Information Technology Systems initiatives, and $46 was incurred through various other foundations. AHS transferred $45 in funding to operating initiatives, returned $8 in surplus funds on completed projects back to funding agents, and recognized $2 in unrealized gains on investments. AHS has $230 available at March 31, 2014 for future use.

Unrestricted net assets

During the year, AHS generated an operating surplus of $156, of which $36 related to internally funded tangible capital asset activities. AHS had $266 of unrestricted net assets and $87 of reserves at March 31, 2014 available for future use.

FINANCIAL REPORTING, CONTROL AND ACCOUNTABILITY

Financial Reporting

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 (PSAS) and the reporting requirements of Alberta Health Financial Directive 12. The chart of accounts that AHS uses to report expenses by program 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 quarterly and annual financial reports are available at www.albertahealthservices.ca under publications.

The Auditor General of Alberta is the appointed 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.

Financial Control and Accountability

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.

Appointed in 2013-14, the Official Administrator provides oversight and carries out its risk management mandate primarily through committees which include: Audit and Finance Advisory Committee, Quality Assurance & Patient Safety Advisory Committee, and Human Resources Advisory Committee.

The Audit and Finance Advisory Committee has responsibility to assist in fulfilling the financial oversight responsibilities of AHS and in overseeing management's administration of AHS on finance and audit related items.

AHS has established an internal audit function with the mandate of providing independent assurance to management and the Official Administrator 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 policy 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.

Through the Compliance Coordination Committee, AHS has also implemented a compliance program for its Human Resources, Contracting, Procurement and Supply Management, Information Technology and Finance departments.

Future Changes to PSAS

PSAS continues to evolve and as such, various exposure drafts have been issued for comment by the Canadian Public Sector Accounting Board which may impact future accounting and disclosure requirements. Additionally, the interpretation and application of PSAS specifically to Government Not-for-Profit Organizations continues to be debated by various stakeholders including auditors and standard setters. AHS continues to actively monitor and assess the impact of any resulting changes made to PSAS.

In June 2010, the Public Sector Accounting Board issued PS 3260 – Liability for Contaminated Sites. This accounting standard is effective for fiscal years starting on or after April 1, 2014. 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. AHS would be required to recognize a liability related to the remediation of such contaminated site subject to certain recognition criteria. Management does not expect the implementation of this standard to have a significant impact on the consolidated financial statements.

THREE YEAR RESULTS

Consolidated Statement of Operations Years Ended March 31			
	2014	2013 [1]	2012 [1]
Revenue:			
Alberta Health transfers			
Base operating grant	$10,496	$10,214	$9,634
Other operating grants	1,257	1,068	826
Capital grants	87	106	121
Other government transfers	387	393	346
Fees and charges	432	412	416
Ancillary operations	126	118	122
Donations, fundraising, and non- government grants	155	144	147
Investment and other income	284	219	222
Total Revenue	**13,224**	**12,674**	**11,834**
Expenses:			
Inpatient acute nursing services	3,069	2,972	2,761
Emergency and other outpatient services	1,510	1,440	1,352
Facility-based continuing care services	896	906	878
Ambulance services	443	409	395
Community-based care	1,040	955	865
Home care	506	507	453
Diagnostic and therapeutic services	2,193	2,075	1,961
Promotion, prevention and protection services	333	331	308
Research and education	222	225	218
Administration	444	444	397
Information technology	517	455	435
Support services	1,895	1,849	1,724
Total Expenses	**13,068**	**12,568**	**11,747**
Operating Surplus	**$156**	**$106**	**$87**

Schedule of Expenses by Object Years Ended March 31			
	2014	2013	2012
Salaries and benefits	$7,049	$6,753	$6,161
Contracts with health service providers	2,258	2,166	2,018
Contracts under the Health Care Protection Act	19	17	18
Drugs and gases	427	388	388
Medical and surgical supplies	399	392	360
Other contracted services	1,090	1,099	1,056
Other	1,261	1,220	1,271
Amortization, disposals and write-downs	565	533	475
Total Expenses	**$13,068**	**$12,568**	**$11,747**

[1] *Certain 2013 and 2012 amounts have been reclassified to conform to 2014 presentation.*

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

Long-Term Spending Trends, Cost Drivers and Sustainability

The growth rate in AHS' expenses slowed from 7% in 2012-13 to 4% in 2013-14. This has been accomplished through focused efforts to manage labour costs, non-clinical contracted services, and administration and overhead costs.

For 2014-15 and future years, significant cost pressures are anticipated as a result of population growth, aging and morbidity, increasing utilization of services, and increases in unit costs including compensation increases and inflation.

To achieve financial sustainability, AHS will enhance quality, manage cost growth and ensure value for money. This will include initiatives to manage unit costs, achieve operational efficiencies and productivity improvements, and optimize service delivery. In addition, there will be focused efforts to strengthen community and primary health care to deliver care in the most appropriate setting.

Key Risks

AHS actively monitors and manages risks that may impact the achievement of its strategic directions. The Enterprise Risk Management (ERM) priority risk areas for AHS are:

- Sustainable Workforce
- Appropriateness of Care
- Patient Satisfaction
- Stakeholder Engagement
- Financial Sustainability
- Patient Safety

Risk mitigation plans are being developed for each priority risk area to guide risk management activities.

In addition to the priority risk areas, there are financial risks. AHS will actively manage these risks and implement mitigation strategies. These risks include:

- Salaries and benefits account for a significant proportion of AHS' expenses. Collective agreements with the United Nurses of Alberta, the Alberta Union of Provincial Employees (General Support Services) and the Health Sciences Association of Alberta are all under negotiation.

- Non-compensation costs may be higher than anticipated due to increased cost inflation in areas such as drugs, medical and surgical supplies and contracted services. AHS is working on initiatives to mitigate cost increases, including contract reviews and bulk purchasing opportunities, along with work by Strategic Clinical Networks to promote evidence informed standards.

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2014

Alberta Health Services

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying consolidated financial statements for the year ended March 31, 2014 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 under Alberta Health Services' administration

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Audit and Finance Advisory Committee. This 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 Official Administrator for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Audit and Finance Advisory 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]

Vickie Kaminski
President and Chief Executive Officer
Alberta Health Services

[Original Signed by]

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

[Original Signed by]

Brenda Huband
Interim President and Chief Executive Officer,
Zone and Health Operations
Alberta Health Services

[Original Signed by]

Rick Trimp
Interim President and Chief Executive Officer,
Population Health and Province-Wide Services
Alberta Health Services

June 5, 2014

Independent Auditor's Report

To the Official Administrator of Alberta Health Services

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, 2014, and the consolidated statements of operations, accumulated remeasurement gains and losses, 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, 2014, and the results of its operations, its remeasurement gains and losses, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

[Original signed by Merwan N. Saher, FCA]

Auditor General

June 5, 2014

Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS
YEAR ENDED MARCH 31

	2014		2013
	Budget (Note 3)	Actual	Actual (Note 26)
Revenue:			
Alberta Health transfers			
Base operating grant	$ 10,521,000	$ 10,495,788	$ 10,213,791
Other operating grants	1,436,000	1,257,279	1,068,026
Capital grants	98,000	87,173	106,688
Other government transfers (Note 4)	389,000	386,792	393,135
Fees and charges	456,000	432,198	412,038
Ancillary operations	129,000	125,653	117,726
Donations, fundraising, and non-government grants (Note 5)	131,000	155,039	144,067
Investment and other income (Note 6)	195,000	284,228	219,132
TOTAL REVENUE	13,355,000	13,224,150	12,674,603
Expenses:			
Inpatient acute nursing services	3,004,000	3,069,095	2,972,309
Emergency and other outpatient services	1,530,000	1,509,880	1,440,730
Facility-based continuing care services	929,000	895,989	905,909
Ambulance services	421,000	442,848	409,239
Community-based care	1,164,000	1,040,473	954,522
Home care	501,000	505,751	507,009
Diagnostic and therapeutic services	2,234,000	2,193,635	2,074,711
Promotion, prevention, and protection services	361,000	333,189	330,775
Research and education	252,000	221,838	224,623
Administration (Note 7)	481,000	443,991	444,358
Information technology	479,000	516,643	454,919
Support services (Note 8)	1,999,000	1,895,127	1,849,108
TOTAL EXPENSES (Schedule 1)	13,355,000	13,068,459	12,568,212
OPERATING SURPLUS	$ -	155,691	106,391
Accumulated surplus, beginning of year		1,078,114	971,723
Accumulated surplus, end of year (Note 19)		$ 1,233,805	$ 1,078,114

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

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CONSOLIDATED STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31

	2014 Actual	2013 Actual (Note 26)
Assets:		
Cash and cash equivalents (Note 11)	$ 606,070	$ 684,604
Portfolio investments (Note 12)	1,728,853	1,415,223
Accounts receivable (Note 13)	379,245	363,421
Other assets	11,604	12,455
Tangible capital assets (Note 14)	7,502,495	7,515,882
Inventories for consumption	98,252	93,548
Prepaid expenses (Note 24)	106,399	86,119
TOTAL ASSETS	$ 10,432,918	$ 10,171,252
Liabilities:		
Accounts payable and accrued liabilities (Note 15)	$ 1,195,016	$ 1,157,924
Employee future benefits (Note 16)	554,532	524,827
Deferred revenue (Note 17)	7,005,555	6,959,575
Debt (Note 18)	350,368	375,384
TOTAL LIABILITIES	9,105,471	9,017,710
Net Assets:		
Accumulated surplus (Note 19)	1,233,805	1,078,114
Accumulated remeasurement gains and losses	24,846	10,221
Endowments (Note 20)	68,796	65,207
TOTAL NET ASSETS	1,327,447	1,153,542
	$ 10,432,918	$ 10,171,252

Contractual Obligations and Contingent Liabilities (Note 21)

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

Approved by:

[Original Signed by]

_____

Dr. John Cowell
Official Administrator
Alberta Health Services

CONSOLIDATED STATEMENT OF CASH FLOWS
YEAR ENDED MARCH 31

	2014 Budget (Note 3)	2014 Actual	2013 Actual (Note 26)
Operating transactions:			
Operating surplus	$ -	$ 155,691	$ 106,391
Non-cash items:			
Amortization, disposals, and write-downs	560,000	564,926	533,168
Recognition of expended deferred capital revenue	(390,000)	(374,317)	(375,307)
Revenue recognized for acquisition of land	-	(1,224)	(15)
Decrease (increase) in:			
Accounts receivable related to operating transactions	(32,000)	(37,073)	56,217
Inventories for consumption	(5,000)	(4,704)	3,192
Other assets	1,000	851	25,627
Prepaid expenses	(16,000)	(20,280)	(26,533)
Increase (decrease) in:			
Accounts payable and accrued liabilities related to operating transactions	37,000	150,230	(90,874)
Employee future benefits	8,000	29,705	10,312
Deferred revenue related to operating transactions	37,000	(44,840)	(131,555)
Cash provided by operating transactions	200,000	418,965	110,623
Capital transactions:			
Acquisition of tangible capital assets	(410,000)	(286,015)	(527,349)
Increase (decrease) in accounts payable and accrued liabilities related to capital transactions	13,000	(111,640)	(103,939)
Cash applied to capital transactions	(397,000)	(397,655)	(631,288)
Investing transactions:			
Purchase of portfolio investments	(2,327,000)	(3,851,627)	(2,573,213)
Proceeds on sale of portfolio investments	2,402,000	3,572,082	2,731,366
Cash provided by (applied to) investing transactions	75,000	(279,545)	158,153
Financing transactions:			
Deferred capital revenue received	144,000	206,276	250,962
Deferred capital revenue returned	(2,000)	(7,957)	(128,042)
Deferred capital revenue payable transferred from accounts payable and accrued liabilities	-	-	119,754
Proceeds from debt	-	-	32,300
Principal payments on debt	(18,000)	(18,618)	(40,384)
Cash provided by financing transactions	124,000	179,701	234,590
Net increase (decrease) in cash and cash equivalents	2,000	(78,534)	(127,922)
Cash and cash equivalents, beginning of year	883,000	684,604	812,526
Cash and cash equivalents, end of year	$ 885,000	$ 606,070	$ 684,604

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

CONSOLIDATED STATEMENT OF ACCUMULATED REMEASUREMENT GAINS AND LOSSES
YEAR ENDED MARCH 31

	2014 Actual	2013 Actual (Note 26)
Balance, beginning of year	$ 10,221	$ -
Adjustment on adoption of the financial instruments standard	-	5,272
Unrestricted unrealized net gains on portfolio investments	29,581	6,858
Amounts reclassified to the Consolidated Statement of Operations related to portfolio investments	(14,956)	(1,909)
Net remeasurement gains for the year	14,625	10,221
Balance, end of year (Note 12)	$ 24,846	$ 10,221

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2014

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 amalgamation 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 example, the Department of Health is responsible for paying most physician fees. For a complete picture of the costs of provincial healthcare, readers should consult the consolidated financial statements of the Government of Alberta.

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.

AHS is exempt from the payment of income taxes under the *Income Tax Act* (Canada).

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

AHS operates as a Government Not-for-Profit Organization. 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).

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 following entities which are controlled by AHS as at March 31, 2014:

Wholly Owned Subsidiaries:

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Foundations and Trusts:

Airdrie Health Foundation
Alberta Cancer Foundation (ACF)
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
Capital Care Charitable Trust
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Trust
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation
Grimshaw/Berwyn Hospital Foundation
Jasper Health Care Foundation
Lacombe Hospital and Care Centre Foundation
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
Viking Health Foundation
Vulcan County Health and Wellness Foundation
Windy Slopes Health Foundation

The following foundations are also considered controlled, but are in the process of being wound-up or are considered to be inactive:

Central Peace Hospital Foundation
Lakeland Regional Health Authority
Manning Community Health Centre Foundation
McLennan Community Health Care Foundation
Peace Health Region Foundation
Vermillion and Region Health and Wellness Foundation

Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP):

AHS consolidates its interest in the 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. The LPIP is exempt from the payment of income tax but is subject to the Alberta provincial premium tax.

Other:

Queen Elizabeth II Hospital Child Care Centre

(ii) Government Partnerships

AHS uses the proportionate consolidation method to account for its 30% interest in the HUTV Limited Partnership (HUTV) with David Chittick Management Ltd, its 50% interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta, and its 50% interest in the Primary Care Network (PCN) government partnerships with physician groups (Note 23).

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) Primary Care Network
Big Country Primary Care Network
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 Cache Primary Care Network
Grande Prairie Primary Care Network
Highland Primary Care Network
Kalyna Country (Vegreville/Vermillion) 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/Consort 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 include the payments to voluntary and private organizations under contract to provide health services in the Province of Alberta (Note 9). Also included are certain tangible capital assets owned by AHS but operated by contracted health service providers. Other operations not funded by AHS and other assets and liabilities of the contracted health service providers are not included in these consolidated financial statements. These consolidated financial statements also do not include the trust funds administered on behalf of others (Note 25).

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(b) Revenue Recognition

Revenue is recognized in the period in which the transactions or events occur that give rise to the revenue as described below. 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 Grants

Transfers from AH, other governments, and other government entities are referred to as government grants.

Government grants are recorded as deferred revenue if the terms for use of the grant, or the terms along with AHS' actions and communications as to the use of the grant, create a liability. These grants are recognized as revenue as the terms are met and, when applicable, AHS complies with its communicated use of the grant. All unrealized gains and losses attributable to these grants are recognized as an increase or decrease in deferred revenue.

All other government grants without terms for the use of the grant are recorded and recognized as revenue when AHS is eligible to receive the funds.

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

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

Unrestricted donations, fundraising, and non-government grants 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, and non-government grants 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. All unrealized gains and losses attributable to externally restricted donations, fundraising and non-government grants are recognized as an increase or decrease in deferred revenue.

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) Grants and Donations of or for Land

AHS records grants 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) Endowments

Donations, fundraising, government grants, and non-government grants that must be maintained in perpetuity are recognized as a direct increase in endowment net assets when received or receivable.

All unrealized gains and losses attributable to endowments are recognized as an increase or decrease in deferred revenue.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Expendable realized gains and losses attributable to endowments are recognized as increases or decreases in deferred revenue when received or receivable and are subsequently recognized in the Consolidated Statement of Operations when terms of use are met, as stipulated by the donors. Realized investment gains for endowment capital preservation purposes are recognized as a direct increase in endowment net assets when received or receivable.

(v) Fees and Charges, Ancillary Operation, and Other Income

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

(vi) Investment Income

Investment income includes dividend and interest income, and realized gains or losses on the sale of portfolio investments. Unrealized gains and losses on portfolio investments that are not from restricted grants or donations are recognized in the Consolidated Statement of Accumulated Remeasurement Gains and Losses until the related investments are sold. Once realized, these gains or losses are recognized in the Consolidated Statement of Operations except for restricted investment income which is recognized as revenue in the period the related expenses are incurred or the terms of use are met.

(c) Expenses

The key elements of AHS' expense recognition policy are:

(i) Directly incurred 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 sourcing 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.

(ii) Expenses incurred include contracted health services provided by other entities in support of AHS' responsibilities and operations and are disclosed in Note 9.

(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 cash equivalents and portfolio investments	Measured at fair value with changes in fair values recognized in the Consolidated Statement of Accumulated Remeasurement Gains and Losses, accounts payable, 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 cost or amortized cost using the effective interest rate method.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

PSAS requires portfolio investments in equity instruments 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 and fixed income securities 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, 2014, AHS has no embedded derivatives that require separation from the host contract.

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 cash and cash equivalents and portfolio investments are expensed as incurred. Investment management fees are expensed as incurred. The purchase and sale of cash and cash equivalents and portfolio investments are accounted for using trade-date accounting.

(e) Inventories For Consumption

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

(f) 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 including 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 donation. When AHS cannot determine the fair value, in-kind contributions are recorded at a nominal value. Costs incurred by Alberta Infrastructure (AI) to build tangible capital assets on behalf of AHS are recorded by AHS as work in progress and expended deferred capital revenue as AI incurs costs.

Works of art, historical treasures, and collections are expensed when purchased or contributed and not recognized in tangible capital assets.

The threshold for capitalizing new systems development is $250 and major system enhancements is $100. The threshold for all other tangible capital assets is $5. All land is capitalized.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

	Useful Life
Facilities and improvements	10-40 years
Equipment	2-20 years
Information systems	3-5 years
Leased vehicles, facilities and improvements	Term of lease
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 assets are put into service.

Leases transferring substantially all benefits and risks of tangible capital asset ownership are reported as tangible capital asset acquisitions financed by long-term obligations. These capital lease obligations are recorded at the present value of the minimum lease payments excluding executory costs (e.g. insurance, maintenance costs, etc.).

The discount rate used to determine the present value of the lease payments is the lower of AHS' rate for incremental borrowing or the interest rate implicit in the lease. Note 18(c) provides a schedule of repayments and amount of interest on the leases.

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.

(g) 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 based on years of service and final average earnings. 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 as a co-sponsor accounts for its share of obligations for these pension plans relating to former and current employees of all of the organizations included in the Government of Alberta (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 Executive Retirement Plans (SERPs)

AHS sponsors SERPs which are funded and has three Retirement Compensation Arrangements (RCA) for these plans. These plans cover certain employees and supplement the benefits under AHS' registered plans that are limited by the *Income Tax Act* (Canada). Each plan was closed to new entrants effective April 1, 2009. A majority of the SERPs are final average plans; however, certain participant groups have their benefits determined on a career average basis. Also, some participant groups receive post-retirement indexing similar to the benefits provided under the registered defined benefit pension plans, while others receive non-indexed benefits.

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

The obligations and costs of these 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 retirement benefit cost of SERPs reported in these consolidated financial statements is comprised of the retirement benefits expense and the retirement benefits interest expense. The key components of retirement benefits expense include the current period benefit cost, 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. Costs shown reflect the total estimated cost to provide annual pension income over an actuarially determined post employment period. SERP provides future pension benefits to participants based on years of service and earnings. The cost of these benefits is actuarially determined using the projected benefit method pro-rated on services, a market interest rate, and management's best estimate of expected costs and the period of benefit coverage. 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.

In the case of a curtailment event which results in the elimination for a significant number of active employees of the right to earn defined benefits for their future services, a curtailment gain or loss is recorded. Gains and losses determined upon a curtailment are accounted for in the period of the curtailment.

(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, excluding pay at risk, if any, 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 replenishing sick leave benefits as these are renewed annually.

The AHS sick leave liability is based on an actuarial evaluation as at March 31, 2012, and extrapolated for the years ending March 31, 2013 and March 31, 2014. The next required actuarial valuation will be as of March 31, 2015.

The accumulating non-vesting sick leave liability is actuarially determined using the projected benefit method prorated on 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.

(h) Net Assets

Net assets represent the difference between the carrying value of assets held by AHS and its liabilities.

PSAS requires a "net debt" presentation for the statement of financial position in the summary financial statements of government. Net debt presentation reports the difference between financial assets and liabilities as "net debt" or "net financial assets" as an indicator of the future revenue required to pay for past transactions and events. AHS operates within the government reporting entity, and does not finance all of its expenditures by independently raising revenue. Accordingly, these consolidated financial statements do not report a net debt indicator.

(i) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. The amounts recorded for amortization of tangible capital assets is based on the estimated useful life of the related 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. 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.

The establishment of the provision for unpaid claims relies on the judgment and opinions of many individuals; historical precedent and trends; prevailing legal, economic, and 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.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(j) Reserves

Certain amounts, as approved by the Official Administrator, are set aside in accumulated surplus for future operating and capital purposes. Transfers to or from reserves are an adjustment to the respective reserve when approved.

(k) Future Accounting Changes

In June 2010 the Public Sector Accounting Board issued PS 3260 – Liability for Contaminated Sites, which specifically relates to sites no longer in productive use. This accounting standard is effective for fiscal years starting on or after April 1, 2014. 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. AHS would be required to recognize a liability related to the remediation of such contaminated sites subject to certain recognition criteria. Management does not expect the implementation of this standard to have a significant impact on the consolidated financial statements.

Note 3 Budget

The AHS Health Plan and Business Plan 2013-16, which included the 2013-14 annual budget, was approved by the members of the former AHS Board on April 8, 2013 and submitted to the Minister.

In 2013-14, AHS reclassified the following programs in its budget to be consistent with the Canadian Institute of Health Information (CIHI) definitions:

(i) $40,000 related to community cancer clinics and outpatient cancer drugs were reclassified from community-based care to emergency and other outpatient services.
(ii) $15,000 related to midwifery was reclassified from emergency and other outpatient services to community-based care.
(iii) $10,000 related to high cost drugs in Calgary was reclassified from community-based care to facility-based continuing care services.
(iv) $4,000 related to emergency preparedness was reclassified from promotion, prevention and protection services to support services.

In addition, the budget for $10,000 physicians' service revenue was reclassified from AH transfers other operating grants to investment and other income.

	Board Approved Budget	Reclassifications	Reported Budget
Revenue			
Alberta Health transfers	$ 1,446,000	$ (10,000)	$ 1,436,000
Investment and other Income	185,000	10,000	195,000
Expenses			
Emergency and other outpatient services	1,505,000	25,000	1,530,000
Facility-based continuing care services	919,000	10,000	929,000
Community-based care	1,199,000	(35,000)	1,164,000
Promotion, prevention and protection services	365,000	(4,000)	361,000
Support services	1,995,000	4,000	1,999,000

Note 4 Other Government Transfers

Other government transfers include amounts transferred from provincial and federal governments, and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

	2014	2013
Unrestricted operating transactions	$ 48,479	$ 48,807
Restricted operating transactions	83,982	105,203
Restricted capital transactions	254,331	239,125
	$ 386,792	$ 393,135

Note 5 Donations, Fundraising, and Non-Government Grants

	2014	2013
Unrestricted operating transactions	$ 10,480	$ 2,181
Restricted operating transactions	111,746	112,392
Restricted capital transactions	32,813	29,494
	$ 155,039	$ 144,067

Note 6 Investment and Other Income

	2014	2013
Investment income	$ 57,757	$ 42,724
Other income:		
External recoveries excluding administrative services provided to others	132,553	107,964
External recoveries for administrative services provided to others (Note 7)	12,065	5,247
Purchase incentives and rebates	35,443	28,917
Other revenue	46,410	34,280
	$ 284,228	$ 219,132

Note 7 Administration

	2014	2013
General administration[(a)]	$ 207,424	$ 197,550
Human resources[(b)]	96,821	103,105
Finance[(c)]	63,657	64,551
Communications[(d)]	17,309	20,202
Administration expense of contracted health service providers (Note 9)[(e)]	58,780	58,950
Total administration expense	$ 443,991	$ 444,358
Less external recoveries for administrative services provided to others (Note 6)	(12,065)	(5,247)
Net administration expense	$ 431,926	$ 439,111

Net administration expense has been presented to align with the CIHI definition. Activities and costs directly supporting clinical activities are not included in administration.

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

Note 7 Administration (continued)

(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 transmittal of AHS' communications including telephone, paging, monitors, telex, fax, visitor information, and mail services. It also includes personnel dedicated to maintenance and repair of communication systems and devices.

(e) Administrative expense of contracted health service providers is an allocation for general administration, human resources, finance, and communication expenses incurred by voluntary and private health service providers with whom AHS contracts for health services. The allocation of expenses for contracts with health service providers is in Note 9.

Note 8 Support Services

	2014	2013
Facilities operations	$ 779,972	$ 731,741
Patient: health records, food services, and transportation	335,892	328,965
Material management	172,827	197,888
Housekeeping, laundry, and linen	209,887	196,844
Support services expense of contracted health service providers (Note 9)	116,496	113,808
Ancillary operations	109,970	110,337
Fundraising expenses and grants awarded	34,089	35,314
Emergency preparedness services	4,536	6,080
Other	131,458	128,131
	$ 1,895,127	$ 1,849,108

Note 9 Contracts with Health Service Providers

AHS is responsible for the delivery and operation of the public health system in Alberta. To this end, AHS has contracts with various voluntary and private health service providers to continue to provide health services throughout Alberta.

The direct AHS funding provided and the associated allocation of expenses in the Consolidated Statement of Operations is as follows:

Note 9 Contracts with Health Service Providers (continued)

	2014	2013
Voluntary health service providers	$ 1,320,027	$ 1,300,032
Private health service providers	938,015	866,237
Total direct AHS funding	$ 2,258,042	$ 2,166,269

	2014	2013
Inpatient acute nursing services	$ 294,230	$ 286,308
Emergency and other outpatient services	97,049	87,787
Facility-based continuing care services	568,462	543,821
Ambulance services	165,451	153,199
Community-based care	432,470	407,065
Home care	169,358	175,647
Diagnostic and therapeutic services	342,309	325,307
Promotion, prevention, and protection services	9,911	7,886
Research and education	1,291	6,106
Administration (Note 7)	58,780	58,950
Information technology	2,235	385
Support services (Note 8)	116,496	113,808
Total allocated expenses	$ 2,258,042	$ 2,166,269

Note 10 Financial Instruments

AHS is exposed to a variety of financial risks associated with the entity's financial instruments. These financial risks include market risk, price risk, interest rate risk, foreign currency risk, credit risk, and liquidity risk.

(a) Market Risk

Market risk is the risk of adverse financial impact as a consequence of market movements such as interest rates, currency rates, and other price changes.

In order to earn financial returns at an acceptable level of market risk, each of the investment policies have established a maximum asset mix. The AHS Investment Bylaw has established maximum 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 maximum 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 maximum asset mix ranges of 80% to 87% for cash and fixed income securities, 10% to 15% for equities, and 3% to 5% for real estate.

The CHT Statement of Investment Policies and Goals has established a maximum 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.

Note 10 Financial Instruments (continued)

(b) 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 investment funds. If equity market indices (S&P/TSX, S&P%, 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 2.30% of total investments (2013 - 1.50%).

A 10% change in market value relating to equity securities would have increased or decreased fair value by approximately $41,042 (2013 - $21,329).

(c) Interest Rate Risk

Interest rate risk is the risk that the value of a financial instrument might be adversely affected by a change in the 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.

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $41,733 (2013 - $34,661).

Portfolio investments include fixed income securities, such as bonds, and have an average effective yield of 2.20% (2013 - 1.79%) per year maturing between 2014 and 2053. The securities have the following average maturity structure:

	2014	2013
1 – 5 years	78%	81%
6 – 10 years	11%	17%
Over 10 years	11%	2%

Asset Class	< 1 year	1-5 years	> 5 years	Average Effective Market Yield
Interest bearing securities	1.55%	1.87%	3.48%	2.20%

(d) 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 investments denominated in foreign currencies is translated into Canadian dollars using the reporting date exchange rate. AHS is exposed to foreign exchange fluctuations on its cash and investments balances denominated in foreign currencies. During the year these fluctuations were not significant. 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, 2014, investments in non-Canadian equities represented 5.40% (March 31, 2013 – 1.58%) of total portfolio investments.

Note 10 Financial Instruments (continued)

(e) 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 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. 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 publically 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.

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, 2014.

Credit Rating	2014	2013
Investment Grade (AAA to BBB-)	94%	94%
Speculative Grade (BB+ or lower)	-%	-%
Unrated	6%	6%
	100%	100%

(f) 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 11 Cash and Cash Equivalents

	2014	2013
Cash	$ 186,373	$ 165,602
Money market securities less than 90 days	419,697	519,002
Total cash and cash equivalents	$ 606,070	$ 684,604

Cash is comprised of cash on hand and demand deposits. Cash equivalents are short-term highly liquid investments that are readily convertible to known amounts of cash that are subject to an insignificant risk of change in value. Cash equivalents are held for the purpose of meeting short-term commitments rather than for investment purposes.

Cash and cash equivalents include money market securities which are comprised of Government of Canada treasury bills maturing June 2014 and bearing interest at an average yield of 0.97% at March 31, 2014 (March 31, 2013 – 0.95%).

Note 12 Portfolio Investments

	2014		2013	
	Fair Value	Cost	Fair Value	Cost
Money market securities greater than 90 days	$ 27,898	$ 27,898	$ 63,192	$ 63,192
Fixed income securities	1,290,533	1,280,753	1,138,744	1,128,522
Equities	410,422	350,735	213,287	188,127
Total portfolio investments	$ 1,728,853	$ 1,659,386	$ 1,415,223	$ 1,379,841

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

	2014	2013
AHS Investment Bylaw	$ 1,411,162	$ 1,138,667
ACF Investment Policy	126,554	109,002
LPIP Investment Policy	112,432	96,413
CHT Statement of Investment Policies and Goals	78,705	71,141
	$ 1,728,853	$ 1,415,223

Portfolio investments are measured at fair value with the differences between cost and fair value being recorded as a remeasurement gain or loss. The following are the net remeasurement gains on portfolio investments:

	2014	2013
Unrestricted unrealized net gains recorded in the Consolidated Statement of Accumulated Remeasurement Gains and Losses	$ 24,846	$ 10,221
Restricted unrealized net gains attributable to endowments and recorded in unexpended deferred operating revenue (Note 17(a) and (d))	10,495	9,105
Restricted unrealized net gains attributable to and recorded in:		
Unexpended deferred operating revenue (Note 17(a) and (d))	25,234	7,741
Unexpended deferred capital revenue (Note 17(b) and (e))	6,236	4,161
Accounts payable and accrued liabilities (Note 15)	2,656	4,154
	$ 69,467	$ 35,382

Note 12 Portfolio Investments (continued)

Fair Value Hierarchy

	2014		
	Level 1	Level 2	Total
Equities traded in active market	$ 365,879	$ -	$ 365,879
Others designated to fair value category	$ -	$ 1,362,974	$ 1,362,974
March 31, 2014 total amount	$ 365,879	$ 1,362,974	$ 1,728,853
Percent of total	21%	79%	100%

	2013		
	Level 1	Level 2	Total
Equities traded in active market	$ 208,058	$ -	$ 208,058
Others designated to fair value category	$ -	$ 1,207,165	$ 1,207,165
March 31, 2013 total amount	$ 208,058	$ 1,207,165	$ 1,415,223
Percent of total	15%	85%	100%

Note 13 Accounts Receivable

	2014			2013
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Patient accounts receivable	$ 112,839	$ 23,661	$ 89,178	$ 86,548
AH operating grants receivable	105,668	-	105,668	99,109
AH capital grants receivable	-	-	-	2,650
Other operating grants receivable	42,337	-	42,337	19,183
Other capital grants receivable	79,357	-	79,357	97,956
Other accounts receivable	63,681	976	62,705	57,975
	$ 403,882	$ 24,637	$ 379,245	$ 363,421

Accounts receivable are unsecured and non-interest bearing. At March 31, 2013, the total allowance for doubtful accounts was $32,584.

Note 14 Tangible Capital Assets

Historical cost	2013	Additions[a]	Transfers for work-in-progress	Disposals and write-downs[b]	2014
Facilities and improvements	$ 7,937,594	$ -	$ 192,700	$ -	$ 8,130,294
Work in progress	687,757	420,682	(383,260)	-	725,179
Equipment	2,113,416	112,285	368	(99,441)	2,126,628
Information systems	1,060,820	17,348	163,170	(27,892)	1,213,446
Building service equipment	425,940	-	20,982	(12)	446,910
Land	109,444	1,224	-	(599)	110,069
Leased facilities and improvements	166,233	-	5,963	-	172,196
Land improvements	67,640	-	77	-	67,717
	$ 12,568,844	$ 551,539	$ -	$ (127,944)	$ 12,992,439

Accumulated amortization	2013	Amortization expense	Effect of transfers	Effect of disposals and write-downs[b]	2014
Facilities and improvements	$ 2,497,372	$ 220,620	$ -	$ -	$ 2,717,992
Work in progress	-	-	-	-	-
Equipment	1,390,108	157,055	-	(98,814)	1,448,349
Information systems	761,878	142,734	-	(25,270)	879,342
Building service equipment	241,222	25,874	-	(12)	267,084
Land	-	-	-	-	-
Leased facilities and improvements	109,603	12,018	-	-	121,621
Land improvements	52,779	2,777	-	-	55,556
	$ 5,052,962	$ 561,078	$ -	$ (124,096)	$ 5,489,944

	Net Book Value	
	2014	2013
Facilities and improvements	$ 5,412,302	$ 5,440,222
Work in progress	725,179	687,757
Equipment	678,279	723,308
Information systems	334,104	298,942
Building service equipment	179,826	184,718
Land	110,069	109,444
Leased facilities and improvements	50,575	56,630
Land improvements	12,161	14,861
	$ 7,502,495	$ 7,515,882

Note 14 Tangible Capital Assets (continued)

(a) Transferred Tangible Capital Assets

Additions include non-cash work in progress totalling $270,698 (2013 - $293,041) and land totalling $1,224 (2013- $nil).

(b) Disposals and Write-Downs

Disposals and write-downs include disposals of $107,839 and a write-down of information systems at a cost of $20,105 (2013 - disposals of $65,932 and write-downs of $nil) with an effect to accumulated amortization for disposals of $106,614 and write-downs of $17,482 (2013 - disposals of $60,658 and write-downs of $nil).

(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
Two Hills Helipad	Stella Stefiuk	2041
Northeast Community Health Centre	City of Edmonton	2046
Foothills Medical Centre Parkade	University of Calgary	2054
McConnell Place North	City of Edmonton	2056
Alberta Children's Hospital	University of Calgary	2101

(d) Leased Equipment

Equipment includes assets acquired through capital leases at a cost of $17,499 (2013 - $24,728) with accumulated amortization of $12,058 (2013 - $12,000). Equipment additions for the year ended March 31, 2014 include a net decrease of $6,398 related to vehicle capital leases (2013 – net increase of $13,489).

(e) Capitalized Interest

Total capitalized interest for the year ended March 31, 2014 was $nil (2013 - $3,489).

Note 15 Accounts Payable and Accrued Liabilities

	2014	2013
Payroll remittances payable and accrued liabilities	$ 597,282	$ 553,181
Trade accounts payable and accrued liabilities[a]	439,867	456,154
Provision for unpaid claims[b]	115,968	102,774
Other liabilities	39,243	41,661
	1,192,360	1,153,770
Unrealized net gains on portfolio investments related to accounts payable and accrued liabilities (Note 12)	2,656	4,154
	$ 1,195,016	$ 1,157,924

(a) Trade Accounts Payable and Accrued Liabilities

Trade accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $45,153 (2013 - $156,793).

(b) Provision for Unpaid Claims

Provision for unpaid claims represents the losses from identified claims likely to be paid and provisions for liabilities incurred but not yet reported.

Note 15 Accounts Payable and Accrued Liabilities (continued)

Under accepted actuarial practice, the appropriate value of the claims liabilities is the discounted value of such liabilities plus the provision for adverse deviation. The provision for unpaid claims has been estimated using the discounted value of claim liabilities based on the expected market yield of the respective portfolio using a discount rate of 2.50% (2013 - 2.40%).

Note 16 Employee Future Benefits

	2014	2013
Accrued vacation pay	$ 458,513	$ 433,811
Accumulating non-vesting sick leave liability[(a)]	96,019	91,016
Registered defined benefit pension plans[(b)][(c)]	-	-
	$ 554,532	$ 524,827

(a) Accumulating non-vesting sick leave liability

Sick leave benefits are paid by AHS; there are no employee contributions and no plan assets. The following table summarizes the accumulating non-vesting sick leave liability.

	2014	2013
Change in accrued benefit obligation and funded status		
Accrued benefit obligation and funded status, beginning of year	$ 99,465	$ 96,558
Current service cost	8,408	8,247
Interest cost	3,430	3,231
Plan amendments	287	-
Benefits paid	(7,898)	(7,680)
Actuarial gain	(6,560)	(891)
Accrued benefit obligation and funded status, end of year	$ 97,132	$ 99,465
Reconciliation to accrued benefit liability		
Funded status - deficit	$ 97,132	$ 99,465
Unamortized net actuarial loss	(1,113)	(8,449)
Accrued benefit liability	$ 96,019	$ 91,016
Components of expense		
Current service cost	$ 8,408	$ 8,247
Interest cost	3,430	3,231
Amortization of net actuarial loss	776	849
Recognition of past service costs	287	-
Net expense	$ 12,901	$ 12,327
Assumptions		
Discount rate – beginning of period	3.30%	3.20%
Discount rate – end of period	3.80%	3.30%
Rate of compensation increase per year	2013-2014	2012-2013
	3.25%	3.25%
	2014-2015	2013-2014
	0.25%	3.25%
	Thereafter 3.25%	Thereafter 3.25%

Note 16 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.

The contribution rates were reviewed by the LAPP Board of Trustees in 2013 and are to be reviewed at least once every three years based on a report prepared by LAPP's actuary. AHS and its employees made the following contributions:

Calendar 2013		Calendar 2012	
Employer	**Employees**	**Employer**	**Employees**
$483,270 10.43% of pensionable earnings up to the YMPE and 14.47% of the excess	$442,720 9.43% of pensionable earnings up to the YMPE and 13.47% of the excess	$435,992 9.91% of pensionable earnings up to the YMPE and 13.74% of the excess	$398,564 8.91% of pensionable earnings up to the YMPE and 12.74% of the excess

AHS contributed $483,270 (2012 - $435,992) of the LAPP's total employer contributions of $1,076,067 from January 1, 2013 to December 31, 2013 (December 31, 2012 - $1,012,225).

(ii) LAPP Deficit

An actuarial valuation of the LAPP was carried out as at December 31, 2012 by Mercer (Canada) Limited and results were then extrapolated to December 31, 2013. LAPP's net assets available for benefits divided by LAPP's pension obligation shows that the LAPP is 85% (2012 - 82%) funded.

	December 31, 2013	December 31, 2012
LAPP net assets available for benefits	$ 26,550,184	$ 22,862,497
LAPP pension obligation	31,411,700	27,839,800
LAPP deficiency	$ (4,861,516)	$ (4,977,303)

The 2014 and 2015 LAPP contribution rates are as follows:

Calendar 2015 (estimated)[(i)]		Calendar 2014	
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

(i) The 2015 LAPP contribution rates are estimates and subject to change.

Note 16 Employee Future Benefits (continued)

(c) Management Employees Pension Plan (MEPP)

At December 31, 2013 the MEPP reported a surplus of $50,457 (2012 - deficiency of $303,423).

(d) Supplemental Executive Retirement Plans (SERPs)

As at March 31, 2014 an accrued benefit liability of $1,242 is included in accounts payable and accrued liabilities (2013 - $1,635).

AHS sponsors SERPs which are funded and has three RCAs for these plans. Under the terms of the SERPs, participants will receive retirement benefits that supplement the benefits under AHS' registered plans that are limited by the *Income Tax Act* (Canada). As required under the plans' terms, any unfunded obligations identified in the actuarial valuation completed at the end of each fiscal year must be fully funded within 61 days. Based on the most recent actuarial valuation for the purpose of establishing the minimum funding contribution, the SERPs are fully funded as at March 31, 2014.

	2014	2013
Change in accrued benefit obligation		
Accrued benefit obligation, beginning of year	$ 44,709	$ 35,185
Change in actuarial assumption for discount rate	-	9,632
Current service cost	133	492
Interest cost	1,201	1,219
Benefit payments	(3,926)	(2,333)
Actuarial losses	1,313	514
Accrued benefit obligation, end of year	$ 43,430	$ 44,709
Change in plan assets		
Market value of plan assets, beginning of year	$ 43,582	$ 43,704
Actual return on plan assets	1,571	2,196
Actual employer contributions	53	15
Benefit payments	(3,926)	(2,333)
Fair value of plan assets, end of year	$ 41,280	$ 43,582
Reconciliation of funded status to accrued benefit asset (liability)		
Funded status of the plan	$ (2,150)	$ (1,127)
Unrecognized net actuarial losses (gains)	908	(508)
Accrued benefit liability, end of year	$ (1,242)	$ (1,635)

A portion of SERP is secured by a letter of credit held by the trustee and a refundable tax balance held by the federal government. The required amount of the letter of credit during the year was $2,973 (2013 - $2,896) and is expected to increase.

Note 16 Employee Future Benefits (continued)

Net actuarial gains or losses are amortized over a period of one year.

	2014	2013
Determination of net benefit cost		
Current period benefit cost	$ 133	$ 492
Amortization of actuarial gains	(508)	-
Interest cost on the accrued benefit obligation	1,201	1,219
Expected return on plan assets	(1,166)	(1,174)
Net benefit cost	$ (340)	$ 537
Change in actuarial assumption for discount rate	$ -	$ 9,632
Members		
Active	35	44
Retired and terminated	59	54
Total members	94	98
Assumptions		
Weighted average discount rate to determine year end obligations	2.80%	2.75%
Weighted average discount rate to determine net benefit costs	2.75%	2.75%
Expected return on assets	2.75%	2.75%
Expected average remaining service life time	1	1
Rate of compensation increase per year	2013-2014	2012-2013
	0.00%	0.00%
	Thereafter	Thereafter
	0.00%	0.00%

(e) Pension expense

	2014	2013
Local Authorities Pension Plan (LAPP)	$ 498,110	$ 452,993
Defined contribution pension plans and group RRSPs	44,930	42,208
Supplemental Pension Plan (SPP)	1,866	2,127
Management Employees Pension Plan (MEPP)	631	722
Change in actuarial assumptions for SERPs	-	9,632
Supplemental Executive Retirement Plans (SERPs)	(340)	537
	$ 545,197	$ 508,219

Note 17 Deferred Revenue

	2014	2013
Unexpended deferred operating revenue[(a)(d)]	$ 499,231	$ 483,953
Unexpended deferred capital revenue[(b)(e)]	229,855	240,358
Expended deferred capital revenue[(c)]	6,276,469	6,235,264
	$ 7,005,555	$ 6,959,575

(a) Unexpended deferred operating revenue represents unspent resources with stipulations or external restrictions related to operating expenditures. Changes in the unexpended deferred operating revenue balance are as follows:

	2014				2013
	AH	Other government[(i)]	Donors and non-government	Total	Total
Balance, beginning of year	$ 222,223	$ 26,470	$ 235,260	$ 483,953	$ 547,174
Received or receivable during the year	1,230,771	67,449	127,871	1,426,091	1,175,660
Restricted investment income	346	1,939	3,988	6,273	9,193
Transferred from unexpended deferred capital revenue	13,772	28,380	2,672	44,824	52,955
Recognized as revenue from funder	(1,257,279)	(83,982)	(111,746)	(1,453,007)	(1,292,804)
Recognized as revenue from other sources	(314)	-	(27,472)	(27,786)	(25,071)
	209,519	40,256	230,573	480,348	467,107
Changes in unrealized net gain attributable to endowments and recorded in unexpended deferred operating revenue (Note 12)	-	-	1,390	1,390	9,105
Changes in unrealized net gain on portfolio investments related to unexpended deferred operating revenue (Note 12)	1,412	848	15,233	17,493	7,741
Balance, end of year	$ 210,931	$ 41,104	$ 247,196	$ 499,231	$ 483,953

[(i)] The balance at March 31, 2014 for other government includes $1,213 of unexpended deferred operating revenue received from the federal government (March 31, 2013 - $1,264).

Note 17 Deferred Revenue (continued)

(b) Unexpended deferred capital revenue represents unspent resources with stipulations or external restrictions related to the purchase of tangible capital assets. Changes in the unexpended deferred capital revenue balance are as follows:

	2014				2013
	AH	Other government	Donors and non-government	Total	Total
Balance, beginning of year	$ 149,120	$ 17,044	$ 74,194	$ 240,358	$ 383,171
Received or receivable during the year	43,986	89,665	51,229	184,880	255,836
Transferred tangible capital assets (Note 14(a))	-	270,569	129	270,698	293,041
Restricted investment income	147	-	-	147	1,264
Unexpended deferred capital revenue returned	(2,772)	-	(5,185)	(7,957)	(8,288)
Transfer to expended deferred capital revenue	(59,468)	(309,107)	(45,723)	(414,298)	(635,857)
Transferred to unexpended deferred operating revenue	(13,772)	(28,380)	(2,672)	(44,824)	(52,955)
Used for the acquisition of land	-	(1,224)	-	(1,224)	(15)
	117,241	38,567	71,972	227,780	236,197
Changes in unrealized net gain on portfolio investments related to unexpended deferred capital revenue (Note 12)	603	401	1,071	2,075	4,161
Balance, end of year	$ 117,844	$ 38,968	$ 73,043	$ 229,855	$ 240,358

(c) Expended deferred capital revenue represent external resources spent in the acquisition of tangible capital assets, stipulated for use in the provision of services over their useful lives. Revenue is recognized over the useful life of the assets. Changes in the expended deferred capital revenue balance are as follows:

	2014				2013
	AH	Other government	Donors and non-government	Total	Total
Balance, beginning of year	$ 435,362	$ 5,622,020	$ 177,882	$ 6,235,264	$ 5,974,714
Transferred from unexpended deferred capital revenue	59,468	309,107	45,723	414,298	635,857
Used for the acquisition of land	-	1,224	-	1,224	15
Less amounts recognized as revenue	(87,173)	(254,331)	(32,813)	(374,317)	(375,322)
Balance, end of year	$ 407,657	$ 5,678,020	$ 190,792	$ 6,276,469	$ 6,235,264

Note 17 Deferred Revenue (continued)

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

	2014				2013
	AH	Other government	Donors and non-government	Total	Total
Research and education	$ 640	$ 4,027	$ 122,744	$ 127,411	$ 116,566
Cancer prevention, screening and treatment	38,138	72	49,072	87,282	86,184
Primary Care Networks	64,101	-	78	64,179	56,923
Physician revenue and alternate relationship plans	32,801	1,524	11	34,336	37,948
Promotion, prevention and community	22,515	7,071	3,484	33,070	18,180
Addiction and mental health	22,176	2,377	5	24,558	48,994
Inpatient acute nursing services	638	7,306	4,443	12,387	7,857
Administration and support services	3,430	3,739	4,558	11,727	13,126
Continuing care and seniors health	9,179	667	1,802	11,648	11,083
Long term care partnerships	-	10,800	-	10,800	8,772
Emergency and outpatient services	5,135	359	4,514	10,008	13,041
Others less than $10,000	6,529	1,878	27,689	36,096	48,433
	205,282	39,820	218,400	463,502	467,107
Unrealized net gain attributable to endowments and recorded in unexpended deferred operating revenue (Note 12)	-	-	10,495	10,495	9,105
Unrealized net gain on portfolio investments related to unexpended deferred operating revenue (Note 12)	5,649	1,284	18,301	25,234	7,741
	$ 210,931	$ 41,104	$ 247,196	$ 499,231	$ 483,953

Note 17 Deferred Revenue (continued)

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

	2014	2013
AH		
Information systems:		
Diagnostic Imaging Upgrade Project	$ 10,040	$ 11,339
Access to Health Service Information Management/ Information Technology	9,808	17,767
Provincial Health Information Exchange	7,910	10,469
Regional Shared Health Information Program	6,297	18,616
Information systems less than $10,000	46,182	65,961
	80,237	124,152
Medical Equipment Replacement Upgrade Program	22,650	10,305
Equipment less than $10,000	11,061	11,370
Total AH	113,948	145,827
Other government		
Facilities and improvements:		
Infrastructure maintenance projects	25,197	8,383
Facilities and improvements less than $10,000	12,654	7,945
Total other government	37,851	16,328
Donors and non-government		
Equipment less than $10,000	59,159	64,847
Facilities and improvements less than $10,000	12,661	9,195
Total donors and non-government	71,820	74,042
	223,619	236,197
Unrealized net gain on portfolio investments related to unexpended deferred capital revenue (Note 12)	6,236	4,161
	$ 229,855	$ 240,358

Note 18 Debt

	2014	2013
Debentures payable[(a)]:		
Parkade loan #1	$ 39,925	$ 42,276
Parkade loan #2	36,681	38,637
Parkade loan #3	45,790	47,815
Parkade loan #4	166,778	172,674
Parkade loan #5	40,207	41,617
Calgary Laboratory Services purchase	-	3,472
Obligation under leased tangible capital assets[(b)]	19,002	26,675
Other	1,985	2,218
	$ 350,368	$ 375,384

(a) AHS issued debentures to Alberta Capital Financing Authority (ACFA), a related party, to finance the construction of parkades and the purchase of the remaining 50.01% ownership interest in CLS. 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.

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%
Calgary Laboratory Services purchase	May 2013	4.6810%

(b) The leased tangible capital assets include a site lease with the University of Calgary and vehicle leases.

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

AHS is contractually committed to future capital lease payments for vehicles until 2018. The implicit interest rate payable on these leases is 2.08%.

(c) As at March 31, 2014 AHS holds a $220,000 (2013 - $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, 2014, AHS has $nil (2013 - $nil) draws against this facility.

AHS also holds a $33,000 (2013 - $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties relating to construction projects. At March 31, 2014, AHS has $3,310 (March 31, 2013 - $4,585) in letters of credit outstanding against this facility.

Note 18 Debt (continued)

AHS is committed to making payments as follows:

Year ended March 31	Debentures Payable, Term/Other Loan and Mortgages Payable Principal payments	Leased Tangible Capital Assets Minimum lease payments
2015	$ 14,533	$ 5,041
2016	15,221	2,886
2017	15,943	1,843
2018	16,698	1,473
2019	17,490	1,525
Thereafter	251,481	13,855
	$ 331,366	26,623
Less: interest		(7,621)
		$ 19,002

During the year, the amount of interest expensed was $16,984 (2013 - $14,480), of which loan interest was $16,054 (2013 - $13,047) and other interest charges were $930 (2013 - $1,433).

Note 19 Accumulated Surplus

Accumulated surplus is comprised of the following:

	Unrestricted net assets [(a)]	Reserves for future purposes [(b)]	Net assets invested in tangible capital assets[(c)]	Accumulated surplus
Balance as at March 31, 2013	$ 82,823	$ 78,727	$ 916,564	$ 1,078,114
Operating surplus	155,691	-	-	155,691
Tangible capital assets purchased with internal funds	(137,260)	-	137,260	-
Amortization of internally funded tangible capital assets	190,609	-	(190,609)	-
Repayment of debt used to fund tangible capital assets	(15,903)	-	15,903	-
Net receipt of life lease deposits	101		(101)	-
Transfer of revenue for acquisition of land	(1,224)	-	1,224	-
Transfer of reserves for future purposes	(8,542)	8,542	-	-
Balance as at March 31, 2014	$ 266,295	$ 87,269	$ 880,241	$ 1,233,805

(a) Unrestricted Net Assets

Unrestricted net assets represents the portion of accumulated surplus that has not already been invested in tangible capital assets or reserved for future purposes.

Note 19 Accumulated Surplus (continued)

(b) Reserves for Future Purposes

The Official Administrator has approved the restriction of net assets for future purposes as follows:

	2014	2013
Parkade infrastructure reserve [(i)]	$ 50,325	$ 32,745
Cancer research reserve [(ii)]	15,596	17,289
Specific local initiatives reserve [(iii)]	14,142	11,919
South Health Campus [(iv)]	6,637	16,444
Retail food services infrastructure reserve[(v)]	569	330
Reserves for future purposes	$ 87,269	$ 78,727

(i) Restriction of parking services surpluses to establish a parking infrastructure reserve for future major maintenance, upgrades, and construction.
(ii) Restriction of operating net assets to fund cancer research.
(iii) Restriction of operating net assets for specific local initiatives as a result of local fundraising.
(iv) Restriction of operating net assets to assist with funding start up costs for South Health Campus in Calgary.
(v) Restriction of retail food services surplus to assist with future upgrades, maintenance, equipment, and construction costs for retail food service operations.

(c) Net Assets Invested in Tangible Capital Assets

Restriction of net assets equal to the net book value of internally funded tangible capital assets as these net assets are not available for any other purpose.

Note 20 Endowments

	2014	2013
Balance, beginning of year	$ 65,207	$ 63,740
Endowments received or receivable	3,589	1,467
Balance, end of year	$ 68,796	$ 65,207

Note 21 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 for premises as follows:

Year ended March 31	Total lease payments
2015	$ 52,178
2016	47,354
2017	42,606
2018	32,703
2019	21,427
Thereafter	75,499
	$ 271,767

Note 21 Contractual Obligations and Contingent Liabilities (continued)

(b) Tangible Capital Assets

AHS has the following outstanding contractual commitments for purchases of tangible capital assets:

		2014
Facilities and improvements	$	37,062
Equipment		61,149
Information systems		17,343
	$	115,554

AI also records contractual commitments for the purchase of tangible capital assets to AHS. The $115,554 of commitments do not include the commitments for AI for the construction of AHS facilities.

(c) Contracted Health Service Providers

AHS contracts on an ongoing basis with voluntary and private health service providers to provide health services in Alberta as disclosed in Note 9. AHS has contracted for services in the year ending March 31, 2015 similar to those provided by these providers in 2013-14.

(d) 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, 2014, accruals have been recorded as part of the provision for unpaid claims (Note 15). 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 204 legal claims (2013 - 187 claims) related to conditions in existence at March 31, 2014 where the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 172 claims have $321,813 in specified amounts and 32 have no specified amounts (2013 - 172 claims with $317,929 of specified claims and 15 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that may be significantly lower than the claimed amount.

Alberta Health Services has been named as a co-defendant, along with the GOA, in a certified Class Action with regard to increases to long-term accommodation charges, which were increased by Alberta Government regulations enacted on and after August 1, 2003. The amount of the Claim has not yet been specified, but it has been estimated to be between $100,000 and $175,000 per year, based on the amount of the increases in accommodation charges.

Note 22 Related Parties

Transactions with the following related parties are considered to be in the normal course of operations. 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.

The Minister controls AHS through the appointment of the Official Administrator and the former AHS Board by appointing all its members. The viability of AHS' operations depends on transfers from the Ministry. 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.

AHS shares a common relationship and 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 in the normal course of operations between AHS and the other ministries are recorded at their exchange amount as follows:

Note 22 Related Parties (continued)

	Revenue		Expenses	
	2014	2013	2014	2013
Ministry of Innovation and Advanced Education [(i)]	$ 49,686	$ 41,138	$ 114,067	$ 124,899
Ministry of Infrastructure [(ii)]	34,188	66,888	335	137
Other ministries	42,446	39,401	26,887	25,884
Total for the year	$ 126,320	$ 147,427	$ 141,289	$ 150,920

	Receivable from		Payable to	
	2014	2013	2014	2013
Ministry of Innovation and Advanced Education [(i)]	$ 9,756	$ 16,731	$ 19,196	$ 24,425
Ministry of Infrastructure [(ii)]	22,234	40,292	975	-
Other ministries [(iii)]	27,673	3,859	332,938	351,514
Balance, end of year	$ 59,663	$ 60,882	$ 353,109	$ 375,939

(i) Most of AHS transactions with the Ministry of Innovation and 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.

(ii) The transactions with the Ministry of Infrastructure relate to the construction and funding of tangible capital assets (Note 14).

(iii) The payable transactions with other ministries include the debt payable to ACFA (Note 18(a)).

At March 31, 2014 AHS has recorded deferred revenue from other ministries within the GOA of $39,891 (March 31, 2013 - $24,320) related to unexpended deferred operating revenue, $38,968 (March 31, 2013 - $17,044) related to unexpended deferred capital revenue and $5,678,020 (March 31, 2013 - $5,622,020) related to expended deferred capital revenue.

Outstanding contingencies in which AHS has been jointly named with other government entities within the GOA are disclosed in Note 21.

Note 23 Government Partnerships

The following is 100% of the financial position and results of operations for AHS' government partnerships with PCNs, NACTRC and HUTV. AHS has proportionately consolidated 50% of the results of the PCNs and NACTRC, and 30% of HUTV.

	2014	2013
Total assets	$ 144,819	$ 129,071
Total liabilities	144,819	129,071
Net assets	$ -	$ -
Total revenue	$ 175,733	$ 161,036
Total expenses	175,733	161,036
Net operating surplus	$ -	$ -

Note 23 Government Partnerships (continued)

As required by AH, PCNs can only use accumulated surpluses based on approved surplus utilization; therefore, AHS' proportionate share of these surpluses has been recorded by AHS as deferred revenue, and are reflected as liabilities in the above table.

Note 24 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.

Under the terms of the Trust Agreement, no participating employer or eligible employee shall have any right to any surplus or assets of the Trust nor shall they be responsible for any deficits or liabilities of the Trust.

The HBTA maintains various reserves to adequately provide for all current obligations and reported fund balances of $102,201 as at December 31, 2013 ($79,394 as at December 31, 2012). AHS has included in prepaid expenses $74,351 (March 31, 2013 - $57,759) as a share of the HBTA's fund balances representing in substance a prepayment of future contributions. These consolidated financial statements do not include the HBTA other than the premiums paid by AHS. For the period January 1 to December 31, 2013 AHS paid premiums of $280,586 (2012 - $277,894).

Note 25 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, 2014, the balance of funds held in trust by AHS for research and development is $8,033 (2013 - $8,443).

AHS also receives funds in trust from continuing care residents for personal expenses. These amounts are not included above and not consolidated in these financial statements.

Note 26 Corresponding Amounts

Certain 2013 amounts have been reclassified to conform to 2014 presentation.

Note 27 Approval of Consolidated Financial Statements

Upon recommendation by the Audit and Finance Advisory Committee, the consolidated financial statements were approved by the Official Administrator on June 5, 2014.

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

	2014		2013
	Budget (Note 3)	Actual	Actual
Salaries and benefits (Schedule 2)	$ 7,101,000	$ 7,049,361	$ 6,752,659
Contracts with health service providers (Note 9)	2,314,000	2,258,042	2,166,269
Contracts under the Health Care Protection Act	18,000	18,918	16,852
Drugs and gases	412,000	427,462	388,013
Medical and surgical supplies	385,000	399,085	391,649
Other contracted services	1,212,000	1,089,891	1,099,199
Other [(a)]	1,353,000	1,260,774	1,220,403
Amortization, disposals and write-downs (Note 14)	560,000	564,926	533,168
	$ 13,355,000	$ 13,068,459	$ 12,568,212

(a) Significant amounts included in Other are:

Equipment expense	$ 173,960	$ 152,472
Other clinical supplies	141,464	140,350
Utilities	125,454	109,362
Building rent	118,495	115,712
Building and ground expenses	88,991	116,530
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies	88,951	82,497
Minor equipment purchases	78,997	75,864
Food and dietary supplies	70,679	68,080
Office supplies	58,894	52,804
Telecommunications	45,446	53,862
Fundraising and grants awarded	45,404	45,826
Travel	39,337	49,140
Insurance	34,323	23,788
Licenses, fees and membership	19,541	17,876
Education	12,558	13,903
Other	118,280	102,337
	$ 1,260,774	$ 1,220,403

SCHEDULE 2 - CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS
FOR THE YEAR ENDED MARCH 31, 2014

	2014								2013	
						Severance and Termination Benefits [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 Official Administrator/Advisory Committees (Sub-Schedule 2A)	3.59	$ 464	$ 110	$ 15	$ 589	-	$ -	$ 589	-	$ -
Total Former Board (Sub-Schedule 2B)	2.92	-	126	-	126	-	-	126	13.95	593
Total Executive (Sub-Schedule 2C)	15.82	5,452	757	829	7,038	6	2,966	10,004	11.16	5,594
Management Reporting to CEO Reports	30.61	9,204	976	1,700	11,880	-	-	11,880	38.33	12,472
Other Management	3,140.50	375,429	2,039	78,901	456,369	44	5,550	461,919	3,283.83	460,913
Medical Doctors not included above[f]	120.71	38,248	217	1,571	40,036	-	-	40,036	123.61	38,694
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	18,050.68	1,587,096	235,041	343,847	2,165,984	9	54	2,166,038	18,044.91	2,151,085
LPNs	3,946.17	244,005	32,159	49,824	325,988	-	-	325,988	3,869.85	309,251
Other Health Technical & Professionals	14,846.13	1,267,681	72,962	289,652	1,630,295	24	455	1,630,750	14,316.90	1,507,039
Unregulated Health Service Providers	7,144.21	340,859	44,492	73,943	459,294	38	113	459,407	6,904.64	436,485
Other Staff	26,064.69	1,524,310	75,917	340,163	1,940,390	98	2,234	1,942,624	25,649.04	1,820,901
Change in actuarial assumption for discount rate for SERPs	-	-	-	-	-	-	-	-	-	9,632
Total	73,366.03	$ 5,392,748	$ 464,796	$ 1,180,445	$ 7,037,989	219	$ 11,372	$ 7,049,361	72,256.22	$ 6,752,659

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

SUB-SCHEDULE 2A – OFFICIAL ADMINISTRATOR/ADVISORY COMMITTEES REMUNERATION FOR THE YEAR ENDED MARCH 31, 2014

	Term	2014 Committees	2014 Remuneration	2013 Remuneration
Official Administrator				
Dr. John Cowell	Since Sep 10, 2013	AFA, HRA, QAPSA	$ 372	$ -
Janet Davidson	Jun 12, 2013 to Sep 10, 2013	-	166	-
Advisory Committee Participants[g]				
Barbara Burton	Since Dec 11, 2013	HRA	2	-
Phyllis Clark	Oct 21, 2013 to Dec 4, 2013	AFA	1	-
Thomas Feasby	Since Jan 21, 2014	QAPSA	1	-
Martin Harvey	Since Dec 11, 2013	HRA	2	-
Gregory Henders	Since Dec 11, 2013	HRA	2	-
Brian Olson	Since Sep 24, 2013	AFA, HRA (Chair)	12	-
Don Sieben	Since Sep 25, 2013	AFA (Chair)	19	-
Doug Tupper	Since Nov 28, 2013	QAPSA (Chair)	11	-
Gord Winkel	Since Jan 21, 2014	QAPSA	1	-
Total Official Administrator/Advisory Committees			$ 589	$ -

Dr. John Cowell was appointed to the position of Official Administrator for a one year term effective September 10, 2013 (calculated FTE of 0.56) per Ministerial Order 316/2013. Remuneration is $580 per annum plus $87 per annum in lieu of benefits.

Janet Davidson was appointed to the position of Official Administrator effective June 12, 2013 as per Ministerial order 313/2013 until September 10, 2013 (calculated FTE of 0.25) at which time the incumbent left AHS. Remuneration was $580 per annum plus benefits.

Advisory committees were established by the Official Administrator to aid in governing AHS and overseeing the management of AHS' business and affairs. Advisory committee participants are eligible to receive honoraria for meetings attended. Advisory committee chairs are compensated an additional $30 per annum.

Committee legend: AFA = Audit and Finance Advisory, HRA = Human Resources Advisory, QAPSA = Quality Assurance and Patient Safety Advisory

SUB-SCHEDULE 2B – FORMER BOARD REMUNERATION FOR THE YEAR ENDED MARCH 31, 2014

	Term	2014 Committees	2014 Remuneration	2013 Remuneration
Former Board Chair				
Stephen Lockwood	Oct 13, 2010 to Jun 12, 2013	AF, GOV, HA, HR, QS, SIRK	$ 21	$ 75
Former Board Members				
Dr. Ray Block	Feb 18, 2011 to Sep 20, 2012	-	-	24
Teri Lynn Bougie	Nov 20, 2008 to Mar 31, 2013	-	-	53
Dr. Ruth Collins-Nakai	Feb 18, 2011 to Jun 12, 2013	GOV, HR, QS	11	56
Donald Cormack	Mar 5, 2013 to Jun 12, 2013	AF, SIRK, PASC	13	5
Dr. Kamalesh Gangopadhyay	Oct 13, 2010 to Mar 31, 2013	-	-	53
Don Johnson	Feb 18, 2011 to Jun 12, 2013	GOV, HA	13	55
John Lehners	May 15, 2008 to Jun 12, 2013	HA, HR, PASC	13	55
Frederick Ring	Mar 5, 2013 to Jun 12, 2013	HR, QS	12	5
Catherine Roozen[h]	Jul 29, 2008 to Jun 12, 2013	HR, QS, SIRK	-	35
Gary Sciur	Mar 5, 2013 to Jun 12, 2013	GOV, HA	13	4
Don Sieben	May 15, 2008 to Jun 12, 2013	AF, QS	13	55
Dr. Eldon Smith	Feb 18, 2011 to Jun 12, 2013	AF, SIRK	12	54
Sheila Weatherill[i]	Feb 18, 2011 to Aug 2, 2012	-	-	-
Gord Winkel	Nov 20, 2008 to Mar 31, 2013	-	-	56
Former Board Committee Participants[j,k]				
Dr. Thomas Feasby	Jan 27, 2011 to Jun 30, 2012	-	-	-
Dennis Hoffman	Feb 11, 2013 to Jun 12, 2013	AF	3	2
Dr. Jon Meddings	Jul 1, 2012 to Jun 12, 2013	QS	-	3
Dr. Douglas Miller	Jul 1, 2012 to Jun 12, 2013	QS	1	2
Elaine Noel-Bentley	Jun 15, 2012 to Jun 12, 2013	PASC	-	1
Dr. Verna Yiu[i]	Jun 21, 2011 to Jun 30, 2012	-	-	-
Gord Winkel	May 1, 2013 to Jun 12, 2013	QS	1	-
Total Former Board			$ 126	$ 593

Former Board members were remunerated with monthly honoraria and honoraria for attendance at Board and committee meetings and all other AHS Board business up to a maximum limit in accordance with Ministerial Order #50. Although M.O. #50 was repealed by M.O. #93, original rates from M.O. #50 were adopted again as of January 1, 2010. Effective November 1, 2012, the Minister of Health increased the rates for committee meeting attendance.

Committee legend: AF = Audit and Finance, GOV = Governance, HA = Health Advisory, HR = Human Resources, QS = Quality and Safety, SIRK = Strategy, Innovation, Research and Knowledge, PASC = Pension Advisory Sub-Committee

SUB-SCHEDULE 2C - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2014

For the Current Fiscal Year	2014						
	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance and Termination Benefits [e]	Total
Board/Official Administrator Direct Reports[l]							
Vickie Kaminski – President and Chief Executive Officer [p,nn]	-	$ -	$ -	$ -	$ -	$ -	$ -
Brenda Huband – Interim President and Chief Executive Officer, Zone and Health Operations [q,oo]	0.37	148	-	28	176	-	176
Rick Trimp – Interim President and Chief Executive Officer Population Heath and Province-Wide Services [r,oo]	0.37	148	-	29	177	-	177
Duncan Campbell – Acting President and Chief Executive Officer [m,s]	0.09	33	5	5	43		43
Dr. Chris Eagle – President and Chief Executive Officer [t]	0.54	316	8	31	355	-	355
Dr. Chris Eagle – Special Advisor [t]	0.46	264	6	26	296	-	296
Ronda White – Chief Audit Executive [u,pp]	1.00	233	16	42	291	-	291
Noela Inions – Chief Ethics and Compliance Officer [oo]	1.00	226	-	49	275	-	275
Kristin Long – Corporate Secretary [v,oo]	0.75	125	2	11	138	-	138
Patti Grier – Chief of Staff and Corporate Secretary [w,uu]	0.38	74	28	11	113	-	113
David Diamond – Chief External Relations Officer [x,oo]	0.50	161	-	19	180	-	180
CEO Direct Reports[k]							
Duncan Campbell – VP Corporate Services and Chief Financial Officer [m,s]	0.91	392	20	62	474	543	1,017
Deborah Rhodes – Acting VP Corporate Services and Chief Financial Officer [y,pp]	0.48	168	16	30	214	-	214
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta [q,oo]	0.18	67	-	14	81	-	81
Dr. Francois Belanger – VP and Medical Director, Central and Southern Alberta [z,oo]	0.56	185	64	28	277	-	277
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta [aa,oo]	0.21	78	-	10	88	-	88
Deb Gordon – VP Collaborative Practice, Nursing and Health Professions[aa,oo]	0.79	276	-	36	312	-	312
Dr. Tom Noseworthy – Acting VP and Chief Health Operations Officer, Northern Alberta [bb]	0.35	105	60	-	165	-	165
Dr. David Mador – VP and Medical Director, Northern Alberta [cc,qq]	0.56	186	54	36	276	-	276

SUB-SCHEDULE 2C - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2014 (CONTINUED)

For the Current Fiscal Year	2014						
	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance and Termination Benefits [e]	Total
CEO Direct Reports (continued)							
Dr. Verna Yiu – VP, Quality and Chief Medical Officer [m,n,rr]	1.00	$ 495	$ 58	$ 32	$ 585	$ -	$ 585
Rick Trimp – VP, Province-Wide Clinical Supports, Programs and Services [r,oo]	0.18	67	16	14	97	-	97
Mauro Chies – Acting VP, Province-Wide Clinical Supports, Programs and Services [dd,oo]	0.56	129	25	24	178	-	178
Susan McGillivray – Acting VP, People [ee,oo]	0.43	107	14	13	134	-	134
Mark Haley – VP, People [ff]	0.11	76	-	-	76	-	76
Colleen Turner – Acting VP, Community Engagement and Communications [gg,ss]	0.56	131	13	23	167	-	167
Dr. Kathryn Todd – VP, Research, Innovation and Analytics [n,rr]	1.00	250	10	26	286	-	286
Chris Mazurkewich – Former Executive VP and Chief Operating Officer [m,hh,uu]	0.45	211	127	25	363	541	904
Dr. David Megran – Former Executive VP and Chief Medical Officer, Clinical Operations [m,o,il,uu]	0.45	215	83	144	442	730	1,172
Stephen Gould – Former Executive VP, People and Partners [m,jj,uu]	0.48	198	66	24	288	337	625
Bill Trafford – Acting VP and Chief Transition Officer [m,kk,uu]	0.65	222	44	27	293	391	684
Barbara Pitts – Former Senior VP, Priorities and Performance [ll]	0.45	166	22	10	198	424	622
Total Executive	15.82	$ 5,452	$ 757	$ 829	$ 7,038	$ 2,966	$ 10,004

SUB-SCHEDULE 2C - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2014 (CONTINUED)

For the Prior Fiscal Year	2013							
	FTE [a]	Base Salary [b]	Pay-at-Risk Component [c]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance and Termination Benefits [e]	Total
Board Direct Reports								
Dr. Chris Eagle - President and Chief Executive Officer	1.00	$ 580	$ 108	$ 41	$ 65	$ 794	$ -	$ 794
Ronda White - Chief Audit Executive	1.00	206	29	-	41	276	-	276
Noela Inions - Ethics and Compliance Officer	1.00	225	-	-	60	285	-	285
Patti Grier – Chief of Staff and Corporate Secretary	1.00	192	29	-	33	254	-	254
CEO Direct Reports								
Chris Mazurkewich - Executive VP and Chief Operating Officer	1.00	468	93	22	64	647	-	647
Duncan Campbell - Executive VP and Chief Financial Officer	-	-	-	-	-	-	-	-
Allaudin Merali – Executive VP and Chief Financial Officer [mm,tt]	0.24	96	-	10	9	115	-	115
Deborah Rhodes - Acting Chief Financial Officer	0.70	223	34	24	38	319	-	319
Dr. David Megran - Executive VP and Chief Medical Officer, Clinical Operations	1.00	485	98	46	176	805	-	805
Dr. Verna Yiu - Executive VP and Chief Medical Officer, Quality and Medical Affairs	0.63	316	52	36	22	426	-	426
Bill Trafford - Executive VP and Chief Development Officer	1.00	339	55	22	56	472	-	472
Stephen Gould - Executive VP, People and Partners	1.00	411	69	32	68	580	-	580
Dr. Kathryn Todd – Senior VP, Research	0.92	229	35	9	24	297	-	297
Barbara Pitts – Senior VP, Priorities and Performance	0.42	156	23	-	35	214	-	214
Deb Gordon – Senior VP, Health Professions Strategy and Practice and Chief Nursing and Health Professions Officer	0.25	83	12	-	15	110	-	110
Total Executive	11.16	$ 4,009	$ 637	$ 242	$ 706	$ 5,594	$ -	$ 5,594

SUB-SCHEDULE 2D - 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 post 1991. The Supplemental Pension Plan (SPP) is a defined contribution plan and the Supplemental Executive Pension Plan (SERP) is a defined benefit plan. The SERP is disclosed in Notes 2(g)(iii) and 16(d). 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 current period benefit costs and other costs for SERP included in other non-cash benefits disclosed in Sub-Schedule 2C are prorated for the period of time the individual was in their position directly reporting to the Board/Official Administrator and directly reporting to the President and Chief Executive Officer.

	2014				2013			
	SPP	SERP						
	Current period benefit costs[1]	Current period benefit costs[2]	Other Costs[3]	Total	Total	Account Balance or Accrued Benefit Obligation March 31, 2013	Change During the Year[4]	Account Balance or Accrued Benefit Obligation March 31, 2014
Vickie Kaminski – President and Chief Executive Officer	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Brenda Huband - Interim President and Chief Executive Officer, Zone and Health Operations/VP and Chief Health Operations Officer, Central and Southern Alberta - SERP	-	-	(1)	(1)	5	383	13	396
Brenda Huband - Interim President and Chief Executive Officer, Zone and Health Operations/VP and Chief Health Operations Officer, Central and Southern Alberta - SPP	23	-	-	23	15	15	24	39
Rick Trimp - Interim President and Chief Executive Officer, Population Heath and Province-Wide Services/VP, Province-Wide Clinical Supports, Programs and Services	23	-	-	23	4	4	23	27
Duncan Campbell - VP Corporate Services and Chief Financial Officer/Acting President and Chief Executive Officer	-	-	-	-	-	-	-	-
Dr. Chris Eagle - Special Advisor/President and Chief Executive Officer - SERP	-	-	(5)	(5)	(2)	1,700	68	1,768
Dr. Chris Eagle - Special Advisor/President and Chief Executive Officer - SPP	45	-	-	45	43	90	56	146
Ronda White - Chief Audit Executive	9	-	-	9	6	17	10	27
Noela Inions - Chief Ethics and Compliance Officer	8	-	-	8	8	30	12	42
Kristin Long - Corporate Secretary	2	-	-	2		-	2	2
Patti Grier - Chief of Staff and Corporate Secretary	2	-	-	2	4	10	(10)	-
David Diamond - Chief External Relations Officer - SERP	-	-	(5)	(5)	3	207	19	226
David Diamond - Chief External Relations Officer - SPP	18	-	-	18	14	14	19	33
Deborah Rhodes - Acting VP Corporate Services and Chief Financial Officer	21	-	-	21	17	50	27	77
Dr. Francois Belanger - VP and Medical Director, Central and Southern Alberta	19	-	-	19	17	17	20	37

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

	2014				2013			
	SPP	SERP						
	Current period benefit costs[1]	Current period benefit costs[2]	Other Costs[3]	Total	Total	Account Balance[4] or Accrued Benefit Obligation March 31, 2013	Change During the Year[5]	Account Balance[4] or Accrued Benefit Obligation March 31, 2014
Deb Gordon - VP and Chief Health Operations Officer, Northern Alberta/VP Collaborative Practice, Nursing and Health Professions - SERP	$ -	$ -	$ (14)	$ (14)	$ 39	$ 567	$ 44	$ 611
Deb Gordon - VP and Chief Health Operations Officer, Northern Alberta/VP Collaborative Practice, Nursing and Health Professions - SPP	22	-	-	22	8	8	22	30
Dr. Tom Noseworthy - Acting VP and Chief Health Operations Officer, Northern Alberta	-	-	-	-	-	-	-	-
Dr. David Mador - VP and Medical Director, Northern Alberta	20	-	-	20	-	-	20	20
Dr. Verna Yiu – VP, Quality and Chief Medical Officer [n]	-	-	-	-	-	-	-	-
Mauro Chies - Acting VP, Province-Wide Clinical Supports, Programs and Services	8	-	-	8	3	14	9	23
Susan McGillivray - Acting VP, People - SERP	-	-	(3)	(3)	2	128	-	128
Susan McGillivray - Acting VP, People - SPP	11	-	-	11	6	6	11	17
Mark Haley – VP, People	-	-	-	-	-	-	-	-
Colleen Turner - Acting VP, Community Engagement and Communications	9	-	-	9	4	13	12	25
Dr. Kathryn Todd - VP, Research, Innovation and Analytics [n]	-	-	-	-	-	-	-	-
Chris Mazurkewich - Former Executive VP and Chief Operating Officer	14	-	-	14	32	113	(113)	-
Dr. David Megran - Former Executive VP and Chief Medical Officer, Clinical Operations	-	133	(3)	130	138	1,095	(1,095)	-
Stephen Gould - Former Executive VP, People and Partners	13	-	-	13	26	42	(42)	-
Bill Trafford - Acting VP and Chief Transition Officer - SERP	-	-	(4)	(4)	(1)	1,354	(160)	1,194
Bill Trafford - Acting VP and Chief Transition Officer - SPP	12	-	-	12	19	26	(26)	-
Barb Pitts - Former Senior VP, Priorities and Performance	-	-	-	-	9	9	(9)	-

(1) The SPP current period benefit costs are AHS contributions earned in the period.
(2) The SERP costs are not cash payments in the period but are the cost in the period for rights to these future retirement benefits. Current period benefit cost is the actuarial present value of the benefits earned in the fiscal year.
(3) 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.
(4) The account balance represents the total cumulative contributions made by AHS to the SPP as well as cumulative investment gains or losses on the contributions.
(5) Changes in the accrued benefit obligation include current period benefit cost, interest accruing on the obligations, the amortization of any actuarial gains or losses in the period, and gains or losses due to curtailment. 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, 2014

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 former Board Members, former Board Committee participants, the Official Administrator, and Advisory 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 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 reported as other cash benefits.

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

c. Other cash benefits may include as applicable honoraria, overtime, acting pay, market supplements, automobile allowance, lump sum payments, an allowance for professional development and an allowance for personal, financial and tax advice, club memberships and other similar purposes. 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 or termination benefits. Expense reimbursements are also excluded from compensation disclosure except where the expenses meet the definition of the other cash benefits listed above.

Pay-at-risk was discontinued in the current fiscal year. Under the 'pay-at-risk' model, a component of remuneration was withheld during the year and released (in full or in part) based on achievement of performance objectives. Pay-at-risk was paid to some executives terminated without cause based on the terms of their employment agreements [(hh,jj)] and is included in other cash benefits.

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 2D
- 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 and termination benefits include direct or indirect payments to individuals upon termination or through a voluntary exit program. Severance and termination benefits are not included in other cash benefits or non-cash benefits.

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

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2014 (CONTINUED)

Official Administrators and Former Board

g. These individuals are participants of Official Administrator governance advisory committees, but are not AHS employees.

h. Catherine Roozen ceased to claim honoraria October 1, 2012.

i. Sheila Wetherill and Dr. Verna Yiu did not claim honoraria.

j. These individuals were participants of former Board committees, but were not former Board members or AHS employees. However, they were eligible to receive honoraria for meetings attended.

k. Participation by these individuals on former Board committees ceased on June 12, 2013.

Executive

l. AHS has implemented a new titling structure. All references to titles under the former titling structure are preceded by “former position” of executive vice president, senior vice president, and vice president.

m. Incumbents are provided with an automobile allowance. Dollar amounts are included in other cash benefits. No incumbents were provided with an automobile in the current year.

n. 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. AHS reimburses the University for the incumbent’s base salary and benefits including annual performance adjustments. 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.

o. The incumbent was on secondment from the University of Calgary. The incumbent’s total remuneration was comprised of salary amounts from both AHS and the University of Calgary. AHS reimbursed the University for the incumbent’s rank salary; all amounts have been included in base salary. AHS benefits and SERP calculations were based on the salary amounts from AHS.

p. The incumbent held the position effective May 26, 2014. The contract term ends May 26, 2017.

q. The incumbent held the former position of Senior Vice President, Calgary Zone until September 10, 2013 at which time the incumbent was appointed to Vice President and Health Operations Officer, Central and Southern Alberta and became a direct report to the President and Chief Executive Officer. This is a new position as a result of restructuring. The incumbent was additionally appointed to the position of Interim President and Chief Executive officer, Zone and Health Operations effective November 15, 2013 and became a direct report to the Official Administrator. The incumbent received an incremental increase in base salary of $30 per annum effective November 15, 2013 while in the Interim President and Chief Executive Officer, Zone and Health Operations position.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2014 (CONTINUED)

r. The incumbent held the former position of Senior Vice President, Population and Public Health until September 10, 2013 at which time the incumbent was appointed to Acting Vice President, Province-Wide Clinical Supports, Programs and Services and became a direct report to the President and Chief Executive Officer. This is a new position as a result of restructuring. The incumbent received an additional 10% of base salary while in the Acting Vice President, Province-Wide Clinical Supports, Programs and Services position. 'Acting' was removed from this appointment November 15, 2013. The incumbent was additionally appointed to the position of Interim President and Chief Executive Officer, Population Health and Province-Wide Services effective November 15, 2013 and became a direct report to the Official Administrator. The incumbent received an incremental increase in base salary of $30 per annum effective November 15, 2013 while in the Interim President and Chief Executive Officer, Population Health and Province-Wide Services position.

s. The incumbent held the position of Vice President Corporate Services and Chief Financial Officer until October 18, 2013 at which time the incumbent was appointed to Acting President and Chief Executive Officer and became a direct report to the Official Administrator. The incumbent received an additional 10% of base salary while in the Acting President and Chief Executive Officer position. On November 15, 2013, the incumbent returned to his former role on a paid leave of absence until March 31, 2014. The incumbent was engaged to work as an independent contractor for the Canadian Institute of Health Information on a research project commissioned by AHS from April 1, 2014 to March 31, 2015. The cost to AHS of $500 for the research project as well as $43 for relocation expenses has been reported as termination benefits.

t. The incumbent held the position of President and Chief Executive Officer until October 16, 2013 at which time the incumbent moved to the position of Special Advisor to the Official Administrator for a 12 month period ending October 20, 2014. There was no change in compensation from the President and Chief Executive Officer position to the Special Advisor position. The position of Special Advisor comes with no entitlement of severance. The incumbent is also provided with a 3 month sabbatical leave as part of the Special Advisor position. This non-cash benefit has been expensed in the current year.

u. The incumbent held the position of Chief Audit Executive throughout the year. Effective July 17, 2013 the incumbent was also assigned to the interim leadership role for the Legal and Privacy portfolio and received an additional 10% of base salary as a result of the increase to the incumbent's responsibilities.

v. The incumbent held the position of Assistant Corporate Secretary until July 1, 2013 at which time the incumbent was appointed to Acting Corporate Secretary. The incumbent received an additional 8% of base salary while in the Acting Corporate Secretary position. The incumbent was appointed to Corporate Secretary September 1, 2013.

w. The incumbent held the position until August 16, 2013 at which time the incumbent left AHS.

x. The incumbent held the former position of Senior Vice President, Human Resources until September 30, 2013 at which time the incumbent was appointed to Chief External Relations Officer and became a direct report to the Official Administrator.

y. The incumbent held the former position of Acting Chief Financial Officer until April 9, 2013 at which time the incumbent resumed the role of former Senior Vice President, Finance. The incumbent received an additional 7% of base salary while in the Acting Chief Financial Officer position. The incumbent was appointed to Acting Vice President Corporate Services and Chief Financial Officer effective October 17, 2013 and returned to being a direct report to the President and Chief Executive Officer. The incumbent received an additional 10% of base salary while in the Acting Vice President Corporate Services and Chief Financial Officer position.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2014 (CONTINUED)

z. The incumbent held the former position of Senior Vice President and Zone Medical Director, Calgary Zone until September 10, 2013 at which time the incumbent was additionally appointed to Vice President and Medical Director, Central and Southern Alberta and became a direct report to the President and Chief Executive Officer. This is a new position as a result of restructuring.

aa. The incumbent held the position of Vice President, Collaborative Practice, Nursing and Health Professions until January 13, 2014 at which time the incumbent was appointed to Vice President and Chief Health Operations Officer – Northern Alberta while retaining the role of Acting Vice President, Collaborative Practice, Nursing and Health Professions.

bb. The incumbent held the position of Associate Chief Medical Officer, Strategic Clinical Networks and Clinical Care Pathways until September 10, 2013 at which time the incumbent was additionally appointed to Acting Vice President and Chief Health Operations Officer – Northern Alberta and became a direct report to the President and Chief Executive Officer. This is a new position as a result of restructuring. The incumbent was in this role until January 14, 2014 at which time he resumed the role of Associate Chief Medical Officer, Strategic Clinical Networks and Clinical Care Pathways and was no longer a direct report. The incumbent received up to an additional $10 per month while in the Acting Vice President and Chief Health Operations Officer – Northern Alberta position.

cc. The incumbent held the position of Zone Medical Director, Edmonton Zone until September 10, 2013 at which time the incumbent was additionally appointed to Vice President and Medical Director, Northern Alberta and became a direct report to the President and Chief Executive Officer. This is a new position as a result of restructuring.

dd. The incumbent held the former position of Vice President, Diagnostic Imaging Services until September 10, 2013 at which time the incumbent was appointed to Acting Vice President, Province-Wide Clinical Supports, Programs & Services and became a direct report to the President and Chief Executive Officer. The incumbent received an additional 10% of base salary for the period of September 10, 2013 to November 14, 2013 and incremental acting pay of $55 per annum effective November 15, 2013 while in the Acting Vice President, Province-Wide Clinical Supports, Programs & Services position.

ee. The incumbent held the former position of Vice President, Human Resources, HR Client Services and Employee Labour Relations until October 24, 2013 at which time the incumbent was appointed to Acting Vice President, People and became a direct report to the President and Chief Executive Officer. The incumbent received incremental acting pay of $33 per annum while in the Acting Vice President, People position.

ff. The incumbent was engaged by AHS effective August 1, 2013 to advise and provide services related to the leadership and management of AHS' people. The incumbent held the position of VP People and became a direct report to the President and Chief Executive Officer effective September 12, 2013 until October 22, 2013 at which time the incumbent ceased to report directly to the President and Chief Executive Officer. The incumbent received one lump sum payment of $284 as total compensation for all costs following the incumbent's departure from AHS. The amount paid has been allocated for disclosure purposes.

gg. The incumbent held the former position of Vice President, Communications until September 10, 2013 at which time the incumbent was appointed to Acting Vice President, Community Engagement and Communications and became a direct report to the President and Chief Executive Officer. The incumbent received an additional 10% of base salary while in the Acting Vice President, Community Engagement and Communications position.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2014 (CONTINUED)

hh. The incumbent held the position until September 10, 2013 at which time the position was abolished as a result of restructuring. The incumbent received the salary and other accrued entitlements to the date of departure. The reported severance includes 12 months base salary at the rate in effect at the date of departure and 15% of the severance in lieu of benefits. Should the incumbent obtain alternate employment during the 12 month notice period, the monthly payment will cease and the incumbent will be paid a lump sum equal to one-half of any payments then remaining. The incumbent received a proportionate amount of pay-at-risk ($41) for the months worked within the fiscal year based on the prior year's pay-at-risk amount. These terms are in accordance with the incumbent's contract.

ii. The incumbent held the position until September 10, 2013 at which time the position was abolished as a result of restructuring. The incumbent received the salary and other accrued entitlements to the date of departure. The reported severance includes 15 months and 3 weeks of base salary at the rate in effect at the date of departure and 15% of the severance in lieu of benefits. AHS will also make payment for the incumbent to attend an outplacement program for a maximum of 6 months. These terms are in accordance with the incumbent's contract.

jj. The incumbent held the position until September 20, 2013 at which time the incumbent left as a result of restructuring. The incumbent received the salary and other accrued entitlements to the date of departure. The total eligible severance included 12 months base salary at the rate in effect at the date of departure and 15% of the severance in lieu of benefits. Effective February 24, 2014, the incumbent obtained alternate employment. At this point the monthly payments ceased and the incumbent was paid a lump sum equal to one-half of the remaining eligible payments. The incumbent also received a proportionate amount of pay-at-risk ($33) for the months worked within the fiscal year based on the prior year's pay-at-risk amount. These terms are in accordance with the incumbent's contract.

kk. The incumbent held the former position of Executive Vice President and Chief Development Officer until April 30, 2013 at which time the incumbent moved to the part-time position of Senior Advisor to the President and Chief Executive Officer. The incumbent held the position of Senior Advisor to the President and Chief Executive Officer until September 10, 2013 at which time the incumbent was appointed to the position of Acting Vice President and Chief Transformation Officer. This is a new position as a result of restructuring. The incumbent held the position of Acting Vice President and Chief Transformation Officer until November 22, 2013 at which time the position was abolished as a result of restructuring. The reported severance includes 12 months base salary at the rate in effect at the date of departure and 15% of the severance in lieu of benefits. Should the incumbent obtain alternate employment during the 12 month notice period, the monthly payment will cease and the incumbent will be paid a lump sum equal to one-half of any payments then remaining. Effective November 23, 2013, the incumbent was engaged in the role of Senior Advisor, Lab Redesign until May 5, 2014. The incumbent provides services to AHS during this term without receiving compensation or entitlement of severance for this role. However, the incumbent continued and will continue to receive monthly severance payments per the incumbent's Acting Vice President and Chief Transformation Officer termination agreement.

ll. The incumbent held the position until September 10, 2013 at which time the position was abolished as a result of restructuring. The incumbent received the salary and other accrued entitlements to the date of departure. The reported severance includes 52 weeks base salary at the rate in effect at the date of departure and 15% of the severance in lieu of benefits. AHS will also make payment for the incumbent to attend an outplacement program for a maximum of 6 months.

mm. The incumbent held the position effective May 7, 2012 until August 1, 2012 at which time the incumbent left AHS. The incumbent did not receive any severance. On March 14, 2014, the former incumbent filed a statement of claim for damages totaling $6 million.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2014 (CONTINUED)

Termination Liabilities

nn. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to one month annual base salary for each completed month of service to a maximum of twelve months. Monthly severance payments will be reduced by the amount of any employment income or consulting earnings received from a new employer during the month.

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

pp. 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.

qq. 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 installments. The severance payment will be reduced by any employment earnings received from a new employer within the 12 month period.

rr. 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.

ss. In the case of termination without just cause by AHS, the incumbent shall receive severance pay to a maximum of 12 months base salary. The incumbent will also be paid 15% of the severance in lieu of all other benefits.

tt. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to 12 months base salary at the rate in effect at the date of termination. Such severance will be paid in 12 equal monthly installments. The incumbent will also be paid 15% of the severance in lieu of all other benefits. Upon obtaining alternate employment, the incumbent is only entitled to receive one-half of the unpaid severance at that time.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2014 (CONTINUED)

uu. SPP and SERP

Based on the provision of the applicable SPP and SERP, the following outlines the benefits received by individuals who terminated employment with AHS within the 2013-14 fiscal period. As a result of retirement or termination, the incumbents are entitled to the benefits accrued to them up to the date of retirement or termination. For participants of SPP, the benefit includes the account balances as at March 31, 2013 and the current period benefit costs and investment gains or losses related to the account that were incurred during the current year. For participants of SERP, the benefit includes the accrued benefit obligation as at March 31, 2013, the current period benefit cost, interest accruing on the obligations, the amortization of any actuarial gains or losses in the period, and gains or losses due to curtailment that were incurred during the current year as identified in Sub-Schedule 2D. The AHS obligations are paid through either a monthly, annual, or lump sum payment:

Position	Supplemental Plan Commencement Date	Benefit (not in thousands)	Frequency	Payment Terms
Chief of Staff and Corporate Secretary (SPP)	April 25, 2011	$11,036	Once	Lump Sum
Former Executive VP and Chief Operating Officer (SPP)	April 14, 2009	$131,659	Once	Lump Sum
Former Executive VP and Chief Medical Officer, Clinical Operations (SERP)	January 1, 2005	$1,057,766	Once	Lump Sum
Former Executive VP, People and Partners (SPP)	September 19, 2011	$54,826	Once	Lump Sum
Acting VP and Chief Transition Officer (SPP)	December 1, 2011	$40,219	Once	Lump Sum
Acting VP and Chief Transition Officer (SERP)	December 1, 2004	$11,721	Monthly	For a fixed term of 10 years from December 1, 2013 to November 2, 2023

APPENDIX

1. Partner Foundations and Health Trusts
2. Health Quality Council of Alberta (HQCA) Year-End Report
3. Public Interest Disclosure (Whistleblower Protection) Act
4. Monitoring Measures
5. Surgical Contracts
6. List of AHS-Funded Facilities with Bed Numbers
7. Bed Numbers by Zone

PARTNER FOUNDATIONS AND HEALTH TRUSTS

Foundations are important partners of AHS committed to serving their communities, and we are grateful for their support. Raising more than $200 million yearly, our partner foundations make a tremendous impact. The shared commitment between AHS, foundations and their donors in the community translates into positive patient experiences.

AHS worked with foundations and health trusts to establish priorities for the 2013-14 fiscal year. These priorities allowed AHS to better support the valuable work of foundations and included:

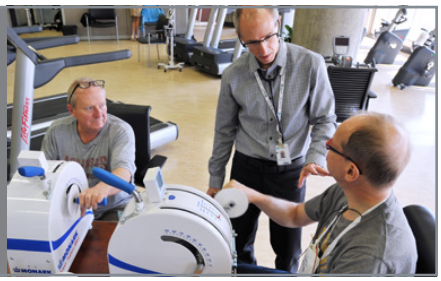
- Refining the AHS procurement process to better track and acknowledge foundation support,
- Building a more focused partnership between zones and foundations by sharpening strategic alignment, and,
- Launching an annual campaign to increase awareness of foundations within AHS and with the public.

Across the five zones, people benefit from the fundraising efforts of their local foundations. With a commitment to enhancing patient care, foundations funded a number of impressive projects in 2013-14.

NORTH ZONE: In 2013, 15 foundations raised $4.3 million for local health care. This was good news for new mothers in Fort McMurray and Wood Buffalo region who can now access support through The Baby Friendly Initiative. This AHS program is delivered through the local breast-feeding clinic and funded by Northern Lights Health Foundation.

NORTH ZONE FOUNDATIONS: Beaverlodge Hospital Foundation, Fairview Health Complex Foundation, Grande Cache Hospital Foundation, Grimshaw/ Berwyn Hospital Foundation, Hinton Health Care Foundation, Hythe Nursing Home Foundation, Jasper Health Care Foundation, Northern Lights Regional Health Foundation, Northwest Health Foundation, Peace River and District Health Foundation, Queen Elizabeth II Hospital Foundation, Regional EMS Foundation, St. Paul & District Hospital Foundation, Swan Hills Hospital Foundation, Valleyview Health Centre Foundation.

EDMONTON ZONE: It was another successful year in the Edmonton Zone, with 12 foundations raising $57 million. The Jim Pattison Centre for Heart Health was launched through a gift received by the University Hospital Foundation. The Pattison Centre provides world-class clinical support, occupational therapy and ongoing cardiac education to patients who have been treated at the Mazankowski Alberta Heart Institute.



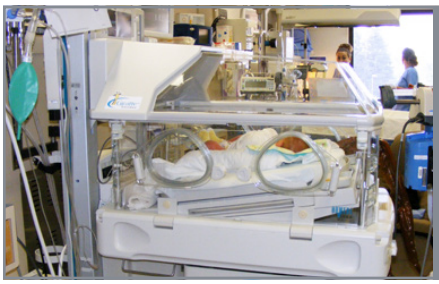
EDMONTON ZONE FOUNDATIONS: Black Gold Health Foundation, Capital Care Foundation, Devon General Hospital Foundation, Fort Saskatchewan Community Hospital Foundation, Glenrose Rehabilitation Hospital Foundation, Mental Health Foundation, Royal Alexandra Hospital Foundation, Stollery Children's Hospital Foundation, Strathcona Community Hospital Foundation, Sturgeon Community Hospital Foundation, Tri-Community Health, Wellness Foundation, University Hospital Foundation.

CENTRAL ZONE: Fifteen foundations and trusts in the Central Zone raised $7.7 million. One example of community impact can be seen at the long-term care unit of Wetaskawin Hospital and Care Centre. With donations through Wetaskawin Health Foundation, new couches, arm chairs, coffee tables, artwork and an electric fireplace were added to the unit.

CENTRAL ZONE FOUNDATIONS: Consort Hospital Foundation, Coronation Health Centre Foundation, David Thompson Health Trust, Daysland Hospital Foundation, Drayton Valley Health Services Foundation, Drumheller Area Health Foundation, Lacombe Health Trust, Ponoka and District Health Foundation, Provost and District Health Services Foundation, Red Deer Regional Hospital Foundation, Stettler Health Services Foundation, Tofield & Area Health Services Foundation, Viking Health Foundation, Wainwright & District Community Foundation, Wetaskiwin Health Foundation.

CALGARY ZONE: Calgary Zone has 11 foundations and trusts that successfully raised $52 million in 2013. Many local programs benefitted, including 34 different program areas at the Rockyview General Hospital. With the support of Calgary Health Trust, the fifth annual "Run for Rockyview" event saw teams of hospital employees running to raise money for wish list items for their units. Among the recipients is the Opthamology Department, which will use the funds to support its ocular oncology program.

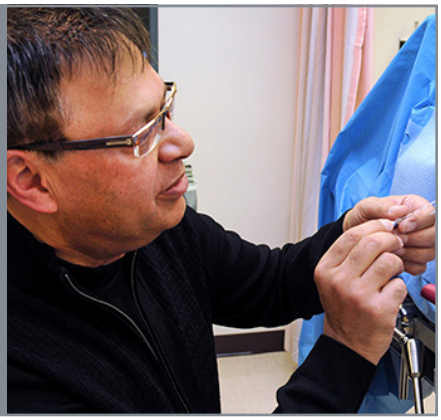
CALGARY ZONE FOUNDATIONS: Airdrie Health Foundation, Alberta Children's Hospital Foundation, Calgary Health Trust, Canmore and Area Health Care Foundation, Claresholm and District Health Foundation, High River District Health Care Foundation, Rosebud Health Foundation, Sheep River Health Trust, Strathmore District Health Foundation, Vulcan County Health & Wellness Foundation, EMS Foundation (Calgary).



SOUTH ZONE: In 2013, the 12 foundations in the South Zone raised $4.7 million to enhance local health care. At the Medicine Hat Regional Hospital, some of its tiniest patients benefited from the fundraising efforts of Medicine Hat & District Health Foundation. The neo-natal intensive care unit received state-of-the-art infant incubators that provide an improved life-sustaining environment for critically ill newborns.

SOUTH ZONE FOUNDATIONS: Bassano & District Health Foundation, Bow Island & District Health Foundation, Brooks & District Health Foundation, Cardston & District Health Foundation, Chinook Regional Hospital Foundation, Crowsnest Pass Health Foundation, Fort Macleod & District Health Foundation, Medicine Hat & District Health Foundation, North County Health Foundation, Oyen & District Health Care Foundation, Taber & District Health Foundation, Windy Slopes Health Foundation.

ALBERTA CANCER FOUNDATION: Working to support programs across all five zones, the Alberta Cancer Foundation raised $33.7 million in 2013. With 43 Albertans receiving a cancer diagnosis each day, the foundation's fundraising efforts benefit research, programs and patients living with cancer. Funding specialized technology for a new breast cancer treatment called breast brachytherapy, the Foundation is helping the Tom Baker Cancer Centre offer an alternative to traditional radiation. By implanting radioactive seeds into the breast, doctors are able to decrease the patient's exposure to radiation, reduce the number of days a patient needs to be at the centre for treatment and enhance the patient's experience.



HEALTH QUALITY COUNCIL OF ALBERTA

AHS continues to partner with the Health Quality Council of Alberta to promote and improve patient safety and health service quality on a provincewide basis. This plays an important part in AHS working towards achieving its mission to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

The reviews conducted by the Health Quality Council of Alberta on AHS' programs and services have been integral towards achieving our goal of a high quality health system. The Health Quality Council of Alberta has provided recommendations as part of the following reviews completed in 2013-14:

- Review of Quality Assurance in Continuing Care Health Services in Alberta.

AHS continues to implement the recommendations provided by the Health Quality Council of Alberta reviews completed prior to 2013-14:

- Review of Operations of Ground Emergency Medical Services in Alberta – January 2013.
- Review of the Quality of Care and Safety of Patients Requiring Access to Emergency Department Care and Cancer Surgery and the Role and Process of Physician Advocacy – February 2012.
- Review of Alberta Response to the 2009 H1N1 Influenza Pandemic – December 2010.
- Quality Assurance Review of the Three Medication and One Expressed Breast Milk Incidents at the Alberta Children's Hospital, Calgary Alberta – March 2010.
- Review of Infection Prevention and Control in the High Prairie Health Complex (focusing on the re-use of the single-use syringes) – July 2009.

AHS implemented all recommendations provided by the Health Quality Council of Alberta and a full review was closed during the 2013-14 year:

- Review of the Safety Implications for Patients Requiring Medevac Services to, and from, the Edmonton International Airport – May 2011.

PUBLIC INTEREST DISCLOSURE (WHISTLEBLOWER PROTECTION) ACT (PIDA)

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

The purposes of the Act include:

- Facilitating the disclosure of wrongdoing
- Protecting those who make a disclosure from reprisal
- Resolving 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 five years, AHS has:

- Developed an internal process and procedures to manage reports of wrongdoing (detailed in the Safe Disclosure/ Whistleblower Policy Frequently Asked Questions).
- Provided resources and ongoing training to managers and staff about PIDA and the internal disclosure process.

In compliance with legislated reporting requirements, from June 1, 2013 to March 31, 2014, 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 coordinates all PIDA disclosures pertaining to AHS, including those that may originate externally via the provincial PIDA Commissioner/Office of the Ombudsman.

MONITORING MEASURES

AHS has developed the 16 performance measures as listed in the 2013-14 Health Action Plan Results section which reflect key areas within the health system that are important to Albertans.

AHS delivers health services in five zones, each with different populations and geography. The measures presented below 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, and access to cancer care, emergency department and surgery. AHS continues to collect and monitor these measures to help support priority-setting and local decision-making. These measures are tactical as they inform the performance of an operational area; or reflect the performance of key drivers of a strategic measure.

The trend column indicates comparison of the most recent 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	2008	2009	2010	2011	2012	2013	Trend
Life Expectancy: The number of years a person would be expected to live, starting at birth, on the basis of mortality statistics. Both sexes combined.							
Provincial	**80.5**	**81.0**	**81.4**	**81.6**	**81.7**	**81.7**	↑
First Nations	69.6	71.1	72.2	70.9	72.4	pending	↑
Non-First Nations	81.0	81.5	82.0	82.3	82.3	pending	↑

Source: Alberta Health

Life expectancy at birth is an indicator of the health of a population, measuring the number of years lived rather than the quality of life. An increased life expectancy tells you people are living longer, it does not tell you why, and it does not tell you anything about the quality of the life being lived. The above data demonstrates over the last six years life expectancy has been improving provincially as well as among First Nations populations. Coronary heart disease, stroke and respiratory infections such as pneumonia were the three leading causes of premature death. Pneumonia is one of the primary causes of death for children under five years of age, along with complications due to premature birth. Life expectancy has increased because tobacco use has gone down and we have had success in lowering heart disease and stroke rates.

AHS is working to improve the health of our population through integrating health promotion (and disease and injury prevention programs) with other health care delivery services, and better coordination between health and other government and municipal sectors.

Potential Years of Life Lost	2008	2009	2010	2011	2012	Trend
Potential Years of Life Lost per 1,000 Population: The total number of years not lived by an individual who died before their 75th birthday.						
Total Population	**49.0**	**46.6**	**44.6**	**43.4**	**43.1**	↑
Females	37.4	37.1	34.2	33.6	32.9	↑
Males	60.0	55.6	54.5	52.9	52.8	↑

Source: Alberta Health

Potential years of life lost is an indicator of premature mortality that gives greater weight to causes of death that occur at a younger age than to those at older ages. It emphasizes the loss of life at an early age and the causes of early deaths such as cancer, injury and cardiovascular disease.

Cancer Screening Participation Rates	2008-09	2009-10	2010-11	2011-12	2012-13	Trend
Breast	55.9%	57.3%	54.8%	58.4%	54.8%	↓
Colorectal	35.5% (2008)	43.0% (2009)	57.0% (2011)	pending	pending	↑
Cervical	70.7% (2007-09)	67.9% (2008-10)	65.0% (2009-11)	63.5% (2010-12)	65.2% (2011-13)	↓

Sources: Colon Cancer Screening in Canada Survey by Canadian Partnership Against Cancer (CPAC); Alberta Breast Cancer Screen Program (ABCSP) and Alberta Health.

The goal is to reduce breast, colorectal and cervical cancer mortality through early detection when treatment is most likely to be effective and will significantly reduce the suffering and substantial costs of end-stage cancer treatment. Death from colorectal cancer is 90 per cent preventable if the disease is caught at early stages. Adequate participation in breast cancer screening is essential for reductions in mortality for women between the ages of 50 and 69 years. Research indicates that more than 90 per cent of cervical cancers can be cured when detected early and treated.

Albertans have the opportunity to change the future of cancer in this province, beginning by asking: What would I do with more time together with my family? The next step is to get started; choose to be more active, to eat healthy, get screened for cancer, avoid tobacco, and limit alcohol.

Influenza Immunization	2009-10	2010-11	2011-12	2012-13	2013-14	Trend
Rates of seasonal influenza immunization by age group						
Children aged six to 23 months	16.0%	27.0%	29.9%	30.2%	35.7%	↑
Adults aged 65 years and older	55.6%	58.9%	60.8%	60.0%	63.6%	↑

Source: Alberta Health and Alberta Health Services

Influenza has a significant seasonal impact on the health of Albertans and tends to be most severe among older Albertans, residents of long-term care facilities, young infants, and those with certain chronic conditions. Albertans with influenza illness can quickly fill acute care hospitals and emergency departments. A high rate of seasonal influenza immunization among children and seniors reduces the incidence of complications and death associated with influenza disease and reduces the spread of disease to other age groups during the influenza season. Providing influenza immunizations to eligible Albertans is a major activity of the public health system. A high rate of coverage will reduce the impact of disease on the health care system.

Childhood Immunization	2009	2010	2011	2012	Trend
Rates of childhood immunization by two years of age in all service zones					
Diphtheria/ tetanus/ acellular pertussis, polio, Hib	77.0%	73.1%	74.4%	72.6%	↓
Measles/ mumps/ rubella	86.7%	85.7%	85.5%	84.3%	↓

Sources: Colon Cancer Screening in Canada Survey by Canadian Partnership Against Cancer (CPAC); Alberta Breast Cancer Screen Program (ABCSP) and Alberta Health.

Immunization is an important, cost-effective and successful public health intervention. In the last century, vaccines have saved more lives than any other health measure. Immunizations protect children and adults from a number of vaccine preventable diseases, some of which can be fatal or produce permanent disabilities. A high rate of immunization can help ensure that the incidence of the covered childhood diseases remains low and outbreaks are controlled. AHS needs to continue to educate and encourage Albertans to immunize their children.

Primary Care	2009-10	2010-11	2011-12	2012-13	2013-14	Trend
Albertans Enrolled in a Primary Care Network (%)	64% (April 2010)	72% (April 2011)	75% (April 2012)	76% (April 2013)	78% (April 2014)	↑
Ambulatory Care Sensitive Conditions: Rate of hospital admissions for health conditions that may be prevented or managed by appropriate primary health care.	298	293	291	293	291	↑
Family Practice Sensitive Conditions: Percent of emergency department or urgent care visits for health conditions that may be appropriately managed at a family physician's office.	27.4%	27.5%	26.4%	26.0%	25.1%	↑

Source: AHS Discharge Abstract Database and Provincial Ambulatory (ED/Urgent Care) Abstract Data.

Appropriate management and control of these chronic conditions in the community could potentially reduce the need for hospitalization, improve efficiency in resource utilization, and in turn, could have an impact on health spending for chronic illnesses in Alberta.

AHS and health care play a vital role in educating and supporting individuals in the management of their chronic conditions to maintain health. Primary care networks and Family Care Clinics are a made-in-Alberta approach to ensure that you receive the right care, from the right health professional, at the right time. Led by family doctors, these networks are improving access to, and better coordinating care and managing chronic conditions for Albertans.

Health Information	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	Trend
Health Link Alberta: Percentage of calls to Health Link that are answered within two minutes.	46%	66%	78%	81%	78%	79%	↑

Source: Health Link Alberta

The goal of Health Link Alberta is to support Albertans in managing their own health. The result is a more knowledgeable public, fewer hospital visits and healthier communities. Health Link Alberta provides health advice and information through a toll-free phone number to all Albertans. Access is 24 hour-a-day, seven-days-a-week and support is provided by experienced registered nurses and other health care professionals. By having a single, coordinated service across the province, AHS is able to provide consistent information to the public.

Children's Mental Health Services	2010-11	2011-12	2012-13	2012-13	Trend
Percent of children aged 0 to 17 years receiving scheduled mental health treatment within 30 days.	75%	76%	80%	81%	↑

Source: AHS Mental Health Services

Improving the mental health and well-being of Alberta's children and youth is an important focus for AHS. Early support and intervention are vital, as research shows that half of all lifetime cases of mental illness begin by age 14. Providing appropriate community services reduces emergency room and hospital visits, thereby providing cost-effective methods of care and, most importantly, improving the lives of those with mental health problems by providing care in the community with a high level of family support.

The Addiction and Mental Health SCN was created to enhance the prevention and treatment of addiction and mental health issues in order to provide the best possible outcomes for patients. Work is underway to develop an EMPATHY Pathway (Empowering a MultiPa-sectoral Pathway Towards Healthy Youth) which is focused on prevention, early identification and treatment of children and youth.

Emergency Department	2009-10	2010-11	2011-12	2012-13	2013-14	Trend
Percentage of patients treated and discharged from the Emergency Department within 4 hours						
Busiest 16 sites	63%	64%	65%	65%	66%	↑
All sites	80%	80%	80%	80%	80%	→
Percentage of patients treated and admitted from the Emergency Department within 8 hours						
Busiest 15 sites	38%	41%	45%	45%	43%	↑
All sites	49%	53%	55%	55%	52%	↑

Sources: Calgary and Edmonton Emergency Department Information System Data (REDIS, EDIS) and AHS Ambulatory Care Reporting System Data (ACRS, NACRS).

Patients treated in an Emergency Department or Urgent Care Centre (ED/UCC) should be assessed and treated in a timely fashion. The length of stay in Emergency Department (ED LOS) is used to assess the timeliness of care delivery. Patients who are treated and then discharged from ED/UCC will typically have a distinctly shorter stay than patients subsequently admitted to hospital due to complexity, admission processes and other factors.

AHS is working hard to improve emergency wait times while ensuring you get the care you need when you need it. Partnering with Alberta Health, AHS has created other options to manage and maintain Albertan's health with Family Care Clinics and primary care networks.

Cancer Wait Time in weeks (90th percentile)	2009-10	2010-11	2011-12	2012-13	2013-14	Trend
Radiation Oncology Access - referral to first consult (from referral to the time of their first appointment with a radiation oncologist)	7.4	6.0	5.3	4.9	4.9	↑
Medical Oncology Access - referral to first consult (from referral to the time of their first appointment with a medical oncologist)	not available	6.0	5.1	4.9	5.6	↑

Source: Cancer Care

Alberta is developing a "radiation corridor" from Lethbridge to Grande Prairie so that nine out of 10 Albertans will have access to radiation therapy within 100 kilometres of home. In the south, the Jack Ady Cancer Centre opened in Lethbridge in 2010, and the Central Alberta Cancer Centre opened in Red Deer in November 2013. The Tom Baker Cancer Centre in Calgary is the comprehensive cancer centre for southern Alberta and a lead centre for the provincewide prevention, research and treatment program. In the north, the Cross Cancer Institute in Edmonton will anchor the radiation corridor. A new cancer centre for Grande Prairie will be part of its new regional hospital.

CancerControl Alberta will bring together cancer facilities and programs under one umbrella to create a comprehensive and coordinated system of cancer prevention, screening, care and research for Alberta. This will improve equity of care across the province and ensure high quality, innovative and safe practices are in place to support a seamless and well-supported cancer patient journey.

Surgery Wait Time (in weeks)	2009-10	2010-11	2011-12	2012-13	2013-14	Trend
CABG Urgency III – Scheduled	31.0	24.0	28.8	25.9	21.5	↑
Cataract Surgery	41.0	46.9	37.3	31.6	30.7	↑
Hip Replacement Surgery	36.4	38.9	39.8	36.3	36.7	→
Knee Replacement Surgery	49.1	48.9	48.0	40.9	41.9	↑
Hip Fracture Repair: % within 48 hours	82.8%	85.7%	84.5%	85.0%	88.5%	↑

Sources: AHS Open Heart Waitlist Database (Edmonton), VELOS, APPROACH and OR data from ORIS, the OR database (Calgary); DIMR from Site Surgery Wait List and Surgical Databases; and Alberta Health.

Providing reasonable access to health service is a major objective and a defining attribute of the publicly-funded health system. Longer waits affect health status and quality of life and result in more costly health services. The Surgery Strategic Clinical Network (SCN) is a provincewide network of dedicated Albertans who are committed to improving the quality of surgical care in Alberta. The Surgery SCN is dedicated to delivering surgical care which is "Sooner, Safer and Smarter," for all Albertans.

For more information on surgery wait times, please refer to Alberta Wait Time website at **www.waittimes.alberta.ca**.

Continuing Care	2009-10	2010-11	2011-12	2012-13	2013-14	Trend
Total Number of People Placed into Continuing Care	not available	**7,038**	**7,700**	**7,761**	**7,694**	↑
Number of patients placed from **acute / subacute** hospital bed into continuing care	not available	4,951	5,355	5,561	5,522	↑
Number of clients placed from **community (at home)** into continuing care	not available	2,087	2,345	2,200	2,172	↑
Average wait time in acute / subacute care hospital bed for continuing care placement (in days)	not available	**54**	**41**	**34**	**31**	↑
Total Number Waiting For Continuing Care Placement:	**1,746**	**1,586**	**1,469**	**1,154**	**1,193**	↑
Number of persons waiting in acute / subacute hospital bed for continuing care placement	707	471	467	453	512	↑
Number of persons waiting in community (at home) for continuing care placement	1,039	1,115	1,002	701	681	↑
Number of unique home care clients	not available	**100,309**	**104,516**	**109,184**	**112,227**	↑

Source: AHS Seniors Health and DIMR

Access to continuing care services is a significant issue in Alberta. By reducing the number of people waiting in a hospital environment for continuing care, we will be able to improve patient flow throughout the system, provide more appropriate care to meet patient needs, decrease wait times and deliver care in a more cost effective manner.

Today, one in nine Albertans are over the age of 65. This is expected to increase to one in five over the next two decades. The aging population creates both challenges and opportunities for the health care system. The Seniors' Health SCN is working on the most effective ways to meet the health care needs of Alberta's seniors based on evidence and best practices within Alberta and around the world.

By attending to the unique needs of seniors within our health care system, we will have a positive impact on both the individual's health outcomes and the efficiency of the health care system.

SURGICAL CONTRACTS

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 determines if the contract is appropriate by assessing sustainability of the public system, access to services, patient safety, appropriateness, effectiveness, cost and public benefit. Contracts with NHSFs provide increased choice of service provider for patients and supplement the resources available in hospitals, while providing good value for public dollars.

The following table summarizes the contracts by service area for 2013-2014:

Service Area	Number of Operators	Number of Procedures Performed
Dermatology *(Only in Edmonton Zone)*	1	25
Ophthalmology – Calgary Zone	5	16,898
Ophthalmology – Edmonton Zone	6	4,290
Ophthalmology – North Zone	1	843
Oral and Maxillofacial Surgery – Calgary Zone	10	896
Oral and Maxillofacial Surgery- Edmonton Zone	8	2047
Otolaryngology (ENT) *(Only in Edmonton Zone)*	2	256
Plastic Surgery *(Only in Edmonton Zone)*	3	432
Pregnancy Termination - Calgary	1	5,045
Pregnancy Termination - Edmonton	1	6,031

There are no surgical contracts with NHSFs in the South and Central Zones.

LIST OF AHS FUNDED FACILITIES

Facility Type	Description	Explanation
Addiction	Addiction Treatment Beds / Spaces	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. Also includes beds for PChAD (Protection of Children Abusing Drugs) program clients and residential beds funded through the Safe Communities Initiative.
Comm. MH	Community Mental Health Beds / Spaces	Mental health support home programs, Canadian Mental Health Association community beds and other mental health community beds/spaces.
Psych	Standalone Psychiatric Facilities	Standalone psychiatric facilities: 1. Alberta Hospital Edmonton (Edmonton) 2. Centennial Centre for Mental Health and Brain Injury (CCMHBI) (Ponoka) 3. Claresholm Centre for Mental Health and Addictions (Claresholm) 4. Southern Alberta Forensic Psychiatric Centre (Calgary) 5. Villa Caritas (Edmonton)
Hospital	Hospital (Acute Care)	Acute care hospitals where active treatment is provided. ED reflects facilities with emergency departments and no acute care beds or inpatient services. CA reflects Cancer Care facilities. Outpatient (OP) reflects facilities providing ambulatory or outpatient services.
Sub-Acute	Sub-Acute in an Auxiliary Hospital	Sub-acute care provided in an auxiliary hospital for the purpose of receiving convalescent and/or rehabilitation services, where it is anticipated that they will achieve their functional potential, to enable them to improve their health status and to successfully return to the community.
LTC	Long-Term Care (includes Auxiliary / Nursing Home)	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.
Palliative	Palliative	Community palliative and end of life care facilities where a designated program or bed for the purpose of receiving palliative care services including end of life and symptom alleviation not in an acute care facility. Includes community hospice beds.
SL	Supportive Living	Supportive Living includes comprehensive services such as the availability of 24-hour nursing care (levels 3 or 4). Supportive Living 4-Dementia 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	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	CACC = Community Ambulatory Care Centre	A 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.
	UCC = Urgent Care Centre AACC = Advanced Ambulatory Care Centre	Urgent Care Centre (UCC) and Advanced Ambulatory Care Centres (AACC) provide assessment, diagnostic and treatment services for unscheduled patients who require immediate medical attention for injuries or/illnesses that require human and technical resources more intensive than what is available in physicians office.

SOUTH ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	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	11								**11**		
Fort MacLeod Health Centre	X	Fort MacLeod				4					**4**		
MacLeod Pioneer Lodge		Fort MacLeod								10	**10**		
Chinook Regional Hospital	X	Lethbridge				279					**279**		
Jadk 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 Home		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	24	**130**		

SOUTH ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	Cancer	Ambulatory
St. Therese Villa		Lethbridge								200	**200**		
Youth Residential Services	X	Lethbridge	8								**8**		
Good Samaritan Garden Vista		Magrath								35	**35**		
Magrath Health Centre	X	Magrath											CACC
Club Sierra		Medicine Hat							50	30	**80**		
Cypress View		Medicine Hat								40	**40**		
Good Samaritan South Ridge Village		Medicine Hat							80	36	**116**		
Leisure Way		Medicine Hat								15	**15**		
Meadow Lands		Medicine Hat								10	**10**		
Medicine Hat Regional Hospital	X	Medicine Hat				218					**218**		
Margery E. Yuill Cancer Centre	X	Medicine Hat	Co-located same campus as 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	20	**120**		
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			**53**	**37**	**0**	**644**	**24**	**20**	**849**	**1,684**	**3,311**		

CALGARY ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	Cancer	Ambulatory
Airdrie Regional 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	6	3							**9**		
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							268		**268**		
Bow Crest Care Centre		Calgary							150		**150**		
Bow View Manor		Calgary							169		**169**		
Calgary Community Rehab Program		Calgary		6							**6**		
Canadian Mental Health Association		Calgary		123							**123**		
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	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	Closed due to flooding.										
Carewest Royal Park	X	Calgary							50		**50**		
Carewest Sarcee	X	Calgary					35	15	85		**135**		

CALGARY ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	Cancer	Ambulatory
Carewest Signal Pointe	X	Calgary							54		**54**		
Centre of Hope - Salvation Army		Calgary	30								**30**		
Clifton Manor		Calgary							258		**258**		
Community Living Alternatives for the Mentally Disabled Association (Community LAMDA)		Calgary		62							**62**		
Eau Claire Retirement Residence		Calgary								73	**73**		
Edgemont Retirement Residence		Calgary								31	**31**		
Enviros Wilderness School Association		Calgary	10								**10**		
Extendicare Cedars Villa		Calgary							248		**248**		
Extendicare Hillcrest		Calgary							112		**112**		
Father Lacombe Care Centre		Calgary							114		**114**		
Foothills Medical Centre	X	Calgary				1,063					**1,063**		
Fresh Start Recovery Centre		Calgary	1								**1**		
Glamorgan Care Centre		Calgary							52		**52**		
Holy Cross Manor		Calgary								100	**100**		
Hull Homes Detox/PChaD		Calgary	12								**12**		
Intercare at Millrise		Calgary							51		**51**		
Intercare Brentwood Care Centre		Calgary							225		**225**		
Intercare Chinook Care Centre		Calgary						14	203		**217**		
Intercare Southwood Care Centre		Calgary						24	196		**220**		
Lighthouse NCR Group Home	X	Calgary		6							**6**		
Mayfair Care Centre		Calgary							142		**142**		
McKenzie Towne Care Centre		Calgary							150		**150**		
McKenzie Towne Retirement Residence		Calgary								42	**42**		
Millrise Place		Calgary								40	**40**		
Monterey Place		Calgary								102	**102**		
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								219	**219**		

CALGARY ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	Cancer	Ambulatory
Peter Lougheed Centre	X	Calgary				555					**555**		
Prince of Peace Harbour		Calgary								32	**32**		
Prince of Peace Manor		Calgary								30	**30**		
Recovery Acres		Calgary	13								**13**		
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				608					**608**		
Rosedale Hospice		Calgary						7			**7**		
Rotary Flames House	X	Calgary						7			**7**		
Scenic Acres Retirement Residence		Calgary								26	**26**		
SCOPE Hunterview House		Calgary		1							**1**		
Sheldon M. Chumir Health Centre	X	Calgary											UCC
South Calgary Health Centre	X	Calgary											UCC
South Health Campus	X	Calgary				269					**269**		
Southern Alberta Foresenic Psychiatric Centre	X	Calgary			33						**33**		
Sunridge Medical Gallery	X	Calgary											CACC
Sunrise Native Addiction Services Society		Calgary	24								**24**		
Tom Baker Cancer Centre	X	Calgary										Ca	
Walden Supportive Living Community		Calgary								167	**167**		
Wentworth Manor/The Residence and The Court		Calgary							83	57	**140**		
Whitehorn Village		Calgary								53	**53**		
Wing Kei Care Centre		Calgary							135		**135**		
Woods Homes ENP (Exceptional Needs Program)		Calgary		7							**7**		
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			120						**120**		

CALGARY ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	Cancer	Ambulatory
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**		
Cochrane Community Health Centre	X	Cochrane											UCC
Aspen Ridge Lodge		Didsbury								30	**30**		
Didsbury District Health Services	X	Didsbury				16			61		**77**		
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	
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**	**342**	**153**	**2,784**	**280**	**95**	**5,003**	**1,431**	**10,384**		

CENTRAL ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	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	7								**7**		
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**	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				32			50		**82**		
Drumheller Community Cancer Centre	X	Drayton Valley	Co-located on same campus as Drayton Valley Hospital									Ca	
Serenity House	X	Drayton Valley								12	**12**		
Sunrise Village Drayton Valley		Drayton Valley								16	**16**		
Drumheller Health Centre	X	Drumheller				33			88		**121**		
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								92	**92**		

CENTRAL ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	Cancer	Ambulatory
Islay Assisted Living	X	Islay								20	**20**		
Killam Health Care Centre		Killam				5			45		**50**		
Royal Oak Manor		Lacombe								111	**111**		
Lacombe Hospital and Care Centre	X	Lacombe				31			75		**106**		
Lamont Health Care Centre		Lamont				15			105		**120**		
Linden Nursing Home		Linden							37		**37**		
Points West Living Lloydminster		Lloydminister								60	**60**		
Dr Cooke Extended Care Centre		Lloydminster							105		**105**		
Lloydminster Hospital		Lloydminster (Sask)				39					**39**	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 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				17			37	10	**64**		
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**		
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**		
Symphony Seniors Living at Aspen Ridge		Red Deer											
Villa Marie		Red Deer								100	**100**		

CENTRAL ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	Cancer	Ambulatory
West Park Lodge		Red Deer								36	**36**		
Rimbey Hospital and Care Centre	X	Rimbey				23			84		**107**		
Clearwater Centre		Rocky Mountain House							40	39	**79**		
Rocky Mountain House Health Centre	X	Rocky Mountain 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			15		**29**		
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				26			48		**74**		
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								66	**66**		
Sunrise Village Wetaskiwin		Wetaskiwin								20	**20**		
Wetaskiwin Hospital and Care Centre	X	Wetaskiwin				65			107		**172**		
Wetaskiwin Meadows		Wetaskiwin								26	**26**		
Wetaskiwin Serenity House (Bosco)		Wetaskiwin		6							**6**		
Total Central Zone			**67**	**31**	**330**	**1,091**	**0**	**10**	**2,287**	**1,350**	**5,166**		

EDMONTON ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	Cancer	Ambulatory
Kipohtakawmik Elders Lodge		Alexander Reserve								13	**13**		
Place Beausejour		Beaumont								38	**38**		
Devon General Hospital	X	Devon				13			11		**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**		
Anderson Hall	X	Edmonton		14							**14**		
Balwin Villa (Excel Society)		Edmonton								100	**100**		
CapitalCare Dickinsfield	X	Edmonton							275		**275**		
CapitalCare Dickinsfield Duplexes	X	Edmonton								14	**14**		
CapitalCare Grandview	X	Edmonton					34		145		**179**		
CapitalCare The Dianne and Irving Kipnes Centre for Veterans	X	Edmonton							120		**120**		
CapitalCare Laurier House Lynnwood	X	Edmonton								80	**80**		
CapitalCare Lynnwood	X	Edmonton							282		**282**		
CapitalCare McConnell Place North	X	Edmonton								36	**36**		
CapitalCare McConnell Place West	X	Edmonton								36	**36**		
CapitalCare Norwood	X	Edmonton					114	23	68		**205**		
CASA House		Edmonton		20							**20**		
Churchill Retirement Community		Edmonton								35	**35**		
Cross Cancer Institute	X	Edmonton				56					**56**	Ca	
Devonshire Care Centre		Edmonton							132		**132**		
Devonshire Manor		Edmonton								59	**59**		
E4C McAuley Apartments		Edmonton											
E4C Meadows Place		Edmonton		16							**16**		
E4C Our Place		Edmonton		10							**10**		
Edmonton Chinatown Care Centre		Edmonton							80	15	**95**		
Edmonton General Continuing Care Centre		Edmonton					20	26	449		**495**		
Edmonton People In Need #4-Batoma House		Edmonton								85	**85**		
Emmanuel Home		Edmonton								15	**15**		

EDMONTON ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	Cancer	Ambulatory
Extendicare Eaux Claires		Edmonton							180		**180**		
Extendicare Holyrood		Edmonton							74		**74**		
Garneau Hall		Edmonton								37	**37**		
George Spady Centre Society		Edmonton	67								**67**		
Glastonbury Village		Edmonton								50	**50**		
Glenrose Rehabilitation Hospital	X	Edmonton				244					**244**		
Good Samaritan Dr. Gerald Zetter Care Centre		Edmonton					10		190		**200**		
Good Samaritan Millwoods Care Centre		Edmonton							60		**60**		
Good Samaritan Southgate Care Centre		Edmonton							226		**226**		
Good Samaritan Wedman House		Edmonton								30	**30**		
Grand Manor		Edmonton								56	**56**		
Grey Nuns Community Hospital		Edmonton				354					**354**		
Hardisty Care Centre		Edmonton							180		**180**		
Health First Strathcona	X	Edmonton											UCC
Henwood Treatment Centre	X	Edmonton	72								**72**		
House Next Door #1, 2, 3		Edmonton		24							**24**		
Innovative Housing - 114 Gravelle		Edmonton								85	**85**		
Innovative Housing - Villa Marguerite		Edmonton								229	**229**		
Jasper Place Continuing Care Centre		Edmonton							100		**100**		
Jellinek House		Edmonton	8								**8**		
Jubilee Lodge Nursing Home		Edmonton							156		**156**		
Laurel Heights		Edmonton								60	**60**		
Lifestyle Options Riverbend		Edmonton								18	**18**		
Lifestyle Options Terra Losa		Edmonton								77	**77**		
Lifestyle Options Whitemud		Edmonton								74	**74**		
McDougall House		Edmonton	11								**11**		
Miller Crossing Care Centre		Edmonton							155		**155**		
Misericordia Community Hospital		Edmonton				275					**275**		
Northeast Community Health Centre	X	Edmonton				ED							
Ottewell Lodge		Edmonton		38							**38**		
Our House		Edmonton	10								**10**		

EDMONTON ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	Cancer	Ambulatory
Recovery Acres Edmonton		Edmonton	23								**23**		
Riverbend Retirement Residence		Edmonton								38	**38**		
Rosedale at Griesbach		Edmonton								165	**165**		
Rosedale Estates		Edmonton								50	**50**		
Royal Alexandra Hospital	X	Edmonton				874					**874**		
Rutherford Heights Retirement Residence		Edmonton								88	**88**		
Saint Thomas Assisted Living Centre		Edmonton								138	**138**		
Salvation Army Grace Manor		Edmonton								80	**80**		
Salvation Army Stepping Stone Supportive Residence		Edmonton								50	**50**		
Shepherd's Care Ashbourne		Edmonton								32	**32**		
Shepherd's Care Greenfield		Edmonton								30	**30**		
Shepherd's Care Kensington		Edmonton							69	87	**156**		
Shepherd's Care Millwoods		Edmonton							147		**147**		
Shepherd's Care Vanguard		Edmonton								100	**100**		
Shepherd's Garden		Edmonton								46	**46**		
South Terrace Continuing Care Centre		Edmonton							114		**114**		
St. Joseph's Auxiliary Hospital		Edmonton						14	188		**202**		
St. Michael's Long-Term Care Centre		Edmonton					7		146		**153**		
Stollery Children's Hospital	X	Edmonton				152					**152**		
The Waterford of Summerlea		Edmonton											
Touchmark at Wedgewood		Edmonton							64		**64**		
Tuoi Hac - Golden Age Manor		Edmonton								91	**91**		
University of Alberta Hospital	X	Edmonton				651					**651**		
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 Community Hospital	X	Fort Saskatchewan				32					**32**		
Rivercrest Care Centre		Fort Saskatchewan							85		**85**		

EDMONTON ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	Cancer	Ambulatory
Extendicare Leduc		Leduc							79		**79**		
Leduc Community Hospital	X	Leduc				70					**70**		
Lifestyle Options Leduc		Leduc								74	**74**		
Salem Manor Nursing Home		Leduc							102		**102**		
Aspen House	X	Morinville								74	**74**		
CapitalCare Strathcona	X	Sherwood Park							111		**111**		
CapitalCare Laurier House Strathcona	X	Sherwood Park								42	**42**		
Country Cottage Seniors Residence		Sherwood Park								26	**26**		
Sherwood Care		Sherwood Park							100		**100**		
Summerwood Village Retirement Residence		Sherwood Park								80	**80**		
Copper Sky Lodge		Spruce Grove								130	**130**		
Good Samaritan Spruce Grove Centre		Spruce Grove								30	**30**		
Citadel Care Centre		St. Albert							129		**129**		
Citadel Mews West		St. Albert								68	**68**		
Poundmaker's Lodge Treatment Center - Youth Addiction (Safe-Com)		St. Albert	58								**58**		
Rosedale St Albert		St. Albert								70	**70**		
Sturgeon Community Hospital	X	St. Albert				149					**149**		
Youville Auxiliary Hospital (Grey Nuns) of St. Albert		St. Albert						1	226		**227**		
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			50		**73**		
Family Care Homes		Various								16	**16**		
Approved Mental Health Care Homes		Various		32							**32**		
Personal Care Homes		Various								241	**241**		
Special Care Homes		Various								156	**156**		
West Country Hearth		Villeneuve								32	**32**		
Total Edmonton Zone			**312**	**164**	**484**	**2,893**	**185**	**64**	**4,963**	**3,363**	**12,428**		

NORTH ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	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								40	**40**		
Beaverlodge Municipal Hospital	X	Beaverlodge				16					**16**		
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			50		**72**		
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**		
Northern Lights Regional Health Centre	X	Fort McMurray				106			31		**137**	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								10	**10**		
Grande Prairie Care Centre		Grande Prairie							60	60	**120**		

NORTH ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	Cancer	Ambulatory
NAC Business & Industry Clinic	X	Grande Prairie	20								**20**		
Northern Addiction Centre	X	Grande Prairie	43								**43**		
Points West Living Grand Prairie		Grande Prairie						10	50	95	**155**		
Queen Elizabeth II Hospital	X	Grande Prairie				150	10		3		**163**		
Grande Prairie Cancer Centre	X	Grande Prairie	Co-located same campus as QEII Hospital									Ca	
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**		

NORTH ZONE

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Psych	Hospital	Subacute	Palliative	LTC	SL	Total Beds	Cancer	Ambulatory
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 Community 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**		
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				15			25		**40**		
Vilna Villa		Vilna								12	**12**		
Smithfield Lodge	X	Westlock								46	**46**		
Westlock Healthcare Centre	X	Westlock				45	8		112		**165**		
Spruce View Lodge		Whitecourt								15	**15**		
Whitecourt Healthcare Centre	X	Whitecourt				22					**22**		
Total North Zone			**127**	**5**	**0**	**899**	**18**	**13**	**1,268**	**669**	**2,999**		

2013-14 AHS Beds Staffed & in Operation Summary as of March 31, 2014

ZONE	ADDICTION AND MENTAL HEALTH			ACUTE CARE	CONTINUING CARE - FACILITY LIVING					SUPPORTIVE LIVING (SL)				TOTAL CONTINUING CARE (LTC + SL)	TOTAL CONTINUING CARE INCLUDING PALLIATIVE	TOTAL BEDS
	ADDICTION	COMMUNITY MENTAL HEALTH	PSYCHIATRIC (STANDALONE FACILITY)	ACUTE CARE	SUB-ACUTE (IN AUX. HOSPITAL)	AUXILIARY HOSPITAL	NURSING HOME	LONG-TERM CARE SUBTOTAL (AUXILIARY + NURSING HOME)	COMMUNITY PALLIATIVE	SL LEVEL 3	SL LEVEL 4	SL LEVEL 4 DEMENTIA	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)			
South	53	37	0	644	24	248	601	849	20	310	933	441	1,684	2,533	2,553	3,311
Calgary	296	342	153	2,784	280	1,112	3,891	5,003	95	229	851	351	1,431	6,434	6,529	10,384
Central	67	31	330	1,091	0	1,340	947	2,287	10	401	701	248	1,350	3,637	3,647	5,166
Edmonton	312	164	484	2,893	185	2,185	2,778	4,963	64	420	2,093	850	3,363	8,326	8,390	12,428
North	127	5	0	899	18	642	626	1,268	13	205	311	153	669	1,937	1,950	2,999
AHS TOTAL	**855**	**579**	**967**	**8,311**	**507**	**5,527**	**8,843**	**14,370**	**202**	**1,565**	**4,889**	**2,043**	**8,497**	**22,867**	**23,069**	**34,288**

2012-13 AHS Beds Staffed & in Operation Summary as of March 31, 2013

ZONE	ADDICTION AND MENTAL HEALTH			ACUTE CARE	CONTINUING CARE - FACILITY LIVING					SUPPORTIVE LIVING (SL)				TOTAL CONTINUING CARE (LTC + SL)	TOTAL CONTINUING CARE INCLUDING PALLIATIVE	TOTAL BEDS
	ADDICTION	COMMUNITY MENTAL HEALTH	PSYCHIATRIC (STANDALONE FACILITY)	ACUTE CARE	SUB-ACUTE (IN AUX. HOSPITAL)	AUXILIARY HOSPITAL	NURSING HOME	LONG-TERM CARE SUBTOTAL (AUXILIARY + NURSING HOME)	COMMUNITY PALLIATIVE	SL LEVEL 3	SL LEVEL 4	SL LEVEL 4 DEMENTIA	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)			
South	53	37	0	654	24	284	601	885	20	310	933	407	1,650	2,535	2,555	3,323
Calgary	296	342	153	2,691	280	1,137	3,945	5,082	95	226	732	312	1,270	6,352	6,447	10,209
Central	67	31	330	1,095	4	1,365	986	2,351	10	407	556	186	1,149	3,500	3,510	5,037
Edmonton	312	166	504	2,885	185	2,185	2,778	4,963	64	420	2,085	849	3,354	8,317	8,381	12,433
North	127	6	0	901	18	646	626	1,272	13	189	270	97	556	1,828	1,841	2,893
AHS TOTAL	**855**	**582**	**987**	**8,226**	**511**	**5,617**	**8,936**	**14,553**	**202**	**1,552**	**4,576**	**1,851**	**7,979**	**22,532**	**22,734**	**33,895**

Number of Beds Changed from 2012-13 to 2013-14

ZONE	ADDICTION AND MENTAL HEALTH			ACUTE CARE	CONTINUING CARE - FACILITY LIVING					SUPPORTIVE LIVING (SL)				TOTAL CONTINUING CARE (LTC + SL)	TOTAL CONTINUING CARE INCLUDING PALLIATIVE	TOTAL BEDS
	ADDICTION	COMMUNITY MENTAL HEALTH	PSYCHIATRIC (STANDALONE FACILITY)	ACUTE CARE	SUB-ACUTE (IN AUX. HOSPITAL)	AUXILIARY HOSPITAL	NURSING HOME	LONG-TERM CARE SUBTOTAL (AUXILIARY + NURSING HOME)	COMMUNITY PALLIATIVE	SL LEVEL 3	SL LEVEL 4	SL LEVEL 4 DEMENTIA	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)			
South	0	0	0	(10)	-	(36)	-	(36)	-	-	-	34	34	(2)	(2)	(12)
Calgary	0	0	0	93	-	(25)	(54)	(79)	-	3	119	39	161	82	82	175
Central	0	0	0	(4)	(4)	(25)	(39)	(64)	-	(6)	145	62	201	137	137	129
Edmonton	0	(2)	(20)	8	-	-	-	-	-	-	8	1	9	9	9	(5)
North	0	(1)	0	(2)	-	(4)	-	(4)	-	16	41	56	113	109	109	106
AHS TOTAL	**0**	**(3)**	**(20)**	**85**	**(4)**	**(90)**	**(93)**	**(183)**	**0**	**13**	**313**	**192**	**518**	**335**	**335**	**393**

Our thanks to the hundreds of people who contributed to the completion of this report.

Alberta Health Services