



2001 Annual Information Form

Health Care is Our Business™

May 15, 2002

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DOCUMENTS INCORPORATED BY REFERENCE

The following documents are incorporated by reference in this Extendicare Inc. 2001 Annual Information Form:

- the Management Information and Proxy Circular of Extendicare Inc. dated March 8, 2002;
- the Management's Discussion and Analysis, found on pages 14 through 26 of the 2001 Annual Report of Extendicare Inc.; and
- the Consolidated Financial Statements and Auditors' Report to the Shareholders of Extendicare Inc., found on pages 27 through 52 of the 2001 Annual Report of Extendicare Inc.

CAUTIONARY NOTICE REGARDING FORWARD-LOOKING STATEMENTS

Information provided by the Company from time to time, including this Annual Information Form and the documents incorporated herein by reference, contain or may contain forward-looking statements concerning the Company's operations, economic performance and financial condition, including the Company's business strategy and forecasts. Forward-looking statements can be identified because they generally contain the words "anticipate", "believe", "estimate", "expect", "objective", "project", or words of like import.

Forward-looking statements reflect management's beliefs and assumptions and are based on information currently available to the Company. They are not guarantees of future performance and involve known and unknown risks, uncertainties and other factors that may cause actual results, performance or achievements of the Company to differ materially from, those expressed or implied in the statements. In addition to the assumptions and other factors referred to specifically in connection with these statements, such factors are identified in the Company's public filings with Canadian and United States securities regulators and include, but are not limited to, the following: changes in the health care industry in general and the long-term care industry in particular because of political and economic influences; changes in regulations governing the industry and the Company's compliance with such regulations; changes in government funding levels for health care services; resident care litigations and other claims against the Company, the Company's ability to attract and retain qualified personnel; the availability and terms of capital to fund the Company's capital expenditures; changes in competition, and demographic changes.

Given the risks and uncertainties, readers are cautioned not to place undue reliance on the Company's forward-looking statements.

INCORPORATION AND REORGANIZATION

In this Annual Information Form, unless the context indicates otherwise, a reference to "Extendicare" or the "Company" means Extendicare Inc. and its subsidiaries. The Extendicare Inc. legal entity is not itself a provider of services or products. Extendicare Inc., which commenced operations in 1968, was continued under the Canada Business Corporations Act by Articles of Continuance that have been amended to change the capital structure and the name of the Company. The registered and principal office of Extendicare Inc. is located at 3000 Steeles Avenue East, Markham, Ontario, Canada L3R 9W2.

CORPORATE OVERVIEW

EXTENDICARE INC.	
EXTENDICARE HEALTH SERVICES, INC.	(100%) (UNITED STATES)
nursing, assisted living and retirement centres; rehabilitative therapy and group purchasing services	
EXTENDICARE (CANADA) INC.	(100%) (CANADA)
nursing and retirement centres; home health care through ParaMed Home Health Care and hospital management	
LAURIER INDEMNITY COMPANY	(100%) (UNITED STATES)
LAURIER INDEMNITY COMPANY, LTD.	(100%) (BERMUDA)
property and casualty insurance for United States health care operations	

SUBSIDIARY COMPANIES

The following is a list of the material direct and indirect subsidiaries of Extendicare Inc.:

<u>Name</u>	<u>Jurisdiction of Incorporation</u>	<u>Percentage of Voting Securities Owned Directly or Indirectly by Extendicare</u>
Extendicare (Canada) Inc.	Canada	100
159524 Canada Inc. (note)	Canada	100
New Orchard Lodge Limited	Canada	100
Extendicare of Indiana, Inc.	Delaware	100
Extendicare Health Facilities Holdings, Inc.	Delaware	100
Extendicare Health Services, Inc.	Delaware	100
Extendicare Homes, Inc.	Delaware	100
Northern Health Facilities, Inc.	Delaware	100
Fir Lane Terrace Convalescent Center, Inc.	Washington	100
Arbors at Toledo, Inc.	Ohio	100
Laurier Indemnity Company	Georgia	100
Laurier Indemnity Company, Ltd.	Bermuda	100

Note: Extendicare Inc., through 159524 Canada Inc., owned a 34.8% common equity interest in Crown Life Insurance Company at December 31, 2001.

BUSINESS OF THE COMPANY

GENERAL

Extendicare Inc., through its subsidiaries, is an operator of long-term care facilities in North America. At December 31, 2001, Extendicare (Canada) Inc. (ECI) and Extendicare Health Services, Inc. (EHSI) operated 217 nursing facilities, with capacity for 24,094 residents. In addition, ECI and EHSI operated 43 assisted living and retirement centres with 2,125 units and managed a hospital unit in Canada with capacity for 120 residents at December 31, 2001. Also offered in the United States are medical specialty services, such as subacute and rehabilitative therapy services, while home health care services are provided in Canada. Of the Company's total revenue, 73.3% is derived from operations in the United States.

The Company's operations in the United States and Canada are organized regionally and are conducted through wholly owned subsidiaries, whose management are experienced and knowledgeable with respect to such country's long-term health care environment.

The following table identifies the number of nursing centres, assisted living and retirement centres, and hospitals operated by ECI and EHSI at December 31, 2001:

	United States		Canada		Total	
	No. of Facilities	Resident Capacity	No. of Facilities	Resident Capacity	No. of Facilities	Resident Capacity
Nursing Centres	157	16,490	60	7,604	217	24,094
Assisted Living and Retirement Centres	41	1,912	2	213	43	2,125
Hospitals/units	-	-	1	120	1	120
TOTAL	198	18,402	63	7,937	261	26,339

INDUSTRY OVERVIEW

United States

Long-term care providers serve one of the fastest growing segments of the population, being the persons 65 years of age and over. In the United States, approximately 12.4% of the 2000 population are aged 65 or older, and the projected annual growth rate for persons over 65 is projected to be 1.8% during the period ending 2020 (2.6% for persons over 85 years of age). In 2000, approximately 2.1 million or 5.9% of all persons aged 65 and over were living in a nursing facility as compared to 5.0% in 1990. That percentage is expected to increase to 8.4% by 2050, when the population aged 65 or older is expected to be 20% of the total population in the United States. The source of this information is from a Health Care Industry Market Update report issued by the Centers for Medicare and Medicaid Services (CMS, formerly Health Care Financing Administration of the Department of Health and Human Services) dated February 2002.

The long-term care and post-acute care industries include nursing facilities, hospital-based facilities, assisted living facilities, intermediate care facilities and home health services. The nursing facility industry comprises the largest part of the long-term care business, with spending of \$92.2 billion in 2000. Approximately 66% of nursing facility beds are owned by for-profit entities, while the remainder are owned by not-for-profit organizations or government agencies. The industry is very fragmented, with no dominant providers; the 10 largest nursing facility companies account for 18.5% of the total facility beds in the sector as reported in CMS reports dated January 2002. Despite the growth in persons aged 65 or older, the number of nursing facilities has declined over the last 14 years from

17,100 in 1986 to 16,944 in 2000, according to CMS. While this has occurred, other segments have experienced rapid growth.

For example, the number of rehabilitation hospitals grew 152% from 1986 to 1998 and the number of hospital-based nursing facilities has increased 108% over the same time period (1,145 to 2,385 facilities).

A variety of assisted living facilities have been built over the past decade offering varying levels of services to the elderly in terms of personal assistance such as 24-hour oversight, housekeeping and meal services. However in 2000 and 2001, 30 of the top assisted living chains reported a 5% decline in capacity; and only recently, according to a report issued in January 2002 by the National Investment Centre for the Senior Housing & Care Industry, has the decline in census stabilized. Given the alternative forms of assisted living facilities or communities, it is difficult to quantify both the growth and current number of assisted living facilities in the United States. A National Academy for State Health Policy – 2001 Report indicated that there are over 32,800 licensed assisted living facilities with over 795,000 units. The largest concentration of assisted living centres (36%) is in the States of California, Florida and Pennsylvania. Since 1998 the number of assisted living facilities has increased 30%, with the majority of the increase in the States of Delaware, Iowa, New Jersey and Wisconsin.

According to the Health Care Industry Market Update report issued in February 2002 by CMS, long-term care spending (defined as nursing facility plus home care expenditures) was estimated at approximately \$94.0 billion in 2000, or approximately 7.1% of total national health expenditures, with nursing facilities accounting for \$92.2 billion of this total. As home health care and subacute care services become more accepted and demographics shift toward an aging population with increased long-term care needs, it is estimated that long-term care expenditures will grow to \$250 billion by the year 2050, representing 7.0% of total national health expenditures.

Canada

In Canada, the population of seniors (persons over 80 years of age) according to Statistics Canada, is expected to increase at a greater rate than the general Canadian population over the period between 2001 and 2026 (an average increase of 3.7% per annum for seniors versus 0.7% for the general population). This result is believed to be due to several factors including the progression of the “baby boom” generation through the demographic cycle and longer life spans. The average age of nursing home residents is in the low to mid-eighties.

Historically in Canada, there has been a restricted supply of new nursing home beds as governments limit new supply in order to maintain the financial health of the industry and to ensure funding costs are kept under control. However, recently there has been a shift to awarding new beds in order to meet the increasing demand for long-term care, particularly in Ontario where, beginning in 1998, 20,000 new beds have been awarded. According to the 2000-2001 Guide to Canadian Healthcare Facilities report, there are 1,917 long-term care centres in Canada representing 148,562 beds. In Ontario and the four Western Provinces, the market where Extencicare operates, there are 1,305 long-term care centres and 104,410 beds.

BUSINESS STRATEGY

Over the past several years, the Company has pursued several key strategies. One strategy has been to concentrate on its core business of owning and operating skilled nursing and assisted living facilities in selected markets in North America. The Company has sold and will continue to sell assets that are non-core, assets that do not provide an adequate rate of return on investment, and assets that are in states that have an unacceptable litigation risk. In pursuing this strategy, the number of beds/units operated by EHSI at December 31, 2001 decreased by 29% from December 31, 1998. The Company plans to grow through a strategy based on its ongoing commitment to provide quality health care services while at the same time, positioning itself to take advantage of the changing health care environment. Through the construction of nursing and assisted living

centres in Ontario, the Company will expand its health care operations in Canada. In the United States, while nursing and assisted living are the core businesses, the Company will also expand through the provision of management services and specialized consulting service contracts with other providers in the industry.

Disposition of Non-core, Under-performing and High Litigation Risk Assets

Extendicare regularly reviews the financial and operational performance and risk level of its facilities. During the past three years, the Company has improved the financial performance of a number of its facilities in the United States, while determining that certain other facilities no longer meet the Company's criteria for financial performance, operational performance or an acceptable level of litigation risk for resident care.

United States

In the United States, EHSI disposed of its home health operation and closed its contracted therapy operation in 1999.

In the State of Florida, EHSI disposed of six nursing homes in 1999 due to the concern of increased general and professional liability claims, and the increased cost or lack of availability of general and professional liability insurance in the State. Throughout 2000, EHSI lobbied through industry associations for legislative changes in the State that would have limited the cost of individual general and professional liability claims, including a cap on punitive damages. However, due to the uncertainty whether such legislative changes would be enacted quickly enough and achieve the required impact, EHSI divested all of its long-term care facilities in the State. During 2000, EHSI was successful in the disposal or leasing of its 32 remaining owned and operated Florida facilities through a series of five separate transactions. During 2000, EHSI also sold its seven outpatient therapy clinics. In 2001, EHSI sold two of the leased facilities in Florida to the lessor, who had an option to purchase the homes.

In October 2001, in order to further reduce its exposure to excessive general and professional liability claims and litigation, EHSI ceased its nursing operations in Texas by leasing four owned facilities and subleasing the remaining 13 facilities to a third-party operator.

Canada

In December 2001, Extendicare (Canada) Inc. (ECI) sold its investment in Accident Injury Management Clinics Inc. (AIM), a rehabilitation therapy business operating in Ontario.

United Kingdom

In December 1999, the Company sold its operations in the United Kingdom, consisting of 14 nursing centres and one hospital.

Cash Flow Management and Debt Reduction

Proceeds from divestitures of United States assets have been used to pay down EHSI's debt in addition to the required principal repayments pursuant to the Syndicated Bank Credit Facility Agreement. Since the acquisition of Arbor Health Care Company (Arbor) in 1997, EHSI has reduced its term bank debt by US\$328.0 million and debt-to-equity coverage from 2.5 to 1 to 2.4 to 1.

EHSI instituted a number of targets for the reduction of accounts receivable and improvement of days sales outstanding of accounts receivable. The majority of these targets were achieved in 2001 with a reduction of both same-facility accounts receivable and overall reduction of days sales outstanding from 48 to 41 days. New targets were established for 2002.

Ownership of Assets

Unlike a number of other long-term care providers, the Company owns rather than leases a majority of its properties. Extencicare believes ownership of such properties increases its flexibility in utilizing facilities, refurbishing facilities to meet changing consumer demands, constructing additions for ancillary services such as for rehabilitative therapy and adding assisted living and retirement facilities adjacent to its nursing facilities. In addition, ownership of facilities enables the Company to control costs without escalating lease payments.

The following table depicts the ownership of facilities operated by ECI and EHSI at December 31, 2001:

	<u>United States</u>		<u>Canada</u>		<u>Total</u>	
	<u>No. of Facilities</u>	<u>Resident Capacity</u>	<u>No. of Facilities</u>	<u>Resident Capacity</u>	<u>No. of Facilities</u>	<u>Resident Capacity</u>
Owned	157	13,973	51	6,827	208	20,800
Leased ⁽¹⁾⁽²⁾	18	1,947	2	129	20	2,076
Managed	23	2,482	10	981	33	3,463
TOTAL	198	18,402	63	7,937	261	26,339

(1) In the United States, except those referred to in note (2) below, the average remaining life of the leases, including renewal options exercisable solely by the Company, ranges from eight months to seven years, the average being three years. EHSI retains an option to purchase the leased property for 12 of the 18 properties.

(2) As of December 31, 2001, seven leased facilities in the States of Ohio and Indiana are on a month-to-month lease arrangement. EHSI has exercised its right to purchase the properties as of September 30, 2000 but negotiations with the landlord to complete the transaction have not resolved all issues and may require arbitration to conclude the matter. EHSI believes it has complied with all the terms of the option and believes the outstanding issues can be resolved.

Long-term Strategy

Extencicare's internal priorities in 2002 will emphasize improving the profitability of its U.S. operations while improving care outcomes across the Company. Externally, Extencicare will strive to raise public understanding of long-term care regulation and funding issues. Inevitably, both government and private funding will increase to reflect the need for supported living for the elderly.

United States

Moving forward into 2002, EHSI will continue with many of the same action plans as previously outlined. All non-core business operations have been disposed of, however a review of assets held under lease arrangements and other under-performing assets will continue. While EHSI's exposure to litigation claims have been significantly reduced by exiting the States of Florida and Texas, the Company will continue to monitor claims trends in specific facilities and states and manage the settlement of existing claims. Although in the short term, opportunities for growth will be limited to new management contracts and consulting arrangements, EHSI plans to grow through a strategy based on its ongoing commitment to the provision of quality health care services while positioning itself to take advantage of the changing health care environment. EHSI will seek out opportunities for management services and consulting contracts with other providers in the industry.

EHSI geographically clusters its long-term care facilities and services in order to offer its customers a broad range of long-term care and related health services, and to improve operating efficiencies. Therefore, future expansion of its owned nursing facility operations is anticipated to be through the selective acquisition and construction of nursing facilities in areas that are in close proximity to its existing facilities, where: (i) management is already in place and has expertise relating to the regulatory and reimbursement environments; (ii) it can participate as an active member of the nursing facility association in the state; and (iii) its reputation is established. In establishing new state or regional clusters, EHSI considers local demographic, regulatory and reimbursement environments of a particular state or region. As a result of Certificate of Need (CON) licensing restrictions, growth of nursing facilities, if any, is expected to be primarily through acquisition.

EHSI's long-term plans also involve the active development and acquisition of assisted living and retirement facilities. Due to the rapidly increasing segment of the U.S. population seeking assisted living and retirement housing accommodations, EHSI expects strong demand for these services in the future. EHSI generally locates its assisted living and retirement facilities adjacent or in close proximity to its nursing facilities, enabling EHSI to utilize existing land, personnel, management and marketing systems, as well as to take advantage of its established reputation. Assisted living facilities allow EHSI to serve its communities better by providing a continuum of service and care that meets a wider variety of needs. In addition, assisted living and retirement facilities generate revenues with a significantly higher private pay component than revenues from nursing facilities.

EHSI intends to maintain its geographic focus on smaller urban communities. EHSI believes that it has established a reputation as a community-oriented long-term care provider and has developed experience in serving and marketing to smaller urban communities. EHSI also believes that operating in such communities results in a more stable workforce.

Canada

In Canada, the Company's strategy is to expand the long-term care operations. In 1998, ECI was chosen by the Government of Ontario to build and operate 1,201 nursing home beds in communities across the Province. The award to ECI, in some cases with partners, was part of the first expansion of long-term care beds in Ontario in over a decade and represented the initial phase (tendering for 6,000 new beds) of a Government program to add 20,000 new nursing home beds in the Province.

ECI will own 905 of these new beds (eight facilities) and operate a further 296 beds (two facilities) awarded to hospitals. ECI's eight new facilities will have capacity of 1,101 residents, comprised of: the 905 new beds awarded; 120 beds to be transferred from existing facilities; and the incorporation of a 38-unit assisted living wing in two of the new facilities.

Construction of six ECI-owned facilities commenced in 2000 and four of the new facilities were completed and opened in 2001, while a fifth was completed and opened in January 2002 (total capacity 609 beds). In March 2001, one of the six facilities under construction was destroyed by fire. The loss from the fire was insured and ECI commenced reconstruction of this facility with plans to open the 160-bed facility in May 2002. The remaining two facilities (capacity 332 beds) will be opened in 2002 and 2003.

One of the facilities (200 beds) that ECI developed in partnership with a hospital was operational in January 2002. ECI intends to start construction in 2002 on another 130-bed facility, pending governmental approval of an arrangement which would combine 96 new long-term beds awarded to a partner with 34 of ECI's existing long-term care beds currently located in leased hospital space.

On May 12, 2000, the Ontario government announced the successful bidders for the second phase of the program to construct new long-term care beds. ECI, in partnership with a hospital, was selected to build one 128-bed long-term care facility. Extendicare is responsible for the development and construction of the new facility and will operate the hospital's beds under a long-term management agreement. This facility is scheduled to be operational in 2003.

In May 2001, the Ontario government announced the awards under the third and final phase of its new bed program. Based upon these awards, ECI is in the process of finalizing plans for the development and financing of two facilities (256 bed capacity) for completion after 2002. For another 199 new beds awarded with partners, ECI will develop and manage a 128-bed facility that is scheduled for completion after 2003 and the remaining 71 beds will be added to facilities that ECI already manages.

ECI had one of the highest success rates in winning awards to own or manage new nursing home beds under the multi-year Ontario government program. Upon full completion of the projects by the end of 2004 and including awards with partners, these projects represent a 38% increase in the current nursing, assisted living and retirement residents served by ECI in Ontario.

In Canada, the Company is focusing on a wide range of health care partnership opportunities, involving public, private and not-for-profit organizations, as well as management and consulting contracts. At December 31, 2001, ECI managed six public sector facilities and four facilities for private owners. ECI has entered into partnerships with hospitals in Ontario and the Company is the largest private health care organization with partnerships involving the public hospital sector.

OPERATIONS

United States

Extendicare's United States health care operations are conducted through EHSI and its subsidiaries. EHSI is one of the ten largest operators of long-term care facilities in the United States in terms of both number of beds and revenues. Through its geographically clustered facilities, EHSI offers a continuum of health care services, including skilled nursing care, assisted living care and related medical specialty services, including subacute care and rehabilitative therapy.

Nursing Care

Nursing facilities provide a broad range of long-term nursing care, including skilled nursing services, subacute care and rehabilitative therapy services to assist patients in the recovery from acute illness or injury. The nursing care and therapy services are provided to persons who do not require the more extensive and specialized services of a hospital. The nursing facilities employ registered nurses, licensed practical nurses, therapists, certified nursing assistants and qualified health care aides who provide care as prescribed by each resident's attending physician. All nursing facilities provide daily dietary services, social services and recreational activities, as well as basic services such as housekeeping and laundry. As of December 31, 2001, EHSI operated for itself 139 nursing facilities (14,164 beds).

Assisted Living and Retirement Centres

In its assisted living facilities, EHSI provides residential accommodations, activities, meals, security, housekeeping, and assistance in the activities of daily living to seniors who require some help, but not the level of nursing care provided in a nursing facility. EHSI's retirement communities provide activities, security, transportation, special amenities, comfortable apartments, housekeeping services and meals. An assisted living facility enhances the value of an existing nursing facility in those situations where the two facilities operate side by side and allows EHSI to better serve the communities in which it operates by providing a broader continuum of services. All of EHSI's assisted living facilities are within close proximity to its nursing facilities. As of December 31, 2001, EHSI operated for itself 36 assisted living and retirement facilities with resident capacity of 1,756 units.

Management and Selected Consulting Services

EHSI applies its operating expertise and knowledge in long-term care for other organizations by providing either full management services through Partners Health Group, LLC, or selected consulting services through Fiscal Services Group, LLC, two wholly owned subsidiaries of EHSI. In addition Virtual Care Provider, Inc. (VCP), a wholly owned subsidiary of Extencicare, provides information technology support in conjunction with EHSI's management and consulting services. Such services are available due to the experienced professionals employed by EHSI who have considerable knowledge and expertise in both the operational and administration aspects of the long-term care industry. On a regional level, EHSI can offer consultants in the areas of nursing, dietary, laundry and housekeeping to long-term care operators under a consulting or full management services basis. Equally, through its head office support group, EHSI can provide professionals to assist operators in the areas of cost reimbursement and accounting services. EHSI provided management services to 18 nursing facilities (2,326 beds) and five assisted living facilities (156 units) and provided selected consulting services to 35 nursing facilities (3,269 beds) as of December 31, 2001. VCP, in its first year of operation, had contracts to service approximately 300 facilities in 2001.

Group Purchasing

UHF Purchasing Group provides purchasing services for over 2,570 nursing facilities in 44 states, in addition to the facilities owned and managed by EHSI. In addition, UHF Purchasing Group administers two separate food purchasing programs for two major long-term care groups that operate over 360 long-term care facilities. The purchasing group offers substantial cost reductions for its members through the contractual volume-based arrangements made with a variety of industry suppliers for food, supplies and capital equipment.

Rehabilitative Therapy Services

EHSI provides rehabilitative therapy services on an inpatient and outpatient basis. The United States health care system is applying pressure on acute and managed care providers to discharge patients more rapidly to less intensive and low-cost care environments. The strong interdisciplinary approach to patient services, in conjunction with the support services that the patient and family receive, are important in optimizing clinical outcomes and level of satisfaction. All of EHSI's nursing facilities have therapy units, some offering 1,500 to 5,000 square feet of therapy space, and developed therapy programs to provide patient-centred outcome-oriented subacute and rehabilitative care. At the majority of EHSI's facilities, rehabilitative therapy services are provided by employed physical, occupational and/or speech-language therapists providing services to both inpatient and outpatient clients requiring physical, occupational, or speech-language therapy.

EHSI also has freestanding rehabilitative therapy clinics that collectively operate within the Company's wholly owned subsidiary, The Progressive Step Corporation. As of December 31, 2001, EHSI operated 20 clinics in the States of Pennsylvania (8), Ohio (1), Texas (1), and Wisconsin (10). These clinics provide services to outpatients requiring physical, occupational and/or speech-language therapy. In addition, the Pennsylvania clinics provide respiratory and psychological and social services. EHSI also provides facial paralysis services in Chicago Illinois, through a third-party supplier. During 2001, the Company opened one clinic and closed one clinic.

Other

Under the former UPC Health Network division, EHSI operated an institutional pharmacy services business, providing pharmacy supplies and services to both EHSI's and other non-affiliated residents, and operated a home health and contracted therapy operation. In September 1998, EHSI sold its institutional pharmacy operations to Omnicare, Inc. and subsequently entered into a preferred provider agreement with Omnicare, Inc. to provide EHSI with quality and cost-efficient pharmacy services. In November 1999, EHSI sold its home health operation to Walgreens Advanced Care, Inc. and closed the contracted therapy operation.

Canada

Extendicare's Canadian health care operations are conducted through ECI and its subsidiaries. ECI is the second largest private-sector operator of long-term care facilities and the largest private sector provider of home health care services in Canada. It operates nursing and retirement centres in five provinces, manages a hospital unit and provides a wide range of related services to the residents of these facilities.

Nursing and Retirement Care Services

Nursing centres provide long-term care, including skilled nursing care, to persons who are no longer able to live independently. Retirement centres provide accommodation, meals and social activities. At December 31, 2001, ECI operated for itself 52 nursing centres and one retirement centre, providing care to 6,956 residents in five provinces. All of ECI's 50 owned nursing centres (6,716 beds) qualify for the accreditation funding, with the exception of the four new facilities. ECI is in the process of seeking accreditation for its newly opened facilities.

Management and Consulting

In Canada, Extendicare manages long-term care centres and a hospital for not-for-profit boards and private organizations seeking to improve management practices, levels of care and operating efficiencies. Most of these contracts include management, accounting and purchasing services, staff training, reimbursement assistance, and where applicable, the implementation of ECI policies and procedures. ECI also is experienced in overseeing the design, construction, development and management of long-term care and chronic care centres. At December 31, 2001, ECI managed one publicly owned hospital unit (120 beds), two municipally owned homes for the aged (181 beds), two interim long-term care units and a nursing facility owned by hospitals (221 beds). ECI also managed three nursing centres (357 beds) and one retirement centre (102 units), which are privately owned. In January 2002, ECI commenced a contract to manage a 200-bed long-term care centre owned by a public hospital. ECI believes there will be more opportunities to provide facility management and consulting services to the public sector.

Home Health Care Services

Through ParaMed Home Health Care (ParaMed), ECI is the largest private-sector home health care company in Canada and provided 6.9 million hours of care and support services during 2001 to clients of all ages through 34 branch offices located in Alberta, British Columbia and Ontario. ParaMed's professional and para-professional staff are skilled in providing complex nursing care, occupational, physical and speech therapy, and home support.

In Ontario, where ParaMed generates over 80% of its business, the Request for Proposal (RFP) process put in place in 1997 for all government-funded service volumes has put pressure on home health care providers. Pricing adjustments have been required in order to compete effectively, while maintaining quality of service. ParaMed has operated successfully under this system and its hours of service have increased by 24% in Ontario since 1997. ParaMed will continue to focus on responding to the competitive RFP process. A shortage of registered nurses across Canada, which is expected to continue for a number of years, has made competitive pricing difficult in light of the need to compete for available nurses. In addition, due to budget constraints of the Ontario government agencies, there has been a reduction in total home care service hours purchased by these agencies during the latter half of 2001 that has continued into 2002. On an annualized basis, this represents a 25% reduction of hours to ParaMed and management anticipates home care hours will stabilize and return to their previous levels when the agencies' budget constraints subside.

Group Purchasing Services

Through its LTC Group Purchasing division (LTC), ECI offers cost-effective purchasing contracts in the areas of food, capital equipment, furnishings, cleaning and nursing supplies, and office products. LTC clients also receive cycle menus, including therapeutic modifications as well as monthly educational packages. Including the Company's Canadian facilities, LTC provides purchasing services to facilities housing more than 24,000 residents in Canada.

Rehabilitative Therapy Services

In December 2001, ECI sold its 88% investment in AIM, the rehabilitation therapy service business.

QUALITY OF CARE

The focus of Extencicare's commitment to excellence emphasizes the corporate philosophy of treating residents with dignity and respect, a philosophy that is implemented and monitored through rigorous standards that management and staff at all levels periodically assess and update.

In the United States, at a regional level, the area directors of care management lead a department that is responsible primarily for implementing care and service standards, policies and procedures, auditing care and service delivery systems, and providing direction and training for all levels of the staff within the nursing facilities and assisted living facilities. The area directors of care management are responsible for developing programs and standards for all professional disciplines and services provided to users of EHSI's services, including nursing, dietary, social services, activities, ethical practices, mental health services, behaviour management, quality validation and continuous quality improvement.

In Canada, each nursing centre has an advisory board composed of family members of residents. These boards work with administrators to develop ideas on how to provide for the needs of residents. Regionally, similar to the operations in the United States, the regional directors are responsible primarily for implementing care and service standards, policies and procedures, auditing care and service delivery systems, and providing direction and training for all levels of the staff within the nursing facilities and assisted living facilities. Continuous Quality Improvement programs ensure quality of care and services are adhered to in all aspects of resident care.

Training of employees at all levels is an integral part of the Company's ongoing efforts to improve and maintain its quality. In the United States, each new nursing facility administrator and assisted living facility manager or director of nursing is required to attend a week of company-provided training to ensure that he or she has an understanding of all aspects of nursing facility operations, including clinical, management and business operations. EHSI conducts additional training for these individuals and all other staff on a regional or local basis. In Canada, each new facility administrator participates in an extensive orientation program covering nursing centre management.

MARKETING

United States

Most of EHSI's long-term care facilities are located in smaller communities. EHSI focuses its marketing efforts predominantly at the local level, believing that the selection of a long-term care facility is strongly influenced by word-of-mouth and referrals from physicians, hospital discharge planners, community leaders, neighbours and family members. The administrator of each long-term care facility is therefore, a key element of EHSI's marketing strategy. Each administrator is responsible for developing relationships with potential referral sources. Administrators are supported through a regional team of marketing personnel, who establish the overall marketing strategy, develop relationships with health maintenance organizations (HMO), preferred provider organizations (PPO), and provide marketing direction with training and community-specific promotional materials. EHSI aims to be the provider of choice in the communities it serves. EHSI's average occupancy for 2001 was 88%, which compares favourably to the average occupancy in the industry of 81% (based upon a Health Care Industry Market Update report issued in February 2002 by CMS).

Canada

In Ontario, new facilities are being constructed under the Government's 1998 program to add 20,000 nursing beds in communities throughout the Province. In order to maintain its current occupancy levels once these new beds are operational, ECI has major upgrade plans for some of its facilities that are located in markets where new facilities will open. This is in addition to regular maintenance programs of all ECI owned facilities. Also, the Company is developing strategies to market its long-term care facilities in each community. The management team at each facility is responsible for marketing the facility locally and is supported by a regional team. Occupancy remained strong in ECI's Canadian facilities and at the end of 2001 was 98%, unchanged from the previous year-end.

MANAGEMENT, FINANCIAL CONTROLS AND COST CONTROLS

Extencare believes that strong management is essential to its success. The members of its Board of Directors have served Extencare on average more than 14 years, while its senior officers, including the senior officers of ECI and EHSI, have on average 22 years of experience in the health care industry and 14 years of service with the Company.

The financial controls of Extencare are centralized by country, in Milwaukee, Wisconsin in the United States and Markham, Ontario in Canada. Within each country, supervision is provided through regional offices.

Centralized accounting systems record each nursing centre's results. Costs are shown on a per patient day basis, along with comparisons to budgets. Senior operating and financial management monitor costs on a monthly basis.

INSURANCE

The Company self-insures certain risks related to general and professional liability, auto liability, employers' liability, health benefits and workers' compensation in certain states for its United States operations. The Company self-insures workers' compensation insurance in the State of Ohio and in lieu of workers' compensation coverage in the State of Texas the Company has an employee benefit plan which provides comparable employer-paid benefits. The Company has purchased workers' compensation insurance through a third-party insurance carrier for the remaining states in which it operates.

Of the risks that the Company self-insures, general and professional liability claims are the most volatile and significant. The Company self-insures its general and professional liability risks through Laurier Indemnity Company, Ltd., which is domiciled in Bermuda, and Laurier Indemnity Company, which is domiciled in the United States. The Company has experienced adverse claims development. Consequently, as of January 1, 2000 the Company's per claim retained risk increased significantly for resident care liability costs, mainly due to the level of risks associated with the Florida and Texas operations. In 2001, EHSI no longer operated nursing and assisted living facilities in the State of Florida and as of October 1, 2001 ceased nursing operations in the State of Texas, thereby reducing the level of exposure to future litigation in these litigious states. However, as a result of an increase in the frequency and severity of claims, the Company recorded a provision to increase its accrual for resident care liability costs in the third quarter of 2001. This additional accrual was based upon an independent actuarial review and was largely attributable to potential claims for Florida and Texas. Changes in the Company's level of retained risk, and other significant assumptions that underlie management's estimates of self-insured liabilities, could have a material effect on the future carrying value of the self-insured liabilities as well as the Company's operating results and liquidity.

The accrual for self-insured liabilities includes estimates of the cost of reported claims and claims incurred but not reported and reflected estimates of loss based on assumptions made by management, including consideration of actuarial projections.

The Company believes that it has sufficient cash resources to meet its estimated current claims payment obligations.

SOURCES OF REVENUE

United States

EHSI derives its revenue from Medicare, Medicaid, and private pay sources. During 2001, EHSI derived approximately 24% (2000 – 24%; 1999 – 22%), 51% (2000 – 51%; 1999 – 50%), and 25% (2000 – 25%; 1999 – 28%) of its revenue from these sources, respectively.

Funds received by EHSI under Medicare and Medicaid are subject to audit with respect to proper application of various payment formulas. Such audits can result in retroactive adjustments to revenue. EHSI believes that the payment formulas applicable to it have been properly applied.

Private Pay

EHSI classifies payments from individuals who pay directly for services without governmental assistance as private pay revenue. The private pay classification also includes revenues from commercial insurers, HMOs, PPOs, and other charge-based payment sources as well as revenue from Medicare Risk HMO plans. Blue Cross and Veteran's Administration payments are included in private pay and are made pursuant to renewable contracts with these payors.

Medicare

Medicare is a health insurance program funded and administered by the federal government primarily for individuals entitled to Social Security who are age 65 or older. A nursing home that is certified by the Medicare program to provide care to Medicare patients is referred to as a skilled nursing facility (SNF) and an operator may designate a specific number of beds within the nursing home as SNF beds. All but two of EHSI's nursing facilities are Medicare-certified. As of December 31, 2001, EHSI had 12,177 Medicare-certified beds. Medicare covers the first 20 days of stay in a SNF in full, and the next 80 days above a daily coinsurance amount, after the individual has qualified by a three-day hospital stay. The Medicare program consists of two parts, Medicare Part A and Medicare Part B. Medicare Part A covers inpatient services for hospitals, nursing facilities, and certain other health care providers, and patients requiring daily professional skilled nursing and other rehabilitative care. Medicare Part B covers services for suppliers of certain medical items, outpatient services, and doctors' services.

During 2001, EHSI received Medicare Part A and Part B payments through two Medicare payment models, which are the Medicare Prospective Payment System (PPS), subject to the phase-in provisions from the previous cost-based reimbursement model, and the Medicare Risk HMO model.

The Balanced Budget Act (BBA), signed into law on August 5, 1997, made numerous changes to the Medicare program through the implementation of the PPS system, which established PPS rates for all skilled nursing facilities and their services. Under PPS, SNFs are reimbursed for Medicare Part A services based on federally established per diem rates as defined by 44 Resource Utilization Groups III (RUGs), which correspond to the acuity level of each patient under the PPS patient-classification system. The patient's RUGs classification dictates the amount that the SNF will receive to care for the patient on a daily basis. The BBA became effective for cost report periods commencing July 1, 1998 and thereafter. The PPS system replaced a former cost-based model, whereby SNFs received interim payments for each facility's expected reimbursable costs, which could be subject to adjustment based upon the submission of a year-end cost report and certain cost limits. For the majority of EHSI's facilities, PPS became effective as of January 1, 1999 and on January 1, 2002 the final stage of the four-year phase down in Medicare rates occurred.

Through the Medicare Risk HMO model, EHSI provides services to Medicare Risk HMO enrollees at a predetermined, negotiated rate. EHSI contracts directly with the HMO participating in the program to provide services to its enrollees. The HMO solicits its enrollees from the general Medicare-eligible beneficiary population. The Medicare beneficiary forfeits his/her traditional Medicare benefits to participate in the Medicare Risk HMO plan.

As a result of the industry coming under financial pressure due to the implementation of PPS and other BBA of 1997 provisions, Congress passed two acts to provide some relief to the industry, namely the Balanced Budget Refinement Act (BBRA) of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000. These laws contained additional funding provisions to assist providers as they adjusted to PPS for an interim period.

The incremental Medicare relief packages received from BBRA and BIPA provided a total US\$2.7 billion in temporary Medicare funding enhancements to the long-term care industry. These funding enhancements fall into two categories. The first category is “Legislative Add-ons”, which included the 16.66% add-on to the nursing component of the RUGs rate and the 4% base adjustment. The Legislative Add-ons are scheduled to sunset on September 30, 2002. Currently, no legislation has been introduced by Congress, nor have recommendations been made by CMS to continue this funding. The second category is “RUGs Refinements” which involved an initial 20% add-on for 15 RUGs categories identified as having high intensity, non-therapy ancillary services (the 20% add-ons from 3 RUGs categories were later redistributed to 14 Rehab categories at 6.7%). The RUGs Refinements continue until such time as CMS refines the RUGs categories. On April 23, 2002, CMS announced its intention to delay the implementation of a RUGs refinement, thereby extending the related add-ons for at least one additional year.

EHSI has estimated the average per diem effect of the Legislative Add-ons to be US\$32.00 and RUGs Refinements to be US\$25.00, based on current rates and acuity mix. The amount of incremental Medicare funding related to the Legislative Add-ons and CMS RUGs Refinements is estimated to be US\$19.0 million and US\$15.0 million, respectively, based on current volumes. A decision to discontinue all or part of the enhancement could have a significant impact on the EHSI.

Medicaid

Medicaid is a state-administered program financed by state funds and matching federal funds. The program provides for medical assistance to the indigent and certain other eligible persons. Medicaid reimbursement formulas are established by each state with the approval of the federal government in accordance with federal guidelines. All of the states in which EHSI operates currently use cost-based reimbursement systems, which generally may be categorized as prospective or retrospective in nature. Under a prospective system, per diem rates are established based upon the historical cost of providing services during a prior year, adjusted to reflect factors such as inflation and any additional services that are required to be performed. Many of the prospective payment systems under which EHSI operates contain an acuity measurement system, which adjusts rates based on the care needs of the patient. Retrospective systems operate similarly to the pre-PPS Medicare program where nursing facilities are paid on an interim basis for services provided, subject to adjustments based on allowable costs, which are generally submitted on an annual basis. Additional payment to a nursing facility by the state or repayment from a nursing facility to the state can result from the submission of cost reports and their ultimate settlement. The majority of the states in which EHSI operates nursing facilities use prospective systems.

With respect to the Medicaid program, the BBA repealed the federal payment standard, which required state Medicaid programs to pay rates that were reasonable and adequate to meet the costs necessary to efficiently and economically operate skilled nursing facilities. As a result, states have considerable flexibility in establishing payment rates for Medicaid services provided after October 1, 1997.

Assisted Living Facilities

Assisted living facility revenue is primarily derived from private pay residents at rates established by EHSI based upon the services provided and market conditions in the area of operation. Approximately 38 states provided or had approval to provide Medicaid reimbursement for services in assisted living facilities covering board and care. An additional six states plan to add Medicaid coverage of services in the near future.

Canada

In Canada, the fees charged by ECI for its nursing centres are regulated by provincial authorities, which often set the rates following consultation with the applicable province's long-term care association. A substantial portion of these fees is funded by provincial programs, with the remainder coming from individuals. In some provinces, the government has delegated authority with respect to funding to regional health authorities, as is the case in Alberta, Saskatchewan, Manitoba and British Columbia.

In Ontario, from where approximately 63% of ECI's Canadian nursing and retirement centre revenue is derived, funding for nursing centres is based upon a system which reimburses for the level of care provided. The system is based upon allocated funds, or "envelopes", by which the provincial government sets rates for services such as nursing, program services, food and accommodation. The cost of providing nursing, program services and food is reimbursed in accordance with scheduled rates. Any deviation from scheduled rates is either at ECI's expense (if actual costs exceed those scheduled) or is returned to the government (if actual costs are below those scheduled). ECI receives a fixed amount per resident day for accommodation and may retain any excess between such amount and actual cost. Supplemental funds are available if the nursing centre is accredited by the Canadian Council on Health Services Accreditation. All of ECI's existing owned nursing centres qualify for the accreditation funding, with the exception of the new facilities. ECI is in the process of seeking accreditation of its new nursing centres.

In 1998, the Ontario Ministry of Health introduced a new funding policy to support the costs of the construction of new beds and the renovation of existing long-term care facilities by 2006. Under the new policy, the Government will fund up to \$75,000 per bed, or \$10.35 per bed per day, over a 20-year period, based on a per bed formula. The funding policy coincided with the introduction of new long-term care facility design standards upon which new compliance premiums had been announced. The policy ranks existing facilities into four categories (based on their design standards) for which they may qualify for compliance funding of up to \$5.00 per bed per day. At December 31, 2001, all but two of ECI's existing Ontario nursing centres were receiving compliance funding at the \$1.00 per bed per day level. The newly opened nursing centres are receiving \$10.35 per bed per day funding.

The Ontario Ministry has recently announced changes to the renovation program to provide for more flexibility under which existing facilities could be completely rebuilt or upgraded in order to qualify for funding. The revised program now has three options that allow for such items as: alternative site scenarios; transitional support through renovation; design flexibility; and possible new bed allocations. A provider may be eligible for different funding levels under these options as follows: the existing redevelopment option (rebuilding or major renovation to 1998 standards) for funding of up to \$10.35 per bed per day over a 20-year period; the new retrofit option for between \$7.00 and \$10.35 per bed per day for a 20-year period; and the new upgrade option for up to \$1.00 per bed per day. ECI is investigating plans to retrofit one facility and upgrade the other in order to meet the Government's current design standards necessary for qualification for enhanced capital funding under these options.

Provincial funding for ECI's nursing centres in Alberta, the next highest revenue source province for ECI, is based on a funding system similar to that in Ontario. Of the three other Western Provinces in which ECI operates, Manitoba and British Columbia set funding on a per patient day basis with annual adjustments and Saskatchewan funds on a monthly rate per resident basis.

Extendicare's Canadian home health care operations, conducted through ParaMed, received 10% of its revenue from private-pay clients in 2001. The remainder of the revenue from home health care operations is derived from tendered contracts with locally administered provincial agencies.

PROPERTIES

The following table lists by state, province and country the nursing centres, assisted living and retirement centres, and hospitals owned, leased and managed by ECI and EHSI at December 31, 2001:

Regions	Nursing Centres		Assisted Living & Retirement Centres		Hospitals/Units		Total	
	No. of Facilities	Resident Capacity	No. of Facilities	Resident Capacity	No. of Facilities	Resident Capacity	No. of Facilities	Resident Capacity
Pennsylvania	27	3,145	8	298	–	–	35	3,443
Massachusetts	5	606	–	–	–	–	5	606
Delaware	1	120	–	–	–	–	1	120
Ohio	30	3,194	3	165	–	–	33	3,359
West Virginia	1	120	–	–	–	–	1	120
Wisconsin	24	2,203	10	443	–	–	34	2,646
Minnesota	10	1,250	1	60	–	–	11	1,310
Indiana	17	1,827	3	133	–	–	20	1,960
Kentucky	18	1,511	1	39	–	–	19	1,550
Washington	15	1,479	8	381	–	–	23	1,860
Oregon	3	194	2	102	–	–	5	296
Idaho	2	178	–	–	–	–	2	178
Louisiana	3	567	–	–	–	–	3	567
Arkansas	1	96	3	181	–	–	4	277
Texas	–	–	2	110	–	–	2	110
Total United States	157	16,490	41	1,912	–	–	198	18,402
Ontario	37	5,188	2	213	1	120	40	5,521
Alberta	15	1,229	–	–	–	–	15	1,229
Saskatchewan	5	654	–	–	–	–	5	654
Manitoba	2	458	–	–	–	–	2	458
British Columbia	1	75	–	–	–	–	1	75
Total Canada	60	7,604	2	213	1	120	63	7,937
TOTAL	217	24,094	43	2,125	1	120	261	26,339

In addition, EHSI operated 20 rehabilitative clinics as follows: Wisconsin – 10; Pennsylvania – 8, Texas – 1; and Ohio – 1.

ParaMed provided its services through 34 locations, substantially all of which were leased, as follows: Ontario – 27; British Columbia – 5; and Alberta – 2.

COMPETITION

United States

The long-term care industry in the United States is highly competitive with companies offering a variety of similar services. EHSI faces competition both locally and regionally from other health care providers, including for-profit and not-for-profit organizations, hospital-based nursing units, rehabilitation hospitals, home health agencies, medical supplies and services agencies and rehabilitative therapy providers. Significant competitive factors affecting the placement of residents in nursing and assisted living centres in the United States include quality of care, services offered, reputation, physical appearance, location and, in the case of private-pay residents, cost of the services. EHSI focuses on word-of-mouth reputation and referrals from each community's medical and health care professionals. There can be no assurance that the Company will not encounter increased competition, which could adversely affect its business, results of operations or financial condition.

Assisted living facilities can be constructed in certain states without any CON being approved by the state. The newer-built assisted living facilities can attract an element of the former private pay nursing facility admissions, which require a lesser degree of care. Since there is little price competition with respect to Medicaid and Medicare residents, a facility's competitive position in the marketplace is attributable to its reputation for quality of services and staff, the range of services offered and location.

EHSI's group purchasing operation competes with other similar operations ranging from small local operators to companies that are national in scope and distribution capability.

EHSI competes with other providers in the acquisition and development of additional facilities. Other competitors may accept a lower rate of return and therefore, present significant price competition. Also, tax-exempt not-for-profit organizations may finance acquisitions and capital expenditures on a tax-exempt basis or receive charitable contributions that are unavailable to EHSI.

Canada

ECI's competitors in the long-term care industry include proprietary and non-proprietary operators. In addition to Extencare, there is only one other publicly traded operator in Canada. In home care, the sector has both for-profit and not-for-profit providers, with ParaMed being the largest private-sector operator.

GOVERNMENT REGULATIONS

United States

The provision of institutional care through nursing facilities is subject to regulation by various federal, state and local government authorities in the United States. There can be no assurance that such authorities will not impose additional restrictions on the Company's activities that might adversely affect the Company's business.

General Regulatory Requirements

Nursing facilities, assisted living facilities, and other health care businesses are subject to annual licensure and other regulatory requirements of state and local authorities. In addition, in order for a nursing facility to be approved for payment under the Medicare and Medicaid reimbursement programs, it must meet the participation requirements of the Social Security Act and the regulations thereunder. The regulatory requirements for nursing facility licensure and participation in Medicare and Medicaid generally prescribe standards relating to provision of services, resident rights, physical environment and administration. Nursing and assisted living facilities generally are subject to unannounced annual inspections by state or local

authorities for purposes of re-licensure and nursing facilities for purposes of re-certification under Medicare and Medicaid.

Environmental Laws and Regulations

Certain federal and state laws govern the handling and disposal of medical, infectious and hazardous waste. Failure to comply with those laws or the regulations promulgated thereunder could subject an entity covered by these laws to fines, criminal penalties and other enforcement actions. EHSI has developed policies with respect to the handling and disposal of medical, infectious and hazardous waste to assure compliance by each of its facilities with those laws and regulations. EHSI incurs on-going operational costs and capital expenditures to remain in compliance with those laws and regulations, however, the capital expenditures to remain in compliance have not been material to EHSI. EHSI believes that it is in substantial compliance with applicable laws and regulations governing these requirements.

Federal regulations promulgated by the Occupational Safety and Health Administration impose additional requirements on EHSI with regard to protecting employees from exposure to blood borne pathogens. EHSI believes that it has policies and procedures in place to preclude valid, material actions by this regulatory body.

Health Insurance Portability and Accountability Act (HIPAA)

In the United States, the Administrative Simplification provisions of HIPAA mandate the promulgation of a set of interlocking regulations that will establish the uniform coding conventions and record formats across all payor types for all electronic transactions central to the processing of all health care claims and health plan enrollments. When implemented in October 2003, the provisions will profoundly change the handling and processing of information and, ultimately, the relationship between patients and their health care providers and insurers. And under the second regulation in the Administrative Simplification package, the implementation of Privacy Standards will be in effect on April 14, 2003 and will require operational changes throughout the health care industry in the United States regarding the handling of all patient information within health care organizations. EHSI has established a HIPAA Work Task force to review and implement the standards required by the legislation and is currently on schedule to comply with the requirements.

Nursing Facility Regulation

The Omnibus Budget Reconciliation Act was passed in 1987 by the United States Congress and included extensive revisions to the Medicare and Medicaid statutory requirement for nursing facilities. These provisions prescribe an outcome-oriented approach to the provision of services and require that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the resident's individualized assessment and plan of care. The rules also established requirements for survey, certification and enforcement procedures.

In 1995, CMS promulgated regulations to implement survey, certification and enforcement procedures. The survey process is intended to review the actual provision of care and services, with an emphasis on resident outcomes to determine whether the care provided meets the assessed needs of the individual residents. Surveys generally are conducted on an unannounced annual basis by state survey agencies. Remedies are assessed for deficiencies based upon the scope and severity of the cited deficiencies. The regulations specify that the remedies are intended to motivate facilities to return to compliance and to facilitate the removal of chronically poor-performing facilities from the program. Remedies range from: directed plans of correction, directed in-service training and state monitoring for minor deficiencies; denial of Medicare or Medicaid reimbursement for existing residents or new admissions and civil monetary penalties up to US\$3,000 per day for deficiencies that do not constitute immediate jeopardy to resident health and safety; and, appointment of temporary management, termination from the program and civil monetary penalties of up to US\$10,000 for one or more deficiencies that

constitute immediate jeopardy to resident health or safety. The regulations allow state survey agencies to identify alternative remedies that must be approved by CMS prior to implementation.

Effective with the implementation of the 1995 regulation, CMS created a concept that allows facilities with acceptable regulatory histories to have an opportunity to correct their deficiencies by a “date certain” and not impose sanctions unless they do not return to compliance. Facilities with deficiencies constituting immediate jeopardy to resident health and safety and those that are classified as poor performing facilities are not given an opportunity to correct their deficiencies prior to the assessment of remedies. From time to time, EHSI receives notices from federal and state regulatory agencies relating to alleged deficiencies for failure to comply with all components of the regulations. While EHSI does not always agree with the positions taken by the agencies, EHSI reviews such notices and takes corrective action when appropriate. Due to the fact that the new regulatory process provides EHSI with limited appeal rights, many alleged deficiencies are not challenged even if EHSI is not in agreement with the allegation. The industry as a whole has raised with CMS its serious concern that the new survey, certification and enforcement process does not appropriately measure performance against applicable requirements and that the process is being applied inconsistently among survey sites. Fundamental to the concern is the change in how surveyors perceive a deficient practice. Prior to July 1995, a deficiency would be identified only if a pattern of less than acceptable performance was observed. Under the present regulation, any lack of perfection produces an alleged deficiency.

The July 1995 regulation mandates that facilities that are not in substantial compliance and do not correct deficiencies within a certain time frame, must be terminated from the Medicare and/or Medicaid programs. Generally, the facility has no more than six months from deficiency identification to correct the deficiency, but shorter time frames apply when immediate jeopardy to the health or safety of the residents is alleged by the survey agency. While EHSI endeavours to comply with all applicable regulatory requirements, from time to time, certain of EHSI’s nursing facilities have been subject to various sanctions and penalties as a result of deficiencies alleged by CMS or state survey agencies.

In November 2000, EHSI operated one facility in Indiana that temporarily lost its certification under the Medicare and Medicaid systems but has since been re-certified under the Medicaid program and is proceeding to be re-certified under the Medicare program. There can be no assurance that EHSI will not be subject to similar sanctions and penalties in the future.

EHSI believes that this performance is comparable to the performance of other similar multi-facility companies. EHSI expects that those of its facilities not in substantial compliance will ultimately achieve this objective. EHSI is unable to predict its compliance outcome in the future and could be adversely affected if a substantial portion of its facilities were determined not to be in compliance with applicable regulations. EHSI believes that it has appropriate systems and mechanisms in place to monitor care and service delivery.

Restrictions on Acquisitions and Construction

Acquisition and construction of additional nursing facilities are subject to state regulation. All of the states in which EHSI currently operates (other than Idaho) have adopted a CON process and other laws to regulate expansion, which generally require that a state agency approve certain acquisitions or physical plant changes and determine that a need exists prior to the addition of beds or services, the implementation of the physical plant changes or the incurrence of certain capital expenditures. Certain states have also passed legislation, enacted rules and regulations, and adopted policies that prohibit, restrict or delay the issuance of CONs. In addition, in most states, the reduction of beds or the closure of a facility requires the approval of the appropriate state regulatory agency and, if EHSI were to determine to reduce beds or close a facility, EHSI could be adversely affected by a failure to obtain or delay in obtaining such approval. To the extent that CON or other similar approvals are required for expansion of EHSI’s operations, either through facility acquisitions, construction of new facilities or additions to existing facilities or expansion or provision of new services or other changes, EHSI’s expansion proposals could be adversely affected by the inability to obtain the necessary

approvals, changes in the standards applicable to such approvals and possible delays and expenses associated with obtaining such approvals.

Regulations regarding the acquisition, construction and operation of assisted living facilities are less stringent than for nursing facilities, and in the absence of uniform federal regulations, states develop their own regulations. However, since 1999, the term assisted living facility has been defined in 29 state regulations and statutes, and regulations currently are in effect or in draft in approximately half of the remaining states. Virtually every state has a licensure process and some form of regulation that may apply to the assisted living provider. If the assisted living provider supplies services that meet the definition of a licensed level of care in the state, the provider must be licensed. Licensure regulations can apply to admission and discharge criteria, and the variety and type of services provided. Many states require the submission of building plans and approval from the state prior to construction; however, the approval process is different from the CON procedure, being more of a clearance process than demand formula. In terms of construction and design, assisted living facilities must meet a stringent set of building regulations including the Life Safety Code (NFPA101). Inspections of assisted living facilities are conducted by state regulators on a periodic basis similar to nursing facilities in most cases.

Regulation of Certain Transactions

Federal law provides for exclusion of practitioners, providers and related persons from participation in most federal health care programs, including the Medicare and Medicaid programs, if the individual or entity has been convicted of a criminal offence related to the delivery of an item or service under these programs or if the individual or entity has been convicted, under state or federal law, of a criminal offence relating to neglect or abuse of residents in connection with the delivery of a health care item or service. Other individuals or entities may be, but are not required to be, excluded from such programs under certain circumstances, including but not limited to the following: conviction related to fraud; conviction relating to obstruction of an investigation; conviction relating to a controlled substance; licensure revocation or suspension; exclusion or suspension from state or federal health care programs; filing claims for excessive charges or unnecessary services or failure to furnish medically necessary services; and, ownership or control by an individual who has been excluded from the Medicaid and/or Medicare programs, against whom a civil monetary penalty related to the Medicaid and/or Medicare programs has been assessed, or who has been convicted of the crimes described in this paragraph.

The illegal remuneration provisions of the Social Security Act make it a felony to solicit, receive, offer to pay or pay any kickback, bribe or rebate in return for referring a resident for any item or service, or in return for purchasing, leasing, ordering or arranging for any good, facility, service or item, for which payment may be made under the federal health care programs. A violation of the illegal remuneration statute may result in the imposition of criminal penalties, including imprisonment for up to five years, the imposition of a fine of up to US\$25,000 or both. A civil action to exclude a provider from the Medicaid and/or Medicare programs may also be brought.

The BBA also includes numerous health fraud provisions, including: new exclusion authority for the transfer of ownership or control interest in an entity to an immediate family or household member in anticipation of, or following, a conviction, assessment, or exclusion; increased mandatory exclusion periods for multiple health fraud convictions, including permanent exclusion for the conviction of three health care-related crimes; authority for the Secretary to refuse to enter into Medicare agreements with convicted felons; new civil monetary penalties for contracting with an excluded provider or violating the federal anti-kickback statute; new surety bond and information disclosure requirements for certain providers and suppliers; and an expansion of the mandatory and permissive exclusions added by the HIPAA of 1996 to any federal health care program (other than the Federal Employees Health Benefits Program).

There are also other civil and criminal statutes applicable to the long-term care industry, such as those governing false claims. Federally and in some states where EHSI operates, there are laws that govern financial arrangements between health care providers.

EHSI believes that it is in compliance and that its practices are not in violation of the foregoing statutes or regulations. EHSI cannot reasonably predict whether enforcement activities will increase at the federal or state level or the effect of any such increase on its business.

Cross Disqualification and De-Licensure

In certain circumstances, conviction of abusive or fraudulent behaviour with respect to any one facility may subject other facilities under common control or ownership to disqualification from participation in Medicaid or Medicare programs. Executive Order 12549 prohibits any company or facility from participating in federal contracts if it or its “principals” have been debarred, suspended or are ineligible, or have been voluntarily excluded, from participation in federal contracts. A principal has been defined as an officer, director, owner, partner, key employee or other person with primary management or supervisory responsibilities. In addition, some state regulations provide that all facilities under common control or ownership licensed within a state are subject to de-licensure if any one or more of such facilities are de-licensed.

Office of the Inspector General

In 1995, a major anti-fraud demonstration project, “Operation Restore Trust” (ORT) was announced by the Office of the Inspector General. A primary purpose for the project is to scrutinize the activities of health care providers who are reimbursed under the Medicare and Medicaid programs. Initial investigation efforts have focused on skilled nursing facilities, home health and hospice agencies, and durable medical equipment suppliers in Texas, Florida, New York, Illinois and California. In May 1997, the Department of Health and Human Services announced that ORT would be expanded during the next two years to include 12 additional states (Arizona, Colorado, Georgia, Louisiana, Massachusetts, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, Virginia and Washington), as well as several other types of health care services. Over the longer term, ORT enforcement actions could include criminal prosecutions, suit for civil penalties, and/or Medicare, Medicaid or federal health care program exclusions. Prior to the November 1997 acquisition of Arbor, one of its subsidiary’s facilities was charged for therapy services, which were inadequately documented. Following this investigation, Arbor adopted measures to strengthen its documentation relating to reimbursable services. While EHSI does not believe that it is the target of any such investigation under ORT, there can be no assurance that substantial amounts will not be expended by EHSI to cooperate with any such investigation or to defend allegations arising therefrom. If it were found that any of EHSI’s practices failed to comply with the anti-fraud provisions, EHSI could be materially adversely affected.

Compliance Program

Compliance with federal, state and local laws and regulations and EHSI policies has always been, and continues to be an EHSI priority. In 2000, EHSI formalized its existing compliance efforts by issuing its Corporate Compliance Program. As part of the Corporate Compliance Program, employees are required to acknowledge their responsibility with respect to compliance.

Canada

In Canada, provincial legislation and regulations closely control all aspects of operation and funding of nursing facilities, including the fee structure, the adequacy of physical facilities, standards of care and accommodation, equipment and personnel. In some provinces, the government has delegated responsibility for the funding and administration of long-term care programs to regional health authorities.

In most provinces, a license must be obtained from the applicable provincial ministry of health in order to operate a nursing centre. There is almost a universal restriction upon the issuance of new licenses across the country because of the funding implications for governments. When new licenses are issued, it is in response to a deficiency of long-term care beds in a particular region, and some form of public competition for the license is required. There are also provincial regulations regarding the sale and transfer of existing licenses, and while such sales are regular occurrences, authorities take steps to determine the adequacy and *bona fides* of the new operator. In addition to, or in some cases in place of, the licensure procedure, operators in some provinces, such as Alberta and Ontario, are required to sign service contracts with the provincial government or regional health authority. These contracts spell out in detail the services to be provided and the remuneration to be received. Nursing centre licenses and service contracts are required to be renewed annually, and do not represent any guarantee of continued operation beyond the term of the license or contract. While it is possible for authorities to revoke a license or cancel a service contract due to inadequate performance by the operator, such actions are rare in Canada and would usually be preceded by a series of warnings, notices and other sanctions. ECI has never had such a license or service contract revoked.

While ECI endeavours to comply with all regulatory requirements in its Canadian nursing facilities, it is not unusual for stringent inspection procedures to identify deficiencies in operations. Every effort is made to correct problem areas that have been legitimately identified.

The environmental laws to which the Company is subject in Canada are similar in effect to the applicable environmental laws in the United States.

EMPLOYEES

Extendicare currently employs approximately 36,700 people, including approximately: 4,500 registered and licensed practical nurses; 12,100 nursing assistants; 1,600 therapists; 7,000 dietary, domestic, maintenance and other staff; 9,000 Canadian home care professionals and other staff; and 2,500 administrative employees who work at corporate and regional offices and facilities. In Canada, there are 55 collective agreements covering approximately 8,800 employees belonging to 16 different unions, operating under five different collective bargaining legislative jurisdictions. In the United States, there are 38 collective agreements among six unions covering approximately 2,260 employees. The Company believes that its relationship with its employees generally is good.

INVESTMENT IN CROWN LIFE INSURANCE COMPANY

Extendicare Inc., through 159524 Canada Inc., owned a 34.8% common equity interest in Crown Life Insurance Company (Crown Life) at December 31, 2001, following the reacquisition in 2001 of Laurier Indemnity Company Ltd.'s interest in Crown Life. Extendicare accounts for its investment in Crown Life on an equity basis. The Company regards its investment in Crown Life as a non-core asset.

On May 7, 2002, Crown Life declared a cash dividend of \$1.00 per common share, payable May 31, 2002. The Company will receive \$1.1 million based upon its ownership of 1,113,690 shares.

On February 22, 2001, Crown Life declared a cash dividend of \$20.30 per common share, which was paid March 15, 2001 and Extencicare received \$22.6 million.

In December 2000, Crown Life completed its acquisition of the common shares not held by its two principal shareholders, HARO Financial Company and Extencicare. As a result of the buy-out of the minority shareholders, Crown Life's common shares were de-listed from the Toronto Stock Exchange on January 15, 2001.

On May 26, 1998 Crown Life entered into an agreement to sell a major portion of its insurance operations to The Canada Life Assurance Company (Canada Life). The sale or indemnity reinsurance of substantially all of Crown Life's insurance business to Canada Life closed on January 1, 1999. The settlement of the transaction was subject to the final determination of policy liabilities in accordance with the sale agreements. Thus, the resulting shareholder's gain on sale was reported in the Crown Life financial results for the fourth quarter of 1999.

Crown Life has provided Canada Life with an option to acquire substantially all of Crown Life's remaining insurance business at any time after January 1, 2004 (or at any time after June 30, 2000 if certain litigation is resolved and Crown Life's ratio of regulatory capital available to regulatory capital required is less than 125%). Crown Life has an option to require Canada Life to make such acquisition at any time after January 1, 2004. In the event of an acquisition after January 1, 2004, Crown Life is required to transfer qualified invested assets equal to policy liabilities at such time to Canada Life.

Canada Life also has an option to make an offer to acquire all outstanding common shares of Crown Life: (i) at any time after January 1, 2004 if the financial exposure related to certain litigation and policyholder claims can be quantified; or (ii) at any time after June 30, 2000 if certain litigation and policyholder claims are resolved and Crown Life's ratio of regulatory capital available to regulatory capital required is less than 125%; or (iii) at any time by agreement with Crown Life's two common shareholders. Crown Life's common shareholders have agreed to accept such offer. Such offer is to be based on the value of assets supporting Crown Life's common shareholders' equity at the time of the offer. Crown Life's common shareholders have the right to require Canada Life to make such offer at any time after January 1, 2004 if the financial exposure related to certain litigation and policyholder claims can be quantified. Crown Life retains the right to distribute to shareholders or otherwise dispose of assets supporting common shareholders' equity prior to any acquisition by Canada Life of Crown Life's common shares pursuant to such offer.

Crown Life has assets of \$1.3 billion. Based in Regina, Saskatchewan, Crown Life is focusing on the development of its investment management activities. Crown Life's remaining insurance business, which is primarily in the United States, is administered by Canada Life Assurance Company under an administrative services agreement.

SELECTED FINANCIAL INFORMATION

	Year ended December 31		
	2001	2000	1999
	(thousands of dollars unless otherwise noted)		
Income Statement Data:			
Revenue			
Nursing and assisted living centres			
United States	1,187,547	1,346,033	1,364,084
Canada	279,559	266,671	260,723
United Kingdom	–	–	35,985
Outpatient therapy and medical supplies – United States	14,733	14,430	63,989
Home health – Canada	171,809	161,323	150,280
Other	50,863	18,949	17,626
	<u>1,704,511</u>	<u>1,807,406</u>	<u>1,892,687</u>
Operating and administrative costs ⁽¹⁾	<u>1,549,152</u>	<u>1,687,408</u>	<u>1,752,845</u>
Earnings before undernoted	155,359	119,998	139,842
Lease costs ⁽¹⁾	28,202	27,529	29,095
Depreciation and amortization	71,547	75,002	86,880
Interest, net	65,248	78,484	91,888
Loss from asset impairment, disposals and other items	50,082	42,747	183,889
Loss before income taxes	(59,720)	(103,764)	(251,910)
Income taxes (recovery)	(12,659)	(36,916)	(69,219)
Minority interests	83	257	(171)
Loss from health care	(47,144)	(67,105)	(182,520)
Share of earnings of Crown Life	10,738	7,827	22,818
Loss for the year	<u>(36,406)</u>	<u>(59,278)</u>	<u>(159,702)</u>
Loss per share			
Basic	(0.52)	(0.81)	(2.14)
Diluted	(0.52)	(0.81)	(2.14)
Operating Statistics:			
Number of facilities (end of period)	261	274	297
Resident capacity (end of period)	26,339	27,052	29,582
Average occupancy rate (percentage)	90.0	89.9	88.2
U.S. payor source as a percentage of total U.S. revenue			
Private Pay	25	25	28
Medicare	24	24	22
Medicaid	51	51	50
Property and equipment capital expenditures	45,377	46,292	50,268
EBITDA margin ⁽²⁾ (percentage)	7.5	5.1	5.9
Balance Sheet Data (at period end):			
Assets			
Cash and short-term investments	26,491	10,181	35,894
Working capital	(38,429)	27,557	96,346
Total health care assets	1,604,302	1,588,345	1,697,800
Investment in Crown Life, equity basis	135,944	147,407	136,323
Total assets	1,740,246	1,735,752	1,834,123
Long-term debt	788,354	802,426	891,955
Shareholders' equity	350,696	381,437	435,933

(1) Certain items have been reclassified from lease costs to operating costs for the years 2000 and 1999.

(2) Earnings before interest, taxes, depreciation and amortization (EBITDA) divided by revenue.

COMPARABILITY OF SELECTED FINANCIAL INFORMATION

Factors affecting the comparability of financial data of the Company include the following significant construction, asset disposals and other major changes in the business.

CONSTRUCTION

1999

The Company opened two nursing facilities, one nursing facility addition and two assisted living facilities in the United States, increasing resident capacity by 358.

2001

In Ontario, ECI completed construction and opened four new nursing facilities with an additional one completed and opened in January 2002. Total bed capacity of these facilities was 609 beds with licences for 40 of the beds transferred from an existing facility. Two of the facilities have 38-unit assisted living wings.

ASSET IMPAIRMENT, DISPOSALS AND OTHER ITEMS

1999

In the United States, the Company disposed of one nursing facility (248 beds) on June 30, 1999 for US\$4.3 million; two nursing facilities (150 beds) on September 30, 1999 for US\$4.8 million; stock of a subsidiary that owned six nursing facilities (763 beds) on December 30, 1999 for US\$40.5 million; and its home health operations on November 30, 1999 for US\$12.7 million. The Company applied the net after-tax proceeds from these dispositions of US\$44.8 million (\$65.2 million) to reduce EHSI's debt in 1999 in the following periods: US\$3.1 million in July; US\$4.6 million in October; US\$10.0 million in November; and US\$27.1 million in December.

On December 7, 1999, the Company disposed of its United Kingdom operations, consisting of 14 nursing facilities and one hospital (983 beds) for proceeds of £26.3 million, £13.0 million of which was used to repay the United Kingdom bank debt.

Primarily as a result of the changes affecting the long-term care industry in the United States, the Company recorded in the fourth quarter of 1999 a provision of \$59.3 million related to the impairment of assets.

In addition, the Company made a provision of \$5.2 million for the closure of two owned facilities and two leased facilities in the United States, for which notice had been given to terminate the lease upon their maturities in June and September 2000.

In the fourth quarter of 1999, the Company recorded a provision for adverse development of general and professional liability costs related to prior years of \$48.3 million. The Company increased its accrual for self-insured general and professional liability costs due to the continuing adverse development of such losses, particularly in the State of Florida.

2000

During 2000, the Company sold or leased all of its long-term care operations in the State of Florida through five separate transactions. In two transactions, two facilities (239 beds) were sold for US\$6.3 million. The Company disposed of 11 nursing centres (1,435 beds) and four assisted living centres (135 units) for initial cash proceeds of US\$30.0 million and contingent consideration in the form of a series of notes, which have an aggregate potential value of up to US\$30.0 million. These notes have a maximum term of 3.5 years and may be retired at any time by the purchaser through the subsequent sale or refinancing of the facilities. The remaining facilities in

the State of Florida were leased to two separate operators, and under the terms of the lease agreements, the lessees have the option to acquire the facilities at pre-determined prices.

The Company disposed of two facilities in other jurisdictions in the United States for US\$2.7 million.

The Company recorded a provision for impairment of assets of \$31.6 million related to assets in the United States. In addition, in the United States, the Company recorded a provision of \$3.6 million primarily related to the closure of two nursing facilities and one assisted living facility, severance costs of \$1.6 million related to the divestiture of Florida operations, and the write-off of deferred financing costs related to the early extinguishment of term debt.

2001

During the year, the Company made provisions totalling \$20.3 million related to ceased operations. These were comprised of a provision of \$3.1 million (US\$2.0 million) related to the closure and or sale of three nursing properties, a loss of \$2.8 million (US\$1.8 million) related to the transfer of Texas nursing operations, and \$14.5 million (US\$9.4 million) in provisions for previously ceased operations, primarily for the Florida nursing homes.

The Company also recorded charges of \$1.3 million related to interest on past years' tax re-assessments and a write-off of deferred financing costs from the early payment of debt.

On December 7, 2001, ECI sold its investment in AIM, a rehabilitative therapy business, resulting in a pre-tax gain of \$1.1 million. Gross proceeds from the sale of \$3.5 million were comprised of cash of \$2.2 million and notes receivable of \$1.3 million.

At the end of September, the EHSI ceased operating its nursing homes in Texas consisting of 17 facilities (1,421 beds) through lease agreements with a third-party operator who has an option to purchase the properties. In addition to the loss described above on transfer of the assets, a provision of \$2.6 million (US\$1.7 million) was recorded for impairment of the remaining Texas properties related to leasehold rights and leasehold improvements.

In September, based upon an independent actuarial review, the Company recorded an additional provision of \$27.0 million for resident care liability costs related to the Company's ceased Florida operations for years prior to 2001.

In April, EHSI sold two leased facilities in Florida to Tandem Health Care, Inc. (Tandem). Tandem had operated the facilities since December 31, 2000 under lease agreements with purchase options. Proceeds consisted of cash of US\$7.0 million, an interest bearing five-year note for US\$2.5 million and US\$1.9 million in cumulative dividend preferred shares, retractable in five years. The sale resulted in a US\$2.1 million gain pre-tax gain which was deferred until the balance of the purchase options that Tandem has on the remaining leased facilities are completed or the options expire. The Company applied US\$4.0 million of the net cash proceeds to reduce its term bank debt.

SHARE CAPITAL TRANSACTIONS

The Company, in each of 2001, 2000 and 1999, filed a Normal Course Issuer Bid for the purchase and cancellation of Subordinate Voting Shares. During 2001, the Company purchased and cancelled 1,744,900 Subordinate Voting Shares at a cost of \$8,237,000 (2000 – 1,284,100 shares at a cost of \$2,807,000). Of the shares purchased and cancelled during 2001, 35,900 shares were purchased under the current Subordinate Voting Share Bid at a cost of \$199,000. The current Subordinate Voting Share Bid, which commenced November 27, 2001, will terminate on the earlier of November 26, 2002 and the date on which a total of 4,000,000 shares have been purchased and cancelled by the Company pursuant to the Bid. In addition, the Company filed a Normal Course Issuer Bid for the purchase and cancellation of 375,000 Multiple Voting Shares, which began on May 1, 2001 and terminated on November 26, 2001. A new Bid was filed, which commenced on November 27, 2001 and will terminate on the earlier of November 26, 2002 and the date on which a total of 640,000 Multiple Voting Shares and 38,200 Class II Preferred Shares, Series 1, have been purchased and cancelled by the Company pursuant to the Bid. During 2001, the Company purchased and cancelled 224,600 Multiple Voting Shares at a cost of \$1,571,000. Of the shares purchased and cancelled during 2001, 19,800 shares were purchased under the current Bid at a cost of \$108,000.

As of April 30, 2002, under the current Bid, 205,900 Subordinate Voting Shares have been purchased at a cost of \$984,000 of which 170,000 shares at a cost of \$785,000 were acquired during 2002. In addition, 130,700 Multiple Voting Shares have been purchased and cancelled at a cost of \$746,000, under the current Bid, of which 110,900 shares at a cost of \$638,000 were acquired during 2002.

DIVIDEND RECORD

Preferred share dividends paid per share by Extendicare in each of the past three fiscal years are as follows:

	Preferred Shares			
	Class I			Class II
	Series 2	Series 3	Series 4	Series 1
		(\$ per share)		
2001	1.1990	1.0500	1.2159	1.280
2000	1.2334	1.2300	1.2507	1.421
1999	1.1659	1.2300	1.1825	1.297

No dividends are currently being paid on the Subordinate Voting Shares and Multiple Voting Shares.

MARKET FOR SECURITIES

The Class I Preferred Shares, Series 2, Series 3 and Series 4; Class II Preferred Shares, Series 1; Subordinate Voting Shares; and Multiple Voting Shares of Extendicare are listed on The Toronto Stock Exchange and the Subordinate Voting Shares are listed on the New York Stock Exchange.

ADDITIONAL INFORMATION

Extencicare shall provide to any person or company, upon request to the Corporate Secretary of the Company, 3000 Steeles Avenue East, Markham, Ontario L3R 9W2, Tel: (905) 470-5534:

- (1) when the securities of the Company are in the course of a distribution pursuant to a short form prospectus or a preliminary short form prospectus which has been filed in respect of a distribution of its securities:
 - (i) one copy of the 2001 Annual Information Form of the Company, together with one copy of any document, or the pertinent pages of any document, incorporated therein by reference;
 - (ii) one copy of the Consolidated Financial Statements and Auditors' Report to the Shareholders of the Company for the financial year ended December 31, 2001, together with one copy of any interim financial statements of the Company subsequent to the Consolidated Financial Statements for the financial year ended December 31, 2001;
 - (iii) one copy of the Management Information and Proxy Circular of the Company dated March 8, 2002 for the annual meeting of shareholders held on May 9, 2002; and
 - (iv) one copy of any other documents that are incorporated by reference into the preliminary short form prospectus or the short form prospectus; or
- (2) at any other time, one copy of the documents referred to in paragraphs (1) (i), (ii) and (iii) above, provided that the Company may require the payment of a reasonable charge from such a person or company who is not a holder of securities of the Company where the documents are furnished by the Company pursuant to this paragraph (2).

Additional information, including remuneration and indebtedness of directors and executive officers, principal holders of the Company's Multiple Voting and Subordinate Voting Shares, options to purchase securities and interests of insiders in material transactions, where applicable, is contained in the Management Information and Proxy Circular of the Company for the annual meeting of shareholders held on May 9, 2002. Additional financial information is provided in the Company's Consolidated Financial Statements for the financial year ended December 31, 2001.

DIRECTORS AND OFFICERS

The following table sets out the full name, municipality of residence, current positions with Extendicare and principal occupations for the past five years of each of the directors and officers of Extendicare:

Name, Current Positions with Extendicare and Municipality of Residence	Principal Occupation for Past Five Years	Director's Term Expires (Annual Meeting)/ Director Since
David J. Hennigar ^(CG) Director, Chairman Bedford, Nova Scotia	Chairman, Annapolis Group Inc. (real estate development and holding company); Chairman, High Liner Foods Incorporated (value added food processor); and Chairman, Acadian Securities Inc. (investment dealer)	2004/1980
H. Michael Burns ^{(CG) (IS)} Director, Deputy Chairman Maple, Ontario	Corporate Director	2005/1978
Frederick B. Ladly ^{(CG) (HR)} Director, Deputy Chairman Fallbrook, Ontario	Vice-Chairman, Crown Life Insurance Company; Deputy Chairman, Extendicare since 1997; prior thereto, President and Chief Executive Officer, Extendicare Inc. from April 1992 to August 1997	2004/1986
Mel Rhineland Director, President and Chief Executive Officer Milwaukee, Wisconsin	President and Chief Executive Officer of Extendicare since August 2000; Chairman and Chief Executive Officer of both Extendicare Health Services Inc. (EHSI) and Extendicare (Canada) Inc. (ECI) since August 2000; during 1999, Mr. Rhineland was appointed President of Extendicare and Chief Executive Officer of both EHSI and ECI; prior thereto he has served as a senior executive in various capacities for Extendicare and its subsidiaries	2003/2000
Derek H. L. Buntain ^{(A) (HR) (IS)} Director Grand Cayman, Cayman Islands	President of The Dundee Bank (private bank serving international clients); and President and Chief Executive Officer, Goodman & Company (Bermuda) Limited (investment counsel)	2005/1995
Sir Graham Day ^{(CG) (HR)} Director Hantsport, Nova Scotia	Chairman, Hydro One Inc. since December 1998 (electricity); Chairman, Sobeys Inc. (national food distributor) since September 2001; and Counsel, Stewart McKelvey Stirling Scales (barristers and solicitors)	2004/1989
George S. Dembroski ^{(A) (IS)} Director Toronto, Ontario	Corporate Director; prior to February 1998, Vice-Chairman, RBC Dominion Securities Limited (investment dealer)	2005/1995
David M. Dunlap ^{(A) (HR)} Director Township of King, Ontario	Chairman, G.F. Thompson Co. Ltd. (manufacturer); and Chairman, Burnley Manufacturing, Inc. (manufacturer)	2003/1980

Name, Current Positions with Extendicare and Municipality of Residence	Principal Occupation for Past Five Years	Director's Term Expires (Annual Meeting)/ Director Since
George A. Fierheller ^{(A) (IS)} Director Toronto, Ontario	President, Four Halls Inc. (investment and consulting company)	2003/1981
Dr. Seth B. Goldsmith ^(CG) Director Hollywood, Florida	Professor of Health Policy and Management, University of Massachusetts; former Chief Executive Officer, Miami Jewish Home & Hospital for the Aged from September 1996 to 1998	2003/1995
Michael J. L. Kirby ^{(CG) (HR)} Director Nepean, Ontario	Senator of the Parliament of Canada	2005/1987
Alvin G. Libin ^(A) Director Calgary, Alberta	President and Chief Executive Officer of Balmon Holdings Ltd. (investment company)	2005/1984
J. Thomas MacQuarrie, Q.C. ^{(A) (HR)} Director Halifax, Nova Scotia	Senior Partner, Stewart McKelvey Stirling Scales (barristers and solicitors)	2004/1980
Mark W. Durishan Vice-President, Finance, and Chief Financial Officer Milwaukee, Wisconsin	Executive of Extendicare since August 1999; prior thereto, Senior Vice President for Finance and Operations, Blue Cross and Blue Shield of Minnesota	
Philip W. Small Senior Vice-President, Strategic Planning and Investor Relations Mequon, Wisconsin	Executive of Extendicare since June 2001; prior thereto, Executive Vice President, Strategic Planning and Operations Support and acting Chief Financial Officer, Beverly Enterprises Corporation of Arkansas	
Len G. Koroneos Vice-President and Treasurer Richmond Hill, Ontario	Executive of Extendicare	
Jillian E. Fountain Corporate Secretary Toronto, Ontario	Executive of Extendicare since 1999; prior thereto, member of Extendicare management	

Notes:

(A) Member of Audit Committee

(HR) Member of Human Resources Committee

(CG) Member of Corporate Governance and Nominating
Committee

(IS) Member of Information Systems Committee

At April 30, 2002, the directors and officers of Extendicare as a group beneficially owned, directly or indirectly, or exercised control or direction over 1,194,231 Subordinate Voting Shares and 8,801,158 Multiple Voting Shares of Extendicare (representing 2.05% and 69.49% of the outstanding Subordinate Voting Shares and Multiple Voting Shares, respectively, and representing 48.21% of the combined votes).

SUPPLEMENTARY INFORMATION

**RECONCILIATION OF CANADIAN AND UNITED STATES
GENERALLY ACCEPTED ACCOUNTING PRINCIPLES**

AUDITORS' REPORT ON SUPPLEMENTARY INFORMATION

The Board of Directors of Extendicare Inc.

Under date of February 21, 2002, we reported on the consolidated balance sheets of Extendicare Inc. (the "Corporation") as at December 31, 2001 and 2000, and the consolidated statements of loss, shareholders' equity and cash flows for each of the years in the three-year period ended December 31, 2001, as incorporated by reference in the Corporations' 2001 Annual Information Form dated May 15, 2002, included in the Annual Report on Form 40-F. In connection with our audits of the aforementioned consolidated financial statements, we also have audited the related supplemental note entitled "Reconciliation of Canadian and United States Generally Accepted Accounting Principles" as set forth in the Annual Information Form. This supplemental note is the responsibility of the Corporation's management. Our responsibility is to express an opinion on this supplemental note based on our audits.

In our opinion, such supplemental note, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein as at December 31, 2001 and 2000 and for each of the years in the three-year period ended December 31, 2001.

(signed) **KPMG** LLP
Chartered Accountants

Toronto, Canada

February 21, 2002

SUPPLEMENTARY INFORMATION

RECONCILIATION OF CANADIAN AND UNITED STATES GENERALLY ACCEPTED ACCOUNTING PRINCIPLES

(in thousands of Canadian dollars, except per share amounts)

GENERAL

The following supplementary information is provided in accordance with the United States Securities Exchange Act of 1934 as required for companies reporting on Form 40-F under the Multijurisdictional Disclosure System.

The areas of material difference between Canadian and United States GAAP and their impact on the consolidated financial statements of the Corporation are described below.

The application of United States GAAP would have the following effect on the net earnings (loss) as reported:

	<u>2001</u>	<u>2000</u>	<u>1999</u>
Loss from health care for the year as reported in accordance with Canadian GAAP	(47,144)	(67,105)	(182,520)
Application of asset and liability method of accounting for income taxes (A)	—	—	(989)
Reclassification of early extinguishment of debt costs to extraordinary item (B)	115	1,039	859
Reclassification of income taxes related to early extinguishment of debt costs to extraordinary item (B)	<u>(46)</u>	<u>(382)</u>	<u>(354)</u>
Loss from health care before extraordinary item for the year as reported in accordance with United States GAAP	<u>(47,075)</u>	<u>(66,448)</u>	<u>(183,004)</u>
Share of earnings of Crown Life for the year as reported in accordance with Canadian GAAP	10,738	7,827	22,818
Application of United States GAAP (C)	<u>(5,873)</u>	<u>15,497</u>	<u>(74,780)</u>
Share of earnings (loss) of Crown Life for the year as reported in accordance with United States GAAP	<u>4,865</u>	<u>23,324</u>	<u>(51,962)</u>
Loss before extraordinary item for the year as reported in accordance with United States GAAP	(42,210)	(43,124)	(234,966)
Reclassification of early extinguishment of debt costs, net of income taxes, to extraordinary item (B)	<u>(69)</u>	<u>(657)</u>	<u>(505)</u>
Loss for the year as reported in accordance with United States GAAP	<u>(42,279)</u>	<u>(43,781)</u>	<u>(235,471)</u>
Other comprehensive income (loss), net of tax (D):			
Foreign currency translation adjustments	16,212	13,599	(82,481)
Unrealized gains (losses) on invested assets	(2,863)	9,334	(32,003)
Cumulative effect of change in accounting for derivative instruments and hedging activities (F)	(292)	—	—
Net current period change in derivative losses (F)	<u>(1,419)</u>	<u>—</u>	<u>—</u>
Other comprehensive income (loss)	<u>11,638</u>	<u>22,933</u>	<u>(114,484)</u>
Comprehensive loss as reported in accordance with United States GAAP	<u>(30,641)</u>	<u>(20,848)</u>	<u>(349,955)</u>
Per share amounts in accordance with United States GAAP			
Loss before extraordinary item	(0.60)	(0.60)	(3.15)
Loss			
Basic	(0.60)	(0.61)	(3.15)
Diluted	(0.60)	(0.61)	(3.15)

The cumulative effect of these adjustments on shareholders' equity is as follows:

	<u>2001</u>	<u>2000</u>	<u>1999</u>
Shareholders' equity in accordance with Canadian GAAP	350,696	381,437	435,933
Application of asset and liability method of accounting for income taxes (A)	–	–	(3,505)
Unrealized gains (losses) on invested assets, net of tax (E)	(1,296)	(1,371)	(5,451)
Unrealized gains (losses) on cash flow hedges, net of tax (F)	(1,760)	–	–
Change in equity carrying value of Crown Life (C)	<u>(9,840)</u>	<u>(433)</u>	<u>(17,626)</u>
Shareholders' equity in accordance with United States GAAP	<u>337,800</u>	<u>379,633</u>	<u>409,351</u>

SUMMARY OF ACCOUNTING POLICY DIFFERENCES

(A) Income Taxes

Under Canadian GAAP, effective January 1, 2000, the Company follows the liability method of accounting for future income taxes (formerly the deferral method). The Canadian standard is now substantially similar to United States GAAP per Statement of Financial Accounting Standards No. 109 Accounting for Income taxes (FAS 109). However, in accordance with the transitional provisions available under Canadian GAAP, the Company did not restate prior period financial statements on implementation of the new standard. The Company recorded a charge to opening retained earnings of \$1,250, representing a \$3,505 change to the consolidated future income tax balance, net of \$2,255 related to the Company's share of Crown Life's implementation of the new standard.

Under Canadian GAAP, future income tax assets and liabilities are measured using income tax rates that are considered to be substantively enacted. Under United States GAAP, deferred income tax assets and liabilities are required to be measured at enacted rates. The impact of this difference in accounting policies was not material with respect to the income tax provision recorded for 2001 and 2000 (1999 – \$nil).

For each of the years ended 2001, 2000 and 1999, the valuation allowance was increased (decreased) by \$(7,533), \$(12,544), and \$34,167, respectively.

The components of the net deferred tax assets and liabilities, as reported in accordance with United States GAAP, are as follows:

	<u>2001</u>	<u>2000</u>		<u>2001</u>	<u>2000</u>
Deferred tax assets in accordance with United States GAAP:			Deferred tax liabilities in accordance with United States GAAP:		
Self-insurance reserves	40,184	40,850	Property and equipment	107,850	103,709
Investment in Crown Life	12,987	19,446	Leasehold rights	3,580	4,061
Employee benefit accruals	14,466	14,073	Other	<u>17,920</u>	<u>14,663</u>
Accounts receivable reserves	11,855	12,272		<u>129,350</u>	<u>122,433</u>
Net capital loss carryforwards	10,902	18,162			
Deferred revenue	5,044	–	Net deferred tax liabilities in accordance with United States GAAP	28,350	36,726
Goodwill	3,220	3,879	Less current net deferred tax assets in accordance with United States GAAP	<u>17,987</u>	<u>15,249</u>
Operating loss carryforwards	22,356	10,496	Non-current net deferred tax liabilities in accordance with United States GAAP	<u>46,337</u>	<u>51,975</u>
Operating reserves	6,285	3,273			
Other	<u>13,356</u>	<u>10,444</u>			
	140,655	132,895			
Valuation allowance	<u>39,655</u>	<u>47,188</u>			
	<u>101,000</u>	<u>85,707</u>			

(B) Extraordinary Item

Under United States GAAP the write-off of unamortized debt issue costs and the charge for debt prepayment costs in connection with the early extinguishment of long-term debt are considered to be extraordinary items and are disclosed net of applicable taxes. Under Canadian GAAP such costs are included in net income. The reclassification to extraordinary item, in accordance with United States GAAP, results in the disclosure of earnings per share before extraordinary item.

(C) Crown Life

The areas of material difference between Canadian GAAP and United States GAAP related to the Company's share of earnings (increase (decrease)) of Crown Life are as follows:

	<u>2001</u>	<u>2000</u>	<u>1999</u>
Policy liabilities	1,733	4,531	11,601
Investment income	(6,805)	7,246	(37,260)
Income taxes	(811)	3,695	(53,233)
Other	10	25	4,112
	<u>(5,873)</u>	<u>15,497</u>	<u>(74,780)</u>

The cumulative effect between Canadian GAAP and United States GAAP related to Crown Life on the Company's shareholders' equity and equity carrying value of Crown Life is as follows:

	<u>2001</u>	<u>2000</u>	<u>1999</u>
Equity carrying value of Crown Life in accordance with Canadian GAAP	<u>135,944</u>	<u>147,407</u>	<u>136,323</u>
Policy liabilities	(2,424)	(1,457)	(5,194)
Invested assets	(15,929)	(4,008)	(18,759)
Income taxes	8,517	5,047	6,364
Other	(4)	(15)	(37)
	<u>(9,840)</u>	<u>(433)</u>	<u>(17,626)</u>
Equity carrying value of Crown Life in accordance with United States GAAP	<u>126,104</u>	<u>146,974</u>	<u>118,697</u>

Policy Liabilities and Deferred Acquisition Costs. Under Canadian GAAP, policy liabilities of Crown Life are calculated using the Canadian asset liability method under which assumptions are adjusted annually based on the expected future experience of the company. Under United States GAAP, liabilities for traditional life insurance products are calculated using assumptions as to future experience, which are set at the time of policy issue. These assumptions are not adjusted unless experience is sufficiently adverse that an overall loss on a block of business is expected over the future duration of the business. Universal life or investment type products are accounted for by the retrospective deposit method under which assumptions are updated at least annually. Under United States GAAP, costs that vary with and are primarily related to the acquisition of insurance products are capitalized separately as assets on the balance sheet. For traditional life products, these costs are charged to expense in future years in proportion to the premium revenue recognized. For universal life or investment type products, these costs are charged to expense in future years in proportion to the emergence of margins expected to be realized over the duration of the block of business.

Invested Assets. Under Canadian GAAP, gains and losses on invested assets of Crown Life are amortized into income. Under United States GAAP, gains and losses on sales of invested assets are included in income when realized. Invested assets that are marketable securities, all of which are considered to be available for sale, are carried at market value with unrealized gains or losses, net of applicable taxes, included in shareholders' equity. The non-land component of investment real estate is amortized over its expected useful life.

Income Taxes. Under Canadian GAAP, effective January 1, 2000, Crown Life follows the liability method of accounting for future income taxes as described in (A) above.

(D) Comprehensive Income

Under United States GAAP, Statement of Financial Accounting Standard No. 130, "Reporting Comprehensive Income" (FAS 130). FAS 130 establishes rules for the reporting and display of comprehensive income and its components. Comprehensive income is net income, plus certain other items that are recorded directly to shareholders' equity. The Company has reported as comprehensive income, foreign currency translation adjustments, and unrealized gains (losses) on invested assets and hedging activities. The amounts reported as unrealized gains (losses) on invested assets and hedging activities are net of tax; income tax expense (recovery) included therein amounted to \$2,331, \$4,536 and \$(19,922) for 2001, 2000 and 1999, respectively.

(E) Securities Available for Sale

United States GAAP requires that non-current marketable securities considered to be available for sale be reported at fair value and the net unrealized holding gain or loss, net of applicable taxes, be reported as a separate component of shareholders' equity. In addition, United States GAAP requires the disclosure of information about the contractual maturities of those securities. There is no similar requirement for Canadian GAAP. The marketable securities within the "Investments held for self-insured liabilities" and "Other investments" captions are all considered to be available for sale.

Investments held for self-insured liabilities include marketable securities at December 31, 2001 and 2000 with maturities as follows:

	<u>2001</u>	<u>2000</u>
Due in one year or less	–	1,504
Due after 1 year through 5 years	26,488	18,507
Due after 5 years through 10 years	2,545	34,063
Due after 10 years	4,304	8,925
	<u>33,337</u>	<u>62,999</u>
Cash and money market funds	12,128	5,200
	<u>45,465</u>	<u>68,199</u>

(F) Derivative Instruments and Hedging Activities

The Company adopted on January 1, 2001, for United States GAAP reporting purposes, Statement No. 133, "Accounting for Derivative Instruments and Hedging Activities" (FAS 133), which was amended in June 2000 by Statement No. 138, "Accounting for Certain Derivative Instruments and Certain Hedging Activities, an Amendment of FASB Statement No. 133" (FAS 138). Under FAS 133 and FAS 138, all derivatives instruments are recognized at fair value on the balance sheet. Changes in the fair value of interest rate swaps that are highly effective in offsetting changes in cash flows of the hedged items and that are designated as hedging instruments of the variability of cash flows associated with floating-rate, long-term debt obligations are reported in other comprehensive income as a component of shareholders' equity. These amounts are subsequently reclassified into interest expense as a yield adjustment in the same period in which the related interest on the floating-rate debt obligations affects earnings. The impact as of January 1, 2001 arising from the adoption of the standards (relating to the fair value of interest rate swaps) was a liability, representing a loss charged to comprehensive income of \$292, net of tax. As of December 31, 2001, the fair value of the interest rate swaps designated as hedging instruments was a liability of \$2,235. In addition, during 2001, an interest rate swap maturing on February 27, 2003, was terminated at a cost of \$805 and under Canadian GAAP is reflected as a deferred charge, amortized to interest expense over the remaining term of the swap. At December 31, 2001, the unamortized deferred charge was \$474. Under United States GAAP, the fair value of the interest rate swaps together with the unamortized deferred charge represented a current period loss charged to other comprehensive income of \$1,419, net of tax. Interest expense for 2001 includes \$34 in net gains representing the cash flow hedge's ineffectiveness arising from differences between the terms of the interest rate swap and the hedged debt obligation.

(G) Disclosure of Allowance for Doubtful Accounts

United States GAAP requires the disclosure of allowances related to accounts and notes receivable. There is no similar requirement under Canadian GAAP. Current accounts receivable at December 31, 2001 and 2000, were reported net of an allowance for doubtful accounts of \$24,475 and \$26,037, respectively.

(H) Disclosure of Accrued Liabilities

United States GAAP requires the separate disclosure of accrued liabilities. There is no similar requirement under Canadian GAAP. At December 31, 2001 and 2000, accrued liabilities were \$234,697 and \$208,310, respectively.

(I) Stock Options

The Company has stock option plans for key employees and for outside directors. The exercise price of the options equals the market price of the underlying stock on the date of grant, which is the measurement date. In accordance with Statement of Financial Accounting Standards No. 123, "Accounting for Stock-based Compensation" (FAS 123) the Company has elected to apply Accounting Principles Board Opinion No. 25, "Accounting for Stock Issued to Employees" (APB Opinion 25) and related interpretations in accounting for its plans and accordingly, has not recognized compensation expense for options granted. If FAS 123 had been followed, the Company's results in each of 2001, 2000 and 1999, would have been reduced by \$1,161, \$1,025 and \$1,410, respectively. For 2001, 2000 and 1999, the basic loss per share before extraordinary items would have been \$(0.62), \$(0.61) and \$(3.16), respectively; and the basic loss per share would have been \$(0.62), \$(0.62) and \$(3.17), respectively. Diluted loss per share for 2001, 2000 and 1999 would have been \$(0.62), \$(0.62) and \$(3.17), respectively.

The pro forma effect on the loss for 1999 is not representative of the pro forma effect on net income in future years, because it does not take into consideration pro forma compensation expense related to grants prior to 1995. The pro forma effect was not fully reflected until 2000.

The fair value of each option grant is estimated on the date of grant using a Black-Scholes option pricing model with the following assumptions used for options granted during 2001, 2000 and 1999:

- a) dividend yield - 0% for all years;
- b) expected volatility – 46.53% to 71.72% for 2001; 69.95% to 74.41% for 2000; and 55.00% for options granted during 1999;
- c) risk-free interest rate – 4.16% to 5.45% for 2001; 5.83% to 6.28% for 2000; and 4.94% to 5.50% for options granted during 1999; and
- d) weighted average expected life – 4.3 years for 2001; 4.4 years for 2000; and 4.3 years for 1999.

The weighted average fair value of options granted were \$2.80, \$2.14 and \$2.56 per share in 2001, 2000 and 1999, respectively. The option valuation model was developed for use in estimating the fair value of traded options, which have no vesting restrictions and are fully transferable. In addition, option valuation models require the input of highly subjective assumptions including the expected stock price volatility. Since Extencicare's stock options have characteristics significantly different from those of traded options, and since variations in the subjective input assumptions can materially affect the fair value estimate, in management's opinion, the existing models do not necessarily provide a reliable single measure of the fair value of its employee stock options.

(J) New United States Accounting Standard

In July 2001, the FASB issued Statement No. 141, "Business Combinations" and Statement No. 142, "Goodwill an Intangible Assets". These statements are substantially consistent with CICA Sections 1581 and 3062, except that under United States GAAP, any transitional impairment charge is recognized in earnings as a cumulative effect of a change in accounting principles. Under Canadian GAAP, the cumulative adjustment is recognized in opening retained earnings.

In August 2001, the Financial Accounting Standards Board issued Statement No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets" (FAS 144). FAS 144 requires that long-lived assets be reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. If the carrying amount of an asset exceeds its estimated future cash flows, an impairment charge is recognized by the amount by which the carrying amount exceeds the fair value of the asset. FAS 144 requires companies to separately report discontinued operations and extends that reporting to a component of an entity that either has been disposed of (by sale, abandonment, or in a distribution to owners) or is classified as held for sale. Assets to be disposed of are reported at the lower of the carrying amount or fair value less costs to sell. The Company is required to adopt FAS 144 for United States GAAP reporting purposes on January 1, 2002.

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