Spring 2015

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DESIGNING STRATEGIC RISK SOLUTIONS Exclusively for the Aging Services Industry
DEAR CARING COMMUNITIES’ MEMBERS AND FRIENDS,

I begin this letter with a few reflections about 2014.

First, by the numbers, 2014 ranks as one of our best years ever. We welcomed more new Members than in any other year, reaching the milestone of doubling our membership since the company began. We achieved an A.M. Best rating “A” (Excellent) as a result of our 2014 review. This all counts and adds to our success.

There is more to Caring Communities that doesn’t add up so easily, yet is just as important. I have the advantage of observing Caring Communities for many years now, so I see many worthy developments that result from hard work by the Members, Board and Management Team over time. One example is the developing character of the company. I see how well we all work together throughout the year, which is very evident in our meeting sessions.

We can be especially pleased with the care we have taken in planning for succession at the Board and Committee levels by inviting and reaching out to those who desire to serve and assuring we have a balance of leadership and skill sets. This year we placed more new people in committee roles than any other. The work of the Governance and Nominating Committee continues with the benefit of Kevin Gerber’s leadership, focusing on developing new leadership and corresponding opportunities for those desiring to serve Caring Communities.

During the Annual Meeting we observed a spirit of fellowship and collegiality, an extremely important characteristic of the company. We will need to find ways to foster and preserve this as we grow, especially as we continue to welcome new Members.

We also see that Caring Communities is getting more attention due to our expanding marketing efforts and also because we are now noteworthy by being among A-rated companies. This is very exciting. It is timely for us to consider our image and brand. Plans are underway to pursue this important strategy and we will keep you posted.

Now we are well on our way in 2015. So far we are on track with our expectations. We are also very engaged in our annual strategic planning process. We look forward to presenting strategy to the Members and spending time in a focused discussion with the Board during our Summer Meetings scheduled for September 9-11, 2015.

On behalf of the Caring Communities team, thank you all, especially all those employees within your organizations who have embraced the importance of risk management.

Sincerely,

G. James Caldwell
President & Chief Executive Officer
ASBURY COMMUNITIES ANNOUNCES NEW PRESIDENT & CEO

Asbury Communities, Inc., is pleased to announce that Doug Leidig has been named President and CEO of Asbury Communities, Inc., effective June 1, 2015.

Doug has served as the Chief Operating Officer of Asbury Communities since 2004, and he has more than 25 years of experience providing services to help older adults lead fulfilling lives. In addition, he has also served as President of The Asbury Group since 2012, leading the for-profit division of Asbury Communities, Inc., that provides management, marketing and integrated technology consulting services on a contract basis to for-profit and not-for-profit senior living entities. As President of The Asbury Group for the past three years, the company’s senior living client base experienced significant growth.

In January 2015, Doug was elected Board Chair of LeadingAge Maryland after serving as Vice Chair for the previous two years. Most recently, he was selected to join the advisory board for Senior Living 100, the premier leadership event for C-level executives from the nation’s largest, most progressive assisted living, independent living and continuing care providers dedicated to advancing the role of senior living in the continuum of care. Doug also serves on the Kairos Health Systems’ Board of Directors.

DAN REXROTH RECEIVES DOCTORATE

Dan Rexroth, Board Chair of Caring Communities and President and CEO of John Knox Village, received his Doctorate of Education in Ethical Leadership from Olivet Nazarene University on May 9, 2015.

Dan started working on his doctoral degree in 2012, traveling to the Chicago area monthly to attend class. He also participated in nine-day intensive courses each summer for the three years he was working toward his degree.

In addition to giving numerous presentations, Dan estimates he wrote around one thousand pages of papers (including his dissertation on governance) and read about 60 textbooks and a few hundred research/scientific articles.

Dan Rexroth has a master’s degree in clinical psychology from Ball State University and a bachelor’s degree from Olivet Nazarene University.

An excellent year made for a memorable meeting, including achieving the coveted rating of “A” (Excellent) from A.M. Best and plans for growth and improvement through comprehensive strategic planning. On a bittersweet note, a fond farewell was given for the retirement of one of Caring Communities’ long-standing Member representatives. The achievements and contributions of Barbara Hood, retiring CEO of Northern California Presbyterian Homes and Services, will be remembered.

The Groskopf Principles—Engaged CEOs, Accountable Risk Management, Skin in the Game, Disciplined Operation, and a Covenant with Policyholders—are alive and well within Caring Communities.
HONORING OUR CERTIFIED PROFESSIONALS IN AGING SERVICES RISK MANAGEMENT

It has come to our attention that not all of our colleagues who earned their certification in 2014 were officially acknowledged at the 2014 NASRM Conference designation ceremony in Chicago, nor were all persons noted in the winter edition of Top Drawer.

Because of the time and effort it takes to earn the certification, and the fact that we are proud of those who make the commitment to achieve the designation, we would like to remedy this situation at this time.

Our 2014 certified professionals are:

• Leah Addis, ECRI Institute
• Roxanne Chase, American Baptist Homes of the West
• Jessica Fels, Episcopal Communities and Services
• Jean Harpel, ECRI Institute
• Kami Hopper, Pleasant Hill Village
• Mary Leary, Mather LifeWays
• Claudette Sherman, ECRI Institute
• Jerry South, Methodist Senior Services

If you were not recognized during the designation ceremony at the 2014 NASRM Conference, we do apologize and you will most definitely be invited to participate in the 2015 NASRM Conference. If you earned your certification after the 2014 NASRM Conference, you will be invited to participate in this year’s ceremony, as is the practice.

Once again—congratulations and nicely done!
ATTORNEY RECORDS REQUESTS—NOW WHAT?
by Laura Lally, JD, Vice President & Chief Claims Officer, Caring Communities

A request from an attorney for a resident’s records, both a cause for concern and an indicator of future litigation, must be handled in a systematic way for best results.

When responding, it is important to confirm that the proper records are being produced and that potential problems are identified in order to avoid or mitigate litigation.

Read the Request
The first step sounds simple, yet a thorough reading reveals that the request provides important information. For example, a request might ask only for the resident’s bills; it might be confined to specific dates or a specific type of care, such as wound-care notes with pictures. This information gives clues as to the purpose of the request. A request only for bills might mean the attorney is collecting medical bills for an incident that occurred before the resident entered the facility, while a request for all records during a specific time probably means the attorney is looking at a specific incident or care that occurred during that time.

Look at the signature on the request. If signed by the resident or by a Power of Attorney, the resident is likely still alive. If signed by someone as the administrator or executor of the estate of the resident, then the resident is no longer alive. In that case, the death certificate may be attached, giving the date, place and cause of death.

If the request comes in the form of a subpoena, then there is already a pending court case. The top left-hand side of the subpoena identifies the parties in the case, and this helps to determine if the subpoena is related to a case against another healthcare provider, an incident that occurred prior to admission, or an estate matter.

Some subpoenas require a record keeper from your organization to appear in court with the original records in order to authenticate the records. If so, it is a good idea to confirm the attendance with the party subpoenaing the records a day or two in advance of the required appearance.

Report the Request to Caring Communities
The organization should notify its designated Caring Communities claims professional of all records requests. If you submitted an earlier report to Caring Communities regarding the underlying incident, do not submit a new incident. Instead, review the prior incident report to refresh yourself regarding the underlying incident. Next, email the entire records request, including any attachments, to your claims professional, referencing the claim number you received when the incident was originally submitted. If there has not previously been an incident submitted, then submit a report to Caring Communities using the web-based claims/incident portal. Once you receive an email confirmation of the submission with a claim number, email the entire records request to Caring Communities. Reference the claim number in the email.

Dig Deeper
Once you’ve confirmed that the records request has been submitted to Caring Communities, do an Internet search of both the attorney and law firm requesting the records. Look at the practice areas section of the law firm’s website. The law firm’s specialties may reveal something about the reason for the records request. Some firms specialize in plaintiff’s automobile injuries, class action claims against pharmaceutical companies or estate matters. If the website notes a specialty in nursing home claims, elder abuse or medical malpractice, there is a good chance the request is focusing on your organization’s care and treatment.
Review all incident reports involving the resident. Identify falls, skin breakdowns and changes in condition. Determine where the resident came from prior to admission, note the admission (and discharge) dates, where the resident went upon discharge and the reasons for any hospitalizations. Update your claims professional with regard to this information.

Once the entire record is assembled, a member of the organization’s nursing staff should review the chart. Often someone who did not work with the resident brings a fresh perspective. The review should focus on concerns raised by the resident or family, the family dynamics, proper documentation, the care provided in light of abnormal symptoms or falls, assessments, adherence to the care plan, updates of the care plan with changes in condition, documentation of medications and treatments, and the overall course of the resident. Any concerns or abnormalities should be brought to the attention of the organization’s Risk Manager and your claims professional at Caring Communities.

Produce the Records

Your Risk Manager and Caring Communities will determine if the records can be produced directly by the organization or if defense counsel should be retained. The decision to retain counsel, and the selection of specific counsel, should be a joint decision between the organization and the Caring Communities claims professional.

Produce only the requested records. Requests for incident reports, employee files, policies and procedures, and other resident’s records should not be produced unless there has been a consultation with the claims professional and the defense counsel.

Make sure all of the applicable records are located and produced. It might be challenging to gather all of the records if the organization uses an electronic medical record, as there may not be a simple way to print the entire electronic record. Similarly, all of the paper records may not be in the main body of the chart. If the entire resident record is requested, make sure that the documents that are kept separately, such as wound notes, MDS forms, ADL sheets and care plans, are included in the production of records.

The chart should also be reviewed for documents that should not be in the records, such as misfiled records of other residents, incident reports and the investigative notes of an incident. If these documents are in the chart, remove them and put them in a folder entitled “Quality Assurance/Privileged Materials.” These documents should only be produced at the direction of defense counsel or the claims professional.

Copy Twice, Produce Once

Once the entire record is assembled, make two complete copies of the records, the first going to the attorney requesting the records, the second to a secure location, labeled with the date it was produced. It should identify for whom the record was produced and contain a copy of the record request. This step is especially important when the resident is still in the community, as the chart is not a static document. The segregation of the portion of the record that was produced will be useful if there is ever a concern whether all requested documents were indeed produced.

Bring any of the resident’s further developments and any subsequent contact by the attorney to the attention of Caring Communities.

Conclusion

An attorney’s records request is frequently a sign of impending litigation, making the review and production of the records important. A proper production may help to avoid litigation. In other instances it may help to identify claims that are appropriate for early resolution.
On February 20, 2015, the Center for Medicare and Medicaid Services (CMS) announced a change to its calculations of the quality rating system for skilled nursing facilities.\(^1\)

Citing improved rating scores since 2008\(^2\), CMS is recalibrating the calculations so fewer facilities receive the five-star quality rating and warned providers their rating scores may go down.

It’s important for organizations to understand the methods used to calculate their rating scores, because these scores are used by over 1.4 million viewers per year\(^3\), such as consumers, regulators and litigators. Each provider should ensure that its rating score properly reflects the level of care and services it offers.

Changes to the current system include assessing antipsychotic medications for short- and long-term residents, revised calculations for staffing levels and higher benchmarks that make achieving the coveted five-star rating more difficult. These changes will affect, of course, the overall rating. With a greater emphasis on quality measures, the number of facilities earning a five-star quality rating fell to 49% from 80%, and the number receiving one-star ratings grew from 8.5% to 13%.

The Five-Star Quality Rating System, first published in 2008, is found on Medicare’s Nursing Home Compare website.\(^4\) This system rates all facilities that accept Medicare and Medicaid reimbursement. The CMS goal is “to provide residents and their families with an easy way to understand assessment of nursing home quality, making meaningful distinctions between high- and low-performing nursing homes.”\(^5\)

**Health Inspection**

The health inspection performance rating includes results from the three most recent standard surveys, any complaint investigations during the most recent three-year period and any repeat visits needed to verify that violations identified have been corrected. The first revisit is not assigned a point value, hence not counted against an organization.

Point values are assigned to the scope and severity of deficiencies cited. G-level deficiencies and higher are assigned additional points. Survey results are weighted: the most recent survey is assigned a weighting factor of one-half the score, results from two years prior are weighted at one-third the score and surveys from three years prior are weighted at one-sixth the score.\(^6\) A low score corresponds to high quality. Life safety code and federal monitoring survey deficiencies are not included in the quality calculations.

CMS acknowledges variations in the way states conduct surveys, recognizing differing skill sets of the surveyors and their supervisors. Further, state management of Medicaid funds and variances in state licensure laws can create “differences in both quality of care and enforcement of that quality.”\(^7\) To counteract this, the quality ratings of health inspections are drawn from the performances of facilities within the same state. The top 10% of the health scores within a state receive a five-star rating. Seventy percent of the facilities in a state are assigned two to
four stars, and the lowest scoring 20% earn one star. These 10%, 70% and 20% breakpoints are modified monthly by including new survey results, complaint-related deficiencies, additional re-visits to verify compliance and information related to resolution of informal disputes.

Staffing Information
There is a great deal of evidence tying nursing home staffing levels to the quality of care and resident outcomes. Staffing rating is based on two measures: total nursing hours per day (RN + LPN + Nurse Aide hours) and RN hours per day. Staffing data is drawn from CMS Form 671 (LTC Facility Application for Medicare and Medicaid). Resident census information is drawn from CMS Form 672 (Resident Census and Conditions). Staffing data includes both full- and part-time staff but does not include hospice staff, “feeding assistants” or private-duty staff paid for by the resident. Staffing information is adjusted by data from the case mix system: the summary of the MDS information for the current residents divided into Resource Utilization Groups (RUG). The staffing quality rating uses the most recent RUG category distribution from the last business day of the last month of each quarter. In February 2015 antipsychotic medication used by long-term residents and short-stay patients was added. The goal is to achieve a 30% reduction in the use of antipsychotic medications, doubling the goal reached in 2013. Ratings for quality measures are calculated from the most recent three quarters of available MDS data and includes, or excludes, data based on the sufficiency of available information.

Overall ratings are based upon health inspections, with staffing and quality measures applied against the health inspection rating to create the overall score. The staffing and quality measures can move the overall rating up or down by as much as two stars, but no facility can achieve more than five stars. This year’s changes to the quality measure scoring will exert a downward pressure on the overall ratings of many facilities. We recommend that providers be prepared to answer questions about a perceived decline in quality of their services should their ratings decline. Increased vigilance is important, so as to ensure that the rating reflects the quality of services offered.

Quality Measures
Data on quality measures is developed from MDS data submitted to CMS. There are 18 quality measures listed on Nursing Home Compare. The rating system uses a subset of 11 measures based on “their validity and reliability, the extent to which a facility’s practices may affect the measure …”.

Three quality measures address care of the short-stay patients, and eight reflect the care of long-term residents. In February 2015 antipsychotic medication used by long-term residents and short-stay patients was added. The goal is to achieve a 30% reduction in the use of antipsychotic medications, doubling the goal reached in 2013. Ratings for quality measures are calculated from the most recent three quarters of available MDS data and includes, or excludes, data based on the sufficiency of available information.

NOTES
3 Id.
5 Id. at p. 2.
6 Id. at p. 4.
7 Design, at p. 6.
8 Id. at p. 7.
9 Id. at p. 8.
10 File download available at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/F5QRS.html
11 Design, at p. 9.
12 The 11 measures figure includes the two new measures regarding antipsychotic use.
13 Id. at p. 10.
14 Id. at p. 11.
15 CMS Press Release, 2/20/15.
16 To be included in the calculation requires data on at least 30 long term resident care related measures and 20 short-stay Measures that do not meet this threshold are noted with “no available data” in the Quality Measures Table. See, Design, at p.13.
17 Id. at p. 16.
It’s no secret that obesity is an epidemic. The most recent estimates suggest more than one-third of U.S. adults are obese, with $1,429 more in annual medical costs than those who are normal weight.

Additionally, new research shows how obesity often extends beyond a person’s physical health—affecting his or her financial and psychological well-being.

As compared to 1980, Americans today are 2.3 times more likely to be obese, and carry a debt load that is 2.6 times greater than their 1980 counterparts, according to the Federal Reserve Board and the Centers for Disease Control and Prevention. In fact, a University of Mainz study, which adjusted its findings for socioeconomic and education levels, found that an overweight person is twice as likely to be indebted as an individual in a healthy weight range. The study evaluated 9,000 Germans, of which 25% were both medically obese and in consumer debt. By comparison, only 11% of the non-indebted group was considered medically obese. The study also found that over-indebtedness was associated with a higher prevalence of depression and tobacco use.

As research continues to uncover evidence of links between obesity, financial and psychological health challenges, employers should better understand the issue so they can help address the problem in their own employee populations.

The Evolution of a Problem

While vast societal improvements have been made over the past few decades, new challenges have followed. For example, people today have less physically demanding jobs than in previous generations. The result is a sort of disconnection from their bodies and physical capabilities. Likewise, the evolution from a barter system to credit cards and checks, where an individual often never even sees or touches his or her money, has created a disconnection with their daily finances. Unfortunately, the more disconnected people are from their money, the more likely they are to spend it. Similarly, if an individual is disconnected from his or her body, it’s less likely he or she will care for it properly. This is referred to as psychological distance, which describes how psychologically removed individuals are from the impact and results of their actions.

Obesity Drives Healthcare Costs

According to the Centers for Disease Control and Prevention, from 1980 to 2010, obesity and the percentage of the workforce that has become disabled have both nearly tripled. Furthermore, obesity-related illnesses, including diabetes, depression and cardiovascular disease, make it difficult or impossible for some to work. For those who are able to remain in the workforce, their employers face considerable expenses associated with managing these illnesses.

The Compounding Effect of Illness and Financial Distress

General health issues, specifically obesity, can be so closely intertwined with financial troubles it can be hard to tell which came first. According to the 2012 Stress in America™ study by the American Psychological Association, money is a major stressor with 69% of people indicating that financial stress is their biggest stressor. Nearly two-thirds of Americans report having serious financial problems, and workers with financial distress report poorer overall health.

Furthermore, debt can lead to stress and depression, both of which often can drive metabolic syndrome. An individual with metabolic syndrome has three or more of the following health risk factors:

- Blood pressure ≥ 130/85 mmHg
- Waist circumference ≥40" for men or ≥ 35" for women, or a body mass index (BMI) ≥ 30
Fasting glucose ≥ 100 mg/dL or nonfasting glucose ≥ 140 mg/dL

■ HDL cholesterol < 40 mg/dL for men or < 50 mg/dL for women

■ Triglycerides ≥ 150 mg/dL

So, how does stress contribute to health risks? Stress is a normal response to a threat, whether real or perceived. In this case, it could be stress related to a shortage of money. Normally, when the stressful situation passes, the response goes away, and the body goes back to normal. But when the stress is unrelenting, which could be the case when it comes to indebtedness, the body is overexposed to stress-related hormones, which puts an individual at risk for a variety of health issues: anxiety, depression, heart disease and weight gain.

Professor Eva Munster and her team also found that, “Over-indebtedness affects a series of risk factors for chronic diseases, such as leisure time activities as well as participation in social activities.” Munster connects the dots between an individual’s over-indebtedness and his or her social interactions. When someone is experiencing financial distress, he or she is less likely to participate in activities such as golf, tennis, going to the gym, and so on. Consequently, these individuals tend to be drawn to a more sedentary, isolated lifestyle. The combination of a desire for high-calorie foods during stressful times and a lack of physical and social activities is a recipe for weight gain that leads to being overweight or obese.

Correlation vs. Cause

It is important to note that the findings referenced above are from studies that show correlation but not necessarily cause. Clearly, debt does not cause obesity or vice versa. However, there are many widely accepted studies linking lower socioeconomic status with obesity. Many postulate that debt leads to obesity because healthier, lower-calorie foods tend to cost more. While not all healthy foods are costly, it’s not difficult to see how fast food, with its dollar menus and supersize options, can seem a better “deal” for someone who is short on funds.

There is a possibility that an individual’s mindset creates a link between debt and obesity. For instance, people who are willing to purchase something they cannot afford now and pay for it later may be just as willing to eat unhealthy food now and pay the “health price” for it later. Human beings, in general, are apt to avoid pain and focus on gaining pleasure. Most people will choose to avoid pain in the present, putting it off until the future, even if that means the pain will be greater. The inverse is also often true of pleasure.

Shifting from Wellness to Well-Being

This insight into the relationships between money, stress and health risks is leading to an important, but not surprising, conclusion. Although physical health is important, an individual’s overall well-being is of utmost importance. True well-being means focusing on mind, body and spirit as a whole.

According to Gallup and Healthway’s Well-Being Index, “By taking a more holistic approach and moving from a wellness strategy to one that includes all facets of an individual’s well-being, employers of all sizes have an opportunity to unlock additional value across their populations.”

As more links are found among economic, social, and health issues, employers will need to embrace a “strategy with well-being at its core … to more effectively identify the root causes of issues that impact important business metrics such as health outcomes, healthcare costs, job performance, turnover and absenteeism,” according to Gallup and Healthway.

This is an important framework for addressing what may be a disconnection in company wellness programs. After all, employees do not live their lives in silos of financial issues, physical issues and psychological issues. All of these factors combine to make an individual who he or she is. When an organization moves toward a culture of overall well-being that addresses all these facets of life, the result may very well be individuals who are able to reach their full potential, which in turn benefits their employers.
This report, covering the year ended 2014, highlights the results of the Caring Communities Group: Caring Communities, a Reciprocal Risk Retention Group; Caring Communities Insurance Company; and Caring Communities Shared Services.

Return premiums (totaling $3.3 million) were paid to Members in March 2015, again exemplifying the tremendous success of Caring Communities during the 2014 calendar year. In addition to the return premiums, Caring Communities allocated $4.0 million to the Member Savings Accounts (MSAs).

Even with interest rates at historic lows, we saw a significant increase in investment income during the year. We invested in higher yielding mutual funds to boost our investment income. Net Investment Income approximated $2.0 million for the year ended December 31, 2014. We continue to pursue strategies to increase our investment income, while at the same time preserve our portfolio values. The cash and invested assets now total over $79.2 million at December 31, 2014, up from $73.0 million at December 31, 2013. The total portfolio (a composite of fixed income and equities) increased 4.00%, which compared favorably to the benchmark return of 3.99%. The fixed income portfolio slightly underperformed the Barclays Intermediate Aggregate Bond Index, increasing 4.11%, versus 4.12% for the benchmark. Over the previous 5 years, the fixed income portfolio has outperformed the Barclays Intermediate Aggregate Bond Index by 4 basis points. The equity portfolio outperformed its 4.16% benchmark, returning 4.79% for the year ended December 31, 2014. Because of this performance, equities now represent approximately 15% of the total investment portfolio as of December 31, 2014.

Revenues for the organization increased for the year ended December 31, 2014, as compared to 2013, due to the addition of five new Members, with new premiums written exceeding $2 million. Gross Premiums Written totaled $23.6 million for the year ended December 31, 2014, up from $21.3 million for the year ended December 31, 2013.

Over the past year, we have experienced an increase in claim payments, causing us to enhance our risk-management strategies. Although our loss ratio continues to be low in relation to our peers, we continue to look into ways to reduce those events that lead to losses. Loss and Expense Ratios still outperform our peers and were extremely favorable for the 2014 year. For the year ended December 31, 2014, the Loss Ratio was 42.9%, and the Expense Ratio was 23.4%.

We continue to show a very strong financial position with profitable results, and expect this to continue throughout 2015.

Congratulations to our Members as 2014 was another stellar year for Caring Communities!

With very best regards,

Chad C. Swigert
Vice President/Chief Financial Officer
Caring Communities
### CONSOLIDATED BALANCE SHEETS
**December 31, 2014 & 2013**

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<th>2014</th>
<th>2013</th>
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<td>Cash &amp; cash equivalents</td>
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<th>Liabilities &amp; Subscribers’ Equity</th>
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<td>Unpaid losses &amp; loss adjustment expenses</td>
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<td>Profit contingent &amp; swing rate reserves</td>
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<td>Reinsurance premium payable</td>
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<td>Losses payable</td>
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<td>Accounts payable &amp; accrued expenses</td>
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<td>Premiums received in advance</td>
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<td>Unearned premium</td>
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<td>Unearned ceding commission</td>
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<tr>
<td>Income tax payable</td>
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<tr>
<td>Accrued subscriber dividends</td>
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<tr>
<td><strong>Total liabilities</strong></td>
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<table>
<thead>
<tr>
<th>Subscribers’ equity</th>
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<td>Contributed surplus</td>
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<td>Unassigned surplus</td>
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<td>Subscriber savings accounts</td>
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<td>Accumulated other comprehensive income</td>
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<td><strong>Total subscribers’ equity</strong></td>
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<tr>
<td><strong>Total liabilities &amp; subscribers’ equity</strong></td>
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### CONSOLIDATED STATEMENTS OF OPERATIONS
For the years ended December 31, 2014 & 2013

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<tr>
<th>Revenue</th>
<th>2014</th>
<th>2013</th>
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<td>Premiums earned, net</td>
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<tr>
<th>Expenses</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losses &amp; loss adjustment expenses incurred</td>
<td>$7,250,268</td>
<td>$5,267,702</td>
</tr>
<tr>
<td>General, administrative &amp; underwriting expense</td>
<td>$6,071,445</td>
<td>$5,552,751</td>
</tr>
<tr>
<td>Premium taxes</td>
<td>$256,912</td>
<td>$583,476</td>
</tr>
<tr>
<td>Subscriber dividend</td>
<td>$3,351,279</td>
<td>$5,043,266</td>
</tr>
<tr>
<td><strong>Total expenses</strong></td>
<td>$16,929,904</td>
<td>$16,447,195</td>
</tr>
</tbody>
</table>

| Income before income taxes | $3,959,273 | $3,467,977 |
| Income tax benefit        | ($166,093)   | ($51,403)   |
| **Net income**            | $4,125,366   | $3,519,380  |

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**Recent audited financials available upon request**
WELCOME TO MIMI McCaHILL

Mimi brings a wealth of professional experience in healthcare, both as an executive and as a bedside registered nurse. Prior to joining Caring Communities, Mimi worked as a Director of Risk Management for a Chicago-based tertiary medical center, and for the last six years, has served as the Chief Nursing Officer/Director of Quality for another Chicago hospital. Mimi has extensive experience in Risk Management, Health Law, and Quality Assurance and Performance Improvement.

Mimi received her Bachelors of Science degree in Nursing from Saint Louis University, Saint Louis, Missouri. She also holds a Juris Doctorate degree from Loyola University Chicago, with a certificate in health law.

Mimi will provide a critical component of leadership and strategy for the Risk Management System at Caring Communities. We are confident she will quickly become a valued member of the Caring Communities Management Team.

WELCOME TO ADAM VILLALOBOS

Please welcome Adam Villalobos as he joins the Caring Communities staff as our new IT Manager.

Adam began working for Caring Communities in January 2011 as Office Assistant while attending school full-time. During that time he helped the Administrative, Underwriting and Claims departments with their day-to-day operations. In December of 2014, he graduated with a Bachelor’s of Science degree from the University of Wisconsin–Parkside, majoring in Management Information Systems.

Adam’s background in technology and familiarity with Caring Communities’ needs will help to keep us current with technology trends and future IT developments in senior care and housing.

WHERE IN THE WORLD?

Dan Rexroth, President & CEO at John Knox Village, brought the Caring Communities flag to Havana, Cuba.

John Kotovsky, President & CEO at Lutheran Senior Services, dove at the Great Barrier Reef, Australia.
CaringComm.org
Membership with Caring Communities represents a strategic opportunity in contrast to an annual insurance buying decision. Members are the owners and policyholders of the company that provides their professional, general and excess liability insurance protection. Members invest in and own their risks exclusively with other Senior Housing Community Care and Service Providers, all known to one another. They have common interests, commitments and incentives, and thereby are directly rewarded by sharing the profits of the company, based on performance, the greater share to the best performers. Members work together in providing the safest environments and practices for their residents, people under their care and their employees.

To learn more about Membership in Caring Communities, please contact Ashur Odishoo, National Director Sales and Marketing, at 773.750.5117 or via e-mail at aodishoo@caringcomm.org.

UPCOMING EVENTS

Caring Communities Biannual Members, Board and Committee Meetings
September 9–11, 2015
Pillar and Post
Niagara-on-the-Lake, Ontario, Canada

National Aging Services Risk Management Conference
October 8–9, 2015
Preconference Sessions October 7
The Doubletree by Hilton Chicago
Magnificent Mile
Chicago, IL

Risk Management Webinars
Creating a Culture of Safety
June 16, 2015
1:00–2:30 p.m. Eastern

Claims Management: Marketing Materials
July 14, 2015
1:00–2:30 p.m. Eastern

Bedside to Boardroom: Effective Risk Management Reporting to the Board
August 18, 2015
1:00–2:30 p.m. Eastern