



# Alberta Health Services

2010/11

Operating Budget and Business Plan

June 28, 2010

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# 1 Message from Chief Executive Officer

The creation of a single health organization for the Province was an innovative decision and has now been supported by a five year funding agreement. This will provide our young organization a financial framework within which we can focus on improving health services and changing the health experience of Albertans.

Premier Stelmach has enunciated the vision that Alberta should have the best performing, publicly funded, health system in Canada. This will require significant improvement in all three of our goals of access, quality and sustainability. In this context sustainability is about both efficiency as well as keeping all Albertans healthy.

Our Health Plan reflects a five year vision of significant improvements in three major service and patient experience areas – primary and community care, access to treatments when needed, and support in older age. We have termed these three Transformational Improvement Programs: Building a Primary Care Foundation; Improving Access Reducing Wait Times; Choice and Quality for Seniors.

In addition we have identified two other priorities for action: one to assist our staff and physicians in the critical work they do supporting and delivering health services; the other to develop the critical infrastructure and business processes to derive the benefits from this immense merger. We have titled the former, Enabling Our People to achieve excellence in health services. The latter we have called, Enabling One Health Service.

Our Operating Budget and Business Plan for 2010/11 represents our financial plan for the first year of our Health Plan. It outlines how we propose to utilize our year one funding to further Health Plan priorities.

I recognize as a new organization, we need to focus on building strong foundations – investing in clinical networks, new information systems, infrastructure and business processes to name a few. While these foundations will support and strengthen healthcare in this province, we also need to embrace the opportunities we now have as one health system.

Our Operating Budget and Business Plan for 2010/11 describes investments to further our Health Plan including: support existing services, increase access, build foundations to improve services; cover increases in operating costs, realize efficiencies and prepare to meet Albertans' health needs for the future. This will be accomplished within our funding resources.

Dr Stephen Duckett

President and Chief Executive Officer

## 2 Executive Summary

The 2010/11 Operating Budget and Business Plan document indicates how available financial and other resources will be allocated this fiscal year. It communicates the results AHS expects to achieve for the year. It links these expenditures and expectations to AHS' five year Health Plan which articulates very specific improvements in health system performance that are expected for year one of the plan.

AHS' consolidated budget reflects the entire organization including all unrestricted and restricted funds, our wholly owned subsidiaries (Carewest, Calgary Laboratory Services, Capital Care Group), Emergency Medical Services (EMS), and the proportionate share of all partnerships (Primary Care Networks). The consolidated budget represents the full and comprehensive picture of AHS and the budget that is submitted to the Minister of Health and Wellness.

The Budget describes funding as the one input, however it cannot, with any justice, describe what the men and women of Alberta Health Services do every day for Albertans and Alberta. Section 3 provides a numerical sketch of what AHS does every day. The 2010/11 Budget provides funding to build on current operations to enhance access and quality.

This document provides an overview of the Health Plan. It emphasizes that the Operating Budget and Business Plan has been built to stabilize the organization and to further the priorities outlined in the Health Plan. In the 2010/11 fiscal year the emphasis is on improved choices and access to services for seniors (for example, reducing the number of persons waiting in the community for continuing care beds by 21%).

The document offers brief highlights from the past fiscal year. The context for building the five year Health Plan and more particularly the Operating Budget and Business Plan is described.

The process for building the budget for this year is detailed and a budget overview is provided. Revenue and expense forecasts as well as an operating statement are provided and explained. General forecast risks are indicated and specific forecast risks for particular revenues and expenditures are described. A brief description of capital requirements which must be funded through operating surplus is presented.

The fiscal plan for 2010/11 reflects an expectation that we will meet Health Plan expectations for this year while living within our means.

Finally, a five year outlook for revenue and expenditure is provided along with an assessment of that outlook.

### 3 Alberta Health Services – quick facts

#### **Annual Service Volumes (Preliminary 2009/10)**

1,980,000	Emergency Department Visits
178,000	Urgent Care Visits
363,000	Hospital Discharges
51,000	Births
60,000	Home Care Clients
1,030,000	Health Link Calls
48,860,000	Laboratory Procedures
149,500	MRI Exams
416,500	CT Exams

#### *Cancer Care*

510,000	Cancer Patient Visits
46,000	Cancer Patients Receive Treatment, Care & Support

#### *Mental Health*

15,000	Mental Health Hospital Admissions
493,000	Outpatient Community Mental Health Visits

## 4 2009/10 in review

### 4.1 Overview

This spring marked the first-year anniversary of Alberta Health Services. The past year has been a time of profound change in health care in Alberta as the organization moves forward with the largest merger in Canadian history. AHS is now the largest health care organization in Canada and the largest employer in Alberta.

AHS has made its priorities clear: access, quality and sustainability, all of which address the government's vision of having the best performing, publicly funded health care system in Canada. AHS is committed to helping achieve that vision.

2009/2010 was a foundational year for AHS. Twelve predecessor entities have merged, and AHS has taken over direct provision of ground emergency medical services in much of the province. AHS has achieved approximately \$660 million in savings and avoided annual costs and made progress in building a strong, province-wide health care structure. The government's recently announced five-year funding plan provides AHS with stable funding, and establishes a solid financial foundation for the organization.

Across the province, AHS is engaging with local Health Advisory Councils to ensure that regional and community issues are heard and understood. AHS continues to work in collaboration with the Province of Alberta to establish health care priorities and policy that will benefit all Albertans. Quality, access and sustainability will continue to serve as the cornerstones of our strategic planning.

### 4.2 Beds Increased

**Exhibit 4.1 Alberta Health Services Beds by Type**

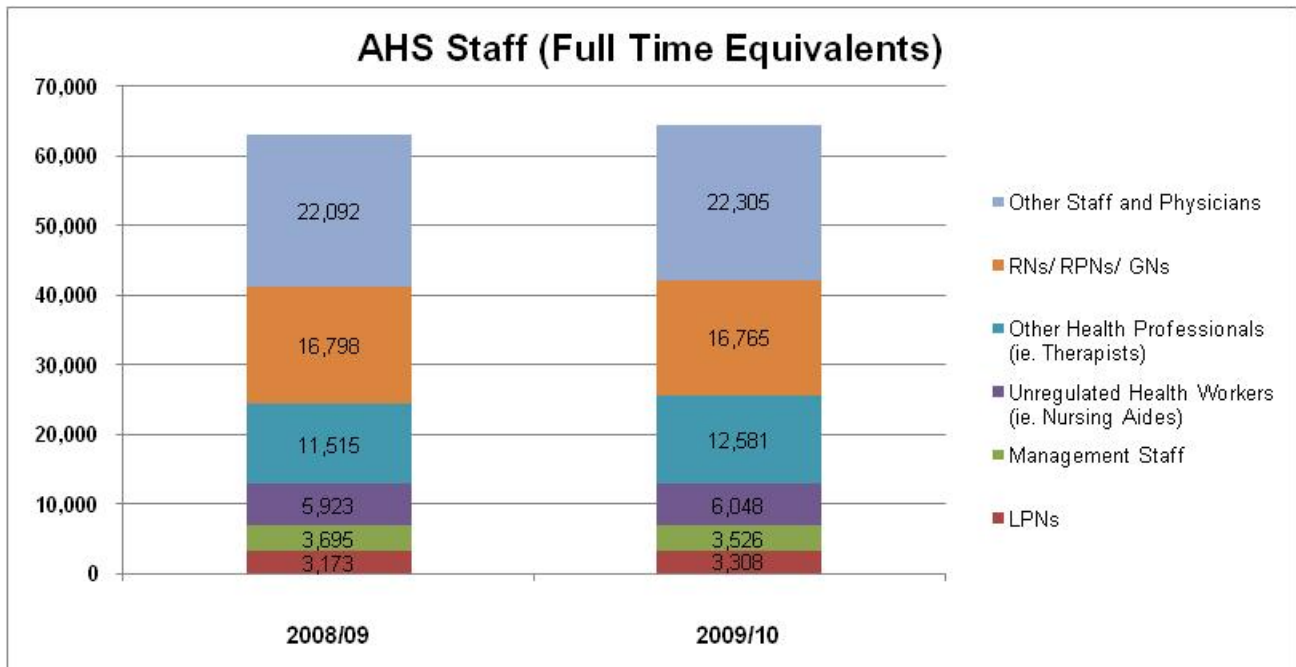
Number of Beds/Spaces	As of March 31, 2009	As of March 31, 2010	Change	% Change
Acute Care	7,719	7,802	83	1%
Mental Health	1,310	1,312	2	0%
Addiction	1,295	1,409	114	9%
Continuing Care Beds	19,176	19,557	381	2%
Sub-acute	415	418	3	1%
Palliative and Hospice	160	162	2	1%
Other	48	54	6	13%
<b>Alberta Total</b>	<b>30,123</b>	<b>30,714</b>	<b>591</b>	<b>2%</b>

Improving Albertans' access to health care remains a priority for AHS. In the year ending March 31, 2010, AHS increased the number of beds, or spaces, in facilities across the province. This represents an overall increase in the number of beds/spaces for patients requiring multiple levels of care, including acute care, supportive living care, and care for those with addictions. Expansion of continuing care beds will continue to be a priority in the years ahead (see Exhibit 5.2).

### 4.3 Staff Increased

Staffing in AHS increased 2% over the year. A significant proportion of this was due to assuming responsibility for Emergency Medical Services (included in 'other health professionals'). However, even without this addition, the staff complement increased by approximately 1%. Increases occurred across most categories of staff, although there was a reduction of 5% in management staff.

**Exhibit 4.2**



### 4.4 Spending Increased

AHS spending increased about 8% between 2008/09 and 2009/10, in part due to AHS taking over responsibility for ambulance services. Spending on community and home based care increased 14%, reflecting the high priority for this area.

Exhibit 4.3

**Alberta Health Services**  
**2008/2009 & 2009/2010 Comparative**  
**For the year ended March 31, 2010**  
(in millions)

***COMPARISON OF 2008/09 and 2009/10 EXPENSES***

**EXPENSES**

Inpatient acute nursing care services  
Emergency and outpatient services  
Facility-based continuing care services  
Community-based care  
Home care  
Diagnostic and therapeutic services  
Prevention etc. \*\*  
Research and education  
Administration, Information technology and Support services  
Other

**TOTAL EXPENSES (excluding Ambulance services)**

Ambulance services

**TOTAL EXPENSES**

	2008/2009 Actual	2009/2010 Actual *	Net Change from 2008/2009 Actual	
			Variance Increase/ (Decrease)	% Net Change
	\$ 2,399	\$ 2,524	\$ 125	5.2 %
	1,099	1,152	53	4.8 %
	756	778	22	2.9 %
	546	685	139	25.4 %
	393	383	(10)	(2.5 %)
	1,717	1,810	93	5.4 %
	297	317	20	6.7 %
	227	216	(11)	(5.1 %)
	2,047	2,122	75	3.7 %
	216	164	(52)	(24.1 %)
<b>TOTAL EXPENSES (excluding Ambulance services)</b>	<b>\$ 9,698</b>	<b>\$ 10,151</b>	<b>\$ 453</b>	<b>4.7 %</b>
Ambulance services	44	326	282	642.1 %
<b>TOTAL EXPENSES</b>	<b>\$ 9,742</b>	<b>\$ 10,477</b>	<b>\$ 735</b>	<b>7.5 %</b>

\* As per 2009/2010 draft audited June 10th financial statements

\*\* Prevention etc. is comprised primarily of health promotion, disease and injury prevention, health protection, and emergency preparedness which includes pandemic planning and preparedness.

## 5 Moving forward

This document presents the rationale and background to support the budget for the first year of Alberta Health Services (AHS) five year Health Plan. Expected changes in performance are specified in the Health Plan.

### 5.1 The Five Year Funding Plan

The 2010/11 Provincial Government Budget increased the allocation to Alberta Health Services by:

- Adjusting AHS's "base funding" to the level at which it was operating in 2009/10.
- Increasing base funding by 6%, as the first instalment of a phased growth program over the five-year funding agreement period (6% in each of the first three years and 4.5% for each of the two following years).

In addition, the accumulated deficit to March 31/10 is eliminated through one time funding.

As a result of these commitments AHS will see an increase of \$1.324 billion to the 2010/11 budget, which includes an adjustment to 2009/10 base funding to reflect current spending levels as well as a 6% increase to form the 2010/11 budget.

This gives AHS the ability to make long-term plans, while maintaining budget control. In previous years, AHS' predecessor organizations were increasing spending by 10-11% annually. Even with the increased funding in the Five Year Funding Plan, AHS will need to maintain tight controls over its spending to ensure sustainability into the future

### 5.2 Health Plan

The 2010-2015 Health Plan outlines a five year vision for AHS and for health care improvements for Albertans. This vision is ambitious and will require the ongoing commitment of the Province as well as the commitment of all 85,000 AHS staff members, to ensure that high quality services are accessible for all.

AHS has three overarching goals: Quality, (that health care services are safe, effective and patient focused) Access (that appropriate health care services are available) and Sustainability (that health care services are provided within available resources both now and into the future). The Health Plan expands on these goals and further defines specific strategies and initiatives that will be implemented to meet these goals.

The Health Plan outlines three service-related Transformational Improvement Programs or foundational elements that will serve as our guideposts for the next five years. These three priorities are summarized below and will be integrated through a focus on meeting the needs of communities and reducing the burden of disease and illness. We will include consideration of the patient journey and the communities in which they live to provide focused, integrated solutions.

1. **Building a primary care foundation.** Patient-centred, coordinated and comprehensive health care provided through a robust primary care system has been shown to improve the health of a population and to increase the efficiency of health care delivery. It is imperative that AHS, in partnership with Alberta Health and Wellness, offer Albertans access to the best primary care

system, and, in turn the best opportunity to maintain good health and access to the services they need.

2. **Improving access and reducing wait times.** Timely access to health care results in better clinical outcomes. The development of provincial standards for clinical practice and wait times will help stabilize and improve access to care.
3. **Choice and quality for seniors.** One in five Albertans will be seniors within the next 20 years. It is imperative that seniors have access to services and supports to remain healthy and independent as long as possible. Through investment in supportive living we will expand choice for seniors and ensure seniors receive the right care at the right time, in the right place.

As a new organization, we are also concerned with building a strong integrated foundation for future success, and have identified two further priorities for action:

4. **Enabling our people to achieve excellence in health services.** The performance of our health care system is directly related to the people who provide care and service to citizens, families and communities across the Province. AHS is committed to empowering staff and physicians to provide high quality care and service by providing appropriate supports, such as education, an attractive and safe work environment and the necessary tools. AHS must engage all staff and physicians if we are to realize our goals.
5. **Enabling one health service.** The delivery of high quality, safe healthcare services depends on efficient and effective supports. AHS is committed to developing administrative support systems and business processes that enable staff and physicians to provide excellent health service to patients, families and communities. The integration of the twelve former entities is a significant undertaking that requires proper planning and determined execution.

## 5.3 The Overall Goal

What does success look like for AHS?

The Health Plan outlines a series of specific performance measures that will gauge our progress toward meeting our goals and objectives.

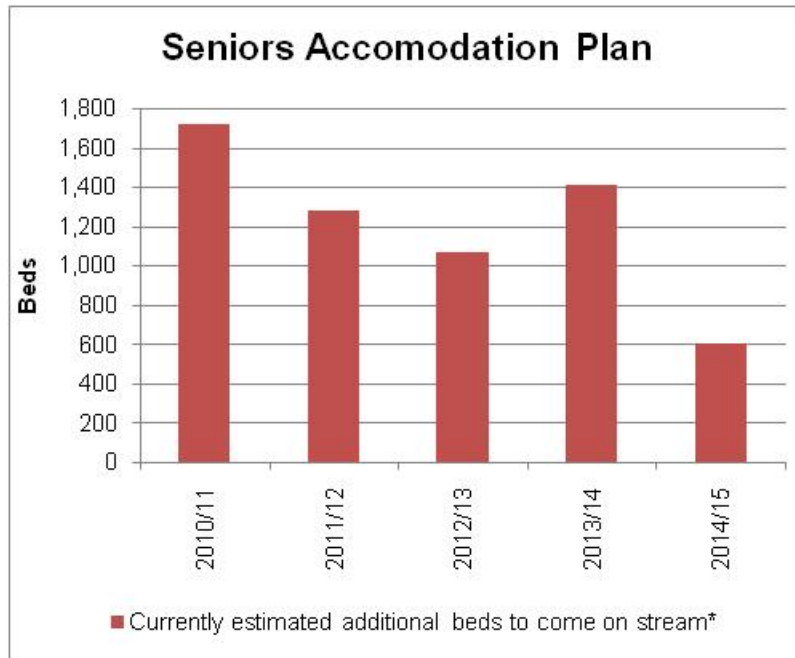
Alberta is a relatively high spending province, in terms of total health expenditure, on an age-gender adjusted basis. Despite this higher level of expenditure, Alberta does not have better outcomes. In terms of health adjusted life expectancy, for example, Alberta is below the national average.

Over time Alberta Health Services is striving to improve the health status of Albertans, measured by life expectancy (or health adjusted life expectancy), while improving value, measured by health expenditures per capita.

## 5.4 Addressing seniors' accommodation needs

Many seniors now wait long periods in hospital for appropriate accommodation. AHS will allocate significant funding to meet the needs of seniors in this budget year and in the coming years (see Exhibit 5.1). AHS currently has plans in place to open at least 1100 and up to 1700 continuing care beds in this budget year and over 4000 in the subsequent four years.

**Exhibit 5.1**

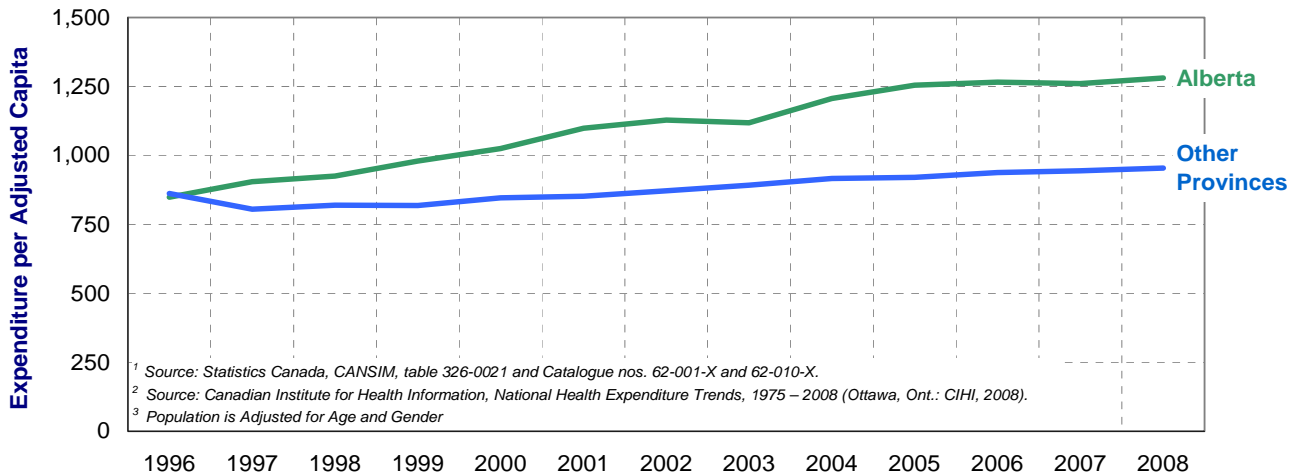


**5.5 Improving acute hospital care**

Alberta over a period of approximately 10 years has made significant investments in acute care capacity, especially compared to other provinces (see Exhibit 5.2 which includes all operating costs for hospitals).

**Exhibit 5.2**

**Provincial Government Constant (2002) Expenditure on Hospitals<sup>1,2,3</sup>**  
*per Adjusted Capita, by Jurisdiction, 1996 to 2008*



<sup>1</sup> Source: Statistics Canada, CANSIM, table 326-0021 and Catalogue nos. 62-001-X and 62-010-X.

<sup>2</sup> Source: Canadian Institute for Health Information, National Health Expenditure Trends, 1975 – 2008 (Ottawa, Ont.: CIHI, 2008).

<sup>3</sup> Population is Adjusted for Age and Gender

In the immediate term AHS' will leverage the existing investments in operating costs for hospitals and use existing acute capacity better. The most effective way of doing so in the immediate term is to reduce the number of acute beds occupied by patients awaiting transfer to seniors' accommodation. This will be a priority for AHS in 2010/11. Acute beds vacated by transferring patients to seniors' accommodation will become available for acute patients. This will also enable us reduce the routine use of beds meant to be for temporary surge capacity ('overcapacity' beds).

There are a number of new acute facilities available for commissioning in 2010/11. The budget provides for much of this space to be occupied by transferring acute patients from existing, older space. This generally represents a quality improvement for patients. New spaces are generally larger, so commissioning these, even without bringing additional beds on stream, incurs additional costs which are funded in this budget.

AHS will be evaluating the efficiency of acute care beds currently in service using a tool devised for that purpose. This tool uses measures such as use of beds for Alternate Level of Care patients, comparison of length of stay (after standardizing for case mix), and relative use of beds for conditions where utilization might have been reduced by better primary care or public health interventions. This information will inform future acute care capacity planning, efficiency strategies, priority setting and service development in primary care.

## 6 Building the Budget

### 6.1 2010/11 Budget

The starting point for the 2010/11 Budget was the 2009/10 level of expenditures (calculated based on February year-to-date results annualized by number of days) less the annualized 2009/10 savings and forecast savings from initiatives in progress.

To facilitate a systematic approach budget review meetings were conducted with each area that had \$100 million or more in annual operating expenses in 2009/10. Twenty-six of these meetings were held over a period of four weeks. These reviews were conducted by the CEO and the CFO with each relevant Executive Vice-President, Senior Vice-President and/or Vice-President. Business units responsible for budgets of less than \$100 million were covered in single portfolio meetings.

Each meeting reviewed savings initiatives, annualization costs due to services started in 2009/10, cost pressures and vacant positions, actions to address programs with grant funding expiring during 2010/11 and preliminary identification of new investments (as Transformational Improvement Programs).

Approval of allocations followed a set of common principles as outlined below:

- Annualizations of positions in place at the end of 2009/10 were approved for increment.
- Cost pressures such as education and minor equipment were treated as provincial issues to be funded in an equitable manner.
- Incremental positions required to address activity pressures offset by savings in overtime and casual costs were approved using an assumption that these positions on average will be filled midyear.

- Funding to be reallocated between cost centers to reflect existing accountability lines was identified.

Funding for priority initiatives has generally been held centrally to allow for more systematic and careful review following preparation of detailed business cases. This will better position AHS to meet strategic objectives in 2011/12 and beyond.

Savings targets have been allocated to a number of units (for example contracting procurement and supply management) to reflect the additional savings for 2010/11 as a result of decisions in 2009/10. An efficiency dividend of 1% is to be implemented from 1 April 2011 to facilitate reprioritization for investment in 2011/12. Additional savings will be required in years in which funding for specific restricted grants are scheduled to expire.

The 2010/11 budget process involved close cooperation between finance staff and operational leads. Funding for every position in the organization will now be assigned to appropriate cost centers with costs of positions being reassigned to reflect the organizational chart and management responsibilities. This will allow, for the first time, budget tracking and clear line of sight budget accountability from the President and Chief Executive Officer to all business units. With this clarity, budget control and accountability will be more effective with managers being given greater responsibility and accountability to manage their own budgets. The one-time Vacancy Management Process, introduced to ensure financial control in the absence of an effective position control system, will be abolished effective 1 July 2010.

The Health Plan describes how AHS intends to improve services to the population of Alberta in the coming five years. It details priorities for the organization and provides specific performance expectations for these priorities by year. It describes how these priorities are further reinforced by annual performance agreements for the leaders within the organization. The performance improvements described for 2010/11 are the deliverables for this Operating Budget and Business Plan.

## 6.2 Future budgets

The budget build process in future years will be modeled on the 2010/11 process. For 2010/11, the quantum of base funding was not announced until February. In contrast, the new five-year funding agreement provides funding certainty now for future budget years, subject to treatment of expiring grants (see section 9.2 below).

This means that, for the 2011/12 budgets and beyond, the proposed budget can be considered and approved before the start of the year. In addition over the next two years departments will begin to develop zero based budgets.

Key dates in the budget monitoring and approval cycle will be:

Item	Timeframe
Forecast remainder of the current year	October
<i>Mid-year review, forward year preview</i> Validate current year forecast and Budget for upcoming year by area. Finance and CEO meetings with each budget owner whose budget exceeds \$100M	November
Budget to Audit and Finance	January

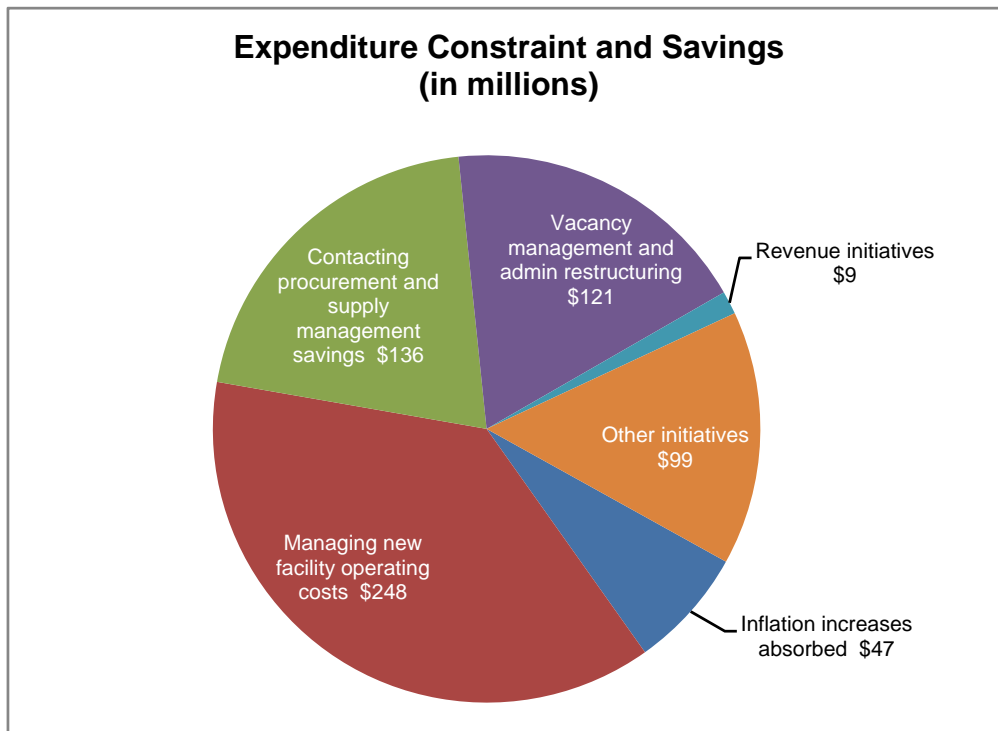
<b>Board Approval of Budget</b>	<b>February</b>
Budget allocations to budget owners	March
End of year review	May

### 6.3 2009/10 and 2010/11 Expenditure Constraint and Savings

The initial 2009/10 Budget projected a \$1.1 billion deficit. This reflected a projected expenditure increase of 12.8% from 2008/09. The primary objective of savings initiatives in 2009/10 was to manage the increase in expenditures through specific savings initiatives including: managing facilities within existing resources, strategic sourcing (procurement), revenue initiatives (such as parking and food services), and administrative restructuring, including Finance, Human Resources, Corporate Services, Support Services, and IT. In addition the organization achieved significant savings through vacancy management and cost containment initiatives.

Initiatives completed in 2009/10 resulted in almost \$500M of savings and cost avoidance. This reduced the rate of increase in expenditures from 12.8% in prior years to 8.4% in 2009/10. The 2010/11 annualized impact of these initiatives amount to \$660 million as depicted in Exhibit 6.1 below.

**Exhibit 6.1**



## 7 Budget Overview

### 7.1 The 2009/10 Budget Environment

The 2009/10 Budget set very ambitious expenditure constraint and savings targets; savings targets that had to be achieved within a nine-month period. The approach to expenditure reduction was guided by two main principles:

- minimize adverse impact on access or quality
- minimize compulsory staff lay-offs

Crucial to these strategies was the vacancy management program which tightened controls on recruitment. A consequence of these controls was extensive vacancies across the system, held in readiness for potential service reductions. This situation has changed with the new five-year funding plan. Many of these vacancies will need to be filled in 2010/11 in order to maintain service levels. However as vacancies are reviewed consideration is being given to take this opportunity to change staff mix.

### 7.2 Key service developments, 2010/11

The budget provides for two key areas for service improvements for Albertans. First, is AHS' plan to expand seniors' accommodation. As demonstrated in Exhibit 5.1, AHS plans to open up to 6000 beds over the course of the five year funding plan, with between 1100-1700 of these coming on stream in 2010/11, an 8% increase. Over the five years, there'll be up to 30% increase in seniors' beds.

This expansion will have real benefits for seniors on a number of dimensions:

- There will be increased choice for seniors across Alberta as more supportive living beds are opened to complement long term care beds
- The increased number of beds will mean seniors will not have to wait as long for needed accommodation
- Seniors currently waiting in acute facilities for continuing care beds will be able to move to more home-like and quiet seniors' facilities.

The expansion of seniors' accommodation and the expected reduction in so called 'alternate level of care' patients, will free up beds for acute patients. This along with other initiatives will lead to a second benefit of this budget, a reduction of patients waiting inappropriately in hospital emergency departments for admission to a ward bed. This in turn will lead to a reduction in emergency department wait times.

### 7.3 Sources of Funding and Revenue

Alberta Health and Wellness (AHW) is AHS's primary source of funding and provides 88% of the 2010/11 Budget. AHW base funding for 2010/11 increased by \$1.3 billion, comprised of an adjustment to the 2009/10 base funding and a 6% or \$512 million increase in 2010/11 operating funding. (Appendix 12.1 - Statement of Operations).

Other sources of funds include Fees and Charges, Ancillary Operations (such as parking and food services), Investment Income, Amortized External Capital Contributions, Restricted Grants and Donations. Increases in Fees and charges are due to increases in patient activity. Increases in Amortized External Capital Contributions are offset by increased amortization expense of externally funded capital assets coming into service.

Total funds of \$11.76 billion will be recognized as revenue in 2010/11. This represents a funding and revenue increase of \$1.5 billion over 2009/10. Components of total revenue and funding are outlined in Exhibit 8.1. A one-time payment of \$527 million of the AHW grant will be utilized to pay off the accumulated deficit and the remaining \$11.23 billion will be used to provide health services to Albertans in 2010/11. Exhibit 7.1 below outlines the key areas of expenditure increases in the 2010/11 Budget. In addition, \$168 million will be realized through further savings initiatives.

### Exhibit 7.1

<b>Business plan: Major Categories of Net Expenditure Increases</b>		
<b>Allocation</b>	<b>10/11 Funding (upper limit)<sup>1</sup></b>	<b>Explanation</b>
Transformational Improvement Programs	\$ 50 million  (\$300 million annualized)	Investment in Transformational Improvement Programs is intended to support a select number of initiatives which are described in Section 5.2 to further AHS' longer term strategy (detailed in the Health Plan). Focused investments such as these which are targeted to specific strategic priorities will occur each year. Precise investments have not been finalized but will be made based upon business cases which will assess the impact of these initiatives on furthering priorities such as quality, access and sustainability.
New Seniors' Beds	\$ 81 million	The allocation to seniors' beds reflects the importance attributed to expanding services available to seniors in the community. This is the first year of an ongoing commitment which will enhance choice and quality for seniors. The expansion of seniors' beds will facilitate a significant reduction in Alternate Level of Care patients in acute hospitals, in turn allowing for an improvement in flow of patients from emergency departments into ward accommodation.
Relocating Services to New Facilities	\$ 25 million	Funding allocations are necessary to support increased operating costs (such as utilities and protective services) associated with construction of additional acute care capacity while a strategy is finalized for the appropriate number, mix and distribution of beds in the Province.
Annualization	\$ 148 million	Annualization costs represent additional costs of initiatives which were started part way through the previous year but will incur a full

<sup>1</sup> Allocations for projects which commence after the start of the financial year will be held centrally and released to Business Units as required. The allocation shown in this column will be reduced depending on initiative commencement date.

		year's costs in this fiscal year.
Compensation Rate Increases	\$ 161 million	The bulk of AHS' expenditures, \$5.7 billion or approximately 52% (see Exhibit 8.2), are to pay the people directly employed by AHS in supporting and delivering health services. The compensation allocation is to cover increases (approximately 5%, excluding UNA) in those costs.
Service Provider Rate Increases	\$ 67 million	Service providers such as long-term care operators experience annual increases in operating costs. An allocation for increases, which in the case of long-term care facilities will be linked to the commencement of activity-based funding, has been provided.
Medical Fees and Contract Rate Increases	\$ 43 million	This allocation provides for rate increases in medical fees and other purchased services, such as housekeeping and information technology.
Non-Compensation Inflation	\$ 26 million	This allocation provides for rate increases for drugs, gases, medical/surgical supplies and other supplies as well as interest payments.
Savings Annualizations	(\$ 89) million	Annualization of savings resulting from merger and integration activities. This represents additional savings of initiatives which were started part way through the previous year but will incur a full year's cost offset in this fiscal year.
<b>Subtotal</b>	<b>\$ 512 million</b>	<b>6% increase in base funding</b>
Additional Savings	(\$ 79) million	Additional savings resulting from merger and integration activities. Primarily comprised procurement initiatives.
Adjustments for Cost Pressures	\$ 303 million	Some of the expenditure reductions in 2009/10 were in part achieved by tight control of vacancies, cost containment in discretionary expenditures such as minor equipment and education. These are not all sustainable in the long term. In addition there are necessary increases in activities in some areas compared to 2009/10 levels. This allocation allows the organization to adjust for such cost pressures. This allocation includes items such as: funding for expired grants, additional Emergency Medical Services transfers, utilities, operating costs related to infrastructure maintenance programs, vacant positions, etc.
Contingency	\$ 38 million	Provision for forecast risk (See Section 9).
Deficit Elimination	\$ 527 million	Allocation of one time funding to pay off 2009/10 accumulated deficit
Equipment and IT Expenditures	\$ 200 million	Not all equipment and IT expenses are funded through specified government investments. The current year allocation is a reflection of the need for AHS to support necessary priorities which can only be achieved through investment of operating funds.
<b>Total</b>	<b>\$ 1.5 billion</b>	

In 2010/11, the key budget priority will be on reducing emergency department wait times.

There are two main strategies incorporated in this budget to effect this:

- Significantly increase continuing care capacity by at least 1100 and up to 1700 spaces this year. This will help to address the 'backdoor' blockage in hospitals, allowing people awaiting placement for a seniors' facility to move into appropriate accommodation. Acute beds vacated by this process will be kept open releasing capacity to improve flow through the hospital for people to be transferred from emergency departments.
- Opening demonstration Medical Assessment Units at Rockyview General Hospital and the Royal Alexandra Hospital.

# 8 Consolidated Budget

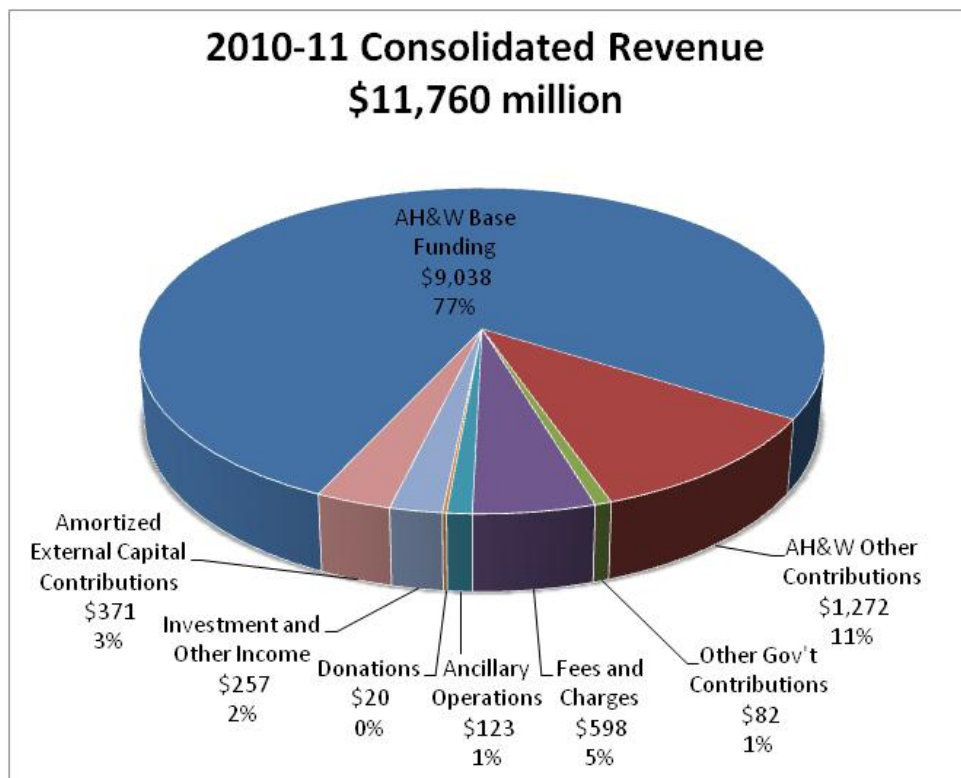
## 8.1 Overview

AHS' consolidated budget reflects the entire organization including all unrestricted and restricted funds, all wholly owned subsidiaries (Carewest, Calgary Laboratory Services, Capital Care Group), Emergency Medical Services (EMS), and the proportionate share of all partnerships (Primary Care Networks). The consolidated budget represents the full and comprehensive picture of AHS and the budget that is submitted to the Minister of Health & Wellness.

The consolidated budget is prepared under Canadian Generally Accepted Accounting Principles (GAAP) and Financial Directives issued by Alberta Health and Wellness. These principles and directives outline how and when revenues and expenditures are to be recognized within the budget. Restricted funding received is reflected as deferred contributions until expenditures have been incurred against it, at which point the funding is recognized as revenue.

The budget allows AHS to operate within its funding resources. In order to do so it has to set aside one-time funds for deficit elimination and funds for internally funded equipment and IT. As a result, AHS is projecting an operating budgeted surplus of \$630 million (see Appendix 12.1 Statement of Operations) for the period April 1, 2010 to March 31, 2011. This surplus will be utilized to pay off the 2009/10 accumulated deficit of \$527 million and provide a \$103 million net provision for internally funded capital equipment and IT purchases (\$200 million less internal amortization of \$97 million).

**Exhibit 8.1**



## 8.2 Consolidated Revenues

Alberta Health and Wellness unrestricted base funding for 2010/11 is \$9.04 billion, an increase of \$1.3 billion from 2009/10. Funding includes an adjustment to establish a stabilized 2009/10 operating base and an additional 6% funding increase for the 2010/11 fiscal year.

Alberta Health and Wellness Other Contributions of \$1.3 billion include \$527 million of projected one-time funding to address the 2009/10 accumulated deficit. It also includes \$745 million of restricted grant funding for special purpose programs and projects.

Other Government Contributions are budgeted at \$82 million for 2010/11. These generally consist of grant funding for special purpose programs and projects.

Patient Fees and Charges are budgeted at \$598 million for the 2010/11 fiscal year. These primarily relate to per diem charges for inpatient stays.

Ancillary Operations are budgeted at \$123 million for 2010/11; these include items such as parking and food services.

Donations are budgeted at \$20 million and are generally targeted for specific purposes by the Donors and therefore offset by corresponding increases in other expenses.

Investment and Other Income is budgeted at \$257 million comprised of interest income, dividends, net realized gains and losses on disposal of investment, recoveries, and revenue from sources external to AHS (drug companies, medical supply companies, universities, and other non-governmental grants).

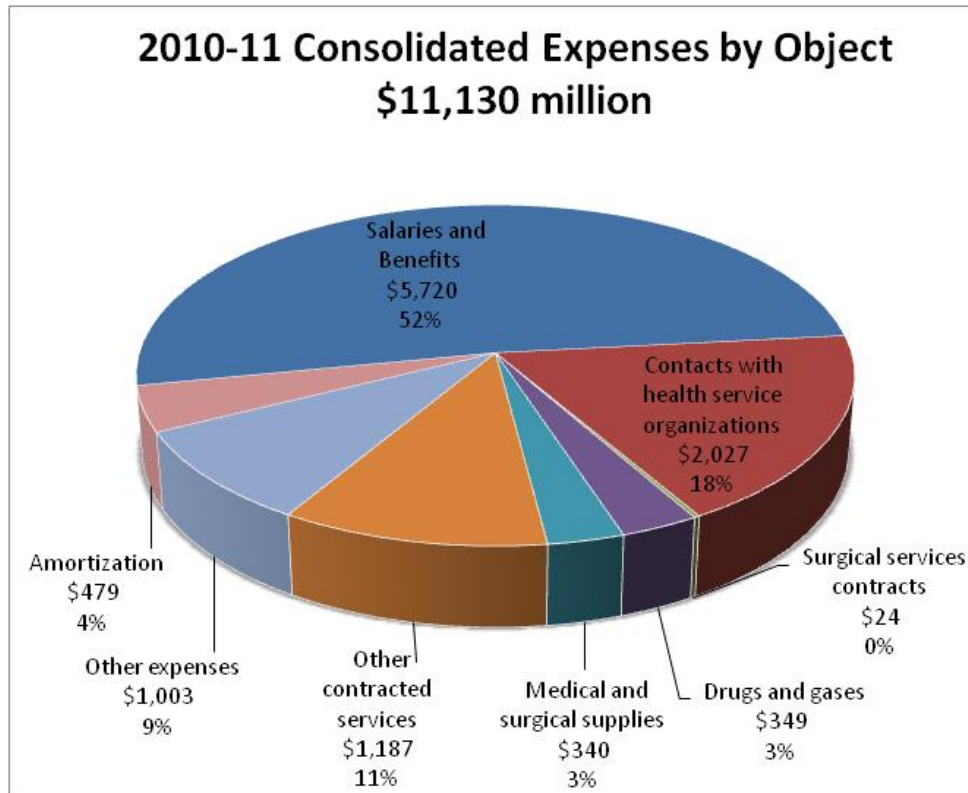
Amortized External Capital Contributions are budgeted at \$371 million, an increase of \$65 million over the 2009/10 actual revenues. This represents substantially completed projects to be capitalized where amortization will begin in 2010/11.

## 8.3 Consolidated Expenditures

Consolidated expenditures for 2010/11 are budgeted at \$11.13 billion (see Appendix 12.2, Schedule of Revenue and Expenses by Object), a \$652 million increase over 2009/10 actual expenditures. Expenditures by major category (Object) are portrayed in Exhibit 8.2 below.

The allocation of expenses to expense categories within operations (e.g. inpatient acute nursing care services) is completed at a detail level once the budget has been approved. Therefore, the following explanations are provided by object (e.g. salaries and benefits) in Exhibit 8.2.

**Exhibit 8.2**



Salaries and Benefits are budgeted at \$5.8 billion and account for 52% of the consolidated expenditures. These expenditures include staff engaged in clinical professions, research, ancillary operations, and support functions across the entire organization.


Budgeted expenditures for Contracts with Health Service Providers are \$2.03 billion. This comprises primarily of costs paid to continuing care providers including the increase from investment in approximately 1100 to 1700 new continuing care spaces as well as a 4% rate adjustment for contracted service provider costs.

Contracts under Health Care Protection Act for surgical services are budgeted at \$24 million, an increase of 7.4% over the 2009/10 expenditures representing both inflation increases and increased projected volumes in 2010/11 for the Non-Hospital Surgical Facilities.

Drugs and Gases are budgeted at \$354 million, a \$21 million or 6.4% increase over 2009/10 costs and includes allocations for rate and volume increases.

Medical and Surgical Supplies are budgeted at \$345 million, an increase of \$25 million or 7.7%, including inflationary increases of approximately 2% and volume increases as a result of additional service capacity.

Other Contracted Services are budgeted at \$1.19 billion, an increase of \$91 million over 2009/10 costs. Other Contracted Services include contracted physician costs, referred out laboratory services, and non-health related contracted providers such as housekeeping, security, and professional consultants. The 2010/11 budget for these contracts includes an inflation increase. However this is



largely offset by anticipated savings achieved from the provincial consolidation of some of these AHS contracts.

Other Expenses (which include equipment expenses, building and ground maintenance, other clinical supplies, insurance, etc.) are budgeted at \$1.01 billion, an increase of \$5 million or 0.5%.

Amortization is budgeted at \$478 million, an increase of \$70 million or 17.2%. This represents substantially completed projects to be capitalized where amortization will begin in 2010/11 (offset by amortized external capital contributions in the revenue section above).

## 8.4 2010/11 Statement of Operations and Business Plan

### Exhibit 8.3

	2009/2010 Budget	2009/2010 Actual *	2010/2011 Budget **	Net Change from 2009/2010 Actual	
				Variance Increase/ (Decrease)	% Net Change
<b>REVENUE</b>					
Alberta Health and Wellness base funding	\$ 7,714	\$ 7,714	\$ 9,038	\$ 1,324	17.2 %
Alberta Health and Wellness other contributions	716	1,169	1,272	103	8.8 %
Other government contributions	81	81	82	1	0.7 %
Fees and charges	585	578	598	20	3.5 %
Ancillary operations	109	123	123	0	0.0 %
Donations	16	18	20	2	12.5 %
Investment and other income	247	251	257	6	2.3 %
Amortized external capital contributions	301	305	371	65	21.5 %
<b>TOTAL REVENUE</b>	<b>\$ 9,768</b>	<b>\$ 10,239</b>	<b>\$ 11,760</b>	<b>\$ 1,521</b>	<b>14.9 %</b>
<b>EXPENSES</b>					
Inpatient acute nursing care services	2,733	2,524	2,681	158	6.2 %
Emergency and outpatient services	1,146	1,152	1,231	79	6.9 %
Facility-based continuing care services	788	778	871	92	11.8 %
Ambulance services	316	326	353	26	8.1 %
Community-based care	730	685	747	62	9.1 %
Home care	368	383	411	28	7.3 %
Diagnostic and therapeutic services	1,723	1,810	1,907	97	5.4 %
Prevention etc. ***	340	317	353	36	11.3 %
Research and education	204	216	219	3	1.3 %
Administration, Information technology, & Support services	2,123	2,122	2,155	33	1.6 %
Amortization of facilities and improvements	168	147	202	55	37.4 %
Capital assets write down	-	3		(3)	(100.0 %)
Funded transition costs (Note 6)	14	14		(14)	(100.0 %)
<b>TOTAL EXPENSES</b>	<b>\$ 10,653</b>	<b>\$ 10,477</b>	<b>\$ 11,130</b>	<b>\$ 652</b>	<b>6.2 %</b>
<b>Excess/(deficiency) of revenue over expenses</b>	<b>\$ (885)</b>	<b>\$ (238)</b>	<b>\$ 630</b>	<b>\$ 869</b>	<b>(364.4 %)</b>

\* As per 2009/2010 draft audited June 10th financial statements

\*\* 2010/2011 Budget to be resubmitted once detailed budget is completed

\*\*\* Prevention etc. is comprised primarily of health promotion, disease and injury prevention, health protection, and emergency preparedness which includes pandemic planning and preparedness.

## 9 2010/11 Forecast Risks

Maintaining a balanced and sustainable operating budget is critical to AHS. Providing a complex array of quality health services tailored to individual and population health needs generates significant inherent risks to maintaining a balanced budget. AHS is committed to providing these services and mitigating financial risks.

### 9.1 High-level Risks

Although there are risks associated with specific revenues and expenditures which will be described in this section, there are broader organizational and environmental risks that could have an impact on the 2010/11 forecast. Exhibit 9.1 outlines these risks and identifies AHS' mitigating strategies.

**Exhibit 9.1 Key high-level risks**


Risk	Mitigating Strategy
AHS' ongoing operations are large, complex and challenging. Merger activities are also significant. Many staff and physicians are necessarily involved in both of these activities. All of this activity increases the risks of unintended events and results.	Focusing on priorities and effectively managing these priorities as projects. Recognizing that staff will need support with both activities.
Increases to operating budgets going forward will not be at the historical rates. Alignment of activities, performance and funding must be maintained.	Effective and ongoing communication with operational managers and the continued inclusion of specific financial performance expectations in senior managers' performance agreements.
Significant unanticipated increases in health service utilization.	Manage activity levels and achieve committed improvements in system performance. Continue to review and improve efficiency of business units

### 9.2 Revenue Risks

Alberta Health and Wellness Base Funding is AHS' primary source of revenue. Given the five year funding agreement with the Province, this (base) funding has been assured.

Alberta Health and Wellness Other Contributions (including Alberta Health and Wellness restricted, Alberta Infrastructure, Alberta Seniors), which amount to \$1,289 million or 11% of total revenues, present risks to AHS. Changes to processes for Restricted and Capital Grants may put AHS at risk of reduced revenue without sufficient lead time to adjust expenditure levels. Maintaining the operation of programs without these grants will require additional operating funding, reallocating existing budget or adjustment to service levels.

For 2010/11 \$43 million in restricted grants will expire. The related expenditures cannot be eliminated and the net increase in expenditures has been absorbed into the 2010/11 Budget. An estimated \$415 million of restricted funding is scheduled to expire in 2011/12, \$17 million in 2012/13 and \$144 million in 2013/14. This is reflected under "other Alberta Health and Wellness Contributions in Exhibit 11.1



(Five Year Revenue Outlook). This is a very significant item for the 2011/12 budget although given the nature of these grants, the risk that they will not be renewed is judged to be low at this time.

Overall revenue from sources other than the Province (12%) represents relatively small risk. Approvals to changes in rates which can be charged to clients and patients for uninsured services can be delayed or denied by the Province. Revenues from ancillary operations, such as parking and food services, can vary with activity or market conditions and investment income will vary with market conditions. Risks surrounding Other Government Contributions, Fees and Charges, and Investment and Other Income originate from uncertainty around funding continuance, residential and acute patient volumes and financial market conditions and volatility. Although these revenues only represent a small portion of AHS' overall revenue, these risks could impact AHS' ability to meet budget expectations.

### 9.3 Expenditure Risks

The AHS expense budget is comprised largely of human resource costs (approximately 52% arising from AHS staff salaries and benefits, and an additional 18% for contracted health service provider staff). Rate and volume changes in staffing and contracted providers pose a significant budget risk.

Negotiated collective agreements are in place for Health Sciences Association of Alberta (HSAA), Alberta Union of Provincial Employees (AUPE), General Support Services (GSS) and Auxiliary Nursing. These contracts contain provisions for increases of 4.5%, 5.0%, and 4.5% respectively and therefore there are no rate risks related to these three contracts. The quantum of these increases would not be sustainable in the out years of the five-year agreement. Expenses for contracted service providers also pose a risk to AHS. Negotiating increases for providers has proven difficult in the past. Rate increases based on consumer price indexes (CPI) have been met with reductions in services or substantial deficits for AHS' subsidiaries and partners

Staffing issues, maintenance of aging facilities, and increases to services result in funding pressures and risks for AHS. The introduction of activity-based funding in some areas will improve transparency of funding and tie funding to productivity. This can help mitigate many of these risks. However implementation of activity-based funding is phased over a number of years, mitigating risks for contractors and leaving residual risks with AHS over the implementation period.

Utility costs (which represent approximately \$100 million of the budget) are always an area of risk. While electricity and natural gas prices have been relatively low since the economic downturn in 2009, energy prices are highly volatile reacting to unpredictable environmental, political, and economic drivers. To mitigate some of this risk AHS is examining introduction of a hedging program to reduce volatility risks related to utility pricing.

While overall inflation is expected to remain low, costs for medical equipment, drugs and supplies have typically exceeded the overall inflationary average. These cost pressures are being mitigated with savings initiatives in procurement.

## 10 Operating Capital

### 10.1 \$200 M Internally Funded Equipment and Information Technology

During the course of 2010/11 AHS will invest \$65 million of internal funds in capital equipment and \$135 million in information technology projects. This \$200 million plus an additional \$10 million for the repayment of long-term debt is offset by \$107 million in 2010/11 amortization of internally funded assets resulting in a \$103 million deficit in unrestricted net assets. This deficit will be funded through the projected operating surplus of \$630 million (\$527 million for 2009/10 deficit and \$103 million for unrestricted net asset deficit).

### 10.2 Debt Funded Projects

Debt-financed projects, parking structures (four valued at \$275 million), will require \$83 million of debt financing in this budget year. In addition, \$20 million of financing has been secured through a software license provider to fund the cost of additional necessary software licenses. Revenue, principal and interest payments have been captured in the Schedule of Revenue and Expenses by Object and the Statement of Changes in Net Assets (Appendices 12.2 and 12.3).

# 11 AHS Five Year Outlook

## 11.1 Five Year Outlook

### Exhibit 11.1 Five Year Outlook

	2010/2011 Budget	2011/2012 Outlook	2012/2013 Outlook	2013/2014 Outlook	2014/2015 Outlook
<b>REVENUE</b>					
Budget Starting Point	\$ 9,935	\$ 11,760	\$ 11,373	\$ 11,945	\$ 12,272
Incremental Revenue:					
AHW Base Funding	1,324	542	575	457	478
Expiring Grants	(43)	(415)	(17)	(144)	-
Other Revenue Inflation	17	13	13	14	14
<b>TOTAL REVENUE</b>	<b>\$ 11,233</b>	<b>\$ 11,900</b>	<b>\$ 11,945</b>	<b>\$ 12,272</b>	<b>\$ 12,763</b>
AHW One Time Funding	527	(527)			
<b>TOTAL REVENUE (including One Time Funding)</b>	<b>\$ 11,760</b>	<b>\$ 11,373</b>	<b>\$ 11,945</b>	<b>\$ 12,272</b>	<b>\$ 12,763</b>
<b>EXPENSES</b>					
Budget Starting Point	\$ 10,658	\$ 11,130	\$ 11,373	\$ 11,945	\$ 12,272
Incremental Expenses:					
TIPs	50	250	184	110	154
Seniors Plan Growth	81	88	59	46	22
Relocating Services to New Facilities	25	27	57	15	15
Annualizations	148	-	-	-	-
Compensation Rate Adjustments	161	161	174	180	183
Service Provider Rate Adjustments	67	81	86	91	94
Med Fees/Other Contracts Rate Adjustments	43	48	50	53	54
Non Compensation Inflation	26	34	34	34	32
Savings	(168)	(501)	(131)	(262)	(126)
Contingency	38	56	59	61	63
<b>TOTAL EXPENSES</b>	<b>\$ 11,130</b>	<b>\$ 11,373</b>	<b>\$ 11,945</b>	<b>\$ 12,272</b>	<b>\$ 12,763</b>
<b>Excess/(deficiency) of revenue over expenses</b>	<b>\$ 630</b>	<b>\$ 0</b>	<b>\$ 0</b>	<b>\$ (0)</b>	<b>\$ 0</b>

Given the five year funding plan from Alberta Health and Wellness, the AHS five year revenue outlook includes a 6% base funding increase for 2010/11, 2011/12 and 2012/13 and a 4.5% increase for 2013/14 and 2014/15.

This five year outlook assumes restricted grants funded by Alberta Health and Wellness will be discontinued based upon their current end dates and that there will be no increase in base operating funds to offset these amounts (judged to be low risk at this time). All Other Revenue, such as donations, fees and charges, investments, and other government contributions are assumed to increase at 2.0% for 2011/12 and beyond.

A provision has been made for Transformational Improvement Program expenditures in the final three years of this outlook. An updated provision will be made in future outlooks once we have stabilized the organization and have a more detailed assessment of our success with improved wait times, better

emergency access, and provincial requirements for acute care. This also involves further efficiency dividends on existing services to facilitate reprioritization. The only provision included in the five year outlook for acute capacity is the cost related to relocating services to new facilities referenced earlier in this document.

The Seniors Plan is based on the number of continuing care beds being opened in each year: at least 1100 and up to 1700 beds in 2010/11, over 1275 beds in 2011/12, and over 1000 in 2012/13 and a total of 2000 for the final two years.

Costs for relocating to new facilities reflect utility and support services costs based on the timing of opening facilities.

Annualizations in forward years are reflected in the TIP category.

Salary and Benefit provisions include both the union rate increases and projected out-of-scope compensation increases. Based on historic costs, provision for adjustments to continuing care provider and physician contracts is 4%.

For all non-compensation items such as drugs and gases, medical supplies, and other supplies, the inflation increase was assumed to be 1.7% across all five years.

Savings are assumed to be 1% and incremented by amounts necessary to balance the operating budget in years that grants expire.

## 11.2 Overall Outlook

This five year forecast demonstrates that with judicious management, a stable environment, and modest increases in costs, AHS will be able to manage and achieve improvements in the effectiveness of services it provides. It also demonstrates quite clearly that AHS does not have a lot of room to manoeuvre. A spike in labour costs, a requirement for unanticipated new acute beds or any one of many other material events could impact the organization's financial sustainability.

Of particular concern is the current schedule for expiring restricted grants in 2011/12 which will have to be addressed on a timely basis. However, given the nature of these grants, the risk that they will not be renewed is judged to be low at this time.

Continuous improvement in the manner AHS deploys and utilizes available resources will be essential to achieving success for AHS and the population it serves.

# 12 Appendices

## 12.1 Statement of Operations

	2009/2010 Budget	2009/2010 Actual *	2010/2011 Budget **	Net Change from 2009/2010 Actual	
				Variance Increase/ (Decrease)	% Net Change
<b>REVENUE</b>					
Alberta Health and Wellness base funding	\$ 7,714	\$ 7,714	\$ 9,038	\$ 1,324	17.2 %
Alberta Health and Wellness other contributions	716	1,169	1,272	103	8.8 %
Other government contributions	81	81	82	1	0.7 %
Fees and charges	585	578	598	20	3.5 %
Ancillary operations	109	123	123	0	0.0 %
Donations	16	18	20	2	12.5 %
Investment and other income	247	251	257	6	2.3 %
Amortized external capital contributions	301	305	371	65	21.5 %
<b>TOTAL REVENUE</b>	<b>\$ 9,768</b>	<b>\$ 10,239</b>	<b>\$ 11,760</b>	<b>\$ 1,521</b>	<b>14.9 %</b>
<b>EXPENSES</b>					
Inpatient acute nursing care services	2,733	2,524	2,681	158	6.2 %
Emergency and outpatient services	1,146	1,152	1,231	79	6.9 %
Facility-based continuing care services	788	778	871	92	11.8 %
Ambulance services	316	326	353	26	8.1 %
Community-based care	730	685	747	62	9.1 %
Home care	368	383	411	28	7.3 %
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Prevention etc. ***	340	317	353	36	11.3 %
Research and education	204	216	219	3	1.3 %
Administration, Information technology, & Support services	2,123	2,122	2,155	33	1.6 %
Amortization of facilities and improvements	168	147	202	55	37.4 %
Capital assets write down	-	3		(3)	(100.0 %)
Funded transition costs (Note 6)	14	14		(14)	(100.0 %)
<b>TOTAL EXPENSES</b>	<b>\$ 10,653</b>	<b>\$ 10,477</b>	<b>\$ 11,130</b>	<b>\$ 652</b>	<b>6.2 %</b>
<b>Excess/(deficiency) of revenue over expenses</b>	<b>\$ (885)</b>	<b>\$ (238)</b>	<b>\$ 630</b>	<b>\$ 869</b>	<b>(364.4 %)</b>

\* As per 2009/2010 draft audited June 10th financial statements

\*\* 2010/2011 Budget to be resubmitted once detailed budget is completed

\*\*\* Prevention etc. is comprised primarily of health promotion, disease and injury prevention, health protection, and emergency preparedness which includes pandemic planning and preparedness.

## 12.2 Schedule of Revenues and Expenses by Object

	2009/2010 Budget	2009/2010 Actual *	2010/2011 Budget **	Net Change from 2009/2010 Actual	
				Variance Increase/ (Decrease)	% Net Change
<b>REVENUE</b>					
Alberta Health and Wellness base funding	\$ 7,714	\$ 7,714	\$ 9,038	\$ 1,324	17.2%
Alberta Health and Wellness other contributions	716	1,169	1,272	103	8.8%
Other government contributions	81	81	82	1	0.7%
Fees and charges	585	578	598	20	3.5%
Ancillary operations	109	123	123	0	0.0%
Donations	16	18	20	2	12.5%
Investment and other income	247	251	257	6	2.3%
Amortized external capital contributions	301	305	371	65	21.5%
<b>TOTAL REVENUE</b>	<b>\$ 9,768</b>	<b>\$ 10,239</b>	<b>\$ 11,760</b>	<b>\$ 1,521</b>	<b>14.9%</b>
<b>EXPENSES</b>					
Salaries and Benefits	\$ 5,493	\$ 5,483	\$ 5,720	\$ 237	4.3%
Contacts with health service organizations	1,717	1,800	\$ 2,027	\$ 227	12.6%
Surgical services contracts	24	24	\$ 24	\$ 0	1.1%
Drugs and gases	335	333	\$ 349	\$ 17	5.0%
Medical and surgical supplies	336	320	\$ 340	\$ 20	6.3%
Other contracted services	1,148	1,102	\$ 1,187	\$ 85	7.7%
Other expenses	1,195	1,004	\$ 1,003	\$ (1)	(0.1%)
Amortization	390	408	\$ 478	\$ 70	17.2%
Loss on disposal of capital assets	15	3	\$ 1	\$ (2)	(66.7%)
Capital assets write down	-	-	\$ -	\$ -	- %
<b>TOTAL EXPENSES</b>	<b>\$ 10,653</b>	<b>\$ 10,476</b>	<b>\$ 11,130</b>	<b>\$ 652</b>	<b>6.2%</b>
<b>Excess/(deficiency) of revenue over expenses</b>	<b>\$ (885)</b>	<b>\$ (238)</b>	<b>\$ 630</b>	<b>\$ 869</b>	<b>(365.7%)</b>

\* As per 2009/2010 draft audited June 10th financial statements

\*\* 2010/2011 Budget to be resubmitted once detailed budget is completed

## 12.3 Subsidiaries

	2009/2010 Budget	2009/2010 Actual *	2010/2011 Budget **	Net Change from 2009/2010 Actual	
				Variance Increase/ (Decrease)	% Net Change
<b>Calgary Lab Services</b>					
Revenue	\$ 193	\$ 193	\$ 194	\$ 1	0.4 %
Expenses	193	191	193	2	1.2 %
Excess/(deficiency) of revenue over expenses	\$ -	\$ 2	\$ 1	\$ 3	136.8 %
<b>Capital Care Group Inc.</b>					
Revenue	\$ 140	\$ 141	\$ 138	\$ (3)	(2.3 %)
Expenses	140	140	146	5	3.8 %
Excess/(deficiency) of revenue over expenses	\$ -	\$ 1	\$ (8)	\$ 2	320.8 %
<b>Carewest</b>					
Revenue	\$ 132	\$ 135	\$ 143	\$ 8	6.2 %
Expenses	132	133	143	10	7.6 %
Excess/(deficiency) of revenue over expenses	\$ 0	\$ 2	\$ 0	\$ 19	989.3 %
<b>TOTAL CLS, CCG, CW***</b>					
Revenue	\$ 466	\$ 470	\$ 476	\$ 6	1.3 %
Expenses	465	465	482	18	3.8 %
Excess/(deficiency) of revenue over expenses	\$ 0	\$ 5	\$ (7)	\$ 24	496.1 %

\* As per 2009/2010 draft audited June 10th financial statements

\*\* 2010/2011 Budget to confirmed based on approval by each subsidiaries respective Board

\*\*\* Included in the Consolidated Statement of Operations and Consolidated Schedule of Expenses by Object

Note: Capital Care Budget is under review by AHS.

## 12.4 Statement of Changes in Net Assets

	Accumulated surplus / (deficit)	Accumulated net unrealized gains/ (losses) on investments	Internally funded net assets invested in capital assets	Sub Total	Endowments	TOTAL
<b>BALANCE AT MARCH 31, 2010</b>	\$ (527)	\$ 17	\$ 628	\$ 118	\$ 10	\$ 128
Excess/ (deficiency) of revenue over expenses	630	-	-	630	-	630
Capital assets purchased with internal funds	(200)	-	200	-	-	-
Amortization of internally funded capital assets	108	-	(108)	-	-	-
Repayment of long-term debt used to fund capital assets	(11)	-	11	-	-	-
Net unrealized gains/(losses) arising during the year on investments	-	(2)	-	(2)	-	(2)
Transfer of net realized losses/(gains) on investments to revenue	-	-	-	-	-	-
Other	-	-	-	-	-	-
<b>BALANCE AT MARCH 31, 2011</b>	\$ -	\$ 15	\$ 731	\$ 746	\$ 10	\$ 756

## 12.5 Statement of Financial Position

	2009/2010 Actual *	2010/2011 Budget **	Variance from 2009/2010 Actual	
			Variance Increase/ (Decrease)	% Variance
<b>ASSETS</b>				
Current:				
Cash	\$ 977	\$ 1,334	\$ 357	36.5 %
Accounts receivable	167	167	-	- %
Contributions receivable from Alberta Health and Wellness	79	79	-	- %
Inventories	108	108	-	- %
Prepaid expenses	55	55	-	- %
	1,386	1,743	357	25.8 %
Non-current cash and investments				
Capital contributions receivable	1,000	61	(939)	(93.9 %)
Capital assets	110	100	(10)	(9.1 %)
Other assets	6,151	7,273	1,122	18.2 %
	128	110	(18)	(14.1 %)
<b>TOTAL ASSETS</b>	<b>\$ 8,775</b>	<b>\$ 9,287</b>	<b>\$ 512</b>	<b>5.8 %</b>

### LIABILITIES and NET ASSETS

#### Current:

Accounts payable and accrued liabilities	\$ 963	\$ 888	\$ (75)	(7.8 %)
Accrued vacation pay	357	357	-	- %
Deferred contributions	568	511	(57)	(10.0 %)
Current portion of long-term debt	13	13	-	- %
	1,901	1,769	(132)	(6.9 %)

#### Non-Current:

Deferred contributions	163	163	-	- %
Deferred capital contributions	1,046	31	(1,015)	(97.0 %)
Long-term debt	263	360	97	36.9 %
Unamortized external capital contributions	5,255	6,189	934	17.8 %
Other liabilities	19	19	-	- %
	6,746	6,762	16	0.2 %

#### Net assets:

Accumulated surplus/(deficit)	(527)	-	527	100.0 %
Internally funded net assets invested in capital assets	628	731	103	16.4 %
Accumulated net unrealized gains/(losses) on investments	17	15	(2)	-11.8%
Operating net assets	118	746	628	(532.2 %)
Endowments	10	10	-	- %
	128	756	628	490.6 %
<b>TOTAL LIABILITIES AND NET ASSETS</b>	<b>\$ 8,775</b>	<b>\$ 9,287</b>	<b>\$ 512</b>	<b>5.8 %</b>

\* As per 2009/2010 draft audited June 10th financial statements

\*\* 2010/2011 Budget to be resubmitted once detailed budget is completed

## 12.6 Statement of Operations – Category Definitions

**Alberta Health and Wellness (AHW) Contributions – Unrestricted** is the main operating funding source to provide health care services to the population of Alberta and is approximately 88% of total revenue for AHS.

**AHW Contributions – Restricted** is revenue that can only be used for specific projects and is recognized when the related expenses are incurred.

**Fees and charges** consists of patient revenue for health services at rates set by the Minister of Health and Wellness and collected by AHS and contracted long-term care providers from individuals, Workers Compensation Board (WCB), federal and provincial governments, and other responsible parties such as Alberta Blue Cross and insurance companies.

**Investment and other income** is comprised of interest income, dividends, net realized gains and losses on disposal of investment, recoveries and revenue from sources external to AHS such as drug companies, medical supply companies, and universities and other non-government grants.

**Other revenue** consists of federal and provincial (excluding AH&W) government contributions, donations from foundations, trusts and individuals as well as revenue from ancillary operations such as parking, non-patient food services, and sale of goods and services.

**Amortized external capital contributions** is the restricted revenue recognized from external agencies for capital assets that are amortized during the period.

**Inpatient acute nursing care services** is comprised predominantly of nursing units, including medical, surgical, intensive care, obstetrics, pediatrics and mental health. This category also includes operating and recovery rooms.

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


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

**Ambulance services** is comprised of emergency medical services (EMS), including ambulance, patient transport, and EMS central dispatch.

**Community-based care** is comprised primarily of assisted living, including designated assisted living, and palliative and hospice care. This category also consists of community programs, primary care networks (PCN's), urgent care centres, and community mental health.

**Home care** is comprised of home nursing and support.

**Diagnostic and therapeutic services** is comprised primarily of clinical lab (both in the community and acute), diagnostic imaging, pharmacy, acute and community therapeutic services such as physiotherapy, occupational therapy, respiratory therapy and speech language pathology.



**Prevention, etc.** (Also referred to by AHW as **Promotion, prevention and protection services**) is comprised primarily of health promotion, disease and injury prevention, health protection, and emergency preparedness which includes H1N1 planning and preparedness.

**Administration** is comprised of human resources, finance and general administration.

**Information technology** is comprised of infrastructure and systems support, device and print services, data processing, system development and software.

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

**Amortization of facilities and improvements** is comprised of amortization of buildings, building service equipment and land improvements capitalized by AHS (exclusive of the portion of amortization charged to ancillary operations). Amortization of equipment is not disclosed separately on the statement of operations, but is instead included in each of the other expense classifications above.