GENESIS HEALTH VENTURES INC /PA
Form 10-K/A
October 14, 2003

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

<R>

FORM 10-K/A

(Mark One)

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 **FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 2002**

OR

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from_____to_____

Commission File Number 0-33217

GENESIS HEALTH VENTURES, INC.

(Exact name of Registrant as specified in its charter)

Pennsylvania	101 East State Street Kennett Square, PA 19348	06-1132947
(State or other jurisdiction ofincorporation or organization)	(Address of principal executive offices including zip code)	(I.R.S. Employer Identification Number)

(610) 444-6350
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

NONE

Securities registered pursuant to Section 12(g) of the Act:

Title of each class

Common Stock, par value $.02 per share
Warrants to purchase common stock, par value $.02 per share, exercisable until October 2, 2002

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

YES NO

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (subsection 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K/A or any amendment to this Form 10-K/A.

;

The aggregate market value of voting and non-voting common stock held by non-affiliates of the registrant is $513,882,000[(1)]. As of December 23, 2002, 41,023,763 shares of the registrant’s common stock were outstanding and 550,022 shares are to be issued in connection with the registrant’s joint plan of reorganization confirmed by the Bankruptcy Court on September 20, 2001.

Indicate by check mark whether the registrant is an accelerated filer (as defined by Rule 12b-2 of the Act)

YES (2) NO

APPLICABLE ONLY TO REGISTRANTS INVOLVED IN BANKRUPTCY PROCEEDINGS DURING THE PRECEDING FIVE YEARS:

Indicate by check mark whether the registrant has filed all documents and reports required to be filed by Section 12, 13, or 15(d) of the Securities Exchange Act of 1934 subsequent to the distribution of securities under a plan confirmed by a court.

YES NO

DOCUMENTS INCORPORATED BY REFERENCE

NONE

(1) The aggregate market value of the voting and non-voting common stock set forth above equals the number of shares of the registrant’s common stock outstanding, reduced by the number of shares of common stock held by officers, directors and shareholders owning in excess of 10% of the registrant’s common stock, multiplied by the last reported sale price for the registrant’s common stock on December 23, 2002. The information provided shall in no way be construed as an admission that any officer, director or 10% shareholder of the registrant may or may not be deemed an affiliate of the registrant or that he/it is the beneficial owner of the shares reported as being held by him/it, and any such inference is hereby disclaimed. The information provided herein is included solely for record keeping purposes of the Securities and Exchange Commission.

(2) The registrant meets the definition of “accelerated filer” (as defined by Rule12b-2 of the Act). However, the registrant notes that the phase-in period for accelerated deadlines of quarterly and annual reports will begin for reports filed by companies that meet the definition of “accelerated filer” as of the end of their first fiscal year ending on or after December 15, 2002. Accordingly, such rules do not currently apply to the registrant.

EXPLANATORY NOTE

We are filing this Amendment No. 1 to our Annual Report on Form 10-K for the fiscal year ended September 30, 2002 as filed with the Securities and Exchange Commission (SEC) on December 30, 2002, to amend certain items. The amendments to the Annual Report on Form 10-K included in the Form 10-K/A are in response to comments received from the Staff of the Division of Corporate Finance of the SEC in connection with their review of Genesis HealthCare Corporation's Form 10 filed with the SEC. Consequently, the Company has determined to revise the accounting for the restructuring of its investment in Multicare as follows:

- The Series H and I Preferred Stock issued in connection with the transaction will be valued at $198.0 million rather than their $420.0 million face value. The Series H and I Preferred Stock was subsequently accreted to the face value when the Company filed for Chapter 11 bankruptcy protection in the third quarter of fiscal 2000; and

- The transaction will be treated as a substantive acquisition of the remaining 56.4% equity of Multicare and accordingly, the Company will account for the transaction as a step acquisition and will not recognize the joint venture partners' 56.4% interest in the equity and losses of Multicare on its balance sheet and statement of operations.

The restatement results in significant changes to several account captions in the Company's fiscal 2001 and 2000 statements of operations, most notably other operating expenses, debt restructuring and reorganization costs, interest expense, income taxes and minority interests. These adjustments will have the net effect of decreasing the net loss attributable to common shareholders for the fiscal year ended September 30, 2000 by $0.5 million from $883.5 million to $883.0 million and the net income attributable to common shareholders for the fiscal year ended September 30, 2001 will decrease by $0.5 million from $247.0 million to $246.5 million.

The adjustments have no effect on the Company's cash flow for the periods presented and do not affect the Company's financial statements for the periods after October 1, 2001 when it emerged from reorganization. The specific items amended are Items 6, 7 and 8 of Part II. This Form 10-K/A does not reflect events occurring after the filing of the original Form 10-K, or modify or update those disclosures in anyway other than as required to reflect the effects of the restatement.

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Cautionary Statements Regarding Forward Looking Statements

As used herein, unless the context otherwise requires, “Genesis,” the “Company,”“we,” “our” or “us” refers to Genesis Health Ventures, Inc. and our subsidiaries.

Statements made in this report, and in our other public filings and releases, which are not historical facts contain “forward-looking” statements (as defined in the Private Securities Litigation Reform Act of 1995) that involve risks and uncertainties and are subject to change at any time. These forward-looking statements may include, but are not limited to:

- &#149 statements contained in “Risk Factors”;
- &#149 certain statements in “Management’s Discussion and Analysis of Financial Condition and Results of Operations,” and our notes to our consolidated financial statements, such as our ability to meet our liquidity needs, scheduled debt and interest payments, and expected future capital expenditure requirements; the expected effects of government regulation on reimbursement for services provided; and our ability to successfully implement our strategic objectives and achieve certain performance improvement initiatives within our pharmacy services segment; the expected financial impact of severance and related costs; the expected reduction in medical supply revenues; the expected receipt of a $22 million breakup fee; the expected costs in fiscal 2003 and the foreseeable future; estimates in our critical accounting policies including, our allowance for doubtful accounts, our anticipated impact of long-lived asset impairments and our ability to provide for loss reserves for self-insured programs; and our ability to maintain restricted investments in marketable securities representing the level of outstanding insurance losses we expect to pay;
- &#149 certain statements contained in “Business” concerning strategy, corporate integrity programs, insurance coverage, environmental matters, government regulations and the Medicare and Medicaid programs, and reimbursement for services provided; and
- &#149 certain statements in “Legal Proceedings” regarding the effects of litigation.

The forward-looking statements involve known and unknown risks, uncertainties and other factors that are, in some cases, beyond our control. You are cautioned that these statements are not guarantees of future performance and that actual results and trends in the future may differ materially.

Factors that could cause actual results to differ materially include, but are not limited to the following, which are discussed more fully in “Risk Factors”:

- &#149 changes in the reimbursement rates or methods of payment from Medicare and Medicaid, or the implementation of other measures to reduce the reimbursement for our services;
- &#149 the expiration of enactments providing for additional governmental funding;
- &#149 changes in pharmacy legislation and payment formulas;
- &#149 the impact of federal and state regulations;
- &#149 changes in payor mix and payment methodologies;
- &#149 further consolidation of managed care organizations and other third party payors;
- &#149 competition in our businesses;
- &#149 an increase in insurance costs and potential liability for losses not covered by, or in excess of, our insurance;
- &#149 competition for qualified staff in the healthcare industry;
- &#149 our ability to control operating costs and generate sufficient cash flow to meet operational and financial requirements;
- &#149 an economic downturn or changes in the laws affecting our business in those markets in which we operate;
- &#149 the impact of our reliance on one pharmacy supplier to provide a significant portion of our pharmacy products;
- &#149 the impact of acquisitions and/or a possible sale or spin-off of our eldercare business;
- &#149 the ability to implement and achieve certain strategic objectives;
- &#149 the difficulty in evaluating certain of our financial information due to a lack of comparability following the emergence from bankruptcy; and
- &#149

acts of God or public authorities, war, civil unrest, terrorism, fire, floods, earthquakes and other matters beyond our control.

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In addition to these factors and any risks and uncertainties specifically identified in the text surrounding forward-looking statements, any statements in this report or the reports and other documents filed by us with the SEC that warn of risks or uncertainties associated with future results, events or circumstances also identify factors that could cause actual results to differ materially from those expressed in or implied by the forward-looking statements.

All subsequent written and oral forward-looking statements attributable to us or any person acting on our behalf are expressly qualified in their entirety by the cautionary statements contained or referred to in this section. We do not undertake any obligation to release publicly any revisions to these forward-looking statements to reflect events or circumstances after the date of this report or to reflect the occurrence of unanticipated events, except as may be required under applicable securities law.

Risk Factors

Changes in the reimbursement rates or methods of payment from Medicare and Medicaid have adversely affected our revenues and operating margins and additional changes in Medicare and Medicaid or the implementation of other measures to reduce the reimbursement for our services may further negatively impact us.

We currently receive over 60% of our revenues from Medicare and Medicaid. The healthcare industry is experiencing a strong trend toward cost containment, as the government seeks to impose lower reimbursement and utilization rates and negotiate reduced payment schedules with providers. These cost containment measures generally have resulted in reduced rates of reimbursement for services that we provide, including skilled nursing facility services, pharmacy services and therapy services.

Legislative and regulatory action have resulted in continuing changes to Medicare and Medicaid reimbursement programs. These changes have negatively affected us, and include the following:

- &#149 the adoption of the Medicare prospective payment system pursuant to the Balanced Budget Act of 1997, as modified by the Medicare Balanced Budget Refinement Act;
- &#149 adoption of the Benefits Improvement Protection Act of 2000; and
- &#149 the repeal of the Boren Amendment federal payment standard for Medicaid payments to nursing facilities.

The changes have limited, and are expected to continue to limit, payment increases under these programs. Also, the timing of payments made under the Medicare and Medicaid programs is subject to regulatory action and governmental budgetary constraints. In recent years, the time period between submission of claims and payment has increased. Further, within the statutory framework of the Medicare and Medicaid programs, there are a substantial number of areas subject to administrative rulings and interpretations that may further affect payments made under those programs. Further, the federal and state governments may reduce the funds available under those programs in the future or require more stringent utilization and quality reviews of eldercare centers or other providers. There can be no assurances that adjustments from Medicare or Medicaid audits will not have a material adverse effect on us.

The Benefits Improvement and Protection Act enactment mandates a phase out of intergovernmental transfer transactions by states whereby states inflate the payments to certain public facilities to increase federal matching funds. This action may reduce federal support for a number of state Medicaid plans. The reduced federal payments may adversely affect aggregate available funds, thereby requiring states to reduce payments to all providers. We operate in several of the states that will experience a contraction of federal matching funds.

With the repeal of the federal payment standards, there can be no assurances that budget constraints or other factors will not cause states to reduce Medicaid reimbursement to nursing facilities and pharmacies or that payments to nursing facilities and pharmacies will be made on a timely basis.

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Additionally, the recent economic downturn may reduce state spending on Medicaid programs. Recent data compiled by the National Conference of State Legislatures indicates that the recent economic downturn has had a detrimental effect on state revenues. Historically, these budget pressures have translated into reductions in state spending. Given that Medicaid outlays are a significant component of state budgets, we expect continuing cost containment pressures on Medicaid outlays for nursing homes and pharmacy services in the states in which we operate.

Effective October 1, 2002, our revenues are adversely affected by expiring Medicare provisions; although Congress may restore a portion of lost Medicare revenues.

A number of provisions of the Balanced Budget Refinement Act and the Benefits Improvement and Protection Act enactments, providing additional funding for Medicare participating skilled nursing facilities, expired on September 30, 2002. The expiration of these provisions is estimated to reduce our Medicare per diems per beneficiary, on average, by $34.

On April 23, 2002, the Centers for Medicare and Medicaid Services issued a press statement announcing that the agency would not proceed with its previously announced changes in the skilled nursing facility case-mix classification system. In its announcement, the Centers for Medicare and Medicaid Services clarified that case-mix refinements would be postponed for a full year. It issued notice of fiscal year 2003 rates in the Federal Register, July 31, 2002. Effective October 1, 2002, rates will be increased by a 2.6% annual market basket adjustment. The Centers for Medicare and Medicaid Services estimates that, even with this upward adjustment, average Medicare rates will be 8.8% lower than the current year because of the reduced payment caused by the expiring statutory add-ons.

We estimate that the “Skilled Nursing Facilities Medicare Cliff,” factoring in the administrative decision not to proceed with changes in the case-mix refinements at this time and without factoring in any additional Congressional action, will expose the skilled nursing facility sector to a 10% reduction. For us, this reduction could have an adverse annual revenue and operating income impact from continuing operations beginning October 1, 2002 of approximately $28 million after taking into consideration the 2.6% annual market basket adjustment.

The Skilled Nursing Facility Medicare Cliff could adversely impact the liquidity of our pharmacy and other service related business customers, resulting in their inability to pay us, or to pay us timely, for our products and services. This factor, coupled with the adverse impact of the Skilled Nursing Facility Medicare Cliff to the liquidity of our eldercare business, could require us to borrow in order to fund our working capital needs, and in turn, cause us to become more highly leveraged.

There may be additional provisions in the Medicare legislation affecting our other businesses. Congress may consider changes affecting pharmacy, rehabilitation therapy, diagnostic services and the payment for services in other health settings. There are two issues in particular that could have measurable negative impact, practitioner fee schedules and caps on Medicare Part B therapies. Absent Congressional action, the formula driven payment structure for calendar year 2003 physician and non-physician fee schedules will be reduced by 4.4%. This reduction affects not only doctors, but also payment for most professional practitioners including licensed rehabilitation professionals. Moreover, absent Congressional action, the moratorium on implementing payment caps on therapy services expires. Medicare Part B therapy services in calendar year 2003 will be subjected to the caps and are expected to reduce our annual revenues and operating income approximately $17 million and $3 million, respectfully.

It is not possible to quantify fully the effect of recent legislation, the interpretation or administration of such legislation or any other governmental initiatives on our business. Accordingly, there can be no assurance that the impact of these changes or any future healthcare legislation will not further adversely affect our business. There can be no assurance that payments under governmental and private third-party payor programs will be timely, will remain at levels comparable to present levels or will, in the future, be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to such programs. Our financial condition and results of operations may be affected by the reimbursement process, which in the healthcare industry is complex and can involve lengthy delays between the time that revenue is recognized and the time that reimbursement amounts are settled.

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Changes in pharmacy legislation and payment formulas could adversely affect our NeighborCare® pharmacy operations.

Pharmacy coverage and cost containment are important policy debates at both the federal and state levels. One of the most contentious issues before the 107th Congress was legislation expanding coverage under Medicare for outpatient pharmaceutical services. In June, 2002 the House of Representatives passed a comprehensive measure that would have expanded coverage administered by pharmacy benefit managers. The Senate deadlocked in its deliberations. Medicare pharmacy coverage was an important issue during the 2002 mid-term Congressional elections and, therefore, it is not unreasonable to expect that the 108th Congress will resume consideration of a benefit expansion. Many of the measures considered during the 107th Congress would include institutional long-term care pharmacy as covered under the definitions of an outpatient Medicare benefit. The measure that passed the House of Representatives included provisions that would shift responsibility for pharmacy coverage for dually eligible Medicare beneficiaries from coverage currently provided under state Medicaid programs to coverage under the new Medicare benefit. If enacted, this approach could significantly alter the administration of and payment for long-term care pharmacy services.

A number of states have enacted or are considering containment initiatives. Many have focused on reducing what the state Medicaid program will pay for drug acquisition costs. Most states have lowered payment to a negative percentage of average wholesale price. Some have attempted to impose more stringent pricing standards. Institutional pharmacies are often paid a dispensing fee over and above the payment for the drug. To the extent that changes in the payment for drugs is not accompanied by an increase in the dispensing fee, margins could erode. Some states have explored efforts to restrict utilization (preferred drug lists, prior-authorization, formularies). A few states have attempted to extend the preferred Medicaid pricing to all Medicare beneficiaries. NeighborCare, our wholly-owned pharmacy business, has joined with other leading multi-state institutional pharmacy companies to form the Alliance for Long Term Care Pharmacy (LTCPA) in an effort to influence the outcomes of both federal and state-specific legislative and regulatory activities. In this collaboration, LTCPA provides leadership to responding to specific issues. Presently, LTCPA has engaged representation in 23 states and Washington, DC. Such efforts are augmented by the government relations specialists of the various companies and by active grassroots efforts of pharmacy professionals. These proactive steps have been successful in an number of instances, but given the budgetary concerns of both federal and state governments, neither LTCPA nor NeighborCare could assure that changes in payment formulas and delivery requirements will not have negative impact going forward.

We conduct business in a heavily regulated industry, and changes in regulations and violations of regulations may result in increased costs or sanctions.

Our business is subject to extensive federal, state and, in some cases, local regulation with respect to, among other things, licensure and certification of eldercare centers and pharmacy operations, controlled substances and health planning in addition to reimbursement. For our eldercare centers, this regulation relates, among other things, to the adequacy of physical plant and equipment, qualifications of personnel, standards of care and operational requirements. For pharmacy and medical supply products and services, this regulation relates, among other things, to operational requirements, documentation, licensure, certification and regulation of controlled substances. Compliance with these regulatory requirements, as interpreted and amended from time to time, can increase operating costs and thereby adversely affect the financial viability of our business. Because these laws are amended from time to time and are subject to interpretation, we cannot predict when and to what extent liability may arise. Failure to comply with current or future regulatory requirements could also result in the imposition of various remedies including (with respect to inpatient care) fines, restrictions on admission, the revocation of licensure, decertification, imposition of temporary management or the closure of a facility or site of service.

We are subject to periodic audits by the Medicare and Medicaid programs, which have various rights and remedies against us if they assert that we have overcharged the programs or failed to comply with program requirements. Rights and remedies available to these programs include repayment of any amounts alleged to be overpayments or in violation of program requirements, or making deductions from future amounts due to us. These programs may also impose fines, criminal penalties or program exclusions. Other third-party payor sources also reserve rights to conduct audits and make monetary adjustments.

In the ordinary course of our business, we receive notices of deficiencies for failure to comply with various regulatory requirements. We review such notices and takes appropriate corrective action. In most cases, we and the reviewing agency will agree upon the measures that will bring the center or service site into compliance with regulatory requirements. In some cases or upon repeat violations, the reviewing agency may take various adverse actions against a provider, including but not limited to:

- &#149 the imposition of fines;
- &#149 suspension of payments for new admissions to the center; and
- &#149 in extreme circumstances, decertification from participation in the Medicare or Medicaid programs and revocation of a center's or service site's license.

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These actions may adversely affect a provider's ability to continue to operate, the ability to provide certain services and/or eligibility to participate in the Medicare or Medicaid programs or to receive payments from other payors. Additionally, actions taken against one center or service site may subject other centers or service sites under common control or ownership to adverse remedies.

We are also subject to federal and state laws that govern financial and other arrangements between healthcare providers. These laws often prohibit certain direct and indirect payments or fee-splitting arrangements between healthcare providers that are designed to encourage the referral of patients to a particular provider for medical products and services. Furthermore, some states restrict certain business relationships between physicians and other providers of healthcare services. Many states prohibit business corporations from providing, or holding themselves out as a provider of, medical care. Possible sanctions for violation of any of these restrictions or prohibitions include loss of licensure or eligibility to participate in reimbursement programs and civil and criminal penalties. These laws vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. From time to time, we have sought guidance as to the interpretation of these laws; however, there can be no assurance that such laws will ultimately be interpreted in a manner consistent with our practices.

In July 1998, the federal government issued a new initiative to promote the quality of care in nursing homes. Following this pronouncement, it has become more difficult for nursing facilities to maintain licensure and certification. We have experienced and expect to continue to experience increased costs in connection with maintaining our licenses and certifications as well as increased enforcement actions.

We face additional federal requirements that mandate major changes in the transmission and retention of health information. The Health Insurance Portability and Accountability Act of 1996 was enacted to ensure, first, that employees can retain and at times transfer their health insurance when they change jobs, and second, to simplify health care administrative processes. This simplification includes expanded protection of the privacy and security of personal medical data and requires the adoption of standards for the exchange of electronic health information. Among the standards that the Secretary of Health and Human Services will adopt pursuant to the Health Insurance Portability and Accountability Act are standards for electronic transactions and code sets, unique identifiers for providers, employers, health plans and individuals, security and electronic signatures, privacy and enforcement. Although the Health Insurance Portability and Accountability Act was intended to ultimately reduce administrative expenses and burdens faced within the healthcare industry, we believe that implementation of this law will result in additional costs. Failure to comply with the Health Insurance Portability and Accountability Act could result in fines and penalties that could have a material adverse effect on us.

The operation of our eldercare centers is subject to federal and state laws prohibiting fraud by healthcare providers, including criminal provisions, which prohibit filing false claims or making false statements to receive payment or certification under Medicaid, or failing to refund overpayments or improper payments. Violation of these criminal provisions is a felony punishable by imprisonment and/or fines. We may be subject to fines and treble damage claims if it violates the civil provisions that prohibit the knowing filing of a false claim or the knowing use of false statements to obtain payment.

State and federal governments are devoting increased attention and resources to anti-fraud initiatives against healthcare providers. The Health Insurance Portability and Accountability Act and the Balanced Budget Act of 1997 expanded the penalties for health care fraud, including broader provisions for the exclusion of providers from the Medicaid program. We have established policies and procedures that we believe are sufficient to ensure that our facilities will operate in substantial compliance with these anti-fraud and abuse requirements. While we believe that our business practices are consistent with Medicaid criteria, those criteria are often vague and subject to change and interpretation. Aggressive anti-fraud actions, however, could have an adverse effect on our financial position, results of operations and cash flows.

We are subject to federal and state laws that impose repackaging, labeling and package insert requirements on pharmacies that repackage drugs for distribution beyond the regular practice of dispensing or selling drugs directly to patients at retail outlets. A drug repackager must register with the Food and Drug Administration, referred to as the "FDA," as a manufacturing establishment and is subject to FDA inspection for compliance with relevant good manufacturing practices. We hold all the required registrations and licenses and believe that we are in compliance with all related regulations. In addition, we believe that we comply with all relevant requirements of the Prescription Drug Marketing Act for the transfer and shipment of pharmaceuticals. Failure to comply with FDA regulations could result in fines and other penalties, including loss of licensure and could have a

material adverse effect on our business.

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State laws and regulations could affect our ability to grow.

Many states in which we operate our business have adopted certificate of need or similar laws that generally require that a state agency approve certain acquisitions and determine that the need for certain bed additions, new services and capital expenditures or other changes exist prior to the acquisition or addition of beds or services, the implementation of other changes or the expenditure of capital. State approvals are generally issued for a specified maximum expenditure and require implementation of the proposal within a specified period of time. Failure to obtain the necessary state approval can result in the inability to provide the service, to operate the centers, to complete the acquisition, addition or other change, and can also result in the imposition of sanctions or adverse action on the center's license and adverse reimbursement action. There can be no assurance that we will be able to obtain certificate of need approval for all future projects requiring such approval.

Possible changes in the case mix of patients as well as payor mix and payment methodologies may significantly affect our profitability.

The sources and amounts of our patient revenues will be determined by a number of factors, including licensed bed capacity and occupancy rates of our centers, the mix of patients and the rates of reimbursement among payors. Likewise, payment for pharmacy and medical supply services, including the institutional pharmacy services of our NeighborCare® pharmacy operations and therapy services provided by our rehabilitation therapy services business, will vary based upon payor and payment methodologies. Changes in the case mix of the patients as well as payor mix among private pay, Medicare and Medicaid will significantly affect our profitability. Particularly, any significant increase in our Medicaid population could have a material adverse effect on our financial position, results of operations and cash flow, especially if states operating these programs continue to limit, or more aggressively seek limits on, reimbursement rates.

Further consolidation of managed care organizations and other third-party payors may adversely affect our profits.

Managed care organizations and other third-party payors have continued to consolidate in order to enhance their ability to influence the delivery of healthcare services. Consequently, the healthcare needs of a large percentage of the United States population are increasingly served by a small number of managed care organizations. These organizations generally enter into service agreements with a limited number of providers for needed services. To the extent that such organizations terminate us as a preferred provider and/or engage our competitors as a preferred or exclusive provider, our business could be materially adversely affected. In addition, private payors, including managed care payors, increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk through prepaid capitation arrangements.

We face intense competition in our business.

The healthcare industry is highly competitive. We compete with a variety of other companies in providing eldercare services, many of which have greater financial and other resources and may be more established in their respective communities than us. Competing companies may offer newer or different centers or services than we do and may thereby attract customers who are either presently customers of our eldercare centers or are otherwise receiving our eldercare services.

The provision of pharmacy services in the long-term care industry is highly competitive. NeighborCare is one of the largest providers of pharmacy services to the long-term care industry in the United States. In the 41 states we sell pharmacy products and services, we compete with multiple local, regional and national institutional pharmacies. Institutional pharmacies compete principally on the basis of quality, cost effectiveness and service level.

We compete in providing other specialty medical services with a variety of different companies. Generally, this competition is national, regional and local in nature. The primary competitive factors in these businesses are similar to those in the inpatient and pharmacy business and include reputation, the cost of services, the quality of clinical services, responsiveness to customer needs, and the ability to provide support in other areas such as third party reimbursement, information management and patient record-keeping.

An increase in insurance costs may adversely affect our operating cash flow, and we may be liable for losses not covered by or in excess of our insurance.

We have experienced an adverse effect on our operating cash flow due to an increase in the cost of certain of our insurance programs. Rising costs of eldercare malpractice litigation, and losses stemming from these malpractice lawsuits and a constriction of insurers have caused many insurance carriers to raise the cost of insurance premiums or refuse to write insurance policies for nursing homes. Also, a tightening of the reinsurance market has affected property, auto and excess liability insurance carriers. Accordingly, the costs of all insurance premiums have increased. These problems are particularly acute in the State of Florida where, because of a greater number and higher amount of claims, general liability and professional liability costs have become increasingly expensive. We own or leases approximately 1,500 skilled nursing beds in the State of Florida, representing six percent of our total owned and leased beds.

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We carry property, workers' compensation insurance, general and professional liability coverage on our behalf and on behalf of our subsidiaries in amounts deemed adequate by management. However, there can be no assurance that any current or future claims will not exceed applicable insurance coverage.

In addition, for certain of our workers' compensation insurance, professional liability coverage and health insurance provided to our employees, we are self-insured. Accordingly, we are liable for payments to be made under those plans. To the extent claims are greater than estimated, they could adversely affect our financial position, results of operations and cash flows.

We could experience significant increases in our operating costs due to intense competition for qualified staff and minimum staffing laws in the healthcare industry.

We and the healthcare industry continue to experience shortages in qualified professional clinical staff, including pharmacists. We compete with other healthcare providers and with non-healthcare providers for both professional and non-professional employees. As the demand for these services continually exceeds the supply of available and qualified staff, we and our competitors have been forced to offer more attractive wage and benefit packages to these professionals and to utilize outside contractors for these services at premium rates. Furthermore, the competitive arena for this shrinking labor market has created high turnover among clinical professional staff as many seek to take advantage of the supply of available positions, each offering new and more attractive wage and benefit packages. In addition to the wage pressures inherent in this environment, the cost of training new employees amid the high turnover rates has caused added pressure on our operating margins. Lastly, increased attention to the quality of care provided in skilled nursing facilities has caused several states to consider minimum staffing laws that could further increase the gap between demand for and supply of qualified individuals and lead to higher labor costs. While we have been able to retain the services of an adequate number of qualified personnel to staff our facilities appropriately and maintain our standards of quality care, there can be no assurance that continued shortages will not in the future affect our ability to attract and maintain an adequate staff of qualified healthcare personnel. A lack of qualified personnel at a facility could result in significant increases in labor costs at such facility or otherwise adversely affect operations at such facility. Any of these developments could adversely affect our operating results or expansion plans.

If we are unable to control operating costs and generate sufficient cash flow to meet operational and financial requirements, including servicing our indebtedness, our business operations may be adversely affected.

Cost containment and lower reimbursement levels by third-party payors, including federal and state governments, have had a significant impact on the healthcare industry as a whole and on our cash flows. Our operating margins continue to be under pressure because of continuing regulatory scrutiny and growth in operating expenses, such as labor costs and insurance premiums. In addition, as a result of competitive pressures, our ability to maintain operating margins through price increases to private patients is limited. Further, in connection with our reorganization, we entered into our senior secured credit facility. If we are unable to service our indebtedness, our business operations will be adversely affected. Therefore, we will have to generate sufficient cash flow to meet operational and financing requirements, which includes servicing our indebtedness. If we are unable to do so, our business operations and revenues may be materially adversely affected.

If we fail to generate significant cash flow to service our debt, we may have to refinance all or a portion of our debt to obtain additional financing.

Our ability to make payments on our existing and future debt and to pay our expenses will depend on our ability to generate cash in the future. Our ability to generate cash is subject to various risks and uncertainties, including those disclosed in this section and prevailing economic, regulatory and other conditions beyond our control. Based on our current level of operations, we believe that our cash flow from operations and other capital resources will be sufficient to meet our liquidity needs for the foreseeable future. However, we cannot assure you that these capital resources will be sufficient to enable us to repay our debt and to pay our expenses. If we do not have enough cash to make these payments, we may be required to refinance all or part of our debt, sell assets, curtail discretionary capital expenditures or borrow more money. We cannot assure you that it will be able to do these things on commercially reasonable terms, if at all. In addition, the terms of our existing or future debt agreements may restrict it from pursuing any of these alternatives.

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The agreements governing our existing debt and preferred stock contain, and future debt may contain, various covenants that limit our discretion in the operation of our business.

The agreements and instruments governing our existing debt contain, and the agreements and instruments governing our future debt may contain, various restrictive covenants that, among other things, require it to comply with or maintain certain financial tests and ratios and restrict our ability to:

- &#149 incur more debt;
- &#149 pay dividends, redeem stock or make other distributions;
- &#149 make certain investments;
- &#149 create liens;
- &#149 enter into transactions with affiliates;
- &#149 make acquisitions;
- &#149 merge or consolidate; and
- &#149 transfer or sell assets.

Our ability to comply with these covenants is subject to various risks and uncertainties. In addition, events beyond our control could affect our ability to comply with and maintain the financial tests and ratios. Any failure by us to comply with and maintain all applicable financial tests and ratios and to comply with all applicable covenants could result in an event of default with respect to, and the acceleration of the maturity of, and the termination of the commitments to make further extension of credit under a substantial portion of our debt. If we were unable to repay debt to our senior lenders, these lenders could proceed against the collateral securing that debt. Even if we are able to comply with all applicable covenants, the restrictions on our ability to operate our business in our sole discretion could harm our business by, among other things, limiting our ability to take advantage of financing, mergers, acquisitions and other corporate opportunities.

The terms of our outstanding preferred stock also contain restrictions on our ability to complete certain types of transactions without the consent of the holders of our preferred stock.

A significant portion of our business is concentrated in certain markets and the recent economic downturn or changes in the laws affecting our business in those markets could have a material adverse effect on our operating results.

We receive approximately 59% of our revenue from operations in Pennsylvania, New Jersey, Massachusetts and Maryland. The economic condition of these markets could affect the ability of our customers and third-party payors to reimburse us for our services through a reduction of disposable household income or the ultimate reduction of the tax base used to generate state funding of their respective Medicaid programs. An economic downturn, or changes in the laws affecting our business in these markets and in surrounding markets, could have a material adverse effect on our financial position, results of operations and cash flows.

Our NeighborCare pharmacy operations purchase a significant portion of our products from one supplier.

Our NeighborCare pharmacy operations obtain approximately 94% of our products from one supplier pursuant to contracts that are terminable by either party on 90 days' notice. If these contracts are terminated, there can be no assurance that NeighborCare's operations would not be disrupted or that NeighborCare could obtain the products at similar cost.

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We may make acquisitions that could subject us to a number of operating risks.

We anticipate that we may make acquisitions of, investments in and strategic alliances with complementary businesses to enable us to add services for our core customer base and for adjacent markets, and to expand each of our businesses geographically. However, implementation of this strategy entails a number of risks, including:

- &#149 inaccurate assessment of undisclosed liabilities;
- &#149 entry into markets in which we may have limited or no experience;
- &#149 diversion of management's attention from our core business;
- difficulties in assimilating the operations of an acquired business or in realizing projected efficiencies and cost savings;
- increase in our indebtedness and a limitation in our ability to access additional capital when needed; and
- obtaining anticipated revenue synergies or cost reductions are also a risk in many acquisitions.

Certain changes may be necessary to integrate the acquired businesses into our operations to assimilate many new employees and to implement reporting, monitoring, compliance and forecasting procedures.

We are exploring strategic business alternatives, including the sale or spin-off of our ElderCare® business.

On October 2, 2002, we announced that we had retained UBS Warburg LLC and Goldman Sachs & Co. to assist us in exploring various strategic business alternatives, including, but not limited to, the potential sale or spin-off of our ElderCare networks of skilled nursing and assisted living centers. There can be no assurance that we will successfully complete any potential sale or spin-off of the ElderCare business or that any such transaction, if completed, will increase shareholder value.

Financial information related to our post-emergence operations is limited, and, therefore, it is difficult to compare post-emergence financial information with that of prior periods.

Since we emerged from bankruptcy on October 2, 2001, there is limited operating and financial data available from which to analyze our operating results and cash flows. As a result of fresh-start reporting, it is difficult to compare information reflecting our results of operations and financial condition after our emergence from bankruptcy to the results of prior periods. See "Selected Financial Data."

Provisions in Pennsylvania law and our corporate charter documents could delay or prevent a change in control.

As a Pennsylvania corporation, we are governed by the Pennsylvania Business Corporation Law of 1988, as amended, referred to as "Pennsylvania corporation law." Pennsylvania corporation law provides that the board of directors of a corporation in discharging its duties, including its response to a potential merger or takeover, may consider the effect of any action upon employees, shareholders, suppliers, customers and creditors of the corporation as well as upon, communities in which offices or other establishments of the corporation are located and all other pertinent factors. In addition, under Pennsylvania corporation law, subject to certain exceptions, a business combination between us and a beneficial owner of more than 20% of our stock may be accomplished only if certain conditions are met.

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Our articles of incorporation contain certain provisions that may affect a person's decision to implement a takeover of us, including the following provisions:

- a classified board of directors beginning at the first shareholder meeting for the election of directors after October 2, 2002, with each director having a three-year term;

- a provision providing that certain business combinations involving us, unless approved by at least 75% of the board of directors, will require the affirmative vote of at least 80% of our voting stock;

- a provision permitting the board of directors to oppose a tender or other offer for our constituents and to consider any pertinent issue in connection with such offer including, but not limited to, the reputation of the offer, the value of the offered securities and any applicable legal or regulatory issues raised by the offer; and

- the authority to issue preferred stock with rights to be designated by the board of directors.

The overall effect of the foregoing provisions may be to deter a future tender offer or other offers to acquire us or our shares. Shareholders might view such an offer to be in their best interest if the offer includes a substantial premium over the market price of the common stock at that time. In addition, these provisions may assist our management in retaining our position and place us in a better position to resist changes that the shareholders may want to make if dissatisfied with the conduct of our business.

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PART I

ITEM 1: BUSINESS

General

Genesis Health Ventures, Inc. was incorporated in May 1985 as a Pennsylvania corporation. As used herein, unless the context otherwise requires, "Genesis," the "Company,""we,""our" or "us" refers to Genesis Health Ventures, In and its subsidiaries.

We are a leading provider of healthcare and support services to the elderly. Our operations are comprised of two primary business segments, pharmacy services and inpatient services. These segments are complemented by an array of other service capabilities. See "Management's Discussion and Analysis of Financial Condition and Results of Operations Certain Transactions and Events Change in Strategic Direction and Objectives."

We provide pharmacy services nationwide through our NeighborCare® integrated pharmacy operation that serves approximately 247,000 institutional beds in long-term care settings. We also operate 31 community-based retail pharmacies.

We provide inpatient services through skilled nursing and assisted living centers primarily located in the eastern United States. We currently own, lease, manage or jointly-own 256 eldercare centers with 31,073 beds, of which 20 centers with 2,291 beds have been identified as either held for sale or discontinued operations. See Management's Discussion and Analysis of Financial Condition and Results of Operations Certain Transactions and Events Assets Held for Sale and Discontinued Operations.

We also provide rehabilitation services, diagnostic services, respiratory services, hospitality services, group purchasing services and healthcare consulting services.

Description of Business

Pharmacy Services

We provide pharmacy services in 41 states through our NeighborCare pharmacy operations. Our NeighborCare pharmacy operations consist of 59 institutional pharmacies (two are jointly-owned) and 22 medical supply and home medical equipment distribution centers (four are jointly-owned). In addition, we operate 31 community-based retail pharmacies (two are jointly-owned) which are located in or near medical centers, hospitals and physician office complexes. The community-based retail pharmacies provide prescription and over-the-counter medications and certain medical supplies as well as personal service and consultation by licensed pharmacists.

The largest sub-segment, institutional pharmacy services, provides prescription and non-prescription pharmaceuticals, infusion therapy, and medical supplies and equipment to eldercare centers operated by us, as well as to independent healthcare providers by contract.

Approximately 83% of NeighborCare revenues in fiscal 2002 consisted of the provision of prescription and non-prescription pharmaceuticals. Approximately 92% of the sales attributable to all pharmacy operations in the twelve months ended September 30, 2002 were generated through external contracts with independent healthcare providers, with the balance attributable to centers owned or leased by us.

We purchase, repackage and dispense prescription and non-prescription medication in accordance with physician orders and deliver such prescriptions to eldercare centers for administration to individual residents by the eldercare center's clinical staff. We offer pharmaceuticals to our customers through a unit dose packaging, dispensing and delivery system, typically in 30-day supplies. We believe a unit dose delivery system improves control over the provision of drugs and reduces errors in drug administration to eldercare residents.

We obtain approximately 94% of our pharmacy products from one supplier pursuant to a contract that is terminable by either party on 90 days notice. We have not experienced any difficulty in obtaining pharmacy products or supplies used in the conduct of our business.

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We also provide pharmacy consulting services including monitoring and reporting on prescription drug therapy and assisting in compliance with applicable state and federal regulations. Federal and state regulations mandate that long-term care facilities improve the quality of patient care by procuring consultant pharmacist services to monitor and report on prescription drug therapy. Our consulting services include:

- review of each resident's drug regimen to assess the appropriateness and efficiency of drug therapies, including a review of medical records, monitoring drug interactions with other drugs or food, monitoring laboratory test results and recommending alternate therapies;
- participation on quality assurance and other committees of our customers;
- monitoring and reporting on facility-wide drug usage;
- development and maintenance of pharmaceutical policy and procedure manuals; and
- assistance with state and federal regulatory compliance as they pertain to patient care.

The following table reflects the payor mix of pharmacy service revenues for the respective years ended September 30:

	2002	2001	2000
Long term care facilities and other	58%	60%	62%
Medicaid	40	37	35
Medicare	2	3	3
Total	100%	100%	100%

See "Revenue Sources" and "Government Regulation".

Inpatient Services

We own, lease, manage or jointly-own 256 eldercare centers having 31,073 beds, including 33 stand-alone assisted living facilities and 19 transitional care units, located in 15 states, and concentrated in five geographic regions: New England Region (Massachusetts / Connecticut / New Hampshire / Vermont / Rhode Island); Midatlantic Region (Greater Philadelphia / Delaware Valley / New Jersey); Chesapeake Region (Southern Delaware / Eastern Shore of Maryland / Baltimore, Maryland / Washington D.C. / Virginia); Southern Region (Central Florida); and Allegheny / Midwest Region (West Virginia / Western Pennsylvania / Illinois / Wisconsin). We also are affiliated with 25 "member centers" having 4,416 beds that, for a fee, have access to many of the resources and capabilities of our eldercare network. See "Management's Discussion and Analysis of Financial Condition and Results of Operations - Certain Transactions and Events - Change in Strategic Direction and Objectives."

Our eldercare services focus on the central medical and physical issues facing the more medically demanding elderly. By integrating the talents of physicians with case management, comprehensive discharge planning and, where necessary, home support services, we believe we provide cost-effective care management to achieve superior outcomes and return customers to the community. We believe that our orientation toward achieving improved customer outcomes through our eldercare networks has resulted in increased utilization of specialty medical services, high occupancy of available beds, enhanced quality payor mix and a broader base of repeat customers.

Our skilled nursing centers offer three levels of care for our customers: skilled, intermediate and personal. Skilled care provides 24-hour per day professional services of a registered nurse; intermediate care provides less intensive nursing care; and personal care provides for the needs of customers requiring minimal supervision and assistance. Each eldercare center is supervised by a licensed healthcare administrator and engages the services of a medical director to supervise the delivery of healthcare services to residents and a director of nursing to

supervise the nursing staff. We maintain a corporate quality assurance program to monitor regulatory compliance and to enhance the standard of care provided in each center.

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We have established and actively market programs for elderly and other customers who require subacute levels of medical care. These programs include ventilator care, intravenous therapy, post-surgical recovery, respiratory management, orthopedic or neurological rehabilitation, terminal care and various forms of coma, pain and wound management. Private insurance companies and other third party payors, including certain state Medicaid programs, have recognized that treating customers requiring subacute medical care in centers such as those we operate is a cost-effective alternative to treatment in an acute care hospital. We provide subacute care at rates that we believe are substantially below the rates typically charged by acute care hospitals for comparable services.

The following table sets forth information regarding our average number of beds in service and the average occupancy levels at our eldercare centers for the respective years ended September 30:

	2002	2001	2000
Average Beds in Service: (1) (2)			
Owned and Leased Facilities	24,139	24,783	14,286
Managed and Jointly-Owned Facilities	7,898	9,215	23,779
Occupancy Based on Average Beds in Service:			
Owned and Leased Facilities	91%	91%	91%
Managed and Jointly-Owned Facilities	91%	88%	91%

(1) In connection with the consummation of our joint plan of reorganization, 10,702 Multicare beds classified as “Managed and Jointly-Owned Facilities” prior to 2001 were reclassified as “Owned and Leased Facilities.” See “ Reorganization.”

(2) Includes 2,291 owned and leased beds, principally located in the states of Wisconsin and Illinois, which have been identified as either held for sale or discontinued operations.

The following table reflects the payor mix of inpatient service revenues for the respective years ended September 30:

	2002	2001	2000
Medicaid	48%	48%	49%
Medicare	30	28	25
Private pay and other	22	24	26
Total	100%	100%	100%

See “Revenue Sources” and “Government Regulation”.

Other Service-Related Businesses

Rehabilitation Therapy. We provide an extensive range of rehabilitation therapy services, including speech pathology, physical therapy and occupational therapy in all five of our eldercare regional market concentrations. These services are provided by approximately 3,500 licensed rehabilitation therapists and assistants employed or contracted by us at substantially all of the eldercare centers we operate, as well as by contract to healthcare facilities operated by others and through any one of our 15 certified rehabilitation agencies.

Management Services. We provide management services to 69 eldercare centers and transitional care units, which are the eldercare centers jointly-owned and / or managed referred to in Inpatient Services above, pursuant to management agreements that provide generally for the day-to-day responsibility for the operation and management of the centers. In turn, we receive management fees, depending on the agreement, computed as

either an overall fixed fee, a fixed fee per customer, a percentage of net revenues of the center plus an incentive fee, or a percentage of gross revenues of the center with some incentive clauses. The various management agreements, including renewal option periods, are scheduled to terminate between 2003 and 2011.

Tidewater Group Purchasing. We own and operate The Tidewater Healthcare Shared Services Group, Inc., one of the largest long-term care group purchasing companies in the country. We have negotiated contracts with 78 national and 175 regional vendors. Tidewater provides purchasing and shared service programs specially designed to meet the needs of eldercare centers and other long-term care facilities. Tidewater's services are contracted to approximately 4,000 members with over 400,000 beds in 46 states and the District of Columbia.

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Other Services. We employ 68 physicians, physician assistants and nurse practitioners that are primarily involved in designing and administering clinical programs and directing patient care. We also provide an array of other specialty medical services in certain parts of our eldercare network, including portable x-ray and other diagnostic services; home healthcare services; consulting services; respiratory health services and hospitality services such as dietary, housekeeping, laundry, plant operations and facilities management services.

We are exploring strategic business alternatives, including the sale or spin-off of our eldercare assets. See "Management's Discussion and Analysis of Financial Condition and Results of Operations - Certain Transactions and Events - Change in Strategic Direction and Objectives."

The following table sets forth the amount of our total net revenue from continuing operations contributed by our business segments and other businesses after the elimination of intercompany revenues for the fiscal periods presented (in thousands):

	2002	2001	2000
Inpatient services	$ 1,330,993	$ 1,255,525	$ 1,227,250
Pharmacy services	1,123,854	1,036,245	949,829
Other revenue	168,832	160,401	150,548
	$ 2,623,679	$ 2,452,171	$ 2,327,627

See note 23 to our consolidated financial statements -"Segment Information" and "Management's Discussion and Analysis of Financial Condition and Results of Operations - Results of Operations" for additional disclosure of financial information regarding our segments. Also, see "Management's Discussion and Analysis of Financial Condition and Results of Operations - General" for a discussion of our reportable segments and our other businesses. Also, see "Management's Discussion and Analysis of Financial Condition and Results of Operations - Seasonality", for a description of the seasonality of our business.

Revenue Sources

We receive revenues from Medicare, Medicaid, private insurance, self-pay residents, other third party payors and long term care facilities that utilize our pharmacy and other service related businesses. The healthcare industry is experiencing the effects of the trend toward cost containment as federal and state governments and other third party payors seek to impose lower reimbursement and utilization rates and negotiate reduced payment schedules with providers. These cost containment measures, combined with the increasing influence of managed care payors and competition for patients, generally have resulted in reduced rates of reimbursement for services provided by us.

The sources and amounts of our patient revenues will be determined by a number of factors, including licensed bed capacity and occupancy rates of our centers, the mix of patients and the rates of reimbursement among payors. Likewise, payment for ancillary medical services, including the institutional pharmacy services of NeighborCare and therapy services provided by our rehabilitation therapy services business, will vary based upon payor and payment methodologies. Changes in the case mix of the patients as well as payor mix among private pay, Medicare, and Medicaid will significantly affect our profitability.

Medicare and Medicaid. The Health Insurance for Aged and Disabled Act (Title XVIII of the Social Security Act), known as "Medicare," has made available to nearly every United States citizen 65 years of age and older a broad program of health insurance designed to help the nation's elderly meet hospital and other health care costs. Health insurance coverage has been extended to certain persons under the age of 65 qualifying as disabled and those having end-stage renal disease. Medicare includes three related health insurance programs: (i) hospital insurance referred to as Medicare Part A; (ii) supplementary medical insurance, referred to as Medicare Part B; and (iii) a managed care option for beneficiaries who are entitled to Medicare Part A and enrolled in Medicare Part B, referred to as Medicare+Choice or Medicare Part C. The Medicare program is currently administered by fiscal intermediaries (for Medicare Part A and s ome Medicare Part B services) and carriers (for Medicare Part B) under the direction of the Centers for Medicare and Medicaid Services a division of the Department of Health and

Human Services.

Medicaid (Title XIX of the Social Security Act) is a federal□state matching program, whereby the federal government, under a needs based formula, matches funds provided by the participating states for medical assistance to "medically indigent" persons. The programs are administered by the applicable state welfare or social service agencies under federal rules. Although Medicaid programs vary from state to state, traditionally they have provided for the payment of certain expenses, up to established limits, at rates determined in accordance with each state’s regulations. For skilled nursing centers, most states pay prospective rates, and have some form of acuity adjustment. In addition to facility based services, most states cover an array of medical ancillary services, including those services provided by institutional pharmacies. Payment methodologies for these services vary based upon state preferences and practices permitted under federal rules.

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Medicare and Medicaid are subject to statutory and regulatory changes, retroactive rate adjustments, administrative rulings and government funding restrictions, all of which may materially affect the timing and/or levels of payments to us for our services.

We are subject to periodic audits by the Medicare and Medicaid programs, which have various rights and remedies against us if they assert that we have overcharged the programs or failed to comply with program requirements. These rights and remedies may include requiring the repayment of any amounts alleged to be overpayments or in violation of program requirements, or making deductions from future amounts due to us. Such programs may also impose fines, criminal penalties or program exclusions. Other third party payor sources also reserve rights to conduct audits and make monetary adjustments.

Laws Affecting Revenues. Congress has enacted three major laws during the past six years that have significantly altered payment for nursing home and medical ancillary services. The Balanced Budget Act of 1997, signed into law on August 5, 1997, reduced federal spending on Medicare and Medicaid programs. The Medicare Balanced Budget Refinement Act, enacted in November 1999 addressed a number of the funding difficulties caused by the Balanced Budget Act of 1997. The Benefits Improvement and Protection Act of 2000, was enacted on December 15, 2000, further modifying the law and restoring additional funding. The following provides a brief summary of these laws and an overview of the impact of these enactments on us.

Under the Balanced Budget Act of 1997, participating skilled nursing facilities are reimbursed under a prospective payment system for inpatient Medicare covered services. We often refer to the prospective payment system as PPS. The PPS commenced with a facility's first cost reporting period beginning on or after July 1, 1998. Under PPS, nursing facilities are paid a predetermined amount per patient, per day (“per diem”) based on the anticipated costs of treating patients. The per diem rate is determined by classifying each patient into one of forty-four resource utilization groups using the information gathered as a result of each patient's minimum data set assessment. We often refer to a resource utilization group as a RUG. There is a separate per diem rate for each of the RUG classifications. The per diem rate also covers rehabilitation and non-rehabilitation ancillary services. The law phased in PPS over a three-year period.

As implemented by the Centers for Medicare and Medicaid Services, the PPS has had an adverse impact on the Medicare revenues of many skilled nursing facilities. There have been three primary problems. First, the base year calculations understate costs. Second, the market basket index used to trend payments forward does not adequately reflect market experience. Third, the RUG case mix allocation is not adequately predictive of the costs of care for patients, and does not equitably allocate funding, especially for non-therapy ancillary services.

In November 1999, the Balanced Budget Refinement Act was passed in Congress. This enactment provided relief for certain reductions in Medicare reimbursement caused by the Balanced Budget Act of 1997. For covered skilled nursing facility services furnished on or after April 1, 2000, the federal per diem rate was increased by 20% for 15 RUG payment categories. While this provision was initially expected to adjust payment rates for only six months, the Centers for Medicare and Medicaid Services withdrew proposed RUG refinement rules. These payment add-ons will continue until the Centers for Medicare and Medicaid Services completes certain mandated recalculations of current RUG weightings. On April 23, 2002, the Centers for Medicare and Medicaid Services issued a press statement announcing that the agency would not proceed with its previously announced changes in the skilled nursing facility case-mix classification system. In its announcement, the Cente rs for Medicare and Medicaid Services clarified that case-mix refinements would be postponed for a full year (through our fiscal year 2003).

For fiscal years 2001 and 2002, the Balanced Budget Refinement Act mandated the federal per diem rates for all RUG categories be increased by an additional 4% over the required market basket adjustment. The law provided that certain specific services (such as prostheses and chemotherapy drugs) would be reimbursed separately from and in addition to the federal per diem rate. A provision was included that provided for cost report years beginning on or after January 1, 2000, skilled nursing facilities could waive the PPS transition period and elect to receive 100% of the federal per diem rate. The enactment also lifted for two years a $1,500 cap on rehabilitation therapy services provided under Medicare Part B.

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On December 15, 2000, Congress passed the Benefits Improvement and Protection Act that increased the nursing component of federal PPS rates by 16.7% for the period from April 1, 2001 through September 30, 2002. The legislation also changed the 20% add-on to 3 of the 14 rehabilitation RUG categories to a 6.7% add-on to all 14 rehabilitation RUG categories beginning April 1, 2001. The Medicare Part B consolidated billing provision of the Balanced Budget Refinement Act was repealed except for Medicare Part B therapy services and the moratorium on the $1,500 therapy caps which was extended through calendar year 2002. These changes have had a positive impact on operating results.

A number of provisions of the Balanced Budget Refinement Act and the Benefits Improvement and Protection Act enactments which provided additional funding for Medicare participating skilled nursing facilities expired on September 30, 2002. The expiration of these provisions has reduced our Medicare per diems per beneficiary, on average, by $34.

The Centers for Medicare and Medicaid Services issued notice of fiscal year 2003 rates for the skilled nursing facilities PPS in the Federal Register, July 31, 2002. Effective October 1, 2002, rates will be increased by a 2.6% annual market basket adjustment. The Centers for Medicare and Medicaid Services estimate that, even with this upward adjustment, average Medicare rates will be 8.8% lower than the current year because of the reduced payment caused by the expiring statutory add-ons.

We estimate that the “Skilled Nursing Facilities Medicare Cliff,” factoring in the administrative decision not to proceed with changes in the case-mix refinements at this time and without factoring in any additional Congressional action, will expose the skilled nursing facility sector to a 10% reduction. For us, this reduction could have an adverse annual revenue and operating income impact from continuing operations beginning October 1, 2002 of approximately $28 million after taking into consideration the 2.6% annual market basket adjustment.

The Skilled Nursing Facility Medicare Cliff could adversely impact the liquidity of our pharmacy and other service related business customers, resulting in their inability to pay us, or to pay us timely, for our products and services. This factor, coupled with the adverse impact of the Skilled Nursing Facility Medicare Cliff to the liquidity of our eldercare business, could require us to borrow in order to fund our working capital needs, and in turn, cause us to become more highly leveraged.

There may be additional provisions in the Medicare legislation affecting our other businesses. Congress may consider changes affecting pharmacy, rehabilitation therapy, diagnostic services and the payment for services in other health settings. There are two issues in particular that could have measurable negative impact, practitioner fee schedules and caps on Medicare Part B therapies. Absent Congressional action, the formula driven payment structure for calendar year 2003 physician and non-physician fee schedules will be reduced by 4.4%. This reduction affects not only doctors, but also payment for most professional practitioners including licensed rehabilitation professionals. Moreover, absent Congressional action, the moratorium on implementing payment caps on therapy services expires. Medicare Part B therapy services in calendar year 2003 will be subjected to the caps and are expected to reduce our annual revenues and operating income approximately $17 million and $3 million, respectfully.

The prospects for legislative relief are uncertain. The 107th Congress adjourned without resolving Medicare provider issues. The 108th Congress begins January 7, 2003. During the 107th Congress, the House of Representatives passed a package of Medicare amendments (late June 2002). Under the House-passed measure, portions of the expiring provisions would be retained. The Balanced Budget Refinement Act increase of 4% would expire, and the 16.6% add-on of the Benefits Improvement and Protection Act to the nursing portion of the skilled nursing facility PPS rates would be reduced to 12% in 2003, 10% in 2004, and 8% in 2005. Under this proposal, fiscal year 2003 rates would be 5.2% lower than those of the current year. Several attempts were made to secure Senate consideration of a slightly more favorable package of legislative amendments. Prospects for expeditious action by the incoming Congress are uncertain.

It is not possible to quantify fully the effect of potential legislative changes, the interpretation or administration of such legislation or any other governmental initiatives on our business. Accordingly, there can be no assurance that the impact of these changes or any future healthcare legislation will not further adversely affect our business. There can be no assurance that payments under governmental and private third-party payor programs will be timely, will remain at levels comparable to present levels or will, in the future, be sufficient to cover the

costs allocable to patients eligible for reimbursement pursuant to such programs. Our financial condition and results of operations may be affected by the reimbursement process, which in the healthcare industry is complex and can involve lengthy delays between the time that revenue is recognized and the time that reimbursement amounts are settled.

Our average Medicare rate per patient day in fiscal 1997, prior to the implementation of the PPS, was over $400. In Fiscal 1998, 1999, 2000, 2001 and 2002, the average Medicare rate per patient day was $390, $302, $294, $323 and $336, respectively.

The Balance Budget Act of 1997 contains provisions that have affected amounts paid to our NeighborCare pharmacy operations for pharmacy and medical supply products and services. Reimbursement for certain products covered under Medicare Part B is limited to 95% of the "average wholesale price." The move to PPS under the Balance Budget Act of 1997 has made pricing a more important consideration in the selection of pharmacy providers. Also, Congress included provisions in the Balance Budget Act of 1997 that would require nursing facilities to submit all claims for Medicare covered services that their residents receive, both Medicare Part A and Medicare Part B, even if such services are provided by outside suppliers, including but not limited to pharmacy and rehabilitation therapy providers, except for certain excluded services. The Benefits Improvement and Protection Act, enacted in December 2000, repealed this provision, except for therapy services.

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The Balance Budget Act of 1997 included several provisions affecting Medicaid. The Balance Budget Act of 1997 repealed the "Boren Amendment" federal payment standard for Medicaid payments to nursing facilities effective October 1, 1997. The Boren Amendment required that Medicaid payments to certain healthcare providers be reasonable and adequate in order to cover the costs of efficiently and economically operated healthcare facilities. Under the Balance Budget Act of 1997, states must now use a public notice and comment period in order to determine rates and provide interested parties a reasonable opportunity to comment on proposed rates and the justification for and the methodology used in calculating such rates. With the repeal of the federal payment standards**,** there can be no assurances that budget constraints or other factors will not cause states to reduce Medicaid reimbursement to nursing facilities and pharmacies or that payments to nursing facili ties and pharmacies will be made on a timely basis. The Balance Budget Act of 1997 also grants greater flexibility to states to establish Medicaid managed care projects without the need to obtain a federal waiver. Although these projects generally exempt institutional care, including nursing facilities and institutional pharmacy services, no assurances can be given that these projects ultimately will not change the reimbursement methodology for nursing facility services or institutional pharmacy services from fee‑for‑service to managed care negotiated or capitated rates. We anticipate that federal and state governments will continue to review and assess alternative health care delivery systems and payment methodologies.

The Benefits Improvement and Protection Act enacted a phase out of intergovernmental transfer transactions by states whereby states artificially inflate the payments to certain public facilities to increase federal matching funds. This action may reduce federal support for a number of state Medicaid plans. The reduced federal payments may impact aggregate available funds requiring states to further contain payments to providers. We operate in several of the states that will experience a contraction of federal matching funds.

There are numerous reports affirming that the recent economic downturn has had a detrimental affect on state revenues. Historically these budget pressures have translated into reductions in state spending. Given that Medicaid outlays are a significant component of state budgets, we expect continuing cost containment pressures on Medicaid outlays for nursing homes and pharmacy services in the states in which we operate.

The reimbursement rates for pharmacy services under Medicaid are determined on a state‑by‑state basis subject to review by the Centers for Medicare and Medicaid Services and applicable federal law. In most states, pharmacy services are priced at the lower of "usual and customary" charges or cost (which generally is defined as a function of average wholesale price and may include a profit percentage) plus a dispensing fee. Certain states have "lowest charge legislation" or "most favored nation provisions" which require our institutional pharmacy and medical supply operation to charge Medicaid no more than its lowest charge to other consumers in the state. Since 2000, federal Medicaid requirements establishing payment caps on certain drugs have been periodically revised. NeighborCare has participated in the efforts to review and interact with the Centers for Medicare and Medicaid Services on the revisions. This proactive involvement has helped in modifyi ng the rate structures and thereby minimizing the impact of the new rules on NeighborCare’s operations.

Pharmacy coverage and cost containment are important policy debates at both the federal and state levels. One of the most contentious issues before the 107th Congress was legislation expanding coverage under Medicare for outpatient pharmaceutical services. In June, 2002 the House of Representatives passed a comprehensive measure that would have expanded coverage administered by pharmacy benefit managers. The Senate deadlocked in its deliberations. Medicare pharmacy coverage was an important issue during the 2002 mid‑term Congressional elections and, therefore, it is not unreasonable to expect that the 108th Congress will resume consideration of a benefit expansion. Many of the measures considered during the 107th Congress would include institutional long‑term care pharmacy as covered under the definitions of an outpatient Medicare benefit. The measure that passed the House of Representatives included provisions that would shift responsibility for pharmacy coverage for dually eligible Medicare beneficiaries from coverage currently provided under state Medicaid programs to coverage under the new Medicare benefit. If enacted, this approach could significantly alter the administration of and payment for long‑term care pharmacy services.

A number of states have enacted or are considering containment initiatives. Many have focused on reducing what the state Medicaid program will pay for drug acquisition costs. Most states have lowered payment to a negative percentage of average wholesale price. Some have attempted to impose more stringent pricing standards. Institutional pharmacies are often paid a dispensing fee over and above the payment for the drug. To the extent that changes in the payment for drugs are not accompanied by an increase in the dispensing fee, margins could erode. Some states have explored efforts to restrict utilization (preferred drug lists, prior‑authorization, formularies). A few states have attempted to extend the preferred Medicaid pricing to all Medicare beneficiaries.

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NeighborCare has joined with other leading multi-state institutional pharmacy companies to form the Alliance for Long Term Care Pharmacy (LTCPA) in an effort to influence the outcomes of both federal and state-specific legislative and regulatory activities. In this collaboration, LTCPA provides leadership to responding to specific issues. Presently, LTCPA has engaged representation in 23 states and Washington, DC. Such efforts are augmented by the government relations specialists of the various companies and by active grassroots efforts of pharmacy professionals. These proactive steps have been successful in an number of instances, but given the budgetary concerns of both federal and state governments. There can be no assurance that changes in payment formulas and delivery requirements will not have a negative impact going forward.

Federal and state governments continue to focus on efforts to curb spending on health care programs such as Medicare and Medicaid. Such efforts have not been limited to skilled nursing facilities and pharmacy services, but have and will most likely include other services provided by us, including therapy services. We cannot at this time predict the extent to which these proposals will be adopted or, if adopted and implemented, what effect, if any, such proposals will have on us. Efforts to impose reduced allowances, greater discounts and more stringent cost controls by government and other payors are expected to continue.

Government Regulation

Our business is subject to extensive federal, state and, in some cases, local regulation with respect to, among other things, licensure, certification and health planning. For our eldercare centers, this regulation relates, among other things, to the adequacy of physical plant and equipment, qualifications of personnel, standards of care and operational requirements. For pharmacy and medical supply products and services, this regulation relates, among other things, to operational requirements, reimbursement, documentation, licensure, certification and regulation of controlled substances. Compliance with such regulatory requirements, as interpreted and amended from time to time, can increase operating costs and thereby adversely affect the financial viability of our business. Failure to comply with current or future regulatory requirements could also result in the imposition of various remedies including fines, restrictions on admission, the revocation of licensu re, decertification, imposition of temporary management or the closure of the facility.

All of our eldercare centers and healthcare services, to the extent required, are licensed under applicable law. All skilled nursing centers and healthcare services, or practitioners providing the services therein, are certified or approved as providers under one or more of the Medicaid and Medicare programs. Generally, assisted living centers are not eligible to be certified under Medicare or Medicaid. Licensing, certification and other applicable standards vary from jurisdiction to jurisdiction and are revised periodically. State and local agencies survey all skilled nursing centers on a regular basis to determine whether such centers are in compliance with governmental operating and health standards and conditions for participation in government sponsored third party payor programs. We believe that our eldercare centers and other sites of service are in substantial compliance with the various Medicare, Medicaid and state regulatory requirements applicable to them. However, in the ordinary course of our business, we receive notices of deficiencies for failure to comply with various regulatory requirements. We review such notices and take appropriate corrective action. In most cases, we and the reviewing agency will agree upon the measures to be taken to bring the center into compliance with regulatory requirements. In some cases, the reviewing agency may take various adverse actions against a provider, including but not limited to:

- the imposition of fines;
- suspension of payments for all or new admissions to the center; and
- in extreme circumstances, decertification from participation in the Medicare or Medicaid programs and revocation of a center’s or site of service’s license.

These actions may adversely affect a center’s ability to continue to operate, ability to provide certain services, and/or eligibility to participate in the Medicare or Medicaid programs or to receive payments from other payors. Certain of our centers have received notices in the past from state and federal agencies that, as a result of certain alleged deficiencies, the agency was taking steps to decertify the centers from participation in Medicare and Medicaid programs.

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All of our owned and leased skilled nursing centers are currently certified to receive benefits provided under Medicare. Additionally, all of our skilled nursing centers are currently certified to receive benefits under Medicaid. Both initial and continuing qualifications of a skilled nursing center to participate in such programs depend upon many factors including accommodations, equipment, services, patient care, safety, personnel, physical environment, and adequate policies, procedures and controls.

During 2002, the Centers for Medicare and Medicaid Services piloted a new nursing home quality initiative in six states. Our facilities cooperated in these initiatives to generate improved reporting and public awareness. Based on the success of the pilot program the Centers for Medicare and Medicaid Services has announced its intention to roll out the program nationwide within the coming few months. In addition to the changes being driven by public agencies, a number of nursing home companies in conjunction with several national trade associations have signed a quality covenant. This covenant establishes quality benchmarks the signing companies are striving to obtain.

Many states in which we operate have adopted certificate of need or similar laws which generally require that a state agency approve certain acquisitions and determine that the need for certain bed additions, new services, and capital expenditures or other changes exist prior to the acquisition or addition of beds or services, the implementation of other changes, or the expenditure of capital. State approvals are generally issued for a specified maximum expenditure and require implementation of the proposal within a specified period of time. Failure to obtain the necessary state approval can result in:

- the inability to provide the service;
- the inability to operate the centers;
- the inability to complete the acquisition, addition or other change; and
- the imposition of sanctions or adverse action on the center's license and adverse reimbursement action.

During recent years several states have passed legislation altering their certificate of need requirements. Virginia is expected to phase out its certificate of need requirement, and Maryland is studying a similar action. These changes are not expected to materially alter our business opportunities.

We are also subject to federal and state laws that govern financial and other arrangements between healthcare providers. These laws often prohibit certain direct and indirect payments or fee-splitting arrangements between healthcare providers that are designed to induce or encourage the referral of patients to, or the recommendation of, a particular provider for medical products and services. These laws include:

- the “anti-kickback” provisions of the federal Medicare and Medicaid programs, which prohibit, among other things, knowingly and willfully soliciting, receiving, offering or paying any remuneration (including any kickback, bribe or rebate) directly or indirectly in return for or to induce the referral of an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under Medicare or Medicaid; and
- the “Stark laws” which prohibit, with limited exceptions, the referral of patients by physicians for certain services, including home health services, physical therapy and occupational therapy, to an entity in which the physician has a financial interest.

In addition, some states restrict certain business relationships between physicians and other providers of healthcare services. Many states prohibit business corporations from providing, or holding themselves out as a provider of medical care. Possible sanctions for violation of any of these restrictions or prohibitions include loss of licensure or eligibility to participate in reimbursement programs and civil and criminal penalties. These laws vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies. From time to time, we have sought guidance as to the interpretation of these laws, however, there can be no assurance that such laws will ultimately be interpreted in a manner consistent with our practices.

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There have also been a number of recent federal and state legislative and regulatory initiatives concerning reimbursement under the Medicare and Medicaid programs. During the past few years, the Department of Health and Human Services has issued a series of voluntary compliance guidelines. These compliance guidelines provide guidance on acceptable practices. Skilled nursing facility services and durable medical equipment, prosthetics, orthotics, supplies, and supplier performance practices have been among the services addressed in these publications. Our Corporate Integrity Program is working to assure that our practices conform. The Department of Health and Human Services also issues fraud alerts and advisory opinions. Directives concerning double billing, home health services and the provision of medical supplies to nursing facilities have been released. It is anticipated that areas addressed by these advisories may come under closer scrutiny by the government. While we have focused our internal compliance reviews to assure our practices conform with government instructions, we cannot accurately predict the impact of any such initiatives. See “Cautionary Statements Regarding Forward Looking Statements” and “ Revenue Sources.”

We face additional federal requirements that mandate major changes in the transmission and retention of health information. The Health Insurance Portability and Accountability Act of 1996 was enacted to ensure, first, that employees can retain and at times transfer their health insurance when they change jobs, and secondly, to simplify health care administrative processes. This simplification includes expanded protection of the privacy and security of personal medical data and requires the adoption of standards for the exchange of electronic health information. Among the standards that the Department of Health and Human Services may adopt pursuant to the Health Insurance Portability and Accountability Act are standards for the following: electronic transactions and code sets; unique identifiers for providers, employers, health plans and individuals; security and electronic signatures; privacy; and enforcement.

Although the Health Insurance Portability and Accountability Act was intended to ultimately reduce administrative expenses and burdens faced within the healthcare industry, we believe that implementation of this law will result in additional costs. We have established a Health Insurance Portability and Accountability Act task force consisting of clinical, financial and information services professionals focused on the Health Insurance Portability and Accountability Act compliance.

The Department of Health and Human Services has released two rules to date mandating the use of new standards with respect to certain health care transactions and health information. The first rule establishes uniform standards for common health care transactions, including:

- health care claims information;
- plan eligibility, referral certification and authorization;
- claims status;
- plan enrollment and disenrollment;
- payment and remittance advice;
- plan premium payments; and
- coordination of benefits.

Second, the Department of Health and Human Services has released standards relating to the privacy of individually identifiable health information. These standards not only require our compliance with rules governing the use and disclosure of protected health information, but they also require us to impose those rules, by contract, on any business associate to whom we disclose information. The Department of Health and Human Services has proposed rules governing the security of health information, but has not yet issued these rules in final form.

The Department of Health and Human Services finalized the transaction standards on August 17, 2000. While we initially were required to comply with them by October 16, 2002, Congress passed legislation in December 2001

that delays for one year (until October 16, 2003) the compliance date, but only for entities that submit a compliance plan to the Department of Health and Human Services by the original implementation deadline. The Department of Health and Human Services issued the privacy standards on December 28, 2000, and, after certain delays, they became effective on April 14, 2001, with a compliance date of April 14, 2003. Once the Department of Health and Human Services has issued the security regulations in final form, affected parties will have approximately two years to be fully compliant. Sanctions for failing to comply with the Health Insurance Portability and Accountability Act health information practices provisions include criminal penalties and civil sanctions.

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Management is in the process of evaluating the effect of Health Insurance Portability and Accountability Act on us. At this time, management anticipates that we will be able to fully comply with those Health Insurance Portability and Accountability Act requirements that have been adopted. However, management cannot at this time estimate the cost of compliance, nor can management estimate the cost of compliance with standards that have not yet been finalized by the Department of Health and Human Services.

It is not possible to fully quantify the effect of recent legislation, the interpretation or administration of such legislation or any other governmental initiatives on our business. Accordingly, there can be no assurance that the impact of these changes or any future healthcare legislation will not adversely affect our business. There can be no assurance that payments under governmental and private third party payor programs will be timely, will remain at levels comparable to present levels or will, in the future, be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to such programs. Our financial condition and results of operations may be affected by the reimbursement process, which in our industry is complex and can involve lengthy delays between the time that revenue is recognized and the time that reimbursement amounts are settled.

Marketing

Marketing for eldercare centers is focused at the local level and is conducted primarily by a dedicated regional marketing staff, who call on referral sources such as hospitals, hospital discharge planners, doctors, churches and various community organizations. In addition to those efforts, our marketing objective is to maintain public awareness of our eldercare centers and their capabilities. We take advantage of our regional concentrations in our marketing efforts, where appropriate, through consolidated marketing programs, which benefit more than one center. Toll-free regional phone lines assist the marketing staff and direct referral sources, which speeds admissions by automated tracking of bed availability and specialty care capabilities for each of our centers and all of our affiliated centers.

We market specialty medical services to independent healthcare providers, in addition to providing such services to our owned, leased, managed and affiliated eldercare centers. We market our institutional pharmacy services, rehabilitation therapy services, group purchasing, respiratory therapy, diagnostic services and consulting services through a direct sales force which primarily calls on eldercare centers, hospitals, clinics and home health agencies.

In addition, a corporate marketing department supports the eldercare centers and service companies in developing promotional materials and literature focusing on our philosophy of care, services provided and quality clinical standards as well as providing industry research. See “Government Regulation” for a discussion of the federal and state laws which limit financial and other arrangements between healthcare providers.

We operate our core business under the names Genesis ElderCareand NeighborCare. Our logos, trademarks and service marks are featured in print advertisements in publications serving the regional markets in which we operate. Our marketing is aimed at increasing awareness among decision makers in key professional and business audiences. We are using advertising, including our toll free Genesis ElderCare lines, to promote our brand names in trade, professional and business publications and to promote services directly to consumers.

Personnel

At September 30, 2002, we employed over 44,000 people, including approximately 32,000 full-time and 12,000 part-time employees. Approximately 19% of these employees are pharmacists, physicians, nurses and other clinical professional staff.

We currently have 66 facilities that are covered by, or are negotiating, collective bargaining agreements. The agreements expire at various dates from December 2002 through 2006 and cover approximately 4,800 employees. We believe that our relationship with our employees is generally good.

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We and our industry continue to experience shortages in qualified clinical professional staff, including pharmacists. We compete with other healthcare providers and with non-healthcare providers for both professional and non-professional employees. As the demand for these services continually exceeds the supply of available and qualified staff, we and our competitors have been forced to offer more attractive wage and benefit packages to these professionals and to utilize outside contractors for these services at premium rates. Furthermore, the competitive arena for this shrinking labor market has created high turnover among clinical professional staff as many seek to take advantage of the supply of available positions, each offering new and more attractive wage and benefit packages. In addition to the wage pressures inherent in this environment, the cost of training new employees amid the high turnover rates has created added pressure on our operating margins. While we have been able to retain the services of an adequate number of qualified personnel to staff our facilities and sites of service appropriately and maintain our standards of quality care, there can be no assurance that continued shortages will not affect our ability to attract and maintain an adequate staff of qualified healthcare personnel in the future. A lack of qualified personnel at a facility could result in significant increases in labor costs at such facility or otherwise adversely affect operations at such facility. Any of these developments could adversely affect our operating results or expansion plans. See “Risk Factors.”

Employee Training and Development

We believe that nursing and professional staff retention and development has been and continues to be a critical factor in our successful operation. In response to this challenge, a compensation program which provides for annual merit reviews as well as financial and quality of care incentives has been implemented to promote staff motivation and productivity and to reduce turnover rates. Management believes that our wage rates for professional nursing and pharmacy staff are commensurate with market rates.

In addition, we have established an internal training and development program for both nurse assistants and nurses. Employee training is emphasized through a variety of in-house programs as well as a tuition reimbursement program. We have established, the Genesis Nursing Assistant Specialist Program. Classes, which are held on the employee’s time, at our cost, last for approximately six months and provide advanced instruction in nursing care. When all of the requirements for class participation have been met, the nurse aides graduate and are awarded the title of geriatric nursing assistant specialist and they are given a salary adjustment. The geriatric nursing assistant specialist then takes on additional responsibilities, acting in an enhanced, leadership roll in the center. As a geriatric nursing assistant specialist continues along his/her career path, we provide further incentives.

Similar programs are currently under development for both pharmacy technicians and nursing assistants who work in the assisted living environment. In addition, plans are underway to include specialized studies in the areas of end of life and/or dementia for future geriatric nursing assistant specialists.

We began a junior level management and leadership training program in 1990 referred to as the Pilot Light Program. The target audience for this training is registered nurses and licensed practical nurses occupying charge nurse positions within our nursing centers as well as our junior level corporate managers. Over 1,300 participants have graduated from this program.

Corporate Integrity Program

Our Corporate Integrity Program was developed to assure that we continue to achieve our goal of providing a high level of care and service in a manner consistent with all applicable state and federal laws and regulations, and our internal standard of conduct. This program is intended to allow personnel to prevent, detect and resolve any conduct or action that fails to satisfy all applicable laws and our standard of conduct.

We have a corporate compliance officer responsible for administering the Corporate Integrity Program. The corporate compliance officer, with the approval of the chief executive officer or the board of directors, may use any of our resources to evaluate and resolve compliance issues. The corporate compliance officer reports significant compliance issues to the board of directors.

We established the Corporate Integrity Program hotline, which offers a toll-free number available to all of our employees to report non-compliance issues. Employee calls to the hotline will be kept anonymous unless the employee waves his/her right to anonymity. All calls reporting alleged non-compliance are logged, investigated,

addressed and remedied by appropriate company officials.

The corporate integrity subcommittee was established to ensure a mechanism exists for us to monitor compliance issues. The corporate integrity subcommittee members are senior members of the reimbursement, risk management, human resources, legal, clinical practices, internal audit and operations departments.

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Periodically, we receive information from the Department of Health and Human Services regarding individuals and providers that are excluded from participation in Medicare, Medicaid and other federal healthcare programs. Providers may include medical directors, attending physicians, vendors, consultants and therapists. On a monthly basis, management compares the information provided by the Department of Health and Human Services to databases containing providers and individuals doing business with us. Any potential matches are investigated and any necessary corrective action is taken to ensure we cease doing business with that provider and/or individual.

Competition in the Healthcare Services Industry

We compete with a variety of other companies in providing healthcare services. Certain competing companies have greater financial and other resources and may be more established in their respective communities than us. Competing companies may offer newer or different centers or services than us and may thereby attract our customers who are either presently residents of our eldercare centers or are otherwise receiving our healthcare services.

The provision of pharmacy services in the long-term care industry is highly competitive. NeighborCare is one of the largest providers of pharmacy services to the long-term care industry in the United States. In the 41 states we sell pharmacy products and services, we compete with multiple local, regional and national institutional pharmacies. Institutional pharmacies compete principally on the basis of quality, cost effectiveness and service level. In addition, we compete with multiple local, regional and national retail pharmacies; many of whom are more established in the markets in which we operate.

We operate eldercare centers in 15 states. In each market, our eldercare centers may compete for customers with rehabilitation hospitals, subacute units of hospitals, skilled or intermediate nursing centers, and personal care or residential centers. Certain of these providers are operated by not-for-profit organizations and similar businesses that can finance capital expenditures on a tax-exempt basis or receive charitable contributions unavailable to us. In competing for customers, a center's local reputation is of paramount importance. Referrals typically come from acute care hospitals, physicians, religious groups, health maintenance organizations, the customer's families and friends, and other community organizations.

Members of a customer's family generally actively participate in the selection of an eldercare center. Competition for subacute patients is intense among acute care hospitals with long-term care capability, rehabilitation hospitals and other specialty providers and is expected to remain so in the future. Important competitive factors include the reputation in the community, services offered, the appearance of a center, and the cost of services.

We compete in providing other specialty medical services with a variety of different companies. Generally, this competition is national, regional and local in nature. The primary competitive factors in these businesses are similar to those in the inpatient and pharmacy business and include reputation, the cost of services, the quality of clinical services, responsiveness to customer needs, and the ability to provide support in other areas such as third party reimbursement, information management and patient record-keeping. See “Risk Factors.”

Insurance

We have experienced an adverse effect on our operating cash flow due to an increase in the cost of certain of our insurance programs. Rising costs of eldercare malpractice litigation, and losses stemming from these malpractice lawsuits and a constriction of insurers have caused many insurance carriers to raise the cost of insurance premiums or refuse to write insurance policies for nursing homes. Also, a tightening of the reinsurance market has affected property, auto and excess liability insurance carriers. Accordingly, the costs of all insurance premiums have increased. These problems are particularly acute in the State of Florida where, because of a greater number and higher amount of claims, general liability and professional liability costs have become increasingly expensive. We own or lease approximately 1,500 skilled nursing beds in the State of Florida, representing six percent of our total owned and leased beds.

Prior to June 1, 2000, we purchased general and professional liability insurance coverage from various commercial insurers on a first dollar coverage basis. Beginning with the June 1, 2000 policy, we have purchased general and professional liability insurance coverage from a commercial insurer subject to per claim retentions. These retentions are insured by our wholly-owned captive insurance company, Liberty Health Corp., LTD. Liberty

Health Corp. is currently insuring workers' compensation, auto and general and professional liability insurance retentions.

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Workers' compensation insurance has been maintained as statutorily required, or in certain jurisdictions for certain periods, we have qualified as exempt or self-insured. Most of the commercial insurance purchased is loss sensitive in nature. As a result, we are responsible for adverse loss development.

We provide several health insurance options to our employees, including a self-insured health plan and several fully-insured health maintenance organizations.

We believe that adequate reserves are in place to cover the ultimate liability related to general and professional liability, workers' compensation and health insurance claims exposure. However, there can be no assurance that any current or future claims will not exceed applicable insurance coverage.

Environmental Matters

We are subject to various federal, state and local statutes and ordinances regulating the discharge of materials into the environment. Management does not believe that we will be required to expend any material amounts in order to comply with these laws and regulations or that compliance will materially affect our capital expenditures, results of operations or financial condition.

Reorganization

On October 2, 2001, the effective date, we and The Multicare Companies, Inc., our 43.6% owned affiliate, consummated a joint plan of reorganization under Chapter 11 of the Bankruptcy Code pursuant to a September 20, 2001 order entered by the U.S. Bankruptcy Court for the District of Delaware approving our joint plan of reorganization. We have been operating out of bankruptcy since October 2, 2001.

See "Management's Discussion and Analysis of Financial Condition and Results of Operations Certain Transactions and Events" for a further description of the nature and results of our reorganization and a description of other recent matters impacting our business and results of operations.

See "Risk Factors".

Available Information

Our Internet address is www.ghv.com. Information contained on our website is not part of this annual report on Form 10-K. We make available free of charge on www.ghv.com our annual report on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exhange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC.

In addition, you may request a copy of these filings (excluding exhibits) at no cost by writing or telephoning us at the following address or telephone number:

Genesis Health Ventures, Inc.
101 East State Street
Kennett Square, PA 19348
Attention: Investor Relations
Telephone: (610) 925 2000

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ITEM 2: PROPERTIES

Pharmacy Sites of Service

The following table provides information by state as of November 30, 2002 regarding the pharmacy service locations owned or leased by our NeighborCare pharmacy operations.

All but three of these sites are leased. Our inability to make rental payments under these leases could result in loss of the leased property through eviction or other proceedings. Certain leases do not provide for non-disturbance from the mortgagee of the fee interest in the property and consequently these leases are subject to termination in the event that the mortgage is foreclosed following a default by the owner.

	Institutional Pharmacies	Medical Supply/ Home Medical Equipment Sites	Community Based Pharmacies	Total	Total Square Feet
Pennsylvania	5	4	2	11	208,724
Maryland	6	5	27	38	204,272
New Jersey	4	1	1	6	200,592
Virginia	4	2	1	7	76,628
Florida	3	2	-	5	62,499
California	4	1	-	5	59,187
Indiana	3	-	-	3	38,500
Wisconsin	4	-	-	4	37,112
Massachusetts	2	1	-	3	30,265
South Carolina	3	1	-	4	26,899
Connecticut	1	1	-	2	24,960
Illinois	4	1	-	5	22,777
Rhode Island	1	-	-	1	21,600
New Hampshire	1	1	-	2	20,000
Ohio	1	-	-	1	16,200
West Virginia	1	-	-	1	15,794
Colorado	1	-	-	1	15,238
Oklahoma	1	1	-	2	14,905
Michigan	1	-	-	1	12,000
Oregon	1	-	-	1	10,000
North Carolina	2	-	-	2	9,700
Iowa	1	-	-	1	6,803
New York	2	1	-	3	6,000
Kentucky	1	-	-	1	5,000
Texas	1	-	-	1	3,262
Washington	1	-	-	1	2,971
Totals	59	22	31	112	1,151,888

Two institutional pharmacies, four medical supply / home medical equipment sites and two community based pharmacies are jointly-owned by us and independent third-parties.

We believe that our physical properties are well maintained and are in a suitable condition for the conduct of our business.

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Inpatient Sites of Service

The following table provides information by state as of November 30, 2002 regarding the eldercare centers we own, lease and manage. Included in the center count are 33 stand-alone assisted living facilities with 3,003 units and 19 skilled nursing facilities with 666 assisted living units. Certain properties are leased by the respective operating entities from third parties. If we are unable to make rental payments under these leases it could result in loss of the leased property through eviction or other proceedings. Certain leases do not provide for non-disturbance from the mortgagee of the fee interest in the property and consequently these leases are subject to termination in the event that the mortgage is foreclosed following a default by the owner.

	Wholly-Owned Centers		Leased Centers		Managed Centers (1)		Total	
	Centers	Beds	Centers	Beds	Centers	Beds	Centers	Beds
Pennsylvania	29	3,778	7	688	9	1,633	45	6,099
New Jersey	20	3,095	12	1,976	8	747	40	5,818
Maryland	13	1,686	6	843	12	1,675	31	4,204
Massachusetts	13	1,742	2	250	28	1,961	43	3,953
West Virginia	14	1,306	5	394	4	270	23	1,970
Florida	13	1,626	2	178			15	1,804
Connecticut	10	1,511			2	168	12	1,679
New Hampshire	8	814	4	366	1	85	13	1,265
Illinois	9	919					9	919
Delaware	4	502			3	319	7	821
Virginia	4	556	1	240			5	796
Wisconsin	5	718					5	718
Rhode Island	3	373					3	373
North Carolina					2	340	2	340
Vermont	3	314					3	314
Totals	148	18,940	39	4,935	69	7,198	256	31,073

(1) Managed centers include 31 centers with 4,312 beds that are jointly-owned by us and independent third-parties. Also included in “managed centers” are 19 transitional care units with 481 beds located in hospitals principally in the state of Massachusetts.

Included in the total centers listed above are 20 centers with 2,291 beds that have been identified as either held for sale or discontinued operations, principally in the states of Illinois and Wisconsin.

We believe that our physical properties are well maintained and are in a suitable condition for the conduct of our business.

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ITEM 3: LEGAL PROCEEDINGS

We are a party to litigation arising in the ordinary course of business. See “Cautionary Statements Regarding Forward Looking Statements.”

U.S. ex rel Scherfel v. Genesis Health Ventures et al.

In this action, brought in United States District Court for the District of New Jersey on March 16, 2000, the plaintiff alleges that a pharmacy purchased by NeighborCare failed to process Medicaid credits for returned medications. The allegations are vaguely alleged for other jurisdictions. While the action was under seal in United States District Court, we fully cooperated with the Department of Justice’s evaluation of the allegations. On or about March 2001, the Department of Justice declined to intervene in the suit and prosecute the allegations. The U.S. District court action is no longer under seal but remains administratively stayed pending resolution of the bankruptcy issues.

The plaintiff filed a proof of claim in our bankruptcy proceedings initially for approximately $650 million and more recently submitted an amended claim in the amount of approximately $325 million. We believe the allegations have no merit and have objected to the proof of claim. In connection with an estimation of the proof of claim in the bankruptcy proceeding, Debtors filed a motion for summary judgment urging that the claim be estimated at zero. On or about January 24, 2002, the bankruptcy court granted Debtors’ motion and estimated the claim at zero. On or about February 11, 2002, the plaintiff appealed the bankruptcy court’s granting of summary judgment to the U.S. District Court in Delaware and sought an injunction preventing the distribution of assets according to the joint plan of reorganization. The injunction was subsequently denied by the U.S. District Court for several reasons, including that the plaintiff was unlikely to succeed on the merits. When the injunction was denied by the U.S. District Court, the assets previously reserved for the plaintiff’s claim were distributed in accordance with the joint plan of reorganization. A hearing on the merits of the appeal was held by teleconference on or about November 11, 2002, and a final decision from the U.S. District Court is pending.

Litigation Relating to Manor Care, Inc.

We and our affiliates and Manor Care, Inc. and its affiliates had outstanding legal actions against each other stemming from the acquisition by our NeighborCare subsidiary of Manor Care’s pharmacy subsidiary, Vitalink. Set forth below are descriptions of all of these legal actions.

Manor Care, Inc. v. Genesis Health Ventures, Inc.

On August 17, 1999, Manor Care filed a lawsuit in the United States District Court for the District of Delaware against us. In this action, plaintiff brings claims under the federal securities laws resulting from alleged misrepresentations and omissions made by us in connection with Manor Care’s acquisition of our series G preferred stock as compensation for its sale of Vitalink to us. Plaintiff seeks compensatory damages of unspecified amount, rescission of Manor Care’s purchase of the series G preferred stock, and the return of the consideration paid by Manor Care at the time of our acquisition of Vitalink from Manor Care.

We filed a motion to dismiss this action. On September 29, 2000, the Court granted that motion in part and denied it in part. Specifically, the Court dismissed plaintiff’s allegations regarding purportedly fraudulent statements concerning: our knowledge as to certain legislative changes to the Medicare program; the effect of our affiliate Multicare on our earnings; our intent with respect to the issuance of preferred stock; and our ability to declare dividends on the series G preferred stock. Accordingly, the only allegations that were not dismissed from this action concern our alleged failure to include certain financial information in the registration statement we filed in connection with its acquisition of Vitalink, and allegedly fraudulent statements concerning our labor relations. Our motion to consolidate this action with the action Genesis Health Ventures Inc. v. HCR Manor Care, Inc., Manor Care, Inc., Paul A. Ormond, and Stewart Bainum, Jr., described above, has been denied.

On October 22, 2001, plaintiff filed a motion to reconsider the Court’s decision to dismiss this action in part, and we filed our opposition to that motion. On December 5, 2001, we filed a motion to dismiss the entire action pursuant to our joint plan of reorganization and the Bankruptcy Court’s order confirming that reorganization plan, which extinguish plaintiff’s claims against us except to the extent that those claims may be applied as set□off or recoupment against claims brought by us. (As discussed below, the defendants repled the claims in this action as

affirmative defenses of set-off or recoupment against the claims we have filed in Genesis Health Ventures, Inc. v. HCR Manor Care, Inc., Civil Action No. 99-287 (D. Del.)).

On August 15, 2002, Genesis announced that Genesis and HCR Manor Care, Inc. have agreed to withdraw all outstanding legal actions against each other stemming from this matter.

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Motion to Assume the Master Service Agreements, filed in In re Genesis Health Ventures, Inc.

On January 16, 2001, NeighborCare filed a motion with the United States Bankruptcy Court for the District of Delaware seeking to assume the Master Service Agreements in its chapter 11 case. This motion was heard at the same time the Bankruptcy Court considered Manor Care's motion to lift the automatic stay. The Bankruptcy Court postponed any decision on the motion to assume pending the outcome of the AAA Arbitration. This issue is still pending.

NeighborCare Pharmacy Services, Inc. v. Omnicare, Inc. and Heartland Healthcare Services

On July 26, 1999, NeighborCare filed an action in the Circuit Court for Baltimore County, Maryland against Omnicare, Inc. and Heartland Healthcare Services, a joint venture between Omnicare and Manor Care. In this action, NeighborCare seeks injunctive relief, and compensatory and punitive damages of not less than $200 million, in connection with defendants' tortious interference with the Master Service Agreements.

The two defendants each filed motions to dismiss, or, in the alternative, to stay this action pending the resolution of the AAA Arbitration. On November 12, 1999, the Court granted the motions to stay, and set a January 31, 2000 hearing date for the motions to dismiss. Defendants subsequently withdrew their motions to dismiss prior to the hearing date.

NeighborCare Pharmacy Services, Inc. v. HCR Manor Care, Inc., Manor Care, Inc.and ManorCare Health Services, Inc.

On May 7, 1999, our wholly-owned subsidiary, NeighborCare, filed a demand for arbitration under the commercial arbitration rules of the American Arbitration Association against HCR Manor Care, Inc., Manor Care, Inc. and ManorCare Health Services, Inc, collectively referred to as the respondents. The AAA arbitration principally concerns two long-term master service agreements between NeighborCare and ManorCare Health Services, Inc. Pursuant to one of these agreements, referred to as the master pharmacy agreement, NeighborCare provides pharmacy services to long-term care facilities owned or operated by Manor Care. Pursuant to the other agreement, referred to as the master infusion therapy agreement, NeighborCare provides infusion therapy products and services to Manor Care long-term care facilities.

In the AAA arbitration, NeighborCare sought injunctive relief and compensatory damages in connection with respondents' attempt to terminate the master service agreements, and respondents' failure to provide NeighborCare with the right to serve as the preferred provider of pharmacy and infusion therapy services to all Manor Care long-term care facilities pursuant to the master service agreements.

Respondents filed counterclaims requesting declaratory relief approving the purported termination of the master service agreements, as well as counterclaims seeking compensatory damages in connection with alleged overcharges under the two agreements.

The arbitrator, on May 17, 2000, declined to dismiss NeighborCare's claims for money damages for breach of its contractual right to serve as the preferred provider to all Manor Care long-term care facilities. However, the arbitrator did dismiss, without prejudice, NeighborCare's claim for specific performance of that right.

On June 15, 2000, in anticipation of our possible bankruptcy filing, the arbitrator stayed the AAA arbitration. In connection with this stay, the parties agreed that respondents may pay NeighborCare 90% of the face amount of all invoices for pharmaceutical and infusion therapy goods and services that NeighborCare renders to respondents under the master service agreements. The parties agreed, however, that respondents must continue to pay NeighborCare the full face amount of all invoices for pharmacy consulting services under the master service agreements.

On February 14, 2002, the arbitrator ruled in favor of NeighborCare. The arbitrator found that Manor Care did not lawfully terminate its service contracts with NeighborCare. As a result, the contracts between NeighborCare and Manor Care, which expire in October 2004, remain in full force until that time. The arbitrator also determined that NeighborCare had the right to damages because it was not offered the opportunity to service facilities owned and operated by Healthcare & Retirement Corporation of America, Inc., which was deemed to be

an affiliate of Manor Care under the contract. The arbitrator awarded us $23.4 million, plus pre-judgment interest, in compensatory damages. In addition, the arbitrator terminated his prior ruling that allowed Manor Care to withhold 10% of the payments owed to NeighborCare and Manor Care paid us an additional $9.1 million in funds representing the amounts withheld during the course of the AAA arbitration pursuant to the ar bitrator's prior ruling.

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In response to post-decision motions filed by NeighborCare and by respondents, the Arbitrator recalculated NeighborCare's damages, reducing them by approximately $2 million, and ruled that NeighborCare was not obligated, as a result of certain past events, to renegotiate the prices it offers to respondents for pharmacy and infusion therapy products and services.

Genesis Health Ventures, Inc. v. HCR Manor Care, Inc., Manor Care, Inc., Paul A. Ormond, and Stewart Bainum, Jr.

On May 7, 1999, we filed an action in the United States District Court for the District of Delaware against HCR Manor Care, Inc., Manor Care, Inc., Paul A. Ormond, and Stewart Bainum, Jr. In this action, we seek compensatory and punitive damages exceeding $2 million for federal securities fraud, common-law fraud, negligent misrepresentation and controlling person liability in connection with material misrepresentations and omissions made by defendants during the course of our acquisition of Vitalink. We further seek injunctive relief with respect to Manor Care's failure to dispose of its ownership interests in Heartland Healthcare Services, a competitor of NeighborCare, pursuant to a non-competition provision found in a side agreement between Genesis, Vitalink and Manor Care.

Defendants filed a motion to dismiss or stay this action pending the resolution of the AAA arbitration. On March 22, 2000, the Court denied the defendants' motion to dismiss, but granted the motion to stay the case pending resolution of the AAA arbitration.

Manor Care of America, Inc. v. Genesis Health Ventures, Inc., the Cypress Group L.L.C., TPG Partners II, L.P., and Nazem, Inc.

On December 22, 1999, MCAI filed a lawsuit in the United States District Court for the Northern District of Ohio against us, the Cypress Group L.L.C., TPG Partners II, L.P., and Nazem, Inc. In this action, MCAI brings claims of federal securities fraud in connection with alleged misrepresentations and omissions made by us in connection with our issuance of Series H Preferred Stock and Series I Preferred Stock (the "Senior Preferred Stock") on or about November 15, 1999. In connection with the issuance of the Senior Preferred Stock, MCAI also brings state law breach-of-contract claims with respect to our purported obligations under (1) a Rights Agreement entered into between us and MCAI at the time of our acquisition of Vitalink from MCAI, and (2) the terms of the Series G Preferred Stock issued to MCAI in connection with the Vitalink transaction. MCAI seeks rescission of the Senior Preferred Stock and unspecified monetary damages.

On February 29, 2000, we filed a motion to dismiss this action on the ground, among others, that the sole federal claim alleged fails to state a cause of action under federal securities laws. That motion has been fully briefed. In response to our reorganization, the Court, on July 19, 2000, stayed this action and ordered the case closed subject to reopening upon written motion.

Withdrawal of Outstanding Legal Actions

On August 15, 2002, we and Manor Care agreed to withdraw all of the remaining pending legal actions described above against each other stemming from the acquisition by our subsidiary, NeighborCare, of Manor Care's pharmacy subsidiary, Vitalink. We and Manor Care have also agreed to withdraw the prior pharmacy service agreement and have entered into a new pharmacy service agreement. The new pharmacy service agreement will run through January 2006 and covers approximately 200 Manor Care facilities. The new pharmacy service agreement replaced the agreement we had between us and Manor Care that was set to expire in 2004.

The pricing of the new pharmacy service agreement has been reduced by approximately $12.5 million annually based upon current sales volumes. The new pharmacy service agreement is retroactive to June 1, 2002.

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Litigation Relating to the NCS Transaction

On August 1, 2002, Omnicare, Inc. filed a lawsuit in the Court of Chancery, County of New Castle, State of Delaware against NCS, its directors, we and Geneva Sub and subsequently filed an amended complaint on August 12, 2002 and a second amended complaint on September 23, 2002, referred to as the “Omnicare complaint.” In the Omnicare complaint, Omnicare alleged, among other things, that by agreeing to the terms of the voting agreements and the merger agreement, the named NCS directors breached their statutory obligation to manage NCS and breached their fiduciary duties to NCS and NCS stockholders; that the grant of proxy under the voting agreements violated NCS's certificate of incorporation and resulted in the shares of NCS class B common stock subject to those agreements (which carry 10 votes per share) being converted automatically into shares of NCS class A common stock (which carry 1 vote per share); and that the termination fee that would be paid by NCS to us under some circumstances is unreasonably high and therefore unenforceable. Omnicare also alleges that we and Geneva Sub aided and abetted the NCS directors in breaching their fiduciary duties to NCS stockholders by entering into the voting agreements and merger agreement. Omnicare asked the court to (i) declare that the NCS class B shares subject to the voting agreements had been irrevocably converted into NCS class A shares; (ii) declare the merger agreement null and void; (iii) preliminarily and permanently enjoin NCS, the NCS directors, us and Geneva Sub from taking further steps or actions with respect to the voting agreements and the merger agreement; (iv) preliminarily and permanently enjoin us and Geneva Sub from aiding and abetting the named NCS directors from breaching their fiduciary duties; (v) declare the termination fee unreasonable, invalid and unenforceable; and (vi) grant Omnicare such other relief as the court deems just and proper, including the cost and disbursements of the action and reasonable attorneys' fees.

On August 7, 2002, Dolphin Limited Partnership L.L.P. ("Dolphin"), on behalf of all holders of NCS Class A common stock (other than the named NCS defendant directors), filed a lawsuit in the Court of Chancery, County of New Castle, State of Delaware against NCS, its directors, us and Genesis Sub (sic). In its complaint, Dolphin alleges that the named NCS directors breached their fiduciary duties to holders of NCS Class A common stock by, among other things, entering into the voting agreements and the merger agreement, and refusing to consider Omnicare's bid and not conditioning the NCS transaction on the approval of the holders of the NCS Class A common stock as a separate class. Dolphin also alleged that we aided and abetted the named NCS directors in breaching their fiduciary duties to the holders of NCS Class A common stock. Dolphin asked the court to (i) declare that the action is a class action and certify Dolphin as the class representative and Dolphin's counsel as the class counsel; (ii) enjoin, preliminarily and permanently, the NCS transaction; (iii) direct that the NCS transaction be conditioned on the approval of the holders of NCS Class A common stock as a separate class; (iv) rescind the NCS transaction in the event that it occurs prior to the court's final judgment or award the holders of NCS Class A common stock recissory damages; (v) direct that the named defendants account to Dolphin and the holders of NCS Class A common stock for all damages caused by the defendants and account for all profits and any special benefits obtained as a result of the alleged breaches of fiduciary duties; (vi) award Dolphin the costs and disbursements of the action, including a reasonable allowance for the fees and expenses of Dolphin's attorneys and experts; and (vii) grant Dolphin and the holders of NCS Class A common stock such further relief as the court deems just and proper.

On December 11, 2002, the Court of Chancery of the State of Delaware, pursuant to an order of the Delaware Supreme Court dated December 10, 2002 which reversed prior rulings of the Court of Chancery, entered an order preliminarily enjoining implementation of the merger between Geneva Sub and NCS pending further proceedings. On December 15, 2002, we and Omnicare entered into a Termination and Settlement Agreement. Pursuant to the Termination and Settlement Agreement, we agreed to terminate the merger agreement on Monday, December 16, 2002 by sending notice thereof to NCS, and Omnicare agreed to pay to Genesis, an amount in cash equal to $22 million less any termination fees paid by or on behalf of NCS to Genesis under the merger agreement. In addition, pursuant to the Termination and Settlement Agreement, Genesis and Omnicare each agreed to release the other party from any claims arising from the merger agreement and not to commence any action against the other party arising out of or in connection with the merger agreement. On December 16, 2002, Genesis terminated the merger agreement in accordance with its terms and provided written notice to NCS. On December 17, NCS paid us a termination fee of $6 million, as provided in the merger agreeement. The remainder of the $22 million agreed to with Omnicare will be paid if and when Omnicare subsequently announced its merger agreement with NCS.

ITEM 4: SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

There were no matters submitted to a vote of shareholders during the fourth quarter of fiscal 2002.

We will hold our 2003 Annual Meeting of Shareholders on April 9, 2003. Pursuant to the proxy rules under the Securities and Exchange Act of 1934, as amended, our shareholders are notified that the deadline for providing us timely notice of any shareholder proposal to be submitted outside of the Rule 14a□8 process for consideration at our 2003 annual meeting of shareholders will be February 1, 2003. As to all matters which we do not have notice on or prior to February 1, 2003, discretionary authority shall be granted to the persons designated in our proxy related to the 2003 annual meeting to vote on such proposal. With respect to inclusion of shareholder proposals in our proxy materials related to the 2003 annual meeting, a shareholder proposal must be submitted to us at our office located at 101 East State Street, Kennett Square, Pennsylvania 19348, by February 1, 2003. Any such proposal must also comply with the proxy rules under the Exchange Act, including Rule 14a□8.

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ITEM 4.1: EXECUTIVE OFFICERS OF THE REGISTRANT

The following table sets forth certain information with respect to our executive officers.

Name	Age	Position
Robert H. Fish	52	Interim Chairman and Chief Executive Officer
George V. Hager, Jr.	46	Executive Vice President and Chief Financial Officer
Richard L. Castor	47	Senior Vice President and Chief Information Officer
Barbara J. Hauswald	43	Senior Vice President and Treasurer
James V. McKeon	38	Senior Vice President and Corporate Controller
Richard Pell, Jr.	54	Senior Vice President, Administration and Chief Compliance Officer
Robert A. Smith	54	President and Chief Operating Officer, NeighborCare Pharmacy
James W. Tabak, Esquire	43	Senior Vice President, Human Resources
James J. Wankmiller, Esquire	48	Senior Vice President, General Counsel and Corporate Secretary

Robert H. Fish has served as our director since October 2001, interim chief executive officer since June 2002 and interim chairman since November 2002. He is a managing partner of Sonoma□Seacrest, LLC, a California□based healthcare practice specializing in strategic planning, performance improvement, and merger and acquisition issues. Prior to joining Sonoma, Mr. Fish served as president and chief executive officer of St. Joseph Health System and president and chief executive officer of ValleyCare Health System. Mr. Fish holds a Bachelor of Arts degree in Sociology and Anthropology from Whittier College and a Masters in Hospital Administration from the University of California at Berkeley.

George V. Hager, Jr. serves as our executive vice president and chief financial officer and is responsible for corporate finance, treasury, investor relations, information services, third party reimbursement, risk management, real estate and property management. Mr. Hager joined us in 1992 as vice president and chief financial officer and was named senior vice president and chief financial officer in 1994. He holds a Bachelor of Arts degree in Economics from Dickinson College and a Master of Business Administration degree from Rutgers Graduate School of Management.

Richard L. Castor has served as our senior vice president and chief information officer since June 2001, chief technology officer since December 2000, and as president of our wholly-owned subsidiary, HealthObjects Corporation, a software development company, since March 1998. Prior to that time, Mr. Castor served as chief technology officer for Aetna for 2 years. Mr. Castor received a Bachelor of Science degree in Computer Science from Denison University in 1977.

Barbara J. Hauswald has served as our senior vice president since April 2000, and joined us as vice president and treasurer in April 1998. Prior to joining us, Ms. Hauswald served as first vice president in the health care banking department of Mellon Bank N.A. She received a Bachelor of Science degree in Commerce in 1981 from the University of Virginia.

James V. McKeon has served as our senior vice president and corporate controller since April 2000. Mr. McKeon joined us in June 1994 as director of financial reporting and investor relations and served as our vice president of finance and investor relations from November 1995 to April 1997. From April 1997 to April 2000, Mr. McKeon served as our vice president and corporate controller. He received a Bachelor of Science degree in Accountancy from Villanova University in 1986.

Richard Pell, Jr. has served as our senior vice president□administration and chief compliance officer since April 1998. Mr. Pell oversees the following areas: human resources, law, government relations, public relations, staff development and corporate communications. He received a Bachelor of Science Degree in Economics from the University of Pennsylvania in 1970 and a Masters Degree in Health Care Administration from the Mt. Sinai School of Medicine, City University of New York in 1975.

Robert A. Smith has served as our president and chief operating officer of NeighborCare, our institutional pharmacy business since May 2001. Prior to being named president, Mr. Smith served as executive vice president and chief operating officer of NeighborCare’s Allegheny region since November 1999. He served as senior vice president of NeighborCare’s Allegheny region since August 1998, a position he held with Vitalink Pharmacy

Services prior to its acquisition by NeighborCare. Mr. Smith has held senior management positions in several long-term care pharmacy organizations since 1988 and holds a Bachelor of Science degree in Pharmacy from Duquesne University.

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James W. Tabak, Esquire has served as our senior vice president of human resources since April 2000. Mr. Tabak oversees and directs the function of the human resource department including human resource planning, employment, training and development, labor relations, compensation, benefits and merit review system. From January 1992, Mr. Tabak served as our associate general counsel and vice president of human resources. He holds a Bachelor of Science degree in Political Science from the University of Pennsylvania and a law degree from The Boston University School of Law.

James J. Wankmiller, Esquire has served as our senior vice president, general counsel and corporate secretary since April 2000. Mr. Wankmiller joined us in October 1996 as vice president and general counsel. Mr. Wankmiller received his Bachelor of Science degree from St. Joseph’s University in 1976 and his Juris Doctorate degree from Villanova University School of Law in 1980. He also serves on the legal subcommittee of the American Health Care Association.

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PART II

ITEM 5: MARKET FOR THE REGISTRANT'S COMMON EQUITY AND RELATED STOCKHOLDER MATTERS

Our common stock currently trades on the Nasdaq National Market under the symbol “GHVI”. From October 15, 2001 until February 7, 2002 our common stock traded on the OTC Bulletin Board under the symbol “GHVE”. Our common stock that was cancelled in connection with our reorganization was traded on the New York Stock Exchange through June 22, 2000 and on the OTC Bulletin Board thereafter. The following table indicates, for each of the quarters in the fiscal year ended September 30, 2002, the range of high and low closing prices of our common stock as reported on the OTC Bulletin Board through February 7, 2002 and on the Nasdaq National Market thereafter. The following table also indicates, for each of the quarters in the fiscal year ended September 30, 2001, the range of high and low closing prices of our common stock that was cancelled in connection with our reorganization as reported on the OTC Bulletin Board.

Fiscal Year Ending	High	Low
September 30, 2002		
First Quarter	$ 26.00	$ 19.20
Second Quarter	$ 21.00	$ 13.74
Third Quarter	$ 21.23	$ 17.70
Fourth Quarter	$ 19.50	$ 14.25
September 30, 2001		
First Quarter	$ 0.20	$ 0.03
Second Quarter	$ 0.41	$ 0.11
Third Quarter	$ 0.36	$ 0.02
Fourth Quarter	$ 0.08	$ 0.01

As of December 23, 2002, there were 6,369 shareholders of record of our common stock. We have never declared or paid cash dividends on our common stock. Our ability to pay dividends on our common stock is restricted by our senior credit facility and senior secured note agreements. See “Management’s Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources”. Management does not anticipate the payment of cash dividends on our common stock in the foreseeable future.

See “Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters Equity Compensation Plans” for disclosure regarding our equity compensation plans.

On October 2, 2001, we and Multicare consummated a joint plan of reorganization under Chapter 11 of the Bankruptcy Code pursuant to a September 20, 2001 order entered by the Bankruptcy Court approving our joint plan of reorganization. In connection with our joint plan of reorganization, we issued or will issue the following securities without registration under the Securities Act of 1933 in reliance on Section 1145 of the Bankruptcy Code and the Bankruptcy Court order confirming our joint plan of reorganization:

- 41,000,000 shares of our common stock to our and Multicare’s creditors as identified in our joint plan of reorganization. We issued 40,449,978 of these shares on various dates from October 2, 2001 to December 23, 2002 and, as of December 23, 2002, 550,022 of these shares of common stock have not yet been issued;

- $242.6 million of senior secured notes on October 2, 2001 to our and Multicare s senior secured creditors as identified in our joint plan of reorganization;

- warrants to our and Multicare’s unsecured creditors as identified in our joint plan of reorganization on various dates in fiscal 2002. The warrants were exercisable to purchase up to 4,559,475 shares of our common stock, subject to adjustment. The warrants, which expired on October 2, 2002, had an exercise price of $20.33 per share of our common stock, subject to adjustment; and

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425,946 shares of our Series A convertible preferred stock to our and Multicare's senior secured creditors as identified in our joint plan of reorganization on various dates in fiscal 2002.

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Each share of Series A convertible preferred stock is convertible at any time and from time to time, at the option of the holder (optional conversion) and all shares of Series A convertible preferred stock will be converted at any time after the first anniversary of the date of original issuance of shares of Series A convertible preferred stock if the average market price for a share of our common stock for 20 consecutive trading days exceeds $30.00 (as adjusted from time to time to reflect stock splits, dividends, recapitalizations, combinations or the like), at our option (a mandatory conversion), in each case into fully paid and nonassessable shares of our common stock.

Each share of Series A convertible preferred stock is convertible into the number of shares of our common stock which results from dividing (x) the liquidation preference of $100 per each such share plus all accrued and unpaid dividends by (y) the conversion price per share of $20.33 subject to adjustment, provided that, upon any conversion of shares of Series A convertible preferred stock, we will have the right to pay to the converting holder in cash the accrued and unpaid dividends on the shares of Series A convertible preferred stock to be converted.

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ITEM 6: SELECTED FINANCIAL DATA

	Successor Company	Predecessor Company			
(Years ended September 30,)	**2002**	**2001[2]**	**2000[2]**	**1999**	**1998**
Statement of Operations Data (in thousands, except per share data)					
Net revenues	$ 2,623,679	$ 2,452,171	$ 2,327,627	$ 1,843,270	$ 1,380,534
Income (loss) from continuing operations	73,794	(1,248,359)	(877,216)	(286,954)	(11,388)
Net income (loss) attributable to common shareholders	70,167	246,474	(882,920)	(290,050)	(25,900)
Per common share data (diluted):					
Earnings (loss) from continuing operations	1.76	(25.66)	(18.63)	(8.09)	(0.32)
Net income (loss) attributable to common shareholders	$ 1.68	$ 5.07	$ (18.75)	$ (8.17)	$ (0.74)
Weighted average common shares diluted	43,351	48,641	47,077	35,485	35,159
Other Financial Data:					
Capital expenditures (in thousands)	$ 51,635	$ 43,721	$ 51,981	$ 77,943	$ 56,663
Operating Data:					
Inpatient Services					
Payor Mix					
Medicaid	48%	48%	49%	52%	49%
Medicare	30%	28%	25%	24%	26%
Private pay and other	22%	24%	26%	24%	25%
Average owned/leased eldercare center beds (1)	24,139	24,783	14,286	15,522	15,137
Occupancy Percentage	91%	91%	91%	91%	92%
Average managed eldercare center beds (1)	7,898	9,215	23,779	23,984	24,234
Pharmacy Services					
Payor Mix					
Long-term care facilities and other	58%	60%	62%	63%	70%
Medicaid	40%	37%	35%	33%	23%
Medicare	2%	3%	3%	4%	7%
Average institutional pharmacy beds served	247,114	253,224	244,409	245,277	109,520

	Successor Company		Predecessor Company		
(As of September 30,)	**2002**	**2001**	**2000[2]**	**1999**	**1998**
Balance Sheet Data (in thousands)					
Working capital	$ 449,006	$ 282,016	$ 304,241	$ 235,704	$ 243,461
Total assets	1,989,495	1,839,220	3,081,998	2,429,914	2,627,368
Liabilities subject to compromise			2,446,673		

Long-term debt	648,939	603,268	10,441	1,484,510	1,358,595
Redeemable preferred stock	44,765	42,600	442,820		
Shareholders' equity (deficit)	$ 914,123	$ 834,858	$ (246,391)	$ 587,890	$ 875,072

(1) In connection with the consummation of the our joint plan or reorganization, 10,702 Multicare beds previously classified as "Managed and Jointly-Owned Facilities" were reclassified as "Owned and Leased Facilities." See "Business Reorganization."

(2) The company has restated its previously reported consolidated financial statements in fiscal years 2001 and 2000 to reflect certain adjustments as discussed in note 2 Restatement of 2001 and 2000 Consolidated Financial Statements of Item 8: Financial Statements and Supplementary Data, which begin on page 63 of this Form 10-K/A.

Please refer to "Management's Discussion and Analysis of Financial Condition and Results of Operations Certain Transactions and Events" for a description of significant transactions. See also "Management's Discussion and Analysis of Financial Condition and Results of Operations Results of Operations Factors Affecting Comparability of Financial Information."

The statement of operations data from continuing operations for all prior year periods has been adjusted for operations identified as discontinued. Operating data of the Predecessor Company has not been adjusted to exclude discontinued operations. See "Management's Discussion and Analysis of Financial Condition and Results of Operations Certain Transactions and Events Assets Held for Sale and Discontinued Operations."

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ITEM 7: MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

General

We are a leading provider of healthcare and support services to the elderly. Our operations are comprised of two primary business segments, pharmacy services and inpatient services. These segments are complemented by an array of other service capabilities. See "Certain Transactions and Events Change in Strategic Direction and Objectives."

We provide pharmacy services nationwide through 59 institutional pharmacies (two are jointly-owned) and 22 medical supply and home medical equipment distribution centers (four are jointly-owned). In addition, we operate 31 community-based retail pharmacies (two are jointly-owned) which are located in or near medical centers, hospitals and physician office complexes.

We provide inpatient services through skilled nursing and assisted living centers primarily located in the eastern United States. We currently own, lease, manage or jointly-own 256 eldercare centers with 31,073 beds of which 20 centers with 2,291 beds have been identified as either held for sale or discontinued operations. See "Certain Transactions and Events Assets Held for Sale and Discontinued Operations." We include the revenues of our owned and our leased centers in inpatient service revenues in our consolidated statements of operations. Management fees earned from our managed and / or jointly-owned centers are included in other revenues in our consolidated statements of operations.

We also provide rehabilitation services, diagnostic services, respiratory services, hospitality services, group purchasing services and healthcare consulting services, the revenues for which are included in other revenues in our consolidated statements of operations.

The company has restated its previously reported consolidated financial statements in fiscal years 2001 and 2000 to reflect certain adjustments as discussed in note 2 Restatement of 2001 and 2000 Consolidated Financial Statements of Item 8: Financial Statements and Supplementary Data, which begins on page 63 of this Form 10-K/A.

Certain Transactions and Events

Reorganization:

Background.

On June 22, 2000, we and certain of our direct and indirect subsidiaries filed for voluntary relief under Chapter 11 of the United States Code (the "Bankruptcy Code") with the United States Bankruptcy Court for the District of Delaware (the "Bankruptcy Court"). On the same date, our 43.6% owned affiliate, The Multicare Companies, Inc., and certain of its direct and indirect subsidiaries, and certain of its affiliates also filed for relief under Chapter 11 of the Bankruptcy Code with the Bankruptcy Court (singularly and collectively referred to herein as "the Chapter 11 cases", "our bankruptcy" or other general references to these cases, unless the context otherwise requires).

Our and Multicare's financial difficulties were attributed to a number of factors. First, the federal government made fundamental changes to the reimbursement for medical services provided to individuals. The changes had a significant adverse impact on the healthcare industry as a whole and on our and Multicare's cash flows. Second, the federal reimbursement changes exacerbated a long-standing problem of inadequate reimbursement by the states for medical services provided to indigent persons under the various state Medicaid programs. Third, numerous other factors adversely affected our and Multicare's cash flows, including increased labor costs, increased professional liability and other insurance costs, and increased interest rates. Finally, as a result of declining governmental reimbursement rates and in the face of rising inflationary costs, we and Multicare were too highly leveraged to service our debt, including our long-term lease obligations.

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On October 2, 2001, the effective date, we and Multicare consummated a joint plan of reorganization under Chapter 11 of the Bankruptcy Code pursuant to a September 20, 2001 order entered by the U.S. Bankruptcy Court approving our joint plan of reorganization. The principal provisions of our joint plan of reorganization were as follows:

- Multicare became our wholly-owned subsidiary. We previously owned 43.6% of Multicare and managed its skilled nursing and assisted living facilities under the Genesis Eldercare brand name;
- &#149 New senior notes, new convertible preferred stock, new common stock and new warrants were issued to our and Multicare's creditors. Approximately 93% of new common stock, $242.6 million in new senior notes and new preferred stock with a liquidation preference of $42.6 million were issued to our and Multicare's senior secured creditors. New one year warrants to purchase an additional 11% of the new common stock were issued, and approximately 7% of the new common stock have been or will be issued to our and Multicare's unsecured creditors;
- &#149 Holders of our and Multicare's pre-Chapter 11 preferred and common stock received no distribution and those instruments were canceled;
- &#149 Claims between us and Multicare were set-off against one another and any remaining claims were waived and released; and
- &#149 A new board of directors was constituted.

On October 2, 2001, and in connection with the consummation of the Plan, we entered into a senior credit facility agreement consisting of the following: (1) a $150 million revolving line of credit (the "Revolving Credit Facility"); (2) a $285 million term loan (the "Term Loan") and (3) an $80 million delayed draw term loan (the "Delayed Draw Term Loan") (collectively the "Senior Credit Facility").

In accordance with SOP 90-7 (as defined below under "Fresh-Start Reporting"), we recorded all expenses incurred as a result of the bankruptcy filing separately as debt restructuring and reorganization costs. A summary of the principal categories of debt restructuring and reorganization costs from continuing operations follows (in thousands):

	Successor Company	Predecessor Company	
	2002	2001	2000
Professional, bank and other fees	$ 2,570	$ 59,393	$ 29,935
Employee benefit related costs, including severance		16,786	4,529
Accretion of allowed claims			395,731
Exit costs of terminated businesses		5,877	
Fresh start valuation adjustments (1)		982,749	
Interest rate swap termination charge			28,331
Post confirmation mortgage adjustment	1,700		
Total	$ 4,270	$ 1,064,805	$ 458,526

(1) Fresh-start valuation adjustments on assets held for sale and discontinued operations totaling $32.4 million were reclassified as a component of the loss on discontinued operations for the twelve months ended September 30, 2001.

Fresh-Start Reporting.

Upon emergence from our Chapter 11 proceedings, we adopted the principles of fresh-start reporting in accordance with the American Institute of Certified Public Accountants Statement of Position 90-7, "*Financial Reporting By Entities in Reorganization Under the Bankruptcy Code*" ("SOP 90-7") / ("fresh-start reporting"). For financial reporting purposes, we adopted the provisions of fresh-start reporting effective September 30, 2001. In connection with the adoption of fresh-start reporting, a new entity was deemed created for financial reporting purposes, the provisions of our joint plan of reorganization were implemented, assets and liabilities were adjusted to their estimated fair values and our accumulated deficit was eliminated.

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Proposed NCS Transaction

On July 28, 2002, we and our wholly-owned subsidiary, Geneva Sub, Inc., entered into an agreement and plan of merger (the "Merger Agreement") with NCS HealthCare, Inc. ("NCS"), pursuant to which NCS was to become a wholly-owned subsidiary of us (the "NCS Transaction"). NCS provides institutional pharmacy services to approximately 196,000 long-term care and assisted living beds in 36 states.

Under the terms of the Merger Agreement, each share of NCS class A and class B common stock were to be converted into 0.1 of a share of our common stock. In connection with the NCS Transaction, two NCS stockholders holding approximately 65% of the voting power of NCS entered into voting agreements with us and NCS ("Voting Agreements") in which they agreed to vote all of their shares of NCS class A and class B common stock in favor of the adoption of the Merger Agreement and against certain other actions specified in the Voting Agreements, and in which they granted a limited proxy to us in furtherance of these actions.

After the Merger Agreement was entered, Omnicare, Inc. made a cash tender offer for all of the NCS shares, at a price per share of $3.50 in cash. In addition, seven separate lawsuits (one of which was filed by Omnicare) were filed alleging in general that certain officers and directors of NCS breached their fiduciary duties to the NCS stockholders by entering into the Merger Agreement and the Voting Agreements, and sought to invalidate the Voting Agreements and enjoin the merger.

On December 11, 2002, the Court of Chancery of the State of Delaware, pursuant to an order of the Delaware Supreme Court dated December 10, 2002 which reversed prior determinations of the Court of Chancery, entered an order preliminary enjoining the consummation of the NCS transaction pending further proceedings.

On December 15, 2002, we entered into a termination and settlement agreement with Omnicare whereby we agreed to terminate the Merger Agreement on December 16, 2002 and Omnicare agreed to pay to us $22 million. In addition, we and Omnicare each agreed to release the other from any claims arising from the Merger Agreement and not commence any action against one another in connection with the Merger Agreement. On December 16, 2002 we provided notice to NCS terminating the Merger Agreement.

Change in Strategic Direction and Objectives:

Historical Perspective.

Since our inception, our principal business plan was to build networks of skilled nursing and assisted living centers in concentrated geographic markets and broaden our array of higher margin specialty medical services; principally institutional pharmacy and rehabilitation services. This "network" strategy was in response to payors' increasing desire to contract with fewer companies to meet their total delivery care needs. By offering a broad array of services, we sought to create an integrated delivery system connecting our eldercare centers and ancillary service capabilities to hospitals, physicians, managed care plans and other providers in a seamless delivery network.

In the mid to late 1990's, we made significant acquisitions of, and investments in, both eldercare and pharmacy operations. These acquired businesses principally operated in existing market concentrations or in contiguous markets deemed attractive to build future eldercare networks. Our stated mission during this period was to "redefine how eldercare is delivered in America by using a coordinated, comprehensive approach that helps older adults define and live a full life". Our eldercare centers were at the core of the network strategy and stated mission.

Leading up to and during our Chapter 11 proceedings, the eldercare segment of our business suffered from significant cuts and pressures in funding sources, nursing labor cost increases in excess of inflation, intensified regulatory oversight and intervention, and increases in the cost of medical malpractice insurance. Also, during this time period, changes in reimbursement policies caused a greater focus on drug costs and utilization by customers of our pharmacy segment, putting pressure on pharmacy pricing and revenue growth. Despite these pricing pressures, we were able to grow pharmacy revenues at between 8%-9% per year between fiscal 1999 and 2001 through, among other things, new customer sales, higher drug pricing and higher drug utilization from existing customers. In fiscal 1997, 65% and 22% of our total revenues were from inpatient services and pharmacy services, respectively. By fiscal 2002, 51% and 43% of our total revenues were from inpatient services and

pharmacy services, respectively.

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Recent Developments.

Upon emergence from Chapter 11 proceedings in October 2001, a new board of directors was constituted. In the second fiscal quarter of 2002, the board of directors approved the engagement of strategic consulting firms in an effort to:

- &#149 evaluate our business portfolio;
- &#149 identify means to optimize each business line; and
- &#149 evaluate market perceptions of us and to recommend strategic alternatives to enhance shareholder value and improve operating margins.

Strategic consultants were also engaged to evaluate certain components of our pharmacy operations in an effort to improve operating margins of that segment.

The conclusions reached and recommendations made in connection with these evaluations suggest greater growth potential and less exposure to regulatory risk in our pharmacy segment than the eldercare segment. Consequently, it is management's intention to shift our long-term strategic focus away from the eldercare network strategy in favor of a greater commitment to the institutional pharmacy business. This fundamental shift in strategic direction is expected to strengthen our financial position, tighten our business focus and improve competitiveness in the pharmacy segment.

In October of 2002, we announced that we retained UBS Warburg LLC and Goldman Sachs & Co. to assist in exploring certain strategic alternatives, including but not limited to, the potential sale or spin-off of our eldercare assets.

In addition to our long-term strategy to invest in the pharmacy segment, management established the following short-term strategic objectives:

- &#149 evaluate and reduce overhead costs;
- &#149 implement pharmacy segment margin expansion plans;
- &#149 pursue operational efficiencies in the inpatient services segment;
- &#149 retain a permanent chief executive officer;
- &#149 pursue selective acquisitions; and
- &#149 evaluate and rationalize under-performing assets and business lines.

Our progress to date on each of these objectives is as follow:

Evaluate and reduce overhead costs. In the fourth fiscal quarter of 2002, we completed an annualized $16 million expense reduction program, which included the elimination of over 130 positions, coupled with cuts to certain non-labor expenses.

Implement pharmacy segment margin expansion plans. The primary elements of our pharmacy segment margin expansion plans include reducing product acquisition costs, improving labor utilization, evaluating segment specific overhead costs, implementing operational best demonstrated practices and improving credit administration. Beginning in the fourth fiscal quarter of 2002, NeighborCare has begun implementation of certain best demonstrated practice initiatives in five of its seven pharmacy regions, and will expand to all pharmacy regions in fiscal 2003.

Pursue operational efficiencies in the inpatient services segment. The primary elements of our inpatient services segment operational efficiency improvements include a continued focus on increasing quality payor mix, improving labor utilization, consolidating key business processes and better leveraging our existing infrastructure within our core markets to improve occupancy.

Retain a permanent chief executive officer. We have engaged an outside executive search firm to identify and recruit a permanent chief executive officer.

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Pursue selective acquisitions. We continue to critically evaluate selective acquisitions, particularly pharmacy and other health service related businesses.

Evaluate and rationalize under-performing assets and business lines. In the normal course of business, we continually evaluate the performance of our operating units, with an emphasis on selling or closing under-performing or non-strategic assets.

Strategic planning, severance and other related costs.

We have incurred costs that are attributable to our long term objective of transforming to a pharmacy based business and our short term objectives discussed above. These costs are expected to continue for the foreseeable future and are segregated in the statement of operations as “strategic planning, severance and other related costs”. Details of these costs and the amounts incurred, but not paid at September 30, 2002 follow (in thousands):

	2002 Expense	Accrued at September 30, 2002
Severance and related costs	$ 16,410	$ 1,100
Strategic consulting fees	4,730	621
Asset impairments	4,875	
Total	$ 26,015	$ 1,721

Severance and related costs. In the third fiscal quarter of 2002, Michael R. Walker resigned as our chief executive officer. Our board of directors appointed Robert H. Fish as interim chief executive officer. Also, in the third quarter of fiscal 2002, David C. Barr resigned as vice chairman. Mr. Barr was responsible for oversight of the Genesis Health Services entities which include pharmacy, rehabilitation therapy, respiratory health services, hospitality services group purchasing, consulting and diagnostic services. We recognized $12.6 million in severance and related costs relating to the transition agreements with Mr. Walker and Mr. Barr.

In fiscal 2002, we announced an expense reduction program, which included the termination of over 100 individuals resulting in $3.8 million of severance related costs. At September 30, 2002, $1.1 million remains unpaid, which is expected to be paid during fiscal 2003.

Subsequent to the fiscal year end, in October 2002, Richard R. Howard resigned as vice chairman. Mr. Howard was responsible for oversight of Genesis ElderCare’s regional operations, as well as clinical practice, real estate and property management. We expect to recognize $4.7 million in severance and related costs in the first quarter of fiscal 2003 in connection with Mr. Howard’s transition agreement. See “Cautionary Statements Regarding Forward Looking Statements”.

Strategic consulting fees. During fiscal 2002, we engaged several strategic consulting firms at a cost of $4.7 million, in connection with several of our new strategic objectives. Initially, these firms were engaged to assist the board of directors and management in the evaluation of our existing business model and the development of our strategic alternatives. Additional services were procured to assist in the evaluation of our pharmacy sales and marketing function and the bid selection process in connection with the potential sale of the eldercare business.

We entered into a separate consulting engagement to evaluate certain components of our pharmacy operations in an effort to improve operating margins of that segment. The resulting performance improvement initiatives are generally focused in the areas of:

- &#149 customer account management; and
- &#149 operational cost reductions through best demonstrated practices, centralized repackaging and automated dispensing enhancements.

We recognize the cost of such consulting fees as the services are performed, and expect to incur $2.0 million of additional consulting fees in fiscal 2003, principally to continue the pharmacy performance improvement initiatives. These performance improvement initiatives are expected to be fully operational by fiscal 2004. If successful, we believe we can improve current pharmacy operating income by as much as $18 million per year. See “Cautionary Statements Regarding Forward Looking Statements”.

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Asset Impairments. In the fourth quarter of fiscal 2002, we incurred $4.9 million of asset impairment charges consisting of the write-down in carrying value of two idle eldercare real estate properties and the exit of an internet based business-to-business joint-venture partnership. We expect to incur an additional $2 million of costs in fiscal 2003 in order to complete our exit of the internet based business-to-business joint venture partnership. See “Cautionary Statements Regarding Forward Looking Statements”.

Medical Supplies Service Agreement

During the third quarter of fiscal 2002, NeighborCare entered into a seven year agreement with Medline Industries, Inc. for the fulfillment of NeighborCare's bulk medical supply services to its customers. Under the agreement, Medline will provide order intake, warehousing, delivery and invoicing services. NeighborCare will earn a service fee from Medline for providing sales and marketing services, calculated as a percentage of the revenues earned by Medline for sales to NeighborCare customers. As a result of this agreement, NeighborCare will no longer recognize revenue for the sale of bulk medical supplies to its customers. The agreement does not include certain products and services that NeighborCare will continue to sell directly to customers. It is estimated that the agreement will result in an annual reduction of medical supply revenue of approximately $45 million with no significant impact on operating or net income.

Arbitration Award

On February 14, 2002, an arbitrator ruled in favor of NeighborCare on all claims and counterclaims in the lawsuit involving HCR Manor Care, Inc. and certain of its affiliates. The arbitrator found that HCR Manor Care did not lawfully terminate the Master Service Agreements with NeighborCare, so that those contracts remain in full force and effect until the end of September 2004. The arbitrator awarded NeighborCare $21.9 million in damages, which were recognized in fiscal 2002, for respondents’ failure to allow NeighborCare to exercise its right under the Master Service Agreements to service facilities owned and operated by a subsidiary of respondent HCR Manor Care. In addition, the arbitrator terminated his prior ruling that allowed respondents to withhold 10% of their payments to NeighborCare, and respondents paid NeighborCare $9.1 million in funds representing the amounts withheld during the course of the Arbitration pursuant to the arbitrator’s prior ruling.

See — “Legal Proceedings”.

Amended Pharmacy Service Agreement with HCR Manor Care

On August 15, 2002, we announced that we and HCR Manor Care, Inc. have agreed to withdraw all outstanding legal actions against each other stemming from the acquisition by our subsidiary, NeighborCare, of HCR Manor Care□s pharmacy subsidiary, Vitalink. We and HCR Manor Care have also agreed to withdraw the prior pharmacy service agreement and have entered into a new pharmacy service agreement. The new pharmacy service agreement will run through January 2006 and covers approximately 200 of HCR Manor Care□s facilities. The new pharmacy service agreement replaces the current pharmacy service agreement between the two companies that was set to expire in 2004.

The pricing in the new pharmacy service agreement has been reduced by approximately $12.5 million annually based upon current sales volumes, and is retroactive to June 1, 2002.

See — “Legal Proceedings”.

Amended Pharmacy Service Agreement with Mariner Post-Acute Network, Inc.

Our NeighborCare pharmacy operations provide services to 58 centers operated by Mariner Post-Acute Network. Inc., referred to as “Mariner,” which represents four percent and two percent of net revenues of NeighborCare and Genesis, respectively. On January 18, 2000, Mariner filed voluntary petitions under Chapter 11 with the Bankruptcy Court, giving Mariner certain rights under protection of the Bankruptcy Court to reject the service contracts for those centers.

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Effective November 1, 2001, the Mariner Bankruptcy Court approved a settlement between NeighborCare and Mariner relating to these Mariner service contracts, whereby, among other things: the form of the contracts was restated and new pricing was implemented; and the term of the contracts was extended for eighteen months through April 30, 2003, except that Mariner has the right to terminate a limited number of service contracts in the event of the disposition or closure of the subject facility. There can be no assurance that these services will continue to be provided after the contracts current terms expire.

Assets Held for Sale and Discontinued Operations

On September 30, 2001, we adopted the provisions of Statement of Financial Accounting Standards, No. 144 Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed Of (SFAS 144). Under SFAS 144, discontinued businesses or assets held for sale are removed from the results of continuing operations. During fiscal 2002, we classified our ambulance business, all eldercare centers located in the states of Wisconsin and Illinois, five eldercare centers in other states and one medical supply distribution site as either held for sale or closed. The results of operations in the current and prior year periods, along with any costs to exit such businesses in the current year period, are classified as discontinued operations in the consolidated statements of operations. Businesses sold or closed prior to our adoption of SFAS 144 continue to be reported in the results of continuing operations.

We intend to sell our assets held for sale within the next year and, accordingly, have classified the $46.1 million carrying value as assets held for sale in the consolidated balance sheet.

The following table sets forth the components of income (loss) from discontinued operations (in thousands):

	Successor Company	Predecessor Company	
	2002	2001	2000
Net operating income (loss) of discontinued businesses	$ 541	$ (15,085)	$ 7,720
Loss on discontinuation of businesses	(6,487)		
Income tax (expense) benefit	2,319		(3,012)
Income (loss) from discontinued operations, net of taxes	$ (3,627)	$ (15,085)	$ 4,708

The loss on discontinuation of businesses includes the write-down of assets to estimated net realizable value.

Sale of Ohio Operations

In fiscal 2000, effective May 31, 2000, Multicare sold 14 eldercare centers with 1,128 beds located in the state of Ohio for $33 million. We recorded a loss on the sale of the Ohio properties of $7.9 million.

Vitalink Transaction

In fiscal 1998, effective August 28, 1998, we consummated the merger agreement with Vitalink Pharmacy Services, Inc., referred to as Vitalink, pursuant to which Vitalink merged with and into our wholly-owned subsidiary. Vitalink provides pharmaceutical products and services, enteral and parenteral therapy supplies and services, urological and ostomy products, intravenous products and services and pharmacy consulting services to independent healthcare facilities.

Multicare Transaction and Restructuring

In fiscal 1998, effective October 1, 1997, Genesis ElderCare Corp., a Delaware corporation owned 43.6% by us, acquired Multicare, pursuant to a tender offer and merger (the “Multicare Transaction”). Multicare was in the business of providing eldercare and specialty medical services in selected geographic regions. In connection with the Multicare Transaction, we entered into a management agreement pursuant to which we managed Multicare’s operations. We also entered into an asset purchase agreement with Multicare and certain of its subsidiaries pursuant to which we acquired all of the assets used in Multicare’s outpatient and inpatient rehabilitation therapy business, and a stock purchase agreement with Multicare and certain subsidiaries pursuant to which we acquired all of the outstanding capital stock and limited partnership interest of certain subsidiaries of Multicare that were engaged in the business of providing institutional pharmacy services to third parties.

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Multicare Joint Venture Restructuring

In fiscal 1998, Genesis ElderCare Corp., a Delaware corporation of which Genesis owned 43.6%, acquired Multicare pursuant to a tender offer and merger. Multicare was in the business of providing eldercare and specialty medical services in selected geographic regions. Contemporaneous with the acquisition, Genesis entered into a management agreement pursuant to which it managed Multicare's operations. In connection with the respective investments in the common stock of Genesis ElderCare Corp., Genesis and its joint venture partners entered into a put/call agreement relating to their respective ownership interests in Genesis ElderCare Corp. Under the put/call agreement, the Company had the option to purchase Genesis ElderCare Corp. common stock held by its joint venture partners at a price determined pursuant to the terms of the put/call agreement (the "call"). Genesis' joint venture partners had the option to sell such Genesis ElderCare Corp. common stock to the Company at a price determined pursuant to the put/call agreement (the "put"). The put did not include a guaranteed return to the joint venture partners and it could be satisfied at the Company's election by the issuance of its common stock.

In fiscal 2000, the Company entered into a restructuring agreement with its Multicare joint venture partners. Under the agreement, in exchange for 24,369 shares of its Series H Senior Subordinated Convertible Participating Cumulative Preferred Stock and 17,631 shares of its Series I Senior Convertible Exchangeable Participating Cumulative Preferred Stock (collectively the "Series H and I Preferred"), the other joint venture partners, among other things:

- terminated the put option under the put/call agreement;
- amended the call option to provide Genesis with the right to purchase all of the shares of common stock of Genesis ElderCare Corp. not owned by the Company for $2.0 million in cash at any time prior to the October 8, 2009 expiration. The Company's joint venture partners continued to own 56.4% of Genesis ElderCare Corp.'s common stock;
- granted Genesis an irrevocable proxy to vote the shares of common stock of Genesis ElderCare Corp. held by the Company's joint venture partners on all matters to be voted on by shareholders, including the election of directors;
- granted Genesis the right to appoint two-thirds of the members of the Genesis ElderCare Corp. board of directors;
- granted Genesis the right to appoint 100% of the members of the operating committee of the Genesis ElderCare Corp. board of directors; and
- provided, in a separate but related transaction, a $50.0 million infusion of cash in the form of the joint venture partners' purchase of Genesis common stock.

Amendments made to the stockholders' agreement and the put / call agreement gave the Company managerial, operational and financial control of Multicare, such that the Company began consolidating the financial statements of Multicare effective October 1, 1999.

Because of the amendments to the stockholders' agreement and the fact that the amended call agreement gave the Company the right to purchase the remaining 56.4% interest in Multicare for a nominal $2.0 million, the Company effectively acquired the joint venture partners 56.4% equity interest in the restructuring transaction and began accounting for Multicare as a wholly-owned subsidiary.

The Multicare joint venture restructuring transaction has been accounted for as a step acquisition, whereby the Company recorded the assets and liabilities of Multicare at 43.6% of their historical cost and 56.4% of their fair value. The Series H and I Preferred stock issued by Genesis as consideration in the Multicare joint venture restructuring was recorded at its estimated fair value of $198.0 million, representing the then market value of the underlying Genesis common stock that the Series H and I Preferred were convertible into. The Series H and I Preferred were issued with a face value of $420.0 million. Subsequent to the Multicare joint venture restructuring transaction, and using the effective interest method, the Company recorded preferred stock

dividend expense in fiscal 2000 of $12.8 million representing the accretion of the $198.0 million fair value to the $420.0 million face value of the Series H and I Preferred. This accretion was recorded until the Company filed for Chapter 11 bankruptcy protection at which time the Company recognized a charge included in debt restructuring and reorganization costs for the remaining difference between the carrying value and face value of the Series H and I Preferred because the face value of the Series H and I Preferred was an allowed bankruptcy claim.

In connection with the step acquisition accounting, the Company recorded approximately $168.0 million of goodwill. The most significant other purchase accounting adjustment was the recognition of 56.4% of Multicare's debt obligations at fair value, resulting in a debt discount of approximately $207.4 million. Subsequent to the Multicare joint venture restructuring transaction, and using the effective interest method, the Company accreted the $568.6 million carrying value of Multicare debt to the $776.0 million contractual obligation of the debt. This accretion was recorded until the Company filed for Chapter 11 bankruptcy protection at which time the Company recognized a charge included in debt restructuring and reorganization costs for the remaining difference between the carrying value and face value of the debt because the face value of the debt was an allowed bankruptcy claim.

Results of Operations

Factors Affecting Comparability of Financial Information

As a consequence of the implementation of fresh-start reporting effective September 30, 2001, the financial information presented in the consolidated statement of operations and the statement of cash flows for the twelve months ended September 30, 2002 are generally not comparable to the financial results for the corresponding periods in fiscal 2001. To highlight the lack of comparability, a solid vertical line separates the pre-emergence financial information from the post-emergence financial information in the accompanying consolidated financial statements and the notes thereto. Any financial information herein labeled "Predecessor Company" refers to periods prior to the adoption of fresh-start reporting, while those labeled "Successor Company" refer to periods following adoption of fresh-start reporting.

The lack of comparability in the accompanying consolidated financial statements is most apparent in our capital costs (lease, interest, depreciation and amortization), as well as with debt restructuring and reorganization costs, and preferred dividends. We believe that business segment operating revenue and operating income of the Predecessor Company are generally comparable to those of the Successor Company.

Fiscal 2002, fiscal 2001 and fiscal 2000 financial information has been adjusted to exclude operations identified as either held for sale or discontinued since our September 30, 2001 adoption of SFAS No. 144. Properties identified as held for sale or discontinued prior to our September 30, 2001 adoption of SFAS No. 144 continue to be reflected in the results from continuing operations. See "&#151 Certain Transactions and Events &#151 Assets Held for Sale and Discontinued Operations".

Operating income is defined as income after operating expenses as they appear on the our consolidated statements of operations and is calculated by subtracting salaries, wages and benefits; cost of sales; other operating expenses and strategic planning, severance and related costs from net revenues.

Fiscal 2002 Compared to Fiscal 2001:

Consolidated Results

Revenues

For the twelve months ended September 30, 2002, revenues grew $171.5 million, or 7%, to $2,623.7 million compared to $2,452.2 million for the same period in the prior year. Of this growth, external pharmacy services revenue increased by $87.6 million, inpatient services revenue grew by $75.5 million and all other business lines grew $8.4 million. See "Segment Results" discussed further in this section for a discussion of revenue fluctations.

Operating Expenses

Salaries, wages and benefits for the twelve months ended September 30, 2002 increased $63.2 million, or 6%, to $1,108.6 million from $1,045.4 million for the same period in the prior year. This increase was offset by

reductions of $9.3 million resulting from divested eldercare centers exited in the twelve months ended September 30, 2001. Salaries, wages and benefits cost, considering the impact of divested eldercare centers, increased $72.5 million, or 7%, driven by operational growth, inflationary cost increases and the relative mix of employed labor versus agency labor costs. Expressed as a percentage of revenues, adjusted on a same-store-basis for the impact of divested eldercare centers, salaries, wages and benefits were relatively unchanged for the twelve months ended September 30, 2002 at 42.3% compared to 42.5% for the same period in the prior year.

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Cost of sales increased $62.7 million, or 10%, for the twelve months ended September 30, 2002 to $705.5 million from $642.8 million in the same period in the prior year. Of this increase, approximately $54.3 million is attributed to pharmacy revenue growth, with the remaining $8.4 million attributed to margin compression related to changes in payor and product mix.

Our other operating expenses, including our general and administrative expenses, decreased $83.3 million, or 13%, for the twelve months ended September 30, 2002 to $554.1 million compared to $637.4 million in the prior year. Of this reduction, $101.6 million relates to costs recorded in the twelve months ended September 30, 2001 in connection with certain uncollectible receivables, insurance related costs and other charges included in other operating expenses (included in other operating expenses and described more fully in the comparison of fiscal 2001 and 2000). After considering these costs and the loss of other operating costs of divested eldercare centers ($4.3 million for the twelve months ended September 30, 2001), other operating expenses increased $22.6 million, or 4%.

For the twelve months ended September 30, 2002, we incurred $26 million of costs that are attributable to our change in strategic direction and objectives. These costs are expected to continue for the foreseeable future below the levels incurred in the current year and are segregated in the statement of operations as “strategic planning, severance and related costs”. There were no strategic planning, severance and related costs incurred in fiscal 2001. For a detailed discussion of these costs, see “&#151 Certain Transactions and Events &#151 Change in Strategic Direction and Objectives - Strategic Planning, Severance and Related Costs”.

Capital Costs and Other

During the twelve months ended September 30, 2002, we recorded a net gain of $21.9 million resulting from the award in the Manor Care arbitration. In addition, we also recorded $1.9 million of gains on other legal settlements in the twelve months ended September 30, 2002.

In October 2000, we sold an idle 232 bed eldercare center for cash consideration of $7 million, resulting in a net gain on sale of $1.8 million. In April 2001, we sold an operational 121 bed eldercare center for cash consideration of $0.5 million, resulting in a net loss of $2.3 million. The impact of these transactions was a net loss on sale of eldercare centers of approximately $0.5 million.

Depreciation and amortization expense decreased $40.2 million to $63.1 million for the twelve months ended September 30, 2002 compared to $103.3 million for the same period in the prior year. The decrease was primarily caused by the impact of fresh-start reporting on the carrying value of our property, plant and equipment, which were adjusted to their estimated fair values as of September 30, 2001, and our September 30, 2001 adoption of an accounting pronouncement which no longer requires the amortization of goodwill.

Lease expense decreased $6.3 million for the twelve months ended September 30, 2002, to $27.7 million compared to $34.0 million for the same period in the prior year. Of this decrease, $2.1 million is attributed to the divestitures or lease modifications of certain leased eldercare centers. The remaining decrease of $4.2 million is principally attributed to the discharge in bankruptcy of our lease financing facility.

Interest expense decreased $70.6 million for the twelve months ended September 30, 2002 to $48 million, compared to $118.6 million for the same period in the prior year. For the twelve months ended September 30, 2001, in accordance with SOP 90-7, we ceased accruing interest following the petition date, June 22, 2000, on certain long-term debt instruments classified as liabilities subject to compromise. Our contractual interest expense for the twelve months ended September 30, 2001 was $214 million, leaving $95.4 million of interest expense unaccrued for that period as a result of the Chapter 11 cases. Interest expense for the twelve months ended September 30, 2002 has been accrued at the contractual rates. Contractual interest expense for the twelve months ended September 30, 2002 decreased by $166 million compared to the same period in the prior year. This decrease is attributed to the overall reduction of debt levels following our emergence from bankruptcy in addition to a lower weighted average borrowing rate.

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During the twelve months ended September 30, 2002, we recorded $4.3 million of debt restructuring and reorganization costs. $2.6 million related to post confirmation liabilities payable to the United States Trustee related to Chapter 11 cases that remained open. With the exception of three open cases, all other Chapter 11 cases were closed in July 2002. The remaining $1.7 million represents a post confirmation charge resulting from a settlement reached with the lender of a pre-petition mortgage obligation for an amount that exceeded the estimated loan value established in the September 30, 2001 fresh-start balance sheet by $1.7 million. During the twelve months ended September 30, 2001, we recorded $1,064.8 million of debt restructuring and reorganization costs, consisting of legal, bank, accounting and other costs of $59.4 million; $16.8 million for certain bankruptcy related salary and benefit related costs, principally for a court approved special recognition program; $5.9 million of costs associated with the divestiture of certain businesses; and fresh-start valuation adjustments of $982.7 million. Fresh-start valuation adjustments were recorded pursuant to the provisions of SOP 90-7, which require entities to record their assets and their liabilities at estimated fair values. The fresh-start valuation adjustment as described relates only to continuing operations and is principally the result of the elimination of predecessor company goodwill and the revaluation of property, plant and equipment to estimated fair values.

Income tax expense for the twelve months ended September 30, 2002 of $42.8 million was offset by a $10.3 million tax credit realized pursuant to the Job Creation and Worker Assistance Act of 2002. Our income tax expense is estimated using an effective tax rate of 39%. We did not record any income tax expense for the twelve months ended September 30, 2001 due to our operating losses.

Equity in net earnings of unconsolidated affiliates for the twelve months ended September 30, 2002 was $1.6 million compared to equity in net loss of unconsolidated affiliates of $10.2 million for the same period in the prior year, which is attributed to changes in the earnings / losses reported by our unconsolidated affiliates.

Minority interests decreased $5.0 million during the twelve months ended September 30, 2002 to a loss of $2.8 million compared to income of $2.2 million for the comparable period in the prior year.

Preferred stock dividends decreased $43.0 million to $2.6 million during the twelve months ended September 30, 2002 compared to $45.6 million for the comparable period in the prior year. This decrease is attributed to the cancellation of our predecessor company preferred stock and related dividends, and offset with dividends on $42.6 million of the preferred stock issued in connection with our joint plan of reorganization. At September 30, 2002, there were 421,796 shares of preferred stock outstanding.

Losses from discontinued operations decreased $11.5 million for the twelve months ended September 30, 2002, to $3.6 million from $15.1 million for the same period in the prior year. During the twelve months ended September 30, 2002, we identified 22 businesses as either held for sale or discontinued operations. The results of operations in the current year and prior year periods, along with any costs to exit such businesses in the current year period, have been classified as discontinued operations in the consolidated statements of operations. Businesses sold or closed prior to our October 1, 2001 adoption of SFAS 144 continue to be reported in the results of continuing operations. The decrease in losses from discontinued operations for the twelve months ended September 30, 2002 compared to the same period in the prior year is principally due to the level of fixed asset write-downs to fair value in the 2001 period by the discontinued businesses in connection with their adoption of fresh start reporting. See “&#151 Certain Transactions and Events &#151 Assets Held For Sale and Discontinued Operations”.

We recognized a $1,509.9 million extraordinary gain during the twelve months ended September 30, 2001 in connection with the discharge of liabilities subject to compromise pursuant to our joint plan of reorganization.

Segment Results

We have two reportable segments: (1) inpatient services and (2) pharmacy services. For a reconciliation of segment financial information to the consolidated statements of operations, see note 23 to our consolidated financial statements &#151 “Segment Information.”

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Inpatient Services

Inpatient services revenue increased $75.5 million, or 6%, to $1,331 million for the twelve months ended September 30, 2002 from $1,255.5 million for the same period in the previous year. Of this increase, $88 million is principally attributed to increased payment rates. Our average rate per patient day for the twelve months ended September 30, 2002 was $183 compared to $169 for the comparable period in the prior year. This increase in the average rate per patient day is principally driven by the full year effect of the April, 2001 implementation of the Benefits Improvement and Protection Act on our average Medicare rate per patient day ($336 in 2002 versus $326 in 2001), as well as increased Medicaid rates ($137 in 2002 versus $127 in 2001) in certain states, most notably in the states of Maryland and Florida. Our non-Medicaid revenue mix ("Quality Mix") for the twelve months ended September 30, 2002 was 50.1% and relatively unchanged compared to 50.0% for the comparable period in the prior year. Our rate increases are offset by a decrease in revenue of $12.5 million resulting from eldercare center divestitures. Total patient days decreased 132,038 to 7,287,876 during the twelve months ended September 30, 2002 compared to 7,419,914 during the comparable period last year. Of this decrease, 121,768 patient days are attributed to eldercare center divestitures and decreased operating census of 19,709 patient days as the result of a decline in overall occupancy; offset by the addition of 9,439 patient days of two new eldercare centers.

Operating expenses for the twelve months ended September 30, 2002 increased $50.2 million, or 5%, to $1,160.8 million from $1,110.6 million for the same period in the prior year. The primary cost for this segment is salary, wage and benefit costs, which increased $26.6 million, or 4% for the twelve months ended September 30, 2002 to $645 million from $618.4 million for the same period in the prior year. This increase is net of $9.3 million of reduced salary, wage and benefit costs resulting from eldercare center divestitures. Salary, wage and benefit costs, considering the impact of divested eldercare centers, increased $35.9 million, or 6%, driven by inflationary cost increases and the relative mix of employed labor versus agency labor costs. As a percentage of net revenue, salary, wage and benefit costs, once adjusted for the impact of divested eldercare centers, was 48.5% for the twelve months ended September 30, 2002 compared to 49% for the comparable period in the prior year. The decline in this ratio is attributed to a disproportionate increase in revenue as a result of the full year impact of the Benefits Improvement Protection Act in 2002 as compared to the increase in labor related costs. The inpatient services segment has experienced continued pressure on wage and benefit related costs mitigated by less reliance on agency labor (primarily nursing costs) resulting from improved hiring and retention trends. Other operating expenses, once reduced for the impact of divested eldercare centers ($4.2 million for the twelve months ended September 30, 2001), increased $27.8 million, or 6%, to $515.8 million for the twelve months ended September 30, 2002 compared to $488 million for the same period last year. The increase was primarily driven by $9.4 million of additional ancillary supply costs to treat a higher acuity customer base, increased property and general liability insurance of $9.5 million and other operating costs of $11.0 million; offset by decreased agency labor costs (principally nursing costs) of $2.1 million. External labor agencies charge us a premium labor rate compared to salary, wage and benefits earned by employees.

As a result of the factors described above, operating income increased $25.4 million, or 18%, to $170.2 million for the twelve months ended September 30, 2002 from $144.8 million for the same period in the prior year. Operating income margin improved to 12.8% in the twelve months ended September 30, 2002 from 11.5% for the same period in the prior year. Operating income of our segments does not include an allocation of corporate overhead costs and certain other adjustments.

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Pharmacy Services

Pharmacy services revenue (before intersegment eliminations) increased $90 million, or 8%, to $1,224.4 million for the twelve months ended September 30, 2002 compared to $1,134.4 million for twelve months ended September 30, 2001. Revenues from intersegment customers, which are eliminated in consolidation, increased $2.4 million, or 2%, to $100.5 million for the twelve months ended September 30, 2002 compared to $98.1 million for the same period in the prior year. The increase in pharmacy service revenues with external customers increased $87.6 million, or 8%, due to favorable changes in bed mix and patient acuity, and increased product pricing.

Cost of sales (before intersegment eliminations) increased $61.3 million, or 9%, for the twelve months ended September 30, 2002, to $764 million from $702.7 million for the same period in the prior year. Of this growth, $55.7 million is attributed to pharmacy and medical supply revenue growth, and $5.6 million is due to margin compression related changes in payor mix and reductions in reimbursement rates. As a percentage of revenue, cost of sales for the twelve months ended September 30, 2002 and 2001 was 62%. Other operating expenses for this segment, including salaries, wages and benefits, increased $17 million, or 5%, to $348.1 million for the twelve months ended September 30, 2002 compared to $331.1 million for the same period in the prior year. As a percentage of revenue, other operating costs declined to 28% for the twelve months ended September 30, 2002 from 29% for the comparable period in the prior year. This decline is attributed to improved cost control and the leveraging of fixed costs against increased revenues.

As a result of the factors described above, operating income increased $11.7 million, or 12% to $112.3 million for twelve months ended September 30, 2002 from $100.6 million for the same period in the prior year. Operating income margin improved to 9.2% in the twelve months ended September 30, 2002 from 8.9% in the same period in the current year. Operating income of our segments does not include an allocation of corporate overhead costs and certain other adjustments.

Fiscal 2001 Compared to Fiscal 2000:
Consolidated Results

Revenues

For the twelve months ended September 30, 2001, net revenues increased $124.6 million, or 5%, to $2,452.2 million from $2,327.6 million. Of this growth, external pharmacy services revenue increased by $86.4 million, inpatient service revenue increased $28.3 million and all other business lines grew $9.9 million. See “Segment Results” discussed further in this section.

Operating Expenses

Salaries, wages and benefits for the twelve months ended September 30, 2001 increased $10.1 million, or 1%, to $1,045.4 million from $1,035.3 million for the same period in the prior year. This increase is offset by net reductions of $24.3 million resulting from divested eldercare centers exited and new eldercare centers under operation in the twelve months ended September 30, 2000. Salaries, wages and benefits cost, considering the impact of divested and new eldercare centers, increased $34.4 million or 3% driven by operational growth, inflationary cost increases and the relative mix of employed labor versus agency labor costs. Expressed as a percentage of revenues, adjusted on a same-store-basis for the impact of divested and new eldercare centers, salaries, wages and benefits decreased for the twelve months ended September 30, 2001 to 42.6% compared to 44.6% for the same period in the prior year. This decrease as a percentage of revenue resulted from net revenue growth in our pharmacy segment which is our least labor intensive business, and therefore did not require proportional increases in labor related costs.

Cost of sales increased $68.8 million, or 12%, for the twelve months ended September 30, 2001 to $642.8 million from $574 million in the same period in the prior year. Of this increase, $52.2 million is attributed primarily to pharmacy revenue growth, with the remaining $16.6 million attributed to margin compression related to changes in payor and product mix.

Our other operating expenses, including our general and administrative expenses, decreased $171.2 million, or 21%, for the twelve months ended September 30, 2001 to $637.4 million from $808.6 million in the prior year. Of

the net decrease, $213.8 million is attributed to a decrease in certain charges for the twelve month periods ended September 30, 2001 and 2000 equaling $101.6 million and $315.4 million, respectively (included in other operating expenses and described more fully in the paragraphs and tables that follow). In addition, operating expense was reduced by approximately $18.6 million for the net operating cost savings resulting from divested and new eldercare centers. Agency labor costs, including nursing agency costs, increased approximately $12.8 million in the twelve months September 30, 2001. The remaining operating cost growth of $48.5 million is attributed to operational growth and general inflationary cost increases.

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During fiscal 2001, we recorded costs in connection with certain uncollectible receivables, insurance related costs and other charges included in other operating expenses. The following table and discussion provides additional information on these charges (in thousands):

	2001
Notes receivable, advances, and trade receivables, due from affiliated businesses formerly owned or managed deemed uncollectible	$ 30,048
Uncollectible trade receivables	39,249
Self-insured and related program costs	15,110
Other charges	17,231
Total uncollectible receivable, insurance related and other charges included in other operating expenses	$ 101,638

In fiscal 2001, we performed periodic assessments of the collectibility of amounts due from certain affiliated businesses in light of the adverse impact of PPS on their liquidity and profitability. As a result of our assessment, the carrying value of notes receivable, advances and trade receivables due from affiliates was written down by $30 million.

In fiscal 2001, we performed a re-evaluation of our allowance for doubtful accounts triggered by deteriorations in the agings of certain categories of receivables. We believe that such deteriorations in the agings were due to several prolonged negative factors related to the operational effects of the bankruptcy filings such as personnel shortages and the time demands required in normalizing relations with vendors and addressing a multitude of bankruptcy issues. As a result of this re-evaluation, we determined that an increase in the allowance for doubtful accounts of $39.2 million was necessary.

In fiscal 2001, as a result of adverse claims development we re-evaluated the levels of reserves established for certain self-insured health and workers' compensation benefits and other insurance related programs. These charges were $15.1 million.

In addition, we incurred charges of $17.2 million during fiscal 2001, principally related to contract and litigation matters and settlements, and certain other charges.

During fiscal 2000, we recorded charges in connection with the impairment of long-lived assets and other impairments and charges. The following table and discussion provides additional information on these charges (in thousands):

	2000
Impairment of long-lived assets	$ 174,715
Exit costs and write-off of unrecoverable assets of six eldercare centers closed or leases terminated	28,363
Investments in information systems development abandoned in fiscal 2000	19,200
Uncollectible trade and notes receivable due to customer bankruptcy or other liquidity issues	41,955

Other charges, including third party appeal issues and other cost settlement balances deemed uncollectible and insurance related adjustments	51,181
Total asset impairments and other charges included in other operating expenses	$ 315,414

During fiscal 2000, in connection with our budget preparations for the forthcoming year and in accordance with Statement of Accounting Standards No. 121 “Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to be Disposed of” (“SFAS No. 121”), we reviewed the current and projected undiscounted cash flows of our eldercare centers and our NeighborCare pharmacy operations. This review indicated that the assets of certain eldercare centers were impaired. The fair market value of businesses deemed potentially impaired were then estimated and compared to the carrying values of the long-lived assets. Any excess long-lived asset carrying value over the estimated fair value was written-off. Fair value was estimated using a per bed value determined by us. The total loss for SFAS No. 121 impairments of $174.7 million is associated with 48 eldercare centers. No impairment charge was assessed on the long-lived assets of our NeighborCare pharmacy operations. The impairment charge recorded resulted in the write-off of $125.7 million of goodwill and $34.6 million of property, plant and equipment.

During fiscal 2000, we closed or were in the process of closing or terminating the leases of six underperforming eldercare centers with 842 combined beds. As a result, a charge of $28.4 million was recorded to account for certain impaired and abandoned assets of these eldercare centers.

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As a result of our Chapter 11 bankruptcy filing and curtailment in funding availability, we assessed the recoverability of our investment in certain information systems developed internally for the operating needs of our institutional pharmacy and infusion therapy businesses. Our assessment determined that $19.2 million of the carrying value of our investment in these systems was unrecoverable through estimated future product sales to third parties and future operating efficiencies.

During fiscal 2000, we performed periodic assessments of the collectibility of amounts due from certain affiliated businesses in light of the adverse impact of PPS on their liquidity and profitability. In certain cases, customers filed for protection under Chapter 11 of the Bankruptcy Code. As a result of our assessment, the carrying value of notes receivable, advances and trade receivables due from these customers was written down $42 million.

In the fourth quarter of fiscal 2000, we performed an assessment of the collectibility of certain aged amounts due from third party payors and concluded that $12.5 million was unrecoverable. In addition, as a result of adverse claims development we reevaluated the levels of reserves established for certain self-insured and other programs, including workers' compensation and general liability insurance, resulting in a charge of $35.2 million.

Capital costs and other

During the twelve months ended September 30, 2001, we sold an idle 232 bed eldercare center for cash consideration of $7 million, resulting in a net gain of $1.8 million; and we sold an underperforming 121 bed eldercare center for cash consideration of $0.5 million, resulting in a net loss of $2.3 million. The impact of these transactions was a net loss on sale of eldercare centers of $0.5 million for the twelve months ended September 30, 2001. During the twelve months ended September 30, 2000, effective May 31, 2000, Multicare sold 14 eldercare centers with 1,128 beds located in the state of Ohio for $33 million. As a result of this transaction, we recorded a loss on sale of the Ohio properties of $7.9 million.

Depreciation and amortization expense decreased $8.5 million, principally attributed to the fourth quarter of fiscal 2000 write-off of impaired goodwill and property, plant and equipment and the sale, closure or lease terminations of certain eldercare centers.

Lease expense decreased $2.8 million, of which $2.2 million is attributed to the closures or lease terminations of certain eldercare centers, offset by an increase of $1.2 million attributed to the consolidation of two newly leased eldercare centers. The remaining decrease of $1.8 million is principally attributed to a decline in the weighted average borrowing rate associated with a lease financing facility.

Interest expense decreased $105.2 million. In accordance with SOP 90-7, we ceased accruing interest following the petition date, June 22, 2000, on certain long-term debt instruments classified as liabilities subject to compromise. Our contractual interest expense for the twelve months ended September 30, 2001 was $214 million, leaving $95.4 million of interest expense unaccrued for that period as a result of the Chapter 11 filings. Contractual interest expense for the twelve months ended September 30, 2001 decreased by $17.5 million compared to $231.5 million for the same period in the prior year. Approximately, $34.4 million of the decrease is primarily attributed to a lower weighted average borrowing rate, offset by additional net capital and working capital borrowings under the Genesis debtor-in-possession financing facility resulting in additional interest expense of $16.9 million.

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During the twelve month periods ending September 30, 2001 and 2000 we recorded charges in connection with debt restructuring and reorganization costs of $1,064.8 million and $458.5 million, respectively. In the twelve months ended September 30, 2001, we recorded legal, bank, accounting and other costs of $59.4 million in connection with the Chapter 11 cases; $16.8 million for certain bankruptcy related salary and benefit related costs, principally for a court approved special recognition program; $5.9 million of costs associated with the divestiture of certain businesses and fresh-start valuation adjustments of $982.7 million. Fresh-start valuation adjustments were recorded pursuant to the provisions of SOP 90-7, which require entities to record their assets and their liabilities at estimated fair values. The fresh-start valuation adjustment as described relates only to continuing operations and is principally the result of the elimination of predecessor company goodwill and the revaluation of property, plant and equipment to estimated fair values. During the twelve months ended September 30, 2000, we recorded legal, bank, accounting and other costs of $29.9 million in connection with the Chapter 11 cases and $4.5 million for certain bankruptcy related salary and benefit related costs, principally for a court approved special recognition program. Also during the twelve months ended September 30, 2000, as a result of the nonpayment of interest under our then existing credit facility, certain provisions under existing interest rate swap arrangements with Citibank were triggered. Citibank notified us that they elected to force early termination of the interest rate swap arrangements, and asserted a $28.3 million obligation. The Company recorded $395.7 million for the accretion of allowed claims representing the accelerated accretion of the carrying value of certain debt and preferred stock instruments to the amount of such instruments contractual value upon the Company's filing for Chapter 11 bankruptcy.

Equity in net loss of unconsolidated affiliates for the twelve months ended September 30, 2001 was $10.2 million compared to $2.4 million for the comparable period in the prior year. This increase of $7.8 million is attributed to changes in the earnings / losses reported by our unconsolidated affiliates.

Minority interests increased $3.6 million during the twelve months ended September 30, 2001 to $2.2 million compared to a loss of $1.4 million for the comparable period in the prior year.

As a result of the consummation of our joint plan of reorganization, and in accordance with the provisions of SOP 90□7, we recorded a $1,509.9 million extraordinary gain on the discharge of certain of our indebtedness in the twelve months ended September 30, 2001.

Effective October 1, 1999, we adopted the provisions of the American Institute of Certified Public Accountant's Statement of Position 98-5 "*Reporting on the Costs of Start-Up Activities*" ("SOP 98-5") which requires start-up costs be expensed as incurred. For the twelve months ended September 30, 2000, the cumulative effect of expensing all unamortized start-up costs at October 1, 1999 was $16.4 million pre tax and $10.4 million after tax.

Preferred stock dividends decreased $9.8 million to $45.6 million during the twelve months ended September 30, 2001 compared to $55.4 million for the comparable period in the prior year. This decrease is principally attributed to the accretion of preferred dividends on our predecessor company preferred stock during the twelve months ended September 30, 2000 to its face value prior to our filing for Chapter 11 bankruptcy protection.

Segment Results

Inpatient Services

Inpatient service revenue increased $28.3 million in the twelve months ended September 30, 2001 to $1,255.5 million from $1,227.3 million in the prior year. Of this increase, $71.4 million is principally attributed to increased payment rates. Our average rate per patient day for the twelve months ended September 30, 2001 was $169 compared to $153 for the comparable period in the prior year. This increase in the average rate per patient day is principally driven by the effect of the implementation of the Balanced Budget Refinement Act and the Benefits Improvement and Protection Act on our average Medicare rate per patient day ($326 in 2001 versus $291 in 2000). Our non-Medicaid revenue mix ("Quality Mix") for the twelve months ended September 30, 2001 was 50.0% compared to 49.3% for the comparable period in the prior year. Our rate increases are offset by a net decrease in revenue of $43.1 million resulting from eldercare center divestitures and new eldercare centers under operation. Total patient days decreased 438,318 to 7,419,914 during the twelve months ended September 30, 2001 compared to 7,858,232 during the comparable period last year. Of this decrease, 374,373 patient days are attributed to eldercare center divestitures, offset by the consolidation of new eldercare centers under operation. A decrease of 20,329 patient days compared to the comparable period in the prior year is attributed to

one additional calendar day in fiscal 2000 due to a leap year. The remaining decrease of 43,616 is the result of a decrease in overall occupancy.

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During fiscal 2000, the majority of our eldercare centers located in the state of New Jersey transferred their hospitality function from in-house employees to agency labor employed by our wholly-owned hospitality services business. That fundamental change resulted in a significant reduction in the salaries, wages and benefits expense of the inpatient segment and a corresponding increase in agency purchased services recorded as a component of other operating expenses. Consequently, the ensuing discussion of operating expenses includes both salaries, wages and benefits and other operating costs on a consolidated basis for ease of analysis when comparing the 2001 and 2000 fiscal periods. Operating expenses for the twelve months ended September 30, 2001 increased $43.2 million to $1,110.7 million from $1,067.5 million for the same period in the prior year. In fiscal 2001, as a result of adverse claims development we reevaluated the levels of reserves established for certain self-insured health and workers' compensation benefits and other insurance related programs. For the inpatient services segment, these charges were $5.5 million. These increases are reduced by net operating cost savings of approximately $36.8 million for eldercare center divestitures and new eldercare centers under operation. Considering the impact of divested and new eldercare centers and self□insured benefit program charges, operating expenses increased $74.5 million, or 7%, driven by inflationary cost increases and continued pressure on wage and benefit related costs, including a greater reliance on agency labor (primarily nursing costs) in fiscal 2001 compared to fiscal 2000.

As a result of the factors described above, operating income declined $14.9 million, or 9%, to $144.9 million for the twelve months ended September 30, 2001 from $159.8 million in the prior year. Operating income margin declined to 11.5% in the twelve months ended September 30, 2001 compared to 13% for the same period in the prior year. Operating income of our segments does not include an allocation of corporate overhead costs and certain other adjustments.

Pharmacy Services

Pharmacy services revenue (before intersegment eliminations) increased $84.6 million, or 8%, to $1,134.4 million for the twelve months ended September 30, 2001 compared to $1,049.8 million for twelve months ended September 30, 2000. Revenues from intersegment customers, which are eliminated in consolidation, decreased $1.8 million, or 2%, to $98.1 million for the twelve months ended September 30, 2001 compared to $99.9 million for the same period in the prior year, due to eldercare center divestitures. The increase in pharmacy service revenues with external customers was $86.4 million or 9% due to favorable changes in bed mix and patient acuity, and increased product pricing.

Cost of sales (before intersegment eliminations) increased $70.1 million, or 11%, for the twelve months ended September 30, 2001, to $702.7 million from $632.6 million for the same period in the prior year. Of this growth, $51 million is attributed to pharmacy services revenue growth, and $19.1 million is due to margin compression, related changes in payor mix and reductions in reimbursement rates. As a percentage of revenue, cost of sales for the twelve months ended September 30, 2001 and 2000 were 62% and 60%, respectively. Other operating expenses for this segment, including salaries, wages and benefits, increased $2.9 million, or 1%, to $331.1 million for the twelve months ended September 30, 2001 compared to $328.2 million for the same period in the prior year. As a percentage of revenue, other operating costs declined to 29% for the twelve months ended September 30, 2001 from 31% for the comparable period in the prior year. This decline is attributed to improved cost control and the leveraging of fixed costs against increased revenues.

As a result of the factors described above, operating income increased $11.7 million, or 13% to $100.6 million for twelve months ended September 30, 2001 from $88.9 million for the same period in the prior year. Operating income margin improved to 8.9% in the twelve months ended September 30, 2001 from 8.5% for the same period in the prior year. Operating income of our segments does not include an allocation of corporate overhead costs and certain other adjustments.

Liquidity and Capital Resources

Working Capital and Cash Flows

At September 30, 2002, we had cash and equivalents of $148 million, net working capital of $449 million and $149.1 million of unused commitment under our $150 million Revolving Credit Facility.

At September 30, 2002, we had restricted investments in marketable securities of $86.1 million, which are held by Liberty Health Corp. LTD., referred to as LHC, our wholly-owned captive insurance subsidiary incorporated under the laws of Bermuda. The investments held by LHC are restricted by statutory capital requirements in Bermuda. In addition, certain of these investments are pledged as security for letters of credit issued by LHC. As a result of such restrictions and encumbrances, we and LHC are precluded from freely transferring funds through intercompany loans, advances or cash dividends.

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Our cash flow from operations before debt restructuring and reorganization costs for the twelve months ended September 30, 2002 generated cash of $233.4 million compared to $51.7 million for the twelve months ended September 30, 2001, principally due to higher levels of operating income, reduced interest and lease payments following our reorganization, improvement in the collection of accounts receivable, receipt of $21.9 million in cash proceeds for an arbitration award and the timing of vendor payments and employee wages. During the second quarter of fiscal 2002, we borrowed $42 million from the Delayed Draw Term Loan to finance the repayment of all trade balances due to NeighborCare® Pharmacy's primary supplier of pharmacy products. This change in credit terms resulted in reduced pharmacy product acquisition costs, partially offset by an increase in interest expense on the incremental Delayed Draw Term Loan borrowings. Assuming no future changes in variable rates of interest, the net impact of this transaction is positive to our cash flows. Cash payments for debt restructuring and reorganization costs were $54.2 million for the twelve months ended September 30, 2002 compared to $44.4 million for the same period in the prior year. We believe that cash flow from operations, along with available borrowings under our Revolving Credit Facility, are sufficient to meet our current liquidity needs.

Our days sales outstanding at September 30, 2002 was 54 days compared to 60 days at September 30, 2001. This reduction is principally due to improvement in the collection of accounts receivable.

Our net cash used in investing activities for the twelve months ended September 30, 2002 was $94.8 million, and includes $51.6 million of capital expenditures. Capital expenditures consist primarily of betterments and expansion of eldercare centers and investments in computer hardware and software. In order to maintain our physical properties in a suitable condition to conduct our business and meet regulatory requirements, we expect to continue to incur capital expenditure costs at levels at or above those for the twelve months ended September 30, 2002 for the foreseeable future.

Our investing activities for the twelve months ended September 30, 2002 also include $33.9 million in net investments in restricted investments in marketable securities, representing the current period funding of self-insured workers' compensation and general / professional liability insurance retentions held by LHC, and $10.5 million in connection with the exercise of an option to purchase three formerly leased eldercare centers.

Our cash flows from investing activities for the twelve months ended September 30, 2002 and 2001 include $3 million and $7 million, respectively, of cash proceeds from the sale of eldercare center assets.

Our financing activities for the twelve months ended September 30, 2002, resulted in net cash inflows of $31.5 million, and include $80 million of cash proceeds from borrowings under the Delayed Draw Term Loan, of which $10 million were used to finance the price of the purchase option to purchase three previously leased eldercare centers, and $28 million was used to refinance several mortgages at more favorable rates of interest. The Delayed Draw Term Loan was amended in December 2001 to allow $42 million of available credit under that loan to be used to restructure credit terms with NeighborCare pharmacy's primary supplier of pharmacy products, as previously discussed. The Delayed Draw Term Loan is fully drawn at September 30, 2002 and is being repaid with no additional borrowings available under the Delayed Draw Term Loan.

The Senior Credit Facility requires that we achieve certain levels of fixed versus variable interest rate exposure. We were required to either enter into interest rate swap agreements that effectively fix or cap the interest cost on at least 50% of our consolidated debt or refinance such debt to achieve a mix of fixed rate debt of at least 50%. In order to meet this requirement, we entered into interest rate swap agreements that effectively convert underlying variable rate debt into fixed rate debt, as well as a cap agreement. At September 30, 2002, after considering the $275 million notional principal amount of these agreements, our effective debt mix is 48% variable rate and 52% fixed rate. See — "Quantitative and Qualitative Disclosures About Market Risk."

The Senior Credit Facility contains an annual excess cash flow payment requirement. At the end of each fiscal year, we are required to prepare an excess cash flow calculation as defined in the senior credit agreement. Of the amount determined as excess cash flow, 75% is to be paid to our senior lenders in the form of a mandatory payment by December 31 of each year. As of September 30, 2002, we estimate that $27 million will be paid on or near December 31, 2002 pursuant to the excess cash flow recapture provision, and as a result, this estimated level of payment has been classified in our consolidated balance sheet under the current installments of long-term debt.

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The agreements and instruments governing our existing debt contain, and the agreements and instruments governing Genesis' future debt may contain, various restrictive covenants that, among other things, require us to comply with or maintain certain financial tests and ratios and restrict our ability to:

- &#149 incur more debt;
- &#149 pay dividends, redeem stock or make other distributions;
- &#149 make certain investments;
- &#149 create liens;
- &#149 enter into transactions with affiliates;
- &#149 make acquisitions;
- &#149 merge or consolidate; and
- &#149 transfer or sell assets.

The Senior Credit Facility requires us to maintain compliance with certain financial and non-financial covenants, including minimum EBITDAR (as defined); limitations on capital expenditures, maximum leverage ratios, minimum fixed charge coverage ratios and minimum net worth.

On October 2, 2001 and in connection with the consummation of our joint plan of reorganization, we entered an indenture agreement in the principal amount of $242.6 million (the "Senior Secured Notes"). The Senior Secured Notes bear interest at LIBOR plus 5.0% (6.79% at September 30, 2002), and amortize one percent each year and mature on April 2, 2007. The Senior Secured Notes are secured by a junior lien on real property and related fixtures of substantially all of the our subsidiaries, subject to liens granted to the lenders' interests subject to the Senior Credit Facility. The Senior Secured Notes may be prepaid at any time without penalty, subject to restrictions in place under the Senior Credit Facility. Compliance with certain financial and non-financial covenants is required, but they are less restrictive than those required by the Senior Credit Facility.

For the twelve months ended September 30, 2002, we incurred $41.3 million of lease obligation costs and expect to continue to incur lease costs at or above levels approximating those for the twelve months ended September 30, 2002 for the foreseeable future. We classify operating lease costs associated with our eldercare centers and corporate office sites as lease expense in the consolidated statement of operations, while the operating lease costs of pharmacy and other health service sites are included within other operating expenses. For the twelve months ended September 30, 2002, our lease expense was reduced $5 million in connection with the amortization of net unfavorable lease credits established in fresh-start reporting. Consequently, our cash basis lease cost was $45.8 million.

We believe that we have adequate capital resources at our disposal to fund currently anticipated capital expenditures as well as current and projected debt service requirements.

Proposed NCS Transaction

In connection with our proposed merger with NCS, we incurred legal, bank and transaction related costs. Such costs do not exceed the $22 million break-up fee we anticipate receiving in the first and second quarters of fiscal 2003. We will recognize a gain in the first quarter of fiscal 2003 representing the $22 million break-up fee less the costs we incurred in connection with the proposed NCS Transaction.

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Financial Commitments

We have future obligations for debt repayments, capital leases and future minimum rentals under operating leases. The obligations as of September 30, 2002 are summarized as follows (in thousands):

	Payments Due by Period				
Contractual Obligation	**Total**	**Less than 1 year**	**1-3 years**	**4-5 years**	**Thereafter**
Long-term debt	$ 679,402	$ 37,011	$ 19,616	$ 566,278	$ 56,497
Capital lease obligations	10,281	3,733	4,568	1,980	
Operating leases	217,901	41,290	73,757	52,180	50,674
	$ 907,584	$ 82,034	$ 97,941	$ 620,438	$ 107,171

Certain of our underlying long-term debt and lease obligations require us to maintain compliance with financial and non-financial covenants, including minimum EBITDAR (as defined); limitations on capital expenditures, maximum leverage ratios, minimum fixed charge coverage ratios and minimum net worth. Failure to meet these covenants or the occurrence of other defaults, such as non-payment, could result in the acceleration of the maturity of such obligations.

We also have contingent obligations related to outstanding lines of credit, letters of credit and guarantees. These commitments as of September 30, 2002 are summarized as follows (in thousands):

	Amount of Commitment Expiration Per Period				
Off-Balance Sheet Commitments	**Total**	**Less than 1 year**	**1-3 years**	**4-5 years**	**Thereafter**
Lines of credit	$ 4,960	$	$	$	$ 4,960
Letters of credit	894	894			
Guarantees	22,856		5,778	265	16,813
	$ 28,710	$ 894	$ 5,778	$ 265	$ 21,773

Requests for providing commitments to extend financial guarantees and extend credit are reviewed and approved by senior management. Management regularly reviews all outstanding commitments, letters of credit and financial guarantees, and the results of these reviews are considered in assessing the need for any reserves for possible credit and guarantee loss.

We have extended $7.4 million in working capital lines of credit to certain jointly owned and managed companies, of which $5.0 million were unused at September 30, 2002. Credit risk represents the accounting loss that would be recognized at the reporting date if the affiliate companies were unable to repay any amounts utilized under the working capital lines of credit. Commitments to extend credit to third parties are conditional agreements generally having fixed expiration or termination dates and specific interest rates and purposes.

We have posted $0.9 million of outstanding letters of credit. The letters of credit guarantee performance to third parties of various trade activities. The letters of credit are not recorded as liabilities on our balance sheet unless they are probable of being utilized by the third party. The financial risk approximates the amount of outstanding letters of credit.

We are a party to joint venture partnerships whereby our ownership interests are 50% or less of the total capital of the partnerships. We account for these partnerships using the equity method of accounting and, therefore, the

assets, liabilities and operating results of these partnerships are not consolidated with ours. The carrying value of our investment in joint venture partnerships is $14.1 million at September 30, 2002. Our share of the income (loss) of these partnerships for the years ended September 30, 2002, 2001 and 2000 was $1.6 million, $(10.2) million and $(2.4) million, respectively. Although we are not contractually obligated to fund operating losses of these partnerships, in certain cases, we have extended credit to such joint venture partnerships in the past and may decide to do so in the future in order to realize economic benefits from our joint venture relationship. Management assesses the creditworthiness of such partnerships in the same manner it does other third-parties. We have provided $11.5 million of financial guarantees related to loan commitments of four jointly owned and managed companies. We have also provided $11.3 million of financial guarantees related to lease obligations of one jointly-owned and managed company that operates four eldercare centers. The guarantees are not recorded as liabilities on our balance sheet unless we are required to perform under the guarantee. Credit risk represents the accounting loss that would be recognized at the reporting date if counter-parties failed to perform completely as contracted. The credit risk amounts are equal to the contractual amounts, assuming that the amounts are fully advanced and that no amounts could be recovered from other parties.

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Our business activities do not include the use of unconsolidated special purpose entities.

Warrants

In connection with our reorganization, we issued warrants to purchase 4,559,475 shares of our common stock. This represents 11% of the common stock issued in connection with our joint plan of reorganization. The warrants, which expired on October 2, 2002, had an exercise price of $20.33 per share of common stock.

Income Taxes

Pursuant to the Job Creation and Worker Assistance Act of 2002, which extended the net operating loss carryback period to five years, we were able to carryback certain net operating loss ("NOL") carryforwards originating in the year ended September 30, 2001. This enabled us to recover $10.3 million in federal tax refunds during the twelve months ended September 30, 2002, which offset tax expense calculated at our estimated effective tax rate of approximately 39%.

Following consummation of our joint plan of reorganization, and after reduction for (1) the aforementioned NOL carrybacks and (2) cancellation of prepetition indebtedness as provided under Section 108 of the Internal Revenue Code, we had NOL carryforwards of $278 million, which expire between September 30, 2020 and September 30, 2021. Under applicable limitations imposed by Section 382 of the Internal Revenue Code, our ability to utilize these loss carryforwards became subject to annual limitation of $43.3 million, inclusive of a separate limitation for Multicare. During the year ended September 30, 2002, we utilized $8 million of loss carryforwards. Pursuant to SOP 90-7, the income tax benefit of the NOL utilization served to reduce goodwill. We have NOL carryforwards of $270 million remaining at September 30, 2002. There can be no assurances that we will be able to utilize these NOL's and, consequently, a 100% valuation allowance against these NOL's has been provided. Other deferred tax assets include $3.3 million for built-in losses recognized by Multicare during the fiscal year ended September 30, 2002 in excess of its separate limitation under Section 382.

Revenue Sources

We receive revenues from Medicare, Medicaid, private insurance, self-pay residents, other third party payors and long-term care facilities which utilize our pharmacy and other specialty medical services. The healthcare industry is experiencing the effects of the federal and state governments' trend toward cost containment, as government and other third party payors seek to impose lower reimbursement and utilization rates and negotiate reduced payment schedules with providers. These cost containment measures, combined with the increasing influence of managed care payors and competition for patients, have resulted in reduced rates of reimbursement for services we provide.

On December 15, 2000, Congress passed the Benefits Improvement and Protection Act that increased the nursing component of federal PPS rates by 16.7% for the period from April 1, 2001 through September 30, 2002. The legislation also changed the 20% add-on to 3 of the 14 rehabilitation RUG categories to a 6.7 % add-on to all 14 rehabilitation RUG categories beginning April 1, 2001. The Part B consolidated billing provision of Balanced Budget Refinement Act was repealed except for Medicare Part B therapy services and the moratorium on the $1,500 therapy caps was extended through calendar year 2002. These changes have had a positive impact on operating results.

A number of provisions of the Balanced Budget Refinement Act and the Benefits Improvement and Protection Act enactments providing additional funding for Medicare participating skilled nursing facilities expired on September 30, 2002. The expiration of these provisions has reduced our Medicare per diems per beneficiary, on average, by $34.

The prospects for legislative relief are uncertain. The 107th Congress adjourned without resolving Medicare provider issues. The 108th Congress begins January 7, 2003. During the 107th Congress, the House of Representatives passed a package of Medicare amendments (late June 2002). Under the House-passed measure, portions of the expiring provisions would be retained. The Balanced Budget Refinement Act increase of 4% would expire, and the 16.6% add-on of the Benefits Improvement and Protection Act to the nursing portion of the skilled nursing facility prospective payment system rates would be reduced to 12% in 2003, 10% in 2004, and 8% in 2005. Under this proposal, fiscal year 2003 rates would be 5.2% lower than those of the current year. Several

attempts were made to secure Senate consideration of a slightly more favorable package of legislative amendments. Prospects for expeditious action by the incoming Congress are uncertain.

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The Centers for Medicare and Medicaid Services issued notice of fiscal year 2003 rates for Skilled Nursing Facility PPS in the Federal Register, July 31, 2002. Effective October 1, 2002, rates were increased by a 2.6% annual market basket adjustment. The Centers for Medicare and Medicaid Services estimates that, even with this upward adjustment, average Medicare rates will be 8.8% lower than the current year because of the reduced payment caused by the expiring statutory add-ons.

Our estimate of the impact of the "Skilled Nursing Facilities Medicare Cliff", factoring in the administrative decision not to proceed with changes in the case-mix refinements at this time and without factoring in any additional Congressional action, exposes the skilled nursing facility sector to a 10% reduction. For us, this reduction could have an adverse impact to annual revenue and operating income from continuing operations beginning October 1, 2002 of approximately $28 million after taking into consideration the 2.6% annual market basket adjustment. There may be additional provisions in the Medicare legislation affecting our other businesses. Congress may consider changes affecting pharmacy, rehabilitation therapy, diagnostic services and the payment for services in other health settings. There are two issues in particular that could have measurable negative impact, practitioner fee schedules and caps on Medicare Part B therapies. Absent Congressional action, the formula driven payment structure for calendar year 2003 physician and non-physician fee schedules will be reduced by 4.4%. This reduction affects not only doctors, but also payment for most professional practitioners including licensed rehabilitation professionals. Moreover, absent Congressional action, the moratorium on implementing payment caps on therapy services expires. Medicare Part B therapy services in calendar year 2003 will be subject to the caps and are expected to reduce our revenues and operating income by approximately $17 million and $3 million, respectively.

A number of states have enacted or are considering containment initiatives. Many have focused on reducing what the state Medicaid program will pay for drug acquisition costs. Most states have lowered payment to a negative percentage of average wholesale price. Some have attempted to impose more stringent pricing standards. Institutional pharmacies are often paid a dispensing fee over and above the payment for the drug. To the extent that changes in the payment for drugs are not accompanied by an increase in the dispensing fee, margins could erode. Some states have explored efforts to restrict utilization (preferred drug lists, prior-authorization, formularies). A few states have attempted to extend the preferred Medicaid pricing to all Medicare beneficiaries.

NeighborCare has joined with other leading multi-state institutional pharmacy companies to form the Alliance for Long Term Care Pharmacy (LTCPA) in an effort to influence the outcomes of both federal and state-specific legislative and regulatory activities. In this collaboration, LTCPA provides leadership to responding to specific issues. Presently, LTCPA has engaged representation in 23 states and Washington, DC. Such efforts are augmented by the government relations specialists of the various companies and by active grassroots efforts of pharmacy professionals. These proactive steps have been successful in an number of instances, but given the budgetary concerns of both federal and state governments. There can be no assurance that changes in payment formulas and delivery requirements will not have a negative impact going forward.

It is not possible to quantify fully the effect of potential legislative changes, the interpretation or administration of such legislation or any other governmental initiatives on our business. Accordingly, there can be no assurance that the impact of these changes or any future healthcare legislation will not further adversely affect our business. There can be no assurance that payments under governmental and private third-party payor programs will be timely, will remain at levels comparable to present levels or will, in the future, be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to such programs. Our financial condition and results of operations may be affected by the reimbursement process, which in the healthcare industry is complex and can involve lengthy delays between the time that revenue is recognized and the time that reimbursement amounts are settled.

Recent Accounting Pronouncements

In May 2002, the Financial Accounting Standards Board ("FASB") issued Statement of Financial Accounting Standards ("SFAS") No. 145, "*Recission of FASB Statements No. 4, 44 and 64, Amendment of FASB Statement No. 13 and Technical Corrections as of April 2002*" ("SFAS 145"). SFAS 145 rescinds SFAS No. 4*, "Reporting Gains and Losses from Extinguishment of Debt"*, which required that gains and losses from extinguishment of debt that were included in the determination of net income be aggregated and, if material, classified as an extraordinary item, net of the related income tax effect. Under SFAS 145, gains or losses from extinguishment of debt should be classified as extraordinary items only if they meet the criteria in Accounting Principles Board Opinion No. 30 ("APB 30"), *"Reporting Results of Operations Reporting the Effects of Disposal of a Segment of a Business."*Applying the criteria in APB 30 will distinguish transactions that are part of an entity's recurring operations from those that are unusual or infrequent or that meet the criteria for classification as an

extraordinary item. SFAS 145 is effective for fiscal years beginning after May 15, 2002 for provisions related to SFAS No. 4, effective for all transactions occurring after May 15, 2002 for provisions related to SFAS No. 13 and effective for all financial statements issued on or after May 15, 2002 for all other provisions of SFAS 145. Beginning in our fiscal year 2003, we expect the most significant impact of the adoption of SFAS 145 will be the change in classification of any gains or losses on the extinguishment of debt that were classified as extraordinary items in prior periods that do not meet the new criteria of APB 30 for classification as extraordinary items. This reclassification will include the $1,509.9 million extraordinary gain recognized in fiscal 2001 in connection with the discharge of liabilities subject to compromise upon emergence from Chapter 11 bankruptcy.

In July 2002, the FASB issued SFAS No. 146 "*Accounting for Costs Associated with Exit or Disposal Activities*" ("SFAS No. 146"). SFAS No. 146 addresses significant issues regarding the recognition, measurement, and reporting of costs associated with exit and disposal activities, including restructuring activities. SFAS No. 146 also addresses recognition of certain costs related to terminating a contract that is not a capital lease, costs to consolidate facilities or relocate employees, and termination benefits provided to employees that are involuntarily terminated under the terms of a one□time benefit arrangement that is not an ongoing benefit arrangement or an individual deferred compensation contract. SFAS No. 146 is effective for exit or disposal activities that are initiated after December 31, 2002.

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In November 2002, the FASB issued Interpretation No. 45, "*Guarantor's Accounting and Disclosure Requirements for Guarantees, Including Guarantees of Indebtedness of Others*"(the Interpretation), which addresses the disclosures to be made by a guarantor in its interim and annual financial statements about its obligations under guarantees. The Interpretation also requires the recognition of a liability by a guarantor at the inception of certain guarantees. The new requirements are effective for interim and annual financial statements ending after December 15, 2002. The Interpretation requires the guarantor to recognize a liability for the non-contingent component of the guarantee. This is the obligation to stand ready to perform in the event that specified triggering events or conditions occur. The initial measurement of this liability is the fair value of the guarantee at inception. The recognition of the liability is required even if it is not probable that payments will be required under the guarantee or if the guarantee was issued with a premium payment or as part of a transaction with multiple elements. We will apply the recognition and measurement provisions for all guarantees entered into or modified after December 31, 2002. In addition, we will adopt the disclosure requirements of the Interpretation for the quarter ended December 31, 2002. We do not expect the adoption of the Interpretation to have a material impact on our consolidated financial statements.

Critical Accounting Policies

In December 2001, the SEC issued Financial Reporting Release No. 60, "Cautionary Advice Regarding Disclosure About Critical Accounting Policies," referred to as "FR 60," suggesting that companies provide additional disclosure and commentary on those accounting policies considered most critical. FR 60 considers an accounting policy to be critical if it is important to the registrant's financial condition and results, and requires significant judgment and estimates on the part of management in its application. Our critical accounting estimates and the related assumptions are evaluated periodically as conditions warrant, and changes to such estimates are recorded as new information or changed conditions require revision. Application of the critical accounting policies requires management's significant judgments, often as the result of the need to make estimates of matters that are inherently uncertain. If actual results were to differ materially from the estimates made, the reported results could be materially affected. Our senior management has reviewed these critical accounting policies and estimates with our audit committee. We believe that the following represents our critical accounting policies as contemplated by FR 60. For a summary of all of our significant accounting policies, including critical accounting policies discussed below, see note 1 "Summary of Significant Accounting Policies" to our consolidated financial statements.

Allowance for Doubtful Accounts

We utilize the "Aging Method" to evaluate the adequacy of our allowance for doubtful accounts. This method is based upon applying estimated standard allowance requirement percentages to each accounts receivable aging category for each type of payor. We have developed estimated standard allowance requirement percentages by utilizing historical collection trends and our understanding of the nature and collectibility of receivables in the various aging categories and the various segments of our business. The standard allowance percentages are developed by payor type as the accounts receivable from each payor type have unique characteristics. The allowance for doubtful accounts is determined utilizing the aging method described above while also considering accounts specifically identified as uncollectible. Accounts receivable that we specifically estimate to be uncollectible, based upon the age of the receivables, the results of collection efforts or other circumstances, are fully reserved for in the allowance for doubtful accounts until they are written-off.

In fiscal 2001, we performed a re-evaluation of our allowance for doubtful accounts triggered by deterioration in the agings of certain categories of receivables. We believe that such deteriorations were due to several prolonged negative factors related to the operational effects of our bankruptcy filings, personnel shortages, the time demands required in normalizing relations with vendors and addressing a multitude of other bankruptcy issues. As a result of this re-evaluation, we determined that an increase to the allowance for doubtful accounts of $39.2 million was necessary, and certain changes to the aging method resulting in higher levels of allowance for doubtful accounts requirements were also necessary.

In fiscal 2000, we performed a specific account review for certain large customers in light of the adverse impact of PPS on their liquidity and profitability. In certain cases, these customers filed for protection under Chapter 11 of the Bankruptcy Code. As a result of these assessments, we determined that an increase to the allowance for doubtful accounts of $42 million was necessary. Because such adjustments were based upon a specific account review of several high risk customers, no significant changes to the aging method were deemed necessary.

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Over the past three years, and in connection with the adjustments made in fiscal 2000 and 2001, we have continued to refine our assumptions and methodologies underlying the aging method. We believe the assumptions used in aging method employed in fiscal 2002, coupled with continued improvements in our collection patterns, suggest that our allowance for doubtful accounts is adequately provided for at September 30, 2002. However, because the assumptions underlying the aging method are based upon historical collection data, there is a risk that our current assumptions are not reflective of more recent collection patterns. Changes in overall collection patterns can be caused by market conditions and/or budgetary constraints of government funded programs such as Medicare and Medicaid. Such changes can adversely impact the collectibility of receivables, but not be addressed in a timely fashion when using the aging method, until updates to our periodic historical collection studies are completed and implemented.

At least annually, we update our historical collection studies in order to evaluate the propriety of the assumptions underlying the aging method. Any changes to the underlying assumptions are implemented immediately. Changes to these assumptions can have a material impact on our bad debt expense, which is reported in the consolidated statements of operations as a component of other operating expenses.

Loss Reserves For Certain Self-Insured Programs

General and Professional Liability and Workers Compensation

General and professional liability costs for the long-term care industry have become increasingly expensive. Specifically, rising costs of eldercare malpractice litigation, and losses stemming from these malpractice lawsuits and a constriction of insurers have caused many insurance carriers to raise the cost of insurance premiums or refuse to write insurance policies for nursing homes. These problems are particularly acute in the State of Florida where, because certain laws allow for significantly higher liability awards than in other states, general liability and professional liability costs have increased substantially. We own or lease approximately 1,500 skilled nursing beds in the State of Florida, representing six percent of our total owned and leased beds.

Prior to June 1, 2000, we had first dollar coverage for general and professional liability costs with third party insurers; accordingly, we have no exposure for claims prior to that date. Effective June 1, 2000, we began insuring a substantial portion of our professional liability risks through our wholly-owned insurance company, LHC. Specifically, we are responsible for the first dollar of each claim (on a claims-made basis), up to a self-insurance retention limit determined by the individual policies, subject to aggregate limits for each policy year. The self-insured retention limits amount to $14 million, $19 million and $22 million for the policy years ended May 31, 2001, 2002 and 2003, respectively. For policy years 2001 and 2002, any costs above these retention limits are covered by third party insurance carriers. For policy year 2003 (June 2002 to May 2003), we have retained an additional self-insurance layer of $5 million. Since the June 1, 2000 inception of the self-insurance program through September 30, 2002, our cumulative self-insurance retention levels are $42 million and our provision for these losses is $28.2. Assuming our actual losses were to reach our retention limits in each of the three policy years, our additional exposure is approximately $13.8 million which, if incurred, would be recognized as an increase to our other operating expenses in our consolidated statements of operations in the period such exposure became known. In addition, we have provided $3.7 million for the estimated costs of claims incurred but not reported as of September 30, 2002.

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Beginning in 1994, we insured our workers compensation exposure, principally via self-insurance retentions and large deductible programs. We in turn insured these programs through our wholly-owned captive, LHC. In addition, we inherited legacy workers compensation programs from acquisitions we completed.

Over the past three years, the majority of our workers compensation coverage was structured as follows: For policy year 2001 (June 1, 2000 - May 31, 2001) we were insured on a first dollar coverage basis for our Multicare subsidiaries, and insured through an incurred loss retrospectively rated policy for our non-Multicare subsidiaries; and for policy years 2002-2003 (June 1, 2001 - May 31, 2003) we have large deductible programs, the deductibles for which are insured through LHC.

For policy year 2001, our incurred losses recognized through September 30, 2002 were $15.5 million. Our development factors are updated quarterly and are based upon commonly used industry standards. Any changes to the incurred losses are recognized quarterly as an adjustment to salaries, wages and benefits in our consolidated statements of operations. We are insured through a third party insurer for aggregate claims in excess of $44.1 million.

For policy years 2002 and 2003, LHC insures us up to the first $0.5 million per incident. All claims above $0.5 million per incident are insured through a third-party insurer. We have aggregate self-insured retentions of $48 million and $52.8 million in policy years 2002 and 2003, respectively. Claims above these aggregate limits are insured through a third party-insurer as of September 30, 2002. Our provision for losses in these policy years is $30.1 million as of September 30, 2002. Our reserve levels are evaluated on a quarterly basis. Any necessary adjustments are recognized as an adjustment to salaries, wages and benefits in our consolidated statements of operations.

We record outstanding losses and loss expenses for both general and professiona