Health

Annual Report
2015-16

Alberta
Government

Note to Readers:

Copies of the annual report are available on the Ministry of Health website:
www.health.alberta.ca

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Information about the entities that were part of the Ministry of Health in 2015-16 is available on their respective websites:

Alberta Health Services
www.albertahealthservices.ca

Health Quality Council of Alberta
www.hqca.ca

Alberta Innovates – Health Solutions
www.aihealthsolutions.ca

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Health

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Preface

The Public Accounts of Alberta are prepared in accordance with the *Financial Administration Act* and the *Fiscal Planning and Transparency Act*. The Public Accounts consist of the annual report of the Government of Alberta and the annual reports of each of the 20 ministries.

The annual report of the Government of Alberta contains ministers' accountability statements, the consolidated financial statements of the province and *Measuring Up* report, which compares actual performance results to desired results set out in the government's strategic plan.

This annual report of the Ministry of Health contains the minister's accountability statement, the audited consolidated financial statements of the ministry and a comparison of actual performance results to desired results set out in the ministry business plan. This ministry annual report also includes:

- **the financial statements of entities making up the ministry including the Department of Health, Alberta Health Services, Health Quality Council of Alberta, and Alberta Innovates – Health Solutions for which the minister is responsible;**

- **other financial information as required by the *Financial Administration Act* and *Fiscal Planning and Transparency Act*, either as separate reports or as a part of the financial statements, to the extent that the ministry has anything to report.**

Minister's Accountability Statement

The ministry's annual report for the year ended March 31, 2016, was prepared under my direction in accordance with the *Fiscal Planning and Transparency Act* and the government's accounting policies. All of the government's policy decisions as at June 6, 2016, with material economic or fiscal implications of which I am aware have been considered in the preparation of this report.

Original signed by

Honourable Sarah Hoffman

Minister of Health

Message from the Minister

It has been just over one year since our government took office and I was appointed Minister of Health. Although I knew it would not be easy to improve a system that is large, complex and expensive, I was certain I could count on the hard work of ministry staff who would work tirelessly with me to improve health care for all Albertans. Throughout the past year, that has certainly been the case as the dedicated staff of Alberta Health and on the front lines at Alberta Health Services demonstrated their commitment and expertise to enhance Alberta's health system.

Our progress over the past year has included stabilizing the health system by appointing a new Alberta Health Services Board. We also passed Bill 3, the *Appropriation (Interim Supply) Act*, to reverse the previous government's proposed cuts to health care and to protect the services that are so important to Albertans.

We made significant strides in health infrastructure by investing in the new Calgary Cancer Centre and earmarking funds for the Stollery Children's Hospital. And we began needed work to transform our health care system to one that's sustainable and adequately funded for the future, and that brings care closer to homes and communities.

Other work involved banning the sale of menthol tobacco products to help reduce tobacco use among Alberta's youth. We also initiated a review of our province's mental health system and are taking immediate action on six of the recommendations that came out of the review. And we continued making progress on our commitment to build 2,000 new long-term care and dementia beds for Albertans across the province.

In December, our government took action to address the drastic rise in deaths caused by illicit fentanyl use. We expanded access to naloxone to reverse fentanyl overdoses and allowed nurses to prescribe the drug, paramedics to distribute it, and emergency medical responders to administer and distribute naloxone. Albertans can get free naloxone kits at pharmacies across the province.

Moving ahead, I would like to reiterate my vision for Alberta's health care system: to make sure Albertans get the right care, in the right place, at the right time, by the right provider, with the right information.

Original signed by

Honourable Sarah Hoffman
Minister of Health

Message from the Associate Minister

It has been an honour to work beside Minister Hoffman, and the dedicated staff at Alberta Health to improve health outcomes for Albertans. I have witnessed the incredible commitment and hard work of our health care partners and the many professionals who are generous with their expertise and insights.

I have learned there are many emotional issues when it comes to the health of ourselves and our families, but solutions must be evidence-based to ensure sustainability and success.

I'm proud that for the first time in Alberta a comprehensive review of our mental health system was completed. With the input and support of many stakeholders, it has informed a cross-ministry response to assist Albertans living with mental health issues and addictions.

The addition of 18 addiction treatment spaces was one step we took in addressing the heartbreaking number of fentanyl deaths we have seen in this province. And with the development of the *Alberta Dementia Strategy* and *Action Plan* we can now improve supports to the more than 39,000 Albertans suffering with dementia by addressing gaps in prevention, diagnosis and services.

Taking care of vulnerable individuals is a priority for Albertans, and it is a priority for Alberta Health.

Can we improve health outcomes for expectant mothers? Research has shown us that women who give birth with the assistance of a midwife tend to have shorter lengths of stay in hospitals, are more likely to breast feed, and require fewer medical interventions. Enabling choices for women and the safe delivery of babies, by publicly funding midwives, has brought health care closer to home and provided a cost effective way to deliver quality pre- and post-natal care.

Certainly one of the most sensitive and complex issues introduced to the medical community this past year was the Supreme Court ruling legalizing medical assistance in dying. My colleagues Dr. Swann and Dr. Turner were invaluable as we wrestled through the hopes and concerns of thousands of Albertans during consultation. Thanks to the tireless work of ministry staff, the College of Physicians and Surgeons, Alberta Health Services and other stakeholders, Alberta will have a framework in which the rights of patients and health care professionals are protected while ensuring safeguards are in place for the vulnerable.

Our health is everything, and Albertans care deeply about the health services and support their government provides to them and their families. I look forward to continued collaboration with our health care partners and ensuring accessible, quality, sustainable health care for all Albertans.

Original signed by

Honourable Brandy Payne
Associate Minister of Health

Management's Responsibility for Reporting

The Ministry of Health includes the Department of Health, Alberta Health Services, Health Quality Council of Alberta, and Alberta Innovates – Health Solutions. The executives of the individual entities within the ministry have the primary responsibility and accountability for the respective entities. Collectively, the executives ensure the ministry complies with all relevant legislation, regulations and policies.

Ministry business plans, annual reports, performance results and the supporting management information are integral to the government's fiscal and strategic plan, annual report, quarterly reports and other financial and performance reporting.

Responsibility for the integrity and objectivity of the consolidated financial statements and performance results for the ministry rests with the Minister of Health. Under the direction of the minister, I oversee the preparation of the ministry's annual report, including consolidated financial statements and performance results. The consolidated financial statements and the performance results, of necessity, include amounts that are based on estimates and judgments. The consolidated financial statements are prepared in accordance with Canadian public sector accounting standards. The performance measures are prepared in accordance with the following criteria:

- Reliability – information used in applying performance measure methodologies agrees with the underlying source data for the current and prior years' results.
- Understandability – the performance measure methodologies and results are presented clearly.
- Comparability – the methodologies for performance measure preparation are applied consistently for the current and prior years' results.
- Completeness – goals, performance measures and related targets match those included in the ministry's Budget 2015.

As Deputy Minister, in addition to program responsibilities, I am responsible for the ministry's financial administration and reporting functions. The ministry maintains systems of financial management and internal control which give consideration to costs, benefits, and risks that are designed to:

- provide reasonable assurance that transactions are properly authorized, executed in accordance with prescribed legislation and regulations, and properly recorded so as to maintain accountability of public money;
- provide information to manage and report on performance;
- safeguard the assets and properties of the province under ministry administration;
- provide Executive Council, the President of Treasury Board and the Minister of Finance, and the Minister of Health information needed to fulfill their responsibilities; and,
- facilitate preparation of ministry business plans and annual reports required under the *Fiscal Planning and Transparency Act.*

In fulfilling my responsibilities for the ministry, I have relied, as necessary, on the executives of the individual entities within the ministry.

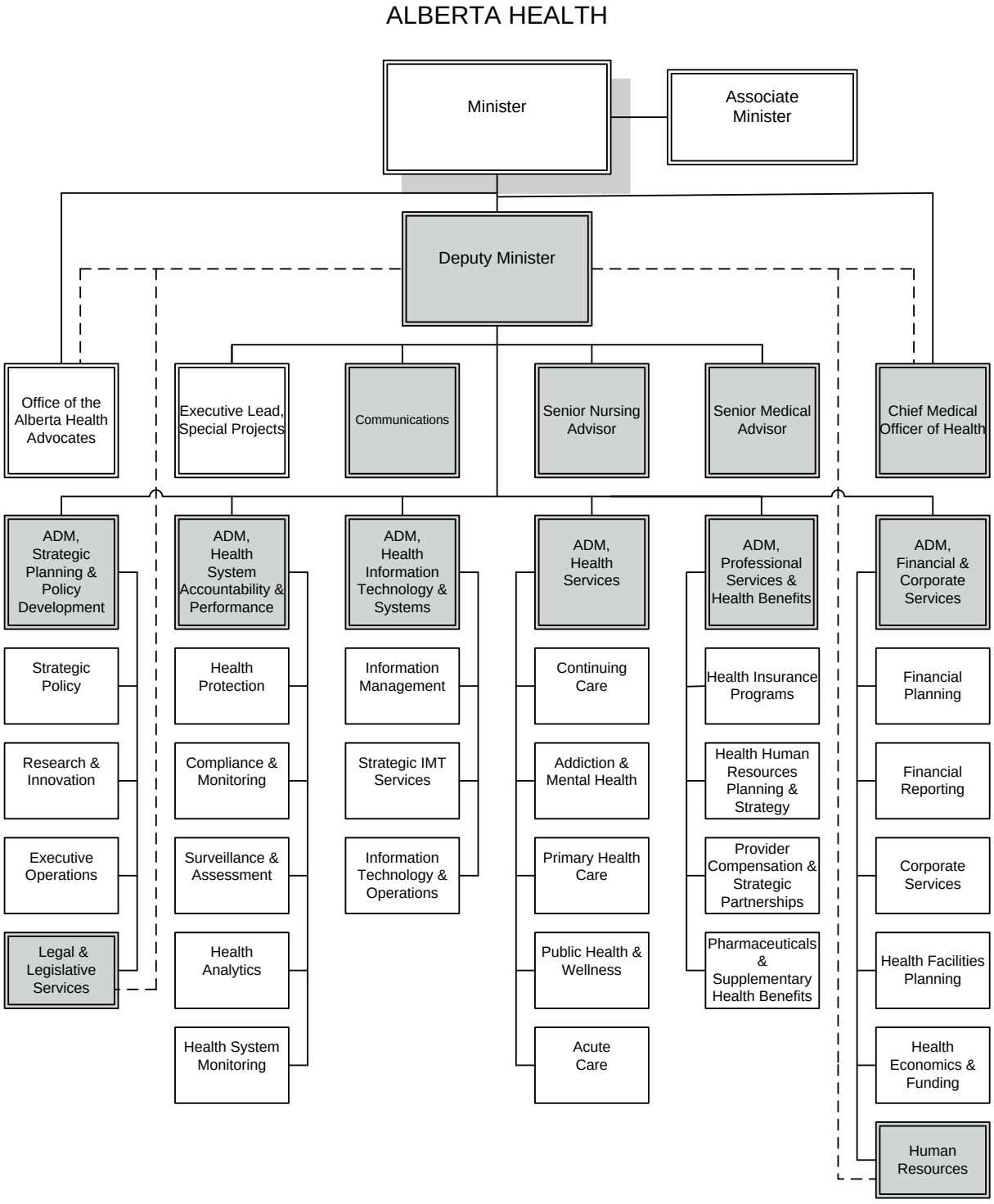
Original signed by

Carl Amrhein
Deputy Minister of Health
June 6, 2016

RESULTS ANALYSIS
Ministry Overview

Results Analysis

Ministry Overview



Legend:
Black Solid Line – Line Authority
Black Dotted Line – Functional
Shaded Boxes – Member of Senior Management Team

The Minister of Health is responsible for setting policy and overseeing the health system to ensure the health of Albertans is protected, resources are aligned with the goals of the government, and public dollars are used appropriately. During 2015-16, the ministry was comprised of the Department of Health, Alberta Health Services, the Health Quality Council of Alberta, and Alberta Innovates – Health Solutions.

The Department of Health's focus and role is strategic in developing policy, setting standards and regulations, ensuring accountability, and pursuing innovations on behalf of Albertans. Receiving direction from the Minister, the Deputy Minister is responsible for the daily operations of the department.

Deputy Minister's Office – provides leadership and encourages innovation for the purpose of promoting and supporting healthy living, ensuring quality health services, leading the health system, and working collaboratively with partners. It also provides policy coordination, issues management, and communications support to the department.

- **Communications Branch** – provides Albertans and health system partners with information about ministry policies, programs, and initiatives. The branch works with department staff to develop and implement communications plans and offers communications support, such as media relations, issues management, writing and editing services, product development, and online communications services. The branch also works closely with Alberta Health Services and other reporting entities to coordinate ministry communications.

- **Senior Medical Advisor** and **Senior Nursing Advisor** – provide executive leadership, strategic advice, and clinical and nursing expertise to the department on a range of provincial health policy and program-specific issues. The Senior Medical Advisor and Senior Nursing Advisor also work with external stakeholders and organizations on health system transformation initiatives such as primary health care reform, health human resource planning, professional standards and practice, physician compensation, and safety and quality initiatives.

- **Executive Lead, Special Projects** – provides executive leadership and support to the Deputy Minister and other senior executives on the development of key departmental initiatives related to health system transformation.

Strategic Planning and Policy Development Division – works across all levels of government and with external stakeholders, and leads on the development of strategic policy frameworks and health system policy, the department's intergovernmental strategy, Indigenous health policy and programs, and the ministry's research and innovation initiatives. The division also has responsibility for business planning and enterprise risk management, ministerial correspondence, support for the governance of the ministry's agencies and boards, and the ministry's response to applications under Alberta's *Freedom of Information and Protection of Privacy Act*. It also provides legal and legislative review services to the department.

Health System Accountability and Performance Division – is responsible for providing oversight and public assurance to Albertans that they are receiving the best care in a safe and effective manner; this includes overseeing the performance of Alberta Health Services. The division also functions to protect the health of Albertans by providing strategic direction and leadership on the development of provincial policies, strategies, and standards regarding disease control and prevention, health surveillance, environmental public health, and emergency preparedness.

Health Information Technology and Systems Division – is responsible for the planning and delivery of information management and technology systems that support the strategic goals of the ministry and the health system. This includes leading on the identification or renewal of business development opportunities within the ministry, with provincial health system organizations, and across the Government of Alberta.

Health Services Division – oversees all service sectors of the health care system with a significant focus on the policies, guidelines, standards, and provincial strategies associated with the delivery of services by Alberta Health Services and other agencies/organizations. Sectors of care include continuing care (long-term care, supportive living, and home care), addiction and mental health, maternal-infant health, child and youth health, primary health care, public health and wellness, and acute care (hospitals, ambulatory care and emergency medical services). The division also coordinates and integrates health system priorities and plans across other ministries as well as across national and provincial governments and organizations.

Professional Services and Health Benefits Division – oversees provincial health workforce policies and regulations, provider compensation and major agreements, pharmaceuticals and supplemental health benefits, and the governance and administration of the Alberta Health Care Insurance Plan. The division works in close collaboration with its key stakeholders, including physicians, pharmacists, professional colleges and associations, and other internal and external to the government partners, to design and administer evidence-informed, value-oriented policies and health benefits that serve the needs of all Albertans. The division is also responsible for negotiations with the Alberta Medical Association and is the ministry's lead on new and innovative health provider compensation initiatives.

Financial and Corporate Services Division – forecasts and manages the ministry's budget and funds, monitors its financial activities, prepares the department and ministry financial statements, and provides health economic and funding analyses for the health system to monitor whether the goals set by government are met or exceeded. Working with Alberta Infrastructure, the division approves project planning documents and prepares the provincial health capital plan submission. The division is also responsible for human resource services, procurement services, contracting-based and other administrative corporate services to enable the department to fulfill its mandate.

Office of the Chief Medical Officer of Health – works within the ministry, across government ministries, and with other stakeholders such as Alberta Health Services to facilitate and support processes, policies, and programs that build healthy communities. The Chief Medical Officer of Health provides public health expertise on all issues of public health importance. This includes taking necessary steps to: respond to new and emerging pathogens; control measures and intervention programs to limit the spread of communicable diseases; infection prevention and control measures; and, health risk assessments.

Office of the Alberta Health Advocates – includes the Health Advocate, the Mental Health Patient Advocate, and the Seniors' Advocate. The office supports Albertans in resolving their health-related concerns by helping them navigate the health care system, referring individuals to the appropriate complaints resolution services, providing information about the Alberta Health Charter, engaging seniors and families on issues of importance to them, requesting the inspection of provincial health care facilities, and addressing patients' issues and concerns in relation to the *Mental Health Act*.

RESULTS ANALYSIS
Discussion of Analysis and Results

Results Analysis

Discussion and Analysis of Results

Introduction

The Government of Alberta is committed to a stable health system in Alberta. That means a stable and secure budget for health care and managing the growth in health spending in ways that lead to savings and which better position the health care system to deliver good quality care.

The major areas of spending in Alberta's health care system are hospital services, doctor compensation, public health and pharmaceuticals. In three of these areas, Alberta is at the top or near the top in spending compared to other large provinces.

In 2015-16, the government laid the groundwork to advance measured steps to bend the cost curve and initiate transformation of the health system. Some key building blocks initiated were:

Responsible Fiscal Management: In May 2015, the Government of Alberta reversed planned budget reductions including decreases for Alberta Health Services' operating budget. This prevented the elimination of approximately 1,500 front line nursing and health care positions. Subsequently, Budget 2015 moved to stabilize the public health care system by initiating the process of providing predictable, long-term funding, and decreasing in a measured way, the annual growth rate of the health budget.

Governance for Alberta Health Services: In October 2015, the government created a new board to govern Alberta Health Services and further stabilize Alberta's health care system. The new Alberta Health Services Board includes strong health system, governance and financial expertise and will be crucial in supporting quality and patient-centred care.

Engagement with Physicians: The government initiated discussions with the Alberta Medical Association to establish a new agreement. The negotiations are aimed at managing the rate of growth of the physician services budget, improving the effective provision of health care to Albertans, and jointly ensuring the sustainability of the health care system.

Challenges: Alberta's population is growing and changing in demographic. Over the past 10 years, the province's population increased at an annual growth rate of 2.6 per cent; and, by 2031, one in five Albertans will be 65 years of age or older. Further, a gap in the health status of Indigenous people compared with that of non-Indigenous people continues to exist. Other challenges include the rising rates of chronic disease and an increasingly expensive health care system.

For the past 20 years, spending on health care in Alberta has been going up by an average of nearly six per cent a year – well beyond inflation and population growth. Between 2000 and 2010, it grew by 10.3 per cent. Since 2010, it has grown by 4.4 per cent. Overall, health care spending now accounts for about 40 per cent of the government's overall provincial budget.

This rate of spending is not sustainable. In Alberta, the average per capita health spending is now more than 20 per cent more than the national average and as much as 40 per cent higher when adjusted for age and gender.

While Alberta's health care spending is among the highest in Canada, the province is not always getting the best health outcomes. In general, acute care services in Alberta are excellent; however, access to specialists and mental health services, and emergency room wait times need to be improved.

The health care system is complex and its various components interconnected. Specifically, the acute care system, comprised of hospitals and other care centres that include inpatient beds, is bookended by the primary care system at one end and the continuing care system at the other end.

Against this backdrop, the Ministry of Health is working to transform the province's health care system to one that provides better population health outcomes in a sustainable way. The goal is to ensure Albertans get the right care, in the right place, at the right time, by the right health care team, with the right information.

Key Strategies and Initiatives: During 2015-16, the ministry moved forward on a number of key strategies and initiatives to better align health services with the needs and expectations of Albertans, such as:

- Shifting the continuing care system to providing more community-based home care and personal care services and adding new continuing care spaces in communities based on need;
- Working with key stakeholders, including Primary Care Networks, to redesign the primary health care system to be more integrated and community-based, and aligned with community population health needs;
- Taking immediate action on recommendations from the report of the Alberta Mental Health Review Committee;
- Supporting the development of a Strategic Clinical Network for Population, Public and Aboriginal Health;
- Developing a Wait Time Measurement and Waitlist Management Policy to address long wait times for scheduled services;
- Developing a provincial health human resources strategy to modernize the way Alberta plans for, and optimizes, its health workforce;
- Signing a memorandum of agreement with the Alberta Medical Association to begin negotiations with physicians;
- Enhancing and expanding electronic health records so health care providers have access to available health information and Albertans can enter and track their health and wellness information; and,
- Health infrastructure spending on new or expanded facilities in Edmonton, Calgary, Grande Prairie, High Prairie, Lethbridge, Edson, and Medicine Hat.

The following information provides details about the Ministry's progress and achievements in responding to the desired outcomes set out in the 2015-18 Health Business Plan.

DESIRED OUTCOME ONE: Improved health outcomes for all Albertans.

Achievements

(1.1) Expand home care which includes enhancing home and community care capacity.

The continuing care system continues to shift toward community-based care. Alberta's home and community care program provides a range of in-home and community-based health and personal support services necessary to help Albertans maintain their independence while avoiding or delaying admission to facility-based care. Expanding home and community care services to reduce use of more costly facility-based care is key to decreasing the rate of growth in health system costs.

The ministry completed initial planning for an expanded model of home and community care, including a zone-by-zone assessment of differences in the availability of home care services. Increasing service availability in rural areas will be a priority moving forward.

In 2015-16, the ministry provided $20 million in grant funding for a collection of innovative home care initiatives. The programs support Albertans so they can remain in their own homes longer, return home as quickly as possible after a hospital stay, and avoid premature or unnecessary admission to continuing care facilities and hospitals. Evaluation results from these initiatives will help inform future directions in home and community care.

(1.2) Create 2,000 public long-term care spaces over four years to improve seniors' care and take pressure off acute care systems.

The Government of Alberta is committed to increasing continuing care capacity in the province. Creating new spaces will help ensure vulnerable Albertans can remain in their communities, close to family and friends. The spaces will also help ease pressure on Alberta's acute care system by helping people transition out of hospitals and into care that better meets their needs. It will also mean less pressure on emergency departments, and more timely admission for those who need acute care.

On October 29, 2015, the government announced that 25 projects would receive capital grant funding under the Affordable Supportive Living Initiative (ASLI) to provide new continuing care spaces. These projects were approved following a thorough review of the 2014-15 ASLI program to ensure the projects were financially viable, located in the communities with the highest need, and aligned with government priorities for dementia and long-term care spaces.

ASLI funds will cover up to 50 per cent of capital costs of the new spaces, with remaining capital funding coming from the applicants. Contracts with Alberta Health Services will provide operating funding for dementia care and long-term care spaces. Grant recipients are required to maintain the spaces at government-established accommodation charges for 30 years.

(1.3) Implement an addiction and mental health strategy.

In June 2015, the government initiated a comprehensive review of Alberta's addiction and mental health system. Released in February 2016, *Valuing Mental Health: Report of the Alberta Mental Health Review Committee* was the result of extensive consultations with Albertans through an online survey and public meetings. The final report included 32 recommendations aimed at supporting mental health by strengthening service delivery for Albertans living with mental illness and/or addiction. The government has accepted the report and identified six recommendations for immediate action, including establishing an implementation team to lead this work with cross-ministry and other partners.

Other recommendations from the committee for immediate implementation include increasing technology-based solutions by launching a child and youth mental health website (which launched in May, 2016), and developing a performance monitoring and evaluation framework to track implementation progress of the report's recommendations and benefits to Albertans.

One common theme arising from the work of the Mental Health Review Committee was the need for stronger supports for Albertans struggling with addiction. In March 2016, the government announced it was opening 18 additional treatment spaces to meet the needs of people in Medicine Hat and the surrounding areas. Also announced was a commitment to open up to 31 additional addiction treatment spaces in several communities, including:

- three new social detoxification beds for children and youth in the Protection of Children Abusing Drugs protective safe house in Calgary;
- six to eight new adult detoxification beds in Lethbridge; and,
- 20 beds that will be upgraded to provide medical detoxification services in Red Deer.

The last several years have seen a substantial increase in the use of illicit fentanyl, which is highly toxic and a very small amount can be deadly. In 2015, there were 272 overdose deaths involving fentanyl in Alberta. The government has undertaken several initiatives to address this issue, including:

- expanding the scope of practice for registered nurses, emergency medical technicians, and emergency medical responders to allow them to distribute and administer naloxone, a drug that can be used to reverse fentanyl and other opioid overdoses;
- enabling pharmacies across Alberta to provide take-home naloxone kits free of charge;
- providing funding to the Alberta Community Council on HIV to offer overdose prevention support and 3,000 take-home naloxone kits through its partner agencies (by March 2016, this project had distributed 1,438 kits throughout the province and reported 122 overdose reversals);
- supporting and funding Alberta Health Services to develop a centralized take-home naloxone kit training and distribution program (through this program more than 700 sites are distributing 6,000 publicly funded take-home naloxone kits to Albertans who need them);
- working with Health Canada, Alberta Health Services and First Nations communities to ensure naloxone is available to First Nations people on and off reserve; and,
- working in partnership with First Nations, Métis and Inuit communities to develop an opioid addiction action plan.

The government also passed the *Tobacco Reduction Amendment Regulation* to include a ban on the sale of menthol tobacco products. This ban, which began on October 1, 2015, is aimed at preventing children and youth from accessing and using flavoured tobacco products, as lifetime use of tobacco almost always begins by the time youth graduate from high school.

(1.4) Enhance the delivery of primary health care services to enable Albertans to be as healthy as they can be.

Primary health care is the first place people go for diagnosis and treatment of a health issue or injury, to manage a health condition, or for wellness advice and programs. Primary health care may include a visit to a family doctor, a consultation with a nurse practitioner, advice from a pharmacist or an appointment with a dietitian or therapist.

In collaboration with stakeholders, the ministry is leading the development of policies that: support comprehensive, integrated, community-based primary health care services that enhance the delivery of care; establish building blocks for change; align health services with community population health and cultural needs; and, increase the value and return on public investment in primary health care to support long-term sustainability. In support of this work, the ministry hosted two Primary Health Care Stakeholder Discussion forums.

As part of its internal oversight responsibility, Alberta Health undertook a review of Primary Care Networks (PCNs). The ministry regularly reviews each PCN as part of the grant reporting cycle; however, this was the first multi-PCN review to examine the overall operational and financial practices of PCNs. The review also served to address the Auditor General's 2012 recommendation that systematic oversight of PCNs be improved. An action plan has been developed and the department will be working to improve governance accountability, funding models, and expectations for service and performance responsibilities.

(1.5) Address the increasing rates of dementia with an aging population.

As of 2014, more than 39,000 Albertans have been diagnosed, and are living with dementia. If nothing changes, this number is expected to grow substantially in the coming years. The cost of dementia includes direct financial impacts as well as the indirect impacts on society, caregivers, individuals living with dementia, and the economy.

Alberta Health has been working closely with other ministries, Alberta Health Services, key stakeholders, and Albertans living with dementia and their caregivers, on the development of an Alberta Dementia Strategy and Action Plan. This work began in October 2014 in response to the growing number of Albertans living with dementia and the existing gaps in supports and services, such as caregiver support and timely diagnosis.

The strategy is intended to improve the care and support for Albertans living with dementia and their caregivers. It will also address areas of brain health and risk reduction, and raise awareness about dementia and its impact on individuals, families, communities, and the health system. The action plan, outlines steps to achieve the following vision as set out in the strategy: 'Albertans are committed to optimizing brain health, and valuing and supporting people impacted by dementia from its onset through to end of life'—and desired outcomes over a five-year period.

(1.6) Improve the quality of care provided to continuing care clients.

Provincial standards for publicly funded continuing care health services are designed to ensure home care, supportive living, and long-term care operators provide quality health-related services to their residents. These standards address the publicly funded basic health care and personal care services provided to continuing care clients by nurses, therapists, health care aides, and other health care providers.

After extensive consultations, the ministry updated the Continuing Care Health Service Standards, which were last revised in 2008. The revised standards, which came into effect on April 1, 2016, enhance quality and safety, are more client-centered, and have a focus on added training for health care providers. The ministry has also developed an information guide to support continuing care service providers in achieving compliance with the revised standards.

(1.7) Improve the effectiveness and efficiency of emergency and ambulance services.

Ensuring that Albertans have the best possible access to Emergency Medical Services (EMS) is critical and the department is working closely with Alberta Health Services to improve the availability and quality of EMS services across the province.

Alberta Health Services EMS has implemented measures to increase efficiencies. Examples include consolidating crews at hospitals where one EMS crew takes charge of two or three patients to free other crews to return to service, and pausing inter-facility transfers when ambulance availability meets a critical threshold, thereby making those ambulances available for emergency calls.

Alberta Health Services tracks the time EMS crews spend at hospitals and provides weekly reports to the ministry on progress towards the target of having EMS crews back in service to respond to emergency calls within 90 minutes of arrival at hospitals 90 per cent of the time. In December 2015, Alberta Health Services launched a public-facing EMS performance dashboard that includes a metric for EMS hospital time in Calgary and Edmonton.

EMS practitioners operate in unique circumstances relative to other health care providers and have an increased chance of post-traumatic stress. Since 2014, Alberta Health Services has employed a provincial Critical Incident Stress Management model to mitigate post-traumatic stress disorder in affected EMS practitioners. In addition, Alberta Health Services has established an EMS Psychological Health and Safety Advisory Committee made up of front line EMS practitioners, senior managers, and representatives from the Ministry of Health. The mandate of the committee is to incorporate recommendations from front line EMS staff to develop new policies and improve mental health programs to better protect the health and safety of all EMS staff. The committee recently commissioned a survey of EMS practitioners entitled “Guarding Minds at Work”. The results of the survey are being analyzed and will be shared with the department to inform future policy development.

The department has begun work on updating and consolidating the policies contained in the *Emergency Health Services (Interim) Regulation (2009), Licensing and Ambulance Maintenance Regulation (1999)*, and *Staff, Vehicle and Equipment Regulation (1999)*, into one proposed regulation under the *Emergency Health Services Act*. The proposed regulation will help keep ambulances on the road and ready to respond to emergencies, improve the care provided to Albertans, and improve the safety of patients and health providers. This work is expected to continue into the 2016-17 fiscal year.

(1.8) Enhance and expand electronic health records to assist Albertans in taking an active role in managing their health and well-being by providing resources and tools through the personal health portal.

Information is foundational to support evidence-based health care delivery, policy development, and decision-making. In order to transform the health system, access to information from across the continuum to both support delivery of care and gain broader insights must be improved.

Alberta Netcare is the name for all the projects related to the provincial Electronic Health Record, a secure and confidential electronic system of Alberta patients' health information. The portal enables both the public and health care providers (registered users) to access available health information, with new content continually being added. Alberta Netcare has almost 50,000 active users and is now being rolled out to continuing care facilities.

Personal Health Record is a secure online tool that allows Albertans to enter and track their health and wellness information, and get medication information available in their provincial electronic health record. Through a limited rollout of the Personal Health Record in November 2015, Alberta Health was able to gather preliminary feedback on the system and ensure that it is ready to launch to Albertans. The 800 Albertans that participated in this early enrolment now have a secure place in which to store and share their health information. In addition, a subset of these 800 participants verified their identities and have access to their medication records.

MyHealth.Alberta.ca is a public website that provides health care information on topics of interest to Albertans to help them manage their own health and wellness. In collaboration with stakeholders, content was expanded to include information on palliative and end-of-life care, heart surgery in Alberta, a heart disease risk calculator, coping strategies for mobility issues, how to incorporate fitness into daily life, and sleep strategies for headache management. MyHealth.Alberta.ca has also enabled over 200,000 Albertans to register their intent to donate organs and tissue. In addition, content from the Healthy U website was consolidated into MyHealth.Alberta.ca.

To support the language needs of Alberta's diverse population, a number of topics on MyHealth.Alberta.ca have been translated into other languages, including Chinese (Simplified and Traditional), Punjabi, Vietnamese, French, Spanish and Arabic.

The ministry is supporting Alberta Health Services in its implementation of a common Clinical Information System. This system will replace aging and obsolete information technology platforms and support continuous improvement in health care delivery to Albertans.

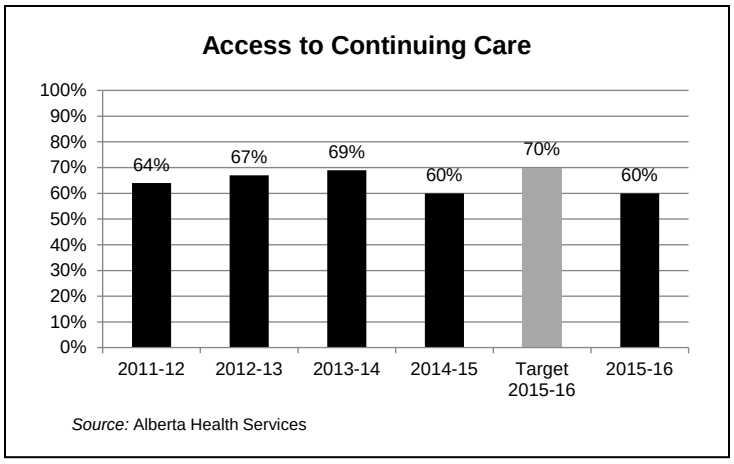
Performance Measures and Indicators

Performance Measure 1.a **Access to continuing care: Percentage of clients placed within 30 days of being assessed.**

This measure is used to monitor and report on access to continuing care living options in Alberta, as indicated by the wait times experienced by individuals admitted within the reporting period.

Results Analysis

The decline in performance in getting clients into continuing care spaces in 2014-15, continued through 2015-16, and is likely due to issues associated with a policy change.



In May 2015, Alberta Health Services began implementing the new *Designated Living Option: Access and Waitlist Management in Continuing Care* policy, which establishes a consistent, principle-based, transparent approach for individuals to access a continuing care living option. The approach taken in this new policy (as compared to the previous "First Available Bed" policy, rescinded in June 2013) is more person-centred. The new policy requires that each client and their family receives enough information, support, and time to decide on one or more living options that will be suitable to meet the client's needs and preferences. This additional time is necessary to ensure that clients and families have sufficient opportunity for research and discussions to support them in making an important life decision. This process may impact the length of time between assessment and admission for those waiting for admission to a continuing care living option.

Capacity issues are expected to be partly addressed when the planned 2,000 long-term care and dementia care spaces become available over the next few years. Planned expansions and improvements to home and community care are also expected to help to address current capacity issues.

The department and Alberta Health Services have recently agreed to set a performance target on this measure for 2016-17 of 62 per cent, increasing three per cent annually through 2018-19, which will allow for stabilization to continue and improvements to be made as capacity development progresses.

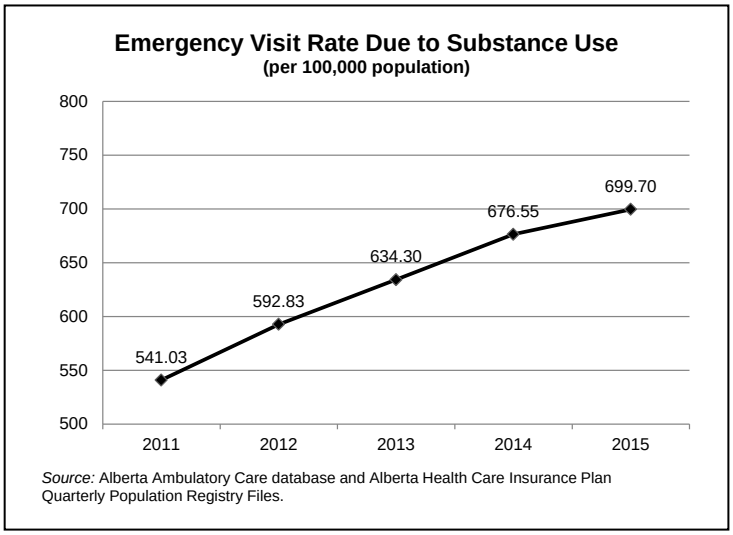
Performance Indicator 1.a Emergency visit rate due to substance use (per 100,000 population).

This indicator provides the rate of visits to emergency departments and urgent care centres related to substance use and misuse. In addition to emergency visits due to psychoactive substance use, this indicator includes emergency visits due to use of alcohol or non-psychoactive substances. The term 'substance' (as compared with 'drug' as used in Health's 2015-18 Business Plan) more accurately reflects the diagnostic codes used in the methodology, which is unchanged from previous years.

Results Analysis

Alcohol accounts for the largest proportion of substances in the result; however, opioids also represent a significant proportion.

Emergency visits due to alcohol use and opioid use have increased between 2011 and 2015. As reported by enforcement and medical professionals across the province, an increase in the availability of illicit opioids (particularly illicit fentanyl which is more toxic than other opioids) has contributed significantly to the increase in emergency visit rate due to psychoactive substance use.



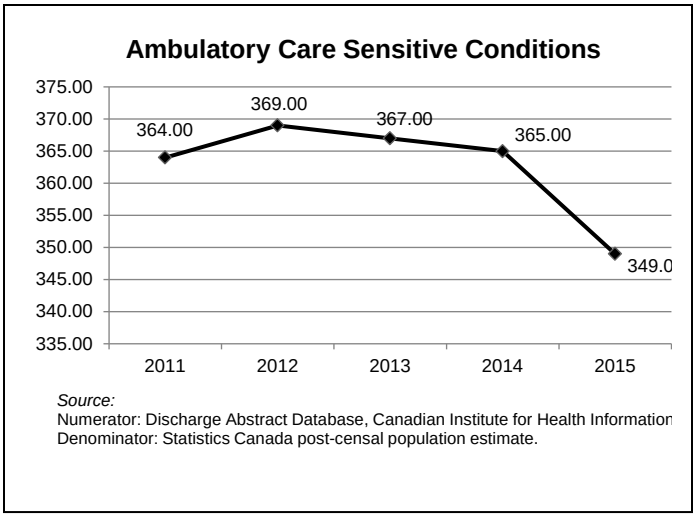
Source: Alberta Ambulatory Care database and Alberta Health Care Insurance Plan Quarterly Population Registry Files.

Performance Indicator 1.b **Ambulatory care sensitive conditions: Hospitalization rate for patients under 75 years of age with conditions that could be prevented or reduced if they received appropriate care in an ambulatory setting.**

Ambulatory care is provided outside of a hospital inpatient setting, such as in community clinics operated by Alberta Health Services, urgent care centres, and emergency departments. Hospitalization for an ambulatory care sensitive condition is considered an indicator of access to appropriate primary health care.

Results Analysis

The ambulatory care sensitive conditions for this indicator are comprised of: grand mal status and other epileptic convulsions; chronic obstructive pulmonary diseases; asthma; heart failure and pulmonary edema; hypertension; angina; and diabetes. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could potentially prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. A disproportionately high rate is presumed to reflect problems in obtaining access to appropriate primary care.



Since their inception in 2005, Primary Care Networks (PCNs) have provided programs such as hypertension prevention and control, diabetes education and management, and asthma education and management. The declining hospitalization rate for patients with ambulatory care sensitive conditions may, in part, be attributed to the success of these PCN programs.

DESIRED OUTCOME TWO: The well-being of Albertans is supported through population health initiatives.

Achievements

(2.1) Strengthen policies and practices to protect environmental public health, based on environmental public health science and international best practices.

During spring and summer 2015, the ministry's environmental public health science team used air quality monitoring data, satellite imagery, and advanced modelling software to assess predictive wildfire smoke advisories. This has improved the capacity of Albertans to make healthy decisions about outdoor activities in advance of poor air quality days.

Using the best available scientific information, the team also contributed to the revision of Alberta Tier 1 and 2 Soil and Groundwater Remediation Guidelines. These guidelines, which incorporate revised human toxicity reference values, will provide a higher degree of public health protection from naturally occurring and industrial chemical contaminants.

The ministry collaborated with all levels of government, industry, and non-governmental organizations through the Clean Air Strategic Alliance in the development of a Good Practices Guide for Odour Management in Alberta, which was released in November 2015. The guide will enable a coordinated approach to address odours, which are one of the most common air quality complaints and can directly and indirectly affect health and quality of life.

(2.2) Modernize the food safety inspection system, in partnership with Alberta Health Services and other government ministries.

Alberta Health is responsible for the administration of the *Public Health Act* and *Food Regulation*. Enforcement of this legislation is the responsibility of Alberta Health Services through its inspection programs. Alberta Agriculture and Forestry administers and enforces acts and regulations (such as the *Meat Inspection Act*) that support inspections of slaughter and associated meat processing.

Alberta Health, Alberta Health Services and Alberta Agriculture and Forestry are working together to strengthen the province's food safety system, throughout the supply chain, to better protect the public from food borne illness. This includes collaboration to revise the regulations that support the operational alignment of meat processing inspections and oversight. In addition, Alberta Health is reviewing the *Food Regulation* in order to identify and address needs and gaps within the industry that it regulates.

Work was also undertaken to provide more information to the public regarding government oversight practices. To this end, the Accountability and Reporting Working Group established annual reporting measures for food safety. Subsequently, Alberta Health Services and Alberta Agriculture and Forestry posted the number and frequency of inspections for 2014 on their respective websites; such annual reporting will continue into the future. The working group also identified additional food safety reporting measures for future consideration.

(2.3) Develop and implement programs related to maternal, infant, child and youth health.

The ministries of Health, Education, and Human Services are partnering to transition the Early Development Instrument (EDI) collection, analysis, and reporting, from a research project spanning 2009-2014, into a Government of Alberta program. The EDI measures children's ability to meet age appropriate developmental expectations in five general domains: physical health and well-being; social competence; emotional maturity; language and cognitive development; and, communication skills and general knowledge.

In 2015-16, with support from the department, Alberta Health Services completed the implementation plan for the universal Early Hearing Detection and Intervention program. This included the development of patient educational resources, training resources, and the screening pathway and clinical algorithms. Implementation of the program will take place in phases over the next year.

(2.4) Develop a whole-of-government approach to wellness and collaborate with key partners to build community capacity in support of wellness.

The ministry supports the well-being of Albertans through the development and monitoring of population-based public health policies and investment in health initiatives that support Albertans in making healthy choices in their lives. These activities are undertaken in collaboration with other ministries, Alberta Health Services, communities, and a variety of stakeholders, to foster integrated approaches to public health and wellness.

Two difficult and long-term challenges to supporting the well-being of Albertans are:

- the complexity of factors affecting health and well-being over a life-time, including social determinants of health, personal beliefs and values, and the physical environments in which Albertans live and work; and,
- influencing Albertans toward adopting healthier behaviours through public health initiatives.

A Health in All Policies analysis process and toolkit were developed as a key step in building a whole-of-government approach to health. These supports encourage Government of Alberta policy practitioners to take the social determinants of health into account when developing and/or evaluating public policy.

Alberta's Communities ChooseWell program facilitated 260 communities to support healthy eating and active living initiatives. In 2015, 108 surveyed communities agreed that the program: strengthened local partnerships for healthy living (77 per cent); increased participation in programs and activities (79 per cent); and, increased community-wide knowledge of healthy eating and active living (90 per cent). Projects supporting First Nations and Métis communities, and organizations serving urban Indigenous populations, enhanced food security, taught traditional ways of gathering and preparing foods, and engaged youth in physical activity through traditional recreational activities.

The Alberta Healthy School Community Wellness Fund supports the implementation of the Comprehensive School Health approach, which is an internationally-recognized and effective approach for building healthy school communities. To date, implementation of the Comprehensive School Health approach has facilitated 59 of 61 school jurisdictions, including reserve and charter schools, to improve access to food and nutrition-related information, increase physical activity, and create a sense of belonging and connectedness.

The Ever Active Schools program continues to support Comprehensive School Health. In the past year, the program brought health and education leaders together to address student mental health in school communities. The program also supported First Nations communities in their development of resiliency strategies. For example, the Kanai Board of Education developed a school wellness policy rooted in Blackfoot culture that enabled them to increase their graduation rate from one graduate in 2010 to 26 graduates in 2015.

To address alcohol-related harms (including binge drinking) and to create a culture of moderation, the department continues to work collaboratively with Alberta Health Services, the Alberta Gaming and Liquor Commission, and other government ministries to implement the Alberta Alcohol Strategy. Initiatives that have been undertaken include:

- raising awareness of Canada's Low-Risk Alcohol Drinking Guidelines;
- supporting health professionals to work with patients who have alcohol-related issues;
- developing responsible alcohol training programs for service industry staff;
- developing an accreditation program to promote responsible management and operation of liquor-licensed premises; and,
- supporting local community coalitions through training, consultation and seed-funding to mobilize and reduce the harms associated with alcohol and other drug use.

In February 2016, the *Alberta Population Attributable Risk* study, a major new study, was released by scientists working with the Alberta Cancer Prevention Legacy Fund. According to the study, about 45 per cent of cancer cases in Alberta are linked to lifestyle and environmental risk factors, and are preventable. The AlbertaPreventsCancer.ca website provides information to empower Albertans to take action to reduce their risk of cancer.

The department, Alberta Health Services, and CancerCare Alberta, supported healthier workplaces and communities through a variety of initiatives including tobacco cessation, HPV immunizations, community data and assessment tools, and workplace improvement projects. Health care providers across the province implemented appropriate screening tests and services to reduce Albertans' risk of cancer progression.

(2.5) Improve and protect the health of Albertans through a variety of strategies, including increased immunization rates.

Alberta's Pandemic Influenza Plan supports coordination between the Government of Alberta and Alberta Health Services pandemic operational plans. It also serves as a reference for local authorities, business and industry, and other stakeholders' pandemic operational plans. In January 2016, Alberta's Ethical Framework for Responding to Pandemic Influenza was completed. The framework can be used to assist in making decisions on common pandemic influenza-related ethical dilemmas such as vaccine priority decisions, compensation for health care workers, antiviral prioritization, and many others. The framework completes all of the ministry's follow-up actions resulting from the Health Quality Council of Alberta's review of the response to the 2009 H1N1 influenza pandemic.

Influenza has a significant impact on the health of Albertans and tends to be most severe among older Albertans, residents of long-term care facilities, infants and young children, and those with certain chronic medical conditions. The ministry's annual influenza immunization campaign is an important population health initiative intended to decrease the risk of outbreaks, illness, and death among all Albertans.

More than 1.43 million Albertans (approximately 27 per cent of the population) received the influenza vaccine during the 2015-16 influenza season (a drop of three per cent from the previous year). Community pharmacists administered over 475,268 doses of influenza vaccine (a drop of three per cent from the previous year) and Alberta Health Services administered 434,930 doses (a drop of 16 per cent from the previous year). Reports also show a three per cent drop, from 64 per cent to 61 per cent, in the percentage of Alberta Health Services healthcare workers who received influenza immunization.

The less severe influenza season, with fewer instances of fatalities and admissions to hospital, likely contributed to the three per cent decrease in the overall rate of immunization when compared to 2014-15, as people are more willing to forgo immunization in what they perceive to be a less severe season.

(2.6) Develop initiatives with Aboriginal partners and the federal government to improve health services.

Various national, provincial, regional, community, and population-specific studies have identified a wide health gap between Aboriginal and non-Aboriginal Albertans. Through commitments embodied in the United Nations Declaration on the Rights of Indigenous Peoples, and the Calls to Action of the Truth and Reconciliation Commission, the Government of Alberta has committed to addressing health challenges experienced by Alberta's First Nations and Métis populations.

The department and Alberta Health Services continue to be engaged at trilateral Health Services Integration Fund and Joint Action Health Plan tables with Health Canada and Treaty 6, 7 and 8 First Nations in Alberta. The objective of these tables is to enhance relationships and collaborate on initiatives to improve the health outcomes of First Nations people in Alberta.

The ministry led a multi-partner task group and developed policy options to benefit First Nations Albertans by improving access to, and coordination of, the Alberta Aids to Daily Living Program and the Medical Supplies and Equipment portion of the federally funded Non-Insured Health Benefits Program.

The department supported the development of a Strategic Clinical Network (SCN) for Population, Public and Aboriginal Health. SCNs are the mechanism that Alberta Health Services uses to support physicians, clinical leaders in Alberta Health Services and the community-at-large to develop and implement evidence-informed, clinician-led, team-delivered health improvement strategies across Alberta.

The Population, Public and Aboriginal Health SCN will be engaged with zone and provincial Alberta Health Services operations, as well as the ministry (including Alberta's Chief Medical Officer of Health), external partners, community members, interest groups, municipalities, and community-based organizations. The goal of the SCN is to respond effectively to the public health needs of Albertans and address determinants of individual and community health and well-being.

(2.7) Implement a Wait Time Measurement and Waitlist Management Policy to address long wait times in the health care system.

Albertans want transparent and standardized information about expected wait times so they can plan their lives, determine the best options for care, and navigate the health system easily. They also want assurance that wait lists are managed fairly. Clinicians want transparent and standardized information so they can better advise and care for their patients, and easily find consultants available to take referrals. Administrators and government want transparent and standardized information about access so they can make better decisions to allocate resources where they are needed, and improve equity and safety for patients.

The department's Wait Time Measurement and Waitlist Management Policy to address long wait times for scheduled services is nearing completion. The aim of the policy is to improve access to care and develop capability to better monitor and report on access to care. Consultation with Alberta Health Services and external stakeholders, including the Alberta Medical Association, College of Physicians and Surgeons of Alberta, and other regulatory colleges, has been extensive. Once the policy is approved, the department can move forward with further consultation on implementation of the policy.

The Wait Time Measurement and Waitlist Management Policy aligns with initiatives that Alberta Health Services has underway, such as the Path to Care, Closed Loop Referral, and e-Referral initiatives. In November 2015, Alberta Health Services implemented the Adult Coding Access Targets for Surgery (ACATS) for high volume surgical sites across the province. ACATS reports are available to surgeons and administrators to provide information on how long patients have been waiting in relation to their access target so wait lists for surgery can be managed more effectively. ACATS is also being rolled out for smaller surgical sites that do not have electronic operating room information systems.

A program evaluation of the initial components of Alberta Health Services' e-Referral (i.e., for hip and knee joint replacement surgery, and breast and lung cancer) was conducted in December 2015. Results of the evaluation will be used to make process improvements.

The ministry updated the reporting of wait times to the Canadian Institute for Health Information (CIHI) from using the "Decision to Treat to Treatment" (DTT) interval to the more accurate "Ready to Treat to Treatment" (RTT) interval for its April 2015 public report. The RTT wait time is a more accurate reflection of the health system-related wait times that patients face for their procedures because it removes the portion of the wait time that a patient is not medically or functionally ready for their procedure, as well as any time related to the patient's decision to defer the procedure. As of April 2015, the RTT interval is reported on the Alberta Wait Time Reporting system for hip and knee joint replacement surgery, cataract surgery, coronary artery bypass graft surgery, and radiation therapy (cancer treatment).

Performance Measures and Indicators

Performance Measure 2.a **Influenza immunization: Percentage of Albertans who have received the recommended annual influenza immunization.**

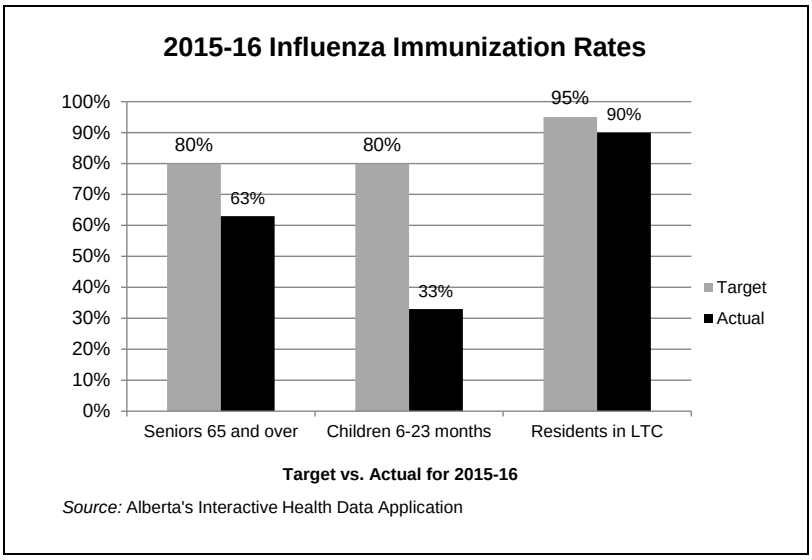
This performance measure tracks efforts towards immunization among high risk groups that include seniors (aged 65 and over), young children (aged six months to 23 months) and residents of long-term care facilities. Influenza immunization targets are set by the ministry in consultation with Alberta's Chief Medical Officer of Health and are based on national immunization targets as agreed to by the National Consensus Conference for Vaccine-Preventable Diseases in Canada in 2005. (**Note:** immunization targets for *Seniors 65 and over* and *Children 6-23 months* were incorrectly reported at 75% instead of 80% in the 2015-18 ministry business plan).

	Five-year Influenza Immunization Rates				
	2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**
Influenza immunization: Percentage of Albertans who have received the recommended seasonal immunization:					
· **Seniors aged 65 and over**	61%	60%	64%	61%	63%
· **Children aged 6 to 23 months**	29%	30%	34%	34%	33%
· **Residents of long-term care facilities**	91%	89%	88%	90%	90%

Results Analysis

There was a two per cent increase in the immunization rate for seniors; however, immunization rates for all three high risk groups remained below the 2015-16 targets.

The 33 per cent immunization rate for children aged six months to 23 months was well below the target of 80 per cent. Improving the influenza immunization rate for young children and their household contacts continues to be a priority.



Source: Alberta's Interactive Health Data Application

Alberta Health Services has used a number of strategies to increase influenza immunization rates for young children, such as more drop-in clinics (including day- and child-care centres), offering influenza immunization to children as they presented for other routine childhood immunization, and targeted reminder calls and mail-outs. Parents have responded well to lunch-time and supper-hour clinics and reminders; however, this has not yet translated into improvements in overall immunization rates. Another key strategy to address low immunization rates for children aged six months to 23 months is improved communication to parents about the medical and scientific evidence for the safety and benefits of immunization.

Performance Measure 2.b Childhood immunization rates (by age two).

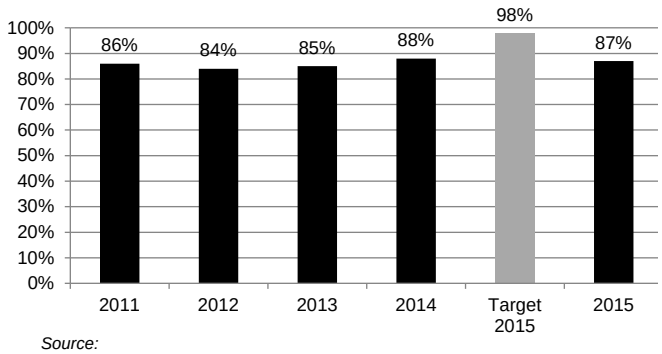
This measure indicates efforts towards protecting children from a number of vaccine-preventable diseases, some of which can be fatal or produce permanent disabilities. A high rate of immunization reduces the incidence of these diseases and also serves to control outbreaks. Targets are set by the ministry in consultation with Alberta's Chief Medical Officer of Health and are based on national immunization targets as agreed to by the National Consensus Conference for Vaccine-Preventable Diseases in Canada in 2005.

Results Analysis

There was a one per cent decrease in the rate of immunization to prevent measles, mumps and rubella (MMR) during 2015-16. The decrease in the rate of immunization to prevent diphtheria, tetanus, pertussis, polio and haemophilus influenza type b (DTaP-IPV-Hib) was also one per cent lower over the same period.

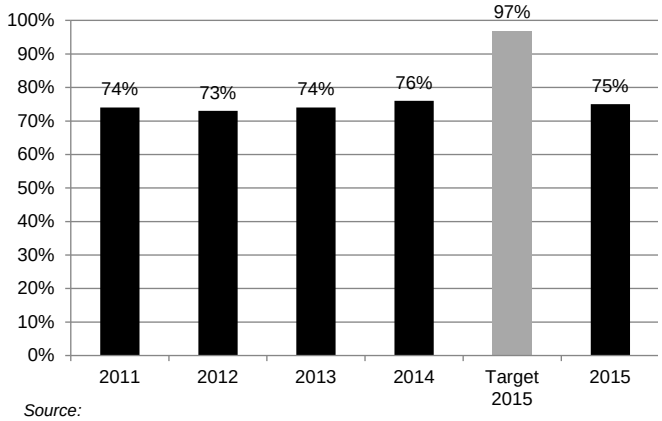
The difference in the rate between the two types of immunization may, in part, be explained by the differences in immunization schedule. The schedule for the DTaP-IPB-Hib vaccine is a four dose series with the last dose offered at 18 months of age, while the protocol for the MMR vaccine is one dose by two years of age. Another contributing factor is that public health involvement with parents drops off after children reach one year of age, therefore parents may forget they need to have their child immunized.

There are many factors that influence parental decisions to immunize their children, including whether parents believe vaccines are safe and/or effective against preventing the disease. Another contributing factor is the misinformation that is readily accessible on the internet, where the source sounds authentic and credible but has no science-based evidence.



Childhood Immunization Rates by Age 2
Measles, mumps, rubella

Source:
Numerator: Immunization/Adverse Reactions to Immunization system.
Denominator: The ministry's Population Estimates, based on mid-year (June 30) registration populations estimates.



Childhood Immunization Rates by Age 2
Diphtheria, tetanus, pertussis, polio, Hib

Source:
Numerator: Immunization/Adverse Reactions to Immunization system.
Denominator: The ministry's Population Estimates, based on mid-year (June 30) registration populations estimates.

The ministry is focusing on educating health professionals and parents about the safety and effectiveness of vaccines so that parents can make an informed choice. When parents have the facts, the vast majority choose to immunize their children. Alberta Health Services has implemented a project to reduce clinic wait times and improve the collection and reporting of immunization data at the local geographical level. This will inform strategies to improve immunization rates in the coming year.

Performance Measure 2.c **Healthy Alberta Trend Index (HATi): Average number of health risk factors per person aged 20 to 64 years.**

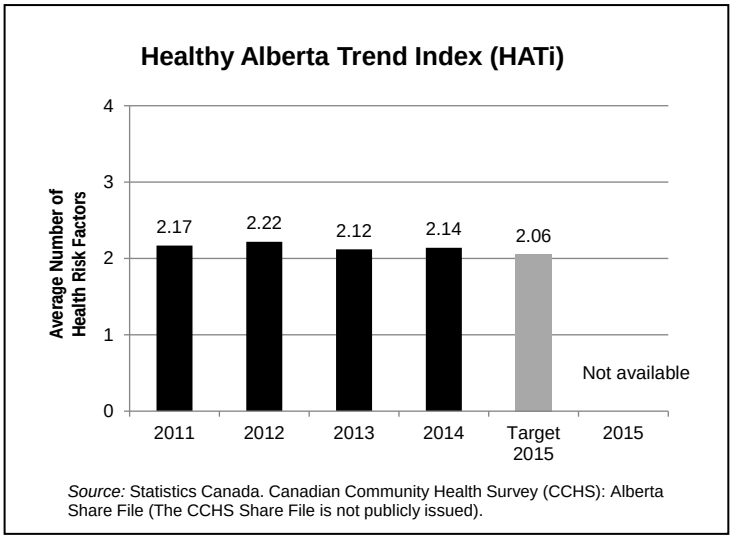
The Healthy Alberta Trend Index (HATi) is a composite index that measures six, self-reported complex health behaviours: consumption of fruit and vegetables; physical activity; daily smoking; life stress; overweight/obesity; and, binge drinking alcohol.

Results Analysis

The index measures population level shifts therefore the changes over time are small, incremental and often fluctuating. Shifts in the trends are driven by a range of factors including to a large extent, social and economic conditions, as well as by targeted policy and program initiatives that are of sufficient reach, scope, and dose to have an effective impact on whole populations.

The HATi result is between 0 and 6 where, from a risk factor perspective, 0 would be most healthy and 6 would be most unhealthy (in terms of risky health behaviours for each indicator making up the HATi).

Results for 2014 were compared to results for 2013 because results are not available for 2015 at the time of publication of this report. Although public health initiatives have had some success in lowering risky health behaviours, such as smoking, the index has remained relatively stable over time.



Source: Statistics Canada. Canadian Community Health Survey (CCHS): Alberta Share File (The CCHS Share File is not publicly issued).

The government has implemented several initiatives to influence the HATi trend, such as:

- preventing and reducing tobacco use;
- cross-government work to implement the Alberta Alcohol Strategy;
- raising awareness of Canada's Low-Risk Alcohol Drinking Guidelines; and,
- a social marketing campaign encouraging young Albertans and their parents to eat five helpings of fruit and vegetables, and to get one hour of physical activity per day.

These initiatives, and others led by community partners and municipalities, are helping to address rates of physical inactivity, overweight and obesity, and stress levels with the goal that they will translate into reductions in the HATi index for adults over time.

Trend Analysis

Consumption of Fruit and Vegetables – Females have consistently fared better on this indicator than males. From 2013 to 2014, the percentage of Albertans who reported that they were eating more than five servings of fruit and vegetables decreased by 3.7 per cent. This result may have been impacted in 2013-14 by a 2.6 per cent increase in the cost of food in Alberta. (Consumer Price Index: www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/perecon156j-eng.htm)

Physical Activity – In 2014, 57 per cent of Albertans reported being active or moderately active. The results for this indicator have been consistent over time with very little difference between the proportion of males and females that report engaging in regular physical activity.

Daily Smoking – This indicator has been consistently and significantly decreasing over time, driven primarily by the decline in the number of female daily smokers. In 2014, a drop in the number of male daily smokers also contributed to the decline from 20.8 per cent in 2012 to 16.5 per cent in 2014.

In Alberta, tobacco prevention and reduction efforts are guided by *Creating Tobacco-free Futures: Alberta's Strategy to Prevent and Reduce Tobacco Use, 2012-2022*. Several initiatives focused on preventing and reducing tobacco use have been implemented since 2002 including: tobacco tax increases; implementation of comprehensive tobacco control legislation (particularly aimed at youth); increased availability of tobacco cessation services; tobacco cessation training for health professionals; grant funding for community projects; and, several public awareness campaigns.

Life Stress – More males consistently report self-perceived stress levels as "extremely" or "quite a bit stressful" than females; however, the differences are relatively small. This measure has been very stable over time.

Overweight/Obesity – Although the results for Body Mass Index (BMI) have been relatively stable for this indicator for both males and females, there has been a slight increase overall since 2003 and a steady increase every year since 2010. The proportion of males that are overweight has also been consistently and significantly higher than for females.

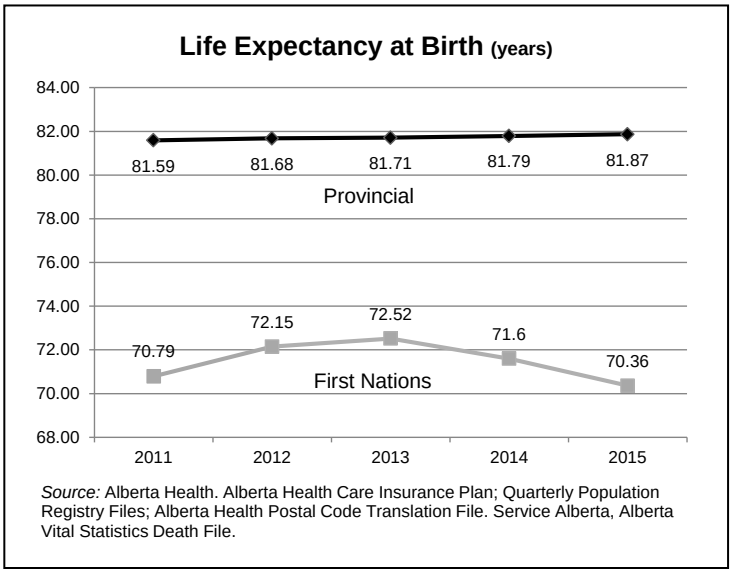
Binge Drinking Alcohol – Almost twice as many males report binge drinking compared to females; however, the relative proportion of binge drinking among both sexes has remained relatively constant over time. In 2014, the percentage of Albertans reporting binge drinking decreased to 11.7 per cent from 14 per cent in 2013. This reduction is due to a decrease in binge drinking in males by almost six per cent from 2013 to 2014. Binge drinking among females increased slightly in the same time period. Binge drinking rates remain a concern for the Government of Alberta, especially among youth and young adult populations.

Performance Indicator 2.a Life expectancy at birth (years).

Life expectancy at birth provides the number of years a given birth cohort would be expected to live if current age and sex mortality rates remained in place. Life expectancy is an indicator of the overall health status of a population.

Results Analysis

There is a large difference in life expectancy for Alberta's First Nations population in comparison to Alberta's total provincial population.



Source: Alberta Health. Alberta Health Care Insurance Plan; Quarterly Population Registry Files; Alberta Health Postal Code Translation File. Service Alberta, Alberta Vital Statistics Death File.

Life expectancy at birth in 2015 was 70.36 years for First Nations people – about 12 years shorter than 81.87 years for the total provincial population.

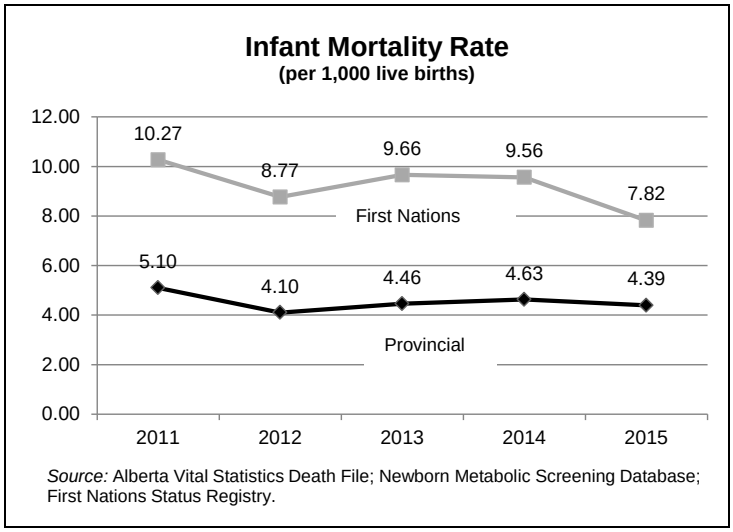
In comparison to Alberta's total population, the First Nations population experiences an infant mortality rate that is more than one and a half times higher, a suicide rate that is five to seven times higher, a higher rate of diabetes, and significantly higher rates of arthritis, asthma, heart disease, and high blood pressure. This is consistent with national results which indicate the health of Indigenous peoples is much worse than for Canadians as a whole. To improve the health status of a population, a broad range of factors need to be considered including health services, personal health practices and coping skills, and social factors such as housing and education.

Performance Indicator 2.b Infant mortality rate (per 1,000 live births).

The infant mortality rate provides the number of infants aged less than one year that die, per 1,000 live births. Like life expectancy, infant mortality rate is an indicator of the overall health status of a population.

Results Analysis

For First Nations people, the infant mortality rate was 7.82 (per 1,000 live births) in 2015, more than one and a half times the provincial infant mortality rate of 4.39.



Source: Alberta Vital Statistics Death File; Newborn Metabolic Screening Database; First Nations Status Registry.

Compared to Alberta's total population, the First Nations population experiences a higher number of preterm births. Many other factors influence infant mortality including the mother's level of education, access to health services, personal health behaviours, and social factors.

DESIRED OUTCOME THREE: Albertans receive care from highly skilled health care providers and teams, working to their full scope of practice.

Achievements

(3.1) Improve access to health care providers across the province and develop sustainable strategies that ensure the appropriate education, scope of practice, supply and distribution of health care providers.

To achieve the desired outcome, the ministry must work with partners to ensure a sufficient supply and distribution of appropriately trained personnel to meet current and future needs. Currently, Alberta's health workforce is comprised of an estimated 151,000 individuals. Approximately 70 per cent of the health budget is spent on health human resources. There is an ongoing challenge to manage costs while protecting front line services and improving outcomes for Albertans.

Modernizing the way Alberta plans for, and optimizes, its health workforce will ensure the ministry can continue to meet the health care needs of Albertans. The ministry is leading on the development of a provincial health human resources strategy that includes a vision, mission, guiding principles, underlying assumptions, and objectives, along with recommendations and a detailed action plan. It will also highlight key areas of focus to coordinate the supply, deployment, distribution, and retention of the workforce, by using a systematic approach that coordinates efforts across stakeholders. This approach supports the delivery of new models of care and different configurations of health providers to meet the health care needs of Albertans, now and in the future. Putting the plan into action will require commitment and effort from many stakeholders and public participation.

High quality health care requires consistent practice excellence and compliance with professional standards and regulations. A diverse range of workforce optimization initiatives have been implemented across the health system. Many have focused on maximizing the expanded scope of practice of specific health professions (e.g., pharmacists, optometrists, licensed practical nurses), or integrating complementary health providers into the health system (e.g., nurse practitioners, midwives). As Alberta's population grows, ages and continues to live longer with multiple chronic conditions, new models of care and different configurations of health providers may be required.

In June 2015, the revised Optometrists Profession Regulation came into effect. The regulation allows all optometrists who have successfully completed the Advanced Scope of Practice Certification Course to:

- prescribe, dispense or sell an oral or topical Schedule 1 or 2 drug for the purposes of the practice of optometry;
- manage and treat glaucoma in an independent manner;
- order and analyze laboratory tests; and,
- order and apply non-ionizing radiation in the form of ultrasound.

The Alberta College of Optometrists has adopted new Standards of Practice and Clinical Practice Guidelines for these new areas of practice. The expanded scope of practice will reduce the need for referrals to specialists for basic eye care services. Albertans will have immediate access to the eye care they need closer to home, particularly in rural Alberta.

In September 2015, the government announced an additional $1.8 million to fund 400 more midwife supported births in Alberta, which also includes pre- and post-natal care. This brings the number of publicly supported births by midwives to approximately 2,774 per year. Midwives provide safe services for women with low-risk pregnancies. Midwifery health care is associated with fewer preterm and low-weight babies. Alberta has publicly funded midwifery care since 2009. In March 2016, the Minister reconfirmed the support for expanding midwifery within the province.

There are currently 94 registered midwives in Alberta who are governed by the College of Alberta Midwives and regulated under the *Health Disciplines Act* and the *Midwifery Regulation*. Midwives must follow the standards of practice, which are part of the *Midwifery Regulation*, developed to ensure the safety of expectant mothers and their babies.

(3.2) Enhance accountability and promote practice excellence among regulated health care providers.

In addition to Alberta Health Services, 29 regulatory colleges have been established to create a high performing, accountable, and patient-centred health system. These colleges, as self-governing bodies, provide oversight on the conduct and competency of their members. This includes establishing and enforcing a code of ethics, standards of practice, and the requirements for registration and continuing competence of nearly 100,000 regulated health professionals.

Currently, all regulated health professions are governed by regulatory colleges under the *Health Professions Act* (26 colleges) or *Health Disciplines Act* (three colleges). Implementation of this legislation through the regulatory colleges promotes practice excellence and accountability of the regulated health professionals who provide care to Albertans. This collaboration with regulatory colleges is vital in developing and maintaining public confidence in the quality and delivery of care, since confidence can be eroded quickly by a negative experience with a health care provider.

During 2015-16, the ministry, in collaboration with the Alberta Federation of Regulated Health Professionals, neared the completion of an extensive review of the *Health Professions Act*. The review yielded suggestions to strengthen the Act in protecting the public, promoting accountability, and enabling health professionals to work to their full scope of practice to support team-based care. Work is progressing on proposed legislative amendments.

(3.3) Develop sustainable physician compensation models which enable the provision of high quality care and support collaborative practice within a team-based environment.

Funding mechanisms for the health workforce must reflect fair rates for the nature of the work performed, be adaptable, flexible and responsive to changing environments, and enhance existing funding models to deliver on health system evolution priorities and workforce optimization. With respect to physician compensation, the goal is to develop sustainable physician compensation models which align with the evolving role of physicians, and other healthcare providers, in a high-performing healthcare system.

The ministry and the Alberta Medical Association commenced formal negotiations on issues affecting the fiscal state and sustainability of our province's health care system—such as managing the rate of growth of the physician services budget, improving the effective provision of health care to Albertans, and jointly ensuring the sustainability of Alberta's health care system.

In February 2016, the Institute of Health Economics and the University of Calgary's O'Brien Institute for Public Health hosted *Physicians as Stewards of Public Resources*, a policy forum sponsored by the Alberta Medical Association and the Ministry of Health. The forum brought together health care leaders from across Canada to discuss issues related to physician compensation in Alberta. Health care experts were engaged in an unbiased and evidence-informed dialogue to support reform of physician services in Alberta's health system to further advance sound social policy on value-based alignment of compensation with high quality care and outcomes. A summary report of the event, outlining main themes and topics of discussion, is being prepared to inform further deliberations on this matter.

The government, in partnership with Alberta Health Services, the Universities of Alberta and Calgary, and the province's faculties of medicine, held a number of stakeholder discussions and workshops that culminated in the development of a new Academic Medicine Framework. The new structure will enable the government to better support medical schools to train new physicians in both acute and primary care, as well conduct research and teach the next generation of physicians. This ensures that Albertans continue to receive high quality health care at an affordable cost.

The government has also added six new Clinical Alternative Relationship Plans (Clinical ARPs), which compensate physicians for providing a set of clinical services at defined facilities to a target population. These new Clinical ARPs increased the number of primary care programs and locations available to Albertans.

(3.4) Increase access to primary health care services.

A key priority of the government is to ensure Albertans have the best possible access to primary health care services and that they get the right care, in the right place, at the right time, by the right provider, with the right information, in a fiscally responsible manner. Access to health care services can be limited by geography, hours of operation, and wait times. One of the five provincial objectives for Primary Care Networks (PCNs) is to manage access to appropriate round-the-clock primary care services.

Starting in 2015-16, each PCN is required to report to the department on the percentage of physicians using a standard access measure to track wait times. A toolkit was developed in February 2016 by the department of Health, Alberta Health Services, and PCNs to support this measure. PCN primary health care team members (including physicians) also receive support through Alberta Health Services, PCNs and department-funded quality improvement programs. These programs will improve processes and address capacity issues and are expected to lead to improved access for Albertans.

Performance Measures and Indicators

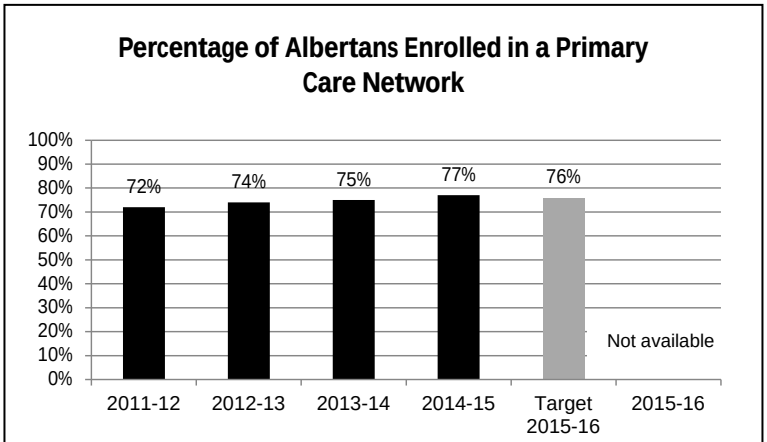
Performance Measure 3.a **Access to primary care through Primary Care Networks: Percentage of Albertans enrolled in a Primary Care Network.**

This measure indicates the degree to which Albertans use primary care networks (PCNs) to access health services and is based on patient enrollment on March 31 of each fiscal year.

Results Analysis

The 2015-16 result for this performance measure is not available for reporting.

For 2014-15, the result for this measure shows that 77 per cent of Albertans have access to primary care through a PCN. This result is one per cent higher than the target of 76 per cent for 2015-16 and is an increase of two per cent from the previous year.



Source: Alberta Health. Alberta Health Care Insurance Plan Statistical Supplement, 2014-15

The increase in the percentage of patients enrolled in a PCN may be due to an increase of 274 in the number of physicians participating in existing PCNs in 2014-15. This increase brings the total number of physicians participating in PCNs in 2014-15 to 3,564. The trend demonstrates a gradual increase over time in both the number of physicians and Albertans associated with PCNs.

DESIRED OUTCOME FOUR: A high quality, stable, accountable and sustainable health system.

Achievements

(4.1) Create a stable budget for health care services to help people and their families receive the right care, at the right time, from the right provider, and in the right place.

The Government of Alberta is committed to ensuring the sustainability of the health care system today and into the future, while maintaining the quality of front line services and meeting the health care needs of Albertans. This means transforming the health system to one that provides better outcomes in a sustainable way.

As a starting point, the Government of Alberta reversed planned budget reductions proposed in March 2015, including decreases for Alberta Health Services' base operating funding. This prevented the elimination of approximately 1,500 front line nursing and health care positions. With the introduction of *Budget 2015* in October 2015, the government moved to stabilize the public health care system by providing predictable, long-term funding and decreasing the annual growth rate of the health budget.

Alberta has been among the highest in per capita spending on health care for many years. An important factor in transforming the health care system is controlling those costs that have been growing the fastest: acute care (hospitals); physician compensation; and, drugs.

With respect to acute care, Alberta Health Services continues to review operational best practices where resources can be realigned to support the changing needs of patients. This is the single best way to reduce costs, maintain or improve care, and ensure sustainability.

The ministry signed a memorandum of agreement with the Alberta Medical Association to begin negotiations regarding physician compensation with the objective of slowing the growth rate of the physician services budget, as well as improving the effective provision of health care to Albertans.

The rising cost of prescription drugs continues to put pressure on government expenditures. Alberta is an active participant, in collaborative efforts with other Canadian jurisdictions, to achieve better pricing on drugs and address other pharmaceutical-related matters, such as best practices regarding the availability of generic drugs. The pan-Canadian Pharmaceutical Alliance (pCPA) experienced significant success in 2015-16 with the establishment of the Office of the pCPA and the addition of Québec and federal drug plans. This is expected to lead to increased consistency of coverage across Canada. The pCPA's expanded negotiating power will help all drug plans achieve lower, more sustainable drug costs. As of April 30, 2016, the pCPA had completed 105 negotiations and 23 negotiations are underway. These are significant steps to reducing the overall cost of the province's publicly funded drug plans and ensuring Albertans can afford prescription drugs.

Alberta continues to seek out other opportunities to reduce drug costs. In October 2015, the government launched the Retina Anti-Vascular Endothelial Growth Factor Program for Intraocular Disease (RAPID), a pilot project in partnership with the Retina Society of Alberta. Under the RAPID program, Albertans are able to choose treatment with either of two drugs, both of which treat age-related macular degeneration, diabetic macular edema, retinal vein occlusion, and other retinal conditions. The program is expected to save the province between $23 million and $46 million over three years and has resulted in over 4,000 individuals receiving treatments for retina conditions with no out-of-pocket costs for their treatments.

(4.2) Ensure regional health care needs are heard and addressed.

The Government of Alberta is committed to meeting the health care needs of all Albertans, both urban and rural. These needs will be reflected within initiatives in the priority areas of primary health care, continuing care, and mental health and addictions.

The Alberta Health Services Board established five sub-committees that include members of the public. In particular, the Community Engagement sub-committee will focus on engagement with communities and municipalities to understand and address the community population health and cultural needs. In addition, the ministry has directed that the composition of Primary Care Network boards include community representation to ensure that local community population health and cultural needs are being considered in the business decisions of Primary Care Networks.

(4.3) Repair aging health infrastructure and build new health care facilities, where appropriate, to ensure that such infrastructure meets current and future health care needs.

The Government of Alberta committed to strengthening health infrastructure to protect and improve health care services for Albertans. This includes funding to position Edmonton's health facilities for the future and to set a path for a new Calgary Cancer Centre.

As part of the five-year capital plan, $11.8 million was spent in Edmonton to expand the Stollery Children's Hospital surgical suite and $2.25 million to redevelop and expand the critical care units. In addition, $20.5 million was spent on Addictions and Detox Centres and the new CASA Centre in Edmonton to support child, adolescent and family mental health.

In Calgary, $2 million was spent to advance the planning for the new Calgary Cancer Centre at the Foothills Medical Centre campus. The Calgary Cancer Centre will replace the Tom Baker Cancer Centre and provide inpatient beds and additional patient services. Construction is scheduled to begin in 2017 and the Centre is expected to open by 2024. The new Cancer Centre is integral to meeting Alberta's rising need for cancer care and providing world-class cancer treatment for patients and families in Calgary and southern Alberta.

A total of $347 million was spent to continue construction of new or expanded hospitals in the communities of Grande Prairie, High Prairie, Lethbridge, Edson, and Medicine Hat.

The government also provides annual funding to Alberta Health Services to maintain health facilities across the province. In 2015-16, $87.5 million was provided to Alberta Health Services for health facility maintenance across the province to ensure high standards for our health care workers and their patients.

(4.4) Enhance accountability through improved governance structures and establish clear mandates and roles for all health agencies, boards and commissions.

The *Alberta Public Agencies Governance Act* requires agencies to have a mandate and roles document, codes of conduct, and a competency-based recruitment process. These documents and processes must be made publicly available.

The ministry is working to ensure its agencies, which are governed by the Act, meet these requirements. The Mandate and Roles document for the Public Health Appeal Board was signed in February 2016. The Mandate and Roles documents for other ministry agencies are nearing completion.

In regard to competencies, the recruitment process that led to the selection of the Alberta Health Services Board in October 2015 ensured that appointed members have firsthand knowledge of health care delivery, governance, and fiscal planning. The Board's role is to oversee the health delivery system with the objective of strengthening and stabilizing it in a prudent and sustainable way.

In November 2015, the establishment of an Alberta Provincial Blood Coordinating Program was approved. This program will focus on coordinating transfusion medicine programs and support enhanced quality, safety, and accountability for public spending on blood and blood products.

(4.5) Improve performance of emergency departments for enhanced patient flow through the acute care system.

Wait times in emergency departments are affected by many factors, including the volume of patients and the severity of their conditions. In Alberta, all patients presenting to emergency departments are assessed according to the Canadian Triage and Acuity Scale so those most in need can be seen first. Improving the performance of emergency departments for patient flow is an operational activity undertaken by Alberta Health Services and endorsed and monitored by the Department of Health.

Alberta Health Services is undertaking many quality improvement projects in its hospitals and has established the Emergency Strategic Clinical Network (ESCN), which includes health care professionals and patients, with a goal of improving emergency services in Alberta. The ESCN is working to ensure that resources are used to their fullest to improve the journey of patients and their family through emergency care, as well as making sure all Albertans receive high quality care.

Emergency department performance for Length of Stay for Admitted Patients declined in 2014, which may, in part, be due to the revocation of Alberta Health Services' former *First Available Bed* policy for access to continuing care. In May 2015, Alberta Health Services introduced a new *Designated Living Option: Access and Waitlist Management in Continuing Care* policy which requires that each client and their family receives sufficient information, support, and time to decide on one or more living options that will be suitable to meet the client's needs and preferences.

(4.6) Implement a system-wide response to chronic disease management by aligning and integrating current work being done on chronic disease across the province.

Alberta Health is engaged in developing a framework for preventing and managing chronic conditions and diseases which will provide specific goals and outcomes for improving patient access and care. The framework intends to engage patients in their care, provide high quality care augmented by information systems, and coordinate services across the province.

As a first step, the ministry is aligning and integrating work currently underway across the province on chronic disease prevention and management, and developing a common vision to guide next steps. During 2015-16, two consensus meetings with stakeholders across the ministry and Alberta Health Services were held, with the objective of developing a common, integrated vision for chronic condition and disease prevention and management.

(4.7) Increase the capacity for evidence-informed practice and policy through clinical information systems, enhance data sharing, research, innovation, health technology assessment, and knowledge transfer.

The Health Research and Innovation Collaboratory is a coordinating body comprised of senior representatives from the ministries of Health (including Alberta Health Services), Advanced Education, and Economic Development and Trade (including the former organizations Alberta Innovates - Health Solutions and Alberta Innovates - Technology Futures). The department, along with partner organizations in the collaboratory, identified key priorities that will enable research and innovation to support a sustainable health system and improve health outcomes for all Albertans, including Alberta's Indigenous population. These priorities will inform future health research and innovation investments and facilitate the development and application of evidence to support decision making in the health system.

The ministry continued its cross-ministry efforts to identify and assess health solutions that are of benefit to Albertans. One such example included the announcement in October 2015 of a collaborative partnership between the Government of Alberta, 3M Canada, the University of Calgary's W21C, and Alberta Innovates - Health Solutions to enhance medical product testing and validation in the province.

Health technology assessment is a critical tool for supporting evidence-informed decision making. During 2015-16, the ministry:

- re-designed the Alberta Health Technologies Decision Process (AHTDP) and developed new products such as Evidence Synthesis and Appraisal Reviews, which will improve timeliness and responsiveness, expand efficiencies, and align more closely with health system priorities;
- undertook the first post-policy implementation review of an AHTDP-informed decision, which resulted in a decision to reallocate resources to areas of higher priority; and,
- conducted six reviews, including on Newborn Blood Spot Screening and Hepatitis C Virus Screening.

The department also published a number of new data sets to Alberta's Open Government Portal including: 132 Primary Care Community Profiles datasets; 65 Alberta Health Care Insurance Plan Statistical Supplement datasets for 2014-15; and the Alberta Environment Public Health Information Network 'Mercury in Fish' data set.

Performance Measures and Indicators

The performance measures and performance indicators that follow help the ministry focus efforts to support a high quality health care system.

The health system provides a range of services for patients at various points and stages in their healthcare experience. Patients can move back and forth between four general areas of need: being healthy; getting better; living with illness or disability; and end of life. To reach the goal of providing consistently high quality care, the *Alberta Quality Matrix for Health* guides consistency around the four general areas of need and six dimensions of quality health care:

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

Performance Measure 4.a **Satisfaction with health care services received: Percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year.**

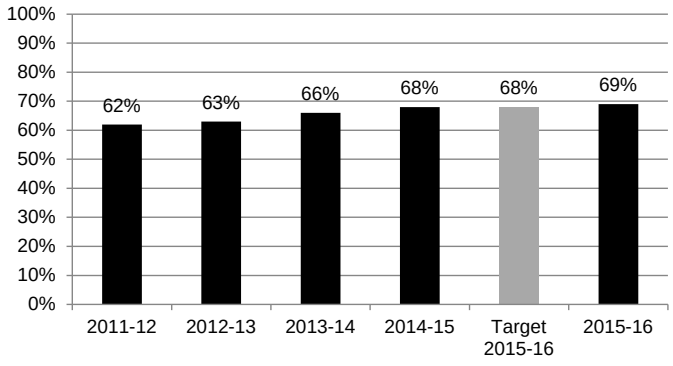
Patient satisfaction with health care services received is a crucial and critical dimension of quality. It is an indicator of the structure, process, and outcomes of care in Alberta's health care system, and helps assess performance of the health system in delivering high quality, patient-centred care.

Satisfaction ratings are obtained from Albertans who have accessed health services in the province within the past year. Services include those that may be provided by family physicians, specialist physicians, pharmacists, mental health therapists, or other healthcare professionals.

Results Analysis

In 2015-16, 69 per cent of Albertans surveyed were satisfied or very satisfied with health care services received. This exceeds the target of 68 per cent, by one per cent. Results are reliable within 2.5 per cent, 19 times out of 20.

In addition to personal experiences with the health care system, survey respondents may be influenced by recent news reports, current events, changes to local health system infrastructure, and perceptions of policy or system changes.

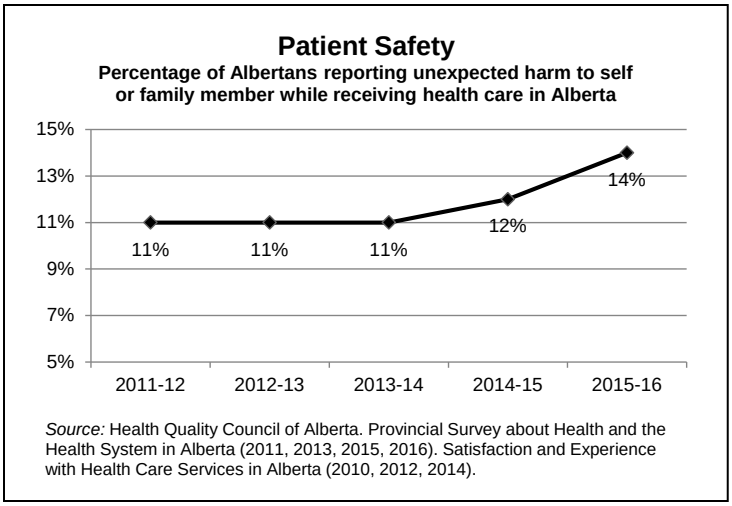


Source: Health Quality Council of Alberta. Provincial Survey about Health and the Health System in Alberta (2011, 2013, 2015, 2016). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services in Alberta (2010, 2012, 2014).

Performance Indicator 4.a **Patient Safety: Percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year.**

Patient experience with adverse events is a high level indicator of system safety. Sometimes when people receive health care, unexpected harm can occur as a result of that care. Such unexpected harm is different from complications which may occur as an expected risk of some treatments.

Unexpected harm can affect a patient's health and/or quality of life and can result in additional or prolonged treatment, pain or suffering, disability or death. Monitoring patient experience supports the provision of safe care to improve patient outcomes and fosters continuous improvement in patient safety in Alberta.



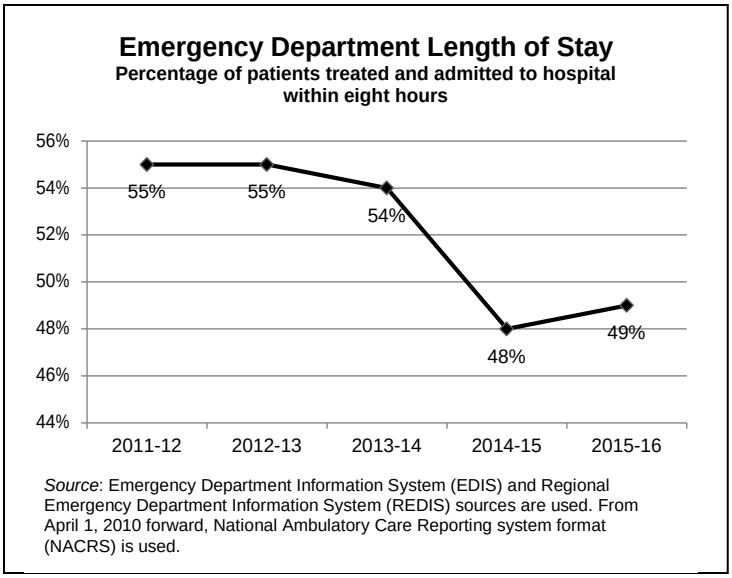
Source: Health Quality Council of Alberta. Provincial Survey about Health and the Health System in Alberta (2011, 2013, 2015, 2016). Satisfaction and Experience with Health Care Services in Alberta (2010, 2012, 2014).

Results Analysis

The results for the last five years show the experience reported by survey participants as stable for three years but increasing over the past two years. Results are reliable within 1.9 per cent, 19 times out of 20.

Performance Indicator 4.b **Emergency department length of stay: Percentage of patients treated and admitted to hospital within eight hours (all sites).**

Patients treated in an emergency department or urgent care centre should be assessed and treated in a timely fashion to ensure quality of care. This indicator tracks length of stay in emergency departments that are located in facilities with inpatient spaces. The emergency department length of stay for admitted patients is measured from the earliest reported time after arrival in the emergency department (either the triage or registration time) to the time the patient enters the hospital as an inpatient following discharge from the emergency department.



Source: Emergency Department Information System (EDIS) and Regional Emergency Department Information System (REDIS) sources are used. From April 1, 2010 forward, National Ambulatory Care Reporting system format (NACRS) is used.

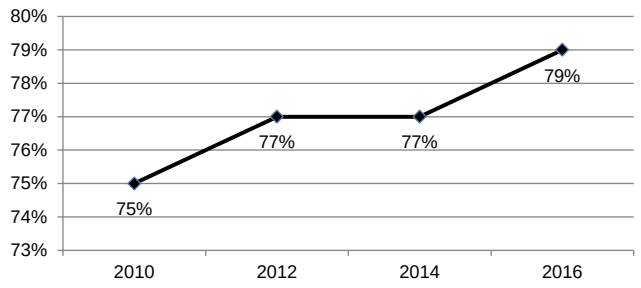
Results Analysis

For 2015-16, the percentage of patients treated and admitted to hospital within eight hours (all sites) increased from 48 per cent to 49 per cent. It is expected that this number will continue to increase as initiatives to improve emergency department performance begin to show results.

Performance Indicator 4.c Albertans' rating of the quality of health care services received (biennial survey).

This indicator examines Albertans' perceptions of the overall quality of health care services received within the past year.

Services include those that may be provided by family physicians, specialist physicians, pharmacists, mental health therapists, or other healthcare professionals. This rating is an indicator of whether Alberta's health care system is safe, effective, patient-centred, timely, efficient, and equitable in meeting the needs of Albertans.



Source: Health Quality Council of Alberta. Provincial Survey about Health and the Health System in Alberta (2011, 2013, 2015, 2016). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services in Alberta (2010, 2012, 2014).

Results Analysis

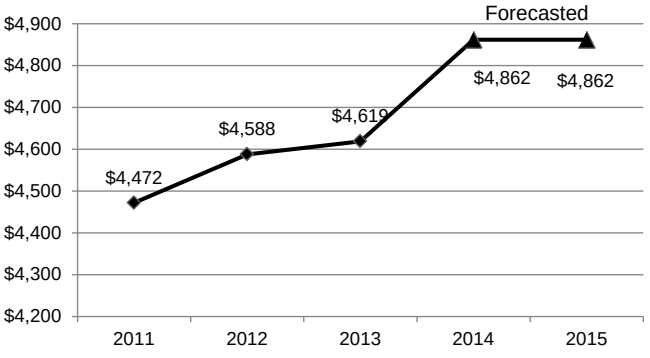
In 2016, more than three-quarters (79 per cent) of survey respondents described the quality of health care services received as good or excellent. This is similar to previous results: 77 per cent (2014), 77 per cent (2012), and 75 per cent (2010). Results are reliable within 2.2 per cent, 19 times out of 20.

Performance Indicator 4.d Per Capita provincial government health expenditures.

This measure includes spending by the ministry (including Alberta Health Services) and health-related spending by other government departments and agencies. The target is to limit overall government health spending growth to 2.5 per cent over the next three years. In conjunction with population growth, this measure is a direct link to the overall success of cost containment initiatives.

Results Analysis

The 20 year trend in per capita cost has increased in excess of six per cent per year. Due to cost containment efforts, recent trends have been much more focused on cost control. The current forecast results for 2014 and 2015 show no change in per capita provincial government health expenditures and the annual growth since 2011 has been moderate at only 2.1 per cent.



Source: Canadian Institute of Health Information (CIHI) National Health Expenditure Trends, 1975 to 2015.

Working in full collaboration with partners, the ministry is working to ensure value for money by improving health outcomes while bringing spending more in line with other provinces, particularly with respect to the high-cost areas of acute care (hospitals), physicians, and prescription drugs. Curbing spending in these areas will free up valuable health dollars to invest in primary care, mental health services, home care, and seniors care.

RESULTS ANALYSIS

Performance Measure and Indicator Methodology

Results Analysis

Performance Measure and Indicator Methodology

Performance Measures indicate the degree of success a ministry has in achieving its desired outcomes. Performance measures contain targets which identify a desired level of performance to be achieved in each year of the business plan.

Performance Indicators assist in assessing performance where causal links are not necessarily obvious. The ministry may or may not have direct influence on a performance indicator therefore they do not contain targets.

Performance Measure 1.a	Access to continuing care: Percentage of clients placed in continuing care within 30 days of being assessed						
	RESULTS					**TARGET**	
	2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2015-16**	
	64%	67%	69%	60%	**60%**	**70%**	

Source
Alberta Health Services: Data are extracted from 7 Meditech rings for the South, Central and North Zones and from 2 Strata Health Pathways applications by the Calgary and Edmonton Zones.

Methodology
Percentage of clients admitted to a Continuing Care Living Option (Supportive or Facility Living) within 30 days of the Assessed and Approved date.

Continuing Care Living Option refers to the level of care in a publicly funded resident accommodation that provides health and support services appropriate to meet the client's assessed unmet needs (i.e., Designated Supportive Living Level 3, 4, 4-Dementia, or Long-Term Care).

Assessed and Approved date refers to the date the client is placed on the waitlist for a Continuing Care Living Option following the completion of the assessment and approval process.

Calculation of Results: The number of individuals admitted to a Continuing Care Living Option within 30 days of their Assessed and Approved Date, divided by the total number of individuals admitted to a Continuing Care Living Option (Supportive or Facility Living) during the reporting period, multiplied by 100.

Performance Indicator 1.a	Emergency visit rate due to substance* use (per 100,000 population)

* The title of this indicator has been changed from 'drug' use to 'substance' use. In addition to emergency visits due to psychoactive substance use, this indicator includes emergency visits due to use of alcohol or non-psychoactive substances. The term 'substance' more accurately reflects the diagnostic codes used in the methodology, which is unchanged from previous years.

RESULTS				
2011	**2012**	**2013**	**2014**	**2015**
541.03	592.83	634.30	676.55	**699.7**[1]

Note:

1. The 2015 result is preliminary until July 2016.

Source

Alberta Ambulatory Care database and Alberta Health Care Insurance Plan (AHCIP) Quarterly Population Registry Files.

Methodology

Each emergency visit in the Ambulatory Care database is valid. Emergency visits are any hospital discharges beginning with any of the following MIS codes: 71310 (Ambulatory care services described as emergency), 71513 (Community Urgent Care Centre), 71514 (Community Advanced Ambulatory Care Centre). A discharge (or emergency visit) occurs when a patient leaves the hospital—by death; transfer to another facility; discharge to home; or against the medical advice.

Only Alberta residents are included in the numerator. Diagnosis assignment: Only the emergency visit rates based on the most responsible diagnosis fields are available. Age and sex assignment: The date of birth and sex on the mid-year population registry file is used to calculate the age and sex of the individual as of June 30 each year. The population excludes members of the Armed Forces, RCMP, inmates in Federal Penitentiaries, or those who have opted out of the Alberta Health Care Insurance Plan.

Calculation of Results: The visit rate is calculated by dividing the number of emergency visits due to substance use (for a given age, sex) in a given year, by the total population for a given age and sex and multiplying by 100,000.

Performance Indicator 1.b	Ambulatory care sensitive conditions: Hospitalization rate for patients under 75 years of age with conditions that could be prevented or reduced if they received appropriate care in an ambulatory setting

	RESULTS				
	2011	**2012**	**2013**	**2014**	**2015**
	364[1]	369[1]	367[1]	365[1]	**349[2]**

Notes:

1. Previously published results for 2011-2014 have been recalculated using the Canadian population in 2011, consistent with the methodology used by Canadian Institute for Health Information (CIHI) to standardize age. Using the 2011 Canadian population figure enables comparisons between Alberta and other jurisdictions in Canada.

2. The 2015 result is a preliminary. The rate may increase slightly once all data from the final quarter of 2015-16 is submitted to CIHI.

The Ambulatory Care Sensitive Conditions (ACSC) performance measures reported by Alberta Health Services (AHS) in its 2015-16 annual report differ from those reported here. The measures reported by AHS are based on the previous CIHI methodology that used the 1991 population to standardize age; this was the method used throughout AHS's accountability reporting documents for 2015-16.

Source

Numerator: Discharge Abstract Database; Canadian Institute for Health Information.
Denominator: Statistics Canada post-censal population estimate. The age-standardized ACSC rate is based on the 2011 Canadian Population.

Methodology

Numerator: Total number of acute care hospitalizations for patients under age 75 years for ACSCs:

- Inclusion Criteria: Any most responsible diagnosis code of: grand mal status and other epileptic convulsions; chronic obstructive pulmonary diseases; acute lower respiratory infection; asthma; diabetes; heart failure and pulmonary edema (excluding cases with cardiac procedures); hypertension (excluding cases with cardiac procedures); angina (excluding cases with cardiac procedures).
- Exclusion Criteria: Individuals 75 years of age and older; death before discharge; admission category recorded as newborn or stillbirth.

Denominator: The denominator is the total mid-year population younger than age 75.

Calculation of Results: Total number of acute care hospitalizations for ACSCs under age 75 years, divided by the total mid-year population under age 75 years, multiplied by 100,000 (age adjusted).

Performance Measure 2.a	Influenza immunization: Percentage of Albertans who have received the recommended annual influenza immunization · Seniors aged 65 and over · Children aged 6 months to 23 months · Residents of long-term care facilities					
POPULATION	**RESULTS**					**TARGET**
	2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2015-16**
Seniors Aged 65 and over	61%	60%	64%	61%	**63%**	**80%**
Children Aged 6 to 23 months	29%	30%	34%	34%	**33%**	**80%**
Residents of LTC facilities	91%	89%	88%	90%	**90%**	**95%**

Note: Influenza immunization targets are set by the ministry in consultation with Alberta's Chief Medical Officer of Health and are based on national immunization coverage targets as agreed to by the National Consensus Conference for Vaccine-Preventable Diseases in Canada in 2005.

(**Note:** immunization targets for *Seniors 65 and over* and *Children 6-23 months* were incorrectly reported at 75% instead of 80% in the 2015-18 ministry business plan.)

Source

Numerator: Number of those immunized by age category: Alberta Health Services Zones; Alberta Health's weekly pharmacists data; First Nations and Inuit Health; Health Canada; Alberta Region.
Denominator: For seniors and children, the denominator is the ministry's population estimates, based on mid-year (June 30) registration population estimates. For residents of long-term care facilities the denominator is the number of residents as of December 15, 2015 from Alberta's Interactive Health Data Application.

Methodology

Data is representative of all doses administered up until April 2, 2016. Data are collected during the influenza season, when the influenza vaccine is administered, which is typically October 1 to March 31 each year. However, there may be immunization events that fall outside this range depending on how long the influenza virus circulates in Alberta and which are not included in the immunization rate data.

Data is aggregated by each zone and sent centrally for inclusion into the provincial Alberta Health Services report. Data includes all immunizations delivered by Alberta Health Services, community providers including, but not limited to, physician offices, pharmacists, occupational health service providers, long-term care, acute care, student health services at post-secondary institutions, and First Nations Inuit Health Branch.

First Nations people living on-reserve are included. Immunization data is manually collected in each zone by Alberta Health Services.

Calculation of Results:

Seniors aged 65 and over

Immunization rate equals the number of seniors aged 65 years and over who received one dose of the influenza vaccine, divided by the mid-year population estimate of age category, multiplied by 100.

Children aged 6 to 23 months
Immunization rate equals the number of children aged six months to 23 months who received dose two of two doses, or an annual dose of the influenza vaccine, divided by the mid-year population estimate of age category, multiplied by 100.

Children, aged six months to 23 months who require two doses of the influenza vaccine will only be included if they have received two doses during the current season up to and including April 2, 2016. Doses administered between April 1 and 30, 2016 will not be included in 2015-16, but will be included in the next season. Children six to 23 months of age who have received two doses in the past season will be included if they receive an annual (single) dose during the 2015-16 season.

Residents of long-term care facilities
Immunization rate equals the number of residents in long-term care facilities on December 15, 2015 who had received one dose of the influenza vaccine between October 1, 2015 and December 15, 2015, divided by the number of residents in long-term care facilities on December 15, 2015, multiplied by 100. (**Note**: It is necessary to define the number of residents of long-term care facilities on December 15, due to the high turnover in this population. Otherwise the result would be an immunization rate over 100 per cent).

Performance Measure 2.b	Childhood immunization rates (by age two) · Diphtheria, tetanus, pertussis, polio, Hib · Measles, mumps, rubella					
IMMUNIZATION	**RESULTS**					**TARGET**
	2011	**2012**	**2013**	**2014**	**2015**	**2015**
Diphtheria, tetanus, pertussis, polio, Hib	74%	73%	74%	76%	**75%**	**97%**
Measles, mumps, rubella	86%	84%	85%	88%	**87%**	**98%**
Note: Immunization targets are set by the ministry in consultation with Alberta's Chief Medical Officer of Health and are based on national immunization coverage targets as agreed to by the National Consensus Conference for Vaccine-Preventable Diseases in Canada in 2005.						

Source

Numerator: Immunization/Adverse Reactions to Immunization (Imm/ARI) system. Aggregate data is obtained from First Nations sources for Aboriginal children living on reserve.
Denominator: The ministry's Population Estimates, based on mid-year (June 30) registration population estimates.

Methodology

The numerator data (number of children immunized with required effective dose) are submitted electronically into the provincial immunization registry [Immunization/Adverse Reactions to Immunization (Imm/ARI)] from feeder systems at Alberta Health Services. Aggregate data is obtained from First Nations sources for Aboriginal children living on-reserve.

Calculation of Results: Childhood immunization rate equals the number of children by two years of age who have received the required immunization, divided by the mid-year population of two-year-olds, multiplied by 100.

Measles, mumps, rubella immunization rate equals the number of children who have received one dose of MMR (or MMRV), divided number of children that are two years of age, multiplied by 100

Diphtheria, tetanus, pertussis, polio, Hib (DTaP-IPV-Hib) immunization rate equals the number of children receiving four doses of DTaP-IPV-Hib divided by the number of children that are two years of age, multiplied by 100.

Performance Measure 2.c	Healthy Alberta Trend Index (HATi)[1]: Average number of health risk factors per person aged 20 to 64 years

RESULTS					TARGET
2011	**2012**	**2013**	**2014**	**2015**	**2015**
2.17	2.22	2.12[2]	**2.14**	N/A At time of publication	**2.06**

Notes:

1. The index has been renamed from Healthy Alberta Risk Trend Index (HARTi) to Healthy Alberta Trend Index (HATi). The revised name is a better description of the index which includes behavior that is a risk to health (e.g., binge drinking alcohol) as well as healthy behavior (e.g., consumption of fruit and vegetables).

2. In 2013, the question related to the frequency of binge drinking changed. The question now asks: "How often in the past 12 months have you had (4 or more – for females)/(5 or more – for males) drinks on one occasion?" Previously the question asked both males and females about 5 or more drinks. This changes the binge drinking estimates included in the index. The 2013 results are therefore not directly comparable to the results of previous years.

Source

Statistics Canada. Canadian Community Health Survey: Alberta Share File (not publicly issued).

Methodology

The Canadian Community Health Survey (CCHS) has been conducted annually since 2007 and is a cross-sectional survey that collects information related to health status, health care utilization, and health determinants for the Canadian population. The CCHS includes a wide range of questions about the health and health behaviours of residents in each province. The CCHS covers the population 12 years of age and over living in the ten provinces and the three territories. Excluded from the survey's coverage are persons living on reserves and other Aboriginal settlements in the provinces; full-time members of the Canadian Forces; and, the institutionalized population.

Statistics Canada provides a Provincial Share file to each provincial/territorial health ministry. This file contains detailed survey responses for those participants agreeing to disclosure to the ministry. In Alberta, the share file represents between 92 per cent and 95 per cent of participants in each cycle of the master file.

The calculation of the HATi involves each of the six indicators listed below being dichotomized as 0 or 1 (0 for not having the behaviour or 1 for having the behaviour) and totaling them from a risk factor perspective; meaning a 6 would be most unhealthy and 0 would be most healthy.

1. Life Stress – Respondents self-reporting life stress as extremely or quite a bit stressful.
2. BMI Category – Respondents self-reporting as "overweight" or "obese" (BMI of 25 or higher).
3. Fruit and Vegetable Consumption – Respondents self-reporting having eaten five or more servings of fruit and vegetables per day.

4. Physical Activity – Respondents who are moderately active or active. Category derived from reported physical activities.
5. Smoking Status – Respondents who are current daily smokers.
6. Binge Drinking frequency – Respondents reporting having five or more drinks (for male) or four or more drinks (for female) two or more times per month.

Calculation of Results: Taking into account that Fruit and Vegetable Consumption and Physical Activity are measuring healthy activities, the HATi result equals (Overweight value) plus (1 minus Fruit and Vegetable Consumption value) plus (Daily Smoker value) plus (Binge Drinker value) plus (Life Stress value) plus (1 minus Physical Activity value).

Performance Indicator 2.a	Life expectancy at birth: Provincial and First Nations					
	POPULATION	**RESULTS** (years)				
		2011	**2012**	**2013**	**2014**	**2015**
	Provincial	81.59	81.68	81.71	81.79[1]	**81.87**
	First Nations	70.79	72.15[1]	72.52[1]	71.60[1]	**70.36**
	Note: 1. Where noted in the table, in response to updated data from Alberta Vital Statistics and Alberta Health Care Insurance Plan, the results replace the following historical results: Provincial: 81.80 (2014); First Nations: 72.16 (2012); 72.53 (2013); 71.68 (2014).					

Source

Alberta Health. Alberta Health Care Insurance Plan (AHCIP); Quarterly Population Registry Files; Alberta Health Postal Code Translation File (PCTF). Service Alberta, Alberta Vital Statistics Death File.

Methodology

Life expectancy can be interpreted as the average number of years a hypothetical age cohort would live if they were subjected to the current mortality conditions throughout the rest of their lives.

Life expectancy is calculated using the commonly-used “period” life table methodology. A detailed description of the methodology used to convert age-sex specific death rates into life expectancy at birth can be found in Appendix 3 of the Alberta Health report Chronic Disease Projections Methodology, 2008. (www.health.alberta.ca/documents/Chronic-Disease-Method-2008.pdf).

An individual is determined to have a First Nations status if ever present on the First Nations Status Registry. The First Nations registry would include anyone ever having registered with the Alberta Health Care Insurance Plan (AHCIP) as either status First Nations or Inuit and would also include some Alberta residents belonging to out-of-province bands. Non-Status Indians and Métis cannot be identified in the AHCIP population registry so would not be included. The registry also includes individuals on accounts where the main account holder is First Nations (even though the individual is not).

Performance Indicator 2.b Infant mortality rate (per 1,000 live births):
- Provincial
- First Nation

POPULATION	RESULTS (infant deaths per 1,000 live births)				
	2011	**2012**	**2013**	**2014**	**2015**
Provincial	5.10	4.10	4.46	4.63[1]	**4.39**
First Nations	10.27[1]	8.77[1]	9.66[1]	9.56[1]	**7.82**

Note:

1. Where noted in the table, in response to uploaded data from Alberta Vital Statistics and Alberta Health Care Insurance Plan, the results replace the following historical results:
   Provincial: 4.57 (2014);
   First Nation: 10.29 (2011); 8.78 (2012); 9.69 (2013); 9.60 (2014).

Source

Alberta Vital Statistics Death File; Newborn Metabolic Screening Database; First Nations Status Registry.

Methodology

The infant mortality rate is calculated by dividing the number of infant deaths during a calendar year by the number of live births. Infant deaths are identified from the Alberta Vital Statistics Death file, while live births are identified from the Newborn Metabolic Screening Database.

An individual is determined to have a First Nations status if ever present on the First Nations Status Registry. The First Nations registry would include anyone ever having registered with the Alberta Health Care Insurance Plan (AHCIP) as either status First Nations or Inuit and would also include some Alberta residents belonging to out-of-province bands. Non-Status Indians and Métis cannot be identified in the AHCIP population registry so would not be included. The registry also includes individuals on accounts where the main account holder is First Nations (even though the individual is not).

Performance Measure 3.a	Access to primary care through primary care networks: Percentage of Albertans enrolled in a primary care network						
	RESULTS					**TARGET**	
	2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2015-16**	
	72%	74%	75%	**77%**	N/A at time of publication	**76%**	

Source
Government of Alberta. Alberta Health. Alberta Health Care Insurance Plan (AHCIP) Statistical Supplement, 2014-15.

Methodology
This measure is defined as the percentage of Albertans enrolled in a Primary Care Network (PCN) in a the government's fiscal year (April 1 to March 31).

Numerator: The numerator is the total number of patients enrolled in a PCN in a given year (April 1 to March 31), as reported in Table 2.29 Primary Care Networks: Distribution by Health Region (Alberta Health Services Zone), Number of Primary Care Physicians, Number of Patients, and Total Payments for the Service Year (April 1 to March 31), Alberta Health Care Insurance Plan Statistical Supplement.

As reported in Table 2.29 of the AHCIP Statistical Supplement, patients are considered to be enrolled in a PCN if they are assigned to a physician, nurse practitioner, or pediatrician registered to a PCN.

There are four steps used to assign a patient to a physician:

Step 1 Patients who have seen one physician, nurse practitioner, or pediatrician only are assigned to that physician or nurse practitioner.

Step 2 Patients who have seen more than one physician, but one physician is predominant, are then assigned to that physician.

Step 3 Patients who have seen multiple physicians the same number of times are assigned to the physician who did the physical examination last.

Step 4 Patients who have seen multiple physicians the same number of times, and had no physical examination done, are assigned to the physician who saw the patient last.

These four steps are part of the four-cut methodology.

The number of patients linked to a PCN is calculated by the payments issued to the program, which is associated with the providers within the PCN. The payments to the PCN are identified by the payments the providers receive through the Claims Assessment System (CLASS). CLASS is an application that collects and processes claims transactions for physicians of multiple disciplines and provides information of compensation for physician services.

Denominator: The denominator is the total population registered with a Personal Health Number and covered under the Alberta Health Care Insurance Plan as at March 31 of a given year. This number is reported in Table 1.1 of the AHCIP Statistical Supplement.

Calculation of Results: The percentage of Albertans enrolled in a PCN equals the total number of Albertans informally enrolled in a PCN in a given year, divided by the total population covered by the Alberta Health Care Insurance Plan as at March 31, in the same year, multiplied by 100.

Performance Measure 4.a	Satisfaction with health care services received: Percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year						
	RESULTS					**TARGET**	
	2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2015-16**	
	62%	63%	66%	68%	**69%**	**68%**	

Source
Health Quality Council of Alberta. Provincial Survey about Health and the Health System in Alberta (2011, 2013, 2015, 2016). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services in Alberta (2010, 2012, 2014).

The provincial population survey is conducted by the Health Quality Council of Alberta for the purpose of obtaining Albertans' views and perceptions on the quality, safety and performance of the publicly funded health care system.

Methodology
The calculation of results for this measure is based on the percentage of respondents to the Health Quality Council of Alberta Provincial Survey about Health and the Health System in Alberta 2016 who responded "satisfied" or "very satisfied" to the question:

> "Thinking about all of your personal experiences within the past year with the health care services in Alberta that we just reviewed, to what degree are you satisfied or dissatisfied with the services you have received? Please use a scale of 1 to 5 where '1' means 'very dissatisfied' and '5' means 'very satisfied'."

From February 2, 2016 to March 26, 2016, data were collected through a telephone survey of 1,510 Albertans residing in randomly selected Alberta households. The overall response rate for the survey was calculated at 35 per cent.

A total of 1,360 (weighted total) respondents answered the question on satisfaction with health care services personally received in Alberta within the past year. Results are reliable within ±2.5 per cent, 19 times out of 20, for this question.

Performance Indicator 4.a	Patient Safety: Percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year				
	RESULTS				
	2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**
	11%	11%	11%	12%	**14%**
	Note: Sometimes when people receive health care, unexpected harm can occur as a result of that care. Such unexpected harm is different from complications which may occur as an expected risk of some treatments.				

Source
Health Quality Council of Alberta. Provincial Survey about Health and the Health System in Alberta (2011, 2013, 2015, 2016). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services in Alberta (2010, 2012, 2014).

The provincial population survey is conducted by the Health Quality Council of Alberta for the purpose of obtaining Albertans' views and perceptions on the quality, safety and performance of the publicly funded health care system.

Methodology
Patient safety is defined as the reduction and mitigation of unsafe acts within the health care system rather than from the patient's underlying illness, as well as through the use of best practices shown to improve patient safety outcomes.

Calculation of results for this measure is based on the percentage of respondents to the Health Quality Council of Alberta. Provincial Survey about Health and the Health System in Alberta 2016 who responded "yes" to the question:

> "To the best of your knowledge, have you, or has a member of your immediate family experienced UNEXPECTED HARM while receiving healthcare in Alberta WITHIN THE PAST YEAR?"

From February 2, 2016 to March 26, 2016, data were collected through a telephone survey of 1,510 Albertans residing in randomly selected Alberta households. The overall response rate for the survey was calculated at 35 per cent.

A total of 1,346 respondents answered the question on experiencing unexpected harm while receiving health care in Alberta within the past year. Results are reliable within ±1.9 per cent, 19 times out of 20, for this question.

Performance Indicators 4.b	Emergency department length of stay: Percentage of patients treated and admitted to hospital within eight hours (all sites)				
	RESULTS				
	2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**
	55%	55%	54%[1]	48%	**49%**
	Note: 1. Revised historical result for 2013-14, as per Alberta Health Services Quarterly Monitoring Measures (www.albertahealthservices.ca/11175.asp)				

Source

Emergency Department Information System (EDIS) and Regional Emergency Department Information System (REDIS) sources are used. From April 1, 2010 forward, National Ambulatory Care Reporting System format (NACRS) is used.

EDIS sites	REDIS sites	NACRS sites
§ Grey Nuns Community Hospital § Leduc Community Hospital § Misericordia Community Hospital § North East Community Health Centre § Royal Alexandra Hospital § Sturgeon Community Hospital § University of Alberta Hospital § Westview Health Centre	§ Alberta Children's Hospital § Foothills Medical Centre § Peter Lougheed Centre § Rockyview General Hospital § Sheldon M Chumir Centre § South Calgary Health Centre	All other sites use NACRS

Methodology

The Emergency Department length of stay for admitted patients is measured from the earliest reported time after arrival in the Emergency Department (either the triage or registration time) to the time the patient enters the hospital as an inpatient (discharged from the Emergency Department). This metric does not apply to Urgent Care facilities as these facilities do not have inpatient spaces. For data sources submitted via abstracting (not operational source systems) the time the patient leaves the emergency department is determined through investigation of the inpatient visit record.

Calculation of Results: Length of Stay will be captured in minutes between a Start Time and End Time where the Start Time is the earliest of either the Emergency Department Triage Time or Visit (Registration) Time, and the End Time is the valid discharge date and time.

The percentage of patients treated and admitted to hospital within eight hours (all sites) equals the number of valid records with a length of stay of less than eight hours (480 minutes), divided by the total number of valid records, multiplied by 100.

Performance Indicators 4.c	Albertans rating of the quality of health care services received (biennial survey)			
	RESULTS			
	2010	**2012**	**2014**	**2016**
	75%[1]	77%[1]	77%[1]	**79%**[1]
	Note: 1. Results for 2010, 2012, 2014 and 2016 are provided as this indicator is reported every second year.			

Source

Health Quality Council of Alberta. Provincial Survey about Health and the Health System in Alberta (2011, 2013, 2015, 2016). Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services in Alberta (2010, 2012, 2014).

The provincial population survey is conducted by the Health Quality Council of Alberta for the purpose of obtaining Albertans' views and perceptions on the quality, safety and performance of the publicly funded health care system.

Methodology

The calculation of results for this measure is based on the percentage of respondents to the Health Quality Council of Alberta Provincial Survey about Health and the Health System in Alberta 2016 who responded "good" or "excellent" to the question:

> "Thinking about all of your personal experiences within the past year with the health care services in Alberta that we just reviewed, how would you describe the overall quality of those services? Excellent, good, fair or poor?"

From February 2, 2016 to March 26, 2016, data were collected through a telephone survey of 1,510 Albertans residing in randomly selected Alberta households. The overall response rate for the survey was calculated at 35 per cent.

A total of 1,360 (weighted total) respondents answered the question on the overall quality of health care services personally received in Alberta within the past year. Results are reliable within ±2.2 per cent, 19 times out of 20, for this question.

Performance Indicators 4.d	Per capita provincial government health expenditures (actual dollars)				
	Results				
	2011	**2012**	**2013**	**2014**	**2015**
	$4,472	$4,588	$4,619	**$4,862** *forecasted*	**$4,862** *forecasted*
	Note: Forecast results for the calendar year are available in November of the forecast year. Actual results have a two year lag.				

Source
Canadian Institute of Health Information (CIHI) National Health Expenditure Trends (NHEX), 1975 to 2015.

Methodology
Data is extracted annually from provincial/territorial government public accounts. Programs and/or program items are classified into health expenditure categories according to accepted and standardized methods and definitions used in estimating national health expenditure. Data from the public accounts is supplemented with information from provincial/territorial government department annual reports and annual statistical reports when available, as well as information provided by provincial/territorial government department officials. Total provincial government health spending figures include spending for health services reported by the provincial/territorial ministry responsible for health as well as by other departments that report spending on health according to national health accounts definitions.

Adjustments for regional health authority and/or hospital deficits or surpluses are not made in NHEX unless the provincial government assumes them. Once assumed by the provincial government, they are allocated to the years when the regional health authority and/or hospitals accumulated them.

During the preparation of this report, CIHI's estimates of provincial/territorial government health expenditure were submitted to provincial/territorial departments of health for review.

To obtain the per capita provincial government health expenditure, the provincial government health spending was divided by population estimates from the Demography Division of Statistics Canada.

FINANCIAL INFORMATION

March 31, 2016

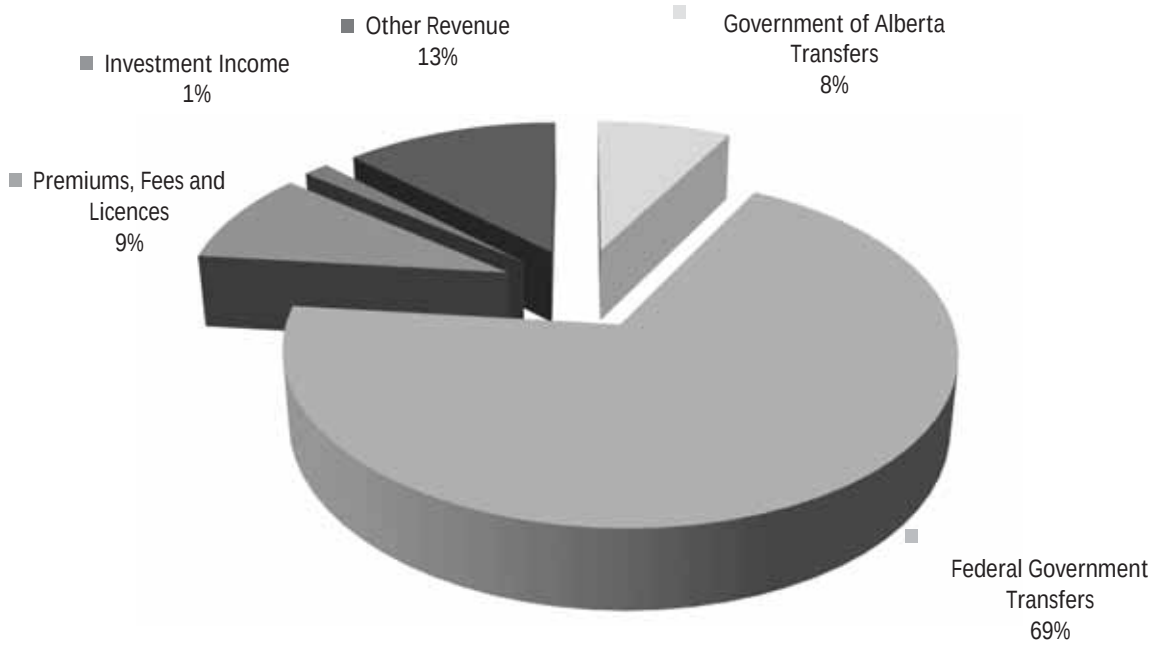
FINANCIAL HIGHLIGHTS

The consolidated Ministry Financial Statements include:

- Department of Health
- Alberta Health Services
- Health Quality Council of Alberta
- Alberta Innovates - Health Solutions

Consolidated Actual Revenues

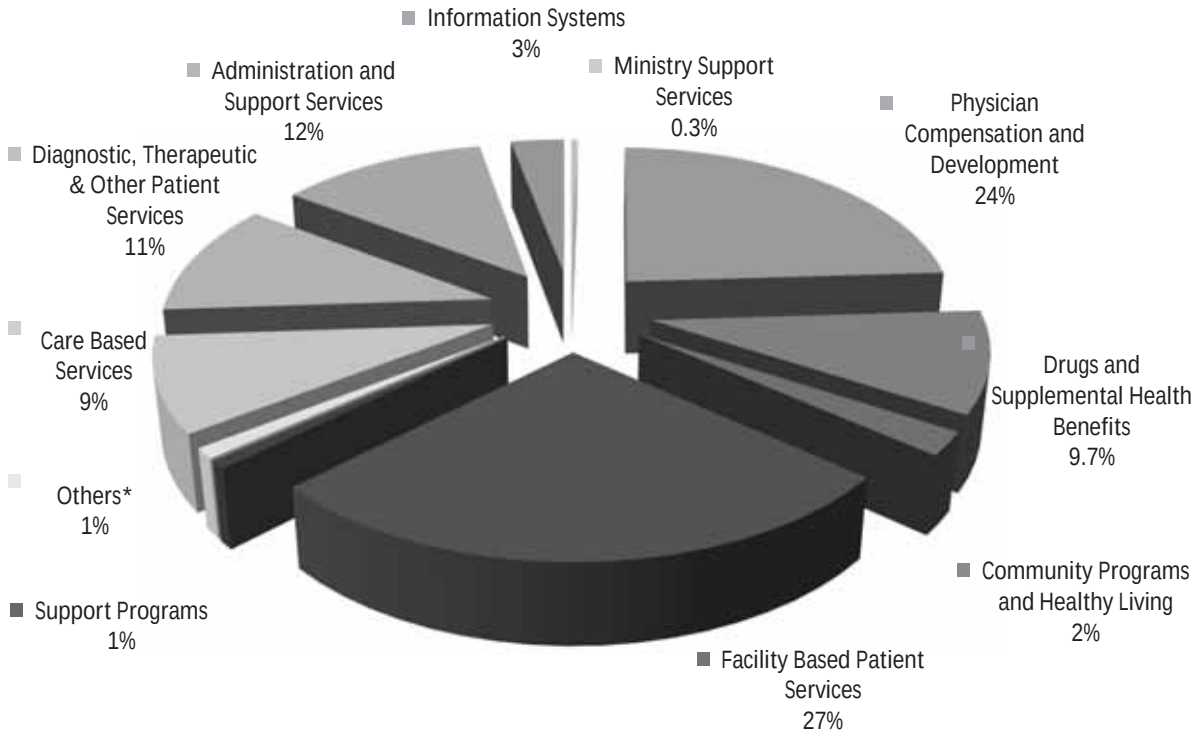
(in thousands)



	2016		2015
	Budget	Actual	Actual
Government of Alberta Transfers	$ 476,520	$ 460,225	$ 505,636
Federal Government Transfers	3,982,598	4,027,519	3,609,982
Premiums, Fees and Licences	521,036	538,032	520,143
Investment Income	61,706	85,350	99,702
Other Revenue	563,514	735,699	706,010
	$ 5,605,374	**$ 5,846,825**	**$ 5,441,473**

Consolidated revenues were higher than budgeted by $241 million and increased by $405 million compared to the prior year. These changes are due to increase in Canada Health Transfer entitlement as a result of annual increase and growth in Alberta's population; higher discount for pharmaceutical drug product listings; increased fees and charges; and increase in third party claims and motor vehicle aggregate assessment.

Consolidated Actual Expenses *(in thousands)*



	2016		2015
	Budget	Actual	Actual
Ministry Support Services	$ 84,219	$ 70,477	$ 73,300
Physician Compensation and Development	4,757,156	4,852,693	4,456,412
Drugs and Supplemental Health Benefits	1,934,472	1,993,900	1,807,828
Community Programs and Healthy Living	473,993	456,583	459,801
Facility Based Patient Services	5,309,174	5,525,030	5,401,030
Care Based Services	1,845,515	1,867,155	1,773,530
Diagnostic, Therapeutic & Other Patient Services	2,331,167	2,239,954	2,173,519
Administration and Support Services	2,376,853	2,454,828	2,462,415
Information Systems	642,382	631,195	646,262
Support Programs	168,167	164,619	155,301
Others*	242,225	203,591	229,557
	$ 20,165,323	**$ 20,460,025**	**$ 19,638,955**

* includes Research and Education, Debt Servicing, 2013 Alberta Flooding, Cancer Research and Prevention Investment, and Infrastructure Support

Consolidated expenses were higher than budgeted by $295 million and increased by $821 million compared to the prior year. These changes are due to higher physician compensation and increase in service volume; increase in claims, growth in population served and increase in costs and demand for drugs and supplemental health benefits. Other contributing factors are cost increases due to collective bargaining increases; increased demand for services; implementation of priority initiatives particularly in the areas of continuing care, community care, and home care; and increased contracts costs with volunatry and private health service providers.

Alberta Health Services, Health Quality Council of Alberta and Alberta Innovates – Health Solutions
Financial Statement Highlights

This section highlights the financial results of Alberta Health Services (AHS), Health Quality Council of Alberta (HQCA) and Alberta Innovates – Health Solutions (AIHS) for the fiscal year ended March 31, 2016. The financial statements were prepared under Alberta Health's Financial Directives (for AHS only) and Public Sector Accounting Standards.

Alberta Health Services

Operating Results

- AHS finished the year ended March 31, 2016, with a $145 million annual deficit, representing 1% of total expenses.
- Expenses were higher than budgeted due to increased health care activity in areas such as home care, acute care, outpatient clinics and related diagnostic and therapeutic services, and a corresponding increase in staffing costs.
- Total revenue was on budget and increased by less than 1% over 2014-15, with Alberta Health transfers accounting for 89% of total revenue.
- Total expenses were 1.1% higher than budget and increased by 2% over 2014-15.
- Administration costs in 2015-16 were $426 million, or 3.0% of total expenses. 2014-15 administration costs were $448 million, or 3.2% of total expenses.
- AHS employed 77,007 Full-Time-Equivalents as of March 31, 2016.

Financial Position

- AHS' accumulated surplus at March 31, 2016, was $1,159 million and consists of four main components: unrestricted surplus, internally restricted surplus for future purposes, invested in tangible capital assets, and endowments.

Health Quality Council of Alberta

Operating Results

- For fiscal 2015-16, HQCA reported an annual deficit of $705 thousand, compared to a prior year surplus of $209 thousand. The deficit was mainly due to implementation of projects that were delayed in 2014-15 and undertaking of the Lab Review and Continuity of Care projects.
- 2015-16 expenses were $7.4 million, compared to $6.9 million in the prior year – a 7.2% increase overall.
- HQCA employed 31 Full-Time-Equivalents as of March 31, 2016.

Financial Position

- At March 31, 2016, HQCA reported net assets of $1.9 million.
- HQCA reported tangible capital assets of $1.2 million at March 31, 2016, compared to $1.1 million in the prior year.

Alberta Innovates – Health Solutions

Operating Results

- For fiscal 2015-16, AIHS reported an annual deficit of $28 million, compared to a prior year surplus of $12.7 million. The deficit was mainly due to implementing multiple projects previously delayed in 2014-15.
- 2015-16 expenses were $103.5 million, compared to $87.6 million in the prior year – an 18.2% increase overall mainly due to a higher program implementation in 2015-16 compared to the prior year with respect to AIHS' strategic investments and partnership funding programs.
- AIHS employed 69 Full-Time-Equivalents as of March 31, 2016.

Financial Position

- At March 31, 2016, AIHS reported net assets of $20.6 million, a decrease of $28 million from the prior year.
- AIHS reported tangible capital assets of $647 thousand at March 31, 2016, compared to $841 thousand in the prior year.
- Effective April 1, 2016, the AIHS entity, including its net assets was transferred from the Ministry of Health to the Ministry of Economic Development and Trade.

FINANCIAL INFORMATION
Ministry of Health

Consolidated Financial Statements

March 31, 2016

Ministry of Health

Consolidated Financial Statements

Year Ended March 31, 2016

Consolidated Financial Statements
March 31, 2016

Independent Auditor's Report

To the Members of the Legislative Assembly

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of the Ministry of Health, which comprise the consolidated statement of financial position as at March 31, 2016, and the consolidated statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Ministry of Health as at March 31, 2016, and the results of its operations, its changes in net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

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

Auditor General

June 6, 2016

Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS

Year Ended March 31, 2016

(in thousands)

	2016		2015
	Budget	Actual	Actual
Revenues (Schedule 1)			
Government Transfers			
Government of Alberta Transfers	$ 476,520	$ 460,225	$ 505,636
Federal Government Transfers	3,982,598	4,027,519	3,609,982
Premiums, Fees and Licences	521,036	538,032	520,143
Investment Income	61,706	85,350	99,702
Other Revenue	563,514	735,699	706,010
	5,605,374	5,846,825	5,441,473
Expenses - Directly Incurred (Note 2b(ii) and Schedules 2 & 4)			
Ministry Support Services	84,219	70,477	73,300
Physician Compensation and Development	4,757,156	4,852,693	4,456,412
Drugs and Supplemental Health Benefits	1,934,472	1,993,900	1,807,828
Community Programs and Healthy Living	473,993	456,583	459,801
Facility Based Patient Services	5,309,174	5,525,030	5,401,030
Care Based Services	1,845,515	1,867,155	1,773,530
Diagnostic, Therapeutic & Other Patient Services	2,331,167	2,239,954	2,173,519
Administration and Support Services	2,376,853	2,454,828	2,462,415
Information Systems	642,382	631,195	646,262
Support Programs	168,167	164,619	155,301
Research and Education	226,225	182,231	180,508
Debt Servicing	16,000	15,373	16,253
2013 Alberta Flooding	-	-	32,796
Cancer Research and Prevention Investment	-	5,000	-
Infrastructure Support	-	987	-
	20,165,323	20,460,025	19,638,955
Annual Deficit	$ (14,559,949)	$ (14,613,200)	$ (14,197,482)

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

CONSOLIDATED STATEMENT OF FINANCIAL POSITION

As at March 31, 2016
(in thousands)

	2016	2015
Financial Assets		
Cash	$ 138,431	$ 429,781
Accounts Receivable (Note 3)	488,045	371,682
Portfolio Investments		
- Operating (Schedule 5)	2,077,933	1,984,555
- Endowments (Note 10 and Schedule 5)	75,966	72,381
	2,780,375	2,858,399
Liabilities		
Accounts Payable and Accrued Liabilities (Note 4)	2,349,530	2,450,059
Deferred Revenue (Note 5)	270,099	261,326
Unspent Deferred Capital Contributions (Note 5)	90,382	96,019
Notes, Debentures and Mortgages (Note 6)	326,909	321,835
	3,036,920	3,129,239
Net Debt	(256,545)	(270,840)
Non-Financial Assets		
Tangible Capital Assets (Note 7)	7,646,835	7,592,752
Inventories of Supplies	116,249	120,895
Prepaid Expenses	116,423	126,649
	7,879,507	7,840,296
Net Assets Before Spent Deferred Capital Contributions	7,622,962	7,569,456
Spent Deferred Capital Contributions (Note 5)	6,248,201	6,030,567
Net Assets	$ 1,374,761	$ 1,538,889
Net Assets, Beginning of Year	$ 1,538,889	$ 1,512,672
Annual Deficit	(14,613,200)	(14,197,482)
Net Financing Provided from General Revenues	14,449,072	14,223,699
Net Assets, End of Year	$ 1,374,761	$ 1,538,889

Contractual Obligations and Contingent Liabilities (Notes 8 and 9)

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

CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT

Year Ended March 31, 2016

(in thousands)

	2016		2015
	Budget	Actual	Actual
Annual Deficit	$ (14,559,949)	$ (14,613,200)	$ (14,197,482)
Acquisition of Tangible Capital Assets (Note 7)	(916,515)	(662,694)	(663,805)
Amortization of Tangible Capital Assets (Note 7)	636,982	608,126	652,518
Write-down of Tangible Capital Assets		485	1,794
Acquisition of Inventories of Supplies	(757,400)	(842,876)	(799,429)
Consumption of Inventories of Supplies	749,700	846,265	795,425
Write-down of Inventories of Supplies		1,257	646
Change in Prepaid Expenses		10,226	(20,111)
Change in Spent Deferred Capital Contributions (Note 5)		217,634	144,362
Net Financing Provided from General Revenues		14,449,072	14,223,699
Decrease in Net Debt		14,295	137,617
Net Debt, Beginning of Year		(270,840)	(408,457)
Net Debt, End of Year		$ (256,545)	$ (270,840)

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

CONSOLIDATED STATEMENT OF CASH FLOWS

Year Ended March 31, 2016

(in thousands)	2016	2015
Operating Transactions		
Annual Deficit	$ (14,613,200)	$ (14,197,482)
Non-cash items:		
Amortization of Tangible Capital Assets (Note 7)	608,126	652,518
Spent Deferred Capital Contributions recognized as Revenue (Note 5)	(319,001)	(340,763)
Write-down of Tangible Capital Assets / Inventories of Supplies	1,742	2,440
Valuation Adjustments and write-downs	57,622	70,480
Realized Gain on Sale of Portfolio Investments	(15,048)	(29,794)
	(14,279,759)	(13,842,601)
(Increase) in Accounts Receivable	(148,396)	(58,534)
(Decrease) in Accounts Payable and Accrued Liabilities	(126,118)	(27,583)
(Decrease) in Deferred Revenue	(28,147)	(33,499)
Decrease (Increase) in Inventories of Supplies	3,389	(4,004)
Decrease (Increase) in Prepaid Expenses	10,226	(20,111)
Cash (applied to) Operating Transactions	(14,568,805)	(13,986,332)
Capital Transactions		
Acquisition of Tangible Capital Assets (Note 7)	(262,702)	(251,099)
Cash (applied to) Capital Transactions	(262,702)	(251,099)
Investing Transactions		
Purchase of Portfolio Investments	(4,230,911)	(4,203,953)
Proceeds on Disposal of Portfolio Investments	4,148,996	4,321,693
Cash (applied to) provided by Investing Transactions	(81,915)	117,740
Financing Transactions		
Net Financing provided from General Revenues	14,449,072	14,223,699
Restricted Deferred Capital Contribution received	172,626	95,596
Restricted Deferred Capital Contribution returned	(4,700)	(13,811)
Principal payments of Notes, Debentures and Mortgages	(15,226)	(34,305)
Proceeds from Notes, Debentures and Mortgages	20,300	5,772
Cash provided by Financing Transactions	14,622,072	14,276,951
(Decrease) Increase in Cash	(291,350)	157,260
Cash, Beginning of Year	429,781	272,521
Cash, End of Year	$ 138,431	$ 429,781

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2016

Note 1 Authority and Purpose

The Minister of Health (Minister) has been designated as responsible for various Acts by the *Government Organization Act*, Chapter G-10, revised Statutes of Alberta 2000 and its regulations. Following are the organizations that comprise the Ministry of Health (Ministry) and the authority under which each organization operates.

Department of Health	*Government Organization Act*
Alberta Health Services	*Regional Health Authorities Act*
Health Quality Council of Alberta	*Health Quality Council of Alberta Act*
Alberta Innovates– Health Solutions	*Alberta Research and Innovation Act*

In support of the Government of Alberta's commitments for a stable and improved public health care system, the Ministry is to ensure that Albertans receive the right health care services, at the right time, in the right place, provided by the right health care providers and teams.

Note 2 Summary of Significant Accounting Policies and Reporting Practices

These consolidated financial statements are prepared in accordance with Canadian Public Sector Accounting Standards.

(a) Reporting Entity and method of consolidation

The reporting entity is the Ministry of Health, for which the Minister of Health is accountable. The accounts of the Department are fully consolidated with the entities listed in Schedule 6 on a line-by-line basis.

Revenue and expense, capital, investing and financing transactions and related asset and liability balances between the consolidated entities have been eliminated. Accounting policies have been adjusted to conform with those of the Ministry.

The threshold for eliminating inter-entity transactions among SUCH (Schools, Universities, Colleges and Hospitals) sector entities and between SUCH sector entities and other government controlled entities is $1,000,000 for particular transaction types and balances. Transactions involving school boards are subject to a $100,000 threshold for particular transaction types and balances.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

Alberta Health Services (AHS) has entered into various partnerships with entities outside the reporting entity. AHS uses the proportionate consolidation method to account for its 50% interest in the Primary Care Network government partnerships with physician groups, its 50% interest in the Northern Alberta Clinical Trials Centre partnership with the University of Alberta, and its 30% interest in the HUTV Limited Partnership with David Chittick Management Ltd.

(b) Basis of Financial Reporting

(i) Revenues

All revenues are reported on the accrual basis of accounting. Cash received for which goods or services have not been provided by year end is recorded as deferred revenue.

Investment income earned from restricted sources is deferred and recognized when the stipulations imposed have been met. Gains and losses on investments are not recognized in the Consolidated Statement of Operations until realized.

Government Transfers

Transfers from the Government of Canada and other governments are referred to as government transfers.

Government transfers and the associated externally restricted investment income are recorded as deferred capital contributions or deferred revenue if the eligibility criteria for use of the transfer, or the stipulations together along with the Ministry's 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, the Ministry complies with its communicated use of these transfers.

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

Donations and Non-Government Grants

Donations and non-government grants are received from individuals, corporations, and private sector not-for-profit organizations. Donations and non-government grants may be unrestricted or externally restricted for operating or capital purposes. Unrestricted donations and non-government grants are recorded as revenue in the year received or in the year the funds are committed and the amounts can be reasonably estimated. Externally restricted donations, non-government grants, and realized gains and losses for the associated externally restricted investment income are recorded as deferred revenue if the terms for their use, or the terms along with the Ministry's actions and communications as to the use, create a liability. These resources are recognized as revenue as the terms are met and, when applicable, the Ministry complies with its communicated use.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

Grants and Donations for Land

The Ministry recognizes transfers and donations for the purchase of land as a liability when received, and as revenue when the Ministry purchases the land. The Ministry recognizes in-kind contributions of land as revenue at the fair value of the land. When the Ministry cannot determine the fair value, it records such in-kind contributions at a nominal value.

(ii) Expenses

Directly Incurred

Directly incurred expenses are those costs the Ministry has primary responsibility and accountability for.

In addition to program operating expenses such as grants, salaries, supplies etc., directly incurred expenses also include:

- amortization of tangible capital assets.
- consumption of inventories of supplies.
- pension costs which comprise the cost of employer contributions for current service of employees during the year.
- valuation adjustments which include changes in the valuation allowances used to reflect financial assets at their net recoverable or other appropriate value. Valuation adjustments also represent the change in management's estimate of future payments arising from obligations relating to vacation and sick pay.

Grants are recognized as an expense in the period the transfer is authorized and all eligibility criteria have been met by the recipient.

Incurred by Others

Services contributed by other related entities in support of the Ministry's operations are not recognized and are disclosed in Schedule 3 and 4.

(iii) Financial Assets

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 assets are the Ministry's financial claims on external organizations and individuals at the year end.

Cash

Cash comprises of cash on hand and demand deposits.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

Accounts Receivable

Accounts receivable are recorded at the lower of cost or net recoverable value. A valuation allowance is recorded when recovery is uncertain.

Portfolio Investments

Portfolio investments are recorded at cost less any write-downs associated with a loss in value that is other than a temporary decline. A write-down of a portfolio investment to reflect a loss in value is not reversed for a subsequent increase in value. Gains and losses on investments are recognized when an investment is sold or when there is a permanent impairment in the value of an investment.

Endowments

Endowments are included in Financial Assets and Net Assets in the Consolidated Statement of Financial Position. Endowment contributions, matching contributions, and associated investment income allocated for preservation of endowment capital purchasing power are recognized as other revenue in the Consolidated Statement of Operations in the period in which they are received. Donors have placed restrictions on their contribution to the endowment funds. Capital preservation, investment returns and the impact of inflation may also form restrictions on these funds.

(iv) Liabilities

Liabilities represent present obligations of the ministry to external organizations and individuals arising from transactions or events occurring before the year end. They are recorded when there is an appropriate basis of measurement and management can reasonably estimate the amount.

Liabilities also include:
- all financial claims payable by Ministry at the year end;
- accrued employee vacation entitlements; and
- contingent liabilities where future liabilities are likely.

Where the Ministry has received restricted contributions which have not been fully used in the period, this gives rise to deferred revenue.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(v) Non-Financial Assets

Non-financial assets are limited to tangible capital assets, inventories of supplies and prepaid expenses.

Tangible Capital Assets

Tangible capital assets of the Ministry are recorded at historical cost and amortized on a straight-line basis over the estimated useful lives of the assets. Costs incurred and reported by the Ministry of Infrastructure to build tangible capital assets on behalf of AHS are recorded as work in progress and spent deferred capital contributions. The threshold for capitalizing new systems development is $250,000 and the threshold for major enhancements is $100,000. The threshold for all other tangible capital assets is $5,000. All land is capitalized.

Amortization is only charged if the tangible capital asset is put into service.

Inventories of Supplies

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

Prepaid Expenses

Prepaid expenses are recorded at cost and amortized based on the terms of the agreement.

Assets acquired by right are not included.

(vi) Foundations

Various foundations have been established under the *Regional Health Authorities Act* for the purpose of raising funds for the benefit of Alberta. Depending on how the foundations are established, AHS either controls the foundations or has an economic interest in them. Foundations that are controlled by AHS are consolidated in its consolidated financial statements.

(vii) Valuation of Financial Assets and Liabilities

Fair value is the amount of consideration agreed upon in an arm's length transaction between knowledgeable, willing parties who are under no compulsion to act.

The fair values of cash, accounts receivable, and accounts payable and accrued liabilities are estimated to approximate their carrying values because of the short-term nature of these instruments.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(viii) Measurement Uncertainty

Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. Measurement uncertainty that is material to these financial statements exists in the accrual of the Canada Health Transfer.

The Canada Health Transfer is determined on an equal per capita cash basis whereas the transfers were determined on an equal per capita basis prior to 2014-15, and included both cash and tax point transfers. Measurement uncertainty for the Canada Health Transfer relates to the tax transfer component for 2013-14 which has not been finalized. As the value of income tax points (personal and corporate) transferred historically is finalized, it is used to adjust the entitlements of open prior years. Accordingly, the amount is estimated and could change by a material amount.

(c) Change in Accounting Policy

Adoption of the Net Debt Model

The net debt presentation (with reclassification of comparatives) has been adopted for the presentation of financial statements. Net financial assets or net debt is measured as the difference between the Ministry's financial assets and liabilities.

The effect of this change results in changing the presentation of the Consolidated Statement of Financial Position and adding the Consolidated Statement of Change in Net Debt.

(d) Future Accounting Changes

In June 2015 the Public Sector Accounting Board issued these following accounting standards:

- **PS 2200 Related Party Disclosures and PS 3420 Inter-Entity Transactions (effective April 1, 2017)**
  PS 2200 defines a related party and establishes disclosures required for related party transactions; PS 3420 establishes standards on how to account for and report transactions between public sector entities that comprise a government's reporting entity from both a provider and recipient perspective.

- **PS 3210 Assets, PS 3320 Contingent Assets, and PS 3380 Contractual Rights (effective April 1, 2017)**
  PS3210 provides guidance for applying the definition of assets set out in FINANCIAL STATEMENT CONCEPTS, Section PS 1000, and establishes general disclosure standards for assets; PS 3320 defines and establishes disclosure standards on contingent assets; PS 3380 defines and establishes disclosure standards on contractual rights.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

- **PS 3430 Restructuring Transactions (effective April 1, 2018)**
  This standard provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related program or operating responsibilities.

PS 3450 Financial Instruments

In June 2011 the Public Sector Accounting Board issued this accounting standard effective April 1, 2019. The Ministry has not yet adopted this standard and has the option of adopting it in fiscal year 2019-20 or earlier. Adoption of this standard requires corresponding adoption of: PS 2601 Foreign Currency Translation; PS 1201 Financial Statement Presentation; and PS 3041 Portfolio Investments in the same fiscal period. These standards provide guidance on: recognition, measurement and disclosure of financial instruments; standards on how to account for and report transactions that are denominated in a foreign currency; general reporting principles and standards for the disclosure of information in financial statements; and how to account for and report portfolio investments.

Management is currently assessing the impact of these standards on the financial statements.

Note 3 Accounts Receivable
(in thousands)

	2016			2015
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Accounts Receivable	$ 518,137	$ (30,092)	$ 488,045	$ 371,682

Accounts receivable are unsecured and non-interest bearing.

Note 4 Accounts Payable and Accrued Liabilities
(in thousands)

	2016	2015
Accounts Payable and Accrued Liabilities	$ 1,683,568	$ 1,827,425
Employee Future Benefits	631,772	605,072
Capital Lease Obligations [(a)]	34,190	17,562
	$ 2,349,530	$ 2,450,059

[(a)] Capital Lease Obligations includes a site lease with the University of Calgary, a site lease in Peace River, and vehicle leases.

Principal repayment requirements in each of the next five years and thereafter are as follows:

	Capital Lease Obligations
2016-17	$ 5,043
2017-18	3,522
2018-19	3,061
2019-20	2,932
2020-21	2,694
Thereafter	29,963
Less: amount representing interest under leases	(13,025)
	$ 34,190

Note 5 Deferred Revenue and Deferred Capital Contributions
(in thousands)

	2016	2015
Deferred Revenue [(i)]	$ 270,099	$ 261,326
Unspent Deferred Capital Contributions [(ii)]	90,382	96,019
Spent Deferred Capital Contributions [(iii)]	6,248,201	6,030,567
	$ 6,608,682	$ 6,387,912

(i) Deferred revenue represents unexpended resources with stipulations relating to operating expenditure or payments received prior to services being provided. Changes in balances in deferred revenue are as follows:

	2016				2015
	Federal government	Government of Alberta	Other	Total	Total
Balance, beginning of year	$ 15,085	$ 27,136	$ 219,105	$ 261,326	$ 271,808
Received/receivable during the year	9,376	38,596	200,901	248,873	229,325
Restricted realized investment income	1	2,209	4,208	6,418	7,012
Transferred from (to) unspent deferred capital contributions	-	40,746	(3,826)	36,920	23,017
Recognized as revenue during the year	(9,514)	(80,636)	(193,288)	(283,438)	(269,836)
Balance, end of year	$ 14,948	$ 28,051	$ 227,100	$ 270,099	$ 261,326

(ii) Unspent deferred capital contributions represent unspent resources with stipulations or external restrictions related to the purchase of tangible capital assets. Changes in balances in unspent deferred capital contributions are as follows:

	2016			2015
	Government of Alberta	Other	Total	Total
Balance, beginning of year	$ 8,371	$ 87,648	$ 96,019	$ 109,670
Received/receivable during the year	130,409	42,175	172,584	95,596
Transferred tangible capital assets	399,927	65	399,992	412,706
Restricted realized investment income	42	-	42	-
Contributions returned	(2)	(4,698)	(4,700)	(13,811)
Transferred (to) from deferred revenue	(40,746)	3,826	(36,920)	(23,017)
Transferred to spent deferred capital contributions	(488,846)	(47,789)	(536,635)	(485,125)
Balance, end of year	$ 9,155	$ 81,227	$ 90,382	$ 96,019

Note 5 Deferred Revenue and Deferred Capital Contributions (continued)
(in thousands)

(iii) Spent deferred capital contributions represent resources which have been spent for acquisition of tangible capital assets stipulated to be used over their useful life. Revenue is recognized over the useful life of the assets. Changes in balances in spent deferred capital contributions are as follows:

	2016			2015
	Government of Alberta	Other	Total	Total
Balance, beginning of year	$ 5,835,000	$ 195,567	$ 6,030,567	$ 5,886,205
Transferred from unspent deferred capital contributions	488,846	47,789	536,635	485,125
Recognized as revenue during the year	(268,090)	(50,911)	(319,001)	(340,763)
Balance, end of year	$ 6,055,756	$ 192,445	$ 6,248,201	$ 6,030,567

Note 6 Notes, Debentures and Mortgages
(in thousands)

	2016			2015
	Maturity	Interest Rate	Book Value	Book Value
Debentures [(a)]	2026 to 2035	3.61-4.93%	$ 325,430	$ 320,098
Other debt			1,479	1,737
Total			$ 326,909	$ 321,835

[(a)] The debentures have been issued by AHS to the Alberta Capital Finance Authority.

Principal repayment requirements in each of the next five years and thereafter are as follows:

	Debentures and Other Debt
2016-17	$ 16,824
2017-18	17,612
2018-19	18,437
2019-20	19,300
2020-21	20,205
Thereafter	234,531
	$ 326,909

Note 7 Tangible Capital Assets
(in thousands)

	2016							2015
	Land	Buildings [1]	Land Improvements	Equipment	Computer Hardware and Software	Leasehold Assets	Total	Total
Estimated Useful Life	Indefinite	10-40 years	5-40 years	3-20 years	3-10 years	Term of Lease		
Historical Cost [2]								
Beginning of year	$ 110,068	$ 9,626,794	$ 69,147	$ 2,171,942	$ 1,605,201	$ 210,819	$ 13,793,971	$ 13,197,749
Additions [3]	-	497,614	1,771	109,974	25,624	27,711	662,694	663,805
Disposals, including write-downs	-	(838)	-	(114,791)	(48,010)	(980)	(164,619)	(67,583)
	110,068	10,123,570	70,918	2,167,125	1,582,815	237,550	14,292,046	13,793,971
Accumulated Amortization								
Beginning of year	-	3,260,758	57,952	1,592,585	1,141,985	147,939	6,201,219	5,614,490
Amortization expense	-	251,942	2,333	190,733	147,860	15,258	608,126	652,518
Effect of disposals	-	(789)	-	(114,380)	(47,999)	(966)	(164,134)	(65,789)
	-	3,511,911	60,285	1,668,938	1,241,846	162,231	6,645,211	6,201,219
Net Book Value at March 31, 2016	$ 110,068	$ 6,611,659	$ 10,633	$ 498,187	$ 340,969	$ 75,319	$ 7,646,835	
Net Book Value at March 31, 2015	$ 110,068	$ 6,366,036	$ 11,195	$ 579,357	$ 463,216	$ 62,880		$ 7,592,752

[1] Buildings include parking lots.
[2] Historical cost includes work-in-progress at March 31, 2016 totaling $1,094,501 (2015 - $850,367).
[3] Additions include total transferred capital assets of $399,992 (2015 - $412,706) consisting of $399,927 from Ministry of Infrastructure (2015 - $412,623) and $65 from other sources (2015 - $83).

Note 8 Contractual Obligations
(in thousands)

Contractual obligations are obligations of the Ministry to others that will become liabilities in the future when the terms of those contracts or agreements are met. As at March 31, 2016, the Ministry has the following contractual obligations:

	2016	2015
Specific Programs Commitments	$ 513,530	$ 607,521
Capital Contracts	80,866	160,310
Service Contracts and Operating Leases	409,779	460,085
	$ 1,004,175	$ 1,227,916

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

	Specific Programs Commitments	Capital Contracts	Service Contracts and Operating Leases	Total
2017	$ 369,227	$ 61,815	$ 113,913	$ 544,955
2018	93,017	19,001	92,545	204,563
2019	40,197	6	63,478	103,681
2020	5,946	6	54,969	60,921
2021	2,694	6	21,187	23,887
Thereafter	2,449	32	63,687	66,168
	$ 513,530	$ 80,866	$ 409,779	$ 1,004,175

Canadian Blood Services

The Government of Alberta is committed to provide funding to the Canadian Blood Services (CBS) for the provision of blood services in Canada. This commitment was outlined in a Memorandum of Understanding, signed in January 1998, which recorded the understandings and commitments of the Minister of Health of Canada and the Provincial and Territorial Ministers of Health (except Quebec) regarding their respective roles and responsibilities in a renewed national blood system.

Alberta's obligation for the operational costs of CBS is determined on a per capita basis, and the costs for fractionated blood and blood products is determined on the basis of annual utilization of these products. During the year, payments to CBS amounted to $191,000 (2015 - $160,500).

Note 9 Contingent Liabilities and Equity Agreements
(in dollars)

Equity Agreements with Voluntary Hospital Owners

The Ministry has a contingent liability for buy-out of equity under Equity Agreements entered into between the Ministry and Voluntary Hospital Owners. The Ministry's payout liability is contingent upon notification by the voluntary hospital owner of termination of the equity agreement. At March 31, 2016, the contingent payout liability upon termination is estimated at $12.8 million (2015 - $12.8 million).

Other Contingent Liabilities

The Ministry has been named in 183 (2015: 191) claims of which the outcome is not determinable. Of these claims, 165 (2015: 167) have specified amounts totalling $326.9 million (2015: $312.8 million). The resolution of indeterminable claims may result in a liability, if any, that may be significantly lower than the claimed amount.

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

Indemnity

As described in Note 8, CBS provides blood services in Alberta. CBS has established two wholly-owned captive insurance corporations, CBS Insurance Company Limited (CBSI) and Canadian Blood Services Captive Insurance Company Limited (CBSE). CBSI provides insurance coverage up to $250 million with respect to risks associated with the operation of the blood system.

CBSE was capitalized in whole through funding from the provinces and territories (except Quebec), through a Captive Support Agreement dated September 28, 2006 (“CSA”), between the provinces, territories, and CBSE. Under the CSA, each of the provinces and territories provided their Pro Rata Share (as defined in the CSA) through an indemnity. Alberta’s Pro Rata Share is 13.1% of CBSE’s total capital amount, which amounts to $98.0 million. Authority for Alberta to provide the indemnity under the CSA is pursuant to section 5.05 of the Indemnity Authorization Regulation 22/1997, under the *Financial Administration Act*.

The expense recognition criterion for the indemnity is notification from CBS that the indemnity is required. At March 31, 2016, no amount has been recognized for this indemnity.

Note 10 Endowment Funds
(in thousands)

Endowments are included in financial assets in the Consolidated Statement of Financial Position. Donors have placed restrictions that the original contribution should not be spent, except where the legislation allows for encroachment on the capital of the endowment. Capital preservation, investment returns, and the impact of inflation may also form restrictions on these funds.

	2016	2015
Balance, beginning of year	$ 72,381	$ 68,796
Endowment contributions	3,585	3,585
Balance, end of year	$ 75,966	$ 72,381

Note 11 Trust Funds under Administration
(in thousands)

Trust funds under administration are funds consisting of public money over which the Legislature has no power of appropriation. Because the Ministry has no equity in the funds and administers them for the purposes of various trusts, they are not included in the consolidated financial statements. As at March 31, 2016, trust funds under administration were as follows:

	2016	2015
Research and development, education and others	$ 5,542	$ 8,480

Note 12 Benefit Plans
(in thousands)

Except as noted below, the Ministry participates in the multi-employer pension plans: Management Employees Pension Plan, Public Service Pension Plan, Local Authorities Pension Plan, and Supplementary Executive Retirement Plan for Public Service Managers. The expense for these pension plans is equivalent to the employer's annual contributions.

In addition, AHS also participates in Supplemental Pension Plan and Group Registered Retirement Savings Plans (GRRSPs) which are defined contribution plans for certain employee groups.

Certain entities in the Ministry also provide defined Supplementary Executive Retirement Plans for certain management staff. At March 31, 2016, these plans have net accrued benefit liability of $1,111 (2015 – accrued benefit liability of $2,041). The accrued benefit liability is included in accounts payable and accrued liabilities.

At December 31, 2015, the Management Employees Pension Plan reported a surplus of $299,051 (2014 - $75,805), the Public Service Pension Plan reported a deficiency of $133,188 (2014 - $803,299), the Local Authorities Pension Plan reported a deficiency of $923,416 (2014 - $2,454,636) and the Supplementary Retirement Plan for Public Service Managers had a deficiency of $16,305 (2014 - $17,203).

Note 12 Benefit Plans (continued)
(in thousands)

The Ministry's pension expense for the year is as follows:

	2016	2015
Registered Benefit Plans	$ 584,414	$ 561,872
Supplemental Executive Retirement Plans	(762)	981
Supplemental Pension Plan and GRRSPs	49,255	48,815
	$ 632,907	$ 611,668

The Ministry also participates in two multi-employer Long Term Disability Income Continuance Plans. At March 31, 2016, the Bargaining Unit Plan reported an actuarial surplus of $83,066 (2015 - $86,888) and the Management, Opted Out and Excluded Plan reported an actuarial surplus of $29,246 (2015 - $32,343). The expense for these two plans is limited to the employer's annual contributions for the year.

Note 13 Comparative Figures

Certain 2015 figures have been reclassified to conform to the 2016 presentation.

Note 14 Subsequent Events

- In May 2016, wildfires seriously affected Fort McMurray and surrounding communities. The government is in the process of providing financial assistance for uninsurable loss and damage through its Disaster Recovery Programs (DRP). The DRP is administered and funded by Alberta Emergency Management Agency through the authority of the Disaster Recovery Regulation.

  The Province, subject to certain criteria, may recover part of the above costs from the federal government through the Disaster Financial Assistance Arrangement, pending approval through its Order in Council.

  The financial impact on the Ministry may be significant but is uncertain at this stage.

- Effective April 1, 2016 responsibility for the Alberta Innovates-Health Solutions will be transferred to the Ministry of Economic Development and Trade. As a result AIHS will not be a controlled entity reporting to the Minister of Health and consolidated in the Ministry's financial statements.

Note 15 Approval of Financial Statements

The consolidated financial statements were approved by the senior financial officer and the deputy minister.

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2016

Schedule 1

Consolidated Revenues

(in thousands)

	2016	2015
Government of Alberta Transfers		
Alberta Cancer Prevention Legacy Fund	$ 23,000	$ 25,000
Alberta Heritage Foundation for Medical Research Endowment Fund	55,160	91,386
Other Government Departments	382,065	389,250
	460,225	505,636
Federal Government Transfers		
Canada Health Transfer	4,013,942	3,601,124
Other	13,577	8,858
	4,027,519	3,609,982
Premiums, Fees and Licences		
Supplementary Health Benefit Premiums	46,543	47,753
Fees and Charges	491,487	472,388
Other	2	2
	538,032	520,143
Investment Income	85,350	99,702
Other Revenue		
Third Party Recoveries	129,057	114,247
Previous years' refunds of expenditure	28,177	18,783
Donations	163,693	167,290
Ancillary operations	133,220	133,118
Miscellaneous	281,552	272,572
	735,699	706,010
	$ 5,846,825	$ 5,441,473

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2016

Schedule 2

Consolidated Expenses - Directly Incurred Detailed by Object

(in thousands)

	2016	2015
Grants	$ 6,074,458	$ 5,514,797
Supplies and Services	5,027,911	4,981,293
Salaries, Wages and Employee Benefits	7,854,047	7,645,863
Amortization of Tangible Capital Assets	608,126	652,518
Consumption of Inventories of Supplies	846,265	795,425
Financial Transactions and Other	49,218	49,059
	$ 20,460,025	$ 19,638,955

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2016

Schedule 3

Consolidated Related Party Transactions

(in thousands)

Related parties are those entities consolidated or accounted for on a modified equity basis in the Province of Alberta's consolidated financial statements. Related parties also include key management personnel in the Ministry.

The Ministry and its employees paid or collected certain taxes and fees set by regulation for permits, licenses and other charges. These amounts were incurred in the normal course of business, reflect charges applicable to all users, and have been excluded from this Schedule.

The Ministry had the following transactions with related parties recorded in the Consolidated Statement of Operations and the Consolidated Statement of Financial Position at the amount of consideration agreed upon between the related parties.

	2016	2015 (Restated)
Revenues		
Government of Alberta Transfers		
- Transfer from funds	$ 78,160	$ 116,386
- Alberta Infrastructure	311,432	312,045
- Other Ministries	70,339	77,354
Other	39,593	43,850
	$ 499,524	$ 549,635
Expenses - Directly Incurred		
Grants	$ 315,454	$ 290,873
Other	163,064	160,847
Interest	14,351	15,359
	$ 492,869	$ 467,079
Receivables	$ 72,529	$ 27,305
Payables/Deferred Revenue -Alberta Infrastructure	$ 6,079,989	$ 5,856,511
-Other Ministries	47,786	47,847
	$ 6,127,775	$ 5,904,358
Debt	$ 326,909	$ 321,835
Contractual Obligations	$ 189,880	$ 242,870

The Ministry receives services under contracts managed by Service Alberta. Any commitments under these contracts are reported by Service Alberta.

The Ministry also had the following transactions with related parties for which no consideration was exchanged. The amounts for these related party transactions are estimated based on the costs incurred by the service provider to provide the service. These amounts are not recorded in the consolidated financial statements and are disclosed in Schedule 4.

	2016	2015
Expenses - Incurred by Others		
Accommodation	$ 36,608	$ 34,724
Legal Services	4,591	4,792
Business Services	8,576	9,132
	$ 49,775	$ 48,648

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2016

Schedule 4

Consolidated Allocated Costs

(in thousands)

	2016					2015
		Expenses - Incurred by Others				
Program	Expenses [1]	Accommodation Costs [2]	Legal Services [3]	Business Services [4]	Total	Total
Ministry Support Services	$ 70,477	$ 36,608	$ 4,591	$ 8,576	$ 120,252	$ 73,300
Physician Compensation and Development	4,852,693	-	-	-	4,852,693	4,505,060
Drugs and Supplemental Health Benefits	1,993,900	-	-	-	1,993,900	1,807,828
Community Programs and Healthy Living	456,583	-	-	-	456,583	459,801
Facility Based Patient Services	5,525,030	-	-	-	5,525,030	5,401,030
Care Based Services	1,867,155	-	-	-	1,867,155	1,773,530
Diagnostic,Therapeutic & Other Patient Services	2,239,954	-	-	-	2,239,954	2,173,519
Administration and Support Services	2,454,828	-	-	-	2,454,828	2,462,415
Information Systems	631,195	-	-	-	631,195	646,262
Support Programs	164,619	-	-	-	164,619	155,301
Research and Education	182,231	-	-	-	182,231	180,508
Debt Servicing	15,373	-	-	-	15,373	16,253
2013 Alberta Flooding	-	-	-	-	-	32,796
Cancer Research and Prevention Investment	5,000	-	-	-	5,000	-
Infrastructure Support	987	-	-	-	987	-
	$ 20,460,025	$ 36,608	$ 4,591	$ 8,576	$ 20,509,800	$ 19,687,603

[1] Expenses - Directly Incurred as per Consolidated Statement of Operations.

[2] Costs shown for Accommodation (includes grants in lieu of taxes) on Schedule 3.

[3] Costs shown for Legal Services on Schedule 3.

[4] Costs shown for Business Services on Schedule 3 include charges for IT support, vehicles, internal audit services and other services.

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2016

Schedule 5
Consolidated Portfolio Investments
(in thousands)

	2016		2015	
	Cost	Fair Value	Cost	Fair Value
Interest bearing securities [(a)]				
Deposits and short-term securities	$ 248,636	$ 248,636	$ 219,505	$ 219,505
Bonds and mortgages	1,466,168	1,476,511	1,476,687	1,514,894
	1,714,804	1,725,147	1,696,192	1,734,399
Equities:				
Canadian public equities	155,830	169,064	215,393	251,346
Global public equities	283,265	293,295	145,351	187,748
	439,095	462,359	360,744	439,094
Total Portfolio Investments	$ 2,153,899	$ 2,187,506	$ 2,056,936	$ 2,173,493

	2016		2015	
	Cost	Fair Value	Cost	Fair Value
Operating	$ 2,077,933	$ 2,111,540	$ 1,984,555	$ 2,101,112
Endowments	75,966	75,966	72,381	72,381
Total Portfolio Investments	$ 2,153,899	$ 2,187,506	$ 2,056,936	$ 2,173,493

(a) Interest-bearing securities reported as at March 31, 2016 have an average effective yield of 1.61% (2015 – 1.52%) per annum.

Schedules to the Consolidated Financial Statements
Year Ended March 31, 2016

Schedule 6
List of Entities Included in the Consolidated Financial Statements

Department of Health

Health Quality Council of Alberta

Alberta Innovates - Health Solutions

Alberta Foundation for Health Research

Alberta Health Services

Wholly Owned Subsidiaries

Calgary Laboratory Services Ltd.
Capital Care Group Inc.
Carewest

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

AHS consolidates its interest in the LPIP. AHS has the majority of representation on the LPIP's governance board and is therefore considered to control the LPIP.

Controlled Foundations

Airdrie Health Foundation
Alberta Cancer Foundation (ACF)
Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Calgary Health Trust (CHT)
Canmore and Area Health Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Trust
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation
Grimshaw/Berwyn Hospital Foundation
Jasper Health Care Foundation
Lac La Biche Regional Health Foundation *(effective September 2015)*
Lacombe Hospital and Care Centre Foundation
Medicine Hat and District Health Foundation
Mental Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Peace River and District Health Foundation
Ponoka and District Health Foundation
Stettler Health Services Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Two Hills Health Centre Foundation *(effective December 2014)*
Vermillion and Region Health and Wellness Foundation *(inactive)*
Viking Health Foundation
Vulcan County Health and Wellness Foundation
Windy Slopes Health Foundation

Schedules to the Consolidated Financial Statements
Year Ended March 31, 2016

Schedule 6 (continued)
List of Entities Included in the Consolidated Financial Statements

Alberta Health Services

Other

Queen Elizabeth II Hospital Child Care Centre

Partnerships

AHS uses the proportionate consolidation method to account for its:

- 30% interest in the HUTV Limited Partnership with David Chittick Management Ltd
- 50% interest in the Northern Alberta Clinical Trials Centre partnership with the University of Alberta
- 50% interest in the Primary Care Network (PCN) government partnerships with physician groups.

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

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

FINANCIAL INFORMATION
Department of Health

Financial Statements

March 31, 2016

Department of Health

Financial Statements

Year Ended March 31, 2016

Financial Statements
March 31, 2016

AUDITOR GENERAL
Alberta

Independent Auditor's Report

To the Minister of Health

Report on the Financial Statements

I have audited the accompanying financial statements of the Department of Health, which comprise the statement of financial position as at March 31, 2016, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In my opinion, the financial statements present fairly, in all material respects, the financial position of the Department of Health as at March 31, 2016, and the results of its operations, its changes in net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

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

Auditor General

June 6, 2016

Edmonton, Alberta

STATEMENT OF OPERATIONS

Year Ended March 31, 2016
(in thousands)

	2016		2015
	Budget	Actual	Actual
Revenues (Schedule 1)			
Government Transfers			
Government of Alberta Transfers	$ 96,280	$ 78,160	$ 116,386
Federal Government Transfers	3,969,288	4,016,289	3,603,575
Premiums, Fees and Licences	48,001	46,545	47,755
Other Revenue	176,517	284,220	217,362
	4,290,086	4,425,214	3,985,078
Expenses - Directly Incurred (Note 2b(ii) and Schedule 8)			
Programs (Schedules 3 and 4)			
Ministry Support Services	84,219	70,737	73,409
Alberta Health Services	11,329,850	11,329,850	11,212,618
Physician Compensation and Development	4,347,263	4,396,348	4,008,745
Primary Health Care/Addictions and Mental Health	280,284	272,951	309,337
Continuing Care Initiatives	27,000	24,181	26,861
Alberta Innovates - Health Solutions	71,280	55,160	91,386
Allied Health Services	92,845	92,260	82,832
Human Tissue and Blood Services	184,680	192,093	161,916
Drugs and Supplemental Health Benefits	1,801,358	1,861,545	1,655,043
Community Programs and Healthy Living	130,908	118,118	124,633
Support Programs	209,620	203,770	199,140
Information Systems	96,143	76,011	96,008
Infrastructure Support	39,887	30,507	13,272
Cancer Research and Prevention Investment	25,000	23,000	25,000
2013 Alberta Flooding	-	-	16,368
	18,720,337	18,746,531	18,096,568
Annual Deficit	$ (14,430,251)	$ (14,321,317)	$ (14,111,490)

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

STATEMENT OF FINANCIAL POSITION

As at March 31, 2016
(in thousands)

	2016	2015
Financial Assets		
Cash	$ 329	$ 309
Accounts Receivable (Note 3)	154,873	94,900
	155,202	95,209
Liabilities		
Accounts Payable and Accrued Liabilities (Note 4)	555,171	631,048
Deferred Revenue	9,786	10,511
	564,957	641,559
Net Debt	(409,755)	(546,350)
Non-Financial Assets		
Tangible Capital Assets (Note 6)	71,904	79,681
Inventories of Supplies	21,810	24,313
	93,714	103,994
Net Liabilities Before Spent Deferred Capital Contributions	(316,041)	(442,356)
Spent Deferred Capital Contributions (Note 5)	-	1,440
Net Liabilities	$ (316,041)	$ (443,796)
Net Liabilities, Beginning of Year	$ (443,796)	$ (556,005)
Annual Deficit	(14,321,317)	(14,111,490)
Net Financing Provided from General Revenues	14,449,072	14,223,699
Net Liabilities, End of Year	$ (316,041)	$ (443,796)

Contractual Obligations and Contingent Liabilities (Notes 7 and 8)

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

STATEMENT OF CHANGE IN NET DEBT

Year Ended March 31, 2016

(in thousands)	2016 Budget	2016 Actual	2015 Actual
Annual Deficit	$ (14,430,251)	$ (14,321,317)	$ (14,111,490)
Acquisition of Tangible Capital Assets (Note 6)	(24,700)	(11,414)	(20,440)
Amortization of Tangible Capital Assets (Note 6)	18,750	19,182	19,995
Write-downs of Tangible Capital Assets		9	435
Accquistion of Inventories of Supplies	(64,400)	(58,557)	(61,154)
Consumption of Inventories of Supplies	57,700	59,803	55,481
Write-downs of Inventories of Supplies		1,257	645
Change in Spent Deferred Capital Contributions (Note 5)		(1,440)	(513)
Net Financing Provided from General Revenues		14,449,072	14,223,699
Decrease in Net Debt		$ 136,595	$ 106,658
Net Debt, Beginning of Year		(546,350)	(653,008)
Net Debt, End of Year		$ (409,755)	$ (546,350)

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

STATEMENT OF CASH FLOWS

Year Ended March 31, 2016
(in thousands)

	2016	2015
Operating Transactions		
Annual Deficit	$ (14,321,317)	$ (14,111,490)
Non-cash items included in Annual Deficit:		
Amortization of Tangible Capital Assets (Note 6)	19,182	19,995
Spent Deferred Capital Contributions recognized as Revenue (Note 5)	(1,440)	(513)
Valuation Adjustments and write-downs	5,741	5,155
	(14,297,834)	(14,086,853)
(Increase) in Accounts Receivable	(64,642)	(43,049)
(Decrease) in Accounts Payable and Accrued Liabilities	(75,683)	(73,041)
(Decrease) Increase in Deferred Revenue	(725)	4,304
Decrease (Increase) in Inventories of Supplies	1,246	(5,673)
Cash (applied to) Operating Transactions	(14,437,638)	(14,204,312)
Capital Transactions		
Acquisition of Tangible Capital Assets (Note 6)	(11,414)	(20,440)
Cash (applied to) Capital Transactions	(11,414)	(20,440)
Financing Transactions		
Net Financing Provided from General Revenues	14,449,072	14,223,699
Cash provided by Financing Transactions	14,449,072	14,223,699
Increase (Decrease) in Cash	20	(1,053)
Cash, Beginning of Year	309	1,362
Cash, End of Year	$ 329	$ 309

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

NOTES TO THE FINANCIAL STATEMENTS
MARCH 31, 2016

Note 1 Authority and Purpose

The Department of Health (the Department) operates under the authority of the *Government Organization Act*, Chapter G-10, Revised Statutes of Alberta 2000.

In support of the Government of Alberta's commitments for a stable and improved public health care system, the Department is to ensure that Albertans receive the right health care services, at the right time, in the right place, provided by the right health care providers and teams.

Note 2 Summary of Significant Accounting Policies and Reporting Practices

These financial statements are prepared in accordance with Canadian Public Sector Accounting Standards.

(a) Reporting Entity

The reporting entity is the Department of Health, which is part of the Ministry of Health and for which the Minister of Health is accountable.

Other entities reporting to the Minister are Alberta Health Services (AHS), the Health Quality Council of Alberta (HQCA), and the Alberta Innovates-Health Solutions (AIHS). The activities of these organizations are not included in these financial statements.

The Ministry Annual Report provides a more comprehensive accounting of the financial position and results of the Ministry's operations for which the Minister is accountable.

All Departments of the Government of Alberta operate within the General Revenue Fund (the Fund). The Fund is administered by the President of Treasury Board and Minister of Finance. All cash receipts of Departments are deposited into the Fund and all cash disbursements made by Departments are paid from the Fund. Net Financing Provided from General Revenues is the difference between all cash receipts and all cash disbursements made.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(b) Basis of Financial Reporting

(i) Revenues

All revenues are reported on the accrual basis of accounting.

Government Transfers

Transfers from other Government of Alberta departments and federal government are referred to as government transfers.

Government transfers are recorded as deferred capital contributions or deferred revenue if the eligibility criteria of the transfer, or the stipulations, together with the department's actions and communications as to the use of transfers create a liability. These transfers are recognized as revenues as the stipulations are met and, when applicable, the department complies with its communicated uses of these transfers.

All other government transfers, without terms for the use of the transfer, are recorded as revenue when the transfer is authorized and the department meets the eligibility criteria (if any).

Deferred Revenue

Cash received for which goods or services have not been provided by year end is recorded as deferred revenue.

Credit or Recovery

Credit or recovery initiatives provide a basis for authorizing spending. Credit or recovery is shown in the details of the Government Estimates for a supply vote.

If budgeted revenues are not fully realized, spending is reduced by an equivalent amount. If actual credit or recovery amounts exceed budget, the Department may, with the approval of the Treasury Board Committee, use the excess revenue to fund additional expenses of the program. Schedule 2 discloses information on the Department's credit or recovery initiatives.

(ii) Expenses

Directly Incurred

Directly incurred expenses are those costs the Department has primary responsibility and accountability for, as reflected in the Government's budget documents.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

In addition to program operating expenses such as grants, salaries, supplies etc., directly incurred expenses also include:

- amortization of tangible capital assets.
- consumption of inventories of supplies.
- pension costs, which are the cost of employer contributions for current service of employees during the year.
- valuation adjustments which include changes in the valuation allowances used to reflect financial assets at their net recoverable or other appropriate value. Valuation adjustments also represent the change in management's estimate of future payments arising from obligations relating to vacation pay.

Grants are recognized as an expense in the period the transfer is authorized and all eligibility criteria have been met by the recipient.

Incurred by Others

Services contributed by other related entities in support of the Department's operations are not recognized and are disclosed in Schedule 7 and Schedule 8.

(iii) Financial Assets

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 assets of the Department are limited to financial claims, such as advances to and receivables from other organizations, employees and other individuals.

Accounts Receivable

Accounts receivable are recorded at the lower of cost or net recoverable value. A valuation allowance is recorded when recovery is uncertain.

(iv) Liabilities

Liabilities are present obligations of a government to others arising from past transactions or events, the settlement of which is expected to result in the future sacrifice of economic benefits.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(v) Non-Financial Assets

Non-financial assets are acquired, constructed or developed assets that do not normally provide resources to discharge existing liabilities, but instead:

(a) are normally employed to deliver government services;
(b) may be consumed in the normal course of operations; and
(c) are not for sale in the normal course of operations.

Non-financial assets of the department are limited to tangible capital assets and inventories of supplies.

Tangible Capital Assets

Tangible capital assets of the Department are recorded at historical cost and amortized on a straight-line basis over the estimated useful lives of the assets. The threshold for capitalizing new systems development is $250,000 and the threshold for major systems enhancements is $100,000. The threshold for all other tangible capital assets is $5,000.

Amortization is only charged if the tangible capital asset is put into service.

Inventories of Supplies

Inventories consist of vaccines and sera for distribution at no cost. Inventories of supplies are valued at the lower of cost, determined on a first-in, first-out basis, and replacement cost.

Assets acquired by right are not included.

(vi) Valuation of Financial Assets and Liabilities

Fair value is the amount of consideration agreed upon in an arm's length transaction between knowledgeable, willing parties who are under no compulsion to act.

The fair values of cash, accounts receivable, and accounts payable and accrued liabilities are estimated to approximate their carrying values because of the short-term nature of these instruments.

(vii) Measurement Uncertainty

Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. Measurement uncertainty that is material to these financial statements exists in the accrual of the Canada Health Transfer.

The Canada Health Transfer is determined on an equal per capita cash basis whereas the transfers were determined on an equal per capita basis prior to 2014-15, and included both cash and tax point transfers. Measurement uncertainty for the Canada Health Transfer relates to the tax transfer component for 2013-14 which has not been finalized. As the value of income tax points (personal and corporate) transferred historically is finalized, it is used to adjust the entitlements of open prior years. Accordingly, the amount is estimated and could change by a material amount.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(c) Change in Accounting Policy

A net debt presentation (with reclassification of comparatives) has been adopted for the presentation of financial statements. Net Debt is measured as the difference between the Department's financial assets and liabilities.

The effect of this change results in changing the presentation of the Statement of Financial Position and adding an additional Statement of Change in Net Debt.

(d) Future Accounting Changes

In June 2015 the Public Sector Accounting Board issued these following accounting standards:

- **PS 2200 Related Party Disclosures and PS 3420 Inter-Entity Transactions (effective April 1, 2017)**
  PS 2200 defines a related party and establishes disclosures required for related party transactions; PS 3420 establishes standards on how to account for and report transactions between public sector entities that comprise a government's reporting entity from both a provider and recipient perspective.

- **PS 3210 Assets, PS 3320 Contingent Assets, and PS 3380 Contractual Rights (effective April 1, 2017)**
  PS 3210 provides guidance for applying the definition of assets set out in FINANCIAL STATEMENT CONCEPTS, Section PS 1000, and establishes general disclosure standards for assets; PS 3320 defines and establishes disclosure standards on contingent assets; PS 3380 defines and establishes disclosure standards on contractual rights.

- **PS 3430 Restructuring Transactions (effective April 1, 2018)**
  This standard provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/ or liabilities, together with related program or operating responsibilities.

PS 3450 Financial Instruments
In June 2011 the Public Sector Accounting Board issued this accounting standard effective April 1, 2019. The department has not yet adopted this standard and has the option of adopting it in fiscal year 2019-20 or earlier. Adoption of this standard requires corresponding adoption of: PS 2601 Foreign Currency Translation; PS 1201 Financial Statement Presentation; and PS 3041 Portfolio Investments in the same fiscal period. These standards provide guidance on: recognition, measurement and disclosure of financial instruments; standards on how to account for and report transactions that are denominated in a foreign currency; general reporting principles and standards for the disclosure of information in financial statements; and how to account for and report portfolio investments.

Management is currently assessing the impact of these standards on the financial statements.

Note 3 Accounts Receivable
(in thousands)

	2016			2015
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Accounts Receivable	$ 155,766	$ (893)	$ 154,873	$ 94,900

Accounts receivable are unsecured and non-interest bearing.

Note 4 Accounts Payable and Accrued Liabilities
(in thousands)

	2016	2015
Accounts payable and accrued liabilities	$ 545,241	$ 620,923
Accrued vacation pay	9,930	10,125
	$ 555,171	$ 631,048

Note 5 Spent Deferred Capital Contributions
(in thousands)

Spent deferred capital contributions represent resources which have been spent for acquisition of tangible capital assets stipulated to be used over their useful life. Revenue is recognized over the useful life of the assets. Changes in balances in spent deferred capital contributions are as follows:

	2016	2015
Balance, beginning of year	$ 1,440	$ 1,953
Recognized as revenue during the year	(1,440)	(513)
Balance, end of year	$ -	$ 1,440

Note 6 Tangible Capital Assets
(in thousands)

	2016			2015
	Equipment [1]	Computer Hardware and Software	Total	Total
Estimated Useful Life	10 years	3 - 10 years		
Historical Cost [2]				
Beginning of year	$ 2,394	$ 219,054	$ 221,448	$ 201,498
Additions	-	11,414	11,414	20,440
Disposals, including write-downs	-	(398)	(398)	(490)
	2,394	230,070	232,464	221,448
Accumulated Amortization				
Beginning of year	1,917	139,850	141,767	121,827
Amortization expense	177	19,005	19,182	19,995
Effect of disposals	-	(389)	(389)	(55)
	2,094	158,466	160,560	141,767
Net Book Value at March 31, 2016	$ 300	$ 71,604	$ 71,904	
Net Book Value at March 31, 2015	$ 477	$ 79,204		$ 79,681

(1) Equipment includes office equipment and furniture.

(2) Historical cost includes work-in-progress at March 31, 2016 for computer hardware and software totaling $8,377 (2015 - $15,023).

Note 7 Contractual Obligations
(in thousands)

Contractual obligations are obligations of the Department to others that will become liabilities in the future when the terms of those contracts or agreements are met. As at March 31, 2016, the Department has the following contractual obligations:

	2016	2015
Specific Programs Commitments	$ 358,330	$ 875,849
Capital Contracts	6,147	16,106
Service Contracts	165,214	201,011
	$ 529,691	$ 1,092,966

Estimated payment requirements for each of the next five years and thereafter are as follows:

	Specific Programs Commitments	Capital Contracts	Service Contracts	Total
2017	$ 298,674	$ 5,776	$ 58,431	$ 362,881
2018	46,033	321	48,589	94,943
2019	12,999	6	29,658	42,663
2020	493	6	28,023	28,522
2021	131	6	513	650
Thereafter	-	32	-	32
	$ 358,330	$ 6,147	$ 165,214	$ 529,691

Canadian Blood Services

The Government of Alberta is committed to provide funding to Canadian Blood Services (CBS) for the provision of blood services in Alberta. This commitment was outlined in a Memorandum of Understanding, signed in January 1998, which recorded the understandings and commitments of the Minister of Health of Canada and the Provincial and Territorial Ministers of Health (except Quebec) regarding their respective roles and responsibilities in a renewed national blood system.

Alberta's obligation for the operational costs of CBS is determined on a per capita basis, and the costs for fractionated blood and blood products is determined on the basis of annual utilization of these products. During the year, payments to CBS amounted to $191,000 (2015 - $160,500).

Note 8 Contingent Liabilities and Equity Agreements
(in dollars)

Equity Agreements with Voluntary Hospital Owners

The Department has a contingent liability for buy-out of equity under Equity Agreements entered into between the Department and Voluntary Hospital Owners. The Department's payout liability is contingent upon notification by the voluntary hospital owner of termination of the equity agreement. At March 31, 2016, the contingent payout liability upon termination is estimated at $12.8 million (2015 - $12.8 million).

Other Contingent Liabilities

The Department has been named in fourteen claims (2015 – fourteen claims), the outcome of which is not determinable. Of these claims, ten have specified amounts totaling $101.5 million (2015 – eleven claims with a specified amount of $34.2 million). Included in the total claims, nine claims totaling $100.9 million (2015 – seven claims totaling $32.1 million) are covered in whole or in part by the Alberta Risk Management Fund. The resolution of indeterminable claims may result in a liability, if any, that may be significantly lower than the claimed amount.

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

Indemnity

As described in Note 7, CBS provides blood services in Alberta. CBS has established two wholly-owned captive insurance corporations, CBS Insurance Company Limited (CBSI) and Canadian Blood Services Captive Insurance Company Limited (CBSE). CBSI provides insurance coverage up to $250 million with respect to risks associated with the operation of the blood system.

CBSE was capitalized in whole through funding from the provinces and territories (except Quebec), through a Captive Support Agreement dated September 28, 2006 (“CSA”), between the provinces, territories, and CBSE. Under the CSA, each of the provinces and territories provided their Pro Rata Share (as defined in the CSA) through an indemnity. Alberta’s Pro Rata Share is 13.1% of CBSE’s total capital amount, which amounts to $98.0 million. Authority for Alberta to provide the indemnity under the CSA is pursuant to section 5.05 of the Indemnity Authorization Regulation 22/1997, under the *Financial Administration Act*.

The expense recognition criterion for the indemnity is notification from CBS that the indemnity is required. At March 31, 2016, no amount has been recognized for this indemnity.

Note 9 Payments under Reciprocal and Other Agreements
(in thousands)

The Department entered into agreements, under the Alberta Health Care Insurance Plan, with other Provincial and Territorial Governments to provide health services on their behalf. The Department pays service providers for services rendered under the agreements and recovers the amount paid from the program sponsors. Service providers include Alberta Health Services and physicians. Costs under these agreements are incurred by the Department under authority in section 25 of the *Financial Administration Act*.

Accounts receivable includes $31,673 (2015- $40,236).

Amounts paid under agreements with program sponsors are as follows:

	2016	2015
Other Provincial and Territorial Governments	$ 308,559	$ 280,361
Other Agreements	-	768
	$ 308,559	$ 281,129

Note 10 Benefit Plans
(in thousands)

The Department participates in the multi-employer pension plans: Management Employees Pension Plan, Public Service Pension Plan and Supplementary Retirement Plan for Public Service Managers. The expense for these pension plans is equivalent to the annual contributions of $12,925 for the year ended March 31, 2016 (2015 - $13,175). The Department is not responsible for future funding of the plan deficit other than through contribution increases.

At December 31, 2015, the Management Employees Pension Plan reported a surplus of $299,051 (2014 - $75,805), the Public Service Pension Plan reported a deficiency of $133,188 (2014 - $803,299) and the Supplementary Retirement Plan for Public Service Managers reported a deficiency of $16,305 (2014 - $17,203).

The Department also participates in two multi-employer Long Term Disability Income Continuance Plans. At March 31, 2016, the Bargaining Unit Plan reported an actuarial surplus of $83,066 (2015 - $86,888) and the Management, Opted Out and Excluded Plan reported an actuarial surplus of $29,246 (2015 - $32,343). The expense for these two plans is limited to the employer’s annual contributions for the year.

Note 11 Comparative Figures

Certain 2015 figures have been reclassified to conform to the 2016 presentation.

Note 12 Subsequent Event

In May 2016, wildfires seriously affected Fort McMurray and surrounding communities. The government is in the process of providing financial assistance for uninsurable loss and damage through its Disaster Recovery Programs (DRP). The DRP is administered and funded by Alberta Emergency Management Agency through the authority of the Disaster Recovery Regulation.

The Province, subject to certain criteria, may recover part of the above costs from the federal government through the Disaster Financial Assistance Arrangement, pending approval through its Order in Council.

The financial impact on the Department may be significant but is uncertain at this stage.

Note 13 Approval of Financial Statements

The financial statements were approved by the senior financial officer and the deputy minister.

Schedule to Financial Statements

Year Ended March 31, 2016

SCHEDULE 1

Revenues

(in thousands)

	2016		2015
	Budget	Actual	Actual
Government of Alberta Transfers			
Alberta Cancer Prevention Legacy Fund	$ 25,000	$ 23,000	$ 25,000
Alberta Heritage Foundation for Medical Research Endowment Fund	71,280	55,160	91,386
	96,280	78,160	116,386
Federal Government Transfers			
Canada Health Transfer	3,966,890	4,013,942	3,601,124
Other	2,398	2,347	2,451
	3,969,288	4,016,289	3,603,575
Premiums, Fees and Licences			
Supplementary Health Benefit Premiums	48,000	46,543	47,753
Other	1	2	2
	48,001	46,545	47,755
Other Revenue			
Third Party Recoveries	109,340	129,056	114,247
Previous years' refunds of expenditure	4,000	36,254	24,148
Miscellaneous	63,177	118,910	78,967
	176,517	284,220	217,362
	$ 4,290,086	$ 4,425,214	$ 3,985,078

Schedule to Financial Statements

Year Ended March 31, 2016

SCHEDULE 2

Credit or Recovery

(in thousands)

	2016				
	Authorized	Actual Revenue Recognized	Deferred Revenue	Actual Revenue Received / Receivable	(Shortfall) / Excess
Support Programs					
Other Support Programs [a]	$ 1,000	$ -	$ -	$ -	$ (1,000)
	$ 1,000	$ -	$ -	$ -	$ (1,000)

[a] The Department receives funding from Health Canada to enhance existing health services to persons with chronic Hepatitis C virus infection.

Schedule to Financial Statements

Year Ended March 31, 2016

SCHEDULE 3

Expenses - Directly Incurred Detailed by Object

(in thousands)

	2016		2015
	Budget	Actual	Actual
Grants	$ 18,400,122	$ 18,455,362	$ 17,791,898
Supplies and Services	126,857	105,554	119,968
Salaries, Wages and Employee Benefits	114,798	100,625	104,070
Amortization of Tangible Capital Assets	18,750	19,182	19,995
Consumption of Inventories of Supplies	57,700	59,803	55,481
Other	2,110	6,005	5,156
	$ 18,720,337	$ 18,746,531	$ 18,096,568

Schedule to Financial Statements

Year Ended March 31, 2016

SCHEDULE 4

Lapse/Encumbrance

(in thousands)

Program - Operating Expense	Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
1 Ministry Support Services						
1.1 Minister's Office	$ 844	$ -	$ -	$ 844	$ 795	$ 49
1.2 Associate Minister's Office	-	-	-	-	43	(43)
1.3 Deputy Minister's Office	1,326	-	-	1,326	1,322	4
1.4 Communications	3,623	-	-	3,623	3,930	(307)
1.5 Strategic Corporate Support	49,594	-	-	49,594	43,669	5,925
1.6 Policy Development and Strategic Support	22,862	-	-	22,862	17,336	5,526
1.7 Health Advocates' Office	1,720	-	-	1,720	1,335	385
1.8 Health System Projects	4,000	-	-	4,000	2,325	1,675
Sub-Total	83,969	-	-	83,969	70,755	13,214
2 Alberta Health Services						
2.1 Acute Care Services	4,341,751	-	-	4,341,751	4,341,751	-
2.2 Facility and Home-Based Continuing Care Services	1,378,046	-	-	1,378,046	1,378,046	-
2.3 Community and Population Health Services	1,296,548	-	-	1,296,548	1,296,548	-
2.4 Diagnostic and Therapeutic Services	2,126,707	-	-	2,126,707	2,126,707	-
2.5 Support Services	2,186,798	-	-	2,186,798	2,186,798	-
Sub-Total	11,329,850	-	-	11,329,850	11,329,850	-
3 Physician Compensation and Development						
3.1 Program Support	9,275	-	-	9,275	8,096	1,179
3.2 Primary Care Physician Remuneration	1,396,527	-	-	1,396,527	1,390,414	6,113
3.3 Specialist Physician Remuneration	2,391,644	-	-	2,391,644	2,432,884	(41,240)
3.4 Physician Development	175,058	-	-	175,058	173,074	1,984
3.5 Physician Benefits	374,759	-	-	374,759	388,947	(14,188)
Sub-Total	4,347,263	-	-	4,347,263	4,393,415	(46,152)

Schedule to Financial Statements

Year Ended March 31, 2016

SCHEDULE 4 (Cont'd)

Lapse/Encumbrance

(in thousands)

Program - Operating Expense	Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
4 Primary Health Care/Addictions and Mental Health						
4.1 Program Support	$ 6,749	$ -	$ -	$ 6,749	$ 4,474	$ 2,275
4.2 Family Care Clinics	5,000	-	-	5,000	176	4,824
4.3 Primary Care Networks	168,005	-	-	168,005	168,172	(167)
4.4 Addictions and Mental Health	100,530	-	-	100,530	100,129	401
Sub-Total	280,284	-	-	280,284	272,951	7,333
5 Continuing Care Initiatives	27,000	-	-	27,000	24,181	2,819
6 Alberta Innovates - Health Solutions	71,280	-	-	71,280	55,160	16,120
7 Allied Health Services	92,845	-	-	92,845	92,260	585
8 Human Tissue and Blood Services	184,680	-	-	184,680	192,093	(7,413)
9 Drugs and Supplemental Health Benefits						
9.1 Program Support	36,129	-	-	36,129	37,786	(1,657)
9.2 Outpatient Cancer Therapy Drugs	162,109	-	-	162,109	159,281	2,828
9.3 Outpatient Specialized High Cost Drugs	127,440	-	-	127,440	121,120	6,320
9.4 Seniors Drug Benefits	557,989	-	-	557,989	557,923	66
9.5 Seniors Dental, Optical and Supplemental Health Benefits	121,503	-	-	121,503	116,751	4,752
9.6 Non-Group Drug Benefits	197,198	-	-	197,198	231,537	(34,339)
9.7 Non-Group Supplemental Health Benefits	800	-	-	800	884	(84)
9.8 Assured Income for the Severely Handicapped Health Benefit	221,412	-	-	221,412	231,816	(10,404)
9.9 Child Health Benefit	28,234	-	-	28,234	28,800	(566)
9.10 Adult Health Benefit	153,824	-	-	153,824	171,859	(18,035)
9.11 Alberta Aids to Daily Living	142,000	-	-	142,000	142,465	(465)
9.12 Pharmaceutical Innovation and Management	45,820	-	-	45,820	52,443	(6,623)
Sub-Total	1,794,458	-	-	1,794,458	1,852,665	(58,207)

Schedule to Financial Statements

Year Ended March 31, 2016

SCHEDULE 4 (Cont'd)

Lapse/Encumbrance

(in thousands)

Program - Operating Expense	Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
10 Community Programs and Healthy Living						
10.1 Program Support	$ 17,470	$ -	$ -	$ 17,470	$ 14,984	$ 2,486
10.2 Immunization Support	6,967	-	-	6,967	6,648	319
10.3 Insulin Pump Therapy Program	10,500	-	-	10,500	12,573	(2,073)
10.4 Community-Based Health Services	45,171	-	-	45,171	29,998	15,173
Sub-Total	80,108	-	-	80,108	64,203	15,905
11 Support Programs						
11.1 Program Support	10,664	-	-	10,664	10,108	556
11.2 Out of Province Health Care Services	134,357	-	-	134,357	137,727	(3,370)
11.3 Health Services Provided in Correctional Facilities	33,575	-	-	33,575	31,273	2,302
11.4 Health Quality Council of Alberta	6,611	-	-	6,611	6,611	-
11.5 Protection for Persons in Care	2,349	-	-	2,349	1,368	981
11.6 Monitoring, Investigations and Licensing	7,900	-	-	7,900	6,490	1,410
11.7 Other Support Programs	12,164	-	-	12,164	10,193	1,971
Sub-Total	207,620	-	-	207,620	203,770	3,850
12 Information Systems						
12.1 Program Support	7,682	-	-	7,682	6,224	1,458
12.2 Development and Operations	69,961	-	-	69,961	50,774	19,187
Sub-Total	77,643	-	-	77,643	56,998	20,645

Schedule to Financial Statements

Year Ended March 31, 2016

SCHEDULE 4 (Cont'd)

Lapse/Encumbrance

(in thousands)

Program - Operating Expense	Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
14 Cancer Research and Prevention Investment	$ 25,000	$ -	$ -	$ 25,000	$ 23,000	$ 2,000
Credit or Recovery (Shortfall) (Schedule 2)	-	-	(1,000)	(1,000)	-	(1,000)
Total	$ 18,602,000	$ -	$ (1,000)	$ 18,601,000	$ 18,631,301	$ (30,301)
Lapse/(Encumbrance)						$ (30,301)
Program - Capital						
12 Information Systems						
12.2 Development and Operations	$ 24,700	$ -	$ -	$ 24,700	$ 11,414	$ 13,286
13 Infrastructure Support						
13.1 External Information Systems Development	16,387	-	-	16,387	7,120	9,267
13.2 Medical Equipment Replacement and Upgrade Program	23,500	-	-	23,500	23,387	113
Total	$ 64,587	$ -	$ -	$ 64,587	$ 41,921	$ 22,666
Lapse/(Encumbrance)						$ 22,666

Schedule to Financial Statements

Year Ended March 31, 2016

SCHEDULE 4 (Cont'd)

Lapse/Encumbrance

(in thousands)

	Voted Estimate [1]	Supplementary Estimate	Adjustments [2]	Adjusted Voted Estimate	Voted Actuals [3]	Unexpended / (Over Expended)
Program - Financial						
9 Drugs and Supplemental Health Benefits						
9.3 Outpatient Specialized High Cost Drugs	$ 8,900	$ -	$ (1,959)	$ 6,941	$ 7,144	$ (203)
10 Community Programs and Healthy Living						
10.2 Immunization Support	55,500	-	(3,295)	52,205	51,413	792
Total	$ 64,400	$ -	$ (5,254)	$ 59,146	$ 58,557	$ 589
Lapse/(Encumbrance)						$ 589

[1] As per "Expense Vote by Program", "Capital Investment Vote by Program" and "Financial Transactions Vote by Program" page 136 to 138 of 2015-16 Government Estimates.

[2] Adjustments include encumbrances, capital carryforward amounts and credit or recovery increases approved by Treasury Board Committee and credit or recovery shortfalls. An encumbrance is incurred when, on a vote by vote basis, the total of actual disbursements in the prior year exceed the total adjusted estimate. All calculated encumbrances from the prior year are reflected as an adjustment to reduce the corresponding voted estimate in the current year.

[3] Actuals exclude non-voted amounts such as amortization, inventory consumption, and valuation adjustments.

Schedule to Financial Statements

Year Ended March 31, 2016

SCHEDULE 5

Lottery Fund Estimates

(in thousands)

	Lottery Fund Estimates	Actual	Unexpended (Over Expended)
Alberta Health Services			
- Community and Population Health Services	$ 757,992	$ 757,992	$ -
	$ 757,992	$ 757,992	$ -

This table shows details of the initiatives within the department that are funded by the Lottery Fund and compares it to the actual results.

Schedule to Financial Statements

Year Ended March 31, 2016

SCHEDULE 6

Salary and Benefits Disclosure

(in dollars)

	2016				2015
	Base Salary [1]	Other Cash Benefits [2]	Other Non-cash Benefits [3]	Total	Total
Deputy Minister [4][5]	$ 409,748	$ 85,802	$ 2,533	$ 498,083	$ 607,851
Chief Delivery Officer [6]	-	-	-	-	272,394
Executives - Assistant Deputy Ministers					
Financial and Corporate Services	222,141	-	60,285	282,426	266,396
Health Information Technology and Systems [7]	183,447	29,801	48,744	261,992	226,919
Health Services [8]	153,201	99,892	40,180	293,273	262,513
Health System Accountability and Performance	195,105	-	49,942	245,047	230,155
Professional Services and Health Benefits	186,842	-	48,534	235,376	215,045
Strategic Planning and Policy Development	213,616	-	58,960	272,576	251,252
Executives - Other					
Executive Director, Human Resources	147,102	100	39,379	186,581	173,296

[1] Base salary includes regular salary and earnings such as acting pay.

[2] Other cash benefits include vacation payouts, lump sum payments, and automobile allowances. Included in other cash benefits is severance of $94,499 paid as a result of termination agreement. There were no bonuses paid in 2016.

[3] Other non-cash benefits include government's share of all employee benefits and contributions or payments made on behalf of employees including pension, supplementary retirement plan, health care, dental coverage, group life insurance, short and long-term disability plans, professional memberships and tuition fees.

[4] Automobile provided to the previous incumbent, no dollar amount included in other non-cash benefits.

[5] The position was occupied by two individuals at different times during the year. The current incumbent was appointed to the position effective August 4, 2015 under an arrangement between the University of Alberta (incumbent's employer) and the Department. Salary and benefits to the incumbent are being paid by the University and reimbursed by the Department. The amount paid to the University for the period is $262,240 which is allocated between base salary and other cash benefits.

[6] The previous incumbent was temporarily assigned to a working group with the Department of Treasury Board and Finance since April 1, 2015 and effective December 1, 2015 the position was abolished.

[7] This position was occupied by two individuals at different times during the year. The current incumbent is in an acting capacity effective November 2, 2015.

[8] This position was occupied by three individuals at different times during the year. The first incumbent was in office until November 6, 2015. The incumbent from Financial and Corporate Services was in an acting capacity during the interim until February 5, 2016 when the current incumbent was appointed.

Schedule to Financial Statements

Year Ended March 31, 2016

SCHEDULE 7

Related Party Transactions

(in thousands)

Related parties are those entities consolidated or accounted for on the modified equity basis in the Government of Alberta's financial statements. Related parties also include key management personnel in the department. Entities in the Ministry include AHS, HQCA, and AIHS.

The Department and its employees paid or collected certain taxes and fees set by regulation for permits, licences and other charges. These amounts were incurred in the normal course of business, reflect charges applicable to all users, and have been excluded from this schedule.

The Department had the following transactions with related parties recorded on the Statement of Operations and the Statement of Financial Position at the amount of consideration agreed upon between the related parties.

	Entities in the Ministry		Other Entities	
	2016	2015	2016	2015 (Restated)
Revenues				
Grants	$ -	$ -	$ 78,160	$ 116,386
Other	3,812	2,027	508	66
	$ 3,812	$ 2,027	$ 78,668	$ 116,452
Expenses - Directly Incurred				
Grants [1]	$ 12,386,954	$ 12,250,115	$ 232,638	$ 222,534
Other Services	1,309	-	11,335	10,602
	$ 12,388,263	$ 12,250,115	$ 243,973	$ 233,136
Receivable from	$ 287	$ 88	$ 3	$ 9
Payable to	$ 72,515	$ 49,888	$ 4,904	$ 5,004
Contractual Obligations	$ 100,747	$ 457,397	$ 15,394	$ 41,598

[1] The grants paid to AHS include amounts that are separately reported on the Statement of Operations.

The Department also had the following transactions with related parties for which no consideration was exchanged. The amounts for these related party transactions are estimated based on the costs incurred by the service provider to provide the service. These amounts are not recorded in the financial statements but are disclosed in Schedule 8.

	Entities in the Ministry		Other Entities	
	2016	2015	2016	2015
Expenses - Incurred by Others				
Accommodation	$ -	$ -	$ 12,304	$ 11,594
Legal Services	-	-	4,591	4,792
Business Services	-	-	8,576	9,132
	$ -	$ -	$ 25,471	$ 25,518

Schedule to Financial Statements

Year Ended March 31, 2016

SCHEDULE 8
Allocated Costs

(in thousands)

	2016					2015
		Expenses - Incurred by Others				
	Expenses [1]	Accommodation Costs [2]	Legal Services [3]	Business Services [4]	Total	Total
Ministry Support Services	$ 70,737	$ 12,304	$ 4,591	$ 8,576	$ 96,208	$ 98,927
Alberta Health Services	11,329,850	-	-	-	11,329,850	11,212,618
Physician Compensation and Development	4,396,348	-	-	-	4,396,348	4,008,745
Primary Health Care/Addictions and Mental Health	272,951	-	-	-	272,951	309,337
Continuing Care Initiatives	24,181	-	-	-	24,181	26,861
Alberta Innovates - Health Solutions	55,160	-	-	-	55,160	91,386
Allied Health Services	92,260	-	-	-	92,260	82,832
Human Tissue and Blood Services	192,093	-	-	-	192,093	161,916
Drugs and Supplemental Health Benefits	1,861,545	-	-	-	1,861,545	1,655,043
Community Programs and Healthy Living	118,118	-	-	-	118,118	124,633
Support Programs	203,770	-	-	-	203,770	199,140
Information Systems	76,011	-	-	-	76,011	96,008
Infrastructure Support	30,507	-	-	-	30,507	13,272
Cancer Research and Prevention Investment	23,000	-	-	-	23,000	25,000
2013 Alberta Flooding	-	-	-	-	-	16,368
	$ 18,746,531	$ 12,304	$ 4,591	$ 8,576	$ 18,772,002	$ 18,122,086

[1] Expenses - Directly Incurred as per Statement of Operations.

[2] Costs shown for Accommodation (includes grants in lieu of taxes) on Schedule 7.

[3] Costs shown for Legal Services on Schedule 7.

[4] Costs shown for Business Services on Schedule 7 include charges for IT support, vehicles, internal audit services and other services.

FINANCIAL INFORMATION
Alberta Health Services

Consolidated Financial Statements

March 31, 2016

CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2016

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying consolidated financial statements for the year ended March 31, 2016 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Public Sector Accounting Standards and the financial directives issued by Alberta Health, and of necessity include some amounts based on estimates and judgment.

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

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

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

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

Original signed by

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

Original signed by

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

June 3, 2016

Independent Auditor's Report

To the Minister of Health

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of Alberta Health Services, which comprise the consolidated statement of financial position as at March 31, 2016, the consolidated statements of operations, remeasurement gains and losses, change in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Alberta Health Services as at March 31, 2016, and the results of its operations, its remeasurement gains and losses, its changes in net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

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

Auditor General

June 3, 2016

Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS
YEAR ENDED MARCH 31

	2016		2015
	Budget (Note 3)	Actual	Actual (Schedule 3)
Revenue:			
Alberta Health transfers			
Base operating	$ 11,330,000	$ 11,329,851	$ 10,851,204
Other operating	1,110,000	1,064,739	1,378,438
Capital	84,000	84,716	92,907
Other government transfers (Note 4)	416,000	416,554	420,599
Fees and charges	507,000	491,487	472,389
Ancillary operations	132,000	133,220	133,118
Donations, fundraising, and non-government contributions (Note 5)	166,000	163,221	167,290
Investment and other income (Note 6)	208,000	267,931	308,308
TOTAL REVENUE	**13,953,000**	**13,951,719**	**13,824,253**
Expenses:			
Inpatient acute nursing services	3,157,000	3,268,711	3,213,808
Emergency and other outpatient services	1,619,000	1,635,271	1,586,065
Facility-based continuing care services	1,047,000	1,035,366	1,005,796
Ambulance services	468,000	478,068	475,430
Community-based care	1,222,000	1,205,926	1,138,026
Home care	542,000	567,657	535,617
Diagnostic and therapeutic services	2,248,000	2,274,271	2,234,862
Promotion, prevention, and protection services	379,000	363,149	360,911
Research and education	240,000	224,316	235,411
Administration (Note 7)	454,000	426,264	448,030
Information technology	566,000	565,158	568,861
Support services (Note 8)	2,011,000	2,055,706	2,023,940
TOTAL EXPENSES (Schedule 1)	**13,953,000**	**14,099,863**	**13,826,757**
ANNUAL OPERATING SURPLUS (DEFICIT)	**-**	**(148,144)**	**(2,504)**
Endowment contributions and reinvested income	-	3,585	3,585
ANNUAL SURPLUS (DEFICIT)	**$ -**	**$ (144,559)**	**$ 1,081**
Accumulated surplus, beginning of year		1,303,682	1,302,601
Accumulated surplus, end of year (Note 19)		**$ 1,159,123**	**$ 1,303,682**

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

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31

	2016 Actual	2015 Actual (Schedule 3)
Financial Assets:		
Cash	$ 79,867	$ 331,847
Portfolio investments (Note 10)	2,187,506	2,173,493
Accounts receivable (Note 11)	393,493	313,972
Other assets	11,826	12,179
	2,672,692	2,831,491
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,236,312	1,273,899
Employee future benefits (Note 13)	620,687	594,603
Unexpended deferred operating revenue (Note 14)	429,515	491,254
Unexpended deferred capital revenue (Note 15)	148,319	178,078
Debt (Note 17)	326,909	321,831
	2,761,742	2,859,665
NET DEBT	**(89,050)**	**(28,174)**
Non-Financial Assets:		
Tangible capital assets (Note 18)	7,573,071	7,511,137
Inventories for consumption	94,439	96,583
Prepaid expenses	116,117	126,610
	7,783,627	7,734,330
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	7,694,577	7,706,156
Expended deferred capital revenue (Note 16)	6,530,432	6,363,699
NET ASSETS	**1,164,145**	**1,342,457**
Net Assets is comprised of:		
Accumulated surplus (Note 19)	1,159,123	1,303,682
Accumulated remeasurement gains and losses	5,022	38,775
	$ 1,164,145	**$ 1,342,457**

Contractual Obligations and Contingent Liabilities (Note 20)

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

Approved by the Board of Directors:

Original signed by

Linda Hughes
Board Chair

Original signed by

David Carpenter, FCPA, FCA
Audit & Risk Committee Chair

CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT
YEAR ENDED MARCH 31

	2016		2015
	Budget (Note 3)	Actual	Actual
Annual surplus (deficit)	$ -	$ (144,559)	$ 1,081
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets (Note 18)	(940,000)	(650,785)	(642,235)
Amortization, disposals and write-downs of tangible capital assets (Note 18)	618,000	588,851	633,593
Effect of other changes:			
Net increase in expended deferred capital revenue	290,000	166,733	87,230
Net (increase) decrease in inventories for consumption	(1,000)	2,144	1,669
Net (increase) decrease in prepaid expense	10,000	10,493	(20,211)
Net (increase) decrease in remeasurement gains (losses)	(16,000)	(33,753)	13,929
(Increase) decrease in net debt	**(39,000)**	**(60,876)**	**75,056**
Net debt, beginning of year	(28,000)	(28,174)	(103,230)
Net debt, end of year	**$ (67,000)**	**$ (89,050)**	**$ (28,174)**

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

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEAR ENDED MARCH 31		
	2016 Actual	2015 Actual
Accumulated remeasurement gains, beginning of year	$ 38,775	$ 24,846
Unrestricted unrealized net gains (losses) on portfolio investments	(18,705)	43,724
Amounts reclassified to the Consolidated Statement of Operations related to portfolio investments	(15,048)	(29,795)
Net remeasurement gains (losses) for the year	**(33,753)**	**13,929**
Accumulated remeasurement gains, end of year (Note 10)	**$ 5,022**	**$ 38,775**

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

CONSOLIDATED STATEMENT OF CASH FLOWS
YEAR ENDED MARCH 31

	2016 Actual	2015 Actual (Schedule 3)
Operating transactions:		
Annual surplus (deficit)	$ (144,559)	$ 1,081
Non-cash items:		
Amortization, disposals, and write-downs	588,851	633,593
Recognition of expended deferred capital revenue	(394,294)	(427,506)
Decrease (increase) in:		
Accounts receivable related to operating transactions	(49,250)	72,533
Inventories for consumption	2,144	1,669
Other assets	353	(575)
Prepaid expenses	10,493	(20,211)
Increase (decrease) in:		
Accounts payable and accrued liabilities related to operating transactions	(39,564)	85,372
Employee future benefits	26,084	40,071
Deferred revenue related to operating transactions	(80,367)	(74,491)
Cash provided by (applied to) operating transactions	(80,109)	311,536
Capital transactions:		
Acquisition of tangible capital assets	(233,213)	(229,734)
Increase (decrease) in accounts payable and accrued liabilities related to capital transactions	(6,434)	(31,797)
Cash provided by (applied to) capital transactions	(239,647)	(261,531)
Investing transactions:		
Purchase of portfolio investments	(4,230,911)	(4,203,953)
Proceeds on disposals of portfolio investments	4,133,948	4,291,898
Cash provided by (applied to) investing transactions	(96,963)	87,945
Financing transactions:		
Restricted capital revenue received	164,359	96,977
Restricted capital revenue returned	(4,698)	(14,119)
Proceeds from debt	20,300	5,000
Principal payments on debt	(15,222)	(14,535)
Cash provided by (applied to) financing transactions	164,739	73,323
Net increase (decrease) in cash	**(251,980)**	**211,273**
Cash, beginning of year	331,847	120,574
Cash, end of year	**$ 79,867**	**$ 331,847**

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2016

Note 1 Authority, Purpose and Operations

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

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

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

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

The AHS consolidated financial statements include the revenue and expenses associated with its responsibilities. These consolidated financial statements do not reflect the complete costs of provincial health care. For example, the Department of Health is responsible for paying most physician fees. For a complete picture of the costs of provincial healthcare, readers should consult the consolidated financial statements of the Government of Alberta (GOA).

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

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

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

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

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

(i) Controlled Entities

The consolidated financial statements reflect the assets, liabilities, revenues, and expenses of the following entities which are controlled by AHS:

Wholly Owned Subsidiaries:

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Foundations:

Airdrie Health Foundation
Alberta Cancer Foundation (ACF)
Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Calgary Health Trust (CHT)
Canmore and Area Health Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Trust
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation
Grimshaw/Berwyn Hospital Foundation
Jasper Health Care Foundation
Lac La Biche Regional Health Foundation *(effective September 2015)*
Lacombe Hospital and Care Centre Foundation
Medicine Hat and District Health Foundation
Mental Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Peace River and District Health Foundation
Ponoka and District Health Foundation
Stettler Health Services Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Two Hills Health Centre Foundation *(effective December 2014)*
Vermillion and Region Health and Wellness Foundation *(inactive)*
Viking Health Foundation
Vulcan County Health and Wellness Foundation
Windy Slopes Health Foundation

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

AHS consolidates its interest in the LPIP. AHS has the majority of representation on the LPIP's governance board and is therefore considered to control the LPIP. The main purpose of the LPIP is to share the risks of general and professional liability to lessen the impact on any one subscriber.

Other:

Queen Elizabeth II Hospital Child Care Centre

(ii) Government Partnerships

AHS uses the proportionate consolidation method to account for its 50% interest in the Primary Care Network (PCN) government partnerships with physician groups, its 50% interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta, and its 30% interest in the HUTV Limited Partnership (HUTV) with David Chittick Management Ltd., (Note 22).

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

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

(iii) Other

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

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

Adjustments are made for consolidated entities whose fiscal year-end are different from AHS' fiscal year end. This only consists of LPIP with a fiscal year-end of December 31, 2015.

(b) Revenue Recognition

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

(i) Government Transfers

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

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

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

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

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

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

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

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

(iii) Transfers and Donations of or for Land

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

(iv) Endowments

Endowments are included in Financial Assets and Accumulated Surplus in the Consolidated Statement of Financial Position. Endowments contributions and associated investment income are recognized in the Consolidated Statement of Operations in the period in which they are received. Donors have placed restrictions on their contribution to the endowment funds.

All unrealized gains and losses attributable to endowments are recognized as an increase or decrease in deferred revenue. Realized gains and losses on portfolio investments attributable to endowments are recognized as increases or decreases in deferred revenue when received or receivable and are subsequently recognized in the Consolidated Statement of Operations when the terms of use are met, as stipulated by the donors.

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

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

(vi) Investment Income

Investment income includes dividend and interest income, and realized gains or losses on the sale of portfolio investments. Unrealized gains and losses on portfolio investments that are not from restricted transfers or donations are recognized in the Consolidated Statement of Remeasurement Gains and Losses until the related investments are sold. Once realized, these gains or losses are recognized in the Consolidated Statement of Operations. Investment income and unrealized gains and losses that are from restricted transfers or donations are allocated to the respective transfer or donation balances according to the provisions within the individual agreements.

(c) Expenses

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

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(d) Financial Instruments

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

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

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

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

AHS measures and recognizes embedded derivatives separately from the host contract when the economic characteristics and risk of the embedded derivative are not closely related to those of the host contract, when it meets the definition of a derivative and, when the entire contract is not measured at fair value. Embedded derivatives are recorded at fair value. For the year ended March 31, 2016, AHS has no embedded derivatives that require separation from the host contract.

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

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

Transaction costs associated with the acquisition and disposal of 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

Cash is comprised of cash on hand and demand deposits.

(f) Inventories For Consumption

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

(g) Tangible Capital Assets

Tangible capital assets and work in progress are recorded at cost, which includes amounts that are directly related to the acquisition, design, construction, development, improvement, or betterment of the assets. Cost includes overhead directly attributable to construction and development as well as interest costs that are directly attributable to the acquisition or construction of the asset. Contributed tangible capital assets and work in progress acquired from other government organizations and other entities are recorded at their fair value on the date of donation. When AHS cannot determine the fair value, in-kind contributions are recorded at a nominal value. Costs incurred by Alberta Infrastructure (AI) to build tangible capital assets on behalf of AHS are recorded by AHS as work in progress and expended deferred capital revenue as AI incurs costs.

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

	Useful Life
Facilities and improvements	10-40 years
Equipment	3-20 years
Information systems	3-5 years
Leased vehicles, facilities and improvements	Term of lease
Building service equipment	5-40 years
Land improvements	5-40 years

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

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

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

(h) Employee Future Benefits

(i) Registered Benefit Pension Plans

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

(ii) Other Defined Contribution Pension Plans

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

(iii) Supplemental Executive Retirement Plans (SERPs)

AHS sponsors SERPs, which are funded, and has three Retirement Compensation Arrangements (RCA) for these plans. The SERPs cover certain employees and supplement the benefits under AHS' registered plans that are limited by the Income Tax Act (Canada). Each plan was closed to new entrants effective April 1, 2009. SERPs provide future pension benefits to participants based on years of service and earnings.

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

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

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

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

(iv) Supplemental Pension Plan (SPP)

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

(v) Sick Leave Liability

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

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

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

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

(vi) Other Benefits

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

(i) Liability for Contaminated Sites

Contaminated sites are a result of contamination being introduced into air, soil, water, or sediment of a chemical, organic or radioactive material or live organism that exceeds an environmental standard. The liability is recorded net of any expected recoveries. 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.

(j) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. The amount recorded for amortization of tangible capital assets is based on the estimated useful life of the related assets while the recognition of expended deferred capital revenue depends on when the terms for the use of the funding are met and, when applicable, AHS complies with its communicated use of the funding. The amounts recorded for employee future benefits are based on estimated future cash flows. The provision for unpaid claims, allowance for doubtful accounts and accrued liabilities are subject to significant management estimates and assumptions. These estimates and assumptions are reviewed at least annually. Actual results could differ from the estimates determined by management in these consolidated financial statements, and these differences, which may be material, could require adjustment in subsequent reporting periods.

The establishment of the provision for unpaid claims relies on the judgment and opinions of many individuals; historical precedent and trends; prevailing legal, economic, and social and regulatory trends; and expectation as to future developments. The process of determining the provision necessarily involves risks that the actual results will deviate perhaps materially from the best estimates made.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(k) Internally Restricted Surplus for Future Purposes

Certain amounts, as approved by the AHS Board, are set aside in accumulated surplus for future operating and capital purposes. Transfers to or from internally restricted surplus for future purposes are recorded to the respective reserved surplus when approved.

(l) Changes in Accounting Policy

Adoption of the Net Debt Presentation

The net debt model (with reclassification of comparatives) has been adopted for the presentation of financial statements. Net debt is measured as the difference between AHS' financial assets and liabilities.

The effect of this change has resulted in a change in the presentation of the Consolidated Statement of Financial Position and the inclusion of the Consolidated Statement of Change in Net Debt. The impact of this change on the Consolidated Statement of Financial Position is presented in Schedule 3.

Endowment Contributions and Reinvested Income

Effective April 1, 2015, endowment contributions are recognized in the Consolidated Statement of Operations in the period in which they are received. In prior years, such transactions were recognized as direct increases to endowments on the Consolidated Statement of Financial Position in the period they were received. This change in accounting policy has been applied retroactively with restatement of comparative financial information presented in Schedule 3.

(m) Future Accounting Changes

During fiscal 2015-16 the Public Sector Accounting Board issued the following accounting standards:

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

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

Note 3 Budget

The AHS Health Plan and Business Plan 2015-18, which included the 2015-16 annual budget, was approved by the Minister of Health on January 19, 2016. Subsequently, reclassification adjustments were made to the originally approved budget in order to align with the presentation of current year results. Refer to Schedule 3.

Note 4 Other Government Transfers

	2016	2015
Unrestricted operating	$ 60,272	$ 52,760
Restricted operating	88,192	82,578
Restricted capital	268,090	285,261
	$ 416,554	**$ 420,599**

Other government transfers include $409,882 (2015 – $414,442) transferred from the GOA and $6,672 (2015 – $6,157) from the federal government, and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

Note 5 Donations, Fundraising, and Non-Government Contributions

	2016	2015
Unrestricted operating	$ 2,622	$ 4,230
Restricted operating	119,111	113,722
Restricted capital	41,488	49,338
	$ 163,221	**$ 167,290**

Note 6 Investment and Other Income

	2016	2015
Investment income	$ 84,900	$ 98,841
Other income:		
External recoveries from the GOA (Note 21)	38,422	43,809
Other revenue	144,609	165,658
	$ 267,931	**$ 308,308**

Other revenue includes revenue related to administrative services provided to other organizations of $10,906 (2015 – $11,978) (Note 7).

Note 7 Administration

	2016	2015
General administration[a]	$ 222,884	$ 228,640
Human resources[b]	91,278	99,325
Finance[c]	61,872	65,187
Communications[d]	12,596	16,492
Direct administration expense incurred by AHS	388,630	409,644
Administration expense of full-spectrum contracted health service providers)[e]	37,634	38,386
Total administration expense	**426,264**	**448,030**
Less revenue related to administrative services provided to other organizations (Note 6)	(10,906)	(11,978)
Net administration expense	**$ 415,358**	**$ 436,052**

Net administration expense has been presented to align with the Canadian Institute of Health Information (CIHI) definition. Activities and costs directly supporting clinical activities are not included in administration.

Note 7 Administration (continued)

The following are the direct administration expenses incurred by AHS:

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

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

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

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

In addition, AHS recognizes the following indirect costs as administration expense:

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

Note 8 Support Services

	2016	2015
Facilities operations	$ 814,993	$ 831,756
Patient: health records, food services, and transportation	373,682	346,648
Materials management	214,422	180,568
Housekeeping, laundry, and linen	192,341	192,280
Support services expense of full-spectrum contracted health service providers	143,701	150,623
Ancillary operations	110,389	110,889
Fundraising expenses and grants awarded	48,028	38,682
Emergency preparedness services	4,353	3,992
Other	153,797	168,502
	$ 2,055,706	**$ 2,023,940**

Note 9 Financial Instruments

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

(a) Market Risk

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

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

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

The LPIP Investment Policy has established an asset mix policy of 80% to 87% for cash and fixed income securities, 10% to 15% for equities, and 3% to 5% for real estate.

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

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

Note 9 Financial Instruments (continued)

AHS assesses the sensitivity of its portfolio to market risk based on historical volatility of equity and fixed income markets. The volatility is determined using a ten year average based on fixed income and equity market fluctuations and is applied to the total portfolio. Based on the volatility average of 2.69% (2015 – 2.55%) increase or decrease, with all other variables held constant, the increase or decrease in accumulated remeasurement gains and losses would be $45,939 (2015 – $43,297).

(b) Price Risk

Price risk relates to the possibility that equity investments will change in fair value due to future fluctuations in market prices caused by factors specific to an individual equity investment or other factors affecting all equities traded in the market. AHS is exposed to price risk associated with the underlying equity investments held in investment funds. If equity market indices (S&P/TSX, S&P1500 and MSCI ACWI and their sectors) declined by 10%, and all other variables are held constant, the potential loss in fair value to AHS would be approximately 2.11% of total investments (March 31, 2015 – 2.02%).

A 10% change in market value relating to equity securities would have increased or decreased fair value by approximately $46,236 (March 31, 2015 – $43,909).

(c) Interest Rate Risk

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

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

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

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $65,654 (March 31, 2015 – $68,803).

Portfolio investments include fixed income securities, such as bonds and money market securities, and have an average effective yield of 1.61% (2015 – 1.52%) per year maturing between 2016 and 2067. The securities have the following average maturity structure:

	2016	2015
0 – 5 years	76%	74%
6 – 10 years	13%	13%
Over 10 years	11%	13%

	Effective Market Yield			Average Effective Market Yield
Asset Class	< 1 year	1-5 years	> 5 years	
Interest bearing securities	0.69%	1.40%	2.74%	1.61%

(d) Foreign Currency Risk

Foreign currency risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates. The fair value of cash and investments denominated in foreign currencies is translated into Canadian dollars using the reporting date exchange rate. AHS is exposed to foreign exchange fluctuations on its cash denominated in foreign currencies. At March 31, 2016, there were no investment balances denominated in foreign currency. Foreign exchange fluctuations on its cash balances are partially mitigated by futures contracts and minimal ending foreign currency cash balances. During the year, the effect of these fluctuations was not significant. AHS has policies which provide management with guidance to mitigate foreign currency risk.

Foreign currency risk is managed by the fact that the investment policies limit non-Canadian equities to a maximum of 10% to 45% of the total investment portfolio, depending on the policy. At March 31, 2016, investments in non-Canadian equities represented 13.40% (March 31, 2015 – 8.60%) of total portfolio investments.

At March 31, 2016, AHS held US dollar forward contracts with ATB Financial to mitigate its exposure to currency fluctuations relating to US dollar accounts payable. As at March 31, 2016, AHS held forward contracts for future settlement of $24,000 (2015 – $24,000). The fair value of these forward contracts as at March 31, 2016 was a loss of $141 (2015 – gain of $2,310) and is included in portfolio investments (Note 10).

Note 9 Financial Instruments (continued)

(e) Credit Risk

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

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

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

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

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

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

The following table summarizes AHS' investment in debt securities by counterparty credit rating at March 31, 2016.

Credit Rating	2016	2015
Investment Grade (AAA to BBB)	90%	95%
Unrated	10%	5%
	100%	**100%**

(f) Liquidity Risk

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

Note 10 Portfolio Investments

	2016		2015	
	Fair Value	Cost	Fair Value	Cost
Cash held for investments	$ 108,650	$ 108,650	$ 100,031	$ 100,031
Interest bearing securities:				
Money market securities	139,986	139,986	119,474	119,474
Fixed income securities	1,476,511	1,466,168	1,514,894	1,476,687
	1,616,497	**1,606,154**	**1,634,368**	**1,596,161**
Equities:				
Canadian public equities	169,064	155,830	251,346	215,393
Global public equities	293,295	283,265	187,748	145,351
	462,359	**439,095**	**439,094**	**360,744**
Total portfolio investments	**$ 2,187,506**	**$ 2,153,899**	**$ 2,173,493**	**$ 2,056,936**

Included in the portfolio investments is $147,572 (March 31, 2015 – $149,727) that is restricted for use as per the requirements in Sections 99 and 100 of the Insurance Act of Alberta, based on the December 31, 2015 audited financial statements of LPIP. Endowment contributions included in portfolio investments amount to $75,966 (March 31, 2015 – $72,381).

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

	2016	2015
AHS Investment Bylaw & Policy	$ 1,752,970	$ 1,757,452
ACF Investment Policy	153,158	155,084
LPIP Investment Policy	176,610	160,292
CHT Statement of Investment Policies and Goals	104,768	100,665
	$ 2,187,506	**$ 2,173,493**

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

	2016	2015
Accumulated remeasurement gains	$ 5,022	$ 38,775
Restricted unrealized net gains attributable to endowments and portfolio investments related to unexpended deferred operating revenue (Note 14(b))	28,558	58,325
Restricted unrealized net gains attributable to and recorded in:		
Unexpended deferred capital revenue (Note 15(b))	27	10,288
Accounts payable and accrued liabilities (Note 12)	-	9,169
	$ 33,607	**$ 116,557**

Fair Value Hierarchy

	2016		
	Level 1	Level 2	Total
Cash held for investments	$ -	$ 108,650	$ 108,650
Money market securities	-	139,986	139,986
Fixed income securities	-	1,476,511	1,476,511
Equities	361,539	100,820	462,359
March 31, 2016 total amount	**$ 361,539**	**$ 1,825,967**	**$ 2,187,506**
Percent of total	17%	83%	100%

Note 10 Portfolio Investments (continued)

	2015		
	Level 1	Level 2	Total
Cash held for investments	$ -	$ 100,031	$ 100,031
Money market securities	-	119,474	119,474
Fixed income securities	-	1,514,894	1,514,894
Equities	358,251	80,843	439,094
March 31, 2015 total amount	**$ 358,251**	**$ 1,815,242**	**$ 2,173,493**
Percent of total	16%	84%	100%

Note 11 Accounts Receivable

	2016			2015
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Patient accounts receivable	$ 127,723	$ 29,091	$ 98,632	$ 100,590
AH operating transfers receivable	72,387	-	72,387	44,426
AH capital transfers receivable	-	-	-	1,200
Other operating grants receivable	20,984	-	20,984	28,683
Other capital grants receivable	116,888	-	116,888	85,417
Other accounts receivable	84,710	108	84,602	53,656
	$ 422,692	**$ 29,199**	**$ 393,493**	**$ 313,972**

At March 31, 2015, the total allowance for doubtful accounts was $28,680.

Note 12 Accounts Payable and Accrued Liabilities

	2016	2015
Payroll remittances payable and related accrued liabilities	$ 651,578	$ 680,324
Trade accounts payable and accrued liabilities[(a)]	371,670	385,667
Provision for unpaid claims[(b)]	136,378	138,525
Other liabilities	42,496	42,648
Obligation under leased tangible capital assets[(c)]	34,190	17,566
	1,236,312	**1,264,730**
Unrealized net gains on portfolio investments related to accounts payable and accrued liabilities (Note 10)	-	9,169
	$ 1,236,312	**$ 1,273,899**

(a) Trade Accounts Payable and Accrued Liabilities

Trade accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $57,445 (2015 – $62,923).

(b) Provision for Unpaid Claims

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

The provision has been estimated using the discounted value of claim liabilities using a discount rate of 1.95% (2015 – 2.15%) plus a provision for adverse deviation, based on actuarial estimation.

(c) Leased tangible capital assets

The leased tangible capital assets include a site lease with the University of Calgary and a site lease in Peace River, as well as vehicle leases.

The University of Calgary lease expires January 2028. The implicit interest rate payable on this lease is 6.50% (2015 – 6.50%). There are no renewal options, purchase options or escalation clauses related to this leased tangible capital asset.

Note 12 Accounts Payable and Accrued Liabilities (continued)

AHS entered into a lease in Peace River with a term of 20 years and options to renew for two additional terms of 5 years each. The site was occupied in March 2016. The implicit interest rate payable on this lease is 3.4% (2015 – nil).

AHS is contractually committed to future capital lease payments for vehicles until 2020. The implicit interest rate payable on these leases is 1.38% (2015 – 1.60%).

AHS is committed to making payments for leased tangible capital assets as follows:

Year ended March 31	Minimum Lease Payments
2017	$ 5,043
2018	3,522
2019	3,061
2020	2,932
2021	2,694
Thereafter	29,963
	47,215
Less: interest	(13,025)
	$ 34,190

(d) Liability for Contaminated Sites

For the fiscal year ended March 31, 2016, AHS has not identified any liability for contaminated sites (2015 – $nil).

Note 13 Employee Future Benefits

	2016	2015
Accrued vacation pay	$ 514,672	$ 493,845
Accumulating non-vesting sick leave liability[(a)]	106,015	100,758
Registered defined benefit pension plans[(b) (c)]	-	-
	$ 620,687	**$ 594,603**

(a) Accumulating Non-Vesting Sick Leave Liability

Sick leave benefits are paid by AHS; there are no employee contributions and no plan assets.

The AHS sick leave liability is based on an actuarial valuation as at March 31, 2015, and extrapolated for the year ended March 31, 2016.

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

Note 13 Employee Future Benefits (continued)

	2016	2015
Change in accrued benefit obligation and funded status		
Accrued benefit obligation and funded status, beginning of year	$ 114,979	$ 97,132
Current service cost	9,939	8,884
Interest cost	3,486	3,871
Benefits paid	(9,435)	(8,243)
Actuarial loss	-	13,335
Accrued benefit obligation and funded status, end of year	**$ 118,969**	**$ 114,979**
Reconciliation to accrued benefit liability		
Funded status – deficit	$ 118,969	$ 114,979
Unamortized net actuarial loss	(12,954)	(14,221)
Accrued benefit liability	**$ 106,015**	**$ 100,758**
Components of expense		
Current service cost	$ 9,939	$ 8,884
Interest cost	3,486	3,871
Amortization of net actuarial loss	1,267	227
Net expense	**$ 14,692**	**$ 12,982**
Assumptions		
Discount rate – beginning of year	2.90%	3.80%
Discount rate – end of year	2.90%	2.90%
Rate of compensation increase per year	2015-2016 3.21% 2016-2017 2.43% Thereafter 3.25%	2014-2015 0.25% 2015-2016 3.21% Thereafter 3.25%

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

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

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

The contribution rates were reviewed by the LAPP Board of Trustees in 2015 and are to be reviewed at least once every three years based on a report prepared by LAPP's actuary. AHS and its employees made the following contributions:

Calendar 2015		Calendar 2014	
Employer	**Employees**	**Employer**	**Employees**
$563,424	$519,561	$541,683	$500,179
11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess	11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess

AHS contributed $563,424 (2014 – $541,683) of the LAPP's total employer contributions of $1,282,937 from January 1, 2015 to December 31, 2015 (December 31, 2014 – $1,227,346).

Note 13 Employee Future Benefits (continued)

(ii) LAPP Deficit

An actuarial valuation of the LAPP was carried out as at December 31, 2014 by Mercer (Canada) Limited and these results were then extrapolated to December 31, 2015 for use in the LAPP 2015 audited financial statements. LAPP's net assets available for benefits divided by LAPP's pension obligation shows that the LAPP is 97% (2014 – 93%) funded.

	December 31, 2015	December 31, 2014
LAPP net assets available for benefits	$ 34,419,584	$ 30,790,364
LAPP pension obligation	35,343,000	33,245,000
LAPP deficiency	**$ (923,416)**	**$ (2,454,636)**

The 2016 and 2017 LAPP contribution rates are as follows:

Calendar 2017 (estimated)[i]		Calendar 2016	
Employer	**Employees**	**Employer**	**Employees**
11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess	11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess

[i] The 2017 LAPP contribution rates are estimates and subject to change.

(c) Management Employees Pension Plan (MEPP)

At December 31, 2015 the MEPP reported a surplus of $299,051 (December 31, 2014 – surplus of $75,805).

(d) Pension Expense

	2016	2015
Local Authorities Pension Plan	$ 570,438	$ 547,676
Defined contribution pension plans and group RRSPs	46,763	45,575
Supplemental Pension Plan	1,882	2,795
Supplemental Executive Retirement Plans[i]	(788)	964
Management Employees Pension Plan	668	691
	$ 618,963	**$ 597,701**

[i] AHS uses the straight line method to amortize actuarial gains and losses over the expected average remaining service life of the plan members. The SERP recovery is due to prior year unamortized net actuarial gains being recognized in 2015-16.

Note 14 Unexpended Deferred Operating Revenue

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

	2016				2015
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 203,727	$ 27,377	$ 260,150	$ 491,254	$ 499,231
Received or receivable during the year, net of repayments	1,012,325	45,744	152,918	1,210,987	1,519,601
Restricted investment income	205	2,167	4,207	6,579	7,340
Transferred from (to) unexpended deferred capital revenue	11,994	40,227	(3,826)	48,395	43,917
Recognized as revenue	(1,064,739)	(88,192)	(119,111)	(1,272,042)	(1,574,738)
Miscellaneous other revenue recognized	(204)	(10)	(25,677)	(25,891)	(26,693)
	163,308	**27,313**	**268,661**	**459,282**	**468,658**
Changes in unrealized net gain attributable to endowments and portfolio investments related to unexpended deferred operating revenue	(10,055)	(2,258)	(17,454)	(29,767)	22,596
Balance, end of year	**$ 153,253**	**$ 25,055**	**$ 251,207**	**$ 429,515**	**$ 491,254**

[(i)] The balance at March 31, 2016 for other government includes $549 of unexpended deferred operating revenue received from the federal government (March 31, 2015 – $973). The remaining balance in other government all relates to the GOA, see Note 21.

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

	2016				2015
	AH	Other Government	Donors and Non-Government	Total	Total[(i)]
Research and education	$ 18,383	$ 3,889	$ 135,876	$ 158,148	$ 148,504
Primary Care Networks	44,146	-	-	44,146	71,230
Physician revenue and alternate relationship plans	20,715	945	-	21,660	22,576
Addiction and mental health	19,314	16	-	19,330	20,049
Cancer prevention, screening and treatment	17,144	6	1,711	18,861	33,001
Long term care partnerships	-	15,479	-	15,479	13,230
Promotion, prevention and community	10,236	1,437	2,447	14,120	26,467
Emergency and outpatient services	6,756	77	4,200	11,033	8,843
Information technology	5,049	(154)	85	4,980	11,739
Continuing care and seniors health	2,748	-	52	2,800	10,019
Administration and support services	3,437	2,333	61,470	67,240	49,117
Others less than $10,000	5,302	1,025	16,833	23,160	18,154
	153,230	**25,053**	**222,674**	**400,957**	**432,929**
Unrealized net gain attributable to endowments and portfolio investments related to unexpended deferred operating revenue (Note 10)	23	2	28,533	28,558	58,325
	$ 153,253	**$ 25,055**	**$ 251,207**	**$ 429,515**	**$ 491,254**

[(i)] Certain 2015 amounts have been reclassified to conform to 2016 presentation.

Note 15 Unexpended Deferred Capital Revenue

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

	2016				2015
	AH	Other Government(i)	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 77,866	$ 9,838	$ 90,374	$ 178,078	$ 229,855
Received or receivable during the year	30,787	130,565	33,215	194,567	103,997
Transferred tangible capital assets (Note 18(a))	-	399,927	65	399,992	412,706
Restricted investment income	21	42	-	63	240
Unexpended deferred capital revenue returned	2	(2)	(4,698)	(4,698)	(14,119)
Transfer to expended deferred capital revenue	(32,697)	(489,501)	(38,829)	(561,027)	(514,736)
Transferred (to) from unexpended deferred operating revenue	(11,994)	(40,227)	3,826	(48,395)	(43,917)
	63,985	**10,642**	**83,953**	**158,580**	**174,026**
Changes in unrealized net gain on portfolio investments related to unexpended deferred capital revenue	(6,069)	(1,467)	(2,725)	(10,261)	4,052
Balance, end of year	**$ 57,916**	**$ 9,175**	**$ 81,228**	**$ 148,319**	**$ 178,078**

(i) All balances relate to the GOA, see Note 21.

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

	2016	2015
AH		
Information systems less than $10,000	$ 38,741	$ 52,587
Medical Equipment Replacement Upgrade Program	11,367	11,707
Equipment less than $10,000	7,781	7,477
Total AH	**57,889**	**71,771**
Other government		
Facilities and improvements less than $10,000	9,176	8,371
Total other government	**9,176**	**8,371**
Donors and non-government		
Equipment less than $10,000	73,918	86,995
Facilities and improvements less than $10,000	7,309	653
Total donors and non-government	**81,227**	**87,648**
Unrealized net gain on portfolio investments related to unexpended deferred capital revenue (Note 10)	27	10,288
	$ 148,319	**$ 178,078**

Note 16 Expended Deferred Capital Revenue

Expended deferred capital revenue represents external resources spent in the acquisition of tangible capital assets stipulated for use in the provision of services over their useful lives. Changes in the expended deferred capital revenue balance are as follows:

	2016				2015
	AH	Other Government(i)	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 349,831	$ 5,835,000	$ 178,868	$ 6,363,699	$ 6,276,469
Transferred from unexpended deferred capital revenue	32,697	489,501	38,829	561,027	514,736
Less: amounts recognized as revenue	(84,716)	(268,090)	(41,488)	(394,294)	(427,506)
Balance, end of year	**$ 297,812**	**$ 6,056,411**	**$ 176,209**	**$ 6,530,432**	**$ 6,363,699**

(i) All balances relate to the GOA, see Note 21.

Note 17 Debt

	2016	2015
Debentures payable[(a)]:		
Parkade loan #1	$ 34,903	$ 37,469
Parkade loan #2	32,505	34,639
Parkade loan #3	41,432	43,664
Parkade loan #4	154,086	160,585
Parkade loan #5	37,204	38,737
Parkade loan #6	25,300	5,000
Other	1,479	1,737
	$ 326,909	**$ 321,831**

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

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

	Maturity Date	Fixed Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Parkade loan #6	December 2035	3.6090%

(b) As at March 31, 2016, AHS has access to a $220,000 (March 31, 2015 – $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, 2016, AHS has $nil (March 31, 2015 – $nil) draws against this facility.

AHS also has access to a $33,000 (March 31, 2015 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2016, AHS has $3,664 (March 31, 2015 – $3,100) in a letter of credit outstanding against this facility.

AHS is committed to making payments as follows:

	Debentures Payable, Term/Other Loan and Mortgages Payable
Year ended March 31	Principal Payments
2017	$ 16,824
2018	17,612
2019	18,437
2020	19,300
2021	20,205
Thereafter	234,531
	$ 326,909

During the year, the amount of total interest expensed including leased tangible capital assets was $15,249 (2015 – $16,253).

Note 18 Tangible Capital Assets

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

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

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

(a) Transferred Tangible Capital Assets

Additions include total transferred capital assets of $399,992 (2015 – $412,706) consisting of $399,927 from AI (2015 – $412,623) and $65 from other sources (2015 – $83).

(b) Disposals and Write-Downs

Disposals and write-downs include disposals of $164,172 and a write-down at a cost of $nil (2015 – disposals of $66,439 and write-down of a facility at a cost of $450) with an effect to accumulated amortization for disposals of $163,701 and write-downs of $nil (2015 – disposals of $65,385 and write-downs of $146).

(c) Leased Equipment

Equipment includes assets acquired through capital leases at a cost of $15,694 (2015 – $17,037) with accumulated amortization of $11,859 (March 31, 2015 – $12,294). For the year ended March 31, 2016, leased equipment included a net decrease of $362 related to vehicle capital leases (2015 – net decrease of $205).

Note 18 Tangible Capital Assets (continued)

(d) Leased Land

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

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

Note 19 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2016					2015
	Unrestricted Surplus[a]	Internally Restricted Surplus for Future Purposes[b]	Invested in Tangible Capital Assets[c]	Endowments[d]	Total	Total
Balance, beginning of year	$ 272,317	$ 154,900	$ 804,084	$ 72,381	$ 1,303,682	$ 1,302,601
Annual surplus (deficit)	(144,559)	-	-	-	(144,559)	1,081
Tangible capital assets purchased with internal funds	(50,665)	-	50,665	-	-	-
Amortization of internally funded tangible capital assets	194,557	-	(194,557)	-	-	-
Repayment of debt used to fund tangible capital assets	(15,222)	-	15,222	-	-	-
Payments on capital lease obligations	(957)	-	957	-	-	-
Net repayment of life lease deposits	(56)	-	56	-	-	-
Transfer of internally restricted surplus for future purposes	(126,350)	126,350	-	-	-	-
Transfer of endowment contributions	(3,585)	-	-	3,585	-	-
Balance, end of year	**$ 125,480**	**$ 281,250**	**$ 676,427**	**$ 75,966**	**$ 1,159,123**	**$ 1,303,682**

(a) Unrestricted Surplus

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

Note 19 Accumulated Surplus (continued)

(b) Internally Restricted Surplus for Future Purposes

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

	2016	2015
Future capital purposes [(i)]	$ 102,141	$ 10,000
Parkade infrastructure [(ii)]	73,488	60,920
Insurance equity requirements [(iii)]	41,431	20,012
Provincial Clinical Information Systems initiative [(iv)]	30,158	32,000
Specific local initiatives [(v)]	17,046	15,205
Cancer research [(vi)]	14,935	16,079
Retail food services infrastructure [(vii)]	2,051	684
Internally restricted surplus for future purposes	**$ 281,250**	**$ 154,900**

(i) Restriction of unrestricted surplus related to future capital purposes.
(ii) Restriction of parking services (ancillary operation) surplus to establish parking infrastructure for future major maintenance, upgrades, and construction.
(iii) Restriction of unrestricted surplus related to equity of the LPIP.
(iv) Restriction of unrestricted surplus related to fund the Provincial Clinical Information Systems Initiative.
(v) Restriction of unrestricted surplus for specific local initiatives as a result of local fundraising.
(vi) Restriction of unrestricted surplus to fund cancer research.
(vii) Restriction of retail food services (ancillary operation) surplus to assist with future upgrades, maintenance, equipment, and construction costs for retail food service operations.

(c) Invested in Tangible Capital Assets

The restriction of accumulated surplus is equal to the net book value of internally funded tangible capital assets as these amounts are not available for any other purpose.

(d) Endowments

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

Note 20 Contractual Obligations and Contingent Liabilities

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

(a) Leases

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

Year ended March 31	Total Lease Payments
2017	$ 55,678
2018	43,842
2019	33,122
2020	26,248
2021	19,977
Thereafter	62,641
	$ 241,508

(b) Contingent Liabilities

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

Accruals have been made in specific instances where it is likely that losses will be incurred based on a reasonable estimate. As at March 31, 2016, accruals have been recorded as part of the provision for unpaid claims (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.

Note 20 Contractual Obligations and Contingent Liabilities (continued)

AHS has been named in 176 legal claims (2015 – 182 claims) related to conditions in existence at March 31, 2016 where the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 162 claims have $240,665 in specified amounts and 14 have no specified amounts (2015 – 160 claims with $283,332 of specified claims and 22 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that may be different than the claimed amount.

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

Note 21 Related Parties

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

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

Related parties also include key management personnel of AHS. Related party transactions with key management personnel primarily consist of compensation related payments to employees and senior management and are considered to be undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length. No other material related party transactions were identified for the year ended March 31, 2016.

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

	Revenue[i]		Expenses	
	2016	2015	2016	2015
Ministry of Advanced Education[ii]	$ 59,868	$ 61,789	$ 137,586	$ 131,866
Ministry of Infrastructure[iii]	340,028	339,484	24,796	24,501
Other ministries[iv]	49,096	56,978	29,814	34,091
Total for the year	**$ 448,992**	**$ 458,251**	**$ 192,196**	**$ 190,458**

	Receivable from		Payable to	
	2016	2015	2016	2015
Ministry of Advanced Education [ii]	$ 11,203	$ 8,014	$ 19,009	$ 18,204
Ministry of Infrastructure [iii]	49,688	9,370	-	88
Other ministries [iv]	11,318	13,764	329,757	325,010
Balance, end of year	**$ 72,209**	**$ 31,148**	**$ 348,766**	**$ 343,302**

(i) Revenues with GOA ministries include other government transfers of $409,882 (2015 – $414,442), (Note 4), and other income of $38,422 (2015 – $43,809), (Note 6), and fees and charges of $688 (2015 – $nil).

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

(iii) The transactions with the Ministry of Infrastructure relate to the construction and funding of tangible capital assets. These transactions include operating transfers of $47,634 (2015 – $31,093) and capital transfers recognized of $268,090 (2015 – $285,261) relating to tangible capital assets with stipulations or external restrictions to utilize over their remaining useful lives (Note 4). AHS has also recorded an in-kind transfer and expense of $24,304 (2015 – $23,130) for space that is provided by AI rent free. Transactions with AI also include the transfer of non-cash work-in-progress of $399,927 (2015 – $412,623) included in total amounts disclosed in Note 18(a).

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

At March 31, 2016, AHS has recorded deferred revenue from other ministries within the GOA, excluding AH, of $24,506 (March 31, 2015 – $26,404) related to unexpended deferred operating revenue (Note 14), $9,175 (March 31, 2015 – $9,838) related to unexpended deferred capital revenue (Note 15) and $6,056,411 (March 31, 2015 – $5,835,000) related to expended deferred capital revenue (Note 16).

Note 21 Related Parties (continued)

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

Note 22 Government Partnerships

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

	2016	2015
Financial assets	$ 122,784	$ 160,437
Liabilities	122,784	160,437
Accumulated surplus	$ -	$ -
Total revenue	$ 229,955	$ 201,229
Total expenses	229,955	201,229
Annual surplus	**$ -**	**$ -**

AHS has proportionately consolidated 50% of the results of the PCNs and NACTRC and 30% of HUTV.

As required by AH, PCNs can only use accumulated surpluses based on approved surplus utilization; therefore, AHS' proportionate share of these surpluses has been recorded by AHS as deferred revenue.

Note 23 Trusts under Administration

(a) Health Benefit Trust of Alberta (HBTA)

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

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

The HBTA maintains various reserves to adequately provide for all current obligations and reported fund balances of $97,502 as at December 31, 2015 (December 31, 2014 – $116,453). AHS has included in prepaid expenses $71,664 (March 31, 2015 – $85,593) as a share of the HBTA's fund balances representing in substance a prepayment of future premiums. These consolidated financial statements do not include the HBTA other than the premiums paid by AHS. For the period January 1 to December 31, 2015 AHS paid premiums of $311,307 (2014 – $290,440).

(b) Other Trust Funds

AHS receives funds in trust for research and development, education, and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2016, the balance of funds held in trust by AHS for research and development is $3,762 (March 31, 2015 – $6,425).

AHS receives funds in trust from continuing care residents for personal expenses. As at March 31, 2016, the balance of these funds is $1,780 (March 31, 2015 – $2,055). These amounts are not included in the consolidated financial statements.

Note 24 Subsequent Events

In early May, wildfires seriously affected the City of Fort McMurray and parts of the Regional Municipality of Wood Buffalo. In response, AHS evacuated its facilities. Preparation for re-entry is underway including restoring AHS health care facilities for service. AHS did not sustain significant structural damage to its facilities as a result of the fire. AHS is currently working with its insurers to assess the financial impact on AHS. This financial impact cannot be estimated at this time.

Note 25 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on June 3, 2016.

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

	2016		2015
	Budget (Note 3)	Actual	Actual (Schedule 3)
Salaries and benefits (Schedule 2)	$ 7,611,000	$ 7,741,667	$ 7,531,854
Contracts with health service providers	2,409,000	2,451,216	2,375,811
Contracts under the Health Care Protection Act	18,000	19,300	19,141
Drugs and gases	427,000	417,110	411,672
Medical and surgical supplies	390,000	414,053	403,626
Other contracted services	1,164,000	1,134,353	1,137,794
Other[(a)]	1,316,000	1,333,313	1,313,266
Amortization, disposals and write-downs (Note 18)	618,000	588,851	633,593
	$ 13,953,000	**$ 14,099,863**	**$ 13,826,757**
(a) Significant amounts included in Other are:			
Equipment expense		$ 208,119	$ 181,131
Other clinical supplies		149,183	141,884
Building rent		126,825	124,291
Utilities		107,608	118,766
Building and ground expenses		107,011	86,388
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies		87,497	89,054
Food and dietary supplies		80,078	76,144
Minor equipment purchases		69,436	57,484
Office supplies		58,506	62,450
Fundraising and grants awarded		54,426	58,815
Telecommunications		42,070	44,945
Travel		39,462	43,131
Licenses, fees and memberships		24,803	25,434
Insurance		24,199	48,589
Education		13,628	16,026
Other		140,462	138,734
		$ 1,333,313	**$ 1,313,266**

SCHEDULE 2 - CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2016

	2016								2015	
						Severance [e]				
	FTE[a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Number of Individuals	Amount	Total	FTE [a][1]	Total [1]
Total Board (Sub-Schedule 2A)	4.42	$ -	$ 147	$ -	$ 147	-	$ -	$ 147	-	$ -
Total Former Official Administrator / Former Advisory Committees (Sub-Schedule 2B)	4.62	124	124	-	248	-	-	248	8.72	736
Total Executive (Sub-Schedule 2C)	14.38	5,126	113	768	6,007	2	559	6,566	14.57	6,668
Management Reporting to CEO Direct Reports	54.81	12,632	179	2,492	15,303	2	295	15,598	56.27	16,123
Other Management	3,093.23	366,475	2,630	85,721	454,826	4	283	455,109	3,108.27	459,227
Medical Doctors not included above[f]	156.89	49,034	639	3,355	53,028	1	98	53,126	165.56	54,254
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	18,773.62	1,731,921	263,215	391,104	2,386,240	1	6	2,386,246	18,609.99	2,338,268
LPNs	4,691.76	307,308	42,438	67,294	417,040	-	-	417,040	4,448.03	385,469
Other Health Technical & Professional	15,964.01	1,410,394	82,606	330,737	1,823,737	14	270	1,824,007	15,687.38	1,779,324
Unregulated Health Service Providers	8,542.13	427,916	58,710	98,710	585,336	-	-	585,336	8,344.09	552,739
Other Staff	25,707.59	1,549,951	103,293	344,541	1,997,785	18	459	1,998,244	25,511.64	1,939,046
Total	**77,007.46**	**$ 5,860,881**	**$ 554,094**	**$ 1,324,722**	**$ 7,739,697**	**42**	**$ 1,970**	**$ 7,741,667**	**75,954.52**	**$ 7,531,854**

(1) Certain 2015 amounts have been reclassified to conform to 2016 presentation.

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

SUB-SCHEDULE 2A – BOARD REMUNERATION FOR THE YEAR ENDED MARCH 31, 2016

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

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

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

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

SUB-SCHEDULE 2B – FORMER OFFICIAL ADMINISTRATOR / FORMER ADVISORY COMMITTEES REMUNERATION FOR THE YEAR ENDED MARCH 31, 2016

	Term	2016 Committees	2016 Remuneration	2015 Remuneration
Former Official Administrator				
David Carpenter	Aug 25, 2015 to Nov 27, 2015	ARC, FC, HRAC, QSAC	$ 21	$ -
Dr. Carl Amrhein	Nov 17, 2014 to Aug 24, 2015	ARC, FC, HRAC, QSAC	129	186
Janet Davidson	Sep 10, 2014 to Nov 16, 2014	-	-	119
Dr. John Cowell	Sep 10, 2013 to Sep 9, 2014	-	-	295
Former Advisory Committee Participants[(i)]				
Barbara Burton	Dec 11, 2013 to Nov 26, 2015	HRAC (Chair), QSAC	25	6
Dr. Thomas Feasby	Jan 21, 2014 to Nov 26, 2015	QSAC	2	2
Martin Harvey	Dec 11, 2013 to Nov 26, 2015	HRAC	3	2
Gregory Henders	Dec 11, 2013 to Feb 13, 2015	-	-	2
Brian Olson	Sep 24, 2013 to Jan 31, 2015	-	-	33
Don Sieben	Sep 25, 2013 to Nov 26, 2015	ARC (Chair), FC (Chair), HRAC, QSAC	33	44
Doug Tupper	Nov 28, 2013 to Nov 26, 2015	ARC, FC, HRAC, QSAC (Chair)	33	44
Gord Winkel	Jan 21, 2014 to Nov 26, 2015	QSAC	2	3
Total Former Official Administrator / Former Advisory Committees			**$ 248**	**$ 736**

David Carpenter was appointed to the position of Official Administrator effective August 25, 2015 as per Ministerial Order 315/2015 with a term to end either on December 31, 2015 or in the event that a Board Chair is appointed, on the day that the Chair's appointment takes effect. The incumbent's term ended November 27, 2015 when the Board Chair's appointment took effect as per Ministerial Order 318/2015. The incumbent was remunerated with monthly honoraria of $5 and honoraria for attendance at AHS governance committee meetings up to a maximum limit of $3 per month.

Dr. Carl Amrhein was appointed to the position of Official Administrator as per Ministerial Order 314/2014 with a term that expired on June 30, 2015. During that term, the incumbent was on secondment from the University of Alberta. AHS reimbursed the University for the incumbent's base salary and benefits including annual performance adjustments. Remuneration was not to exceed $330 for the term. The incumbent was reappointed to the position of Official Administrator effective July 1, 2015 as per Ministerial Order 308/2015 with a term to end either on December 31, 2015 or in the event that a Board Chair is appointed, on the day that the Chair's appointment takes effect. The incumbent's term ended August 24, 2015 when Ministerial Order 308/2015 was repealed by Ministerial Order 315/2015. During the second term, the incumbent was remunerated with monthly honoraria of $5 and honoraria for attendance at AHS governance committee meetings up to a maximum limit of $3 per month. The incumbent received no remuneration from AHS for the month of August while holding both the positions of Official Administrator and Alberta Deputy Minister of Health.

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

Committee legend: ARC = Audit and Risk Committee, FC = Finance Committee, HRAC = Human Resources Advisory Committee, QSAC = Quality and Safety Advisory Committee

SUB-SCHEDULE 2C - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2016

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

SUB-SCHEDULE 2C - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2016 (CONTINUED)

	2015						
For the Prior Fiscal Year	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Official Administrator Direct Reports							
Vickie Kaminski – President and Chief Executive Officer	0.85	$ 459	$ -	$ 88	$ 547	$ -	$ 547
Brenda Huband – Interim President and Chief Executive Officer, Zone and Health Operations	0.15	60	-	12	72	-	72
Rick Trimp – Interim President and Chief Executive Officer Population Heath and Province-Wide Services	0.15	60	-	8	68	-	68
Dr. Chris Eagle – Special Advisor	0.34	195	83	75	353	-	353
Ronda White – Chief Audit Executive	1.00	237	2	60	299	-	299
Catherine MacNeill – Acting Corporate Secretary	0.50	92	-	23	115	-	115
Kristin Long – Corporate Secretary	0.16	32	-	25	57	-	57
David Diamond – Chief External Relations Officer	0.61	196	12	35	243	-	243
CEO Direct Reports							
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta	0.85	315	-	68	383	-	383
Dr. Francois Belanger – VP and Medical Director, Central and Southern Alberta	1.00	455	-	145	600	-	600
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta	1.00	371	-	83	454	-	454
Dr. David Mador – VP and Medical Director, Northern Alberta	1.00	455	-	92	547	-	547
Linda Dempster – VP Collaborative Practice, Nursing and Health Professions	0.02	5	-	2	7	-	7
Dr. Verna Yiu – VP, Quality and Chief Medical Officer	1.00	548	35	33	616	-	616
Rick Trimp – VP, Province-Wide Clinical Supports, Programs and Services	0.44	163	30	24	217	196	413
Mauro Chies – Acting VP, Province-Wide Clinical Supports, Programs and Services	0.15	35	8	8	51	-	51
Dr. Kathryn Todd – VP, Research, Innovation and Analytics	1.00	278	10	28	316	-	316
Robert Armstrong – Acting VP, Human Resources	0.75	184	26	43	253	-	253
Susan McGillivray – Acting VP, People	0.25	62	8	11	81	-	81
Carmel Turpin – VP, Community Engagement and Communications	0.41	119	-	31	150	-	150
Colleen Turner – Acting VP, Community Engagement and Communications	0.59	139	14	38	191	-	191
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer	1.00	360	18	81	459	-	459
Noela Inions – Chief Ethics and Compliance Officer	1.00	226	-	58	284	-	284
Salimah Walji-Shivji – General Counsel, Legal and Privacy	0.35	84	-	25	109	-	109
Total Executive	**14.57**	**$ 5,130**	**$ 246**	**$ 1,096**	**$ 6,472**	**$ 196**	**$ 6,668**

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

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

	2016			2015			
	SPP	SERP					
	Current period benefit costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2015	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2016
Dr. Verna Yiu - Interim President and Chief Executive Officer/ VP, Quality and Chief Medical Officer [p]	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Vickie Kaminski - President and Chief Executive Officer [5]	-	-	-	39	39	(39)	-
Ronda White - Chief Audit Executive	10	-	10	10	39	12	51
Brenda Huband - VP and Chief Health Operations Officer, Central and Southern Alberta							
SERP	-	(8)	(8)	9	412	10	422
SPP	25	-	25	26	67	28	95
Dr. Ted Braun - Acting VP and Medical Director, Central and Southern Alberta							
SERP	-	(4)	(4)	4	211	6	217
SPP	16	-	16	15	40	18	58
Dr. Francois Belanger - Interim VP, Quality and Chief Medical Officer/VP and Medical Director, Central and Southern Alberta	35	-	35	50	89	38	127
Deb Gordon - VP and Chief Health Operations Officer, Northern Alberta							
SERP	-	(11)	(11)	14	610	16	626
SPP	25	-	25	26	57	28	85
Dr. David Mador - VP and Medical Director, Northern Alberta	35	-	35	48	69	37	106
Dave Bilan - Interim VP Collaborative Practice, Nursing and Health Professions	-	-	-	-	-	-	-
Linda Dempster - VP Collaborative Practice, Nursing and Health Professions [5]	-	-	-	-	-	-	-
Dr. Kathryn Todd - VP, Research, Innovation and Analytics [p]	-	-	-	-	-	-	-
Todd Gilchrist - VP, Human Resources	31	-	31	-	-	31	31
Robert Armstrong - Acting VP, Human Resources	4	-	4	11	26	(26)	-
Colleen Turner - Interim VP, Community Engagement and Communications	10	-	10	10	37	11	48
Carmel Turpin - VP, Community Engagement and Communications [5]	-	-	-	7	7	(7)	-

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

	2016			2015			
	SPP	SERP					
	Current period benefit costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2015	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2016
Deborah Rhodes - VP, Corporate Services and Chief Financial Officer	$ 25	$ -	$ 25	$ 25	$ 108	$ 30	$ 138
Noela Inions - Chief Ethics and Compliance Officer	8	-	8	8	54	10	64
Vivian Simpkin - Interim General Counsel, Legal and Privacy	5	-	5	9	20	(20)	-
Salimah Walji-Shivji - General Counsel, Legal and Privacy	5	-	5	6	26	(26)	-
Sharon Lehr - Chief Program Officer, Operational Benchmarking and Efficiency	15	-	15	-	-	15	15

(1) The SPP current period benefit costs are AHS contributions earned in the period.
(2) Other SERP costs include retirement benefits, interest expense on the obligations, and amortization of actuarial gains and losses, offset by the expected return on the plans' assets. AHS uses the straight line method to amortize actuarial gains and losses over the expected average remaining service life of the plan members. The SERP recovery is due to prior year unamortized net actuarial gains being recognized in 2015-16.
(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.
(5) The SPP had not fully vested at the time of the employee's departure, and as a result no current period benefit costs were incurred and the March 31, 2015 balance has been reversed accordingly.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2016

Definitions

a. For this schedule, full time equivalents (FTE) are determined by actual hours earned divided by 2,030.50 annual base hours. FTE for the Board / former Official Administrator and 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. Base salary in the current fiscal year includes compensation for an additional day earned by employees due to the leap year.

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

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

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

   Other non-cash benefits for executive were restated to include the AHS incurred expense in the fiscal year for the Health Spending and Personal Spending accounts for the incumbent where applicable. The prior year was restated to be comparable to current year presentation.

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

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

Board and Advisory Committee Participants

g. This individual did not claim honoraria.

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

Former Official Administrators and Former Advisory Committee Participants

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

Executive

j. The incumbent held the position of Vice President, Quality and Chief Medical Officer until January 11, 2016 at which time the incumbent was appointed to Interim President and Chief Executive Officer. The incumbent received acting pay while in the Interim President and Chief Executive Officer position. The incumbent was appointed President and Chief Executive Officer effective June 3, 2016.

k. The incumbent tendered their resignation letter on November 25, 2015 effective February 26, 2016. The incumbent held the position until February 5, 2016 at which time the incumbent left AHS. At the time of their departure the incumbent received a lump sum payment of $31 in lieu of the completion of the notice period included in Other cash benefits. In addition, the incumbent received a vacation payout of $71 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.

l. The incumbent held the position of Associate Zone Medical Director, Calgary Zone until January 11, 2016 at which time the incumbent was appointed to Acting Vice President and Medical Director, Central and Southern Alberta and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in base salary while in the Acting Vice President and Medical Director, Central and Southern Alberta position.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2016 (CONTINUED)

m. The incumbent held the position of Vice President and Medical Director, Central and Southern Alberta until January 11, 2016 at which time the incumbent was appointed to Interim Vice President, Quality and Chief Medical Officer.

n. The incumbent held the position of Executive Director, Health Professions – Strategy and Practice until November 27, 2015 at which time the incumbent was appointed to Interim Vice President, Collaborative Practice, Nursing and Health Professions and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in base salary while in the Interim Vice President, Collaborative Practice, Nursing and Health Professions position.

o. The incumbent held the position until November 27, 2015 at which time the incumbent left AHS. At this time the incumbent received a vacation payout of $31 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.

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

q. The incumbent was appointed to the position effective May 4, 2015.

r. The incumbent held the position of Acting Vice President, Human Resources and received acting pay until May 3, 2015 at which time the incumbent resumed the role of Senior Program Officer, HR Shared Services, Workforce Strategies and Total Rewards and was no longer a direct report to the President and Chief Executive Officer.

s. The incumbent held the position of Senior Program Officer, Communications until January 11, 2016 at which time the incumbent was appointed to Interim Vice President Community Engagement and Communications and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in base salary while in the Interim Vice President, Community Engagement and Communications position.

t. The incumbent held the position until January 11, 2016 at which time the incumbent left AHS. The incumbent received salary and other accrued entitlements to the date of departure. The reported severance included 40 weeks base salary at the rate in effect at the date of departure, 15% of the severance in lieu of benefits, and 10% of the severance for purposes of relocation expenses. AHS will also make payments for the incumbent to attend an outplacement program for a maximum of six months. In addition, the incumbent received a vacation payout of $24 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.

u. The incumbent held the position of Associate General Counsel, Corporate & Commercial Law until September 16, 2015 at which time the incumbent was appointed to Interim General Counsel, Legal and Privacy and became a direct report to the President and Chief Executive Officer. The incumbent received acting pay while in the Interim General Counsel, Legal and Privacy position. The incumbent held the Interim General Counsel, Legal & Privacy position until December 4, 2015 at which time the incumbent left AHS. At this time the incumbent received a vacation payout of $29 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. As a result of restructuring, the position of General Counsel, Legal & Privacy ceased to be a direct report to the President and Chief Executive Officer effective December 7, 2015.

v. The incumbent held the position until September 16, 2015 at which time the incumbent left AHS. The incumbent received salary and other accrued entitlements to the date of departure. The reported severance included 50 weeks base salary at the rate in effect at the date of departure and 15% of the severance in lieu of benefits. AHS will also make payments for the incumbent to attend an outplacement program for a maximum of six months. In addition, the incumbent received a vacation payout of $56 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.

w. The incumbent was appointed to the position effective June 1, 2015. As a result of restructuring, the incumbent ceased to be a direct report to the President and Chief Executive Officer effective January 11, 2016.

Termination Obligations

x. 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.

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

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

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2016 (CONTINUED)

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

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

cc. SPP

Based on the provision of the applicable SPP, the following outlines the benefits received by individuals who terminated employment with AHS within the 2015-16 fiscal period. As a result of retirement or termination, the incumbents are entitled to the benefits accrued to them up to the date of retirement or termination. For participants of SPP, the benefit includes the account balances as at March 31, 2015 and the current period benefit costs and investment gains or losses related to the account that were incurred during the current year. The AHS obligations are paid through either a lump sum payment or regular instalments:

Position[1]	Supplemental Plan Commencement Date	Benefit (not in thousands)	Frequency	Payment Terms
Interim General Counsel, Legal and Privacy (SPP)	December 20, 2010	$25,835	Once	January 2016
General Counsel, Legal and Privacy (SPP)	December 20, 2010	$30,818	Once	October 2015

(1) Pertains only to those individuals for which the applicable SPP were fully vested at the time their employment with AHS ended.

SCHEDULE 3 – ADJUSTMENTS DUE TO CHANGES IN ACCOUNTING POLICY AND OTHER RECLASSIFICATIONS FOR THE YEAR ENDED MARCH 31

(a) Reconciliation of the Approved Budget for the Consolidated Statement of Operations

	2016 Approved Budget	Changes in Accounting Policy (Note 2(l))	Other Reclassifications[a]	2016 Reported Budget
Revenue:				
Alberta Health transfers				
Base operating	$ 11,330,000	$ -	$ -	$ 11,330,000
Other operating	1,110,000	-	-	1,110,000
Capital	84,000	-	-	84,000
Other government transfers	416,000	-	-	416,000
Fees and charges	507,000	-	-	507,000
Ancillary operations	132,000	-	-	132,000
Donations, fundraising, and non-government contributions	166,000	-	-	166,000
Investment and other income	208,000	-	-	208,000
TOTAL REVENUE	**13,953,000**	**-**	**-**	**13,953,000**
Expenses:				
Inpatient acute nursing services	3,210,000	-	(53,000)	3,157,000
Emergency and other outpatient services	1,620,000	-	(1,000)	1,619,000
Facility-based continuing care services	984,000	-	63,000	1,047,000
Ambulance services	468,000	-	-	468,000
Community-based care	1,227,000	-	(5,000)	1,222,000
Home care	536,000	-	6,000	542,000
Diagnostic and therapeutic services	2,329,000	-	(81,000)	2,248,000
Promotion, prevention, and protection services	376,000	-	3,000	379,000
Research and education	238,000	-	2,000	240,000
Administration	450,000	-	4,000	454,000
Information technology	565,000	-	1,000	566,000
Support services	1,950,000	-	61,000	2,011,000
TOTAL EXPENSES (Schedule 1)	**13,953,000**	**-**	**-**	**13,953,000**
ANNUAL OPERATING SURPLUS (DEFICIT)	**-**	**-**	**-**	**-**
Endowment contributions and reinvested income	-	-	-	-
ANNUAL SURPLUS (DEFICIT)	**$ -**	**$ -**	**$ -**	**$ -**

(a) In 2015-16, AHS reclassified prior year comparatives to conform with current year presentation due to:
- i) a change in methodology related to expense allocations for contracts with health service providers, and
- ii) better alignment of transactions with Alberta Health and the CIHI standards.

SCHEDULE 3 – ADJUSTMENTS DUE TO CHANGES IN ACCOUNTING POLICY AND OTHER RECLASSIFICATIONS FOR THE YEAR ENDED MARCH 31

(b) Reconciliation of the Prior Year Comparative for the Consolidated Statement of Operations

	2015 as Previously Presented	Changes in Accounting Policy (Note 2(l))	Other Reclassifications[a]	2015 Revised
Revenue:				
Alberta Health transfers				
Base operating	$ 10,851,204	$ -	$ -	$ 10,851,204
Other operating	1,378,438	-	-	1,378,438
Capital	92,907	-	-	92,907
Other government transfers (Note 4)	420,599	-	-	420,599
Fees and charges	445,912	-	26,477	472,389
Ancillary operations	133,118	-	-	133,118
Donations, fundraising, and non-government contributions (Note 5)	167,290	-	-	167,290
Investment and other income (Note 6)	308,308	-	-	308,308
TOTAL REVENUE	**13,797,776**	**-**	**26,477**	**13,824,253**
Expenses:				
Inpatient acute nursing services	3,247,819	-	(34,011)	3,213,808
Emergency and other outpatient services	1,581,887	-	4,178	1,586,065
Facility-based continuing care services	940,411	-	65,385	1,005,796
Ambulance services	468,031	-	7,399	475,430
Community-based care	1,139,337	-	(1,311)	1,138,026
Home care	530,501	-	5,116	535,617
Diagnostic and therapeutic services	2,314,445	-	(79,583)	2,234,862
Promotion, prevention, and protection services	358,933	-	1,978	360,911
Research and education	232,162	-	3,249	235,411
Administration (Note 7)	448,491	-	(461)	448,030
Information technology	567,792	-	1,069	568,861
Support services (Note 8)	1,970,471	-	53,469	2,023,940
TOTAL EXPENSES (Schedule 1)	**13,800,280**	**-**	**26,477**	**13,826,757**
ANNUAL OPERATING SURPLUS (DEFICIT)	**(2,504)**	**-**	**-**	**(2,504)**
Endowment contributions and reinvested income	-	3,585	-	3,585
ANNUAL SURPLUS (DEFICIT)	**$ (2,504)**	**$ 3,585**	**$ -**	**$ 1,081**
Accumulated surplus, beginning of year	1,233,805	-	68,796	1,302,601
Accumulated surplus, end of year (Note 19)	**$ 1,231,301**	**$ 3,585**	**$ 68,796**	**$ 1,303,682**

(a) In 2015-16, AHS reclassified prior year comparatives to conform with current year presentation due to:
- i) a change in methodology related to expense allocations for contracts with health service providers,
- ii) better alignment of transactions with Alberta Health and the CIHI standards, and
- iii) the reclassification of bad debts expense from net of revenues to expenses.

SCHEDULE 3 – ADJUSTMENTS DUE TO CHANGES IN ACCOUNTING POLICY AND OTHER RECLASSIFICATIONS FOR THE YEAR ENDED MARCH 31

(c) Reconciliation of the Prior Year Comparative for the Consolidated Statement of Financial Position

	2015 as Previously Presented	Changes in Accounting Policy (Note 2(l))	Other Reclassifications[a]	2015 Revised
Financial Assets:				
Cash	$ 549,779	$ -	$ (217,932)	$ 331,847
Portfolio investments (Note 10)	1,955,561	-	217,932	2,173,493
Accounts receivable (Note 11)	313,972	-	-	313,972
Other assets	12,179	-	-	12,179
Tangible capital assets	7,511,137	(7,511,137)	-	-
Inventories for consumption	96,583	(96,583)	-	-
Prepaid expenses	126,610	(126,610)	-	-
	10,565,821	(7,734,330)	-	2,831,491
Liabilities:				
Accounts payable and accrued liabilities (Note 12)	1,256,333	-	17,566	1,273,899
Employee future benefits (Note 13)	594,603	-	-	594,603
Deferred revenue	7,033,031	(7,033,031)	-	-
Unexpended deferred operating revenue (Note 14)	-	491,254	-	491,254
Unexpended deferred capital revenue (Note 15)	-	178,078	-	178,078
Debt (Note 17)	339,397	-	(17,566)	321,831
	9,223,364	(6,363,699)	-	2,859,665
NET DEBT	**-**	**-**	**-**	**(28,174)**
Non-Financial Assets:				
Tangible capital assets (Note 18)	-	7,511,137	-	7,511,137
Inventories for consumption	-	96,583	-	96,583
Prepaid expenses	-	126,610	-	126,610
	-	7,734,330	-	7,734,330
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	-	7,706,156	-	7,706,156
Expended deferred capital revenue (Note 16)	-	6,363,699	-	6,363,699
NET ASSETS	**-**	**1,342,457**	**-**	**1,342,457**
Net assets is comprised of:				
Accumulated surplus (Note 19)	1,231,301	-	72,381	1,303,682
Accumulated remeasurement gains and losses	38,775	-	-	38,775
Endowments	72,381	-	(72,381)	-
	$ 1,342,457	**$ -**	**$ -**	**$ 1,342,457**

(a) In 2015-16, AHS reclassified prior year comparatives to conform with current year presentation due to:
- i) cash equivalents deemed to be held for investment purposes reclassified to portfolio investments, and
- ii) capital lease obligations reclassified from debt to accounts payable and accrued liabilities due to better alignment of presentation of transactions with Alberta Health.

SCHEDULE 3 – ADJUSTMENTS DUE TO CHANGES IN ACCOUNTING POLICY AND OTHER RECLASSIFICATIONS FOR THE YEAR ENDED MARCH 31

(d) Reconciliation of the Prior Year Comparative for the Consolidated Statement of Cash Flows

	2015 as Previously Presented	Changes in Accounting Policy (Note 2(l))	Other Reclassifications[a]	2015 Revised
Operating transactions:				
Annual surplus (deficit)	$ (2,504)	$ 3,585	$ -	$ 1,081
Non-cash items:				
Amortization, disposals, and write-downs	633,593	-	-	633,593
Recognition of expended deferred capital revenue	(427,506)	-	-	(427,506)
Revenue recognized for acquisition of land	-	-	-	-
Decrease (increase) in:				
Accounts receivable related to operating transactions	72,533	-	-	72,533
Inventories for consumption	1,669	-	-	1,669
Other assets	(575)	-	-	(575)
Prepaid expenses	(20,211)	-	-	(20,211)
Increase (decrease) in:				
Accounts payable and accrued liabilities related to operating transactions	85,372	-	-	85,372
Employee future benefits	40,071	-	-	40,071
Deferred revenue related to operating transactions	(70,906)	(3,585)	-	(74,491)
Cash provided by (applied to) operating transactions	311,536	-	-	311,536
Capital transactions:				
Acquisition of tangible capital assets	(229,734)	-	-	(229,734)
Increase (decrease) in accounts payable and accrued liabilities related to capital transactions	(30,566)	-	(1,231)	(31,797)
Cash provided by (applied) to capital transactions	(260,300)	-	(1,231)	(261,531)
Investing transactions:				
Purchase of portfolio investments	(3,134,674)	-	(1,069,279)	(4,203,953)
Proceeds on disposals of portfolio investments	2,955,055	-	1,336,843	4,291,898
Cash provided by (applied to) investing transactions	(179,619)	-	267,564	87,945
Financing transactions:				
Restricted capital revenue received	96,977	-	-	96,977
Restricted capital revenue returned	(14,119)	-	-	(14,119)
Proceeds from debt	5,772	-	(772)	5,000
Principal payments on debt	(16,538)	-	2,003	(14,535)
Cash provided by (applied to) financing transactions	72,092	-	1,231	73,323
Net increase (decrease) in cash	**(56,291)**	**-**	**267,564**	**211,273**
Cash, beginning of year	606,070	-	(485,496)	120,574
Cash, end of year	**$ 549,779**	**$ -**	**$ (217,932)**	**$ 331,847**

(a) In 2015-16, AHS reclassified prior year comparatives to conform with current year presentation due to:
- i) cash equivalents deemed to be held for investment purposes reclassified to portfolio investments, and
- ii) capital lease obligations reclassified from debt to accounts payable and accrued liabilities due to better alignment of presentation of transactions with Alberta Health.

SCHEDULE 3 – ADJUSTMENTS DUE TO CHANGES IN ACCOUNTING POLICY AND OTHER RECLASSIFICATIONS FOR THE YEAR ENDED MARCH 31

(e) Reconciliation of the Prior Year Comparative for the Consolidated Schedule of Expenses by Object

	2015 as Previously Presented	Changes in Accounting Policy (Note 2(l))	Other Reclassifications[a]	2015 Revised
Salaries and benefits (Schedule 2)	$ 7,531,854	$ -	$ -	$ 7,531,854
Contracts with health service providers	2,375,811	-	-	2,375,811
Contracts under the Health Care Protection Act	19,141	-	-	19,141
Drugs and gases	411,672	-	-	411,672
Medical and surgical supplies	403,626	-	-	403,626
Other contracted services	1,137,794	-	-	1,137,794
Other	1,286,789	-	26,477	1,313,266
Amortization, disposals and write-downs (Note 18)	633,593	-	-	633,593
	$ 13,800,280	**$ -**	**$ 26,477**	**$ 13,826,757**

(a) In 2015-16, AHS reclassified prior year comparatives to conform with current year presentation due to the reclassification of bad debts expense from net of revenues to expenses.

FINANCIAL INFORMATION
Health Quality Council of Alberta

Financial Statements

March 31, 2016

HEALTH QUALITY COUNCIL OF ALBERTA

FINANCIAL STATEMENTS

YEAR ENDED MARCH 31, 2016

HEALTH QUALITY COUNCIL OF ALBERTA

MANAGEMENT'S RESPONSIBILITY FOR THE FINANCIAL STATEMENTS

MARCH 31, 2016

The accompanying financial statements are the responsibility of management and have been reviewed and approved by Senior Management. The financial statements were prepared in accordance with Canadian Public Sector Accounting Standards, and of necessity, include some amounts that are based on estimates and judgement.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains a system of internal accounting controls comprising written policies, standards and procedures, a formal authorization structure, and satisfactory processes for reviewing internal controls. This system provides management with reasonable assurance that transactions are in accordance with governing legislation and are properly authorized, reliable financial records are maintained, and assets are adequately safeguarded.

The Health Quality Council of Alberta's Board of Directors carries out their responsibility for the financial statements through the Audit and Finance Committee. The Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the financial statements to the Health Quality Council of Alberta Board of Directors for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Audit and Finance Committee.

The Auditor General of Alberta provides an independent audit of the 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 financial statements prepared by management.

On behalf of the Health Quality Council of Alberta.

Original signed by

Chief Executive Officer
Andrew Neuner
May 31, 2016

Original signed by

Controller
Jessica Wing
May 31, 2016

Independent Auditor's Report

To the Board of Directors of the Health Quality Council of Alberta

Report on the Financial Statements

I have audited the accompanying financial statements of the Health Quality Council of Alberta, which comprise the statement of financial position as at March 31, 2016, and the statements of operations, change in net financial assets and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In my opinion, the financial statements present fairly, in all material respects, the financial position of the Health Quality Council of Alberta as at March 31, 2016, and the results of its operations, its remeasurement gains and losses, its changes in net financial assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

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

Auditor General

May 31, 2016

Edmonton, Alberta

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF OPERATIONS
Year ended March 31

	2016		2015
	Budget	Actual	Actual
	(in thousands)		
Revenues			
Government transfers			
Alberta Health - operating grant	$ 6,611	$ 6,611	$ 6,959
Investment income	8	9	17
Other revenue	-	26	101
	6,619	6,646	7,077
Expenses			
Administration	2,666	2,838	2,419
Survey, measure and monitor initiatives	2,463	2,257	2,176
Patient safety initiatives	1,171	1,038	947
Quality initiatives	772	707	817
Communication	389	402	460
Ministerial assessment/study	-	109	22
Other assessment/study	-	-	27
	7,461	7,351	6,868
Annual operating (deficit) surplus	(842)	(705)	209
Accumulated operating surplus, beginning of year		2,595	2,386
Accumulated operating surplus, end of year	$	$ 1,890	$ 2,595

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

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF FINANCIAL POSITION
As at March 31

	2016	2015
	(in thousands)	
Financial Assets		
Cash	$ 1,579	$ 2,271
Accounts receivable (Note 5)	47	109
	1,626	2,380
Liabilities		
Accounts payable and accrued liabilities	844	834
Employee future benefits (Note 7)	43	17
Deferred revenue (Note 8)	7	-
Deferred lease inducements (Note 9)	81	110
	975	961
Net Financial Assets	651	1,419
Non-Financial Assets		
Tangible capital assets (Note 10)	1,186	1,137
Prepaid expenses	53	39
	1,239	1,176
Net Assets	1,890	2,595
Net Assets		
Accumulated operating surplus (Note 12)	$ 1,890	$ 2,595

Contractual obligations (Note 11).

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

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF CHANGE IN NET FINANCIAL ASSETS
Year ended March 31

	2016		2015
	Budget	Actual	Actual
		(in thousands)	
Annual operating (deficit) surplus	$ (842)	$ (705)	$ 209
Acquisition of tangible capital assets		(217)	(1,007)
Amortization of tangible capital assets (Note 10)	111	168	19
Change in prepaid expenses		(14)	(4)
(Decrease) in net financial assets in the year		(768)	(783)
Net financial assets, beginning of year		1,419	2,202
Net financial assets, end of year	$	$ 651	$ 1,419

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

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF CASH FLOWS
Year ended March 31

	2016	2015
	(in thousands)	
Operating Transactions		
Annual operating (deficit) surplus	$ (705)	$ 209
Non-cash items:		
Amortization of tangible capital assets (Note 10)	168	19
Amortization of tenant inducements (Note 9)	(47)	(27)
Increase in employee future benefits (Note 7)	26	17
	(558)	218
Decrease in accounts receivable	62	123
(Increase) in prepaid expenses	(14)	(4)
Increase (Decrease) in accounts payable and accrued liabilities	10	(202)
Increase (Decrease) in deferred revenue	7	(5)
Increase in deferred tenant inducements	18	137
Cash (applied to) provided by operating transactions	(475)	267
Capital Transactions		
Acquisition of tangible capital assets	(217)	(1,007)
Cash applied to capital transactions	(217)	(1,007)
(Decrease) in cash	(692)	(740)
Cash at beginning of year	2,271	3,011
Cash at end of year	$ 1,579	$ 2,271

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

HEALTH QUALITY COUNCIL OF ALBERTA
NOTES TO THE FINANCIAL STATEMENTS
MARCH 31, 2016
(in thousands)

Note 1 AUTHORITY

The Health Quality Council of Alberta (HQCA) is a corporation under the *Health Quality Council of Alberta Act* and a government not-for-profit organization.

Pursuant to the *Health Quality Council of Alberta Act*, the HQCA has a mandate to promote and improve patient safety and health service quality on a province-wide basis.

The Health Quality Council of Alberta is exempt from income taxes under the *Income Tax Act.*

Note 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES

These financial statements are prepared in accordance with Canadian Public Sector Accounting Standards (PSAS).

(a) Reporting Entity

The financial statements reflect the assets, liabilities, revenues and expenses of the HQCA.

(b) Basis of Financial Reporting

Revenues

All revenues are reported on the accrual basis of accounting. Cash received, for which services have not been provided by year end is recorded as deferred revenue.

Government transfers
Transfers from the Government of Alberta, other governments and other government entities are referred to as government transfers.

Government transfers and the associated externally restricted investment income are recorded as deferred revenue if the eligibility criteria for use of the transfer, or the stipulations together with the HQCA's 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, the HQCA complies with its communicated use of these transfers.

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

Note 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (CONT'D)

(b) Basis of Financial Reporting (Cont'd)

Expenses

Expenses are reported on an accrual basis. The cost of all goods consumed and services received during the year are expensed.

Government transfers are recorded as expenses when the transfer is authorized and eligibility criteria, if any, have been met by the recipient.

Valuation of Financial Assets and Liabilities

The HQCA's financial assets and liabilities are generally measured as follows:

Financial Statement Component	Measurement
Cash	Cost
Accounts receivable	Lower of cost or net recoverable value
Accounts payable and accrued liabilities	Cost

The HQCA does not hold equities traded in an active market, nor engage in derivative contracts or foreign currency transactions. The HQCA is not exposed to remeasurement gains or losses and, consequently, a statement of remeasurement gains and losses is not presented.

Financial Assets

Financial assets are the HQCA's financial claims on external organizations and individuals at the year end.

Cash
Cash comprises cash on hand and demand deposits.

Accounts Receivable
Accounts receivable are recorded at the lower of cost or net recoverable value. A valuation allowance is recorded when recovery is uncertain.

Note 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (CONT'D)

(b) Basis of Financial Reporting (Cont'd)

Liabilities

Liabilities represent present obligations of the HQCA to external organizations and individuals arising from transactions or events occurring before the year end. They are recorded when there is an appropriate basis of measurement and management can reasonably estimate the amount.

Liabilities also include:

- All financial claims payable by the HQCA at year end;
- Accrued employee vacation entitlements; and
- Contingent liabilities where future liabilities are likely.

Deferred Tenant Inducements

Deferred tenant inducements represents amounts or an amount received for leasehold improvements and the value of a rent-free period. Lease inducements are deferred and amortized on a straight-line basis over the term of the related lease and the amortization is recorded as a reduction of rent expense for the year.

Employee Future Benefits

The HQCA Board has approved a defined contribution Supplementary Executive Retirement Plan (SERP) for certain members of its executive staff. The SERP supplements the benefit under the HQCA registered plan that is limited by the *Income Tax Act* (Canada). The HQCA contributes a certain percentage of an eligible employee's pensionable earnings in excess of the limits of the *Income Tax Act* (Canada). This plan provides participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participants.

Note 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (CONT'D)

(b) Basis of Financial Reporting (Cont'd)

Non-Financial Assets

Non-financial assets are limited to tangible capital assets and prepaid expenses.

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 of the asset.

Work-in-progress, which includes leasehold improvement projects, is not amortized until after the project is complete and the asset is put into service.

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

Computer hardware and software	5 years
Office equipment	10 years
Leasehold improvements	Over term of lease

Tangible capital assets are written down when conditions indicate that they no longer contribute to the HQCA's ability to provide services, or when the value of future economic benefits associated with the tangible capital assets are less than their book value.

Prepaid Expense

Prepaid expense are recorded at cost and amortized based on the terms of the agreement.

Funds and Reserves

Certain amounts, as approved by the Board of Directors, are set aside in accumulated operating surplus for future operating and capital purposes. Transfers to/from funds and reserves are an adjustment to the respective fund when approved.

Measurement Uncertainty

Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. The amounts recorded for amortization of tangible capital assets are based on estimates of the useful life of the related assets. Actual results could differ from estimates.

Note 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (CONT'D)

(c) Accounting Change

Adoption of the Net Debt Presentation

The net debt model (with reclassification of comparatives) has been adopted for the presentation of financial statements. Net financial assets or net debt is measured as the difference between the HQCA's financial assets and liabilities.

The effect of this change results in changing the presentation of the Statement of Financial Position and adding the Statement of Change in Net Financial Assets.

Note 3 FUTURE ACCOUNTING CHANGES

In June 2015 the Public Sector Accounting Board issued the following accounting standards:

- **PS 2200 Related Party Disclosures and PS 3420 Inter-Entity Transactions (effective April 1, 2017)**
  PS 2200 defines a related party and establishes disclosures required for related party transactions. PS 3420 establishes standards on how to account for and report transactions between public sector entities that comprise a government's reporting entity from both a provider and recipient perspective. Management is currently assessing the impact of these standards on the financial statements.

- **PS 3210 Assets, PS 3320 Contingent Assets, and PS 3380 Contractual Rights (effective April 1, 2017)**
  PS3210 provides guidance for applying the definition of assets set out in FINANCIAL STATEMENT CONCEPTS, Section PS 1000, and establishes general disclosure standards for assets; PS 3320 defines and establishes disclosure standards on contingent assets; PS 3380 defines and establishes disclosure standards on contractual rights. Management is currently assessing the impact of these standards on the financial statements.

- **PS 3430 Restructuring Transactions (effective April 1, 2018)**
  This standard provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related program or operating responsibilities. Management is currently assessing the impact of these standards on the financial statements.

Note 4 BUDGET

The HQCA's 2015-2016 business plan with a budgeted deficit of ($842) was approved by the Board of Directors on May 28, 2015. The approved financial plan was submitted to the Ministry of Health.

(in thousands)

Note 5 ACCOUNTS RECEIVABLE

	2016			2015
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Due from Alberta Health Services	$ -	$ -	$ -	$ 2
Other receivables	47	-	47	107
	$ 47	$ -	$ 47	$ 109

Note 6 FINANCIAL RISK MANAGEMENT

The HQCA has the following financial instruments: accounts receivable, accounts payable and accrued liabilities.

The HQCA has exposure to the following risks from its use of financial instruments: interest rate risk, liquidity risk and other price risk.

(a) Interest rate risk

Interest rate risk is the risk that the rate of return and future cash flows on the HQCA's short-term investments will fluctuate because of changes in market interest rates. As the HQCA invests in short term deposits of 90 days or less and accounts payable are non-interest bearing, the HQCA is not exposed to significant interest rate risk relating to its financial assets and liabilities.

(b) Liquidity risk

Liquidity risk is the risk that the HQCA will encounter difficulty in meeting obligations associated with financial liabilities. The HQCA enters into transactions to purchase goods and services on credit. Liquidity risk is measured by reviewing the HQCA's future net cash flows for the possibility of negative net cash flow. The HQCA manages the liquidity risk resulting from its accounts payable obligations by maintaining cash resources and investing in short-term deposits of 90 days or less.

(c) Other price risk

Other price risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices (other than those arising from interest rate risk or foreign currency risk), whether those changes are caused by factors specific to the individual financial instrument or its issuer, or factors affecting all similar financial instruments traded in the market. Price risk is managed by holding short-term deposits for 90 days or less.

(in thousands)

Note 6 FINANCIAL RISK MANAGEMENT (CONT'D)

(d) Credit risk

The HQCA is exposed to credit risk from potential non-payment of accounts receivable. During the fiscal year most of the HQCA's receivables are from provincial agencies; therefore the credit risk is minimized.

Note 7 BENEFIT PLAN

The HQCA participates in the Local Authorities Pension Plan (LAPP), a multi- employer defined benefit pension plan.

The HQCA accounts for this multi-employer pension plan on a defined contribution basis. The HQCA is not responsible for future funding of the plan deficit other than through contribution increases. Pension expense recorded in the financial statements is equivalent to HQCA's annual contributions of $383 for the year ended March 31, 2016 (2015 - $330).

At December 31, 2015, the Local Authorities Pension Plan reported a deficiency of $923,416 (2014 deficiency of $2,454,636).

The Supplementary Executive Retirement Plan (SERP) expense for the year ended March 31, 2016 is $26 (2015 - $17).

Note 8 DEFERRED REVENUE

Deferred revenue represents unspent externally restricted resources. Changes in the balance are as follows:

	2016	2015
Balance, beginning of the year	$ -	$ 5
Amount received	25	-
Amounts recognized in revenue	(18)	-
Amount repaid	-	(5)
Balance, end of the year	$ 7	$ -

(in thousands)

Note 9 DEFERRED LEASE INDUCEMENTS

The HQCA received a leasehold inducement of $137 for renovations in 2015. The inducement is accounted for as a reduction of rent expense and amortized over the term of the lease.

In 2016, the HQCA received a lease inducement in the form of free rent relating to a lease renewal of the premises effective 2018. This amount will be amortized on a straight-line basis over the term of the related lease and the amortization is recorded as a reduction of rent expense for the year starting 2018.

	2016	2015
Lease inducements - renovations	$ 137	$ 137
Lease inducements - rent free periods	18	-
Less accumulated amortization	(74)	(27)
	$ 81	$ 110

HEALTH QUALITY COUNCIL OF ALBERTA
NOTES TO THE FINANCIAL STATEMENTS
MARCH 31, 2016
(in thousands)

Note 10 TANGIBLE CAPITAL ASSETS

	2016					2015
	Work-in-progress	Equipment	Computer Hardware & Software	Leasehold Improvements	Total	Total
Estimated useful life		10 yrs	5 yrs	5 – 10 yrs		
Historical Cost						
Beginning of year	$ 1,029	$ 133	$ 371	$ 45	$ 1,578	$ 679
Transfer	(1,029)	120	-	909	-	-
Additions	-	112	51	54	217	1,007
Disposals, including write-downs	-	-	-	-	-	(108)
	-	365	422	1,008	1,795	1,578
Accumulated Amortization						
Beginning of year	-	95	312	34	441	530
Amortization expense	-	26	22	120	168	19
Effect of disposals including write-downs	-	-	-	-	-	(108)
	-	121	334	154	609	441
Net book value at March 31, 2016	-	$ 244	$ 88	$ 854	$ 1,186	
Net book value at March 31, 2015	$ 1,029	$ 38	$ 59	$ 11		$ 1,137

(in thousands)

Note 11 CONTRACTUAL OBLIGATIONS

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

Estimated payment requirements for each of the next five years and thereafter are as follows:

Year ended March 31	Total lease payments
2016 - 17	$ 414
2017 - 18	378
2018 – 19	394
2019 - 20	489
2020 - 21	502
Thereafter	1,013
	$ 3,190

Note 12 ACCUMULATED OPERATING SURPLUS

Accumulated operating surplus is comprised of the following:

	Investment in Tangible Capital Assets [(a)]	Internally Restricted Surplus[(b)]	Unrestricted Surplus (Deficit)	Total	2015
Balance, April 1, 2015	$ 1,026	$ 71	$ 1,498	$ 2,595	$ 2,386
Annual operating (deficit)	-	-	(705)	(705)	209
Net investment in capital assets	17	-	(17)	-	-
Transfers	-	776	(776)	-	-
Balance, March 31, 2016	$ 1,043	$ 847	$ -	$ 1,890	$ 2,595

(a) Net assets equal to the net book value of internally funded tangible capital assets are restricted as these net assets are not available for any other purpose.

(in thousands)

Note 12 ACCUMULATED OPERATING SURPLUS (CONT'D)

(b) The internally restricted surplus represents amounts set aside by the Board for future purposes. Those amounts are not available for other purposes without the approval of the Board. Internally restricted surplus is summarized as follows:

	2016	2015
Framework and related resources development	$ 132	$ -
Patient focused measurement	465	-
Health system performance reporting	250	-
Ministerial review[1]	-	71
	$ 847	$ 71

(1) Funds have been reallocated to projects

Note 13 COMPARATIVE FIGURES

Certain 2015 figures have been reclassified to conform to the 2016 presentation.

Note 14 APPROVAL OF THE FINANCIAL STATEMENTS

The financial statements were approved by the HQCA Board of Directors on June 1, 2016.

Schedule 1

HEALTH QUALITY COUNCIL OF ALBERTA
EXPENSES – DETAILED BY OBJECT
YEAR ENDED MARCH 31, 2016

	2016		2015
	Budget	Actual	Actual
	(in thousands)		
Salaries and benefits	$ 4,335	$ 4,210	$ 3,755
Supplies, services and other	3,015	2,973	3,094
Amortization of tangible capital assets	111	168	19
	$ 7,461	$ 7,351	$ 6,868

Schedule 2

HEALTH QUALITY COUNCIL OF ALBERTA
SALARY AND BENEFITS DISCLOSURE
YEAR ENDED MARCH 31, 2016

	2016				2015
	Base Salary [1]	Other Cash Benefits [2]	Other Non-Cash Benefits [3]	Total	Total
	(in thousands)				
Board of Directors-Chair	$ -	$ 12	$ -	$ 12	$ 13
Board of Directors-Members	-	35	-	35	48
Chief Executive Officer [4]	350		56	406	234
Acting Chief Executive Officer [5]	-	-	-	-	251
Executive Director	184		35	219	224
	$ 534	$ 47	$ 91	$ 672	$ 770

(1) Base salary includes pensionable base pay.

(2) Other cash benefits include honoraria for board members and vacation for employees.

(3) Other non-cash benefits include: employer's portion of all employee benefits and contributions or payments made on behalf of employees, including pension, Supplementary Executive Retirement Plan, health care, dental coverage, vision coverage, out of country medical benefits, group life insurance, accidental disability and dismemberment insurance, long and short-term disability plans, employee assistance program, employment insurance and parking.

(4) In 2015, the current CEO held the position for 6 months effective September 8, 2014 versus 12 months in 2016.

(5) The Acting CEO held the position from October 1, 2013 to September 5, 2014.

Schedule 3

HEALTH QUALITY COUNCIL OF ALBERTA
RELATED PARTY TRANSACTIONS
YEAR ENDED MARCH 31

Related parties are those entities consolidated or accounted for on a modified equity basis in the Province of Alberta's financial statements. Related parties also include key management personnel in the HQCA.

The HQCA had the following transactions with related parties recorded in the Statements of Operations and the Statements of Financial Position at the amount of consideration agreed upon between the related parties.

	2016	2015
	(in thousands)	
Revenues		
Grants	$ 6,611	$ 6,959
Other	-	99
	$ 6,611	$ 7,058
Expenses		
Other services	$ 465	$ 465
Grants	30	20
	$ 495	$ 485
Receivable from related parties	$ -	$ 2
Payable to related parties	$ 76	$ 79

FINANCIAL INFORMATION
Alberta Innovates - Health Solutions

Consolidated Financial Statements

March 31, 2016

Alberta Innovates – Health Solutions

Consolidated Financial Statements

Year Ended **March 31, 2016**

Alberta Innovates – Health Solutions

Consolidated Financial Statements

Year Ended **March 31, 2016**

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Alberta Innovates Health Solutions

aihealthsolutions.ca
1500 - 10104 103 Avenue NW
Edmonton, Alberta, Canada T5J 4A7
Tel 780-423-5727 Fax 780-429-3509
Toll Free 1-877-423-5727

MANAGEMENT'S RESPONSIBILITY FOR THE CONSOLIDATED FINANCIAL STATEMENTS MARCH 31, 2016

The accompanying consolidated financial statements 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 of necessity, include some amounts that are based on estimates and judgement.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains a system of internal accounting controls comprising written policies, standards and procedures, a formal authorization structure, and satisfactory processes for reviewing internal controls. This system provides management with reasonable assurance that transactions are in accordance with governing legislation and are properly authorized, reliable financial records are maintained, and assets are adequately safeguarded.

Alberta Innovates Health Solutions Board of Directors carries out their responsibility for the consolidated financial statements through the Finance and Audit Committee. The Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the consolidated financial statements to Alberta Innovates Health Solutions Board of Directors for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Finance and Audit Committee.

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

Original signed by

Dr. Pamela Valentine
Chief Executive Officer (interim)

May 31, 2016

Original signed by

Maureen Fromhart
Vice President, Corporate Services

Alberta Government

Independent Auditor's Report

To the Board of Directors of Alberta Innovates—Health Solutions

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of Alberta Innovates—Health Solutions, which comprise the consolidated statement of financial position as at March 31, 2016, and the consolidated statements of operations, change in net financial assets, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the consolidated financial position of Alberta Innovates—Health Solutions as at March 31, 2016, and the results of its operations, its remeasurement gains and losses, its changes in net financial assets, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

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

Auditor General

May 31, 2016

Edmonton, Alberta

ALBERTA INNOVATES - HEALTH SOLUTIONS
CONSOLIDATED STATEMENT OF OPERATIONS
YEAR ENDED MARCH 31

	2016		2015
	Budget	Actual	Actual
	(in thousands)		
Revenues			
Government Transfers			
Government of Alberta Grants	$ 86,433	$ 69,207	$ 97,932
Partnership Revenue	5,310	5,030	500
Investment Income	266	352	882
Other Revenues	308	868	933
	92,317	75,457	100,247
Expenses			
Strategic Investments	73,888	63,831	60,454
Partnership Funding Programs	25,780	24,272	12,109
Administration	9,500	10,617	8,896
Platforms	9,360	4,762	6,119
	118,528	103,482	87,578
Annual (Deficit) Surplus	(26,211)	(28,025)	12,669
Accumulated Surplus, Beginning of Year	48,600	48,600	35,931
Accumulated Surplus, End of Year	$ 22,389	$ 20,575	$ 48,600

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

ALBERTA INNOVATES - HEALTH SOLUTIONS
CONSOLIDATED STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31

	2016	2015
	(in thousands)	
Financial Assets		
Cash (Note 5)	$ 56,656	$ 95,245
Accounts Receivable (Note 6)	592	680
	57,248	95,925
Liabilities		
Accounts Payable and Accrued Liabilities (Note 8)	9,579	9,421
Deferred Revenue (Note 9)	27,792	38,687
Benefit Plans (Note 10(b))	202	328
	37,573	48,436
Net Financial Assets	19,675	47,489
Non-Financial Assets		
Tangible Capital Assets (Note 11)	647	841
Prepaid Expenses	253	270
	900	1,111
Net Assets		
Accumulated Surplus (Note 12)	$ 20,575	$ 48,600

Contractual Obligations (Note 13)

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

Original signed by

Judy Fairburn
Chair

Original signed by

Doug Gilpin
Vice - Chair

ALBERTA INNOVATES - HEALTH SOLUTIONS
CONSOLIDATED STATEMENT OF OPERATIONS
YEAR ENDED MARCH 31

	2016		2015
	Budget	Actual	Actual
	(in thousands)		
Revenues			
Government Transfers			
Government of Alberta Grants	$ 86,433	$ 69,207	$ 97,932
Partnership Revenue	5,310	5,030	500
Investment Income	266	352	882
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ALBERTA INNOVATES - HEALTH SOLUTIONS
CONSOLIDATED STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31

	2016	2015
	(in thousands)	
Financial Assets		
Cash (Note 5)	$ 56,656	$ 95,245
Accounts Receivable (Note 6)	592	680
	57,248	95,925
Liabilities		
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	900	1,111
Net Assets		
Accumulated Surplus (Note 12)	$ 20,575	$ 48,600

Contractual Obligations (Note 13)

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

original signed

ALBERTA INNOVATES - HEALTH SOLUTIONS
CONSOLIDATED STATEMENT OF CHANGE IN NET FINANCIAL ASSETS
YEAR ENDED MARCH 31

	2016		2015
	Budget	Actual	Actual
	(in thousands)		
Annual (Deficit) Surplus	$ (26,211)	$ (28,025)	$ 12,669
Acquisition of Tangible Capital Assets	(615)	(143)	(167)
Amortization of Tangible Capital Assets	375	332	269
Loss on Disposal of Tangible Assets	-	5	-
Proceeds on Sale of Tangible Capital Assets	-	-	-
Change in Prepaid Expenses	-	17	(165)
(Decrease) Increase in Net Financial Assets in the Year	(26,451)	(27,814)	12,606
Net Financial Assets, Beginning of Year	47,489	47,489	34,883
Net Financial Assets, End of Year	$ 21,038	$ 19,675	$ 47,489

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

ALBERTA INNOVATES - HEALTH SOLUTIONS
CONSOLIDATED STATEMENT OF CASH FLOWS
YEAR ENDED MARCH 31

	2016	2015
	(in thousands)	
Operating Transactions		
Annual (Deficit) Surplus	$ (28,025)	$ 12,669
Non-cash items:		
Amortization of Tangible Capital Assets	332	269
Deferred Revenue Recognized as Revenue	(24,076)	(12,046)
Loss on Disposal of Tangible Capital Assets	5	-
	(51,764)	892
Decrease in Accounts Receivable	88	7,742
Decrease (Increase) in Prepaid Expenses	17	(165)
Increase (Decrease) in Accounts Payable and Accrued Liabilities	158	(2,550)
Change in Employee Future Benefit Liabilities	(126)	(50)
Increase in Deferred Revenue	13,181	26,970
Cash Provided by (Applied to) Operating Transactions	(38,446)	32,839
Capital Transactions		
Acquisition of Tangible Capital Assets	(143)	(167)
Cash Applied to Capital Transactions	(143)	(167)
(Decrease) Increase in Cash	(38,589)	32,672
Cash, Beginning of Year	95,245	62,573
Cash, End of Year	$ 56,656	$ 95,245

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

ALBERTA INNOVATES – HEALTH SOLUTIONS
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2016

NOTE 1 AUTHORITY

Alberta Innovates – Health Solutions (the Corporation) is a Provincial Corporation, as defined in the Financial Administration Act that was established on January 1, 2010 and operates under the authority of the *Alberta Research and Innovation Act*. The mandate of the Corporation is to support the economic and social well-being of Albertans, health research and innovation activities that are aligned to meet Government of Alberta priorities, including, without limitation, activities directed at the development and growth of the health sector, the discovery of new knowledge and the application of that knowledge.

The Corporation is exempt from income taxes under the *Income Tax Act.*

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES

These consolidated financial statements are prepared in accordance with Canadian public sector accounting standards (PSAS).

a) Reporting Entity and Method of Consolidation

The consolidated financial statements reflect the assets, liabilities, revenues and expenses of the reporting entity, which is comprised of the Corporation and the Alberta Foundation for Health Research (AFHR). The AFHR operates under the *Alberta Companies Act* and is a registered charitable organization for income tax purposes. The Foundation's activities are directed to promote and support medical research. All intercompany balances and transactions have been eliminated on consolidation.

b) Basis of Financial Reporting

Revenue Recognition
All revenues are reported on the accrual basis of accounting. Cash received for which goods or services have not been provided by year end is recorded as deferred revenue. Externally restricted revenue, including partnership revenue, is recognized as revenue in the period in which the resources are used for the purpose specified. Funds received prior to meeting the criterion are recorded as deferred revenue until the resources are used for the purpose specified.

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (Cont'd)

Operating and unrestricted grants are recognized as revenue in the year the transfers are received or receivable. Restricted grants are included in deferred revenue when received, and recognized as revenue when the Corporation meets the conditions of the grant.

Investment income includes interest income.

Investment income earned from restricted sources is deferred and recognized when the terms imposed have been met.

Government transfers

Transfers from the Government of Alberta, other governments, and other government entities are referred to as government transfers.

Government transfers and the associated externally restricted investment income are recorded as deferred revenue if the eligibility criteria for use of the transfer, or the stipulations together with the Corporation's 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, the Corporation complies with its communicated use of the transfer.

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

Donations and Non-government contributions

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

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

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (Cont'd)

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

Expenses

Expenses are reported on an accrual basis. The cost of all goods consumed and services received during the year are expensed.

Directly incurred expenses are costs the Corporation has primary responsibility and accountability for. In addition to operating expenses such as salaries and supplies, directly incurred expenses also include:

- Amortization of tangible capital assets.
- Pension costs which comprise of the cost of employer contributions for current service of employees during the year.
- Valuation adjustments which include changes in the valuation allowances used to reflect financial assets at their net recoverable or other appropriate value. Valuation adjustments also represent the change in management's estimate of future payments arising from obligations relating to vacation pay.

Grants are recognized as expenses when authorized, eligibility criteria, if any, are met, and a reasonable estimate of the amounts can be made.

Valuation of Financial Assets and Liabilities

The Corporation's financial assets and liabilities are generally measured as follows:

Financial Statement Component	Measurement
Cash	Cost
Accounts receivable and other assets	Lower of cost or net recoverable value
Accounts payable and accrued liabilities	Cost

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (Cont'd)

The Corporation has no assets or liabilities in the fair value category, has not engaged in foreign currency transactions and has no remeasurement gains or losses. Consequently, no statement of remeasurement gains or losses has been presented.

Financial Assets

Financial assets are the Corporation's financial claims on external organizations and individuals.

The Consolidated Cash Investment Trust Fund (CCITF) is managed with the objective of providing competitive interest income to depositors while maintaining appropriate security and liquidity of depositors' capital. The portfolio is comprised of high-quality, short-term and mid-term fixed income securities with a maximum to maturity of three years.

Accounts Receivable
Accounts receivable are recorded at the lower of cost or net recoverable value. A valuation allowance is recorded when recovery is uncertain.

Liabilities

Liabilities represent present obligations of the Corporation to external organizations and individuals arising from transactions or events occurring before the year end. They are recorded when there is an appropriate basis of measurement and management can reasonably estimate the amount.

Liabilities also include:

- All financial claims payable by the Corporation at the year end
- Accrued employee vacation entitlements; and
- Contingent liabilities where future liabilities are likely.

Non-Financial Assets

Non-financial assets are limited to tangible capital assets and prepaid expenses.

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (Cont'd)

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 of the asset.

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

Furniture and Equipment	5 – 10 years
Computer Hardware and Software	3 years
Leasehold Improvements	over the lease term

Tangible capital assets are written down when conditions indicate that they no longer contribute to the Corporation's ability to provide services or when the value of future economic benefits associated with the tangible capital assets are less than their net book value.

Prepaid Expenses

Prepaid expenses are recorded at cost and amortized base on terms of the agreement.

Measurement uncertainty

The measurement of certain assets and liabilities is contingent upon future events; therefore, the preparation of these consolidated financial statements requires the use of estimates, which may vary from actual results. Management uses judgment to determine such estimates. In management's opinion, the resulting estimates are within reasonable limits of materiality and are in accordance with the significant accounting policies summarized above.

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES (Cont'd)

c) Changes in Accounting Policy

Adoption of the Net Debt Presentation
The net debt presentation (with reclassification of comparatives) have been adopted for the presentation of the consolidated financial statements. Net debt or net financial assets is measured as the difference between the Corporation's financial assets and liabilities.

The effect of this change results in changing the presentation of the Statement of Financial Position and adding the Statement of Change in Net Financial Assets.

NOTE 3 FUTURE ACCOUNTING CHANGES

In June 2015 the Public Sector Accounting Board issued the following standards:

PS 2200 Related Party Disclosures and PS 3420 Inter-Entity Transactions (effective April 1, 2017)
PS 2200 defines a related party and establishes disclosures required for related party transactions; PS 3420 establishes standards on how to account for and report transactions between public sector entities that comprise a government's reporting entity from both a provider and recipient perspective. Management is currently assessing the impact of these standards on the consolidated financial statements.

PS 3210 Assets, PS 3320 Contingent Assets, and PS 3380 Contractual Rights (effective April 1, 2017)
PS 3210 provides guidance for applying the definition of assets set out in FINANCIAL STATEMENT CONCEPTS, Section PS 1000, and establishes general disclosure standards for assets; PS 3320 defines and establishes disclosures on contractual rights. Management is currently assessing the impact of these standards on the consolidated financial statements.

PS 3430 Restructuring Transactions (effective April 1, 2018)
This standard provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related program or operating transferors and recipients of assets and/or liabilities, together with related program or operating responsibilities.

Management is currently assessing the impact of these standards on the consolidated financial statements.

NOTE 4 BUDGET

(in thousands)

A preliminary business plan with a budgeted deficit of $26,211 was approved by the Board on December 8, 2015and the full financial plan was submitted to the Minister of Health. The budget reported in the statement of operations reflects the original $26,211 deficit.

NOTE 5 CASH

(in thousands)

Cash in the amount of $56,656 (2015 - $95,245) include deposits in the Consolidated Cash Investment Trust Fund (CCITF) amounting to $56,570 (2015 - $95,096). Cash as at March 31, 2016 includes restricted cash of $34,430 (2015 - $42,785). As at March 31, 2016, securities held by the Corporation have a return of 0.8% per annum (2015: 1.2% per annum).

Due to the short-term nature of CCITF investments, the carrying value approximates fair value.

NOTE 6 ACCOUNTS RECEIVABLE

(in thousands)

	2016			2015
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Accounts Receivable	$ 592	$ -	$ 592	$ 680

Accounts receivable are unsecured, non-interest bearing and reported at their net realizable value.

NOTE 7 FINANCIAL RISK MANAGEMENT

The Corporation's financial instruments include cash and cash equivalents, accounts receivable and other assets and accounts payable and accrued liabilities. The Corporation is not involved in any hedging relationships through its operations and does not hold or use any derivative financial instruments for trading purposes.

The Corporation's financial instruments are exposed to credit risk, market risk and liquidity risk.

a) Credit Risk

Counterparty credit risk is the risk of loss arising from the failure of a counterparty to fully honour its financial obligations with the corporation. The Corporation's accounts receivable are exposed to credit risk. Management manages this risk by continually monitoring the creditworthiness of counterparties and by dealing with counterparties that it believes are creditworthy.

b) Market Risk

Market risk is the risk of loss from unfavourable change in fair value or future cash flows of a financial instruments causing financial loss. Market risk is comprised of currency risk, interest rate risk and price risk. The Corporation's cash is exposed to interest rate risk. Management manages this risk by continually monitoring the Corporation's deposits in the CCITF and their corresponding rate of return.

c) Liquidity Risk

Liquidity risk is the risk that the Corporation will encounter difficulty in meeting obligations associated with its financial liabilities. The Corporation's accounts payable and accrued liabilities are exposed to liquidity risk. Management manages this risk by continually monitoring cash flows.

NOTE 8 ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

(in thousands)

	2016	2015
Accounts Payable and Accrued Liabilities	$ 9,491	$ 9,270
Other	88	151
	$ 9,579	$ 9,421

NOTE 9 DEFERRED REVENUE

(in thousands)

	2016				2015
	Government of Alberta	Federal Government	Non-Government	Total	Total
Balance, Beginning of Year	$ 29,935	$ 7,609	$ 1,143	$ 38,687	$ 23,763
Received/receivable During the Year	7,740	5,310	-	13,050	26,851
Restricted Realized Investment Income	131	-	-	131	119
Less Amount Recognized as Revenue	(19,046)	(4,558)	(472)	(24,076)	(12,046)
Balance, End of Year	$ 18,760	$ 8,361	$ 671	$ 27,792	$ 38,687

NOTE 10 BENEFIT PLANS

(in thousands)

(a) Pension Plan

The Corporation participates in a Defined Contribution Pension Plan pension. The expense for this pension plan is $610 (2015 - $445). AIHS accounts for this plan on a defined contribution basis.

(b) Accrued Retirement Allowance

The Benefit Plans consists of the unfunded liability for the Corporation's supplemental retirement plan, the benefits under which are paid for entirely by the Corporation when they come due. There are no plan assets. There are no active members remaining in the plan and one retired member eligible for benefits.

At March 31, 2016 these plans have net accrued liability of $202 (2015-$328).

	2016	2015
Benefit Plans, Beginning of Year	$ 328	$ 378
Interest Cost	3	3
Benefits Paid	(129)	(53)
Benefit Plans, End of Year	$ 202	$ 328

NOTE 11 TANGIBLE CAPITAL ASSETS

(in thousands)

	2016				2015
	Equipment	Computer hardware & software (c)	Leasehold improvements (b)	Total	Total
Estimated Useful Life	5-10 years	3 years			
Historical Costs (a)					
Beginning of Year	$ 456	$ 1,954	$ 888	$ 3,298	$ 3,133
Additions	6	113	24	143	167
Disposals	(18)	(31)	-	(49)	(2)
	444	2,036	912	3,392	3,298
Accumulated Amortization					
Beginning of Year	358	1,306	793	2,457	2,190
Amortization Expense	13	295	24	332	269
Effects of Disposals	(16)	(28)	-	(44)	(2)
	355	1,573	817	2,745	2,457
Net Book Value at March 31, 2016	$ 89	$ 463	$ 95	$ 647	
Net Book Value at March 31, 2015	$ 97	$ 649	$ 95		$ 841

(a) Equipment includes office equipment and furniture, and other equipment.
(b) Leasehold improvements are amortized over the lease term.
(c) Historical cost includes computer hardware and software work-in-progress at March 31, 2016 totaling $nil (2015 - $31).

NOTE 12 ACCUMULATED SURPLUS

(in thousands)

Accumulated surplus is comprised of the following:

	2016			2015
	Investments in Tangible Capital Assets	Unrestricted Surplus	Total	Total
Balance, Beginning of Year	$ 841	$ 47,759	$ 48,600	$ 35,931
Annual (Deficit) Surplus	-	(28,025)	(28,025)	12,669
Net Investment in Capital Assets	(194)	194	-	-
Balance, End of Year	$ 647	$ 19,928	$ 20,575	$ 48,600

NOTE 13 CONTRACTUAL OBLIGATIONS

(in thousands)

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

	2016	2015
Obligations under grants and awards and office premises	$ 178,124	$ 184,746

Estimated payment requirements for each of the next five years and thereafter are as follows:

	Grant and Awards (a)	Office Premises (b)	Total
2016-17	$ 73,845	$ 609	$ 74,454
2017-18	56,795	682	57,477
2018-19	34,591	698	35,289
2019-20	4,964	698	5,662
2020-21	2,061	698	2,759
Thereafter	1,436	1,047	2,483
	$ 173,692	$ 4,432	$ 178,124

(a) Grants and awards are recorded as commitments when all terms and conditions have been agreed to but eligibility criteria have not been met.
(b) The Corporation has entered into a 104 month lease for office premises. The lease expires on September 30, 2022.

NOTE 14 COMPARATIVES FIGURES

Certain 2015 figures have been reclassified to conform to the 2016 presentation.

NOTE 15 SUBSEQUENT EVENT

On April 14, 2016, the Government of Alberta announced the amalgamation of the four Alberta Innovates corporations, BIO Solutions, Technology Futures, Energy and Environment Solutions, and Health Solutions into one, along with a wholly owned subsidiary corporation to provide a specialized applied research services. Government will introduce legislation in 2016 to legally create the new entity. Until then, each of the four existing corporations will retain their legal identity.

As the four Alberta Innovates corporations are still legal entities until legislation to create the new corporation is passed and in force later fiscal 2016-2017, the Lieutenant Governor in Council has appointed a new Board of Directors to serve for all four of the Alberta Innovates corporations.

This amalgamation will have a significant financial impact on future operations of the four Corporations but an estimate of the financial impact cannot be made at this time.

NOTE 16 APPROVAL OF CONSOLIDATED FINANCIAL STATEMENTS

These consolidated financial statements were approved by the Board of Directors of Alberta Innovates – Health Solutions on May 31, 2016.

ALBERTA INNOVATES - HEALTH SOLUTIONS
SCHEDULE 1
EXPENSES - DETAILED BY OBJECT
YEAR ENDED MARCH 31

	2016		2015
	Budget	Actual	Actual
	(in thousands)		
Grants	$ 99,851	$ 88,640	$ 74,021
Supplies and Services	11,280	6,960	7,043
Salaries, Wages and Employee Benefits	7,022	7,545	6,245
Amortization of Tangible Capital Assets	375	332	269
Loss on Disposal of Tangible Capital Assets		5	-
	$ 118,528	$ 103,482	$ 87,578

ALBERTA INNOVATES - HEALTH SOLUTIONS
SCHEDULE 2
SALARY AND BENEFITS DISCLOSURE
YEAR ENDED MARCH 31

	2016				2015
	Base Salary (1)	Other Cash Benefits (2)	Other Non-Cash Benefits (3)	Total	Total
	(in thousands)				
Chair of the Board	$ -	$ -	$ -	$ -	$ -
Board Members	-	23	-	23	25
Chief Executive Officer (interim) (4)	255		33	288	386
Chief Partnership Officer (4)	-	-	-	-	294
Executives/Vice Presidents:					
Vice President - Corporate Services	225	-	28	253	222
Vice President - Initiatives and Innovation (5)	225	-	27	252	203
Vice President - Provincial Platforms & SPOR (6)	250	-	31	281	75
Executive Director, Operations (7)	175	-	31	206	97
	$ 1,130	$ 23	$ 150	$ 1,303	$ 1,302

(1) Base salary includes regular salary.

(2) Other cash benefits includes honoraria.

(3) Other non-cash benefits includes the share of all employee benefits and contributions or payments made on behalf of employees including pension, health care, dental coverage, group life insurance, health spending accounts, short and long-term disability plans and professional memberships.

(4) On March 5, 2015 the Chief Partnership Officer and the Chief Executive Officer (interim) positions were combined after the Chief Executive Officer passed away.

(5) The Vice President – Health Technologies position was reclassified as Vice President – Initiatives and Innovations on December 16, 2014.

(6) The Vice President – Provincial Platforms & SPOR was a new position effective January 5, 2015.

(7) The Strategic Advisor, CEO position was reclassified as Executive Director, Operations on June 1, 2015

ALBERTA INNOVATES - HEALTH SOLUTIONS
SCHEDULE 3
RELATED PARTY TRANSACTIONS
YEAR ENDED MARCH 31

Related parties are those entities consolidated or accounted for on a modified equity basis in the Government of Alberta's financial statements. Related parties also include key management personnel in the corporation. The corporation and its employees paid of collected certain taxes and fees set by regulation for premiums, licenses and other charges. These amounts were incurred in the normal course of business, reflect changes applicable to all users, and have been excluded from this schedule.

The Corporation had the following transactions with related parties which are recorded on the Consolidated Statement of Operations and the Consolidated Statement of Financial Position at the amount of consideration agreed upon between the related parties.

	Entities in the Ministry		Other Entities Outside of the Ministry	
	2016	**2015**	**2016**	**2015**
	(in thousands)			
Revenues				
Grants	$ 69,119	$ 97,113	$ 88	$ 819
Other	197	156	4	7
	69,316	97,269	92	826
Expenses - Directly Incurred				
Grants	3,854	3,062	82,362	69,063
Other Services	98	192	459	692
	$ 3,952	$ 3,254	$ 82,821	$ 69,755
Receivables from	$ 78	$ 45	$ 427	$ 524
Payables to	$ 698	$ 153	$ 8,072	$ 7,883
Deferred Revenue	$ 15,892	$ 27,004	$ 2,868	$ 2,931
Contractual Obligations	$ 3,844	$ 6,375	$ 169,461	$ 172,719

ALBERTA INNOVATES - HEALTH SOLUTIONS
SCHEDULE 4
BUDGET
YEAR ENDED MARCH 31, 2016

	Original Budget	Reclassifications	Budget
		(in thousands)	
Revenues			
Government Transfers			
Government of Alberta Grants	$ 86,433	$ -	$ 86,433
Partnership Revenue	5,310	-	5,310
Investment Income	266	-	266
Other Revenues	308	-	308
	92,317	-	92,317
Expenses			
Strategic Investments	73,888	-	73,888
Partnership Funding Programs [(1)]	25,463	317	25,780
Administration	9,500	-	9,500
Platforms	9,360	-	9,360
Partnerships [(1)]	317	(317)	-
	118,528	-	118,528
Annual Deficit	$ (26,211)	$ -	$ (26,211)

[(1)] Partnership expenses reallocated to Partnership Funding Programs

OTHER FINANCIAL INFORMATION
Ministry of Health

Unaudited Information

DEPARTMENT OF HEALTH

STATEMENT OF REMISSIONS, COMPROMISES AND WRITE-OFFS

FOR THE YEAR ENDED MARCH 31, 2016

(in thousands)

	2016	2015
Write-Offs		
Medical Claim Recoveries	$ 2,135	$ 2,426
Product Listing Agreements	2,106	1,200
Other Receivables	428	418
Total Remissions, Compromises and Write-offs	$ 4,669	$ 4,044

The above statement has been prepared pursuant to Section 23 of the *Financial Administration Act*. The statement includes all remissions, compromises and write-offs made or approved during the fiscal year.

Other Statutory Reports

Public Interest Disclosure Act

Section 32 of the *Public Interest Disclosure Act* requires the Ministry to report annually on the following parts of the Act:

(a) the number of disclosures received by the designated officer of the Public Interest Disclosure Office, the number of disclosures acted on and the number of disclosures not acted on by the designated officer;
(b) the number of investigations commenced by the designated officer as a result of disclosures;
(c) in the case of an investigation that results in a finding of wrongdoing, a description of the wrongdoing and any recommendations made or corrective measures taken in relation to the wrongdoing or the reasons why no corrective measure was taken.

In 2015-16 for the ministry, there were no disclosures of wrongdoing filed with the Public Interest Disclosure Office pursuant to the Act.