AHS Annual Report

Alberta Health Services

Reporting Period:
April 1, 2024 to March 31, 2025

Alberta Health Services

The *2024-25 Alberta Health Services Annual Report* was prepared in accordance with the *Sustainable Fiscal Planning and Reporting Act* and *Provincial Health Agencies Act*. The 2024-25 fiscal year spanned from April 1, 2024, to March 31, 2025. All material economic and fiscal implications known as of June 1, 2025, have been considered in preparing the Annual Report.

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

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Message from the Official Administrator and Interim President & Chief Executive Officer

The end of the 2024-25 fiscal year found Alberta Health Services (AHS) close to completing its transformation from a provincial health authority to becoming a leading, hospital-based service provider. It's the right role for AHS.

Over the last 15 years, AHS was responsible for most healthcare delivery and decisions in the province. Lots of excellent work was being done by AHS staff but we weren't getting the results that we needed across the province.

A review of high-functioning healthcare jurisdictions around the world showed these jurisdictions placed very clear focus on four key areas: acute care, primary care, assisted living, and mental health and addictions. In Alberta, organizations have been established that will focus on and be accountable for each of these areas. Creating this new provincial model for healthcare delivery has been a long journey for everyone, and not without its challenges, but the good news is that refocusing work is expected to be complete in 2025-26.

For AHS — which will operate under the purview of the new Acute Care Alberta organization — what this means is rather than having to take on everything, we're able to focus very clearly and concisely on hospital-based service delivery offering a range of acute care services, surgeries and hospital administration. We can focus on improving surgical and emergency wait times and improving patient flow. We will partner with other organizations and increase collaboration in a way where we see people move more seamlessly through their healthcare journey in Alberta.

These are the goals, and this is the vision, that I shared with AHS teams as I met with them in person and online soon after my arrival in January 2025. During my site visits, I saw our teams pursuing opportunities for improvement in their workplaces. I appreciated their problem-solving nature, their fearless advice, and their honesty in sharing what's working and what's not. This feedback was so important to me and the AHS leadership team to better understand both the challenges and opportunities on the front lines. These discussions will continue into 2025-26 as AHS moves from a period of transformation to a period of system improvement.

And the system is improving in several areas. This annual report shows, in 2024-25 compared to the previous fiscal year:

- Total surgical volumes (within AHS facilities and chartered surgical facilities) are up 4.3 per cent, representing more than 13,000 additional surgeries.
- Number of CT exams are up 8.3 per cent, representing nearly 50,000 additional CT exams.
- Number of lab tests are up nine per cent, representing 7.9 million additional tests.
- Number of AHS physicians is up 2.4 per cent, representing 228 additional physicians.

Meanwhile, patient access to services is improving through virtual care options, and the five-year phased rollout of Connect Care across the province is now complete. This past fiscal year, there were still more than two million visits to AHS emergency departments and more than 5.8 million ambulatory care visits. AHS teams should be proud of this, and together we will build upon this momentum.

Albertans continue to rely heavily on AHS for acute care services, and the organization continues to be an important part of the healthcare system, operating many sites and employing a tremendous number of dedicated staff with important responsibilities to patients and their families. This will not change in the years ahead, as AHS embraces its new mandate, which will put the patient first and give our front-line teams the tools and support they need to deliver seamless and timely care.

I am grateful for the staff and teams who continue to step up for patients, families and their colleagues. Together, we're building a stronger, more focused AHS.

Original signed by

Andre Tremblay
Interim President & Chief Executive Officer
Official Administrator
Alberta Health Services

About Alberta Health Services

Who We Are

Alberta Health Services (AHS) delivers a broad range of health services to more than 4.8 million Albertans on behalf of, and in accordance with the mandate set by the Government of Alberta.

Over the past year, AHS has undergone significant change as it shifts from being a provincial health authority to an acute care service provider. This transition is part of the Government of Alberta's refocus initiative which aims to establish four new provincial health agencies each focused on a specific area of functional importance. These agencies, which include Recovery Alberta (RA), Primary Care Alberta (PCA), Acute Care Alberta (ACA), and Assisted Living Alberta (ALA), will provide oversight and coordination of service delivery, seamless care between different health providers, and improved local decision-making, health access and outcomes. Within this refocus, AHS reports to ACA as of April 1, 2025, and is accountable for the delivery of hospital acute care services for all Albertans.

Throughout this transition, AHS has worked to minimize impacts to its workforce, disruptions to service delivery, and provided quality care. AHS is proud to be recognized as one of Canada's Best Diversity Employers for 2024 that fosters a workplace where everyone feels safe, healthy, valued and included, and able to reach their full potential.

Workforce & Volunteers

In 2024-25, AHS had more than 105,000[1] direct AHS employees (excluding Covenant Health and other contracted health service providers) and more than 14,600 staff working in AHS' wholly owned subsidiaries such as Carewest, CapitalCare Group, and Alberta Precision Laboratories (APL).

AHS was also supported by more than 12,100 independently practicing physicians, approximately 9,700[2] of whom are members of the AHS medical staff (including active, temporary and community appointments). Similarly, AHS is supported by nearly 180 midwives on the AHS midwifery staff who provide care both in the community and in our facilities.

Volunteers share a commitment to improving the quality of the patient and family experience. AHS' 10,400[3] volunteers contributed more than 744,000 volunteer hours this past year to help keep Albertans safe and healthy. Volunteers support many areas of AHS' work – in our facilities, at our planning tables and in our communities. Volunteers work across our acute care hospitals, rehabilitation hospitals and home care programs, and in cancer care, pediatric care, continuing care and public health programs.

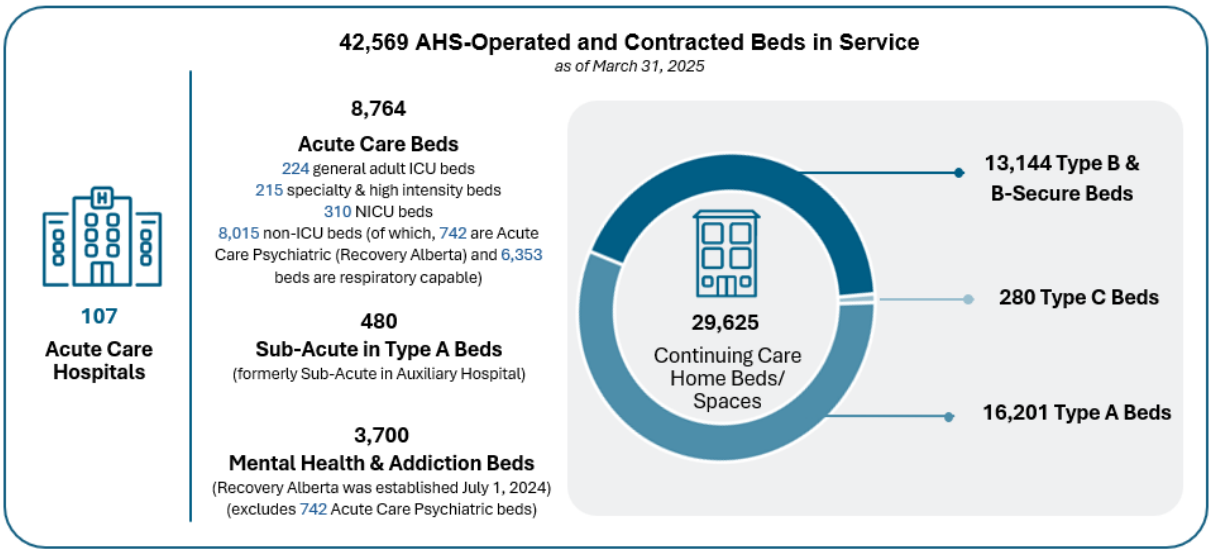
[1] Total excludes Recovery Alberta employees.

[2] Includes physicians in the Provincial Department of Public Health, the Provincial Department of Laboratory Medicine, and Recovery Alberta, as well as dentists and podiatrists.

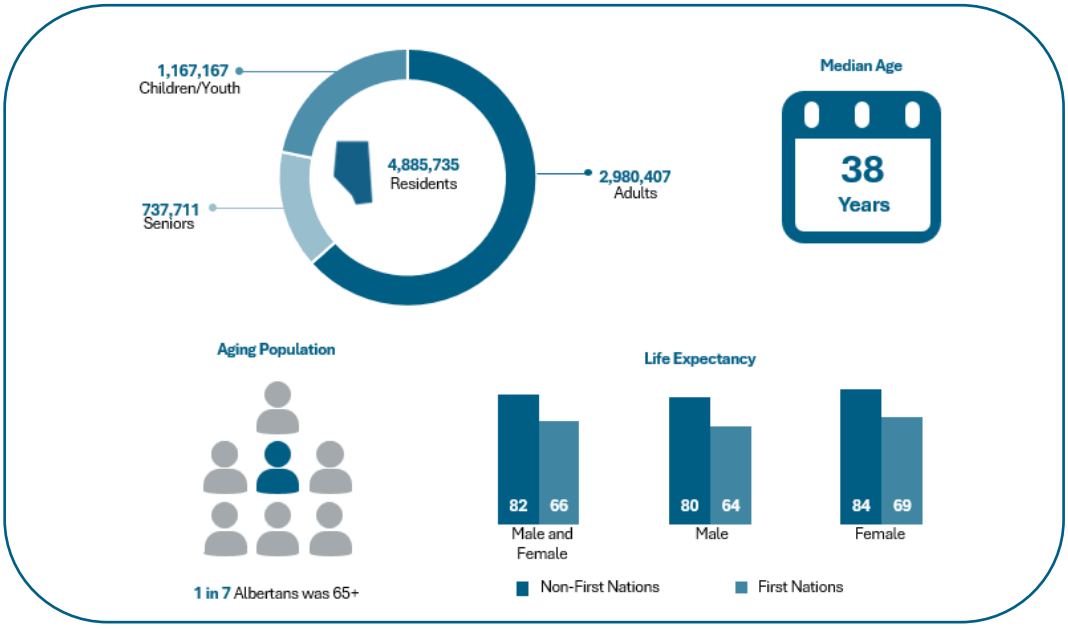
[3] Total includes Patient and Family Advisor volunteers as well as volunteers supporting Recovery Alberta and Primary Care Alberta.

Facilities & Beds

In 2024-25, AHS programs and services were offered at close to 900[4] facilities throughout the province, including hospitals, continuing care homes (including Type A (formerly long-term care), Type B/Type B-Secure (formerly designated supportive living), Type C (formerly community palliative and hospice), and contracted care sites), cancer centres, addiction and mental health facilities, and community ambulatory care centres. All facilities and programs were operated in compliance with relevant legislation.



Alberta Demographics



Source: Alberta Interactive Health Data Application (IHDA); Population estimates for 2024

[4] This includes Primary Care Networks and Public Health Centres.

AHS Health & Business Plan

AHS' new role as a hospital-based acute care services provider is guided by the 2024-27 Health Plan and 2024-25 Business Plan. This plan is a legislated document that articulates the organization's strategy and plan to implement the direction and priorities set by the Ministry of Health. The plan also addresses how AHS will carry out its responsibilities and measure its overall performance.

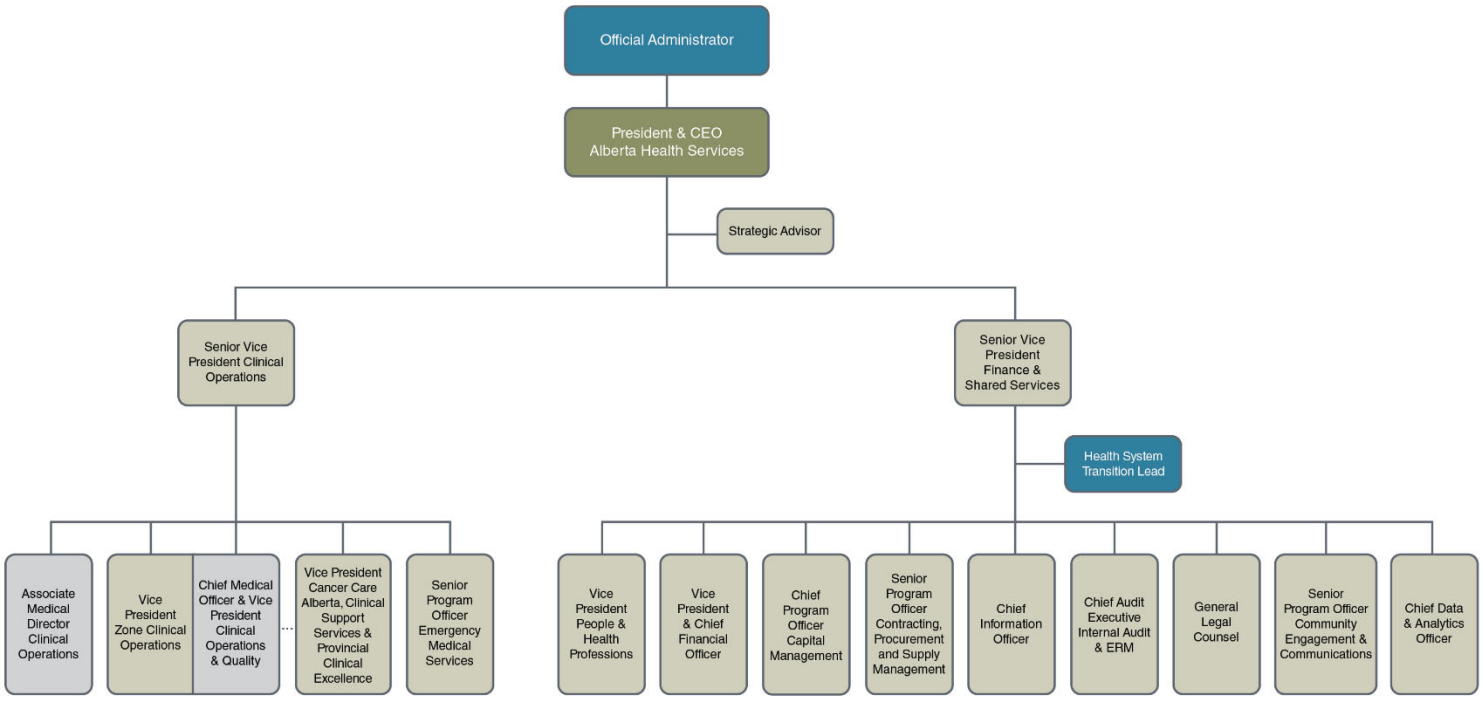
The Health Plan is organized according to three long-range goals (system sustainability, access, and quality and safety), and 10 objectives with corresponding actions that describe the work required to provide a patient-focused, quality health system that is accessible, culturally safe and sustainable for years to come. To ensure accountability and transparency on AHS's progress and performance in achieving the goals and objectives identified in the Health Plan, the Minister of Health has provided direction for AHS to submit an Annual Report. The 2024-25 Annual Performance Report reflects work accomplished and progress made between April 1, 2024 and March 31, 2025.

AHS Governance & Accountability

In addition to his role as Interim Chief Executive Officer, Andre Tremblay was appointed as Official Administrator for AHS by the Minister of Health on January 31, 2025. In accordance with the *Provincial Health Agencies Act*, the Official Administrator is responsible for governance oversight and decision-making functions of the former AHS Board. The Official Administrator is accountable to the Minister of Health and the Premier of Alberta.

As part of the Government of Alberta's refocusing of the healthcare system, AHS will become a service provider and will report to Acute Care Alberta which oversees the delivery of hospital care, urgent care, cancer care, clinical operations, surgeries, and emergency health services to all Albertans. In November 2024, the Government of Alberta announced the transition from five healthcare delivery zones to seven regional health corridors. Work is underway at AHS to support this transition, including a shift towards more local decision-making and hospital-based leadership. A facility-based leadership pilot is anticipated to commence at 10 sites across the province in late 2025-26.

AHS Organizational Structure



Advisory Councils

Advisory Councils help bring the voice of Alberta's communities to healthcare services. To learn more, visit www.ahs.ca/advisorycouncils.

Health Advisory Councils (HACs)

Since 2008, the HACs provided local perspectives to healthcare service delivery in Alberta by engaging the public and providing input on what was working well and areas for improvement. The 12 HACs represented geographical areas within the province. In November 2023, the Government of Alberta announced the refocus initiative and as part of this, HACs were replaced with a new model to be operated by Alberta Health: Regional Advisory Councils (RACs) and an Indigenous Advisory Council. As a result, HACs ceased operations in June 2024. In early 2024, HACs were involved in North Zone Emergency and Disaster management; Virtual Chronic Pain Clinics; the Home to Hospital to Home Program; Wellspring Cancer Support Alberta; and Alberta Healthy Living Program. HACs engaged with zone leadership about health system refocus work underway by the Government of Alberta. Government officials met with HAC members through January to April 2024 to seek their input and advice as they planned for the 14 new RACs and Indigenous Advisory Council, and members were encouraged to apply for the new Councils.

Provincial Advisory Councils

As part of the refocus, addiction and mental health services were transitioned to the new health agency, Recovery Alberta. In light of this, the **Addiction and Mental Health Provincial Advisory Council** paused all activity effective January 2024. Prior to this, the Council provided recommendations to improve system access, quality of service and patient satisfaction.

The **Cancer Provincial Advisory Council** provides advice related to cancer services, including screening and prevention, diagnosis, treatment and care, and research. Members are experts in cancer-related fields, have a loved one affected by cancer or are cancer survivors. Council activities were paused in early 2024 pending government decision.

The **Seniors & Continuing Care Provincial Advisory Council** focuses on improving the delivery of AHS services to seniors and Albertans receiving continuing care services and supports. In 2024-25, the Council provided input on the Alberta Quality of Life Framework and participated in the Patient Partner Outcome Measures to provide input on health-related quality of life for older adults.

The **Sexual Orientation, Gender Identity & Expression Provincial Advisory Council** provides advice on healthcare matters to create a safer, more inclusive, and welcoming healthcare environment for sexual and gender minority (Two Spirit, lesbian, gay, bisexual, transgender, queer, and Intersex Acknowledgement or 2SLGBTQI+) patients and their families. In 2024-25, the Council learned about Sexually Transmitted Illness rates and trends and provided feedback on the Safer Places Toolkit. Council activities were paused in mid-2024 pending government decision.

Patient and Family Advisory Council (PFAC)

The PFAC includes dedicated patient and family advisors from across Alberta who contribute their time, expertise, and lived experiences to shape and elevate the quality, safety, and overall experience of health services. Consulting with the PFAC helps meet Accreditation Standards, fulfill program objectives, and advance patient and family centred care. In 2024-25, members dedicated over 1000 volunteer hours, consulting on 53 initiatives, including the Behavioral Safety Program, Virtual Health, Connect Care, alternate level of care case management, and patient transfers. The PFAC engaged in policies, including Prevention of Harassment and Violence, Hand Hygiene, Falls Prevention, Family Presence, and Suicide Risk Management. Several council members were recruited to strategic-level bodies, including the AHS Quality Assurance Committee, the Quality, Safety & Outcomes Improvement Executive Committee, and the Infection Prevention & Control Research Advisory Committee. It also facilitated the addition of 10 new advisors from the former Strategic Clinical Networks, bringing its membership to 34 and increasing the diversity of experiences and perspectives.

Clinician Council

This Council ensures diverse voices and experiences propel decision-making throughout the organization. More than 80 clinicians and leaders from all levels and areas of AHS are part of the Council's multidisciplinary forums. The Council exchanges knowledge and collaborates with those developing and implementing AHS plans, projects, and programs. In the past year, members informed nine initiatives including Addressing Malnutrition in Alberta, Cancer Diagnosis Program, Neonatal Abstinence, Behavioral Safety Program, and Healthcare During the Anthropocene Era, Skin/Wound Product Nano Salv, Allied Health Clinical Education Navigator, and Learn Improve Together/Program Improvement Networks. Meetings are supported by the AHS President & CEO who engages with members and learns about what is important to them.

Service Delivery Information

Provincial Quick Facts

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

	2021-22	2022-23	2023-24	2024-25
Primary and Continuing Care / Population Health				
Ambulatory Care Visits[1,2]	5,208,409	4,872,283	5,011,103	5,844,830
EMS Events	672,898	661,177	724,783	740,805
Food Safety Inspections	33,728	48,569	55,009	54,520
Health Link Calls Received – Clinical*	1,444,868	756,806	719,929	706,700
Health Link Calls Received – Non-Clinical*	2,291,770	604,799	394,883	329,731
Health Link Outbound Calls – Clinical*	59,775	43,587	95,046	156,315
Health Link Outbound Calls – Non-Clinical*	494,208	337,899	150,259	52,645
Poison Information Calls (PADIS)	48,392	49,398	49,621	48,421
Seasonal Influenza Immunizations**	1,207,403	1,276,970	1,147,663	Pending
Number of Clients Placed from Acute / Subacute Hospital[3]	5,193	5,814	NA	5,592
Number of Clients Placed from Community (home)[3]	3,471	3,618	NA	4,037
Number of Unique Home Care Clients[1,3,4]	121,608	126,306	NA	NA
Acute Care				
Emergency Department Visits (all sites)[1]	1,824,366	1,983,852	2,028,171	2,055,298
Urgent Care Visits[1]	193,948	221,066	233,784	244,829
Hospital Discharges[1]	376,019	380,268	392,787	405,048
Births[1]	47,297	45,755	47,601	49,917
Total Hospital Days[1]	2,614,642	2,826,571	2,965,272	3,039,567
Average Length of Stay (in days)	7.0	7.4	7.5	7.5
Alternate Level of Care Total Discharges[1]	15,434	17,303	18,196	19,631
Ambulatory Care Sensitive Conditions Hospital Discharges[1]	10,540	12,311	12,557	13,376
Diagnostic / Specific Procedures				
Hip Replacements (scheduled and emergency)[5]	6,116	7,434	8,106	8,058
Knee Replacements (scheduled and emergency)[5]	5,404	7,504	9,441	9,031
Cataract Surgery[5]	48,867	40,290	47,628	49,311
Total Surgical Volumes (Main OR and CSF)[5]	278,628	295,763	305,711	318,829
MRI Exams	235,241	231,033	255,200	268,566
CT Exams	508,071	520,507	595,817	645,451
X-rays	1,697,532	1,746,125	1,780,812	1,851,494
Lab Tests[1]	81,854,618	82,410,198	87,980,881	95,894,976
Cancer Care				
Consults: Total Patient Visits[6]	NA	NA	28,061	28,685
Follow-Ups: Total Patient Visits [6]	NA	NA	200,312	206,062
Systemic Treatment: Total Patient Visits[6]	NA	NA	111,006	121,701
Radiation Therapy Treatment: Total Patient Visits[6]	NA	NA	136,070	136,177
Workforce				
AHS Physicians	8,697	8,849	9,171[7]	9,717
AHS Staff	112,373	111,159	113,897	115,464[8]
AHS Volunteers	9,186	9,100	9,729	9,629[9]
AHS Volunteer Hours	484,838	558,289	690,672	733,232[10]

Data updated as of June 9, 2025. Definitions can be found at **https://www.ahs.ca/about/Page11905.aspx**

[1] Historical data has been restated due to reporting updates.

[2] From April 1, 2023 to November 4, 2023, Ambulatory Visit data is no longer collected in National Ambulatory Care Reporting System (NACRS) for South Zone and part of the North Zone prior to the Epic implementation on Nov 5, 2023 (Wave 7). As such, only Chartered Surgical Facilities (CSF) and Day Surgery are available for reporting. This will impact the volumes for these zones as well as the provincial totals.

[3] Continuing Care Living Options: there are data outages for zones that resulted in the provincial total not being calculated. The specific outages include: 2023-24 Q1 - Missing Central Zone; 2023-24 Q2 - Missing Central Zone; 2023-24 Q3 - Missing South Zone/Central Zone/North Zone.

[4] Home Care data gaps exist across all zones due to the transition to Connect Care. The Central Zone data gap began on November 5, 2023 (Q3 2023/24), followed by the Calgary Zone on May 4, 2024 (Q1 2024/25). Data gaps for the South, Edmonton, and North Zones began on November 2, 2024 (Q3 2024/25).

[5] Historic surgical values have been restated due to the reconciliation of CSF data and improvements in methodology. As AHS continues to optimize methods for improved reporting, these numbers may be subject to further changes. Surgical volume data was extracted April 25, 2025.

[6] Cancer Care Alberta has implemented substantial enhancements to its workflows and methodologies, notably with the introduction of Connect Care. Consequently, previous metrics such as 'Patient Visits to Cancer Care' and 'Unique Patients to Cancer Care' have been retired and succeeded by four (4) new metrics: 'Consults: Total Patient Visits', 'Follow-ups: Total Patient Visits', 'Systemic Treatment: Total Patient Visits', and 'Radiation Therapy Treatment: Total Patient Visits'. These new measures reflect the shared care model of cancer treatment. Additionally, the measures are only available at a provincial level. This update is effective as of 2024-25 Q1. Data is available as of April 1, 2023.

[7] This number does not include physicians in the Department of Public Health or physicians in the Provincial Department of Laboratory Medicine. The total for 2023-24 including these two departments was 9,489 physicians.

[8] The total for 2024-25 includes the 10.580 employees within Recovery Alberta.

[9] This number does not include the 825 volunteers that served as Patient & Family Advisors in 2024-25.

[10] This number does not include the 11,076 Patient Engagement volunteer hours that were completed in 2024-25.

* As of 2021-22, the measure “Health Link Calls” was expanded to four separate measures to better represent activity. ‘Clinical’ refers to calls requiring nursing, addiction and mental health, respiratory illness clinical services, rehabilitation, etc. ‘Non-Clinical’ refers to calls requiring information and/or referral, respiratory illness non-clinical services, tobacco cessation, immunization booking, etc. The variability associated with Health Link measures over the past year is driven by two key factors: the growing complexity of calls related to new and expanded clinical processes (e.g., Virtual MD, EMS/811 shared response line, Mobile Integrated Health) and staffing challenges due to vacancies. Additionally, substantial quarter-to-quarter variations in measurement methodology have made direct comparisons unreliable, leading to the decision not to report year-to-date comparisons.

** Source: Alberta Health Influenza Immunization Report 2023-24 pending the release of the report. Provincial values are from the Alberta Health Respiratory Virus Dashboard for the 2023-24 season. Zone values are not yet available

Bed Numbers Summary

Since April 1, 2024, AHS has opened **209** net new community care beds/spaces including **197** Type A & B and **12** Type C Continuing Care Beds, as well as **10** Sub-Acute in Type A and **22** community mental health & addiction beds. AHS remains committed to providing more community-based options and coordinating better access to needed beds in both our acute care and emergency care system.

Number of Beds/Spaces	March 31, 2024	March 31, 2025	Difference	% Change
Acute Care				
Acute Care	7,290	7,273	-17	-0.2%
Acute Care Psychiatric (Recovery Alberta established Jul 1, 2024)	741	742*	1	0.1%
General Adult Intensive Care Unit (ICU)	223	224	1	0.4%
Specialty ICU	222	215	-7	-3.2%
Neonatal ICU	309	310	1	0.3%
Total Acute Care	**8,785**	**8,764**	**-21**	**-0.2%**
Addiction and Mental Health (Recovery Alberta established July 1, 2024)				
Psychiatric (Standalone facilities)	936	936	0	0.0%
Addiction Treatment	1,354	1,414	60	4.4%
Community Mental Health	1,388	1,350	-38	-2.7%
Total Addiction and Mental Health	**3,678**	**3,700**	**22**	**0.6%**
Community Based Care				
Continuing Care Homes (CCH)				
Type A CCH (formerly Long-Term Care)				
Type A CCH (formerly Auxiliary Hospital)	5,611	5,607	-4	-0.1%
Type A CCH (formerly Nursing Home)	10,601	10,594	-7	-0.1%
Sub-Total Type A CCH	**16,212**	**16,201**	**-11**	**-0.1%**
Type B & Type B-Secure CCH (formerly Designated Supportive Living (DSL))				
Type B (formerly Designated Supportive Living 3)	1,089	1,070	-19	-1.7%
Type B (formerly Designated Supportive Living 4)	7,809	7,968	159	2.0%
Type B-Secure CCH (formerly Designated Supportive Living 4D)	4,038	4,106	68	1.7%
Sub-Total Type B & Type B Secure CCH (formerly Designated Supportive Living 3, 4, 4D)	**12,936**	**13,144**	**208**	**1.6%**
Sub-Total Type A, B, & B Secure CCH (formerly Long-Term Care & Designated Supportive Living)	**29,148**	**29,345**	**197**	0.7%
Type C CCH (formerly Community Palliative & End of Life Care (PEOLC))				
Type C CCH (formerly Community PEOLC)	268	280	12	4.5%
Total CCH – Type A, B, B Secure & C (formerly LTC, DSL & PEOLC)	**29,416**	**29,625**	**209**	**0.7%**
Sub-Acute in Type A (formerly Sub-Acute in Auxiliary Hospital)				
Subtotal Sub-Acute in Type A	470	480	10	2.1%
Total Community Based Care – Type A, B, B Secure, C, Sub-Acute in Type A	**29,886**	**30,105**	**219**	**0.7%**
PROVINCIAL TOTAL	**42,349**	**42,569**	**220**	**0.5%**

Source: Acute Care Alberta (ACA) Bed Audit as of March 31, 2025. Mental health & addiction beds were included in this summary as Recovery Alberta was established Jul 1, 2024. Notes:

* These Acute Care Psychiatric beds now fall under the purview of Recovery Alberta

- The summary of Beds Staffed & In Operation was reported by ACA as of March 31, 2025. It includes all beds staffed and in operation which are operated and/or contracted by ACA in acute care, addiction and mental health, Type A CCH (formerly long-term care), Type B & Type B-Secure CCH (formerly designated supportive living 3, 4, 4D), Type C (formerly Community Palliative & End of Life Care) and Sub-Acute in Type A (formerly Sub-Acute in Auxiliary Hospital).
- Beds may be restated from previous AHS Annual Reports and AHS Bi-Annual Bed Audits (formerly Bed Surveys) due to reporting corrections.
- Continuing Care Homes capacity does not include Integrated Home Living Spaces and AMH Wrap-Around Services.
- The AHS Bi-Annual Bed Audit (September 2024) has been updated to align with the new terminology in the New *Continuing Care Act* which came into effect April 1, 2024. Mar 2025 - Sub-Acute in Long Term Care (Auxiliary Hospital) was renamed Sub-Acute in Type A CCH - follows *Hospital Act.*

AHS Performance in 2024-25

Accreditation

Accreditation compares our health services with national standards of excellence to help identify what AHS is doing well and how we can improve. A new accreditation decision of 'Accredited' was awarded by Accreditation Canada in 2023, valid until 2027. AHS continues to maintain accredited status with the College of Physicians and Surgeons of Alberta for diagnostic facilities. AHS-funded partners which include Alberta Precision Laboratories, Covenant Health and Lamont Health Care Centre, also continue to maintain accredited status with the College of Physicians and Surgeons of Alberta. More information can be found online at www.ahs.ca/about/Page190.aspx.

During the spring 2024 survey, Accreditation Canada assessed emergency and disaster management at the corporate/provincial level with validation at 11 urban hospitals providing acute inpatient, cancer care, rehabilitation and psychiatric services. An assessment of 11 rural hospitals in the Edmonton, Calgary and South zones was also completed. Performance related to relevant clinical services (e.g., emergency department, inpatient medicine, obstetrical services, perioperative services and invasive procedures, and long-term care services) and foundational standards (i.e., emergency and disaster management, infection prevention and control, leadership, medication management, reprocessing of reusable medical devices and service excellence) were assessed.

During the fall 2024 survey, program-based assessments of emergency department, inpatient medicine, pediatric and adult critical care, and transplant services were completed throughout the province at 20 hospitals and urgent care centres. Performance related to foundational standards (i.e., emergency and disaster management, infection prevention and control, leadership, medication management and service excellence) were also assessed. Emergency medical services were assessed at 29 locations throughout the province, which included embedded infection prevention and control, medication management and service excellence criteria.

Surveyors observed teams of skilled professionals working collaboratively to deliver safe, high-quality, and compassionate care, demonstrating a strong commitment to continuous improvement.

Leading in Health

In 2022-23, the most recent year with national data, Alberta spent 2.8 per cent of expenses on administrative expenses. This is the lowest of the 10 provinces and 36 per cent lower than the national average of 4.4 per cent.

The Canadian Institute for Health Information (CIHI) has developed indicators to measure the health of Canadians and health system performance in Canada. According to the latest statistics (2023-24), Alberta is a national leader in many areas of healthcare delivery. These indicators help inform how Alberta's health authority performs nationally. The indicators below represent where CIHI shows Alberta is performing better than the national average.

- Fewer self-harm hospitalizations
- Fewer repeat stays for mental health & substance use
- Fewer obstetric traumas for instrument-assisted vaginal deliveries
- Fewer patients (medical, surgical, obstetric, pediatric combined) readmitted to hospital
- Fewer medical patients readmitted to hospital
- Fewer obstetric patients readmitted to hospital
- Lower restraint use in long-term care
- Lower potentially inappropriate use of antipsychotics in long-term care
- Fewer hospitalized heart attacks
- Fewer hospitalized strokes

Summary of Performance Results

Enhancing or maintaining performance across the health delivery system also requires regular monitoring. AHS currently has 17 performance measures that reflect key areas of focus within the health system and align to the goals and objectives identified in the 2024-27 Health Plan. These measures are used to assess and quantify progress towards achieving targeted improvements in these areas. The performance measure summary and dashboard provide an overview of the progress being made to advance health outcomes and seamless service delivery across the province. Specific performance summaries for each measure can be found under the corresponding objectives of this report.

Areas of Performance Improvement

Vacancy rate (AHS only)

Overtime rate (AHS only)

EMS response time (50th percentile) - Remote

Areas of Performance Stability (within 3 per cent change from the same period last year)

Balanced budget (within 1%)

EMS response time (50th percentile) – Metro & Urban Areas

EMS response time (50th percentile) – Communities over 3000 residents

EMS response time (50th percentile) – Rural (communities under 3000 residents)

ED wait time to see a doctor (50th percentile)

Alternate level of care percentage

Percentage of CT scans within target

Adult patient satisfaction with hospital experience

Childhood immunization rate: DTaP-IPV-Hib (Dose 4 by age 2)

Childhood immunization rate: MMR (Dose 1 by age 2)

Areas of Performance Deterioration

Number of Albertans waiting for continuing care

Total time in ED for patients admitted to hospital (50th percentile)

Number of cases on waitlist outside clinically recommended wait times at all surgical sites (excluding Stollery and Alberta Children's Hospitals)

Percentage of MRI scans within target

Performance Measure – Dashboard

The 2024-25 performance results are summarized in the dashboard below.

Change in Performance Legend	
Performance Improvement:	• ≥3% relative change in a desirable direction when compared to the same period last year.
Stable:	• Less than 3% change in either direction when compared to the same period last year.
Performance Deterioration:	• ≥3% relative change in an undesirable direction compared to the same period last year.

AHS Performance Measure		2021-22	2022-23	2023-24	2024-25	2024-25 Target	Change in Performance (change in value)
GOAL: System Sustainability							
Number of Albertans waiting for continuing care		1,664	1,825	2,063	2,449	At or below 2023-24 results	18.7%
Balanced budget (within 1%)		0.8%	0.5%	1.0%[1]	0.4%	Maintain	Not applicable
Vacancy rate (AHS only)*		14.2%	14.8%	11.8%	11.3%	At or below 2023-24 results	-4.7%
Overtime rate (AHS only)*		2.3%	2.8%	2.8%	2.4%	At or below 2023-24 results	-14.3%
GOAL: Access							
EMS response time (50th percentile)	Metro & Urban Areas	7.8 min	8.8 min	7.6 min	7.6 min	At or below 2023-24 results	-0.1%
	Communities >3000 residents	9.3 min	9.0 min	8.1 min	8.0 min	At or below 2023-24 results	-1.5%
	Rural (communities under 3000 residents)	16.6 min	17.0 min	16.0 min	15.7 min	At or below 2023-24 results	-1.9%
	Remote	19.9 min	20.3 min	20.7 min	20.0 min	At or below 2023-24 results	-3.0%
ED wait time to see a doctor (50th percentile)		1.8 hrs	2.5 hrs	2.6 hrs	2.5 hrs	At or below 2023-24 results	-0.4%
Total time in ED for patients admitted to hospital (50th percentile)		10.3 hrs	13.2 hrs	12.9 hrs	13.4 hrs	At or below 2023-24 results	4.0%
Number of cases on waitlist outside clinically recommended wait times at all surgical sites (except Stollery and Alberta Children's Hospitals)		43,597	32,199	27,159	31,626	At or below 2023-24 results	16.4%
Alternate level of care percentage		13.3%	14.9%	14.6%	14.5%	At or below 2023-24 results	-1.0%
Percentage of MRI scans within target		64%	54%	46%	42%	At or above 2023-24 results	-8.6%
Percentage of CT scans within target		88%	85%	81%	80%	At or above 2023-24 results	-1.2%
GOAL: Quality & Safety							
Adult patient satisfaction with hospital experience		65.6%	63.4%	63.4%	64.3%	At or above 2023-24 results	1.4%
Childhood immunization rate: DTaP-IPV-Hib (Dose 4 by age 2)**		72.5% (2021)	70.8%[2] (2022)	70.6% (2023)	68.9% (2024)	At or above 2023-24 results	-2.5%
Childhood immunization rate: MMR (Dose 1 by age 2)**		83.3%[1] (2021)	82.2%[2] (2022)	81.8%[2] (2023)	80.1% (2024)	At or above 2023-24 results	-2.0%

*Workforce data for Recovery Alberta has been excluded from vacancy and overtime rates.

**Childhood immunization rates are measured over the calendar year.

[1] Historical data has been restated due to reporting updates.

[2] Historical data has been restated for the two (2) childhood immunization measures due to Alberta Health reporting updates.

Note: Values have been rounded for public reporting. The percentage change is calculated using unrounded numbers.

2024-25 Supplementary Measures Dashboard

Supplementary measures include EMS response wait times and ED flow metrics. Both metrics are reported at the 90th percentile to enable comparability to previously reported metrics. CIHI surgical wait time measures, reported at 50th percentile, have also been included to provide transparency against national comparators.

AHS Supplementary Measure		2021-22	2022-23	2023-24	2024-25	Change in Performance (change in value)
GOAL: Access						
EMS Response Time:						
Time in minutes after a call is received at EMS dispatch that patients wait for an EMS crew to arrive on scene for a life-threatening event 90% of the time.	Metro & Urban Areas	14.6	17.5	13.8	13.7	-0.8%
	Communities >3000 residents	18.6	18.9	16.3	16.7	2.5%
	Rural (Communities <3000 residents)	33.8	33.8*	33.3	33.0	-0.9%
	Remote	55.4	61.8	64.9	64.4	-0.6%
ED Wait Time:						
ED Wait time to see doctor: Time to see a physician after being triaged on arrival 90% of the time in the 16 largest sites (hours).		4.5	6.2**	6.7	7.0	3.7%
Total time in ED for patients admitted to hospital: Time from when a patient is triaged to when they are transferred to a hospital bed 90% of the time in the 16 largest sites (hours).		26.7	35.3	34.5*	37.8	9.7%
Surgical Wait Time for Selected Procedures (50 per cent of the time):* **						
Bladder Cancer Surgery (days)		26	30	34	33	-2.9%
Breast Cancer Surgery (days)		18	21	22	23	4.5%
Colorectal Cancer Surgery (days)		23	25	26	24	-7.7%
Lung Cancer Surgery (days)		27	34	31	34	9.7%
Prostate Cancer Surgery (days)		62	76	57	67	17.5%
Coronary Artery Bypass Graft (days)		6	7	8	10	25.0%
Cataract Surgery (days)		75	75	90	85	-5.6%
Hip Replacement (days)		154	232	140	109	-22.1%
Knee Replacement (days)		186	283	188	139	-26.1%
Hip Fracture Repair (hours)		20	21	21	21	0.0%

*Historical data has been restated due to reporting updates.

**Historical data updated, and a minor methodology change resulted in a restatement of the 2022-23 value. The new methodology excludes patients who left the ED without being seen.

***The surgical wait times are calculated based on wait time data for the first two quarters of the fiscal year (April–September). Data sourced from https://www.cihi.ca/en/explore-wait-times-for-priority-procedures-across-Canada

Goal: System Sustainability

Objective 1: Support refocus initiative and continuity of care

AHS will support Alberta Health in the healthcare refocusing and is committed to a functionally integrated system that prioritizes continuity of care and positive patient outcomes. AHS will work to ensure patients receive seamless and coordinated care across healthcare providers during this period of change.

Actions & Achievements

Support the transition of AHS from regional health authority to service provider.

- The operational stand up of Recovery Alberta (RA) on September 1, 2024, advanced the organizational refocus initiative as staff and functions specific to mental health & addictions were transitioned from AHS to the new provincial health agency.
- The operational stand up of Primary Care Alberta (PCA) on February 1, 2025, advanced the organizational refocus initiative as staff and functions specific to primary care were transitioned from AHS to the new provincial health agency.
- The legal stand up of Acute Care Alberta (ACA) on February 1, 2025, resulted in the secondment of some AHS staff to support transition planning for ACA's first operational day 1 on April 1, 2025.
- Seniors and Community Support Services appointed AHS staff to form a transition team that will support the standup of Assisted Living Alberta (ALA). ALA became a legal entity on April 1, 2025, and will become operational on July 1, 2025.
- AHS responded to data and information requests to support the transition of responsibilities from AHS to the new agencies.

Support internal change management as AHS transitions from regional health authority to service provider through 2024-25 and beyond.

- A Change Management Network was established by the Ministry of Health to lead the changes that support the refocus initiative. As a member of the network, AHS is providing feedback on the change management strategy.
- AHS leadership is supporting the organizational transition by increasing their availability to staff and sharing information as it becomes available through CEO communication to all staff and monthly updates to senior leaders.
- Regular updates to staff are provided by the AHS CEO through virtual town hall meetings and include refocus updates when Ministry announcements are released. Internal messages are aligned with the Ministry's refocus messaging to ensure consistency. Ongoing town halls will be a component of a comprehensive AHS communications and engagement strategy being developed to ensure staff are informed and supported throughout refocusing efforts.
- Upon the establishment of AHS as a service provider, AHS will engage staff on common purpose, values and culture in the context of a refocused health system.

Support the necessary approach and steps to facilitate the transition of leadership, administrative support, and AHS staff to the new provincial health agencies and Alberta Health.

- Letters of understanding with unions have facilitated the transfer of staff to the new provincial health agencies.
- To ensure that workforce decisions are well-informed, AHS is providing Alberta Health, Seniors and Community Support Services and contractors with regularly updated data that details all employees and positions.
- Regular meetings with Alberta Health, Seniors and Community Support Services and consultants guide planning and address transitions to the provincial health agencies. AHS has also engaged in transitioning planning to ensure the seamless transition of resources as each agency is established.

Provide support and recommendations to Alberta Health related to the delivery of corporate and clinical support services in a refocused health system.

- AHS provided recommendations related to the future state approach for clinical and corporate services and continues to support the seamless delivery of these services across the four provincial health agencies and service delivery organizations (e.g., AHS and Covenant Health). AHS will continue to support implementation of any decisions related to the delivery of corporate and clinical support services in a refocused health system. Transition Services Framework Agreements and Transition Service Agreements for each functional service area have been established with the provincial health agencies to ensure continuity of these services in the interim.
- AHS is participating in the Shared Services Working Group that has been established by Alberta Health to inform planning for a shared services organization within the refocused health system.

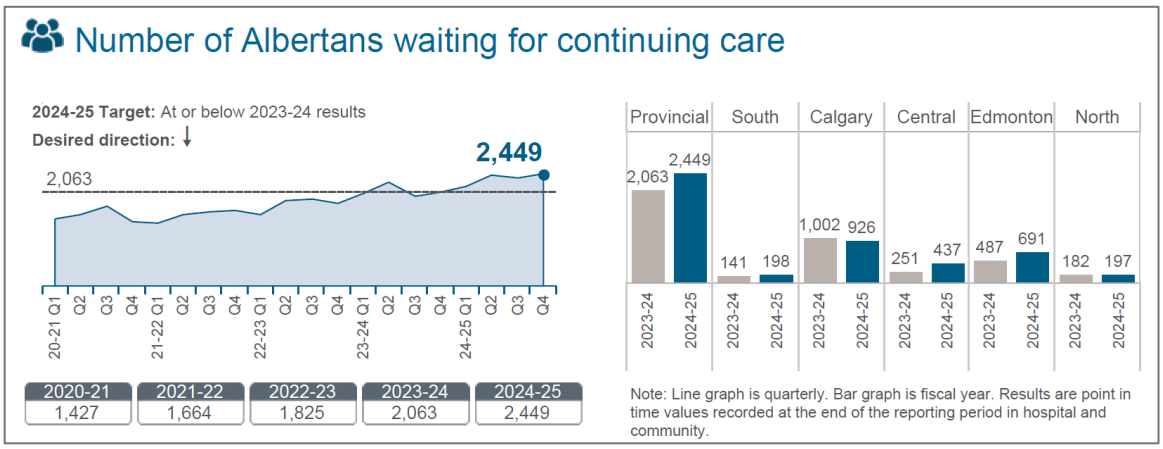
Engage with AHS workforce to support the future provincial health agencies.

- Frequently Asked Question (FAQ) documents were created by AHS and the Ministry of Health to facilitate the stand up of RA, PCA and ACA. Similar documents are being prepared to support the standup of ALA and the Shared Services Organization.
- Through workforce engagement, action planning is underway related to the Our People Survey results, which were released in March 2025. The survey results give leadership the opportunity to leverage feedback from staff and respond to the needs of the AHS workforce during this time of change.

Support the transition by ensuring continuity of care and access to primary care, acute care, public health, continuing care, and mental health and addiction services.

- AHS supported frontline operations, addressed key challenges and identified areas of concern for future state service provider operations. This includes responding to emerging health service delivery needs, such as the recent measles outbreak, and ensuring coordination and alignment with Alberta Health direction and priorities.
- AHS supported the transition of acute care system accountabilities to ACA. This included oversight of access to high-quality care, acute care patient flow, and capacity planning which were transitioned to ACA on April 1, 2025.
- Establishment of ALA, the provincial health agency for continuing care is underway. As part of the transition, AHS is working closely with the Ministry for Seniors, Community and Social Services to monitor continuing care capacity to ensure overall system efficiency and timely and appropriate access to care.

Performance Measure Summary



Results:

This measure represents the number of people waiting in hospital or community who are approved and ready for placement in Type B Continuing Care Homes (CCH) (previously Designated Supportive Living) or Type A CCH (previously Long-Term Care). The lower the number the better, as it demonstrates availability of Type A or Type B CCH beds, as well as overall system efficiency through timely and appropriate access to continuing care.

At the end of the 2024-25 fiscal year, there were 2,449 patients waiting for continuing care placement. This is an 18.7 per cent deterioration compared to the same period last fiscal year (2,063). Although AHS has opened 209 continuing care home beds which include Type A, B, B-Secure, C, in the last 12 months, the current demand is outpacing capacity. More specifically, in 2023-24, 1,780 Type A and Type B beds were required to keep pace with population growth and aging as well as reduce alternate level of care pressures in hospitals. However, with only 630 Type A, B, B-Secure and C continuing care home beds opening in 2023-24, AHS entered 2024-25 with a supply gap of approximately 1,157 beds and only 200 additional beds planned for the year.

Objective 2: Achieve a balanced budget

AHS will need multiple strategies to find savings and efficiencies to control growth of expenses driven by inflation and population growth. Teams will be accountable for managing overtime, vacancies, agency staff usage, limiting discretionary spending, and finding additional efficiencies through program reviews.

Actions & Achievements

Achieve a balanced budget by implementing savings initiatives.

- AHS achieved a balanced budget in 2024-25 with a $71 million operating surplus, representing 0.4 per cent of total expenses. This result reflects the impact of AHS transferring all responsibilities and the oversight of mental health and addiction services to RA effective September 1, 2024 and the delivery of primary care services to PCA effective February 1, 2025.

Manage expenses by limiting discretionary spending, managing vacant positions, and achieving efficiencies.

- Cost strategies implemented in 2023-24 have remained in place throughout 2024-25. These include review of all vacant positions by leadership prior to posting, restrictions on discretionary spending, analysis of overtime and updating guidelines, guidance on the use of agency nurses, and review of management and non-union positions.

Conduct program reviews and prioritize initiatives to achieve the required savings.

- Program reviews were completed by all AHS portfolios. Over 900 savings opportunities were identified and of these, over 600 were approved with savings of $231[5] million in 2024-25. This is lower than the target of $382 million in savings, however additional government funding contributed to AHS achieving a balanced budget in 2024-25.

Pursue revenue-generating initiatives.

- Revenue-generating initiatives proposed as part of AHS' efficiency and cost management strategies have not been approved through 2024-25. Additional revenue-generating initiatives are expected to be identified as part of this process in 2025-26.

Support the transfer and establishment of budgets from AHS to the new provincial health agencies and service providers.

- The 2024-25 budgets for RA and PCA, as well as the 2025-26 budgets for RA, PCA and ACA were prepared and approved.

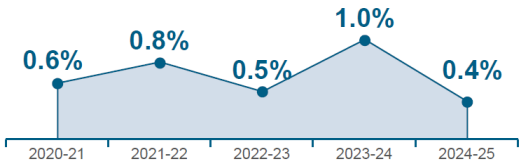
[5] Amounts are for AHS only and exclude Recovery Alberta and Primary Care Alberta.

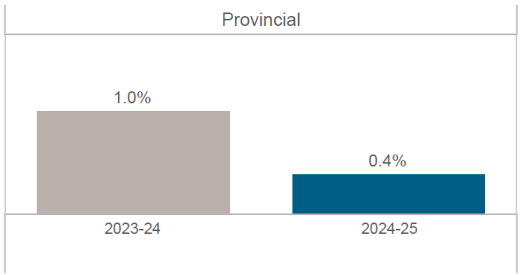
Performance Measure Summary

Balanced Budget (within 1%)

Target: Maintain within 1%

Desired direction: →





Notes:
- 2024-25 results include the impact of AHS transferring all responsibilities and the oversight of mental health and addiction services to Recovery Alberta effective September 1, 2024, and the delivery of primary care services to Primary Care Alberta effective February 1, 2025.
- 2020-21 and 2021-22 results have been restated for the adoption of PS 3280 Asset Retirement Obligations in 2022-23. 2021-22 results are as per comparative column in AHS' March 31, 2023 Consolidated Financial Statements. 2023-24 results are restated due to reporting updates.

Results:

This measure represents the size of the annual surplus (deficit) compared to total actual expenses and reflects whether AHS achieved a balanced operating result. A surplus (deficit) of within one per cent indicates that financial resources are well managed. In 2024-25, AHS maintained a balanced budget within one per cent (0.4%) as per the identified target.

Objective 3: Build a resilient workforce

Patients and their families rely on the expertise and support of our workforce. Timely access to appropriate healthcare depends on a sustainable workforce organized and supported to deliver quality care. Through implementation of its comprehensive Health Workforce Strategy, AHS continues to recruit and retain strong talent. AHS will support initiatives that help build workforce resiliency and support their physical and psychological well-being. In addition, AHS will fill vacancies and identify innovative solutions to address workforce shortages. We will optimize the clinical workforce by ensuring clinical professionals are working to their full scope of practice. These actions will ensure AHS is taking a fiscally responsible approach to managing its workforce by reducing overtime and agency staff usage. AHS will also find opportunities to streamline program administration and processes to clarify accountability and create capacity (e.g., by reducing administrative burden) for our leaders, staff, and physicians.

Actions & Achievements

Recruit frontline staff to fill vacancies, specifically in rural, remote, and Indigenous communities.

- Zones engaged in recruitment activities to fill vacancies, meet retention challenges, reduce overtime and agency staff reliance, and optimize provider scope.
- AHS focused on post-secondary student engagement for graduating allied health and nursing students. This included:
    - Launch of Fall 2024 and Spring 2025 nursing student and new grad recruitment campaigns on the AHS website, as well as advertisements on social media and university job boards.
    - Emails sent to prospective candidate leads generated through allied health and nursing career events, post-secondary information sessions and conferences.
    - Attendance at 112 career events for allied health, nursing, Indigenous and multi-disciplinary programs.
- Through the Internationally Educated Nurse (IEN) recruitment initiative, over 600 offers were accepted and over 200 IENs arrived and began working in Alberta in 2024-25. Ongoing community integration and immigration supports have also been provided.
- AHS engaged in contract negotiations to reduce costs and streamline agency nursing coordination and utilization. This resulted in decreased utilization and a refined focus on critical shortage areas. In the second half of 2024-25, overall usage of agency nurses decreased by 31 per cent (from 198 to 136 registered nurses utilized through an agency).
- Targeted recruitment campaigns by Talent Acquisition have secured qualified health workforce as part of rural, critical care, cancer care, Recovery Alberta, EMS, allied health, and IEN recruitment initiatives.
- Several programs and projects were completed or are in progress to support labour needs and Indigenous hiring practices. Examples include:
    - Career development programs for high school and post-secondary students.
    - Career fairs hosted by Indigenous organizations, First Nations and Tribal Councils.
    - Student employment placement programs.
    - 1:1 high-touch candidate support.
    - Dedicated Indigenous talent webpage which highlights Indigenous-specific information.
    - Support for leadership in the use of best practices and development of local strategies to recruit and retain Indigenous staff.
    - Relationship building to nurture meaningful and lasting connections with Indigenous communities, employment and training agencies, educational institutions, and other organizations.

Provide psychological and wellness supports to the workforce.

- A total of 219 people were trained in 2024-25 as peer supporters within AHS' Peer Support Framework which has transitioned to a sustainable team with resources available on Insite. Similarly, the Peer Support Community of Practice that was launched in March 2024, has grown to 36 members as of Q4YTD. This program provides a space for peer supporters to learn from each other and receive support in their role.
- Usage of the Employee Family Assistance Program has trended downward in 2024-25 and is following a general trend of declining program usage across all industries. As of Q4YTD, overall utilization of the program was 7.3 per cent (annualized rate) compared to 8.1 per cent (annualized rate) for the same period in 2023-24.
- In 2024-25, 43 new sessions were provided to 2,103 workers and leaders on creating and supporting psychological health and safety and supporting mental health at work.
- The Behavioural Safety Program (BSP) supports the prevention of violence or potential violence toward frontline staff. In 2024-25, the BSP Violence/Aggression Screening tool was used 1,864,481 times with 429,490 unique

patients screened. A risk of aggression/violence was also identified in 35,000 occurrences (6%). This represents a 129 per cent increase in use (814,304) and a 163 per cent increase in unique patients screened (162,993) compared to 2023-24. The BSP has been implemented in most emergency and urgent care settings, with implementations pending in remaining sites.

Build a coordinated approach to optimize provider mix and scope of practice.

- AHS supported assessment and analysis of workforce optimization decisions for leaders, which included completion of area data profiles, scope of practice assessments, barriers and facilitator interviews, skill mix options, and scope and team optimization. Recommendations were implemented where appropriate.
- Initiatives are in place across the zones to optimize workforce skill mix and scope of practice including:
    - Increased consistency in overtime allocation and completion of the Workforce Plan in the South Zone.
    - Data review completed in the Calgary Zone to determine areas for greatest workforce optimization opportunities. Ongoing focus is on Women's Health and Emergency Departments.
    - Expansion of the Grow Your Own Community and Rural Route BScN nursing program in the Central Zone. The program originated in Wainwright in 2021, launched in Drayton Valley in 2024, and is planning expansion to Drumheller for 2026.
    - Audits underway in the Edmonton Zone to improve implementation of the Care Hub Model.
    - Integration of various professional roles (e.g., Operating Room technicians, Licensed Practical Nurses, Health Care Aides, and Internationally Educated Nurses) into surgical and acute care teams, and skill mix reviews conducted in the North Zone.

Continue to use enhanced processes, tools and supports to actively manage overtime.

- AHS' overtime management guidelines have been updated and published and are being implemented to help mitigate overtime costs and assist with front-line decision-making.
- Several processes, tools, and supports were used by the zones to actively track and manage overtime. This included decreased use of agency nurses, as well as continued use of overtime guidelines and data to identify high-use areas to target improvement efforts. As of Q4YTD, overtime rates have decreased in all zones.
- Participation in the RN Locum Program in the North Zone has increased by approximately 230 per cent since 2022-23, while the worked hours have increased by approximately 350 per cent over the same period. This program provides assignment opportunities for short term periods of less than 12 months to address high staffing needs.

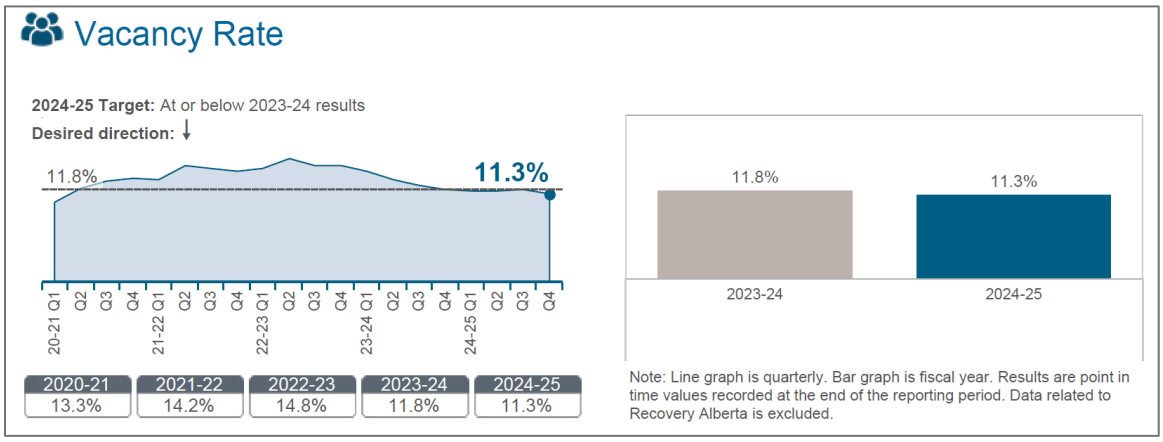
Support leaders in understanding and applying decision-making within their financial authority.

- The replacement of *e-manager*, AHS' business intelligence system, with eLeader has been revised with a phased implementation process and is anticipated to launch in June 2025. This corporate analytics tool will be used by AHS leaders to help monitor key performance indicators and analyze budget, workforce and purchasing trends.
- The AHS management structure was reviewed as part of the Core Review and the refocus work which included finding efficiencies through reduced service duplication and redundant layers as well as addressing manager roles.
- In an effort to reduce costs, AHS completed a review of management, non-union and non-clinical vacancies. In 2024-25, 626 Non-Union Exempt Employee positions were inactivated. This is a 25 per cent increase in the number of NUEE inactivations compared to 2023-24 (500).

Identify programs and processes to reduce the administrative burden on the frontlines.

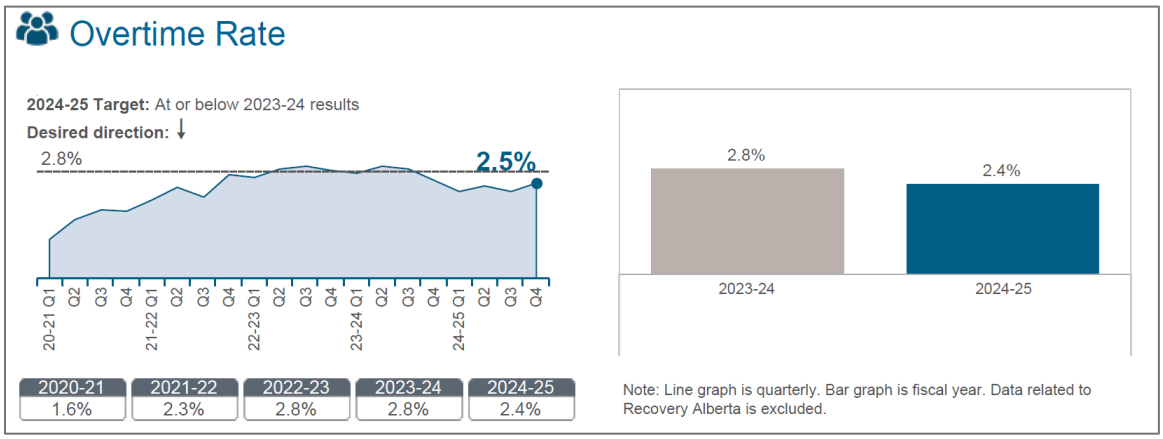
- The revised Workplace Health and Safety (WHS) Leadership Fundamentals course was reduced from over 13 hours to a four-hour, virtually facilitated session. Since its relaunch in January 2025, 134 leaders have attended the sessions.
- Several WHS training courses were reduced in length to decrease the educational and administrative burden on AHS staff. This included several Required Organizational Learning courses such as the Workplace Hazardous Materials Information System (WHMIS) and Working Safely courses. Revisions to the Respectful Workplaces and the Prevention of Harassment and Violence Policy courses will be completed in 2025-26 following approval of policy updates.
- A process for reporting and documenting investigation in MySafetyNet is under development through the Incident Reporting and Investigation Project. This project aims to create an awareness of the importance of reporting safety hazards and incidents, and encouraging open communication and collaboration between staff, leaders and teams involved in a safety investigation. The project is anticipated to be completed in October 2025.
- Zones implemented various initiatives to reduce the administrative burden on frontline staff. For example, in the Calgary Zone, Emergency Equipment Replacement meetings are being combined with Zone Emergency Management Committee meetings along with decreased sign-off touch points and a new checklist. In the Central Zone, capacity reports regarding staff completion of required courses have been streamlined into a single report in Connect Care, and guidelines are in development to reduce redundancy in workload. North Zone is exploring the reallocation of administrative tasks, such as scheduling and payroll, away from RNs to more suitable roles.

Performance Measure Summary



Results:

This measure represents the number of vacant positions as a percentage of total filled and vacant positions throughout AHS. It helps identify areas or positions with the highest staffing needs and supports evidence-based planning to ensure health workforce availability to deliver services. The lower the rate the better, as it demonstrates AHS' ability to fill positions needed to provide and support care to patients and families. In 2024-25, the vacancy rate (11.3 per cent) showed a 4.7 per cent improvement compared to the same period last year (11.8 per cent) and achieved the 2024-25 fiscal year target.



Results:

This measure represents the total number of overtime hours as a percentage of total paid hours for AHS staff. A higher overtime rate indicates that a higher portion of AHS employees' earnings come from overtime, which could suggest long working hours or increased demand for their work. A lower percentage means that employees primarily earn their income through regular hours. As such, the lower the rate the better, as it demonstrates that AHS can manage human resources efficiently and reduce staff burnout while also providing quality care to patients and families. In 2024-25, the overtime rate (2.4 per cent) showed a 14.3 per cent improvement compared to the same period last year (2.8 per cent) and achieved the 2024-25 fiscal year target.

Goal: Access

Objective 4: Improve Emergency Medical Services response times

AHS will continue to maintain ambulance response times to the previous fiscal year. We will ensure prompt response to all emergency calls. AHS will adopt the provincial emergency medical services (EMS) performance framework and performance targets currently under development.

Actions & Achievements

Maintain EMS response times across the province.

- AHS is working to ensure that ambulance availability matches demand. This includes implementation of strategies for recruitment, hiring and retention; employee wellness; and reducing available hours lost to EMS offload delays. In the second half of 2024-25, the vacancy rate improved from 14.6 per cent to 12.9 per cent.

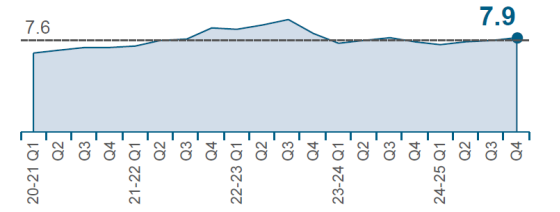
Work with hospitals to maintain or improve EMS offload times in emergency departments.

- AHS implemented the EMS Return to Service initiative which aims to increase ambulance availability and decrease EMS response times in the community by supporting paramedics to safely handover patient care to emergency department staff within a 45-minute target. Projects completed in 2024-25 or are in progress:
    - Developed workflows and automation to alert supervisors when their total hospital time post-transfer of care (a variable uncontrolled by EMS) exceeds 30 minutes.
    - Improved access to supplies at hospital sites for crews; particularly those at regional sites.
    - Provided revised guidelines and expectations to EMS crews to reduce redundancy in reporting.
    - Developed an emergent offload process to support an enhanced return to service when system pressures reach a critical state.
    - Supported staff to perform concurrent return to service activities in which one EMS partner restocks and cleans the EMS unit while the other completes documentation. This occurs on hospital arrival and through the triage process, until bed assignment and following the transfer of care.
- Work continues to implement and monitor the Emergent Offload Initiative which serves as a contingency to ensure EMS availability when other strategies are insufficient.
- Zones are engaged in various activities to address EMS offload times in their emergency departments. For example, in the South and Calgary Zones, adjustments were made to staff schedules to better align with peak EMS demand times. The Red Deer Regional Hospital Centre has assigned a second nurse to support EMS offload during peak hours and has initiated a quality improvement project to improve EMS release times when patients are brought in for diagnostic imaging.

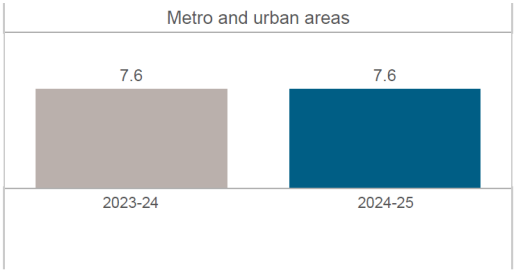
Performance Measure Summary

EMS response time (minutes) for the most urgent calls in metro/urban communities 50% of the time

2024-25 Target: At or below 2023-24 results
Desired direction: ↓



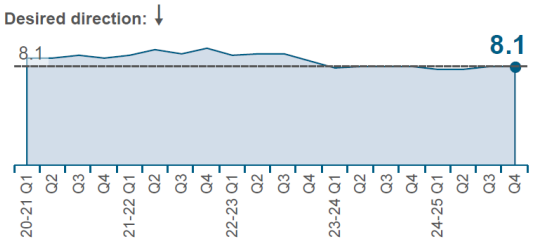
2020-21	2021-22	2022-23	2023-24	2024-25
6.9	7.8	8.8	7.6	7.6



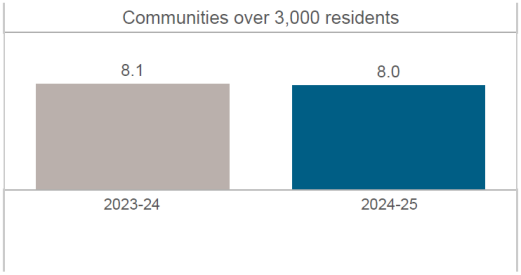
Note: Line graph is quarterly. Bar graph is fiscal year value.

EMS response time (minutes) for the most urgent calls in communities with >3000 residents 50% of the time

2024-25 Target: At or below 2023-24 results
Desired direction: ↓



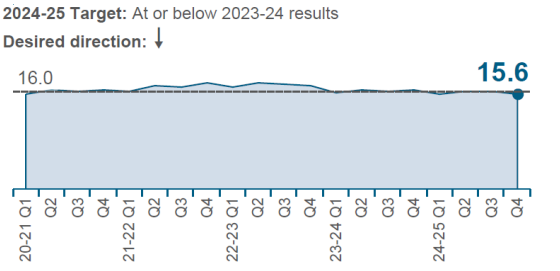
2020-21	2021-22	2022-23	2023-24	2024-25
8.8	9.3	9.0	8.1	8.0



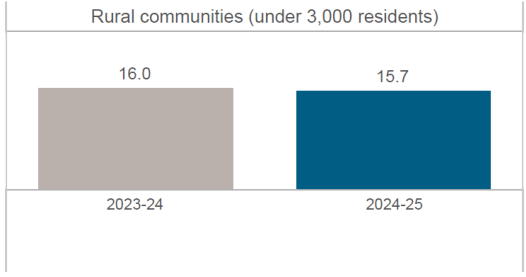
Note: Line graph is quarterly. Bar graph is fiscal year value.

EMS response time (minutes) for the most urgent calls in rural communities 50% of the time

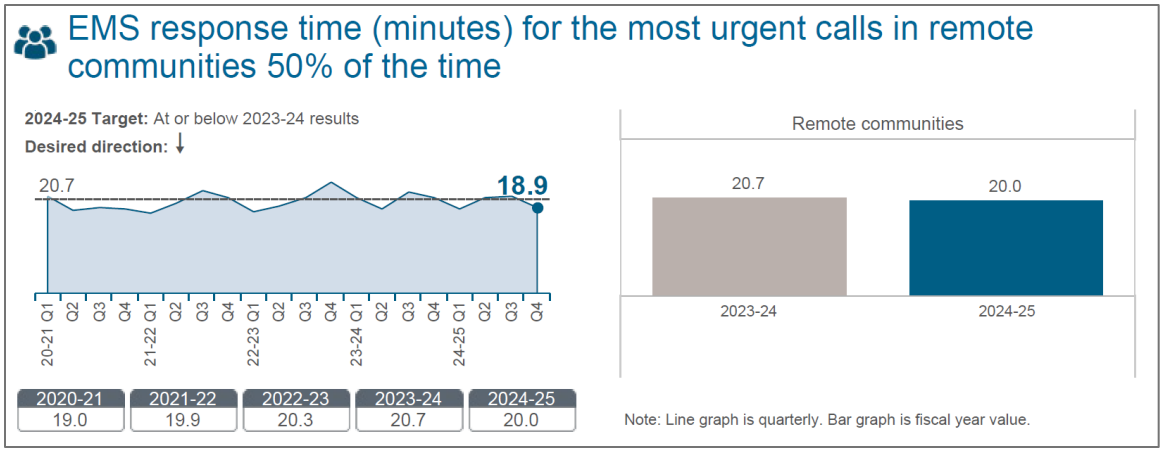
2024-25 Target: At or below 2023-24 results
Desired direction: ↓



2020-21	2021-22	2022-23	2023-24	2024-25
16.0	16.6	17.0	16.0	15.7



Note: Line graph is quarterly. Bar graph is fiscal year value.



Results:

This measure represents the median EMS response time (in minutes) after a 911 call is received at an EMS dispatch centre where a patient waits for an EMS crew to arrive on scene for a life-threatening event 50 per cent of the time. Events that are deemed life threatening (i.e., high acuity) at the time of EMS dispatch, represent the capability of the system to respond urgently when patients need it most. The shorter the time the better, as it demonstrates system responsiveness and ability to provide timely medical care to patients in the community.

The results for 2024-25 are as follows:

- The median EMS response time in metro/urban communities for the most urgent calls remained stable at 7.6 minutes compared to the same period last year (7.6 min) and achieved the target.
- The median EMS response time for communities with greater than 3,000 residents for the most urgent calls remained stable at 8.0 minutes compared to the same period last fiscal year (8.1 min) and achieved the target.
- The median EMS response time for the most urgent calls in rural communities remained stable at 15.7 minutes compared to the same period last year (16.0 min) and achieved the target.
- The median EMS response time for the most urgent calls in rural communities improved by three per cent; from 20.7 minutes in 2023-24 to 20.0 minutes in 2024-25. This measure achieved the target.

Objective 5: Improve emergency department flow

The goal is to keep people with minor health concerns out of emergency departments (EDs) and ensure access to care in a more appropriate setting. Through Alberta Health's refocus initiative, Albertans will receive improved access to primary care services; therefore, we can expect to see improved flow through the EDs.

Actions & Achievements

Implement process improvements to reduce length of stay for patients in the ED.

Process improvements were implemented to reduce patient length of stay in the ED. This included developing new surge protocols, refining overcapacity protocols, optimizing intake models, assigning nursing staff to support EMS offload during peak times, trialing discharge lounges, and extending fast track areas to facilitate earlier treatment. Examples of zone-specific initiatives include:

- Implementation of nurse-initiated protocols at triage in the South Zone and identification of opportunities to streamline the stroke notification process at the Foothills Medical Center in Calgary.
- The Red Deer Regional Hospital Centre is piloting an Artificial Intelligence tool "Jenkins" in their ED. This tool supports efficiencies within physician documentation by reducing administrative burden and allowing physicians to spend more face-to-face time with patients.
- A review of ED portering is in progress to improve site response during peak times in the ED at the University of Alberta Hospital in Edmonton.
- The Grande Prairie Regional Hospital is increasing ambulatory care hours and services (e.g., IV therapy and wound care) to divert patients requiring follow-up care from the ED.

Implement process improvements to reduce ED wait time to see a physician.

Zone-led processes were implemented to improve ED flow, reduce waiting room volumes and ED length of stay including:

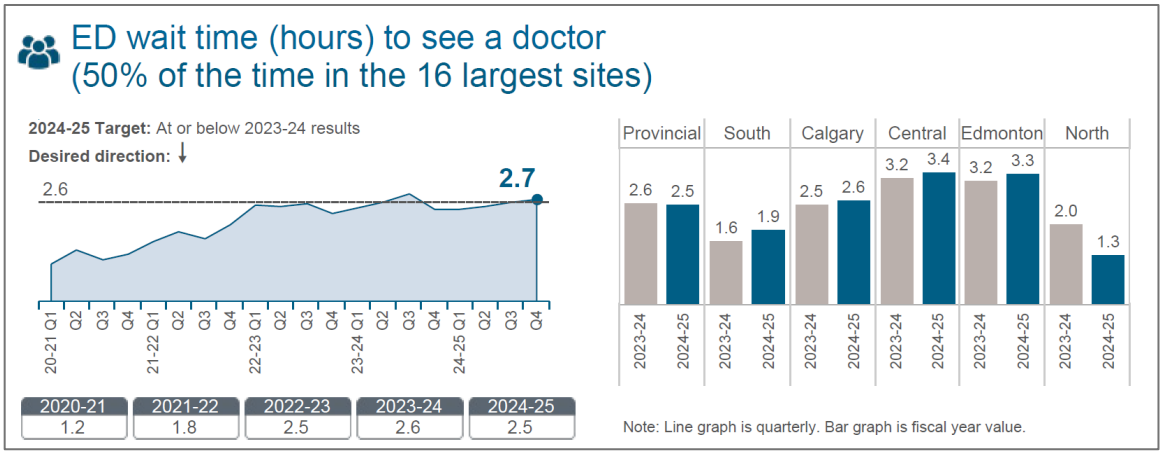
- The South Zone re-developed their site and zone escalation plans and identified additional alternate care spaces on inpatient units to support flow of admitted patients out of the ED.
- The Calgary Zone initiated a quality improvement project in the intake and Fast Track areas which included identification of opportunities to improve turnaround time for consults, lab work and diagnostic imaging. Sites also reviewed opportunities to optimize physician scheduling to better meet patient demand at urgent care centres.
- A new intake model was launched at the Red Deer Regional Hospital Centre to improve ED flow.
- Six acute care sites in the Edmonton Zone implemented a new intake model which maximizes the use of chairs, recliners and assessments stretchers to reduce waiting room volumes, expedite assessment and diagnostics, and reduce overall ED length of stay.
- Low Acuity Fast Track clinics at the Stollery Children's Hospital and Alberta Children's Hospital have continued to support improved patient flow particularly during increased seasonal and respiratory virus activity.
- The Grande Prairie Regional Hospital (GPRH) expanded its hours for the Fast Track area. This dedicated space within the emergency department allows for the rapid assessment and treatment of lower acuity patients which decreases waiting room congestion and supports decreased length of stay.

Support the development of the Primary Care and Recovery Alberta: Mental Health & Addiction Services provincial health agencies.

- Recovery Alberta (RA) became a legal entity on July 1, 2024, and became operational on September 1, 2024. Accountability for all mental health, addiction, and correctional health services provided by AHS transitioned to RA including care in AHS hospitals, outpatient, virtual health, standalone psychiatric and provincial correctional settings, and community bed-based and outreach mental health, withdrawal management, and addiction treatment.
- More than 10,000 staff, 800 physicians, and over 300 contracted service provider relationships were transitioned to RA. A new public-facing website was also launched to provide information about addiction, mental health, and correctional health services programming through RA.

- Primary Care Alberta (PCA) was legally established in November 2024 and became operational on February 1, 2025. PCA is responsible for overseeing the coordination and delivery of primary health care services through various clinics and programs across the province. Approximately 1,350 staff were transitioned from AHS to PCA along with programs and functions from Health Link 811, AHS operated Primary Care Networks, Facilitated Access to Surgical Treatment program, Provincial Midwifery Services, Virtual Care, Access and Navigation, and the Primary Health Care provincial program.

Performance Measure Summary



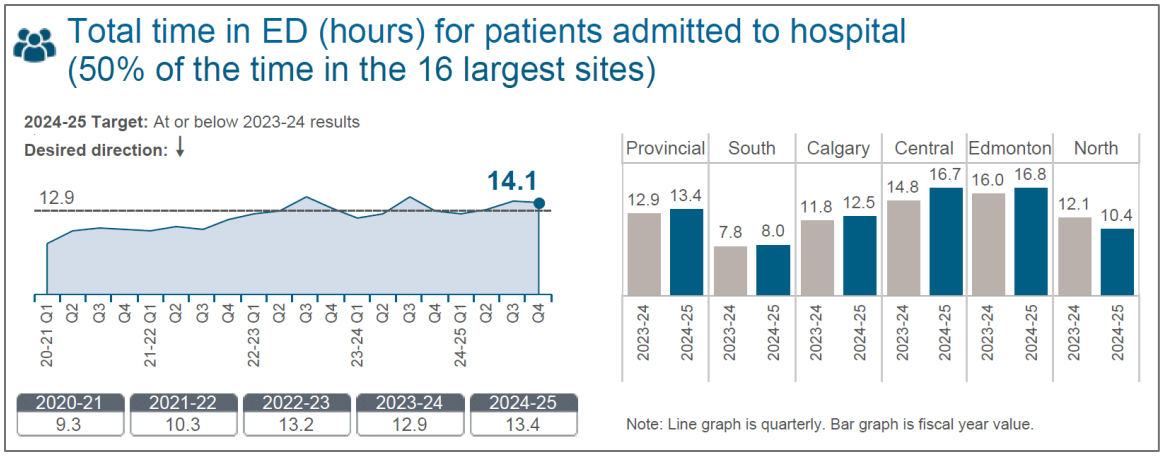
Results:

This measure represents the length of time (in hours) patients wait to see an emergency department (ED) physician after being triaged on arrival 50 per cent of the time in the 16 largest acute care sites in Alberta. Longer waits may result in poorer patient outcomes. The lower the number the better, as it demonstrates that patients are receiving timely assessment and treatment in the ED.

In 2024-25, the ED median wait time to see a doctor remained stable at approximately 2.5 hours compared to the same period last year (2.6 hours). This measure achieved the 2024-25 target despite a five per cent increase in the number of patients presenting in EDs at these sites (826,033 total visits in 2023-24 vs 867,028 total visits in 2024-25). Factors that influence ED wait times include increased patient complexity and acuity as well as increased volumes in emergency departments and inpatient units, particularly during respiratory virus season.

Using a similar definition, in 2023-24, Alberta ranked 7th of seven provinces for the shortest time to see a physician in teaching hospitals 50% of the time (AB=2.8 hours; Canada=1.7 hours; Best Performing Province=1.3 hours) and tied for 4th of seven provinces for community-large hospitals (AB=2.2 hours; Canada=1.6 hours; Best Performing Province=1.2 hours) (CIHI, 2023-24)[6]

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



Results:

This measure represents the time (in hours) from when a patient is triaged in the ED to when they are transferred to a hospital bed 50 per cent of the time, in the 16 largest acute care sites in Alberta. The lower the number the better, as it shows patients are receiving timely assessment and treatment in the ED, as well as being moved into a hospital bed to receive the right care in the right place.

In 2024-25, the median time in the ED for patients admitted to hospital deteriorated by four per cent (13.4 hours) compared to the same period last year (12.9 hours). Although the total time in ED for patients admitted to hospital has increased, AHS has seen an increase of seven per cent in the number of ED visits admitted to hospital compared to the same period last year (158,653 visits in 2023-24 vs 169,977 visits in 2024-25).

Using a similar definition, in 2023-24, Alberta ranked second of seven provinces for the shortest total time in ED for admitted patients for teaching hospitals 50% of the time (AB=12.9 hours; Canada=15.8 hours; Best Performing Province=12.2 hours) and second of seven provinces for community-large hospitals (AB=13.1 hours; Canada=18.1 hours; Best Performing Province=5.7 hours) (CIHI, 2023-24)[7]

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

Objective 6: Reduce surgical wait times

AHS continues its efforts to ensure all scheduled surgeries will be performed within clinically recommended timelines. This will be achieved through various initiatives such as optimization of operating room capacity, waitlist management, expanded use of chartered surgical facilities, and recruitment of surgical workforce, in partnership with Indigenous communities.

Actions & Achievements

Expand surgical clinical workforce through recruitment, retention, and workforce innovation.

- The physician workforce plan was implemented which includes strategies to support physician funding, physician supply (enhanced Postgraduate Medical Education and re-entry programs, recruitment conferences, third party recruitment, sponsorship triage process), and enhancement of Anesthesia Care Teams (e.g., Clinical Assistant recruitment).
- The provincial surgery workforce education strategy (perioperative training program) was implemented to enhance training opportunities alongside clinical workforce increases in nursing, medical device reprocessing and anesthesia support. In the second half of 2024-25, 32 RNs and 21 LPNs were enrolled in the program.
- Other strategies included centralized recruitment, removing recruitment barriers to external talent, increasing student placement opportunities in operating rooms, and supporting the utilization of LPNs in the surgical workforce. This included the development of a Registered Nurse First Assist recruitment, training and budget plans. AHS also worked with external stakeholders to increase the number of cardiovascular perfusionists education seats for the next two fiscal years. These efforts have resulted in an improved overall surgical RN vacancy rate of 8.1 per cent in 2024-25, compared to 8.5 per cent in 2023-24. The surgical RN one-year retention rate has also remained stable at 67 per cent compared to previous years.

Expand the use of the Anesthesia Care Team (ACT) model to maximize anesthesiology workforce.

- AHS continued with the rollout and optimization of the Anesthesia Care Team model provincially. As of Q4YTD, approximately 16,000 procedures were completed under the care of the model, resulting in an estimated 1,300 days of anesthesiologist time released to support other surgical procedures.
- The development of educational content and delivery of program cohorts for the Anesthesia Assistant Education Program (AAEP) is ongoing with a full accreditation assessment from the Canadian Society of Respiratory Therapists expected once multiple cohorts have completed the program. In 2024-25, 13 learners completed the full-time studies program, and an additional six learners will complete the self-directed learning stream that commenced in October 2024.
- To support recruitment, new job descriptions were posted and filled for an anesthesia assistant and a respiratory therapist/Anesthesia Assistant AAEP learner. A job description for a registered nurse anesthesia learner is currently under development.
- Operational reviews were completed in Medicine Hat, Lethbridge, Grande Prairie and Red Deer hospitals to increase and improve anesthesia support services. Training for additional Anesthesia Assistant support is underway in all hospitals.

Improve surgical access and patient experience by implementing central access and intake models, such as Facilitated Access to Specialized Treatment and Rapid Access Clinics.

Facilitated Access to Specialized Treatment (FAST) is a central access and intake program which helps to improve the referral process for specialty surgeries. Program updates for 2024-25 include:

- 149,681 referrals were received across all zones for a total of nine subspecialties (orthopedics, urology, vascular, general surgery, otolaryngology, oral maxillofacial, plastic surgery, neurosurgery and gynecology).
- Central access and intake was launched in Q3 for otolaryngology (South, Central, and North Zones), oral maxillofacial and neurosurgery (Edmonton and Calgary Zones).
- Zone FAST teams and provincial FAST teams joined Primary Care Alberta (PCA) as of February 1, 2025.
- Despite ongoing subspecialty rollout, decreased physician engagement has been noted across zones. This is addressed through review of change management plans and the electronic referral platform, meetings with each subspecialty group to review current reports, processes and feedback, and survey of FAST users through PCA.

Rapid Access Clinics (RAC) facilitate waitlist reduction by supporting the pre-surgical patient journey and providing faster access to specialist care using Expert Musculoskeletal Assessor (EMA) services. A non-physician support performs a musculoskeletal (MSK) assessment for patients waiting for orthopedic surgery. RAC services are targeted at hip and knee osteoarthritis, shoulder, soft tissue knee, and spine MSK continuums. As of Q4YTD:

- 15,138 patients were assessed from three MSK continuums (hip and knee, shoulder, soft tissue knee). There are nine contracted sites hosting a total of 13 clinics as part of Phase 1 of the RAC pilot. Expansion to two additional sites is expected in Q1 of 2025-26.
- Wait times for seven of the 13 clinics are meeting the four-week target; one clinic has wait times that are dropping; and five clinics have wait times that are stagnant or increasing with root cause analysis underway. On average, 45.1 per cent of patients are being redirected from surgical consult towards non-surgical management options, thereby freeing up surgeon time for those who need it.
- A high percentage of patients are reporting satisfaction with RAC care (86.5 per cent) and have deemed care provided by an EMA as acceptable (85.9 per cent).
- An evaluation of Phase 1 of the RAC pilot will be available in April 2025 and will report on program implementation and key performance indicators.

The Provincial Pathways Unit (PPU) program provides clinical and procedural guidance to support consistent patient care and referrals across Alberta in areas such as Gynecology, Respirology, Infectious Disease, Plastic Surgery, etc. In 2024-25, there were 25 new pathways, 5 optimized pathways, and 12 patient pathways. Alberta's Pathway Hub, which is a centralized, online pathway library, also had an average of 3400 monthly visits in 2024-25.

Improve surgery waitlist management, validation, and enhanced surgical prioritization through the Alberta Surgical Initiative.

- As of Q4YTD, there were 31,626 surgery cases waiting longer than clinically recommended at adult surgical facilities, approximately 4,470 more cases than the start of the fiscal year (27,159). Waitlist reductions in Q1 (25,801) were not sustained, with waitlist increases occurring Q2-Q3 due to reduced seasonal activity as well as workforce availability and distribution. Waitlist stabilization with a small reduction in cases has occurred since early Q4, but the overall waitlist remains elevated above previous fiscal periods.
- The provincial surgery waitlist management initiative supports the achievement of waitlist reduction targets and improvement of additional key performance indicators. In 2024-25, actions taken as part of this initiative include:
    - Surgical leaders are following up with surgeons identified to have comparatively large numbers of cases waiting outside clinically recommended wait times to understand contributing factors and collaboratively develop a plan to achieve wait time targets. Strategies include ensuring waitlists are updated, prioritizing bookings for longest-waiting cases and referring patients to colleagues with shorter waitlists.
    - Work under the AHS Surgery Program Improvement Network (PIN) and AHS Provincial Surgery Utilization teams transitioned to Surgical Care Alberta (SCA) on April 1, 2025 and will align within SCA strategies for waitlist reduction. The following is underway to support surgeons, leadership and operational teams:
        - Refinement and implementation of guidelines for managing surgery waitlists.
        - Review and evaluation of Chartered Surgical Facilities impact and waitlist reduction.
        - Refinement of AHS' surgical prioritization tool to support surgery waitlist management.
        - Optimization of the Connect Care waitlist management system to streamline workflows and improve data quality for surgeons.
        - Refinement of the surgical booking system in Connect Care.
        - Enhanced support for administrative workflows associated with surgery waitlist management.

Improve surgical access and optimize operating room capacity at rural sites through the implementation of the Rural Surgical and Obstetrical Networks of Alberta.

The Rural Surgical and Obstetrical Networks of Alberta (RSONA) supports increased availability and use of rural operating rooms through consistent workforce availability as an enabler for increased surgical volume at networked sites. It also increases the availability of 24/7 emergent surgical service access points to optimize patient care. In 2024-25, the following work was undertaken across the program's six streams:

- Residency Training Program focuses on completion of core competency agreement, curriculum development, and training site selection for endoscopy, obstetrics, general surgery and trauma. The first cohort of accepted residents will begin the program as of July 2025. Preceptor recruitment and the establishment of a competency committee for residency evaluation in ongoing.
- Privileging Pathways addresses inconsistencies in obtaining privileges and supports standardization of privileging across rural Alberta using core competencies as a guiding reference. A privileging framework is under review.
- Continuing Medical Education offers virtual and in person skills maintenance opportunities. This included monthly virtual educational events with guest speakers, individual and team coaching, enhanced surgical simulation and

workshops with a specialist in each discipline, and attendance at conferences for ongoing professional education to support skills and consistency in rural patient care.

- Individual Coaching reduces professional isolation through communities of practice and mentorship with team coaching, and participants receive a Rural Surgical Coach certification upon completion of mandatory coaching hours. Intake of coaches to the program and use of digital tools to decrease geographical barriers and provide real-time connections with rural practicing peers is in progress.
- Continuous Quality Improvement reviews evidence of safety, cost, health outcomes and patient satisfaction to identify improvement opportunities. AHS is working with sites for service planning and development of rural quality indicators. Planning is also underway with Fort Saskatchewan for inclusion of Family Physician Enhanced Surgical Skills at the site to support call groups and prevent service closures.
- Organization and Financial Framework supports and guides the development of networks and quality improvement through the streams identified above and facilitates communication between health providers across Alberta. This included the development of an operational plan, key performance indicators, financial tracking and a webpage with supporting documents.

Expand surgical capacity at acute care sites and Chartered Surgical Facilities (CSFs).

- In 2024-25, approximately 318,829[8] cases were completed in main operating rooms in all acute care sites and Chartered Surgical Facilities (CSFs). This is 8,829 cases (2.8%) above the volume targeted for 2024-25 (310,000) and 4.3 per cent greater than the volume achieved in 2023-24 (305,711). This includes 254,140 cases in acute care sites (3,090 cases above target) and 64,689 cases completed in CSFs (equating to 98.3 per cent of total contracted annual volume and the largest volume completed in Alberta CSFs to date).
- Additional actions taken to expand/optimize surgical capacity include:
    - The application of the Institute for Healthcare Optimization (IHO) methodology to reduce scheduling variability and better match demand and capacity for inpatient beds and operating room services. Implementation of this methodology at six acute care sites has shown gains of up to 10 per cent in throughput for a subset of participating services and patient cohorts. An additional 10 acute care facilities were onboarded in Q3.
    - Continued delivery of the Alberta Surgical Initiative capital infrastructure program to support increased surgical access in all zones (>35 projects over five-year grant).
    - Ongoing operational planning to optimize use of rural surgical sites in all zones.
    - Optimization and/or expansion of existing CSFs.

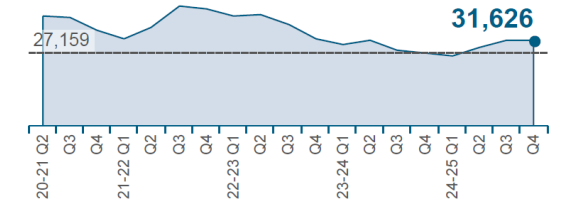
[8] Surgical volume data extracted April 25, 2025

Performance Measure Summary

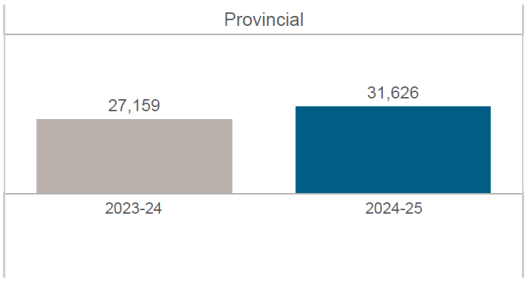
Number of cases on waitlist outside clinically recommended wait times at all surgical sites (except Stollery and Alberta Children's Hospitals)

2024-25 Target: At or below 2023-24 results

Desired direction: ↓



2020-21	2021-22	2022-23	2023-24	2024-25
35,664	43,597	32,199	27,159	31,626



Note: Line graph is quarterly. Bar graph is fiscal year. Surgery wait time quarterly tracking began in 2020-21. Results are point in time values recorded at the end of the reporting period.

Results:

This measure represents the total number of cases booked and waiting for scheduled surgery where the wait time exceeds the clinical target guideline. The lower the number the better, as it indicates that fewer patients are waiting longer than clinically recommended time frames for surgery.

As of the end of the 2024-25 fiscal year, there were 31,626 adult surgery cases waiting longer than the clinically recommended wait time; this is a deterioration of 16.4 per cent compared to the same period last fiscal year (27,159). Initial waitlist reductions seen in Q1 (25,801) were not sustained throughout the remainder of the fiscal year due to reduced seasonal activity and workforce availability and distribution. Population growth and increased demand for surgeries has also contributed to the waitlist trend over the fiscal year. Surgeries completed per capita have been stable the last 3 years (despite 3-4% increases in completed total volumes annually over the last two fiscal years), and these increases are not keeping pace with population growth.

Targeted waitlist reduction strategies continue to be implemented to improve surgery wait times. This includes prioritization of cases waiting the longest, continued implementation of the Provincial Surgery Waitlist Management Operational Directive, as well as improved waitlist analytics and reporting to support surgeons and operational teams in reducing surgical wait times. Additional initiatives include modernization of the surgical prioritization tool and the surgical booking system in Connect Care, optimization of the Connect Care waitlist management system to streamline workflows and improve data quality for surgeons, and educational supports for waitlist management practices.

Objective 7: Improve acute care flow

Appropriate use of acute and community care services is critical to increasing efficiency throughout the continuum of care. Alberta Health's refocus work to increase continuing care capacity will help improve access to care and ensure acute care services and emergency departments are available for those patients who need them most. We will also work with community partners to expand access to acute care services in rural areas for Indigenous and rural communities.

Actions & Achievements

Expedite discharges from hospital with seamless transitions to community care to reduce the number of alternate level of care patients in acute care.

- The Acute Care Bundle Initiative was implemented at the 14 largest acute care sites (excluding Stollery and Alberta Children's Hospitals). This initiative aims to reduce days spent in hospital, reduce hospital readmissions after discharge, and support safe transitions back to primary and community care.
- Alternate Level of Care (ALC) patients are those who no longer require acute care services but occupy an acute care bed or use acute care resources while waiting to be discharged to a more appropriate care setting. In 2024-25, the following initiatives supported expedited discharges and seamless transitions to community care:
    - The Seasonal Capacity Taskforce completed a Calgary Zone project to optimize inpatient urban to rural repatriation. This included increasing the number of weekend acute care discharges as well as optimizing discharge planning and inpatient allied health interventions.
    - The Medical Respite Care Unit in the Edmonton Zone improves community-based options for unhoused and vulnerable populations requiring medical respite and convalescence. There were 150 admissions to the unit from October 2024 to February 2025, with an additional 30 beds planned for 2025-26. An evaluation of the unit will explore opportunities for further reduction in acute care length of stay.
    - In the North Zone, the St. Paul-St. Therese and Cold Lake Health Centres are participating in an ALC collaborative with bi-weekly length of stay reviews to expedite patient discharges and ensure smooth transitions to community care.
    - The Departure Lounge program initiated in Q1 at Grande Prairie Regional Hospital, has also increased from 300 patients in Q2 to over 500 patients as of Q4YTD allowing for faster turnover of beds.

Support patient access to services through virtual care options.

Virtual Health Initiatives:

- A 14-week pilot of Asynchronous Video Observed Therapy (AVOT) was completed by Provincial Tuberculosis (TB) Services to improve access to treatment for patients with active TB. Preliminary results of the pilot showed that the average visit took the same amount of time as a Synchronous Video Observed Therapy visit, less than 10 per cent of AVOT visits required further follow-up, and no additional system costs were required. This approach was also shown to have high and patient and provider satisfaction rates and appeared to be a progressive, patient-oriented method of care that facilitates equitable access to TB treatment.
- The North Zone Virtual Emergency Physician pilot was launched in January 2025 to address emergency department service disruptions such as the unavailability of a local physician. The six-month pilot is in progress in Hinton, Lac La Biche, Elk Point, Beaverlodge and Edson. A quality improvement evaluation framework has been developed to allow for expansion to the Central and South Zones in 2025-26.
- The Stollery Centre for Excellence in Virtual Health is a grant-funded initiative to expand virtual care with the Stollery Children's Hospital. This initiative aims to improve care delivery close to home, care transitions throughout the continuum of care, and access to Stollery-level care, thereby improving health outcomes. It is also anticipated to enhance the patient experience, reduce costs, and create a sustainable Stollery Virtual Care Centre that could act as model for other facilities.
- Virtual Auditory Brainstem Response (ABR) testing uses video and specialized diagnostic equipment to enable audiologists to assess an infant's hearing at a distance. A standardized manual for virtual ABR testing was created by the Early Hearing Detection and Intervention program to outline formal protocol, staff training and technology requirements to support future virtual ABR sites.
- AHS Zoom Enterprise was integrated with Telehealth equipment including carts and designated clinical spaces to enable quick access to video consults in hyper-acute situations and optimize platform usage across the province for both patients and providers.
- A 20-week randomized control trial of 78 complex Chronic Obstructive Pulmonary Disease patients was completed by the Breathe Easy Pulmonary Rehabilitation program to assess the feasibility of integrating digital remote patient

monitoring into a pulmonary rehabilitation program. Preliminary results showed good compliance with patients completing daily recordings an average of 90 per cent of the time over the course of the trial, no reported technical issues or adverse events, and high patient satisfaction with the program.

- The Alberta Family Integrated Care virtual rounds were expanded to the Alberta Children's Hospital and Red Deer Regional Hospital Centre (RDRHC) to enable families who are unable to attend unit rounds in-person, to join virtually.
- Referral, Access, Advice, Placement, Information and Destination provides physicians and healthcare providers with access to timely advice, referral, admission repatriation and consultation for patients. In 2024-25, work was completed on the remaining five call flow maps and a total of 177,239 patient consults were completed, an increase of eight per cent from 2023-24.
- The pediatric component of the Health Link 811 Rehabilitation Advice Line (RAL) which became operational in March 2023, provides wayfinding supports and just-in-time advice for callers. In 2024-25, a total of 776 calls were received by the RAL, a 43 per cent increase compared to the total number of calls received in 2023-24 (543). Reasons for calling the advice line included wayfinding information, speech and language development, motor development, and self/emotional regulation and sensory processing behaviour.
- Over 20,794 calls were transferred from EMS to the Health Link Shared Response Line for 2024-25.

Virtual Home Hospital (VHH):

- A patient experience survey completed in January 2025 showed that 95.3 per cent of patients surveyed were satisfied or very satisfied with the care they received from their VHH and that 98.3 per cent would recommend their VHH to their family and friends.
- The Wetaskiwin Virtual Home Hospital participated in a collaborative study with Brigham and Women's Hospital and the Harvard T.H. Chan School of Public Health in Boston. The study concluded on January 1, 2024, and its findings were released in March 2025. Results showed that delivering care virtually did not compromise quality or patient safety. Patients who received the intervention and were transferred home within three days or less, incurred 27 per cent lower total costs compared to those who remained in hospital. Additionally, 88 per cent of patients reported they would recommend the virtual home hospital experience.
- An additional 15 temporary medicine virtual beds were opened in January 2025 to support the Edmonton Zone. The beds have an average occupancy rate of 82 per cent.

Plan for surge capacity to manage respiratory illnesses and other unanticipated surges in demand.

- The provincial Acute Care Surge Plan was finalized and submitted to the Minister's office in October 2024.
- The provincial acute care surge plan was updated in preparation for the respiratory virus season. Additional temporary ED and inpatient surge capacity was added to support the respiratory virus season and associated increase in demand. As of March 31, 2025, 336 temporary surge spaces were opened across the province (269 inpatient beds and 67 ED spaces).

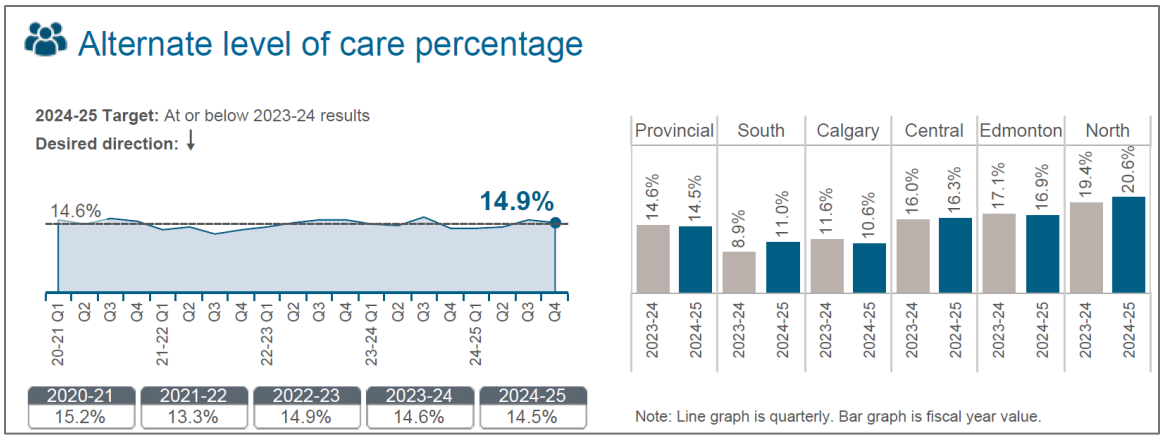
Work with Indigenous partners to improve system integration and outcomes.

- Work continued to increase recruitment to the Indigenous Wellness Program Clinical Alternate Relationship Plan and extend primary care to urban, rural and remote communities. This program provides holistic primary care services to Indigenous patients in their home communities throughout Alberta and in urban centres including the Indigenous Wellness Clinic and Bigstone Medical Clinic (Edmonton), Elbow River Healing Lodge (Calgary), and virtually through the Indigenous Virtual Care Clinic. In 2024-25, there were 55,780 patient visits, an increase of eight per cent from the number of visits in 2023-24 (51,636). There are 90 participating physicians in the plan, an increase of 12 physicians from the last fiscal year.
- To improve access to cultural and traditional healing practices within AHS acute care facilities, AHS is implementing the Access to Indigenous Spiritual Ceremony Policy. In 2024-25, there were 14,001 in-person and virtual patient visits by First Indigenous cultural supports.
- Patient navigation was supported in the South Zone through the establishment of the Indigenous Wellness Core Indigenous Patient Navigator Program (a joint initiative between AHS and Primary Care Networks). This included funding for two temporary full-time Indigenous Patient Navigators in the Chinook Primary Care Network in 2024-25. Funding for these positions has not been renewed for 2025-26.
- Connect Care access for discharge planning is underway in the Calgary Zone. Education sessions are scheduled with Siksika Nation for May 2025 with other Treaty 7 Nations to follow.
- In the Edmonton Zone, the Stollery Awasisak team collaborated with the Indigenous Wellness Core and North Zone partners to review the timeline and safety requirements for the discharge of a medically complex child from the Stollery Children's Hospital to a remote community.

Support Alberta's alternate level of care (ALC) initiative cross-ministerial work led by Alberta Health which aims to coordinate activities, projects, and actions to ensure timely discharge of patients needing more community supports.

- An ALC Steering Committee was established to optimize workflows that supported ALC discharge planning and cross-ministerial efforts led by Alberta Health to address organizational issues that impact ALC length of stay. This work included reviewing recommendations from patient and family advisors, such as integrating the patient perspective to the Committee, exploring opportunities to expand the Case Management Model, strengthening partnerships with Primary Care, reinvesting in Virtual Home Hospital, and collaborating with non-AHS organizations to improve the transition of ALC patients.
- Work is underway to develop a dedicated Provincial ALC page on Insite to serve as a centralized resource for staff to easily access critical documents, Tableau dashboards, and data related to ALC patients.
- Recommendations were reviewed from the Alternative Assessment Process (AAP) pilot in Calgary Zone aimed at reducing time stamps associated with the assessment for a Continuing Care Home. Committee suggestions included spread to other zones and inclusion of the APP process in the list of strategies to address capacity issues.

Performance Measure Summary



Results:

This measure represents the proportion of days patients were assigned to the ALC patient service in all days of service provided across all hospitals. ALC patients are those who no longer require acute care services but occupy an acute care bed or use acute care resources while waiting to be discharged to a more appropriate care setting. The lower the percentage the better, as it indicates inpatient beds are being made available in a timely manner for other patients requiring care and leads to decreased congestion in emergency departments.

In 2024-25, the Alternate Level of Care percentage remained stable at 14.5 per cent compared to the same period last year (14.6 per cent) and achieved the target.

Using a similar definition, in 2023-24, Alberta ranked tied for second among nine provinces for the lowest ALC percentage (AB=14.6%; Canada=16.7%; Best Performing Province=12.4%) (CIHI, 2023-24)[9].

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

Objective 8: Increase access to laboratory and Diagnostic Imaging services

Growth in demand for Diagnostic Imaging (DI) services is outpacing population growth including unprecedented growth in specialized areas within diagnostic imaging. AHS is focused on reducing unnecessary demand through appropriateness strategies while reducing wait times and increasing access to community laboratory and diagnostic imaging services. We want to ensure Albertans receive timely access to appropriate healthcare services and interventions should they require it.

Actions & Achievements

Develop a new investment plan to address the growing demand for diagnostic imaging services.

- To address increased demand and wait times for diagnostic imaging, a multi-year capital funding plan was approved to begin the replacement of AHS' diagnostic imaging equipment. This includes additional operational funding through 2025-26 to ensure maximal utilization of existing equipment.

Continue efforts to fully integrate laboratory services under Alberta Precision Laboratories, such as contract assignments and harmonization, lease assignments, IT system integration, and branding.

- All leases and material contracts were reassigned with contract terms, and contract harmonization is now complete.
- Branding, including modification of former signage, fleet vehicles and apparel is complete.
- Transitioning of all IT applications and infrastructure has been completed.
- Anatomic Pathology Consolidation was completed at the Diagnostic Scientific Centre in Calgary, and the Edmonton Base Lab. This optimizes the flow of samples to fewer labs, keeping time-sensitive cases closer to the point of collection in regional sites and consolidation of cases in Calgary and Edmonton to maximize equipment and staff capacity.

Focus on recruitment, retention, scope of practice and service models of diagnostic imaging and laboratory services, particularly in rural areas.

- A temporary Retention & Recruitment Letter of Understanding between the Health Sciences Association of Alberta and Alberta Precision Laboratories was issued for rural sites with high vacancy rates to help stabilize the workforce.
- A diagnostic imaging-specific recruitment plan has been developed. It includes an advertising plan and attendance at industry recruitment events across the country.
- Targeted promotion of rural placements for lab personnel through an expression of interest process was successfully completed with future engagement plans in place for hard-to-recruit sites.
- A workforce capacity dashboard for lab services personnel was created and in use. Enhancements include x-ray volumes for combined laboratory and x-ray sites as well as costing data are in development.
- Alberta Precision Laboratories has collaborated with the Northern Alberta Institute of Technology to add an additional 15 seats to its two-year Combined Laboratory and Xray Technologist program. It is anticipated that there will be 55 graduates in 2026, an increase from 40 graduates in previous years.
- In partnership with Alberta Society of Radiologists, AHS is finding ways to increase clinical placement of post-secondary students to help increase the number of students enrolled in DI careers.
- Persistent workforce shortages heavily impacted DI's ability to recruit in both urban and rural locations. DI and APL worked collaboratively with AHS clinical operations to determine the best strategies for reducing call-backs in rural facilities which contribute significantly to employee burnout.
- To support rural service sustainability, work is underway to develop lab/diagnostic imaging call-back criteria and explore expanded use of Point-of Care-testing in collaboration with clinical stakeholders.

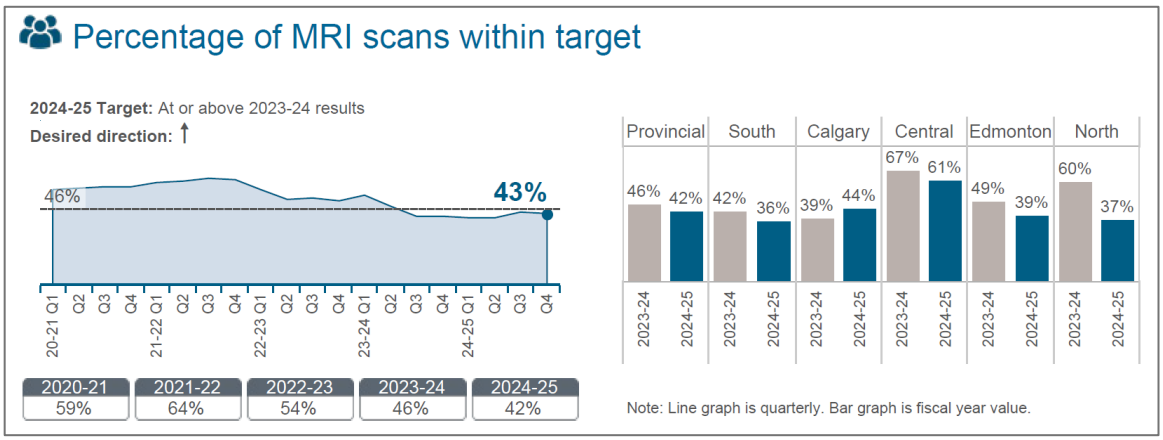
Implement appropriateness initiatives in diagnostic imaging and laboratory services.

- Implementation of an in-house screening test to reduce reliance on specific high-value external testing is underway. Validation of the screening test was completed in March 2025 and data is being reviewed by subject matter experts. Anticipated completion date for this initiative is July 2025 .
- A review of low-utility exam ordering was completed and confirmed that all opportunities to improve clinical appropriateness in inpatient and emergency settings had already been identified.
- An automation bot with artificial intelligence was tested and refined to automatically decline inappropriate MRI knee orders. It is anticipated that go-live testing and launch of this technology will be implemented in the first half of 2025-26.
- Initiatives for duplicate order merging and urine cytology were launched in 2025. For patients with the same test ordered by more than one physician, APL staff can electronically merge duplicative lab orders as opposed to collecting separate specimens for each requisition. This results in patients having less blood drawn, reduces the risk of iatrogenic anemia and allows for improved service and shorter wait times at collections sites. Ongoing monitoring has shown a steady increase in cancelled tests (2.5 per cent of duplicate tests cancelled in February 2025), as well as a downward trend in the total number of urine cytology orders. Opportunities to maximize impact of these initiatives will be explored in 2025-26.

Support access clinical trials for cancer patients by manufacturing the gold standard diagnostic radiopharmaceutical for diagnosis of prostate cancer.

- The Prostate-Specific Membrane Antigen (PSMA)-1007 Access Clinical Trial was launched in the Edmonton Zone in October 2024 and in the Calgary Zone in December 2024. As of March 31, 2025, 185 patients were scanned in the Calgary Zone and 201 patients were scanned in Edmonton. Some of the patients scanned at the outset of the trial have returned for follow-up imaging post-treatment which highlights both the value of timely access to PSMA Positron Emission Tomography and the efficiency of the care pathway in enabling prompt diagnosis and treatment.

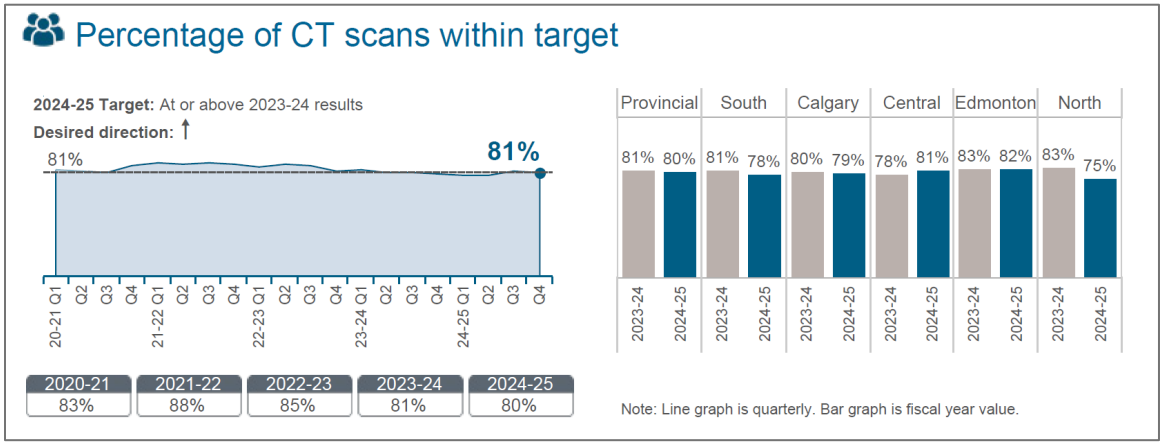
Performance Measure Summary



Results:

This measure represents the percentage of patients seen within established targets for MRI scans. A higher percentage indicates that more patients are receiving MRI scans within recommended time frames. In 2024-25, 42 per cent of MRI scans were completed within target. This is an 8.6 per cent deterioration compared to the same period last year (46 per cent). Factors contributing to the decrease in completed MRI scans include increased referral volumes, limited and aging equipment, and ongoing workforce constraints. While many sites have implemented process improvements and maximized throughput, system-wide capacity remains limited by both the condition and availability of MRI scanners, as well as staffing shortages that prevent extended operating hours or the addition of shifts.

On a related measure, in 2024, Alberta ranked fourth of seven provinces for the shortest wait time for MRI scans 50 per cent of the time (AB=63 days; Canada=57 days; Best Performing Province=34 days) (CIHI Apr-Sep 2024).



Results:

This measure represents the percentage of patients seen within established targets for CT scans. A higher percentage indicates that more patients are receiving CT scans within recommended time frames. In 2024-25, 80 per cent of CT scans were completed within target. This measure remained stable compared to the same period last fiscal year (81 per cent).

On a related measure, in 2024, Alberta ranked fifth of seven provinces for the shortest wait time for CT scans 50 per cent of the time (AB=34 days; Canada=16 days; Best Performing Province=8 days) (CIHI April-September 2024).

Goal: Quality & Safety

Objective 9: Improve patient experience

A focus on quality, including patient experience and safety, ensures systems, capacity and tools are used to improve performance and outcomes. New facilities and programs are creating environments where innovation and best practices support improved care and patient experience. Quality improvement leads to improved clinical practice and performance, and a coordinated and seamless approach to care. Clinical appropriateness ensures the right care is provided by the right providers to the right patient in the right place at the right time, resulting in optimal quality care. Positive patient experiences are linked to better health outcomes, including lower readmission rates and proactive health management. AHS will build on connections, relationships, and partnerships with Indigenous peoples.

Actions & Achievements

Design and implement the Learn Improve Together model for quality management including the establishment of Program Improvement & Integration Networks.

- The acute care Program Improvement Networks (PINs) were established with development of priority initiatives.
- Governance structure for the PINs including the Learn Improve Together (LIT) Coordinating Council and LIT Leadership Council were established to provide communication, standardization and oversight for the programs.

Identify and implement Right Care Alberta clinical appropriateness initiatives.

Clinical appropriateness initiatives help achieve better value for our health care dollars by ensuring that patients only have tests, treatments and clinical procedures that will improve their health outcomes. Examples of initiatives underway include:

- Development of the second Atlas of Clinical Variation including 10 new clinical variation topics (e.g., penicillin allergy de-labeling and variation in hysterectomy utilization) and 18 data analytic packages are under clinical variation review.
- Seventeen active projects in various stages of progress to address clinical appropriateness including:
    - Reducing unnecessary tests and treatments for bronchiolitis leading to decreased wait times as fewer low-value interventions are administered to patients with bronchiolitis in the ED.
    - Reducing low-utility diagnostic imaging in the ED for patients presenting with non-specific dizziness, leading to reduced diagnostic imaging wait times in the ED.
    - Reducing use of Immunoglobin therapy where less costly, therapeutic equivalent treatment options exist, and reducing use relative to dosage, duration and frequency of treatment to decrease overall usage costs by at least five per cent.
- Creation of a video and accompanying narrative on clinical variation that will be presented to all staff via AHS' YouTube channel.

Implement Shared Commitments to improve the healthcare experience of patients.

- Shared Commitments was successfully launched in April 2024. This program includes support resources for staff, health providers (including physicians), and patients and their families. Resources have been translated into 11 languages. A formal evaluation as well as ongoing support to meet accreditation standards on patient rights and responsibilities is planned for 2025-26.
- Uptake of Shared Commitments was supported across the zones through the following:
    - Using feedback from the 2024 Fall Accreditation Survey and Patient Experience Surveys to further integrate shared commitments into everyday practice.
    - Reinforcing shared commitment principles through leadership rounding engagements.
    - Including the Shared Commitments strategy and supporting resources in new manager orientation packages.
    - Posting Patient Experience Survey results on unit quality boards and displaying Shared Commitments posters across various sites.
    - Consulting and engaging with adult and pediatric patient family advisors and councils to identify additional opportunities to incorporate Shared Commitments into the patient and family experience.

Implement quality and safety improvement initiatives to enhance cultural safety, eliminate racism against Indigenous Peoples, and recruit and retain Indigenous Staff.

- AHS developed and/or implemented the following quality improvement initiatives to address racism and enhance culturally sensitive care for Indigenous peoples:
    - The Canadian Institute for Health Information Baseline Cultural Safety assessment was completed by 440 AHS staff. This tool monitors the progress of initiatives and interventions that address anti-Indigenous racism within a healthcare organization.
    - The Information Sharing Agreement with Samson Cree Nation was implemented with the secure transfer of data completed in December 2024. This work is supported through the Indigenous Health Data Ecosystem to enable Indigenous data sovereignty through agreements with Indigenous communities while meeting federal and provincial legal compliance requirements. To date, quality assurance data cleaning has occurred on more than 10,000 records.
    - The Indigenous Workforce Action Plan focuses on recruitment and retention of First Nations, Métis, and Inuit at AHS. This included completion of the Indigenous Workforce Needs Assessment to prioritize targeted interventions, as well as consultation with approximately 60 stakeholders to raise awareness and refine strategic priorities. Implementation is anticipated to start in April 2025.
    - The Indigenous Patient Concerns and Experiences Initiative analyzes AHS Feedback and Concerns Tracking data collected through the Indigenous Support Line (ISL). This data was used at the St. Therese-St. Paul Healthcare Centre to design a multi-year cultural safety action plan for its emergency department. These findings will guide efforts to enhance quality and care for Indigenous patients and families.
    - A *Guide for Disclosure of Harm with Indigenous Patients and Families* was developed to support other existing disclosure resources and provide Indigenous-specific considerations to support culturally safe disclosure conversations. These resources are accessible to staff through the internal AHS website.
- Examples of cultural safety activities within AHS include:
    - Facilitated 89 education workshops attended by over 2,800 AHS staff and volunteers, an increase of 18 per cent in the number of attendees in 2023-24 (2,377). This included a customized, in-person Indigenous Required Organization Learning (ROL) program for all new recruits to AHS' Protective Services team and Emergency Medical Services Dispatchers.
    - A FAQ document was created on the cultural significance, beliefs and practices related to hair and was presented to over 60 physician leaders at AHS.
    - Accreditation was received for the newly redesigned Indigenous Health ROL with the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians.
- Initiatives undertaken in the zones include:
    - In the South Zone, AHS collaborated with Blood Tribe Health and the City of Lethbridge to coordinate services for vulnerable individuals, and Chinook Regional Hospital provided support to 827 patients.
    - In the Calgary Zone, AHS and G4 Health (Bearspaw, Chiniki, Goodstoney, & Tsuut'ina) focused efforts on the Bow Corridor, Canmore Hospital and Rockyview General Hospital. Work is also underway to have the First Nations Community Support Liaison role renamed to Spiritual Community Visitor.
    - The Anti-Racism Simulation (ARSIM) pilot project was completed at the Ponoka in the Central Zone. Data from the project is currently under review with results expected in 2025-26.
    - Edmonton Zone held Indigenous Awareness education sessions for its staff that focused on embedding learnings into everyday work. Métis Cultural Awareness Training sessions were also held.
    - In the North Zone, results from patient feedback surveys are helping to develop staff guidelines and identify areas for improvement.

Improve the patient concerns management process and provide a culturally safe pathway for complaints from Indigenous patients.

- The Indigenous Support Line (ISL) provides supportive listening, connections to health resources, Indigenous cultural supports, and a safe place to bring forward patient concerns for First Nations, Métis, and Inuit patients, their families and the providers who support them. In 2024-25, ISL managed 4,225 calls and made 46 presentations to increase awareness of the support line.
- The Patient Relations website was updated to provide Indigenous providers feedback with a link to ISL.
- South Zone started a project to identify Indigenous callers during the patient concerns intake process and proactively offered cultural supports including awareness of ISL. This project will be expanded to the North and Central Zones.

Protect patient privacy through increased cyber security initiatives and controls.

- A Cyber Security Assessment was completed to inform the AHS Cyber Security Roadmap. This assessment will inform future planning for Connect Care, Information Technology and cyber security for patients and staff.

Launch the new Antimicrobial Stewardship Program within AHS acute care sites.

- AHS' Antimicrobial Stewardship Program aims to improve the appropriateness of antimicrobial use by measuring antimicrobial utilization, reviewing and optimizing antimicrobial prescriptions and offering education for prescribers to align with best practices. The first phase was completed at five acute care sites and five smaller rural sites in the South Zone. A phased approach will be used to implement at all 106 sites. Active projects include penicillin allergy management, expansion in the Neonatal Intensive Care Unit, implementation in the North Zone, creation of a provincial dashboard on appropriateness, and development of Tip Sheets for acute care sites.

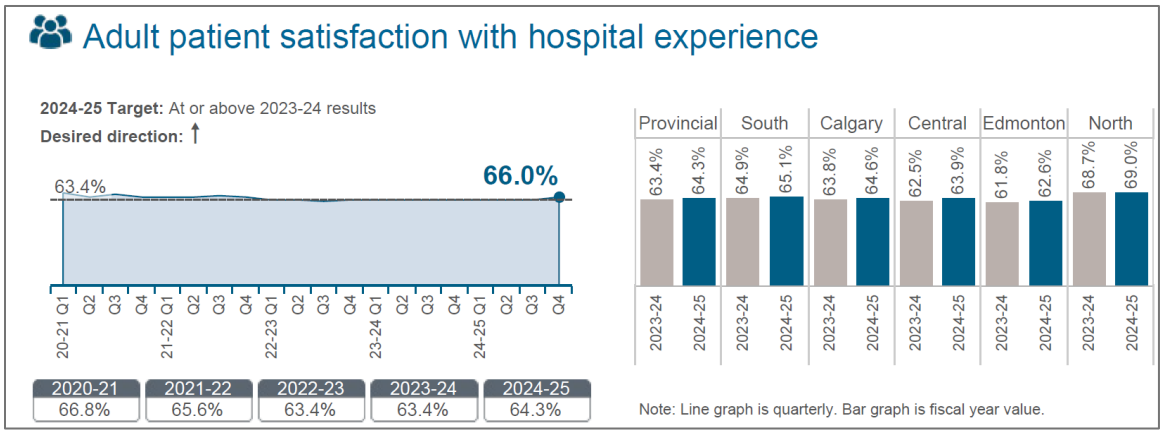
Complete the final two launches of Connect Care to empower Albertans to be partners in health decisions.

- Connect Care completed its eighth launch in May 2024 and its ninth and final launch in November 2024. There are over 125,000 staff, physicians and other healthcare providers using Connect Care to improve care for patients at more than 1,000 sites and programs across all five AHS zones.
- As of March 2025, the MyAHS Connect patient portal has over one million registered Albertans.

Provide dedicated innovation and research space supporting innovative models of cancer care and health delivery in the new Arthur J.E. Child Comprehensive Cancer Centre.

- The Arthur J.E. Child Comprehensive Cancer Centre was opened to outpatients in October 2024 and to inpatients in November 2024. The Alberta Cancer Acute Assessment Unit (AAU) was opened within the centre in February 2025 and is the first unit of its kind in the province as it supports timely, responsive oncology patient care to avoid unnecessary inpatient admission and/or emergency room visits. As of March 31, 2025, the AAU has accepted 94 new patients.
- Initiatives implemented at the new cancer centre in 2024-25 include:
  - Patient gong and long bells to recognize patient achievement in their cancer journey.
  - Indigenous patient engagement with the establishment of a land acknowledgement and a family room.
  - Advanced wayfinding innovation with touchscreen digital display and QR-based wayfinding.
  - Catered Comfort - an app-based meal ordering service for patients.
  - Collaboration through integration of a Patient and Family Advisory Committee into working groups.
  - Individualized patient molds developed in the design lab to improve accuracy in radiation treatment.
  - Integration of the Science Teaching Research Innovation and Exercise (STRIDE) Center within the facility as well as the expansion of the physiotherapy program.

Performance Measure Summary



Results:

This measure is an indicator of system performance from the patient's perspective and monitors patients' overall perceptions associated with the hospital where they received care, based on survey ratings. It identifies the percentage of patients rating hospital care as nine or 10 on a scale from zero to10, where 10 is the best possible rating. The higher the number the better, as it demonstrates more patients are satisfied with their care in hospital. In 2024-25, the percentage of patients rating hospital care as nine or 10 (64.3%) remained stable compared to the same period last year (63.4%) and achieved the target.

In 2021-22, Alberta ranked first among three provinces for the highest overall hospital experience (AB=66%; Canada=63%; Best Performing Province=66%) (CIHI, 2021-22).

Objective 10: Strengthen health promotion and focus on disease/ injury prevention

AHS supports initiatives that prevent avoidable disease and injury and offers comprehensive supports to communities that allow people to be as healthy as possible. A focus on health promotion and creating conditions for people to stay healthier will improve quality of life, ensure system sustainability and avoid health system costs in the future.

Actions & Achievements

Maintain immunization rates for priority populations including children, vulnerable populations and high-risk groups.

- Seven Provincial Immunization Orientation modules are in development and focus on training and supporting AHS immunizers by providing standardized, baseline immunization education to new public health nurses. The modules will be available through MyLearningLink to support AHS immunizers to have the confidence, knowledge, skills and tools to communicate with all clients. All seven modules are anticipated to be launched by November 2025.
- In 2024-25, the seasonal influenza immunization rate for children (ages 6 to 23 months) was 47.1 per cent (2023-24 = 46.8%).
- In 2024-25, the seasonal influenza immunization rate for seniors (ages 65 and older) was 59.4 per cent (2023-24 = 63.9%).

Reduce sexually transmitted and blood-borne infection rates.

- A communications plan was developed to enhance healthcare provider awareness of the syphilis outbreak and care for patients with syphilis. This plan includes a campaign to increase public awareness about syphilis and what can be done to reduce risk. The campaign is anticipated to begin in spring 2025.
- Clinical follow-up of individuals started on HIV Post-Exposure Prophylaxis (PEP) following a blood or bodily fluid exposure (BBFE) was transitioned to Health Link and the Virtual MD program provincewide.
- There were 47 cases of congenital syphilis in 2024[10]. This is a 20 per cent decrease from the number of cases reported in 2023 (59 cases). The following work has been undertaken in the last five years to decrease the number of cases:
    - A prenatal syphilis grant increased staffing in the provincial partner notification nurse team as well as the STI clinic sites in Calgary and Edmonton with a total increase of 9.6 full-time equivalent (FTE).
    - Increased cost pressures funding added capacity by 12 FTE for syphilis case and contact investigations.
    - Establishment of the Syphilis Response Committee which has collaborated on initiatives such as point-of-care testing support, collaboration with Indigenous Services Canada, and grants from the Canadian Institutes for Health Research in high-prevalence communities such as Wetaskiwin and High Level.
    - Collaborative work to support cross-training of public health nurses and increase testing and links to care within communities in the North Zone.

Co-design health promotion and prevention programs with communities (e.g. Healthier Together).

- The Healthier Together initiative guides cities and municipalities toward a healthier way of living, working, learning, and healing to give everyone a fair chance for health. In 2024-25, seven communities and 181 settings-based partners implemented over 60 local initiatives in Airdrie, Edson, Wabasca, Edmonton, Two Hills, Ponoka, Lethbridge County, Municipal District of Taber and area. Engagement with over 4,300 rural and urban partners and 146 settings-based partners has occurred to date. A Social Return on Investment forecast analysis for Healthier Together Edmonton determined that for every dollar invested, the initiative is returning five dollars in social value. Analysis for the remaining Healthier Together Initiatives will be completed in 2025-26.
- The Healthier Together Schools approach provides a framework to facilitate school health promotion initiatives. In 2024-25, 257 education partners were trained to Enhance Well-Being, Enhance Learning using the Comprehensive School Health Approach. To support implementation with schools, one additional evidence-based sun safety action card was developed along with 10 articles for families, six newsletters, and three stories of school implementation which were made available on the Healthier Together website.
- Two Public Health Dental Clinics in the Calgary Zone and one in the Central Zone are providing basic and comprehensive dental treatment services for vulnerable Albertans. In 2024-25, 3,380 patients received services,

[10] Congenital Syphilis cases are measured over the calendar year

25,571 procedures were completed, and 532 emergency department aversions or primary care referrals were made. This is an increase of 14.9 per cent (2,941), 21.7 per cent (21,016), and 26.7 per cent (420) respectively compared with 2023-24. Additional outreach dental services in High Level, McLennan and La Crete were also provided in Q3-Q4 where 1,934 patients were seen, and 5,358 procedures were completed.

Work with existing community-led initiatives on preventing avoidable diseases and injuries for Indigenous peoples.

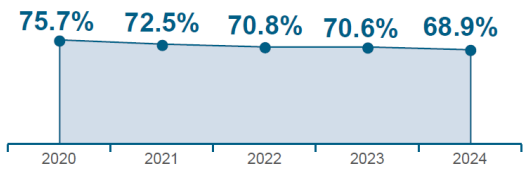
- Communities involved with the Honouring Life Program have reported increased self-esteem and confidence amongst participants, improved coping skills, awareness of mental health issues, suicide prevention, and life and leadership skills. In the second half of 2024-25, funding was provided to two additional First Nations communities and one urban Indigenous organization, along with an increase of two crisis grants and one life promotion grant. As of Q4YTD, 44 life promotion and five crisis grants are currently active.
- First Nations, Métis, and Inuit Elders and Knowledge Keepers were consulted in the development of the learning module *Understanding the difference between traditional tobacco and commercial tobacco – Module 1*. This learning resource is available online to AHS staff. Work on Module 2 is anticipated to be completed in September 2025.

Performance Measure Summary

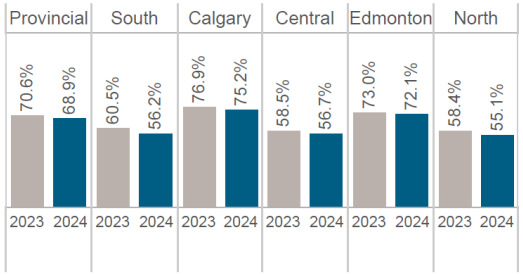
Childhood immunization rate: DTaP-IPV-Hib dose 4 by age 2

Target: At or above 2023 results

Desired direction: ↑



Note: Alberta Health changed the methodology to include First Nations coverage. This change in methodology has been reflected in all years in this report. Historical data has been restated due to Alberta Health reporting updates.



Note: Both graphs are calendar year. The target represents the 2024 AHS organizational target. Alberta Health uses the national target (set by the Public Health Agency of Canada) for childhood immunization by age 2.

Results:

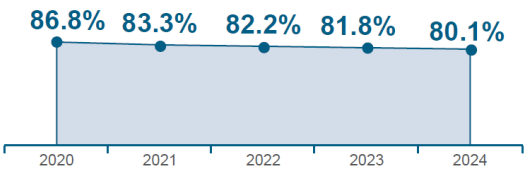
This measure represents the number of children who turned two years of age and had received four doses of diphtheria, tetanus, pertussis, polio and haemophilus influenzae type b (Hib) containing vaccine as a percentage of all children who turned two years of age. The higher the percentage the better, as it demonstrates more children are immunized and protected from preventable childhood diseases. In 2024, the rate (68.9 per cent) remained stable compared to the same period last year (70.6 per cent) and did not achieve the target of 70.6 per cent.

Using a similar definition, in 2021, Alberta ranked ninth among the 10 provinces for DTaP immunization at two years (AB = 75%; Canada = 77%; Best Performing Province = 96%), ninth among nine provinces for Polio immunization at two years (AB = 86%; Canada = 92%; Best Performing Province = 95%), and ninth among the 10 provinces for Hib immunization at two years (AB = 71%; Canada = 75%; Best Performing Province = 96%) (Statistics Canada, 2021).

Childhood immunization rate: MMR dose 1 by age 2

Target: At or above 2023 results

Desired direction: ↑



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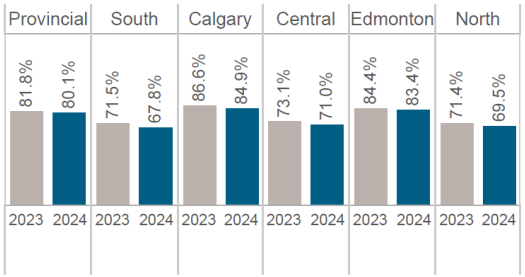


Note: Both graphs are calendar year. The target represents the 2024 AHS organizational target. Alberta Health uses the national target (set by the Public Health Agency of Canada) for childhood immunization by age 2.

Results:

This measure represents the number of children who turned two years of age and had received one dose of mumps, measles, and rubella containing vaccine as a percentage of all children who turned two years of age. The higher the percentage the better, as it demonstrates more children are vaccinated and protected from preventable childhood diseases. In 2024, the rate (80.1 per cent) remained stable compared to the same period last year (81.8 per cent) and did not achieve the target of 81.8 per cent.

Using a similar definition, in 2021, Alberta ranked ninth among the 10 provinces for MMR immunization at two years (AB = 88%; Canada = 92%; Best Performing Province = 98%) (Statistics Canada, 2021).

Financial Summary

Financial Statement Discussion and Analysis

For the year ended March 31, 2025

This *Financial Statement Discussion and Analysis* (FSD&A) provides a financial overview of the results of Alberta Health Services' (AHS) operations and financial position for the year ended March 31, 2025. The FSD&A reports to stakeholders how financial resources are being utilized to provide patient-focused, quality health services that are accessible and sustainable for all Albertans. It serves as an opportunity to communicate with stakeholders about AHS' 2024-25 financial performance as well as cost drivers, strategies and plans to address financial risk and financial sustainability.

This FSD&A has been prepared by and is the responsibility of AHS management and should be read in conjunction with the March 31, 2025 audited consolidated financial statements, notes, and schedules.

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

Highlights

AHS finished the year in a nearly balanced operating position with a $71 million annual operating surplus, representing 0.37 per cent of total expenses.

AHS experienced a significant increase in clinical and other cost pressures due to increased activity across the organization, patient complexity, population growth and aging, and inflation. Increased costs related to the collective bargaining process, as well as similar cost increases for contracted providers further contributed to cost pressures in the year.

In response, AHS implemented cost management strategies, and savings initiatives which partially offset these cost pressures. Financial results were closely monitored throughout the year and higher than expected revenues related to investment and other income, and fees and charges, along with a reduction in health benefits expenses further offset the cost pressures. The remaining pressures were identified and communicated to Alberta Health in AHS' quarterly financial updates and were funded by one-time funding transfers from Alberta Health.

Refocusing Healthcare

Throughout the year AHS supported the refocusing of the healthcare system with the goal of improving health outcomes for all Albertans. In 2024-25, two of the four new provincial health agencies became operational, Recovery Alberta and Primary Care Alberta (PCA). AHS transferred all responsibilities and the oversight of mental health and addiction services to Recovery Alberta effective Sept. 1, 2024, and the delivery of primary care services to PCA effective Feb. 1, 2025. The financial impact of transferring the related assets and liabilities, funding agreements, and applicable budgets to Recovery Alberta and PCA are disclosed in Note 3 – Restructuring, and Schedule 4 – Consolidated Schedule of the Revised Budget in the AHS Consolidated Financial Statements.

Strategic Goals

Under the guidance of the 2024-27 Health Plan, AHS advanced many key long-range goals and objectives related to system sustainability, access, quality and safety.

AHS focused on **system sustainability** by supporting the refocusing of healthcare, while also ensuring continuity of care and access to healthcare services supported by a strong workforce as implemented through the *AHS Health Workforce Strategy*. To realize savings and efficiencies, AHS pursued cost management and savings initiatives throughout the year including enhanced vacancy management, managing discretionary spending, lease space consolidations, contract reductions, and other program and departmental savings.

AHS invested in increased **access** by focusing on reducing surgical wait times, improving acute care and emergency department flow, increasing access to lab and diagnostic imaging, and improving emergency medical services response times.

AHS focused on reducing surgical wait times through ongoing implementation of strategies and resources in the Alberta Surgical Initiative, which was developed in partnership with Alberta Health to ensure more Albertans received scheduled surgeries within clinically recommended timelines. In 2024-25, 318,829 surgeries were performed: a 4.3 per cent increase from the prior year.

To improve acute care flow, AHS invested in hospital capacity, including the update of surge capacity escalation protocols, resulting in the opening of 336 surge beds across the province during the peak of respiratory virus season. AHS also expanded continuing care, community care, and home care options to ease pressures on hospitals and reduce the number of alternate level of care patients in acute care, including $87 million spent to support seniors aging with dignity in their community. The Arthur J.E. Child Comprehensive Cancer Centre opened to the public in October 2024 further supporting local patient needs as well as improving the overall access and referral pathways and options for cancer patients throughout the province. To improve emergency department flow, emphasis was put on ensuring patients had access to care in the appropriate setting, reducing pressure on emergency departments.

To address the increased demand and manage wait times for lab and diagnostic imaging, AHS increased lab capacity through the continued integration of community lab services back to AHS resulting in 8.9 per cent more laboratory tests than in the prior year. AHS also continued to invest in the CT and MRI Action Plan, increasing CT scans 8.3 per cent and MRI scans 5.2 per cent from the prior year.

AHS spent an additional $44 million on emergency medical services in 2024-25 as part of implementing grant funded emergency medical services initiatives, including the expansion of inter-facility transfer resources and direct-delivery ground ambulance capacity in Calgary and Edmonton, and the opening of a new dispatch centre in Fort McMurray.

AHS focused on **quality and safety** in an effort to improve the patient experience and ensure optimal quality of care is provided in a safe environment. Patients will continue to

experience additional benefits and improvements to their health experience through the final launch of Connect Care, AHS' transformative provincial clinical information system, in November 2024. Connect Care provides better care for Albertans by ensuring the whole healthcare team, including patients, have the best possible information throughout their care journey.

Key Financial Trending

Annual Operating Surplus

AHS' annual operating surpluses have averaged one per cent or less of total expenses in each of the past five fiscal years.

(in $ millions)	2025	2024	2023	2022*	2021*
Revenues	19,104	19,028	17,749	17,499	16,789
Expenses	19,033	18,844	17,665	17,368	16,697
Annual operating surplus	**71**	**184**	**84**	**131**	**92**
Accumulated surplus	1,376	1,305	1,121	1,037	906

** Select prior year information has been restated for the adoption of PS 3280 Asset Retirement Obligations in 2022-23.*

Workforce

The largest cost for AHS is workforce compensation (52.9 per cent of total expenses). Alberta continues to experience the workforce challenges of demand for increased health services combined with increased competition for qualified healthcare workers.

AHS continues to implement the *AHS Health Workforce Strategy* in response to short and medium-term challenges and coordinate planning under four strategic pillars to meet medium and long-term workforce needs:

1. Grow our talent supply through recruitment, education, and training.
2. Optimize the workforce with healthcare teams working to their full scope of practice.
3. Improve retention through a multi-faceted, focused action plan.
4. Integrate workforce planning to drive data and evidence-informed decision-making.

Calculated Full-Time Equivalents (FTE) measure the total workload required to address the demands placed on the AHS system compared to the workload of a full-time employee. FTE is the total number of paid hours (including regular hours, overtime, relief, and paid time off), divided by the annual hours of a full-time employee, which is 2022.75 for the current year (2023-24 – 2030.50 due to the leap year).

Calculated FTE	2024-25	2023-24	Increase (Decrease)	
			FTE	%
Clinical staff[1]	55,326	56,685	(1,359)	(2.4)
Other staff[2]	28,728	29,312	(584)	(2.0)
Management – includes both clinical and other management	3,008	3,327	(319)	(9.6)
Total Calculated FTEs	**87,062**	**89,324**	**(2,262)**	**(2.5)**

The decrease in Calculated FTEs was mainly due to the transition of mental health and addiction staff from AHS to Recovery Alberta on Sept. 1, 2024, and reduced overtime. Vacancy rates continued to decrease in the year through efforts made in recruitment and retention, which when combined with operational efforts, contributed to lower overtime rates seen across the organization. The overtime rate decreased from 2.9 per cent in the prior year to 2.4 per cent in 2024-25.

Overall, clinical staff FTEs including registered nurses and emergency medical services decreased compared to the prior year as staff transitioned to Recovery Alberta. However, AHS clinical staff FTEs increased as recruitment and retention efforts in the year targeted vacancies, talent supply, and alternative delivery models. This included launching an emergency medical services recruitment campaign and hiring 208 internationally educated nurses.

AHS continues to be one of the most efficiently managed public sector organizations in Canada, with clinical and other managers overseeing an average of 34 employees each. The average ratio for Canadian public administration agencies, according to the most recent Conference Board of Canada report was 6.5 employees per manager[3].

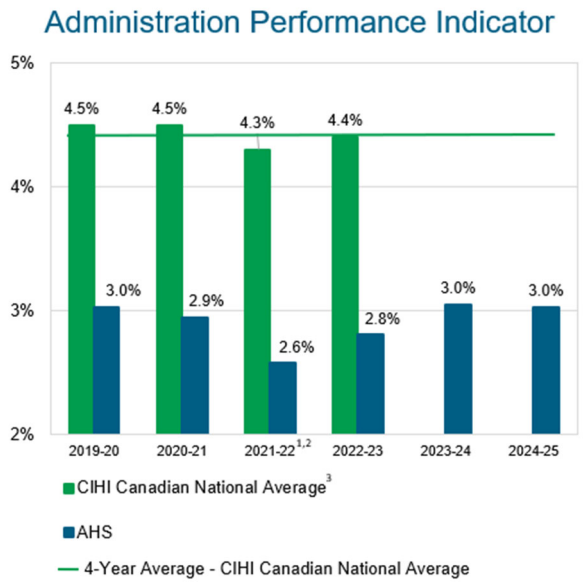
[1] Clinical staff comprise AHS' medical doctors, regulated nurses, health technical and professional staff and unregulated health service providers.

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

[3] Conference Board of Canada. (2022). Human Resources Metrics Survey: https://www.conferenceboard.ca

Administration

The Canadian Institute of Health Information (CIHI) reports the corporate services expense ratio as a financial performance indicator based on administration expense as a percentage of total expenses[4]. For 2024-25, AHS' indicator was 3.0 per cent.



[1] Certain amounts have been reclassified to conform to subsequent years presentation.

[2] 2021-22 AHS administration indicator was impacted by significant additional spending due to COVID-19 across other expense lines, including population and public health, acute care, support services, and diagnostic and therapeutic.

[3] CIHI Canadian national average for the administration indicator for 2023-24 and 2024-25 was not available at the time of publication of this report.

AHS continues to ensure administrative systems and processes are as efficient and effective as possible, to ensure that healthcare dollars are directed wherever possible to improve healthcare system access, performance, quality, and safety.

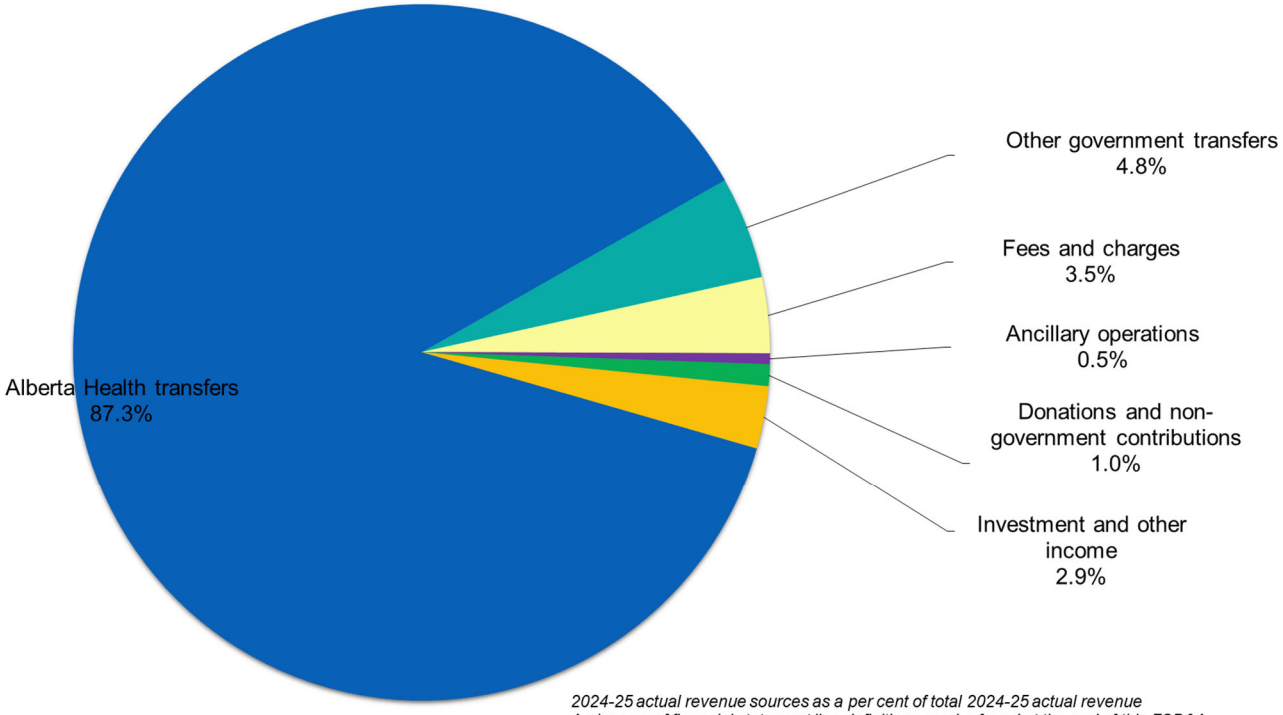
[4]Canadian Institute for Health Information. (n.d.). Your Health System. Retrieved from Interactive Map: Corporate Services Expense Ratio (Percentage), 2022-23: https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en&_ga=2.159018553.2003620571.1683215781-806221219.1682440829#/indicator/041/2/C20018/

Financial Analysis

AHS discloses its results from operations in its consolidated financial statements by function on the *Statement of Operations* and by object on Schedule 1. Actual financial results for 2024-25 operations are analyzed in comparison to the budget and the prior year in this report. As a result of restructuring in the current year, the revised budget in Schedule 4 of the AHS Consolidated Financial Statements has been used for this comparison. A glossary of financial statement line definitions can be found at the end of this FSD&A. An analysis of AHS' financial position compared to the prior year is also discussed in this section.

Operations

Revenues



2024-25 actual revenue sources as a per cent of total 2024-25 actual revenue
A glossary of financial statement line definitions can be found at the end of this FSD&A

Alberta Health transfers accounted for 87.3 per cent of AHS' total revenues in 2024-25 (2023-24 – 90.5 per cent). The decrease in the proportion of Alberta Health revenues to total revenues is a result of higher Other government transfers due to mental health and addictions funding that was received from Alberta Health in the prior year now being received from the Ministry of Mental Health and Addiction (transfers were received up until the transition of mental health and addictions services to Recovery Alberta on Sept. 1, 2024), and higher Investment and other income revenues in the year. AHS' total revenues amounted to $19,104 million, which was $659 million or 3.6 per cent higher than the budget of $18,445 million primarily due to additional one-time base operating funding received from Alberta Health in the year and higher than anticipated Investment and other income.

(in $ millions)	Budget 2024-25 (Revised)	Actual 2024-25	Actual to Budget Variance	Actual 2023-24 (Revised)	Year over Year Increase (Decrease)
Alberta Health transfers	16,288	16,677	389	17,212	(535)
Other government transfers	876	911	35	559	352
Fees and charges	617	668	51	626	42
Ancillary operations	93	95	2	87	8
Donations and non-government contributions	169	203	34	214	(11)
Investment and other income	402	550	148	330	220
Total revenues	**18,445**	**19,104**	**659**	**19,028**	**76**

Actual to Budget

Alberta Health transfers were higher than budget due to one-time transfers provided to support the collective bargaining process and clinical activity pressures.

Other government transfers were higher than budget due to new grant funded initiatives including additional funding provided to support seniors aging with dignity in their community. Partially offsetting the variance were lower than anticipated transfers due to the timing of various infrastructure maintenance projects.

Fees and charges were higher than budget due to increased clinical activity resulting in a higher number of patients who were provided healthcare services that are billable to non-residents, the Workers Compensation Board, the federal government, and other provinces.

Donations and non-government contributions were higher than budget due to increased donations throughout the year, including donations from foundations.

Investment and other income were higher than budget due to increased net realized gains from active portfolio management, higher interest and dividend income due to strong market performance, and higher bond amortization income from the purchase of bonds and treasury bills at a discount. Further contributing to the variance were higher than budgeted recoveries from the Worker's Compensation Board.

Year over Year

Alberta Health transfers were lower than the prior year due to the transition of funding related to mental health and addiction services to the Ministry of Mental Health and Addiction in the year, and lower transfers related to primary care services as operations transferred to PCA effective Feb. 1, 2025. The overall decrease was partially offset by an increase in funding to support investments in improving capacity and patient flow across the healthcare system, one-time funding provided to support the collective bargaining process, and clinical activity pressures.

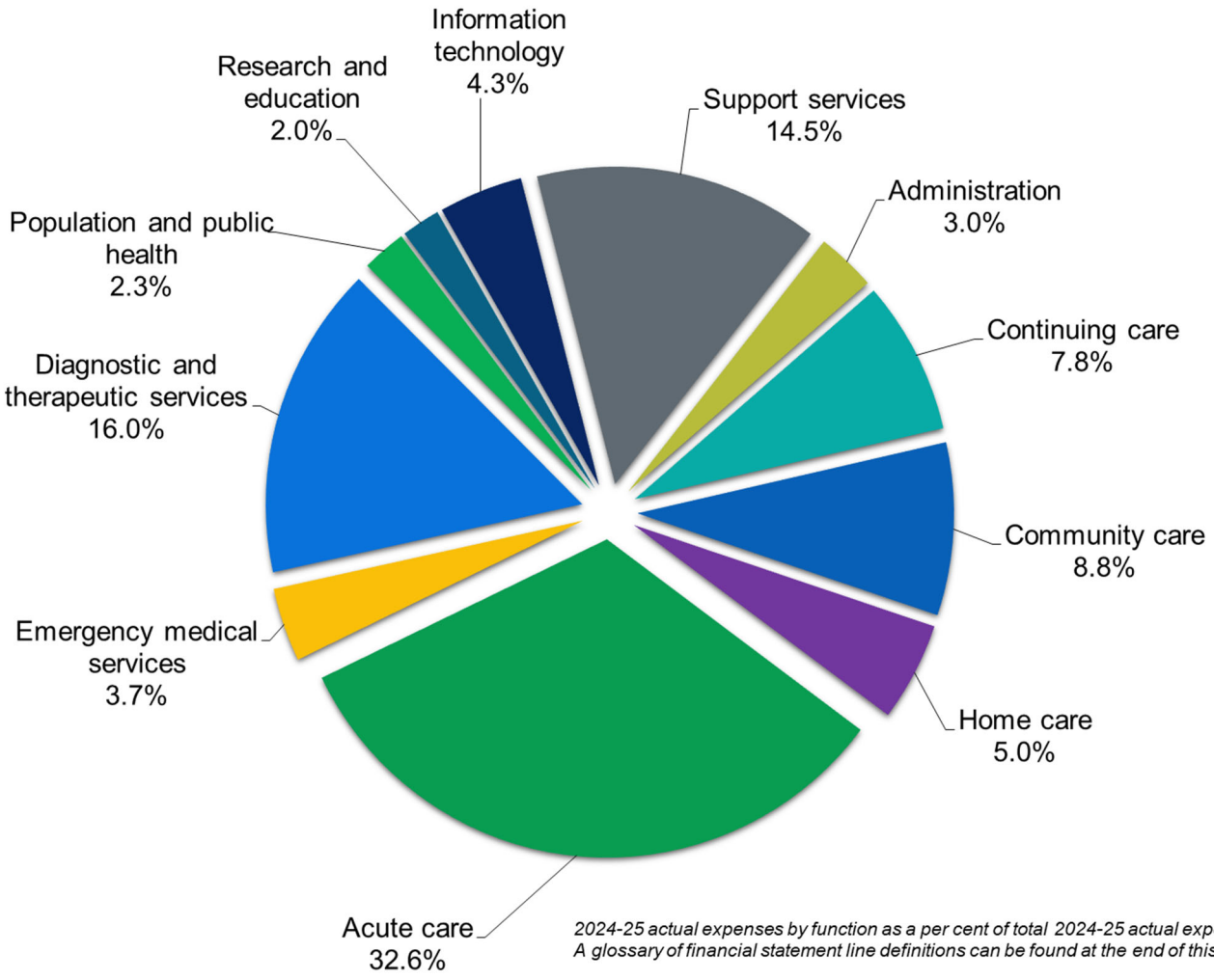
Other government transfers were higher than the prior year due to the transition of funding related to mental health and addiction services to the Ministry of Mental Health and Addiction in the year, and increased funding to support seniors aging with dignity in their community. The overall increase was partially offset by the transition of mental health and addiction grants to Recovery Alberta on Sept. 1, 2024, and lower infrastructure maintenance projects.

Fees and charges were higher than the prior year due to an increase in interprovincial billing rates, and an increased number of patients who were provided healthcare services that are billable to the Workers Compensation Board, the federal government, non-residents, and other responsible parties.

Donations and non-government contributions were lower than the prior year due to an endowment contribution received for the Arthur J.E. Child Comprehensive Cancer Center in the prior year.

Investment and other income were higher than the prior year due to recoveries received under the new transition services agreement between AHS and Recovery Alberta, higher realized gains from active portfolio management, and increased interest and dividend income due to strong market performance.

Expenses by Function



2024-25 actual expenses by function as a per cent of total 2024-25 actual expenses
A glossary of financial statement line definitions can be found at the end of this FSD&A

Expenses by function represent AHS' major distinguishable activities and services. The overall distribution of expenses by function remained consistent with the prior year, with only Community care decreasing slightly to 8.8 per cent (2023-24 – 10.5 per cent) due to the impact of transferring community care services related to mental health and addiction to Recovery Alberta effective Sept. 1, 2024, and primary care to PCA effective Feb. 1, 2025. Acute care, which comprises mainly inpatient, outpatient and emergency services, continued to be the largest function, making up 32.6 per cent of total expenses (2023-24 – 32.3 per cent).

(in $ millions)	Budget 2024-25 (Revised)	Actual 2024-25	Actual to Budget Variance	Actual 2023-24	Year over Year Increase (Decrease)
Continuing care	1,422	1,485	(63)	1,375	110
Community care	1,710	1,668	42	1,984	(316)
Home care	930	959	(29)	844	115
Acute care	5,879	6,208	(329)	6,085	123
Emergency medical services	735	710	25	666	44
Diagnostic and therapeutic services	2,911	3,038	(127)	2,932	106
Population and public health	418	432	(14)	439	(7)
Research and education	377	375	2	353	22
Information technology	804	814	(10)	794	20
Support services	2,703	2,765	(62)	2,798	(33)
Administration	556	576	(20)	574	2
Net effect of restructuring transaction	-	3	(3)	-	3
Total expenses by function	**18,445**	**19,033**	**(588)**	**18,844**	**189**

Actual to Budget

Continuing care was higher than budget due to increased funding provided to Type A home providers to support additional hours of care to address increased activity and other cost pressures, as well as seniors aging with dignity in their community funded by a new restricted grant from the Ministry of Seniors, Community and Social Services. Increased costs related to the collective bargaining process, and the use of agency nursing in Type A homes due to recruitment challenges and staff shortages further contributed to the variance.

Community care was lower than budget due to lower than planned Type B bed openings due to delays with contracted providers, and lower funding accessed by community care operators related to respiratory and other outbreaks, and palliative end of life programs.

Home care was higher than budget due to additional funding provided to home care operators to support seniors aging with dignity in their community funded by a new restricted grant from the Ministry of Seniors, Community and Social Services, increased costs related to the collective bargaining process, and activity growth in client-directed home care services. This was partially offset by delays in implementing home care innovation and palliative home care initiatives.

Acute care was higher than budget due to increased clinical activity and cost pressures resulting from a higher number of inpatients, emergency department visits, operating room cases, higher utilization of grant funded drugs including newly approved drugs and chemotherapy drugs, and an increased usage of medical supplies. Further contributing to the variance were increased costs related to the collective bargaining process, higher use of overtime, relief, and agency nursing throughout the organization, as well as changes in the mix and volume of activities performed resulting in additional staffing and use of medical supplies.

Emergency Department Visits

2,055,298

(2023-24 – 2,028,171)

Emergency medical services were lower than budget due to delays in implementing grant-funded emergency medical services capacity and pressures initiatives.

Diagnostic and therapeutic services were higher than budget due to increased costs related to the collective bargaining process, and higher demand which led to increased activity and other cost pressures, including increased drug utilization, higher patient volumes, and more exams performed.

Population and public health were higher than budget due to higher costs related to the collective bargaining process.

Information technology was higher than budget due to the timing of project work and higher amortization expense related to information systems.

Support services were higher than budget due to increased costs related to the collective bargaining process, and other provisions. Partially offsetting the variance were lower utility costs due to market fluctuations, and the timing of infrastructure maintenance, parkade, and equipment projects.

Administration was higher than budget due to higher liability insurance costs as a result of increased reserves for existing and new claims and claim settlements.

Net effect of restructuring transaction represents the impact of transferring operations, including the related assets and liabilities, to Recovery Alberta and PCA in the year. Refer to Note 3 – Restructuring in the AHS Consolidated Financial Statements.

Year over Year

Continuing care was higher than the prior year due to increased costs related to the collective bargaining process, and increased funding provided to Type A home providers as a result of contract inflation. Additional funding to support Continuing Care Transformation initiatives, and the opening of additional beds in Type A homes related to the Continuing Care Capacity Plan initiative further contributed to the increase. The decreased use of agency nursing in Type A homes partially offset the increase.

Community care was lower than the prior year due to the transfer of community care services related to mental health and addiction to Recovery Alberta effective Sept. 1, 2024, and primary care to PCA effective Feb. 1, 2025. Increased costs related to the collective bargaining process, and the opening of new Type B and C beds in the year partially offset the decrease.

Net New Continuing Care Home Beds Opened Since 2010

9,925

(2023-24 – 9,716)

Home care was higher than the prior year due to additional funding provided to home care operators to support seniors aging with dignity in their community funded by a restricted grant from the Ministry of Seniors, Community and Social Services, and higher costs related to the collective bargaining process. Increased home care activity as AHS and contracted home care providers continued to work towards providing additional hours of care and choices to home care patients further contributed to the increase.

Acute care was higher than the prior year due to increased costs related to the collective bargaining process. Further contributing to the variance was increased clinical activity and other cost pressures resulting from the higher utilization of grant funded drugs including chemotherapy and newly approved drugs, a higher number of inpatients, emergency department visits, operating room cases, and the increased usage and cost of medical supplies. The transfer of acute care services related to mental health and addiction to Recovery Alberta effective Sept. 1, 2024, and a reduction in the use of agency nursing partially offset the increase.

Emergency medical services events

740,805

(2023-24 - 724,783)

Emergency medical services were higher than the prior year due to increased costs related to the collective bargaining process, and the implementation of grant-funded emergency medical services capacity and pressures initiatives, including inter-facility and ground ambulance resources, and the opening of a new dispatch centre.

Diagnostic and therapeutic services were higher than the prior year due to increased costs related to the collective bargaining process, higher demand which led to increased activity, including increased drug utilization, higher patient volumes, and more exams performed, including laboratory, CT and MRI testing. To support this increased activity, the use of relief and overtime further contributed to the increase. The transfer of diagnostic and therapeutic services related to mental health and addiction services to Recovery Alberta effective Sept. 1, 2024, partially offset the increase.

CT & MRI Exams

914,017

(2023-24 – 851,017)

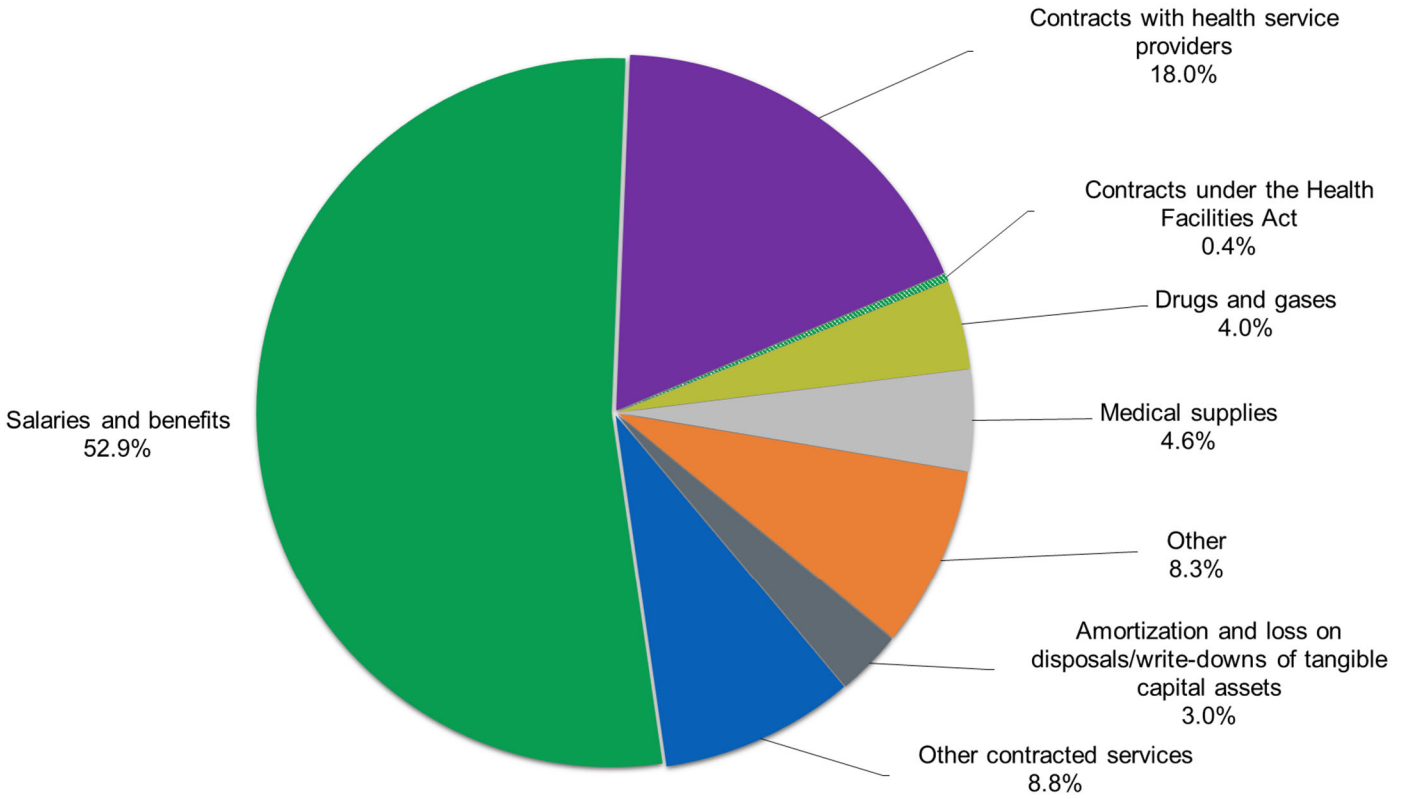
Research and education were higher than the prior year due to increased resident physician compensation costs, and increased costs in various research programs including Cancer Care Clinical Trials and other research in participation with university institutions.

Information technology was higher than the prior year due to increased costs related to the impact of the collective bargaining process, and higher amortization expense related to Connect Care information system additions which included launches eight and nine in the year.

Support services were lower than the prior year due to decreased utility costs resulting from market fluctuations, lower project costs related to infrastructure maintenance, equipment and parking, and savings resulting from cost management strategies implemented in the year. Increased costs related to the collective bargaining process and other provisions partially offset the decrease.

Net effect of restructuring transaction represents the impact of transferring operations, including the related assets and liabilities, to Recovery Alberta and PCA in the year. Refer to Note 3 – Restructuring in the AHS Consolidated Financial Statements.

Expenses by Object



2024-25 actual expenses by object as a per cent of total 2024-25 actual expenses
A glossary of financial statement line definitions can be found at the end of this FSD&A

The overall distribution of expenses by object remained consistent with the prior year, with salaries and benefits making up 52.9 per cent of total expenses (2023-24 – 52.2 per cent). This does not include employees who work for contract providers.

(in $ millions)	Budget 2024-25 (Revised)	Actual 2024-25	Actual to Budget Variance	Actual 2023-24	Year over Year Increase (Decrease)
Salaries and benefits	9,496	10,070	(574)	9,840	230
Contracts with health service providers	3,473	3,435	38	3,466	(31)
Contracts under the Health Facilities Act	77	67	10	56	11
Drugs and gases	735	769	(34)	739	30
Medical supplies	761	870	(109)	815	55
Other contracted services	1,663	1,679	(16)	1,688	(9)
Other	1,678	1,576	102	1,685	(109)
Amortization and loss on disposals/write-downs of tangible capital assets	562	564	(2)	555	9
Net effect of restructuring transaction	-	3	(3)	-	3
Total expenses	**18,445**	**19,033**	**(588)**	**18,844**	**189**

Actual to Budget

Salaries and benefits were higher than budget due to higher costs related to the collective bargaining process, and increased clinical activity and other cost pressures, including both changes in the mix and volume of activities performed, requiring higher staffing levels. Further contributing to the variance was a higher use of overtime and relief throughout the organization resulting from ongoing vacancies and recruitment challenges. Partially offsetting the variance was slower than expected recruitment in certain areas, a reduction in health benefits expenses, and vacancies.

Contracts with health service providers were lower than budget due to delays in certain continuing care, community care, and home care initiatives, including the Continuing Care Transformation initiative, home care innovation and palliative home care initiatives, and delays in Type B bed openings. Partially offsetting the variance were increased costs related to the collective bargaining process.

Lab Tests
95,854,976
(2023-24 – 87,980,881)

Contracts under the *Health Facilities Act* were lower than budget due to lower than planned surgeries performed at chartered surgical facilities in the year.

Drugs and gases were higher than budget due to increased clinical activity including higher utilization of grant funded drugs including newly approved drugs, chemotherapy drugs, and specialized high-cost drugs.

Total Surgical Volumes
318,829
(2023-24 – 305,711)

Medical supplies were higher than budget due to increased clinical activity and changes in the mix and volume of activities performed resulting in a higher volume of surgical procedures performed, higher testing volumes, and higher supplies used such as cardiac heart valves, artificial organs, catheters, and disposable instruments. Increased supply costs due to inflation and vendor price increases further contributed to the variance.

Other contracted services were higher than budget due to additional funding provided to home care operators to support seniors aging with dignity in their community funded by a new restricted grant from the Ministry of Seniors, Community and Social Services, and an increased use of agency nursing throughout the organization to cover staffing needs due to ongoing vacancies and recruitment challenges.

Other was lower than budget due to savings resulting from cost management strategies in areas such as travel, minor equipment purchases, office and orientation supplies, and lease costs. Further contributing to the variance were lower

utility costs due to market fluctuations, the timing of the emergency medical services capacity and pressures initiatives, and the timing of the infrastructure maintenance program, parkade and equipment projects. Partially offsetting the variance are increased provisions.

Net effect of restructuring transaction represents the impact of transferring operations, including the related assets and liabilities, to Recovery Alberta and PCA in the year. Refer to Note 3 – Restructuring in the AHS Consolidated Financial Statements.

Year over Year

Salaries and benefits were higher than the prior year due to the collective bargaining process, and higher costs associated with the transition of community lab services staff back into AHS partway through the prior fiscal year. Further contributing was increased activity, including a higher number of inpatients, emergency room visits, and surgeries performed, and the opening of the Arthur J.E. Child Comprehensive Cancer Centre in the year. The transfer of staff involved in the delivery of mental health and addiction services to Recovery Alberta effective Sept. 1, 2024, and primary care services to PCA effective Feb. 1, 2025 partially offset the increase.

Contracts with health service providers were lower than the prior year due to the transfer of contracted provider costs related to mental health and addiction services to Recovery Alberta effective Sept. 1, 2024, and primary care services to PCA effective Feb. 1, 2025, and lower costs associated with the transition of community lab from a contracted service back into AHS partway through the prior year. Increased costs related to estimated contract rate increases, contract inflation, the opening of additional Type A, B and C beds, and additional funding to contracted providers to support Continuing Care Transformation initiatives partially offset the decrease.

Contracts under the *Health Facilities Act* were higher than the prior year due to an increase in surgeries performed at chartered surgical facilities.

Drugs and gases were higher than the prior year due to the increased utilization of grant funded drugs including chemotherapy drugs, newly approved drugs, and specialized high-cost drugs.

Medical supplies were higher than the prior year due to increased operating room volumes, including surgical procedures performed under the Alberta Surgical Initiative, higher testing volumes, and increased emergency room visits. Further contributing were supply cost increases due to inflation and vendor price increases.

Other was lower than the prior year due to decreased utility costs resulting from market fluctuations, savings resulting from cost management strategies implemented in the year, lower project costs related to infrastructure maintenance, equipment and parking, and the transfer of costs related to mental health and addiction services to Recovery Alberta effective Sept. 1, 2024, and primary care services to PCA effective Feb. 1, 2025.

Net effect of restructuring transaction represents the impact of transferring operations, including the related assets and liabilities, to Recovery Alberta and PCA in the year. Refer to Note 3 – Restructuring in the AHS Consolidated Financial Statements.

Financial Position

(in $ millions)	2024-25	2023-24	Change
Financial assets	4,184	3,587	597
Liabilities	5,174	4,542	632
Net debt	**(990)**	**(955)**	**(35)**
Non-financial assets	11,348	11,020	328
Expended deferred capital revenue	8,913	8,696	217
Net assets	**1,445**	**1,369**	**76**

Financial Assets

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

At year-end, AHS' consolidated **cash and cash equivalents** balances were $526 million, which is sufficient cash on hand to meet cash-flow requirements.

In accordance with AHS' ***Investment*** *Policy* and *Investment Bylaw*, AHS invests in a diversified mix of assets, including high-quality instruments, such as government and corporate bonds and lower-volatility equities. This strategy is meant to preserve AHS' capital while providing a reasonable investment return. AHS' investment portfolio increased $90 million primarily due to higher investment income which was reinvested in the portfolio, partially offset by liquidations and fees. Remeasurement losses were related to uncertainty in the market occurring late in the fiscal year. The investment portfolio had an aggregate return of 8.0 per cent for the year (2023-24 – 6.6 per cent).

Accounts receivable increased $224 million primarily due to increased Alberta Health operating transfers receivable, related to resident physician services compensation and on call program, and the outpatient cancer drug and specialized high-cost drugs programs. Additional contributing factors included increased drug rebates and patient receivables.

Liabilities

Liabilities represent AHS' existing financial obligations at year end.

Accounts payable and accrued liabilities increased $777 million mainly due to higher payroll accruals resulting from the collective bargaining process, and the timing of trade accounts payable. Partially offsetting the increase were changes in the provision for liability claims.

Employee future benefits decreased $76 million mainly due to employees that were transferred to Recovery Alberta and PCA in the year as part of the restructuring.

Unexpended deferred operating revenue decreased $165 million mainly due to transfers to Recovery Alberta and PCA as a result of restructuring, and Alberta Health funding recognized for the outpatient cancer drug program, resident physician services compensation, and various initiatives under physician services. The decrease is partially offset by an increase in foundation donations.

AHS' **debt** is primarily comprised of debentures issued to finance the construction of parking facilities. AHS pledges the revenue derived from all parking facilities as security for the debentures. As of March 31, 2025, AHS' debt balance was $376 million (2023-24 - $416 million). AHS' debt decreased by $40 million due to repayments made during the year.

Asset retirement obligations represent AHS' legal obligation associated with the retirement of tangible capital assets. The liability increased by $96 million primarily due to a revision in estimated remediation cost assumptions used in calculating the liability, offset by projects undertaken during the year.

Non-Financial Assets

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

Tangible Capital Assets			
(in $ millions)	**2024-25**	**2023-24**	**Increase (Decrease)**
Cost	21,534	20,869	665
Less: Accumulated amortization	10,773	10,401	372
Net book value	**10,761**	**10,468**	**293**

AHS receives significant external funding for **tangible capital asset** expenditures, primarily from Government of Alberta ministries. Capital asset additions amounted to $862 million, of which 68 per cent were externally funded (2023-24 – $761 million or 69 per cent). These additions were offset by the $178 million in asset disposals made throughout the year and $19 million in transfers related to restructuring. Several capital projects totaling $379 million were completed during the year,

including the Rockyview General Hospital Redevelopment Initiative and Connect Care launches eight and nine, the installation of building service equipment, and facility initiatives. Capital equipment additions included equipment acquired to support diagnostic services, information technology, and emergency medical services.

The Work-in-Progress balance of $800 million includes facilities construction and improvements, and information technology initiatives that include:

- Provincial Centralized Drug Production and Distribution Initiative
- Red Deer Hospital Redevelopment
- Bridgeland Riverside Continuing Care Centre
- Foothills Medical Centre Power Plant Upgrade

AHS maintains **inventories of supplies** to ensure goods, such as pharmaceuticals, medical and surgical supplies, are available for operational needs. Over the past year, AHS' inventory balance decreased by $8 million primarily due to the drawdown of personal protective equipment (PPE), and medical and surgical supplies. This was partially offset by an increase in pharmaceutical and drug inventories at various cancer centers.

Prepaid expenses increased by $43 million primarily due to an increase in the Health Benefit Trust of Alberta (HBTA) prepaid balance which represents, in substance, AHS' prepayment of future premiums to the HBTA due to reduced employee sick time resulting in fewer short-term and long-term disability claims. Further contributing was an increase in prepaid maintenance contracts partially offset by a provision against a prepaid expense.

Expended Deferred Capital Revenue

Expended deferred capital revenue represents external resources spent on the acquisition of tangible capital assets stipulated for use in the provision of services. These balances are recognized as revenue over the useful lives of the related tangible capital assets acquired. The assets include hospitals and other facilities, equipment, and information technology systems. The increase from the prior year was the result of externally funded tangible capital asset additions to support the development of several major capital projects. Funding from Government of Alberta ministries represented $8,641 million, or 97 per cent of the $8,913 million total balance (2023-24 – $8,455 million or 97 per cent).

Net Assets

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

(in $ millions)	2024-25	2023-24	Increase (Decrease)
Unrestricted surplus	197	379	(182)
Invested in tangible capital assets	1,050	1,057	(7)
Endowments	110	105	5
Internally restricted surplus for insurance equity requirements, foundations, and HBTA	359	124	235
Asset retirement obligations	(340)	(360)	20
Accumulated Surplus	**1,376**	**1,305**	**71**
Accumulated remeasurement gains	69	64	5
Total Net Assets	**1,445**	**1,369**	**76**

The **unrestricted surplus** decreased by $182 million as a result of the transfer to internally restricted surplus for insurance equity requirements, foundations, and HBTA, and the net surplus transferred to asset retirement obligations in the year. Offset by the $71 million operating surplus and the net internal investment in capital assets.

Outlook

Alberta's government is committed to refocusing the health care system to ensure all Albertans get the care they need when and where they need it. This includes the transition of AHS from a health authority to an acute care service provider and hospital operator. As part of this transition, responsibility for certain programs and their budgets, assets and liabilities will transfer from AHS to the new provincial health agencies. These transfers commenced in 2024-25 and will continue in 2025-26.

To centralize the management of public property to enhance accountability and transparency, all freehold real property owned by AHS will be transferred to Alberta Infrastructure in 2025-26 under the Real Property Governance Act, 2024 (Alberta).

Alberta's surging population is creating challenges for the health system. AHS will collaborate with Acute Care Alberta, Covenant Health and chartered surgical facilities to speed up access to high-quality care, reduce wait times and make a patient's journey through acute care efficient, effective and timely. Additional funding will be allocated for hospital capacity, surgeries, laboratory services, diagnostic imaging and cancer care.

Financial sustainability will remain a priority. AHS will manage expense growth by carefully reviewing and prioritizing its resources and managing activity as much as possible. Savings opportunities will be pursued to increase the value that Albertans receive from each health dollar. Work will continue on a patient-focused funding model for select surgical procedures to enhance accountability, transparency and resource allocation.

Financial Reporting, Control and Accountability

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

AHS has an established **Internal Audit** function with the mandate of providing independent advisory and assurance services to management and the Official Administrator on the operations of AHS and its subsidiaries, and the newly established provincial health agencies as they become operational, where AHS has a shared services agreement. Internal Audit's work takes a risk-based approach to evaluating and advising on the efficiency and effectiveness of AHS' governance, risk-management practices, and financial and management controls and processes. The Chief Audit Executive is responsible for coordinating AHS' Enterprise Risk Management function, including the development and implementation of policies and processes for identifying, monitoring, and reporting on key organizational risks, as well as working with management to better understand and manage risk. In addition, the Chief Audit Executive is responsible for the oversight of the Compliance function which conducts compliance audits of contracting, procurement, inventory and asset-management business processes and controls.

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

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

Glossary of Financial Statement Line Definitions

Revenues

Alberta Health transfers comprise of funding received from Alberta Health which may be unrestricted or restricted for operating or capital purposes. Unrestricted Alberta Health transfers are the main source of operating funding for the provision of healthcare services to the population of Alberta. Restricted operating and capital funding can only be used for specific purposes and are recognized when the related expenses are incurred.

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

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

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

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

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

Expenses by Function

Continuing care homes are comprised of Type A (formerly long-term care), Type B (formerly designated supportive living), Type C (formerly palliative and hospice care), and psychiatric care in facilities operated by AHS and contracted providers.

Community care includes Type B (formerly designated supportive living), Type C (formerly palliative and hospice care), and community programs including Primary Care Networks, Family Care Clinics, urgent care centres, community paramedic program, and mental health. This segment excludes community-based dialysis, oncology, and surgical services.

Home care comprises home nursing and support.

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

Emergency medical services comprise ground ambulance, air ambulance, patient transport, and central dispatch. AHS also supports community paramedic programs, as well as other programs that support the learning, development, quality and safety of emergency medical services professionals.

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

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

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

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

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

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

Net effect of restructuring transaction represents the impact of transferring operations, including the related assets and liabilities, to Recovery Alberta and PCA in the year.

Expenses by Object

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

Contracts with health service providers include voluntary and private health service providers with whom AHS contracts for health services, such as continuing care homes comprised of Type A (formerly long-term care), Type B (formerly designated supportive living), and Type C (formerly palliative and hospice care), acute care providers, home care providers and lab service providers. These health service providers incur expenses similar to AHS, such as salaries and benefits, clinical supplies and other expenses.

Contracts under the *Health Facilities Act* relates to contracts with surgical facilities pursuant to the Health Facilities Act – Bill 11 which ensures quality while promoting the delivery of publicly-funded services by allowing contracting out to profit-orientated surgical facilities.

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

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

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

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

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

Net effect of restructuring transaction represents the impact of transferring operations, including the related assets and liabilities, to Recovery Alberta and PCA in the year.

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2025

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying consolidated financial statements for the year ended March 31, 2025 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Public Sector Accounting Standards and include certain disclosures required by the financial directives issued by Alberta Health, and of necessity include some amounts based on estimates and judgment.

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

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

The Official Administrator meets with management and the Auditor General of Alberta to review financial matters, and approves the consolidated financial statements upon finalization of the audit. The Auditor General of Alberta has free access to the Official Administrator.

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]

Andre Tremblay
Interim President and Chief Executive Officer
Alberta Health Services

[Original signed by]

Emily Ma
Interim Vice President and Chief
Financial Officer
Alberta Health Services

June 2, 2025

Auditor General OF ALBERTA

To the Official Administrator of Alberta Health Services, the Minister of Primary and Preventative Health Services, and the Minister of Hospital and Surgical Health Services

Report on the Consolidated Financial Statements

Opinion

I have audited the consolidated financial statements of Alberta Health Services (the Group), which comprise the consolidated statement of financial position as at March 31, 2025, and the consolidated statements of operations, remeasurement gains and losses, change in net debt, and cash flows for the year then ended, and notes to the consolidated financial statements, including a summary of significant accounting policies.

In my opinion, the accompanying consolidated financial statements present fairly, in all material respects, the consolidated financial position of the Group as at March 31, 2025, and the results of its operations, its remeasurement gains and losses, its changes in net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for opinion

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

Emphasis of matter

I draw attention to Note 1, Note 3 and Note 30 of the consolidated financial statements, which describes the authority, purpose and operations, restructuring, and subsequent events of the Group. My opinion is not modified in respect of this matter.

Other information

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

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

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

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

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

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

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

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

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

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

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

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

evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the Group to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the consolidated financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation.
- Plan and perform the group audit to obtain sufficient appropriate audit evidence regarding the financial information of the entities or business units within the Group as a basis for forming an opinion on the group financial statements. I am responsible for the direction, supervision and review of the audit work performed for purposes of the group audit. I remain solely responsible for my audit opinion.

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

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

June 2, 2025
Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS YEAR ENDED MARCH 31			
	2025		2024
	Budget (Note 4) (Schedule 4)	Actual	Actual (Note 29)
Revenues:			
Alberta Health transfers			
Base operating	$ 14,602,924	$ 14,562,674	$ 15,138,434
One-time base operating	-	362,916	286,083
Other operating	1,653,528	1,640,502	1,681,469
Recognition of expended deferred capital revenue	102,100	110,130	106,297
Other government transfers (Note 5)	1,652,176	910,784	558,891
Fees and charges	621,000	667,747	625,668
Ancillary operations	92,700	95,426	87,178
Donations and non-government contributions (Note 6)	170,900	203,410	213,382
Investment and other income (Note 7)	248,700	550,210	330,376
TOTAL REVENUES	**19,144,028**	**19,103,799**	**19,027,778**
Expenses:			
Continuing care	1,425,800	1,484,701	1,375,360
Community care	2,132,200	1,667,596	1,983,628
Home care	930,200	959,280	843,709
Acute care	6,081,528	6,208,453	6,084,875
Emergency medical services	735,400	709,763	665,954
Diagnostic and therapeutic services	2,956,600	3,038,465	2,932,784
Population and public health	420,900	431,697	439,173
Research and education	378,400	375,341	352,707
Information technology	804,300	813,626	793,775
Support services (Note 8)	2,713,800	2,764,742	2,798,372
Administration (Note 9)	564,900	576,314	573,810
Net effect of restructuring transaction (Note 3(a))	-	2,761	-
TOTAL EXPENSES	**19,144,028**	**19,032,739**	**18,844,147**
ANNUAL OPERATING SURPLUS	**-**	**71,060**	**183,631**
Accumulated surplus, beginning of year	1,304,458	1,304,458	1,120,827
Accumulated surplus, end of year (Note 23)	**$ 1,304,458**	**$ 1,375,518**	**$ 1,304,458**

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

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT MARCH 31		
	2025	2024
	Actual	Actual
Financial Assets:		
Cash and cash equivalents	$ 526,238	$ 243,462
Portfolio investments (Note 11)	2,677,619	2,587,692
Accounts receivable (Note 12)	979,173	755,525
	4,183,030	3,586,679
Liabilities:		
Accounts payable and accrued liabilities (Note 14)	2,633,239	1,855,955
Employee future benefits (Note 15)	742,757	818,539
Unexpended deferred operating revenue (Note 16)	532,642	697,922
Unexpended deferred capital revenue (Note 17)	253,901	214,072
Debt (Note 19)	375,587	415,813
Asset retirement obligations (Note 20)	635,463	539,421
	5,173,589	4,541,722
NET DEBT	**(990,559)**	**(955,043)**
Non-Financial Assets:		
Tangible capital assets (Note 21)	10,761,267	10,467,655
Inventories of supplies (Note 22)	189,437	197,169
Prepaid expenses, deposits, and other non-financial assets	397,629	355,181
	11,348,333	11,020,005
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	10,357,774	10,064,962
Expended deferred capital revenue (Note 18)	8,912,554	8,696,431
NET ASSETS	**1,445,220**	**1,368,531**
Net Assets is comprised of:		
Accumulated surplus (Note 23)	1,375,518	1,304,458
Accumulated remeasurement gains	69,702	64,073
	$ 1,445,220	**$ 1,368,531**

Contractual Rights (Note 13)
Contractual Obligations, Contingent Liabilities and Other Matters (Note 24)

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

Approved by:

[Original signed by]

Andre Tremblay
Official Administrator
Alberta Health Services

CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT YEAR ENDED MARCH 31			
	2025		2024
	Budget (Note 4)	Actual	Actual
Annual operating surplus	$ -	$ 71,060	$ 183,631
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets:			
Purchased	(407,100)	(487,388)	(452,501)
Purchased as part of DynaLIFEDX asset purchase	-	-	(71,760)
Leased	(22,000)	(15,185)	(37,753)
Constructed by Alberta Infrastructure on behalf of AHS	(302,000)	(258,231)	(198,774)
Contributed by others	-	-	(24)
Revision to asset retirement cost estimates	-	(101,256)	41,773
Amortization and loss on disposals/write-downs of tangible capital assets	561,900	563,648	555,033
Transferred as a result of restructuring (Note 3(a))	-	4,800	-
Effect of other changes:			
Net increase in expended deferred capital revenue	105,500	218,468	170,966
Net decrease in expended deferred operating revenue	-	-	(116,636)
Net decrease in inventories of supplies	-	7,732	118,442
Net (increase) decrease in prepaid expenses, deposits and other non-financial assets	49,000	(59,629)	(118,968)
Net increase in other non-financial assets due to DynaLIFEDX asset purchase	-	-	(12,845)
Net decrease in other non-financial assets and expended deferred capital revenue due to restructuring (Note 3(a))	-	14,836	-
Net remeasurement gains for the year	20,000	5,629	43,803
Decrease (increase) in net debt for the year	**5,300**	**(35,516)**	**104,387**
Net debt, beginning of year	(955,043)	(955,043)	(1,059,430)
Net debt, end of year	**$ (949,743)**	**$ (990,559)**	**$ (955,043)**

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

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEAR ENDED MARCH 31	2025 Actual	2024 Actual
Unrestricted unrealized (losses) gains attributable to:		
Derivatives	$ (4,643)	$ 586
Portfolio investments		
Quoted in an active market	(360)	6,600
Designated at fair value	58,408	35,815
Amounts reclassified to the Consolidated Statement of Operations:		
Derivatives	(1,369)	(998)
Portfolio investments		
Quoted in an active market	(6,086)	-
Designated at fair value	(40,321)	1,800
Net remeasurement gains for the year	**5,629**	**43,803**
Accumulated remeasurement gains, beginning of year	64,073	20,270
Accumulated remeasurement gains, end of year (Note 11)	**$ 69,702**	**$ 64,073**

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

CONSOLIDATED STATEMENT OF CASH FLOWS YEAR ENDED MARCH 31	2025 Actual	2024 Actual
Operating transactions:		
Annual operating surplus	$ 71,060	$ 183,631
Non-cash items:		
Amortization and loss on disposals/write-downs of tangible capital assets	563,648	555,033
Revenue recognized for acquisition of land	(168)	-
Recognition of expended deferred capital revenue	(365,803)	(355,407)
Recognition of expended deferred operating revenue	-	(116,636)
Gain on disposal of portfolio investments	(74,048)	(13,736)
Change in employee future benefits	(2,007)	24,268
Net effect of restructuring transaction	2,761	-
(Increase) decrease in:		
Cash transferred due to restructuring (Note 3(a))	(53,284)	-
Accounts receivable related to operating transactions	(235,140)	(14,564)
Inventories of supplies	7,732	118,442
Prepaid expenses, deposits, and other non-financial assets	(59,629)	(118,968)
Increase (decrease) in:		
Accounts payable and accrued liabilities	669,650	23,669
Unexpended deferred operating revenue	(29,954)	115,570
Asset retirement obligations	(5,214)	(1,978)
Cash provided by operating transactions	489,604	399,324
Capital transactions:		
Purchased tangible capital assets	(487,388)	(452,501)
DynaLIFEDX purchase consideration net of cash acquired	-	(29,388)
Cash applied to capital transactions	(487,388)	(481,889)
Investing transactions:		
Purchase of portfolio investments	(6,658,023)	(5,284,617)
Proceeds on disposals of portfolio investments	6,634,834	4,948,882
Cash applied to investing transactions	(23,189)	(335,735)
Financing transactions:		
Restricted capital contributions received	372,924	367,372
Unexpended deferred capital revenue returned	(6,887)	(3,626)
Proceeds from debt	-	20,000
Principal payments on debt	(40,226)	(38,275)
Payments on obligations under capital leases	(22,422)	(17,745)
Net receipt (repayment) of life lease deposits	360	(613)
Cash provided by financing transactions	303,749	327,113
Increase (decrease) in cash and cash equivalents	**282,776**	**(91,187)**
Cash and cash equivalents, beginning of year	243,462	334,649
Cash and cash equivalents, end of year	**$ 526,238**	**$ 243,462**

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

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS FOR THE YEAR ENDED MARCH 31, 2025

Note 1 Authority, Purpose and Operations

Alberta Health Services (AHS) was established under the *Regional Health Authorities Act* (Alberta), effective April 1, 2009, as a result of the merger of 12 formerly separate health entities in Alberta. AHS is currently undergoing a significant restructuring which aligns with the *Provincial Health Agencies Act* (Alberta) (PHA Act). According to the PHA Act, the restructuring establishes four sector-based provincial health agencies: Acute Care Alberta (ACA), Primary Care Alberta (PCA), Assisted Living Alberta (ALA), and Recovery Alberta. As a result, through a ministerial order, all powers, duties, responsibilities or functions will be transferred from AHS to the newly established provincial health agencies, provincial health corporations, or other successors. Pursuant to *Ministerial Order 800/2024*, on completion of the transfers, AHS will be wound up as a regional health authority. In accordance with the *Alberta Health Services Provincial Health Corporation Regulation* (Alberta), the entity Alberta Health Services Provincial Health Corporation (PHC) was established on June 1, 2025, for the purposes of delivering health services in the acute care health services sector. This new PHC is accountable to Acute Care Alberta.

To date, provincial health agencies for the mental health and addiction, primary care, and acute care sectors have been established. Recovery Alberta, the provincial health agency responsible for the mental health and addiction sector, was legally established on July 1, 2024, became operational on September 1, 2024, and is accountable to the Minister of Mental Health and Addiction. PCA, the provincial health agency responsible for the primary care sector, was established on November 18, 2024, became operational on February 1, 2025, and is accountable to the Minister of Health. ACA, the provincial health agency responsible for the acute care sector was established on February 1, 2025, and became operational on April 1, 2025. Matters pertaining to restructuring transactions occurring in the current year are discussed further in Note 3. Matters pertaining to restructuring transactions occurring subsequent to year end are discussed further in Note 30.

Pursuant to Section 5 of the *Regional Health Authorities Act* (Alberta) and prior to the effective date of the *Provincial Health Agencies Act* on June 21, 2024, AHS was responsible in Alberta to:

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

Pursuant to Section 5 of the *Provincial Health Agencies Act* (Alberta), effective June 21, 2024, AHS is responsible in Alberta to:

- promote and protect the health of the population and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the population;
- support that reasonable access to quality health services is provided and;
- promote the delivery of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities.

AHS is accountable to the Minister of Health (the Minister). The responsibilities under section 5 of the PHA Act do not apply to AHS with respect to health services that have been transferred by ministerial order to one or more provincial health agencies or other successor. Additionally, AHS has entered into a Transition Services Framework Agreement with each operational PHA to provide clinical and corporate support services.

The AHS consolidated financial statements include the assets, liabilities, revenues and expenses associated with its responsibilities.

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

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

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

(i) Controlled Entities

AHS controls the following three wholly owned subsidiaries:

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

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

- Foundations:

  The largest foundations controlled by AHS are the Alberta Cancer Foundation and the Calgary Health Foundation. AHS also controls 33 other foundations that facilitate fundraising for various initiatives including enhancements to healthcare delivery (including equipment), programs, renovations, and research and education.

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

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

  The LPIP has a fiscal year end of December 31, 2024. Significant transactions occurring between this date and March 31, 2025 have been recorded in these consolidated financial statements.

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

(ii) Government Partnerships

AHS proportionately consolidates its 50% ownership interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta, and its 33.33% ownership interest in the Institute for Reconstructive Sciences in Medicine (iRSM) partnership with the University of Alberta and Covenant Health (Note 26). Additionally, AHS proportionately consolidated its 50% ownership interests in 39 (2024 – 39) Primary Care Network (PCN) partnerships with physician groups up until February 1, 2025.

AHS had entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services to achieve the PCN plan objectives, and to contract and hold property interests required in the delivery of PCN services. Effective February 1, 2025, due to the restructuring, AHS' 50% ownership interests in the 39 PCNs has been transferred to PCA, and AHS is no longer named as a partner (Note 3(a)).

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(iii) Trusts under Administration

These consolidated financial statements do not include trusts administered on behalf of others (Note 27).

(iv) Other

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

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

(b) Revenue Recognition

All revenues are recorded on an accrual basis, except when the accrual cannot be determined within a reasonable degree of certainty or when estimation is impracticable. Revenues from transactions with performance obligations are recognized when AHS provides the promised goods and/or services to a payor. Revenue from transactions with no performance obligations are recognized at their realizable value when AHS has the authority to claim or retain an inflow of economic resources and identifies a past transaction or event that gives rise to an asset. Unallocated costs comprising of materials and services contributed by related parties in support of AHS' operations, are not recognized in these consolidated financial statements.

(i) Government Transfers

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

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

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

Deferred revenue consists of unexpended deferred operating revenue (Note 16), unexpended deferred capital revenue (Note 17), and expended deferred capital revenue (Note 18). The term deferred revenue in these consolidated financial statements refers to the components of deferred revenue as described.

(ii) Donations and Non-Government Contributions

Donations and non-government contributions are received from individuals, corporations, registered charities, and other 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 AHS if the amount can be reasonably estimated and collection is reasonably assured.

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

Endowment contributions are recognized in the Consolidated Statement of Operations in the period in which they are received or receivable.

(iii) Transfers and Donations related to Land

Transfers and donations for the purchase of land are recorded as deferred revenue when received and as revenue when the land is purchased. In-kind donations of land from non-related entities are recorded as revenue at the fair value of the land. When AHS cannot determine the fair value, it records such donations at nominal value. In-kind donations of land from related entities are recorded as revenue at the net book value of the transferring entity.

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

Fees and charges, ancillary operations, and other income are considered revenue arising from exchange transactions with performance obligations. These are recognized in the year that goods are delivered or services are provided by AHS. Amounts received for which goods or services have not been provided by year-end are recorded as deferred revenue.

(v) Investment Income

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

(c) Expenses

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

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

(d) Financial Instruments

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

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

Amortized cost is the amount at which a financial instrument asset or a financial instrument liability is measured at initial recognition minus principal repayments, plus or minus the cumulative amortization using the effective interest method of any difference between that initial amount and the maturity amount, and minus any reduction (directly or through the use of an allowance account) for impairment or uncollectibility.

AHS records equity investments quoted in an active market at fair value and may choose to record other financial assets under the fair value category if there is an investment strategy to evaluate the performance of a group of these financial assets on a fair value basis. AHS has elected to record all portfolio investments at fair value. The relative reliability of information used to measure the fair value is disclosed in Note 11.

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

Contractual obligations are evaluated for the existence of embedded derivatives. 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. An election can be made to either measure the entire contract at fair value or measure the value of the derivative component separately when characteristics of the derivative are not closely related to the economic characteristics and risks of the contract itself. Contracts to buy or sell non-financial items for AHS' normal course of business are not recognized as financial assets or liabilities. AHS does not have any embedded derivatives.

All financial assets are assessed for impairment on an annual basis. When a decline is determined to be other than temporary, the amount of the loss is reported as a realized loss on the Consolidated Statement of Operations. A write-down of a portfolio investment to reflect a loss in value is not reversed for a subsequent increase in value.

A financial liability or a part thereof is derecognized when it is extinguished.

Transaction costs associated with the acquisition and disposal of portfolio investments are expensed as incurred. Investment management fees are expensed as incurred. The purchase and disposition of portfolio investments are recognized on the trade date.

(e) Cash and Cash Equivalents

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(f) Accounts receivable

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

(g) Inventories of Supplies

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

(h) Tangible Capital Assets

Tangible capital assets are recorded at cost less accumulated amortization, 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, and asset retirement cost. Costs incurred by Alberta Infrastructure (AI) to construct tangible capital assets on behalf of AHS are recorded by AHS as work in progress as AI incurs costs.

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

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

	Useful Life
Facilities and improvements	10-70 years
Equipment	3-20 years
Information systems	3-15 years
Building service equipment	5-40 years
Land improvements	5-40 years

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

Leases of tangible capital assets which transfer substantially all benefits and risks of ownership to AHS are accounted for as leased tangible capital assets and leasehold improvements and are amortized over the shorter of the term of the lease or their estimated useful lives. Obligations under capital leases are recorded at the present value of the minimum lease payments excluding executory costs (e.g. insurance, maintenance costs, etc.). The discount rate used to determine the present value of the lease payments is the lower of AHS' rate for incremental borrowing and the interest rate implicit in the lease.

Tangible capital assets are written down to their net recoverable amount when conditions indicate that they no longer contribute to AHS' ability to provide goods and services or when the value of future economic benefits associated with the tangible capital assets are less than their net book value. Write-downs are recorded as part of amortization and loss on disposals / write-downs of tangible capital assets.

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(i) Employee Future Benefits

(i) Defined Benefit Pension Plans

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

AHS participates in the LAPP and MEPP, both of which are multi-employer registered defined benefit pension plans. AHS accounts for these plans on a defined contribution basis. Accordingly, the pension expense recorded for these plans in the consolidated financial statements is comprised of the employer contributions that AHS is required to pay for participating employees during the fiscal year. LAPP and MEPP set the employer contribution rates on an annual basis based on actuarially pre-determined amounts that are expected to provide the plans' future benefit obligations.

Supplemental Executive Retirement Plan (SERP)

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

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

(ii) Defined Contribution Pension Plans

Group Registered Retirement Savings Plans (GRRSPs)

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

Supplemental Pension Plan (SPP)

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

(iii) Other Benefit Plans

Accumulating Non-Vesting Sick Leave

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

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

Note 2 Significant Accounting Policies and Reporting Practices (continued)

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

Other Benefits

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

(j) Asset Retirement Obligations

Asset retirement obligations are legal obligations associated with the retirement of tangible capital assets. A liability for an asset retirement obligation is recognized when, as at the financial reporting date:

(i) there is a legal obligation to incur retirement costs in relation to a tangible capital asset;
(ii) the past transaction or event giving rise to the liability has occurred;
(iii) it is expected that future economic benefits will be given up; and
(iv) a reasonable estimate of the amount can be made.

Asset retirement obligations are initially measured as of the date the legal obligation was incurred, based on management's best estimate of the amount required to retire tangible capital assets.

When a liability for asset retirement obligation is recognized, asset retirement costs related to recognized tangible capital assets in productive use are capitalized by increasing the carrying amount of the related asset and are amortized on a straight- line basis over the estimated useful life of the underlying tangible capital asset (Note 2(h)). Asset retirement costs related to unrecognized tangible capital assets and those not in productive use are expensed. Revisions in estimates are recognized as a change to both the liability and related tangible capital asset in the Consolidated Statement of Financial Position.

(k) Foreign Currency Translation

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

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

(l) Reserves

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

(m) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a difference between the recognized or disclosed amount and another reasonably possible amount. These estimates and assumptions are reviewed at least annually. Actual results could differ from the estimates determined by management in these consolidated financial statements, and these differences could require adjustment in subsequent reporting years.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Measurement uncertainty exists in the fair values reported for portfolio investments designated to the fair value hierarchy (see Note 11). The fair values of these investments are based on estimates. Estimated fair values may not reflect amounts that could be recognized upon immediate sale or amounts that ultimately may be recognized.

The amount recorded for amortization of tangible capital assets is based on the estimated useful life of the related assets while the recognition of expended deferred capital revenue depends on when the terms for the use of the funding are met and, when applicable, AHS complies with its communicated use of the funding. The amounts recorded for accumulating non-vesting sick leave are based on various assumptions including the estimated service life of employees, drawdown rate of sick leave banks and rate of salary escalation. The establishment of the provision for unpaid claims relies on judgment and estimates including historical precedent and trends, prevailing legal, economic, social, and regulatory trends; and expectation as to future developments.

There is measurement uncertainty related to asset retirement obligations as it involves estimates in determining settlement amount and timing of settlement. Changes to any of these estimates and assumptions may result in change to the obligation.

(n) Future Accounting Changes

On April 1, 2026, AHS will adopt the following new conceptual framework and accounting standard approved by the Public Sector Accounting Board:

- **The Conceptual Framework for Financial Reporting in the Public Sector**
  The Conceptual Framework is the foundation for public sector financial reporting standard setting. It replaces the conceptual aspects of Section PS 1000 Financial Statement Concepts and Section PS 1100 Financial Statement Objectives. The conceptual framework highlights considerations fundamental for the consistent application of accounting issues in the absence of specific standards.

- **PS 1202 Financial Statement Presentation**
  Section PS 1202 sets out general and specific requirements for the presentation of information in general purpose financial statements. The financial statement presentation principles are based on the concepts within the Conceptual Framework.

Management is currently assessing the impact of the conceptual framework and the standard on the AHS consolidated financial statements.

Note 3 Restructuring

In accordance with the Government of Alberta's ministerial orders related to the restructuring of AHS, all responsibilities, the oversight and coordination of the delivery of mental health and addiction services, along with certain related assets, liabilities and funding agreements, were transferred from AHS to provincial health agency Recovery Alberta effective September 1, 2024. Similarly, effective February 1, 2025, AHS transferred all responsibilities, the oversight and coordination of the delivery of primary care services, along with certain related assets, liabilities and funding agreements to the provincial health agency PCA. AHS, Recovery Alberta, and PCA are accountable to their respective Ministries within Government of Alberta. AHS did not provide or receive any compensation related to this transfer.

The two remaining provincial health agencies for the acute care and continuing care sectors will become operational after March 31, 2025 (Note 30).

Note 3 Restructuring (continued)

(a) Assets and liabilities

Assets and liabilities were transferred based on a methodology approved by the Minister of Health, which involved transferring an integrated set of assets and liabilities that support mental health and addictions operations for Recovery Alberta and primary care operations for PCA. AHS has signed agreements with Recovery Alberta and PCA for the transfer of these assets and liabilities. AHS is providing cash management services, including investment and portfolio oversight, therefore cash-settled assets and liabilities are shown in the 'Net due from AHS' line below.

The assets and liabilities were transferred at their carrying amounts as follows:

	Recovery Alberta September 1, 2024	Primary Care Alberta February 1, 2025[(i)]	Total
Financial assets:			
Cash and cash equivalents	$ 27	$ 53,257	**$ 53,284**
Portfolio investments	-	2,574	**2,574**
Accounts receivable	8,830	2,662	**11,492**
Net due from AHS	190,825	23,269	**214,094**
	199,682	81,762	**281,444**
Liabilities:			
Accounts payable and accrued liabilities	75,227	24,356	**99,583**
Employee future benefits	64,718	9,058	**73,776**
Unexpended deferred operating revenue	66,786	58,174	**124,960**
	206,731	91,588	**298,319**
NET DEBT	**(7,049)**	**(9,826)**	**(16,875)**
Non-financial assets:			
Tangible capital assets[(ii)]	4,738	62	**4,800**
Prepaid expenses, deposits, and other non-financial assets	5,278	11,903	**17,181**
	10,016	11,965	**21,981**
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	2,967	2,139	**5,106**
Expended deferred capital revenue	2,288	57	**2,345**
Net effect of restructuring	**$ 679**	**$ 2,082**	**$ 2,761**

(i) PCA amounts include 50% ownership in the PCN partnership with physician groups which includes total financial assets of $57,238, liabilities of $68,189 and non-financial assets of $10,951.

(ii) The tangible capital assets transferred to Recovery Alberta and PCA include vehicle leases and equipment with a net book value of $4,738 (cost of $18,203 and accumulated amortization of $13,465) and $62 (cost of $1,281 and accumulated amortization of $1,219) respectively. No real property was transferred to Recovery Alberta or PCA as the properties will be transferring to Alberta Infrastructure effective April 1, 2025 (Note 30).

The restructuring-related costs incurred were attributable to severance costs and were recognized as salaries and benefits expense in the statement of operations. The financial impact of these costs was insignificant.

Note 3 Restructuring (continued)

The related sector contractual obligations were also transferred to Recovery Alberta and PCA. Contracts transferred to Recovery Alberta amounting to $262,703 were related to the continuum of mental health and addiction services and supports, from prevention and intervention to treatment and recovery. Contracts transferred to PCA amounted to $23,635 mainly related to midwifery services.

Recovery Alberta and PCA have each signed a Transition Services Framework Agreement and a Cooperation Agreement with AHS. Together, these agreements will govern the relationship between AHS and the two provincial health agencies throughout the transition. Under the Transition Services Framework Agreement, AHS provides clinical and corporate support services including but not limited to nutrition, food, linen & environmental services, capital management, information technology, protective services, pharmacy services, human resources, financial operations, APL services, and health information management.

(b) Revenue and expenses

The revenues and expenses for mental health and addictions and primary care operations, included in the Statement of Operations before transferring responsibilities to Recovery Alberta on September 1, 2024, and PCA on February 1, 2025, are as follows:

	Mental health and addictions 5 months ended August 31, 2024	**Primary care** 10 months ended January 31, 2025	**Mental health and addictions** 12 months ended March 31, 2024	**Primary care** 12 months ended March 31, 2024
Revenues:				
Alberta Health transfers				
Base operating	$ -	$ 92,872	$ 990,104	$ 106,437
Other operating	284	106,560	1,055	124,735
Recognition of expended deferred capital revenue	115	1	281	2
Other government transfers	470,863	7,244	108,962	8,131
Fees and charges	1,397	3,546	5,805	4,040
Donations and non-government contributions	2,010	3	5,318	-
Investment and other income	7,594	4,460	16,468	8,312
TOTAL REVENUES	**482,263**	**214,686**	**1,127,993**	**251,657**
Expenses by function:				
Continuing care	1,818	-	4,351	-
Community care	275,973	202,252	634,581	236,868
Acute care	170,067	3,794	389,392	4,469
Diagnostic and therapeutic services	31,849	1,304	72,498	1,417
Population and public health	2,194	269	5,963	406
Research and education	1,026	-	2,547	-
Information technology	283	65	511	-
Support services	5,687	1,567	12,945	1,568
Administration	2,945	7,503	5,205	6,929
TOTAL EXPENSES	**491,842**	**216,754**	**1,127,993**	**251,657**
NET OPERATING DEFICIT	**(9,579)**	**(2,068)**	**-**	**-**

Note 3 Restructuring (continued)

	Mental health and addictions 5 months ended August 31, 2024	Primary care 10 months ended January 31, 2025	Mental health and addictions 12 months ended March 31, 2024	Primary care 12 months ended March 31, 2024
Expenses by object:				
Salaries and benefits	$ 376,717	$ 167,931	$ 856,453	$ 188,441
Contracts with health service providers	97,858	25,892	226,283	29,092
Drugs and gases	5,346	91	11,919	167
Medical supplies	938	172	1,751	175
Other contracted services	4,155	1,907	14,196	1,808
Other	6,520	20,745	15,842	31,963
Amortization and loss on disposals/write-downs of tangible capital assets	308	16	1,549	11
	491,842	**216,754**	**1,127,993**	**251,657**

Note 4 Budget

The 2024-25 original annual budget was approved by the former AHS Board on March 28, 2024 for submission to the Minister who approved it on June 24, 2024. The restated annual budget, resulting from the restructuring of AHS (Note 1) was approved by the former AHS Board on January 27, 2025 and submitted to the Minister. A reconciliation from the original to the restated annual budget has been provided in the Consolidated Schedule of the Revised Budget (Schedule 4).

Note 5 Other Government Transfers

	Budget (Note 4)	2025	2024 (Note 29)
Recognition of expended deferred capital revenue (Note 18)	$ 234,200	$ 222,678	$ 216,354
Restricted operating (Note 16(a))	255,338	234,567	282,222
Unrestricted operating	1,162,638	453,539	60,315
	$ 1,652,176	**$ 910,784**	**$ 558,891**

Other government transfers include $897,739 (2024 – $523,929) (Note 25) transferred from the Province of Alberta, $13,045 (2024 – $34,962) from government entities outside the Province of Alberta and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

Note 6 Donations and Non-Government Contributions

	Budget (Note 4)	2025	2024
Recognition of expended deferred capital revenue (Note 18)	$ 33,500	$ 32,995	$ 34,252
Restricted operating (Note 16(a))	136,200	147,036	139,182
Unrestricted operating	1,200	18,732	12,167
Endowment contributions (Note 23)	-	4,647	27,781
	$ 170,900	**$ 203,410**	**$ 213,382**

Note 7 Investment and Other Income

	Budget (Note 4)	2025	2024
Investment income	$ 78,600	$ 176,531	$ 118,227
Other income:			
AH	10,525	24,976	11,507
Other Province of Alberta Ministries (Note 25)	26,000	184,252	29,791
Other [(i)]	133,575	164,451	170,851
	$ 248,700	**$ 550,210**	**$ 330,376**

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

Note 8 Support Services

	Budget (Note 4)	2025	2024
Facilities operations	$ 1,104,300	$ 980,945	$ 1,070,364
Patient health records, food services, and transportation	517,100	516,153	513,793
Housekeeping, laundry, and linen	258,300	265,727	264,093
Materials management	253,000	214,042	233,350
Support services expense of full-spectrum contracted health service providers	179,500	200,641	182,462
Ancillary operations	63,100	60,676	61,412
Fundraising expenses and grants awarded	53,800	62,085	53,310
Other [(i)]	284,700	464,473	419,588
	$ 2,713,800	**$ 2,764,742**	**$ 2,798,372**

[(i)] Other includes valuation adjustments of $588 (2024 – $78,997). The prior year valuation adjustment was due to reduced demand for inventories purchased to support public health emergencies in previous years (Note 22).

Note 9 Administration

	Budget (Note 4)	2025	2024
General administration	$ 259,900	$ 261,283	$ 276,775
Human resources	154,500	154,777	143,236
Finance	85,900	80,472	80,422
Communications	26,300	26,307	28,038
Administration expense of full-spectrum contracted health service providers	38,300	53,475	45,339
	$ 564,900	**$ 576,314**	**$ 573,810**

Note 10 Financial Risk Management

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

(a) Market Risk

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

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

Note 10 Financial Risk Management (continued)

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

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

AHS assesses the sensitivity of its portfolio to market risk based on historical volatility of equity and fixed income markets. Volatility is determined using a ten-year average based on fixed income and equity market fluctuations and is applied to the total portfolio. Based on the volatility average of 3.72% (2024 – 3.70%) increase or decrease, with all other variables held constant, the portfolio could expect an increase or decrease in unrealized net gains and losses of $99,607 (2024 – $95,745).

(i) Price Risk

Price risk relates to the possibility that equity portfolio investments will change in fair value due to future fluctuations in market prices caused by factors specific to an individual equity investment or other factors affecting all equities traded in the market. AHS is exposed to price risk associated with the underlying equity portfolio investments held in pooled funds. If equity market indices (S&P/TSX, S&P1500 and MSCI ACWI and their sectors) declined by 10%, and all other variables are held constant, the potential loss in fair value to AHS would be approximately $54,607 or 2.02% of total portfolio investments (2024 – $53,723 or 2.06%).

(ii) Interest Rate Risk

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

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

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

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $72,416 (2024 – $62,499).

Interest bearing securities have the following average maturity structure:

	2025	2024
Less than one year	31%	33%
1 – 5 years	49%	49%
6 – 10 years	13%	10%
Over 10 years	7%	8%

	Average Effective Market Yield	
Asset Class	2025	2024
Money market instruments	2.81%	5.06%
Fixed income securities	3.13%	4.41%

Note 10 Financial Risk Management (continued)

(iii) Foreign Currency Risk

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

Foreign currency risk is managed by the investment policies which limit non-Canadian equities to a maximum of 10% to 45% of the total investment portfolio, depending on the policy. At March 31, 2025, investments in non-Canadian equities represented 12.9% (2024 – 11.6%) of total portfolio investments.

Foreign exchange fluctuations on cash balances are mitigated by derivatives and holding minimal foreign currency cash balances. AHS holds US dollar forward contracts to manage currency fluctuations relating to its US dollar accounts payable requirements. As at March 31, 2025, AHS held derivatives in the form of forward contracts for future settlement of $22,000 (2024 – $18,000). The fair value of these forward contracts as at March 31, 2025 was $1,139 (2024 – $434) and is included in portfolio investments (Note 11).

(b) Credit Risk

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

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

The carrying amounts of financial assets represent the maximum credit exposure.

Under the investment bylaws and policies governing the consolidated investment portfolio, money market securities are limited to a rating of R1 or equivalent or higher, and no more than 10% may be invested in any one issuer unless guaranteed by the Government of Canada or a Canadian province. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total investment portfolio. Not more than 20% of the investment portfolio may be BBB or equivalent rated bonds. AHS holds unrated mortgage fund investments which are classified as part of AHS' fixed income securities.

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

Credit Rating	2025	2024
AAA	56%	58%
AA	15%	10%
A	14%	17%
BBB	11%	11%
Unrated	4%	4%
	100%	**100%**

Note 10 Financial Risk Management (continued)

(c) Liquidity Risk

Liquidity risk is the risk that AHS will encounter difficulty under both normal and stressed conditions in meeting obligations associated with financial liabilities that are settled by delivery of cash and cash equivalents or another financial asset. Liquidity requirements of AHS are met through funding provided by AH, income generated from portfolio investments, and by investing in liquid assets, such as money market securities, fixed income securities and equities traded in an active market that are easily sold and converted to cash. Short-term borrowing to meet financial obligations would be available through established credit facilities, which have not been drawn upon, as described in Note 19(b).

AHS issued debentures and the committed repayments with respect to these debentures are described in Note 19(c). The following are contractual maturities of the remaining financial liabilities as at March 31, 2025, based on expected undiscounted cash flows.

	Due in less than 1 year	Due in 1-5 years	Due after 5 years
Payroll payable and related accrued liabilities	$ 1,326,452	$ -	$ -
Trade accounts payable and accrued liabilities	979,321	-	-
Other liabilities	6,873	13,323	4,413
	$ 2,312,646	**$ 13,323**	**$ 4,413**

Note 11 Portfolio Investments

	2025		2024	
	Fair Value	Cost	Fair Value	Cost
Cash held for investing purposes	**$ 89,207**	**$ 89,207**	**$ 131,690**	**$ 131,690**
Interest bearing securities:				
Money market securities	597,429	595,809	614,641	614,636
Fixed income securities	1,444,907	1,438,535	1,304,133	1,326,783
	2,042,336	**2,034,344**	**1,918,774**	**1,941,419**
Equities:				
Canadian equity investments and funds	162,401	147,878	199,709	181,927
Global equity investments and funds	344,898	302,168	299,807	224,040
	507,299	**450,046**	**499,516**	**405,967**
Real estate pooled funds	**38,777**	**31,069**	**37,712**	**30,926**
	$ 2,677,619	**$ 2,604,666**	**$ 2,587,692**	**$ 2,510,002**

	2025	2024
Items at fair value		
Portfolio investments designated to the fair value category	$ 2,683,197	$ 2,509,350
Portfolio investments in equity instruments that are quoted in an active market	-	77,908
Derivative (liability) asset, net	(5,578)	434
	$ 2,677,619	**$ 2,587,692**

As at March 31, 2025, included in portfolio investments is $186,071 (2024 – $188,142) that is restricted for use as per the requirements in Sections 99 and 100 of the *Insurance Act* (Alberta). Endowment principal included in portfolio investments amounts to $109,920 (2024 – $105,273) (Note 23).

Note 11 Portfolio Investments (continued)

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

	2025	2024
Accumulated remeasurement gains	$ 69,702	$ 64,073
Restricted unrealized net gains attributable to unexpended deferred operating revenue (Note 16(b))	3,251	13,617
	$ 72,953	**$ 77,690**

Fair Value Hierarchy

The relative reliability of data or inputs used to measure the fair value is determined based on the following fair value hierarchy:

- 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.

	2025			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ -	$ 89,207	$ -	$ 89,207
Interest bearing securities:				
Money market securities	-	597,429	-	597,429
Fixed income securities	-	1,386,625	58,282	1,444,907
Equities:				
Canadian equity investments and funds	-	162,401	-	162,401
Global equity investments and funds	-	344,898	-	344,898
Real estate pooled funds	-	-	38,777	38,777
	$ -	**$ 2,580,560**	**$ 97,059**	**$ 2,677,619**
Percent of total	0%	96%	4%	100%

	2024			
	Level 1	Level 2	Level 3	Total
Cash held for investing purposes	$ -	$ 131,690	$ -	$ 131,690
Interest bearing securities:				
Money market securities	-	614,641	-	614,641
Fixed income securities	-	1,252,966	51,167	1,304,133
Equities:				
Canadian equity investments and funds	77,908	121,801	-	199,709
Global equity investments and funds	-	299,807	-	299,807
Real estate pooled funds	-	-	37,712	37,712
	$ 77,908	**$ 2,420,905**	**$ 88,879**	**$ 2,587,692**
Percent of total	3%	94%	3%	100%

Note 11 Portfolio Investments (continued)

Reconciliation of Investments classified as level 3

	2025		
	Fixed income securities	Real estate pooled funds	Total
Beginning of year	$ 51,167	$ 37,712	$ 88,879
Purchases	1,735	-	1,735
Sales	(1,126)	-	(1,126)
Realized loss	(27)	-	(27)
Gain included in the Consolidated Statement of Remeasurement Gains and Losses	2,012	922	2,934
Transfers in[(i)]	4,521	143	4,664
End of year	**$ 58,282**	**$ 37,777**	**$ 97,059**

	2024		
	Fixed income securities	Real estate pooled funds	Total
Beginning of year	$ 51,325	$ 48,690	$ 100,015
Purchases	2,015	-	2,015
Sales	(333)	(11,129)	(11,462)
Realized (loss) gain	(21)	1,684	1,663
Gain (loss) included in the Consolidated Statement of Remeasurement Gains and Losses	595	(1,533)	(938)
Transfers out[(i)]	(2,414)	-	(2,414)
End of year	**$ 51,167**	**$ 37,712**	**$ 88,879**

(i) Transfers are attributable to changes in the observability of market data.

Note 12 Accounts Receivable

	2025			2024
	Gross	Allowance for Doubtful Accounts	Net	Net (Note 29)
AH operating transfers receivable	$ 371,315	$ -	$ 371,315	$ 129,549
Other capital transfers receivable	99,273	-	99,273	105,534
Patient accounts receivable	171,921	45,782	126,139	116,584
Drugs rebates receivable	148,516	-	148,516	105,960
AH capital transfers receivable	9,755	-	9,755	20,497
Other operating transfers receivable	107,073	-	107,073	89,050
Other accounts receivable	175,817	58,715	117,102	188,351
	$ 1,083,670	**$ 104,497**	**$ 979,173**	**$ 755,525**

Accounts receivable are unsecured and non-interest bearing. At March 31, 2024, the total allowance for doubtful accounts was $54,010 of which $44,350 related to patient accounts receivable.

Note 13 Contractual Rights

Contractual rights are rights of AHS to economic resources arising from contracts or agreements that will result in both assets and revenues in the future when the terms of those contracts or agreements are met.

Estimated amounts that will be received or receivable for each of the next five years and thereafter are as follows:

Year ended March 31	Operating leases	Other contracts[i]	Total
2026	$ 2,424	$ 297,602	$ 300,026
2027	2,194	133,551	135,745
2028	1,974	8,594	10,568
2029	1,283	7,819	9,102
2030	1,100	7,625	8,725
Thereafter	1,914	20,344	22,258
March 31, 2025	**$ 10,889**	**$ 475,535**	**$ 486,424**
March 31, 2024	$ 13,740	$ 70,585	$ 84,325

[i] Other contracts include the transition services framework agreements with Recovery Alberta and PCA of $410,215 (2024 - $nil) (Note 3(a)).

Note 14 Accounts Payable and Accrued Liabilities

	2025	2024
Payroll payable and related accrued liabilities	$ 1,326,452	$ 816,482
Trade accounts payable and accrued liabilities	979,321	692,594
Provision for unpaid claims[a]	158,285	167,598
Obligations under capital leases[b]	134,122	142,882
Other liabilities	35,059	36,399
	$ 2,633,239	**$ 1,855,955**

As at March 31, 2025, accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $244,166 (2024 – $237,885). Of these amounts, $9,526 (2024 – $9,166) comprise life lease deposits received from tenants of certain AHS' long term care facilities, and obligations under capital leases of $134,122 (2024 – $142,882).

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

The provision has been actuarially estimated using the discounted value of claim liabilities using a discount rate of 4.18% (2024 – 4.37%).

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

The obligations will be settled between 2026 and 2041 and have an implicit interest rate payable ranging from 2.53% to 5.41% (2024 – 2.53% to 5.41%).

Note 14 Accounts Payable and Accrued Liabilities (continued)

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

Year ended March 31	Minimum Contract Payments
2026	$ 24,336
2027	22,344
2028	18,458
2029	13,550
2030	10,707
Thereafter	62,928
	152,323
Less: interest	(18,201)
	$ 134,122

Note 15 Employee Future Benefits

	2025	2024
Accrued vacation pay	$ 621,598	$ 680,804
Accumulating non-vesting sick leave[(a)]	121,192	137,552
SERP pension plans	(33)	183
	$ 742,757	**$ 818,539**

(a) Accumulating Non-Vesting Sick Leave

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

	2025	2024
Funded status – deficit	$ 136,098	$ 99,365
Unamortized net actuarial (loss) gain	(14,906)	38,187
Accrued benefit liability	**$ 121,192**	**$ 137,552**

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

	2025	2024
Estimated average remaining service life	13 years	10 years
Draw down rate of accumulated non-vesting sick leave bank	24.10%	18.30%
Discount rate – beginning of year	5.00%	5.60%
Discount rate – end of year	3.63%	5.00%
Rate of compensation increase per year	2024-25	2023-24
	2.00%	2.25%
	2025-26	2024-25
	3.00%	2.00%
	2026-27	2025-26
	3.00%	2.00%
	Thereafter	Thereafter
	2.75%	2.75%

Note 15 Employee Future Benefits (continued)

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP. AHS' employees comprise approximately 42% (2024 - 46%) of the total membership in LAPP. AHS is not responsible for future funding of the plan deficit other than through contribution increases. As AHS is exposed to the risk of contribution rate increases, the following disclosure is provided to explain this risk.

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

(ii) LAPP Surplus

The LAPP carried out an actuarial valuation as at December 31, 2023 and these results were then extrapolated to December 31, 2024.

	December 31, 2024	December 31, 2023
LAPP net assets available for benefits	$ 70,698,830	$ 63,337,859
LAPP pension obligation	51,141,682	48,281,339
LAPP surplus	**$ 19,557,148**	**$ 15,056,520**

The 2025 and 2024 LAPP contribution rates are as follows:

Calendar 2025		Calendar 2024	
Employer	**Employees**	**Employer**	**Employees**
8.45% of pensionable earnings up to the YMPE and 11.65% of the excess	7.45% of pensionable earnings up to the YMPE and 10.65% of the excess	8.45% of pensionable earnings up to the YMPE and 11.65% of the excess	7.45% of pensionable earnings up to the YMPE and 10.65% of the excess

(c) Pension Expense

	2025	2024
Local Authorities Pension Plan	$ 607,841	$ 521,199
Defined contribution pension plans and group RRSPs	39,116	41,331
Other pension plans	1,645	1,727
	$ 648,602	**$ 564,257**

Note 16 Unexpended Deferred Operating Revenue

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

	2025				2024
	AH	Other Government[i]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 225,768	$ 111,259	$ 360,895	$ 697,922	$ 572,628
Adjustment related to Ministry of Seniors, Community, and Social Services[ii]	(8,034)	8,034	-	-	-
Balance, beginning of year (reclassified)	**217,734**	**119,293**	**360,895**	**697,922**	**572,628**
Received or receivable during the year	1,598,305	168,077	164,831	1,931,213	2,016,146
Unexpended deferred operating revenue returned	(840)	(1,595)	(739)	(3,174)	(10,322)
Restricted investment income	1,567	3,467	26,386	31,420	16,860
Transferred from unexpended deferred capital revenue [iii] (Note 17(a))	8,288	52,282	480	61,050	105,058
Transferred due to restructuring (Note 3(a))	(56,687)	(66,513)	(1,760)	(124,960)	-
Recognized as revenue	(1,640,502)	(234,567)	(147,036)	(2,022,105)	(1,996,431)
Miscellaneous other revenue recognized	(1,567)	(125)	(26,666)	(28,358)	(15,742)
	126,298	**40,319**	**376,391**	**543,008**	**688,197**
Changes in unrealized net gains attributable to portfolio investments related to endowments and unexpended deferred operating revenue	2,531	190	(13,087)	(10,366)	9,725
Balance, end of year	**$ 128,829**	**$ 40,509**	**$ 363,304**	**$ 532,642**	**$ 697,922**

[i] The balance for other government includes $1,626 (2024 – $1,879) of unexpended deferred operating revenue received from government entities outside the Province of Alberta. The remaining balance in other government all relates to the Province of Alberta (Note 25).

[ii] On December 12, 2024, the Premier of Alberta approved the transfer of the continuing care department from the Ministry of Health to the Ministry of Seniors, Community, and Social Services. A reclassification has been made to the consolidated financial statements for the year ended March 31, 2024 to reclassify the related continuing care amount from Alberta Health transfers to other government transfers to conform with 2025 presentation.

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

Note 16 Unexpended Deferred Operating Revenue (continued)

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

	2025				2024
	AH	Other Government	Donors and Non-Government	Total	Total (Note 29)
Research and education	$ 6,667	$ 1,242	$ 270,271	$ 278,180	$ 283,879
Acute care	49,448	331	42,922	92,701	153,666
Support services	6,670	3,410	43,593	53,673	49,658
Diagnostic and therapeutic services	28,341	1,507	1,264	31,112	23,086
Continuing care	-	24,356	90	24,446	20,246
Emergency medical services	22,341	1,588	348	24,277	21,254
Administration	9,508	1,133	333	10,974	8,436
Population and public health	1,638	1,754	3,103	6,495	15,121
Community care	285	106	1,795	2,186	100,059
Others individually less than $10,000	2,597	2,739	11	5,347	8,900
	127,495	**38,166**	**363,730**	**529,391**	**684,305**
Unrealized net gain (loss) attributable to portfolio investments related to endowments and unexpended deferred operating revenue (Note 11)	1,334	2,343	(426)	3,251	13,617
	$ 128,829	**$ 40,509**	**$ 363,304**	**$ 532,642**	**$ 697,922**

Note 17 Unexpended Deferred Capital Revenue

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

	2025				2024
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 110,800	$ 2,524	$ 100,748	$ 214,072	$ 177,901
Received or receivable during the year	128,930	223,560	82,963	435,453	473,542
Used for acquisition of land	(168)	-	-	(168)	-
Unexpended deferred capital revenue returned	-	-	(6,887)	(6,887)	(3,626)
Transferred to expended deferred capital revenue (Note 18)	(91,399)	(171,381)	(63,260)	(326,040)	(327,575)
Transferred to unexpended deferred operating revenue[(ii)] (Note 16(a))	(8,288)	(52,282)	(480)	(61,050)	(105,058)
Revenue recognized on settlement of asset retirement obligations (Note 20)	(158)	(945)	(376)	(1,479)	(1,112)
Balance, end of year	**$ 139,717**	**$ 1,476**	**$ 112,708**	**$ 253,901**	**$ 214,072**

(i) The balance for other government includes $32 (2024 - $nil) of unexpended deferred capital revenue received from government entities outside the Province of Alberta. The remaining balance in other government all relates to the Province of Alberta (Note 25).

(ii) The transfer is mainly comprised of restricted capital funding of approved expenditures that did not meet the definition of a tangible capital asset.

Note 17 Unexpended Deferred Capital Revenue (continued)

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

	2025				2024
	AH	Other Government	Donors and Non-Government	Total	Total
Equipment	$ 17,932	$ 111	$ 110,999	$ 129,042	$ 105,298
Information systems	5,278	-	-	5,278	2,952
Facilities and improvements	116,507	1,365	1,709	119,581	105,822
	$ 139,717	**$ 1,476**	**112,708**	**$ 253,901**	**214,072**

Note 18 Expended Deferred Capital Revenue

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

	2025				2024
	AH	Other Government[(i)]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 578,509	$ 7,876,374	$ 241,548	$ 8,696,431	$ 8,525,465
Transferred from unexpended deferred capital revenue (Note 17(a))	91,399	171,381	63,260	326,040	327,575
Constructed tangible capital assets on behalf of AHS	-	258,231	-	258,231	198,774
Contributed tangible capital assets	-	-	-	-	24
Transferred to PHA's due to restructuring (Note 3(a))	(1,303)	(530)	(512)	(2,345)	-
Recognized as revenue	(110,130)	(222,678)	(32,995)	(365,803)	(355,407)
Balance, end of year	**$ 558,475**	**$ 8,082,778**	**$ 271,301**	**$ 8,912,554**	**$ 8,696,431**

(i) The balance includes $294 (2024 - $228) of expended deferred capital revenue received from government entities outside of the Province of Alberta. The remaining balance in other government relates to the Province of Alberta (Note 25).

Note 19 Debt

	2025	2024
Debentures [(a)]:		
Parkade loan #1	$ 6,014	$ 9,811
Parkade loan #2	8,506	11,658
Parkade loan #3	15,626	19,081
Parkade loan #4	78,885	88,956
Parkade loan #5	20,097	22,331
Parkade loan #6	16,105	17,279
Parkade loan #7	36,452	38,774
Parkade loan #8	147,320	149,397
Parkade loan #9	19,407	20,000
Energy savings initiative loan	12,911	14,887
EMS support vehicle loan	14,264	23,639
	$ 375,587	**$ 415,813**

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

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

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

AHS issued a debenture to TBF relating to EMS support vehicles. AHS has pledged the vehicles as security for this debenture.

AHS is in compliance with all performance requirements relating to its debentures as at March 31, 2025.

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

	Maturity Date	Fixed Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Parkade loan #6	December 2035	3.6090%
Parkade loan #7	March 2038	2.6400%
Parkade loan #8	December 2059	3.6010%
Parkade loan #9	March 2044	5.1200%
Energy savings initiative loan	December 2030	2.4160%
EMS support vehicle loan	September 2026	1.1500%

(b) As at March 31, 2025, AHS has access to a $220,000 (2024 – $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, 2025, AHS has $nil (2024 – $nil) drawn against this facility.

AHS also has access to a $33,000 (2024 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2025, AHS has $3,376 (2024 – $3,316) in a letter of credit outstanding against this facility. AHS is in compliance with the terms of the agreement relating to the letter of credit as at March 31, 2025.

Note 19 Debt (continued)

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

Year Ended March 31	Principal	Interest	Total
2026	$ 41,671	$ 14,090	$ 55,761
2027	36,274	12,584	48,858
2028	28,904	11,236	40,140
2029	28,302	10,023	38,325
2030	25,125	8,849	33,974
Thereafter	215,311	99,432	314,743
	$ 375,587	**$ 156,214**	**$ 531,801**

During the year, the total interest related to debt was $15,334 (2024 – $15,788), comprised of capitalized interest of $1,017 (2024 – $nil) (Note 21(a)) and interest expense of $14,317 (2024 – $15,788). Accrued interest at March 31, 2025 amounted to $2,520 (2024 – $2,679).

Note 20 Asset Retirement Obligations

	2025	2024
Asset retirement obligations, beginning of year	$ 539,421	$ 583,172
Liability incurred	-	-
Liability settled and adjustments	(5,214)	(1,978)
Revision in estimates (Note 21)	101,256	(41,773)
Asset retirement obligations, end of year	**$ 635,463**	**$ 539,421**

AHS has asset retirement obligations to remove hazardous asbestos fibre containing materials from its buildings. Regulations require AHS to handle and dispose of the asbestos in a prescribed manner when it is disturbed, such as when the building undergoes renovations or is demolished. Although timing of the asbestos removal is conditional on the building undergoing renovations or being demolished, regulations create an existing obligation for AHS to remove the asbestos when asset retirement activities occur.

The estimate of the liability is based primarily on asbestos abatement rates calculated using the current costs incurred as part of AHS renovation and demolition projects. Third party engineering reports, building schematics, and professional judgments were used in determining the square meters containing asbestos. A funding source for this obligation has not been determined.

The timing of settlement of asset retirement obligations is currently unknown. For the year ended March 31, 2025, a recovery of $3,983 (2024 - $1,978) was recognized, which includes costs incurred by AI on behalf of AHS of $2,504 (2024 - $866) (Note 17(a)).

Note 21 Tangible Capital Assets

Cost	2024	Additions[a]	Transfers/ Adjustments[i]	Transfer related to restructuring (Note 3)	Disposals/ Write-downs	2025
Facilities and improvements	$ 12,983,453	$ -	$ 218,486	$ -	$ -	$ 13,201,939
Work in progress	661,491	525,550	(379,102)	-	(8,371)	799,568
Equipment	3,139,882	226,922	(867)	(19,484)	(98,264)	3,248,189
Information systems	2,384,398	8,671	115,330	-	(70,509)	2,437,890
Building service equipment	1,090,744	-	134,534	-	-	1,225,278
Land[b]	121,781	168	(960)	-	(64)	120,925
Leased facilities and improvements	373,174	453	2,413	-	(183)	375,857
Land improvements	114,042	-	10,462	-	-	124,504
	$ 20,868,965	**$ 761,764**	**$ 100,296**	**$ (19,484)**	**$ (177,391)**	**$ 21,534,150**

Accumulated Amortization	2024	Amortization Expense	Effect of Transfers/ Adjustments[i]	Transfer related to restructuring (Note 3)	Disposals/ Write-downs	2025
Facilities and improvements	$ 5,151,365	$ 134,701	$ -	$ -	$ -	$ 5,286,066
Work in progress	-	-	-	-	-	-
Equipment	2,431,494	170,955	-	(14,684)	(97,339)	2,490,426
Information systems	1,825,309	169,635	-	-	(70,300)	1,924,644
Building service equipment	675,892	58,671	-	-	-	734,563
Land[b]	-	-	-	-	-	-
Leased facilities and improvements	234,030	16,170	-	-	(143)	250,057
Land improvements	83,220	3,907	-	-	-	87,127
	$ 10,401,310	**$ 554,039**	**$ -**	$ (14,684)	**$ (167,782)**	**$ 10,772,883**

Cost	2023	Additions	Transfers/ Adjustments[i]	Disposals/ Write-downs	2024
Facilities and improvements	$ 12,717,651	$ -	$ 267,024	$ (1,222)	$ 12,983,453
Work in progress	665,094	506,115	(509,307)	(411)	661,491
Equipment	2,974,510	207,650	(2,001)	(40,277)	3,139,882
Information systems	2,268,704	14,038	108,723	(7,067)	2,384,398
Building service equipment	1,025,874	-	64,883	(13)	1,090,744
Land[b]	121,749	32	-	-	121,781
Leased facilities and improvements	317,743	33,000	22,431	-	373,174
Land improvements	107,568	-	6,474	-	114,042
	$ 20,198,893	**$ 760,835**	**$ (41,773)**	**$ (48,990)**	**$ 20,868,965**

Accumulated Amortization	2023	Amortization Expense	Effect of Transfers/ Adjustments	Disposals/ Write-downs	2024
Facilities and improvements	$ 4,994,290	$ 158,195	$ -	$ (1,120)	$ 5,151,365
Work in progress	-	-	-	-	-
Equipment	2,298,163	172,250	-	(38,919)	2,431,494
Information systems	1,682,243	150,060	-	(6,994)	1,825,309
Building service equipment	626,105	49,801	-	(14)	675,892
Land[b]	-	-	-	-	-
Leased facilities and improvements	214,316	19,714	-	-	234,030
Land improvements	80,127	3,093	-	-	83,220
	$ 9,895,244	**$ 553,113**	**$ -**	**$ (47,047)**	**$ 10,401,310**

(i) Transfers and adjustments mainly relate to reclassifications between capital asset categories and revisions to asset retirement costs of $101,256 (2024 - $41,773) (Note 20).

Note 21 Tangible Capital Assets (continued)

	Net Book Value	
	2025	2024
Facilities and improvements	$ 7,915,873	$ 7,832,088
Work in progress	799,568	661,491
Equipment	757,763	708,388
Information systems	513,246	559,089
Building service equipment	490,715	414,852
Land[(b)]	120,925	121,781
Leased facilities and improvements	125,800	139,144
Land improvements	37,377	30,822
	$ 10,761,267	**$ 10,467,655**

(a) Additions

Additions include tangible capital assets constructed by AI on behalf of AHS of $258,231 (2024 – $198,774) (Note 25) and $nil (2024 – $24) contributed from other sources. During the year, AHS capitalized interest of $1,017 (2024 – $nil) (Note 19(c)) within work in progress. Capital lease additions amounted to $15,185 (2024 – $37,753).

(b) Leased Land

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

Site	Leased from	Lease Expiry
Banff Health Unit	Banff Mineral Spring Hospital Association	January 2028
Evansburg Community Health Centre	Yellowhead County	April 2031
Bethany Care Centre	Red Deer College	April 2034
Myrnam Land	Eagle Hill Foundation	May 2038
Helipad Land at Two Hills	Stella Stefiuk	August 2041
McConnell Place North	City of Edmonton	September 2044
Northeast Community Health Centre	City of Edmonton	February 2047
Jasper Healthcare Centre	Parks Canada	March 2049
Foothills Medical Centre Parkade	University of Calgary	July 2054
Alberta Children's Hospital	University of Calgary	December 2103
Kaye Edmonton Clinic (Parcel H)	The University of Alberta	February 2109
Laneway adjacent to Queen Elizabeth II Hospital	City of Grande Prairie	Under negotiation
Jasper Residential Property	Parks Canada	Under negotiation

(c) Leased Tangible Capital Assets

Tangible capital assets acquired through capital leases includes vehicle leases, equipment, information systems and facilities with a cost of $594,661 (2024 – $579,537) and accumulated amortization of $349,068 (2024 – $286,709).

(d) Asset Retirement Costs

Facilities and improvements and Building service equipment, include $639,561 (2024 - $538,304) of asset retirement costs and $344,121 (2024 - $359,135) of related accumulated amortization.

Note 22 Inventories of Supplies

	2025	2024
Pharmaceuticals	$ 118,324	$ 106,759
Medical and surgical supplies	42,830	47,395
Other[(i)]	28,283	43,015
	$ 189,437	**$ 197,169**

(i) Other is mainly related to staff wearing apparel such as gowns and masks, housekeeping, and other supplies not included under pharmaceuticals and medical and surgical supplies.

During the year, a valuation adjustment of $588 (2024 – $78,997) was recognized. The prior year's valuation adjustment was due to reduced demand for inventories purchased to support public health emergencies in previous years.

Note 23 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2025					2024
	Unrestricted Surplus	Invested in Tangible Capital Assets[(a)]	Endowments[(b)]	Internally Restricted Surplus for Insurance Equity Requirements, Foundations and HBTA[(c)]	Total	Total
Balance, beginning of year	$ 379,343	$ 696,347	$ 105,273	$ 123,495	$ 1,304,458	$ 1,120,827
Annual operating surplus	71,060	-	-	-	71,060	183,631
Net investment in tangible capital assets	6,747	(6,747)	-	-	-	-
Transfer of insurance equity requirements, foundations and HBTA net surplus	(235,275)	-	-	235,275	-	-
Transfer of net surplus related to asset retirement obligations	(20,229)	20,229	-	-	-	-
Transfer of endowment contributions (Note 6)	(4,647)	-	4,647	-	-	-
Balance, end of year	**$ 196,999**	**$ 709,829**	**$ 109,920**	**$ 358,770**	**$ 1,375,518**	**$ 1,304,458**

Note 23 Accumulated Surplus (continued)

(a) Invested in Tangible Capital Assets

Invested in tangible capital assets represents the portion of accumulated surpluses that has been invested in the acquisition or construction of AHS' assets. The balance is offset by asset retirement costs recognized to date in accumulated surplus net of related liability settlements.

Reconciliation of invested in tangible capital assets:

	2025	2024
Tangible capital assets (Note 21)	$ 10,761,267	$ 10,467,655
Net Book Value of Asset Retirement Costs capitalized (Note 21(d))	(295,440)	(179,169)
Less funded by:		
Expended deferred capital revenue (Note 18)	(8,912,554)	(8,696,431)
Debt (Note 19)	(375,587)	(415,813)
Unexpended debt	15,814	32,405
Obligations under capital leases (Note 14)	(134,122)	(142,882)
Life lease deposits (Note 14)	(9,526)	(9,166)
	$ 1,049,852	**$ 1,056,599**
Asset retirement costs recognized net of related liability settlements	(340,023)	(360,252)
	$ 709,829	**$ 696,347**

(b) Endowments

Endowments represent the portion of accumulated surplus that is restricted and must be maintained in perpetuity. Transfers of endowment contributions from unrestricted surplus include $4,647 (2024 – $27,781) of net contributions received in the year (Note 6).

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

Insurance equity requirements comprise surpluses of $17,250 (2024 – $21,042) related to equity of the LPIP mainly relating to legislative requirements per the Insurance Act. Foundations comprise surpluses amounting to $119,325 (2024 – $102,453) related to donations received by AHS' Controlled Foundations without external restrictions attached. Health Benefit Trust of Alberta (HBTA) comprise surpluses of $222,195 ($2024 – $nil) related to equity representing in substance a prepayment of future premiums to the HBTA.

Note 24 Contractual Obligations, Contingent Liabilities and Other Matters

(a) Contractual Obligations

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

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

Year ended March 31	Services[(i)]	Other[(ii)]	Operating Lease	Capital Projects	Total
2026	$ 3,550,457	$ 476,012	$ 64,410	$ 255,715	$ 4,346,594
2027	1,414,436	213,797	58,579	51,483	1,738,295
2028	1,648,488	292,260	50,808	24,999	2,016,555
2029	1,090,400	77,159	42,335	21,905	1,231,799
2030	955,709	47,522	35,114	13,644	1,051,989
Thereafter	6,439,438	51,141	141,681	-	6,632,260
March 31, 2025	**$ 15,098,928**	**$ 1,157,891**	**$ 392,927**	**$ 367,746**	**$ 17,017,492**
March 31, 2024	$ 16,056,317	$ 1,071,034	$ 372,841	$ 448,478	$ 17,948,670

(i) Service obligations mainly relate to contracts with third parties for the provision of long-term care services and home care services.

(ii) Other obligations mainly relate to contracts with third parties for maintenance, information technology services, software, equipment, and procurement of medical supplies and food.

(b) Contingent Liabilities

(i) Legal Claims

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

Accruals have been made in specific instances where it is likely that losses will be incurred based on a reasonable estimate. As at March 31, 2025, accruals have been recorded as part of the provision for unpaid claims and other liabilities (Note 14). Included in this accrual are claims in which AHS has been jointly named with the Minister. The accrual provided for these claims under the provision for unpaid claims represents AHS' portion of the liability.

AHS has been named in 195 legal claims (2024 – 234 claims) related to conditions in existence at March 31, 2025 where the likelihood of the occurrence of a future event confirming a contingent loss is not determinable. Of these, 158 claims have $623,540 in specified amounts and 37 claims have no specified amounts (2024 – 201 claims with $706,650 of specified claims and 33 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that is different than the claimed amount.

(ii) Collective Agreements

AHS currently has 18 (2024 – 1) collective agreements that have expired as at March 31, 2025. Given that negotiations are ongoing or have not commenced, no additional disclosures have been made.

(c) Other Matters

Management and external parties are currently conducting various investigations into certain procurement practices. These investigations remain ongoing as of the date of the approval of the financial statements. Management is not aware of any material impacts to the presentation of these financial statements as at the date of approval, as these investigations continue.

Note 25 Related Parties

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

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

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

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

	Revenues[a]		Expenses	
	2025	2024 (Restated) (Note 29)	2025	2024
Alberta Advanced Education[b]	$ 50,493	$ 57,875	$ 172,515	$ 184,077
Alberta Infrastructure[c]	282,607	312,158	9,677	12,064
Alberta Mental Health and Addiction[d]	483,961	121,779	-	-
Other ministries[e]	106,377	64,122	18,462	31,749
Provincial Health Agencies[f]	159,304	-	-	-
Total for the year	**$ 1,082,742**	**$ 555,934**	**$ 200,654**	**$ 227,890**

	Receivable from		Payable to	
	2025	2024 (Restated) (Note 29)	2025	2024
Alberta Advanced Education[b]	$ 10,287	$ 11,435	$ 22,822	$ 33,399
Alberta Infrastructure[c]	63,950	69,725	1,955	6,144
Alberta Mental Health and Addiction[d]	-	28,419	-	1,288
Other ministries[e]	87,933	47,928	378,173	419,112
Provincial Health Agencies[f]	-	-	293,694	-
Balance, end of year	**$ 162,170**	**$ 157,507**	**$ 696,644**	**$ 459,943**

(a) Revenues with Province of Alberta ministries include other government transfers of $897,739 (2024 – $523,929), (Note 5), other income of $184,252 (2024 – $29,791) (Note 7), and fees and charges of $751 (2024 – $2,214). A substantial portion of other income is for the provision of corporate and clinical support service provided to the provincial health agencies under the transition services framework agreement.

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

Note 25 Related Parties (continued)

(c) The transactions with AI relate to the construction of tangible capital assets on behalf of AHS. These transactions include operating transfers of $61,424 (2024 – $98,110) and recognition of expended deferred capital revenue of $221,183 (2024 – $214,048) relating to tangible capital assets with stipulations or external restrictions to utilize over their remaining useful lives. Not included in the table above but included in total amounts disclosed in Note 21(a) is tangible capital assets constructed by AI on behalf of AHS of $258,231 (2024 – $198,774).

(d) The transactions with Alberta Mental Health and Addiction, up until the operational date of RA, related to initiatives to support Albertans experiencing addiction and mental health challenges. Subsequent to the operational date, it relates to the corporate and clinical support services being provided by AHS.

(e) The payable transactions with other ministries include the debt payable to TBF (Note 19(a)).

(f) The transactions with provincial health agencies relate to the services provided by AHS in accordance with the transition services agreements. Under the Transition Services Framework Agreement, AHS provides corporate and clinical support services including but not limited to nutrition, food, linen & environmental services, capital management, information technology, protective services, pharmacy services, human resources, financial operations, APL services and health information management.

At March 31, 2025, AHS has recorded deferred revenue from other ministries within the Province of Alberta, excluding AH, of $38,883 (2024 – $117,414) related to unexpended deferred operating revenue (Note 16(a)), $1,444 (2024 – $2,524) related to unexpended deferred capital revenue (Note 17(a)) and $8,082,484 (2024 – $7,876,146) related to expended deferred capital revenue (Note 18).

Contingent liabilities in which AHS has been jointly named with other government entities within the Province of Alberta are disclosed in Note 24.

Note 26 Government Partnerships

AHS has proportionately consolidated 50% of the results of NACTRC and 33.33% of the results in iRSM. AHS also proportionately consolidated its 50% ownership interests in PCNs up until February 1, 2025. Following the transfer of primary care responsibilities to PCA, effective February 1, 2025, AHS no longer holds any ownership interest in PCN's (Note 2(a)(ii) and Note 3). The following is 100% of the financial position and results of operations for AHS' government partnerships.

	2025	2024
Financial assets (portfolio investments, accounts receivable, other assets)	$ 1,526	$ 83,417
Liabilities (trade accounts payable, unexpended deferred operating revenue)	1,526	83,417
Accumulated surplus	**$ -**	**$ -**
Total revenues	$ 250,700	$ 279,160
Total expenses	250,700	279,160
Annual surplus	**$ -**	**$ -**

Note 27 Trusts under Administration

(a) Health Benefit Trust of Alberta (HBTA)

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

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

	2025	2024
Financial assets	$ 365,504	$ 232,932
Liabilities	209	23,983
Net financial assets	365,295	208,949
Non-financial assets	-	-
Net assets	**$ 365,295**	**$ 208,949**

AHS has included in prepaid expenses $222,195 (2024 – $142,539) representing in substance a prepayment of future premiums to the HBTA. For the fiscal year ended March 31, 2025, AHS paid premiums of $692,534 (2024 – $632,746) which is approximately 88% (2024 – 98%) of the total premiums received by the HBTA.

(b) Other Trust Funds

AHS holds funds in trust for research and development, education, and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to 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, 2025, the balance of funds held in trust by AHS for research and development is $100 (2024 – $100).

AHS holds funds in trust from continuing care residents for personal expenses. As at March 31, 2025, the balance of these funds is $3,024 (2024 – $2,185). These amounts are not included in the consolidated financial statements.

AHS and a third party trustee administer the SERP in accordance with a retirement compensation arrangement trust agreement. As at March 31, 2025, there are $24,255 in plan assets (2024 – $25,176). These amounts are not included in the consolidated financial statements.

Note 28 Segment Disclosure

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

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

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

Segments include:

(a) Continuing care

Continuing care homes are comprised of Type A (formerly long-term care), Type B (formerly designated supportive living), Type C (formerly palliative and hospice care), and psychiatric care in facilities operated by AHS and contracted providers.

Note 28 Segment Disclosure (continued)

(b) Community care

Community care includes Type B (formerly designated supportive living), Type C (formerly palliative and hospice care), and community programs including PCN, Family Care Clinics, urgent care centres, community paramedic program, and mental health. This segment excludes community-based dialysis, oncology, and surgical services.

(c) Home care

Home care is comprised of home nursing and support.

(d) Acute care

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

(e) Emergency medical services

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

(f) Diagnostic and therapeutic services

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

(g) Population and public health

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

(h) Research and education

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

(i) Information technology

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

(j) Support services

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

(k) Administration

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

Note 29 Corresponding Amounts

Certain corresponding amounts have been reclassified to conform with 2025 presentation, with the most significant reclass pertaining to the transfer of the continuing care department. On December 12, 2024, the Premier of Alberta approved the transfer of the continuing care department from the Ministry of Health to the Ministry of Seniors, Community and Social Services. As a result, the statement of operations and the accounts receivable note for the year ending March 31, 2024, were updated to reflect this change. Specifically, $30,966 was reclassified from AH transfers to other government transfers in the statement of operations, and $39,000 from AH operating transfers receivable to other operating transfers receivable within accounts receivable (Note 12), to align with the 2025 presentation.

Note 30 Subsequent Events

On November 8, 2023, the Premier of Alberta announced the restructuring of AHS, resulting in the creation of four new agencies focusing on primary care, acute care, continuing care and mental health and addiction. As of March 31, 2025, two agencies, Recovery Alberta and PCA, are operational (Note 3).

The provincial health agency responsible for acute care, ACA, was established on February 1, 2025 and became operational on April 1, 2025. ACA is accountable to the Ministry of Health. On the effective date of April 1, 2025, AHS transferred all of the powers, duties, responsibilities, and functions of AHS necessary for ACA to fulfil its responsibility for the governance and coordination of acute care health services across Alberta. ACA will continue to engage AHS as a service provider to deliver the acute care services until the Minister of Health transfers these acute care services to the new AHS PHC. The full financial effect of the restructuring, including the full impact on AHS assets, liabilities and operations is currently unknown.

The provincial health agency responsible for the continuing care sector, ALA, was established on April 1, 2025, and is expected to be operational by fall 2025. ALA is accountable to the Alberta Ministry of Seniors, Community and Social Services. The full financial effect of the restructuring, including the impact on AHS assets, liabilities and operations is currently unknown.

The *Alberta Health Services Provincial Health Corporation Regulation, Alberta Regulation 213/2024* came into effect June 1, 2025. As a result of this regulation, the entity Alberta Health Services PHC was established for the purposes of delivering health services in the acute care health services sector. The operational date and the full financial effect, including the impact on the AHS assets, liabilities and operations is currently unknown.

On October 31, 2024, the Government of Alberta enacted the Real Property Governance Act, 2024 (Alberta), as part of its efforts to centralize the management of public property to enhance accountability and transparency. Under this legislation, all freehold real property owned by AHS was transferred to AI effective April 1, 2025. Any debt associated with the freehold real property transferred to AI remains with AHS, and no amendments have been made to the terms and conditions of this debt at this time. The analysis of the full financial effect, including the impact on the AHS assets, liabilities, and operations is currently underway.

On March 10, 2025, the Government of Alberta announced that the management and oversight of emergency health services, including ground, air, dispatch and interfacility transfers, will transfer from AHS to ACA later this year. Additionally, on April 8, 2025, the Government of Alberta announced that the cancer care and organ tissue services will transfer from AHS to ACA, which will be responsible for overseeing cancer services within the province. The full financial effect, including the impact on AHS assets, liabilities, and operations is currently unknown.

The Government of Alberta also announced that a new shared services entity is expected to be established and become operational in 2025. This entity will provide corporate and support services for all four provincial health agencies, and service providers. The operational date and the full financial effect, including the impact on AHS assets, liabilities and operations is currently unknown.

Note 30 Subsequent Events (continued)

On May 1, 2025, the Government of Alberta introduced Bill 55, the *Health Statutes Amendment Act*, 2025. The bill proposes additional amendments to the *Provincial Health Agencies Act*, the *Public Health Act*, and other related legislation. As disclosed in public statements from the Government of Alberta, these amendments to the legislation will enable key policy shifts to support refocusing efforts, including updating the oversight and governance for health foundations and reorganize the governance and planning for public health services. The full financial effect, including the impact on AHS assets, liabilities and operations is currently unknown.

On May 16, 2025, the Government of Alberta announced that the Ministry of Health has been divided into two new ministries to improve governance and operational focus across the healthcare system. The newly established Ministry of Hospital and Surgical Health Services, responsible for acute care, including emergency medical services, cancer care, organ and tissue donation, capital planning, procurement, and oversight of ACA. The second newly established Ministry of Primary and Preventative Health Services will oversee primary care, public health, Indigenous health, health workforce and colleges regulation, pharmaceutical and supplementary benefits, diagnostic services, and oversight of PCA. Additionally, the Ministry of Seniors, Community and Social Services has been renamed to Assisted Living and Social Services to reflect its expanded responsibility for ALA.

Effective July 1, 2025, approximately 4,365 positions will be transferred from AHS to ALA and PCA. These include certain positions transitioning to ALA to support seniors health and continuing care as well positions transferring to PCA to support parts of public health, aspects of chronic disease management, and some Indigenous wellness. Medical officers of health will also transition to the Ministry of Primary and Preventative Health Services, with additional responsibilities for public health to be transferred to this Ministry in the future. Additionally, three new provincial health corporations have been established: Emergency Health Services PHC, Cancer Care PHC, and Organ and Tissue Donation and Transplantation PHC. These PHCs are expected to be operational later this year.

Note 31 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the Official Administrator on June 2, 2025 and submitted to the Ministry of Health.

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

	2025		2024
	Budget (Note 4) (Schedule 4)	Actual	Actual
Salaries and benefits	$ 9,935,928	$ 10,069,576	$ 9,839,465
Contracts with health service providers	3,748,600	3,434,674	3,466,333
Contracts under the Health Facilities Act	77,000	67,497	55,824
Drugs and gases[(i)]	742,600	768,984	738,881
Medical supplies[(i)]	731,700	870,581	815,353
Other contracted services	1,664,300	1,679,236	1,688,175
Other[(a)]	1,682,000	1,575,782	1,685,083
Amortization and loss on disposals/write-downs of tangible capital assets (Note 21)	561,900	563,648	555,033
Net effect of restructuring and related transactions (Note 3)	-	2,761	-
	$ 19,144,028	**$ 19,032,739**	**$ 18,844,147**
(a) Significant amounts included in Other are:			
Equipment expense	$ 323,300	$ 323,441	$ 295,346
Utilities	194,400	173,487	230,705
Building and ground expenses	174,800	134,365	174,780
Housekeeping, laundry and linen, staff wearing apparel, plant maintenance and biomedical engineering supplies[(i)]	145,000	123,452	163,538
Building rent	126,000	128,771	125,766
Food and dietary supplies	105,100	94,662	86,029
Fundraising and grants awarded	55,200	77,881	65,734
Insurance and liability claims	47,800	63,662	58,656
Office supplies and courier	54,400	62,735	64,347
Minor equipment purchases	98,100	59,925	103,351
Travel	33,000	39,198	46,165
Telecommunications	37,600	31,790	34,250
Licenses, fees and memberships	24,300	26,717	26,139
Education	15,500	10,663	14,994
Other	247,500	225,033	195,283
	$ 1,682,000	**$ 1,575,782**	**$ 1,685,083**

(i) Includes inventory valuation adjustments of $588 (2024 – $78,997) (Note 22). The current year valuation adjustment is included in medical supplies and the prior year valuation adjustments are included in drugs and gases, medical supplies, and housekeeping, laundry and linen, staff wearing apparel, plant maintenance and biomedical engineering supplies.

SCHEDULE 2 – SCHEDULES OF RENUMERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31

SCHEDULE 2A – OFFICIAL ADMINISTRATOR REMUNERATION FOR THE YEAR ENDED MARCH 31, 2025

	Term	2025 Remuneration	2024 Remuneration
Official Administrator			
Andre Tremblay	Since Jan 31, 2025	$ -	$ -
Total Official Administrator		**$ -**	**$ -**

Andre Tremblay was appointed to the position of Official Administrator effective January 31, 2025 per Ministerial Order 808/2025. The incumbent was not remunerated for this position.

The tenure of the Official Administrator is in lieu of a Board at AHS.

SCHEDULE 2B – FORMER BOARD REMUNERATION FOR THE YEAR ENDED MARCH 31, 2025

	Term	2025 Committees	2025 Remuneration	2024 Remuneration
Former Board Chair[f]				
Angela Fong	Sep 23, 2024 to Jan 31, 2025	FARC, FC, GCHRC	$ 75	$ -
Dr. Lyle Oberg	Nov 8, 2023 to Sep 22, 2024	FARC, FC, GCHRC	188	155
Former Board Members				
Sandy Edmonstone (Vice Chair)	Nov 8, 2023 to Jan 31, 2025	FC (Chair), GCHRC	43	14
Cynthia Farmer[g]	Nov 8, 2023 to Jan 31, 2025	-	-	-
Angela Fong	Nov 21, 2023 to Sep 22, 2024	GCHRC (Chair)	14	12
Paul George Haggis	Nov 8, 2023 to Jan 31, 2025	FARC (Chair), FC	43	14
Darren Hedley[g]	Jan 23, 2025 to Jan 31, 2025	-	-	-
Dr. Lyle Oberg	Sep 23, 2024 to Jan 31, 2025	-	26	-
Evan Romanow[g]	Nov 8, 2023 to Jan 31, 2025	FC	-	-
Andre Tremblay[g]	Nov 8, 2023 to Jan 8, 2025	FARC, FC, GCHRC	-	-
Total Former Board			**$ 389**	**$ 195**

The former Board chair and former Board members were remunerated with monthly honoraria. In addition, former Board members received remuneration for attendance at Board and committee meetings up until September 22, 2024, at which time there was a change in the compensation structure.

Board committees were established by the former Board to assist in governing AHS and overseeing the management of AHS' business and affairs.

Committee legend: FARC = Finance, Audit and Risk Committee, FC = Foundations Committee, GCHRC = Governance, Compliance and Human Resources Committee

SCHEDULE 2C – FORMER OFFICIAL ADMINISTRATOR / FORMER OFFICIAL ADMINISTRATOR COMMITTEE REMUNERATION FOR THE YEAR ENDED MARCH 31, 2025

	Term	2025 Remuneration	2024 Remuneration
Former Official Administrator			
Dr. John Cowell	Nov 17, 2022 to Nov 8, 2023	$ -	$ 436
Former Official Administrator Committee Participants			
Tara Lockyer	Nov 24, 2022 to Nov 8, 2023	-	2
Gregory Turnbull	Nov 24, 2022 to Nov 8, 2023	-	3
Tyler White	Jul 12, 2023 to Nov 8, 2023	-	1
Gord Winkel	Nov 24, 2022 to Nov 8, 2023	-	3
Total Former Official Administrator / Former Official Administrator Committee		**$ -**	**$ 445**

The tenure of the Official Administrator was in lieu of a Board at AHS.

Dr. John Cowell's last term as Official Administrator ended November 8, 2023 per Ministerial Order 307/2023, and did not serve in the fiscal year ended March 31, 2025.

SCHEDULE 2D - EXECUTIVE REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2025

	2025						
For the Current Fiscal Year	**FTE [a]**	**Base Salary [b, h]**	**Other Cash Benefits [c]**	**Other Non-Cash Benefits [d]**	**Subtotal**	**Severance [e]**	**Total**
Official Administrator/Former Board Direct Reports							
Andre Tremblay – Interim President and Chief Executive Officer[i, w]	0.22	$ 48	$ -	$ 11	$ 59	$ -	$ 59
Athana Mentzelopoulos – President and Chief Executive Officer[j]	0.78	454	-	49	503	583	1,086
Ronda White – Chief Audit Executive[k]	0.94	314	2	81	397	-	397
CEO Direct Reports							
Sean Chilton – Senior VP, Clinical Operations[l, x]	1.00	518	3	106	627	-	627
Erin O'Neill – Senior VP, Finance and Shared Services[m, w]	0.06	8	-	-	8	-	8
Dr. Sid Viner – VP and Medical Director, Clinical Operations[k]	0.84	433	22	84	539	-	539
Dr. Peter Jamieson – VP, Quality and Chief Medical Officer[n]	0.84	420	20	128	568	-	568
Susan McGillivray – Interim VP, People and Health Professions[k]	0.94	381	-	77	458	-	458
Karen Horon – VP, Cancer Care Alberta and Clinical Support Services[k]	0.94	363	1	91	455	-	455
Brenda Hubley – Acting VP, Cancer Care Alberta and Clinical Support Services[o]	0.24	74	8	17	99	-	99
Dr. Mircea Fagarasanu – Interim VP, Provincial Clinical Excellence[p]	0.92	250	38	70	358	-	358
Natalie McMurtry – Interim VP, Provincial Clinical Excellence[q]	0.06	18	-	4	22	-	22
Thomas Mountain – Interim Chief Program Officer, Addiction and Mental Health and Correctional Health Services[r]	0.17	46	-	14	60	-	60
Kerry Bales – Chief Program Officer, Addiction and Mental Health and Correctional Health Services[s]	0.25	85	-	27	112	-	112
Christine Myatt – Senior Program Officer, Community Engagement and Communications[t]	0.90	183	-	52	235	-	235
Holly Budd – Acting Senior Program Officer, Community Engagement and Communications[u]	0.04	8	2	1	11	-	11
Michael Lam – Interim VP, Corporate Services and Chief Financial Officer[k]	0.94	329	1	73	403	-	403
Andrea Beckwith-Ferraton – Interim General Counsel and Corporate Secretary[k]	0.94	228	25	79	332	-	332
Tracy Chalaturnyk – Transition Lead[v]	0.92	250	38	52	340	-	340
Total Executive	**11.94**	**$ 4,410**	**$ 160**	**$ 1,016**	**$ 5,586**	**$ 583**	**$ 6,169**
Management Reporting to CEO Direct Reports	**51.21**	**$ 13,663**	**$ 451**	**$ 2,731**	**$ 16,845**	**$ 980**	**$ 17,825**

SCHEDULE 2D - EXECUTIVE REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2025 (CONTINUED)

	2024						
For the Prior Fiscal Year	**FTE [a]**	**Base Salary [b, h]**	**Other Cash Benefits [c]**	**Other Non-Cash Benefits [d]**	**Subtotal**	**Severance [e]**	**Total**
Board/Former Official Administrator Direct Reports							
Athana Mentzelopoulos – President and Chief Executive Officer	0.31	$ 179	$ -	$ 88	$ 267	$ -	$ 267
Sean Chilton – Interim President and Chief Executive Officer	0.06	35	-	6	41	-	41
Mauro Chies – President and Chief Executive Officer	0.63	374	-	85	459	1,386	1,845
Ronda White – Chief Audit Executive	1.00	313	2	73	388	-	388
Athana Mentzelopoulos – Official Administrator Advisor/ Provisional Lead, Emergency Medical Services	0.33	119	-	44	163	-	163
CEO Direct Reports							
Sean Chilton – Interim VP and Chief Operating Officer, Clinical Operations/VP, People, Health Professions and Information Technology	0.94	410	19	102	531	-	531
Lori Anderson – Acting VP and Chief Operating Officer, Clinical Operations	0.03	10	3	2	15	-	15
Deb Gordon – VP and Chief Operating Officer, Clinical Operations	0.52	212	-	7	219	970	1,189
Dr. Sid Viner – VP and Medical Director, Clinical Operations	0.90	436	22	102	560	-	560
Dr. Peter Jamieson – Interim VP, Quality and Chief Medical Officer	0.33	177	-	-	177	-	177
Dr. Francois Belanger – VP, Quality and Chief Medical Officer	0.63	316	-	85	401	1,071	1,472
Susan McGillivray – Interim VP, People and Health Professions	0.60	229	-	61	290	-	290
Karen Horon – VP, Cancer Care Alberta and Clinical Support Services	1.00	331	1	96	428	-	428
Natalie McMurtry – Interim VP, Provincial Clinical Excellence	0.81	219	-	48	267	-	267
Dr. Braden Manns – Interim VP, Provincial Clinical Excellence	0.19	107	2	7	116	-	116
Kerry Bales – Chief Program Officer, Addiction and Mental Health and Correctional Health Services	1.00	328	-	99	427	-	427
Holly Budd – Acting Senior Program Officer, Community Engagement and Communications	0.33	60	12	18	90	-	90
Gail Fredrickson – Interim VP, Community Engagement and Communications	0.07	18	2	3	23	-	23
Colleen Turner – VP, Community Engagement and Communications	0.60	233	-	103	336	792	1,128
Michael Lam – Interim VP, Corporate Services and Chief Financial Officer	0.33	97	12	29	138	-	138
Colleen Purdy – VP, Corporate Services and Chief Financial Officer	0.63	273	-	57	330	504	834
Andrea Beckwith-Ferraton – Interim General Counsel and Corporate Secretary	0.37	86	10	23	119	-	119
Tina Giesbrecht – General Counsel	0.63	165	5	49	219	356	575
Geoffrey Pradella – Chief Strategy Officer	0.35	105	-	26	131	144	275
Total Executive	**12.59**	**$ 4,832**	**$ 90**	**$ 1,213**	**$ 6,135**	**$ 5,223**	**$ 11,358**
Management Reporting to CEO Direct Reports	**59.68**	**$ 14,938**	**$ 468**	**$ 2,844**	**$ 18,250**	**$ 388**	**$ 18,638**

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

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

	2025			2024			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2024	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2025
Andre Tremblay - Interim President and Chief Executive Officer[5]	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Athana Mentzelopoulos - President and Chief Executive Officer[6]	-	-	-	14	14	(14)	-
Ronda White - Chief Audit Executive	16	-	16	14	191	50	241
Sean Chilton – Senior VP, Clinical Operations	38	-	38	30	325	94	419
Erin O'Neill - Senior VP, Finance and Shared Services[5]	-	-	-	-	-	-	-
Dr. Sid Viner - VP and Medical Director, Clinical Operations	36	-	36	31	203	80	283
Dr. Peter Jamieson - Interim VP, Quality and Chief Medical Officer	33	-	33	-	-	33	33
Susan McGillivray - Interim VP, People and Health Professions							
SERP	-	(1)	(1)	(1)	149	8	157
SPP	24	-	24	18	168	27	195
Karen Horon - VP, Cancer Care Alberta and Clinical Support Services	22	-	22	16	68	27	95
Brenda Hubley – Acting VP, Cancer Care Alberta and Clinical Support Services	12	-	12	10	60	22	82
Dr. Mircea Fagarasanu - Interim VP, Provincial Clinical Excellence	8	-	8	8	28	14	42
Natalie McMurtry - Interim VP, Provincial Clinical Excellence	12	-	12	7	13	15	28
Thomas Mountain - Interim Chief Program Officer, Addiction and Mental Health and Correctional Health Services[7]	3	-	3	-	-	-	-
Kerry Bales - Chief Program Officer, Addiction and Mental Health and Correctional Health Services[7]	10	-	10	16	251	(251)	-
Christine Myatt - Senior Program Officer, Community Engagement and Communications	-	-	-	-	-	-	-

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

	2025			2024			
	SPP	SERP					
	Current Period Benefit Costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2024	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2025
Holly Budd - Acting Senior Program Officer, Community Engagement and Communications[8]	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Michael Lam - Interim VP, Corporate Services and Chief Financial Officer	16	-	16	12	101	39	140
Andrea Beckwith-Ferraton - Interim General Counsel and Corporate Secretary	5	-	5	4	48	16	64
Tracy Chalaturnyk - Transition Lead	8	-	8	8	124	30	154

(1) The SPP current period benefit costs are AHS contributions earned in the period.
(2) Other SERP costs include retirement benefits, interest expense on the obligations, and amortization of actuarial gains and losses, offset by the expected return on the plan's assets. AHS uses the straight-line method to amortize actuarial gains and losses over the expected average remaining service life of the plan members.
(3) The account balance represents the total cumulative earned contributions to the SPP as well as cumulative investment gains or losses on the contributions.
(4) Changes in the accrued benefit obligation include current period benefit cost, interest accruing on the obligations and the amortization of any actuarial gains or losses in the period. Changes in the account balance include the current benefit costs and investment gains or losses related to the account.
(5) The incumbent is on temporary secondment from the Government of Alberta, and therefore not eligible for enrollment in the SPP.
(6) The SPP had not fully vested at the time of the incumbent's departure, and as a result no current period benefit costs were incurred.
(7) The incumbent's account balance transitioned to Recovery Alberta effective September 1, 2024.
(8) The incumbent's pensionable earnings were below the threshold for enrollment in the SPP.

FOOTNOTES TO THE SCHEDULES OF REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2025

Definitions

a. For this schedule, full time equivalents (FTE) are determined by actual hours earned divided by 2,022.75 annual base hours (2024 – 2,030.50 hours).

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

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

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

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

Former Board

f. The former Board Chairs were Ex-Officio members on all former Board committees.

g. These individuals did not claim honoraria.

Executive

h. Base salary reported for executives are the actual payments earned during the year, and is therefore contingent on the number of AHS' work days in the year. For the year ended March 31, 2025, the number of work days at AHS was 261 (2024 – 260 work days).

i. Andre Tremblay was appointed to the position of Interim President and Chief Executive Officer effective January 8, 2025. The incumbent was also appointed Official Administrator effective January 31, 2025. The incumbent is on temporary secondment from the Government of Alberta and received remuneration and benefits from AHS commencing February 19, 2025.

j. Athana Mentzelopoulos held the position of President and Chief Executive Officer until January 8, 2025 at which time she left AHS. The incumbent received salary and other accrued entitlements to the date of departure. The reported severance included 12 months base salary at the rate in effect at the date of departure. In addition, the incumbent received a vacation payout of $108 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. The reported severance is still subject to change.

k. As a result of restructuring, the incumbent ceased to be a direct report to the President and Chief Executive Officer effective March 10, 2025.

l. Sean Chilton held the position of Interim VP and Chief Operating Officer, Clinical Operations until February 26, 2025 at which time he was appointed to Senior Vice President, Clinical Operations.

m. Erin O'Neill was appointed to the position of Senior Vice President, Finance and Shared Services effective March 10, 2025. The incumbent is on temporary secondment from the Government of Alberta and received the reported renumeration from AHS in addition to her Government of Alberta compensation.

n. Dr. Peter Jamieson held the position of Interim Vice President, Quality and Chief Medical Officer until April 15, 2024 at which time he was appointed to Vice President, Quality and Chief Medical Officer. The incumbent's remuneration while Interim Vice President, Quality and Chief Medical Officer was as per the terms of a Medical Administrative Services Agreement. The incumbent became an employee of AHS with his appointment as Vice President, Quality and Chief Medical Officer. As a result of restructuring, the incumbent ceased to be a direct report to the President and Chief Executive Officer effective March 10, 2025.

FOOTNOTES TO THE SCHEDULES OF REMUNERATION AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2025 (CONTINUED)

o. Brenda Hubley held the position of Chief Program Officer, Cancer Care Alberta until October 16, 2024 at which time she was appointed to Acting Vice President, Cancer Care Alberta and Clinical Support Services and became a direct report to the President and Chief Executive Officer. This appointment was to provide coverage for a leave of absence by Karen Horon. The incumbent held the position of Acting Vice President, Cancer Care Alberta and Clinical Support Services until January 10, 2025 at which time the incumbent resumed the role of Chief Program Officer, Cancer Care Alberta and was no longer a direct report to the President and Chief Executive Officer.

p. Dr. Mircea Fagarasanu held the position of Senior Program Officer, Workplace Health and Safety until April 8, 2024 at which time he was appointed to Interim Vice President, Provincial Clinical Excellence and became a direct report to the President and Chief Executive Officer. As a result of restructuring, the incumbent ceased to be a direct report to the President and Chief Executive Officer effective March 10, 2025.

q. Natalie McMurtry was seconded to the Government of Alberta for a two-year term effective April 22, 2024. During this secondment, the incumbent is on leave from all duties at AHS and ceases to be a direct report to the President and Chief Executive Officer at AHS.

r. Thomas Mountain held the position of Lead, Addiction and Mental Health Operations until July 1, 2024 at which time he was appointed to Interim Chief Program Officer, Addiction and Mental Health and Correctional Health Services and became a direct report to the President and Chief Executive Officer. The incumbent's position transitioned to Recovery Alberta effective September 1, 2024 as per Ministerial Order 801/2024.

s. Kerry Bales held the position of Chief Program Officer, Addiction and Mental Health and Correctional Health Services until June 30, 2024 at which time he left AHS to assume the position of Chief Executive Officer for Recovery Alberta. In addition, the incumbent received a vacation payout of $95 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.

t. Christine Myatt was appointed to the position of Senior Program Officer, Community Engagement and Communications effective April 16, 2024. As a result of restructuring, the incumbent ceased to be a direct report to the President and Chief Executive Officer effective March 10, 2025.

u. Holly Budd held the position of Acting Senior Program Officer, Community Engagement and Communications until April 16, 2024 at which time she resumed the role of Executive Director, Communications and was no longer a direct report to the President and Chief Executive Officer.

v. Tracy Chalaturnyk was appointed to the temporary role of Transition Lead effective April 8, 2024 and became a direct report to the President and Chief Executive Officer. These duties are in addition to her position as Senior Program Officer, Human Resource Business Partnerships. As a result of restructuring, the incumbent ceased to be a direct report to the President and Chief Executive Officer effective March 10, 2025.

Termination Obligations

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

x. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to 24 months' salary and benefits.

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

	2025									
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Facilities Act	Drugs and gases	Medical supplies	Other contracted services	Other	Amortization and loss on disposals/ write-downs of tangible capital assets	Net effect of restructuring transaction	Total
Continuing care	$ 376,905	$ 1,044,780	$ -	$ 7,645	$ 6,733	$ 27,351	$ 17,655	$ 3,632	$ -	$ 1,484,701
Community care	695,117	877,022	-	5,245	5,168	51,958	32,138	948	-	1,667,596
Home care	406,715	370,276	-	323	12,131	150,055	19,163	617	-	959,280
Acute care	3,476,632	494,095	67,497	699,820	524,880	724,403	152,790	68,336	-	6,208,453
Emergency medical services	382,817	249,786	-	3,470	5,732	3,416	42,991	21,551	-	709,763
Diagnostic and therapeutic services	2,001,386	128,549	-	45,014	298,453	404,704	106,987	53,372	-	3,038,465
Population and public health	367,386	21,726	-	5,728	10,932	8,553	16,694	678	-	431,697
Research and education	208,308	2,345	-	91	547	122,274	41,725	51	-	375,341
Information technology	376,215	1,963	-	-	(203)	25,746	240,682	169,223	-	813,626
Support services	1,363,190	200,698	-	1,648	6,120	114,122	835,067	243,897	-	2,764,742
Administration	414,905	43,434	-	-	88	46,654	69,890	1,343	-	576,314
Net effect of restructuring transaction	-	-	-	-	-	-	-	-	2,761	2,761
Total	**$ 10,069,576**	**$ 3,434,674**	**$ 67,497**	**$ 768,984**	**$ 870,581**	**$ 1,679,236**	**$ 1,575,782**	**$ 563,648**	**$ 2,761**	**$ 19,032,739**

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

	2024								
	Salaries and benefits	Contracts with health service providers	Contracts under the Health Facilities Act	Drugs and gases	Medical supplies	Other contracted services	Other	Amortization and loss on disposals/ write-downs of tangible capital assets	Total
Continuing care	$ 340,236	$ 951,304	$ -	$ 7,566	$ 7,657	$ 42,481	$ 23,068	$ 3,048	$ 1,375,360
Community care	927,558	945,293	-	9,574	5,428	53,219	41,622	934	1,983,628
Home care	370,243	358,439	-	199	11,593	83,992	18,683	560	843,709
Acute care	3,427,032	462,215	55,824	654,905	472,626	744,026	202,602	65,645	6,084,875
Emergency medical services	357,098	230,011	-	2,800	5,952	3,869	49,822	16,402	665,954
Diagnostic and therapeutic services	1,820,366	264,783	-	35,072	256,841	368,902	120,658	66,162	2,932,784
Population and public health	351,956	24,052	-	5,634	23,861	9,609	23,448	613	439,173
Research and education	194,329	3,229	-	108	453	119,400	35,066	122	352,707
Information technology	358,249	1,951	-	-	(32)	42,702	242,264	148,641	793,775
Support services	1,279,425	185,744	-	22,996	30,828	164,998	864,210	250,171	2,798,372
Administration	412,973	39,312	-	27	146	54,977	63,640	2,735	573,810
Total	**$ 9,839,465**	**$ 3,466,333**	**$ 55,824**	**$ 738,881**	**$ 815,353**	**$ 1,688,175**	**$ 1,685,083**	**$ 555,033**	**$ 18,844,147**

SCHEDULE 4 – CONSOLIDATED SCHEDULE OF THE REVISED BUDGET

Reconciliation of the Current Year presentation for the Budget FOR THE YEAR ENDED MARCH 31, 2025				
	2025 Original Budget as currently presented	Transfer of mental health and addiction operations to Recovery Alberta	Transfer of primary care operations to Primary Care Alberta	2025 Revised Budget[(i)]
Revenues:				
Alberta Health transfers				
Base operating	$ 14,602,924	$ (22,292)	(25,525)	$ 14,555,107
Other operating	1,653,528	(505)	(21,728)	1,631,295
Recognition of expended deferred capital revenue	102,100	-	-	102,100
Other government transfers	1,652,176	(773,948)	(2,249)	875,979
Fees and charges	621,000	(3,485)	(708)	616,807
Ancillary operations	92,700	-	-	92,700
Donations and non-government contributions	170,900	(1,671)	-	169,229
Investment and other income[(a)]	248,700	151,092	1,665	401,457
TOTAL REVENUES	**19,144,028**	**(650,809)**	**(48,545)**	**18,444,674**
Expenses:				
Continuing care	1,425,800	(3,909)	-	1,421,891
Community care	2,132,200	(380,384)	(42,218)	1,709,598
Home care	930,200	-	-	930,200
Acute care	6,081,528	(200,640)	(2,088)	5,878,800
Emergency medical services	735,400	-	-	735,400
Diagnostic and therapeutic services	2,956,600	(45,135)	(276)	2,911,189
Population and public health	420,900	(2,702)	(107)	418,091
Research and education	378,400	(1,718)	-	376,682
Information technology	804,300	(283)	-	804,017
Support services	2,713,800	(8,473)	(2,291)	2,703,036
Administration	564,900	(7,565)	(1,565)	555,770
TOTAL EXPENSES	**19,144,028**	**(650,809)**	**(48,545)**	**18,444,674**
ANNUAL OPERATING SURPLUS	**-**	**-**	**-**	**-**
Accumulated surplus, beginning of year	1,304,458	-	-	1,304,458
Accumulated surplus, end of year	**$ 1,304,458**	**$ -**	**-**	**$ 1,304,458**

(i) The revised budget, resulting from the restructuring of AHS (Note 1), was approved by the former AHS Board on January 27, 2025.

SCHEDULE 4 – CONSOLIDATED SCHEDULE OF THE REVISED BUDGET (CONTINUED)

Reconciliation of the Current Year presentation for the Budget FOR THE YEAR ENDED MARCH 31, 2025

	2025 Original Budget	Transfer of mental health and addiction operations to Recovery Alberta	Transfer of primary care operations to Primary Care Alberta	Community Lab Services Correction	2025 Revised Budget[i]
Salaries and benefits	$ 9,935,928	$ (484,130)	(38,794)	82,887	$ 9,495,891
Contracts with health service providers	3,748,600	(137,291)	(4,773)	(133,744)	3,472,792
Contracts under the Health Facilities Act	77,000	-	-	-	77,000
Drugs and gases	742,600	(7,557)	(27)	-	735,016
Medical supplies	731,700	(1,517)	(57)	30,940	761,066
Other contracted services	1,664,300	(8,956)	(628)	8,071	1,662,787
Other	1,682,000	(11,358)	(4,266)	11,846	1,678,222
Amortization and loss on disposals/write-downs of tangible capital assets (Note 21)	561,900	-	-	-	561,900
	$ 19,144,028	**$ (650,809)**	**(48,545)**	**-**	**$ 18,444,674**
(a) Significant amounts included in Other are:					
Equipment expense	$ 323,300	$ (959)	(51)	-	$ 322,290
Utilities	194,400	(2)	-	-	194,398
Building and ground expenses	174,800	(190)	-	-	174,610
Housekeeping, laundry and linen, staff wearing apparel, plant maintenance and biomedical engineering supplies	145,000	(1,051)	(22)	-	143,927
Building rent	126,000	(432)	(117)	-	125,451
Minor equipment purchases	98,100	(286)	(7)	-	97,807
Food and dietary supplies	105,100	(692)	-	-	104,408
Fundraising and grants awarded	55,200	-	-	-	55,200
Office supplies and courier	54,400	(3,164)	(35)	11,846	63,047
Insurance and liability claims	47,800	(14)	(1,032)	-	46,754
Travel	33,000	(1,920)	(45)	-	31,035
Telecommunications	37,600	(28)	(1)	-	37,571
Licenses, fees and memberships	24,300	(192)	(6)	-	24,102
Education	15,500	(284)	(10)	-	15,206
Other	247,500	(2,144)	(2,940)	-	242,416
	$ 1,682,000	**$ (11,358)**	**(4,266)**	**11,846**	**$ 1,678,222**

[i] The revised budget, resulting from the restructuring of AHS (Note 1), was approved by the former AHS Board on January 27, 2025.

Appendix

Patient Concerns

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

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

Concerns and Commendations	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Total Number of Commendations	1,526	1,495	2,142	2,138	2,009	2,228
Total Number of Concerns	10,773	11,602	12,728	12,689	12,469	13,827
Total Number of Concerns reviewed by PCO	20	18	19	14	9	17
Percent of Actions Arising from Concerns Resolved in 30 Days or Less	72%	76%	74%	71%	70%	72%*

*Date timestamps used to calculate the percentage of concerns closed in 30 days or less were adjusted as of November 26, 2024 with the implementation of RL6.

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

Public Interest Disclosure Act (PIDA)

Whistleblower Protection

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

PIDA's purpose is to:

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

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

The AHS Whistleblower Policy was updated in November 2024 to bring additional clarity to the processes reflected in the Policy.

In compliance with legislated reporting requirements, from April 1, 2024 to March 31, 2025, AHS reports as follows:

- Eleven disclosures were received or referred by or referred to AHS' Designated Officer.
- All disclosures were acted on by the Designated Officer.
- No investigations were commenced by the Designated Officer. As of the date of this report, one of the disclosures received in 2024-25 remains under review to determine if an investigation will occur.

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

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

- The subject matter of the concern does not have a public interest component and/or is based solely on a perceived wrong perpetrated against the person reporting the concern.
- After collecting and reviewing records and meeting with officials who have knowledge of the matter, a determination is made that the allegation, if founded, will not meet the definition of wrongdoing under PIDA and the AHS Whistleblower Policy.
- The allegation pertains to an individual who is not a member of the AHS workforce or other circumstances outside the authority of AHS to investigate.
- The allegation is more appropriately dealt with elsewhere.
- The allegation relates to a decision, action, or matter that results from a balanced and informed decision-making process on a public policy or operational issue.
- The allegation is anonymous without contact information and the disclosure does not contain sufficient particulars to form the basis of an investigation.

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

- Referring the matter to another AHS department for action.
- Referring the matter to an external agency for action.
- Providing the reporting person with contact information for a more appropriate organization to receive their concern.

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

AHS contracts services with multiple chartered surgical facilities (CSFs) to provide insured surgical services for ophthalmology, oral maxillofacial, orthopedic, otolaryngology, plastic surgery, dermatology, restorative dental, pregnancy terminations and podiatry. The use of chartered surgical facilities enables AHS to obtain services to enhance surgical access and alleviate capacity pressures within AHS main operating rooms.

Maintaining quality of services in CSFs will require deliberate, targeted, and significant effort. AHS works with Alberta Health and the College of Physicians and Surgeons of Alberta to coordinate activities addressing CSF accreditation, patient safety, quality, and compliance with the *Health Facilities Act* and regulations.

The table below summarizes chartered surgical facility contracts by service area for 2024-25.

Contracted Service Area	# of Contracted Operators covered under HFA	# of HFA Contracted Procedures Performed	Contracted Service Value (actuals)
Dermatology – Edmonton Zone	1	0	-
General Surgery – Edmonton Zone	1	290	$567,400
Ophthalmology – Calgary Zone*	2	23,038	$15,257,489
Ophthalmology – Edmonton Zone*	3	9,791	$6,122,327
Oral and Maxillofacial (OMF) – Calgary Zone	10	2,778	$1,457,776
Oral and Maxillofacial (OMF) – Edmonton Zone	10	5,556	$3,078,091
Orthopedic – Calgary Zone	1	1,312	$7,855,499
Orthopedic – Edmonton Zone	3	4,301	$34,860,476
Otolaryngology (ENT) – Calgary Zone	1	791	$623,916
Otolaryngology (ENT) – Edmonton Zone	3	1,318	$3,421,321
Plastic Surgery – Edmonton Zone	3	1,552	$1,310,235
Plastic Surgery – South Zone	1	10	$38,798
Pregnancy Termination – Calgary Zone	1	5,651	$2,921,011
Pregnancy Termination – Edmonton Zone	1	6,109	$3,421,642

Note:

*There is one Ophthalmology operator that has one contract but is an operator for both Edmonton and Calgary Zones.

- There are no surgical contracts with CSFs in the Central and North Zones.
- The # of Contracted Procedures Performed are reported as of June 16, 2024, and may be amended as final submissions and AHS audit occurs for the CSF sites. Audit continues through to 2025-06-30.
- Procedure totals provided by AHS Clinical Quality Metrics, Provincial CSF Procedures Dashboard.

Glossary

Access to Indigenous Spiritual Ceremony Policy is Canada's most comprehensive policy on access to Indigenous ceremonial practices and helps provide frontline cultural and navigation supports to Indigenous patients and their families. Services include patient advocacy, connection to resources, education and awareness, end-of-life support, psychosocial support, and translation services.

Acute Care Bundle Improvement (ACBI) is a provincially coordinated quality improvement project that integrates evidence-based initiatives aimed at simplifying and standardizing steps that a care provider performs for each patient.

Alberta Surgical Initiative (ASI) is a program of interventions with a focused goal of ensuring all Albertans will receive their required surgeries within clinically appropriate timelines.

Alternate Level of Care is used to describe patients who occupy a bed but do not require the intensity of resources/services provided in that care setting. These patients are clinically stable and/or their status has plateaued, they are at low risk for rapid decline or are not seeking new additional diagnoses by the medical team.

Anesthesia Care Team (ACT) model is when one anesthesiologist provides concurrent supervision for a qualified respiratory therapist, clinical assistant or anesthesia assistant providing anesthesia care in two or more operating room theatres when appropriate.

Anti-Racism Simulation (ARSIM) aims to develop and test educational materials and simulation training to support Indigenous-directed Anti-Racism efforts in emergency departments.

Asynchronous Video Observed Therapy (AVOT) is a form of video-based directly observed therapy where patients record and upload videos of themselves taking their medication, and health professionals review the videos at a later time.

Atlas of Clinical Variation is a document that highlights geographical variation in the delivery of health services and associated health outcomes.

Care Hub is a team of providers working together to provide day-to-day direct patient care to a group of patients within a unit. This may include a combination of RNs, LPNs or HCAs working towards common patient care goals.

Chartered Surgical Facilities (CSFs) are surgical facilities contracted with AHS that provide insured surgical services for dermatology, ophthalmology, oral maxillofacial, otolaryngology, plastic surgery, pregnancy terminations and podiatry.

Comprehensive School Health Approach is a framework for building healthy school communities that support students in reaching their full potential as learners.

Connect Care is a single AHS health record for care provided by AHS and AHS-affiliated healthcare providers. It provides access to personal health information which improves communication with care teams, standardizes care and improves health outcomes.

Digital Remote Patient Monitoring (dRPM) allows Albertans to receive hospital-level care in their homes, using digital devices such as blood pressure monitors, weigh scales, pulse oximeters and thermometers.

ED Fast Track is a process to effectively manage patients admitted to emergency departments with non-urgent complaints. It consists of a separate pathway for patients with less serious conditions who can be treated and discharged more quickly. Triage nurses use specific inclusion criteria based on presenting problems and the triage category.

EMS/811 Shared Response occurs when EMS calls are assessed by EMS dispatch as being low-acuity or non- emergency and may not require an ambulance. Calls are transferred to Health Link 811 for further assessment, guidance, and connection to care.

Facilitated Access to Specialized Treatment (FAST) model is a new central access and intake program for managing referrals in specialty surgeries.

Healthier Together is a community-based partnership that guides cities/municipalities toward healthier ways of living, working, learning, and healing to give everyone a fair chance for health.

HIV PEP refers to the use of antiretroviral medication taken following a potential exposure to HIV through blood or bodily fluids. The medication provides an opportunity to interrupt the HIV viral life cycle if taken within 72 hours of an exposure thus limiting the possibility of permanent infection.

Honouring Life Program provides funding to Indigenous communities and organizations for the design and implementation of culturally grounded life promotion, suicide prevention, and substance use programs for Indigenous youth. The program offers healing through learning and practicing culture as well as community connections between youth and Elders.

Insite is the internal website/intranet for AHS. It serves as a central hub for AHS employees, physicians, and other medical staff to access information, resources, and tools related to their work.

Learn Improve Together (LIT) is a model that aligns and integrates multiple existing structures and committees into new Program Improvement Networks (PIN) that comprise a singular governance model for quality improvement, research and innovation.

MyAHS Connect is a service offered through Alberta Health's MyHealth Records that allows users to manage appointments, access test results and communicate directly with AHS care teams.

Peer Support Framework includes formalized emotional, social and practical support between colleagues, and is used as a form of short-term support to listen to, empathize with, and refer an individual to other supports or resources.

Program Improvement Networks (PINs) are a collaborative effort that bring various stakeholders together to improve specific aspects of the healthcare system and address complex challenges by leveraging expertise and fostering innovation.

Prostate-Specific Membrane Antigen (PSMA)-1007 Access Clinical Trial will provide Albertans with access to the gold standard in Positron Emission Tomography (PET)/Computed Tomography (CT) imaging for the detection and staging of prostate cancer. The trial aims to scan a total of 4,000 patients at sites in Edmonton and Calgary over the two-year grant period.

Rapid Access Clinics (RACs) is a multidisciplinary surgical triage facility.

Referral, Access, Advice, Placement, Information & Destination (RAAPID) is an AHS call centre that serves as a single point of contact for care providers to facilitate the return of patients to a health care facility closest to their home that best meets their health care needs.

Right Care Alberta is a care philosophy that aims to support patients and care providers to collaboratively choose the best evidence-based care that is appropriate, effective, and sustainable.

Shared Commitments support patient involvement in their care through meaningful and diverse engagement which will improve patient experience.

Violence Aggression Screening Tool (VAST) is a training course that prepares staff who interact with patients/clients and families. The training has tools to screen for potential patient-to-worker violence and aggression, a plan using universal safety precautions, and risk and safety plans.