EXTENDICARE

2013 Management's Discussion and Analysis

Year Ended December 31, 2013

Dated: February 26, 2014

...helping people
live better

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Forward-looking Statements

Information provided by Extendicare from time to time, including this Annual Report, contains or may contain forward-looking statements concerning anticipated future events, results, circumstances, economic performance or expectations with respect to Extendicare and its subsidiaries, including, without limitation, statements regarding its business operations, business strategy, and financial condition. Forward-looking statements can be identified by the expressions "anticipate", "believe", "estimate", "expect", "intend", "objective", "plan", "project" or other similar expressions or the negative thereof. These forward-looking statements reflect the Company's current expectations regarding future results, performance or achievements and are based upon information currently available to the Company and on assumptions that the Company believes are reasonable.

Although forward-looking statements are based upon estimates and assumptions that the Company believes are reasonable based upon information currently available, these statements are not representations or guarantees of future results, performance or achievements of the Company. In addition to the assumptions and other factors referred to specifically in connection with these forward-looking statements, factors that could cause the actual results, performance or achievements of Extendicare to differ materially from those expressed or implied by the forward-looking statements are identified in Extendicare's public filings with the Canadian securities regulators and include, without limitation, the following: changes in the overall health of the economy and government; the ability of the Company to attract and retain qualified personnel; changes in the health care industry in general and the long-term care industry in particular because of political and economic influences; changes in applicable accounting policies; changes in regulations governing the industry and the compliance by Extendicare and its subsidiaries with such regulations; changes in government funding levels for health care services; changes in tax laws; resident care and class action litigation, including the Company's exposure to punitive damage claims, increased insurance costs and other claims; the ability of Extendicare to maintain and increase census levels; changes in competition; changes in demographics and local environment economies; changes in foreign exchange and interest rates; changes in the financial markets that may affect the ability of Extendicare to refinance debt; and the availability and terms of capital to Extendicare to fund capital expenditures.

The forward-looking statements contained in this Annual Report are expressly qualified by this cautionary statement. Given these risks and uncertainties, readers are cautioned not to place undue reliance on the forward-looking statements of Extendicare. The forward-looking statements speak only as of the date of this Annual Report. Except as required by applicable securities laws, the Company assumes no obligations to update or revise any forward-looking statements.

Management's Discussion and Analysis

February 26, 2014

BASIS OF PRESENTATION

Extendicare Inc. ("Extendicare" or the "Company") is the successor to Extendicare Real Estate Investment Trust ("Extendicare REIT" or the "REIT") following the conversion of the REIT from an income trust to a corporate structure pursuant to a plan of arrangement effective July 1, 2012 (the "2012 Conversion"). Extendicare's common shares (the "Common Shares") trade on the Toronto Stock Exchange (TSX) under the symbol "EXE".

The 2012 Conversion was accounted for by the Company as a continuity of interest, and accordingly, the consolidated financial statements of the Company are reflective as if the Company had always carried on the business previously carried on indirectly by Extendicare REIT. Comparative information for Extendicare relating to periods prior to the 2012 Conversion is that of its predecessor, Extendicare REIT.

Extendicare has prepared this Management's Discussion and Analysis (MD&A) to provide information to assist its current and prospective investors' understanding of the financial results for the year ended December 31, 2013. This MD&A should be read in conjunction with Extendicare's audited consolidated financial statements for the years ended 2013 and 2012, and the notes thereto, found in Extendicare's 2013 Annual Report. This material is available on Extendicare's website at www.extendicare.com. Additional information about Extendicare, including its latest Annual Information Form, can be found on SEDAR at www.sedar.com.

Extendicare is a leading North American provider of post-acute and long-term senior care services. Extendicare does not carry on business directly, but does so indirectly through its subsidiaries. This MD&A provides information on Extendicare and its subsidiaries, and unless the context otherwise requires, references to "Extendicare", the "Company", "we", "us" and "our" or similar terms refer to Extendicare Inc., either alone or together with its subsidiaries. The registered office of Extendicare is located at 3000 Steeles Avenue East, Markham, Ontario, Canada, L3R 9W2.

This MD&A and the accompanying audited consolidated financial statements for the years ended 2013 and 2012, including the notes thereto, have been prepared in accordance with International Financial Reporting Standards (IFRS). All dollar amounts are in Canadian dollars unless otherwise indicated. Except as otherwise specified, references to years indicate the fiscal year ended December 31, 2013, or December 31 of the year referenced.

The discussion and analysis in this MD&A is based upon information available to management as of February 26, 2014. This MD&A should not be considered all-inclusive, as it excludes changes that may occur in general economic, political and environmental conditions. Additionally, other elements may or may not occur, which could affect the Company in the future.

We use a number of key performance indicators in this document for monitoring and analyzing our financial results. These performance indicators are not defined by IFRS, and are therefore not considered to be generally accepted accounting principles, or GAAP, which may not be comparable to similar measures presented by other companies. Please refer to the "Key Performance Indicators" section of this MD&A. In addition, a discussion of the non-GAAP measures is provided under the heading "Accounting Policies and Estimates – Non-GAAP Measures".

OVERVIEW

Business Strategy

At Extendicare, our strategy is to create value for our shareholders through the effective operation and growth of our core senior care operations and complementary long-term care services. By emphasizing the quality of care provided to our residents and by clustering several long-term care centers together within the geographic areas served, our goal is to build upon our reputation as a leading provider of a full range of post-acute services in the community. In pursuing this strategy, an overriding objective is to continually enhance the quality of clinically based services provided to our residents and other clients. The key components of our value-creation strategy include:

- ensuring the continued delivery of quality care and customer service throughout our organization;
- establishing programs that enable our nursing centers to more efficiently attract higher acuity patients resulting in higher reimbursement rates;

- actively maintaining and improving our asset portfolio through a disciplined capital reinvestment program or, where appropriate, through disposition of underperforming or non-strategic centers;
- focusing on achieving operational efficiencies and internal growth in our core business and, when available, growth through new developments and value-creating acquisitions;
- ensuring the highest safety, quality and risk management practices throughout our operations;
- expanding non-government based revenue sources and diversifying within the long-term care industry through our rehabilitative services, information technology, management and consulting businesses;
- enhancing our Canadian businesses, including long-term care and home health care operations; and
- increasing funds from operations and adjusted funds from operations.

For the past several years, Extendicare has committed its resources to a "back-to-basics" strategy and the prudent stewardship of the management, growth and operations of its business. This commitment has been successful, particularly in the circumstances involving a weak U.S. economy and a challenging and uncertain regulatory environment.

We believe that Extendicare is a financially stable company with a conservative capital structure. The ownership of our real estate coupled with our geographic diversity position us favourably to address the numerous funding and regulatory challenges facing the industry.

Strategic Review

As previously disclosed in May 2013, the board of directors of the Company (the "Board"), through its strategic committee (the "Strategic Committee"), has been undertaking a review of strategic alternatives relating to a separation of the Company's Canadian and U.S. businesses that would be in the best interests of the Company and would reasonably be expected to enhance shareholder value. With the assistance of CitiGroup Global Markets Inc., as a financial advisor, the Company has studied various alternatives extensively and analyzed relevant considerations, including valuation, taxation, curtailment of future liability costs, and strategic implications of each option.

Extendicare confirms that the Strategic Committee continues its work on this initiative and that the Company is currently negotiating with one party towards a transaction that may involve the lease and/or sale of some or all of our U.S. assets or business. There is no certainty that a transaction will be completed in the near term, if at all. Material details will be disclosed to the public when available.

Business Overview

Extendicare, through its wholly owned subsidiary operating entities, is a major provider of short-term and long-term senior care services through its network of owned and operated health care centers in North America, operating 249 senior care centers with capacity for 27,686 residents at December 31, 2013. In addition to the 249 centers that we currently operate, we own 21 centers (1,762 beds) in the State of Kentucky that are leased to a third-party operator. The transfer of the Kentucky operations became effective July 1, 2012, for 19 of the centers and the remaining two centers were transferred effective October 1, 2012, as discussed under the heading "Other Significant Developments – 2012 Kentucky Lease Transaction".

Extendicare's wholly owned U.S. subsidiary, Extendicare Health Services, Inc. and its subsidiaries (collectively "EHSI"), operates 156 senior care centers with capacity for 15,207 residents, and has a significant presence (more than 14% of its resident capacity) in each of Pennsylvania, Michigan, Wisconsin, and Ohio. EHSI offers a continuum of health care services, including nursing care, assisted living and related medical specialty services, such as post-acute care and rehabilitative therapy on an inpatient and outpatient basis.

Extendicare's wholly owned Canadian subsidiary, Extendicare (Canada) Inc. and its subsidiaries (collectively "ECI"), operates 93 senior care centers, with capacity for 12,479 residents. ECI has a significant presence in Ontario and Alberta, where approximately 75% and 13% of its residents are served, respectively. Also, through its ParaMed Home Health Care (ParaMed) division, ECI is the largest provider of publicly funded home health care in Ontario.

Extendicare owns rather than leases a majority of its properties, unlike a number of other long-term care providers. At December 31, 2013, we operated 201 centers that we either owned or leased with options to purchase, representing approximately 99% of our 204 owned or leased centers, excluding those operated under management contracts and the 21

Kentucky centers that have been leased to third-party operators. We believe that ownership increases our operating flexibility by allowing us to: refurbish centers to meet changing consumer demands; expand or add assisted living and retirement centers adjacent to our nursing centers; adjust licensed capacity to avoid occupancy-based rate penalties; divest centers and exit markets at our discretion; and more directly control occupancy costs.

The following depicts ownership and management of senior care centers operated by EHSI and ECI at December 31, 2013. In addition, EHSI owns 21 centers (1,762 beds) in the State of Kentucky that are leased to a third-party operator.

	Nursing Centers		Assisted Living and Retirement Centers		Chronic Care Units		Total	
By Type of Ownership	**No. of Centers**	**Resident Capacity**	**No. of Centers**	**Resident Capacity**	**No. of Centers**	**Resident Capacity**	**No. of Centers**	**Resident Capacity**
United States								
Owned	138	13,960	4	270	–	–	142	14,230
Leased	4	419	–	–	–	–	4	419
Managed	4	399	6	159	–	–	10	558
Total U.S.	146	14,778	10	429	–	–	156	15,207
Canada								
Owned	48	6,688	1	200	–	–	49	6,888
Leased [(1)]	9	1,155	–	76	–	–	9	1,231
Managed	29	3,752	5	488	1	120	35	4,360
Total Canada	86	11,595	6	764	1	120	93	12,479
Total	**232**	**26,373**	**16**	**1,193**	**1**	**120**	**249**	**27,686**

(1) The nine leased centers in Canada are operated under 25-year finance lease arrangements maturing beginning in 2026 through to 2028.

The following reflects the change in operating capacity of our senior care centers during 2013 and 2012.

	2013		2012	
Extendicare Senior Care Centers	**No. of Centers**	**Operational Beds/Units**	**No. of Centers**	**Operational Beds/Units**
As at beginning of year	**246**	**26,828**	261	28,107
Developed [(1)]	**2**	**436**	–	–
Closed [(1)]	**(4)**	**(412)**	–	–
Managed contracts added	**8**	**1,338**	6	738
Managed contracts matured	**(3)**	**(425)**	–	–
Conversion of assisted living wing to skilled nursing center beds [(2)]	**–**	**30**	–	(35)
Divested/leased to third party [(3)]	**–**	**–**	(21)	(1,762)
Operational capacity adjustments [(4)]	**–**	**(109)**	–	(220)
As at end of year	**249**	**27,686**	246	26,828

(1) In April 2013, we opened a new 256-bed nursing center in Sault Ste. Marie and closed two existing nursing centers (215 beds) and transferred 50 beds from another center in the area. In September 2013, we closed the rehabilitation hospital in Michigan (28 beds). In October 2013, we opened a new 180-bed nursing center in Timmins and closed an existing nursing center (119 beds).

(2) We closed an assisted living wing of a skilled nursing center in the 2012 fourth quarter and converted it to skilled nursing beds at the beginning of 2013.

(3) The 2012 activity relates to the Kentucky lease transaction, as discussed under the heading "Other Significant Developments – 2012 Kentucky Lease Transaction".

(4) The reduction in operational capacity was due primarily to U.S. beds removed from service in order to either increase our Medicaid rate or to accommodate rehabilitation suites.

Significant 2013 Events and Developments

This section summarizes the impact of the following items on the operations of Extendicare: the Medicare update; the 2013 U.S. PrivateBank loan refinancing; the 2013/2014 Canadian mortgage refinancings; and legal proceedings and regulatory actions. Refer to the discussion under the heading "Other Significant Developments" for a summary of other developments affecting the financial results or operations of Extendicare.

MEDICARE UPDATE

The U.S. Centers for Medicare & Medicaid Services (CMS) implemented a net market basket increase on October 1, 2013, of 1.3%, consisting of a market basket increase of 2.3% minus a forecasting error of 0.5% and a productivity adjustment of 0.5%. We estimate that the impact of this funding increase will provide us with additional Medicare Part A and Managed Care revenue of approximately US$5.1 million per annum.

As previously reported, the Special U.S. Joint Select Committee on Deficit Reduction failed to make a recommendation to reduce government spending by January 15, 2012, and the long-term care industry was facing automatic Medicare funding reductions of 2% effective January 2, 2013, as a result of sequestration. These cuts were delayed until April 1, 2013, by the signing into law of the *American Taxpayer Relief Act of 2012* (ATRA). The 2% funding reduction effective April 1, 2013, is estimated to reduce our Medicare and Managed Care revenue by approximately US$6.3 million per annum. Sequestration will remain in effect through to 2023, unless there are future legislative changes.

Effective October 2012, CMS established a new medical review process for annual claims over US$3,700 for physical and speech therapy and a second medical review process for annual claims over US$3,700 for occupational therapy. The ATRA extended this review process until December 31, 2013, and the *Pathway for SGR Reform Act of 2013* (the "SGR Act"), enacted into law on December 26, 2013, further extended these requirements until March 31, 2014. EHSI has recorded negative revenue adjustments of US$1.0 million and US$2.3 million in 2012 and 2013, respectively, for denials of therapy services related to this medical review process.

The ATRA also implemented a reduction in the reimbursement for Medicare Part B services due to an increase in the multiple procedure payment reduction (MPPR) percentage from 25% to 50%, effective April 1, 2013. EHSI estimates that this reduction will reduce its annual therapy revenue by approximately US$3.6 million.

The SGR Act postpones an estimated 27% cut to the Medicare Physician Fee Schedule (MPFS) rates through March 31, 2014. Passage of this short-term extension, often referred to as the "Doc Fix", averts cuts to Part B therapy rates received by EHSI amounting to approximately US$11 million per annum. Proposals for a more permanent solution are currently pending.

For a discussion of recent Medicare and Medicaid funding changes, and other factors affecting the outlook for future funding, please refer to the section "Update of Regulatory and Reimbursement Changes Affecting Revenue – United States".

2013 U.S. PRIVATEBANK LOAN REFINANCING

In April 2013, EHSI closed on six mortgages insured with the U.S. Department of Housing and Urban Development Program (HUD) totalling US$37.7 million with a weighted average interest rate of 3.66%, inclusive of mortgage insurance premiums (MIP) of 0.65%, and a weighted average term to maturity of approximately 32 years. The proceeds were used to repay our PrivateBank loans, which had an aggregate principal balance of US$33.8 million as at March 31, 2013. A loss of $0.4 million (US$0.4 million) in connection with the early retirement of this debt was recorded in the 2013 second quarter.

2013/2014 CANADIAN MORTGAGE REFINANCINGS

Effective August 1, 2013, ECI renewed its existing $15.4 million Canada Mortgage and Housing Corporation (CMHC) mortgage on three Ontario nursing centers for a term of five years at a fixed rate of 3.08%.

Effective September 5, 2013, ECI refinanced three Manitoba nursing centers with conventional mortgages totalling $26.0 million at a fixed rate of 4.14% for a term of seven years. The existing mortgages had a balance of $15.3 million at June 30, 2013, maturing November 2013. A loss of $0.2 million in connection with the early retirement of this debt was recorded in the 2013 third quarter.

In January 2014, ECI committed to the renewal of its existing $6.4 million CMHC mortgage on an Ontario nursing center for a term of 10 years at a fixed rate of 3.62%, effective March 1, 2014.

LEGAL PROCEEDINGS AND REGULATORY ACTIONS

The provision of health care services is subject to complex federal, state and provincial laws and regulations, including laws and regulations that are intended to prevent health care fraud and abuse. Extendicare and its consolidated subsidiaries are defendants in various actions and proceedings that are brought against them from time to time in connection with their operations. Recently adopted U.S. health care reform legislation has resulted in an increase in government oversight of the long-term care industry and, as a result, long-term care providers, including Extendicare, are experiencing an increase in government surveys, investigations, audits and scrutiny of their operations. In such circumstances, Extendicare cooperates in responding to information requests and takes the necessary corrective actions. Extendicare accrues for costs that may result from investigations to the extent that an outflow of funds is probable and a reliable estimate of the amount of the associated costs can be made.

As a result of any determination that Extendicare has violated the U.S. Social Security Act or other applicable laws and regulations in connection with a government investigation or otherwise, or in connection with any settlement of an allegation of the same, Extendicare may incur significant costs, fines, civil monetary penalties, recoupments and administrative penalties (including suspension or exclusion from participation in Medicare, Medicaid and other provider programs) and suffer other sanctions. Among other things, as part of the settlement of any investigation or as a result of litigation relating to an investigation, the Company may be required to assume specific procedural and financial obligations under a corporate integrity agreement, which would typically require the Company to retain a third-party monitor and to implement various new reporting and employee training requirements, and/or other arrangement with the government. Any of these outcomes could have a material adverse effect on the business, results of operations and consolidated financial position of Extendicare.

As previously disclosed, EHSI has received subpoenas from the U.S. Department of Health and Human Services, Office of the Inspector General (OIG) relating to the submission of claims that the OIG believes may be in violation of the U.S. Social Security Act. Starting in November 2012, representatives of the OIG and the U.S. Department of Justice (DOJ) have been meeting with senior representatives of EHSI to discuss the OIG's and DOJ's investigations into the submission of claims that relate to the quality of care provided to residents and patients of EHSI's skilled nursing centers and the provision of rehabilitation services. EHSI has continued to work cooperatively with the OIG and DOJ and settlement discussions between EHSI and the OIG and DOJ have been ongoing with a view to resolving the investigations on a nationwide basis. The settlement discussions include the requirement that EHSI enter into a corporate integrity agreement with the OIG, the principal terms and conditions of which have not been agreed to. If EHSI enters into a corporate integrity agreement or incurs any fines, penalties or recoupment as part of a settlement of the OIG and DOJ investigations described above, it would not be an admission by EHSI that EHSI or any of its subsidiaries provided substandard patient care or medically unnecessary rehabilitation services. As at February 26, 2014, settlement discussions between the OIG and DOJ and EHSI and its outside counsel were not sufficiently advanced for EHSI to be able to predict the possible outcomes of the investigations (or any possible related litigation if a settlement with the OIG and DOJ is not reached) and the Company is unable to reliably estimate the range or the amount of the associated costs or loss that may be incurred. Any settlement or the outcome of any related litigation could involve the payment of substantial sums and other sanctions that could have a material adverse effect on the Company's business, results of operations or consolidated financial position. EHSI believes that it is in material compliance with the U.S. Social Security Act and other applicable federal and state laws and regulations. EHSI's nursing centers are subject to periodic unannounced federally mandated inspections by state or federal authorities to determine compliance by the centers with applicable health care laws and regulations. Every effort is made by EHSI to avoid or mitigate deficiencies through quality assurance strategies and to remedy any deficiencies cited by the inspections within the prescribed time period.

KEY PERFORMANCE INDICATORS

In order to compare Extendicare's financial performance between periods, management assesses the key performance indicators for all of its continuing operations. In addition, we assess the operations on a same-facility basis between the reported periods. Set forth below is an analysis of the key performance indicators and a discussion of significant trends when comparing Extendicare's financial results.

The following is a glossary of terms for some of our key performance indicators:

"ADC" means average daily census, and is the number of residents occupying a bed over a period of time, divided by the number of days in that period;

"Average Daily Revenue Rate", or "ADRR" means the aggregate revenue earned divided by the aggregate census in the corresponding period, by payor source;

"Census" is defined as the number of residents occupying beds (or units in the case of an assisted living center) over a period of time;

"CI" means commercial insurance, which is a form of health care coverage in the United States;

"CMI" means case mix index, which is a measure of the relative cost or resources needed to treat the mix of patients or residents;

"**HMO**" means health maintenance organization, which is a type of managed care organization that provides a form of health care coverage in the United States;

"Managed Care" refers collectively to HMO and CI payor sources, but does not include HMOs serving Medicaid residents, which are included in the Medicaid category;

"Non same-facility", in the context of comparing our 2013 and 2012 operations in this document, refers to (i) those centers and businesses that we have ceased operating (including those under a sale agreement), (ii) those centers that are new to our portfolio, since January 1, 2012, and (iii) those centers that are classified as held for sale. For the purposes of comparing our 2013 and 2012 results, the U.S. non same-facility operations is composed of: our 21 skilled nursing centers in the State of Kentucky that were leased out in the latter half of 2012; our rehabilitation hospital in the State of Michigan that was closed at the end of September 2013; and 11 skilled nursing centers that are held for sale. The Canadian non same-facility operations is composed of: our nursing center operations in Sault Ste. Marie and Timmins, Ontario, where we opened two new nursing centers in 2013 that resulted in the closing of three existing centers and the downsizing of another; and our Alberta home health care operations, where we discontinued operating in August 2013;

"Occupancy" is measured as the percentage of census relative to the total available resident capacity. Total operational resident capacity is the number of beds (or units in the case of an assisted living center) available for occupancy multiplied by the number of days in the period;

"Quality Mix" is the measure of the level of non-Medicaid payor sources. In most states, Medicaid is the least attractive payor source as rates are the lowest among all payor types;

"Same-facility", in the context of comparing our 2013 and 2012 operations in this document, refers to those centers and businesses that were operated by us on January 1, 2012, and throughout 2012 and 2013, and are not classified as held for sale; and

"Skilled Mix" refers collectively to Medicare and Managed Care payor sources. These sources generally include residents with short-term rehabilitative needs that we focus on accommodating.

U.S. Operations

We have established clinical programs designed to enable our centers to accommodate higher acuity residents and those requiring rehabilitative care and services. These residents are primarily admitted into our centers with Medicare and Managed Care as their primary funding source. Approximately 43% of our Managed Care residents have rates that are based on the Resource Utilization Groupings (RUGs) classification system, or are partially aligned with the Medicare rates. Medicaid rates are generally lower than rates earned from other sources. Therefore, we consider Skilled Mix to be an important performance measurement indicator. Although higher acuity residents generally produce higher revenue per resident day, profitability may be impacted by the costs associated with the increased resources needed to accommodate the needs of these residents. Additionally, these residents usually have a significantly shorter length of stay. During 2013, approximately 83% (2012 – 82%) of our admissions were Medicare or Managed Care funded, with 49% (2012 – 51%) funded by Medicare and 34% (2012 – 31%) funded by Managed Care.

Through the establishment of specific clinical programs that we market to high-acuity residents who are admitted to our centers to recover from neurological conditions, cardiovascular ailments, joint replacements and other disorders requiring intensive therapy, our revenue is increased. We are also able to return these residents to lower-cost settings faster. The funding source for most of these residents is Medicare or Managed Care. Individuals who do not qualify for a funded program pay for the services directly. Therefore, we focus on these payor types to increase average daily revenue rates and improve Quality Mix census as a percentage of the total ADC. After the short-term rehabilitative portion of a resident's stay, residents who require further longer-term care and who do not have the financial means to pay for it, seek funding from state Medicaid programs at rates that are generally lower than those earned from other sources.

Our data collection and reporting system allows us to electronically track the condition of the residents and services provided for them. This electronic system enables us to operate more efficiently within the RUGs classifications system, by ensuring that appropriate payment is received for services being delivered and, thereby, increasing our average Medicare rates.

SKILLED NURSING CENTER REVENUE BY PAYOR SOURCE

The CMS Medicare net market basket increases for October 1, 2012 and 2013, were 1.8% and 1.3%, respectively. However, our Medicare Part A and Managed Care rates were adversely impacted by the sequestration funding reduction of 2.0% effective April 1, 2013 and our Medicare Part A funding has been impacted by a reduction in co-insurance reimbursement for bad debts, which declined from 100% to 88% on January 1, 2013, and to 76% on January 1, 2014. For the 2013 fourth quarter, our average daily Medicare Part A rate, excluding prior period settlement adjustments, was US$468.78, representing a decrease of 0.3% from US$470.21 in the 2012 fourth quarter, primarily due to the impact of sequestration partially offset by the market basket increase. In comparison to our average daily Medicare Part A rate of US$471.20 in the 2013 third quarter, our rate this quarter declined by 0.5%, primarily due to the reduction in reimbursement for bad debts and a change in acuity mix, partially offset by the net market basket increase. For 2013 compared to 2012, our average daily Medicare Part A rate increased by 1.9% to US$470.21, primarily due to changes in acuity mix, with the impact of the market basket increases being substantially offset by sequestration and reductions in reimbursement for bad debts.

For the 2013 fourth quarter, our average daily Managed Care rate, excluding prior period settlement adjustments, was US$445.03, representing an increase of 1.3% from US$439.41 in the 2012 fourth quarter and a 0.8% decline from US$448.82 in the 2013 third quarter, primarily due to changes in acuity mix. For 2013, our average daily Managed Care rate increased by 2.5% to US$443.27.

Our average daily Medicaid rate, excluding prior period settlement adjustments, increased this quarter by 3.5% to US$200.80 from US$194.03 in the 2012 fourth quarter, and by 0.5% from US$199.76 in the 2013 third quarter. For 2013 compared to 2012, our average daily Medicaid rate increased by 5.4% to US$199.07. However, revenue from Medicaid rate increases was partially offset by higher state provider taxes, resulting in a net increase of 5.0% this year over 2012. In addition, during the 2012 fourth quarter, we became eligible to receive Upper Payment Limit funding for all of our centers in Indiana. Exclusive of this additional funding, the net increase in Medicaid rates this year over 2012 was 3.2%. For the majority of the states in which we operate, Medicaid funding changes take effect in July and October.

The following table provides the percentage of EHSI's revenue by payor source and the average revenue rates for its total skilled nursing center operations, excluding prior period settlement adjustments, on a quarterly and annual basis for each of 2013 and 2012.

	Q1		Q2		Q3		Q4		Year	
(total operations)	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**
Revenue by Payor Source *(%)*										
Medicare	**32.0**	31.9	**29.9**	31.7	**28.8**	30.5	**28.3**	29.7	**29.7**	31.0
Managed Care	**10.9**	10.2	**10.7**	9.6	**10.7**	10.2	**10.8**	10.3	**10.7**	10.1
Skilled Mix	**42.9**	42.1	**40.6**	41.3	**39.5**	40.7	**39.1**	40.0	**40.4**	41.1
Private/other	**8.9**	8.8	**9.6**	9.0	**9.7**	9.4	**10.0**	9.7	**9.6**	9.2
Quality Mix	**51.8**	50.9	**50.2**	50.3	**49.2**	50.1	**49.1**	49.7	**50.0**	50.3
Medicaid	**48.2**	49.1	**49.8**	49.7	**50.8**	49.9	**50.9**	50.3	**50.0**	49.7
Total	**100.0**	100.0	**100.0**	100.0	**100.0**	100.0	**100.0**	100.0	**100.0**	100.0
Average Revenue Rate by Payor Source *(US$)*										
Medicare Part A	**476.08**	456.29	**464.30**	455.25	**471.20**	466.23	**468.78**	470.21	**470.21**	461.45
Medicare Parts A and B	**516.86**	504.91	**504.22**	502.54	**517.06**	519.37	**508.95**	510.68	**511.84**	508.92
Managed Care	**439.44**	426.07	**440.04**	430.66	**448.82**	434.35	**445.03**	439.41	**443.27**	432.38
Private/other	**245.04**	232.15	**244.29**	236.02	**241.26**	237.80	**247.79**	235.69	**244.60**	235.39
Medicaid	**195.39**	185.00	**197.14**	186.83	**199.76**	190.42	**200.80**	194.03	**199.07**	188.87
Weighted average	**270.56**	256.19	**266.26**	256.75	**267.29**	260.47	**267.51**	261.78	**268.44**	258.66

The following table provides the percentage of EHSI's revenue by payor source from its same-facility skilled nursing center operations, excluding prior period settlement adjustments, on a quarterly and annual basis for each of 2013 and 2012.

	Q1		Q2		Q3		Q4		Year	
(same-facility operations)	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**
Revenue by Payor Source *(%)*										
Medicare	**32.2**	32.2	**30.0**	32.3	**29.0**	30.9	**28.6**	29.9	**29.9**	31.3
Managed Care	**10.9**	10.9	**10.8**	10.3	**10.8**	10.3	**10.9**	10.3	**10.8**	10.5
Skilled Mix	**43.1**	43.1	**40.8**	42.6	**39.8**	41.2	**39.5**	40.2	**40.7**	41.8
Private/other	**8.9**	8.9	**9.6**	9.1	**9.5**	9.3	**10.0**	9.6	**9.5**	9.2
Quality Mix	**52.0**	52.0	**50.4**	51.7	**49.3**	50.5	**49.5**	49.8	**50.2**	51.0
Medicaid	**48.0**	48.0	**49.6**	48.3	**50.7**	49.5	**50.5**	50.2	**49.8**	49.0
Total	**100.0**	100.0	**100.0**	100.0	**100.0**	100.0	**100.0**	100.0	**100.0**	100.0

On a same-facility basis, the percentage of our Skilled Mix revenue to total revenue declined to 39.5% from 40.2% in the 2012 fourth quarter, and declined from 39.8% in the 2013 third quarter. These declines were primarily due to declines in Skilled Mix census as discussed in the following section. For 2013, our same-facility Skilled Mix revenue represented 40.7% of total revenue compared to 41.8% in 2012. This decline was primarily due to a decline in Skilled Mix census as discussed in the following section, partially offset by the impact of the change in acuity mix on our average rates as discussed above.

On a same-facility basis, the percentage of Medicare residents receiving therapy services declined to 85.9% in the 2013 fourth quarter from 86.5% in the 2012 fourth quarter and from 86.8% in the 2013 third quarter. For 2013, this percentage improved to 86.5% from 85.8% in 2012.

For more information on Medicare and Medicaid funding in the U.S., including recent developments and their impact or expected impact on Extendicare, please see "Update of Regulatory and Reimbursement Changes Affecting Revenue – United States".

SKILLED NURSING CENTER AVERAGE DAILY CENSUS

The following table provides the ADC, percentage of total ADC, and average occupancy of EHSI's skilled nursing centers from total operations, on a quarterly and annual basis for each of 2013 and 2012.

	Q1		Q2		Q3		Q4		Year	
(total operations)	**2013**	2012	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**
Average Daily Census										
Medicare	**2,055**	2,283	**1,887**	2,263	**1,765**	1,918	**1,767**	1,864	**1,868**	2,081
Managed Care	**821**	861	**770**	804	**756**	768	**770**	748	**779**	795
Skilled Mix	**2,876**	3,144	**2,657**	3,067	**2,521**	2,686	**2,537**	2,612	**2,647**	2,876
Private/other	**1,209**	1,365	**1,256**	1,366	**1,271**	1,287	**1,289**	1,321	**1,256**	1,334
Quality Mix	**4,085**	4,509	**3,913**	4,433	**3,792**	3,973	**3,826**	3,933	**3,903**	4,210
Medicaid	**8,169**	9,568	**8,035**	9,551	**8,070**	8,578	**8,064**	8,302	**8,084**	8,997
Total	**12,254**	14,077	**11,948**	13,984	**11,862**	12,551	**11,890**	12,235	**11,987**	13,207
Census by Payor Type *(%)*										
Medicare	**16.8**	16.2	**15.8**	16.2	**14.9**	15.3	**14.9**	15.2	**15.6**	15.8
Managed Care	**6.7**	6.1	**6.4**	5.7	**6.4**	6.1	**6.5**	6.1	**6.5**	6.0
Skilled Mix	**23.5**	22.3	**22.2**	21.9	**21.3**	21.4	**21.4**	21.3	**22.1**	21.8
Private/other	**9.8**	9.7	**10.6**	9.8	**10.7**	10.3	**10.8**	10.8	**10.5**	10.1
Quality Mix	**33.3**	32.0	**32.8**	31.7	**32.0**	31.7	**32.2**	32.1	**32.6**	31.9
Medicaid	**66.7**	68.0	**67.2**	68.3	**68.0**	68.3	**67.8**	67.9	**67.4**	68.1
Total	**100.0**	100.0	**100.0**	100.0	**100.0**	100.0	**100.0**	100.0	**100.0**	100.0
Average occupancy *(%)*	**84.6**	85.9	**82.6**	85.6	**81.8**	84.9	**82.5**	84.2	**82.9**	85.2

In the latter half of 2012, we transferred our Kentucky operations (21 centers and 1,762 beds) to a third-party operator. Nineteen of the centers were transferred on July 1, 2012 and the remaining two were transferred effective October 1, 2012. This transaction accounts for the majority of the declines in ADC from total operations when comparing ADC in 2013 to quarters prior to the 2012 third quarter.

We continue to be adversely affected by the weak U.S. economic conditions that have reduced disposable income of individuals and resulted in a general restraint by the public on health care spending. Lower hospital census has resulted in fewer admissions, and the implementation of MDS 3.0 and RUG-IV as of October 2010 has also resulted in a small reduction in our average length of stay for short-term admissions. In addition, certain state Medicaid programs are attempting to divert potential admissions to assisted living centers and home care programs to reduce the strain on Medicaid budgets.

We have implemented a number of short-term and longer-term tactics, which take a more strategic approach to identifying and meeting the program and service needs of each community in which we are located. Included in these initiatives is the establishment of Active Life Transition Units (ALTUs) that are upgraded suites targeted to attract our short-term rehabilitation residents. We have completed 17 ALTUs and currently have two additional ALTUs under construction. We plan to continue to expand the number of centers with ALTUs.

EHSI's total skilled nursing center ADC declined by 2.8%, or 345 ADC, to 11,890 in the 2013 fourth quarter from 12,235 in the 2012 fourth quarter. Our same-facility operations contributed lower ADC of 324, and the balance of the decline in ADC of 21 related to our non same-facility operations. Our average occupancy in the 2013 fourth quarter was 82.5% compared to 84.2% in the 2012 fourth quarter and 81.8% in the 2013 third quarter. For 2013, our total skilled nursing center ADC declined by 9.2%, or 1,220 ADC to 11,987 from 13,207 in 2012. Our same-facility operations contributed lower ADC of 317, and the balance of the decline in ADC of 903 related to our non same-facility operations, primarily due to the leasing out of our Kentucky operations in 2012. Our average occupancy from total skilled nursing center operations in 2013 was 82.9% compared to 85.2% in 2012.

The following table provides the ADC, percentage of total ADC, and average occupancy of EHSI's skilled nursing centers from same-facility operations, on a quarterly and annual basis for each of 2013 and 2012.

	Q1		Q2		Q3		Q4		Year	
(same-facility operations)	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**
Average Daily Census										
Medicare	**1,961**	1,928	**1,800**	1,941	**1,686**	1,822	**1,696**	1,778	**1,785**	1,867
Managed Care	**778**	776	**737**	728	**722**	723	**735**	705	**743**	733
Skilled Mix	**2,739**	2,704	**2,537**	2,669	**2,408**	2,545	**2,431**	2,483	**2,528**	2,600
Private/other	**1,148**	1,150	**1,193**	1,167	**1,196**	1,193	**1,218**	1,235	**1,189**	1,186
Quality Mix	**3,887**	3,854	**3,730**	3,836	**3,604**	3,738	**3,649**	3,718	**3,717**	3,786
Medicaid	**7,654**	7,809	**7,529**	7,781	**7,560**	7,888	**7,543**	7,798	**7,571**	7,819
Total	**11,541**	11,663	**11,259**	11,617	**11,164**	11,626	**11,192**	11,516	**11,288**	11,605
Census by Payor Type *(%)*										
Medicare	**17.0**	16.5	**16.0**	16.7	**15.1**	15.7	**15.2**	15.5	**15.8**	16.1
Managed Care	**6.7**	6.7	**6.5**	6.3	**6.5**	6.2	**6.5**	6.1	**6.6**	6.3
Skilled Mix	**23.7**	23.2	**22.5**	23.0	**21.6**	21.9	**21.7**	21.6	**22.4**	22.4
Private/other	**10.0**	9.8	**10.6**	10.0	**10.7**	10.3	**10.9**	10.7	**10.5**	10.2
Quality Mix	**33.7**	33.0	**33.1**	33.0	**32.3**	32.2	**32.6**	32.3	**32.9**	32.6
Medicaid	**66.3**	67.0	**66.9**	67.0	**67.7**	67.8	**67.4**	67.7	**67.1**	67.4
Total	**100.0**	100.0	**100.0**	100.0	**100.0**	100.0	**100.0**	100.0	**100.0**	100.0
Average occupancy (%)	**85.5**	85.6	**83.5**	85.5	**82.8**	85.6	**83.4**	85.1	**83.8**	85.5

Our same-facility skilled nursing center ADC of 11,192 in the 2013 fourth quarter was 324 below the 2012 fourth quarter level of 11,516 due to lower Medicaid ADC of 255, lower Skilled Mix ADC of 52, and lower private/other ADC of 17. In comparison to the 2013 third quarter, our same-facility ADC improved by 28 due to higher Skilled Mix ADC of 23 and higher private/other ADC of 22, partially offset by lower Medicaid ADC of 17. Our average same-facility occupancy was 83.4% this quarter compared to 85.1% in the 2012 fourth quarter, and 82.8% in the 2013 third quarter. For 2013, our same-facility skilled nursing center ADC declined by 2.7%, or 317 ADC to 11,288 from 11,605 in 2012 due to lower Skilled Mix ADC of 72 and lower Medicaid ADC of 248, partially offset by higher private/other ADC of three. Our average occupancy from same-facility skilled nursing center operations in 2013 was 83.8% compared to 85.5% in 2012.

Our same-facility Skilled Mix ADC of 21.7% of our residents in the 2013 fourth quarter improved over 21.6% in each of the 2012 fourth and 2013 third quarters, and was unchanged at 22.4% in each of 2013 and 2012.

Canadian Operations

The funding received by ECI for its nursing centers and home health care services is regulated by provincial authorities (rather than federal authorities), who often set the rates following consultation with the providers and their industry associations. This type of system reduces the potential for a single change or event to significantly affect the reimbursement or regulatory environment for ECI. For more information on government funding in Canada, including recent developments and their impact or expected impact on Extendicare, please see "Update of Regulatory and Reimbursement Changes Affecting Revenue – Canada".

The following table provides ECI's average daily revenue rates and occupancy levels from its total nursing and assisted living center operations, on a quarterly and annual basis for each of 2013 and 2012.

	Q1		Q2		Q3		Q4		Year	
(total operations)	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**
Average revenue rate *($)*	**191.12**	183.92	**192.39**	187.57	**191.86**	186.26	**201.82**	191.15	**194.33**	187.24
Average occupancy *(%)*	**97.5**	97.4	**97.6**	97.8	**98.0**	97.9	**97.8**	98.7	**97.7**	98.0

The following table provides ECI's average daily revenue rates and occupancy levels from its same-facility nursing and assisted living operations, on a quarterly and annual basis for each of 2013 and 2012.

	Q1		Q2		Q3		Q4		Year	
(same-facility operations)	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**
Average revenue rate *($)*	**191.67**	184.69	**192.47**	188.13	**192.19**	186.77	**201.20**	191.80	**194.41**	187.86
Average occupancy *(%)*	**97.5**	97.3	**97.6**	97.7	**98.0**	97.9	**98.2**	98.7	**97.8**	97.9

Revenue from provincial programs represented approximately 68% of ECI's nursing center revenue in 2013 (2012 – 66%). ECI's average daily revenue rate increased by 5.6% to $201.82 in the 2013 fourth quarter from $191.15 in the 2012 fourth quarter, and by 5.2% from $191.86 in the 2013 third quarter. The majority of ECI's nursing center operations are in Ontario, which operates under a funding envelope system, under which a substantial portion of the revenue is tied to flow-through funding. Therefore, the flow-through funding is matched with the related costs for resident care in the periods in which the costs are incurred. As a result, ECI's average revenue rates fluctuate by quarter, and are generally at their lowest in the first quarter and at their highest in the fourth quarter. For 2013, the average daily revenue rate increased by 3.8% to $194.33 from $187.24, and on a same-facility basis it increased by 3.5% to $194.41.

Historically, the supply of long-term care beds in Canada has been very restricted in comparison to the United States. As a result, nursing center operators in Canada typically enjoy higher occupancy levels than those in the United States. Our average occupancy in Canada was 97.7% in 2013 compared to 98.0% in 2012, with the majority of the decline resulting from the fill-up period associated with the opening of a new larger nursing center in Timmins, Ontario this past fall. On a same-facility basis, our average occupancy was relatively unchanged at 97.8% in 2013 compared to 97.9% in 2012. In terms of the quarterly trends throughout the year, slightly lower occupancy levels are to be expected during the winter months as a result of flu outbreaks, which can lead to temporary freezes on admissions.

With respect to our Canadian home health care operations, effective August 2013, ParaMed no longer provides services in Alberta as a result of the outcome of an Alberta Health Services (AHS) initiative to reduce the number of service providers in the province. ParaMed's Alberta operations generated revenue of $7.5 million and Adjusted EBITDA of $1.3 million for the year ended December 31, 2012. For 2013, these operations contributed revenue of $4.2 million and Adjusted EBITDA of $0.4 million. In addition, a pre-tax charge of $0.2 million was recognized this year as part of the "loss from asset impairment, disposals and other items" in connection with the discontinuation of the Alberta home health care operations.

In Ontario, ParaMed's ability to grow its government business has been impeded since 2004 when the government froze the competitive bidding process for all operators in the province. In October 2012, the Ministry of Health and Long-Term Care (MOHLTC) implemented a new model for home health care in Ontario that does not involve a bidding process. Instead, the new service delivery model will place greater emphasis on quality of care and value than past arrangements, with service providers' performance evaluated based on these elements. Performance against an established set of indicators will guide decisions during future contract discussions. We expect that our superior quality service delivery will ensure both retention and growth of current volumes under the MOHLTC's plan to grow community based care. For further details, refer to the discussion under the heading "Update of Regulatory and Reimbursement Changes Affecting Revenue – Canada – Ontario Home Health Care Legislation and Funding".

Revenue from provincial programs represented approximately 98% of ECI's home health care revenue in 2013 (2012 – 97%). Despite discontinuing operations in Alberta last quarter, ParaMed's average daily home health care hours of service increased by 2.3% this quarter to 13,638 from 13,336 in the 2012 fourth quarter, and increased by 2.8% from 13,268 in the 2013 third quarter. For 2013, ParaMed provided 4,911,000 hours of home health care service (13,456 hours per day) compared to 4,796,000 hours of home health care service, or 13,103 hours per day, provided in 2012. In Ontario, ParaMed increased its daily hours of service provided this quarter by 8.1% to 13,637 over 12,616 provided in the 2012 fourth quarter, and by 4.5% over 13,047 provided in the 2013 third quarter. For 2013, ParaMed provided 4,772,000 hours of home health care service in Ontario, 13,074 hours per day, representing an increase of 5.2% over 12,423 hours per day in 2012.

IMPACT OF U.S. DOLLAR AND FOREIGN CURRENCY TRANSLATION

Impact on Financial Statements

The majority of our operations are conducted in the United States, which accounted for 62.8% of consolidated revenue from continuing operations in 2013 (2012 – 64.2%). As a result, changes in the exchange rates used to translate the results of the U.S. operations to Canadian dollars can affect the comparison of the consolidated results.

The following table illustrates the positive/(negative) effect of changes in the average exchange rates used in translating the U.S. results for the 2013 fourth quarter and for 2013.

	Q4		Year	
Exchange Rate Impact on Periods	**2013**	**2012**	**2013**	**2012**
Average U.S./Canadian dollar exchange rate	**1.0489**	0.9916	**1.0299**	0.9996
Continuing Operations *(millions of dollars)*				
Revenue	**17.7**		37.4	
Adjusted EBITDA	**1.0**		2.5	
Net earnings	**(0.5)**		(0.5)	
AFFO	**0.4**		1.0	
Same-facility Operations *(millions of dollars)*				
Revenue	**16.7**		35.1	
Adjusted EBITDA	**0.8**		2.1	

The following table illustrates the contribution from our U.S. operations to selected line items of our financial results and the impact of a one-cent change in the Canadian dollar against the U.S. dollar on those line items, for each of 2013 and 2012.

U.S. Operations	**Results**		**Impact of One-Cent Change in Exchange Rate** [1]	
	2013	**2012**	**2013**	**2012**
(millions of dollars)	*US$*	*US$*	C$	C$
Revenue	***1,234.6***	*1,309.0*	**12.3**	13.1
Adjusted EBITDA	***81.4***	*111.1*	**0.8**	1.1
AFFO	***32.8***	*51.4*	**0.3**	0.5

(1) A weaker Canadian dollar against the U.S. dollar has a positive effect on reported results; while a stronger Canadian dollar has a negative effect on reported results.

Impact of Foreign Currency Forward Contract Strategy on Distributions

We have a foreign currency hedging strategy whereby we monitor and consider entering into foreign currency forward contracts (FCFCs) in order to reduce the risks associated with changes in the U.S. dollar and the impact such changes could have on our Canadian dollar cash available for distribution. The Company has not had any FCFCs in place since June 2011. Management continues to monitor the U.S. to Canadian dollar exchange rate and to consider future FCFCs to the extent that they may be beneficial to the Company.

DIVIDEND POLICY

The declaration and payment of dividends by Extendicare is at the discretion of the Board as to the amount and timing of dividends to be declared and paid, after consideration of a number of factors including results of operations, requirements for capital expenditures and working capital, future financial prospects of Extendicare, debt covenants and obligations, and any other factors deemed relevant by the Board. If the Board determines that it would be in Extendicare's best interests, it may reduce, for any period, the amount and frequency of dividends to be distributed to holders of Common Shares.

As previously announced on April 29, 2013, the Board elected to reduce Extendicare's monthly dividend to $0.04 per share from $0.07 per share, commencing with the May 2013 dividend.

Dividends declared in 2013 totalled $52.0 million, or $0.60 per share, representing approximately 73% of total AFFO of $71.1 million, or $0.820 per basic share. For the year ended 2012, distributions declared totalled $71.5 million, or $0.84 per share, representing approximately 85% of total AFFO of $84.6 million.

Taxability of Dividends

Any distributions made by Extendicare Inc. on its Common Shares will be taxed as dividends. Any such dividends that are designated by Extendicare as "eligible dividends" for Canadian federal income tax purposes will qualify for the enhanced dividend tax credit. However, there may be limitations on the ability of Extendicare to designate all or any portion of any dividends as "eligible dividends" and, accordingly, no assurance can be given as to the extent to which any dividends will be designated as "eligible dividends".

For U.S. tax purposes, any distributions made by Extendicare Inc. on its Common Shares to U.S. residents who meet the statutory holding period requirements for their shares, will be treated as a qualified dividend to the extent such distribution is paid from current or accumulated earnings and profits as determined under U.S. federal income tax principles. It is anticipated that Extendicare will calculate its current earnings and profits to determine the portion of its distributions that may be treated as qualified dividends and communicate this information to U.S. shareholders by January 31st following each calendar year end. Extendicare is not required by law to calculate its accumulated earnings and profits under U.S. federal income tax principles and it has not and will not calculate accumulated earnings and profits. Accordingly, any distributions in excess of current earnings and profits are required to be treated as non-qualified dividends.

ADJUSTED FUNDS FROM OPERATIONS

The following table provides a reconciliation of our Adjusted EBITDA to Funds from Operations (FFO) and AFFO on a quarterly and annual basis for each of 2013 and 2012. (1)

(millions of dollars unless otherwise noted)	Q1		Q2		Q3		Q4		Year	
	2013	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**
Adjusted EBITDA	**39.1**	49.4	**41.5**	43.6	**43.0**	37.3	**32.1**	52.9	**155.7**	183.2
Depreciation for FFEC	**(5.6)**	(5.8)	**(5.5)**	(6.3)	**(5.5)**	(5.7)	**(5.4)**	(5.8)	**(22.0)**	(23.6)
Accretion costs	**(0.8)**	(0.5)	**(0.8)**	(0.6)	**(1.0)**	(0.5)	**(0.8)**	(0.7)	**(3.4)**	(2.3)
Interest, net	**(14.5)**	(16.2)	**(14.5)**	(14.8)	**(15.2)**	(15.4)	**(14.6)**	(15.3)	**(58.8)**	(61.7)
	18.2	26.9	**20.7**	21.9	**21.3**	15.7	**11.3**	31.1	**71.5**	95.6
Current income tax expense (recovery) (2)	**3.4**	2.9	**0.9**	3.0	**3.7**	3.5	**(3.3)**	(2.4)	**4.7**	7.0
FFO (4)	**14.8**	24.0	**19.8**	18.9	**17.6**	12.2	**14.6**	33.5	**66.8**	88.6
Amortization of financing costs and accretion costs	**1.8**	1.4	**1.7**	0.9	**1.9**	1.3	**1.7**	1.7	**7.1**	5.3
Principal portion of government capital funding payments	**0.7**	0.7	**0.9**	0.7	**0.9**	0.7	**0.9**	0.7	**3.4**	2.8
Additional facility maintenance capital expenditures (3)	**0.9**	1.0	**(0.3)**	(1.0)	–	(3.0)	**(6.8)**	(9.1)	**(6.2)**	(12.1)
AFFO (4) (5)	**18.2**	27.1	**22.1**	19.5	**20.4**	11.2	**10.4**	26.8	**71.1**	84.6
Per Basic Share *($)*										
FFO	**0.172**	0.285	**0.228**	0.222	**0.203**	0.143	**0.167**	0.393	**0.770**	1.043
AFFO	**0.211**	0.322	**0.255**	0.230	**0.235**	0.130	**0.119**	0.312	**0.820**	0.994
Per Diluted Share *($)*										
FFO	**0.172**	0.267	**0.219**	0.214	**0.197**	0.145	**0.168**	0.362	**0.756**	0.988
AFFO	**0.203**	0.298	**0.240**	0.221	**0.217**	0.134	**0.124**	0.292	**0.784**	0.945
Distributions *($)*										
Declared *(thousands)*	**18,122**	17,729	**13,004**	17,825	**10,435**	17,922	**10,462**	18,021	**52,023**	71,497
Declared per share	**0.210**	0.210	**0.150**	0.210	**0.120**	0.210	**0.120**	0.210	**0.600**	0.840
Weighted Average Number of Shares ***(thousands)***										
Basic	**86,221**	84,347	**86,658**	84,805	**86,922**	85,260	**87,140**	85,736	**86,738**	85,039
Diluted	**103,192**	98,358	**103,628**	98,618	**103,892**	99,604	**104,109**	105,254	**103,708**	100,420

(1) "Adjusted EBITDA", "FFO", and "AFFO" are not recognized measures under IFRS and do not have a standardized meaning prescribed by IFRS. Refer to the discussion of non-GAAP measures.

(2) Excludes current tax with respect to fair value adjustments, and gains or losses on foreign exchange, financial instruments, asset impairment, disposals and other items that are excluded from the computation of AFFO.

(3) Represents total facility maintenance capital expenditures less depreciation for furniture, fixtures, equipment and computers, or FFEC, already deducted in determining FFO.

(4) In 2012, we reported discontinued operations related to the gain on sale of our U.S. group purchasing organization in January 2012. This gain on sale was excluded in determining FFO or AFFO. Consequently, there was no amount to report as discontinued operations.

(5) A reconciliation of AFFO to cash flow from operating activities is provided under the heading "Liquidity and Capital Resources".

The following provides the segmented AFFO for our U.S. and Canadian operations.

Segmented AFFO	Q1		Q2		Q3		Q4		Year	
(millions of dollars)	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**
U.S. operations *(US$)*	**9.8**	19.5	**11.6**	10.2	**8.7**	0.9	**2.7**	20.8	**32.8**	51.4
U.S. operations *(C$)*	**9.9**	19.5	**11.9**	10.4	**9.0**	0.8	**3.0**	20.7	**33.8**	51.4
Canadian operations	**8.3**	7.6	**10.2**	9.1	**11.4**	10.4	**7.4**	6.1	**37.3**	33.2
AFFO	**18.2**	27.1	**22.1**	19.5	**20.4**	11.2	**10.4**	26.8	**71.1**	84.6

AFFO Review

2013 FOURTH QUARTER

AFFO was $10.4 million ($0.119 per basic share) in the 2013 fourth quarter compared to $26.8 million ($0.312 per basic share) in the 2012 fourth quarter, representing a decrease of $16.8 million, excluding a $0.4 million positive effect of a weaker Canadian dollar. This decline was primarily due to a decrease in Adjusted EBITDA of $21.8 million, partially offset by the timing of facility maintenance capital expenditures, which were lower by $3.0 million, reduced net interest costs and lower current income taxes. Net interest costs were lower by $0.9 million as a result of our debt refinancing. Current income taxes for the 2013 fourth quarter were recovery of $3.3 million compared to a recovery of $2.4 million in the 2012 fourth quarter. The 2013 and 2012 fourth quarters were favourably impacted by book-to-file tax adjustments of approximately $3.6 million and $4.0 million, respectively, primarily related to our U.S. operations. Excluding these book-to-file adjustments, current income taxes represented 2.3% and 5.2% of pre-tax funds from operations (FFO), respectively. A discussion of Adjusted EBITDA by segmented division can be found under the heading "Summary of Quarterly Results – 2013 Fourth Quarter Financial Review".

2013 YEAR

AFFO was $71.1 million ($0.820 per basic share) in 2013, compared to $84.6 million ($0.994 per basic share) in 2012, representing a decrease of $14.5 million, excluding a $1.0 million positive effect of a weaker Canadian dollar. This decline was primarily due to a $30.0 million decrease in Adjusted EBITDA, partially offset by the timing of facility maintenance capital expenditures, which were lower by $8.1 million, lower interest costs of $4.5 million due to our debt refinancing, and lower current income taxes. Current income taxes were $4.7 million in 2013 compared to $7.0 million in 2012, representing 6.6% and 7.3% of pre-tax FFO, respectively. Both years were favourably impacted by book-to-file tax adjustments of approximately $4.0 million in 2013 and $5.2 million in 2012. In addition, the 2012 first quarter results included a non-taxable premium refund of $3.5 million. Excluding these items, current income taxes represented 12.3% of pre-tax FFO in 2013 compared to 10.8% in 2012. A discussion of Adjusted EBITDA by segmented division can be found under the heading "2013 Financial Review".

The effective tax rates on our FFO can be impacted by: adjustments to our estimates of annual deferred timing differences, particularly when dealing with cash-based tax items versus accounting accruals; changes in the proportion of earnings between taxable and non-taxable entities; book-to-file adjustments for prior year filings; and the ability to utilize loss carryforwards. The restructuring of our Canadian legal entities, along with the elimination of the income trust structure under the 2012 Conversion, enhanced our ability to utilize available non-capital loss carryforwards, which reduced our Canadian current income taxes in the last half of 2012 and during 2013. Our Canadian non-capital loss carryforwards were substantially utilized by the end of 2013. As a result, we anticipate that our annual effective tax rate on FFO will increase in 2014 to between 23% and 26%.

Facility maintenance capital expenditures were $12.2 million in the 2013 fourth quarter, compared to $14.9 million in the 2012 fourth quarter and $5.5 million in the 2013 third quarter, representing 2.4%, 3.0% and 1.1% of revenue, respectively. Facility maintenance capital expenditures totalled $28.2 million in 2013 compared to $35.7 million in 2012, representing 1.4% and 1.8% of revenue, respectively. These costs fluctuate on a quarterly basis with the timing of projects and seasonality. It is our intention to spend between 1.5% and 2.0% of revenue annually, which is consistent with our objective to maintain and upgrade our centers. In 2014, we are expecting to spend in the range of $38 million to $43 million in facility maintenance capital expenditures and $15 million to $20 million in growth capital expenditures.

SUMMARY OF QUARTERLY RESULTS

The following is a summary of selected consolidated financial information derived from unaudited interim condensed consolidated financial statements for each of the eight most recently completed quarters.

(thousands of dollars unless otherwise noted)	Q1		Q2		Q3		Q4	
	2013	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**
Revenue	**497,957**	517,188	**498,521**	524,686	**508,613**	498,505	**519,374**	497,034
Adjusted EBITDA (1)	**39,143**	49,373	**41,455**	43,637	**42,992**	37,305	**32,153**	52,938
Adjusted EBITDA margin	***7.9%***	*9.5%*	***8.3%***	*8.3%*	***8.5%***	*7.5%*	***6.2%***	*10.7%*
Earnings (loss) from continuing operations before separately reported gains/losses, net of taxes (1)	**2,762**	9,912	**4,549**	6,384	**4,916**	(3,264)	**(1,893)**	16,500
Average U.S./Canadian dollar exchange rate (2)	**1.0083**	1.0011	**1.0234**	1.0103	**1.0385**	0.9956	**1.0489**	0.9916

(1) Refer to discussion of non-GAAP measures, and the reconciliation of these line items to GAAP measures in the table that follows.

(2) These are the actual Bank of Canada average rates of exchange for the period. The year-to-date revenue and expenses of our foreign operations are translated at the average year-to-date rates of exchange, and the results of the quarters are calculated by deducting the previously reported year-to-date results from the current year-to-date results. In addition, separately reported items such as fair value adjustments, gains or losses related to financial instruments, foreign exchange, asset impairment, disposals and other items, are translated at rates of exchange in effect at the time of the transactions. Therefore, the effective exchange rates calculated from the translated amounts reported above, may differ from the actual average rates of exchange indicated for the period.

The following provides a reconciliation of the line items: (i) "net earnings (loss)" to "earnings (loss) from continuing operations before separately reported gains/losses, net of taxes"; and (ii) "earnings (loss) before income taxes" to "Adjusted EBITDA" for each of the eight most recently completed quarters.

(thousands of dollars)	Q1		Q2		Q3		Q4	
	2013	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**
Net earnings (loss)	**3,846**	49,006	**5,101**	3,675	**4,103**	(4,651)	**(7,798)**	14,626
Add (Deduct) (1):								
Fair value adjustment on convertible debentures	**(1,610)**	(4,987)	**(1,044)**	(120)	**(342)**	(2,029)	**(103)**	2,313
Loss on foreign exchange and financial instruments	**518**	–	**–**	1,103	**–**	–	**1**	–
Loss (gain) from asset impairment, disposals and other items	**8**	423	**492**	1,726	**1,155**	3,847	**6,007**	(367)
Distributions on Exchangeable LP Units	**–**	–	**–**	–	**–**	–	**–**	–
Discontinued operations	**–**	(34,530)	**–**	–	**–**	(431)	**–**	(72)
Earnings (loss) from continuing operations before separately reported gains/losses , net of taxes	**2,762**	9,912	**4,549**	6,384	**4,916**	(3,264)	**(1,893)**	16,500
Earnings (loss) before income taxes	**5,843**	17,717	**7,060**	4,979	**7,169**	(491)	**(11,477)**	15,990
Add (Deduct):								
Depreciation and amortization	**19,046**	19,355	**19,404**	19,455	**19,530**	19,005	**19,949**	18,990
Net finance costs	**14,243**	11,661	**14,274**	16,393	**15,715**	13,944	**15,346**	18,325
Loss (gain) from asset impairment, disposals and other items	**11**	640	**717**	2,810	**578**	4,847	**8,335**	(367)
Adjusted EBITDA	**39,143**	49,373	**41,455**	43,637	**42,992**	37,305	**32,153**	52,938

(1) The separately reported items being added to or deducted from net earnings (loss) are net of income taxes.

The following provides the quarterly segmented Adjusted EBITDA for our U.S. and Canadian operations.

Segmented Adjusted EBITDA	**Q1**		**Q2**		**Q3**		**Q4**	
(thousands of dollars)	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**
U.S. operations *(US$)*	**23,506**	33,721	**23,255**	26,239	**22,688**	17,191	**11,904**	33,923
U.S. operations *(C$)*	**23,701**	33,758	**23,804**	26,544	**23,576**	17,028	**12,704**	33,700
Canadian operations	**15,442**	15,615	**17,651**	17,093	**19,416**	20,277	**19,449**	19,238
Adjusted EBITDA	**39,143**	49,373	**41,455**	43,637	**42,992**	37,305	**32,153**	52,938

There are a number of factors affecting the trend of our quarterly results. For seasonal trends, while year-over-year quarterly comparisons will generally remain appropriate, sequential quarters can vary materially. We already report as separate line items "fair value adjustments", "distributions on Exchangeable LP Units", "loss (gain) on foreign exchange and financial instruments" and "loss (gain) from asset impairment, disposals and other items", which are transitional in nature and would otherwise distort historical trends. With respect to our core operations, the significant factors that impact the results from period to period are as follows:

- Medicare and Managed Care admissions are usually the highest in the first and second quarters; begin to decline during the latter portion of the second quarter; and are generally at their lowest in the summer months when there tends to be fewer elective surgeries performed;
- Medicaid rate changes, including adjustments for CMI and provider taxes, occur with each state's fiscal year, which is July 1st for the majority of the major states in which EHSI operates, and October 1st for Michigan;
- Medicare rate changes generally occur October 1st (federal fiscal year), and typically include a market basket inflationary increase;
- Ontario long-term care providers generally receive annual acuity-based flow-through funding adjustments effective April 1st and accommodation funding increases July 1st, and Alberta long-term care providers generally receive annual inflationary rate increases and acuity-based funding adjustments on April 1st;
- independent actuarial reviews are conducted three times a year, in the second and third quarters and at year end, which may lead to a strengthening, or conversely, a release of the reserves for self-insured liabilities;
- utility costs are generally at their highest in the first quarter and their lowest in the third quarter, with variances between the two of as much as $3.0 million; and
- foreign currency exchange rate fluctuations between the U.S. and Canadian dollars and impact on translation of our U.S. operations from U.S. dollars to Canadian dollars.

Further details on the above can be found under the sections "Overview – Significant 2013 Events and Developments", "Key Performance Indicators", "Impact of U.S. Dollar and Foreign Currency Translation", "Other Significant Developments" and "Update of Regulatory and Reimbursement Changes Affecting Revenue".

2013 Fourth Quarter Financial Review

CONSOLIDATED CONTINUING OPERATIONS

	Q4		**Change**	
(millions of dollars unless otherwise noted)	**2013**	**2012**	**$**	**%**
Revenue	**519.3**	497.0	22.3	*4.5%*
Operating expenses	**468.8**	426.9	41.9	*9.8%*
Administrative costs	**15.5**	14.5	1.0	*6.9%*
Lease costs	**2.9**	2.7	0.2	*7.4%*
Adjusted EBITDA	**32.1**	52.9	(20.8)	*(39.3)%*
Adjusted EBITDA as a % of revenue	***6.2%***	*10.7%*		
Average U.S./Canadian dollar exchange rate	**1.0489**	0.9916		

The average exchange rates used to translate the results of the U.S. operations to Canadian dollars were 1.0489 for the 2013 fourth quarter and 0.9916 for the 2012 fourth quarter. However, separately reported items such as fair value adjustments, gains or losses related to financial instruments, foreign exchange, asset impairment, disposals and other items, are translated at the rates of exchange in effect at the time of the transactions.

Highlights *(variances exclude effect of foreign exchange)*

- Revenue of $519.3 million in the 2013 fourth quarter, included a $6.7 million increase in same-facility operations over the 2012 fourth quarter.
- Average daily Medicare Part A rate decreased by 0.3% this quarter over the 2012 fourth quarter, and the Managed Care rate increased by 1.3%.
- Adjusted EBITDA of $32.1 million in the 2013 fourth quarter declined by $21.8 million over the 2012 fourth quarter.
- Adjusted EBITDA included an increase in the provision for self-insured liabilities of $14.3 million over Q4 2012.
- Adjusted EBITDA margin of 6.2% in the 2013 fourth quarter declined from 10.7% in the 2012 fourth quarter.

Consolidated revenue from continuing operations increased by $22.3 million to $519.3 million in the 2013 fourth quarter from $497.0 million in the 2012 fourth quarter. Non same-facility operations contributed $28.4 million to revenue this quarter and $29.5 million in the 2012 fourth quarter, for a net decline between quarters of $1.1 million. Refer to the glossary under the heading "Key Performance Indicators" for a description of what has been included in non same-facility operations. Excluding a $16.7 million positive effect of a weaker Canadian dollar, revenue from same-facility operations increased by $6.7 million, due to an improvement from our Canadian operations, partially offset by lower revenue from our U.S. operations. Details by segmented operations are discussed below.

Consolidated Adjusted EBITDA from continuing operations declined by $20.8 million to $32.1 million this quarter from $52.9 million in the 2012 fourth quarter, representing 6.2% and 10.7% of revenue, respectively. Non same-facility operations generated Adjusted EBITDA of $3.7 million this quarter and $3.6 million in the 2012 fourth quarter, for a net improvement of $0.1 million between periods. Excluding a $0.8 million positive effect of a weaker Canadian dollar, same-facility Adjusted EBITDA decreased by $21.7 million. The U.S. operations contributed $22.2 million, or US$22.2 million, to this decline, which included a US$14.3 million increase in the provision for self-insured liabilities, a US$4.8 million increase in labour costs primarily due to a change in vacation policy that favourably impacted the 2012 fourth quarter, and a US$3.0 million decrease in prior period revenue settlement adjustments, partially offset by a refund of prior period charges of US$2.0 million recorded in the 2013 fourth quarter. Adjusted EBITDA from same-facility Canadian operations improved by $0.5 million this quarter. Details by segmented operations are discussed below.

Consolidated labour-related costs represented 71.9% of operating and administrative costs in the 2013 fourth quarter compared to 74.3% in the 2012 fourth quarter, and as a percentage of revenue, were 67.1% and 66.0%, respectively. The decline as a percentage of operating and administrative costs this quarter was primarily due to the increase in the provision for self-insured liabilities.

U.S. CONTINUING OPERATIONS

(millions of dollars unless otherwise noted)	**Q4 2013**		**Q4 2012**		**Change**	
	US$	**C$**	**US$**	**C$**	**US$**	**%**
Revenue	**307.2**	***322.3***	313.6	*310.8*	(6.4)	*(2.0)%*
Operating expenses	**284.2**	***298.0***	268.0	*265.5*	16.2	*6.0%*
Administrative costs	**9.3**	***9.8***	10.1	*10.1*	(0.8)	*(7.9)%*
Lease costs	**1.7**	***1.8***	1.6	*1.5*	0.1	*6.3%*
Adjusted EBITDA	**12.0**	***12.7***	33.9	*33.7*	(21.9)	*(64.6)%*
Adjusted EBITDA margin	***3.9%***		*10.8%*			

Revenue from U.S. operations in its functional currency declined by US$6.4 million to US$307.2 million in the 2013 fourth quarter compared to US$313.6 million in the 2012 fourth quarter. Non same-facility operations generated revenue of US$18.1 million this quarter compared to US$19.8 million in the 2012 fourth quarter, for a net decline of US$1.7 million. Refer to the glossary under the heading "Key Performance Indicators" for a description of what has been included in non same-facility operations. Revenue from same-facility operations declined by US$4.7 million between periods, primarily due to lower census levels and a decline in prior period revenue settlements, partially offset by a net increase in average rates. More information on revenue rates and census is provided under "Key Performance Indicators – U.S. Operations".

Same-facility Revenue: 2013 Fourth Quarter Compared to 2012 Fourth Quarter *(US$ millions)*	
(7.4)	– decrease in skilled nursing center resident census (decrease in Medicare $3.6 million, Medicaid $4.6 million, and private/other $0.3 million, partially offset by an increase in Managed Care $1.1 million)
5.6	– increase in average skilled nursing center rates (Medicaid $5.0 million and private/other $1.2 million, partially offset by a decrease in Managed Care $0.6 million)
(3.0)	– decrease in prior period revenue settlement adjustments (charge of $0.7 million in 2013 versus a receipt of $2.3 million in 2012)
0.1	– increase in other revenue
(4.7)	

Operating, administrative and lease costs increased by US$15.5 million to US$295.2 million this quarter compared to US$279.7 million in the 2012 fourth quarter, and were impacted by a reduction in costs from non same-facility operations of US$1.9 million. Costs associated with same-facility operations increased by US$17.4 million, primarily due to a US$14.3 million increase in the provision for self-insured liabilities, a US$4.8 million increase in labour costs primarily due to a change in vacation policy that favourably impacted the 2012 fourth quarter, and other cost increases of US$0.3 million, partially offset by a refund of prior period charges of US$2.0 million recorded in the 2013 fourth quarter. For more information on the provision for self-insured liabilities, refer to the discussion under the heading "Accrual for Self-insured Liabilities" found within the "Liquidity and Capital Resources" section of this MD&A. Labour-related costs from total operations represented 66.1% of operating and administrative costs this quarter, compared to 68.2% in the 2012 fourth quarter, and as a percentage of revenue were 63.1% and 60.5%, respectively.

Adjusted EBITDA from U.S. operations declined by US$21.9 million to US$12.0 million in the 2013 fourth quarter from US$33.9 million in the 2012 fourth quarter, representing 3.9% and 10.8% of revenue, respectively. Adjusted EBITDA from non same-facility operations increased by US$0.2 million (US$2.7 million contribution this quarter compared to US$2.5 million in the same 2012 period). Adjusted EBITDA from same-facility operations decreased by US$22.1 million as a result of higher costs of US$17.4 million and lower revenue of US$4.7 million, as previously discussed.

CANADIAN CONTINUING OPERATIONS

	Q4		**Change**	
(millions of dollars unless otherwise noted)	**2013**	**2012**	**$**	**%**
Revenue	**197.0**	186.2	10.8	*5.8%*
Operating expenses	**170.8**	161.4	9.4	*5.8%*
Administrative costs	**5.7**	4.4	1.3	*29.5%*
Lease costs	**1.1**	1.2	(0.1)	*(8.3)%*
Adjusted EBITDA	**19.4**	19.2	0.2	*1.0%*
Adjusted EBITDA margin	***9.9%***	*10.3%*		

Revenue from Canadian operations grew by $10.8 million to $197.0 million in the 2013 fourth quarter from $186.2 million in the 2012 fourth quarter. Non same-facility operations generated revenue of $9.4 million this quarter compared to $10.1 million in the 2012 fourth quarter, for a net decrease of $0.7 million, which resulted from the discontinuation of the Alberta home health care business, partially offset by the opening of the two new replacement nursing centers in Ontario. Refer to the glossary under the heading "Key Performance Indicators" for a description of what has been included in non same-facility operations. Revenue from same-facility operations improved by $11.5 million between periods due to: growth from nursing and assisted living center operations of $7.8 million, primarily due to funding enhancements, the timing of recognition of revenue under the Ontario envelope system, and a favourable prior period revenue settlement adjustment of $1.2 million recorded in the 2013 fourth quarter; growth from the Ontario home health care operations of $3.0 million, primarily due to an 8.1% increase in daily volumes; and an increase in other revenue of $0.7 million, primarily due to additional centers under management.

Operating, administrative and lease costs increased by $10.6 million to $177.6 million this quarter from $167.0 million in the 2012 fourth quarter. Costs from non same-facility operations were $8.6 million this quarter compared to $9.0 million in the same 2012 period, for a net decrease of $0.4 million. Costs from same-facility operations increased by $11.0 million and included an increase in labour-related costs of $5.9 million, and higher non-wage costs of care, primarily due to the timing of spending under the Ontario nursing center envelope system. Labour-related costs from total operations represented 82.1% of operating and administrative costs this quarter, compared to 84.3% in the 2012 fourth quarter, and as a percentage of revenue were 73.5% and 75.1%, respectively.

Adjusted EBITDA from Canadian operations improved $0.2 million to $19.4 million in the 2013 fourth quarter from $19.2 million in the 2012 fourth quarter, representing 9.9% and 10.3% of revenue, respectively. Adjusted EBITDA from non same-facility operations declined by $0.3 million ($0.8 million contribution this quarter compared to $1.1 million in the same 2012 period). Adjusted EBITDA from same-facility operations improved by $0.5 million, due to higher revenue of $11.5 million, partially offset by increased costs of $11.0 million, as discussed above.

DEPRECIATION AND AMORTIZATION

Depreciation and amortization costs increased by $0.9 million to $19.9 million in the 2013 fourth quarter from $19.0 million in the 2012 fourth quarter, primarily due to a $0.8 million negative effect of a weaker Canadian dollar.

LOSS (GAIN) FROM ASSET IMPAIRMENT, DISPOSALS AND OTHER ITEMS

Extendicare recorded a pre-tax loss of $8.3 million in the 2013 fourth quarter related to: an $8.1 million charge for asset impairment, $7.3 million of which related to the 11 U.S. nursing centers held for sale, and $0.8 million related to the downsizing of one of our nursing centers in Canada upon opening of a new center; and $1.3 million in advisor fees in connection with the Board's strategic review; partially offset by a $1.0 million gain on sale of two closed nursing centers in Canada; and a favourable $0.1 million adjustment to the ParaMed Alberta closing costs. In comparison, we recorded a pre-tax gain of $0.4 million in the 2012 fourth quarter related to the redemption of our 2013 Convertible Debentures. For further information, refer to *note 20* of the 2013 consolidated financial statements.

NET FINANCE COSTS

Net finance costs of $15.3 million in the 2013 fourth quarter were $3.0 million lower than the 2012 fourth quarter level of $18.3 million. This was largely due to a favourable change of $2.4 million with respect to the fair value adjustments on convertible debentures and lower net interest costs of $0.7 million, partially offset by an increase in accretion costs of $0.1 million.

The following table summarizes the components of net finance costs.

	Q4		Change	
(millions of dollars unless otherwise noted)	**2013**	**2012**	**$**	**%**
Interest, net				
Interest expense	**16.0**	16.6	(0.6)	*(3.6)%*
Interest revenue	**(1.4)**	(1.3)	(0.1)	*7.7%*
	14.6	15.3	(0.7)	*(4.6)%*
Accretion				
Accretion of decommissioning provisions	**0.4**	0.4	–	–
Other accretion	**0.4**	0.3	0.1	*33.3%*
	0.8	0.7	0.1	*14.3%*
Fair value adjustment on convertible debentures	**(0.1)**	2.3	(2.4)	*(104.3)%*
Net finance costs	**15.3**	18.3	(3.0)	*(16.4)%*

INCOME TAXES

The tax provision from continuing operations was a recovery of $3.6 million on a pre-tax loss of $11.4 million in the 2013 fourth quarter compared to a tax provision of $1.5 million on pre-tax earnings of $16.0 million in the 2012 fourth quarter. The effective tax rates for each period were distorted by, among other things, the fair value adjustments, gains and losses from financial instruments, foreign exchange, asset impairment, disposals, and other items. The effective tax rate on earnings from continuing operations before separately reported items was 41.6% this quarter compared to 8.0% in the 2012 fourth quarter. As well, both quarters were impacted by favourable book-to-file adjustments of $2.7 million in the 2013 fourth quarter and $3.3 million in the 2012 fourth quarter. After excluding these items, the 2013 fourth quarter reflected a tax provision of $1.4 million on a pre-tax loss of $3.2 million, because of the non-taxable provision for self-insured liabilities. In comparison, after excluding the above items, the tax provision for the 2012 fourth quarter was $4.8 million on pre-tax earnings of $17.9 million, representing an effective tax rate of 26.6%.

2013 SELECTED ANNUAL INFORMATION

The following is a summary of selected annual financial information.

(thousands of dollars unless otherwise noted) Years ended December 31	**2013**	**2012**	**2011**
Revenue	**2,024,465**	2,037,413	2,094,082
Operating expenses	**1,793,368**	1,780,019	1,813,792
Administrative costs	**64,258**	63,155	69,155
Lease costs	**11,096**	10,986	10,999
Total expenses	**1,868,722**	1,854,160	1,893,946
EBITDA	**155,743**	183,253	200,136
Depreciation and amortization	**77,929**	76,805	76,577
Loss from asset impairment, disposals, financing and other items	**9,641**	7,930	62,496
Results from operating activities	**68,173**	98,518	61,063
Interest, net	**58,778**	61,741	85,312
Accretion	**3,380**	2,302	2,029
Distributions on Exchangeable LP Units	**–**	–	2,179
Fair value adjustments	**(3,099)**	(4,823)	(6,023)
Loss (gain) on foreign exchange and financial instruments	**519**	1,103	(553)
Net finance costs	**59,578**	60,323	82,944
Earnings (loss) from continuing operations before income taxes	**8,595**	38,195	(21,881)
Income tax expense	**3,343**	10,572	13,442
Earnings (loss) from continuing operations	**5,252**	27,623	(35,323)
Discontinued operations	**–**	35,033	4,927
Net earnings (loss)	**5,252**	62,656	(30,396)
Add (Deduct):			
Fair value adjustment on convertible debentures, net of taxes	**(3,099)**	(4,823)	577
Fair value adjustment on Exchangeable LP Units, net of taxes	**–**	–	(6,600)
Loss (gain) on foreign exchange and financial instruments, net of taxes	**519**	1,103	(655)
Loss from asset impairment, disposals and other items, net of taxes	**7,662**	5,629	46,808
Distributions on Exchangeable LP Units, net of taxes	**–**	–	2,179
Discontinued operations, net of taxes	**–**	(35,033)	(4,927)
Earnings from continuing operations before separately reported gains/losses and distributions on Exchangeable LP Units, net of taxes	**10,334**	29,532	6,986
Cash distributions per share/unit ($)	**0.60**	0.84	0.84
Total assets *(at year end)*	**1,849,088**	1,807,916	1,830,704
Long-term debt *(at year end)*	**1,016,785**	1,038,787	941,742
Long-term debt including current portion *(at year end)*	**1,164,836**	1,132,235	1,134,440
U.S./Canadian dollar exchange rate			
Average rate for the year	**1.0299**	0.9996	0.9891
Closing rate at year end	**1.0636**	0.9949	1.0170

The closing rates used to translate the assets and liabilities of our U.S. operations were 1.0636 at December 31, 2013, 0.9949 at December 31, 2012, and 1.0170 at December 31, 2011. Total assets at the end of 2012 of $1,807.9 million declined by $22.8 million from $1,830.7 million at the end of 2011, primarily as a result of the stronger Canadian dollar at the end of 2012, which reduced assets by approximately $30.5 million, and was partially offset by an increase in property and equipment due to the construction of two new nursing centers in Canada. Total assets at the end of 2013 of $1,849.1 million increased by $41.2 million from $1,807.9 million at the end 2012, primarily due to the impact of a weaker Canadian dollar at the end of 2013, which increased the assets of our U.S. operations by $89.1 million, and was partially offset by a decline in the balance of property and equipment as a result of depreciation in excess of capital expenditures.

A comparison between the 2013 and the 2012 results is provided in the following discussion "2013 Financial Review" and under the heading "Liquidity and Capital Resources".

2013 FINANCIAL REVIEW

The following is a summary by reporting segment of "revenue", "Adjusted EBITDA", "net finance costs", "net earnings", and "earnings from continuing operations before separately reported gains/losses".

	2013				2012			
(millions of dollars unless otherwise noted)	**U.S.**	**U.S.**	**Canada**	**Total**	**U.S.**	**U.S.**	**Canada**	**Total**
	(US$)				*(US$)*			
Revenue	***1,234.6***	**1,271.5**	**752.9**	**2,024.4**	*1,309.0*	1,308.5	728.9	2,037.4
Operating expenses	***1,104.6***	**1,137.6**	**655.7**	**1,793.3**	*1,147.5*	1,147.0	633.0	1,780.0
Administrative costs	***42.2***	**43.5**	**20.8**	**64.3**	*43.9*	44.0	19.2	63.2
Lease costs	***6.4***	**6.6**	**4.5**	**11.1**	*6.5*	6.5	4.5	11.0
Total expenses	***1,153.2***	**1,187.7**	**681.0**	**1,868.7**	*1,197.9*	1,197.5	656.7	1,854.2
Adjusted EBITDA	***81.4***	**83.8**	**71.9**	**155.7**	*111.1*	111.0	72.2	183.2
Depreciation and amortization	***57.7***	**59.4**	**18.5**	**77.9**	*58.4*	58.4	18.4	76.8
Loss from asset impairment, disposals and other items	***7.2***	**7.7**	**1.9**	**9.6**	*4.6*	4.7	3.2	7.9
Earnings before net finance costs and income taxes	***16.5***	**16.7**	**51.5**	**68.2**	*48.1*	47.9	50.6	98.5
Interest, net	***27.7***	**28.5**	**30.3**	**58.8**	*32.2*	32.2	29.5	61.7
Accretion	***2.3***	**2.4**	**1.0**	**3.4**	*1.8*	1.7	0.6	2.3
Fair value adjustments	**–**	**–**	**(3.1)**	**(3.1)**	–	–	(4.8)	(4.8)
Loss on foreign exchange and financial instruments	**–**	**–**	**0.5**	**0.5**	–	–	1.1	1.1
Net finance costs	***30.0***	**30.9**	**28.7**	**59.6**	*34.0*	33.9	26.4	60.3
Earnings (loss) from continuing operations before income taxes	***(13.5)***	**(14.2)**	**22.8**	**8.6**	*14.1*	14.0	24.2	38.2
Income tax expense (recovery)								
Current	***3.2***	**3.3**	**1.3**	**4.6**	*2.9*	2.9	2.3	5.2
Deferred	***(6.0)***	**(6.3)**	**5.1**	**(1.2)**	*3.2*	3.2	2.2	5.4
Total income tax expense	***(2.8)***	**(3.0)**	**6.4**	**3.4**	*6.1*	6.1	4.5	10.6
Earnings (loss) from continuing operations	***(10.7)***	**(11.2)**	**16.4**	**5.2**	*8.0*	7.9	19.7	27.6
Discontinued operations	**–**	**–**	**–**	**–**	*34.5*	35.0	–	35.0
Net earnings (loss)	***(10.7)***	**(11.2)**	**16.4**	**5.2**	*42.5*	42.9	19.7	62.6
Add (Deduct) [(1)]:								
Fair value adjustment on convertible debentures	**–**	**–**	**(3.1)**	**(3.1)**	–	–	(4.8)	(4.8)
Loss on foreign exchange and financial instruments	**–**	**–**	**0.5**	**0.5**	–	–	1.1	1.1
Loss from asset impairment, disposals and other items	***5.8***	**6.1**	**1.6**	**7.7**	*3.2*	3.3	2.3	5.6
Discontinued operations	**–**	**–**	**–**	**–**	*(34.5)*	(35.0)	–	(35.0)
Earnings (loss) from continuing operations before separately reported gains/losses, net of taxes	***(4.9)***	**(5.1)**	**15.4**	**10.3**	*11.2*	11.2	18.3	29.5
Average U.S./Canadian dollar exchange rate				**1.0299**				0.9996

(1) The separately reported items being added to or deducted from net earnings are net of income taxes.

The average exchange rates used to translate the results of the U.S. operations to Canadian dollars were 1.0299 for 2013 and 0.9996 for 2012. However, separately reported items such as fair value adjustments, gains or losses related to financial instruments, foreign exchange, asset impairment, disposals and other items, are translated at the rates of exchange in effect at the time of the transactions.

Consolidated Continuing Operations

Highlights *(variances exclude effect of foreign exchange)*

- Revenue of $2,024.4 million included a $19.6 million increase in same-facility operations over 2012.
- Average daily revenue rates for Medicare Part A and Managed Care in 2013 increased by 1.9% and 2.5%, respectively, over 2012.
- Adjusted EBITDA of $155.7 million in 2013 declined by $30.0 million, due to an increase in reserves for self-insured liabilities and lower U.S. census levels.
- Adjusted EBITDA margin of 7.7% in 2013 compared to 9.0% in 2012.

Consolidated revenue from continuing operations declined by $13.0 million to $2,024.4 million in 2013 from $2,037.4 million in 2012. Non same-facility operations contributed $116.3 million to revenue this year and $184.0 million in 2012, for a net decline of $67.7 million between years, largely due to the ceasing of operations in the State of Kentucky. Refer to the glossary under the heading "Key Performance Indicators" for a description of what has been included in non same-facility operations. Excluding a $35.1 million positive effect of a weaker Canadian dollar, growth in revenue from same-facility operations was $19.6 million, with an improvement from the Canadian operations of $25.1 million, partially offset by lower revenue from the U.S. operations. Details by segmented operations are discussed below.

Consolidated Adjusted EBITDA from continuing operations declined by $27.5 million to $155.7 million in 2013 from $183.2 million in 2012, representing 7.7% and 9.0% of revenue, respectively. Non same-facility operations generated Adjusted EBITDA of $16.2 million this year and $21.1 million in 2012, for a net decline of $4.9 million. Excluding a $2.1 million positive effect of a weaker Canadian dollar, Adjusted EBITDA from same-facility operations decreased by $24.7 million, as a result of a $26.1 million decline from the U.S. operations, partially offset by a $1.4 million improvement from the Canadian operations. Details by segmented operations are discussed below.

Consolidated labour-related costs in 2013 and 2012 represented 73.4% and 74.0% of operating and administrative costs, respectively, and as a percentage of revenue, were 67.4% and 66.9%, respectively.

U.S. Continuing Operations

Revenue from U.S. operations in its functional currency declined by US$74.4 million to US$1,234.6 million in 2013 compared to US$1,309.0 million in 2012. Non same-facility operations generated revenue of US$76.3 million this period compared to US$145.3 million in 2012, for a net decline of US$69.0 million, of which US$64.0 million was due to the leasing out of our Kentucky operations and the balance related to the 11 skilled nursing centers held for sale and the closure of the rehabilitation hospital. Revenue from same-facility operations declined by US$5.4 million between years primarily due to lower census levels and one less day this year, partially offset by an increase in average revenue rates. More information on revenue rates and census is provided under "Key Performance Indicators – U.S. Operations".

Same-facility Revenue: 2013 Compared to 2012 *(US$ millions)*	
35.9	– increase in average skilled nursing center rates (Medicare $4.0 million, Managed Care $1.1 million, Medicaid $27.6 million and private/other $3.2 million)
(29.5)	– decrease in skilled nursing center resident census (decrease in Medicare $13.9 million, and Medicaid $17.2 million, partially offset by an increase in Managed Care $1.4 million and private/other $0.2 million)
(3.0)	– decrease in nursing ancillary revenue (including declines of $1.3 million for Part B denials in excess of annual limit, and $2.5 million due to change in MPPR percentage effective April 1, 2013)
(3.0)	– decrease in prior period revenue settlement adjustments (charge of $0.4 million in 2013 versus a receipt of $2.6 million in 2012)
(2.8)	– decrease due to one less day this year
(3.0)	– decrease in other revenue
(5.4)	

Operating, administrative and lease costs decreased by US$44.7 million to US$1,153.2 million in 2013 compared to US$1,197.9 million in 2012, and were impacted by a reduction in costs from non same-facility operations of US$65.3 million, of which US$62.1 million was due to the leasing out of our Kentucky operations. Costs associated with same-facility operations increased by US$20.6 million, primarily due to an increase in the provision for self-insured liabilities of US$18.4 million, a premium refund of US$3.5 million received in the 2012 first quarter, and other net cost increases of US$1.8 million, partially offset by a refund of prior period charges of US$2.0 million, and lower labour-

related costs of US$1.1 million, which included favourable workers' compensation adjustments of US$2.7 million. For more information on the provision for self-insured liabilities, refer to the discussion under the heading "Accrual for Self-insured Liabilities" found within the "Liquidity and Capital Resources" section of this MD&A. Labour-related costs from total operations in 2013 and 2012 represented 67.5% and 68.5% of operating and administrative costs, respectively, and as a percentage of revenue were 62.7% and 62.3%, respectively.

Adjusted EBITDA from U.S. operations declined by US$29.7 million to US$81.4 million in 2013 from US$111.1 million in 2012, representing 6.6% and 8.5% of revenue, respectively. Adjusted EBITDA from non same-facility operations declined by US$3.7 million between years (US$13.1 million in 2013 compared to US$16.8 million in 2012). Adjusted EBITDA from same-facility operations declined by US$26.0 million as a result of lower revenue of US$5.4 million and higher costs of US$20.6 million, as previously discussed.

Canadian Continuing Operations

Revenue from Canadian operations grew by $24.0 million to $752.9 million in 2013 from $728.9 million in 2012. Non same-facility operations generated revenue of $37.7 million in 2013 compared to $38.8 million in 2012, for a net decrease of $1.1 million, of which $3.3 million was due to the discontinuance of home health care in Alberta, partially offset by the impact of two new centers in northern Ontario. Refer to the glossary under the heading "Key Performance Indicators" for a description of what has been included in non same-facility operations. Revenue from same-facility operations improved by $25.1 million between years due to: growth from nursing and assisted living center operations of $16.4 million, primarily due to funding enhancements; growth from Ontario home health care operations of $7.1 million, primarily due to a 5.2% increase in daily volumes; and other revenue of $1.6 million, primarily due to additional centers under management.

Operating, administrative and lease costs increased by $24.3 million to $681.0 million in 2013 from $656.7 million in 2012. Costs from non same-facility operations were $35.0 million this year compared to $34.4 million in 2012, for a net increase of $0.6 million primarily due to higher costs of approximately $3.0 million related to the start up of two new centers in northern Ontario, partially offset by the discontinuance of home health care in Alberta. Costs from same-facility operations increased by $23.7 million, primarily due to higher labour-related costs of $18.6 million, and higher non-wage costs of $5.1 million, primarily related to enhanced funding for resident care within the Ontario envelope system. Labour-related costs from total operations in 2013 and 2012 represented 83.7% and 84.0% of operating and administrative costs, respectively, and as a percentage of revenue were 75.2% in both years .

Adjusted EBITDA from Canadian operations was $71.9 million in 2013 compared to $72.2 million in 2012, representing 9.6% and 9.9% of revenue, respectively. Non same-facility operations contributed Adjusted EBITDA of $2.7 million this year compared to $4.4 million in 2012, for a net decline of $1.7 million between years, of which $0.9 million was from the discontinuance of home health care in Alberta and the balance related to the new centers in northern Ontario. Improvements from same-facility operations of $1.4 million resulted from higher revenue of $25.1 million, partially offset by higher costs of $23.7 million, as previously discussed.

Depreciation and Amortization

Depreciation and amortization costs of $77.9 million in 2013 were higher by $1.1 million from $76.8 million in 2012, and included a $1.7 million unfavourable impact of a weaker Canadian dollar, partially offset by a reduction of depreciation and amortization of $0.6 million, primarily due to having fully depreciated certain assets.

Loss from Asset Impairment, Disposals and Other Items

Extendicare recorded a pre-tax loss of $9.6 million in 2013 related to: an $8.0 million charge for asset impairment, $7.3 million of which related to the 11 U.S. nursing centers held for sale; $2.1 million in advisor fees in connection with the Board's strategic review; a $0.7 million charge in connection with the early retirement of debt; and a $0.2 million charge in connection with the closing of our Alberta home health care operations; partially offset by a $1.4 million gain on the sale of three closed nursing centers in Canada. In comparison, we recorded a pre-tax loss of $7.9 million in 2012 related to: a non-cash asset impairment charge of $2.8 million; a $3.6 million loss in connection with the Kentucky lease transaction; and a $1.5 million charge in connection with the early retirement of debt and the 2012 Conversion. For further information, refer to *note 20* of the 2013 consolidated financial statements.

Net Finance Costs

Net finance costs of $59.6 million in 2013 were $0.7 million lower than $60.3 million incurred in 2012. This was due to lower net interest costs of $2.9 million resulting from the debt refinancing, partially offset by a net $1.1 million unfavourable change in the fair value adjustments and loss on foreign exchange and financial instruments, and an increase in accretion costs of $1.1 million primarily related to the issuance of convertible debentures in the latter part of 2012.

The following table summarizes the components of net finance costs.

			Change	
(millions of dollars unless otherwise noted)	**2013**	**2012**	**$**	**%**
Interest, net				
Interest expense	**63.5**	65.3	(1.8)	*(2.8)%*
Interest revenue	**(4.7)**	(3.6)	(1.1)	*30.6%*
	58.8	61.7	(2.9)	*(4.7)%*
Accretion				
Accretion of decommissioning provisions	**1.8**	1.7	0.1	*5.9%*
Other accretion	**1.6**	0.6	1.0	*166.7%*
	3.4	2.3	1.1	*47.8%*
Fair Value Adjustments and Loss on Foreign Exchange and Financial Instruments				
Fair value adjustment on convertible debentures	**(3.1)**	(4.8)	1.7	*(35.4)%*
Loss on foreign exchange and financial instruments	**0.5**	1.1	(0.6)	*(54.5)%*
	(2.6)	(3.7)	1.1	*(29.7)%*
Net finance costs	**59.6**	60.3	(0.7)	*(1.2)%*

Income Taxes

The tax provision from continuing operations was $3.4 million on pre-tax earnings of $8.6 million in 2013 compared to $10.6 million on pre-tax earnings of $38.2 million in 2012, representing effective tax rates of 38.9% and 27.7%, respectively. The effective tax rates for each period were distorted by, among other things, the fair value adjustments, gains and losses from financial instruments, foreign exchange, asset impairment, disposals, and other items. The effective tax rate on earnings from continuing operations before separately reported items was 34.0% this year compared to 30.4% in 2012. As well, both quarters were impacted by favourable book-to-file adjustments of $3.4 million in 2013 and $4.4 million in 2012. Excluding these items, the effective tax rate was 55.8% this year compared to 40.7% in 2012. This change in rates was primarily due to the change in proportion of income among our taxable and non-taxable entities.

OTHER SIGNIFICANT DEVELOPMENTS

The discussion under the heading "Overview – Significant 2013 Events and Developments", summarizes the following items: the Medicare update; the 2013 U.S. PrivateBank loan refinancing; the 2013/2014 Canadian mortgage refinancings; and legal proceedings and regulatory actions. This section provides a summary of other developments that have impacted the financial results or operations of Extendicare for 2013 in comparison to 2012.

Development Projects

The following table depicts the status of the development projects in Ontario, Canada, with further details provided below.

	New Centers				Owned/Leased Centers Closed	
Development Projects (as at December 31, 2013)	**Completion Date**	**Opening Date**	**No. of Centers**	**No. of Beds**	**No. of Centers**	**No. of Beds**
Canada – Owned Long-term Care Centers						
Sault Ste. Marie, Ontario	March/13	April/13	1	256	(2)	(263)
Timmins, Ontario	October/13	October/13	1	180	(1)	(119)
			2	**436**	**(3)**	**(382)**

In 2009, under the first phase of the MOHLTC's redevelopment program for older long-term care centers, ECI received approval to redevelop 382 beds in the cities of Timmins and Sault Ste. Marie and to add an additional 54 long-term care beds to its portfolio. Prior to completion of the new projects, ECI operated three nursing centers with 387 class "C" beds and leased one center with 95 interim beds in Timmins and Sault Ste. Marie. A new 256-bed nursing center in Sault Ste. Marie was completed in March 2013 and opened to residents in April 2013, following which we closed one of our owned centers and the leased center in the community. A new 180-bed nursing center in Timmins was completed and opened to residents in October 2013, following which we closed our existing owned center in the community. With the completion of these projects in Sault Ste. Marie and Timmins, ECI now owns and operates in these communities, 436 beds in two new centers and 100 class "C" beds in an existing center to be considered for redevelopment at a later date. For further information on the MOHLTC redevelopment program, refer to the discussion under the heading "Update of Regulatory and Reimbursement Changes Affecting Revenue – Canada – Ontario Redevelopment Program".

The cost of the two Ontario projects was approximately $80 million. Conventional financing for approximately 88% of the total estimated cost for the two projects was secured in 2011. In addition, we are receiving a capital funding subsidy from the MOHLTC of approximately $2.0 million annually over a 25-year period. The combined annual Adjusted EBITDA of the four existing centers (482 beds) was approximately $3.0 million in 2012. It is anticipated that once the new centers are fully operational the incremental Adjusted EBITDA for the three centers (536 beds) will be approximately $1.8 million, excluding the capital funding for the two new centers (436 beds).

Financing Activity

CANADA

Royal Bank of Canada Credit Facility

Extendicare has a demand credit facility with the Royal Bank of Canada (the "RBC Credit Facility") that, as at December 31, 2013, was secured by 13 class "C" nursing centers in Ontario and is guaranteed by certain Canadian subsidiaries of Extendicare. During 2013, the demand working capital line was reduced to $64.0 million from $70.0 million following the completion of two new nursing centers in northern Ontario, which resulted in the transfer of licensed beds from nursing centers that secured the line to conventional financing for the new centers.

As at December 31, 2013, Extendicare had letters of credit totalling $42.3 million issued under the working capital line, of which $42.0 million was issued to secure executive pension obligations, and $0.3 million related to construction projects. The RBC Credit Facility has no financial covenants, but does contain normal and customary terms including the periodic re-appraisal of the centers that could limit the maximum amount available under the working capital line.

2012 Issue of 2019 Convertible Debentures and Redemption of 2013 Convertible Debentures

In 2012, Extendicare issued $126.5 million of aggregate principal amount of 6.00% convertible unsecured debentures due September 30, 2019, convertible at $11.25 per common share (the "2019 Debentures"). The initial offering for $110.0 million of the 2019 Debentures closed on September 25, 2012, and the exercise of the over-allotment option for $16.5 million closed on October 1, 2012.

The net proceeds from the offering were approximately $120.7 million, of which $94.0 million was used by Extendicare to redeem all of Extendicare's outstanding 7.25% convertible unsecured subordinate debentures due June 30, 2013 (the "2013 Debentures") on October 29, 2012. The redemption price of the 2013 Debentures was $94.0 million (principal of $91.8 million with accrued and unpaid interest of $2.2 million).

2011/2012 CMHC Mortgage Refinancing

In December 2011, Extendicare's Canadian operations refinanced $72.4 million of CMHC-insured mortgages secured by 20 centers that were at fixed rates of 9.81%, maturing in March 2013. The new CMHC-insured mortgages consisted of $36.2 million secured by nine centers at a fixed rate of 2.986% maturing in 2022, $22.9 million secured by nine centers at a fixed rate of 2.22% maturing in 2017, and variable-rate bridge loans for $13.3 million secured by two centers. A prepayment penalty of approximately $7.5 million was recognized in the 2011 fourth quarter. The annualized interest savings from this refinancing is estimated to be $5 million. The variable-rate bridge loans of $13.3 million were refinanced during 2012 with fixed-rate CMHC mortgages totalling $19.5 million with a weighted average interest rate of 3.03%, due in 2022.

Mortgage Activity – Development Projects

In January 2012, ECI replaced a construction loan on its new nursing center in Edmonton, Alberta, with a 10-year $17.4 million CMHC-insured mortgage at a fixed rate of 3.81%, with payments amortized over 30 years.

UNITED STATES

2011/2012 Refinancing Plan – HUD Mortgages

During 2012, EHSI completed the refinancing of approximately US$636 million of debt with approximately US$506 million in HUD-insured mortgages and US$130 million of cash on hand. During 2011 and 2012, EHSI closed on 68 HUD loans with a principal balance of US$506.3 million in connection with this refinancing. These new HUD-insured mortgages have a weighted average interest rate of approximately 4.33%, inclusive of MIP, and term to maturity of about 33 years. The annualized interest savings from the refinancing is estimated to be US$20 million.

In July 2010, EHSI received approval as a corporate entity to proceed with HUD applications, subject to an overall limit of US$550.0 million, and in December 2011, received approval to increase the overall limit to US$585.0 million, which expires in September 2014. EHSI already had approximately US$27 million of HUD loans issued prior to refinancing of approximately US$506 million. In April 2013, EHSI refinanced the PrivateBank loans with six HUD loans totalling US$37.7 million. Consequently, EHSI has utilized approximately US$572 million of its US$585.0 million overall limit. As at December 31, 2013, EHSI had 57 unencumbered centers with an estimated value of between US$250 million and US$300 million, which includes 19 centers that are leased to a third-party operator in Kentucky.

In July 2012, EHSI prepaid US$10.3 million of HUD-insured mortgages with a weighted average interest rate including MIP of 5.77% and closed on new HUD-insured mortgages totalling US$11.2 million with a weighted average interest rate including MIP of 3.55%. A loss on refinancing and retirement of debt of $0.8 million (US$0.8 million) was recorded in the 2012 third quarter associated with this refinancing.

EHSI Credit Facility

In 2012, EHSI entered into a new US$100.0 million senior secured revolving credit facility with a three-year term to June 2015 with floating-rate interest based on a pricing grid, to replace its US$70.0 million credit facility that matured in June 2012. This new credit facility consists of a US$80.0 million real estate based facility that was finalized in June 2012, and a US$20.0 million accounts receivable based credit facility that was finalized in September 2012. References to "EHSI Credit Facility" in this report mean either the new US$100.0 million line of credit entered into in 2012, or the former US$70.0 million line of credit that matured in June 2012, as the context requires.

The maximum amount available to be borrowed under the US$80.0 million portion of the EHSI Credit Facility is determined based on the lesser of: (i) 50% of the appraised values of the 20 skilled nursing centers collateralizing the EHSI Credit Facility; or (ii) an amount based on the actual net cash flow of these centers for the last 12 months. As at December 31, 2013, the maximum amount available under the real estate based facility was US$66.4 million. The maximum amount available to be borrowed under the US$20.0 million portion of the EHSI Credit Facility is based upon 80% of eligible receivables that are less than 90 days old. As at December 31, 2013, the maximum amount available under the accounts receivable based facility was US$20.0 million.

As at December 31, 2013, we had drawn US$2.1 million on the EHSI Credit Facility and had issued US$8.3 million under letters of credit, leaving US$76.0 million of the maximum available, subject to leverage requirements. At EHSI's option, the interest rate is either the eurodollar rate, with a floor set at 1%, plus a margin from 4% to 4.50%, or the U.S. prime rate plus a margin from 3% to 3.50%, with the specific margin based on EHSI's consolidated leverage ratio as defined in the EHSI Credit Facility. The interest rate at December 31, 2013, was 5.50% (December 31, 2012 – 5.25%).

For further information on the U.S. and Canadian refinancings, refer to *note 14* of the 2013 consolidated financial statements.

2012 Kentucky Lease Transaction

In May 2012, EHSI entered into an agreement to lease all 21 of its skilled nursing centers in the State of Kentucky (1,762 beds) to an experienced third-party long-term care operator based in Texas that operates through its affiliates in a number of other states. Nineteen of these centers (1,545 beds) were leased effective July 1, 2012, and the remaining two centers (217 beds) were leased effective October 1, 2012. Under the agreement, the operating leases have 10-year terms with two 5-year extensions at the option of the operator. In addition, if certain conditions are met, the operator has the option to purchase all of the centers during the initial lease term at agreed-upon per bed amounts. As a result of this transaction, EHSI no longer operates skilled nursing centers in Kentucky. The decision to exit the State of Kentucky is consistent with Extendicare's continuing strategy for achieving ongoing performance improvements, which includes the divestiture of operations that impede growth or create undue risk exposure. According to the *2013 AON Long Term Care General Liability and Professional Liability Actuarial Analysis*, the loss rate per occupied bed (limited to US$1.0 million per occurrence) in Kentucky has increased from US$2,220 per bed in 2005 to US$7,350 per bed in 2012.

During 2012, we recorded a pre-tax loss in connection with this transaction of $3.6 million (US$3.6 million), of which $2.6 million was recorded in the 2012 second quarter and $1.0 million in the 2012 third quarter. For the six months ended June 30, 2012, during which time all 21 Kentucky centers were still operated by EHSI, they generated annualized revenue of US$135.2 million and Adjusted EBITDA of US$18.2 million, including an allocation of US$12.0 million in provisions made for self-insured liabilities. Based on these annualized results, the estimated impact of the lease transaction was a reduction in Adjusted EBITDA of approximately $3.2 million per annum and a reduction in AFFO of approximately $0.6 million or $0.007 per share per annum.

For further information, refer to *note 9* of the 2013 consolidated financial statements.

Divestitures and Disposal Group Held for Sale

Extendicare continually assesses the performance of its asset portfolio, and for those assets that fail to meet operating and financial standards, a decision may be made to dispose of the asset. Assets to be disposed of are recorded at the lower of the carrying value or estimated fair value net of disposal costs. For further information, refer to *note 8* of the 2013 consolidated financial statements.

2013 ACTIVITY

As at December 31, 2013, Extendicare had assets, net of liabilities, held for sale with a net book value of $20.1 million consisting of 11 U.S. skilled nursing centers held for sale in various states and one closed nursing center in Washington.

In December 2013, EHSI decided to sell 11 skilled nursing centers located in various states due to poor operational performance and the need for future capital expenditures. The assets and liabilities of these nursing centers, totalling $36.2 million (US$34.0 million) and $16.3 million (US$15.4 million), respectively, were reclassified to assets and liabilities held for sale, respectively. EHSI expects to complete the sale of these centers within the next 12 months. In December 2013, we recorded an impairment charge of $7.3 million (US$6.8 million) to reduce the net book value of the properties to their estimated fair value net of disposal costs.

During 2013, we sold three properties for $3.7 million, one in Alberta and two in Ontario, that had been closed following our completion of three newly built centers in the same communities.

2012 ACTIVITY

As at December 31, 2012, Extendicare had assets, net of liabilities, held for sale with a net book value of $2.6 million consisting of two closed nursing centers in Washington and Alberta, and two Ontario nursing centers that were closed upon completion of new centers in 2013.

In January 2012, EHSI finalized and closed on the sale of its group purchasing organization, or GPO, for cash proceeds of US$56.0 million, resulting in a pre-tax gain of $56.5 million (US$55.7 million), or an after-tax gain of $35.0 million (US$34.5 million). An agreement in principle had been reached in December 2011 between EHSI and Navigator Group Purchasing, a subsidiary of Managed Health Care Associates, Inc., resulting in the reclassification of our U.S. GPO operations to discontinued operations at the end of 2011.

Economic Environment

The global and U.S. economy has had an indirect impact on the long-term care industry since the 2008 downturn due to the unprecedented loss of jobs in the U.S., reduction of health care benefits along with the loss of disposable income for elective health care services. As a result, there has been a reduction in admissions to our U.S. nursing centers and a concerted effort by federal, provincial and state governments to restrain or reduce funding of health programs. In response to the economic environment, Extendicare has undertaken several courses of action to minimize risks and maintain liquidity, including:

- reducing growth projects along with divestiture of underperforming assets and non-core businesses;
- implementing significant cost reduction initiatives;
- refinancing a significant portion of long-term debt with low-cost government-insured mortgages;
- monitoring cash usage; and
- maintaining solid banking relationships.

For the near term, there are no indications that the economy and economic risks affecting the industry are improving. Therefore, Extendicare plans to continue to monitor and implement steps to address these challenges. Below is a summary of the past and future uncertainties and significant risks that could have a material impact on Extendicare and its subsidiaries.

STATE, PROVINCIAL AND FEDERAL FUNDING AND REGULATORY PRESSURE

Reductions in Medicaid, Medicare and provincial funding for long-term care due to the economic downturn could have a material adverse effect on our earnings. Our business is highly labour intensive, with labour costs representing approximately 73% of our consolidated operating costs for 2013 (2012– 74%). As a result of resident care needs and regulatory requirements, we have limited ability to reduce or manage our labour costs. In addition, any escalation of regulatory pressure by CMS, state or provincial level government agencies could have a negative impact on our operating costs and thereby reduce our earnings.

A number of states in which we operate have faced severe budgetary shortfalls, resulting in reductions in Medicaid funding or increases at rates below inflation. The temporary increase in funding for state Medicaid programs, through the federal medical assistance percentage, or FMAP funding increase, ended on June 30, 2011. As a result, a number of states are facing considerable financial pressures that could result in future Medicaid rate reductions, despite some economic improvement in certain regions.

Effective October 1, 2011, CMS implemented reductions in Medicare funding to skilled nursing centers, along with other changes (referred to as the "2011 CMS Final Rule"), that we estimate have reduced EHSI's revenue and EBITDA by approximately US$64 million on an annualized basis. We have taken measures to help mitigate the adverse effect of the elimination of group therapy and the assessment process changes, such as employing more therapists and improving productivity. In addition, EHSI took action to reduce operational and corporate office staff and realize savings in supplies, drugs, and third-party service arrangements with vendors, the majority of which were implemented by October 1, 2011, and the balance by the beginning of 2012. We estimate that these savings reduced EHSI's general, administrative and non-wage operating costs by approximately US$24 million on an annualized basis. None of these cost saving measures involved a reduction of direct care staffing at our centers. Therefore, we estimate that the net negative effect of the 2011 CMS Final Rule on our Adjusted EBITDA, partially offset by our cost saving initiatives, was approximately US$40 million on an annualized basis.

A more detailed discussion of recent developments impacting Medicare and Medicaid rates is provided under the heading "Update of Regulatory and Reimbursement Changes Affecting Revenue – United States".

DECLINE IN OCCUPANCY IN THE U.S.

Our average skilled nursing center occupancy rates have declined from 86.0% in 2010 to 82.9% in 2013, due to the reasons discussed below. However, due to the implementation of programs to attract short-term rehabilitation residents, our Skilled Mix census as a percentage of our total skilled nursing center census has remained unchanged at 22.1% in each of 2010 and 2013.

The global economic downturn that began in 2008 and the continuing slow recovery have reduced disposable income of individuals, reduced employment and resulted in a general restraint by the public on health care spending. We believe that the decline we have experienced in Medicare and total admissions was in part due to individuals deferring hospital elective

surgery due to the economy and the resulting reduction in required post-acute care. Our future earnings could be eroded further should the level of admissions decrease as a result of a reduction in the financial resources or health insurance coverage of our prospective residents.

Another reason for the decline in skilled nursing center occupancy levels has been the concerted effort by state Medicaid programs to increase the level of care thresholds and to shift potential nursing center residents to home care programs and assisted living centers. In addition, Managed Care organizations have increasingly focused on reducing the period of coverage in skilled nursing centers and on seeking alternative lower care options for their clients, in order to reduce costs to the Medicaid program.

In response to the decline in short-term admissions in the U.S., we have refocused and refined our strategic marketing plans, are working on strategic alliances within the marketplaces in which we operate, and have invested to increase the number of rehabilitation suites within our portfolio to increase our market share in communities where we anticipate returns on our investments that meet our criteria. Included in these initiatives is the establishment of ALTUs, which are upgraded suites within our centers targeted to attract short-term rehabilitation residents. Since launching the program in 2009, we have completed 17 ALTUs and have two additional ALTUs under construction, with plans to continue to expand the number of ALTUs.

UPDATE OF REGULATORY AND REIMBURSEMENT CHANGES AFFECTING REVENUE

We operate in a competitive marketplace and depend substantially on revenue derived from government sources, with the remaining revenue from commercial insurers, managed care and private individuals. Ongoing pressures from government programs, along with other health care payors seeking to control costs and/or limit reimbursement rates for medical services, are a risk to us. Government agencies have steadily increased their enforcement activity over the past several years. As a result, in addition to increasing resources to improve the quality of services provided to our residents, we are continually allocating increased resources to ensure compliance with applicable laws and regulations and to respond to inspections, investigations and/or enforcement actions. Our costs to respond to and/or defend surveys, inspections, audits and investigations are significant and are likely to increase in the current environment.

Non-compliance with applicable laws and licensure requirements governing long-term care could result in adverse consequences, including severe penalties, which may include criminal sanctions and fines, civil monetary penalties and fines, administrative and other sanctions, including the exclusion from participation in the Medicare and Medicaid programs, or one or more third-party payor networks. We may be required to refund amounts that have been paid to us by federal, state and/or provincial funding programs. These penalties could have a material adverse effect on the business, results of operations or financial condition of Extendicare.

United States

The majority of Extendicare's operations are in the United States where 62.8% of its revenue from continuing operations was earned in 2013 (2012 – 64.2%). EHSI receives payment for its services and products from the federal (Medicare) and state (Medicaid) medical assistance programs, Managed Care organizations (including HMO and preferred provider organizations), commercial insurers, the Department of Veterans Affairs, as well as from private payors. During 2013, approximately 49% of our U.S. resident admissions were Medicare funded and approximately 34% were Managed Care funded.

MEDICARE FUNDING

Market Basket Annual Increases

Changes in Medicare funding levels typically occur on October 1st of each year to coincide with the federal government's fiscal year. Notwithstanding the implementation of MDS 3.0 and RUG-IV in October 2010, and the 2011 CMS Final Rule, Medicare funding changes generally represent an inflationary increase for the Medicare Part A funding, otherwise referred to as a "market basket" increase. In addition, Medicare increases are also periodically adjusted for "forecasting errors" that are identified by CMS based upon filed cost reports.

The net market basket increase implemented on October 1, 2013, was 1.3%, consisting of a market basket increase of 2.3% minus a forecasting error of 0.5% and a productivity adjustment of 0.5%. We estimate that the impact of this funding increase will provide us with additional Medicare Part A and Managed Care revenue of approximately US$5.1 million per annum. In comparison, the October 2012 net market basket increase was 1.8%, which consisted of a market basket increase

of 2.5% minus a productivity adjustment of 0.7%. The estimated impact of this 1.8% rate increase was additional Medicare Part A and Managed Care revenue to us of approximately US$7.2 million per annum.

As previously reported, sequestration triggered automatic Medicare funding cuts of 2% effective April 1, 2013. Sequestration will remain in effect through to 2023, unless there are future legislative changes. We estimate that this 2% funding cut has reduced our Medicare and Managed Care revenue by approximately US$6.3 million per annum. For further information refer to the discussion below under the heading "The American Taxpayer Relief Act of 2012".

Consolidated Appropriations Act of 2014

On January 17, 2014, the U.S. President signed into law the *Consolidated Appropriations Act of 2014*, which provides fiscal year 2014 appropriations for all projects and activities of the U.S. federal government. This law did not make any significant changes to Medicare or Medicaid programs but provides funding for existing programs.

Pathway for SGR Reform Act of 2013

On December 26, 2013, the U.S. President signed into law the SGR Act. This law postpones an estimated 27% cut to the MPFS rates through March 31, 2014. Passage of this short-term extension, often referred to as the "Doc Fix", averts cuts to Part B therapy rates received by EHSI amounting to an estimated US$11 million per annum. Proposals for a more permanent solution are currently pending. The SGR Act also called for a 0.5% increase in the Part B fee schedule rates through April 1, 2014.

The SGR Act extends through March 31, 2014, the process for granting exceptions to the monetary caps on Medicare coverage of physical therapy, speech-language pathology, and occupation therapy services.

The SGR Act also extends by two years, from 2021 to 2023, the 2% sequestration funding reductions enacted by the *Budget Control Act of 2011* (see below).

The American Taxpayer Relief Act of 2012

On January 2, 2013, the U.S. President signed into law the ATRA, which included the following:

- A delay until January 1, 2014, of a 27% reduction in Medicare Part B rates previously scheduled to have commenced on January 1, 2013, pursuant to the *Middle Class Tax Relief and Job Creation Act of 2012* (see below). Historically, the rate cuts have been suspended for one-year periods. However, if implemented, the impact of the 27% Part B rate reduction on EHSI's therapy revenue was estimated to be US$11 million per annum.
- A delay until April 1, 2013, of a 2% cut in Medicare Part A funding previously scheduled to have commenced on January 2, 2013, pursuant to the sequestration clause of the *Budget Control Act of 2011* (see below). EHSI estimates that the 2% cut will reduce annual Medicare and Managed Care revenue by approximately US$6.3 million. The 2% reduction applies to net Medicare Part A, Medicare Part B, and HMO RUGs-based payments, after a reduction for co-insurance and deductibles.
- A decrease in reimbursement for Medicare Part B services due to an increase in the MPPR percentage from 25% to 50% effective April 1, 2013. EHSI estimates that this reduction will reduce annual therapy revenue by approximately US$3.6 million. CMS had previously implemented a 25% reduction for residents receiving multiple therapies in the same day.
- An extension of the therapy caps exception process through December 31, 2013 (see "Therapy Caps" below). This exception process allows for automatic exceptions to annual caps set by CMS for Part B therapy services for individuals who are able to prove medical necessity for the therapy. For 2013, these annual caps are US$1,900 for physical and speech therapy and US$1,900 for occupational therapy. For 2012, these annual caps were US$1,880.
- An extension through December 31, 2013, of the required manual medical review for pre-approval for annual therapy charges in excess of US$3,700 for occupational therapy and US$3,700 for physical and speech therapy combined.
    a. Effective January 1, 2013, the manual medical review pre-approval process was replaced by a mandatory Additional Development Request (ADR) pre-payment review process for billed services at or above the US$3,700 threshold.
    b. Beginning April 1, 2013, all billed claims at or above the threshold will be subject to either pre-payment or post-payment review, depending upon state location.

Budget Control Act of 2011 and Sequestration

On August 2, 2011, the U.S. President signed the *Budget Control Act* (BCA) as passed by the House of Representatives and Senate. The BCA brought significant change to the federal budget process by forcing significant cuts to future federal spending while raising the national debt limit. Following months of negotiations and facing default, a process was put into place to reduce the federal deficit. The BCA imposed caps on discretionary spending starting October 1, 2011, intended to generate US$917 billion in savings over the next 10 years. It also put into place a process to find another US$1.2 trillion to US$1.5 trillion in deficit reductions over the next 10 years. While caps on discretionary spending were put into place, the BCA did not specifically make hard policy choices on how to implement cuts. It was left up to Congress and a special bipartisan and bicameral committee to establish policy. The BCA did not make any changes to entitlements but rather imposed caps on spending. To comply with the law, Congress was to have reduced spending by about US$25 billion for the budget cycle starting in October 2011.

The Special Joint Select Committee on Deficit Reduction, referred to as the "Super Committee" was to propose legislation no later than January 15, 2012, to reduce spending by the additional US$1.2 trillion. As the Super Committee was unable to make a recommendation and U.S. Congress failed to pass legislation, a process of sequestration was scheduled to have automatically reduced Medicare funding by 2% beginning January 2, 2013. The implementation of these spending cuts was delayed until April 1, 2013, by the ATRA, as discussed above.

The Middle Class Tax Relief and Job Creation Act of 2012 – Reduction in Reimbursable Bad Debts

On February 22, 2012, the U.S. President signed the *Middle Class Tax Relief and Job Creation Act of 2012* (H.R. 3630) which implemented the following changes:

- Prevented a 27% cut in Medicare physician rates proposed by CMS to begin on March 1, 2012, and instead froze payment rates at their current level until December 31, 2012. These cuts were subsequently delayed until January 1, 2014, by the ATRA, as discussed above.
- Extended the therapy caps exception process through December 31, 2012. This process was later extended through December 31, 2013, by the ATRA, as discussed above.
- Reduced reimbursement for bad debts for dually eligible beneficiaries (Medicare and Medicaid eligible) from 100% to 88% in calendar year 2013, 76% in calendar year 2014 and ultimately to 65% in calendar year 2015. For dually eligible residents, who qualify as such because they lack the resources to pay their Part A co-insurance amounts, long-term care operators bill the Medicaid program for unpaid amounts. In certain states, the Medicaid program reimburses the operator for unpaid amounts, whereas if they do not, the operator can obtain reimbursement through the Medicare program by submitting unpaid claims through their annual filing of cost reports. In the majority of states where EHSI operates, the Medicaid program does not reimburse its centers for unpaid Part A co-insurance and, therefore, EHSI files for reimbursement of approximately US$16 million per annum in reimbursable bad debts. This is essentially cutting the Medicare rates of the nursing centers upon commencement of the co-insurance period, being the 20th day of the resident's stay. The reduction in reimbursement for bad debts reduced EHSI's revenue by US$1.3 million in 2012 (for transitional adjustments) and by US$2.7 million in 2013. It is expected to reduce EHSI's revenue by US$4.5 million and US$5.8 million in 2014 and 2015, respectively. Separately, EHSI obtains reimbursable bad debts for non-dually eligible Part A co-insurance bad debts of approximately US$0.6 million, which is currently reimbursed at 65%.

Therapy Caps

In 2006, CMS implemented a cap on Part B therapy services for physical and speech therapy and another cap for occupational therapy. However, lobbying efforts have been successful in preventing the full implementation of the CMS caps through U.S. Congressional action that established exceptions for individuals who were able to prove medical necessity for the therapy. Effective January 1, 2014, the SGR Act extended through to March 2014, the CMS caps on Part B therapy services for physical and speech therapy at US$1,920 and for occupational therapy at US$1,920, and also extended the automatic exception if the therapy services are considered medically necessary.

Effective October 1, 2012, CMS established a new medical review process for annual claims over US$3,700 for physical and speech therapy and a second medical review process for annual claims over US$3,700 for occupational therapy. The SGR Act has extended this review process until March 31, 2014. EHSI has recorded negative revenue adjustments for denials of therapy services provided in excess of these caps as follows: US$0.1 million, US$0.6 million , US$0.4 million, and US$1.2 million, in each quarter of 2013, respectively; as well as US$1.0 million in the 2012 fourth quarter.

2010 Health Care Reform Legislation Remains a Significant Factor

In March 2010, historic health care reform legislation, the *Patient Protection and Affordable Care Act* (H.R. 3590) (PPACA), was enacted into law at a cost of US$940 billion over 10 years. Amendments to the PPACA were enacted into law on March 30, 2010, with the passage of the *Health Care Education Affordability Act* (HCEAA). In June 2012, the U.S. Supreme Court upheld the constitutionality of most of the provisions of the PPACA and the re-election of the U.S. President in November 2012 eliminated the possibility of the PPACA being repealed. On July 2, 2013, the U.S. Department of Treasury announced that the effective dates of various provisions of the PPACA will be delayed from 2014 to 2015 to give the government and industry additional time to effectively implement these provisions due to their complexity. This delay includes the "employer mandate" that requires employers with more than 50 employees to provide health care insurance to all full-time employees or pay an employer tax (see below). In February 2014, the employer mandate for organizations with between 50 and 99 employees was further amended to delay the requirement until 2016. The U.S. Congress is considering various proposals to confirm the delay of these provisions and to also make other changes.

The PPACA requires all individuals to have a minimum level of health care coverage (the "individual mandate") and the employer mandate requires employers to provide health care coverage, with certain stipulations, for employees. The legislation increases the number of individuals with health care insurance coverage by mandating that all individuals obtain coverage by 2014 through their employer or directly through insurance companies or marketplace "exchanges". The employer mandate has been delayed until January 1, 2015 (for employers with 100 or more employees), or January 1, 2016 (for employers with between 50 and 90 employees), at which time, all employers will have to either offer health care insurance for all full-time employees or pay an employer tax. For employers that offer coverage, the health care plan must provide a minimum value coverage and the employee's portion of the coverage must be affordable based upon the employee's income. For employers that offer such insurance, the employee has the right to opt out and either obtain alternative health insurance from the "health care exchanges" or pay an individual tax. As an alternative, the employer can opt out of providing coverage for its employees and be subject to an employer tax, in which case the employees would obtain their health insurance from the health care exchanges.

EHSI currently offers health care coverage to all of its qualifying employees under several different programs tailored to meet an individual's budget and risk tolerance. Approximately 65% of EHSI's employees have joined one of EHSI's programs. To date, there has not been any material impact from the legislation on our health plan costs as a result of certain plan changes that we have implemented. However, it is difficult to determine, based upon anticipated changes in the legislation, what future changes may have to be made. At the present time, EHSI plans to continue to offer its health plan coverage to all of its full-time employees. However, it is difficult to quantify whether more employees will enrol in the plan and, therefore, EHSI cannot determine the future financial impact of the legislation.

The other key aspects of the legislation that are specific to and impact long-term care providers, among other aspects, are as follows:

(i) a productivity adjustment to Medicare rates commencing October 1, 2011, that will reduce the annual market basket increases by approximately 1%, representing a reduction in Medicare funding of US$14.6 billion over a 10-year period. We anticipate that the annual impact from this Medicare reduction in rates to be approximately US$5 million per annum;

(ii) new transparency requirements and additional employee background check requirements for nursing centers;

(iii) the creation of a new Independent Medicare Payment Advisory Board that will make recommendations to U.S. Congress on Medicare payment rates for health care providers, including skilled nursing centers; and

(iv) a mandate for CMS to create a national, voluntary pilot bundling payment program by 2013.

The additional following provisions were included in the final act:

(i) language that requires MedPAC to take Medicaid into consideration during its analyses for providers, including skilled nursing and home health;

(ii) a federal mandate for states to expand home and community-based services with increased FMAP to states that rebalance spending between institutional and community-based care by October 1, 2015;

(iii) the U.S. Department of Health and Human Services must submit a Medicare value-based purchasing plan for skilled nursing centers by October 1, 2011; and

(iv) as of July 1, 2011, Medicaid will no longer provide payments to states for services related to health care acquired conditions, including conditions acquired in other than hospital settings.

In October 2011, CMS issued final rules on the establishment and operation of Accountable Care Organizations (ACOs). The primary purpose of ACOs is to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients and to provide a more cost effective and integrated health care system. ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care centers. The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

At this point in time, U.S. organizations are not able to predict the final form of the health care reform changes and therefore management is not able to clearly quantify the impact of such on the business, results of operations and financial condition of Extendicare. Management intends to closely analyze the legislation and any subsequent amendments, and proactively respond in a manner with a view to taking advantage of new opportunities and minimizing EHSI's exposure to new risks.

MEDICAID FUNDING

The decline in state tax revenue and increased demand for unemployment and Medicaid services, as a result of the economic downturn, has put state Medicaid budgets under considerable strain. Many states have implemented or expanded their provider tax programs (a tax imposed on providers of long-term care) as a means to increase the levels of funding contributed by the federal government to their Medicaid programs. However, these additional federal funds have only partially mitigated funding cuts of some of the states. Our respective federal and state health care associations have lobbied vigorously for continuation of consistent funding in the sector.

Annual Medicaid Rate Changes

With respect to the 11 states in which EHSI operates skilled nursing centers, annual Medicaid rate changes are effective on July 1st in seven of the states (Idaho, Indiana, Ohio, Oregon, Pennsylvania, Washington and Wisconsin); on October 1st in three of the states (Michigan, Minnesota and West Virginia); and on January 1st in Delaware.

The July 1, 2013, Medicaid rates have been issued for all seven states noted above. The net Medicaid funding for these states, defined as Medicaid rates less provider taxes, increased by approximately 0.2%, or US$0.9 million on an annualized basis. The October 1, 2013, net Medicaid funding changes for Michigan, Minnesota and West Virginia increased by approximately 2.8%, or US$3.5 million on an annualized basis. The January 1, 2013, net Medicaid funding for Delaware decreased by approximately 1.0%, or less than US$0.1 million on an annualized basis.

The average of the net Medicaid funding changes effective in 2013, as of the respective dates for all 11 states in which EHSI operates, is estimated to be an increase of 0.8%, or US$4.4 million on an annualized basis (2012 – net increase of 3.2%, or US$15.8 million, excluding Kentucky). This estimate could be impacted by CMI changes and Medicaid occupancy changes, along with other factors.

Canada

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

In most provinces, a license must be obtained from the applicable provincial ministry of health in order to operate a nursing center. Currently, there is almost a universal restriction upon the issuance of new licenses across the country because of the funding implications for governments. In addition to the license procedure, or in some cases in place of, operators in Alberta, Manitoba and Ontario are required to sign service contracts that incorporate service expectations with the provincial government or regional health authority. These contracts specify the services to be provided and the remuneration to be received. Nursing center licenses and service contracts are subject to annual renewals and do not represent any guarantee of continued operation beyond the term of the license or contract. However, Ontario's new *Long-Term Care Homes Act, 2007* (the "LTC Act 2007"), that was proclaimed into force on July 1, 2010, provides for, among other things: new licensing procedures that include more rigorous standards for license review (including public hearings);

fixed license terms of up to 25 years, after which a new license may or may not be issued; the revocation of a license for continued non-compliance; more onerous duties imposed on long-term care operators; unannounced annual inspections; and a more comprehensive enforcement regime. Long-term care operators will be given notification of whether or not a new license will be issued at least three years before the end of the license term.

The fees charged by ECI for its Canadian nursing centers and home health care services are regulated by provincial authorities, and a substantial portion of these fees are funded by provincial programs, with the remainder paid for by the residents or private home health care clients. Each province has a different system for managing the services provided. As a result, there can be significant variability in the regulations governing the provision of and reimbursement for care from location to location.

Ontario is ECI's largest market for both its long-term care and home health care services. Funding for Ontario long-term care centers is based on reimbursement for the level of care assessed to be required by the residents, in accordance with scheduled rates. The MOHLTC allocates funds through "funding envelopes", specifically: nursing and personal care; programs and support services; and accommodation (which includes a sub-envelope for food). The funding for the nursing and personal care envelopes is generally adjusted annually based on the acuity of residents as determined by a classification assessment of resident care needs. The nursing and personal care, programs and support services, and food envelopes are "flow-through" envelopes, whereby any deviation in actual costs from scheduled rates is either absorbed by the provider (if actual costs exceed funding allocations) or is returned to the MOHLTC (if actual costs are below funding allocations). With respect to the accommodation envelope, providers retain any excess funding received over costs incurred. The province sets the rates for standard accommodation, as well as the maximum amounts that a provider can charge for semi-private and private accommodation (preferred accommodation). The provider is allowed to bill and retain the premiums charged for preferred accommodation. The accommodation rates are substantially paid for by the resident; however, the province guarantees funding for standard accommodation through resident subsidies. Overall funding is occupancy-based, but once the average occupancy level of 97% or higher is achieved, operators receive funding based on 100% occupancy. In 2011, the MOHLTC implemented an occupancy protection program for occupancy levels below 97%, and extended this in fiscal 2012 and 2013. The MOHLTC has not indicated whether it plans to extend the occupancy protection in fiscal 2014. Under the occupancy protection program those with occupancy levels of between 90% and 94% receive funding based on their actual occupancy plus 1% and those with occupancy levels of between 94% and 97% receive funding based on their actual occupancy plus 2%. ECI's Ontario nursing centers averaged 97.7% occupancy in total during 2013, with only one of its centers averaging slightly below 97%.

ONTARIO REDEVELOPMENT PROGRAM

In Ontario, the MOHLTC announced plans in 2007 to redevelop 35,000 older long-term care beds in five phases over 15 years. The first phase of the renewal strategy was launched in April 2009 with the release of the policies and a call for applications for redevelopment. Qualified applicants are eligible for a construction funding subsidy over 25 years that starts at $13.30 per bed per day for large centers of 100 beds or more. Existing centers to be renovated are eligible for relaxed retrofit standards at a reduced construction funding subsidy. Leadership in Energy and Environmental Design (LEED) construction standards must be met, and a $1.00 premium is provided to those centers achieving LEED Silver status.

The overwhelming majority of operators believe that the level of capital funding is insufficient given the current costs of construction and the new design standards, and have expressed their concerns to the government. In response, the MOHLTC commenced a review of the program in 2011, and we are awaiting a report on its recommendations and or proposed changes to the program. Should operators choose not to replace their centers, it could have a significant impact on the number of nursing center beds in the province, which will offer both risks and opportunities for others in the marketplace.

Under the first phase of the MOHLTC's redevelopment program launched in 2009, ECI completed the redevelopment of 382 class "C" beds through the construction of two new nursing centers (refer to "Other Significant Developments – Development Projects"). ECI owns 21 nursing centers with 3,287 class "C" beds in Ontario, which are under review by management to determine their priorities for redevelopment once the government reinitiates its redevelopment program. Should ECI decide to rebuild or renovate all of its remaining class "C" beds, management estimates that the total capital outlay will be in the range of $375 million to $475 million, depending on a number of factors including the cost of construction and prescribed design standards. Management estimates that approximately 20% to 25% of the total cost will be required to be funded by equity.

ONTARIO LONG-TERM CARE FUNDING

All Ontario long-term care centers have implemented a new resident assessment instrument – minimum data set, or RAI-MDS. In April 2010, the MOHLTC began using the RAI-MDS 2.0 version to drive a new case-mix classification methodology using 34 categories under a RUGs-based funding model. This RUGs model will tie resident needs to costs of care in a more impartial and transparent way. In order to facilitate funding stability in the long-term care sector during the implementation process of the new funding model and to prevent unsustainable swings in funding, the MOHLTC implemented a 5% CMI corridor in 2012 and will continue with this funding scheme for all centers during fiscal 2014/2015.

On April 1st each year, the MOHLTC generally provides flow-through funding adjustments on the government funded portion of the fees. In 2013, funding increases of approximately 2% were received in the flow-through envelopes effective April 1, 2013, along with our CMI adjustments. These enhancements are estimated to provide additional revenue to ECI of approximately $3.6 million to offset additional costs for resident care and services within the nursing and program envelopes (April 2012 – $1.5 million).

On July 1st each year, the MOHLTC generally implements annual accommodation funding increases to the per diem rates provided to long-term care providers. The July 1, 2013 funding enhancements increased the daily rates for food costs by $0.12 and the non-flow-through component of the accommodation envelope by $0.59. ECI estimates that this enhanced funding increased its annual revenue by approximately $1.3 million (July 2012 – $2.4 million).

In addition, the MOHLTC introduced modest increases to the preferred accommodation premiums on each of July 1, 2012 and July 1, 2013, of $1.00 per day for semi-private accommodation and $1.75 per day for private accommodation, bringing the maximum preferred accommodation premiums to $10.00 per day for semi-private and $21.50 per day for private. These increases are only applicable to newly admitted residents to beds that are classified as "New" or "A" beds. Residents of "B" and "C" beds will continue to pay the lower daily preferred accommodation premiums of $8.00 for semi-private accommodation and $18.00 for private accommodation. As at December 31, 2013, ECI had 13 "New" nursing centers (1,847 beds) in Ontario of which 1,106 of the beds offered preferred accommodation in the form of private rooms. We will benefit from this premium increase for preferred accommodation over time as new residents are admitted.

In October 2012, the MOHLTC announced changes that will improve the funding and related managerial flexibilities to all long-term care providers. Prior to this change, long-term care providers refunded to the MOHLTC underspent amounts, or conversely absorbed the loss of any overspent amounts, for each of the flow-through envelopes separately. Effective January 1, 2013, long-term care operators will be able to use underspent funds in the nursing or program envelopes to offset pressures in any other flow-through envelope. Extendicare has successfully managed to control its spending under the flow-through envelopes in the past; however, we welcome these changes. In addition, the MOHLTC implemented changes with respect to funding for high-intensity needs, which was previously provided on an application and cost reimbursement basis, and has provided additional funding to cover increased costs of care. Effective January 1, 2013, the daily rates to the flow-through envelopes increased by $1.03, which ECI estimates will increase its annual revenue and operating costs by approximately $1.9 million.

In response to the economic downturn, in 2010 the Ontario government implemented a wage freeze for labour contracts being renewed over the next two years, and indicated its expectation that this should be extended to the government-funded long-term care sector, by announcing that it would not provide funding for any wage increases. As part of the Ontario government's 2012 budget (the "2012 Ontario Budget"), the government has maintained the wage freeze for another two years, and is asking the broader public sector to do the same. The government indicated that it expects existing union contracts will be left intact, and new collective agreements to be negotiated over the next two years should not allow for increases in compensation. The 2012 Ontario Budget states that where agreements cannot be reached that are consistent with the government's plan, the government is prepared to propose necessary administrative and legislative measures. However, since 2010, arbitrators have awarded increases to union wages in the long-term care sector during this period. As a result, in some cases, the incremental cost of these arbitrated wage increases to ECI has exceeded the funding increases outlined above.

ALBERTA LONG-TERM CARE LEGISLATION AND FUNDING

In Alberta, a new activity-based funding system for continuing care centers commenced on April 1, 2010. However, AHS continues to adjust the formulas and the accountabilities. The funding model includes a separate pool for quality incentives funding (QIF) that represents a "quality bonus" awarded to centers meeting or exceeding a set of pre-determined quality criteria. The QIF program was implemented on April 1, 2011, and is subject to further development as quality information and indicators become available. To date, the QIF program has consisted of four pre-determined indicators that are used to determine an operator's eligibility for 0.2% of its government funding. The quality indicators may include such things as: family satisfaction survey results; accreditation status; immunization rates; medication reconciliations; and the implementation of quality improvement initiatives based on the RAI-MDS indicators.

Effective April 1, 2013, the Alberta government provided funding increases to long-term care providers that included an inflationary funding increase of approximately 2.5%, together with adjustments for CMI, occupancy and other factors. ECI estimates that its funding has improved by an average of 2.1% representing annual revenue of approximately $1.6 million (April 2012 – $4.0 million).

Effective January 1, 2013, the Alberta government provided a 5% increase in the long-term care accommodation fees (the portion paid directly by the residents), to recognize the rising costs of delivering accommodation and related services. The last time the accommodation fees increased was in February 2011 at a rate of 3%. ECI estimates that the 5% increase in 2013 will contribute additional annual revenue of approximately $1.3 million.

ONTARIO HOME HEALTH CARE LEGISLATION AND FUNDING

ECI is a major private-sector provider of home health care services in Ontario through ParaMed. Prior to August 2013, ParaMed also operated in Alberta, where approximately 4% of its annual revenue was generated. ParaMed no longer provides services in Alberta as a result of the outcome of an AHS initiative to reduce the number of service providers in the province.

In 2004, the MOHLTC froze the Ontario home health care competitive bidding process for contracts while it undertook a study to improve the procurement model, and during this period, existing contracts were extended. In October 2012, the MOHLTC implemented a new model for home health care that does not involve a bidding process. All CCAC home health care contracts within the province concluded on September 30, 2012, and new open-ended, flexible CCAC home health care contracts commenced on October 1, 2012. ParaMed signed new open-ended contracts for all of its existing CCAC contracts. The agreements provide for six months' notice to providers for termination of a contract, and providers are to provide the CCAC with twelve months' notice of intention to give up a contract. The new service delivery model will place greater emphasis on quality of care and value than past arrangements, with service providers' performance evaluated based on these elements. Performance against an established set of indicators will guide decisions during future contract discussions.

Under the new model, funding will be outcome-based and designed to promote consolidated care for clients in order to address needs and realize improved outcomes. Integrated care for defined population groups (such as hip and knee replacement and wound care) has commenced in 2012 with a small number of clients, and will gradually expand as the service model is improved upon. The introduction of reimbursement for care in these consolidated pathways is anticipated but is not expected to begin before the end of 2014 at the earliest, and will be on the basis of outcomes achieved for these particular population groups. This is a change from the current service delivery model that is fee-for-service, based on client referrals for a single service, with a set number of visits and reimbursement based on each completed visit. Consequently, the new funding model will place greater emphasis on quality of care, value and outcomes, than past arrangements. A small number of CCACs are currently participating in a proof-of-concept period to test the model with select providers, including ParaMed.

ParaMed is evaluating the anticipated effect of these changes to its current operations, and is actively engaged in determining the necessary changes to internal operational processes and external opportunities required to prepare for the introduction of consolidated service client care. Specific strategies for growth in this evolving market remain unknown at the present time. However, in order to minimize disruption to the sector and therefore client care, an effort to maintain current market share of existing service providers throughout the transition to outcome-based care for defined population groups is anticipated. We expect that superior quality service delivery will ensure retention of our current volumes and will also drive opportunities for future growth.

LIQUIDITY AND CAPITAL RESOURCES

Sources and Uses of Cash *(thousands of dollars unless otherwise noted)*	**2013**	**2012**
Cash provided by operating activities, before working capital changes and interest and income taxes	**165,938**	198,848
Net change in operating assets and liabilities		
Accounts receivable	**6,246**	21,111
Other current assets	**4,541**	759
Accounts payable and accrued liabilities	**(15,882)**	(31,701)
	(5,095)	(9,831)
Interest and taxes paid		
Interest paid	**(59,585)**	(60,276)
Interest received	**4,657**	3,509
Income taxes paid	**(7,999)**	(23,463)
	(62,927)	(80,230)
Net cash from operating activities	**97,916**	108,787
Net cash used in investing activities	**(50,436)**	(33,143)
Net cash used in financing activities	**(25,464)**	(83,150)
Foreign exchange gain (loss) on U.S. cash held	**2,585**	(1,114)
Increase (decrease) in cash and short-term investments	**24,601**	(8,620)
Cash and short-term investments at beginning of year	**71,398**	80,018
Cash and short-term investments at end of year	**95,999**	71,398
Average U.S./Canadian dollar exchange rate	**1.0299**	0.9996

At December 31, 2013, Extendicare had cash and short-term investments of $96.0 million compared with $71.4 million at December 31, 2012, representing an increase of $24.6 million. Cash pledged of $18.7 million is excluded from our available cash balance as it relates to US$15.5 million held in escrow pursuant to the HUD regulatory agreements for working capital purposes, and US$1.3 million and $0.8 million designated for future capital expenditures in the U.S. and Canada, respectively.

Net cash from operating activities was a source of $97.9 million in 2013 compared to $108.8 million in 2012, representing a decrease of $10.9 million. The decline in earnings after cash interest and taxes paid was partially offset by a favourable net change in operating assets and liabilities between periods. The change in the operating assets and liabilities were favourable compared to the same period last year primarily due to the impact of timing of purchases and the payroll cycle on accounts payable and accrued liabilities.

Net cash used in investing activities was $50.4 million in 2013 compared to $33.1 million in 2012. The 2013 activity related primarily to expenditures for property, equipment and software. The 2012 activity reflected expenditures for property, equipment and software, partially offset by the sale of our U.S. group purchasing operations for net cash proceeds of $56.3 million.

Purchases of property, equipment and software were $55.8 million in 2013 compared to $84.1 million in 2012. Growth capital expenditures, excluding acquisitions, were $28.7 million this year compared to $49.2 million in 2012, and related to the construction of new beds, building improvements or capital costs aimed at earnings growth. Maintenance capital expenditures, which are the capital costs to sustain and upgrade existing property and equipment assets, were $28.2 million in 2013 compared to $35.7 million in 2012, representing 1.4% and 1.8% of revenue, respectively. These costs fluctuate on a quarterly basis with the timing of projects and seasonality. It is our intention to spend between 1.5% and 2.0% of revenue annually on maintenance capital expenditures, which is consistent with our objective to maintain and upgrade our centers. We are projecting to spend in the range of $38 million to $43 million in facility maintenance capital expenditures and $15 million to $20 million in growth capital expenditures in 2014.

The following table summarizes the components of property, equipment and software expenditures.

Purchase of Property, Equipment and Software *(thousands of dollars unless otherwise noted)*	**2013**	**2012**
Growth expenditures		
U.S. operations *(C$)*	**8,328**	7,343
Canadian operations	**20,419**	41,910
	28,747	49,253
Facility maintenance		
U.S. operations *(C$)*	**20,157**	24,587
Canadian operations	**8,081**	11,136
	28,238	35,723
Deduct: capitalized interest	**(1,232)**	(873)
	55,753	84,103
Average U.S./Canadian dollar exchange rate	**1.0299**	0.9996

Net cash used in financing activities was $25.5 million in 2013 compared to $83.2 million in 2012. The 2013 activity related primarily to the payment of cash dividends of $45.5 million and financing costs of $2.1 million, partially offset by $5.4 million of debt issuances in excess of repayments, a decrease in investments held for self-insured liabilities of $6.9 million, and a $9.8 million release of restricted cash. In comparison, the 2012 activity included an increase of $31.6 million in investments held for self-insured liabilities, cash distributions of $57.0 million, financing costs of $13.1 million, and an $11.8 million increase in restricted cash, partially offset by $30.3 million of debt issuances in excess of repayments. For information on the change in long-term debt, refer to "Liquidity and Capital Resources – Long-term Debt".

Reconciliation of Net Cash from Operating Activities to AFFO

The following table provides a reconciliation of the net cash from operating activities to AFFO on a quarterly and annual basis for each of 2013 and 2012. [1]

	Q1		**Q2**		**Q3**		**Q4**		**Year**	
(millions of dollars)	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**
Net cash from operating activities	**24.0**	17.5	**21.9**	18.8	**27.6**	31.1	**24.4**	41.4	**97.9**	108.8
Add (Deduct):										
Net change in operating assets and liabilities, including interest and taxes	**(0.4)**	(6.1)	**(1.8)**	11.8	**(0.9)**	1.6	**12.8**	(1.9)	**9.7**	5.4
Current tax on fair value adjustments, gain/loss on foreign exchange, financial instruments, asset impairment, disposals and other items	–	21.3	**(0.2)**	(1.0)	–	(0.6)	–	0.1	**(0.2)**	19.8
Net provisions and payments for self-insured liabilities	**(1.7)**	(1.1)	**7.0**	(3.5)	**(1.6)**	(13.1)	**(15.5)**	0.8	**(11.8)**	(16.9)
Depreciation for FFEC	**(5.6)**	(5.8)	**(5.5)**	(6.3)	**(5.5)**	(5.7)	**(5.4)**	(5.8)	**(22.0)**	(23.6)
Principal portion of government capital funding payments	**0.7**	0.7	**0.9**	0.7	**0.9**	0.7	**0.9**	0.7	**3.4**	2.8
Additional facility maintenance capital expenditures [2]	**0.9**	1.0	**(0.3)**	(1.0)	–	(3.0)	**(6.8)**	(9.1)	**(6.2)**	(12.1)
Other	**0.3**	(0.4)	**0.1**	–	**(0.1)**	0.2	–	0.6	**0.3**	0.4
AFFO	**18.2**	27.1	**22.1**	19.5	**20.4**	11.2	**10.4**	26.8	**71.1**	84.6

1) "AFFO" is not a recognized measure under GAAP and does not have a standardized meaning prescribed by GAAP. Refer to the discussion of non-GAAP measures.

2) Represents total facility maintenance capital expenditures less depreciation for furniture, fixtures, equipment and computers (FFEC) already deducted in determining FFO.

Capital Structure

The following table summarizes the continuity of our capital structure for each of 2013 and 2012.

(thousands of dollars unless otherwise noted)	**2013**	**2012**
Shareholders' Equity		
Common Shares	**476,480**	467,463
Equity portion of convertible debentures	**5,573**	5,573
Contributed surplus	**48**	48
	482,101	473,084
Accumulated deficit at beginning of year	**(395,024)**	(386,174)
Net earnings for the year	**5,252**	62,656
Dividends/distributions declared	**(52,022)**	(71,497)
Other		(9)
Accumulated deficit at end of year	**(441,794)**	(395,024)
Accumulated other comprehensive loss	**(2,441)**	(23,400)
Shareholders' equity	**37,866**	54,660
U.S./Canadian dollar exchange rate at end of year	**1.0636**	0.9949

Share Information *(thousands)*	**January 31, 2014**	**December 31, 2013**	**December 31, 2012**
Common Shares (TSX symbol: EXE) [1]	**87,346.3**	**87,266.5**	85,989.4

1) Closing market value per the TSX on January 31, 2014, was $7.14.

The closing rates used to translate assets and liabilities of the U.S. operations were 1.0636 at December 31, 2013, and 0.9949 at December 31, 2012. As a result of the weaker Canadian dollar at December 31, 2013, the assets of Extendicare's U.S. operations increased by approximately $89.1 million, partially offset by an increase in the liabilities of approximately $70.7 million, with the net change in foreign currency translation of $18.4 million included in accumulated other comprehensive loss. Every one-cent increase (decrease) in the Canadian dollar against the U.S. dollar would impact the net assets of our U.S. operations by approximately $2.5 million, and would be reflected as a change in foreign currency translation adjustments in accumulated other comprehensive loss.

DISTRIBUTIONS

We generated AFFO of $71.1 million in 2013, and declared dividends totalling $52.0 million that were paid out from February 15, 2013 to January 15, 2014. The portion distributed in cash was $43.7 million and $8.3 million was by way of shares issued under a dividend reinvestment plan. A total of 1,277,135 Common Shares were issued in 2013 through the dividend reinvestment plan.

In 2012, we generated AFFO of $84.6 million and declared monthly distributions totalling $71.5 million that were paid out from February 15, 2012 to January 15, 2013. The portion distributed in cash was $57.1 million and $14.4 million was by way of shares/units issued under a distribution reinvestment plan. A total of 1,881,488 Common Shares/REIT Units were issued in 2012 through the distribution reinvestment plan.

There are a number of factors that affect the quarterly funds generated for distribution that our Board takes into consideration in determining the monthly distributions for the year. Factors affecting quarterly trends in earnings are discussed under the headings "Adjusted Funds from Operations", "Summary of Quarterly Results" and "2013 Financial Review".

The declaration and payment of future distributions is at the discretion of our Board as to the amount and timing of dividends to be declared and paid, after consideration of a number of factors including results of operations, requirements for capital expenditures and working capital, future financial prospects of Extendicare, debt covenants and obligations, and any other factors deemed relevant by the Board. If our Board determines that it would be in Extendicare's best interests, it may reduce, for any period, the amount and frequency of dividends to be distributed to holders of Common Shares.

NORMAL COURSE ISSUER BID

On July 5, 2012, Extendicare received the approval of the TSX to commence a normal course issuer bid (the "Bid") to purchase for cancellation up to 4.0 million Common Shares, representing approximately 4.8% of the public float on July 1, 2012. The Bid commenced on July 9, 2012, and provided Extendicare with flexibility to repurchase Common Shares for cancellation until July 8, 2013. The Company did not acquire any shares for cancellation under the Bid during 2013. In July 2012, Extendicare acquired for cancellation 13,600 Common Shares at a cost of $0.1 million (average cost of $7.81 per share).

ACCRUAL FOR SELF-INSURED LIABILITIES

The accrual for self-insured liabilities is based on management's best estimate of the ultimate cost to resolve general and professional liability claims, including both known claims and claims that have been incurred but not yet reported by the end of the reporting period. General and professional liability claims are the most volatile and significant of the risks for which Extendicare self-insures. Actual results can differ materially from the estimates made due to a number of factors including the assumptions used by management and other market factors.

As at December 31, 2013, the accrual for self-insured general and professional liabilities increased by $19.4 million to $115.3 million (US$108.4 million) compared to $95.9 million (US$96.4 million) at the beginning of the year. The current period provision, net of claims payments, increased the accrual by $11.8 million, with the balance primarily due to the impact of the weaker Canadian dollar and accretion of the discount.

Payments for self-insured liabilities were $42.7 million in 2013 and $23.9 million in 2012. Provisions for potential general and professional liability claims were $54.5 million (US$52.9 million) in 2013 and $40.8 million (US$40.8 million) in 2012.

The results of our three independent actuarial reviews completed during 2013, necessitated the continued strengthening of our reserves. Our quarterly provisions for 2013 were US$9.4 million, US$9.2 million, US$14.0 million, and US$20.3 million, respectively. Approximately US$22.2 million of the total US$52.9 million recorded in 2013 related to our former Kentucky operations, as we continue to process the settlement of those claims. Of the balance of the provision of US$30.7 million, approximately US$5.7 million related to the strengthening of prior years' reserves in other states, and US$25.0 million related to potential claims for the 2013 period. In 2012, we had indicated that our provision for self-insured liabilities was anticipated to reduce to a level of approximately US$12 million annually following our exit from Kentucky. However, that projected reduction has not occurred due to an increase in claims in other states.

For the year ended December 31, 2012, payments for self-insured liabilities were $23.9 million compared to $35.1 million in 2011. Provisions recorded in 2012 for potential general and professional liability claims were $40.8 million (US$40.8 million), of which $16.6 million (US$16.6 million) related to the strengthening of our prior years' reserves. In comparison, for the 2011 year, our provision for self-insured liabilities was $65.3 million (US$66.0 million), of which $42.8 million (US$43.3 million) related to prior years' reserves. The strengthening of our prior years' reserves was primarily attributable to claims in the State of Kentucky and settlement of certain pre-2012 claims in other states. Excluding prior years' reserve adjustments, our provision for self-insured liabilities was US$24.2 million in 2012 compared to US$22.7 million in 2011. Our claims experience in Kentucky had accounted for more than 50% of our provision for self-insured liabilities in 2011 and 2012.

Management regularly evaluates and periodically engages an independent third-party actuary to provide a report to determine the appropriateness of the carrying value of this liability. In 2011, we commenced the practice of performing an independent actuarial review three times during the calendar year, by adding a review in the second quarter, in addition to the normal third and fourth quarter reviews. Assumptions underlying the determination of the liability are limited by the uncertainty of predicting future events and assessments regarding expectations of several factors. Such factors include, but are not limited to: the frequency and severity of claims, which can differ materially by jurisdiction; trends in claims along with unique and identifiable settlements; coverage limits of third-party reinsurance; the effectiveness of the claims management process; and the outcome of litigation. Therefore, management's estimate of the accrual for general and professional liability claims is significantly influenced by assumptions that are subject to judgement by management and the actuary, which may cause the provision to fluctuate significantly from one reporting period to another. Differences between the ultimate claims costs and our historical provisions for loss and actuarial assumptions and estimates could have a material adverse effect on our business, operating results and financial condition.

Most of the risks that Extendicare self-insures are long-term in nature and accordingly, claims payments for any particular policy year occur over a long period of time. However, management estimates and allocates a current portion of the accrual

for self-insured liabilities on the statement of financial position. As at December 31, 2013, management estimated that $28.1 million of the accrual for self-insured general and professional liabilities will be paid within the next year. The timing of payments is not directly within management's control and, therefore, estimates could change in the future.

Within our Bermuda-based captive insurance company, we hold investments sufficient to support the accrual for self-insured liabilities and to meet the required statutory solvency and liquidity rations. These invested funds are reported in other assets and totalled $118.8 million (US$111.7 million) at December 31, 2013, compared to $115.0 million (US$115.6 million) at December 31, 2012. Management believes there are sufficient cash resources to meet estimated current claims payment obligations.

LONG-TERM DEBT

Long-term debt, including current portion and net of financing costs, was $1,175.2 million at December 31, 2013, compared with $1,132.2 million at December 31, 2012. The current portion of long-term debt was $158.4 million at December 31, 2013, of which $10.3 million was classified as liabilities of disposal group held for sale in connection with two of the 11 U.S. skilled nursing centers held for sale. The remaining current portion of long-term debt of $148.1 million at the end of 2013 includes the convertible unsecured subordinated debentures due in June 2014 (the "2014 Debentures") with a carrying value of $114.2 million, and a face value of $113.9 million. The current portion of long-term debt of $93.4 million at December 31, 2012, included PrivateBank loans of US$33.9 million and $15.5 million of mortgages that were refinanced during 2013.

Details of the components, terms and conditions of long-term debt are provided in *note 14* of the 2013 consolidated financial statements. Extendicare and its subsidiaries are in compliance with all of their respective financial covenants as at December 31, 2013.

The following summarizes the changes in the carrying amounts of long-term debt for each of 2013 and 2012.

Continuity of Long-term Debt *(millions of dollars)*	**2013**	**2012**
Long-term debt at beginning of year, prior to financing costs	**1,163.0**	1,156.6
Issue of long-term debt		
Mortgages	**64.3**	164.4
2019 Debentures (net of $5.8 million allocated to equity)	**–**	120.7
Construction loans	**30.3**	37.7
Notes payable/other	**1.1**	1.1
Redemption of 2013 Debentures at face value	**–**	(91.8)
Net repayment on the EHSI Credit Facility	**(6.2)**	(44.9)
Repayment of long-term debt	**(84.1)**	(162.7)
Revaluation of convertible debentures carried at fair value and accretion	**(2.4)**	(4.7)
Change due to period-end foreign exchange rate	**39.0**	(13.4)
	1,205.0	1,163.0
Financing costs at end of year	**(29.8)**	(30.8)
Long-term debt at end of year	**1,175.2**	1,132.2
Less: portion classified as liabilities of disposal group held for sale	**(10.3)**	–
Less: current portion	**(148.1)**	(93.4)
	1,016.8	1,038.8

Interest Rates and Aggregate Debt Maturities

Management has limited the amount of debt that may be subject to changes in interest rates. As a result, all but $2.2 million (US$2.1 million drawn under the EHSI Credit Facility) of our long-term debt outstanding at December 31, 2013, was at fixed rates.

The weighted average interest rate of our long-term debt was approximately 4.9% as at December 31, 2013 (5.4% for our Canadian operations and 4.3% for our U.S. operations), compared to 5.0% at December 31, 2012. The weighted average term to maturity of our long-term debt, including finance lease obligations, was 19.2 years as at December 31, 2013 (8.9 years for our Canadian operations and 30.1 years for our U.S. operations), compared to 18.5 years as at December 31, 2012. Excluding our finance lease obligations, the weighted average term to maturity of our long-term debt was 19.7 years (7.9 years for our Canadian operations and 30.2 years for our U.S. operations).

Our consolidated interest coverage ratio for 2013 was 2.6 times (2012 – 3.0 times). Interest coverage is defined as Adjusted EBITDA divided by net interest, which represents interest expense net of interest revenue. The decline in our interest coverage for 2013 reflects the decline in our Adjusted EBITDA, partially offset by lower net interest costs.

The following table presents principal, or notional, amounts and related weighted average interest rates by year of maturity for the Company's debt obligations as at December 31, 2013. It incorporates only exposures that existed at that date and does not consider exposures, or positions that could arise subsequently, or future interest rate movements. As a result, the information has limited predictive value. The ultimate results with respect to interest rate fluctuations will depend on the exposures that occur, hedging strategies at the time and interest rate movements.

Debt Obligations *(millions of dollars unless otherwise noted)*	**2014**	**2015**	**2016**	**2017**	**2018**	**After 2018**	**Total**	**Fair Value**
Canadian Operations								
Convertible debentures (at face value)								
Fixed rate	113.9	–	–	–	–	126.5	240.4	242.0
Average interest rate	5.70%	–	–	–	–	6.00%	5.86%	
Long-term debt								
Fixed rate	20.0	14.0	20.4	31.2	18.0	167.9	271.5	282.3
Average interest rate	4.41%	4.66%	4.67%	4.44%	4.88%	5.14%	4.46%	
Finance lease obligations								
Fixed rate	5.0	5.3	5.7	6.1	6.5	77.1	105.7	118.7
Average interest rate	7.00%	7.00%	7.00%	7.00%	7.00%	6.99%	6.99%	
United States Operations [1]								
Long-term debt								
Fixed rate	10.8	11.1	11.6	12.0	12.5	518.8	576.8	549.1
Fixed rate included in liabilities held for sale	0.2	0.2	0.2	0.2	0.3	9.6	10.7	10.7
Average interest rate	4.34%	4.32%	4.28%	4.28%	4.28%	4.30%	4.30%	
Variable rate	–	2.2	–	–	–	–	2.2	2.2
Average interest rate	–	5.50%	–	–	–	–	5.50%	
Finance lease obligations								
Fixed rate	1.5	0.7	0.1	–	–	–	2.3	2.3
Average interest rate	5.12%	5.05%	1.02%	–	–	–	5.12%	

1) U.S. dollar denominated debt is translated to Canadian dollars at a rate of 1.0636.

OTHER CONTRACTUAL OBLIGATIONS

The table below provides summary information about the contractual obligations, other than long-term debt, as at December 31, 2013. Due to the uncertainty as to the timing of payments to be made with respect to certain obligations, the table excludes our self-insured liabilities and decommissioning provisions, totalling $115.3 million and $28.8 million, respectively, as at December 31, 2013, and also excludes our defined benefit pension plan obligations, which are described more fully below.

Other Contractual Obligations *(millions of dollars)*	**Total**	**To the end of 2014**	**2015**	**2016**	**2017**	**2018**	**After 2018**
Canadian Subsidiary Operations							
Operating lease obligations	**9.2**	2.3	1.9	1.6	1.4	1.1	0.9
Purchase obligations	**3.3**	3.3	–	–	–	–	–
United States Subsidiary Operations [1]							
Operating lease obligations	**28.7**	6.1	4.9	4.7	4.3	3.6	5.1
Purchase obligations	**9.5**	9.5	–	–	–	–	–
	50.7	21.2	6.8	6.3	5.7	4.7	6.0

(1) Obligations denominated in U.S. dollars are translated to Canadian dollars at a rate of 1.0636.

In addition to the operating lease amounts identified in the table above, EHSI remains party to master leases between Assisted Living Concepts, Inc. (ALC) and LTC Properties, Inc. (LTC) following the reorganization completed in November 2006. For further details on these commitments, refer to "Off-balance Sheet Arrangements".

Defined Benefit Pension Plan Obligations

The contractual obligations table excludes our defined benefit pension plan obligations. The accrued benefit liability on our statement of financial position as at December 31, 2013, was $35.2 million (December 31, 2012 – $35.8 million). We currently have defined benefit registered and supplementary plans covering certain executives, both of which have been closed to new entrants since 2000. The registered defined benefit plan was in an actuarial deficit of $1.6 million with plan assets of $5.7 million and accrued benefit obligations of $7.3 million as at December 31, 2013 (December 31, 2012 – an actuarial deficit of $1.9 million with plan assets of $5.7 million and accrued benefit obligations of $7.6 million). The accrued benefit obligations of the supplementary plan were $33.6 million as at December 31, 2013 (December 31, 2012 – $33.8 million). We do not set aside assets in connection with the supplementary plan and the benefit payments will be paid from cash from operations. The benefit obligations under the supplementary plan are secured by letters of credit totalling $42.0 million as at December 31, 2013 (December 31, 2012 – $42.7 million). The expected annual benefit payments under the supplementary pension plan that will be funded from cash from operations over the next five years range between $2.0 million and $2.2 million, and the annual contributions to the registered pension plan over the next five years are expected to be less than $0.1 million. Since the majority of our accrued benefit obligations represent our obligation under our non-registered supplementary plan, which is not required to be funded, the recent capital market turmoil is not expected to have a material adverse effect on our cash flow requirements with respect to our pension obligations, or our pension expense.

Future Liquidity and Capital Resources

As at December 31, 2013, Extendicare's consolidated cash on hand totalled $96.0 million, excluding restricted cash of $18.7 million. The balance of cash on hand held by EHSI was US$37.5 million, and EHSI had US$76.0 million available under the EHSI Credit Facility, subject to leverage requirements. Our Canadian operations had cash on hand of $55.7 million and had $21.7 million available under the RBC Credit Facility. In addition, as at December 31, 2013, we had 57 unencumbered nursing centers in the U.S. with an estimated value of between US$250 million and US$300 million, which includes 19 centers that are leased to a third-party operator in Kentucky.

We are currently projected to spend in the range of $38 million to $43 million in facility maintenance capital expenditures and $15 million to $20 million in growth capital expenditures in 2014. As at December 31, 2013, EHSI and ECI had outstanding capital expenditure commitments totalling US$9.0 million and $3.3 million, respectively. EHSI's commitments include a purchase obligation of US$6.0 million to acquire a skilled nursing center (108 beds) that it currently leases in Ohio. ECI's commitments relate to the Timmins construction project.

The 2014 Debentures mature on June 30, 2014, and require Extendicare to either repay them in full or refinance them through the capital markets. Management continues to closely monitor the financial markets and believes that the Company has the full financial capacity and ability to execute a plan to complete the refinancing of the 2014 Debentures. Although management has the confidence to complete the refinancing, there can be no assurance given that the Company will succeed in the refinancing of the 2014 Debentures prior to their maturity.

Management remains confident that cash from operating activities, together with available bank credit facilities, will be sufficient to meet Extendicare's current requirements to support ongoing operations, facility maintenance capital expenditures, and debt repayment obligations. Extendicare's approach to distributing funds available from operations, necessitates raising funds through debt financings and the capital markets to fund strategic acquisitions and growth capital expenditures.

RELATED PARTY TRANSACTIONS

Tim Lukenda, Extendicare's President and Chief Executive Officer, is the former President of Tendercare (Michigan) Inc. (Tendercare), a company acquired by EHSI in 2007, in which Mr. Lukenda owned an approximate 4.6% direct and indirect interest. Mr. Lukenda's employment contract provides a mechanism and process that effectively removes him from the decision-making process in situations where a conflict of interest may arise on any matter between the Company and his previous employer, or with respect to any financial interest that Mr. Lukenda or his family have with the Company.

In connection with the purchase of Tendercare, the acquired working capital was subject to annual adjustments over a four-year period. The final working capital adjustment was paid in the third quarter of 2012, bringing the total of the payments to US$5.5 million by EHSI.

In 2008, ECI acquired LTC Professional Insurance Company, Ltd. (LTC Professional), Tendercare's affiliated insurance company, for a nominal amount. Consideration for the acquisition was adjusted for annually based upon the actuarial

liabilities determined at the end of each year through to 2012. The final adjusting payment was made in March 2013, in the amount of US$0.5 million, bringing the total of the adjustments made to US$5.6 million.

In July 2013, ECI sold one of its closed nursing centers for $1.2 million to a company owned by members of Mr. Lukenda's family, of which Mr. Lukenda owns an approximate 7.1% direct and indirect interest.

In addition, with respect to other long-term care centers that are partly owned by Mr. Lukenda and his immediate family, ECI provides certain management services to a long-term care center in Ontario, Canada, and prior to April 2013, ECI operated under lease arrangements, a second long-term care center in Ontario. In addition, EHSI operates under lease arrangements, a skilled nursing center in Michigan, and until August 2013, EHSI provided certain management services to an assisted living center in Michigan.

OFF-BALANCE SHEET ARRANGEMENTS

Both ALC and EHSI are the lessees under lease agreements with LTC (the "LTC Master Leases"), which cover 37 assisted living properties operated solely by ALC that are not part of EHSI's operations. LTC declined to remove EHSI as a party to the leases at the time of the distribution of ALC by Extendicare to its shareholders in 2006 and, accordingly, EHSI continues to be directly liable to LTC for rent payments and other obligations owing under the LTC Master Leases, notwithstanding that EHSI does not have any financial interest in the operations of the 37 centers. A separation agreement entered into between Extendicare and ALC (the "Separation Agreement"), provides that ALC will indemnify EHSI against any expenses, liabilities and costs incurred by EHSI, including rent payments relating to the LTC Master Leases. The aggregate minimum rental payments for the 2013 calendar year were approximately US$11.8 million and will increase by 2% for the 2014 calendar year. The leases expire in December 2014, and in January 2014, LTC announced that it does not intend to renew the leases with ALC.

In July 2013, all of the outstanding shares of ALC were acquired by an affiliate of TPG Capital, L.P. (TPG), a global private investment firm, for cash. Management does not believe that this transaction will have an impact on either EHSI being a co-tenant under the LTC Master Leases, nor the indemnification between Extendicare and ALC provided within the Separation Agreement.

Extendicare has not recorded any potential liability for this exposure.

RISKS AND UNCERTAINTIES

General Business Risks

Extendicare is subject to general business risks inherent in the long-term care industry, including: increased government regulation and oversight; changing consumer preferences; fluctuations in occupancy levels; the inability to achieve adequate government funding increases; increases in labour costs and other operating costs; possible future changes in labour relations; competition from or the oversupply of other similar properties; changes in neighbourhood or location conditions and general economic conditions; health related risks; disease outbreaks and control risks; changes in accounting principles and policies; the imposition of increased taxes or new taxes; capital expenditure requirements; changes in interest rates; and changes in the availability and cost of long-term financing, which may render refinancing of long-term debt difficult or unattractive. Any one of, or a combination of, these factors may adversely affect the business, results of operations and financial condition of the Company.

Risks Related to Government Funding and Regulatory Changes

Extendicare's earnings are highly reliant on government funding and reimbursement programs, both in the U.S. and in Canada, and the effective management of staffing and other costs of operations, which are strictly monitored by government regulatory authorities. Given that we operate in a labour-intensive industry, where labour-related costs account for a significant portion of our operating costs (approximately 73% in 2013), government funding constraints could have a significant adverse effect on our results from operations and cash flows. Management is unable to predict whether governments will adopt changes in their funding and reimbursement programs, and if adopted and implemented, what effect such changes will have on the Company.

Further information on funding and legislative changes affecting the industry can be found under "Update of Regulatory and Reimbursement Changes Affecting Revenue".

All long-term care providers are subject to surveys, inspections, audits and investigations by government authorities to ensure compliance with applicable laws and licensure requirements of the federal, state and/or provincial funding programs. Nursing centers must comply with applicable regulations that, depending on the jurisdiction in which they operate, may relate to such things as staffing levels, resident care standards, occupational health and safety, resident confidentiality, billing and reimbursement, along with environmental and other standards. The government review process is intended to determine compliance with survey and certification requirements, and other applicable laws. Remedies for survey deficiencies can be levied based upon the scope and severity of the cited deficiencies. Remedies range from the assessment of fines to the withdrawal of payments under the government funding programs. Should a deficiency not be addressed through a plan of correction, a center can be decertified from the funding program. As at December 31, 2013, we had certain centers under plans of correction at EHSI, but no centers had been decertified. While it is not possible to estimate the final outcome of the required corrective actions, the Company has accrued for known remedial costs.

Government agencies have steadily increased their enforcement activity over the past several years. As a result, in addition to increasing resources to improve the quality of services provided to our residents, we are continually allocating increased resources to ensure compliance with applicable laws and regulations and to respond to inspections, investigations and/or enforcement actions. Our costs to respond to and/or defend surveys, inspections, audits and investigations are significant and are likely to increase in the current environment.

Non-compliance with applicable laws and licensure requirements governing long-term care could result in adverse consequences, including severe penalties, which may include criminal sanctions and fines, civil monetary penalties and fines, administrative and other sanctions, including exclusion from participation in the Medicare and Medicaid programs, or one or more third-party payor networks. We may be required to refund amounts that have been paid to us by federal, state and/or provincial funding programs. These penalties could have a material adverse effect on the business, results of operations or financial condition of the Company.

UNITED STATES

EHSI receives payment for its services and products from the federal (Medicare) and state (Medicaid) medical assistance programs, Managed Care organizations (including HMO and preferred provider organizations), commercial insurers, the Department of Veterans Affairs, as well as from private payors.

Limitations on U.S. Medicare and Medicaid reimbursement for health care services are continually proposed. Medicare and Medicaid reimbursement programs are complicated and constantly changing as CMS and the various states continue to refine their programs. There are considerable administrative costs incurred by EHSI in monitoring the changes made within the programs, determining the appropriate actions to be taken to respond to those changes and implementing the required actions to meet the new requirements and minimize the repercussions of the changes to EHSI's reimbursement rates and costs. There can be no assurance that Medicare and Medicaid reimbursement programs will remain at levels comparable to present levels or that they will, in the future, be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to such programs. Therefore, government funding constraints could have a significant adverse effect on the Company's results from operations and cash flows. Further information on funding and legislation changes affecting our industry in the United States can be found under "Update of Regulatory and Reimbursement Changes Affecting Revenue – United States".

EHSI participates in federal and state health care programs and, therefore, is subject to a variety of federal and state laws that are intended to prevent health care fraud and abuse. Violation of these laws is punishable by criminal, civil and administrative penalties, including, in some instances, exclusion from participation in federal and state health care programs. These laws include, but are not limited to, anti-kickback laws, false claims laws, physician self-referral laws and federal criminal health care fraud laws. EHSI cannot reasonably predict whether enforcement activities will increase at the federal or state level or the effect of such enforcement activities on its business and its financial results.

U.S. federal law requires each state to have a Medicaid Fraud Control Unit, which is responsible for investigating provider fraud and resident abuse in Medicaid-funded centers. EHSI has been investigated by these Medicaid Fraud Units previously, but it is not aware of any liability relating thereto at this time. Management believes that EHSI and its subsidiaries have been and continue to be in material compliance with all of these laws as they apply to its companies.

EHSI believes its billing practices, operations and compensation and financial arrangements with referral sources and others materially comply with applicable federal and state requirements. However, EHSI cannot give assurance that a governmental authority will not interpret such requirements in a manner inconsistent with EHSI's interpretation and application.

CANADA

In Canada, provincial legislation and regulations closely control all aspects of the operation and funding of nursing centers, including the fee structure, subsidies, the adequacy of physical centers, standards of care and accommodation, equipment and personnel. There can be no assurance that the current level of fees and subsidies will continue or that such fees will increase commensurate with ECI's costs of care. A reduction of such fees or subsidies could have an adverse effect on the business, results of operations and financial condition of the Company. Further information on funding and legislation changes affecting our industry in Canada can be found under "Update of Regulatory and Reimbursement Changes Affecting Revenue – Canada".

The revocation of a license by authorities or cancellation of a service contract due to inadequate performance by the operator has been historically infrequent in Canada and is usually 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 centers, it is not unusual for stringent inspection procedures to identify deficiencies in operations. Every effort is made to avoid and mitigate notices of deficiencies through quality assurance strategies. As well, all efforts are undertaken to correct all legitimate problem areas that have been identified through regulatory inspections.

In Ontario, licenses for nursing centers are issued for a fixed term not to exceed 25 years, depending on the bed classification in accordance with the LTC Act 2007. Long-term care operations will be given notification of whether or not a new license will be issued at least three years before the end of the license term.

In Ontario, the MOHLTC initiated plans in 2007 to redevelop 35,000 older long-term care beds over 15 years. The first phase of the renewal strategy was launched in 2009, with eligible participants receiving a construction funding subsidy over 25 years. ECI owns 21 nursing centers with 3,287 class "C" beds in Ontario that are at risk of losing their licenses in June 2025 should they not be redeveloped to meet the new standards. In response to concerns raised by the industry regarding the design standards and the adequacy of the construction funding subsidy, the MOHLTC commenced a review of the program in 2011, and we are awaiting a report on its recommendations and or proposed changes to the program (see "Ontario Redevelopment Program" under the heading "Update of Regulatory and Reimbursement Changes Affecting Revenue – Canada").

Risks Related to Litigation

LIABILITY AND INSURANCE

Operators within the long-term care industry, including the Company, face lawsuits alleging negligence, malpractice, or other related claims and, as a result, incur significant costs in connection with defending general and professional liability claims, workers' compensation claims, and property based claims. In addition to large compensatory claims, plaintiffs' attorneys also seek significant punitive damages and attorneys' fees. The Company maintains insurance coverage for the significant majority of risk associated with claims in respect to general and professional liability, directors' and officers' liability, employers' liability, auto liability, health and dental benefits, business income and property. General and professional liability policies currently offered in the long-term care industry are generally only offered on a "claims made" basis, as opposed to "occurrence based" coverage. "Claims made" policies are subject to possible rate increases upon renewal due to a step-up factor used by the insurer.

The Company maintains general and professional liability and property insurance policies through third-party insurers, along with retaining a portion of risk within its Bermuda-based captive insurance structure, in amounts and with the coverage and deductibles it believes are adequate based on the nature and risks of its business, historical experience and industry standards, as well as the type of insurance coverage commercially available in the marketplace. Provisions for loss for our professional liability risks are based upon management's best available information including actuarial estimates. The Bermuda-based captive insurance company of Extendicare is currently appropriately capitalized, but there can be no assurance that it will remain appropriately capitalized in the future should claims against the Company increase significantly.

From time to time, EHSI has elected to self-insure the risk associated with workers' compensation claims up to a certain per claim limit and aggregate exposure limit, along with the arrangement of third-party insured products. In addition, EHSI self-insures its health and dental coverage. The Company's costs are subject to changes caused by the number and nature of claims incurred. The Company employs risk management personnel to assist its centers in the appropriate measures to maintain a safe workplace environment and to manage workers' compensation claims. If the Company is not able to control these costs, this could adversely affect the business, results of operations and financial condition of the Company.

A successful claim against the Company not covered by, or in excess of, such insurance, or in excess of the Company's reserves for self-insured retention levels, could have a material adverse effect on the business, operating results and financial condition of the Company. In many states, state law prohibits or limits insurance coverage for the risk of punitive damages arising from general and professional liability claims and/or litigation. Furthermore, there are certain types of risks, generally of a catastrophic nature, such as war, non-certified acts of terrorism, or environmental contamination, which are either uninsurable or are not insurable on an economically viable basis. Under these circumstances, the Company may be liable for such losses. Also, in order to obtain liability insurance at a more reasonable cost or in some instances to obtain coverage at all, the Company is required to assume self-insurance retention levels for its general and professional liability claims. The Company estimates the value of losses that may occur within its self-insured retention levels based on historical claims, actuarial valuations, third-party administrator estimates, industry data and advice from consultants and legal counsel and endeavours to reserve for such liabilities. If the estimates of the Company are inaccurate or if there are an unexpectedly large number of successful claims that result in liabilities in excess of the reserves of the Company for losses, the operating results of the Company could be negatively affected. Claims against the Company, regardless of their merit or eventual outcome, also may have a material adverse effect on the ability of the Company to attract residents and patients, expand the business of the Company or maintain favourable standings with regulatory authorities. These claims also require management to devote time to matters unrelated to the operation of the business.

The Company has to renew its insurance policies each year or on a periodic basis and negotiate acceptable terms for coverage, exposing it to the volatility of the insurance markets, including the possibility of rate increases resulting from the claims experience of the Company or the aggregate claims experience of the long-term care industry. There can be no assurance that the Company will be able to obtain insurance in the future or, if available, that such coverage will be available on acceptable terms and provide coverage for perils inherent to the senior care industry.

COMPLIANCE WITH REGULATORY REQUIREMENTS

EHSI is subject to review or audit by federal and state governmental agencies to verify compliance with the requirements of the Medicare and Medicaid programs. Audits under the Medicare and Medicaid programs have intensified in recent years. Private payors may also have the right to review or audit our files. These activities could result in an obligation to repay amounts received pursuant to these programs. The payment of penalties, exclusion from participation in one or more government programs or a loss of a contract with a private payor could materially adversely affect the business results of operations and financial condition of the Company.

EHSI is also subject to lawsuits under the Federal False Claims act and comparable state laws. These lawsuits, which may be initiated by whistleblowers, can involve significant monetary damages, attorneys' fees and the award of bounties to private plaintiffs who successfully bring these suits and to the government programs. See "Overview – Significant 2013 Events and Developments – Legal Proceedings and Regulatory Actions".

In the United States and Canada, there are a number of federal, state and provincial laws protecting the confidentiality of certain patient health information, including patient records, and restricting the use and disclosure of that protected information. In particular, the privacy rules under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) in the U.S. and under the *Personal Information Protection and Electronic Documents Act* (PIPEDA) in Canada protect medical records and other personal health information by limiting their use and disclosure of health information to the minimum amount reasonably necessary to accomplish the intended purpose. If the Company was found to be in violation of the privacy or security rules under HIPAA, PIPEDA or other laws protecting the confidentiality of patient health information, it could be subject to sanctions and civil or criminal penalties, which could increase its liabilities, harm its reputation and have a material adverse effect on the business, results of operations and financial condition of the Company.

INDEMNIFICATION OBLIGATIONS BETWEEN ALC AND EXTENDICARE

In connection with the distribution by Extendicare of shares of ALC to shareholders of Extendicare in 2006, Extendicare, EHSI and ALC entered into a number of transactions and agreements, including the Separation Agreement and a number of agreements relating to the transfer of assisted living centers from EHSI to ALC. Pursuant to the Separation Agreement, ALC has agreed to indemnify, defend and hold harmless Extendicare and certain of its related parties for identifiable losses relating to or arising from certain specified matters, including matters relating to or arising from ALC's assisted living care business and Extendicare has agreed to indemnify, defend and hold harmless ALC and certain related parties from certain other specified matters, including matters relating to those assets and liabilities that were not transferred to ALC as part of the separation.

As described under the heading "Off-balance Sheet Arrangements", EHSI is bound by the terms of the LTC Master Leases that cover 37 assisted living properties operated by ALC. The Separation Agreement provides that ALC will indemnify EHSI against any expenses, liabilities and costs incurred by EHSI, including rent payments relating to the LTC Master Leases. The aggregate minimum rental payments for the 2013 calendar year were approximately US$11.8 million and will increase by 2% for the 2014 calendar year. The leases expire in December 2014, and in January 2014, LTC announced that it does not intend to renew the leases with ALC.

Risks Related to Tax Rules and Regulations

Extendicare is subject to audits from federal, state and provincial tax jurisdictions and, therefore, is subject to risk in the interpretation of tax legislation and regulations. Tax regulations are complex and require careful review by the Company's tax management and its external tax consultants. Differences in interpretation of those tax rules and regulations could result in tax assessments and penalties for the untimely payment of the determined tax liability, which could have a material adverse effect on the business, results of operations and financial condition of the Company.

ALC SPIN-OFF

The Extendicare reorganization completed in November 2006 (the "2006 Arrangement") included the distribution by Extendicare of shares of ALC to the shareholders of Extendicare and a number of pre-2006 Arrangement transactions. In connection with the 2006 Arrangement, EHSI received a note upon the transfer of ALC to its Canadian affiliate, which note was subsequently repaid by way of cash, settlement against other notes and dividends of US$476.6 million. Based upon internal calculations, management believes there was sufficient surplus and basis as to not attract any Canadian taxes from the transactions relating to the repayment of the note. Extendicare and its Canadian affiliates are currently under audit by the Canada Revenue Agency (CRA). Should the CRA determine that the available surplus was less than the amount determined by management, Canadian capital gains tax would apply to the shortfall.

Risks Related to Financing

DEBT FINANCING

Due to the level of real property ownership by the Company, a significant portion of the consolidated cash flow of the Company is devoted to servicing debt, and there can be no assurance that the Company will continue to generate sufficient cash flow from operations to meet required interest and principal payments. If the Company were unable to meet interest or principal payments, it could be required to seek renegotiation of such payments or obtain additional equity, debt or other financing.

The 2014 Debentures mature on June 30, 2014, and require Extendicare to either repay them in full or refinance them through the capital markets. Management continues to closely monitor the financial markets and believes that the Company has the full financial capacity and ability to execute a plan to complete the refinancing of the 2014 Debentures. Although management has the confidence to complete the refinancing, there can be no assurance given that the Company will succeed in the refinancing of the 2014 Debentures prior to their maturity.

Extendicare's RBC Credit Facility is a demand facility that is secured by 13 class "C" graded nursing centers in Ontario and is guaranteed by certain Canadian subsidiaries of the Company. The RBC Credit Facility consists of a $64.0 million working capital line that is primarily used to back letters of credit that renew annually. The availability under the working capital line was $21.7 million at December 31, 2013, with letters of credit issued totalling $42.3 million.

Global financial markets and economic events over the past few years have resulted in heightened scrutiny of banking institutions in the lending of credit, and the financial markets continue to be affected by the state of the economy in North America. The Company cannot predict whether future financing will be available, what the terms of such future financing will be (including, whether it will result in a higher cost of borrowing) or whether its existing debt agreements will allow for the timely arrangement and implementation of such future financing. If the Company is unable to obtain additional financing or refinancing when needed or on satisfactory terms, it could have a material adverse effect on the business, operating results and financial condition of the Company.

DEBT COVENANTS

The Company is in compliance with all of its financial covenants as at December 31, 2013. However, there can be no assurance that future covenant requirements will be met. The Company's bank lines and other debt may be affected by its ability to remain in compliance. If the Company does not remain in compliance with its financial covenants, its ability to amend the covenants or refinance its debt may be affected.

CREDIT AND INTEREST RATES

The Company has limited the amount of debt that may be subject to changes in interest rates. As a result, all but $2.2 million of the Company's total long-term debt outstanding at December 31, 2013, was at fixed rates. The Company primarily finances its senior care centers through fixed-rate mortgages and considers securing interest rate swap agreements for any variable-rate debt. The Company maintains risk management control systems to monitor interest rate risk attributable to its outstanding or forecasted debt obligations as well as any offsetting hedge positions. The Company does not enter into financial instruments for trading or speculative purposes.

Risks Related to Foreign Currency Rate Fluctuations

The majority of the Company's operations are conducted in the United States and the financial position and results of the U.S. operations are denominated in U.S. dollars. The U.S. operations accounted for 62.8% of our consolidated revenue from continuing operations and 47.5% of our AFFO in 2013. The revenues and expenses of the self-sustaining U.S. operations are translated at average rates of exchange in effect during the period. Assets and liabilities are translated at the exchange rates in effect at the balance sheet date. As a result, the Company's consolidated financial position is subject to foreign currency fluctuation risk, which could adversely impact its operating results and its cash flows.

As well, the Company's dividends are denominated in Canadian dollars from the operating cash flow generated by both its Canadian and U.S. operations. As a result, the cash available for distribution could be adversely impacted by foreign currency fluctuations. Management has a foreign currency hedging strategy whereby it monitors and considers entering into FCFCs to reduce the risks associated with changes in the U.S. dollar and the impact such changes could have on the Company's Canadian dollar distributions. The Company has not had any FCFCs in place since June 2011. Management continues to monitor the exchange rates and to consider future FCFCs to the extent that they may be beneficial to the Company. There can be no assurance that future FCFCs, if any, will be sufficient to protect the Company against currency exchange rate losses.

Risks of Property Ownership

REAL PROPERTY OWNERSHIP

All real property investments are subject to a degree of risk. They are affected by various factors, including changes in general economic conditions (such as the availability of long-term mortgage funds) and in local conditions (such as an oversupply of space or a reduction in demand for real estate in the area), the attractiveness of the properties to patients and residents, competition from other available space and various other factors. In addition, fluctuations in interest rates could have a material adverse effect on the business, operating results and financial condition of the Company.

Extendicare owns, or operates under finance lease arrangements with options to purchase, approximately 99% of its senior care centers, excluding those it operates under management contracts and the 21 Kentucky centers that have been leased to third-party operators. Senior care centers are limited in terms of alternative uses and, therefore, their values are directly driven by the cash flow from operations. The value of real property depends, in part, on government funding and reimbursement programs. The Company's income and funds available for distribution would be adversely affected if federal, state or provincial governments reduced their funding or reimbursement programs, or if a significant number of patients and residents of the senior care centers were to become unable to meet their financial obligations or experienced significant economic setbacks. In addition, overbuilding in any of the market areas of the Company could cause its properties and centers to experience decreased occupancy or depressed margins, which could adversely affect the business, operating results and financial condition of the Company. Moreover, certain significant expenditures involved in real property investments, such as real estate taxes, maintenance costs and mortgage payments, represent liabilities that must be met regardless of whether the property is producing any income.

Real property investments are relatively illiquid, thereby limiting the ability of the Company to vary its portfolio promptly in response to changed economic or investment conditions. There is a risk that the Company would not be able to sell its assets or that it may realize sale proceeds of less than the current book value of its properties.

CAPITAL INTENSIVE INDUSTRY

The Company must commit a substantial portion of its funds to maintain and enhance its senior care centers and equipment to meet regulatory standards, operate efficiently and remain competitive in its markets. Certain of its competitors may operate centers that are more attractive to potential patients and residents due to their age or physical condition. In Ontario, ECI owns 21 nursing centers with 3,287 class "C" beds that would require redevelopment to meet the new standards initiated by the MOHLTC to redevelop 35,000 older long-term care beds in the province over 15 years. However, this

program is currently under review by the MOHLTC due to concerns raised by ECI and other operators over the design standards and the adequacy of the construction funding subsidy (see "Ontario Redevelopment Program" under the heading "Update of Regulatory and Reimbursement Changes Affecting Revenue – Canada"). These as well as other future capital requirements could have a material adverse effect on the business, operating results and financial condition of the Company.

Risks Related to Growth Activities

CONTINUED GROWTH

The Company expects that it will have opportunities to acquire properties or expand existing centers that may be accretive, but there can be no assurance that this will be the case. The ability of the Company to fund growth will be dependent, in part, on external sources of funding. Lack of availability of such funding could limit the future growth of the Company.

State and provincial efforts to regulate the construction or expansion of health care providers could impair the ability of the Company to expand through construction and redevelopment. Most of the states in which EHSI currently operates have adopted laws to regulate the expansion of nursing centers. Certificate of Need (CON) laws 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. Some states also prohibit, restrict or delay the issuance of a CON, making it difficult to grow our operations other than by acquisition of existing operations and licensure rights from other providers. Many states have established similar CON processes to regulate the expansion of assisted living centers, but the restrictions are less than those for nursing centers. Similarly in Canada, the provinces restrict the number of licensed nursing center beds and any new licenses are awarded through an RFP process.

If a CON or other similar approvals are required in order to expand operations of the Company, the failure of the Company or inability to obtain the necessary approvals, changes in standards applicable to such approvals and possible delays and expenses associated with obtaining such approvals could adversely affect the ability of the Company to expand and, accordingly, to increase its revenue and earnings.

ACQUISITIONS

The success of the acquisition activities of the Company will be determined by numerous factors, including the ability of the Company to identify suitable acquisition targets, competition for acquisition opportunities, purchase price, ability to obtain adequate financing on reasonable terms, financial performance of the centers after acquisition, and the ability of the Company to effectively integrate and operate the acquired centers. Acquired properties may not meet financial or operational expectations due to unexpected costs associated with acquiring the property, as well as the general investment risks inherent in any real estate investment or acquisition. Moreover, newly acquired long-term care centers may require significant management attention or capital expenditures that would otherwise be allocated to existing centers. Any failure by the Company to identify suitable candidates for acquisition or operate the acquired centers effectively may have an adverse effect on the business, results of operations and financial condition of the Company.

ACCOUNTING POLICIES AND ESTIMATES

Non-GAAP Measures

Extendicare assesses and measures operating results and financial position based on performance measures referred to as "net operating income", "EBITDA", "Adjusted EBITDA", "earnings before depreciation, amortization, loss from asset impairment, disposal and other items", "earnings (loss) from continuing operations before separately reported gains/losses and distributions on Exchangeable LP Units", "Funds from Operations", and "Adjusted Funds from Operations". These measures are commonly used by Extendicare and its investors as a means of assessing the performance of the core operations in comparison to prior periods. They are presented by Extendicare on a consistent basis from period to period, thereby allowing for consistent comparability of its operating performance. These are not measures recognized under GAAP and do not have standardized meanings prescribed by GAAP. These non-GAAP measures are presented in this document because either: (i) management believes that they are a relevant measure of the ability of Extendicare to make cash distributions; or (ii) certain ongoing rights and obligations of Extendicare may be calculated using these measures. Such non-GAAP measures may differ from similar computations as reported by other issuers and, accordingly, may not be comparable to similarly titled measures as reported by such issuers. They are not intended to replace earnings (loss) from continuing operations, net earnings (loss), cash flow, or other measures of financial performance and liquidity reported in accordance with GAAP.

References to "net operating income" in this document are to revenue less operating expenses. References to "EBITDA" in this document are to earnings (loss) from continuing operations before net finance costs, income taxes, depreciation and amortization. References to "Adjusted EBITDA" in this document are to EBITDA adjusted to exclude the line item "loss (gain) from asset impairment, disposals and other items". As well, "Adjusted EBITDA" is equivalent to the additional GAAP measure presented in our Statements of Earnings referred to as "earnings before depreciation, amortization, loss from asset impairment, disposal and other items". Management believes that certain lenders, investors and analysts use EBITDA and Adjusted EBITDA to measure a company's ability to service debt and meet other payment obligations, and as a common valuation measurement in the long-term care industry. For example, certain of EHSI's debt covenants use Adjusted EBITDA in their calculations.

References to "earnings (loss) from continuing operations before separately reported gains/losses and distributions on Exchangeable LP Units" in this document are to earnings (loss) from continuing operations excluding the following separately reported line items: "distributions on Exchangeable LP Units", "fair value adjustments", "loss (gain) on foreign exchange and financial instruments", and "loss (gain) from asset impairment, disposals and other items". These line items are reported separately and excluded from certain performance measures, because they are transitional in nature and would otherwise distort historical trends. They relate to the change in the fair value of, or gains and losses on termination of, convertible debentures, Exchangeable LP Units, interest rate agreements and FCFCs, as well as gains or losses on the disposal or impairment of assets, and foreign exchange gains or losses on capital items. In addition, these line items may include provisions for restructuring charges and the write off of unamortized financing costs on early retirement of debt. The above separately reported line items are reported on a pre-tax and on an after-tax basis as a means of deriving earnings from operations and related earnings per share/unit excluding such items.

"Funds from Operations", or "FFO", is defined as Adjusted EBITDA less depreciation for furniture, fixtures, equipment and computers, accretion costs, net interest expense, and current income taxes.

"Adjusted Funds from Operations", or "AFFO", is defined as FFO plus the non-cash portion of financing and accretion costs and the principal portion of government capital funding payments, less the facility maintenance (non-growth) capital expenditures not already reflected in the calculation of FFO.

Both FFO and AFFO are subject to other adjustments, as determined by management in its discretion, that are not representative of Extendicare's operating performance.

Critical Accounting Policies and Estimates

A full discussion of Extendicare's critical accounting policies and estimates is provided in the accompanying notes to the audited consolidated financial statements for the year ended December 31, 2013, and under the heading "Future Change in Accounting Policies" that follows this section.

Management considers an understanding of Extendicare's accounting policies to be essential to an understanding of Extendicare's financial statements because their application requires significant judgement and reliance on estimations of matters that are inherently uncertain. There is measurement uncertainty relating to the accounting policies applied to: revenue recognition and the valuation of accounts receivable; the determination of the recoverable amount of cash generating units (CGU) subject to an impairment test; the valuation of decommissioning provisions; the valuation of self-insured liabilities; the assessment of contingencies; the valuation of financial assets and liabilities; the valuation of share appreciation rights liabilities; and the accounting for tax uncertainties and the tax rates used for valuation of deferred tax assets. The recorded amounts for such items are based on management's best available information and are subject to assumptions and judgement, which may change as time progresses; accordingly, actual results could differ from those estimated.

REVENUE RECOGNITION AND ACCOUNTS RECEIVABLE

In the United States, revenue from skilled nursing centers is derived from various federal and state medical assistance programs, Managed Care providers (for residents with health maintenance and commercial insurance programs), as well as privately from the residents. EHSI derived approximately 77% of its revenue from services provided under various federal or state medical assistance programs during 2013 (2012 – 79%). EHSI records its skilled nursing center revenue in the period in which the services and products are provided at established rates less contractual adjustments. Contractual adjustments include differences between established billing rates and amounts estimated by management as reimbursable under various reimbursement formulas or contracts in effect. Differences between final settlements and amounts recorded in previous periods are reported as adjustments to revenue in the period such settlements are determined. Due to the

complexity of laws and regulations governing the federal and state reimbursement programs, there is the possibility that recorded estimates may change by a material amount.

Extendicare also offers information technology services to smaller long-term care providers through its wholly owned U.S. subsidiary, Virtual Care Provider, Inc. This revenue source is primarily derived from application hosting, customer support, telecommunications, equipment sales and consulting services, and is recognized as these services are provided and equipment is delivered to our customers.

In addition, EHSI derives outpatient therapy revenue in the U.S. by providing rehabilitation therapy services to outside third parties at its clinics. This revenue source is primarily from Managed Care, workers' compensation, self-pay clients and partly from Medicare and Medicaid. Revenue is recognized in the period in which services are provided.

In Canada, the fees charged by ECI for its nursing centers and home health care services are regulated by provincial authorities (rather than federal authorities), and provincial programs fund a substantial portion of these fees, with the balance paid for by the residents or customers. Each province has a different system for managing the services provided. As a result, there can be significant variability from location to location with respect to the regulations for providing care and how centers are reimbursed. In 2013, revenue from provincial programs represented approximately 68% of ECI's nursing center operations, and approximately 98% of its home health care services.

Accounts receivable are recorded at amounts expected from federal, state and provincial reimbursement programs, other third-party payors or from individual residents. Receivables from government agencies represent the only concentrated group of accounts receivable for the Company. As at December 31, 2013, receivables from government agencies represented approximately 71% of the total receivables. Management does not believe that there is any significant credit risk associated with these government agencies other than possible funding delays. Receivables from non-government agencies consist of receivables from Managed Care providers, commercial insurers and private individuals that are subject to differing economic conditions, none of which represents any concentrated credit risk to the Company, as there is no significant exposure to any single party. Management estimates which receivables may be collected within one year and reflects those not expected to be collected within one year as non-current assets. Management periodically evaluates the adequacy of its provision for receivable impairment by conducting a specific account review of amounts in excess of predefined target amounts and aging thresholds, which vary by payor type. Allowances for uncollectibility are considered based upon the evaluation of the circumstances for each of these specific accounts. In addition, management has established percentages for provision for receivable impairment that are based upon historical collection trends for each payor type and age of these receivables. Accounts receivable that are specifically estimated to be uncollectible, based upon the above process, are fully reserved for in the provision for receivable impairment until they are written off or collected. If circumstances change, for instance due to an economic downturn, resulting in higher than expected defaults or denials, management's estimates of the recoverability of receivables could be reduced by a material amount.

Due to differences in the government funding structures for the services provided, the Canadian operations are not subject to the same risks associated with the collection of accounts receivable as are the U.S. operations. As a result, approximately 95% of the Company's allowance for current accounts receivable at December 31, 2013, was associated with the U.S. operations. The allowance for doubtful accounts for current accounts receivable totalled $21.1 million and $18.5 million at December 31, 2013 and 2012, respectively. Days of revenue outstanding were 38 days at December 31, 2013 compared to 39 days as at December 31, 2012.

At December 31, 2013, EHSI had $13.3 million (US$12.5 million) in Medicare and Medicaid settlement receivables, compared to $23.7 million (US$23.8 million) at the end of 2012. There was no allowance on these receivable balances. It is expected that $3.4 million (US$3.2 million) will be substantially collected within one year and is included in accounts receivable as a current asset, compared to $12.3 million (US$12.3 million) at December 31, 2012. The remaining balance has been classified as a long-term receivable in other assets. Medicare settlement receivables are recoveries of Medicare participants' non-payment of Part A co-insurance receivables. Medicaid settlement receivables pertain to cost-based reimbursement programs. Differences between the final settlement and amounts previously recorded are reported as adjustments to revenue in the period of determination.

VALUATION OF CASH GENERATING UNITS AND IMPAIRMENT

Non-financial assets consist of property and equipment, intangible assets with finite lives, intangible assets with indefinite lives and goodwill. A CGU is defined to be the smallest group of assets that generates cash inflows from continuing use that is largely independent of the cash inflows of other assets. The Company has identified each individual center as a CGU.

The carrying amounts of non-financial assets are reviewed at each reporting date to determine whether there is any indication of impairment. If any such indication exists, then the asset's recoverable amount is estimated. For goodwill, and intangible assets that have indefinite useful lives or that are not yet available for use, the recoverable amount is estimated annually at the same time or more frequently if warranted. An impairment loss is recognized in net earnings if the carrying amount of an asset or its related CGU, or group of assets on the same basis as evaluated by management, exceeds its estimated recoverable amount.

The recoverable amount of an asset or a CGU is the greater of its value in use and its fair value less costs to sell. In assessing value in use, the estimated future cash flows are discounted to their present value using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the asset or CGU. Goodwill and indefinite life intangible assets are allocated to their respective CGUs for the purpose of impairment testing. Indefinite life intangible assets and corporate assets that do not generate separate cash flows and are utilized by more than one CGU, are allocated to each CGU for the purpose of impairment testing and are not tested for impairment separately.

Impairment losses recognized in respect of CGUs are allocated first to reduce the carrying amount of any goodwill allocated to the CGU and then to reduce the carrying amounts of the assets in the CGU on a pro rata basis. Impairment losses on goodwill cannot be reversed. In respect of other non-financial assets, impairment losses recognized in prior periods are assessed at each reporting date for any indication that the loss has decreased or no longer exists. An impairment loss is reversed if there has been a change in the estimates used to determine the recoverable amount. An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortization, if no impairment loss had been recognized.

In 2012, we performed the assessment of goodwill of our U.S. operations that resulted in a net pre-tax impairment loss of $0.2 million (US$0.2 million), consisting of a goodwill impairment of $1.1 million (US$1.1 million), a $15.2 million (US$15.5 million) impairment on certain properties and a $16.1 million (US$16.4 million) reversal of a previously recorded impairment loss on property and equipment.

In 2013, our assessment of goodwill for our U.S. operations resulted in a net pre-tax recovery of $0.1 million (US$0.1 million), consisting of a goodwill impairment of $3.7 million (US$3.6 million), an $11.9 million (US$11.5 million) impairment on certain properties and a $15.7 million (US$15.2 million) reversal of a previously recorded impairment loss on property and equipment.

In addition, in December 2013, we decided to sell 11 skilled nursing centers in the U.S. within the next year. Consequently, we recorded an impairment charge of $7.3 million (US$6.8 million) to reduce the net book value of the properties to their estimated fair value.

As for the Canadian operations, based upon the impairment assessment we performed in 2013, we recognized a net pre-tax impairment loss of $0.8 million on certain properties.

The determination of recoverable amounts can be significantly impacted by estimates related to current market valuations, current and future economic conditions in the geographical markets of each CGU, and management's strategic plans within each of its markets. Estimates and assumptions used in the determination of the impairment loss were based upon information that was known at the time, along with future outlook.

In performing the 2013 impairment test on the U.S. operations, the key assumptions used to determine the recoverable amounts were as follows: capitalization rates of 11.8% for nursing centers and 8.5% for assisted living centers; annual maintenance capital expenditures per bed of US$350; and management fees of 5% of revenue. The recoverable amount calculations used discounted pre-tax cash flow projections determined from financial projections based upon both historical and forecasted amounts on which capitalization rates were applied. The calculation was based on the following key assumptions: cash flows were projected based upon historical financial performance along with the forecast impact of Medicare rate reductions in the coming year and past experience on average daily census, factoring in the historical maintenance capital expenditures and management fees; and capitalization rates were based on industry standards on recent transactions.

Based upon this impairment assessment performed in 2013, a 10-basis point increase in the capitalization rate would cause a $0.1 million increase in goodwill impairment of our U.S. operations and no impairment of goodwill on our Canadian operations, assuming all other variables remained constant.

DECOMMISSIONING PROVISIONS

Management has determined that a decommissioning provision exists in the Company's pre-1980 constructed centers for possible asbestos remediation. Although asbestos is currently not a health hazard in any of these centers, appropriate remediation procedures may be required to remove potential asbestos-containing materials, consisting primarily of floor and ceiling tiles, in connection with any major renovation or demolition.

The Company's decommissioning provision, all of which related to asbestos remediation, was $28.8 million at December 31, 2013, compared to $26.9 million at the beginning of the year, with the increase primarily due to the accretion in value. The fair value of the decommissioning provision is estimated by computing the present value of the estimated future costs of remediation based on estimated expected dates of remediation. The computation is based on a number of assumptions, which may vary in the future depending upon the availability of new information, changes in technology and in costs of remediation, and other factors.

The following assumptions were used in calculating the decommissioning provision: (a) discount rates of 6.75% for centers located in Canada and 7.10% for centers located in the U.S.; (b) an estimated timing of the settlement of the provision ranging from 10 to 30 years; and (c) an estimated undiscounted cash flow amount to settle the provision of approximately $50.0 million. There were no changes to the initial timing and estimates of undiscounted cash flow amounts in 2013.

SELF-INSURED LIABILITIES

The Company self-insures for certain risks related to comprehensive general and professional liability (including malpractice insurance), and to a limited degree, workers' compensation (for certain periods), auto liability and health benefits. The Company maintains liability insurance policies through third-party insurers as well as retaining a portion of the risk within its Bermuda-based captive insurance company at a level which the Company believes to be adequate based upon the nature and risks of its business, historical experience and industry standards along with the type of insurance coverage commercially available in the marketplace. The employee related self-insured risks are primarily due within twelve months and, therefore, are included within accrued liabilities as a current liability on an undiscounted basis. The accrual for self-insured liabilities is discounted based upon the projected timing of future payment obligations.

General and professional liability claims are the most volatile and significant type of risks for which the Company self-insures. Furthermore, claim payments for any particular policy year can occur over a period of several years that are limited by state or provincial regulations. The accrual for self-insured liabilities is based on management's best estimate of the ultimate cost to resolve general and professional liability claims, including both known claims and claims that have been incurred but not yet reported by the end of the reporting period. The Company estimates the value of losses that may occur within its self-insured retention levels based upon individual assessment of the settlement using historical information and industry data, supported by actuarial projections, advice from legal counsel, consultants and external risk management. Actual results can differ materially from the estimates made due to a number of factors including the assumptions used by management and other market forces.

Management regularly evaluates and periodically engages an independent third-party actuary to provide a report to determine the appropriateness of the carrying value of this liability. Assumptions underlying the determination of the liability are limited by the uncertainty of predicting future events and assessments regarding expectations of several factors. Such factors include, but are not limited to: the frequency and severity of claims, which can differ materially by jurisdiction; trends in claims along with unique and identifiable settlements; coverage limits of third-party reinsurance; the effectiveness of the claims management process; and the outcome of litigation. Therefore, management's estimate of the accrual for general and professional liability claims is significantly influenced by assumptions that are subject to judgement by management and the actuary, which may cause the provision to fluctuate significantly from one reporting period to another.

At December 31, 2013, the accrual for self-insured general and professional liabilities was $115.3 million compared to $95.9 million at the beginning of the year. Changes in the level of retained risk and other significant assumptions that underlie management's estimates could have a material effect on the future carrying value of the self-insured liabilities. For example a 1% variance in the accrual for self-insured liabilities at December 31, 2013, would have impacted our net earnings by approximately $1.1 million. For further information refer to the discussion under the heading "Liquidity and Capital Resources – Accrual for Self-Insured Liabilities".

TAX UNCERTAINTIES

Tax uncertainties are evaluated on the basis of whether it is more likely than not that a tax position will ultimately be sustained upon examination by the relevant taxing authorities. Tax uncertainties are measured using a probability adjusted or expected value model whereby amounts are recorded if there is any uncertainty about a filing position, determined by multiplying the amount of the exposure by the probability that the entity's filing position will not be sustained. The assessment of tax uncertainties relies on estimates and assumptions and may involve a series of judgements about future events. New information may become available that causes the Company to change its judgement regarding the adequacy of existing tax liabilities. Such changes to tax liabilities will impact tax expense in the period that such a determination is made.

DEFERRED TAX ASSETS AND LIABILITIES

The Company use the liability method, which takes into account the differences between financial statement treatment and tax treatment of certain transactions, assets and liabilities. Deferred tax assets and liabilities are recognized to reflect the expected future tax consequences attributed to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases, and operating loss and tax credit carryforwards. With respect to the Company's investment in its foreign subsidiaries, the Company uses the tax rate applicable to dividend distributions, which is based on management's judgement on when the temporary difference will reverse. Deferred tax assets and liabilities are measured using tax rates (enacted or substantially enacted at the reporting date) anticipated to apply in the periods that the temporary differences are expected to be recovered or settled. In assessing whether the deferred tax assets are realizable, management considers whether it is probable (which the Company has defined as "more likely than not") that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Management considers the scheduled reversal of deferred tax liabilities, projected future taxable income and tax planning strategies in making this assessment. At December 31, 2013, there were capital losses available for Canadian income tax purposes of $20.3 million (2012 – $21.5 million) that can be carried forward indefinitely to apply against future capital gains. No deferred tax assets have been recognized for the future tax benefit of these capital losses of $2.7 million (2012 – $2.9 million).

New Accounting Policies Adopted

Effective January 1, 2013, Extendicare adopted three new accounting amendments and standards issued by the International Accounting Standards Board (IASB): IAS 1 "Presentation of Financial Statements", IFRS 13 "Fair Value Measurement", and IFRS 19 "Post-employment Benefits". These accounting standards are summarized below, and are more fully described in *note 4* of the 2013 consolidated financial statements.

Other new accounting amendments and standards effective commencing this year include: IFRS 10 "Consolidated Financial Statements", IFRS 11 "Joint Arrangements and Consolidated Financial Statements", and IFRS 12 "Disclosure of Interests in Other Entities and Consolidated Financial Statements". The adoption of these standards effective January 1, 2013, did not impact Extendicare's financial position, earnings or cash flows.

PRESENTATION OF FINANCIAL STATEMENTS – OTHER COMPREHENSIVE INCOME

Amendments to IAS 1 "Presentation of Financial Statements: Presentation of Items of Other Comprehensive Income" require entities to segregate items within other comprehensive income (OCI) that may eventually be recognized in our results of operations from those that will not. As these amendments only required changes in the presentation of items in OCI, the impact of adoption did not have a material impact on the financial position, earnings or cash flows.

FAIR VALUE MEASUREMENT

IFRS 13 "Fair Value Measurement" is a new standard that replaces the fair value measurement guidance contained in individual standards with a single source of fair value measurement guidance. For additional details, see *notes 4, 14 and 27(b)* to the 2013 consolidated financial statements. The application of this new standard did not have a material impact on the financial position or results of operations.

POST-EMPLOYMENT BENEFITS

The amended version of IAS 19 "Employee Benefits" requires: actuarial gains and losses be recognized immediately in OCI; the expected rate of return on plan assets to be the same as the discount rate on the defined benefit obligation; and enhanced disclosures. For additional details, see *note 4* to the 2013 consolidated financial statements. There was no

material impact on the adoption of these amendments as the Company had already elected to immediately recognize actuarial gains and losses in OCI, and the plan assets are not material.

Future Change in Accounting Policies

The following new standards, amendments to standards and interpretations are effective for annual periods beginning on or after January 1, 2014, and have not been applied in preparing the financial results for the year ended December 31, 2013.

FINANCIAL INSTRUMENTS

IFRS 9 "Financial Instruments", which replaces IAS 39 "Financial Instruments: Recognition and Measurement", addresses the classification, measurement and recognition of financial assets and financial liabilities. IFRS 9 replaces the four categories of financial assets as required by IAS 39 with two measurement categories, as follows: (i) those measured at fair value; and (ii) those measured at amortized cost. Changes in fair value will be recorded in net earnings under IFRS 9 instead of through OCI under IAS 39. For financial liabilities measured at fair value, fair value changes due to changes in the Company's credit risk are presented in OCI instead of through net earnings unless this would create an accounting mismatch. The date of application has not been determined. The Company is assessing the potential impact of this standard.

FINANCIAL INSTRUMENTS: PRESENTATION – OFFSETTING FINANCIAL ASSETS AND FINANCIAL LIABILITIES

Amendments to IAS 32, which establishes disclosure requirements that are intended to help clarify for financial statement users the effect or potential effect of offsetting arrangements on an entity's financial position. These amendments are effective for the annual period beginning on January 1, 2014. The Company is in the process of assessing the impact of the adoption of these amendments, and does not expect that they will have a material impact on its consolidated financial statements.

LEVIES

IFRS 21 "Levies" clarifies that an entity recognizes the full amount of a liability for a levy during the period in which the activity that triggers payment occurs, as identified by the relevant legislation, instead of amortizing the expense over a period of time. This standard is effective for annual periods beginning on or after January 1, 2014. The Company is in the process of assessing the impact of the adoption of this interpretation on its consolidated financial statements.

Disclosure Controls and Procedures

Disclosure Controls and Procedures (DC&P) are designed to provide reasonable assurance that all relevant information is gathered and reported to senior management, including the Chief Executive Officer (CEO) and the Chief Financial Officer (CFO), on a timely basis so that appropriate decisions can be made regarding public disclosure.

An evaluation of the effectiveness of the DC&P was conducted as at December 31, 2013, by management under the supervision of the Company's CEO and CFO. Based on this evaluation, the CEO and CFO have concluded that as at December 31, 2013, our disclosure controls and procedures, as defined by National Instrument 52-109, Certification of Disclosures in Issuers' Annual and Interim Filings, are effective.

Internal Control over Financial Reporting

Internal Control over Financial Reporting (ICFR) is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements in accordance with Canadian GAAP. Management, under the supervision of the Company's CEO and CFO, has evaluated the effectiveness of our ICFR using the original framework and criteria established by the Committee of Sponsoring Organizations of the Treadway Commission in 1992. Based on this evaluation, management has concluded that our ICFR was effective and that there were no material weaknesses in our ICFR as at December 31, 2013.

ADDITIONAL INFORMATION

Additional information about Extendicare, including its Annual Information Form for the year ended December 31, 2013, may be found on the SEDAR website at www.sedar.com and on Extendicare's website at www.extendicare.com. A copy of this document and other public documents of Extendicare are available upon request to the Corporate Secretary of Extendicare.