Alberta Health Services

2021 - 2022

Annual Report

Alberta Health Services

The *2021-22 Alberta Health Services Annual Report* was prepared in accordance with the *Fiscal Planning and Transparency Act* and *Regional Health Authorities Act*. The 2021-22 fiscal year spanned from April 1, 2021 to March 31, 2022. All material economic and fiscal implications known as of June 1, 2022 have been considered in preparing the Annual Report.

For more information about our programs and services, please visit www.ahs.ca or call Health Link at 811.

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Message from the Board Chair and Interim President & CEO

The Alberta Health Services (AHS) 2021-22 Annual Report encompasses a 12-month period during which the organization supported Albertans through the second year of the global COVID-19 pandemic. Much of the organization's work involved supporting the pharmacy community's rollout of COVID-19 testing and immunizations, as well as the fluid escalation and de-escalation of the healthcare delivery system in response to surges in acute-care demand caused by the pandemic. In 2021-22, AHS demonstrated an ability to be nimble but also to multi-task. This Annual Report shows that, as AHS was responding to the significant daily challenges posed by COVID-19, the organization was also making progress on many other fronts, including recommendations in the *AHS Performance Review*.

Over these 12 months, AHS expanded the volume and scope of virtual care, enabling Albertans to receive more community- and home-based care. Addiction and mental health counselling, chronic disease management programming and ambulatory care visits were offered virtually, when appropriate, improving access to these services (especially for Albertans in rural and remote communities). Using digital remote monitoring, more Albertans received hospital-level care in their home, supported by multi-disciplinary care teams. AHS' provincial clinical information system Connect Care is a key enabler of increased community-based care and healthcare integration. Launch 3 of 9 in Connect Care's phased rollout occurred in 2021-22, as did significant planning for Launch 4 at sites in Edmonton and Calgary.

Also in 2021-22, AHS laid the groundwork for improved access, responsiveness and financial sustainability. The Alberta Surgical Initiative, developed with Alberta Health in 2019, aims to ensure all Albertans receive scheduled surgeries within clinically appropriate timeframes. The EMS 10-Point Plan was implemented to better manage high volumes of EMS calls, freeing ambulances for urgent care needs and enhancing the resilience of our EMS workforce. Meanwhile, AHS administration remains the leanest in the country, at less than three per cent of total expenses[1].

This Annual Report shows that, while our people responded to the immediate and pressing demands of COVID-19, they also took proactive, tangible action toward addressing the gaps and shortcomings highlighted by the pandemic.

[1]CIHI Your Health System In Depth Website, May 2022 update.

We are so incredibly proud of staff, physicians and volunteers whose hard work, dedication and sacrifice have supported Albertans during a global health emergency. With one eye on the here and now, and one eye on the future, our people have AHS moving in the right direction — and we trust the work highlighted in this document led to significant improvements in healthcare quality, accessibility, responsiveness and sustainability.

Original signed by

Gregory Turnbull, QC

AHS Board Chair

Original signed by

Mauro Chies

AHS Interim President & CEO

About Alberta Health Services

Who We Are

Alberta Health Services (AHS) is proud to be part of Canada's first and largest provincewide, integrated health system. As Alberta's regional health authority, AHS plays a significant role in delivering a broad range of health services to more than 4.4 million people living in Alberta. AHS is one of three entities within the Ministry of Health, delivering a broad range of healthcare on behalf of government, and in accordance with the mandate set by government.

AHS is organized into five geographic zones: South, Calgary, Central, Edmonton and North. Zones enable local decision-making and enhance our ability to listen and respond to local communities, staff members, patients and clients.

AHS and its many health service delivery partners, including Covenant Health, physicians practicing in community, allied health professionals, pharmacies, local governments and Indigenous communities, work together to deliver high-quality healthcare to Albertans as well as to some residents of Saskatchewan, British Columbia and the Northwest Territories.

In 2021-22, AHS was recognized as one of Alberta's Top Employers and Canada's Best Diversity Employers. This success can be attributed to the dedication, collaboration and hard work of our staff and volunteers. AHS is proud to be recognized for supporting our people and creating workplaces where everyone feels safe, healthy, valued and included, and able to reach their full potential.

Workforce and Volunteers

AHS has more than 112,300 direct AHS employees (excluding Covenant Health and other contracted health service providers) and more than 13,000 staff working in AHS' wholly-owned subsidiaries, such as Carewest, CapitalCare Group and Alberta Precision Laboratories.

AHS is also supported by more than 11,000 independently practicing physicians, approximately 9,000 of whom are members of the AHS medical staff.

Similarly, AHS is supported by nearly 140 midwives on the AHS midwifery staff who provide care both in the community and in our facilities.

Volunteers play an integral role in fostering environments that support patient- and family-centred care. AHS' 9,100 volunteers contributed more than 492,000 volunteer hours this past year to help keep Albertans safe and healthy. Among their many contributions, volunteers manage patient visits, give input as advisory council members to improve the quality and safety of healthcare, assume wayfinding roles and tend retail shops to raise funds.

Facilities and Beds

AHS programs and services are offered at more than 900 facilities throughout the province, including hospitals, continuing care facilities (including long-term care, designated supportive living, community palliative and hospice, and contracted care sites), cancer centres, addiction and mental health facilities, and community ambulatory care centres. All facilities and programs are operated in compliance with relevant legislation.

Facilities and Beds

106 Acute Care Hospitals

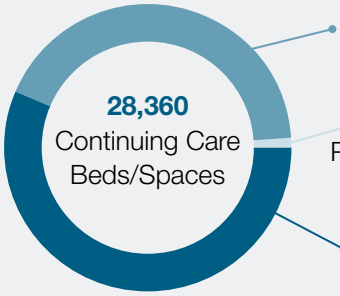
Five Standalone Psychiatric Facilities

40,437 AHS-Operated and Contracted Beds in Service

8,523 Acute Care Beds (**173** ICU beds and **8,350** non-ICU beds)

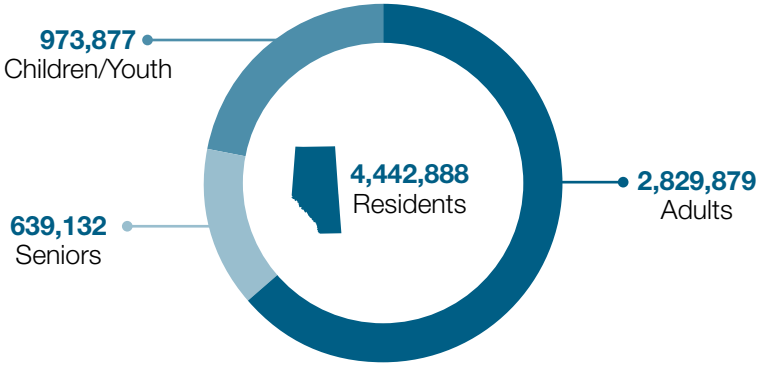
477 Sub-Acute Care Beds

3,077 Addiction and Mental Health Beds/Spaces



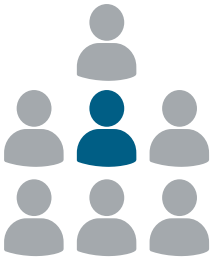
Over the past year, AHS added surge capacity to increase ICU beds from 173 to 381.

Alberta Demographics



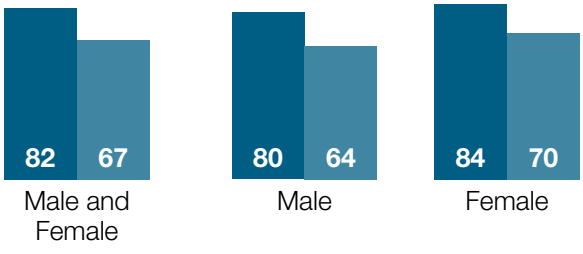
Median Age

Aging Population



1 in 7 Albertans was 65+

Life Expectancy (2020)



Non-First Nations

First Nations

AHS Health Plan & Business Plan

The AHS 2020-22 Health Plan & 2021-22 Business Plan is a legislated public accountability document that describes, at a strategic level, the actions AHS will take in carrying out its legislated responsibilities with a focus on the delivery of quality healthcare services. The AHS 2020-22 Health Plan & 2021-22 Business Plan reflects direction from Alberta Health and is aligned to the Ministry of Health's 2021-24 Business Plan.

This AHS Annual Report reflects progress on priorities and metrics identified in the 2020-22 AHS Health Plan. The AHS Performance section is organized according to the goals, objectives and actions outlined in the 2020-22 AHS Health Plan.

Board Governance

The AHS Board is responsible for the governance of AHS to ensure all Albertans have access to high-quality health services across the province. Led by the Board Chair, Gregory Turnbull, QC, the AHS Board is accountable to the Minister of Health.

The AHS Board has established committees to assist in governing AHS and overseeing the management of AHS' business and affairs: Audit & Risk Committee, Community Engagement Committee, Finance Committee, Governance Committee, Human Resources Committee and Quality & Safety Committee. The purpose and scope of each committee is in accordance with governance best practices and is consistent with the legislation governing AHS. The Board Chair is a member of each committee, and the President & Chief Executive Officer is a non-voting, ex-officio member of each committee.

Board Members

Gregory Turnbull, QC (Chair)
Dr. Sayeh Zielke (Vice-Chair)
Brian Vaasjo
Deborah Apps
Hartley R. Harris
Heidi Overguard
Dr. Jack M. Mintz, CM
Natalia Reiman
Sherri Fountain, QC
Tony Dagnone, CM
Vicki Yellow Old Woman

Mission, Vision & Values

Our mission, vision and values are core statements describing the overall purpose of our organization, how we operate and what keeps us moving forward. It clarifies what we do, who we do it for and why we do it.

AHS Vision Statement

Healthy Albertans.
Healthy Communities.
Together.

AHS Mission

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

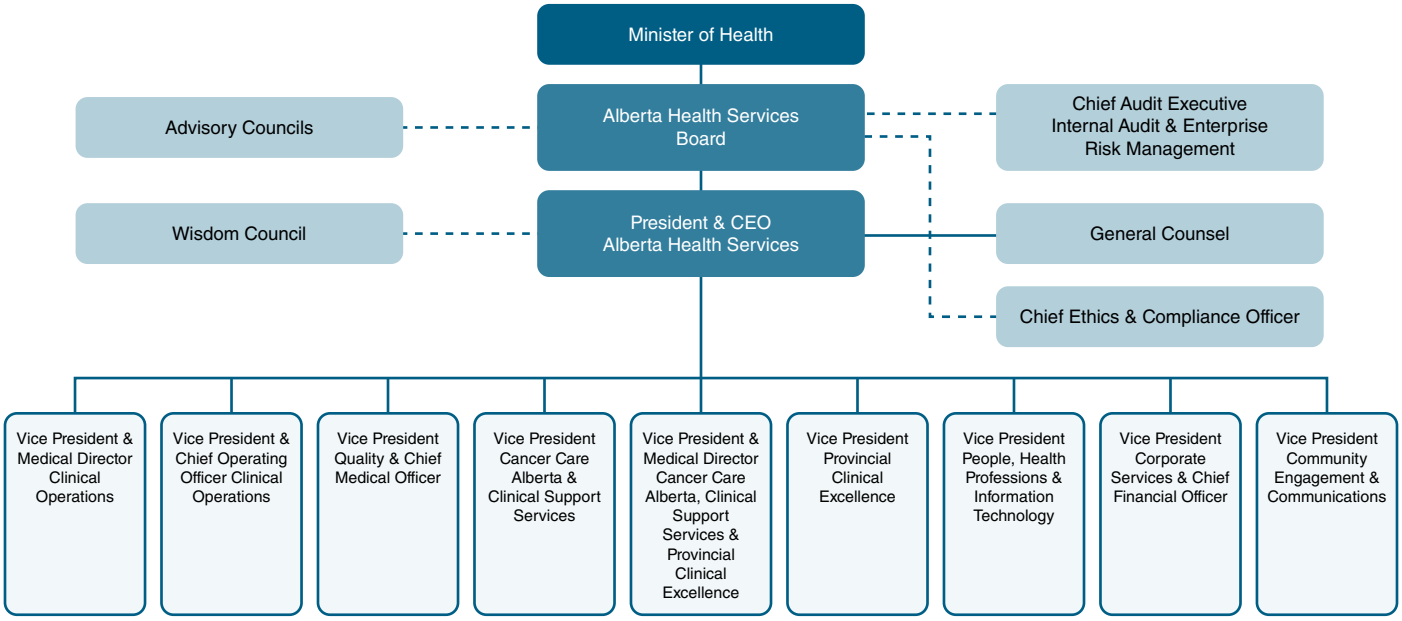
AHS Values

AHS cares

compassion accountability
respect excellence safety

Organizational Structure

Reporting directly to the Board, the President & Chief Executive Officer (CEO) led more than 112,300 caring and dedicated individuals who made up the AHS workforce. Along with leaders and staff in the organization, AHS is proud to have a culture that exemplifies its values, takes a provincial perspective on issues and ensures good ideas developed locally are shared across the province. AHS' organizational structure is represented below, arranged under the AHS Executive Leadership Team reporting directly to the President & CEO.



June 2022

Advisory Councils

Advisory Councils help bring the voice of Alberta's communities to healthcare services.

Health Advisory Councils

Health Advisory Councils (HACs) work in partnership with the AHS Community Engagement team and zone leaders to bring the local perspective to AHS' delivery of healthcare services in Alberta. HACs engage members of the public in communities throughout Alberta and provide advice and feedback on what is working well in the healthcare delivery system and where there are areas in need of improvement. The 12 HACs, which report to the AHS' Board, represent different geographical areas within the province. In 2021-22, HACs participated in a number of high-priority initiatives including COVID-19, EMS hours of work, rural health engagement planning and physician recruitment. To learn more, visit the HACs online at www.ahs.ca/ac/hac.aspx.

Wisdom Council

The Wisdom Council and Elder Circle provide guidance and recommendations to AHS on service delivery, program design and evaluation of provincewide, culturally-appropriate health services delivered by AHS to Alberta's Indigenous peoples. In 2021-22, the Wisdom Council continued to address systemic racism by participating in a discussion led by Diversity and Inclusion on developing an *Anti-Racism Position Statement*. This statement brings a consistent, comprehensive approach to AHS' anti-racism activities and will help the AHS workforce better understand their role in addressing racism.

Alberta Clinician Professional Practice Council

The Alberta Clinician Professional Practice Council is a forum for clinicians to share knowledge and experience to inform decision-making on key AHS programs. The council consists of frontline clinician members, senior operational leaders and practice leaders. Its role is to advise and give feedback on strategies related to patient outcomes, access, clinical practices, quality healthcare and patient safety. In 2021-22, council members provided feedback on several topics including standardized services and approaches in allied health, performance frameworks, psychological health and safety, and anti-racism actions.

Provincial Advisory Councils

The **Addiction and Mental Health Provincial Advisory Council** works in partnership with the AHS Provincial Addiction & Mental Health team on provincewide programs and services. The council provides recommendations that seek to improve system access, quality of service and patient satisfaction. In 2021-22, council members provided their expertise to the Provincial Addiction Counselling Practice Group, the Provincial Addiction and Mental Health Advisory Councils and to adjudicating and participating in Partnership for Research and Innovation in the Health System (PRIHS) grant projects.

The **Cancer Provincial Advisory Council** provides advice related to priorities for cancer services, including screening and prevention, diagnosis, treatment and care, and research. Members are experts in cancer-related fields, have a loved one affected by cancer or are cancer survivors. In 2021-22, council members provided input on several key initiatives including the *Ambulatory Oncology Patient Survey*, the Alberta Cancer Diagnosis Initiative and a new lung cancer screening pilot program.

The **Seniors and Continuing Care Provincial Advisory Council** works in partnership with the AHS Provincial Seniors Health & Continuing Care team to improve the delivery of AHS services to seniors and Albertans receiving continuing care services and supports. In 2021-22, council members provided input on several topics, including a research project for caregivers in the paid labour force, home care service scope and COVID-19 initiatives impacting continuing care.

The **Sexual Orientation, Gender Identity and Expression Provincial Advisory Council** aims to create a safer, more inclusive and welcoming healthcare environment for sexual and gender minority (lesbian, gay, bisexual, transgender,

queer, and 2 Spirit or LGBTQ2S+) patients and their families. In 2021-22, the council was consulted by the Alberta Breast Cancer Screening Program to provide input on inclusive language for promotional materials. The council also developed an internal guiding principles document as a resource for inclusivity in care and in the work environment.

Provincial Patient and Family Advisory Council

The Provincial Patient and Family Advisory Council is comprised of patients and family members from across Alberta who volunteer their time and experience to improve the quality, safety and experience of healthcare services. Together with senior and executive leaders, physicians, clinicians and clinical support teams, advisors work to enhance the principles of patient- and family-centered care through the design and planning of policies and services within AHS. In 2021-22, the Patient & Family Advisory Group and the Connect Care Patient & Family Advisory Committee merged to form PFAC. Members contributed more than 1,600 volunteer hours and participated in more than 50 consultations related to COVID-19 pandemic response, Connect Care, anti-racism, Patient First commitments and the *AHS Performance Review.*

Service Delivery Information

Provincial Quick Facts

The table below provides a snapshot of AHS activity and demonstrates service level changes over the last few years.

	2018-19	2019-20	2020-21	2021-22
Primary Care / Population Health				
Ambulatory Care Visits	6,578,463	6,137,600	5,175,278	5,452,962
Number of Unique/Individual Home Care Clients	119,862	124,975	117,775	121,560
Number of People Placed in Continuing Care	8,098	8,521	7,427	8,664
Health Link Calls*	694,313	891,931	2,291,243	--
Health Link Calls Received – Clinical*	--	--	--	1,444,868
Health Link Calls Received – Non-Clinical*	--	--	--	2,291,770
Health Link Outbound Calls – Clinical*	--	--	--	59,775
Health Link Outbound Calls – Non-Clinical*	--	--	--	494,208
Poison Information Calls (PADIS)	38,785	39,253	38,718	48,392
Seasonal Influenza Immunizations**	1,317,659	1,438,682	1,650,836	1,291,770
EMS Events	560,434	589,498	602,283	672,898
Food Safety Inspections	65,560	48,247	26,171	33,728
Acute Care				
Emergency Department Visits (all sites)	2,056,631	2,062,528	1,552,096	1,824,116
Urgent Care Visits	197,401	202,925	148,166	193,961
Hospital Discharges	401,208	399,281	358,107	375,960
Births	50,793	49,981	46,603	47,292
Total Hospital Days	2,853,001	2,852,150	2,505,858	2,613,603
Average Length of Stay (in days)	7.1	7.1	7.0	7.0
Diagnostic / Specific Procedures				
Hip Replacements (scheduled and emergency)	6,279	6,605	5,802	6,177
Knee Replacements (scheduled and emergency)	6,617	6,233	5,125	5,273
Cataract Surgery	40,554	45,236	44,289	47,744
Main Operating Room Activity	291,450	289,567	271,131	271,375
MRI Exams	204,744	201,118	205,793	235,241
CT Exams	441,938	427,508	462,443	508,071
X-rays	1,845,811	1,846,918	1,532,099	1,697,532
Lab Tests	80,237,687	80,528,613	72,491,239	82,149,662
Cancer Care				
Cancer Patient Visits (patients may have multiple visits)	668,817	704,191	737,212	794,799
Unique/Individual Cancer Patients	59,249	62,513	60,902	64,496
Addiction and Mental Health				
Mental Health Discharges (acute care sites)	25,725	26,443	27,100	27,991
Mental Health Discharges (acute care sites and standalone psychiatric facilities)	29,936	31,154	31,791	33,055
Community Treatment Orders (CTOs) Issued	725	757	802	843
Addiction Residential Treatment & Detoxification Admissions	10,557	10,356	8,166	9,254
Workforce				
AHS Physicians	7,999	7,987	8,792	8,697
AHS Staff	102,717	103,340	108,689	112,373
AHS Volunteers	14,117	16,020	12,241	9,186

Data updated as of May 11, 2022. Definitions can be found at https://www.ahs.ca/about/Page11905.aspx.

** The measure "Health Link Calls" is no longer being reported because Health Link has expanded their services and this measure no longer represents the Health Link business. This measure was changed as of 2021-22 Q1 to four separate measures: 1) "Health Link Calls Received - Clinical", 2) "Health Link Calls Received - Non-Clinical", 3) "Health Link Outbound Calls - Clinical", and 4) "Health Link Outbound Calls - Non-Clinical". Data for the measure "Health Link Outbound calls" (clinical and non-clinical) are only available at a provincial level. 'Clinical' refers to calls requiring nursing, addiction and mental health, COVID-19 clinical services, rehabilitation, etc. 'Non-Clinical' refers to calls requiring information and/or referral, influenza, COVID-19 non-clinical services, tobacco cessation, immunization booking, etc. Health Link call volumes include COVID-19 inquiries and vaccination appointment booking (beginning 2019-20 Q4).*

*** Source: Alberta Health Influenza Immunization Report 2020-2021. 2021-22 Immunization data was not available at the time of reporting, data will be updated as soon as possible.*

Bed Numbers Summary

AHS continues to shift from a focus on providing care in hospitals and care facilities to providing resources and services in the community. We are committed to providing community-based care options for Albertans, including long-term care, designated supportive living, palliative care and home care.

In 2021-22, AHS opened 387 net new continuing care beds. Increasing community capacity means that people are gradually being moved from hospital settings to a more appropriate (and often more cost-effective) community-based setting.

Additional information on bed capacity can be found in *Supplemental Information to the 2021-22 AHS Annual Report*.

Number of Beds/Spaces	March 31, 2021	March 31, 2022	Difference	% Change
Acute Care				
Acute Care	8,513	8,523	10	0.1%
Total Acute Care	**8,513**	**8,523**	**10**	**0.1%**
Addiction and Mental Health				
Psychiatric (stand-alone facilities)	928	928	0	0.0%
Addiction Treatment	1,037	1,258	221	21.3%
Community Mental Health	875	891	16	1.8%
Total Addiction and Mental Health	**2,840**	**3,077**	**237**	**8.3%**
Community-Based Care				
Continuing Care – Long-Term Care (LTC)				
Auxiliary Hospital	5,591	5,569	-22	-0.4%
Nursing Home	10,209	10,433	224	2.2%
Sub-Total Long-Term Care	**15,800**	**16,002**	**202**	**1.3%**
Continuing Care – Designated Supportive Living (DSL)				
Designated Supportive Living 3	1,513	1,470	-43	-2.8%
Designated Supportive Living 4	6,924	7,052	128	1.8%
Designated Supportive Living 4 – Dementia	3,479	3,579	100	2.9%
Sub-Total Designated Supportive Living	**11,916**	**12,101**	**185**	**1.6%**
Sub-Total Long-Term Care & Designated Supportive Living	**27,716**	**28,103**	**387**	**1.4%**
Continuing Care – Community Palliative and End of Life Care (PEOLC)				
Community Palliative and End of Life Care *(out-of-hospital)*	257	257	0	0.0%
Sub-Total Continuing Care *(includes LTC, DSL and PEOLC)*	**27,973**	**28,360**	**387**	**1.4%**
Sub-Acute in Long-Term Care				
Sub-Acute in Long-Term Care (Auxiliary Hospital)	477	477	0	0.0%
Total Community-Based Care *(includes LTC, DSL, PEOLC and Sub-Acute in LTC)*	**28,450**	**28,837**	**387**	**1.4%**
Provincial Total *(includes all beds and spaces)*	**39,803**	**40,437**	**634**	**1.6%**

Source: AHS Bed Survey as of March 31, 2022.

Note: Beds may have been restated since previous AHS Annual Reports and AHS Bi-Annual Bed Surveys due to reporting corrections.

Of the 8,523 acute care beds, 6,089 are non-ICU COVID-capable, 173 are ICU and 217 are specialty ICU.

AHS Performance

Leading in Health

While AHS is striving to improve and address challenges in healthcare delivery, the following examples highlight where Alberta excels compared to the rest of the country. According to the latest statistics from the Canadian Institute for Health Information (CIHI), Alberta is a national leader in many areas of healthcare delivery.

In 2020-21, Alberta spent less than three per cent of expenses on administrative expenses. This is the lowest of the 10 provinces and 34 per cent lower than the national average.

CIHI has developed indicators to measure the health of Canadians and health system performance in Canada. These indicators help inform AHS and Albertans on how we perform nationally. The indicators below represent areas where Alberta is performing better than the national average.

Source: CIHI Your Health System In Depth Website, May 2022 update.

Accreditation

Accreditation compares our health services with national standards of excellence to help identify what AHS is doing well and how we can improve. AHS continues to maintain accredited status with Accreditation Canada and the College of Physicians and Surgeons of Alberta. AHS-funded partners, Covenant Health and Lamont Health Care Centre, also continue to maintain accredited status with Accreditation Canada. More information can be found online at www.ahs.ca/about/Page190.aspx.

During the spring 2021 survey, Accreditation Canada surveyors conducted approximately 1,000 interviews at 10 North Zone and five Central Zone rural hospitals. These 15 sites were assessed over a period of two weeks for emergency, inpatient, obstetrics, peri-operative services and long-term care standards. Performance related to the foundational standards of infection prevention and control, medication management, medical device reprocessing and service excellence were also assessed at these hospitals. Surveyors observed engaged and enthusiastic staff who demonstrated the values of the organization and a commitment to quality and patient safety.

Due to pandemic conditions, sites originally scheduled for the Fall 2021 survey were rescheduled and will be surveyed in Fall 2022 and Spring 2023.

- Higher % of hip fracture surgeries within 48 hours
- Fewer self-harm hospitalizations
- Fewer obstetric traumas for instrument-assisted vaginal deliveries
- Fewer patients (medical, surgical, obstetric and pediatric combined) readmitted to hospital
- Fewer surgical patients readmitted to hospital
- Fewer pediatric patients readmitted to hospital
- Fewer hospitalizations for ambulatory care sensitive conditions
- Lower potentially inappropriate use of antipsychotics in LTC
- Lower restraint use in LTC
- Better perceived health
- Fewer hospitalized heart attacks
- Higher % of residents with improved physical functioning in LTC
- Higher physical activity (aged 18+)

Performance Metric Results Summary Dashboard

Year-end results for AHS' performance metrics are summarized below. Results are reported as 'improved' if there is a three per cent or greater relative change in a desirable direction when compared to the same time period last year; 'deteriorated' if the three per cent or greater relative change is in an undesirable direction; otherwise, results are reported as 'stable'. Additional information can be found in the *Supplemental Information to the 2021-22 AHS Annual Report.*

Goal 1: Improve the Experiences of Patients and Families

65.6% of people placed in **continuing care** within 30 days

Result: Improved

13.3% of beds used by **alternate level of care** patients

Result: Improved

12.6% of **mental health** patients **readmitted** to hospital within 30 days

Result: Deteriorated (Q3YTD)

65.7% of patients **satisfied** with their **hospital experience**

Result: Stable (Q3YTD)

95,101 users registered on **MyAHS Connect Portal**

Result: Improved[1]

Goal 2: Improve Patient and Population Health Outcomes

51.1% of **hip surgeries** performed within 182 days

Result: Stable

39.7% of **knee surgeries** performed within 182 days

Result: Deteriorated

64.2% of **cataract surgeries** performed within 112 days

Result: Improved

3,583,790 Albertans received at least one dose of **COVID-19 vaccine**

Result: Improved[1]

244 hospitalizations per 100k residents for **ambulatory care sensitive conditions**

Result: Deteriorated

92% hand hygiene compliance rate for AHS healthcare workers

Result: Stable

Goal 3: Improve the Experience and Safety of our People

3.57 out of 5 AHS **employee engagement** rate

Result: Improved[2] (2019-20)

4.56 disabiling injuries per 200,000 paid hours

Result: Improved (Q3YTD)

Goal 4: Improve Financial Health and Value for Money

2.2% change in annual **AHS operational expenditure**[3]

Achieved target (3.9%)

$9,172 per **standard hospital stay** (AHS estimated)

Result: Improved

0.99 ratio of acute inpatient days to the **expected length of stay**

Result: Stable

9.2% of patients[4] **readmitted to hospital** within 30 days

Result: Stable (Q3YTD)

1. This is a cumulative measure; result indicates continuous increase over time

2. Compares 2019-20 to 2016-17 survey

3. Excludes incremental COVID-19 related expenses

4. Includes medical, surgical, pediatric and obstetrical patients

Goal 1: Improve the Experiences of Patients and Families

Objective 1: Expand community-based and home care options in the most appropriate setting.

To provide excellent healthcare experiences and to meet the needs of Alberta's growing and aging population, AHS strives to provide Albertans with care where they want it most— in their homes and communities.

Actions and Achievements

Enhance community-based care

- In 2021-22, AHS implemented the Sensory Therapeutic Enhancement Project (STEP) in North Zone which addresses behavioural and psychological symptoms of dementia by promoting safe and enriching care settings where social, psychological, cognitive, emotional and recreational care needs can be met.
- A new service model for outpatient and community physiotherapy was implemented in Calgary and Edmonton Zones. As of March 31, 2022, 128 contracted sites have implemented these standardized services.
- In 2021-22, Mobile Integrated Health and community paramedics expanded the in-home blood transfusions program to communities in the South Zone. Receiving transfusions at home improved quality of life and comfort for patients, and reduced exposure to other illnesses such as COVID-19.
- In January 2022, AHS announced a comprehensive Emergency Medical Services (EMS) 10-point plan that aims to ensure the most critical patients receive timely care and that services remain available and safe for all Albertans. The plan focuses on immediate actions to create capacity within the EMS system, including hiring additional paramedics, transferring low-priority calls to other agencies, stopping the automatic dispatch of ambulances to motor vehicle collisions without injuries and implementation of an "hours of work" project to help ease fatigue. A ministerial-appointed provincial advisory committee is also developing recommendations to address system pressures.

Develop long-term care and designated supportive living spaces in the community

- In 2021-22, AHS opened 387 net new continuing care beds to support individuals who need community-based care and supports. AHS also opened six new continuing care facilities across the province.
- Ward rooms with three or more residents have been eliminated at continuing care sites across the province.
- AHS added surge capacity to address the shortage of continuing care capacity and decrease the number of individuals waiting in acute care for long-term care and designated supportive living during the pandemic. As of March 31, 2022, all temporary surge beds in continuing care have been closed.

Increase capacity for home care supports

- AHS is working with AH and Alberta Seniors and Housing to develop and implement collaborative referral and service delivery approaches to address the clinical and support needs of seniors living in the community. This program increases collaboration between

hospitals, primary care networks, home care and social services to allow seniors to remain in their homes as long as possible, reduces caregiver burnout and improves overall quality of life. In 2021-22, a pilot project was implemented in Calgary Zone for patients discharged from the Foothills Medical Centre, leveraging support from local not-for-profit organizations such as The Way In Network and Carya.

- The Rural Palliative Care In-Home Funding Program supports the provision of end-of-life care in rural and remote areas so clients can remain at home instead of being admitted to hospital. In 2021-22, 179 clients were served by the program allowing 63 per cent to pass away in the comfort of their own home.

Strengthen the patient complaints process

- Working with Alberta Health and the Health Quality Council of Alberta, AHS initiated improvement activities that will enhance the patient complaints process, including competency development and capacity-building for concern management. In 2021-22, no investigations were opened by the Alberta Ombudsman to review administrative fairness, which indicates that AHS is appropriately managing concerns in accordance with the Patient Concerns Resolution Process Regulation (Alberta Regulation 2016/28). Additional information on patient concerns can be found in the Appendix.

Performance Results Summary

Percentage Placed in Continuing Care Within 30 Days

2017-18	2018-19	2019-20	2020-21	2021-22
51.8%	57.9%	60.0%	61.3%	65.6%

Source: AHS Seniors Health Continuing Care Living Options Report, as of April 22, 2022.

- This measure monitors the percentage of people who move from hospitals and communities into community-based continuing care settings. The **higher the percentage the better,** as it demonstrates availability of long-term care or designated supportive living beds.
- As of Q4YTD (year-to-date), the percentage placed in continuing care within 30 days (65.6%) **improved** by seven per cent compared to the same period last year (61.3%).

Percentage of Alternate Level of Care (ALC) Patient Days

2017-18	2018-19	2019-20	2020-21	2021-22
17.5%	16.5%	15.4%	15.2%	13.3%

Source: AHS Provincial Discharge Abstract Database (DAD), as of April 29, 2022.

- This measure monitors the number of days a hospital bed is occupied by a patient who no longer needs acute care services while they wait to be discharged to a more appropriate care setting (called ALC days). The **lower the percentage the better,** as it demonstrates system capacity that meets population needs and suggests appropriate care transitions.
- As of Q4YTD, the percentage of ALC days (13.3%) **improved** by 13 per cent compared to the same period last year (15.2%).
- Using a similar definition, Alberta ranked 3rd among nine provinces for the lowest percentage of alternate level of care days (AB = 15.2%; Canada = 16.7%; Best Performing Province = 12.2%) *(CIHI, 2020-21)**.

Objective 2: Improve sustainability and integration of addiction and mental health care in communities and across the service continuum.

Addiction and mental health (AMH) conditions involve a complex interplay of genetics, personality, childhood experiences, trauma and social determinants of health. These factors result in a diverse range of needs that

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

require comprehensive, culturally-appropriate, well-coordinated and integrated recovery-oriented services within AHS and with partner organizations and ministries.

Actions and Achievements

Enhance access to AMH services

- Referral pathways have been developed to improve transitions and collaboration between the AMH Helpline and other Health Link teams. As of March 31, 2022, more than 64,300 calls were answered by the AMH Helpline.
- The Youth Community Support Program provides a step-down service for youth with complex mental health diagnoses and their families who are discharged from acute inpatient mental health settings. In 2021-22, 75 clients accessed these services. All youth involved in the program demonstrated improved mental health and decreased reliance on emergency services during and after their time in the program.
- Personalized Community Care (PCC) is a provincially-accessed, community-based placement and treatment program for youth up to 19 years of age who are receiving child intervention services. The PCC program supports youth to stabilize and recover from mental health crises through intensive treatment to improve their functioning and well-being. This is a joint initiative with Alberta Health and Children's Services. In 2021-22, the program admitted three clients in Calgary and three clients in Edmonton.
- The *Protection of Children Abusing Drugs Act* (PChAD) is an Alberta law that helps children under the age of 18 whose use of alcohol or drugs will likely cause significant psychological, social or physical harm to themselves or others. AHS provides a 10-day inpatient program aimed at detoxifying, stabilizing and assessing each patient to ensure appropriate supports are identified for youth prior to discharge. In 2021-22, admissions to the program (617) increased by 28 per cent compared to the same period last year (479).

Offer community-based supports in response to the opioid crisis and other emerging needs

- AHS Opioid Dependency Programs clinics provide a variety of treatment services and supports to individuals with opioid use disorder, including opioid agonist therapy, addiction counselling and referral to other community-based services. In 2021-22, AHS enhanced psychosocial services in these clinics, serving more than 6,400 clients across the province.
- The Virtual Opioid Dependency Program works with corrections and law enforcement agencies to enable treatment transitions for clients released from incarceration. In January 2022, a new Low Barrier, Urgent Access team was created to facilitate rapid assessment and treatment initiation in police detention units, supervised consumption services sites and shelters.
- AHS supports opioid response needs through community-based programs that enable holistic Indigenous wellness. In Edmonton, teams facilitated community outreach related to Hepatitis C treatment. In Calgary, the Sheldon M. Chumir Health Centre provided planning support, including offering in-home response services for patients in Siksika Nation.
- Working with community partners, the Provincial Family Violence Treatment Program aims to deliver consistent, comprehensive assessment and treatment services to prevent intimate partner violence. As of March 31, 2022, the program was operational in 25 rural, remote and Indigenous communities across the province. In 2021-22, a pilot expansion site was initiated in Pincher Creek with services delivered by Lethbridge Family Services.

Expand the use of virtual care technology to support AMH care

- AHS supports access to community programs by enabling virtual connections between patients and providers. In 2021-22, AHS used technology to improve emergency and acute psychiatry (Calgary, South and North Zones) and AMH group therapy in Medicine Hat.
- Through engagement with Primary Care Networks, AHS implemented centralized virtual access to AMH assessment, screening and intake in rural Alberta. The program encompasses coordinated intake, clinical decision support and engagement with community service providers.
- A program was implemented in Central Zone to provide crisis support to youth aged 13 to 17. The program includes virtual at-home options and integrates care with other service providers such as schools, counsellors and physicians. Approximately 1,000 unique youth patients visit the emergency room in Central Zone for addiction and mental health issues each year. So far, the program has diverted 127 cases from emergency and hospital.
- AHS continues to develop and offer public resources and tools to support mental health wellness skill-building and resilience. This year, more than 10,000 Albertans registered with Togetherall (a free, online peer-to-peer mental health community) and more than 61,500 people have subscribed to the Text4Hope and Text4Mood programs, which send advice and encouragement via text.

Provide psychosocial supports to respond to the impact of COVID-19

- AHS offers interactive workshops to the public on resilience and stress. HeartMath participants learn about the impact of emotions on the body and develop skills to address stress through communication, decision-making and basic breathing techniques. In 2021-22, 87 virtual workshops were delivered to more than 1,700 participants.
- Through Psychological First Aid (PFA) training, AHS staff and community members learn how to recognize signs of distress, offer help without judgment or assumptions, connect to available resources and implement responder self-care strategies. AHS developed a PFA refresher course focused on the pandemic and in 2021-22, 139 PFA webinars were delivered to more than 2,400 participants.

Establish more addiction treatment spaces

- In 2021-22, AHS increased capacity by 221 beds (including medical detox, social detox, residential treatment and residential recovery) in Fort Macleod, Lethbridge, Medicine Hat, Calgary, Drumheller, Edmonton and Cold Lake.

Performance Results Summary

Unplanned Mental Health Readmissions

2017-18	2018-19	2019-20	2020-21	Q3YTD 2020-21	Q3YTD 2021-22
9.6%	10.7%	10.7%	12.1%	12.1%	12.6%

Source: AHS Provincial Discharge Abstract Database (DAD), as of April 29, 2022.

- This measure monitors the percentage of patients who are unexpectedly readmitted to hospital within 30 days of discharge following mental health care. Monitoring readmissions can help evaluate the appropriateness of discharges and follow-up community care. The **lower the percentage the better,** as it demonstrates appropriate discharge planning and follow-up community care.
- As of Q3YTD, the percentage of unplanned mental health readmissions (12.6%) **deteriorated** by four per cent compared to the same period last year (12.1%). This indicator is reported a quarter later due to requirements to follow-up with patients after the end of the reporting quarter.
- Alberta remains better than the national average for this measure. The national data also shows an increasing trend in mental health readmissions across most provinces. The impacts of COVID-19 may be contributing to this change. Emerging research is showing that the pandemic has had significant mental health impacts in some populations, youth in particular, and AHS saw increased emergency and inpatient utilization for AMH concerns throughout most of 2021. Current initiatives to expand access to community services are underway, which are expected to reduce pressures in this area and readmissions will be monitored as part of ongoing assessment of performance.
- Using a similar definition, Alberta ranked 2nd among nine provinces for the lowest 30-day readmission for mental illness (AB = 13.0%; Canada = 14.2%; Best Performing Province = 12.0%) *(CIHI, 2020-21)*.

Objective 3: Leverage technology and innovation to improve patient- and family-centred care.

AHS is committed to ensuring patients and families have stronger voices, and are fully-informed and involved in decisions about their healthcare. Being active participants in their own care helps Albertans better manage their personal wellness. Technology that is used for virtual care initiatives and Connect Care, enables strong communication between patients, families and healthcare providers.

Actions and Achievements

Implement Connect Care for care provided by AHS and AHS-affiliated healthcare providers

- Connect Care provides physicians, clinicians and clinical operations staff with a single AHS health record and allows Albertans to access personal health information which improves health outcomes and communication with care teams. Connect Care Launch 3 occurred at 31 North Zone sites in April 2021 and included clinical operations and related clinical support programs (e.g., pharmacy, diagnostic imaging, Alberta Precision Labs, Health Information Management, nutrition and food services, etc.). As of March 31, 2022, there were more than 36,600 active users of Connect Care.

Continued implementation of a patient-focused virtual care strategy

- Virtual care use continues to experience growing demand. Video patient care delivery volumes in 2021-22 (433,249) were 10 per cent higher than the same period last year (394,949). Acute specialist consultations are available for a number of areas including critical care, addiction and mental health, cardiac services, antenatal care, rehabilitation and surgical services. Addiction and mental health and intensive care unit virtual supports were also developed in response to the COVID-19 pandemic.
- Virtual Hospital programs were expanded to specialty areas including obstetrics and gynecology, transplant, surgery, and chronic disease management. For example, the Edmonton Zone Virtual Hospital uses digital remote patient monitoring (dRPM) with post-surgical patients, allowing them to recover at home.

Expand virtual care initiatives and strategies

- Health Link provides a 24/7 provincial service to Albertans that includes nurse triage support, general health information and system navigation assistance. As of March 31, 2022, Health Link 811 received more than 3.4 million calls (including COVID-19 calls) which is a 49-per-cent volume increase when compared to the same period last year, and a 392-per-cent increase when compared to pre-pandemic volumes (2018-19). Despite growing call volumes, Health Link achieved a four-per-cent improvement in wait times (10:06 minutes) when compared to the same period last year (10:31 minutes).
- In Q4, Health Link launched a new virtual MD pilot program which aims to reduce demand on emergency departments. This physician triage line provides consultation, assessment and virtual care for patients. In 2021-22, more than 3,000 patients were referred to the triage line, with 96 per cent of patients reporting they were satisfied with the service.
- The Rehabilitation Advice Line is now caring for patients with long-COVID using a combination of phone and video interactions. In 2021-22, more than 6,000 patients were contacted within seven days of discharge from acute care following a COVID-19-related admission. Patients are assessed and connected to appropriate services.
- Telerehabilitation provides access to care for people who may live in areas with limited in-person options or those who have mobility or transportation issues. The Tele-Rehab 2.0 program uses technology to measure and assess patients in remote areas. As of March 31, 2022, 10 sites in North, Central and South Zones delivered the specialized program.
- The Alberta Indigenous Virtual Care Clinic provides same-day visits with family doctors for rural and urban First Nations, Métis and Inuit patients and their families. The clinic aims to remove systemic barriers by increasing access to culturally-safe primary care. The virtual clinic provided primary care services to approximately 2,000 Indigenous patients in more than 140 cities and towns, including providing referrals to AHS specialists for diabetes care and cancer screening and treatment.
- Nearly 64,500 patients were treated for cancer in Alberta last year. AHS continues to expand access to supportive cancer services by offering virtual appointments as an alternative to in-person visits. In 2021-22, more than 8,880 supportive care visits and 3,200 dietitian visits were provided virtually to patients in rural and remote areas.

Improve access to information and medical records

- On behalf of Alberta Health, in 2021-22, AHS added seven new data sources into Netcare and participated with other stakeholders in expanding access to all lab results, including microbiology, pathology, and genetics, without delay, through MyHealth Records.
- As Connect Care rolls out, patients receiving care at enabled sites have the opportunity to access MyAHS Connect, a service

offered through Alberta Health's MyHealth Records, that allows users to manage their appointments, access test results and communicate directly with their AHS healthcare team. As of March 31, 2022, more than 95,000 unique users have accessed the web service and approximately 17,100 users have logged in to the mobile app.

- The Chinook Regional Hospital Emergency Department has leveraged technology to replace printed discharge instructions, which can be easily lost, forgotten or destroyed. Now, patients may use their smartphone to scan a QR code that connects them with relevant documents.

Performance Results Summary

Patient Satisfaction with Hospital Experience

2017-18	2018-19	2019-20	2020-21	Q3YTD 2020-21	Q3YTD 2021-22
64.2%	65.5%	66.3%	66.8%	67.2%	65.7%

Source: AHS Canadian Patient Experiences Survey on Inpatient Care (CPES-IC), as of April 1, 2022.

- This measure monitors patients' overall perceptions associated with the hospital where they received care, based on survey ratings, using a scale from 0-10, where 10 is the best possible rating. Gathering feedback from individuals using hospital services is a critical part of improving the healthcare delivery system. The **higher the number the better,** as it demonstrates more patients are satisfied with their care in hospital.
- As of Q3YTD, the percentage of patients rating hospital care as 9 or 10 (65.7%) remained **stable** compared to the same period last year (67.2%).
- Patient satisfaction continued to be impacted by restrictions to family presence and visitation, access to healthcare services and specialists, and cancellation and postponement of surgeries. AHS works with patients and families to address concerns on a case-by-case basis.
- Using a similar definition, Alberta ranked 1st among five provinces for the highest percentage of patients who said that their overall hospital experience was very good (9-10 out of 10) (AB = 67%; Canada = 65%; Best Performing Province = 67%) *(CIHI, data varies from 2017-18 to 2020-21, AB is 2020-21)*.

MyAHS Connect Portal Users

2019-20	2020-21	2021-22
9,461	38,017	95,101

Source: AHS Connect Care, as of April 6, 2022.

- This measure monitors the number of active Connect Care accounts being accessed via the MyAHS Connect Portal. MyAHS Connect is a patient portal that offers personalized and secure access to a person's AHS health record. The **higher the number the better,** as it demonstrates more Albertans have access to the portal and can be more involved in their care and decision making.
- As of Q4YTD, the number of portal users (95,101) **improved** by 150 per cent compared to the same period last year (38,017). This is a cumulative measure that continuously increases over time.

Goal 2: Improve Patient and Population Health Outcomes

Objective 4: Implement the Alberta Surgical Initiative and reduce CT and MRI wait times.

Wait-time reduction is a key area of focus for AHS. To address increasing surgical wait times, AHS and Alberta Health worked together to develop the Alberta Surgical Initiative (ASI) in 2019 to improve access to surgical care. Similarly, the Diagnostic Imaging CT and MRI Action Plan was developed to manage challenges related to growing demand in CT and MRI services.

Actions and Achievements

Progress on Surgery Recovery

- Wave 4 of the pandemic impacted scheduled surgery activity and the wait-list. AHS implemented a provincial surgery resumption framework in October 2021 to guide progressive reinstatement of surgical activity in all zones. The wait-list for scheduled surgery stabilized in late November 2021 and increased slightly in early 2022 during subsequent pandemic waves.
- AHS' plan to return to pre-pandemic wait times was refreshed in February 2022 after Wave 5 of the pandemic. Surgery wait-list and volume modeling were completed and aligned with operational planning to deliver recovery volumes in the upcoming 2022-23 fiscal year, with ophthalmological procedure wait lists below pre-pandemic levels.

Implement strategies to mitigate surgical delays

- AHS continues to prioritize those patients that are waiting the longest and those that are the sickest. Weekly reviews of scheduled surgery waitlists are completed based on a standardized coding system to prioritize scheduled surgeries. Additional analytical tools to support wait-list management are in development.
- All surgeries that were postponed or delayed during pandemic waves 1-5 have been rebooked.

Advance the Alberta Surgical Initiative

- All projects within the ASI are active and advancing. However, overall progress has been slowed by the pandemic and additional time will be required to achieve ASI targets.
- Innovative surgery workforce strategies have been established to ensure AHS has the skilled workforce available to recover from the pandemic and reduce wait-lists. AHS will increase anesthesia service capacity and draw upon the skills and expertise of respiratory therapists (RTs). Under the new model, one anesthesiologist will oversee two or three surgeries, with one RT providing anesthesia service in each room for cases where minimal sedation is required. This is a key approach to addressing anesthesia workforce shortages and enabling RTs to work to their full scope of practice.
- The AHS Specialty Access Bundle is a consolidation of Alberta Surgical Initiative projects related to improving patient safety, experience and flow between primary care, specialty care and back. The bundle will leverage progress made by existing programs

and coordinate the implementation of several projects, including a provincially-aligned model for non-urgent telephone and electronic specialist advice. Planned work will standardize and simplify the referral process for healthcare providers and the public.

Maximize surgical volumes in chartered surgical facilities (CSF)

- Long-term CSF planning has progressed, including expanded contracted volumes with a focus on ophthalmology and orthopedics. New ophthalmology contracts for Calgary and Edmonton were negotiated for April 1, 2022. Orthopedics interim contracts for Calgary and Edmonton were in place for April 1, 2022. This process uses a request for proposal (RFP) model which is an open and transparent process that yields competitive pricing while ensuring positive patient experience, quality and safety. Additional information on CSFs can be found in the Appendix.

Proceed with the CT/MRI Implementation Plan to reduce CT and MRI wait times

- In 2021-22, AHS increased volumes of completed CT exams (508,071) by 10 per cent compared to the same period last year (462,443), and increased volumes of completed MRI exams (235,241) by 14 per cent compared to the same period last year (205,793).
- In 2021-22, a pilot program aimed at reducing MRIs in surgical assessment of chronic shoulder pain was launched at the Sturgeon Primary Care Network in Edmonton Zone. Clinics utilizing the new tool are actively referring patients for orthopedic surgery without unneeded imaging. This aligns with best practice clinical recommendations.
- In alignment with Choosing Wisely recommendations, Edmonton and South Zones implemented improvements to reduce the number of knee MRIs in patients aged 55 and older with known osteoarthritis to ensure that MRI exams on the wait-list are necessary and beneficial. More than 100 low-value MRIs have been avoided to date.

Performance Results Summary

Percentage of Scheduled Cataract Surgeries Performed Within CIHI Benchmark*

2017-18	2018-19	2019-20	2020-21	2021-22
53.3%	48.2%	45.1%	45.3%	64.2%

Source: Data extracted from hospital operation room data: PICIS, VAX, Meditech, the Alberta Wait Times Reporting (AWTR) website, and Surgical Facilities Contracts (Bill 11) database, as of April 26, 2022.

- Data include elective and scheduled cases for first eyes only.

- Data include surgeries performed within Alberta Health Services (including faith-based sites) and at contracted surgical facilities.

- This measure monitors the percentage of scheduled cataract surgeries performed within the Canadian Institute for Health Information's (CIHI) benchmark of 112 days. Performing surgeries within recommended timeframes supports improved health outcomes and patient satisfaction. The **higher the percentage the better,** as it demonstrates more procedures are being completed within clinically recommended timeframes.
- As of Q4YTD, the percentage of cataract surgeries completed within 112 days (64.2%) **improved** by 42 per cent compared to the same period last year (45.3%).
- More cataract surgeries were performed this year, with an increased percentage performed within the CIHI benchmark of 112 days. This improvement reflects the implementation of the Alberta Surgical Initiative including increasing volumes in ophthalmology contracts with Charted Surgical Facilities (CSFs).
- Using a similar definition, Alberta ranked 4th among the 10 provinces for the highest percentage of cataract surgeries meeting the pan-Canadian benchmark of 16 weeks (AB = 64%; Canada = 66%; Best Performing Province = 76%) *(CIHI Apr-Sep 2021)*.

Percentage of Scheduled Hip Surgeries Performed Within CIHI Benchmark*

2017-18	2018-19	2019-20	2020-21	2021-22
70.5%	68.5%	65.5%	51.6%	51.1%

Source: Data extracted from hospital operating room data: PICIS, VAX, Meditech Operating Room Module and Alberta Wait Time Reporting, as of April 26, 2022.

- Data include elective and scheduled cases only.

- Data include surgeries performed within Alberta Health Services (including faith-based sites) and at contracted surgical facilities.

- This measure monitors the percentage of scheduled hip surgeries performed within the CIHI benchmark of 182 days. Performing surgeries within recommended timeframes supports improved health outcomes and patient satisfaction. The **higher the percentage the better,** as it demonstrates more procedures are being completed within clinically recommended timeframes.
- As of Q4YTD, the percentage of hip surgeries completed within 182 days (51.1%) remained **stable** compared to the same period last year (51.6%).
- Using a similar definition, Alberta ranked tied for 3rd among the 10 provinces for the highest percentage of hip replacements meeting the pan-Canadian benchmark of 26 weeks (AB = 59%; Canada = 65%; Best Performing Province = 75%) *(CIHI Apr-Sep 2021)*.

Percentage of Scheduled Knee Surgeries Performed Within CIHI Benchmark*

2017-18	2018-19	2019-20	2020-21	2021-22
64.6%	65.0%	61.5%	43.3%	39.7%

Source: Data extracted from hospital operating room data: PICIS, VAX, Meditech Operating Room Module and Alberta Wait Time Reporting, as of April 26, 2022.

- Data include elective and scheduled cases only.

-Data include surgeries performed within Alberta Health Services (including faith-based sites) and at contracted surgical facilities.

- This measure monitors the percentage of scheduled knee surgeries performed within the CIHI benchmark of 182 days. Performing surgeries within recommended timeframes supports improved health outcomes and patient satisfaction. The **higher the percentage the better,** as it demonstrates more procedures are being completed within clinically recommended timeframes.
- As of Q4YTD, the percentage of knee surgeries completed within 182 days (39.7%) **deteriorated** by eight per cent compared to the same period last year (43.3%).
- AHS is grateful for the patience of all Albertans who had their surgeries delayed as we took necessary steps to ensure our healthcare delivery system was prepared to respond to COVID-19. Decreasing wait times continues to be a priority for Alberta, and ASI strategies to improve wait times will be embedded throughout surgery recovery planning and implementation. Additional investments for these procedures is also occurring through the ASI including an expansion of orthopedic procedures including hip and knee arthroplasty through chartered surgical facilities.
- Using a similar definition, Alberta ranked 4th among the 10 provinces for the highest percentage of knee replacements meeting the pan-Canadian benchmark of 26 weeks (AB = 49%; Canada = 59%; Best Performing Province = 71%) *(CIHI Apr-Sep 2021)*.

Objective 5: Focus on health promotion through increased prevention of disease and injury.

AHS works with Alberta Health, patients, families and communities to improve the health of the population by preventing disease, illness and injury; managing chronic diseases; improving access to cancer screening, early detection and follow-up; protecting populations from health risks; and promoting public health policies.

**Note: The cataract, hip and knee surgery wait time interval used for comparison with the benchmark is the time a patient is assessed by a specialist as medically, physically able and willing to receive surgery to the date the surgery is performed.*

Actions and Achievements

Manage the COVID-19 pandemic

- In July 2021, contact tracing was discontinued in all but high-risk outbreak settings. In December 2021, case investigation was discontinued for all but high-priority settings. More than 228,000 cases of COVID-19 were investigated in 2021-22.
- AHS supported implementation of the Alberta Vaccine Booking System with pharmacies, Health Link and AHS services. The system supports both COVID-19 and influenza vaccine appointments. Since launching in August 2021, more than two million appointments have been scheduled through the system.
- Following completion of a condensed training program that focused on pandemic-specific competencies, Health Link nurses were hired to support the pandemic response and AHS' capacity to respond to increased COVID-19 call volumes. This year, 129 COVID-only nurses completed the Health Link training program which allowed them to work to the full scope of practice.
- Working with Alberta Health, AHS improved access through Indigenous vaccine clinics that supported off-reserve and off-settlement First Nations, Métis and Inuit populations. In 2021-22, 57 urban clinics offered vaccination, including four designed for children (ages 5-11).
- AHS developed new web resources to promote and share information about COVID-19 immunization for children (ages 5-11). The COVID-19 page for kids (www.ahs.ca/topics/page17746.aspx) had received more than 203,300 views since launching in October, and the *COVIDzilla* game had been accessed more than 27,000 times.
- In 2021-22, AHS launched three Inter-professional Outpatient Program (IPOP) clinics aimed at providing wrap-around care for long-COVID patients suffering from severe symptoms at 12 weeks post-infection. The program connects primary care, specialists and allied health professionals with AHS' Community Accessible Rehabilitation to provide services based on patient need. IPOP clinics can be accessed virtually or in person.

Increase childhood immunization and influenza immunization rates

- While many public health resources were redirected to the pandemic response, AHS continued to provide infant and preschool immunizations, prioritizing appointments at two, four, six and 12 months of age. In 2021-22, the DTaP- IPV-Hib (diphtheria, tetanus, pertussis (whooping cough), polio, haemophilus influenzae type b) immunization rate for children (by age 2) was 75 per cent. The MMR (measles, mumps, rubella) immunization rate for children (by age 2) was 85 per cent.
- Influenza immunization is the most effective way to prevent the flu and its complications. AHS focused on serving high-risk populations including seniors, people experiencing homelessness and marginalized persons who are most at risk for morbidity and mortality due to influenza disease. During the 2021-22 influenza season, 1.2 million doses of influenza vaccine were administered, covering approximately 27 per cent of Albertans. The immunization coverage rate decreased by 27 per cent compared to last season.

Return cancer screening and diagnostic follow-up to pre-pandemic levels

- Overall, breast, cervical and colorectal cancer screening volumes have returned to pre-pandemic levels; AHS continues to evaluate the impact of COVID-19 service disruptions on screening and diagnostic follow-up, and develop strategies to address the backlog. In 2021-22, AHS launched an outreach strategy focused on under and unscreened populations. As part of the campaign, several animated videos, translated into six languages, were developed to provide clear information on the importance of cancer screening and how to access screening services. Information is available at www.screeningforlife.ca.

- In partnership with Indigenous communities and organizations, AHS continued to fund and support 12 community-led cancer prevention and screening projects. In 2021-22, eight projects were concluded. Evaluation and knowledge translation is ongoing with participating communities.
- Care pathways were developed for colorectal cancer and lymphoma to expedite diagnosis and access to supports in the community for patients with high-risk symptoms. Implementation is complete in all zones. Preliminary data shows improved wait-times to diagnosis when the pathway is used.

Enhance a web-based platform for primary and secondary prevention programs in partnership with MyHealth Alberta

- Work continued to integrate population and public health websites under Healthier Together (part of the MyHealth Alberta online platform). The Healthier Together Schools website launched in April 2021 as the new virtual hub for AHS school health promotion. Since launching, the website had received more than 15,000 views from 9,118 unique visitors.

Reduce preventable harm

- In 2021-22, an analysis of Quality Assurance Reviews was completed to identify patient safety hazards to update the AHS *Patient Safety Plan.* Based on report findings, patient safety teams across the organization are collaborating to set priorities and will embed findings into Connect Care's real-time indicator capabilities.
- As a result of an evidence-based evaluation that determined bacterial co-infection is rare with COVID-19, order sets and care pathways were revised to reduce the unnecessary use of antibiotics. AHS teams continue to actively assess emerging COVID-19 drug therapies for possible use in Alberta.
- The provincial Personal Protective Equipment (PPE) Safety Coach program supports reduced transmission of infectious diseases in healthcare settings. Provincial implementation continues with more than 1,700 coaches trained to date.
- In 2021-22, AHS investigated 324 confirmed enteric outbreaks, which is a 72-per-cent increase compared to last year (188). Symptoms common to an enteric outbreak include nausea, vomiting and abdominal pain that may be caused by bacteria, viruses or parasites. This year, changes to reporting requirements led to increased specimen testing for enteric pathogens.
- In 2021-22, AHS investigated 4,878 confirmed non-enteric outbreaks, which is a 12-per-cent increase compared to last year (4,354). Examples of non-enteric outbreaks are chickenpox, measles, influenza and COVID-19. This year, outbreaks increased due to COVID-19 waves and increased transmission of variant strains which contributed to higher levels of community circulation.
- In 2021-22, AHS reported no cases of measles and no pertussis (whooping cough) outbreaks. As reported in 2020-21, this is the second year AHS has reported no cases of either illness.
- In 2021-22, 174 cases of lab-confirmed seasonal influenza were reported. The return of influenza cases this season is likely attributable to reduced restrictions related to travel and public health measures.

Continue work on injury prevention and managing chronic diseases and conditions

- The Fragility and Stability Program reduces the rate of secondary hip fracture related to osteoporosis and provides evidence-based care when fracture occurs. As of March 31, 2022, 11 sites have implemented the program.
- AHS developed a Primary Care Nutrition Pathway for Adults Aged 65+ (co-developed with the Canadian Malnutrition Task Force) to improve prevention, detection and treatment of malnutrition in community settings. In 2021-22, communities in Central Zone implemented the pathway and completed more than 270 nutrition risk screens. Approximately 60 per cent of patients were at nutrition risk and received support.

Implement Office of the Auditor General chronic disease management recommendations

- Working with Alberta Health, all actions recommended by the Office of the Auditor General related to chronic disease management have been completed. AHS made improvements to structures and processes that support overall system quality and efficiency.
- Timely access to gastroenterology specialty care is an issue across Alberta. Nine digestive health primary care pathways are now available online to increase visibility and adoption by primary care providers. Over a one-year period, gastrointestinal pathways prevented approximately 1,500 inappropriate specialty referrals.
- In 2021-22, the Disease-Inclusive Pathway for Transitions in Care (ADAPT) project began work to create a common care transitions pathway for Albertans with complex chronic conditions.

Support Zone Primary Care Network (PCN) Health Service Plans

- AHS plans services jointly with PCNs through the Zone PCN Service Planning process. Opportunities and gaps related to zone-wide alignment and integration of AHS and PCN services are identified in order to address priority health needs of the population. Through implementation of the plans, AHS and PCNs work together to support the primary health care needs of Albertans across all five zones, to improve access and ensure equitable service delivery. Progress reports were submitted to Alberta Health in November 2021.

Support health equity for Indigenous Peoples and communities

- Planning and development of the Indigenous 1-800 Support Line pilot program is nearly complete. Operated by Health Link, the dedicated support line will provide a safe and respectful place for Indigenous Peoples living in Alberta to receive culturally-informed guidance and health system navigation support.
- The Indigenous Patient Concerns and Experience project aims to improve the patient concerns experience for Indigenous Peoples. AHS implemented changes to the Feedback and Concerns Tracking database to include categories for concerns related to discrimination.
- The Integrated Access to Cancer Screening project is testing a new service delivery model that uses a nurse practitioner, in conjunction with mobile screen test services. More than 140 communities were served by 36 clinics, including 26 Indigenous communities, enabling 654 patients to receive integrated cancer screening services.
- The Indigenous Alberta Healthy Communities Approach supports First Nations communities and Métis Settlements to assess their needs, identify local opportunities, set priorities and take action with community and health partners to promote a healthy lifestyle and prevent cancer. This approach will create a platform for Indigenous cancer prevention and screening in Alberta, including an evaluation process which will be completed in spring 2023. To date, more than 400 community members have participated in cancer prevention and screening activities and programs developed or supported by these projects, with 68 per cent of participants reporting improved knowledge of cancer risk factors and healthy lifestyle choices.
- The Honouring Life (HL) program provides funding for the development of community-led projects that aim to increase local capacity for suicide prevention through life promotion and personal development supports for Indigenous youth. Since 2018, more than $10M has been provided to 54 Indigenous communities, Métis Settlements and Indigenous-serving community organizations. HL activities include recreational programs to promote wellness behaviours, knowledge sharing and learning opportunities, in-school and after-school programming, health services and education, and community-led initiatives such as feasts, culture camps, berry picking and community gatherings. Feedback from HL grantees suggests that creating opportunities for youth to engage with their peers, families, Elders and

the broader community greatly helps them to build strong, enduring connections with others and their surrounding environments. Program outcomes show that youth involved with HL-based programming have improved their capacity to identify resources, knowledge and practices to support positive mental health and advocate for themselves, each other and their communities.

Promote initiatives aimed at decreasing rates of syphilis and other sexually-transmitted infections

- This year, AHS began increasing outreach services in the community. For example, in partnership with AHS Addictions and Mental Health services, sexually-transmitted and blood-borne infections testing and treatment services continue to be offered to individuals experiencing addiction. AHS also continued work to increase treatment locations for infectious syphilis, including the availability of bicillin (medication commonly used in the treatment of syphilis) in Primary Care Networks, birth control centres and sexual and reproductive health clinics.
- Partner Notification Nurses encourage testing and provide information and counselling for those who have been exposed to a sexually-transmitted infection. In 2021-22, AHS worked together with the Fort McMurray First Nation Reserve to provide 'test and treat' services in the community. Outreach services were also re-established in Fort McMurray.
- The ECHO+ program aims to increase screening and supports for treatment of Hepatitis C and sexually-transmitted and blood-borne infections for Indigenous communities in Alberta. As of March 31, 2022, the program had engaged with 92 per cent of the 53 Indigenous communities in the province.

Performance Results Summary

Total Alberta Residents Who Received COVID-19 Vaccination (at least the first dose)

Doses	2020-21	2021-22
At Least First Dose	596,114 (13.5%)	3,583,790 (81.1%)
Second Dose	114,695 (2.6%)	3,386,054 (76.6%)

Source: Data was extracted from Imm/ARI by Alberta Health as of June 6, 2022.

- This is a cumulative measure; trend indicates continuous increase in vaccine uptake.

- At Least First Dose refers to people who have received the first dose only plus those who received the first and second dose. Second Dose refers to people who have received both doses.

- Results include vaccinations that took place in AHS sites and non-AHS sites (i.e., pharmacies, doctor's offices, etc.)

- The total population in Alberta was used as the denominator for the calculation of the percentage.

- This measure represents a cumulative count of Albertans who had received at least one dose of COVID-19 vaccine by the end of the reporting period. An effective vaccine will protect someone who receives it by lowering the chance of getting COVID-19 and/or providing protection against severe illness if the person encounters the coronavirus. The **higher the number the better,** as it demonstrates better vaccination coverage across the province.
- As of Q4YTD, the number of people who had received at least the first dose of COVID-19 vaccine (3,583,790) **improved** by 505 per cent compared to the same period last year (592,744).
- Using a similar definition, Alberta ranked 10th among the 10 provinces for the highest percent of the population with at least one dose of a COVID-19 vaccine. (AB = 80.22%, Canada = 84.92%; Best Performing Province = 95.93%) (*Public Health Agency of Canada as of May 22, 2022*).

Hand Hygiene Compliance Rate

2017-18	2018-19	2019-20	2020-21	2021-22
85%	87%	88%	92%	92%

Source: AHS IPC Surveillance and Standards, as of May 18, 2022; Covenant Health Infection Prevention and Control, as of April 5, 2022.

- This measure monitors the percentage of opportunities in which healthcare workers clean their hands during the course of patient care, according to the Canadian Patient Safety Institute's "Four Moments of Hand Hygiene". Hand hygiene is the single most effective strategy to reduce the transmission of infection in the healthcare setting. The **higher the percentage the better,** as it demonstrates more healthcare workers are completing appropriate hand hygiene practices.
- As of Q4YTD, the hand hygiene compliance rate (92%) remained **stable** compared to the same period last year (92%). Hand hygiene compliance has been steadily improving since 2017-18 with sustained results throughout the COVID-19 pandemic.

Objective 6: Improve health outcomes and access to safe, high-quality services for Albertans living in smaller communities, including Indigenous communities.

Working jointly with Alberta Health and healthcare providers, AHS is committed to creating a more integrated healthcare delivery system that provides local services that are co-designed with patients, families and communities. This includes efficiently and effectively delivering health services that respond to the needs of Albertans living in smaller communities, including Indigenous communities, which have unique cultural, economic and geographic characteristics.

Actions and Achievements

Work with Alberta Health to better meet the health needs of smaller communities

- Indigenous Cancer Patient Navigators support patients and families by advocating for patients, supporting traditional practices, and locating services and resources. This year, three navigators completed nearly 3,000 visits with 318 Indigenous patients through the Grande Prairie Cancer Centre, Cross Cancer Institute (Edmonton) and the Tom Baker Cancer Centre (Calgary).
- AHS has continued its targeted recruitment efforts to support the hiring of skilled healthcare workers across rural Alberta. As of March 31, 2022, the rural careers webpage had received over 44,500 views and more than 350 candidates showed interest in rural opportunities. This resulted in the placement of 106 healthcare workers.
- Established in 2014, the Indigenous Wellness Program Alternate Relationship Plan (ARP) compensates physicians for providing health services in Indigenous communities across the province. As of March 31, 2022, 22 communities were being served by 67 physicians under this ARP. Physicians have provided more than 30,700 visits at 20 facilities throughout Alberta (17 First Nation health centres and 3 urban clinics).

Work with Alberta Health to refine our service planning approach with communities across Alberta

- AHS is in the early planning stages with zones to complete service plans for small communities but progress was impacted by system pressures related to the COVID-19 pandemic.
- Long-range service plans for several programs operating in small communities across the province have been developed, including North Zone addiction and mental health and South Zone cardiac clinical services. A plan for provincial EMS is also in development, which supports the EMS 10-Point Plan.

Work with Alberta Health and PCNs to develop and test models of care within primary health care to support chronic disease prevention and management.

- In 2021-22, a primary care physician compensation model and community readiness analysis was completed to support future changes. AHS completed data analysis and identified priority communities for AH's new workforce model.

Performance Results Summary

Ambulatory Care Sensitive Conditions (ACSC) Hospitalization Rate

2017-18	2018-19	2019-20	2020-21	2021-22
333	317	308	231	244

Source: AHS Provincial Discharge Abstract Database (DAD), Patient/ Care-Based Funding Population database, as of May 2, 2022; Postcensal Canadian population estimate (2011) – Statistics Canada (Standard population).

- Provincial total hospitalizations include those with unknown zone records.

- The rate is age-standardized to the 2011 Canadian population and represents the number of ACSC hospitalizations that would be expected per 100K population if the age distribution of Alberta residents was similar to the Canadian population in 2011.

- This measure monitors hospitalizations per 100,000 Alberta residents for medical conditions where appropriate ambulatory care could potentially prevent or reduce the need for admission to hospital. Appropriate care leads to better overall patient health as well as better utilization of resources by avoiding unnecessary hospitalizations. The **lower the rate the better,** as it demonstrates effective primary care and community-based management of these conditions.
- As of Q4YTD, the ACSC hospitalization rate per 100,000 Alberta residents (244) **deteriorated** by six per cent compared to the same period last year (231).
- Creating a more integrated healthcare delivery system ensures that care is provided in the right setting. The increase in hospitalizations for ACSCs, when compared to the same period last year, may be due to multiple factors including overall lower hospital volumes in 2020-21 starting to recover in 2021-22. This increase might also be the result of Albertans not seeking timely care during earlier stages of the COVID-19 pandemic which contributes to exacerbated conditions and higher acuity when presenting for care.
- Using a similar definition, Alberta ranked 4th among nine provinces for fewest admissions for ambulatory care sensitive conditions per 100,000 (AB = 237; Canada = 251; Best Performing Province = 221) *(CIHI, 2020-21)*.

Goal 3: Improve the Experience and Safety of our People

Objective 7: Continue to implement 'Our People Strategy'.

Our People Strategy guides our efforts to enhance the experience of our people while sustaining safe, high-quality healthcare service delivery. 'Our People' refers to the employees, physicians, midwives and volunteers at AHS.

Actions and Achievements

Enhance the experience of our people

- The AHS *Respectful Workplaces and Prevention of Harassment and Violence* policy suite supports a workplace that is safe and healthy. As of March 31, 2022, 72,489 employees had completed the required Level 1 policy course and 14,455 employees had completed the Level 2 course.
- In 2021-22, AHS launched the Employee Development Program and Leadership Development Program which aim to deepen the understanding of AHS values and competencies and develop behaviours that help put those values into action. More than 100 leaders and 54 employees participated in these 12-week programs.

Continue our commitment to diversity, inclusion, cultural competency and sensitivity

- AHS launched its *Anti-Racism Position Statement* on June 30, 2021, as part of continued efforts to combat racism and promote diversity and inclusion across the organization.
- AHS continued to develop new Change the Conversation resources which empower our workforce to engage in dialogue on challenging topics by providing the necessary language and tools. This year, resources were launched on topics including neurodiversity, disability, Black history in Canada and trauma.

Increase psychological safety and mental health and wellness supports

- Not Myself Today is an initiative offered by the Canadian Mental Health Association that works towards building greater employee awareness and understanding of mental health, reducing stigma and fostering safe and supportive cultures. AHS rolled out the program across the organization in September 2021.
- In collaboration with the Employee and Family Assistance Program (EFAP), AHS offers weekly wellness seminars on a variety of topics, including sessions focused on pandemic-related challenges such as stress, fatigue and crisis management. In 2021-22, more than 6,500 employees attended 193 seminars.
- The *Headversity* EFAP App proactively builds mental health resiliency. In 2021, more than 1,600 users used the app, completing more than 2,900 total hours of training.
- The Provincial Addiction & Mental Health Curricula and Experiential Skills (PACES) Learning Pathway launched in fall 2021 and advances learners through core-competency development and skill-training opportunities for practitioners who interact with adult populations experiencing concurrent disorders.
- AHS is offering the Canadian Crisis and Trauma Resource Institute's Trauma Informed Leadership workshop to promote awareness and interest within medical leadership to bring a trauma-

informed approach to their leadership. Since its launch in Q3, approximately 415 medical leaders have participated in the workshop.

Reduce musculoskeletal injuries in our workforce

- An Office Ergonomics course was developed and includes an Alternate Working Arrangement hazard identification assessment and control document to support improved risk management while working from home. As of March 31, 2022, more than 1,500 workers had completed the course.
- Staff in emergency departments and urgent care centres experience some of the highest rates of harassment and violence in the workplace. Harassment and violence prevention plans are in development for approximately 25 sites across the province. Two sites implemented plans in 2021-22.
- AHS launched the *Violence Aggression Screening Tool* (VAST) which gives healthcare teams a way to identify and address patient behavioural safety concerns. The tool is part of the Behavioural Safety Program and is currently available through Connect Care for Launch 1-3 sites.

Build Indigenous workforce representation and supports

- An Indigenous recruitment and retention engagement strategy is in the early stages of development. Workforce demographics data is being gathered and analyzed.
- A dedicated e-mail address (Indigenous.talent@ahs.ca) was created to support Indigenous job seekers experiencing barriers to employment at AHS by providing coaching and advice. An Indigenous Applications section was also added to the AHS careers webpage (www.ahs.ca/careers/Page13096.aspx).
- AHS has partnered with the Rupertsland Institute to offer summer employment through the Métis Youth Summer Student Employment Program which helps Métis youth investigate different career options in healthcare.

Optimize staffing models through evidence-based approaches

- In alignment with *AHS Performance Review* recommendations, AHS is using provincial overtime guidelines to ensure a consistent approach to approving and tracking overtime across the organization.
- AHS developed and validated the *Nursing Workload Acuity Tool* in Connect Care which will be used to inform real-time staffing decisions based on the intensity of care required by a given patient population.
- AHS is in the process of transitioning scheduling activities into a provincial model called Provincial Staffing Services which enables fair and equitable practices through standardization and automation. In 2021-22, more than 8,200 new users were added to the environment for scheduling personnel.

Optimize organizational design

- In alignment with recommendations from the *AHS Performance Review*, the AHS Management Review aims to identify organizational design improvements by conducting a portfolio-by-portfolio assessment of management roles. Implementation timelines continue to be impacted by pandemic response demands. Changes are being made through attrition where feasible.

Performance Results Summary

AHS Workforce Engagement

2016-17	2019-20
3.46	3.57

Source: AHS People portfolio.

- Workforce engagement rate is specific to AHS Employees only, and excludes physicians, volunteers, and midwives.

- This measure monitors our workforce's average responses to the AHS Our People Survey, which uses a five-point rating scale. The rate shows our workforce's commitment to AHS, their work and their colleagues. The **higher the rate the better,** as it demonstrates that more employees feel positive about their work and workplace. High engagement leads to higher productivity, safer patient care, and increased willingness to give discretionary effort at work.
- The 2019-20 workforce engagement rate was 3.57 out of 5. The next survey is expected to be completed in 2022-23.

Disabling Injuries in AHS Workforce

2017-18	2018-19	2019-20	2020-21	Q3YTD 2020-21	Q3YTD 2021-22
4.11	4.12	4.14	5.24	5.33	4.56

Source: WCB Alberta and e-Manager Payroll Analytics (EPA). EPA 2017-21 YTD data as of June 2020. WCB data April-June 2020 as of September 2020. Data retrieval: April 28, 2022.

- This measure monitors the number of AHS workers injured seriously enough to require modified work or time loss from work per 200,000 paid hours (approximately 100 full-time equivalent workers). Understanding this rate enables the organization to identify workplace health and safety programs that will provide AHS employees, volunteers and physicians with a safe and healthy work environment and keep them free from injury. The **lower the rate the better,** as it indicates fewer disabling injuries are occurring at work.
- As of Q3YTD, the disabling injury rate (4.56) **improved** by 14 per cent compared to the same period last year (5.33). This measure is reported one quarter later to allow for more accurate reporting as injuries sustained within the quarter are often reported retroactively outside the quarter.
- AHS employees reported fewer injuries overall with notable decreases in respiratory injury/ illness and dermatitis. However, employees continued to report injuries related to anxiety, stress and fatigue, as well as psychological trauma, which is partially attributable to the high demands of the ongoing pandemic response.

Goal 4: Improve Financial Health and Value for Money

Objective 8: Support financial sustainability through cost-saving initiatives and reduced expenditures.

Working as the health authority responsible for delivering services across the province, AHS is in a unique position to support the sustainability of healthcare service delivery. AHS remains committed to providing high-quality services, while maintaining strong fiscal stewardship of public resources.

Actions and Achievements

Manage within the operating budget by implementing savings initiatives

- AHS continues to progress work on more than 66 initiatives from the *AHS Performance Review*, as approved by the Government of Alberta. AHS provides regular progress updates as part of its accountability to Alberta Health. As of March 31, 2022, AHS has achieved $144M in total cumulative savings.
- AHS is actively reviewing and terminating unneeded contracts and leases that have resulted from the implementation of remote and hybrid staff work arrangements that began during the COVID-19 pandemic. This work aligns with recommendations from the *AHS Performance Review.*

Manage expenses by limiting discretionary spending and managing vacancies

- In alignment with recommendations from the *AHS Performance Review,* all vacant positions in the organization are being reviewed and, where appropriate, removed from the system.
- AHS monitors discretionary expenses regularly across the organization and spending has been reduced in this area. The two areas with the most significant reductions are travel and education expenses. Permanent spending reductions were implemented, in alignment with recommendations from the *AHS Performance Review.*

Pursue revenue-generating initiatives

- In alignment with recommendations from the *AHS Performance Review,* opportunities to sell corporate advertising on both physical and digital properties are being explored. To date, zoning and bylaw assessments have been conducted to determine pilot sites for parkade advertising.
- In 2021-22, AHS implemented new inpatient per diem fees for out-of-province and out-of-country patients with inpatient stays at acute, sub-acute, and auxiliary hospital sites. This change was part of the annual rate-review process that aims to align the daily fee with the current cost of caring for a patient.
- In 2021-22, AHS shifted to Alberta-specific outpatient fee rates for services provided to out-of-province and out-of-country patients in approved hospitals or community ambulatory care centres. Prior to this change, standard national rates were used by all Canadian jurisdictions which resulted in significant gaps between outpatient fees and the cost incurred to provide outpatient services.

Pursue opportunities for asset optimization, automation, contracting and outsourcing

- In alignment with recommendations from the *AHS Performance Review*, AHS continues to explore opportunities to expand robotic process automation (RPA) which uses software to automate manual processes such as data entry. Benefits include reduced error rates and cost savings. RPAs have been implemented for 16 processes, totaling more than 900,000 items processed to date. These efficiencies have freed more than 26,000 hours of capacity.
- AHS completed the provincial transition to a private provider for all standard and operating room linen services. Contracting out linen services promotes consistency and quality while presenting ongoing capital and operating savings over the life of the contract. This work aligns with recommendations from the *AHS Performance Review*.\
- Approximately 130 laboratories across Alberta perform more than 80 million tests annually. In alignment with recommendations from the AHS Performance Review, AHS and Alberta Precision Laboratories are pursuing opportunities to contract out community laboratory services to a third-party provider to optimize services across the province. This model allows for consolidation of testing, where appropriate, to reduce redundancy and leverage benefits realized through economies of scale. In Q1 2021, AHS announced DynaLIFE Medical Labs as the preferred proponent. Negotiations continue with the effective date and transition of services targeted for December 2022. DynaLIFE's current agreement will be further extended from June 30, 2022 until December 4, 2022.
- In order to optimize the organization's Protective Services model, AHS is increasing the ratio of contracted security personnel at several AHS locations which will mitigate risks related

to workforce supply and availability. In 2021-22 progress was made by filling 34 existing vacancies with contracted providers. The increased demand for security services during the COVID-19 pandemic has required AHS to expand use of contracted providers to meet evolving organizational requirements that places patient, visitor and staff safety at the forefront. This work aligns with recommendations from the *AHS Performance Review.*

Streamline procurement and supply chain management

- In alignment with recommendations from the *AHS Performance Review*, AHS is exploring opportunities to contract a provincial Managed Equipment Service that aims to improve cost-effectiveness and access to current, state-of-the-art technology. In 2021-22, a request for information received 35 submissions from 14 unique vendors across five categories (diagnostic imaging, endoscopy, central monitoring, operating room infrastructure and other). This information will be used to develop a request for proposal.

Improve clinical utilization and efficiency of clinical support services, and expand clinical appropriateness initiatives

- AHS continued to leverage operational best practice (OBP) methodology to optimize staffing based on patient demand. Across all acute care sites, after adjusting for COVID-19 disruptions, 48 per cent of units are achieving their OBP staffing targets, exceeding the target of 45 per cent. This work aligns with recommendations from the *AHS Performance Review.*
- Chimeric antigen receptor (CAR) T-cell therapy is an innovative treatment that uses a patient's own immune system to battle cancer cells. The Alberta Cellular Therapy program began accepting patients in 2020-21 for the treatment of lymphoma and leukemia. Since opening in March 2021, 23 patients have received treatment through the program; 10 of these patients received T-cells manufactured locally in Alberta.
- Venting Wisely is an evidence-informed care pathway that leverages team-based care and expertise to improve intensive care unit capacity, care outcomes and perceptions of care quality among patients with respiratory failure requiring mechanical ventilation. Implementation has occurred at 15 of the province's 17 adult ICUs, with all implemented sites exceeding the target of 70 per cent adherence to the pathway.
- Blood Conservation is an evidence-based approach that reduces ineffective, potentially harmful and costly practices regarding the use of blood products and blood testing. Since the rollout, AHS has achieved a 33 per cent relative reduction in low-value albumin use, and 649 patients have avoided unnecessary blood products administration which prevented more than 1,400kg of biomedical waste.

Reduce inefficiencies within the healthcare delivery system

- AHS is working closely with Alberta Health to review the number of policies and forms used in the organization. As of March 31, 2022, AHS had achieved a reduction of more than 1,850 forms and more than 1,950 policy documents, representing a 24-per-cent overall reduction. This achievement exceeded the expected reduction target of 20 per cent.

Continue quality improvement work to reduce hospital length of stay

- Care pathways for surgery are being implemented across adult acute care sites. The National Surgical Quality Improvement Program (NSQIP) has been implemented at all high-acuity adult sites as well as two pediatric sites. In Q3, the median surgical site infection (SSI) rate at NSQIP-enabled sites improved by eight per cent compared to the same period last year. SSIs contribute to poorer health outcomes and longer lengths of stay.
- A *Pediatric Glycemic Management* policy suite was released to support the early recognition and treatment of both hypoglycemia and hyperglycemia in pediatric populations.

Performance Results Summary

Annual Rate of Change in Operational Expenditures

2017-18	2018-19	2019-20	2020-21	2021-22	Target 2021-22
2.5%	3.7%	1.8%	-1.2%	2.2%	3.9%

Source: AHS Annual Audited Consolidated Financial Statements, External Financial Reporting, Finance, AHS general ledger (e-Manager), as of June 1, 2022.

- This measure reflects AHS operational expenditures only.

- This measure monitors the year-over-year change in AHS' operational expenditures (excluding incremental COVID-19 expenses) which are expenses incurred during regular, day-to-day operation such as salaries, benefits and medical supplies. The **lower the percentage the better,** as it demonstrates lower expenditure growth over time.
- The 2021-22 annual rate of change in operational expenditures (2.2%) **achieved target.**

AHS Estimated Cost of a Standard Hospital Stay

2017-18	2018-19	2019-20	2020-21	2021-22
$7,997	$8,118	$8,266	$9,571	$9,172

Source: AHS Provincial Discharge Abstract Database (DAD), AHS General Ledger, Covenant General Ledger and Stat General Ledger, as of April 29, 2022.

- This indicator is calculated by dividing the zone's total inpatient cost by its total acute inpatient weighted cases (obtained from the Discharge Abstract Database).

- Note that the methodology used by AHS is different than that of the Canadian Institute for Health Information resulting in slight differences between the sources.

- This measure monitors the cost-efficiency within hospitals by comparing a hospital's total acute inpatient care expenses to the number of acute inpatient cases, adjusting for differences in the type and acuity of inpatients treated. Acute care hospitals are one of the most expensive sectors of the healthcare system. The goal is to provide safe, high-quality care while keeping costs down. The **lower the value the better,** as it indicates that the cost of treating the average acute inpatient is relatively low.
- As of Q4YTD, the cost of a standard hospital stay ($9,172) **improved** by four per cent compared to the same period last year ($9,571).
- The effects of COVID-19 were first seen in 2020-21 when acute inpatient expenses increased with additional COVID-19-related costs (e.g., personal protective equipment, overtime for isolating staff, etc.) with simultaneous declines in inpatient cases (e.g., cancelled elective surgeries, public health advice to only go to hospitals when necessary, etc.), leading to a large increase in the cost of a standard hospital stay. This year, inpatient cases rose, though not to pre-pandemic levels, and inpatient costs grew more slowly, which has started to reverse the effects seen last fiscal year.
- Alberta ranked 10th among the 10 provinces for the lowest cost of a standard hospital stay (AB = $9,149; Canada = $7,619; Best Performing Province = $6,640) *(CIHI 2020-21)*.

Acute Length of Stay Compared to Expected Length of Stay (ALOS:ELOS)

2017-18	2018-19	2019-20	2020-21	2021-22
1.03	1.03	1.03	0.99	0.99

Source: AHS Provincial Discharge Abstract Database (DAD), as of April 29, 2022.

- This measure monitors the number of acute days that a patient stays in an inpatient hospital compared to the length of stay that is expected based on factors such as patient age, diagnoses, and interventions. To improve service delivery, it is important to manage the length of time patients remain in hospital and improve discharge and transitions from acute care to ensure the most efficient utilization of hospital beds. A **ratio of 1.0 represents a patient stay equal to the expected length of stay.** A ratio less than one indicates the acute stay was shorter than expected, and vice versa.

- As of Q4YTD, the ALOS:ELOS ratio (0.99) remained **stable** compared to the same period last year (0.99).
- Using a similar definition, Alberta ranked 3rd among nine provinces for the lowest ALOS:ELOS ratio (AB = 0.99; Canada = 0.96; Best Performing Province = 0.91) *(CIHI, 2020-21)**.

30-day Overall Unplanned Readmissions

2017-18	2018-19	2019-20	2020-21	Q3YTD 2020-21	Q3YTD 2021-22
9.4%	9.5%	9.4%	9.2%	9.3%	9.2%

Source: CIHI Your Health System: Insight, as of April 25, 2022.

- Results were adjusted by using the Canadian average rate of the Overall Readmission in 2018-19.

- This measure monitors the percentage of patients who are unexpectedly readmitted to hospital within 30 days of discharge following medical, surgical, pediatric or obstetric care. Readmission rates can be influenced by the quality of care provided, the effectiveness of the care transitions and coordination, and the availability and use of community programs. The **lower the percentage the better**, as it demonstrates appropriate discharge planning and continuity of services.
- As of Q3YTD, the percentage of unplanned readmissions (9.2%) remained **stable** compared to the same period last year (9.3%). This measure is reported one quarter later due to requirements to follow up with patients after end of reporting quarter.
- Using a similar definition, Alberta ranked tied for 3rd among nine provinces for the lowest percent of all patients readmitted to hospital (AB = 9.2%; Canada = 9.4%; Best Performing Province = 8.5%) *(CIHI, 2020-21)*.

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

Financial Summary

Financial Statement Discussion and Analysis

For the year ended March 31, 2022

This Financial Statement Discussion and Analysis (FSD&A) provides a financial overview of the results of Alberta Health Services' (AHS) operations and financial position for the year ended March 31, 2022. The FSD&A reports to stakeholders how financial resources are being utilized to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans. It serves as an opportunity to communicate with stakeholders about AHS' 2021-22 financial performance, as well as cost drivers, strategies, and plans to address financial risk and sustainability.

This FSD&A has been prepared by and is the responsibility of AHS management and should be read in conjunction with the March 31, 2022 audited consolidated financial statements, notes, and schedules.

Additional information about AHS is available at www.albertahealthservices.ca

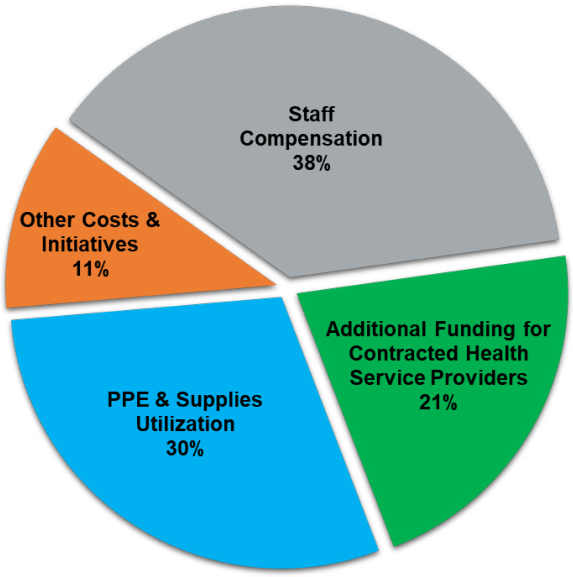
Highlights

The COVID-19 pandemic continued to place unprecedented demands on the healthcare system. AHS successfully navigated this challenge while also managing spending and working towards supporting the provision of providing patient-focused quality care that is accessible for all Albertans. Despite the uncertainty caused by evolving COVID-19 variants over the year, staff, physicians, and contracted providers continued to deliver high quality and safe healthcare services to Albertans.

AHS' 2021-22 pandemic response highlights

- More than 20,000 patients with COVID-19 were cared for in hospitals.
- AHS completed over 2.8 million COVID-19 lab tests and provided over 800,000 rapid test kits to schools and pharmacies.
- Over 800 AHS vaccination service locations operated during the year.

The significant costs incurred by AHS related to the COVID-19 pandemic were primarily funded by Alberta Health transfers. The total incremental expenses associated with the COVID-19 response exceeded $1.6 billion in fiscal 2021-22 ($1.3 billion in 2020-21).



The 2021-22 incremental COVID-19 expenses increased $336 million from the prior year, including higher costs related to staffing levels and overtime in acute care, Health Link services, contact tracing, the distribution of rapid test kits to schools and pharmacies, additional funding for contracted health service providers, and operational costs associated with vaccination centres.

Over the past year, a number of planned initiatives experienced delays to accommodate and enable staff redeployment to support the COVID-19 pandemic response. As a result, AHS finished the year with a $142 million annual operating surplus, representing 0.8% of total expenses.

Despite the impact of the COVID-19 pandemic, AHS made progress in a number of important areas outlined in AHS' 2021-22 Business Plan.

- An additional $127 million was invested in continuing, community, and home care initiatives such as, the Continuing Care Capacity Plan (CCCP), Residential Recovery Services, Opioid Dependency Program, and Indigenous Wellness. AHS also provided additional funding to relieve inflationary pressures for contracted providers.
- AHS invested $18 million more than the prior year in diagnostic and therapeutic services. Over nine million more lab tests were completed than in the prior year as testing resumed to pre-pandemic levels. MRI and CT scans also increased 11% from the prior year as part of the ongoing MRI and CT Implementation Plan.
- AHS continued to invest in and expand its transformative provincial clinical information system, Connect Care, investing over $223 million in operating and capital expenditures in 2021-22 ($978 million since 2017-18).
- COVID-19 had a significant impact on surgical procedures in Alberta. AHS had originally planned to increase surgical volumes to eliminate backlogs and reduce the waitlists for non-urgent surgeries as part of the Alberta Surgical Initiative (ASI). Although AHS was operating at pre-pandemic surgery levels during summer 2021, AHS' backlog grew during the subsequent COVID-19 waves. Continuing to reduce this backlog for Albertans will remain a top priority for AHS in 2022-23.
- The pandemic also served as a catalyst for healthcare innovation and adaptation, notably the wider adoption and acceptance of virtual care. These changes highlight opportunities for AHS to drive and support the expanded use of telehealth and virtual care.

Key Financial Trending

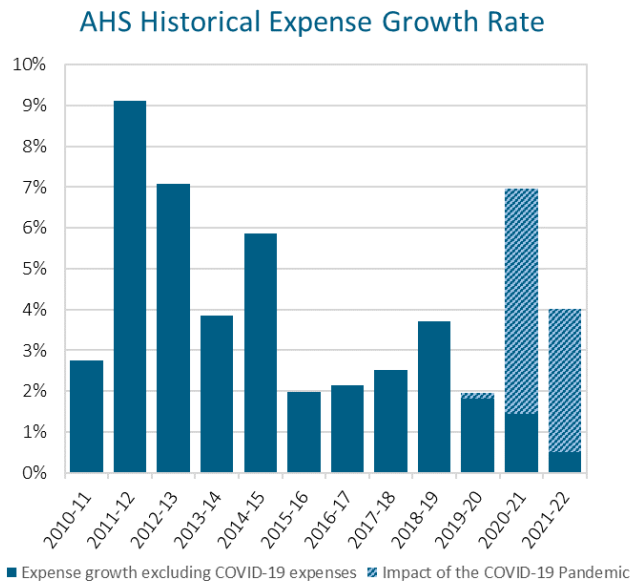
Annual Operating Surplus (Deficit)

AHS' annual operating surpluses and deficits have been less than 1% of total expenses in each of the past five fiscal years.

(in $ millions)	2022	2021	2020	2019	2018
Revenues	17,498	16,789	15,468	15,274	14,856
Expenses	17,356	16,685	15,614	15,313	14,765
Annual operating surplus (deficit)	**142**	**104**	**(146)**	**(39)**	**91**
Accumulated Surplus	1,378	1,236	1,132	1,278	1,317

Expense Growth

As Alberta's population grows and ages, the demand for healthcare services continues to increase. Alberta's inflation rate in March 2022 was also at its highest rate in over 30 years. These factors are driving increased demand and costs across all areas of the healthcare system.



Through various savings initiatives, AHS has slowed the rate of expense growth. AHS' expenses (excluding the impact of COVID-19) have increased by an average of 2.0% per year over the past seven years. However, AHS' average expense growth rate (excluding the impact of COVID-19) was lower than Alberta's inflation and population growth during this period.

144 Million

AHS Review - Cumulative and One-time Savings

AHS continued to make progress on the AHS Performance Review initiatives. AHS has achieved over $144 million in cumulative and one-time savings since April 1, 2020, which have been realized in a number of areas, including:

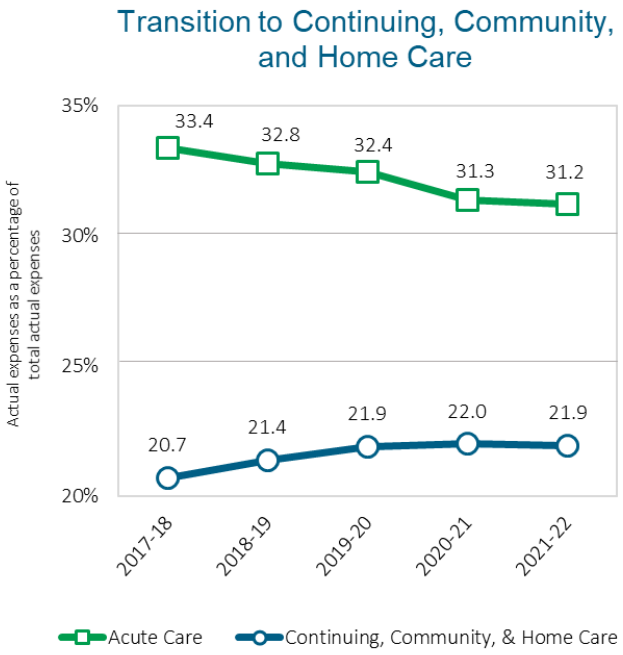
- Changes in service delivery models such as laundry and linen outsourcing.
- Reduction in the number of management positions.
- Insurance premium savings.
- Consolidation of regional dispatch operations in Emergency Medical Services (EMS) communication centres.
- Discretionary savings, such as travel, education, and office supplies.
- Operational Best Practices (OBP) and vacancy management.

These savings along with other sustainability initiatives, have contributed to improving Alberta's per capita health spending national ranking[1].

[1] Alberta Government (n.d.) Provincial Government Health Expenditures Comparisons (Calendar Year). Retrieved from Alberta.ca https://healthanalytics.alberta.ca/SASVisualAnalytics/?reportUri=%2Freports%2Freports%2F6875a53b-928b-4ec1-920d-d237c7c5194b&sectionIndex=0&sso_guest=true&reportViewOnly=true&reportContextBar=false&sas-welcome=false

Continuing, Community, and Home Care

Although Alberta has one of the youngest populations in Canada, by 2046 one in five Albertans is projected to be age 65 or older[2]. The COVID-19 pandemic has reinforced the need to protect higher-risk populations such as residents and staff at continuing care facilities. Therefore, it is important AHS continue to expand continuing, community, and home care options to ease pressures on hospitals so resources can be redirected to allow Albertans to receive safe and quality care in their homes and communities.



AHS' continuing, community, and home care expenses increased $135 from the prior year, representing 21.9% of total expenses, an increase of 1.2% since 2017-18, while the proportion of acute care expenses continued to decrease during the same period.

Workforce

The largest cost for AHS is workforce compensation. Calculated Full Time Equivalents (FTEs) is a useful measure for analysing the demands placed on the health care system as it normalizes for the timing of new hires, and the prevalence of overtime, relief, and part-time employees, which is common in healthcare settings. FTEs are calculated as actual hours earned (including worked hours, vacation, training, overtime, and relief hours), divided by 2022.75 hours — the annual hours of a full-time employee.

Calculated FTE	2021-22	2020-21	Increase (Decrease)	
			FTE	%
Clinical staff[3]	54,214	52,767	1,447	2.7
Other staff[4]	30,285	28,395	1,890	6.7
Management – includes both clinical and other management	3,187	3,253	(66)	(2.0)
Total FTEs	**87,686**	**84,415**	**3,271**	**3.9**

The increase in calculated FTEs in 2021-22 was mainly due to the increased number of employees and overtime required to respond to the COVID-19 pandemic. AHS' workforce grew in 2021-22, with the vast majority being temporary and casual employees hired for contact tracing, Health Link, assessment and vaccination centres, and patient care. Overtime hours were also more than 50% higher than the prior year, mainly due to the COVID-19 pandemic response. The need for overtime was also influenced by higher rates of sick leave during year, which was up almost 20% from the prior year due to COVID-19.

AHS continues to be one of the most efficiently managed public sector organizations in Canada, with clinical and other managers overseeing an average of 34 employees. The average ratio for Canadian public agencies, according to the most recent Conference Board of Canada report was nine employees per manager[5].

[2] Alberta Treasury Board. (n.d.). Alberta Population Projections 2021 – 2046 infographic. Retrieved from Alberta.ca https://open.alberta.ca/dataset/45d8dc72-58d7-4b92-b3e6-589cf1869233/resource/7025f40d-99b7-4709-ae88-05c6bb9872bd/download/alberta-population-projections-infographic-2021-2046.pdf

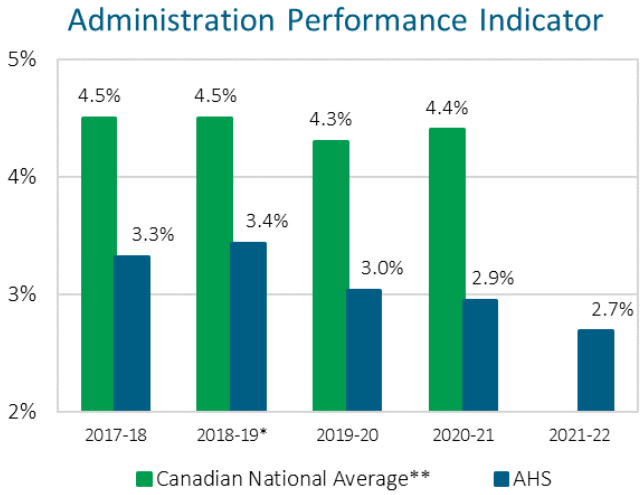
[3] Clinical staff are comprised of AHS' medical doctors, regulated nurses, health technical and professional staff, and unregulated health service providers.

[4] Other staff includes support services employees such as food services, facilities and maintenance, clerical, and administrative support staff.

[5] Conference Board of Canada. (2017). Talent Management Benchmarking: Human Resources Trends and Metrics. Retrieved from Ottawa: The Conference Board of Canada.: https://www.conferenceboard.ca/e-library/abstract.aspx?did=8551

Administration

The Canadian Institute of Health Information (CIHI) reports the corporate services expense ratio as a financial performance indicator based on administration expense as a percentage of total expenses[6]. Last year, AHS' indicator was 2.9% which was the lowest in the country. For 2021-22 AHS' indicator is 2.7%. The decrease in the ratio is primarily due to COVID-19 related costs which increased expenses to a greater extent in other segments of AHS' operations, mainly diagnostic and therapeutic services and population and public health. Increased savings and vacancies also contributed to the reduction.



** Certain amounts have been reclassified to conform to subsequent years presentation*
***CIHI Canadian national average for the administration indicator for 2021-22 was not available at the time of publication of this report.*

AHS continues to have one of the leanest administrations in health care in Canada and continues to look for ways to ensure administrative systems and processes are as efficient and effective as possible, while investing in areas such as quality initiatives, infection control, and research and innovation.

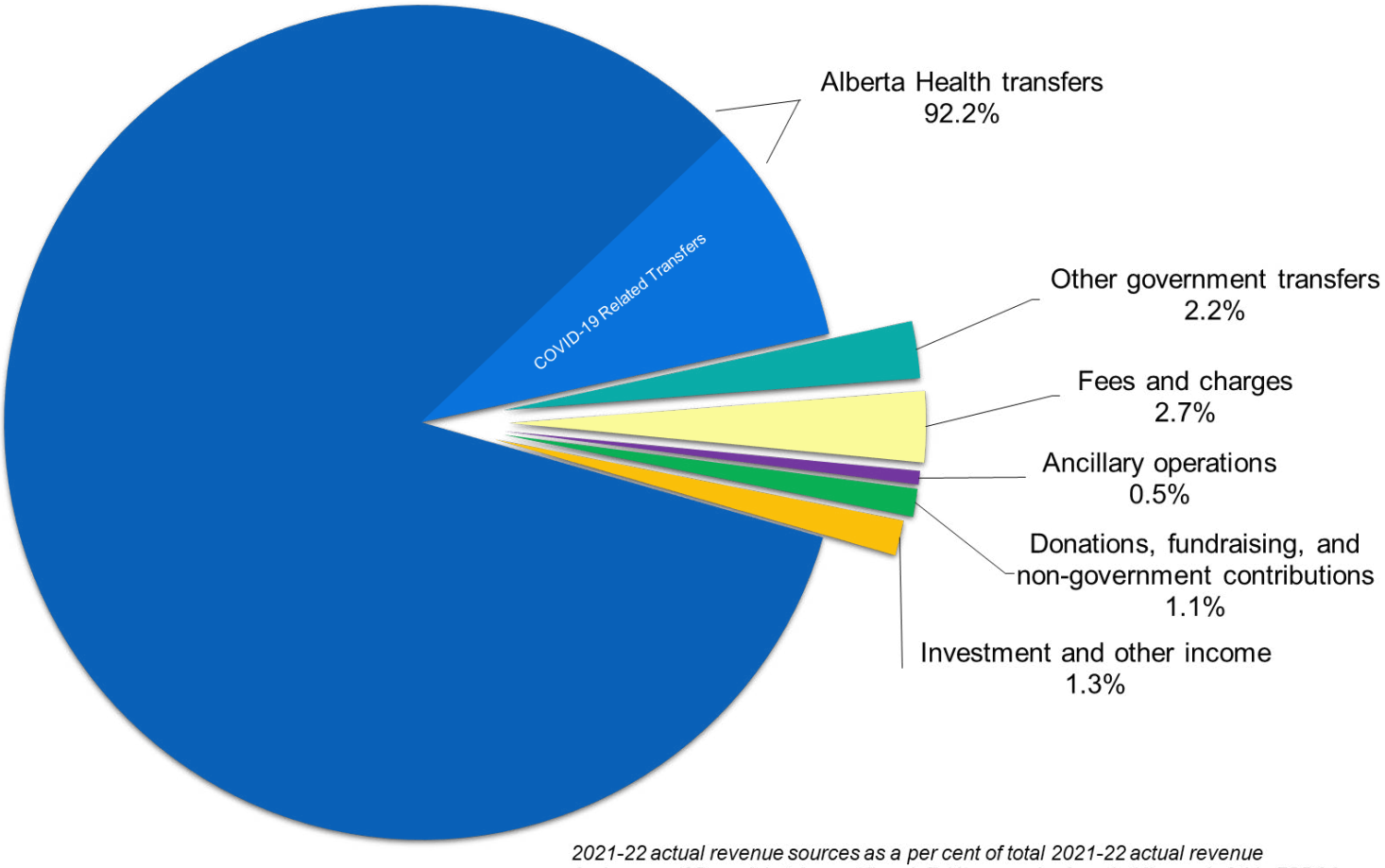
[6] Canadian Institute for Health Information. (n.d.). Your Health System. Retrieved from Interactive Map: Corporate Services Expense Ratio (Percentage), 2020-21: https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/indicator/041/2/C20018/

Financial Analysis

AHS discloses its results from operations in its consolidated financial statements by function on the Statement of Operations and by object on Schedule 1. Actual financial results for 2021-22 operations are analyzed in comparison to the budget and the prior year in this report. A glossary of financial statement line definitions can be found at the end of this FSD&A. An analysis of AHS' financial position compared to prior year is also discussed in this section.

Operations

Revenues



2021-22 actual revenue sources as a per cent of total 2021-22 actual revenue
A glossary of financial statement line definitions can be found at the end of this FSD&A

Alberta Health transfers accounted for 92.2% of AHS' total revenues in 2021-22 (2020-21 – 92.0%). The increase in the proportion of Alberta Health revenues to total revenues is a result of the COVID-19 pandemic, including a combination of additional COVID-19 related transfers and a decrease in other revenue sources, such as fees and charges and ancillary operations. AHS' total revenues amounted to $17,498 million, which was $1,502 million or 9.4% higher than the budget of $15,996 million due to unbudgeted Alberta Health COVID-19 related transfers.

(in $ millions)	Budget 2021-22	Actual 2021-22	Actual to Budget Variance	Actual 2020-21	Year over Year Increase (Decrease)
Alberta Health transfers	14,534	16,124	1,590	15,459	665
Other government transfers	455	383	(72)	462	(79)
Fees and charges	525	478	(47)	422	56
Ancillary operations	145	91	(54)	53	38
Donations, fundraising and non-government contributions	177	186	9	185	1
Investment and other income	160	236	76	208	28
Total revenues	**15,996**	**17,498**	**1,502**	**16,789**	**709**

Actual to Budget

Alberta Health transfers were over budget due to unbudgeted transfers for the COVID-19 pandemic response.

Other government transfers were under budget due to lower than anticipated recognition of externally funded capital revenue related to a change in the useful life of certain AHS facilities which occurred near the end of the previous fiscal year. Unbudgeted receipt of drugs, Personal Protective Equipment (PPE), and supplies from the federal government to support the COVID-19 pandemic response partially offset the variance.

Fees and charges were under budget due to the COVID-19 pandemic which resulted in the delayed implementation of certain revenue initiatives and a lower than budgeted number of patients who were provided care that is billable to other provinces and non-residents of Canada.

Ancillary operations were under budget due to the COVID-19 pandemic which resulted in lower revenues from parking operations and retail food services.

Donations, fundraising and non-government contributions were over budget due to the unbudgeted utilization of high-cost cancer drugs received at no cost from suppliers and subsequently provided at no cost to patients as part of compassionate drug access programs.

Investment and other income was over budget mainly due to higher than anticipated recoveries from external entities.

Year over Year

Alberta Health transfers were higher than the prior year due to an increase in base operating funding and increased transfers related to the COVID-19 pandemic response, newly approved cancer drugs, and various other programs, including addiction and mental health and physician services programs.

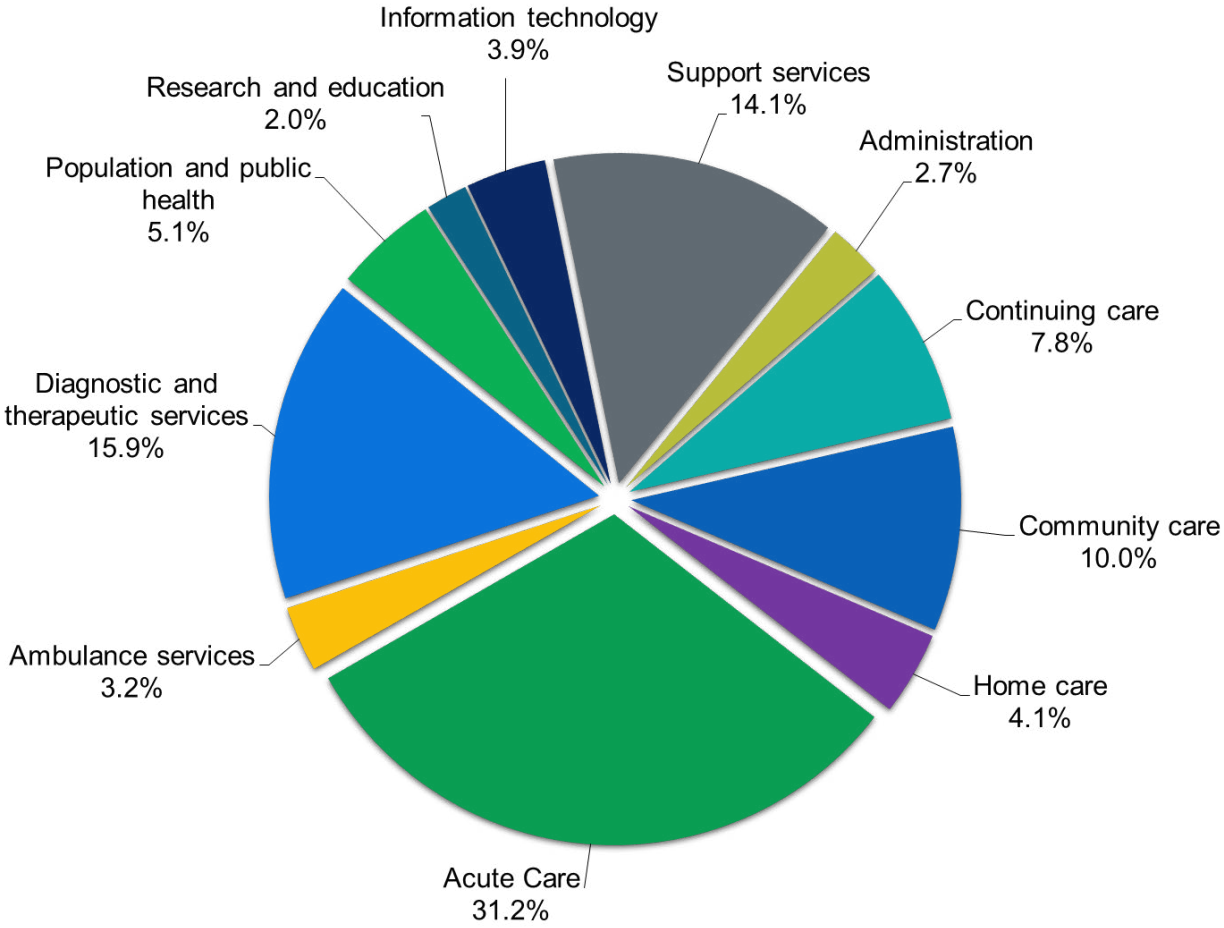
Other government transfers were lower than the prior year due to lower recognition of externally funded capital revenue related to a change in the useful life of certain AHS facilities. Increased federal contributions of drugs and supplies to support the COVID-19 pandemic response partially offset this decrease.

Fees and charges were higher than the prior year due to the easing of COVID-19 restrictions, which resulted in an increased number of patients who were provided care that is billable to other provinces and increased patient revenue as a result of the temporary suspension of certain self-pay patient billings in the prior year.

Ancillary operations were higher than the prior year due to increased revenue from parking and retail food services due to the easing of public health restrictions in the current year.

Investment and other income was higher than the prior year due to increased recoveries from external entities, realized gains on disposal of investments during the year, and dividends received.

Expenses by Function



2021-22 actual expenses by function as a per cent of total 2021-22 actual expenses
A glossary of financial statement line definitions can be found at the end of this FSD&A

Expenses by function represent AHS' major distinguishable activities and services. The overall distribution of expenses by function changed slightly from the prior year due to increased COVID-19 related costs which increased expenses to a greater extent in diagnostic and therapeutic services and population and public health. Acute care, which is comprised mainly of inpatient, outpatient, and emergency services, continued to be the largest function, making up 31.2% of total expenses (2020-21 – 31.3%).

(in $ millions)	Budget 2021-22	Actual 2021-22	Actual to Budget Variance	Actual 2020-21	Year over Year Increase (Decrease)
Continuing care	1,222	1,357	(135)	1,318	39
Community care	1,624	1,732	(108)	1,666	66
Home care	736	710	26	680	30
Acute care	5,017	5,423	(406)	5,222	201
Ambulance services	544	558	(14)	542	16
Diagnostic and therapeutic services	2,577	2,757	(180)	2,726	31
Population and public health	357	876	(519)	754	122
Research and education	347	351	(4)	333	18
Information technology	724	678	46	627	51
Support services	2,359	2,448	(89)	2,325	123
Administration	489	466	23	492	(26)
Total expenses by function	**15,996**	**17,356**	**(1,360)**	**16,685**	**671**

The costs incurred by AHS related to the COVID-19 pandemic were not included in the 2021-22 budget. These costs were primarily funded by unbudgeted Alberta Health transfers.

Actual to Budget

Continuing care was over budget due to funding provided to support long-term care providers and PPE utilization related to the COVID-19 pandemic response. Delayed CCCP bed openings as a result of facility construction and lease finalization delays partially offset the variance.

Community care was over budget due to funding provided to supportive living facilities and other community health providers and PPE utilization related to the COVID-19 pandemic response, as well as higher than budgeted spending for new or expanded initiatives. Vacancies and delayed CCCP bed openings partially offset the variance.

Unique Home Care Clients

121,560

(2020-21 - 117,775)

Home care was under budget due to reduced home care services compared to the budget for a variety of reasons including clients wanting less people in their homes during the pandemic and vacancies. Additional funding to support contracted home care providers and PPE utilization related to the COVID-19 pandemic response partially offset the variance.

Acute care was over budget due to costs related to caring for COVID-19 patients in hospitals, including increased PPE utilization, staffing levels, and overtime. The deferral of ASI due to the COVID-19 pandemic response partially offset the variance.

Emergency Room Visits

1,824,116

(2020-21 – 1,552,096)

Diagnostic and therapeutic services was over budget due to the costs associated with COVID-19 lab testing including the utilization of reagents and other laboratory supplies.

Population and public health was over budget due to the COVID-19 pandemic response, including operating COVID-19 vaccination and assessment centres, entry screening, contact tracing, Health Link, and the utilization of rapid test kits and PPE, including the distribution to schools and pharmacies.

Information technology was under budget due to adjustments to the timing of Connect Care Launch dates to accommodate and enable staff to be redeployed to support COVID-19 pandemic response. IT licences and equipment required for the pandemic response partially offset the variance.

Support services was over budget due to a valuation adjustment for PPE inventory which no longer meets clinical standards and requirements but is being held for donation to third parties, and higher costs related to the COVID-19 pandemic, including increased protective and housekeeping services. Lower than budgeted amortization related to a change in the useful life of certain AHS facilities partially offset the variance.

Administration was under budget mainly due to vacancies and lower than budgeted insurance costs.

Year over Year

Continuing care was higher than the prior year due to the opening of long-term care beds related to CCCP and contract inflation.

Community care was higher than the prior year due to the opening of new supporting living beds related to CCCP, contract inflation, and increased expenses related to Primary Care Networks and addiction and mental health initiatives, including Residential Recovery Services and Opioid Dependency Program.

Net New Continuing Care Beds Opened Since 2010

8,660

(2020-21 –8,273)

Home care was higher than the prior year due to the gradual increased demand for services as a result of higher levels of vaccination in the community and the easing of public health restrictions.

Acute care was higher than the prior year due to increased activity, including more emergency room visits and surgeries performed this year, and caring for COVID-19 patients in hospitals, including increased PPE utilization, higher staffing levels, and overtime.

Surgical Procedures[7]

330,569

(2020-21 –326,347)

Diagnostic and therapeutic services was higher than the prior year due to the increased volume of lab tests completed this year and increased diagnostic imaging scans related to the ongoing MRI and CT Implementation Plan.

CT & MRI Exams

743,312

(2020-21 –668,236)

Population and public health was higher than the prior year due to increased costs associated with AHS' COVID-19 vaccination centres, entry screening, contact tracing, and the distribution of rapid test kits to schools and pharmacies.

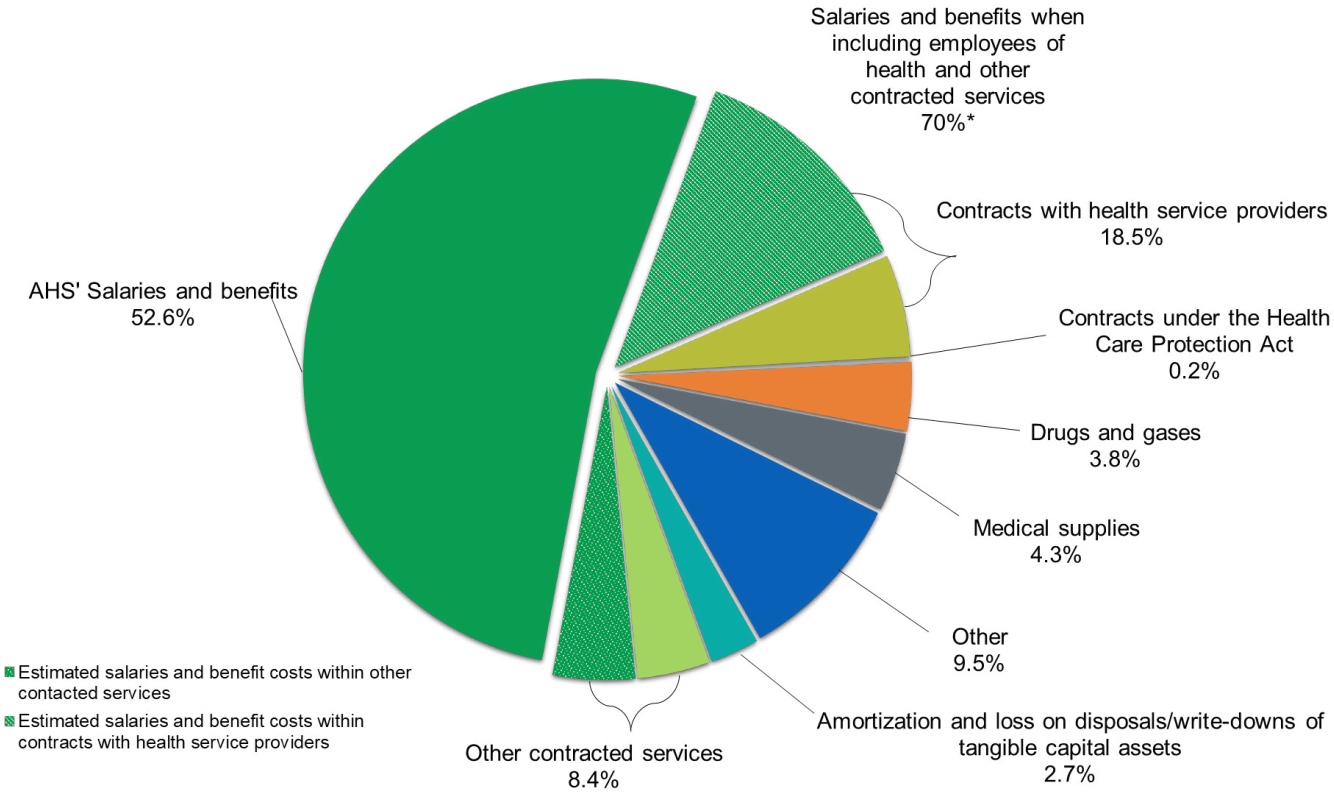
Information technology was higher than the prior year due to the ongoing implementation of Connect Care and increased onboarding and training costs to support Launch 4, which will be the largest launch to date. Higher amortization expense due to increased Connect Care equipment additions and IT licences and equipment required for the continued COVID-19 pandemic response further contributed to the increase.

Support services was higher than the prior year due to a valuation adjustment for PPE inventory, higher utility costs, and increased maintenance projects. The increase was partially offset by lower amortization expense due to a change in useful life of certain AHS facilities.

Administration was lower than the prior year due to decreased insurance costs.

[7] Includes Hip & Knee Replacements, Cataract Surgery, & Main Operating Room Activity.

Expenses by Object



**This figure is management's best estimate*
2021-22 actual expenses by object as a per cent of total 2021-22 actual expenses
A glossary of financial statement line definitions can be found at the end of this FSD&A

The overall distribution of expenses by object remained mostly consistent with prior years, with salaries and benefits making up 52.6**%** of total expenses (2020-21 – 53.0%). COVID-19 related costs increased expenses to a greater extent in other and medical supplies. When including the employees of AHS' contracted health service providers and other contracted services, the percentage increases to approximately 70%.

(in $ millions)	Budget 2021-22	Actual 2021-22	Actual to Budget Variance	Actual 2020-21	Year over Year Increase (Decrease)
Salaries and benefits	8,615	9,136	(521)	8,836	300
Contracts with health service providers	2,943	3,211	(268)	3,079	132
Contracts under the *Health Facilities Act*	22	28	(6)	22	6
Drugs and gases	600	651	(51)	593	58
Medical supplies	570	748	(178)	652	96
Other contracted services	1,336	1,477	(141)	1,368	109
Other	1,283	1,641	(358)	1,572	69
Amortization and loss on disposals/write-downs of tangible capital assets	627	464	163	563	(99)
Total expenses by object	**15,996**	**17,356**	**(1,360)**	**16,685**	**671**

The costs incurred by AHS related to the COVID-19 pandemic were not included in the 2021-22 budget. These costs were primarily funded by unbudgeted Alberta Health transfers.

Actual to Budget

Salaries and benefits was over budget due to higher staffing levels to support the COVID-19 pandemic response, including higher than budgeted overtime. Delayed initiatives as a result of the pandemic response including Connect Care and ASI, as well as rolling vacancies throughout the organization partially offset the variance.

Contracts with health service providers was over budget due to funding provided to support long term care providers, designated supportive living facilities, acute care, lab services, and other community health programs related to the COVID-19 pandemic response. Delayed CCCP bed openings partially offset the variance.

Births

47,292

(2020-21 – 46,603)

Drugs and gases was over budget due to increased utilization of COVID-19 drugs and unbudgeted cancer drugs related to compassionate access programs.

Medical supplies was over budget due to increased use of lab testing supplies and gloves, as well as the distribution of rapid tests kits to schools and pharmacies.

Other contracted services was over budget due to the COVID-19 pandemic response, including costs related to physician services, on-site protective services, housekeeping services, and border testing, as well as increased utilization of contracted health care workers in continuing care settings due to vacancies.

Other was over budget due to COVID-19 related PPE, including the use of masks, gowns, goggles, face shields, disinfecting wipes, and hand sanitizer, as well as the increased cost of utilities and fuel for ambulances.

EMS Events

672,898

(2020-21 – 602,283)

Amortization and loss on disposals/write-downs of tangible capital assets was under budget due to the change in useful life of certain AHS facilities resulting in lower than budgeted amortization.

Year over Year

Salaries and benefits was higher than the prior year due to the COVID-19 pandemic response, including higher staffing levels and overtime, as well as increased activity, including more emergency department visits and surgeries performed this year.

Contracts with health service providers was higher than the prior year due to the opening of new supporting living and long term care beds related to CCCP, continuing care contract inflation, and increased funding provided to support home care services, COVID-19 lab tests, and acute care for COVID-19 patients.

Lab Tests

82,149,662

(2020-21 – 72,491,239)

Drugs and gases was higher than the prior year due to increased utilization of COVID-19 drugs and high cost cancer drugs.

Medical supplies was higher than the prior year due to the distribution of rapid test kits to schools and pharmacies.

Other contracted services was higher than the prior year due to COVID-19 contact tracing, new or expanded physician services, increased diagnostic imaging scans related to the ongoing MRI and CT Implementation Plan, and increased utilization of contracted health care workers due to vacancies.

Other was higher than the prior year due to increased utility costs and maintenance projects.

Amortization and loss on disposals/write-downs of tangible capital assets was lower than the prior year due to the change in useful life of certain AHS facilities resulting in lower amortization than the prior year.

Financial Position

(in $ millions)	2021-22	2020-21	Change
Financial assets	3,399	3,374	25
Liabilities	3,864	3,956	(92)
Net financial assets (Net debt)	**(465)**	**(582)**	**117**
Non-financial assets	10,484	10,128	356
Expended deferred revenue	8,616	8,254	362
Net assets	**1,403**	**1,292**	**111**

Financial Assets

Financial assets are the financial resources available to AHS to settle its liabilities or to finance future operations.

At year-end, AHS' consolidated **cash and cash equivalents** balances were $201 million which is sufficient cash on hand to meet cash flow requirements.

In accordance with AHS' **Investment** Policy and Investment Bylaw, AHS invests in a diversified mix of assets including, high quality instruments, such as government and corporate bonds and lower volatility equities. This strategy is meant to preserve AHS' capital while providing a reasonable investment return. The portfolio is sufficiently liquid in nature to enable AHS to respond to cash flow requirements quickly and efficiently. AHS' investments portfolio increased by $373 million due to higher net investment contributions during the year, and generated a total return, both realized and unrealized gains, of 0**%** (2020-21 – 12%). The decrease in total return relates to lower realized gains and a recent decrease in fair market value of investments. Rising interest rates have impacted bond valuations and tempered economic expectations, while market uncertainly due to supply chain issues and international conflict has caused investor risk tolerance to decrease resulting in corresponding market movement.

Accounts receivable decreased by $72 million due to the receipt of Alberta Health transfers from the prior year. The overall decrease was partially offset by increased receivables related to drug rebates and recoveries.

Liabilities

Liabilities are existing financial obligations of AHS at year end.

Unexpended deferred operating revenue decreased $112 million mainly due to the return of prior year Alberta Health funding related to the COVID-19 pandemic response as a new funding agreement was executed for 2021-22, as well as the recognition of prior year Outpatient Cancer Drug Benefit Program funding and a decrease in unrealized gains. Increased foundation donations and the deferral of addictions and mental health and allied health initiatives partially offset the decrease.

AHS' **debt** is primarily comprised of debentures issued to the Government of Alberta to finance the construction of parking facilities. AHS pledges the revenue derived from all parking facilities as security for the debentures. As at March 31, 2022, AHS' debt balance was $455 million (2020-21 – $456 million). During the year, loan proceeds of $26 million were received to support the purchase of new EMS ambulances and vehicles.

Non-Financial Assets

Non-financial assets are assets that are not intended to be monetized for settling AHS' liabilities. While tangible capital assets are AHS' most significant non-financial assets, other non-financial assets include inventories of supplies and prepaid expenses.

Tangible Capital Assets			
(in $ millions)	2021-22	2020-21	Increase (Decrease)
Cost	18,929	18,152	777
Accumulated amortization	9,134	8,797	337
Net book value	**9,795**	**9,355**	**440**

AHS receives significant external funding for **tangible capital asset** expenditures, primarily from Government of Alberta ministries. Capital asset additions amounted to $905 million, of which 81% were externally funded (2020-21 – 88%).

Several capital projects totaling $229 million were completed during the year, including Connect Care Launch 3, the installation of building service equipment, and facility renovations. Capital equipment additions included equipment acquired to support the COVID-19 pandemic response, diagnostic services, information technology, and EMS.

The Work-in-Progress balance of $1,934 million includes facilities, improvements, and information technology capital expenditures that support AHS' initiatives, including:

- Connect Care
- Calgary Cancer Centre and parkade
- Norwood Care Centre

AHS maintains a constant level of **inventories of supplies** on hand to ensure goods, such as pharmaceuticals, and medical and clinical supplies, are available for operational needs. AHS' inventory balance decreased by $51 million primarily due to a valuation adjustment for PPE, as well as a decrease in lab testing supplies, in part due to reduced COVID-19 PCR testing towards the end of the fiscal year. The decrease was partially offset by COVID-19 rapid test kit purchases and pharmaceutical drugs to treat COVID-19 patients received from the Public Health Agency of Canada.

Expended Deferred Revenue

Expended deferred capital revenue represents external resources spent on the acquisition of capital assets, stipulated for use in the provision of services. These balances are recognized as revenue over the useful lives of the related tangible capital assets acquired. The assets include hospitals and other facilities, equipment, and information technology systems. The increase from the prior year is the result of externally funded tangible capital asset additions to support the development of several major capital projects. Funding from Government of Alberta ministries represented $8,067 million, or 97% of the $8,279 million total balance (2020-21 – 97%).

Expended deferred operating revenue represents external resources spent on the acquisition of certain inventories. These balances are recognized as revenue as the related inventories are consumed. This balance decreased by $90 million from the prior year due to a valuation adjustment for PPE, as well as a decrease in lab testing supplies in part due to reduced COVID-19 PCR testing near the end of the fiscal year. The decrease was partially offset by COVID-19 rapid test kit purchases.

Net Assets

AHS is in an overall positive net asset position, reflecting the amount by which assets exceed liabilities. This measure represents the net economic position of the organization from all years of operations.

(in $ millions)	2021-22	2020-21	Increase (Decrease)
Unrestricted Surplus	235	151	84
Invested in tangible capital assets	944	925	19
Endowments	77	76	1
Internally restricted surplus for insurance equity requirements and foundations	122	84	38
Accumulated Surplus	**1,378**	**1,236**	**142**
Accumulated Remeasurement Gains	25	56	(31)
Total Net Assets	**1,403**	**1,292**	**111**

The **unrestricted surplus** grew $84 million as a result of the $142 million operating surplus, offset by internal investment in tangible capital assets and an increase to internally restricted surplus for insurance equity requirements and foundations.

Outlook

Over the next several years, AHS will implement a number of priority initiatives that will support the provision of patient-focused quality care that is accessible for all Albertans. AHS recognizes the need to recover from the health system impacts of COVID-19 and plans to meet and then exceed pre-pandemic levels of performance in a number of key areas.

AHS will improve wait times for surgeries and diagnostic imaging, invest in EMS, and continue to increase and enhance the availability of continuing, community, and home care options. The implementation of Connect Care will continue and, in time, give healthcare providers immediate access to tools for decision-making and give patients access to their own health information. AHS, in conjunction with Alberta Health and Alberta Infrastructure, will continue to support facilities, equipment, and other infrastructure needed to deliver quality health services.

Alberta's population is growing and aging, costs are rising, and there is an ongoing focus on the recruitment and retention of healthcare resources. AHS will need to manage these risks in order to implement its key priority initiatives while managing cost growth and improving quality. Through the implementation of a formalized Sustainability Program, AHS holds leaders accountable to deliver on innovative initiatives that enable systemic transformation including reductions in greenhouse gas emissions to ensure that the health delivery system, our people, and the environment is sustainable for current and future generations.

More information on the outlook and corresponding risks can be found in the AHS Health Plan and Business Plan.

Financial Reporting, Control and Accountability

The AHS consolidated financial statements have been prepared in accordance with **Canadian Public Sector Accounting Standards.** In addition, the consolidated financial statements include certain disclosures required by the financial directives issued by Alberta Health. The chart of accounts that AHS uses to report expenses by function and by object is based on the national standards from the Canadian Institute for Health Information (CIHI). Detailed site-based results are submitted to CIHI annually for analysis and reporting on Canada's health system and the health of Canadians. AHS' annual reports are available at **www.albertahealthservices.ca** under "Publications and Transparency".

An effective and integrated governance model is an essential component to improving the delivery of care services to Albertans and the way the organization operates.

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

The **Audit & Risk Committee** assists the Board in fulfilling their oversight responsibilities with respect to enterprise risk management and compliance, external financial reporting, internal controls over financial reporting, internal audit, and the external audit. The Finance Committee assists the Board in fulfilling their financial oversight responsibilities including those pertaining to the Health Plan and Business Plan, the budget, and the investment portfolio.

AHS has an established **Internal Audit** function with the mandate of providing independent advisory and assurance services to management and the Board on AHS operations. Internal Audit's work takes a risk-based approach to evaluating and advising on the efficiency and effectiveness of AHS' governance, risk management practices, and financial and management controls and processes. The Chief Audit Executive is also responsible for coordinating AHS' Enterprise Risk Management function, including the development and implementation of policies and processes for identifying, monitoring, and reporting on key organizational risks, as well as working with the Board and management to better understand and manage risk.

As a component of the Internal Audit function, AHS has an **Internal Controls over Financial Reporting** (ICOFR) team, which is tasked with ensuring the financial reporting environment has a sustainable framework of internal controls that mitigates the risk of material misstatements. In fulfilling its mandate, ICOFR provides assurance on the design and operational effectiveness of financial reporting controls using a risk-based approach.

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

Glossary of Financial Statement Line Definitions

These definitions are based on the national standards from the Canadian Institute for Health Information (CIHI) and are in accordance with the financial directives issued by Alberta Health.

Revenues

Alberta Health transfers are comprised of all funding received from Alberta Health; unrestricted, restricted operating, and capital. Unrestricted Alberta Health transfers are the main source of operating funding to provide health-care services to the population of Alberta. Restricted operating and capital funding can only be used for specific purposes and are recognized when the related expenses are incurred.

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

Fees and charges consist of patient revenue from medically necessary health services provided to patients, and collected by AHS from individuals, Workers' Compensation Board (WCB), federal and provincial governments, and other parties, such as Alberta Blue Cross and other insurance companies.

Ancillary operations consist of revenue from the sale of goods and services that are unrelated to the direct provision of health services such as parking services, AHS operated non-patient food services, gift shops, and rental of television and cable to patients and residents. This excludes revenue from activities that support the provision of health services, promote and protect the health of the population, or work toward the prevention of disease and injury.

Donations, fundraising, and non-government contributions are comprised of revenue that can be unrestricted or restricted for operating or capital purposes. Restricted amounts received are recognized as revenue when the related stipulations are met.

Investment and other income is comprised of interest income, dividends, net realized gains and losses on disposal of investments, recoveries from external sources other than ancillary operations, and miscellaneous revenues that cannot be classified elsewhere.

Continuing care is comprised of long-term care including chronic and psychiatric care in facilities operated by AHS and contracted providers.

Community care includes supportive living, palliative and hospice care, and community programs including Primary Care Networks, Family Care Clinics, urgent care centres, and community mental health. This segment excludes community-based dialysis, oncology, and surgical services.

Home care is comprised of home nursing and support.

Acute care is comprised predominantly of patient care units such as medical, surgical, intensive care, respirology intensive care, obstetrics, pediatrics, mental health, emergency, day/night care, clinics, day surgery, communicable diseases, and contracted surgical services. This category also includes operating and recovery rooms.

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

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

Population and public health is comprised primarily of health promotion, disease and injury prevention, health protection. This category also includes immunizations, traveller's health clinics, outbreaks, screening programs, and disease surveillance. Excludes activities associated with treatment of communicable diseases.

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

Information technology is comprised of costs pertaining to the provision of service and consultation in the design, development, and implementation of information technology services and systems.

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

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

Expenses by Object

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

Contracts with health service providers include voluntary and private health service providers with whom AHS contracts for health services, such as long-term care facilities, acute care providers, home care providers, and lab service providers. These health service providers incur expenses similar to AHS, such as salaries and benefits, clinical supplies and other expenses.

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

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

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

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

Other expenses relate to those expenses not classified elsewhere, including personal protective equipment.

Amortization and losses on disposals/write-downs of tangible capital assets relates to the periodic charges to expenses representing the estimated portion of the cost of the respective tangible capital asset that expired through use and age during the period. A loss on disposal/write-down of capital assets occurs when the net book value (defined as historical cost less accumulated amortization) exceeds the proceeds/fair value from the disposal/write-down

Consolidated Financial Statements

March 31, 2022

Management's Responsibility For Financial Reporting

The accompanying consolidated financial statements for the year ended March 31, 2022 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 include certain disclosures required by 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 funds;
- safeguard the assets and properties of the "Province of Alberta" that are the responsibility of Alberta Health Services.

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

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

Original signed by

Mauro Chies

Interim President and
Chief Executive Officer

Alberta Health Services

Original signed by

Colleen Purdy, CPA, CMA

Vice President Corporate Services
and Chief Financial Officer

Alberta Health Services

June 1, 2022

Auditor General
OF ALBERTA

Independent Auditor's Report

To the Members of the Alberta Health Services Board and the Minister of Health

Report on the Consolidated Financial Statements

Opinion

I have audited the consolidated financial statements of Alberta Health Services (the Group), which comprise the consolidated statement of financial position as at March 31, 2022, and the consolidated statements of operations, remeasurement gains and losses, change in net financial assets (net debt), and cash flows for the year then ended, and notes to the consolidated financial statements, including a summary of significant accounting policies.

In my opinion, the accompanying consolidated financial statements present fairly, in all material respects, the consolidated financial position of the Group as at March 31, 2022, and the results of its operations, its remeasurement gains and losses, its changes in net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for opinion

I conducted my audit in accordance with Canadian generally accepted auditing standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Consolidated Financial Statements* section of my report. I am independent of the Group in accordance with the ethical requirements that are relevant to my audit of the consolidated financial statements in Canada, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Other information

Management is responsible for the other information. The other information comprises the information included in the *Annual Report*, but does not include the consolidated financial statements and my auditor's report thereon. The *Annual Report* is expected to be made available to me after the date of this auditor's report.

My opinion on the consolidated financial statements does not cover the other information and I do not express any form of assurance conclusion thereon.

In connection with my audit of the consolidated financial statements, my responsibility is to read the other information identified above and, in doing so, consider whether the other information is materially inconsistent with the consolidated financial statements or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

If, based on the work I will perform on this other information, I conclude that there is a material misstatement of this other information, I am required to communicate the matter to those charged with governance.

Responsibilities of management and those charged with governance for the consolidated financial statements

Management is responsible for the preparation and fair presentation of the 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 the consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is responsible for assessing the Group's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless an intention exists to liquidate or to cease operations, or there is no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the Group's financial reporting process.

Auditor's responsibilities for the audit of the consolidated financial statements

My objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these consolidated financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, I exercise professional judgment and maintain professional skepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 Group's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Group's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the consolidated financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the Group to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the consolidated financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

- Obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the Group to express an opinion on the consolidated financial statements. I am responsible for the direction, supervision and performance of the group audit. I remain solely responsible for my audit opinion.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

[Original signed by W. Doug Wylie FCPA, FCMA, ICD.D]
Auditor General

June 1, 2022
Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS YEAR ENDED MARCH 31	2022		2021
	Budget (Note 3)	Actual	Actual
Revenues:			
Alberta Health transfers			
Base operating	$ 13,099,000	$ 13,097,557	$ 12,756,769
One-time base operating	-	71,003	145,566
Other operating	1,374,000	2,859,669	2,480,646
Recognition of expended deferred capital revenue	61,000	95,777	76,407
Other government transfers (Note 4)	455,000	382,887	461,929
Fees and charges	525,000	478,313	421,523
Ancillary operations	145,000	91,369	53,546
Donations, fundraising, and non-government contributions (Note 5)	177,000	185,893	184,874
Investment and other income (Note 6)	160,000	236,292	207,826
TOTAL REVENUES	**15,996,000**	**17,498,760**	**16,789,086**
Expenses:			
Continuing care	1,222,000	1,357,126	1,318,537
Community care	1,624,000	1,731,760	1,666,107
Home care	736,000	709,715	680,119
Acute care	5,017,000	5,423,320	5,221,723
Ambulance services	544,000	557,720	542,463
Diagnostic and therapeutic services	2,577,000	2,757,593	2,725,780
Population and public health	357,000	876,457	754,294
Research and education	347,000	351,106	333,252
Information technology	724,000	677,737	626,792
Support services (Note 7)	2,359,000	2,447,719	2,324,094
Administration (Note 8)	489,000	466,012	492,253
TOTAL EXPENSES (Schedules 1 and 3)	**15,996,000**	**17,356,265**	**16,685,414**
ANNUAL OPERATING SURPLUS	**-**	**142,495**	**103,672**
Accumulated surplus, beginning of year	1,236,000	1,236,273	1,132,601
Accumulated surplus, end of year (Note 20)	**$ 1,236,000**	**$ 1,378,768**	**$ 1,236,273**

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

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT MARCH 31		
	2022 Actual	2021 Actual
Financial Assets:		
Cash and cash equivalents	$ 200,691	$ 477,148
Portfolio investments (Note 10)	2,603,605	2,231,069
Accounts receivable (Note 11)	594,429	665,415
	3,398,725	3,373,632
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,951,855	1,932,777
Employee future benefits (Note 13)	777,878	760,786
Unexpended deferred operating revenue (Note 14)	529,707	641,469
Unexpended deferred capital revenue (Note 15)	149,516	165,111
Debt (Note 17)	454,993	455,659
	3,863,949	3,955,802
NET FINANCIAL ASSETS (NET DEBT)	**(465,224)**	**(582,170)**
Non-Financial Assets:		
Tangible capital assets (Note 18)	9,795,230	9,355,263
Inventories of supplies (Note 19)	513,019	563,928
Prepaid expenses, deposits, and other non-financial assets	176,570	209,366
	10,484,819	10,128,557
NET ASSETS BEFORE EXPENDED DEFERRED REVENUE	10,019,595	9,546,387
Expended deferred revenue (Note 16)	8,615,941	8,254,337
NET ASSETS	**1,403,654**	**1,292,050**
Net Assets is comprised of:		
Accumulated surplus (Note 20)	1,378,768	1,236,273
Accumulated remeasurement gains	24,886	55,777
	$ 1,403,654	**$ 1,292,050**

Contractual Obligations and Contingent Liabilities (Note 21)
Impact of COVID-19 Pandemic (Note 26)

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

Approved by the Alberta Health Services Board:

[Original Signed By]

Gregory Turnbull
Board Chair

[Original Signed By]

Jack Mintz
Audit & Risk Committee Chair

CONSOLIDATED STATEMENT OF CHANGE IN NET FINANCIAL ASSETS (NET DEBT) YEAR ENDED MARCH 31	2022		2021
	Budget (Note 3)	Actual	Actual
Annual operating surplus	$ -	$ 142,495	$ 103,672
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets:			
Purchased	(519,000)	(463,646)	(455,920)
Leased	-	(15,646)	(63,214)
Constructed by Alberta Infrastructure on behalf of AHS	(510,000)	(425,337)	(543,417)
Contributed	-	(522)	(334)
Amortization and loss on disposals/write-downs of tangible capital assets	627,000	465,184	563,582
Effect of other changes:			
Net increase in expended deferred capital revenue	381,000	452,077	467,277
Net (decrease) increase in expended deferred operating revenue	-	(90,473)	427,445
Net (increase) decrease in inventories of supplies	(2,000)	50,909	(436,630)
Net (increase) decrease in prepaid expenses, deposits and other non-financial assets	(8,000)	32,796	2,114
Net remeasurement gains (losses) for the year	19,000	(30,891)	51,945
Change in net financial assets (net debt) for the year	**(12,000)**	**116,946**	**116,520**
Net financial assets (net debt), beginning of year	(582,000)	(582,170)	(698,690)
Net financial assets (net debt), end of year	**$ (594,000)**	**$ (465,224)**	**$ (582,170)**

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

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEAR ENDED MARCH 31			
	2022		2021
	Budget (Note 3)	Actual	Actual
Unrestricted unrealized gains (losses) attributable to:			
Derivatives	$ -	$ (24)	$ (1,245)
Portfolio investments	42,000	(29,270)	82,973
Amounts reclassified to the Consolidated Statement of Operations:			
Portfolio investments	(23,000)	(1,597)	(29,783)
Net remeasurement gains (losses) for the year	**19,000**	**(30,891)**	**51,945**
Accumulated remeasurement gains, beginning of year	56,000	55,777	3,832
Accumulated remeasurement gains, end of year (Note 10)	**$ 75,000**	**$ 24,886**	**$ 55,777**

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

CONSOLIDATED STATEMENT OF CASH FLOWS YEAR ENDED MARCH 31	2022 Actual	2021 Actual (Note 27)
Operating transactions:		
Annual operating surplus	$ 142,495	$ 103,672
Non-cash items:		
Amortization and loss on disposals/write-downs of tangible capital assets	465,184	563,582
Revenue recognized for acquisition of land	(987)	-
Recognition of expended deferred capital revenue	(298,774)	(385,639)
Recognition of expended deferred operating revenue	(453,686)	(469,181)
Gain on disposal of portfolio investments	(36,100)	(36,946)
Change in employee future benefits	17,092	48,791
Decrease (increase) in:		
Accounts receivable related to operating transactions	70,986	(54,844)
Inventories of supplies	50,909	(329,170)
Prepaid expenses, deposits, and other non-financial assets	32,796	2,114
Increase (decrease) in:		
Accounts payable and accrued liabilities	35,567	281,460
Unexpended deferred operating revenue	(111,762)	235,518
Cash applied to operating transactions	(86,280)	(40,643)
Capital transactions:		
Purchased tangible capital assets	(463,646)	(455,920)
Cash applied to capital transactions	(463,646)	(455,920)
Investing transactions:		
Purchase of portfolio investments	(3,806,735)	(2,339,784)
Proceeds on disposals of portfolio investments	3,439,408	1,669,801
Cash applied to investing transactions	(367,327)	(669,983)
Financing transactions:		
Restricted operating contributions received	363,213	789,166
Restricted capital contributions received	310,803	366,649
Unexpended deferred capital revenue returned	(419)	(1,196)
Proceeds from debt	26,000	-
Principal payments on debt	(26,666)	(25,892)
Payments on obligations under capital leases	(30,642)	(22,327)
Net repayment of life lease deposits	(1,493)	(1,484)
Cash provided by financing transactions	640,796	1,104,916
Decrease in cash and cash equivalents	**(276,457)**	**(61,630)**
Cash and cash equivalents, beginning of year	477,148	538,778
Cash and cash equivalents, end of year	**$ 200,691**	**$ 477,148**

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS FOR THE YEAR ENDED MARCH 31, 2022

Note 1 Authority, Purpose and Operations

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

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

- promote and protect the health of the population and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the population;
- determine priorities in the provision of health services and allocate resources accordingly;
- ensure that reasonable access to quality health services is provided 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.

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 assets, liabilities, revenues and expenses associated with its responsibilities.

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

These consolidated financial statements have been prepared in accordance with Canadian Public Sector Accounting Standards. In addition, the financial statements include certain disclosures required by the financial directives issued by Alberta Health (AH).

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

(i) Controlled Entities

AHS controls the following three entities:

- Alberta Precision Laboratories Ltd. - provides medical diagnostic services throughout Alberta.
- CapitalCare Group Inc. - manages continuing care programs and facilities in the Edmonton area.
- Carewest - manages continuing care programs and facilities in the Calgary area.

AHS has majority representation on, or the right to appoint, the governance boards, indicating control of the following entities:

- Foundations and other organizations:

  The largest foundations controlled by AHS are the Alberta Cancer Foundation and the Calgary Health Foundation. AHS also controls 32 other foundations to facilitate fundraising for various initiatives including enhancements to healthcare delivery (including equipment), programs, renovations, and research and education.
- Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP)

  The LPIP's main purpose is to share the risks of general and professional liability to lessen the impact on any one subscriber. Effective April 1, 2020, the LPIP ceased providing new liability coverage and continues in operation for the limited purpose of winding up its affairs.

  The LPIP has a fiscal year end of December 31, 2021. Significant transactions occurring between this date and March 31, 2022 have been recorded in these consolidated financial statements.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

(ii) Government Partnerships

AHS proportionately consolidates its 50% interests in 40 Primary Care Network (PCN) partnerships with physician groups, its 50% interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta, and its 33.33% interest in the Institute for Reconstructive Sciences in Medicine (iRSM) partnership with the University of Alberta and Covenant Health (Note 23).

AHS entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services to achieve the PCN plan objectives, and to contract and hold property interests required in the delivery of PCN services.

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

(iii) Trusts under Administration

These consolidated financial statements do not include trusts administered on behalf of others (Note 24).

(iv) Other

AHS is responsible for the delivery and operation of the public health system in Alberta (Note 1) and contracts with various voluntary and private health service providers to provide health services throughout Alberta. The largest of these service providers is Covenant Health, a denominational health care organization, providing a full spectrum of care including operating several hospitals and long-term care facilities. Covenant Health is an independent, separate legal entity with a separate Board of Directors and accordingly, these consolidated financial statements do not include their assets, liabilities or results of operations. However, the payments for contracts with health service providers such as Covenant Health are recorded as expenses in the Consolidated Statement of Operations.

In addition, AHS provides administrative services to certain foundations and contracted health care providers not included in these consolidated financial statements.

(b) Revenue Recognition

Revenue is recognized in the year in which the transactions or events that give rise to the revenue as described below occur. All revenue is recorded on an accrual basis, except when the accrual cannot be determined within a reasonable degree of certainty or when estimation is impracticable. Unallocated costs comprising of materials and services contributed by related parties in support of AHS' operations, are not recognized in these consolidated financial statements.

(i) Government Transfers

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

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

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

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

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

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

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

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

(iii) Transfers and Donations related to Land

Transfers and donations for the purchase of land are recorded as deferred revenue when received and as revenue when the land is purchased.

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

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

(v) Investment Income

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

(c) Expenses

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

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

(d) Financial Instruments

Financial instruments comprise financial assets and financial liabilities. Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not for consumption in the normal course of operations. Financial liabilities are contractual obligations to deliver cash or another financial asset to another entity or to exchange financial instruments with another entity under conditions that are potentially unfavourable to AHS.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

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

AHS records equity investments quoted in an active market at fair value and 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 all portfolio investments at fair value. The three levels of information that may be used to measure fair value are:

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

AHS measures and recognizes embedded derivatives separately from the host contract when the economic characteristics and risk of the embedded derivative are not closely related to those of the host contract, when it meets the definition of a derivative and, when the entire contract is not measured at fair value.

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

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

A financial liability or its part is derecognized when it is extinguished.

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

(e) Cash and Cash Equivalents

Cash is comprised of cash on hand and demand deposits. Cash equivalents include amounts in interest bearing accounts and are subject to an insignificant risk of change in value. Cash and cash equivalents are held for the purpose of meeting short-term commitments rather than for investment purposes.

(f) Inventories of Supplies

Purchased inventories of supplies are valued at lower of cost (defined as moving average cost) and replacement cost. Contributed inventories of supplies are recorded at fair value when such value can reasonably be determined.

(g) Tangible Capital Assets

Tangible capital assets are recorded at cost, which includes amounts that are directly related to the acquisition, design, construction, development, improvement, or betterment of the assets. Cost includes overhead directly attributable to construction and development as well as interest costs that are directly attributable to the acquisition or construction

Note 2 Significant Accounting Policies and Reporting Practices (continued)

of the asset. Costs incurred by Alberta Infrastructure (AI) to construct tangible capital assets on behalf of AHS are recorded by AHS as work in progress as AI incurs costs.

Contributed tangible capital assets from non-related entities are recognized at their fair value at the date of the contribution when fair value can be reasonably determined. When AHS cannot determine the fair value, it records such contributions at nominal value.

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

	Useful Life
Facilities and improvements (effective Feb 1, 2021)	10-70 years
Facilities and improvements (prior to Feb 1, 2021)	10-40 years
Equipment	3-20 years
Information systems	3-15 years
Building service equipment	5-40 years
Land improvements	5-40 years

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

Leases of tangible capital assets which transfer substantially all benefits and risks of ownership are accounted for as leased tangible capital assets and leasehold improvements are amortized over the shorter of the term of the lease or their estimated useful lives. Obligations under capital leases 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 and the interest rate implicit in the lease.

Tangible capital assets are written down to their net recoverable amount 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. Write-downs are recorded as part of amortization and loss on disposals / write-downs of tangible capital assets.

Intangibles and other assets inherited by right and that have not been purchased are not recognized in these consolidated financial statements. Similarly, works of art, historical treasures, and collections are not recognized as tangible capital assets.

(h) Employee Future Benefits

(i) Defined Benefit Pension Plans

Local Authorities Pension Plan (LAPP) and Management Employees Pension Plan (MEPP)

AHS participates in the LAPP and MEPP which are multi-employer registered defined benefit pension plans. 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 plans' future benefits.

Supplemental Executive Retirement Plan (SERP)

The SERP covers certain employees and supplements the benefits under AHS' registered plans that are limited by the *Income Tax Act* (Canada). The SERP has been closed to new entrants since April 1, 2009. The SERP provides future pension benefits to participants based on years of service and earnings.

As required under the *Income Tax Act* (Canada), approximately half of the assets are held in a non-interest bearing Refundable Tax Account with the Canada Revenue Agency. The remaining assets of the SERP are invested in a combination of Canadian equities and Canadian fixed income securities.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(ii) Defined Contribution Pension Plans

Group Registered Retirement Savings Plans (GRRSPs)

AHS sponsors 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.

Supplemental Pension Plan (SPP)

Subsequent to April 1, 2009, staff that would have otherwise been eligible for SERP have been enrolled in a defined contribution SPP. The SPP supplements the benefits under AHS registered plans that are limited by the *Income Tax Act* (Canada). AHS contributes a percentage of an eligible employee's pensionable earnings, in excess of the limits of the *Income Tax Act* (Canada). The SPP 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.

(iii) Other Benefit Plans

Accumulating Non-Vesting Sick Leave

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' 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 recognizes a liability and expense for accumulating non-vesting sick leave benefits using an actuarial cost method as the employees render services to earn the benefits. The liability and expense is determined using the projected benefit method pro-rated for service and management's best estimates of expected discount rate, inflation, rate of compensation increase, termination and retirement dates, and mortality. Actuarial gains and losses are amortized on a straight-line basis over the expected average remaining service life of the related employee groups.

AHS does not record a liability for sick leave benefits that do not accumulate beyond the current reporting year as these are renewed annually.

Other Benefits

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

(i) Liability for Contaminated Sites

Contaminated sites are a result of contamination being introduced into air, soil, water, or sediment of a chemical, organic or radioactive material or live organism that exceeds an environmental standard. A liability for remediation of contaminated sites is recognized when all of the following criteria are met:

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(j) Foreign Currency Translation

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

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

(k) Reserves

Certain amounts, as approved by the AHS Board, may be set aside in accumulated surplus for use by AHS for future purposes. Transfers to, or from, are recorded to the respective reserve account when approved. Reserves include Invested in Tangible Capital Assets, Internally Restricted Surplus for Insurance Equity Requirements and Foundations.

(l) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a difference between the recognized or disclosed amount and another reasonably possible amount. 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 could require adjustment in subsequent reporting years.

The amount 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 accumulating non-vesting sick leave are based on various assumptions including the estimated service life of employees, drawdown rate of sick leave banks and rate of salary escalation. The establishment of the provision for unpaid claims relies on judgment and estimates including historical precedent and trends, prevailing legal, economic, social, and regulatory trends; and expectation as to future developments.

(m) Future Accounting Changes

The following accounting standards and guideline are applicable in future years:

- **PS 3280 – Asset Retirement Obligations (effective April 1, 2022)**
  PS 3280 provides guidance on how to account for and report a liability for retirement of a tangible capital asset. AHS plans to adopt this accounting standard on a modified retroactive basis, consistent with the transitional provisions in PS 3280, and information presented for comparative purposes will be restated.

- **PS 3400 – Revenue (effective April 1, 2023)**
  PS 3400 provides guidance on how to account for and report revenue, and specifically, it differentiates between revenue arising from exchange and non-exchange transactions.

- **PSG-8 – Purchased Intangibles (effective April 1, 2023)**
  PSG-8 provides guidance on the recognition, accounting, and classification of purchased intangible assets.

- **PS 3160 – Public Private Partnerships (effective April 1, 2023)**
  PS 3160 provides guidance on how to account for public private partnerships between public and private sector entities, where the public sector entity procures infrastructure using a private sector partner.

AHS is currently assessing the impact of these standards and guideline on future consolidated financial statements.

Note 3 Budget

The 2021-22 annual budget, was approved by the AHS Board on March 11, 2021 for submission to the Minister who approved it on April 30, 2021. The budget excludes COVID-19 revenues and expenses.

Note 4 Other Government Transfers

	Budget	2022	2021
Recognition of expended deferred capital revenue (Note 16 (a))	$ 314,000	$ 169,977	$ 275,022
Restricted operating (Note 14 (a))	100,000	95,774	154,063
Unrestricted operating	41,000	117,136	32,844
	$ 455,000	**$ 382,887**	**$ 461,929**

Other government transfers include $284,500 (2021 – $384,161) transferred from the Province of Alberta, $98,387 (2021 – $77,768) from government entities outside the Province of Alberta and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

Note 5 Donations, Fundraising, and Non-Government Contributions

	Budget	2022	2021
Recognition of expended deferred capital revenue (Note 16 (a))	$ 36,000	$ 33,020	$ 34,210
Restricted operating (Note 14(a))	138,000	123,946	138,272
Unrestricted operating	3,000	27,213	12,162
Endowment contributions (Note 20)	-	1,714	230
	$ 177,000	**$ 185,893**	**$ 184,874**

Note 6 Investment and Other Income

	Budget	2022	2021
Investment income	$ 55,000	$ 75,643	$ 63,660
Other income:			
AH	11,000	11,817	12,520
Other Province of Alberta Ministries (Note 22)	31,000	24,646	23,369
Other [(i)]	63,000	124,186	108,277
	$ 160,000	**$ 236,292**	**$ 207,826**

[(i)] Other mainly relates to recoveries for services provided to third parties.

Note 7 Support Services

	Budget	2022	2021
Facilities operations	$ 878,000	$ 884,389	$ 929,664
Patient health records, food services, and transportation	407,000	446,921	440,661
Housekeeping, laundry, and linen	239,000	233,797	232,345
Materials management	177,000	221,805	199,877
Support services expense of full-spectrum contracted health service providers	153,000	159,647	162,745
Ancillary operations	97,000	76,291	77,013
Fundraising expenses and grants awarded	49,000	44,296	46,861
Other [(i)]	359,000	380,573	234,928
	$ 2,359,000	**$ 2,447,719**	**$ 2,324,094**

[(ii)] Other costs includes a valuation adjustment of $109,034 (2021 – $nil) relating to personal protective equipment inventories that no longer meet clinical standards and requirements (Note 19).

Note 8 Administration

	Budget	2022	2021
General administration	$ 231,000	$ 211,690	$ 234,454
Human resources	117,000	118,230	114,337
Finance	75,000	73,758	73,480
Communications	25,000	22,972	27,986
Administration expense of full-spectrum contracted health service providers	41,000	39,362	41,996
	$ 489,000	**$ 466,012**	**$ 492,253**

Note 9 Financial Risk Management

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

(a) Market Risk

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

In accordance with the AHS investment bylaw and policy, AHS manages market risk by maintaining a conservative and diversified portfolio, and engages Alberta Investment Management Corporation, a related party, to manage the portfolio. Compliance with the bylaw and policy is monitored and reported to the Finance Committee on a quarterly basis.

In order to earn financial returns at an acceptable level of market risk, the consolidated investment portfolio is governed by investment bylaws and policies with clearly established target asset mixes. The target assets range between 0% to 100% for cash and money market securities, 0% to 80% for fixed income securities and 0% to 70% for equity holdings.

Risk is reduced through asset class diversification, diversification within each asset class, and portfolio quality constraints governing the quality of portfolio holdings.

AHS assesses the sensitivity of its portfolio to market risk based on historical volatility of equity and fixed income markets. Volatility is determined using a ten year average based on fixed income and equity market fluctuations and is applied to the total portfolio. Based on the volatility average of 3.60% (2021 – 3.10%) increase or decrease, with all other variables held constant, the portfolio could expect an increase or decrease in accumulated remeasurement gains and losses and unrealized net gains and losses attributable to unexpended deferred operating revenue of $71,795 (2021 – $50,016).

(i) Price Risk

Price risk relates to the possibility that equity portfolio 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 portfolio investments held in pooled funds. If equity market indices (S&P/TSX, S&P1500 and MSCI ACWI and their sectors) declined by 10%, and all other variables are held constant, the potential loss in fair value to AHS would be approximately $58,868 or 2.25% of total portfolio investments (March 31, 2021 – $49,592 or 2.21%).

(ii) Interest Rate Risk

Interest rate risk is the risk that the value of a financial instrument might be adversely affected by a change in market interest rates. AHS manages the interest rate risk exposure of its fixed income securities 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

Note 9 Financial Risk Management (continued)

rate fluctuations over the term of the outstanding debt. The fair value of fixed rate debt fluctuates with changes in market interest rates but the related future cash flows will not change.

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

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $66,173 (March 31, 2021 – $52,994).

Interest bearing securities have the following average maturity structure:

	2022	2021
Less than one year	31%	58%
1 – 5 years	48%	20%
6 – 10 years	11%	10%
Over 10 years	9%	12%

	Average Effective Market Yield	
Asset Class	**2022**	**2021**
Money market instruments	0.89%	0.20%
Fixed income securities	2.62%	1.35%

(iii) Foreign Currency Risk

Foreign currency risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates. Cash and cash equivalents and portfolio investments denominated in foreign currencies are translated into Canadian dollars on a daily basis using the reporting date exchange rate. Both the realized gain/loss and remeasurement gain/loss comprise actual gains or losses on the underlying instrument as well as changes in foreign exchange rates at the time of the valuation. AHS

is exposed to foreign exchange fluctuations on its cash denominated in foreign currencies. AHS is also exposed to changes in the valuation on its global equity funds attributable to fluctuations in foreign currency.

Foreign currency risk is managed by the investment policies which limit non-Canadian equities to a maximum of 10% to 45% of the total investment portfolio, depending on the policy. At March 31, 2022, investments in non-Canadian equities represented 13.6% (March 31, 2021 – 13.1%) of total portfolio investments.

Foreign exchange fluctuations on cash balances are mitigated by derivatives and holding minimal foreign currency cash balances. AHS holds US dollar forward contracts to manage currency fluctuations relating to its US dollar accounts payable requirements. As at March 31, 2022, AHS held derivatives in the form of forward contracts for future settlement of $24,000 (2021 – $8,000). The fair value of these forward contracts as at March 31, 2022 was $(16) (2021 – $8) and is included in portfolio investments (Note 10).

(b) Credit Risk

Credit risk is the risk of loss arising from the failure of a counterparty to fully honour its contractual 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. 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, and the federal government. AHS periodically reviews the collectability of its accounts receivable and establishes an allowance based on its best estimate of potentially uncollectible amounts.

Under the investment bylaw and policies governing the consolidated investment portfolio, 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 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 and no more than 40% of the total investment portfolio. Not more than 20% of the

Note 9 Financial Risk Management (continued)

investment portfolio may be BBB or equivalent rated bonds. AHS holds unrated mortgage fund investments which are classified as part of AHS' fixed income securities.

The following table summarizes AHS' investment in debt securities by counterparty credit rating at March 31. The unrated securities consist of low volatility pooled mortgages that are not rated on an active market.

Credit Rating	2022	2021
Investment Grade (AAA to BBB)	97%	96%
Unrated	3%	4%
	100%	**100%**

(c) Liquidity Risk

Liquidity risk is the risk that AHS will encounter difficulty under both normal and stressed conditions in meeting obligations associated with financial liabilities that are settled by delivery of cash and cash equivalents or another financial asset. Liquidity requirements of AHS are met through funding provided by AH, income generated from portfolio investments, and by investing in liquid assets, such as money market securities, fixed income securities and equities traded in an active market that are easily sold and converted to cash. Short term borrowing to meet financial obligations would be available through established credit facilities, which have not been drawn upon, as described in Note 17(c).

Note 10 Portfolio Investments

	2022		2021	
	Fair Value	Cost	Fair Value	Cost
Cash held for investing purposes	**$ 126,002**	**$ 126,002**	**$ 119,313**	**$ 119,313**
Interest bearing securities:				
Money market securities	530,043	530,210	818,910	818,910
Fixed income securities	1,358,881	1,403,265	786,459	783,669
	1,888,924	**1,933,475**	**1,605,369**	**1,602,579**
Equities:				
Canadian equity investments	25,761	22,707	54,802	43,885
Canadian equity funds	163,375	140,740	83,912	65,759
Global equity funds	354,516	294,912	327,050	235,030
	543,652	**458,359**	**465,764**	**344,674**
Real estate pooled funds	**45,027**	**40,371**	**40,623**	**40,342**
	$ 2,603,605	**$ 2,558,207**	**$ 2,231,069**	**$ 2,106,908**

	2022	2021
Items at fair value		
Portfolio investments designated to the fair value category	$ 2,577,860	$ 2,176,259
Portfolio investments in equity instruments that are quoted in an active market	25,761	54,802
Derivatives	(16)	8
	$ 2,603,605	**$ 2,231,069**

Included in portfolio investments is $215,299 (2021 – $227,688) that is restricted for use as per the requirements in Sections 99 and 100 of the *Insurance Act* (Alberta). Endowment principal included in portfolio investments amounts to $77,382 (2021 – $75,668).

The following are the total net remeasurement gains on portfolio investments:

Note 10 Portfolio Investments (continued)

	2022	2021
Accumulated remeasurement gains	$ 24,886	$ 55,777
Restricted unrealized net gains attributable to unexpended deferred operating revenue (Note 14(b))	20,512	68,384
	$ 45,398	**$ 124,161**

Fair Value Hierarchy

	2022			
	Level 1	Level 2	Level 3	Total
Interest bearing securities:				
Money market securities	$ -	$ 530,043	$ -	$ 530,043
Fixed income securities	-	1,307,828	51,053	1,358,881
Equities:				
Canadian equity investments and funds	25,761	163,375	-	189,136
Global equity funds	-	354,516	-	354,516
Real estate pooled funds	-	-	45,027	45,027
	$ 25,761	**$ 2,355,762**	**$ 96,080**	**$ 2,477,603**
Percent of total	1%	95%	4%	100%

	2021			
	Level 1	Level 2	Level 3	Total
Interest bearing securities:				
Money market securities	$ -	$ 818,910	$ -	$ 818,910
Fixed income securities	-	734,874	51,585	786,459
Equities:				
Canadian equity investments and funds	54,802	83,912	-	138,714
Global equity funds	-	327,050	-	327,050
Real estate pooled funds	-	-	40,623	40,623
	$ 54,802	**$ 1,964,746**	**$ 92,208**	**$ 2,111,756**
Percent of total	3%	93%	4%	100%

Reconciliation of Investments classified as level 3

	2022		
	Fixed income securities	Real estate pooled funds	Total
Beginning of year	$ 51,585	$ 40,623	$ 92,208
Purchases	1,192	29	1,221
Sales	-	-	-
(Loss) gain included in the Consolidated Statement of Remeasurement Gains and Losses	(1,663)	4,375	2,712
Transfers out	(61)	-	(61)
End of year	**$ 51,053**	**$ 45,027**	**$ 96,080**

Note 10 Portfolio Investments (continued)

	2021		
	Fixed income securities	Real estate pooled funds	Total
Beginning of year	$ 75,213	$ 40,837	$ 116,050
Purchases	1,828	74	1,902
Sales	(24,045)	-	(24,045)
Gain (loss) included in the Consolidated Statement of Remeasurement Gains and Losses	1,708	(288)	1,420
Transfers out	(3,119)		(3,119)
End of year	**$ 51,585**	**$ 40,623**	**$ 92,208**

Note 11 Accounts Receivable

	2022			2021
	Gross	Allowance for Doubtful Accounts	Net	Net
AH operating transfers receivable [(i)]	$ 194,000	$	$ 194,000	$ 317,233
Other capital transfers receivable	96,127		96,127	74,409
Patient accounts receivable	116,576	42,081	74,495	69,851
Drugs rebates receivable	83,982		83,982	59,731
AH capital transfers receivable	21,400		21,400	55,822
Other operating transfers receivable	20,334		20,334	17,540
Other accounts receivable	113,777	9,686	104,091	70,829
	$ 646,196	**$ 51,767**	**$ 594,429**	**$ 665,415**

Accounts receivable are unsecured and non-interest bearing. At March 31, 2021, the total allowance for doubtful accounts was $34,891 of which $34,490 related to patient accounts receivable.

[(i)] AH operating transfers receivable at March 31, 2021 included a COVID-19 related amount of $92,169 that was cancelled in the year as part of a new agreement with AH (Note 14(a)).

Note 12 Accounts Payable and Accrued Liabilities

	2022	2021
Payroll payable and related accrued liabilities	$ 807,029	$ 796,747
Trade accounts payable and accrued liabilities	756,193	713,204
Provision for unpaid claims[(a)]	191,618	214,611
Obligations under capital leases[(b)]	129,882	144,877
Other liabilities	67,133	63,338
	$ 1,951,855	**$ 1,932,777**

Accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $250,754 (2021 – $338,379). Of these amounts, $10,025 (2021 – $11,518) comprise life lease deposits received from tenants of certain AHS' long term care facilities, amounts payable to AI of $23,550 (2021 – $97,050) related to a project funded by debt, and obligations under capital leases of $129,882 (2021 – $144,877).

(a) Provision for unpaid claims is an estimate of liability claims against AHS. It is influenced by factors such as historical trends involving claim payment patterns, loss payments, number of unpaid claims, claims severity and claim frequency patterns.

Note 12 Accounts Payable and Accrued Liabilities (continued)

The provision has been estimated using the discounted value of claim liabilities using a discount rate of 3.00% (2021 – 1.90%) plus a provision for adverse deviation, based on actuarial estimates.

(b) Obligations under capital leases include site leases with the University of Calgary, vehicle leases, equipment, obligations related to a clinical information system, site leases for ambulance services and a community care service facility.

The obligations will be settled between 2023 and 2041 and have an implicit interest rate payable ranging from 2.53% to 5.07% (2021 – 0.92% to 5.07%).

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

Year ended March 31	Minimum Contract Payments
2023	$ 24,656
2024	13,566
2025	12,670
2026	11,355
2027	9,853
Thereafter	82,561
Less: interest	(24,779)
	$ 129,882

Note 13 Employee Future Benefits

	2022	2021
Accrued vacation pay	$ 640,004	$ 626,599
Accumulating non-vesting sick leave[(a)]	135,445	130,745
SERP/SPP pension plans	2,429	3,442
	$ 777,878	**$ 760,786**

(a) Accumulating Non-Vesting Sick Leave

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

	2022	2021
Funded status – deficit	$ 145,281	$ 149,885
Unamortized net actuarial loss	(9,836)	(19,140)
Accrued benefit liability	**$ 135,445**	**$ 130,745**

Key assumptions used in the determination of the accumulating non-vesting sick leave liability are:

	2022	2021
Estimated average remaining service life	13 years	13 years
Draw down rate of accumulated non-vesting sick leave bank	18.30%	18.30%
Discount rate – beginning of year	1.77%	2.14%
Discount rate – end of year	2.50%	1.77%
Rate of compensation increase per year	2021-22 1.25% 2022-23 1.25% Thereafter 2.75%	2020-21 0.25% 2021-22 0.25% Thereafter 2.25%

Note 13 Employee Future Benefits (continued)

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP. AHS' employees comprise approximately 47% (2021 - 47%) of the total membership in LAPP. AHS is not responsible for future funding of the plan deficit other than through contribution increases. As AHS is exposed to the risk of contribution rate increases, the following disclosure is provided to explain this risk.

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

(ii) LAPP Surplus

The LAPP carried out an actuarial valuation as at December 31, 2020 and these results were then extrapolated to December 31, 2021.

	December 31, 2021	December 31, 2020
LAPP net assets available for benefits	$ 61,715,000	$ 53,599,237
LAPP pension obligation	49,792,629	48,637,900
LAPP surplus	**$ 11,922,371**	**$ 4,961,337**

The 2022 and 2021 LAPP contribution rates are as follows:

Calendar 2022		Calendar 2021	
Employer	**Employees**	**Employer**	**Employees**
8.45% of pensionable earnings up to the YMPE and 12.80% of the excess	7.45% of pensionable earnings up to the YMPE and 11.80% of the excess	9.39% of pensionable earnings up to the YMPE and 13.84% of the excess	8.39% of pensionable earnings up to the YMPE and 12.84% of the excess

(c) Pension Expense

	2022	2021
Local Authorities Pension Plan	$ 555,331	$ 536,504
Defined contribution pension plans and group RRSPs	42,545	43,561
Other pension plans	1,012	4,417
	$ 598,888	**$ 584,482**

Note 14 Unexpended Deferred Operating Revenue

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

	2022				2021
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 300,196	$ 29,561	$ 311,712	$ 641,469	$ 405,951
Received or receivable during the year	2,782,460	35,251	151,564	2,969,275	3,241,690
Unexpended deferred operating revenue returned[(ii)]	(97,511)	(34)	(154)	(97,699)	(4,916)
Restricted investment income	182	1,855	34,292	36,329	13,017
Transferred from unexpended deferred capital revenue [(iii)]	27,766	60,906	1,852	90,524	46,665
Transferred to expended deferred operating revenue	(363,213)	-	-	(363,213)	(789,166)
Recognized as revenue	(2,445,513)	(95,774)	(123,946)	(2,665,233)	(2,303,796)
Miscellaneous other revenue recognized	(181)	(49)	(33,643)	(33,873)	(12,683)
	204,186	**31,716**	**341,677**	**577,579**	**596,762**
Changes in unrealized net gains attributable to portfolio investments related to endowments and unexpended deferred operating revenue	(779)	(1,369)	(45,724)	(47,872)	44,707
Balance, end of year	**$ 203,407**	**$ 30,347**	**$ 295,953**	**$ 529,707**	**$ 641,469**

[(i)] The balance for other government includes $535 (2021 – $677) of unexpended deferred operating revenue received from government entities outside the Province of Alberta. The remaining balance in other government all relates to the Province of Alberta (Note 22).

[(ii)] The unexpended deferred operating revenue returned to AH in the year includes a COVID-19 related receivable balance of $92,169 at March 31, 2021 that was cancelled in the current year as part of a new agreement with AH (Note 11).

[(iii)] The transfer is mainly comprised of restricted capital funding that was used for approved expenditures that did not meet the definition of a tangible capital asset.

Note 14 Unexpended Deferred Operating Revenue (continued)

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

	2022				2021
	AH	Other Government	Donors and Non-Government	Total	Total
Research and education	$ 8,852	$ 3,021	$ 191,933	$ 203,806	$ 188,878
COVID-19 pandemic response and support	29,768	-	767	30,535	108,414
Support services	3,444	446	63,069	66,959	58,168
Physician revenue and alternate relationship plans	28,325	446	-	28,771	48,216
Addiction and mental health	44,815	3,778	1,522	50,115	45,897
Cancer prevention, screening and treatment	29,967	34	2,422	32,423	45,391
Primary Care Networks	20,299	-	-	20,299	21,095
Promotion, prevention and community	17,876	207	171	18,254	17,362
Long term care partnerships	-	19,109	-	19,109	17,304
Diagnostic and therapeutic services	14,845	-	1,377	16,222	1,374
Others individually less than $10,000	4,397	1,656	16,649	22,702	20,986
	202,588	**28,697**	**277,910**	**509,195**	**573,085**
Unrealized net gain attributable to portfolio investments related to endowments and unexpended deferred operating revenue (Note 10)	819	1,650	18,043	20,512	68,384
	$ 203,407	**$ 30,347**	**$ 295,953**	**$ 529,707**	**$ 641,469**

Note 15 Unexpended Deferred Capital Revenue

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

	2022				2021
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 74,594	$ 4,207	$ 86,310	$ 165,111	$ 108,823
Received or receivable during the year	147,338	197,413	56,576	401,327	413,314
Used for the acquisition of land	(987)	-	-	(987)	-
Unexpended deferred capital revenue returned	(419)	-	-	(419)	(1,196)
Transferred to expended deferred capital revenue	(140,632)	(136,980)	(47,380)	(324,992)	(309,165)
Transferred to unexpended deferred operating revenue[(ii)]	(27,766)	(60,906)	(1,852)	(90,524)	(46,665)
Balance, end of year	**$ 52,128**	**$ 3,734**	**$ 93,654**	**$ 149,516**	**$ 165,111**

[(i)] The balance for other government all relates to the Province of Alberta (Note 22).
[(ii)] The transfer is mainly comprised of restricted capital funding of approved expenditures that did not meet the definition of a tangible capital asset.

Note 15 Unexpended Deferred Capital Revenue (continued)

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

	2022	2021
AH		
COVID-19 related projects and equipment	$ 2,476	$ 29,380
Continuing Care Beds	18,844	20,000
Information systems	2,946	4,214
Medical Equipment Replacement Upgrade Program	-	322
Diagnostic equipment	9,560	216
Alberta Surgical Initiative Capital Program	-	-
Rural Health Facilities Revitalization Program	17,697	-
Other equipment	605	20,462
Total AH	**52,128**	**74,594**
Other government		
Facilities and improvements	3,734	4,207
Total other government	**3,734**	**4,207**
Donors and non-government		
Equipment	81,336	74,540
Facilities and improvements	12,282	11,764
COVID-19 related projects and equipment	36	6
Total donors and non-government	**93,654**	**86,310**
	$ 149,516	**$ 165,111**

Note 16 Expended Deferred Revenue

	2022	2021
Expended deferred capital revenue[a]	$ 8,278,969	$ 7,826,892
Expended deferred operating revenue[b]	336,972	427,445
	$ 8,615,941	**$ 8,254,337**

(a) Expended deferred capital revenue

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

	2022				2021
	AH	Other Government[i]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 587,533	$ 7,042,745	$ 196,614	$ 7,826,892	$ 7,359,615
Transferred from unexpended deferred capital revenue	140,632	136,980	47,380	324,992	309,165
Constructed tangible capital assets on behalf of AHS	-	425,337	-	425,337	543,417
Contributed tangible capital assets	-	-	522	522	334
Recognized as revenue	(95,777)	(169,977)	(33,020)	(298,774)	(385,639)
Balance, end of year	**$ 632,388**	**$ 7,435,085**	**$ 211,496**	**$ 8,278,969**	**$ 7,826,892**

[i] The balance includes $nil (2021 – $4) of expended deferred capital revenue received from government entities outside the Province of Alberta. The remaining balance in other government all relates to the Province of Alberta (Note 22).

Note 16 Expended Deferred Revenue (continued)

(b) Expended deferred operating revenue

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

	2022			2021
	AH	Other Government[(i)]	Total	Total
Balance, beginning of year	$ 387,915	$ 39,530	$ 427,445	$ -
Transferred from unexpended deferred operating revenue	363,213	-	363,213	789,166
Contributed inventories of supplies	-	-	-	107,460
Recognized as unrestricted revenue	-	(39,530)	(39,530)	-
Recognized as restricted revenue	(414,156)	-	(414,156)	(469,181)
Balance, end of year	**$ 336,972**	**$ -**	**$ 336,972**	**$ 427,445**

[(i)] The balance relates to contributions received from a government entity outside the Province of Alberta.

The balance at March 31, 2022 of expended deferred operating revenue pertains to purchased or contributed but unused COVID-19 supplies of $336,972 (2021 – $417,201) and a related prepayment of $nil (2021 – $10,244).

Note 17 Debt

	2022	2021
Debentures [(a)]:		
Parkade loan #1	$ 16,925	$ 20,257
Parkade loan #2	17,567	20,334
Parkade loan #3	25,507	28,493
Parkade loan #4	107,687	116,390
Parkade loan #5	26,528	28,498
Parkade loan #6	19,504	20,559
Parkade loan #7	43,240	45,388
Parkade loan #8	153,334	155,200
Energy savings initiative loan	18,701	20,540
EMS support vehicle loan[(b)]	37,500	-
	466,493	455,659
Loan proceeds to be received[(b)]	(11,500)	-
	$ 454,993	**$ 455,659**

(a) Alberta Treasury Board and Finance (TBF) is responsible for the administration of the Province's lending program.

AHS issued debentures to TBF, a related party, to finance the construction of parkades. AHS has pledged revenue derived directly or indirectly from the operations of all parking facilities being constructed, renovated, owned, and operated by AHS as security for these debentures.

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

AHS is in compliance with all performance requirements relating to its debentures as at March 31, 2022.

(b) AHS issued a debenture to TBF relating to EMS support vehicles. AHS has pledged the vehicles as security for this debenture. As at March 31, 2022 AHS has received $26,000 of the $37,500 debenture. The remaining $11,500 in proceeds will be received in 2022-23 fiscal year.

Note 17 Debt (continued)

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

	Maturity Date	Fixed Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Parkade loan #6	December 2035	3.6090%
Parkade loan #7	March 2038	2.6400%
Parkade loan #8	December 2059	3.6010%
Energy savings initiative loan	December 2030	2.4160%
EMS support vehicle loan	September 2026	1.1500%

(c) As at March 31, 2022, AHS has access to a $220,000 (2021 – $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, 2022, AHS has $nil (2021 – $nil) draws against this facility.

AHS also has access to a $33,000 (2021 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2022, AHS has $3,626 (2021 – $3,772) in a letter of credit outstanding against this facility. AHS is in compliance with the terms of the agreement relating to the letter of credit as at March 31, 2022.

(d) AHS is committed to making principal and interest payments with respect to its outstanding debt as follows:

Year Ended March 31	Principal	Interest	Total
2023	32,405	17,086	49,491
2024	38,275	15,876	54,151
2025	39,633	14,519	54,152
2026	41,047	13,104	54,151
2027	35,618	11,630	47,248
Thereafter	279,515	120,304	399,819
	$ 466,493	**192,519**	**659,012**

During the year, the total interest related to debt was $17,903 (2021 – $18,827), comprised of capitalized interest of $5,553 (2021 – $5,565) (Note 18a) and interest expense of $12,350 (2021 – $13,262). Accrued interest at March 31, 2022 amounted to $2,893 (2021 – $3,006).

Note 18 Tangible Capital Assets

Cost	2021	Additions[a]	Transfers	Disposals/write-downs	2022
Facilities and improvements	$ 10,517,852	$ 106	$ 86,342	$ (11,144)	$ 10,593,156
Work in progress	1,492,842	672,654	(229,305)	(2,143)	1,934,048
Equipment	2,724,823	195,508	1,160	(98,057)	2,823,434
Information systems	2,014,793	35,708	71,953	(15,687)	2,106,767
Building service equipment	918,156	188	57,664	(794)	975,214
Land[b]	116,840	987	-	(23)	117,804
Leased facilities and improvements	256,700	-	6,178	-	262,878
Land improvements	110,023	-	6,008	(21)	116,010
	$ 18,152,029	**$ 905,151**	**$ -**	**$ (127,869)**	**$ 18,929,311**

Accumulated Amortization	2021	Amortization Expense	Effect of Transfers	Disposals/write-downs	2022
Facilities and improvements	$ 4,420,368	$ 121,983	$ -	$ (10,835)	$ 4,531,516
Work in progress	-	-	-	-	-
Equipment	2,131,296	155,655	-	(96,251)	2,190,700
Information systems	1,449,602	121,835	-	(15,358)	1,556,079
Building service equipment	524,346	48,269	-	(707)	571,908
Land[b]	-	-	-	-	-
Leased facilities and improvements	196,225	9,275	-	-	205,500
Land improvements	74,929	3,470	-	(21)	78,378
	$ 8,796,766	**$ 460,487**	**$ -**	**$ (123,172)**	**$ 9,134,081**

Cost	2020	Additions[a]	Transfers	Disposals/write-downs	2021
Facilities and improvements	$ 9,645,300	$ -	$ 874,506	$ (1,954)	$ 10,517,852
Work in progress	1,744,688	875,266	(1,127,112)	-	1,492,842
Equipment	2,623,616	162,205	(7,147)	(53,851)	2,724,823
Information systems	1,827,799	25,414	175,590	(14,010)	2,014,793
Building service equipment	840,122	-	78,034	-	918,156
Land[b]	116,926	-	-	(86)	116,840
Leased facilities and improvements	255,393	-	1,307	-	256,700
Land improvements	105,581	-	4,822	(380)	110,023
	$ 17,159,425	**$ 1,062,885**	**$ -**	**$ (70,281)**	**$ 18,152,029**

Accumulated Amortization	2020	Amortization Expense	Effect of Transfers	Disposals/write-downs	2021
Facilities and improvements	$ 4,175,901	$ 245,717	$ -	$ (1,250)	$ 4,420,368
Work in progress	-	-	-	-	-
Equipment	2,034,711	149,694	-	(53,109)	2,131,296
Information systems	1,356,789	104,110	-	(11,297)	1,449,602
Building service equipment	476,980	47,366	-	-	524,346
Land[b]	-	-	-	-	-
Leased facilities and improvements	187,033	9,192	-	-	196,225
Land improvements	72,051	3,258	-	(380)	74,929
	$ 8,303,465	**$ 559,337**	**$ -**	**$ (66,036)**	**$ 8,796,766**

Note 18 Tangible Capital Assets (continued)

	Net Book Value	
	2022	2021
Facilities and improvements	$ 6,061,640	$ 6,097,484
Work in progress	1,934,048	1,492,842
Equipment	632,734	593,527
Information systems	550,688	565,191
Building service equipment	403,306	393,810
Land[(b)]	117,804	116,840
Leased facilities and improvements	57,378	60,475
Land improvements	37,632	35,094
	$ 9,795,230	**$ 9,355,263**

(a) Additions

Additions include tangible capital assets constructed by AI on behalf of AHS of $425,337 (2021 – $543,417) and $522 contributed from other sources (2021 – $334). During the year, AHS capitalized interest of $5,553 (2021 – $5,565) (Note 17d) within work in progress. Also included in additions is $26,327 (2021 - $45,525) of COVID-19 related tangible capital assets. Capital lease additions amounted to $15,646 (2021 – $63,214).

(b) Leased Land

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

Site	Leased from	Lease Expiry
Parking Lot at Queen Elizabeth II Hospital	Town of Grande Prairie	June 2022
Laneway adjacent to Queen Elizabeth II Hospital	Town of Grande Prairie	December 2023
Evansburg Community Health Centre	Yellowhead County	April 2031
Bethany Care Centre	Red Deer College	April 2034
Myrnam Land	Eagle Hill Foundation	May 2038
Helipad Land at Two Hills	Stella Stefiuk	August 2041
McConnell Place North	City of Edmonton	September 2044
Northeast Community Health Centre	City of Edmonton	February 2047
Jasper Healthcare Centre	Parks Canada	March 2049
Foothills Medical Centre Parkade	University of Calgary	July 2054
Alberta Children's Hospital	University of Calgary	December 2103
Kaye Edmonton Clinic (Parcel H)	The University of Alberta	February 2109

(c) Leased Tangible Capital Assets

Tangible capital assets acquired through capital leases includes vehicle leases, equipment, information systems and facilities with a cost of $397,498 (2021 – $375,816) and accumulated amortization of $240,358 (2021 – $218,004).

Note 19 Inventories of Supplies

	2022	2021
Pharmaceuticals	$ 93,018	$ 78,088
Medical and Surgical Supplies	49,450	52,941
Personal Protective Equipment	246,440	374,201
COVID-19 Laboratory testing supplies	13,048	22,480
COVID-19 Rapid Test Kits	93,826	20,520
Other	17,237	15,698
	$ 513,019	**$ 563,928**

Inventories of $1,301,316 (2021 – $1,170,549) were expensed during the year. A valuation adjustment of $109,034 (2021 – $nil) has been recorded relating to personal protective equipment inventories that no longer meet clinical standards and requirements (Note 7).

AHS holds and distributes COVID-19 rapid test kits, provided at no cost by the Federal Government, on behalf of AH. These inventories are excluded from these consolidated financial statements. During the year, AHS received $286,607 of rapid test kits, issued $168,968 during the year and is holding $117,639 on behalf of AH as at March 31, 2022.

Note 20 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2022					2021
	Unrestricted Surplus	Invested in Tangible Capital Assets[a]	Endowments[b]	Internally Restricted Surplus for Insurance Equity Requirements and Foundations[c]	Total	Total
Balance, beginning of year	$ 151,092	$ 925,563	$ 75,668	$ 83,950	$ 1,236,273	$ 1,132,601
Annual operating surplus	142,495	-	-	-	142,495	103,672
Net investment in tangible capital assets	(18,610)	18,610	-	-	-	-
Transfer of insurance equity requirements and foundations surpluses	(37,640)	-	-	37,640	-	-
Transfer of endowment contributions (note 5)	(1,714)	-	1,714	-	-	-
Balance, end of year	**$ 235,623**	**$ 944,173**	**$ 77,382**	**$ 121,590**	**$ 1,378,768**	**$ 1,236,273**

(a) Invested in Tangible Capital Assets

The accumulated surplus invested in tangible capital assets represents the net book value of tangible capital assets that have previously been purchased with AHS' unrestricted surplus.

Note 20 Accumulated Surplus (continued)

Reconciliation of invested in tangible capital assets:

	2022	2021
Tangible capital assets (Note 18)	$ 9,795,230	$ 9,355,263
Less funded by:		
Expended deferred capital revenue (Note 16(a))	(8,278,969)	(7,826,892)
Debt (Note 17)	(454,993)	(455,659)
Unexpended debt	22,812	9,246
Obligations under capital leases (Note 12(b))	(129,882)	(144,877)
Life lease deposits (Note 12)	(10,025)	(11,518)
	$ 944,173	**$ 925,563**

(b) Endowments

Endowments represent the portion of accumulated surplus that is restricted and must be maintained in perpetuity. Transfers of endowment contributions from unrestricted surplus include $1,714 (2021 – $230) of contributions received in the year (Note 5).

(c) Internally Restricted Surplus for Insurance Equity Requirements and Foundations

Insurance equity requirements comprise surpluses of $33,239 (2021 – $20,912) related to equity of the LPIP mainly relating to legislative requirements per the Insurance Act. Foundations comprise surpluses amounting to $88,351 (2021 – $63,038) related to donations received by AHS' Controlled Foundations without external restrictions attached.

Note 21 Contractual Obligations and Contingent Liabilities

(a) Contractual Obligations

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

The estimated aggregate amount payable for the unexpired terms of these contractual obligations are as follows:

Year ended March 31	Services[(i)]	Other[(ii)]	Operating Lease	Capital Projects	Total[(iii)]
2023	$ 3,106,507	$ 481,816	$ 61,947	$ 233,510	$ 3,883,780
2024	1,560,293	264,582	52,678	26,320	1,903,873
2025	1,334,355	162,003	43,687	135	1,540,180
2026	1,151,708	83,209	32,737	-	1,267,654
2027	779,178	57,705	28,546	-	865,429
Thereafter	7,859,939	53,003	80,193	-	7,993,135
March 31, 2022	**15,791,980**	**1,102,318**	**299,788**	**259,965**	**17,454,051**
March 31, 2021	**$ 15,709,505**	**$ 1,234,006**	**$ 328,133**	**$ 258,671**	**$ 17,530,315**

(i) Service obligations mainly relate to contracts with third parties for the provision of long-term care and home care services.
(ii) Other obligations mainly relate to contracts with third parties for maintenance, information technology services, software, equipment, and procurement of medical supplies and food.
(iii) The total contractual obligations exclude the impacts of the outsourcing of community laboratory services discussed in Note 21(b).

Note 21 Contractual Obligations and Contingent Liabilities (continued)

(b) Outsourcing of Community Laboratory Services

In 2020, the Minister of Health announced plans to explore the outsourcing of community laboratory services in Alberta. As a result, AHS issued a formal Request for Proposal (RFP) for the provision of community laboratory services, which included patient service centre operations, logistics management, analytical testing and information management. On May 30, 2022, AHS and a third party service provider finalized and executed a Services Agreement and Ancillary Agreements that will result in the transition of delivering community laboratory services across the province to the third party service provider commencing fiscal 2022-23. The agreement will extend over an initial term of 14 years and four months with an estimated commitment of $4.6 billion. This transfer of service does not change AHS' mandate to provide laboratory services within Alberta. AHS plans to continue with the delivery of acute care hospital laboratory, urgent care laboratory, and public health laboratory services and specialty complex and esoteric testing services. The transition of community laboratory services from AHS to the third party service provider is expected to be completed by March 31, 2023.

(c) Contingent Liabilities

i. Legal Claims

AHS is subject to legal claims during its normal course of business. AHS recognizes a liability when the assessment of a claim indicates that a future event is likely to confirm that a liability has been 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, 2022, accruals have been recorded as part of the provision for unpaid claims and other liabilities (Note 12). Included in this accrual are claims in which AHS has been jointly named with the Minister. The accrual provided for these claims under the provision for unpaid claims represents AHS' portion of the liability.

AHS has been named in 283 legal claims (2021 – 314 claims) related to conditions in existence at March 31, 2022 where the likelihood of the occurrence of a future event confirming a contingent loss is not determinable. Of these, 247 claims have $759,551 in specified amounts and 36 have no specified amounts (2021 – 258 claims with $728,811 of specified claims and 56 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that is different than the claimed amount.

ii. Collective Agreements

AHS currently has 18 (2021 – 19) collective agreements that have expired and are currently under negotiation at March 31, 2022. Given that negotiations are ongoing, no additional disclosures have been made.

Note 22 Related Parties

Transactions with related parties are included within these consolidated financial statements, unless otherwise stated.

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

Related parties also include key management personnel of AHS. AHS has defined key management personnel to include those disclosed in Schedules 2A and 2B of these consolidated financial statements, except management reporting to CEO direct reports. Related party transactions with key management personnel primarily consist of compensation related payments and are undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length.

AHS is a related party with respect to those entities consolidated or included on a modified equity basis in the consolidated financial statements of the Province of Alberta. Entities consolidated or included on a modified equity basis have been grouped with their respective ministry and transactions between AHS and the other ministries are recorded at their exchange amount as follows:

	Revenues[a]		Expenses	
	2022	2021	2022	2021
Alberta Advanced Education[b]	$ 54,214	$ 55,415	$ 191,646	$ 182,453
Alberta Infrastructure[c]	235,899	319,155	314	252
Other ministries	23,791	35,040	76,418	57,497
Total for the year	**$ 313,904**	**$ 409,610**	**$ 268,378**	**$ 240,202**

	Receivable from		Payable to	
	2022	2021	2022	2021
Alberta Advanced Education[b]	$ 4,983	$ 6,115	$ 38,066	$ 32,561
Alberta Infrastructure[c]	62,504	43,834	23,550	97,050
Other ministries[d]	8,078	8,395	458,768	459,148
Balance, end of year	**$ 75,565**	**$ 58,344**	**$ 520,384**	**$ 588,759**

(a) Revenues with Province of Alberta ministries include other government transfers of $284,500 (2021 – $384,161), (Note 4), other income of $24,646 (2021 – $23,369) (Note 6), and fees and charges of $4,758 (2021 – $2,080).

(b) Most of AHS' transactions with Alberta 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 transactions reported are a result of funding provided from one to the other and recoveries of shared costs.

(c) The transactions with AI relate to the construction of tangible capital assets on behalf of AHS. These transactions include operating transfers of $66,983 (2021 – $44,614) and recognition of expended deferred capital revenue of $168,916 (2021 – $274,541) relating to tangible capital assets with stipulations or external restrictions to utilize over their remaining useful lives. Not included in the table above but included in total amounts disclosed in Note 18(a) is tangible capital assets constructed by AI on behalf of AHS of $425,337 (2021 – $543,417).

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

At March 31, 2022, AHS has recorded deferred revenue from other ministries within the Province of Alberta, excluding AH, of $29,812 (2021 – $28,884) related to unexpended deferred operating revenue (Note 14), $3,734 (2021 – $4,207) related to unexpended deferred capital revenue (Note 15) and $7,435,085 (2021 – $7,042,740) related to expended deferred capital revenue (Note 16(a)).

Contingent liabilities in which AHS has been jointly named with other government entities within the Province of Alberta are disclosed in Note 21.

Note 23 Government Partnerships

AHS has proportionately consolidated 50% of the results of the PCNs and NACTRC and 33.33% of the results in iRSM. The following is 100% of the financial position and results of operations for AHS' government partnerships.

	2022	2021
Financial assets (portfolio investments, accounts receivable, other assets)	$ 63,639	$ 67,275
Liabilities (trade accounts payable, unexpended deferred operating revenue)	63,639	67,275
Accumulated surplus	$ -	$ -
Total revenues	$ 260,700	$ 260,508
Total expenses	260,700	260,508
Annual surplus	**$ -**	**$ -**

Note 24 Trusts under Administration

(a) Health Benefit Trust of Alberta (HBTA)

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

The HBTA's balances as at March 31 are as follows:

	2022	2021
Financial assets	$ 113,003	$ 108,516
Liabilities	31,927	17,698
Net financial assets	$ 81,076	$ 90,818
Non-financial assets	4	12
Net assets	**$ 81,080**	**$ 90,830**

AHS has included in prepaid expenses $49,749 (2021 – $57,179) representing in substance a prepayment of future premiums to the HBTA. For the fiscal year ended March 31, 2022, AHS paid premiums of $494,645 (2021 – $431,569) which is approximately 98% (2021 – 98%) of the total premiums received by the HBTA

(b) Other Trust Funds

AHS holds 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 appropriate the funds or 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, 2022, the balance of funds held in trust by AHS for research and development is $100 (2021 – $100).

AHS holds funds in trust from continuing care residents for personal expenses. As at March 31, 2022, the balance of these funds is $1,832 (2021 – $1,595). These amounts are not included in the consolidated financial statements.

AHS and a third party trustee administer the SERP in accordance with a retirement compensation arrangement trust agreement. As at March 31, 2022, there are $29,429 in plan assets (2021 – $30,329). These amounts are not included in the consolidated financial statements.

Note 25 Segment Disclosure

The Consolidated Schedule of Segment Disclosures – *Schedule 3* is intended to enable users to better understand the reporting entity and identify the resources allocated to the major activities of AHS.

AHS' revenues, as reported on the Consolidated Statement of Operations, are most informatively presented by source and are not reasonably assignable to the reportable segments. For each reported segment, the expenses are directly or reasonably attributable to the segment.

The segments have been selected based on the presentation that is adopted for the financial reporting, planning and budget processes, and represent the major distinguishable activities of AHS.

Segments include:

(a) Continuing care

Continuing care is comprised of long-term care including chronic and psychiatric care in facilities operated by AHS and contracted providers.

(b) Community care

Community care includes supportive living, palliative and hospice care, and community programs including Primary Care Networks, Family Care Clinics, urgent care centres, and community mental health. This segment excludes community-based dialysis, oncology, and surgical services.

(c) Home care

Home care is comprised of home nursing and support.

(d) Acute care

Acute care is comprised predominantly of patient care units such as medical, surgical, intensive care, obstetrics, pediatrics, mental health, emergency, day/night care, clinics, day surgery, and contracted surgical services. This segment also includes operating and recovery rooms.

(e) Ambulance services

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

(f) Diagnostic and therapeutic services

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

(g) Population and public health

Population and public health is comprised primarily of health promotion, disease and injury prevention, and health protection.

(h) Research and education

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

(i) Information technology

Information technology is comprised of costs pertaining to the provision of service and consultation in the design, development, and implementation of information technology services and systems.

Note 25 Segment Disclosure (continued)

(j) Support services

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

(k) Administration

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

Note 26 Impact of COVID-19 Pandemic

Alberta continues to be impacted by the COVID-19 pandemic, with hospitalizations and cases applying additional stress on Alberta's health care system.

The pandemic continues to impact AHS in many areas, including:

- Supporting Albertans with contact tracing, testing and treatment for COVID-19;
- The provision of personal protective equipment (PPE) including hand sanitizer and disinfectant solutions for the overall safety of Albertans;
- The delivery of COVID -19 rapid test kits to Albertans. A portion of the COVID-19 rapid test kits under this program were provided at no cost by the Federal Government. AHS holds and distributes these COVID-19 rapid test kits on behalf of AH, and therefore they are excluded from the consolidated financial statements;
- Funding provided to third party service providers, including long term care and home care providers that have been significantly impacted by COVID-19;
- The operation of assessment and treatments centers;
- Increasing capacity at acute care sites for treatment and assessment of COVID-19 cases;
- Delays or deferrals of certain health care related services;
- Redeployment of parts of the AHS workforce to areas with the greatest need to support front line efforts;
- Vaccine deployment initiatives including the staffing and setup of various facilities for the administration of vaccines. Given that AH has not allocated the costs of the vaccines to AHS, these costs are excluded from the consolidated financial statements; and
- Delays in the implementation of certain information systems initiatives.

Included within the consolidated statement of operations are incremental expenses of $1,621,619 (2021 - $1,286,399) associated with AHS's pandemic response activities. AHS has recorded $1,606,515 (2021 - $1,286,399) of revenue to partially offset these expenses. In addition AHS has recognized $71,003 (2021 - $145,566) of revenue to partially offset reduced revenue associated with out of province and out of country patient billings, parking, self-pay medical fees, retail food services and rent abatements.

Note 27 Corresponding Amounts

Certain amounts have been reclassified to conform to 2022 presentation. An adjustment has been made to the Consolidated Statement of Cash Flows for year ended March 31, 2021 to reclassify restricted contributions received and used to purchase COVID-19 supplies of $789,166 from operating transactions to financing transactions.

Note 28 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on June 1, 2022 and submitted to the Minister for approval.

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

	2022		2021
	Budget (Note 3)	Actual	Actual
Salaries and benefits	$ 8,615,000	$ 9,136,225	$ 8,836,269
Contracts with health service providers	2,943,000	3,210,555	3,078,611
Contracts under the Health Facilities Act	22,000	27,695	21,828
Drugs and gases	600,000	651,495	592,640
Medical supplies	570,000	747,809	652,304
Other contracted services	1,336,000	1,476,530	1,368,110
Other[a]	1,283,000	1,640,772	1,572,070
Amortization and loss on disposals/write-downs of tangible capital assets (Note 18)	627,000	465,184	563,582
	$ 15,996,000	**$ 17,356,265**	**$ 16,685,414**
(a) Significant amounts included in Other are:			
Housekeeping, laundry and linen, staff wearing apparel, plant maintenance and biomedical engineering supplies[i][ii]	$ 88,000	$ 378,838	$ 439,087
Equipment expense	229,000	253,690	237,216
Utilities	117,000	163,234	129,022
Building and ground expenses	109,000	134,362	95,966
Building rent	129,000	133,268	128,496
Food and dietary supplies	81,000	75,929	69,530
Minor equipment purchases	52,000	75,498	74,794
Office supplies	51,000	67,017	57,701
Fundraising and grants awarded	52,000	50,573	47,323
Telecommunications	40,000	32,520	34,339
Insurance and liability claims	50,000	31,383	58,180
Travel	34,000	30,011	22,473
Licenses, fees and memberships	22,000	28,310	21,116
Education	12,000	9,389	8,325
Other	217,000	176,750	148,502
	$ 1,283,000	**$ 1,640,772**	**$ 1,572,070**

[i] Includes PPE, such as procedural masks, N95s, gowns, face shields and goggles, as well as other COVID-19 supplies such as hand sanitizers, disinfecting wipes and other cleaning supplies.

[ii] Valuation adjustment of $109,034 (2021 - $nil) has been recorded relating to personal protective equipment inventories that no longer meet clinical standards and requirements (Note 19).

SCHEDULE 2 - SCHEDULES OF REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2022

SCHEDULE 2A – BOARD REMUNERATION FOR THE YEAR ENDED MARCH 31, 2022

	Term	2022 Committees	2022 Remuneration	2021 Remuneration
Board Chairs[f]				
Gregory Turnbull	Since Dec 8, 2021	AOC, ARC, CEC, FC, GC, HRC, QSC	$ 22	$ -
David Weyant	Aug 20, 2019 to Dec 7, 2021	AOC, ARC, CEC, FC, GC, HRC, QSC	45	71
Board Members				
Dr. Sayeh Zielke (Vice Chair)	Since Sep 28, 2020	ARC, CEC, FC, HRC, QSC (Chair)	49	21
Dr. Brenda Hemmelgarn (Vice Chair)	Nov 27, 2015 to Jan 22, 2021	-	-	36
Deborah Apps	Since Jan 19, 2021	CEC, FC, QSC	32	6
David Carpenter	Nov 27, 2015 to Jun 1, 2021	ARC (Chair), FC (Chair)	8	37
Tony Dagnone	Since Jan 19, 2021	FC, HRC, QSC	32	8
Richard Dicerni	Nov 27, 2015 to Aug 31, 2020	-	-	10
Sherri Fountain	Since Jan 19, 2021	AOC, FC, GC (Chair), HRC	35	8
Hartley Harris	Since Aug 9, 2021	AOC, FC, GC, HRC	20	-
Stephen Mandel	Sep 25, 2019 to Sep 27, 2021	AOC (Chair), CEC, FC, QSC	18	32
Jack Mintz	Since Jun 3, 2021	ARC (Chair), FC, GC	26	-
Heidi Overguard	Since Sep 25, 2019	AOC, CEC, FC, GC, HRC (Chair), QSC	36	33
Natalia Reiman	Since Jan 19, 2021	ARC, CEC, FC, GC, HRC	33	8
Hugh Sommerville	Nov 27, 2015 to Jan 25, 2021	-	-	24
Brian Vaasjo	Since Aug 20, 2019	AOC (Chair), ARC, FC (Chair), GC	35	32
Glenda Yeates	Nov 27, 2015 to Jun 1, 2021	ARC, FC, QSC (Chair)	6	33
Vicki Yellow Old Woman	Since Sep 28, 2020	ARC, CEC (Chair), FC, GC, HRC	36	19
Board Committee Participants[g]				
Dr. William Ghali	Since Oct 1, 2021	QSC	2	-
Irv Kipnes	Apr 9, 2021 to Dec 3 2021	AOC	3	-
Stephen Livergant	Since Apr 9, 2021	AOC	2	-
Dr. Brian Postl	Jan 1, 2018 to Jul 2, 2021	QSC	1	3
Gord Winkel	Since Nov 27, 2015	QSC	3	3
Total Board			**$ 444**	**$ 384**

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

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

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

SCHEDULE 2B - EXECUTIVE REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2022

	2022						
For the Current Fiscal Year	FTE [a]	Base Salary [b,h]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board Direct Reports							
President and Chief Executive Officer[i]	1.00	$ 574	$ -	$ 117	$ 691	$ -	$ 691
Chief Audit Executive[j,o]	1.00	277	1	34	312	-	312
CEO Direct Reports							
VP and Chief Operating Officer, Clinical Operations[o]	1.00	370	-	72	442	-	442
VP and Medical Director, Clinical Operations[k,o]	0.51	229	11	58	298	-	298
VP and Medical Director, Clinical Operations[l,p]	0.37	147	-	18	165	-	165
VP, Quality and Chief Medical Officer[o]	1.00	464	-	48	512	-	512
VP, People, Health Professions and Information Technology[m,o]	1.00	330	1	40	371	-	371
VP, Cancer Care Alberta and Clinical Support Services[o]	1.00	330	-	66	396	-	396
VP, Provincial Clinical Excellence[n,q]	1.00	289	13	48	350	-	350
VP and Medical Director, Cancer Care Alberta, Clinical Support Services and Provincial Clinical Excellence[n,q]	1.00	450	32	46	528	-	528
VP, Community Engagement and Communications[o]	1.00	330	-	79	409	-	409
VP, Corporate Services and Chief Financial Officer[o]	1.00	400	1	88	489	-	489
General Counsel[o]	1.00	255	4	65	324	-	324
Total Executive	**11.88**	**$ 4,445**	**$ 63**	**$ 779**	**$ 5,287**	**$ -**	**$ 5,287**
Management Reporting to CEO Direct Reports	**54.24**	**$ 13,023**	**$ 520**	**$ 2,011**	**$ 15,554**	**$ 221**	**$ 15,775**

SCHEDULE 2B - EXECUTIVE REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2022 (CONTINUED)

	2021						
For the Prior Fiscal Year	FTE [a]	Base Salary [b,h]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board Direct Reports							
President and Chief Executive Officer	1.00	$ 574	$ -	$ 119	$ 693	$ -	$ 693
Chief Audit Executive	1.00	277	1	75	353	-	353
Chief Ethics and Compliance Officer	0.57	121	-	25	146	-	146
CEO Direct Reports							
VP and Chief Operating Officer, Clinical Operations	1.00	370	-	135	505	-	505
VP and Medical Director, Clinical Operations	1.00	397	-	92	489	-	489
VP, Quality and Chief Medical Officer	1.00	464	-	73	537	-	537
VP, People, Health Professions and Information Technology	1.00	330	1	68	399	-	399
VP, People	0.57	255	-	39	294	-	294
VP, Cancer Care Alberta and Clinical Support Services	1.00	330	-	81	411	-	411
VP, Provincial Clinical Excellence	1.00	289	14	47	350	-	350
VP and Medical Director, Cancer Care Alberta, Clinical Support Services and Provincial Clinical Excellence	1.00	450	33	44	527	-	527
VP, Community Engagement and Communications	1.00	330	-	72	402	-	402
VP, Corporate Services and Chief Financial Officer	0.75	301	-	90	391	-	391
Interim VP, Corporate Services and Chief Financial Officer	0.27	96	9	4	109	-	109
General Counsel	0.43	109	3	30	142	-	142
Total Executive	**12.59**	**$ 4,693**	**$ 61**	**$ 994**	**$ 5,748**	**$ -**	**$ 5,748**
Management Reporting to CEO Direct Reports	**55.63**	**$ 12,978**	**$ 682**	**$ 2,883**	**$ 16,543**	**$ 35**	**$ 16,578**

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

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

	2022			2021			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2021	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2022
President and Chief Executive Officer	$ 47	$ -	$ 47	$ 48	$ 269	$ 67	$ 336
Chief Audit Executive	11	-	11	12	139	25	164
VP and Chief Operating Officer, Clinical Operations							
SERP	-	(20)	(20)	36	683	(12)	671
SPP	22	-	22	23	255	35	290
VP and Medical Director, Clinical Operations	25	-	25	23	92	42	134
VP and Medical Director, Clinical Operations							
SERP	-	(7)	(7)	11	218	(218)	-
SPP	10	-	10	27	232	(232)	-
VP, Quality and Chief Medical Officer	34	-	34	35	392	66	458
VP, People, Health Professions and Information Technology	17	-	17	19	233	33	266
VP, Cancer Care Alberta and Clinical Support Services	17	-	17	19	168	29	197
VP, Provincial Clinical Excellence[n]	-	-	-	-	-	-	-
VP and Medical Director, Cancer Care Alberta, Clinical Support Services and Provincial Clinical Excellence[n]	-	-	-	-	-	-	-
VP, Community Engagement and Communications	17	-	17	19	183	32	215
VP, Corporate Services and Chief Financial Officer	26	-	26	20	20	26	46
General Counsel	8	-	8	10	81	13	94

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

FOOTNOTES TO THE SCHEDULES OF REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2022

Definitions

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

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

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

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

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

Board and Board Committee Participants

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

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

Executive

h. Base salary reported for executives are the actual payments earned during the year, and is therefore contingent on the number of AHS' work days in the year. For the year ended March 31, 2022, the number of work days at AHS is 261 (2021 – 261 work days).

i. The incumbent was engaged in an employment agreement with AHS while on leave of absence from the University of Alberta. The incumbent held the position until April 4, 2022, at which time the incumbent left AHS. The incumbent received salary and other accrued entitlements to the date of departure, followed by a lump sum severance of $660 to be paid in fiscal 2022-23.

j. The incumbent received vacation payouts totaling $32 during the year for unused accrued vacation earned in prior periods; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

k. The incumbent held the position of Zone Medical Director, Calgary Zone until September 7, 2021 at which time the incumbent was appointed to Vice President and Medical Director, Clinical Operations and became a direct report to the President and Chief Executive Officer.

l. The incumbent held the position until August 13, 2021 at which time the incumbent left AHS. At this time, the incumbent received a vacation payout of $18 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

m. The incumbent received vacation payouts totaling $35 during the year for unused accrued vacation earned in prior periods; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

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

Termination Obligations

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

FOOTNOTES TO THE SCHEDULES OF REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2022 (CONTINUED)

p. Based on the provision of the applicable SPP and SERP, the following outlines the benefits received by the incumbent who terminated employment with AHS within the 2021-22 fiscal period. As a result of retirement, the incumbent is entitled to the benefits accrued to them up to the date of retirement. For participants of SPP, the benefit includes the account balances as at March 31, 2021 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, 2021, the current period benefit cost, interest accruing on the obligations, and the amortization of any actuarial gains or losses in the period that were incurred during the current year as identified in Schedule 2C.

Supplemental Plan	Supplemental Plan Commencement Date	Benefit (not in thousands)	Frequency	Payment Terms
SPP	May 1, 2012	$36,825 increasing annually to $37,193	Annually	For a fixed term of 7 years from September 2021 to January 2027
SERP	October 1, 2008	$1,853	Monthly	For a fixed term of 10 years from September 1, 2021 to August 1, 2031

q. 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.

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF SEGMENT DISCLOSURES FOR THE YEAR ENDED MARCH 31

	2022								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Facilities Act	Drugs and gases	Medical supplies	Other contracted services	Other	Amortization and loss on disposals/ write-downs of tangible capital assets	Total
Continuing care	$ 331,305	$ 957,042	$ -	$ 7,482	$ 8,808	$ 21,343	$ 28,545	$ 2,601	$ 1,357,126
Community care	718,732	861,783	-	14,310	4,643	62,097	69,490	705	1,731,760
Home care	345,575	241,528	-	192	11,306	89,492	21,538	84	709,715
Acute care	3,185,441	434,549	27,695	593,905	374,673	562,322	181,194	63,541	5,423,320
Ambulance services	322,248	169,603	-	2,600	5,470	2,505	39,073	16,221	557,720
Diagnostic and therapeutic services	1,638,490	322,681	-	26,366	256,530	338,966	119,709	54,851	2,757,593
Population and public health	587,502	25,323	-	5,068	73,958	65,299	119,027	280	876,457
Research and education	186,288	3,021	-	80	1,182	123,751	36,662	122	351,106
Information technology	319,306	18,244	-	-	37	32,215	187,367	120,568	677,737
Support services	1,122,649	162,770	-	1,479	10,815	145,495	800,714	203,797	2,447,719
Administration	378,689	14,011	-	13	387	33,045	37,453	2,414	466,012
Total	**$ 9,136,225**	**$ 3,210,555**	**$ 27,695**	**$ 651,495**	**$ 747,809**	**$ 1,476,530**	**$ 1,640,772**	**$ 465,184**	**$ 17,356,265**

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF SEGMENT DISCLOSURES (CONTINUED)
FOR THE YEAR ENDED MARCH 31

	2021								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Facilities Act	Drugs and gases	Medical supplies	Other contracted services	Other	Amortization and loss on disposals/ write-downs of tangible capital assets	Total
Continuing care	$ 330,419	$ 930,329	$ -	$ 8,301	$ 5,679	$ 9,293	$ 31,946	$ 2,570	$ 1,318,537
Community care	693,825	836,030	-	4,427	3,549	59,099	68,546	631	1,666,107
Home care	339,150	215,509	-	194	9,716	86,642	28,867	41	680,119
Acute care	3,084,291	406,462	21,828	546,778	339,941	556,030	200,791	65,602	5,221,723
Ambulance services	311,550	172,407	-	2,001	4,878	1,499	31,427	18,701	542,463
Diagnostic and therapeutic services	1,669,032	300,123	-	26,798	246,586	314,378	118,017	50,846	2,725,780
Population and public health	437,911	15,572	-	2,668	32,663	31,650	233,510	320	754,294
Research and education	188,877	2,161	-	96	1,993	120,339	19,667	119	333,252
Information technology	302,708	18,285	-	-	7	28,092	175,120	102,580	626,792
Support services	1,110,292	164,706	-	1,375	7,056	130,287	591,154	319,224	2,324,094
Administration	368,214	17,027	-	2	236	30,801	73,025	2,948	492,253
Total	**$ 8,836,269**	**$ 3,078,611**	**$ 21,828**	**$ 592,640**	**$ 652,304**	**$ 1,368,110**	**$ 1,572,070**	**$ 563,582**	**$ 16,685,414**

Compensation Analysis and Discussion

Non-Union Exempt Employees

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

Total Compensation Philosophy

AHS reinforces outstanding patient care for all Albertans by attracting, retaining and engaging talented and committed employees. We do this with total compensation that is competitive and fair and that motivates and rewards performance while demonstrating sound fiscal management and sustainability. Principles set out in the total compensation policy guided by AHS' total compensation philosophy reflect competitive market positioning, internal equity, performance orientation, affordability, individual flexibility, and shared employee/employer responsibility.

Total Compensation Strategy

AHS ensures the process used to set total compensation, establish and maintain good governance, and incorporate best practices is transparent. AHS Non-Union Exempt Employees are currently under a salary freeze that applies to all government agencies, boards, and commissions until June 30, 2022. The job rates for executive, senior leadership, and other non-union exempt salary ranges are intended to be representative of the median of the national healthcare and Alberta public sector markets. Outside of the salary-freeze environment, to ensure total compensation remains market competitive, AHS monitors its market positioning on a regular basis. Due to the current salary freeze, AHS has not adjusted its pay bands since the 2013-14 fiscal year. AHS' total compensation programs and practices encourage behaviours that will promote a patient-focused, quality healthcare delivery system that is sustainable and accessible for all Albertans.

Total Compensation Plan Structure

AHS is committed to providing a comprehensive total compensation package including salary, benefits, pension, and other programs and services to attract, retain and engage talented and committed employees. AHS' total compensation is comprised of direct, indirect and non-financial compensation. Elements within direct and indirect compensation fit the overall total compensation strategy by driving accountability and performance, demonstrating sound fiscal management, and promoting a sense of integrity and equity. Non-financial compensation includes employee appreciation initiatives that support the health and well-being of employees.

Direct Compensation includes pay received as wages and salaries. AHS has no incentive, variable pay, or pay-at-risk of any kind. Base salary ranges were designed to be competitive at median (50th percentile) of the national healthcare market and the Alberta public sector market. An employee's individual base salary is set based on their skills, education, experience, and internal equity.

Indirect Compensation includes benefits (life insurance, long-term disability, dental and various health and wellness options) and terms and conditions.

All AHS employees are eligible to participate in the Local Authorities Pension Plan (LAPP). LAPP is a defined benefit plan where enrollment is mandatory for anyone working in a regular position of 30 hours or more per week. Benefits under this plan are capped at the maximum pension benefit limit allowed under the federal *Income Tax Act,* a salary of $180,758 in 2021. All employees over the salary cap are eligible for a Supplemental Pension Plan (SPP) benefit. Unlike the LAPP, the SPP is a defined contribution plan that provides annual notional contributions that are allocated to, and invested as directed, by each member. The SPP helps AHS to compete in its market at lower cost and minimizes risk to the organization. AHS does not provide car allowances or perquisite allowances to its executives or employees.

Total Compensation Governance

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

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

Total Compensation Reporting

The *Schedule 2 – Consolidated Schedule of Remuneration and Benefits* in the annual audited consolidated financial statements for the year ended March 31, 2022, provides complete disclosure of salary, benefits, and all other compensation earned by the direct reports to the Board and the direct reports to the President & CEO for years ended March 31, 2021, and March 31, 2022. The Board's compensation is also disclosed in *Schedule 2 – Consolidated Schedule of Remuneration and Benefits* in the annual audited consolidated financial statements for the year ended March 31, 2022. The *Schedule 2* information on total compensation philosophy and practices can be found on the AHS website.

Total Compensation 2021-22 Information Updates

The *Public Service Compensation Transparency Act* requires compensation disclosure from Alberta agencies, boards, and commissions, including AHS. As required, AHS disclosed the names and compensation of employees whose annual earnings were over $135,317 in the 2020 calendar year on AHS' external website and the Alberta Government compensation disclosure database by June 30, 2021. AHS will continue this process by disclosing the names and compensation of employees whose earnings are over $136,805 for the 2021 calendar year.

Effective April 1, 2018, the Government of Alberta also enacted a new *Salary Restraint Regulation* which formalizes the salary-restraint measures for the agencies covered by *Alberta Public Agencies Governance Act* (APAGA). This regulation outlines key provisions regarding the salary restraint and defines terms of the freeze. The regulation also includes a section of permitted adjustments that allow for base salary increases in select circumstances and in accordance with the public agency's existing

policies. In March 2022, the Government of Alberta extended the salary freeze without interruption and with the same key provisions for the salary restraint up to June 30, 2022.

Compensation regulation under the *Reform of Agencies, Boards*, and Commissions Compensation Act (RABCCA) came into effect on March 16, 2017, and established total compensation, including salary and benefits, for Chief Executive Officers or equivalent in 27 designated public agencies that are part of the APAGA. AHS is exempt from this regulation and the executive compensation structure developed by the Government of Alberta. Although exempt, AHS is required to submit an executive compensation plan to government. This compensation plan is submitted annually to demonstrate how AHS aligns to the key compensation principles outlined in RABCCA and help ensure alignment of its compensation practices. Transparency will continue through mandated salary disclosure.

Appendix

Patient Concerns

Patients and families are at the heart of everything we do. AHS has a robust Patient Concerns Resolution Process (PCRP) to review and respond to feedback, commendations and concerns, from patients and families. When a concern is received, a Patient Concerns Consultant gathers information and works with Program Leadership and Senior Leadership to resolve the concern. If the complainant is not satisfied with the response received, the concern will be escalated to higher levels of AHS leadership. If the complainant remains unsatisfied following internal escalation, the concern will be forwarded to the Patient Concerns Officer (PCO) who will determine if the PCRP has been followed and whether other options exist to resolve the concern. If the complainant believes the decision of the PCO to be unfair, they have the right to contact the Alberta Ombudsman to request an external review regarding administrative fairness. For more information, visit us online at www.ahs.ca/about/patientfeedback.aspx.

All reported concerns and commendations are tracked and monitored to identify areas for broader improvement. The table below summarizes the volume and type of feedback received, and the concerns that required escalation to the PCO.

Concerns and Commendations	2018-19	2019-20	2020-21	2021-22
Total Number of Commendations	1,696	1,526	1,495	2,142
Total Number of Concerns	10,392	10,773	11,602	12,728
Total Number of Concerns reviewed by PCO	3	20	18	19
Percent of Actions Arising from Concerns Resolved in 30 Days or Less	71%	72%	76%	74%

Notes:

- Data includes Covenant Health

- Due to the nature of concerns data, it is not possible to provide a rate or percentage because there is no meaningful denominator that can be used. Members of the public who have not yet accessed AHS services may identify concerns or multiple people (i.e., patients, friends or families) may identify the same concern. The number of concerns and commendations is provided for information on the volume of feedback received by the Patient Relations Department. Successful management of concerns is being monitored through the percentage closed within guidelines and the number of concerns escalated.

Public Interest Disclosure Act (PIDA)

Whistleblower Protection

The *Public Interest Disclosure Act* (PIDA) protects employees when disclosing certain kinds of wrongdoing they observe in the AHS workplace. The AHS *Whistleblower Policy* is aligned with PIDA.

PIDA's purpose is to:

- Facilitate the disclosure and investigation of significant and serious matters at AHS that may be unlawful, dangerous to the public, or injurious to the public interest.
- Protect those who make a disclosure from reprisal.
- Implement recommendations arising from investigations.
- Provide for the determination of appropriate remedies arising from reprisals.
- Promote confidence in the public sector.

The AHS Designated Officer co-ordinates all PIDA disclosures pertaining to AHS, including those that may originate externally via the Alberta Public Interest Commissioner.

Over the past year, AHS has:

- Updated the organization's online whistleblower learning module.

Consistent with direction from Alberta Public Interest Commissioner, reports to the Designated Officer of non-compliance with orders issued by the Chief Medical Officer of Health to support Alberta's response to the COVID-19 public health emergency were not considered as disclosures under PIDA.

In compliance with legislated reporting requirements, from April 1, 2021 to March 31, 2022, AHS reports that 16 disclosures were received by or referred to AHS' Designated Officer:

- 16 disclosures acted on by the Designated Officer.
- No disclosures not acted on by the Designated Officer.
- No investigations commenced by the Designated Officer.
- Not applicable – for any investigation that results in a finding of wrongdoing, a description of wrongdoing, recommendations made or corrective measures taken, and if no corrective action has been taken, the reasons for that.

AHS counts the reporting or referral of a matter to the Designated Officer as a disclosure under PIDA if the allegation(s), if founded, would constitute wrongdoing (as defined in PIDA and the AHS *Whistleblower Policy*) by AHS or by a member of the AHS workforce.

Common reasons for not commencing an investigation under PIDA and the AHS *Whistleblower Policy* are:

- After collecting and reviewing records and meeting with officials who have knowledge of the matter, subsequently determining that the allegation, if founded, will not meet the definition of "wrongdoing" under PIDA and the AHS *Whistleblower Policy*.
- The allegation pertains to an individual who is not a member of the AHS workforce or other circumstances outside the authority of AHS to investigate.
- The allegation is anonymous without contact information and the disclosure does not contain sufficient particulars to form the basis of an investigation.

Common actions taken by the Designated Officer to manage a disclosure that is not subject to an investigation include:

- Referring the matter to another AHS department for action.
- Referring the matter to an external agency for action.

Chartered Surgical Facility Contracts under the Health Facilities Act (Alberta)

AHS contracts services with multiple chartered surgical facilities (CSFs) to provide insured surgical services for ophthalmology, oral maxillofacial, orthopedic, otolaryngology, plastic surgery, dermatology, restorative dental, pregnancy terminations and podiatry. The use of chartered surgical facilities enables AHS to obtain services to enhance surgical access and alleviate capacity pressures within AHS main operating rooms. Maintaining quality of services in CSFs will require deliberate, targeted and significant effort. AHS works with Alberta Health and the College of Physicians and Surgeons of Alberta to coordinate activities addressing CSF accreditation, patient safety, quality, and compliance with the *Health Facilities Act* and regulations (previously known as the *Health Care Protection Act*).

As a part of the Alberta Surgical Initiative, contracted service areas will be expanded beginning in 2021-22. Volumes for existing services are also expected to increase in the upcoming fiscal year.

The table below summarizes chartered surgical facility contracts by service area for 2021-22:

2021-22 Chartered Surgical Facilities

Contracted Service Area	# of Contracted Operators	# of Contracted Procedures Performed
Dermatology– Edmonton Zone	1	5
Dermatology – Calgary Zone*	2	284
Dermatology – Edmonton Zone (non-HFA)	1	265
Ophthalmology – Calgary Zone	4	20,689
Ophthalmology – Edmonton Zone	4	8,968
Oral and Maxillofacial – Calgary Zone	8	1,821
Oral and Maxillofacial – Edmonton Zone	10	4,519
Orthopedic – Calgary Zone	1	374
Orthopedic – Edmonton Zone	2	516
Otolaryngology – Edmonton Zone	2	441
Plastic Surgery – Edmonton Zone	3	1,249
Pregnancy Termination – Calgary Zone	1	4,858*
Pregnancy Termination – Edmonton Zone	1	5,591
Restorative Dental – South Zone	6	190
Restorative Dental – Calgary Zone**	1	637
Restorative Dental – Edmonton Zone	2	339
Podiatry – Calgary Zone	2	776

Note: There are no surgical contracts with CSFs in the Central and North Zones that fall under the Health Facilities Act.

** The Calgary Zone Pregnancy Termination number was revised as of October 6, 2022. All previous statements on surgeries performed in CSFs would have been based on the previous information. This revision changes numbers included in the Alberta Health 2021-22 Annual Report.*

*** Procedure totals provided by AHS Clinical Quality Metrics, Provincial CSF Procedures Dashboard. All remaining procedure totals provided by AHS Bill 11, billing system. Calgary Zone data captured as of April 11, 2022.*

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