Long Term Care

General Liability and

Professional Liability

Actuarial Analysis

Submitted by:

Aon Risk Consultants, Inc.

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Introduction

At the request of the American Health Care Association (AHCA), Aon Risk Consultants, Inc. (Aon) has conducted an actuarial analysis of the cost of general liability and professional liability (GL/PL) claims to the long term care industry operating in the United States.

The specific objectives of this study are to:

1. **Identify the national trends in the cost of GL/PL claims for the long term care industry.** These trends are measured by monitoring the change in the number of claims reported (frequency), the size of claims (severity) and the overall cost per exposure (loss cost).

2. **Identify state specific trends and their correlation to currently observed and future expected national trends.** Specific areas of the country for which separate analysis is included in this study are the states of Alabama, Arkansas, California, Florida, Georgia, Mississippi, Texas and West Virginia. All other states are analyzed as a group and labeled accordingly in the exhibits contained in this report.

3. **Identify trends in commercial insurance affordability and availability.** These trends are measured by monitoring the most recent policy year changes in premium levels, deductibles, per occurrence limits of liability and annual aggregate limits of liability for commercially insured long term care operators.

4. **Estimate the portion of GL/PL loss costs paid as indemnification to claimants versus the portion paid for litigation costs.** Defense costs are easily identified in the claim detail files used to perform this study. The estimated portion of total claim costs attributed to defense costs, including investigation and attorney fees, is based on

the average of the claim data provided to us. Plaintiff attorney costs are estimated as a portion of the indemnity payment to the plaintiff.

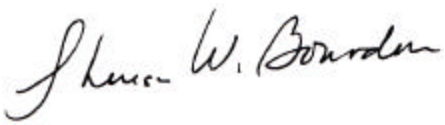
5. **Identify the distribution of losses by size of loss.** A histogram depicting the number of reported losses in incremental size of loss bands provides an indication of the variance of loss sizes, the magnitude of the large losses and the number of claims excess of $1 million.

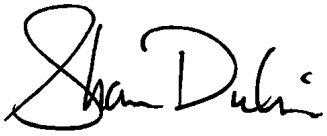
The results presented in this study are based on a comprehensive database of long term care general/professional liability losses and allocated loss adjustment expenses (ALAE) as reported to us by long term care providers operating around the country. Approximately 20,000 individual non-zero claims from long term care facilities were aggregated to perform this study. The facilities included in this database combined operate approximately 440,000 licensed nursing home beds and 32,000 assisted or independent living beds around the country. They represent approximately 26% of the beds in the United States.

An executive summary containing our conclusions and recommendations can be found in this report. It is provided to give an overview of our national findings. More detailed benchmarks highlighting the national trends and identifying the state trends underlying the national increases are provided after the executive summary. Following the presentation of national and state specific loss trends is a section on the effects these trends are having on commercial insurance premium and coverage terms. Sections describing the data sources and defining common actuarial terms follow.

Should there be any questions regarding this report, we will be available to discuss them with you.

Respectfully Submitted,





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Executive Summary

National trends in GL/PL losses are increasing at an alarming rate. In the five-year period between 1990 and 1995 costs more than doubled from $240 per bed to $590 per bed. Since 1995 costs have quadrupled to an estimated $2,360 per bed. The countrywide increases are the result of an explosion in litigation that started in a handful of states and is spreading to a multitude of regions throughout the country. This increase in litigation is raising the number of claims individual long term care operators are incurring each year. In addition, the average size of each claim is steadily going up across the country at annual increases well ahead of inflation. In many states, the increase in liability costs is largely offsetting annual increases in medicaid reimbursements.

Based on our actuarial analysis of the long term care industry data provided to us, which represents 26% of the U.S., we find the following:

- The average long term care GL/PL cost per annual occupied skilled nursing bed has increased at an annual rate of 24% a year from $240 in 1990 to $2,360 in 2001. National costs are now ten times higher than they were in the early 1990's.
- The long term care operators represented in this study report $1.9 billion in GL/PL liability claims incurred between 1990 and 2001. The expected ultimate cost of claims incurred in this period is $3.7 billion, taking into consideration the claims in the pipeline and the as yet to be determined outcomes of open cases.
- These same providers, which represent only 26% of the providers in the United States, are projected to incur $1 billion in GL/PL claims in 2002 alone. Extrapolated to a national basis this exposure is a multi-billion dollar a year cost to the nursing home industry.
- The average size of a GL/PL claim has tripled from $67,000 in 1990 to $219,000 in 2001.
- Countrywide, long term care operators now incur 11 claims per year for every 1000 occupied skilled nursing care beds. This is three times higher than the 1990 frequency rate of 3.6 claims per 1000 beds.
- Florida and Texas were leaders in driving the increase in GL/PL costs for the long term care industry. With trends during the 1990's in the range of 25% to 35% a year, costs in these two states have risen to close to $11,000 per bed in Florida and $5,500 per bed in Texas.
- Numerous states across the country are indicating similar annual trends including Georgia (50%), West Virginia (50%), Arkansas (45%), Mississippi (40%), Alabama (31%), and California (29%). With current costs in these states up to $3,300 per bed, it won't take long at these annual trend rates to reach Florida level loss costs.

- GL/PL claim costs have absorbed 20% ($3.78) of the $18.47 increase in the countrywide average Medicaid reimbursement rate from 1995 to 2000.
- Almost half of the total amount of claim costs paid for GL/PL claims in the long term care industry is going directly to attorneys.

Insurance markets have responded to this claim crisis by severely restricting their capacity to write long term care GL/PL insurance. Insurance companies continue to exit the marketplace and cannot provide coverage when faced with this magnitude of losses, explosion in growth of claims, and extreme unpredictability of results. Where coverage has been available, based on the commercially insured respondents to our study, the following trends are indicated:

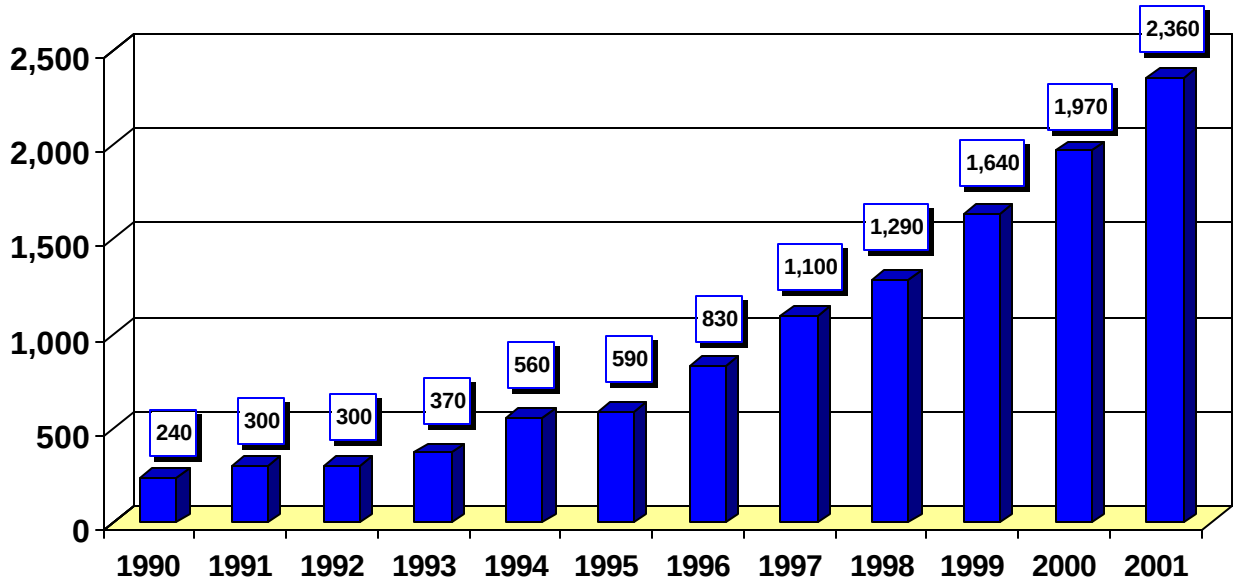
- Annual commercial insurance premium levels increased on average 130% between 2000 and 2001, often with reduced coverage. This increase is well in excess of the annual countrywide loss cost increase of 24% indicated in our study. It is reflective of the significant inadequacy of prior premium levels and the extreme uncertainty associated with projecting future claim costs.
- On average, a quarter of a million more dollars of premium was charged per insured for almost half a million less coverage per claim.
- Per occurrence available limits of liability available from the commercial insurance marketplace were reduced on average by just under half a million dollars per insured.
- Annual aggregate limits of liability available from the commercial insurance marketplace were reduced on average by $2.3 million per insured.

Countrywide Long Term Care GL/PL Trends

GL/PL Loss Costs in the United States are Significantly Increasing

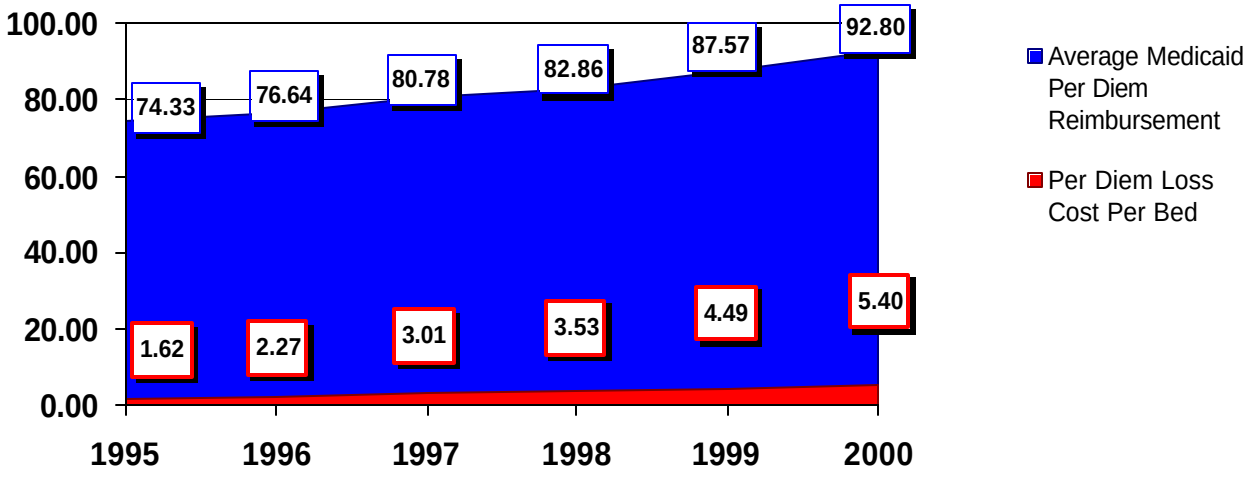
The cost per occupied long term care bed of GL/PL losses are increasing at an annual rate of 24% a year as the following graph shows:

Countrywide Loss Cost Per Occupied Bed



On a per diem basis, the loss cost is increasing as a percent of Medicaid reimbursements, from 2% in 1995 to 6% in 2000 as shown in the graph below. As Medicaid reimbursements have increased 25% over the past six years, the GL/PL loss cost has increased over 200%. As a result, although the reimbursement rate has increased $18.47 during this period, insurance costs have absorbed 20% ($3.78) of that growth.

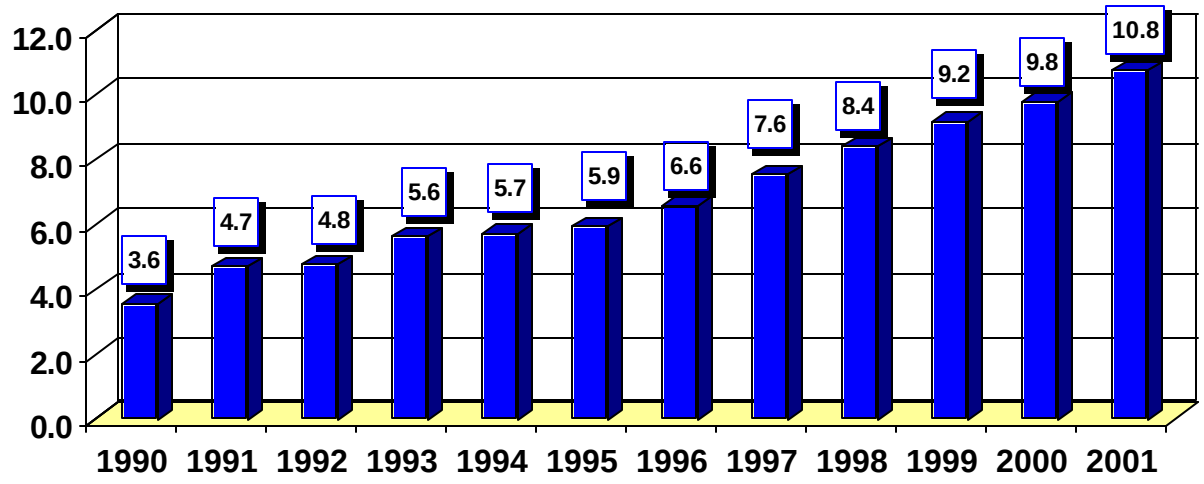
Countrywide Per Diem Loss Cost Versus Medicaid Reimbursement



The Long Term Care Industry is Incurring More Claims Per Bed Every Year

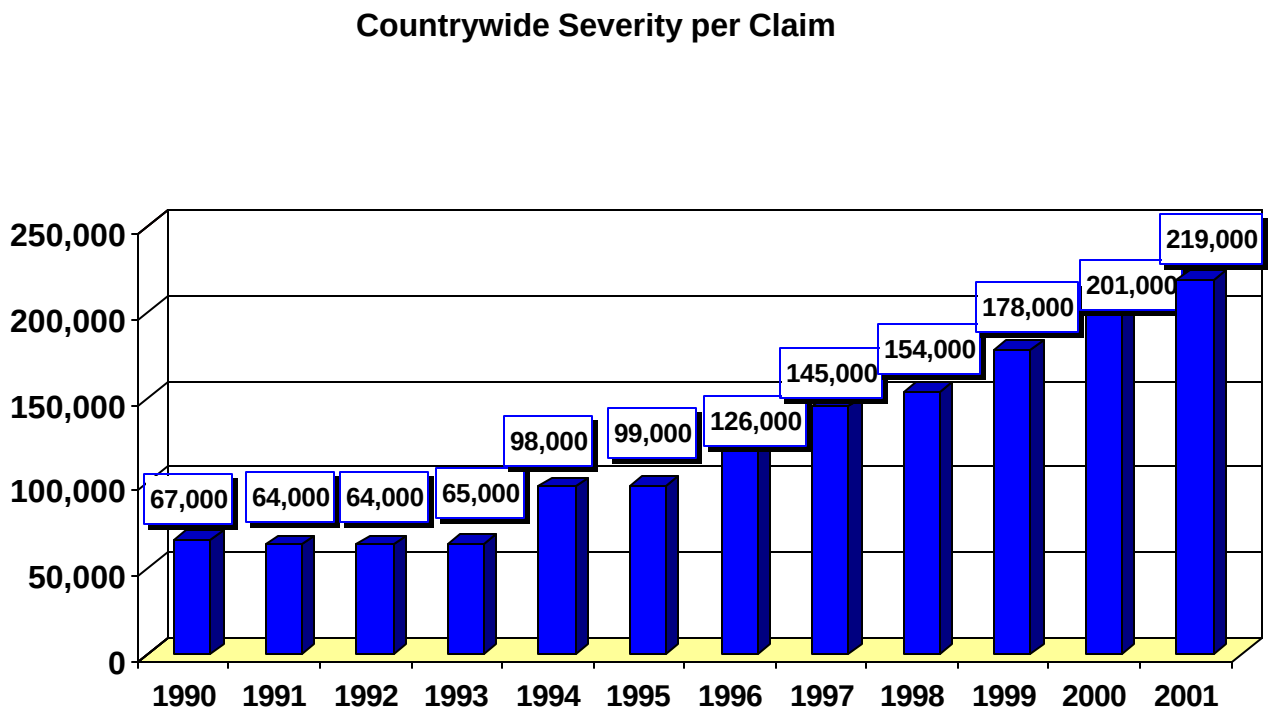
The annual number of GL/PL claims per 1,000 beds in this country has been increasing over the last twelve years and currently is 3 times higher than the 1990 frequency per bed:

Countrywide Annual Number of Claims per 1,000 Occupied Beds



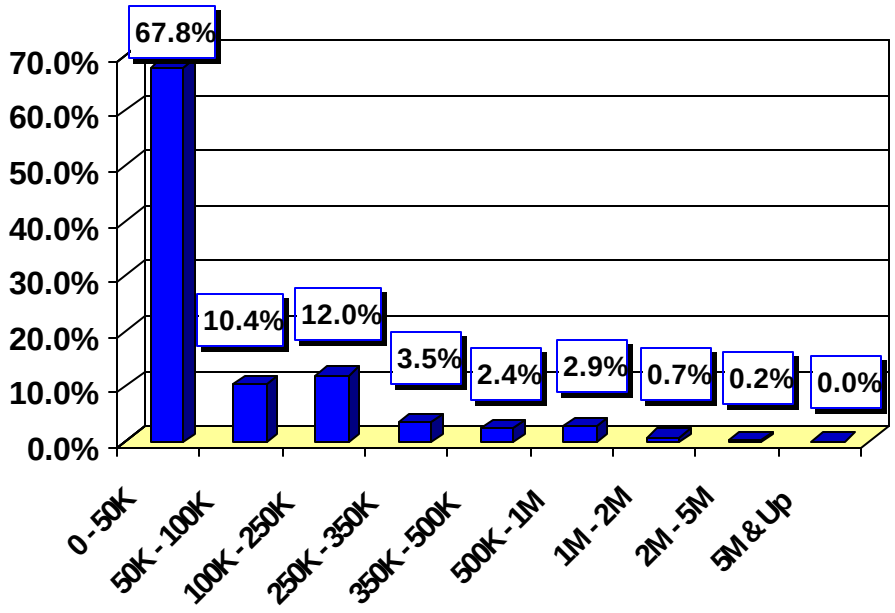
Larger Jury Verdicts and Claim Settlements are Driving Up the Average Size of Losses

The average size of GL/PL claims is increasing 13% per year. Current claim sizes are triple the average size at the beginning of the last decade:



A key factor driving the average severity trends is the increase in the number of extremely large claims. The distribution of GL/PL losses by size shows approximately 32% of the currently reported claims are greater than $50,000.

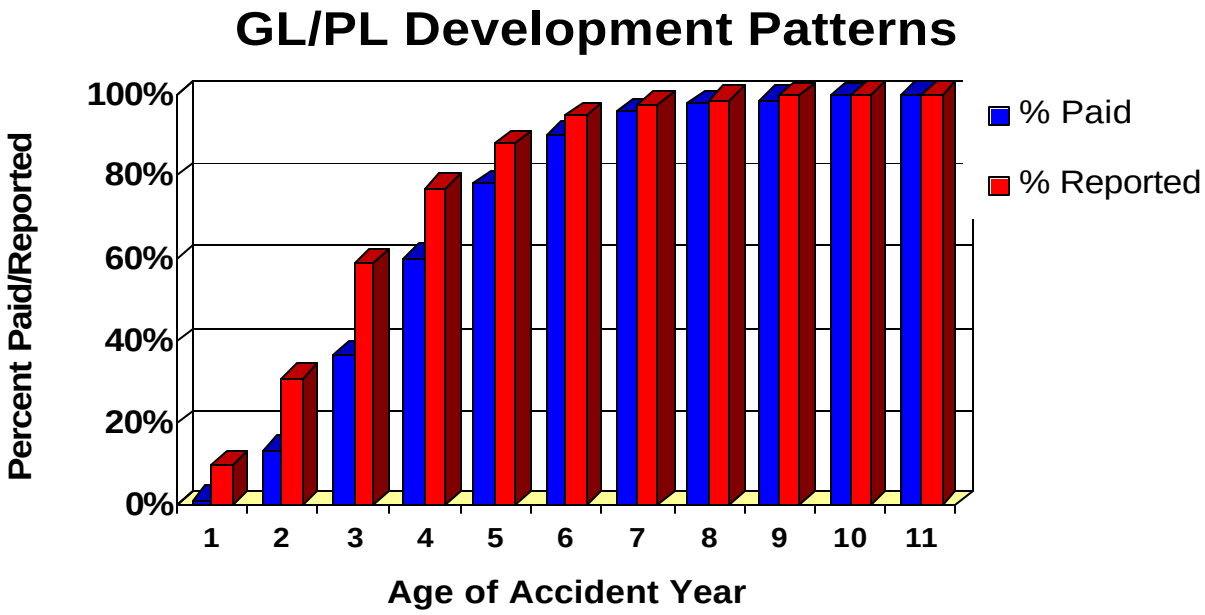
Countrywide Percentage of Claims Reported by Size of Loss



A total of 211 claims reported in our survey are greater than or equal to $1 million. Of these, 10 claims are in excess of $5 million. These counts represent only currently reported claims at company estimated case reserve levels. By the time many of these claims are taken to trial and/or settled, the number expected to exceed $1 million will increase significantly.

GL/PL Loss Development Extends Eleven Years

For the long term care industry, it takes approximately ten years before all claim cost estimates related to incidents from a particular period of time are reported. It takes approximately eleven years before all claims from incidents occurring during a year of operations are closed and the actual costs are known. The following graph shows the percentage reported and paid at each age until all claims are closed:

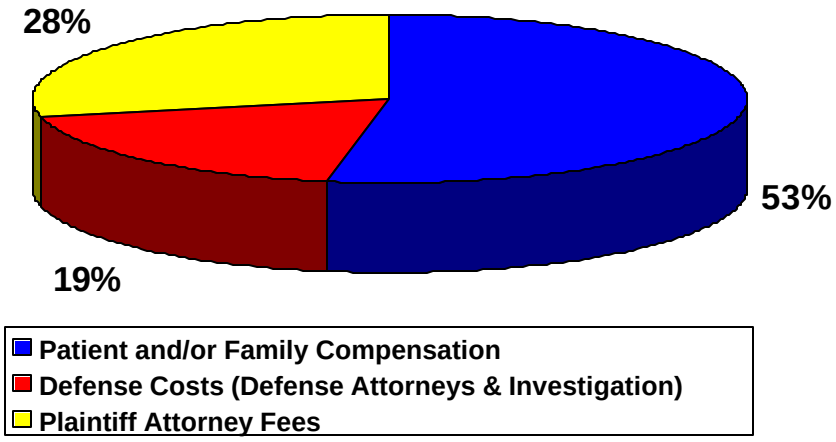


Almost Half of the Total Claim Dollars are Litigation Costs

It is estimated that 47% of the total amount of claim costs paid for GL/PL claims of the long term care industry are covering litigation costs. Based on the database of claims used in this study, 19% of total losses are allocated loss adjustment expenses, which represent defense costs such as investigation and attorney fees. The remaining 81% represent the amount paid in total to the plaintiff, including amounts retained by the plaintiff's attorneys. Of this amount, based on state Bar standards for contingency fees*, it is estimated that the

* Insurance claim data does not break down the indemnity component of loss between plaintiff and attorney because this is privileged information. However, state Bar rules provide some guidelines. For example, the Florida Bar Rules of Professional Conduct, Section 4.1, Client – Lawyer Relationship, provides a standard of contingency fees that, if exceeded, would be considered to be clearly excessive. The fee schedule shown in this section varies depending on the timing of filing for arbitration or the entry of judgment, but generally ranges from 33 1/3% to 40% for any recovery up to $1 million. Lower contingency fees are recommended for the portion of recoveries above $1 million.

plaintiff's attorneys retain approximately 35%. Of the total loss dollars, this represents 28%. Consequently, 47%, or almost half, of total long term care industry GL/PL losses are litigation costs.



Distribution of Compensation

The Impact of Patient Rights Laws

Depending on individual state laws, lawsuits against nursing homes often include allegations beyond the traditional causes of action against acute care providers. Patient care lawsuits filed against hospitals and physicians typically are based on allegations of medical malpractice and fall under the corresponding state statutes. Allegations against nursing homes may include causes of action based upon nursing home patient protection laws or elder abuse laws. Based upon a review of the patient protection laws applicable to long term care residents in each of the 50 states, we find the following:

The two states with the highest per bed loss cost both have had strong patient rights statutes for the period under review in this study. Florida's Patients Bill of Rights (Statute 400.002), which applied to Florida resident care liability claims up until May 15, 2001, guaranteed the patient's right to be informed, provided adequate care, and treated with dignity, among many other rights. The violation remedies provided under this statute include actual damages, punitive damages and attorney's fees.

Effective with claims that occur on or after May 15, 2001, Florida resident's rights claims fall exclusively under recently enacted Senate bills 1200 and 1202. The impact of this revision on post May 15, 2001 Florida GL/PL claim trends is not evident in our database, yet. However, an increase in Florida claim frequency for incidents occurring prior to May 15, 2001 is evident, triggered by the October 4, 2001 cut-off for filing claims under the old Statute 400 punitive damage provisions.

Texas' Patients' Bill of Rights (Chapter 247 of the Texas Health and Safety Code) itemizes 14 rights including, "the right to … a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident." While the Texas statute does not specifically provide for punitive damages as a remedy for violations, cases involving injury to the elderly were specifically exempt from the 1995 Texas tort reform punitive damage cap.

In addition to Florida and Texas, several other states we have identified has having higher than average loss cost trends have patients' bill of rights statutes specific to the long term care industry. These include Arkansas, California, and Georgia.

Despite the correlation in these states, not all states with patient rights statutes have experienced the same trends in the cost of GL/PL claims. More than half of the states in the United States have some form of a patients' bill of rights. However, states vary on issues such as enforcement by lawsuit, reimbursement of attorney's fees, limits of liability, statute of limitations and damage caps.

Similarly, not all states identified as having higher than expected loss costs have patients' bill of rights. For example, neither Alabama, Mississippi, or West Virginia currently has a long term care specific patients' rights statute.

State Specific Long Term Care GL/PL Trends

The countrywide increases in long term care GL/PL costs are the result of an explosion in litigation that started in a handful of states and is spreading to a multitude of regions throughout the country. This increase in litigation is raising the number of claims individual long term care operators are incurring each year. In addition, the average size of each claim is steadily going up across the country at annual increases well ahead of inflation. In many states, the increase in liability costs is largely offsetting annual increases in medicaid reimbursements.

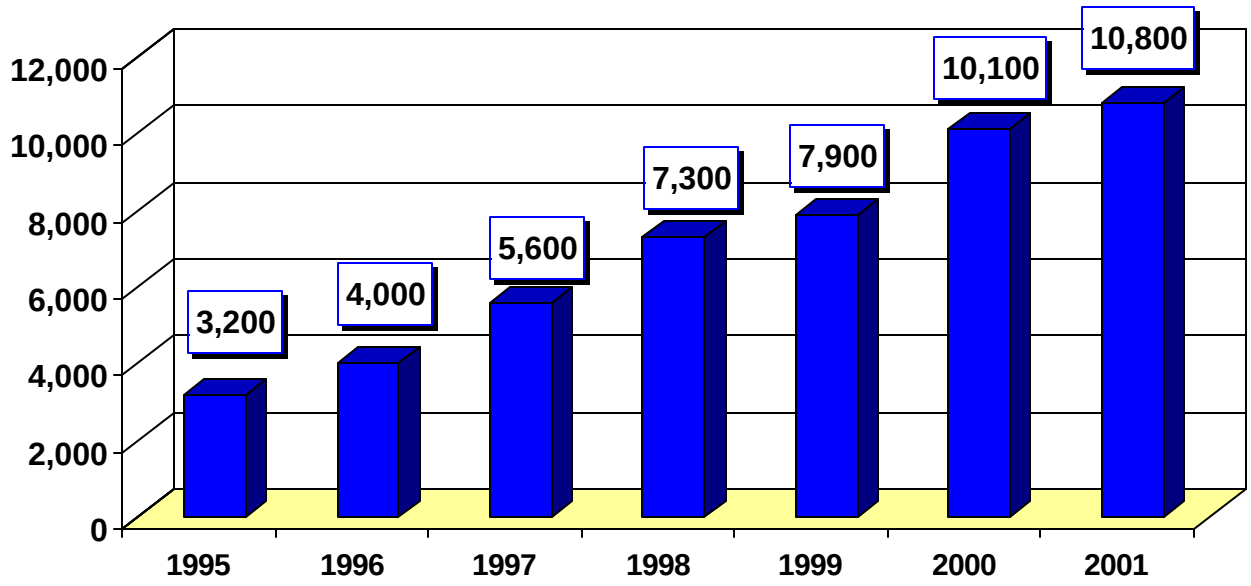
The following sections highlight the spread of litigation activity across the country on a state by state basis for eight states identified as leading the trends in claim activity. These states include Alabama, Arkansas, California, Florida, Georgia, Mississippi, Texas, and West Virginia. These states were selected based on two criteria: an indicated higher than average loss cost and a credible percentage of nursing homes participating from the state. Due to the later criterion, it should be recognized that there may be states with higher than average loss costs that we have not included due to lack of data. An analysis at the end of this section presents the loss cost trends for all other states combined, which indicates trends well in excess of normal tort liability inflation.

Florida

The participants in this study represent approximately 36,000 occupied beds in the state of Florida. This is 52% of all Florida nursing home beds.

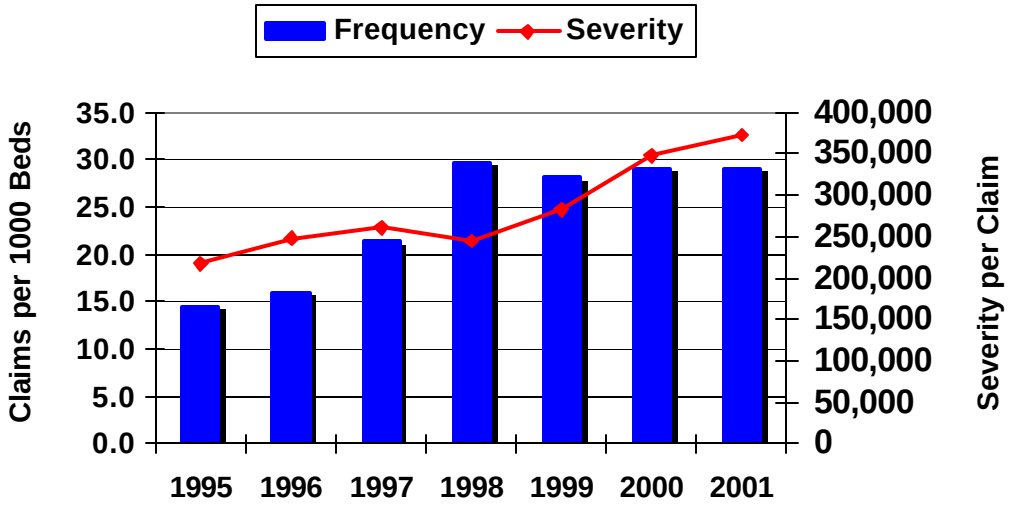
The cost per bed of GL/PL losses is materially higher in Florida than the rest of the United States as the following graph shows:

Florida Loss Cost per Occupied Bed



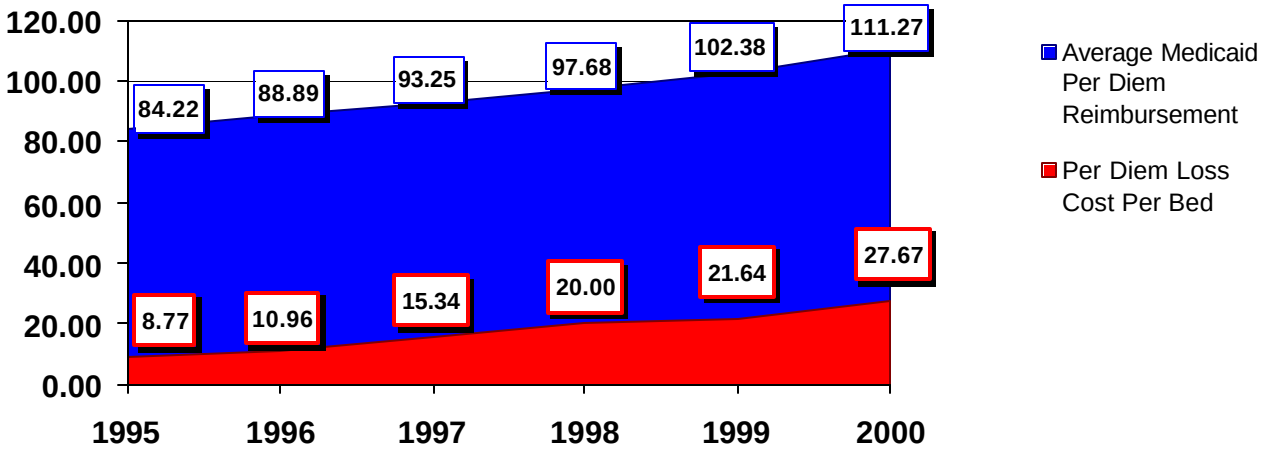
Underlying the loss cost increases are dramatic increases in the number of claims filed and the average size of claims. For incidents occurring during 2001, Florida facilities will report approximately 29 claims for every 1,000 occupied beds. The average size of these claims is projected to be $373,000.

Florida Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Florida Medicaid reimbursements, from 10% in 1995 to 25% in 2000 as shown in the graph below. As Medicaid reimbursements have increased 32% over the past six years, the GL/PL loss cost has increased over 200%. As a result, although the reimbursement rate has increased $27.05 during this period, insurance costs have absorbed 70% ($18.90) of that growth.

Florida Per Diem Loss Cost Versus Medicaid Reimbursement



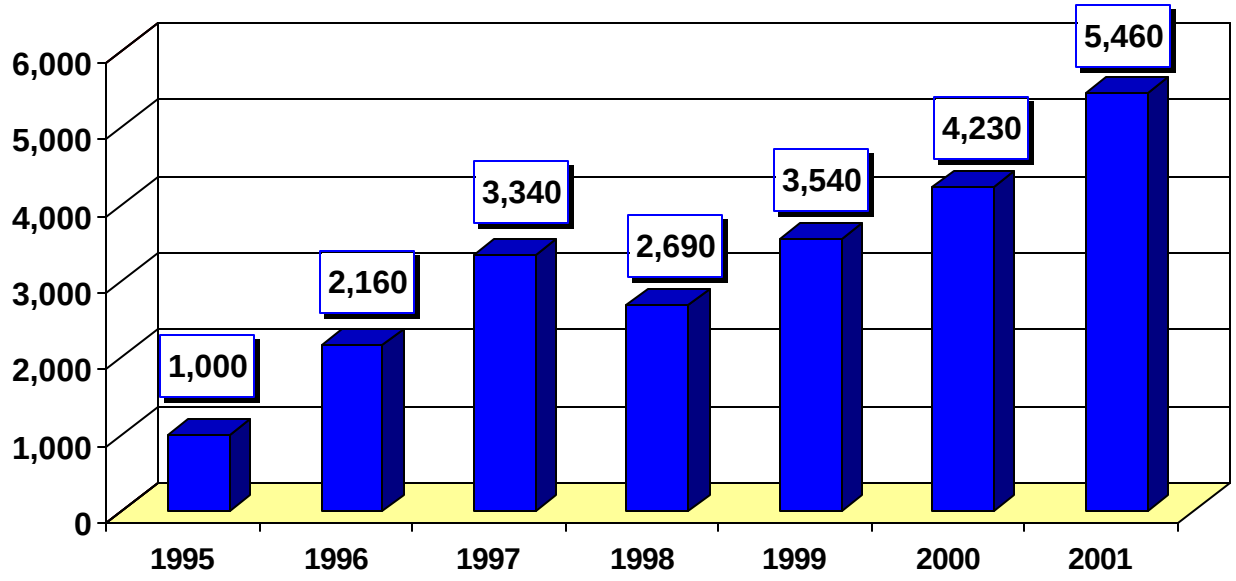
A strong patient rights statute was in effect from the late 1980's until May 15, 2001. Effective with claims that occur on or after May 15, 2001, Florida resident's rights claims fall exclusively under recently enacted Senate bills 1200 and 1202. The impact of this revision on post May 15, 2001 Florida GL/PL claim trends is not yet evident in our database. However, an increase in Florida claim frequency for incidents occurring prior to May 15, 2001 is evident, triggered by the October 4, 2001 cut-off for filing claims under the old Statute 400 punitive damage provisions.

Texas

The participants in this study represent approximately 27,000 occupied beds in the state of Texas. This is 24% of all Texas nursing home beds.

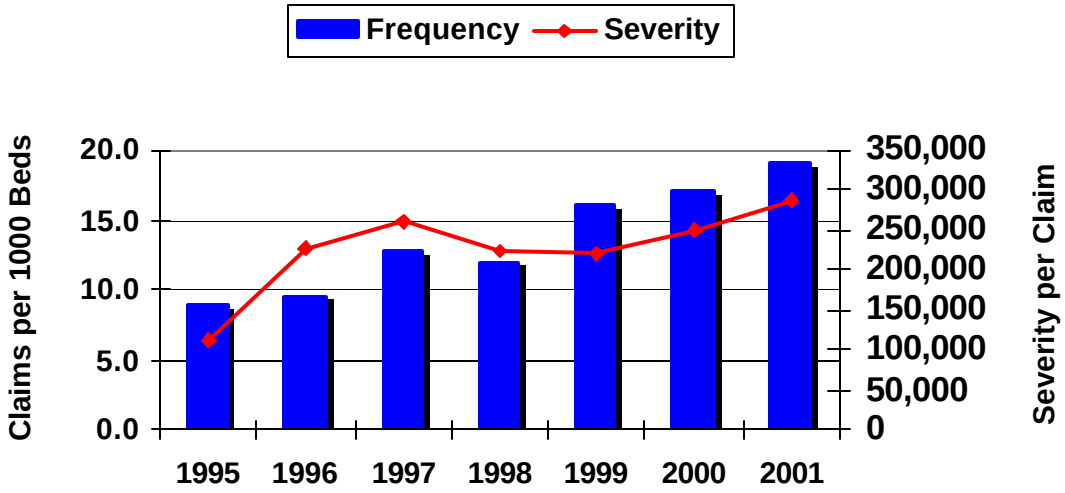
Texas GL/PL loss costs are the second highest in the country. The Texas average cost per bed has increased from $1,000 in 1995 to $5,460 in 2001 as the following graph shows:

Texas Loss Cost per Occupied Bed



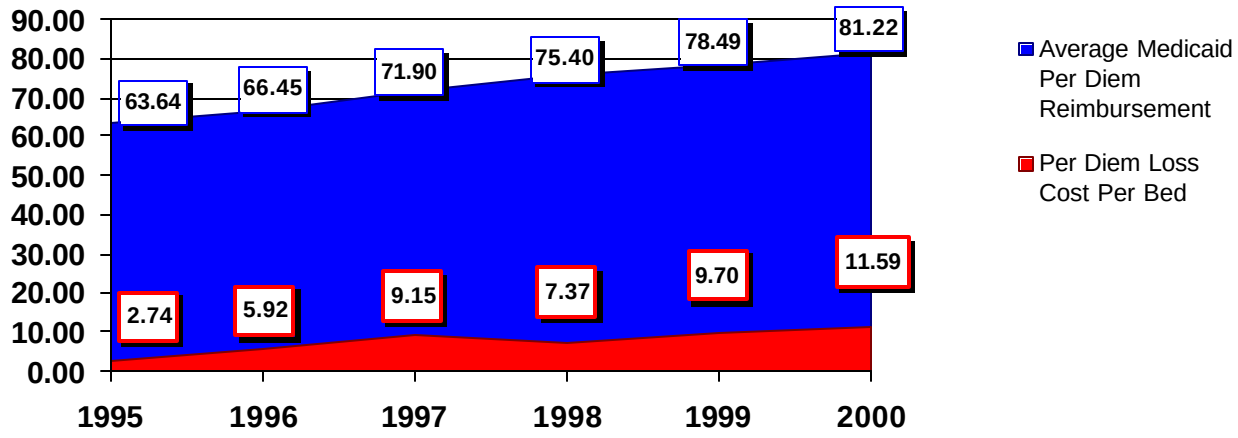
Like Florida, an increase in the number of claims per bed per year is a driving force behind the Texas loss cost increases. Texas long term care providers currently incur 19 claims a year per 1,000 occupied beds. The average size of claims in Texas, however, have been more consistent over the past six years, albeit, consistently high relative to less litigious parts of the country.

Texas Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Texas Medicaid reimbursements, from 4% in 1995 to 14% in 2000 as shown in the graph below. As Medicaid reimbursements have increased 27.6% over the past six years, the GL/PL loss cost has increased over 300%. As a result, although the reimbursement rate has increased $17.58 during this period, insurance costs have absorbed 50% ($8.85) of that growth.

Texas Per Diem Loss Cost Versus Medicaid Reimbursement

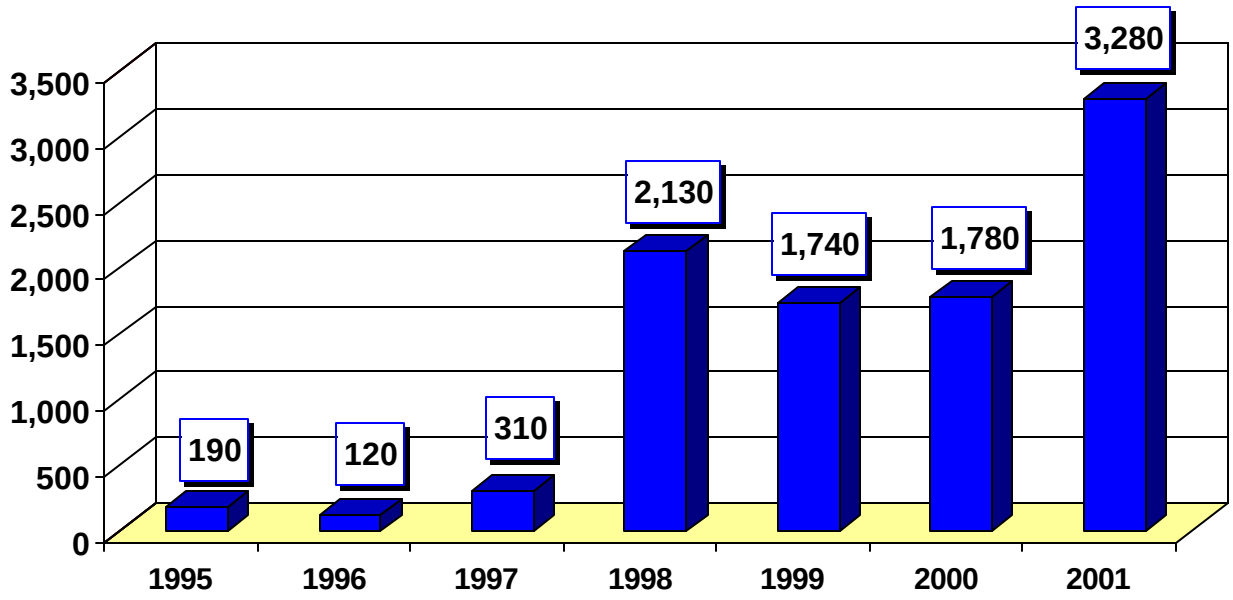


Arkansas

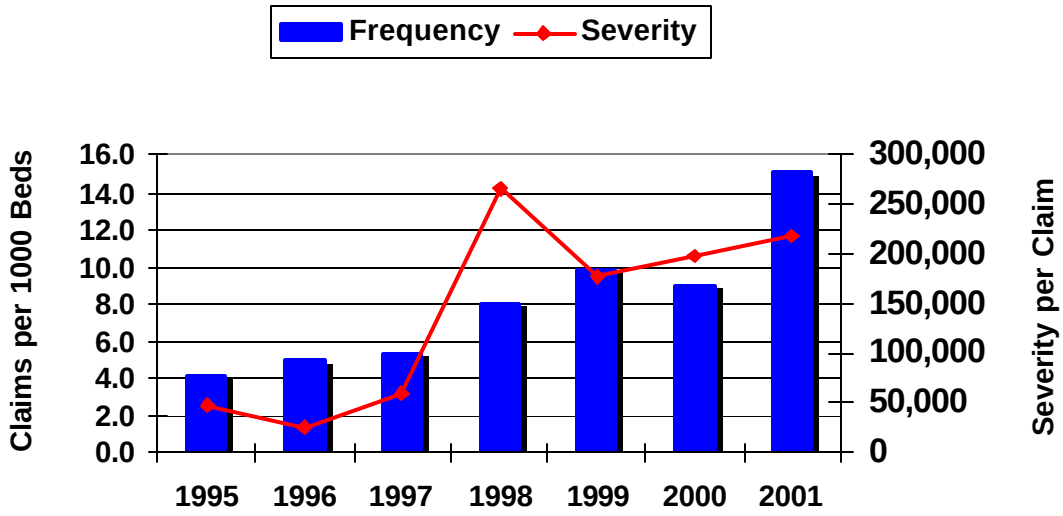
The participants in this study represent approximately 7,500 occupied beds in the state of Arkansas. This is 26% of all Arkansas nursing home beds.

Arkansas loss costs have increased dramatically in the last four years. Prior to 1998 Arkansas long term care providers incurred an average GL/PL cost per bed of around $200 - $300. In 1998 the number of claims incurred started increasing dramatically over prior years and several resulted in multi-million dollar payments. Since 1998 the number of claims has continued to climb and the average size is expected to continue at post 1998 levels. Of particular concern is that the number of claims already reported for 2001 incidents exceeds any other year to date, even though, at this point, most 2001 occurrences are unreported.

Arkansas Loss Cost per Occupied Bed

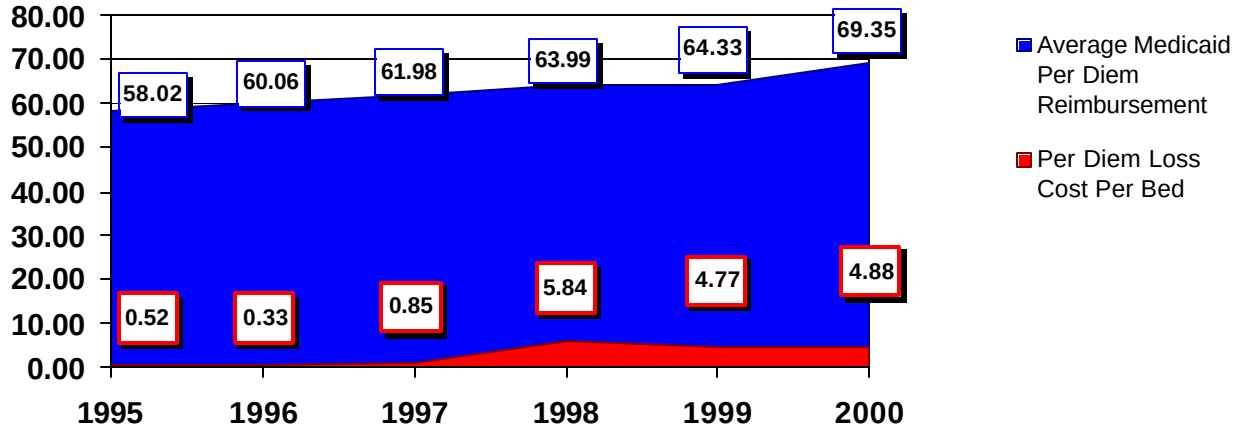


Arkansas Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Arkansas Medicaid reimbursements, from 1% in 1995 to 7% in 2000 as shown in the graph below. As Medicaid reimbursements have increased 20% over the past six years, the GL/PL loss cost has increased over 800%. As a result, although the reimbursement rate has increased $11.33 during this period, insurance costs have absorbed 39% ($4.36) of that growth.

Arkansas Per Diem Loss Cost Versus Medicaid Reimbursement

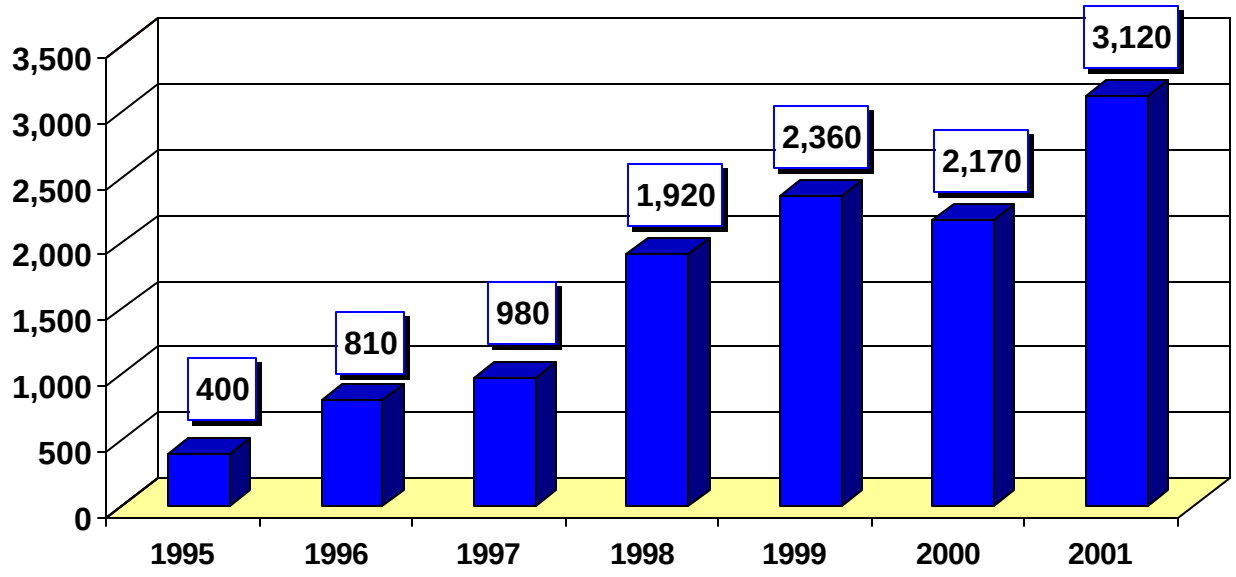


Alabama

The participants in this study represent approximately 18,000 occupied beds in the state of Alabama. This is 80% of all Alabama nursing home beds.

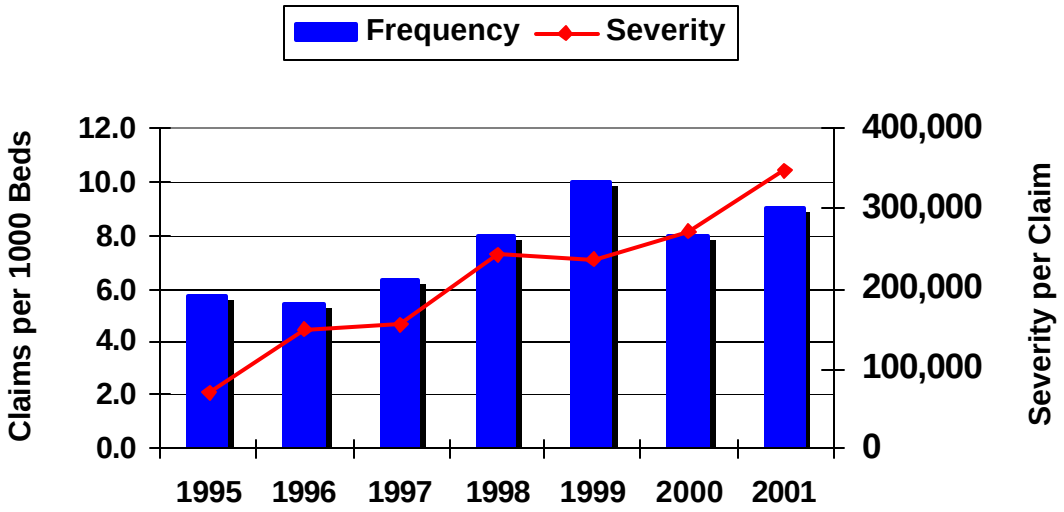
Alabama loss costs are similar to Arkansas, although the increasing trends started a few years earlier. Alabama loss costs have steadily increased from $400 per bed in 1995 to an estimated $3,120 in 2001.

Alabama Loss Cost per Occupied Bed



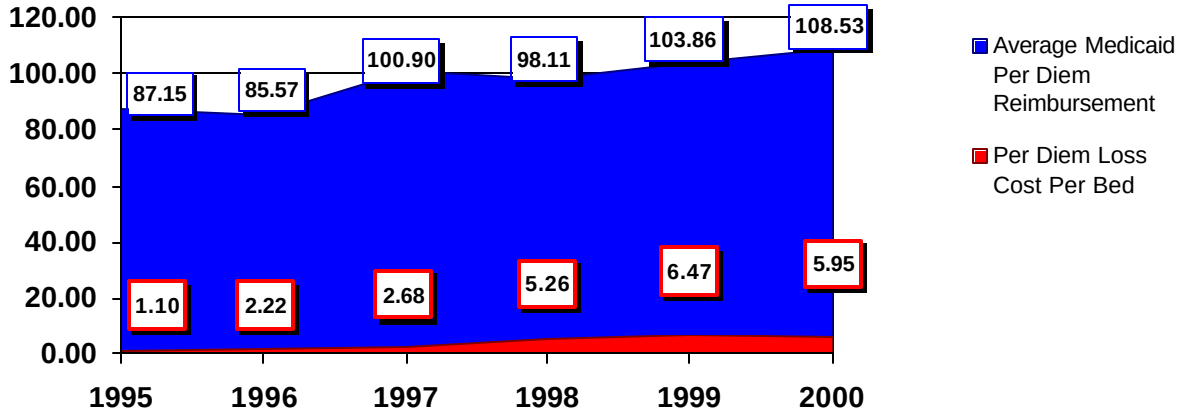
The number of claims in Alabama has shot up from around 5 per 1000 beds in 1995 to between 8 to 10 in the last few years. In addition, the average size of Alabama claims continues to rise at estimated annual increases of 19% a year and is approaching levels similar to Florida.

Alabama Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Alabama Medicaid reimbursements, from 1% in 1995 to 5% in 2000 as shown in the graph below. As Medicaid reimbursements have increased 25% over the past six years, the GL/PL loss cost has increased over 400%. As a result, although the reimbursement rate has increased $21.38 during this period, insurance costs have absorbed 23% ($4.85) of that growth.

Alabama Per Diem Loss Cost Versus Medicaid Reimbursement

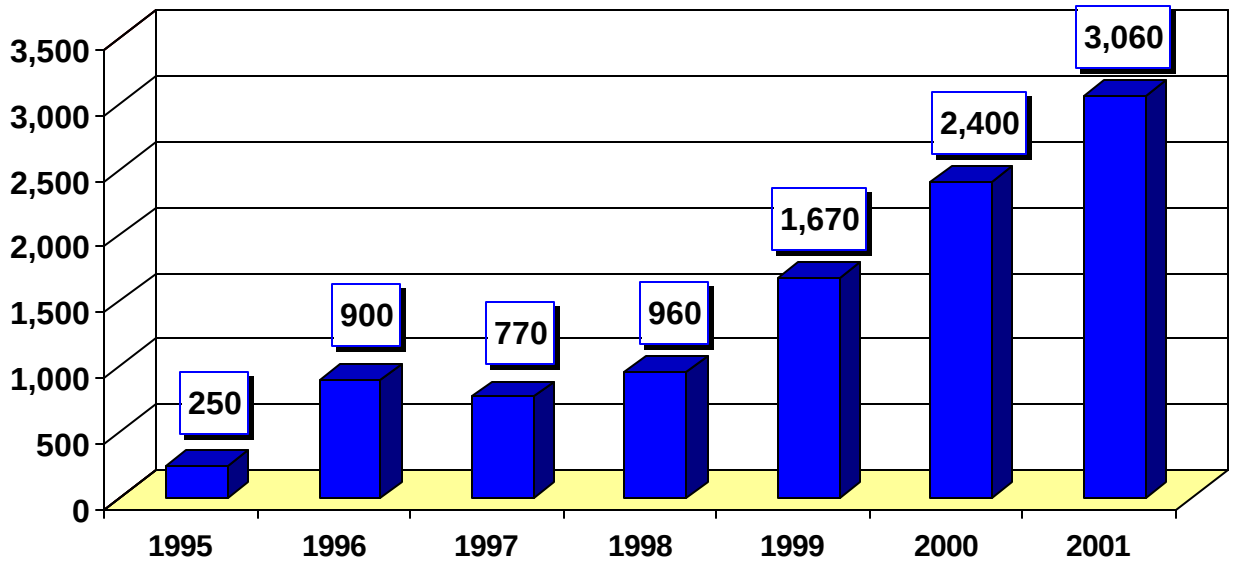


Mississippi

The participants in this study represent approximately 6,200 occupied beds in the state of Mississippi. This is 40% of all Mississippi nursing home beds.

Mississippi loss costs have been increasing at an annual rate of 40%. Prior to 1996 Mississippi long term care providers incurred an average GL/PL cost per bed of around $200 - $400. But costs started climbing in 1996 and they are projected to reach $3,060 per bed for 2001 occurrences.

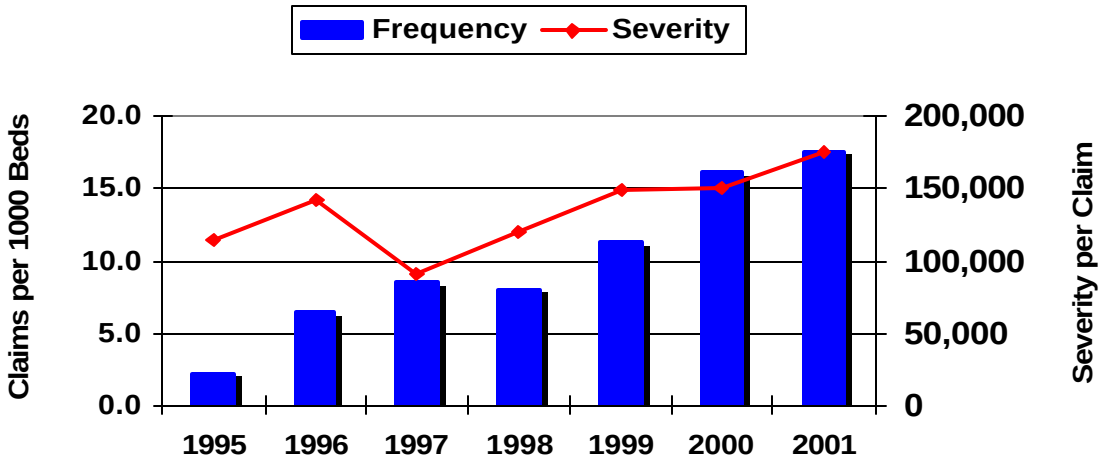
Mississippi Loss Cost per Occupied Bed



As in other states, the driving factors are increased frequency combined with higher average severity per claim. In 1996 the number of claims incurred took a dramatic jump up from 3 claims per 1000 beds to 7 claims, and they have continued rising since. For 2001 we project 18 claims per 1000 occupied beds. The average severity, while lower than

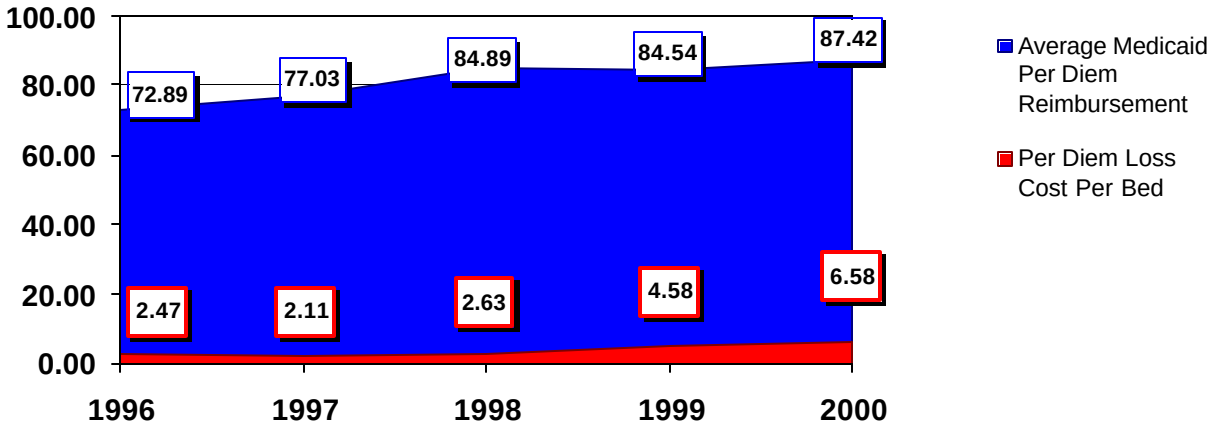
Florida and Alabama levels, has increased on average 20% over the last decade from less than $50,000 per claim to $175,000 per claim.

Mississippi Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Mississippi Medicaid reimbursements, from 3% in 1996 to 8% in 2000 as shown in the graph below. As Medicaid reimbursements have increased 20% over the past five years, the GL/PL loss cost has increased over 150%. As a result, although the reimbursement rate has increased $14.53 during this period, insurance costs have absorbed 28% ($4.11) of that growth.

Mississippi Per Diem Loss Cost Versus Medicaid Reimbursement

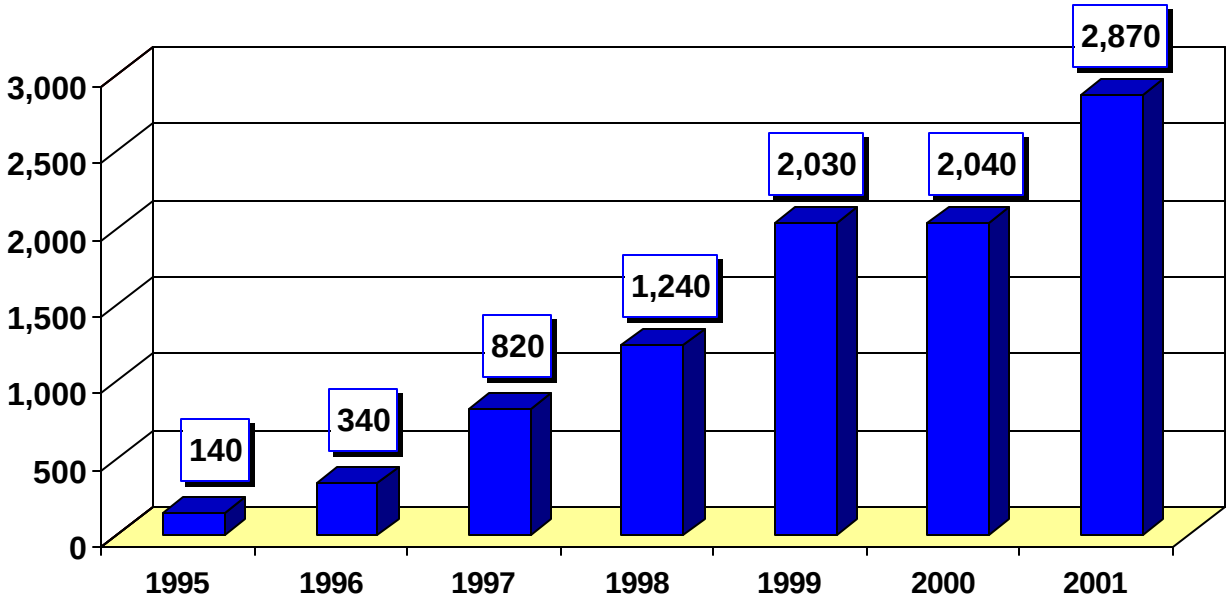


Georgia

The participants in this study represent approximately 11,000 occupied beds in the state of Georgia. This is 31% of all Georgia nursing home beds.

Georgia loss costs have been increasing at an annual rate of 40%. Similar to Arkansas, Alabama and Mississippi, prior to 1997 Georgia long term care providers incurred an average GL/PL cost per bed of around $200 - $400. For occurrence year 2001 Georgia loss costs are projected to reach $2,870.

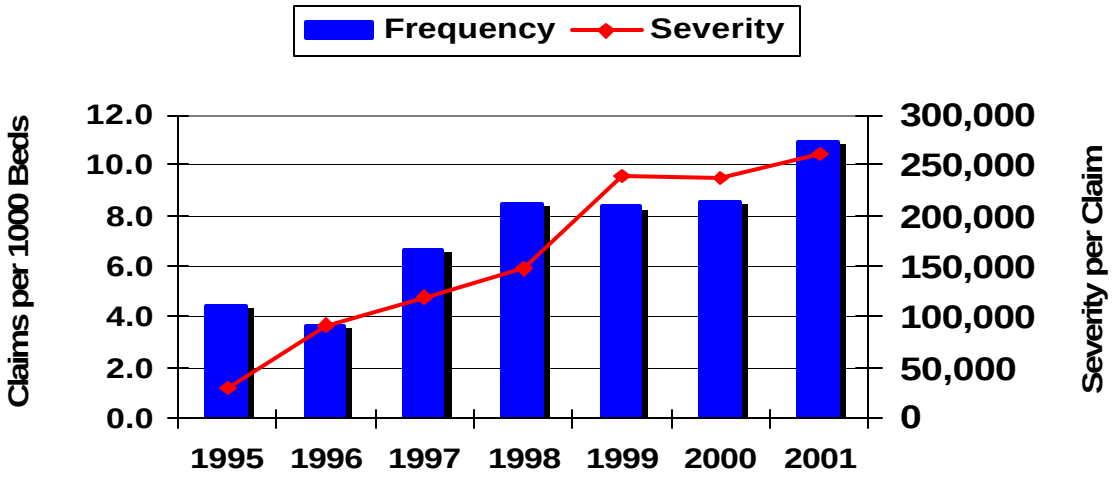
Georgia Loss Cost per Occupied Bed



As in other states, the driving factors are increased frequency combined with higher average severity per claim. While the number of claims was gradually increasing from 2 claims per 1000 beds in the early 1990's to 3 claims per 1000 beds in the mid-1990's, they took a dramatic jump up to 7 claims in 1997, and are projected to reach 9 to 11 claims

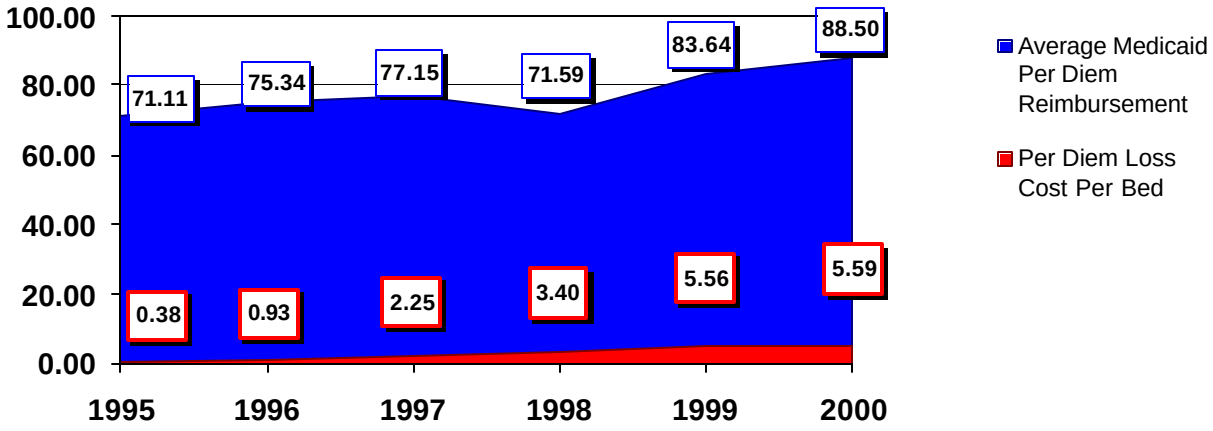
per 1000 beds in 2001. The average severity in Georgia is growing at alarming rates, from $31,000 in 1995 to $261,000 in 2001.

Georgia Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Georgia Medicaid reimbursements, from 1% in 1995 to 6% in 2000 as shown in the graph below. As Medicaid reimbursements have increased 25% over the past six years, the GL/PL loss cost has increased over 1300%. As a result, although the reimbursement rate has increased $17.39 during this period, insurance costs have absorbed 30% ($5.21) of that growth.

Georgia Per Diem Loss Cost Versus Medicaid Reimbursement

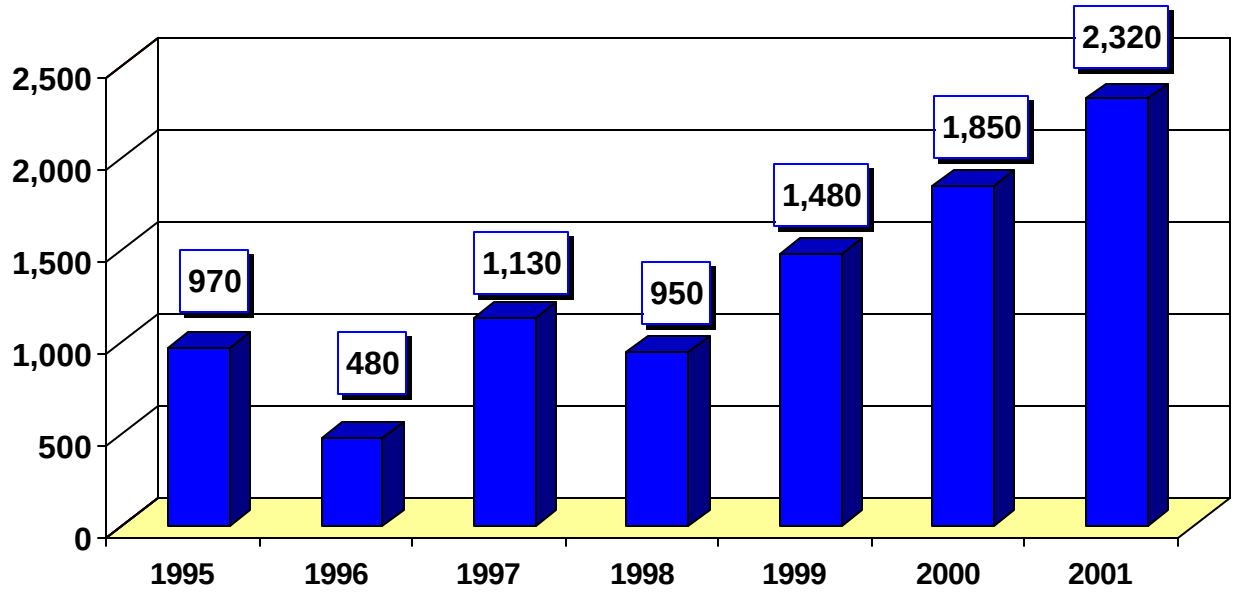


California

The participants in this study represent approximately 27,000 occupied beds in the state of California. This is 22% of all California nursing home beds.

Similar to many of the southern states presented above, California loss costs in the early part of the last decade hovered in the $100 to $300 range per bed. In 1994 the number of claims per bed started creeping up and in 1995 the average size of California patient liability claims jumped dramatically. Loss costs are now projected to be $2,320.

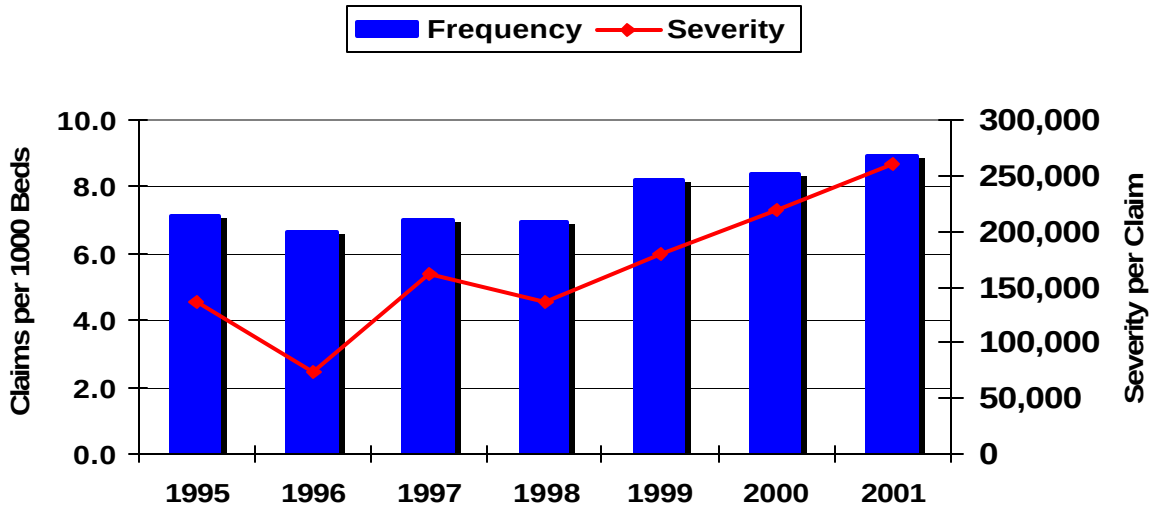
California Loss Cost per Occupied Bed



What differentiates California from the southern states is that frequency rates have not been trending up as quickly. While Alabama, Arkansas, Georgia and Mississippi have all incurred 10% or higher annual frequency trends, California frequency rates are increasing at a relatively modest 6% a year. Part of the reason California trends are lower is that California frequency and severity levels have historically been higher than most other parts of the country. It is likely that proximity to Florida and the corresponding publicity regarding

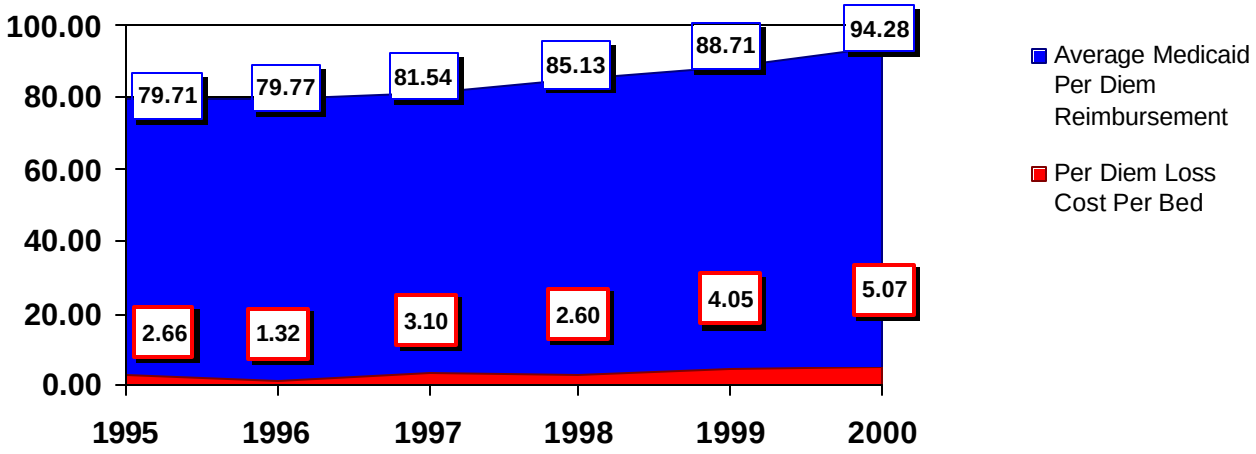
patient liability lawsuits has had an impact on the rapidly rising trends in southern states as compared to California.

California Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of California Medicaid reimbursements, from 3% in 1995 to 5% in 2000 as shown in the graph below. As Medicaid reimbursements have increased 18% over the past six years, the GL/PL loss cost has increased almost 100%. As a result, although the reimbursement rate has increased $14.57 during this period, insurance costs have absorbed 17% ($2.41) of that growth.

California Per Diem Loss Cost Versus Medicaid Reimbursement

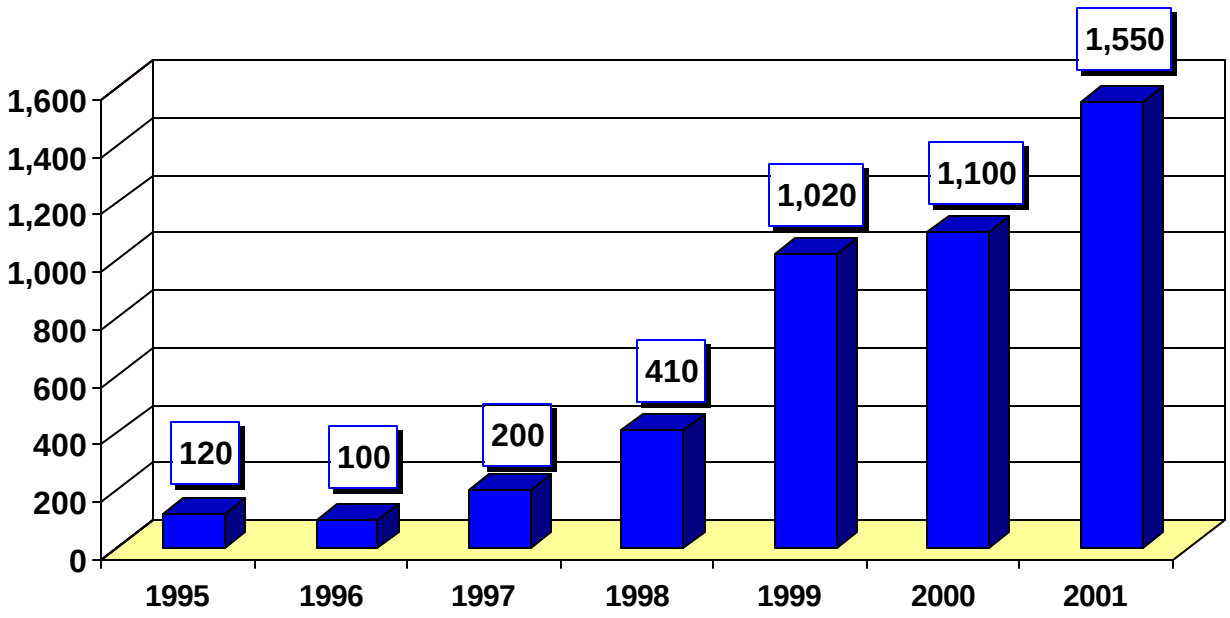


West Virginia

The participants in this study represent approximately 5,500 occupied beds in the state of West Virginia. This is 53% of all West Virginia nursing home beds.

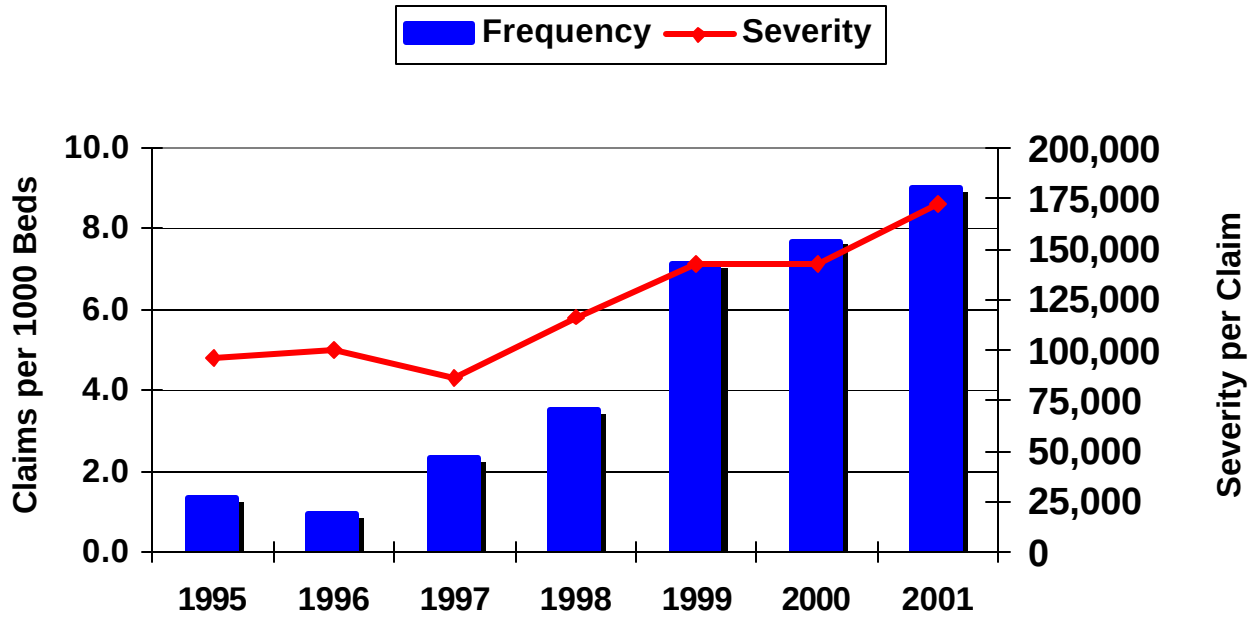
West Virginia loss costs have only recently shot up in the last 3 years, rising from $120 per bed in 1995 to an estimated $1,550 in 2001.

West Virginia Loss Cost per Occupied Bed



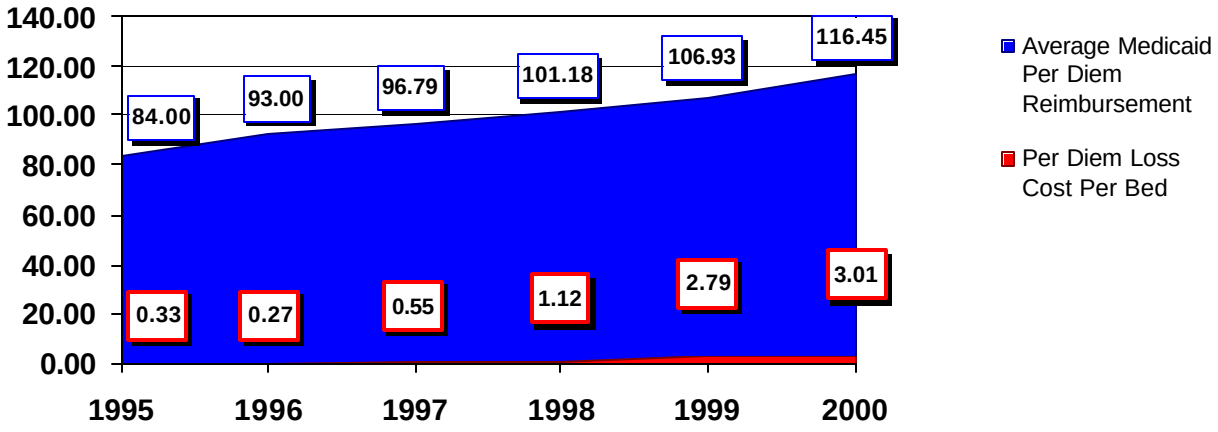
As in other states, the driving factors are increased frequency combined with higher average severity per claim. While the number of claims was fairly steady at between 1 to 2 claims per 1000 beds in the early to mid 1990's, they took a dramatic jump up to 7 claims in 1999. For occurrence year 2001, based on the number of claims already reported and the historical observed frequency levels, we are projecting 9 claims per 1000 beds. The average severity in West Virginia has grown annually from $96,000 in 1995 to an estimated $172,000 in 2001.

West Virginia Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of West Virginia Medicaid reimbursements, from less than 1% in 1995 to 3% in 2000 as shown in the graph below. As Medicaid reimbursements have increased 38.6% over the past six years, the GL/PL loss cost has increased over 800%. As a result, although the reimbursement rate has increased $32.45 during this period, insurance costs have absorbed 8% ($2.68) of that growth.

West Virginia Per Diem Loss Cost Versus Medicaid Reimbursement

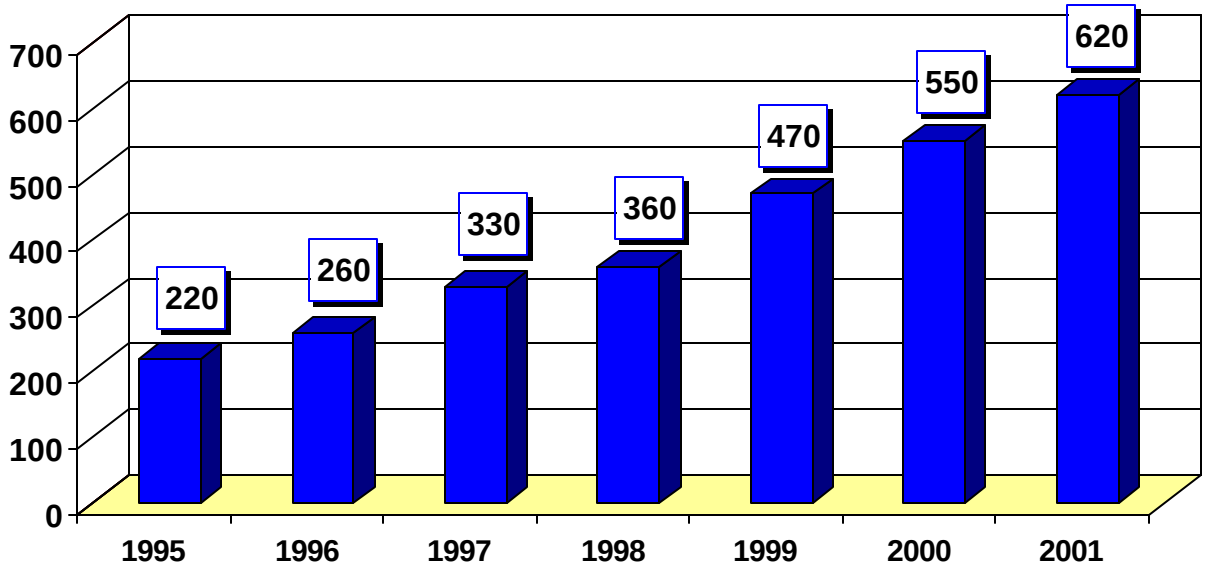


All Other States Combined

The participants in this study represent approximately 261,300 occupied beds in the remainder of the country (that is, excluding Alabama, Arkansas, California, Florida, Georgia, Mississippi, Texas and West Virginia). This is 21% of all nursing home beds in the remaining states.

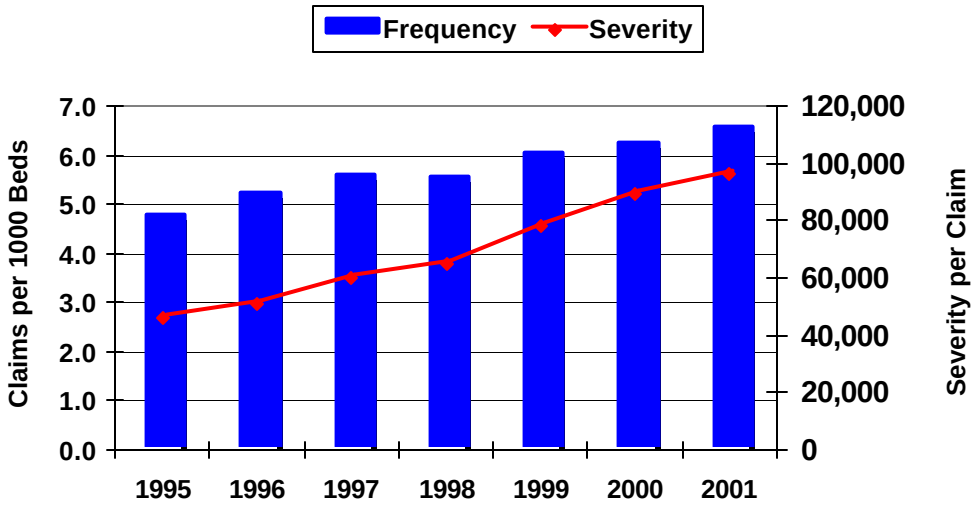
Even outside the high cost states presented above, GL/PL loss costs are increasing at an annual rate of 20% a year. This is well ahead of inflation and much higher than typically GL/PL claim cost increases for other industries, which tend to be in the 5% to 10% range a year. Our analysis of claims in all other states indicates that loss costs have risen from $220 in 1995 to $620 in 2001.

All Other States Loss Cost per Occupied Bed



The 20% annual loss cost increase is the result of a 5.0% annual increase in the number of claims, combined with a 14% annual increase in the average size of a claim.

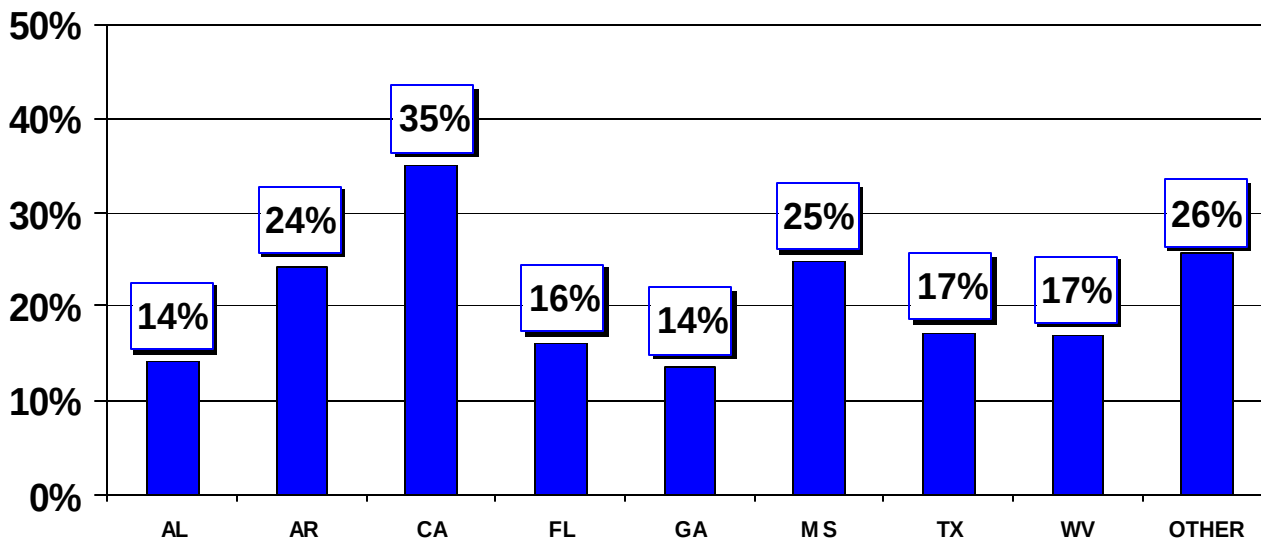
All Other States Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



ALAE

The component of total claim dollars used to defend claims, referred to as allocated loss adjustment expenses or ALAE varies by state as follows:

Percentage of Paid ALAE to Total Paid*



*Although CA has the highest percentage of ALAE to Total Paid, the average ALAE payment in CA is approximately the same as in Florida. The ratio of ALAE paid to total paid in California is higher because the indemnity component in California is much lower than in Florida.

Insurance Premium and Coverage Analysis

Insurance premium has drastically increased and coverage terms have been severely restricted for those survey respondents who have been commercially insured for their GL/PL exposure. Of the 60 total participants in this study, 29 provided insurance premium and coverage terms for policy years 2000 and 2001. These respondents are primarily comprised of the smaller, independent and regional providers. On average, the respondents to this section of the survey operate less than 3,000 licensed beds. The median size of respondents is closer to 1,000 beds. The large national chains are, for the most part, self-insured and did not report commercial insurance coverage information. The following sections provide details on the impact to the survey respondents of higher premiums, lower available limits of liability, and modified deductibles.

Premium Increases

On average, annual commercial GL/PL insurance premiums increased $240,352. For participants who were able to give a comparison of 2000 to 2001 coverage terms, this represents an average increase of 130% over last year. Only one respondent reported a premium decrease (of $17,465) and that respondent had its limits of liability reduced from $1,000,000 per occurrence and $3,000,000 annual aggregate in 2000 to $100,000 per occurrence and $300,000 aggregate in 2001. The maximum premium increase, as a percent of last year's premium, was 548% for an independent facility in West Virginia.

Change in Annual Premium - Policy Year 2000 to 2001

Amount of Change	Number of Respondents	Total Dollar Amount	Average Dollar Amount
Less than $0	1	($17,465)	($17,465)
$0 - $50,000	17	$245,300	$14,429
$50,001 - $100,000	3	$210,660	$70,220
$100,001 - $500,000	3	$976,665	$325,555
$500,001 - $1,000,000	3	$2,360,941	$786,980
Greater than $1,000,000	2	$3,194,100	$1,597,050
Total	29	$6,970,201	$240,352

Limit of Liability Reductions

In addition to large premium increases, survey respondents reported an average decrease in per occurrence available limits of liability of $474,074. That is, on average, a quarter of a million more dollars was charged for almost half a million less coverage per claim.

Change in Occurrence Limits - Policy Year 2000 to 2001

Amount of Change	Number of Respondents	Total Dollar Amount	Average Dollar Amount
Decreased more than $1,000,000	4	($14,000,000)	($3,500,000)
Decreased $500,001 - $1,000,000	1	($900,000)	($900,000)
Decreased $100,001 - $500,000	0	$0	$0
Decreased $50,001 - $100,000	0	$0	$0
Decreased $1 - $50,000	0	$0	$0
Increased $0 - $50,000	20	$0	$0
Increased $50,001 - $100,000	0	$0	$0
Increased $100,001 - $500,000	1	$100,000	$100,000
Increased $500,001 - $1,000,000	0	$0	$0
Increased more than $1,000,000	1	$2,000,000	$2,000,000
Total	27	($12,800,000)	($474,074)

While the majority of respondents (20 of 27 providing limits of liability comparisons) reported no change in their per occurrence limit of liability, five respondents had limit reductions of $500,000 or more per claim. Four of these respondents had per claim limits reduced by more than $1,000,000.

In addition to per occurrence reductions, annual aggregate limits of liability declined by an average amount of $2.3 million. In total dollars, aggregate limits were reduced $62.4 million for the 27 respondents to this coverage issue. While the majority of this reduction relates to 3 respondents, it is evidence of the reduction in capacity available from the commercial insurance marketplace for insuring long term care liability exposures.

Change in Annual Aggregate Limits - Policy Years 2000 to 2001

Amount of Change	Number of Respondents	Total Dollar Amount	Average Dollar Amount
Decreased more than $1,000,000	3	($62,700,000)	($20,900,000)
Decreased $500,001 - $1,000,000	3	($3,000,000)	($1,000,000)
Decreased $100,001 - $500,000	0	$0	$0
Decreased $50,001 - $100,000	0	$0	$0
Decreased $1 - $50,000	0	$0	$0
Increased $0 - $50,000	18	$0	$0
Increased $50,001 - $100,000	0	$0	$0
Increased $100,001 - $500,000	1	$300,000	$300,000
Increased $500,001 - $1,000,000	1	$1,000,000	$1,000,000
Increased more than $1,000,000	1	$2,000,000	$2,000,000
Total	27	($62,400,000)	($2,311,111)

Deductibles Changes

The majority of respondents reported little or no change in their per occurrence deductible. Two respondents reported decreases in their per occurrence deductible. For one, a single facility operator, the decrease was only $1,500 per occurrence (a $2,500 deductible was reduced to $1,000 per occurrence) and it was accompanied by a 212% increase in

premium. For the other, a regional provider operating across a handful of states, the decrease from a deductible of $500,000 to $50,000 was accompanied by a $900,000 premium increase (43% higher than expiring premium).

Change in Per Claim Deductible - Policy Year 2000 to 2001

Amount of Change	Number of Respondents	Total Dollar Amount	Average Dollar Amount
Less than $0	2	($451,500)	($225,750)
$0 - $50,000	18	$27,000	$1,500
$50,001 - $100,000	0	$0	$0
$100,001 - $500,000	0	$0	$0
$500,001 - $1,000,000	0	$0	$0
Greater than $1,000,000	0	$0	$0
Total	20	($424,500)	($21,225)

Of the few respondents (15) who reported annual aggregate deductible information, deductibles were either unchanged or slightly increased between policy year 2000 and 2001.

Amount of Change	Number of Respondents	Total Dollar Amount	Average Dollar Amount
Less than $0	0	$0	$0
$0 - $50,000	14	$12,000	$857
$50,001 - $100,000	0	$0	$0
$100,001 - $500,000	1	$125,000	$125,000
$500,001 - $1,000,000	0	$0	$0
Greater than $1,000,000	0	$0	$0
Total	15	$137,000	$9,133

Change in Annual Aggregate Deductible – Policy Year 2000 to 2001

Conditions and Limitations

The projections contained in our analysis rely on methods and assumptions that are in accordance with standard actuarial practice. Except where specifically noted, the results of this analysis are based entirely on the loss and exposure data provided to us by the long term care facilities that responded to the AHCA data call. Readers of this report should keep the following observations in mind:

1. We have relied on this loss and exposure information without detailed verification or audit other than checks for reasonableness. We do not assume any responsibility for errors or omissions in the data or material provided to us.

2. We have assumed that losses reported to us in the aggregate will develop to higher ultimate amounts by the time all claims arising from incidents that have occurred in the historical period under study are reported and eventually closed. This assumption is based on the historical reporting patterns of the long term care industry and is in accordance with standard actuarial practice. Individual claims will likely develop more or less than the percentage of aggregate development. The adjustments we have made to past experience reflect the average effects of changes in the cost of claims.

3. We have assumed that the losses reported to us represent the unlimited amount of indemnity, ALAE and punitive damages paid and reserved as of the report date. To the extent losses have been limited and/or punitive damages not reported, our loss projections may be understated.

4. The losses presented in this report are on a nominal, undiscounted basis. They represent the actual dollars paid on an ultimate basis by the time all claims are closed. No recognition of the time value of money or the cost of capital has been included in our projections.

5. Except where specifically noted, the loss projections presented in this report are based strictly on the claim detail provided to us and, therefore, are a function of the exposure characteristics of the sixty long term care providers who responded to the data call. Fifteen of these long term care providers, representing a significant portion of exposure, are predominantly multi-facility, for-profit operations providing primarily skilled nursing care. The remaining operators are comprised of regional, state or independent long term care providers, both for-profit and not-for-profit. The large majority of the providers who responded are primarily skilled nursing care operators, although there is some representation by operators of exclusively assisted living facilities. The analyses contained in this report represent a blend of the experience of this varied group of participants. Individual nursing home operators around the country or in the states or state groupings presented in this report may have different loss costs depending on their level of nursing care, profit status, and independence.

6. The report is strictly for the use of the American Health Care Association and its members. In addition, this report is being made available to all long term care providers who participated in the data request. This report may also be released to regulatory authorities. If this report is distributed, the report should be distributed in its entirety. All recipients of this report should be aware that the Aon actuaries who signed the report are available to answer questions about it.

The above notwithstanding, we believe that the projections in this report are reasonable, and are based on sound actuarial methods and assumptions. Our conclusions are subject to the ordinary limitations involved in any actuarial analysis, and must not be viewed as absolute or guaranteed results.

Data Sources

The analyses contained in this report are entirely based on an industrywide call to long term care operators for data on GL/PL claims incurred during the last five to twelve years.

Sixty long term care providers responded to our call in whole or in part. The respondents range in size from independent single facility operators to large national multi-facility companies. Operators responded from forty-nine states (all except Alaska) and the District of Columbia. Fifteen of the respondents are for-profit, multi-facility long term care providers with facilities in numerous states. Six of the respondents are regional operators with facilities in no more than three states. The remaining thirty-nine respondents are small independent operators concentrated in one state with one or more facilities. Most of the respondents provide primarily skilled nursing care, although at least one of the respondents is strictly an assisted living facility operator.

In developing the benchmarks presented in this report we have relied on the following data.

- **Individual claim detail** – This database is a compilation of 20,359 non-zero long term care general/professional liability claims occurring over the past twelve years. The information included by individual claim is status, accident date, report date, close date, state, indemnity paid, allocated loss adjustment expense paid, total paid, indemnity incurred, allocated loss adjustment expense incurred, and total incurred.

- **Historical Loss Development Triangles** – Incurred and paid loss development factors and claim count development factors are derived from a consolidation of the reporting patterns of four of the largest long term care providers. These four providers represent approximately 64% of the loss data reported to us. Historical reporting patterns are not available from the other long term care providers. However, the similarity of the patterns for the four reporting providers and the credibility of the consolidated development pattern justify the use of these patterns to estimate ultimate development for the group of providers as a whole.

- **Occupied Beds** – Annual occupied bed counts corresponding to the years for which loss experience is provided are utilized in this analysis to develop the relative loss cost per bed. Annual licensed bed counts are multiplied by average occupancy rates to derive annual occupied beds. For long term care providers who could not provide average occupancy rates an occupancy rate of 89% has been assumed for skilled nursing care providers and 80% for assisted living providers. For all states combined, there are approximately 472,000 licensed beds of which more than 415,000 are occupied.

- **Medicaid Reimbursement Rates** – Average Medicaid per diem reimbursement rates by state for each of years 1995 through 2000 are based on rates published by HCIA Inc. and Arthur Anderson & Co. in their report, "The Guide to the Nursing Home Industry." Countrywide average rates are derived by weighting state rates by industry occupied beds by state.

Definitions

The following definitions are provided to help the users of this report fully understand the analyses presented and the resulting conclusions.

ALAE

ALAE is an abbreviation for allocated loss adjustment expense. ALAE refers to costs, in addition to indemnity payments and reserves, which are incurred in handling claims. Typically, these costs are comprised of legal fees paid by the insured entity in investigating and defending claims. In the context of this study ALAE represents defense costs. The majority of claim data used in this study contained a separate field to identify ALAE costs separately from indemnity costs. Whether separately identified or not, allocated loss adjustment expenses are included in the reported loss information, loss reserving methodologies and loss projections contained in this report. All references to losses throughout our report and exhibits include ALAE except where noted otherwise.

Deductible

A deductible is a layer of loss retained by an insured entity. The insured pays amounts below the deductible and the insurance company pays amounts above the deductible. The higher the deductible the lower the commercial insurance premium. However, this is largely offset by the cost of the portion of claims below the deductible.

Retention is another word commonly used to refer to a deductible. Companies with high deductibles, or retentions, are commonly referred to as self-insured.

A deductible can apply on a per occurrence basis, that is for each individual loss, and/or on an aggregate basis for a given period of time. A typically GL/PL deductible for the health care industry may be expressed as $1,000,000/$3,000,000, meaning $1 million per occurrence and $3 million in the aggregate for the year. With this deductible the insured is responsible for paying the first $1 million of each claim, subject to a maximum total of $3 million for the year.

Deductibles can apply to the indemnity portion of losses only or the combined cost of indemnity and ALAE.

The losses included in this report are prior to the application of any deductible or retention. That is, they represent the total amount of loss from first dollar to the unlimited reported amount.

Defense Costs

In the context of this report, defense costs include attorneys' fees and other directly allocable costs associated with defending a company against GL/PL claims.

Exposure

Actuaries select an exposure base such that the incidence of claims will tend to vary directly with the exposure of the entity at risk. The actuary must consider both the historical loss level and the corresponding exposures in evaluating historical claim liabilities and expected future costs. It is important to choose an exposure measure that is relevant to the unique situation of each risk group.

In this study we use an exposure base of occupied beds. Occupied beds are calculated by multiplying the number of licensed beds by the average annual occupancy rate. There is a strong correlation between the number of occupied beds and the total amount of losses incurred by a long term care facility. Not all beds are equal in terms of their risk exposure, however. An assisted living bed generates fewer dollars of GL/PL claim activity than a skilled care bed. We have adjusted all beds in this study to the equivalent of a skilled nursing care bed.

By dividing losses by exposures we develop comparative estimates of the long term care industry GL/PL loss costs between states, types of facilities (multi-chain vs. independent) and years of operation.

Frequency

Frequency is the ratio of the number of claims divided by exposures. In this report we measure frequency on an annual basis as the number of claims projected for the given time period divided by the number of occupied beds during that same period. In our summary exhibits we present frequency as the number of claims a year for every 1,000 beds.

General Liability

General liability exposure generally relates to those sums an entity becomes legally obligated to pay as damages because of a bodily injury (typically including personal and advertising injury) or property damage.

Indemnity

Indemnity refers to the component of claim costs actually paid or reserved to be paid to the plaintiff. Indemnity costs include both the amount provided for the plaintiff, either as a jury award or a settlement, and the amount retained by the plaintiff's attorney. However, in most claim files, including those used to do this study, the split between plaintiff award and plaintiff attorney is not provided. Indemnity may also include punitive damages, although this is not consistently treated among companies.

Limit of Liability

A limit of liability is a maximum amount of coverage provided by an insurance transaction. Above the limit of liability, the insured is responsible for all losses. Limits of liability may be expressed on a per occurrence basis or an aggregate basis, similar to deductibles. The losses included in this study are not limited.

Loss Cost

Loss cost is the cost per exposure of settling and defending claims. Loss cost is calculated as the ratio of total dollars of losses (indemnity and ALAE) to total exposures for a given period of time. In this report exposures are selected to be occupied beds and the time period is one year. Consequently, a loss cost represents the annual amount per occupied bed expected to be paid to defend, settle and/or litigate GL/PL claims arising from incidents occurring during the respective year.

Loss Development

Loss development refers to the change in the estimated value of losses attributable to a body of claims or to a time period until all the claims are closed.

Generally, the reported losses will increase over time for several reasons. First, it is impossible to estimate precisely the ultimate losses and legal expenses for claims when they are initially reported. The estimated unpaid loss for a claim, called a case reserve, is adjusted up or down as more information is obtained. In the aggregate, the upward adjustments tend to be greater than the downward ones. Second, it takes a period of time for some claims to be discovered, reported, and recorded. Claims which have been incurred but have not been reported are called “pure” IBNR claims. Third, closed claims are sometimes reopened. This may be due to legislation, which applies retroactively to claims that have closed. In this report, except where specifically noted, projected loss costs, frequencies and severities by state and by year are all inclusive of actuarially indicated expected loss development.

Loss development also refers to the increase in paid losses as claims are reported, paid to their ultimate values, and closed.

Loss Trend

Loss trend is the change in claim frequency and/or severity from one time period to the next. Factors that affect the frequency and severity of claims are constantly changing over time. Examples of causes include inflation, societal attitudes toward legal action, and changes in laws. Actuaries use trend factors to adjust historical loss experience to comparable levels.

Premium

Premium is the amount paid to an insurance entity to cover costs associated with claims arising from a specifically defined risk. In the context of this report, premium refers to the premium paid for GL/PL insurance. Premium generally is developed as the expected loss cost for the period of coverage plus other underwriting expenses including commission, premium taxes, and general expenses incurred operating an insurance company.

Professional Liability

Professional liability exposure relates to those sums an entity becomes legally obligated to pay as damages and associated claims and defense expenses because of a negligent act, error or omission in the rendering or failure to render professional services.

Severity

Severity refers to the total dollar amount of a claim including indemnity and ALAE. In this report we measure the average severity for a given year by dividing the total dollars of losses for all claims incurred in the year by the total number of claims.

Underwriting Expenses

Underwriting expenses are expenses incurred in writing commercial insurance in addition to claim (indemnity and ALAE) expenses. Underwriting expenses generally include commission paid to agents and brokers, premium taxes and other general expenses incurred operating an insurance company. Underwriting expenses, when added to claim expenses, represent the total cost underlying commercial insurance premium. In this study we present only the loss costs associated with GL/PL claims. Underwriting expenses are in addition to these costs where GL/PL exposure is commercially insured.

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