

**ANNUAL  
INFORMATION  
FORM 2000**

**EXTENDICARE**

*Health Care is Our Business*™

May 15, 2001

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## **DOCUMENTS INCORPORATED BY REFERENCE**

The following documents are incorporated by reference in this Extendicare Inc. 2000 Annual Information Form:

- The Management Information and Proxy Circular of Extendicare Inc. dated February 28, 2001;
- The Management's Discussion and Analysis, found on pages 13 through 25 of the 2000 Annual Report of Extendicare Inc.;
- The Consolidated Financial Statements and Auditors' Report to the Shareholders of Extendicare Inc., found on pages 26 through 52 of the 2000 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. Forward-looking statements can be identified because they generally contain the words "anticipate", "believe", "estimate", "expect", "objective", "project", or a similar expression.

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; liabilities 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 "Extencicare" or the "Company" means Extencicare Inc. and its subsidiaries. Extencicare 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 Extencicare Inc. is located at 3000 Steeles Avenue East, Markham, Ontario L3R 9W2.

### CORPORATE OVERVIEW

<b>EXTENDICARE INC.</b>	
<b>EXTENDICARE HEALTH SERVICES, INC.</b>	(100%) (UNITED STATES) nursing, assisted living and retirement centres; rehabilitative therapy and group purchasing services
<b>EXTENDICARE (CANADA) INC.</b>	(100%) (CANADA) nursing and retirement centres; home health care through ParaMed Home Health Care; rehabilitative therapy through Accident Injury Management Clinics Inc.; and hospital management
<b>LAURIER INDEMNITY COMPANY</b>	(100%) (UNITED STATES)
<b>LAURIER INDEMNITY COMPANY, LTD.</b>	(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 Extencicare Inc.:

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

Note: Extencicare Inc., through 159524 Canada Inc. and Laurier Indemnity Company, Ltd., owned a 34.8% common equity interest in Crown Life Insurance Company at December 31, 2000. Subsequent to December 31, 2000, 159524 Canada Inc. acquired Laurier Indemnity Company Ltd.'s interest in Crown Life.

## BUSINESS OF THE COMPANY

### GENERAL

Extendicare is one of the largest operators of long-term care facilities in North America with resident capacity at December 31, 2000 of 24,733 in 229 nursing facilities in the United States and Canada. In addition, Extendicare operates 44 assisted living and retirement centres with 2,199 units and manages a hospital unit in Canada with capacity for 120 residents. The Company also provides medical specialty services, including subacute and rehabilitative therapy services in the United States, and home health care and rehabilitative therapy services in Canada. Of the Company's total revenue, 76.2% 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 the Company at December 31, 2000:

	<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>
Nursing Centres	171	17,495	58	7,238	229	24,733
Assisted Living and Retirement Centres	41	1,925	3	274	44	2,199
Hospitals/units	–	–	1	120	1	120
<b>TOTAL</b>	<u>212</u>	<u>19,420</u>	<u>62</u>	<u>7,632</u>	<u>274</u>	<u>27,052</u>

### BUSINESS STRATEGY

In 1998, the Company made a strategic decision to concentrate on its core business of owning and operating skilled nursing and assisted living facilities in selected markets in North America. In pursuing this strategy, the number of beds/units operated by the Company at December 31, 2000 decreased by 17% from December 31, 1998. The Company has sold and will continue to sell assets that are non-core, do not provide adequate rates of return on investment, or continue to otherwise impair financial results. The Company plans to continue 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, and growth in home care operations, the Company will continue to expand its health care operations in Canada. In the United States, the Company will continue to seek out opportunities for alternative management services and consulting contracts with other providers in the industry. With respect to the long-term care operations, the Company geographically clusters its long-term care facilities and services in order to offer its residents a broad range of long-term care and ancillary services and improve operating efficiencies.

## **Disposition of Non-core Business Operations and Under-performing Assets**

### ***United States***

In the United States, Extencicare Health Services, Inc. (EHSI) disposed of its pharmacy operation during 1998 and in 1999 disposed of its home health operation and closed down the contracted therapy operation. During 2000, EHSI sold seven of its outpatient therapy clinics in Florida.

In states other than Florida, EHSI closed one facility in 1998 and two facilities in 1999, two of which were subsequently sold in 2000. EHSI exercised its option not to renew the lease on two nursing facilities in 1999, and terminated operations at these facilities in 2000. In 2000, EHSI exercised its option not to renew the lease at one nursing facility, made provisions for closure of another and closed one assisted living facility.

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 continued to lobby through industry associations for legislative changes in the State that would limit 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 decided to divest 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.

### ***United Kingdom***

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

Extencicare continually monitors the financial and operational performance of its facilities. During the past two 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 or operational performance. These facilities have been identified to potential purchasers for possible divestiture.

## **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\$262.0 million and debt-to-equity coverage from 2.5:1 to 2.2:1

EHSI has 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 2000 with a reduction of both same-facility accounts receivable and overall reduction of days sales outstanding from 54 to 47 days. New targets have been established for 2001.

## 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 nursing facilities. In addition, ownership of facilities enables the Company to control costs without regard to escalating lease payments.

The following table depicts the ownership of facilities operated by Extencicare at December 31, 2000:

	<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	161	14,524	47	6,344	208	20,868
Leased <sup>(1)(2)</sup>	30	2,814	3	170	33	2,984
Managed	21	2,082	12	1,118	33	3,200
<b>TOTAL</b>	<b>212</b>	<b>19,420</b>	<b>62</b>	<b>7,632</b>	<b>274</b>	<b>27,052</b>

(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 four months to 11 years, the average being seven years. EHSI retains an option to purchase the leased property for 24 of the 30 properties.

(2) As of December 31, 2000, seven leased facilities in the States of Ohio and Indiana are on a month-to-month lease arrangement. EHSI had exercised its right to purchase the properties as of September 30, 2000 but has entered into negotiations with the landlord to conclude issues involved in completing the transaction. Though negotiations are not finalized, EHSI believes it has complied with all terms of the option and believes that settlement of outstanding issues can be resolved.

## Long-term Strategy

Extencicare's internal priorities in 2001 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 2001, EHSI will continue with many of the same action plans as previously outlined. And though opportunities for growth will be restrained to new management contracts and consulting arrangements over the next year, EHSI plans to continue 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 alternative 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, and the relative immaturity of the assisted living market in the United States, EHSI expects strong demand for these services in the foreseeable 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, thereby improving operating margins.

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.

### ***Canada***

In Canada, the Company's strategy is to expand both the long-term care operations and home care businesses. In the fourth quarter of 1998, Extencare (Canada) Inc. (ECI) was chosen by the Government of Ontario to build and operate 1,201 nursing home beds in communities across the Province. ECI will own 905 of these new beds (eight facilities) and operate a further 296 beds (two facilities) that are owned by hospitals. This represents an increase of 25% from the nursing home beds currently operated by Extencare in Ontario. The award to ECI and its 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 6,700 new beds) of an eight-year Government program to add 20,000 new nursing home beds in the Province.

Construction of six ECI-owned facilities (653 beds) commenced in 2000 and five of these are scheduled to be operational during 2001. In March 2001, one of the six facilities under construction was destroyed by fire. ECI believes that its insurance coverage will cover any material loss from the fire. ECI plans to commence reconstructing this facility later in 2001. The remaining two facilities for which ECI was awarded beds will be constructed during 2001 and 2002. In addition, ECI is transferring licenses for 120 beds from two of its existing facilities to two of its new facilities and ECI is incorporating 38 assisted living units in each of two other new facilities. In total, ECI is constructing 1,101 owned nursing beds and assisted living units in Ontario.

One of the facilities (200 beds) that ECI is developing in partnership with a hospital commenced construction in the latter half of 2000 and this facility is expected to be operational during the winter of 2001/2002. Construction of the other facility that ECI is operating in partnership is expected to commence during 2001. For this facility, ECI is combining 34 of its long-term care beds that currently are operational with the 96 beds awarded to the hospital to construct a new 130-bed facility.

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. Extencare, in partnership with a hospital, was selected to build one 128-bed long-term care facility. Extencare is responsible for the development and construction of the new facility and will operate the hospital's beds under a management agreement. This facility is scheduled to be operational during 2002.

Late in 2000, the Ontario government announced the third and final phase of this program. Requests for the tendering of the final 5,500 beds were due January 31, 2001 and the successful bidders have not yet been announced. Extendicare is participating in the third round of competition and is bidding on a portion of the beds to be awarded both alone and with partners.

In Canada, the Company is expanding its management contracts with both the public and private sectors. The Company manages eight 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. Through its geographically clustered facilities, the Company 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 and a full range of personal support. 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, 2000, EHSI operated for itself 155 nursing facilities (15,569 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, 2000, EHSI operated for itself 36 assisted living and retirement facilities with resident capacity of 1,769 units.

### ***Management and Selected Consulting Services***

EHSI applies its operating expertise and knowledge in long-term care by providing either full management or selected consulting services for other organizations. 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, information technology, and accounting services. EHSI provided management services to 16 nursing facilities (1,926 beds) and five assisted living facilities (156 units) and provided selected consulting services to 12 nursing facilities (1,258 beds) as of December 31, 2000.

### ***Group Purchasing***

UHF Purchasing Group provides purchasing services for over 2,677 nursing facilities in 36 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 435 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. In response to this market trend, all of EHSI's nursing facilities have expanded their 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 who provide services to both inpatient and outpatient clients who require physical, occupational, or speech-language therapy.

EHSI has rehabilitative therapy clinics that collectively operate within the Company's wholly owned subsidiary, The Progressive Step Corporation. As of December 31, 2000, EHSI operated 20 clinics in the States of Pennsylvania (7), Ohio (1), Texas (1), and Wisconsin (11). 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. During 2000, the Company opened two clinics, closed three clinics and sold all seven of its clinics located in the State of Florida. In January 2001, the Company opened one new clinic in Pennsylvania.

### ***Other***

Under the former UPC Health Network division, EHSI operated an institutional pharmacy services business, providing pharmacy supplies and services to both the Company'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**

Extencicare's Canadian health care operations are conducted through ECI and its subsidiaries. ECI is the second largest 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 geriatric 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, 2000, ECI operated for itself 49 nursing centres and one retirement centres, providing care to 6,514 residents in five provinces. All of ECI's 46 owned nursing centres (6,271 beds) are accredited by the Canadian Council on Health Services Accreditation.

### ***Management and Consulting***

In Canada, Extencicare manages long-term care centres and a hospital for not-for-profit boards and private organizations seeking to improve 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, 2000, ECI managed one publicly owned hospital unit (120 beds), three municipally owned homes for the aged (241 beds), three interim long-term care units and one nursing facility owned by hospitals (242 beds), and two nursing centres (314 beds) and two retirement centres (201 units) that are privately owned. 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, providing 7.0 million hours of care and support services during 2000 to clients of all ages through 35 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. ParaMed is also active in community programs – such as support for disabled children in schools and respite care for parents – that enable clients to enrich their lives through increased independence.

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 25% 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. Two communities in British Columbia have conducted RFPs but no other communities in the Province have announced plans to issue RFPs. Information technology upgrades are under way, which will improve ParaMed's ability to meet the demands of its clients for responsiveness and consistency of staffing.

### ***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 more than 24,000 residents in Canada.

### ***Rehabilitative Therapy Services***

Extendicare owns 88% of Accident Injury Management Clinics Inc. (AIM), which operates in Ontario. Currently, AIM owns five, has an investment in one and has joint ventures with eighteen clinics.

Each of the clinics provides a wide-range of comprehensive health-related services including medical-legal independent evaluations, multidisciplinary rehabilitation, physiotherapy, chiropractic and registered massage therapy treatments, wellness intervention programs, and occupational services relating to disability management. In addition, three clinics provide Financial Services Commission of Ontario approved assessments and one is licensed to provide rehabilitation to injured workers under the Workers' Compensation of Ontario community clinic status.

Approximately 95% of the funding for these services is provided by individuals, employers, and insurance companies, with the remaining 5% provided by the Ontario government's health plan.

AIM's services incorporate health care professionals from a variety of disciplines. These professionals add value in areas that require primary prevention and assessments of individuals who are at risk of developing lifestyle-related diseases such as heart disease and osteoporosis. In addition, AIM facilitates drug research trials through physician consultants.

## **QUALITY OF CARE**

The focus of Extendicare'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. 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 Extendicare's long-term care facilities are located in smaller communities. In the United States, EHSI focuses its marketing efforts predominantly at the local level. EHSI believes 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, preferred provider organizations, and provide marketing direction with training and community-specific promotional materials.

### **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, the Company has upgraded certain of its facilities that are located in markets where new facilities will open. In addition, 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.

Given the current regulatory environment in Canada, in provinces other than Ontario, nursing centres generally are fully occupied and it is unnecessary for Extendicare to carry out extensive marketing for these nursing centres.

## **MANAGEMENT, FINANCIAL CONTROLS AND COST CONTROLS**

Extendicare believes that strong management is essential to its success. The members of its Board of Directors have served Extendicare on average more than 13 years, while its senior officers, including the senior officers of ECI and EHSI, have on average 21 years of experience in the health care industry and 13 years of service with the Company.

The financial controls of Extendicare 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 and health benefits for its United States operations. Prior to 1997, for states which permit commercial insurance carriers (excluding Texas), workers' compensation insurance was provided to employees through the Company's two captive insurance companies, Laurier Indemnity Company, which is domiciled in the United States, and Laurier Indemnity Company, Ltd., which is domiciled in Bermuda. Commencing in 1997, the Company has purchased workers' compensation insurance in these states through a third-party insurance carrier. In Ohio, where workers' compensation is not permitted to be insured by commercial carriers, the Company has elected to self-insure this risk. Also, the Company continues to operate self-insured plans in respect of prior years for employees of Arbor.

Since 1992, the Company has elected under the laws of the State of Texas, not to provide workers' compensation insurance to its employees. In lieu of workers' compensation coverage, the Company provides an employee benefit plan which provides employer-paid benefits comparable to benefits of the State workers' compensation plan.

The Company self-insures its general and professional liability, and auto liability risks, through Laurier Indemnity Company, Ltd. and Laurier Indemnity Company. Effective January 1, 2000, the Company's retained risk for general and professional liability risks increased substantially due to the adverse claims experienced by the captive companies, particularly in respect of risks in the State of Florida. Effective December 31, 2000, the Company no longer operates nursing and assisted living facilities in the State of Florida. This will limit the Company's exposure to future litigation claims in that State.

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

The Company believes that it has sufficient cash resources to fund current claims payments.

## **SOURCES OF REVENUE**

### **United States**

EHSI derives its revenue from Medicare, Medicaid, and private pay sources. During 2000, EHSI derived approximately 24% (1999 – 22%; 1998 – 29%), 51% (1999 – 50%; 1998 – 43%), and 25% (1999 – 28%; 1998 – 28%) of its revenue from these sources, respectively. These percentages have been restated to include the resident co-payment portion within the respective Medicare or Medicaid revenue where previously the co-payment was included with private.

### ***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 one of EHSI's nursing facilities are Medicare-certified. As of December 31, 2000, EHSI had 7,717 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 2000, EHSI received Medicare Part A and Part B payments through two Medicare payment models, which were 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 (RUGs), which correspond to the acuity levels 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 replaces 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. For EHSI, PPS became effective for three facilities in 1998 with the remainder being subject to PPS as of January 1, 1999. The PPS per diem rates, under certain criteria, are to be phased into effect over a four-year period, whereby facilities in excess of the established rates will be moved downward to the lower PPS rate.

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.

Funds received by EHSI under Medicare pre-PPS 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.

## ***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.

### ***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 negotiation 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 64% 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 the Company'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 patient 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 Extendicare's owned nursing centres qualify for the accreditation funding.

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. 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 have 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 year-end, all but two of ECI's Ontario nursing centres were receiving compliance funding at the \$1.00 per bed per day level. ECI plans to rebuild these two facilities to meet the Government's current design standards. These facilities would then qualify for the capital funding program that provides funding of \$10.35 per bed per day.

Provincial funding for the Company's nursing centres in Alberta, the next highest revenue source province for the Company, is based on a system similar to that in Ontario. With the exception of Saskatchewan, which funds resident care on a monthly rate per resident, the other provinces in which ECI operates set funding on a per patient day basis, according to a negotiated schedule.

Extendicare's Canadian home health care operations, conducted through ParaMed, received 11% of its revenue from private-pay clients in 2000. The remainder of the revenue from home health care operations is derived from tendered contracts with locally administered provincial agencies.

ECI's Ontario rehabilitative therapy services, conducted through AIM, receive revenue primarily from individuals, employers, and insurance companies. Ontario legislation provides that individuals injured in automobile accidents are entitled to rehabilitative therapy services. In addition, the Workplace Safety and Insurance Board funds individuals injured in work-related situations or involved with disability claims.

## PROPERTIES

The following table lists by state, province and country the nursing centres, assisted living and retirement centres, and hospitals owned, leased or managed by the Company at December 31, 2000:

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	3,143	8	301	–	–	35	3,444
Massachusetts	5	606	–	–	–	–	5	606
Delaware	1	120	–	–	–	–	1	120
Ohio	30	3,214	3	171	–	–	33	3,385
West Virginia	1	120	–	–	–	–	1	120
Wisconsin	24	2,212	10	444	–	–	34	2,656
Minnesota	10	1,290	1	60	–	–	11	1,350
Indiana	17	1,827	3	133	–	–	20	1,960
Kentucky	18	1,511	1	39	–	–	19	1,550
Washington	15	1,452	8	382	–	–	23	1,834
Oregon	3	211	2	97	–	–	5	308
Idaho	2	179	–	–	–	–	2	179
Texas	16	1,347	2	110	–	–	18	1,457
Arkansas	1	96	3	188	–	–	4	284
Louisiana	1	167	–	–	–	–	1	167
<b>Total United States</b>	<b>171</b>	<b>17,495</b>	<b>41</b>	<b>1,925</b>	<b>–</b>	<b>–</b>	<b>212</b>	<b>19,420</b>
Ontario	36	4,865	3	274	1	120	40	5,259
Alberta	14	1,186	–	–	–	–	14	1,186
Saskatchewan	5	654	–	–	–	–	5	654
Manitoba	2	458	–	–	–	–	2	458
British Columbia	1	75	–	–	–	–	1	75
<b>Total Canada</b>	<b>58</b>	<b>7,238</b>	<b>3</b>	<b>274</b>	<b>1</b>	<b>120</b>	<b>62</b>	<b>7,632</b>
<b>TOTAL</b>	<b>229</b>	<b>24,733</b>	<b>44</b>	<b>2,199</b>	<b>1</b>	<b>120</b>	<b>274</b>	<b>27,052</b>

In addition, EHSI operated 20 rehabilitative clinics as follows: Wisconsin – 11; Texas – 1; Ohio – 1; and Pennsylvania – 7.

ParaMed and AIM provided their services through 62 locations, substantially all of which were leased, as follows: Ontario – 53; British Columbia – 7; 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 medical supplies and services and group purchasing operation competes with other similar operations ranging from small local operators to companies that are national in scope and distribution capability.

EHSI also 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.

## **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 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. In January 2001, the OSHA Ergonomic Final Rule was passed and the Company is taking appropriate steps to review and implement these new ergonomic standards.

### ***Omnibus Budget Reconciliation Act - 1987***

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.

The Health Care Financing Administration (HCFA) of the Department of Health and Human Services promulgated regulations in 1995 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 HCFA prior to implementation.

Effective with the implementation of the 1995 regulation, HCFA 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 HCFA its serious concern that the 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 HCFA or state survey agencies. In 1998, EHSI operated one facility in Maryland that lost its certification under the Medicare and Medicaid systems and subsequently, ceased its operations.

In November 2000, EHSI operated one facility in Indiana that temporarily lost its certification under the Medicare and Medicaid systems and remains under scrutiny of the State survey agency. In February 2001, the State renewed the license for the facility and the facility is re-certified in the Medicaid 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.

Acquisition, construction and operation of assisted living facilities are less stringent than 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 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 Balanced Budget Act 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 Health Insurance Portability and Accountability Act 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***

Provincial legislation and regulations closely control all aspects of operation and funding including 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 is required 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.

In Ontario, Government reimbursement includes funding based on a facility's attainment of design standards. Current design standards, which were introduced in 1998, provide for additional funding for facilities that are classified into the three highest design standard categories. ECI has made efforts to upgrade its facilities with the result that, at the present time, all but two of its facilities receive compliance funding. The Company plans to rebuild these two facilities to meet the current design standards, and once complete, these facilities would qualify for capital funding.

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**

Extencicare currently employs approximately 38,800 people, including approximately: 5,100 registered and licensed practical nurses; 12,400 nursing assistants; 1,800 therapists; 6,500 dietary, domestic, maintenance and other staff; 10,300 Canadian home care professionals and other staff; and 2,700 administrative employees who work at corporate and regional offices and facilities. In Canada, there are 112 collective agreements covering approximately 11,000 employees belonging to 15 different unions, operating under five different collective bargaining legislative jurisdictions. In the United States, there are 35 collective agreements among six unions covering approximately 2,050 employees. The Company believes that its relationship with its employees generally is good.

## **INVESTMENT IN CROWN LIFE INSURANCE COMPANY**

Extencicare Inc., through 159524 Canada Inc. and Laurier Indemnity Company, Ltd., owned a 34.8% common equity interest in Crown Life Insurance Company (Crown Life) at December 31, 2000. Subsequent to December 31, 2000, 159524 Canada Inc. reacquired Laurier Indemnity Company Ltd.'s interest in Crown Life. Extencicare 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 February 22, 2001, the Board of Directors of Crown Life declared a cash dividend of \$20.30 per common share, which was paid March 15, 2001.

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 assets of \$1.4 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.

## **DIVIDEND RECORD**

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

	<b>Preferred Shares</b>			
	<b>Class I</b>			<b>Class II</b>
	<b>Series 2</b>	<b>Series 3</b>	<b>Series 4</b>	<b>Series 1</b>
2000	\$1.2334	\$1.2300	\$1.2507	\$1.421
1999	1.1659	1.2300	1.1825	1.297
1998	1.1149	1.2300	1.1306	1.303

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

## SELECTED FINANCIAL INFORMATION

	Year ended December 31		
	2000	1999	1998
<i>(thousands of dollars unless otherwise noted)</i>			
<b>Income Statement Data:</b>			
<b>Revenue</b>			
Nursing and assisted living centres			
United States	1,346,033	1,364,084	1,470,539
Canada	266,671	260,723	240,782
United Kingdom	–	35,985	38,412
Medical supplies and outpatient therapy – United States	14,430	63,989	209,308
Home health – Canada	161,323	150,280	134,984
Other	18,949	17,626	18,843
	1,807,406	1,892,687	2,112,868
<b>Operating and administrative costs</b>	<b>1,683,990</b>	<b>1,749,613</b>	<b>1,859,780</b>
<b>Earnings before undernoted</b>	<b>123,416</b>	<b>143,074</b>	<b>253,088</b>
Lease costs	30,947	32,327	27,792
Depreciation and amortization	75,002	86,880	82,685
Interest, net	78,484	91,888	99,240
Loss (gain) from asset impairment, disposals and other items	42,747	183,889	(131,566)
<b>Earnings (loss) before income taxes</b>	<b>(103,764)</b>	<b>(251,910)</b>	<b>174,937</b>
Income taxes (recovery)	(36,916)	(69,219)	112,149
Minority interests	257	(171)	976
<b>Net earnings (loss) from health care</b>	<b>(67,105)</b>	<b>(182,520)</b>	<b>61,812</b>
<b>Share of earnings of Crown Life</b>	<b>7,827</b>	<b>22,818</b>	<b>3,520</b>
<b>Net earnings (loss)</b>	<b>(59,278)</b>	<b>(159,702)</b>	<b>65,332</b>
<b>Earnings (loss) per share</b>			
Basic	(0.81)	(2.14)	0.85
Fully diluted	(0.81)	(2.14)	0.84
<b>Operating Statistics:</b>			
Number of facilities (end of period)	274	297	322
Resident capacity (end of period)	27,052	29,582	32,426
Average occupancy rate (percentage)	89.9	88.2	88.9
U.S. payor source as a percentage of total U.S. revenue <sup>(1)</sup>			
Private Pay	25	28	28
Medicare	24	22	29
Medicaid	51	50	43
Property and equipment capital expenditures	46,292	50,268	113,342
EBITDA margin <sup>(2)</sup> (percentage)	5.1	5.9	10.7
<b>Balance Sheet Data (at period end):</b>			
<b>Assets</b>			
Cash and short-term investments	10,181	35,894	28,501
Working capital	27,557	96,346	18,508
Total health care assets	1,588,345	1,697,800	2,089,207
Investment in Crown Life, equity basis	147,407	136,323	132,631
Total assets	1,735,752	1,834,123	2,221,838
<b>Long-term debt</b>	<b>802,426</b>	<b>891,955</b>	<b>1,004,261</b>
<b>Shareholders' equity</b>	<b>381,437</b>	<b>435,933</b>	<b>656,853</b>

(1) The U.S. payor source percentages have been restated to include the resident co-payment portion within the respective Medicare or Medicaid revenue. Previously it was included in private revenue.

(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 acquisitions or disposals and major changes in the business.

### ACQUISITIONS

*1998*

The Company invested \$30.1 million for the acquisition of five nursing centres, one assisted living centre and the operating assets of four medical specialty services-related businesses in the United States.

### CONSTRUCTION

*1998*

The Company opened four nursing facilities, one nursing facility addition and five assisted living facilities in the United States. These activities increased resident capacity by 675.

*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.

### ASSET IMPAIRMENT, DISPOSALS AND OTHER ITEMS

*1998*

The Company sold the pharmacy operations of EHSI to Omnicare, Inc. for proceeds of \$377.6 million on September 16, 1998. The sale resulted in a gain of \$150.9 million. Goodwill and other intangible assets were reduced by \$148.5 million related to the pharmacy operations sold. The net sale proceeds were used to repay US\$165.0 million of EHSI's term credit facilities.

Also during 1998, the Company recorded a provision of \$12.2 million for adverse development of general and professional liability costs related to prior years.

*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*

Effective April 18, 2001, the Company 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 carrying value of the facilities approximated the amount of the net proceeds. The Company applied US\$4.0 million of the net cash proceeds to reduce its term bank debt.

## **SHARE CAPITAL TRANSACTIONS**

In each of 2000, 1999 and 1998, the Company filed a Normal Course Issuer Bid (the "SV Bid") for the purchase and cancellation of Subordinate Voting Shares. During 2000, the Company purchased and cancelled 1,284,100 Subordinate Voting Shares at a cost of \$2,807,000 (1999 – 1,197,800 shares at a cost of \$4,669,000). The current SV Bid, which commenced November 27, 2000, will terminate on the earlier of November 26, 2001 and the date on which a total of 4,000,000 Subordinate Voting Shares have been purchased and cancelled by the Company pursuant to the Bid. As of April 30, 2001, 1,470,600 Subordinate Voting Shares have been purchased and cancelled under the current SV Bid at a cost of \$5,308,000, of which 296,000 shares at a cost of \$742,000 were acquired during 2000.

On April 26, 2001, the Company filed a Normal Course Issuer Bid for the purchase and cancellation of up to 375,000 Multiple Voting Shares (the "MV Bid"). The MV Bid became effective May 1, 2001 and expires no later than November 26, 2001.

## **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**

Extendicare 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 2000 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, 2000, 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, 2000;
  - (iii) one copy of the Management Information and Proxy Circular of the Company dated February 28, 2001 for the annual meeting of shareholders held on April 25, 2001; 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 April 25, 2001. Additional financial information is provided in the Company's Consolidated Financial Statements for the financial year ended December 31, 2000.

## 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
<b>David J. Hennigar</b> <sup>(CG)</sup> Director, Chairman Bedford, Nova Scotia	Chairman, Annapolis Group Inc. (real estate development and holding company); Chairman, High Liner Foods Inc. (value added food processor); and Chairman, Acadian Securities Inc. (investment dealer)	2004/1980
<b>H. Michael Burns</b> <sup>(CG) (IS)</sup> Director, Deputy Chairman Maple, Ontario	Corporate Director	2002/1978
<b>Frederick B. Ladly</b> <sup>(CG) (HR) (QS)</sup> Director, Deputy Chairman Fallbrook, Ontario	Vice-Chairman, Crown Life Insurance Company since Jan./96; President and Chief Executive Officer, Extendicare Inc. from Apr./92 to Aug./97, Deputy Chairman since 1997	2004/1986
<b>Mel Rhineland</b> Director, President and Chief Executive Officer Milwaukee, Wisconsin	President and Chief Executive Officer of Extendicare Inc. since Aug./00; Chairman and Chief Executive Officer of Extendicare Health Services Inc. since Aug./00; and Chairman and Chief Executive Officer of Extendicare (Canada) Inc. since Aug./00; during 1999, Mr. Rhineland was appointed President of Extendicare and Chief Executive Officer of both Extendicare Health Services, Inc. and Extendicare (Canada) Inc.; prior thereto as a senior executive in various capacities for Extendicare Inc. and its subsidiaries	2003/2000
<b>Derek H. L. Buntain</b> <sup>(HR) (IS)</sup> Director Paget, Bermuda	President and Chief Executive Officer, Goodman & Company (Bermuda) Limited (investment counsel)	2002/1995
<b>Sir Graham Day</b> <sup>(CG) (HR)</sup> Director Hantsport, Nova Scotia	Chairman, Hydro One Inc. since Dec./98 (electricity); and Counsel, Stewart McKelvey Stirling Scales (barristers and solicitors)	2004/1989
<b>George S. Dembroski</b> <sup>(A) (IS)</sup> Director Toronto, Ontario	Corporate Director; prior to Feb./98, Vice-Chairman, RBC Dominion Securities Limited (investment dealer)	2002/1995
<b>David M. Dunlap</b> <sup>(A) (HR) (QS)</sup> 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
<b>George A. Fierheller</b> <sup>(A) (IS)</sup> Director Toronto, Ontario	President, Four Halls Inc. (investment and consulting company) since Jan./97; prior thereto, Vice-Chairman, Rogers Communications Inc. (national communications)	2003/1981
<b>Dr. Seth B. Goldsmith</b> <sup>(CG) (QS)</sup> Director Hollywood, Florida	Professor of Health Policy and Management, University of Massachusetts; former Chief Executive Officer, Miami Jewish Home & Hospital for the Aged from Sept./96 to 1998	2003/1995
<b>Michael J. L. Kirby</b> <sup>(CG) (HR) (QS)</sup> Director Nepean, Ontario	Senator of the Parliament of Canada	2002/1987
<b>Alvin G. Libin</b> <sup>(A)</sup> Director Calgary, Alberta	President of Balmon Holdings Ltd. (investment company)	2002/1984
<b>J. Thomas MacQuarrie, Q.C.</b> <sup>(A) (HR)</sup> Director Halifax, Nova Scotia	Senior Partner, Stewart McKelvey Stirling Scales (barristers and solicitors)	2004/1980
<b>Mark W. Durishan</b> Vice-President, Finance, and Chief Financial Officer Brookfield, Wisconsin	Executive of Extendicare since August 1999; prior thereto, Senior Vice President for Finance and Operations, Blue Cross and Blue Shield of Minnesota	
<b>Len G. Koroneos</b> Vice-President and Treasurer Richmond Hill, Ontario	Executive of Extendicare	
<b>Jillian E. Fountain</b> Corporate Secretary Toronto, Ontario	Member of Extendicare management	

Notes:

- (A) Member of Audit Committee (IS) Member of Information Systems Committee  
(CG) Member of Corporate Governance and Nominating Committee (QS) Member of Quality/Standards Committee  
(HR) Member of Human Resources Committee

At April 30, 2001, the directors and officers of Extendicare as a group beneficially owned, directly or indirectly, or exercised control or direction over 1,180,471 Subordinate Voting Shares and 8,823,562 Multiple Voting Shares of Extendicare (representing 2.00% and 67.03% of the outstanding Subordinate Voting Shares and Multiple Voting Shares, respectively, and representing 46.91% 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 22, 2001, we reported on the consolidated balance sheets of Extendicare Inc. (the "Corporation") as at December 31, 2000 and 1999, and the consolidated statements of earnings (loss), shareholders' equity and cash flows for each of the years in the three-year period ended December 31, 2000, as incorporated by reference in the Corporations' 2000 Annual Information Form dated May 15, 2001, 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, 2000 and 1999 and for each of the years in the three-year period ended December 31, 2000.

(signed) **KPMG LLP**  
Chartered Accountants

Toronto, Canada

February 22, 2001

## SUPPLEMENTARY INFORMATION

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

(dollars in thousands, except per share amounts)

#### GENERAL

The following supplementary information is provided in accordance with the 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:

	<b>2000</b>	<b>1999</b>	<b>1998</b>
Net earnings (loss) from health care for the year as reported in accordance with Canadian GAAP	(67,105)	(182,520)	61,812
Application of asset and liability method of accounting for income taxes (A)	–	(989)	(7,558)
Reclassification of early extinguishment of debt costs to extraordinary item (B)	1,039	859	4,127
Reclassification of income taxes related to early extinguishment of debt costs to extraordinary item (B)	(382)	(354)	(1,602)
Earnings (loss) from health care before extraordinary item for the year as reported in accordance with United States GAAP	(66,448)	(183,004)	56,779
Share of earnings of Crown Life for the year as reported in accordance with Canadian GAAP	7,827	22,818	3,520
Application of United States GAAP (C)	15,497	(74,780)	(15,000)
Share of loss of Crown Life for the year as reported in accordance with United States GAAP	23,324	(51,962)	(11,480)
Earnings (loss) before extraordinary item for the year as reported in accordance with United States GAAP	(43,124)	(234,966)	45,299
Reclassification of early extinguishment of debt costs, net of income taxes, to extraordinary item (B)	(657)	(505)	(2,525)
Net earnings (loss) for the year as reported in accordance with United States GAAP	(43,781)	(235,471)	42,774
Other comprehensive income (loss), net of tax (D):			
Foreign currency translation adjustments	13,599	(82,481)	42,357
Unrealized gains (losses) on invested assets	9,334	(32,003)	4,184
Other comprehensive income (loss)	22,933	(114,484)	46,541
Comprehensive income (loss) as reported in accordance with United States GAAP	(20,848)	(349,955)	89,315
Per share amounts in accordance with United States GAAP			
Earnings (loss) before extraordinary item	(0.60)	(3.15)	0.58
Net earnings (loss)			
Basic	(0.61)	(3.15)	0.55
Diluted	(0.61)	(3.15)	0.55

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

	<u>2000</u>	<u>1999</u>	<u>1998</u>
Shareholders' equity in accordance with Canadian GAAP	381,437	435,933	656,853
Application of asset and liability method of accounting for income taxes (A)	–	(3,505)	(4,598)
Unrealized gains (losses) on invested assets, net of tax (E)	(1,371)	(5,451)	2,112
Change in equity carrying value of Crown Life (C)	<u>(433)</u>	<u>(17,626)</u>	<u>82,486</u>
Shareholders' equity in accordance with United States GAAP	<u><u>379,633</u></u>	<u><u>409,351</u></u>	<u><u>736,853</u></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 2000 (1999 and 1998 – \$nil).

For each of the years ended 2000, 1999 and 1998, the valuation allowance was increased (decreased) by \$(18,765), \$34,167, and \$(3,936), respectively.

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

	<u>2000</u>	<u>1999</u>		<u>2000</u>	<u>1999</u>
Deferred tax assets in accordance with United States GAAP:			Deferred tax liabilities in accordance with United States GAAP:		
Investment in Crown Life	19,446	32,638	Property and equipment	111,020	98,249
Employee benefit accruals	14,073	25,210	Leasehold rights	4,061	4,646
Accounts receivable reserves	12,272	26,220	Other	<u>7,352</u>	<u>9,491</u>
Net capital loss carryforwards	18,162	23,801		<u>122,433</u>	<u>112,386</u>
Self-insurance reserves	40,850	765			
Operating loss carryforwards	3,270	5,761	Net deferred tax liabilities in accordance with United States GAAP	36,726	39,060
Operating reserves	3,273	4,305	Less current net deferred tax assets in accordance with United States GAAP	<u>15,249</u>	<u>28,624</u>
Goodwill	3,879	4,406	Non-current net deferred tax liabilities in accordance with United States GAAP	<u><u>51,975</u></u>	<u><u>67,684</u></u>
Other	<u>11,449</u>	<u>9,952</u>			
	<u>126,674</u>	<u>133,058</u>			
Valuation allowance	<u>(40,967)</u>	<u>(59,732)</u>			
	<u><u>85,707</u></u>	<u><u>73,326</u></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 non-current liabilities are considered to be extraordinary items and are disclosed net of applicable taxes. Under Canadian GAAP such costs are considered to be unusual items and are disclosed as a separate line item, prior to applicable taxes. 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 Corporation's share of earnings (increase (decrease)) of Crown Life are as follows:

	<u>2000</u>	<u>1999</u>	<u>1998</u>
Policy liabilities	4,531	11,601	(22,027)
Investment income	7,246	(37,260)	11,557
Income taxes	3,695	(53,233)	(5,470)
Other	25	4,112	940
	<u>15,497</u>	<u>(74,780)</u>	<u>(15,000)</u>

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

	<u>2000</u>	<u>1999</u>	<u>1998</u>
Equity carrying value of Crown Life in accordance with Canadian GAAP	<u>147,407</u>	<u>136,323</u>	<u>132,631</u>
Policy liabilities	(1,457)	(5,194)	(25,507)
Invested assets	(4,008)	(18,759)	68,598
Income taxes	5,047	6,364	43,548
Other	(15)	(37)	(4,153)
	<u>(433)</u>	<u>(17,626)</u>	<u>82,486</u>
Equity carrying value of Crown Life in accordance with United States GAAP	<u>146,974</u>	<u>118,697</u>	<u>215,117</u>

*Policy Liabilities and Deferred Acquisition Costs.* Under Canadian GAAP, policy liabilities of Crown Life are calculated using the policy premium 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**

Effective January 1, 1998 the Corporation, for reporting in accordance with United States GAAP, adopted Statement of Financial Accounting Standard No. 130, "Reporting Comprehensive Income" (FAS 130). FAS 130 established new 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 Corporation has reported as comprehensive income foreign currency translation adjustments and unrealized gains (losses) on invested assets. The amounts reported as unrealized gains (losses) on invested assets are net of tax, income tax expense (recovery) included therein amounted to \$4,536, \$(19,922) and \$1,189 for 2000, 1999 and 1998, 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, 2000 and 1999 with maturities as follows:

	<u>2000</u>	<u>1999</u>
Due in one year or less	1,504	3,467
Due after 1 year through 5 years	18,507	22,560
Due after 5 years through 10 years	34,063	30,236
Due after 10 years	8,925	3,960
	<u>62,999</u>	<u>60,223</u>
Cash and money market funds	5,200	18,210
	<u>68,199</u>	<u>78,433</u>

**(F) 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, 2000 and 1999, are reported net of an allowance for doubtful accounts of \$26,037 and \$37,568, respectively.

**(G) 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, 2000 and 1999, accrued liabilities were \$208,310 and \$194,570, respectively.

## **(H) Stock Options**

The Corporation 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 Corporation 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, did not recognize compensation expense for options granted in 2000, 1999 and 1998. If FAS 123 had been followed in 2000, 1999 and 1998, the Corporation's net earnings (loss) would have been reduced by \$1,025, \$1,025 and \$1,410, respectively. Basic earnings (loss) per share for 2000, 1999 and 1998 would have been reduced to \$(0.61), \$(3.16) and \$0.56, respectively, on earnings (loss) before extraordinary item, \$(0.62), \$(3.17) and \$0.53, respectively, on net earnings (loss). Diluted earnings (loss) per share for 2000, 1999 and 1998 would have been reduced to \$(0.62), \$(3.17) and \$0.53, respectively.

The pro forma effect on net earnings (loss) for 1999 and 1998 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 2000, 1999 and 1998:

- a) dividend yield - 0% for all years;
- b) expected volatility – 69.95% to 74.41% for 2000; 55.00% for 1999; and 32.32% for options granted during 1998;
- c) risk-free interest rate – 5.83% to 6.28% for 2000; 4.94% to 5.50% for 1999; and 5.13% for options granted during 1998; and
- d) weighted average expected life – 4.4 years for 2000; 4.3 years for 1999; and 4.0 years for 1998.

The weighted average fair value of options granted was \$2.14, \$2.56 and \$5.21 per share in 2000, 1999 and 1998, 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.

## **(I) New Accounting Standard**

In June 1998, the Financial Accounting Standards Board issued Statement No. 133, "Accounting for Derivative Instruments and for 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" and is now effective for the Company on January 1, 2001. Under this standard, all derivatives will be recognized at fair value in the balance sheet. Derivatives that are not hedges will be adjusted to fair value through earnings. If the derivative is a hedge, depending on the nature of the hedge, changes in the fair value will either be offset against the change in the fair value of the hedged assets, liabilities or firm commitments through earnings, or it will be recognized in other comprehensive income until the hedged item is recognized in earnings. If the change in the fair value of the derivative is not completely offset by the change in the value of the item it is hedging, the difference will be recognized immediately in earnings.

The Company has adopted the new standard on January 1, 2001. The ultimate impact of this standard on the Company's earnings and financial position under United States GAAP is dependent on the hedging strategies applied to the Company's derivative portfolio and the composition of that portfolio on and after January 1, 2001. The impact on January 1, 2001 arising from the adoption of the standard (relating to fair value of interest rate swaps) is an increase of \$292 in consolidated liabilities (including income tax effect), a decrease of \$292 in other comprehensive income, and no impact on earnings.

# EXTENDICARE