BEVERLY ENTERPRISES INC
Form 10-K
March 15, 2005

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549
Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2004

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.beverlycorp.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, and attached Rights to Purchase Series A Junior Participating Preferred Stock, $1.00 par value	New York Stock Exchange and Pacific 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 $908,046,901 as of June 30, 2004.

108,787,095

(Number of shares of common stock outstanding, net of treasury shares, as of February 28, 2005)

Part III incorporates by reference certain portions of the Proxy Statement for the Annual Stockholders Meeting scheduled to be held on April 21, 2005.

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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 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 document contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements may be identified by words such as expects, anticipates, intends, plans, believes, seeks, estimates or words of similar meaning and include, but are not limited to, statements about o expected future business and financial performance. Forward-looking statements are based on management s current expectations and assumptions, which are inherently subject to uncertainties, risks and changes in circumstances that are difficult to predict. Actual outcomes and results may differ materially from these expectations and assumptions due to changes in, among other things, political, economic, business, competitive, market, regulatory, demographic and other factors. We undertake no obligation to publicly update or revise any forward-looking information, whether as a result of new information, future developments or otherwise.

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PART I

ITEM 1. BUSINESS.

Operations and Services

Our business consists principally of providing healthcare services, primarily including the operation of nursing facilities, assisted living centers, hospice locations, outpatient clinics and rehabilitation therapy services. We are one of the largest operators of nursing facilities in the United States. As of December 31, 2004, we operated 351 nursing facilities with a total of 36,995 licensed beds. Our nursing facilities are located in 23 states and the District of Columbia and range in capacity from 34 to 355 licensed beds (see Item 2). As of December 31, 2004, we also operated 18 assisted living centers containing 495 units, 52 hospice and home health locations and 10 outpatient clinics, and we provided rehabilitation therapy services in 37 states and the District of Columbia. We currently have 27 nursing facilities (2,572 beds) and 10 outpatient clinics classified as held for sale.

Our operations are currently organized into three primary operating segments: Nursing Facilities, Aegis and AseraCare.

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 90% of our revenues from continuing operations for the year ended December 31, 2004. 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. Aegis is one of the largest contract therapy companies in the United States, providing rehabilitation therapy services under contract to our nursing facilities as well as 585 third-party customers as of December 31, 2004, and accounted for approximately 6% of our revenues for the year ended December 31, 2004. 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.

AseraCare. Our AseraCare operations primarily provide hospice services within nursing facilities and patients homes and accounted for approximately 3% of our revenues for the year ended December 31, 2004. 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.

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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

nursing facility 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, 2004	71%	55%	12%	28%	17%	17%
December 31, 2003	70%	56%	12%	26%	18%	18%
December 31, 2002	70%	55%	11%	27%	19%	18%

Our Aegis segment revenues are provided by non-governmental customers that obtain their revenues primarily from government programs. Our AseraCare segment obtains more than 95% of its revenues from Medicare.

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, hospice and home health and other services, as well as sales of pharmaceuticals.

Reimbursement by Medicaid Programs

Medicaid programs currently exist in all of the 23 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 federally 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 utilize various forms of cost-based reimbursement systems. 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. 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 adjusted to reflect patient acuity, similar to the methodology utilized in Medicare s prospective payment system (PPS). Many other states are actively developing reimbursement systems based on patient acuity. 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.

Currently 17 of the states in which we operate, representing approximately 76% of our facilities, have provider tax plans in place, including three states that are either in the process of implementing newly approved plans, or are currently seeking the necessary approvals from the Centers for Medicare and Medicaid Services (CMS). Provider tax plans generate additional federal matching funds to the states for Medicaid reimbursement purposes, and

implementation of a provider tax plan requires approval by CMS in order to

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qualify for federal matching funds. These plans usually take the form of a bed tax or a quality assessment fee, which is imposed uniformly across classes of providers within the state. In turn, the state utilizes the additional federal matching funds generated by the tax to pay increased reimbursement rates to the providers, which often include a repayment of a portion of the provider tax based on the provider s percentage of Medicaid patients. The proposed budget for federal fiscal year 2006 (the Federal Budget) includes proposed reform of the Medicaid program to cut a total of $60.0 billion in projected Medicaid expenditure growth over 10 years, including a provision that would reduce the maximum amount of provider taxes that a state may impose on providers for purposes of qualifying for federal matching funds from 6% of a state s Medicaid outlay to 3%. No assurances can be made as to the ultimate outcome of this budget proposal or the future of provider tax plan provisions.

We have experienced increases in our state Medicaid rates averaging 6.1%, 4.6% and 3.5% for the years ended December 31, 2004, 2003 and 2002, respectively. 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 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 14 rehabilitation RUG categories.

These add-ons may expire when CMS releases its refinements to the current RUG payment system. It is expected that these refinements will not be implemented until at least October 1, 2005 at the earliest. We currently generate approximately $32.2 million in annual revenues related to these add-ons.

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 a new two-year moratorium on the Part B therapy caps through December 31, 2005.

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The Prescription Drug Bill also required 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.

In addition to these provisions, the Prescription Drug Bill included two key provisions impacting Medicare beneficiaries: a new federal prescription drug benefit; and enhanced health plan choices in the existing Medicare Advantage program. As a result of the new drug benefit, beginning in 2006 Medicare beneficiaries can get prescription drug coverage and new support for their existing drug coverage through health and prescription drug plans that contract with Medicare. The regulations ensure that the most vulnerable of low-income beneficiaries, many of whom are nursing home residents, who do not sign up for a drug plan by the middle of December 2005 will be automatically enrolled by Medicare to further ensure there is no gap in coverage. In addition, the final regulations include strong incentives for the prescription drug plans to contract with long-term care pharmacies in order to ensure that beneficiaries residing in nursing homes continue to have access to the specialized services provided by long-term care pharmacy providers.

In 2004, CMS issued a revised rule regarding changing the method of payment for inpatient rehabilitation facilities (IRFs) from a cost-based, retrospective reimbursement system to a diagnosis-specific inpatient prospective payment system. It provides for a three-year phase-in to distinguish those patients who should undergo rehabilitation therapy in a skilled nursing facility and those who would benefit from more expensive rehabilitation therapy in an IRF. At least 75 percent of an IRF s inpatients must be treated for one or more conditions specified in these regulations that typically require intensive inpatient rehabilitation (the 75 percent rule). According to Federal government data, implementation of the 75 percent rule could save the Medicare program as much as $370 million per year by having rehabilitation therapy patients receive care in the most suitable setting (an IRF, a skilled nursing facility, or through home health care). Current Medicare reimbursement for services provided in an IRF setting are significantly higher than in other rehabilitation settings. Although we believe this could favorably impact our admissions, we cannot currently estimate the ultimate impact this rule will have on our operating results or cash flows, if any.

The proposed Federal Budget that was released in February 2005 contains provisions to cut Medicare funding for skilled nursing facilities by more than $1.5 billion for fiscal year 2006 by issuing regulations implementing RUG refinements and then eliminating the two add-ons described above. In addition, the Federal Budget proposes 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 $1.9 million, $3.8 million and $5.7 million for the first, second and third year, respectively. We cannot currently determine if, or when, this proposal will be implemented.

Government Regulation

Survey, Certification and Licensure

Our nursing facilities, assisted living centers, hospice locations and home health agencies 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.

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CMS survey and certification regulations regarding implementation of the Medicare and Medicaid provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) were revised significantly in March 1999. Among the provisions that CMS 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 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 or alternatively, penalties of $1,000 to $10,000 per instance;

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

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), which was subsequently revised in 2002 and 2004. This agreement requires that we monitor our activities, on an ongoing basis, to ensure our compliance with the requirements of participation in federal healthcare programs. It also includes functional and training obligations, audit

and review requirements and recordkeeping and reporting requirements. The 2002 revisions were made to reflect a permanent injunction requiring our nursing facilities in California to conduct additional training programs and to hire an independent quality monitor for our nursing facilities in California, Arizona, Hawaii and Washington to assess our quality care systems. We have divested all of our nursing facilities in Arizona, Washington and Hawaii and a substantial portion of our nursing facilities in California. The April 2004 revisions were made to extend the services of a quality monitor

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to all of our nursing facilities and to reflect a modification of the requirements under the agreement with respect to training and education. 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. In 2002, 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.

We have analyzed the revised CMS regulations with respect to our programs and facilities, as well as compliance data for the past two years. Results of CMS surveys for the past two years 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 that our nursing facilities, on an overall basis, have improved their survey performance year over year specifically in the number of deficiencies and the percent of surveys resulting in substandard quality of care. 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

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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;

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

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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 up to $50,000 and damages of not more than three times the amount of payment received from the prohibited activity.

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 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.

Although we could be adversely affected if a substantial portion of our programs or facilities were eventually determined not to be in compliance with HHS regulations, including, but not limited to, the information in this section, we believe our programs and facilities are generally in compliance.

Regulation Governing the Privacy and Transmission of Healthcare Information

In addition to its antifraud provisions, HIPAA also includes regulations which standardize electronic data interchange and protect the privacy 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;

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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.

Final regulations, and modifications to these regulations, establishing standards for electronic data transactions and code sets, as required under HIPAA, have been 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. Congress has granted extensions to providers whose Medicare and Medicaid trading partners are not ready to implement these standards. 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. The HIPAA employer identification standard is designed to ensure industry uniformity when reporting this data element in standardized transactions and required no changes in our operations. We believe we are generally compliant with the privacy and employer identification standards.

We must comply with the HIPAA security standards by April 20, 2005. We must comply with the provider identification standard by May 23, 2007. 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 are 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.

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. Our ability to compete successfully with other long-term healthcare providers 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 nursing facility; and

the cost of care in each locality.

We also compete with a variety of other companies in providing rehabilitation therapy and hospice services. The primary national competitors for our service businesses include RehabCare Group, Inc., Vitas Healthcare Corporation, Odyssey HealthCare, Inc., VistaCare, Inc., and Heartland Home Health Care and Hospice. Our ability to compete successfully with these and other service providers depends on a number of factors, which include:

the number of competitors in the local market;

price relative to perceived value;

employee retention and training;

quality of care; and

referral sources.

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

Employees and Labor Relations

At December 31, 2004, we, primarily through our operating subsidiaries, had approximately 34,300 full and part-time employees. Approximately 10% of our employees, employed in 93 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 would have on our future operations.

A national shortage of nurses, therapists and other trained personnel, as well as general inflationary pressures, have required us to adjust our wage and benefits packages in order to compete for qualified personnel. In 2004, labor costs accounted for approximately 52% of the operating expenses of our Nursing Facilities segment, 91% of our Aegis segment and 59% of our AseraCare 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.

We are not currently facing a staffing shortage in all markets where we operate; however, in certain markets with shortages of healthcare workers we have used high cost temporary help to supplement staffing levels. We are addressing our staffing challenges through innovative recruiting and retention programs and training initiatives. However, 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.

Risks Relating to Our Company

Our substantial indebtedness could adversely affect our financial health.

At December 31, 2004, we had total indebtedness on our consolidated balance sheet of $558.2 million. Our level of indebtedness on the balance sheet has declined by 25% over the last three years. Our consolidated balance sheet also included a liability of $48.8 million at December 31, 2004, representing the present value of the remaining obligation we owe to the federal government under a civil settlement agreement. The reduction in these obligations was primarily accomplished through the use of proceeds from divestitures and cash generated from the collection of accounts receivable.

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 best 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

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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, including indebtedness to finance potential acquisitions and expansions. The terms of our existing debt instruments and the indentures relating to our public notes allow us to incur additional indebtedness if certain conditions and financial tests are met. We have $90.0 million of revolving credit under our senior credit facility ($15.0 million of which availability at December 31, 2004 was being used for letters of credit) and can draw up to $40.0 million of letters of credit under our letter of credit facility ($21.5 million of which was available at December 31, 2004). If new indebtedness is added to our current debt levels, the related risks 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, which is, to a certain extent, subject to general economic, financial, competitive, legislative, regulatory and other factors that are beyond our control.

At December 31, 2004, we had cash and cash equivalents totaling $215.7 million and availability of $75.0 million under our revolving credit facility and $21.5 million under our letter of credit facility. 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 $12.2 million, to make normal recurring annual capital additions and improvements estimated to be $100.0 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, 2005.

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.

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. 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;

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 January 2005, a group including Arnold Whitman, the Chief Executive Officer of Formation Capital, LLC and Appaloosa Management, LP, a New Jersey based hedge fund, among others, publicly announced an unsolicited indication of interest in acquiring all of our outstanding common stock. This announcement

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resulted in an immediate, sharp increase in our common stock s trading price. There can be no assurance that the market price for our common stock will remain at its current level, or that it will not fall to, or below, the trading price on the day prior to the announcement. Moreover, the efforts by the Whitman/Appaloosa group to take control of our board and related actions have led to an increased volume in the trading of our common stock and attracted the investment of various hedge funds and arbitrageurs. The acquisition of our common stock by these groups may cause an increased degree of speculation and volatility that will adversely affect the price of our common stock.

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 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 could incur substantial legal fees and our management s attention and resources could be diverted from operating our business in order to respond to the litigation (see Item 3).

Holders of our $115.0 million of 2.75% 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. Given the recent trading activity in our common stock, we believe it is likely that the notes will become convertible at the beginning of the second quarter of 2005, but we are unable to predict the impact the conversion would have on the price of our common stock. The shares underlying the notes, since their issuance in October 2003, are included in the calculation of our diluted earnings per share in accordance with Emerging Issues Task Force Issue No. 04-8, *The Effect of Contingently Convertible Debt on Diluted Earnings per Share.*

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.

For the year ended December 31, 2004, 55%, 28% and 17% of our nursing facility revenues from continuing operations were derived from Medicaid, Medicare and private and other sources, respectively. For the year ended December 31, 2004, 97% of our AseraCare revenues were derived from Medicare. Although Aegis revenues are provided by non-governmental customers, these customers obtain their revenues primarily from government programs. 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.

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 (see Revenue Sources *Reimbursement by Medicaid Programs* and *Reimbursement by Medicare).*

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

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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 (see Government Regulation *Survey, Certification and Licensure*).

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 by 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 and hospice operations. The investigations include:

cost reporting and billing practices;

Medicare hospice reimbursement caps;

quality of care;

average length of stay in hospice locations;

financial relationships with referral sources; and

proper documentation of medical necessity for services provided.

As a large, for profit corporation we also are subject, in the ordinary course of business, to reviews, audits and investigations by other governmental agencies who have regulatory control over various aspects of our operations. An adverse ruling as a result of such a review, audit, or investigation could have an adverse impact on our financial condition and results of operations.

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 internally 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.

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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 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. In addition, we incur considerable administrative costs in monitoring the changes made within the programs, determining the appropriate actions to be taken in response to those changes, implementing the required actions to meet the new requirements and minimizing the repercussions of the changes to our organization, reimbursement rates and costs. 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 expensive and unpredictable general and professional liability costs.

General and professional liability costs for the long-term care industry have become expensive and difficult to estimate. During the past ten years, there have been significant increases for us, as well as others, in insurance premiums and claims costs. The volatility of these costs have resulted from dynamic changes in frequency and severity of claims, rapid growth in trend rates, and varying claim payment patterns, as well as a changing legal and insurance environment.

Insurance coverage may become expensive and difficult to obtain for long-term care companies, and our insurance carriers could become insolvent and unable to reimburse us.

Primarily as a result of general and professional liability costs for long-term care providers, insurance companies are ceasing to insure long-term care companies, or severely limiting their capacity to write long-term care general and professional liability insurance. When insurance coverage is available, insurance carriers are typically requiring companies to significantly increase their liability retention levels and/or pay substantially higher premiums for reduced coverage. This has been the case for most insurance coverages, including workers compensation and general and professional liabilities. We have experienced higher premiums and retention levels in the past. However, our insurance covering general and professional liabilities and workers compensation was renewed in the second quarter of 2004 with retention levels remaining consistent and premiums being generally the same as the prior year. We cannot assure you that we will be able to renew our insurance coverages in future years on terms as favorable as those we currently have.

We have purchased insurance for workers compensation, property, casualty and other risks from numerous insurance companies. We exercise care in selecting companies from which we purchase insurance, including review of published ratings by recognized rating agencies, advice from national brokers and consultants and review of trade information sources. There exists a risk that any of these insurance companies may become insolvent and unable to fulfill their obligation to defend, pay or reimburse us when that obligation becomes due. Although we believe the companies we have purchased insurance from are solvent, in light of the dramatic changes occurring in the insurance industry in recent years, we cannot assure you that they will remain solvent and able to fulfill their obligations.

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Our Nursing Facilities segment is capital intensive and has significant cash requirements to maintain current operations, to complete projects underway and to achieve our long-term strategic plan.

We operated 351 nursing facilities, of which 27 are classified as held for sale, as of December 31, 2004, and 18 assisted living centers. Our Nursing Facilities revenue and future growth is dependent on the condition of our assets. To effectively compete for residents, we have to continually invest in the appearance and maintenance of our nursing facilities and assisted living centers. In addition, to meet regulatory standards, we are required to invest capital in our physical plant and equipment. Certain of our competitors operate locations that are not as old and that may appear better maintained than ours. We expect to commit a substantial portion of our cash flow to maintain and enhance the underlying assets of our Nursing Facilities segment. If we are unable to adequately maintain, enhance and, as needed, modernize our physical plant and equipment, we may subsequently lose residents which could adversely affect our business and results of operations.

Efforts to regulate the construction or expansion of healthcare providers could impair our ability to expand our operations.

Some states and local jurisdictions require healthcare providers (including skilled nursing facilities, assisted living centers, hospices and home health agencies) to obtain prior approval, known as a certificate of need (a CON), for: