BEVERLY ENTERPRISES INC
Form 10-K
March 03, 2004

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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

x **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2003

OR

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission file number: 1-9550

BEVERLY ENTERPRISES, INC.

(Exact name of Registrant as specified in its charter)

Delaware	**62-1691861**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

One Thousand Beverly Way

Fort Smith, Arkansas 72919
(Address of principal executive offices)

Registrant s telephone number, including area code: **(479) 201-2000**

Registrant s website: **www.beverlycares.com**

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

Title of each class	**Name of each exchange on which registered**
Common Stock, $.10 par value	New York Stock Exchange
	Pacific Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: **NONE**

Indicate by check mark whether 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 Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes þ No o

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K 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 or any amendment to this Form 10-K. o

Indicate by check mark if Registrant is an accelerated filer (as defined in Exchange Act Rule 12b-2). Yes þ No o

The aggregate market value of the voting and non-voting common stock held by nonaffiliates of Registrant was $368,035,217 as of June 30, 2003.

107,334,234

(Number of shares of common stock outstanding, net of treasury shares, as of February 27, 2004)

Part III is incorporated by reference from the Proxy Statement for the Annual Stockholders Meeting to be held on May 20, 2004.

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FORWARD-LOOKING STATEMENTS

References throughout this document to the Company include Beverly Enterprises, Inc. and its wholly owned subsidiaries. In accordance with the Securities and Exchange Commission s (SEC) Plain English guidelines, this Annual Report on Form 10-K has been written in the first person. In this document, the words we , our , ours and us refer only to Beverly Enterprises, Inc. and its wholly owned subsidiaries and not to any other person.

This Annual Report on Form 10-K, and other information we provide from time to time, contains certain statements that are not historical facts and may be forward-looking statements within the meaning of United States federal securities law. All statements regarding our expected future financial position, results of operations or cash flows, continued performance improvements, ability to service, refinance, replace and comply with our debt obligations, ability to finance growth opportunities, ability to control our patient care liability costs, ability to respond to changes in government regulations, ability to execute our three-year strategic plan, and similar statements including, without limitation, those containing words such as believes, anticipates, expects, intends, estimates, plans, and other similar expressions are forward-looking statements. These forward-looking statements reflect management s beliefs and assumptions and are based on information currently available to management. Forward-looking statements involve known and unknown risks, uncertainties and other factors that may cause our actual results, performance, achievements or industry results to be materially different from any future results, performance or achievements expressed or implied by us in those statements. These risks, uncertainties and other factors include, among others:

- national and local economic conditions, including their effect on the availability and cost of labor, utilities and materials;
- the effect of government regulations and changes in regulations governing the healthcare industry, including our compliance with such regulations;
- changes in Medicare and Medicaid payment levels and methodologies and the application of such methodologies by the government and its fiscal intermediaries;
- the effects of adopting new accounting standards;
- liabilities and other claims asserted against us, including patient care liabilities, as well as the resolution of lawsuits brought about by the announcement or settlement of government investigations and the announcement of increases in reserves for patient care liabilities;
- our ability to predict future reserve levels for patient care and workers compensation liabilities;
- our ability to obtain adequate insurance coverage with financially viable insurance carriers, as well as the ability of our insurance carriers to fulfill their obligations;
- our ability to execute strategic divestitures in a timely manner at fair value;
- our ability to improve our fundamental business processes and reduce costs throughout the organization;
- our ability to attract and retain qualified personnel;
- the availability and terms of capital to fund acquisitions, capital improvements and ongoing operations;
- our ability to repurchase our stock and changes in the stock price after any such repurchases;
- the competitive environment in which we operate;
- our ability to maintain and increase census (volume of residents) levels; and
- demographic changes.

See Item 1. Business for a discussion of various governmental regulations and other operating factors relating to the healthcare industry and the related risk factors. You should carefully consider the risks described herein before making any investment decisions in the Company. These risks and uncertainties are

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not the only ones facing the Company. There may be additional risks that we do not presently know of or that we currently deem immaterial. If any of these risks actually occur, our business, financial condition, results of operations or cash flows could be materially and adversely affected. In that case, the trading price of our common stock could decline, and you may lose all or part of your investment. Given these risks and uncertainties, we can give no assurances that these forward-looking statements will, in fact, transpire and, therefore, we caution investors not to place undue reliance on them. We are not obligated to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise.

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PART I

ITEM 1. BUSINESS.
General

2003 was an important transition year for Beverly. Our improved financial and operating results validate the strategic plan that has guided the turnaround during the past three years. We strengthened our portfolio of nursing facilities and continued to concentrate these operations in strategic markets that provide attractive growth potential. We also continued the profitable growth of our eldercare service businesses, where margins are attractive and ongoing capital requirements are lower. We further strengthened our financial position by reducing on and off-balance sheet debt by a total of $133.4 million. Our year-end cash position for 2003 was $258.8 million, more than double the total at the end of 2002. We refinanced $325.0 million of debt to achieve lower interest costs, extend maturities and provide increased financial flexibility.

A major issue facing the nursing facility industry is rising costs for patient care liabilities. We believe we made significant progress during 2003 to contain this issue. In late 2002, we identified facilities that represented a disproportionately high share of those projected costs collectively approximately 50 percent and we committed to a divestiture program during 2003 and 2004. During 2003, we divested or closed a total of 81 nursing facilities and seven assisted living centers that represented 36 percent of those projected costs. We used the net cash proceeds of these divestitures more than $200 million to reduce debt and strengthen our liquidity position.

We believe we have the strategic framework, seasoned management team and financial resources to continue the profitable growth of the Company.

Operations and Services

Our business consists principally of providing healthcare services, primarily including the operation of nursing facilities, assisted living centers, hospice and home care centers, outpatient clinics and rehabilitation therapy services. We are one of the largest operators of nursing facilities in the United States. As of December 31, 2003, we operated 373 nursing facilities with a total of 39,435 licensed beds. Our nursing facilities are located in 24 states and the District of Columbia and range in capacity from 24 to 355 licensed beds. (See Item 2. Properties.) As of December 31, 2003, we also operated 20 assisted living centers containing 535 units, 23 hospice and home care centers and 10 outpatient clinics, and we provided rehabilitation therapy services in 36 states and the District of Columbia.

Our operations are currently organized into three primary operating segments: Nursing Facilities, AEGIS and Home Care.

Nursing Facilities. Our Nursing Facilities operations provide long-term healthcare and rehabilitation services through the operation of skilled nursing facilities and assisted living centers and accounted for approximately 94% of our revenues for the year ended December 31, 2003. Our facilities provide residents with routine long-term care services, including daily nursing, dietary, social and recreational services and a full range of pharmacy services and medical supplies. Our skilled nursing staff also provides complex and intensive medical services to residents with higher acuity needs outside the traditional acute-care hospital setting. We have designed our assisted living centers to provide residents with a greater degree of independence while still offering routine services and, if required, limited medical care.

AEGIS. Our AEGIS segment provides rehabilitation therapy services under contract to our nursing facilities, as well as 510 third-party nursing facilities as of December 31, 2003, and accounted for approximately 4% of our revenues for the year ended December 31, 2003. AEGIS offers occupational, physical and speech therapy services designed to maximize function and independence, assist in recovery from medical conditions and compensate for remaining disabilities.

Home Care. Our Home Care operations, which accounted for approximately 2% of our revenues for the year ended December 31, 2003, primarily provide hospice services within our nursing facilities, in facilities

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operated by other healthcare providers and in patients homes. Our hospice services include palliative care for terminally ill patients, as well as pastoral, counseling and bereavement services for the families of hospice patients.

Revenue Sources

Overview

We receive payments for services provided to patients from:

each of the states in which our facilities are located under the applicable Medicaid program;

the federal government under the Medicare program and the Department of Veterans Affairs; and

private and other payors, including commercial insurers and managed care payors.

The following table sets forth for the periods indicated:

nursing facility patient days derived from the indicated sources of payment as a percentage of total nursing facility patient days; and

revenues derived from the indicated sources of payment as a percentage of total revenues.

	Medicaid		Medicare		Private and Other	
	Patient Days	Revenues	Patient Days	Revenues	Patient Days	Revenues
Years Ended:						
December 31, 2003	71%	53%	12%	26%	17%	21%
December 31, 2002	71%	53%	11%	27%	18%	20%
December 31, 2001	72%	55%	10%	25%	18%	20%

Changes in the mix of our patient population among the Medicare, Medicaid and private categories can significantly impact our revenues and profitability. In most states, private patient care is the most profitable, and Medicaid patient care is the least profitable. We receive revenues by providing room and board, occupational, physical, speech, respiratory and intravenous therapy, as well as sales of pharmaceuticals and other services.

Reimbursement by Medicaid Programs

Medicaid programs currently exist in all of the 24 states, and the District of Columbia, in which we operate nursing facilities. These programs differ in certain respects from state to state, but they are all subject to federal-imposed requirements. At least 50% of the funds available under these programs is provided by the federal government under a matching program.

Currently, most state Medicaid programs use a cost-based reimbursement system. This means that a facility is reimbursed for the reasonable direct and indirect allowable costs it incurs in providing routine patient care services (as defined by the programs). These reasonable costs normally include certain allowances for administrative and general costs, as well as the costs of property and equipment (e.g., depreciation and interest, fair rental allowance or rental expense). In addition, certain states provide for efficiency incentives, subject to certain cost ceilings.

State Medicaid reimbursement programs vary as to the level of allowable costs that are reimbursed to operators. In some states, cost-based reimbursement is subject to retrospective adjustment through cost report settlement. In other states, reimbursements made to a facility that are subsequently determined to be less than or in excess of allowable costs may be adjusted through future reimbursements to the facility and to other facilities owned by the same operator. Still other states reimburse facilities based upon costs from a prior base year, adjusted for inflation. More than 50% of the states we currently operate in have enacted reimbursement programs that are based on patient acuity versus traditional cost-based methodologies. Many other states are actively developing reimbursement systems based on patient acuity or that follow a

methodology similar to

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Medicare s prospective payment system (PPS). We are unable to estimate the ultimate impact of any changes in state reimbursement programs on our future consolidated financial position, results of operations, or cash flows.

While federal regulations do not provide states with grounds to curtail funding of their Medicaid cost reimbursement programs due to state budget deficiencies, states have done so in the past. No assurance can be given that states will not do so in the future or that the future funding of Medicaid programs will remain at levels comparable to the present levels.

The Balanced Budget Act of 1997 (the Budget Act) broadened the states authority to develop their own standards for setting payment rates. The law requires each state to use a public process for establishing proposed rates whereby the methodologies and justifications used for setting such rates are available for public review and comment. This requires facilities to become more involved in the rate setting process since failure to do so may interfere with a facility s ability to challenge rates later. Currently, several states in which we have substantial operations are experiencing deficits in their fiscal operating budgets. There can be no assurance that these states, as well as other states in which we operate, will not reduce payment rates.

Reimbursement by Medicare

Healthcare system reform and concerns over rising Medicare costs have been priorities for both the federal and state governments. The Budget Act included numerous program changes directed at balancing the federal budget. In addition to the Medicaid changes described above, the legislation changed Medicare policy in a number of ways, including the phase-in of PPS for skilled nursing facilities. PPS reimburses a skilled nursing facility based upon the acuity level of Medicare patients. Acuity level is determined by classifying a patient into one of 44 Resource Utilization Grouping (RUG) categories, based on the nature of the patient s condition and services needed.

In 1999 and 2000, refinements were made to the Budget Act. These refinements restored substantial Medicare funding to skilled nursing facilities and other healthcare providers originally eliminated by the Budget Act. A number of the refinements made in 1999 and 2000 remain in place today, including, among other things:

a 20% add-on for 12 high acuity non-therapy RUG categories; and

a 6.7% add-on for all rehabilitation RUG categories.

These add-ons are scheduled to expire when the Centers for Medicare and Medicaid Services (CMS) release their refinements to the current RUG payment system. It is expected that these refinements will not be implemented until at least October 1, 2005. We currently generate approximately $33.7 million in annual revenues related to these add-ons. We cannot predict when CMS will release its refinements nor can we predict what their ultimate impact will be on our operating results or cash flows, if any.

In addition, the 1999 and 2000 refinements to the Budget Act included a three-year moratorium on two $1,500 Part B therapy caps, which expired on December 31, 2002. After several delays in implementation during 2003, the annual caps of $1,590 for physical and speech therapy services combined and $1,590 for occupational therapy services, which were adjusted for inflation, were applied to services provided during the period from September 1, 2003 through December 8, 2003. On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the Prescription Drug Bill) was signed into law and included an additional two-year moratorium on the Part B therapy caps until December 31, 2005.

The Prescription Drug Bill also requires payments to skilled nursing facilities to be increased by 128% for residents with AIDS, added a pilot program in certain states for national and state criminal background checks for workers who provide direct patient care in skilled nursing facilities, and mandated that hospitals include new information about the availability of skilled nursing facility care in notices of discharge given to patients.

CMS implemented two increases in nursing facility Medicare rates effective October 1, 2003. The first increase of 3.26% was a cumulative correction for understated market basket increases that CMS had relied on since 1998. The second increase of 3.0%, which is applied to the Medicare rates subsequent to being

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adjusted for the 3.26% increase above, was an annual market basket increase for the federal fiscal year beginning October 1, 2003. The combined impact of these increases resulted in additional revenues of $6.9 million during the fourth quarter of 2003. Based on our current volume and mix of Medicare patients, we estimate these increases will result in an additional $20.9 million of revenues for the first nine months of 2004, for an annual impact of $27.8 million.

On February 10, 2003, CMS published a proposed rule to reduce by 30 percent the amount that Medicare reimburses skilled nursing facilities and other non-hospital providers for bad debts arising from uncollectible Medicare coinsurance and deductibles. The proposal is to phase in the reduction over a three-year period at 10 percent per year. Based on our current volume of Medicare bad debts, this proposed rule would reduce our revenues by $1.6 million, $3.1 million and $5.0 million for the first, second and third year, respectively. We cannot currently determine if and when this rule will be implemented.

Government Regulation

Survey, Certification and Licensure

Our nursing facilities, assisted living centers, home health agencies and hospices are subject to state licensure and certification requirements under the Medicare, Medicaid and Veterans Administration programs. While regulations and licensing requirements vary based upon provider type and from state to state, they typically address, among other things, administration and supervision, personnel qualifications, physical plant specifications, nursing, rehabilitative therapy and medical services and resident rights and responsibilities. If we fail to comply with applicable licensing or certification requirements, we may be subject to civil money penalties, loss of licensure or termination of our participation in the Medicare, Medicaid or Veterans Administration programs. Changes in the laws or new interpretations of existing laws as applied to our nursing facilities, assisted living centers or other components of our healthcare businesses may have a significant impact on our operations and costs of doing business.

In 1989, CMS published new survey and certification regulations to implement the Medicare and Medicaid provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). OBRA 1987 mandated enhanced quality of care requirements for participation by skilled nursing facilities under Medicare and nursing facilities under Medicaid. After additional changes in the law, survey and certification regulations became effective in October 1990. Final nursing facility enforcement regulations were published in November 1994 and were revised significantly in March 1999. Among the provisions that CMS has adopted are requirements that:

surveys focus on residents outcomes;

all deviations from the participation requirements will be considered deficiencies, but all deficiencies will not constitute noncompliance; and

penalties will result for certain types of deficiencies.

The regulations also identify remedies, as alternatives to termination from participation, and specify the categories of deficiencies for which these remedies will be applied. These remedies include:

installation of temporary management;

denial of payment for new admissions;

denial of payment for all patients;

civil money penalties of $50 to $3,000 per day or per instance for deficiencies that do not put a resident in immediate jeopardy and $3,050 to $10,000 per day for deficiencies that have caused or are likely to cause serious injury or death;

closure of facility and/or transfer of patients in emergencies;

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directed plans of correction; and

directed in-service training.

In the ordinary course of our business, and like other providers in the healthcare industry, we receive requests for information from government agencies in connection with their regulatory or investigational authority and notices of deficiencies for failure to comply with various regulatory requirements. We review such requests and notices and we believe that we take appropriate corrective action. In most cases, with respect to the notices, the facility or other provider and the reviewing agency will agree upon the steps to be taken to bring the facility into compliance with regulatory requirements. In some cases or upon repeat violations, the reviewing agency may take a number of adverse actions against a provider. These adverse actions include:

the imposition of fines;

temporary suspension of admission of new patients to the facility;

decertification from participation in the Medicare or Medicaid programs; or

in extreme circumstances, revocation of a facility s license.

We have been subject to certain of these adverse actions in the past and could be subject to adverse actions in the future, which could result in significant penalties, as well as adverse publicity. The results of current or future enforcements or actions could have an adverse effect on our operations or financial position.

In February 2000, as part of the settlement of an investigation by the federal government into our allocation of certain costs to the Medicare program, we entered into a Corporate Integrity Agreement with the United States Department of Justice and the Office of Inspector General (the OIG). This agreement requires that we monitor our compliance with the requirements of the federal healthcare programs and addresses our obligations to ensure that we comply. It includes our functional and training obligations, audit and review requirements, recordkeeping and reporting requirements, as well as penalties for breach or noncompliance of the agreement. We believe that we are generally in compliance with the requirements of the Corporate Integrity Agreement and file annual reports with the OIG documenting our compliance. Failure to comply with the Corporate Integrity Agreement may result in penalties or exclusion from the Medicare and Medicaid programs.

Nursing Facility Quality Initiative

In November 2002, CMS implemented Nursing Home Compare, a national initiative to publicly report quality measures to improve the quality of care of each Medicare and Medicaid certified nursing facility. In January 2004, CMS upgraded this program to include enhanced quality measures. This report uses a set of quality indicators calculated from the minimum data set assessments prepared by the nursing facilities on each resident. The quality measures are intended to assist consumers in evaluating nursing facilities, and to assist CMS in working with the nursing facility industry to develop quality improvement programs where needed. We have implemented an internal software program allowing each facility access to their real-time CMS enhanced quality measures. This enables the facility to compare their performance to local, state and national averages along with the ability to analyze which residents are included in each quality measure. Many of our facilities were selected to participate in their individual state Quality Improvement Organizations in a three-year nursing home collaboration to improve these quality measures.

We developed and utilize a program called the Beverly Quality System to help ensure quality care is provided in all of our facilities. The program is comprised of four elements: facility-based Quality Assurance and Assessment Committees; Quality Councils; facility performance assessments and a performance improvement model. All elements of the Beverly Quality System are addressed by a multi-disciplinary team that includes regional and district level business leaders and clinical consultants. Additional consultative support is provided by designated Quality Management Directors within the organization.

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We have analyzed the revised CMS regulations with respect to our programs and facilities, as well as compliance data for the past year. Results of CMS surveys for the past year determined that a significant majority of our nursing facilities surveyed were in substantial compliance with CMS, and specific state, requirements for participation. Our analysis shows Beverly facilities have improved their survey performance year over year. Although we could be adversely affected if a substantial portion of our programs or facilities were eventually determined not to be in compliance with CMS regulations, we believe our programs and facilities are generally in compliance.

Regulations Governing Healthcare Fraud and Abuse

The Social Security Act and regulations of the Department of Health and Human Services (HHS) state that any entities or individuals who have been convicted of a criminal offense related to the delivery of an item or service under the Medicare or Medicaid programs or who have been convicted, under state or federal law, of a criminal offense relating to neglect or abuse of residents in connection with the delivery of a healthcare item or service cannot participate in the Medicare or Medicaid programs. Furthermore, any entities or individuals who have been convicted of fraud, who have had their licenses revoked or suspended, or who have failed to provide services of adequate quality may be excluded from the Medicare and Medicaid programs.

There are fraud and abuse anti-kickback provisions of the Social Security Act (the Antifraud Amendments) that make it a criminal felony offense to knowingly and willfully offer, pay, solicit or receive payment or any other remuneration in order to induce, or in return for the receipt of, business for which reimbursement is provided under government health programs, including Medicare and Medicaid. In addition, violators can be subject to civil penalties, as well as exclusion from government health programs. The Antifraud Amendments have been broadly interpreted to make payment of any kind, including many types of business and financial arrangements among providers, and between providers and beneficiaries, potentially illegal if any purpose of the payment or financial arrangement is to induce a referral. Accordingly, joint ventures, space and equipment rentals, management and personal services contracts, and certain investment arrangements among providers may be subject to increased regulatory scrutiny.

From time to time, HHS puts into effect regulations describing or clarifying certain arrangements that are not subject to enforcement action under the Social Security Act (the Safe Harbors). The Safe Harbors described in the regulations are narrow, leaving a wide range of economic relationships, which many hospitals, physicians and other healthcare providers consider to be legitimate business arrangements, possibly subject to enforcement action under the Antifraud Amendments. The Safe Harbor regulations do not intend to comprehensively describe all lawful relationships between healthcare providers and referral sources. The Safe Harbor regulations state that just because an arrangement does not qualify for Safe Harbor protection does not mean it violates the Antifraud Amendments. However, a failure to meet all the elements of a potentially applicable Safe Harbor may subject a particular arrangement or relationship to increased regulatory scrutiny.

In addition to the Antifraud Amendments, Section 1877 of the Social Security Act, known as the Stark Law, imposes restrictions on referrals between physicians and certain entities with which the physicians have financial relationships. The Stark Law provides that if a physician (or an immediate family member of a physician) has a financial relationship with an entity that provides certain designated health services, the physician may not refer a Medicare or Medicaid patient to the entity for those designated services, unless an exception applies. In addition, the entity may not bill for services provided by that physician unless an exception to the financial relationship exists. Designated health services include certain services, such as physical therapy, occupational therapy, outpatient prescription drugs and home health. The types of financial relationships that can trigger the referral and billing prohibitions include ownership or investment interests, as well as compensation arrangements. Penalties for violating the law are severe, and include:

denial of payment for services provided;

civil money penalties of $15,000 for each item or service claimed;

refunds of any amounts collected;

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assessments of up to twice the amount claimed for each service;

civil money penalties up to $100,000 for each arrangement or scheme designed to circumvent the Stark Law s prohibitions; and

exclusion from the Medicare and Medicaid programs.

Many states where we operate have laws similar to the Antifraud Amendments and the Stark Law, but with broader effect since they apply regardless of the source of payment for care. These laws typically provide criminal and civil penalties, as well as loss of licensure. The scope of these state laws is broad and little precedent exists for their interpretation or enforcement.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes comprehensive revisions or supplements to the Antifraud Amendments. Under HIPAA, it is a federal criminal offense to commit healthcare fraud. Healthcare fraud is defined as knowingly and willfully executing or attempting to execute a scheme or device to defraud any healthcare benefit program. In addition, for the first time, HIPAA granted federal enforcement officials the ability to exclude from the Medicare and Medicaid programs any investors, officers and managing employees associated with business entities that have committed healthcare fraud, even if the investor, officer or employee had no actual knowledge of the fraud. HIPAA established that it is a violation to pay or otherwise give anything of value to a Medicare or Medicaid beneficiary if one knows or has reason to know that the payment would be likely to influence such beneficiary to order or receive services from a particular provider or practitioner.

The Budget Act also contained a significant number of new fraud and abuse provisions. For example, civil money penalties may also be imposed for violations of the Antifraud Amendments (previously, exclusion or criminal prosecution were the only actions under the Antifraud Amendments), as well as for contracting with an individual or entity that a provider knows or should know is excluded from a federal healthcare program. A person is subject to mandatory exclusion from participation in federal healthcare programs upon conviction for certain defined healthcare offenses. The Budget Act provides a minimum ten-year period for exclusion from participation in federal healthcare programs for providers convicted of a prior healthcare offense. The Budget Act also provides for civil money penalties of $50,000 and damages of not more than three times the amount of payment received from the prohibited activity.

In 1976, Congress established the OIG at HHS to identify and eliminate fraud, abuse and waste in HHS programs and to promote efficiencies in HHS departmental operations. The OIG carries out this mission through a nationwide program of audits, investigations and inspections. In order to provide guidance to healthcare providers on ways to engage in legitimate business practices and avoid scrutiny under the fraud and abuse statutes, the OIG has from time to time issued fraud alerts identifying segments of the healthcare industry and particular practices that are vulnerable to abuse. The fraud alerts encourage persons having information about potentially abusive practices or transactions to report such information to the OIG. The OIG has issued three fraud alerts targeting the skilled nursing industry:

an August 1995 alert which relates to the provision of medical supplies to nursing facilities, fraudulent billing for medical supplies and equipment and fraudulent supplier transactions;

a May 1996 alert which focuses on the provision of fraudulent professional services to nursing facility residents; and

a March 1998 alert which addresses the interrelationship between hospice services and the nursing facility industry, and potentially illegal practices and arrangements.

In addition to laws addressing referral relationships, several federal laws impose criminal and civil sanctions for fraudulent and abusive billing practices. The Federal False Claims Act imposes sanctions, consisting of monetary penalties of up to $11,000 for each claim and three times the amount of damages, on entities and persons who knowingly present or cause to be presented to the federal government a false or fraudulent claim for payment. Also, the statute allows private parties to bring *qui tam* whistleblower lawsuits alleging false claims. Some states have adopted similar whistleblower and/or false claims provisions. The Social Security Act prohibits the knowing and willful making of a false statement or misrepresentation of a

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material fact with respect to the submission of a claim for payment under government health programs (including the Medicare and Medicaid programs). Violations of this provision are a felony offense punishable by fines and imprisonment. Government prosecutors are increasing their use of the Federal False Claims Act to prosecute quality of care deficiencies in healthcare facilities. Their theory behind this is that the submission of a claim for services provided in a manner that falls short of quality of care standards can constitute the submission of a false claim.

In addition to increasing the resources devoted to investigating allegations of fraud and abuse in the Medicare and Medicaid programs, federal and state regulatory and law enforcement authorities are taking an increasingly strict view of the requirements imposed on healthcare providers by the Social Security Act and Medicare and Medicaid regulations. From time to time, we, like other healthcare providers, are required to provide records to state or federal agencies to aid in such investigations. It is possible that these entities could initiate investigations in the future at facilities we operate and that such investigations could result in significant penalties, as well as adverse publicity.

Regulation Governing the Privacy and Transmission of Healthcare Information

In addition to its antifraud provisions, HIPAA also requires improved efficiency in healthcare delivery by standardizing electronic data interchange and by protecting the confidentiality and security of health data. More specifically, HIPAA calls for:

standardization of certain electronic patient health, administrative and financial data;

unique health identifiers for employers, health plans and healthcare providers;

privacy standards protecting the privacy of individually identifiable health information; and

security standards protecting the confidentiality and integrity of electronically held individually identifiable health information.

In August 2000, final regulations establishing standards for electronic data transactions and code sets, as required under HIPAA, were released. These standards are designed to allow entities within the healthcare industry to exchange medical, billing and other information and to process transactions in a more timely and cost effective manner. Modifications to the electronic data transactions and code sets standards were issued on February 20, 2003, and further modifications were released March 10, 2003. Subsequently, on July 24, 2003 and September 23, 2003, Congress granted extensions to providers whose Medicare and Medicaid trading partners were not yet ready. We are already complying with the transactions standards where possible. We will begin operating in a compliant manner with the remaining trading partners as they become ready.

The HIPAA privacy standards are designed to protect the privacy of certain individually identifiable health information. The privacy standards have required us to make certain updates to our policies and procedures and conduct training for our employees surrounding these standards. We believe we are compliant with the privacy standards.

We must comply with the HIPAA security standards by April 21, 2005, with civil and criminal penalties for noncompliance. We must comply with the employer identification standard before May 23, 2005. We believe that we will be in compliance with these standards as required.

HHS has estimated that implementation of the electronic transactions and code sets, the privacy standards and the security standards will cost the healthcare industry between $1.8 billion and $6.3 billion over a five-year period. We continue to evaluate and update our processes and procedures to meet the requirements of the new standards; however, we cannot assure you that all of the parties with whom we do business will be in compliance with HIPAA. We do not believe our ongoing implementation to comply with HIPAA will have a material impact on our consolidated financial position, results of operations or cash flows.

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Competitive Conditions

Our nursing facilities compete primarily on a local and regional basis with other long-term care providers, some of whom may own as few as a single nursing facility. Our primary national competitors include Manor Care, Inc., Kindred Healthcare, Inc., Genesis HealthCare Corporation, Extendicare Health Services, Inc. and Mariner Health Care, Inc. We also compete with a variety of other companies in providing rehabilitation therapy services, hospice services and assisted living services.

Our ability to compete successfully varies from location to location and depends on a number of factors, which include:

the number of competitors in the local market;

the types of services available;

quality of care;

reputation, age and appearance of each facility; and

the cost of care in each locality.

In general, we seek to compete in each market by establishing a reputation within the local community for quality healthcare services, attractive and comfortable facilities, and providing specialized healthcare. Increased competition in the future could limit our ability to attract and retain residents or to expand our business.

Employees and Labor Relations

At December 31, 2003, we had approximately 36,300 full and part time employees.

Approximately 9% of our employees, employed in 86 of our nursing facilities, are represented by various labor unions. Although our facilities have never experienced any material work stoppages and we believe that our relations with employees and labor organizations are generally good, we cannot predict the effect continued union representation or organizational activities will have on our future operations.

A national shortage of nurses and other trained personnel and general inflationary pressures have required us to adjust our wage and benefits packages in order to compete for qualified personnel. In 2003, labor costs accounted for approximately 54% of the operating expenses of our Nursing Facilities segment, 92% of our AEGIS segment and 59% of our Home Care segment. We compete with other healthcare providers to attract and retain qualified or skilled personnel. We also compete with various industries for lower-wage employees. Although we currently do not face a staffing shortage in all markets where we operate, we have used high-priced temporary help to supplement staffing levels in certain markets with shortages of healthcare workers. Although we are addressing this challenge through recruiting and retention programs and training initiatives, these programs and initiatives may not stabilize or improve our ability to attract and retain these personnel. Our inability to control labor availability and costs could have an adverse effect on our future operating results.

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Executive Officers

The following table sets forth the name, position and age of each of our executive officers. Each executive officer is elected or appointed by the Board of Directors. The executive officers as of December 31, 2003, are as follows:

Name	Position	Age
William R. Floyd	Chairman of the Board, President, Chief Executive Officer and Director	59
Douglas J. Babb	Executive Vice President, Chief Administrative and Legal Officer and Secretary	51
David R. Devereaux	Chief Operating Officer Nursing Facilities	41
Jeffrey P. Freimark	Executive Vice President, Chief Financial and Information Officer	48
Cindy H. Susienka	Executive Vice President and President AEGIS Therapies and Home Care	44
Patrice K. Acosta	Senior Vice President Quality of Life Programs	47
Steven A. Brigance	Senior Vice President- Litigation and Assistant Chief Legal Officer	51
Pamela H. Daniels	Senior Vice President, Controller and Chief Accounting Officer	40
Lawrence Deans	Senior Vice President Human Resources	52
James M. Griffith	Senior Vice President Investor Relations and Corporate Communications	61
Patricia C. Kolling	Senior Vice President Compliance	57
Blaise J. Mercadante	Senior Vice President Marketing and New Business Innovation	50
Harold A. Price	Senior Vice President Sales and Business Development	54
Richard D. Skelly, Jr.	Senior Vice President and Treasurer	44
Chris W. Roussos	President CERES Strategies	39
Dwight C. Kouri	Vice President Corporate Development	49

Mr. Floyd joined us in April 2000 as President and Chief Operating Officer. He was elected Chief Executive Officer in February 2001 and Chairman of the Board in December 2001. From 1996 to 1998, he was Chief Executive Officer of Choice Hotels International, and from 1995 to 1996, he was Chief Operating Officer of Taco Bell Corporation. He has been a director since July 2000.

Mr. Babb joined us in April 2000 as Executive Vice President, General Counsel and Secretary. He was named head of Government Relations in January 2001 and Chief Administrative and Legal Officer in October 2002. Mr. Babb was Senior Vice President Merchandise Business Unit for Burlington Northern Santa Fe Corporation from 1997 to 1999.

Mr. Devereaux joined us in August 1998 as Senior Vice President Operations for the Specialty Services Division of the Nursing Facilities segment. He was elected President of the corporations within the Nursing Facilities segment in January 2001 and Chief Operating Officer in July 2001.

Mr. Freimark joined us in January 2002 as Executive Vice President and Chief Financial Officer. He became head of Information Technology in October 2002. From May 2001 to January 4, 2002, he was Senior Executive Vice President and Chief Financial Officer of OfficeMax, Inc. From March 1997 to May 2001, he was with The Grand Union Company where he held positions as Executive Vice President, Chief Financial Officer and President and Chief Executive Officer.

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Ms. Susienka joined us in June 1998 as President AEGIS Therapies and was elected President Home Care Services in March 2002. She was elected Executive Vice President in December 2003.

Ms. Acosta joined us in October 1996 as Vice President Risk Management. She was elected Senior Vice President Professional Services in January 2001 and Senior Vice President Quality of Life Programs in October 2003.

Mr. Brigance joined us in January 2001 as Vice President and General Counsel Litigation and was elected Senior Vice President and Assistant Chief Legal Officer in December 2003. From 1995 to 2001, he was Special Counsel with Leboeuf Lamb, Greene and MacRae in Washington, D.C.

Ms. Daniels joined us in May 1988 as Audit Coordinator. She was elected Vice President, Controller and Chief Accounting Officer in October 1996 and Senior Vice President in December 1999.

Mr. Deans joined us in November 2003 as Senior Vice President Human Resources. From September 1999 to November 2003, he was Chief Human Resources Officer at Jones Lang LaSalle. From February 1998 to June 1999, he was Vice President Human Resources of Alliant Foodservice, Inc.

Mr. Griffith joined us in November 1995 as Senior Vice President Investor Relations and Corporate Communications.

Ms. Kolling joined us in February 1989 as a rehabilitation consultant. She was elected Vice President Rehabilitation in 1994, Vice President PPS in 1998 and Vice President Medicare Programs in 2000. She was elected Senior Vice President Compliance in October 2002.

Mr. Mercadante joined us in January 2002 as Senior Vice President Marketing and New Business Innovation. From 1999 to 2002, he was President of Blazing Insights Group, and from 1996 to 1999, he was Executive Vice President Marketing at Universal Studios.

Mr. Price joined us in August 2002 as Senior Vice President Sales and Business Development. Prior to that, he worked with us on a consulting basis for 18 months. Before becoming a consultant, he was Vice President Strategic Relations and Business Development for SelfCare, Inc. from 1999 to 2000.

Mr. Skelly joined us in April 2002 as Senior Vice President and Treasurer. From September 2001 to March 2002, he served as Senior Vice President and Treasurer of OfficeMax, Inc. From June 1997 to August 2001, he held various positions with The Grand Union Company, including Acting Chief Financial Officer and Treasurer.

Mr. Roussos joined us in August 2001 as a management designee of our former Matrix segment. He was elected President of Matrix in February 2002 and President of CERES Strategies in October 2002. From 2000 to 2001, he was Division General Manager of American Homestar, and from 1996 to 2000, he was General Manager of Fleetwood Enterprises.

Mr. Kouri joined us in December 1992 as Senior Counsel Transactions. He was elected Vice President Development in 1997 and Vice President Corporate Development in 2002.

Risks Relating to Our Company

Our substantial indebtedness could adversely affect our financial health.

We have a significant amount of indebtedness. At December 31, 2003, 2002 and 2001, we had total indebtedness on our consolidated balance sheets of $566.2 million, $630.2 million and $741.7 million, respectively. Our consolidated balance sheets also included a liability of $61.9 million, $73.9 million and $84.9 million, at December 31, 2003, 2002 and 2001, respectively, representing the present value of the remaining obligation we owe to the federal government under a civil settlement agreement. In addition, at December 31, 2003, 2002 and 2001, we had $70.0 million, $139.5 million and $182.4 million, respectively, of off-balance sheet obligations. Our level of indebtedness has declined significantly over the last two years. The reduction in these obligations was primarily accomplished through the use of proceeds from divestitures and cash generated from the collection of accounts receivable. We expect to continue to reduce our indebtedness

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through cash on hand, cash generated by operations and proceeds from selected divestitures of non-strategic assets.

Our substantial indebtedness could have important consequences to you. For example, it could:

increase our vulnerability to general adverse economic and industry conditions;

require us to dedicate a substantial portion of our cash flow from operations to payments on our indebtedness, thereby reducing the availability of our cash flow to fund working capital, capital expenditures and other general corporate activities;

limit our flexibility in planning for, or reacting to, changes in our business and industry;

place us at a competitive disadvantage compared to other less leveraged competitors;

limit our ability to pursue business opportunities that may be in our interest; and

limit our ability to borrow additional funds.

In addition, the indentures relating to our publicly traded notes contain restrictive covenants and our senior credit facility contains financial and other restrictive covenants that limit our ability to engage in activities that may be in our long-term best interest. Our failure to comply with those covenants could result in an event of default, which, if not cured or waived, could result in the acceleration of a substantial amount of our debt.

Despite current indebtedness levels, we and our subsidiaries may still be able to incur substantially more debt. This could further increase the risks associated with our substantial leverage.

We may be able to incur substantial additional indebtedness in the future. The terms of our existing debt instruments and the indentures relating to our notes do not fully prohibit us from doing so. We currently are able to borrow up to $75.0 million of revolving credit under our senior credit facility ($41.3 million of which availability we are currently using for letters of credit). If new indebtedness is added to our current debt levels, the related risks that we now face could increase.

To service our indebtedness, we will require a significant amount of cash. Our ability to generate cash depends on many factors, some of which are beyond our control.

Our ability to make payments on and to refinance our indebtedness and to fund planned capital expenditures will depend on our ability to generate cash in the future. This, to a certain extent, is subject to general economic, financial, competitive, legislative, regulatory and other factors that are beyond our control.

At December 31, 2003 and 2002, we had cash and cash equivalents totaling $258.8 million and $115.4 million, respectively, and availability under our revolving credit facility of $33.7 million and $124.1 million, respectively. During 2003, we generated cash from operations of $69.9 million. We currently anticipate that cash on hand, cash flows from operations and availability under our banking arrangements will be adequate to repay our debts due within one year of $13.4 million, to make normal recurring annual capital additions and improvements of $80.0 million, to make operating lease and other contractual obligation payments, to make selective acquisitions, including the purchase of previously leased facilities, and to meet working capital requirements for the twelve months ending December 31, 2004.

We cannot assure you, however, that our business will generate sufficient cash flow from operations, that currently anticipated cost savings and operating improvements will be realized on schedule or that future borrowings will be available in an amount sufficient to enable us to pay our indebtedness or to fund our other liquidity needs. We may need to refinance all or a portion of our indebtedness on or before maturity. We cannot assure you that we will be able to refinance any of our indebtedness on commercially reasonable terms or at all.

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Our reported earnings per share may be more volatile because of the contingent conversion provision of our 2.75% convertible subordinated notes.

Holders of the convertible subordinated notes are entitled to convert the notes into our common stock if the closing sale price of our common stock for at least 20 consecutive trading days in the 30 consecutive trading day period ending on the last day of the immediately preceding fiscal quarter is more than 120% of the conversion price (or $8.94 per share) in effect on that 30th trade day, among other circumstances. Until this contingency or another conversion contingency is met, the shares underlying the notes are not included in the calculation of our basic or diluted earnings per share. Should a conversion contingency be met, diluted earnings per share is expected to decrease as a result of the inclusion of the underlying shares in the diluted earnings per share calculation. Volatility in our stock price could cause this condition to be met in one quarter and not in a subsequent quarter, increasing the volatility of our diluted earnings per share. (See Part II Item 8 Note 9.)

The price of our common stock may fluctuate significantly.

The price of our common stock has been, and is likely to continue to be, highly volatile, which means that it could decline substantially. The price of our common stock could fluctuate significantly for the following reasons, among others:

future announcements concerning us or our competitors;

quarterly variations in operating results;

business acquisitions or divestitures;

changes in earnings estimates by analysts;

changes in third-party reimbursement practices;

regulatory developments;

changes in the number of outstanding shares; or

fluctuations in the economy or general market conditions.

In addition, stock markets in general, and the market for shares of healthcare stocks in particular, have experienced extreme price and volume fluctuations in recent years which have frequently been unrelated to the operating performance of the affected companies. These broad market fluctuations may adversely affect the market price of our common stock. The market price of our common stock could decline below its current price and the market price of our common stock may fluctuate significantly in the future. These fluctuations may be unrelated to our performance.

In the past, stockholders have often instituted securities class action litigation after periods of volatility in the market price of a company s securities. If a stockholder files a securities class action lawsuit against us, we would incur substantial legal fees and our management s attention and resources would be diverted from operating our business in order to respond to the litigation. (See Item 3. Legal Proceedings.)

We rely on reimbursement from governmental programs for a majority of our revenues and we cannot assure you that reimbursement levels will not decrease in the future.

Changes in the reimbursement policies of the Medicare or Medicaid programs as a result of budget cuts by federal and state governments or other legislative and regulatory actions could have an adverse effect on our consolidated financial position, results of operations and cash flows.

We have experienced increases in our state Medicaid rates averaging 4.6%, 3.6% and 6.7% for the years ended December 31, 2003, 2002 and 2001, respectively. However, in the past, states have curtailed their Medicaid payments as a result of budget considerations. Curtailments of Medicaid funding by a state can affect long-term care providers and/or other non-eldercare providers in that state. Currently, several states in which we operate are experiencing deficits in their fiscal operating budgets. There can be no assurance that

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those states in which we operate that are experiencing budget deficits, as well as other states in which we operate, will not reduce payment rates.

The Budget Act broadened the states authority to develop their own standards for setting payment rates. It requires each state to use a public process for establishing proposed rates whereby the methodologies and justifications used for setting such rates are available for public review and comment. This requires nursing facilities to become more involved in the rate setting process since failure to do so may interfere with a facility s ability to challenge rates later.

In recent years, there have also been reductions in payments to skilled nursing facilities under the Medicare program. Although the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act of 2000 (BIPA) reversed certain rate reductions enacted under the Budget Act, some of these increases expired on September 30, 2002, the so-called Medicare cliff. While CMS announced two increases to skilled nursing facility rates effective October 2003, and will continue certain add-ons for high-acuity patients until CMS refines the RUG system, there can be no assurances that payments from the Medicare program will remain at levels comparable to present levels or will, in the future, be sufficient to cover the costs allocable to Medicare patients.

In addition, as required by the Budget Act, CMS imposed annual limits per beneficiary of $1,590 for physical and speech therapy services combined and $1,590 for occupational therapy. These caps were applied to services provided during the period from September 1, 2003 through December 8, 2003. Although Congress imposed a further moratorium from December 8, 2003 through December 31, 2005 in the provisions of the Prescription Drug Bill, there can be no assurance that the caps will not go into effect on January 1, 2006.

On February 10, 2003, CMS published a proposed rule to reduce by 30 percent the amount that Medicare reimburses skilled nursing facilities and other non-hospital providers for bad debts arising from uncollectible Medicare coinsurance and deductibles. The proposal is to phase in the reduction over a three-year period at 10 percent per year. Based on our current volume of Medicare bad debts, this proposed rule would reduce our revenues by $1.6 million, $3.1 million and $5.0 million for the first, second and third year, respectively. We cannot currently determine if and when this rule will be implemented.

Governmental payment programs are subject to statutory and regulatory changes, retroactive rate adjustments, administrative or executive orders and government funding restrictions, all of which may materially decrease the rate of government program payments to us for our services. Our financial condition and results of operations may be adversely affected by reductions in reimbursement levels and the reimbursement process in general, 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 industry is heavily regulated by the government, which requires our compliance with a variety of laws.

The operation of our facilities and the services we provide are subject to periodic inspection by governmental authorities to ensure that we are complying with standards established for continued licensure under state law and certification for participation under the Medicare and Medicaid programs. Additionally, in certain states, certificates of need or other similar approvals are required for expansion of our operations. We could be adversely affected if we are unable to obtain these approvals, if the standards applicable to approvals or the interpretation of those standards change and by possible delays and expenses associated with obtaining approvals. Our failure to obtain, retain or renew any required regulatory approvals, licenses or certificates could prevent us from being reimbursed for certain of our services.

In the ordinary course of our business, and like other providers in the healthcare industry, we receive requests for information from government agencies in connection with their regulatory or investigational authority and notices of deficiencies for failure to comply with various regulatory requirements. We review all such notices and we believe that we take timely and appropriate corrective action. In most cases, with respect to these notices, the facility and the reviewing agency will agree upon the steps to be taken to bring the facility

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into compliance with regulatory requirements. In some cases or upon repeat violations, the reviewing agency may take a number of adverse actions against a facility. These adverse actions include:

the imposition of fines;

temporary suspension of payment for new patients to the facility;

decertification from participation in the Medicare or Medicaid programs; or

in extreme circumstances, revocation of a facility s license.

We have been subject to certain of these adverse actions in the past and could be subject to adverse actions in the future which could result in significant penalties, as well as adverse publicity. Any such penalties or adverse publicity could have an adverse effect on our financial condition and results of operations.

We face periodic reviews, audits and investigations under our contracts with federal and state government agencies, and these audits could have adverse findings that may negatively impact our business.

As a result of our participation in the Medicare and Medicaid programs, we are subject to various governmental reviews, audits and investigations to verify our compliance with these programs and applicable laws and regulations. Private pay sources also reserve the right to conduct audits. An adverse review, audit or investigation could result in:

refunding amounts we have been paid pursuant to the Medicare or Medicaid programs or from private payors;

state or federal agencies imposing fines, penalties and other sanctions on us;

loss of our right to participate in the Medicare or Medicaid programs or one or more private payor networks; and

damage to our reputation in various markets.

Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of healthcare companies and, in particular, skilled nursing facilities. The investigations include:

cost reporting and billing practices;

quality of care;

financial relationships with referral sources; and

medical necessity of services provided.

We also are subject to potential lawsuits under a federal whistleblower statute designed to combat fraud and abuse in the healthcare industry. These lawsuits can involve significant monetary awards to private plaintiffs who successfully bring these suits.

We are required to comply with laws governing the transmission and privacy of health information.

HIPAA requires us to comply with certain standards for the exchange of individually identifiable health information within our Company and with third parties, such as payors, business associates and patients. These include standards for common healthcare transactions, such as claims information, plan eligibility, payment information and the use of electronic signatures; unique identifiers for providers, employers, and health plans; security; and privacy.

Sanctions for failing to comply with the HIPAA health information practices provisions include criminal penalties and civil sanctions. The security standards went into effect in April 2003, with a compliance date in April 2005 for most covered entities. We cannot assure you that all of the parties with whom we do business will be in compliance with HIPAA. If we fail to comply with these standards, we could be subject to criminal

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penalties and civil sanctions, which could have an adverse effect on our financial condition and results of operations.

Healthcare reform legislation may adversely affect our business.

In recent years, there have been numerous initiatives on the federal and state levels for comprehensive reforms affecting the payment for and availability of healthcare services. Aspects of certain of these healthcare initiatives, such as reductions in funding of the Medicare and Medicaid programs, potential changes in reimbursement regulations by CMS, enhanced pressure to contain healthcare costs by Medicare, Medicaid and other payors, greater state flexibility and additional operational requirements, could adversely affect us. There can be no assurance as to the ultimate content, timing or effect of any healthcare reform legislation, nor is it possible at this time to estimate the impact of potential legislation on us. That impact may have an adverse effect on our financial condition and results of operations.

We are subject to increasingly expensive and unpredictable patient care liability costs.

General and professional liability costs for the long-term care industry have become increasingly expensive and difficult to estimate. We and others have experienced substantial increases in both the number of claims and lawsuits, as well as the size of the typical claim and lawsuit. The long-term care industry has previously experienced significant, unexpected increases in estimated ultimate costs for claims in certain states or areas. In Texas and Florida, for example, the growth in patient care liability claims and lawsuits reached a level where it was not possible for us to continue to operate profitably and we disposed of all our facilities in Texas in 1996 and Florida in 2002.

We also have initiated several strategic and tactical actions to mitigate the impact of these rising costs. In late 2002, we identified those nursing facilities that represented a disproportionately high share of projected patient care liability costs. In early 2003, we began implementing a strategy to divest, over a two-year period, properties that accounted for approximately 50% of the annual patient care liability costs projected at that time. We upgraded our risk management and litigation functions, and adopted a more coordinated and aggressive legal defense strategy. We began using voluntary arbitration agreements in most of our nursing facilities and improved communications with residents and their families to resolve issues before they reach litigation. In addition, we remain committed to continually improving the quality of care we provide, adopting clinical performance indicators to evaluate the care at each facility and including quality care as a significant component of incentive compensation at the facility, regional and corporate levels