

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

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

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FORM 10-K/A

(Mark One)

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

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

For the transition period from _____ to _____

Commission File Number 0-33217

GENESIS HEALTH VENTURES, INC.

(Exact name of Registrant as specified in its charter)

Pennsylvania	101 East State Street	
(State or other jurisdiction	Kennett Square, PA 19348	
of incorporation or	(Address of principal	06-1132947
organization)	executive	(I.R.S. Employer
	offices including zip code)	Identification Number)
	(610) 444-6350	
	(Registrant's telephone number, including area code)	

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

NONE

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

Title of each class

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

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

YES NO

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

;

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

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

YES (2) NO

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

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

YES NO

DOCUMENTS INCORPORATED BY REFERENCE

NONE

- (1) The aggregate market value of the voting and non-voting common stock set forth above equals the number of shares of the registrant's common stock outstanding, reduced by the number of shares of common stock held by officers, directors and shareholders owning in excess of 10% of the registrant's common stock, multiplied by the last reported sale price for the registrant's common stock on December 23, 2002. The information provided shall in no way be construed as an admission that any officer, director or 10% shareholder of the registrant may or may not be deemed an affiliate of the registrant or that he/it is the beneficial owner of the shares reported as being held by him/it, and any such inference is hereby disclaimed. The information provided herein is included solely for record keeping purposes of the Securities and Exchange Commission.
- (2) The registrant meets the definition of "accelerated filer" (as defined by Rule 12b-2 of the Act). However, the registrant notes that the phase-in period for accelerated deadlines of quarterly and annual reports will begin for reports filed by companies that meet the definition of "accelerated filer" as of the end of their first fiscal year ending on or after December 15, 2002. Accordingly, such rules do not currently apply to the registrant.
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EXPLANATORY NOTE

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

- ☐ The Series H and I Preferred Stock issued in connection with the transaction will be valued at \$198.0 million rather than their \$420.0 million face value. The Series H and I Preferred Stock was subsequently accreted to the face value when the Company filed for Chapter 11 bankruptcy protection in the third quarter of fiscal 2000; and
- ☐ The transaction will be treated as a substantive acquisition of the remaining 56.4% equity of Multicare and accordingly, the Company will account for the transaction as a step acquisition and will not recognize the joint venture partners' 56.4% interest in the equity and losses of Multicare on its balance sheet and statement of operations.

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

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

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Cautionary Statements Regarding Forward Looking Statements

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

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

• statements contained in "Risk Factors";

• certain statements in "Management's Discussion and Analysis of Financial Condition and Results of Operations," and our notes to our consolidated financial statements, such as our ability to meet our liquidity needs, scheduled debt and interest payments, and expected future capital expenditure requirements; the expected effects of government regulation on reimbursement for services provided; and our ability to successfully implement our strategic objectives and achieve certain performance improvement initiatives within our pharmacy services segment; the expected financial impact of severance and related costs; the expected reduction in medical supply revenues; the expected receipt of a \$22 million breakup fee; the expected costs in fiscal 2003 and the foreseeable future; estimates in our critical accounting policies including, our allowance for doubtful accounts, our anticipated impact of long-lived asset impairments and our ability to provide for loss reserves for self-insured programs; and our ability to maintain restricted investments in marketable securities representing the level of outstanding insurance losses we expect to pay;

• certain statements contained in "Business" concerning strategy, corporate integrity programs, insurance coverage, environmental matters, government regulations and the Medicare and Medicaid programs, and reimbursement for services provided; and

• certain statements in "Legal Proceedings" regarding the effects of litigation.

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

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

• changes in the reimbursement rates or methods of payment from Medicare and Medicaid, or the implementation of other measures to reduce the reimbursement for our services;

• the expiration of enactments providing for additional governmental funding;

• changes in pharmacy legislation and payment formulas;

• the impact of federal and state regulations;

• changes in payor mix and payment methodologies;

• further consolidation of managed care organizations and other third party payors;

• competition in our businesses;

• an increase in insurance costs and potential liability for losses not covered by, or in excess of, our insurance;

• competition for qualified staff in the healthcare industry;

• our ability to control operating costs and generate sufficient cash flow to meet operational and financial requirements;

• an economic downturn or changes in the laws affecting our business in those markets in which we operate;

• the impact of our reliance on one pharmacy supplier to provide a significant portion of our pharmacy products;

• the impact of acquisitions and/or a possible sale or spin-off of our eldercare business;

• the ability to implement and achieve certain strategic objectives;

• the difficulty in evaluating certain of our financial information due to a lack of comparability following the emergence from bankruptcy; and

•

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

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

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

Risk Factors

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

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

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

•the adoption of the Medicare prospective payment system pursuant to the Balanced Budget Act of 1997, as modified by the Medicare Balanced Budget Refinement Act;

•adoption of the Benefits Improvement Protection Act of 2000; and

•the repeal of the Boren Amendment federal payment standard for Medicaid payments to nursing facilities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

• the imposition of fines;

• suspension of payments for new admissions to the center; and

• in extreme circumstances, decertification from participation in the Medicare or Medicaid programs and revocation of a center's or service site's license.

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

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

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

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

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

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

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

material adverse effect on our business.

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State laws and regulations could affect our ability to grow.

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

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

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

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

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

We face intense competition in our business.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- ☐ a classified board of directors beginning at the first shareholder meeting for the election of directors after October 2, 2002, with each director having a three-year term;
- ☐ a provision providing that certain business combinations involving us, unless approved by at least 75% of the board of directors, will require the affirmative vote of at least 80% of our voting stock;
- ☐ a provision permitting the board of directors to oppose a tender or other offer for our constituents and to consider any pertinent issue in connection with such offer including, but not limited to, the reputation of the offer, the value of the offered securities and any applicable legal or regulatory issues raised by the offer; and
- ☐ the authority to issue preferred stock with rights to be designated by the board of directors.

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

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PART I

ITEM 1: BUSINESS

General

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

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

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

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

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

Description of Business

Pharmacy Services

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

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

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

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

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

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

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

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

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

See "Revenue Sources" and "Government Regulation".

Inpatient Services

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

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

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

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

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

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

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

- (1) In connection with the consummation of our joint plan of reorganization, 10,702 Multicare beds classified as "Managed and Jointly-Owned Facilities" prior to 2001 were reclassified as "Owned and Leased Facilities." See "Reorganization."
- (2) Includes 2,291 owned and leased beds, principally located in the states of Wisconsin and Illinois, which have been identified as either held for sale or discontinued operations.

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

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

See "Revenue Sources" and "Government Regulation".

Other Service-Related Businesses

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

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

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

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

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

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

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

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

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

Revenue Sources

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

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

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

Human Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Government Regulation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Marketing

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

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

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

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

Personnel

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

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

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

Employee Training and Development

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

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

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

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

Corporate Integrity Program

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

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

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

addressed and remedied by appropriate company officials.

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

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

Competition in the Healthcare Services Industry

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

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

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

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

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

Insurance

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

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

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

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

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

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

Environmental Matters

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

Reorganization

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

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

See "Risk Factors".

Available Information

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

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

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

[Back to Index](#)**ITEM 2: PROPERTIES****Pharmacy Sites of Service**

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

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

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

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

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

[Back to Index](#)**Inpatient Sites of Service**

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

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

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

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

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

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ITEM 3: LEGAL PROCEEDINGS

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

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

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

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

Litigation Relating to Manor Care, Inc.

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

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

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

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

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

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

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

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

On January 16, 2001, NeighborCare filed a motion with the United States Bankruptcy Court for the District of Columbia.