VISTACARE INC
Form S-1
April 29, 2003

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As filed with the Securities and Exchange Commission on April 29, 2003
Registration No. 333-

SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form S-1
REGISTRATION STATEMENT UNDER
THE SECURITIES ACT OF 1933

VistaCare, Inc.
(Exact Name of Registrant as Specified in its Charter)

Delaware	**8099**	**06-1521534**
(State or Other Jurisdiction of Incorporation or Organization)	*(Primary Standard Industrial Classification Code Number)*	*(I.R.S. Employer Identification Number)*

8125 North Hayden Road, Suite 300,

Scottsdale, Arizona 85258, (480) 648-4545
(Address, Including Zip Code, and Telephone Number, Including Area Code, of Registrant s Principal Executive Offices)

Richard R. Slager

President and Chief Executive Officer
8125 North Hayden Road, Suite 300, Scottsdale, Arizona 85258, (480) 648-4545
(Name, Address, Including Zip Code, and Telephone Number, Including Area Code, of Agent for Service)

Copies to:

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Approximate Date of Commencement of Proposed Sale to the Public: As soon as practicable after this registration statement becomes effective.

If any of the securities being registered on this form are to be offered on a delayed or continuous basis pursuant to Rule 415 under the Securities Act of 1933, check the following box. o

If this form is filed to register additional securities for an offering pursuant to Rule 462(b) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o

If this form is a post-effective amendment filed pursuant to Rule 462(c) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement of the same offering. o

If this form is a post-effective amendment filed pursuant to Rule 462(d) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement of the same offering. o

If delivery of the prospectus is expected to be made pursuant to Rule 434, check the following box. o

CALCULATION OF REGISTRATION FEE

Title of each Class of Securities to be Registered	Amount to be Registered(1)	Proposed Maximum Offering Price Per Share(2)	Proposed Maximum Aggregate Offering Price	Amount of Registration Fee
Class A Common Stock, $.01 par value	5,060,000 shares	$18.08	$91,484,800	$7,401(3)

(1) Includes 660,000 shares which may be sold if the Underwriters over-allotment option is exercised.

(2) Calculated in accordance with Rule 457(c) under the Securities Act of 1933 based on the average high and low sale prices of the common stock of the registrant on April 25, 2003, as reported on the Nasdaq National Market.

(3) This registrant, VistaCare, Inc., made an overpayment of $1,173 in connection with the filing of a registration statement on Form S-1 (Registration No. 33-98033) initially filed with the Securities and Exchange Commission on August 13, 2002. Of such overpayment, $88 is being offset against the currently due filing fee.

The registrant hereby amends this registration statement on such date or dates as may be necessary to delay its effective date until the registrant shall file a further amendment which specifically states that this registration statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of 1933 or until the registration statement shall become effective on such date as the Securities and Exchange Commission, acting pursuant to said Section 8(a), may determine.

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The information in this prospectus is not complete and may be changed. We may not sell these securities until the registration statement filed with the Securities and Exchange Commission is effective. This prospectus is not an offer to sell these securities and is not soliciting an offer to buy these securities in any state where the offer or sale is not permitted.

Subject to Completion, dated April 29, 2003

PROSPECTUS

4,400,000 Shares

Class A Common Stock

All of the shares of our Class A Common Stock are being sold by the selling stockholders named in this prospectus. We will not receive any of the proceeds from the sale of shares by the selling stockholders.

Our shares are quoted on the Nasdaq National Market under the symbol VSTA . On April 28, 2003, the last sale price of our common stock as reported on the Nasdaq National Market was $19.25 per share.

Investing in our common stock involves risks. See Risk Factors beginning on page 7.

	Per Share	Total
Public offering price	$	$
Underwriting discount	$	$
Proceeds to the selling stockholders (before expenses)	$	$

The selling stockholders have granted the underwriters a 30-day option to purchase up to an aggregate of 660,000 additional shares of common stock on the same terms and conditions as set forth above to cover over-allotments, if any.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or passed upon the adequacy or accuracy of this prospectus. Any representation to the contrary is a criminal offense.

Lehman Brothers, on behalf of the underwriters, expects to deliver the shares on or about , 2003.

LEHMAN BROTHERS **SG COWEN**

WILLIAM BLAIR & COMPANY **JEFFERIES & COMPANY, INC.**

, 2003

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You should rely only on the information contained in this prospectus. We have not authorized anyone to provide you with information that is different from that contained in this prospectus. This prospectus is not an offer to sell or a solicitation of an offer to buy shares in any jurisdiction where such offer or any sale of shares would be unlawful. The information in this prospectus is complete and accurate only as of the date on the front cover regardless of the time of delivery of this prospectus or of any sale of shares.

Until , 2003, 25 days after the date of this offering, all dealers that effect transactions in our shares, whether or not participating in this offering, may be required to deliver a prospectus. This is in addition to the dealers obligation to deliver a prospectus when acting as underwriters and with respect to their unsold allotments or subscriptions.

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PROSPECTUS SUMMARY

This summary highlights information contained elsewhere in this prospectus and does not contain all of the information you should consider in making your investment decision. You should read this summary together with the more detailed information, including our financial statements and the related notes, elsewhere in this prospectus.

VistaCare, Inc.

Overview of Our Business

We are a leading provider of hospice services in the United States. Through interdisciplinary teams of physicians, nurses, home healthcare aides, social workers, spiritual and other counselors and volunteers, we provide care primarily designed to reduce pain and enhance the quality of life of terminally ill patients, most commonly in the patient s home or other residence of choice. Our mission is to provide superior and financially responsible care for the physical, spiritual and emotional needs of our patients and their families, while maintaining a supportive environment for our employees.

We have grown rapidly since commencing operations in 1995. In 1998, we completed two significant acquisitions that increased our census from approximately 350 patients to approximately 1,750 patients. Since then, we have more than doubled our patient census primarily through growth of our existing hospice programs, which we sometimes refer to in this prospectus as same-store growth. As of March 31, 2003, we had 39 hospice programs serving patients in 14 states with a census of approximately 4,300 patients. Our net patient revenue was $132.9 million in 2002. For the three months ended March 31, 2003, our net patient revenue was $42.0 million, a 51.6% increase over our net patient revenue of $27.7 million for the three months ended March 31, 2002.

Our rapid growth has presented challenges. For example, our 1998 acquisitions required us to spend considerable time and resources integrating our systems and operating methods with those of the acquired businesses. Our efforts to improve our same-store growth required us to invest in the development of more extensive referral relationships. As a result of these and other challenges, we incurred net losses before accrued preferred stock dividends of $0.4 million and $6.7 million in 2000 and 2001, respectively. However, we recorded net income before accrued preferred stock dividends of $7.6 million and $2.8 million for the year ended December 31, 2002 and the three months ended March 31, 2003, respectively.

We plan to continue our expansion through same-store growth and the development of new hospice programs, as well as through strategic alliances, partnerships and acquisitions. We expect that our growth strategy will present challenges similar to those we have faced in the past. However, as a result of the experience of our management team and our investment in information technology infrastructure, employee training and regulatory compliance programs, we believe we have developed a solid platform for future growth.

Our operations are built around a mission-oriented philosophy that emphasizes superior care and open access to our services. We believe our high care standards, distinctive service philosophy and expertise in cost-effective care management help us develop strong relationships with the medical and consumer communities we serve and give us a competitive advantage in obtaining patient referrals.

Overview of the Hospice Care Industry

Since the opening of the first hospice in the United States in the 1970s, hospice care has grown into a multi-billion dollar industry that served approximately 700,000 patients in 2000 through more than 3,100 hospice care programs. Today, Medicare pays for the majority of hospice services. Hospice care is also covered by most private insurance plans, and 43 states and the District of Columbia provide hospice coverage to their Medicaid beneficiaries. Medicare hospice expenditures alone are expected to reach an estimated $5.0 billion in 2003.

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Market Opportunity

We believe that the hospice care industry is poised for substantial growth over the next several years as a result of the following factors:

Awareness and Acceptance of Hospice Care Services is Expanding. Recent trends, including dramatic increases in the number of patients receiving hospice care and in the amount of Medicare hospice expenditures, demonstrate that awareness and acceptance of hospice care is expanding.

Hospice Care Provides Significant Cost Savings Over Traditional Care. Recent estimates have concluded that the cost of care for hospice patients is substantially less than the cost of care for similarly situated patients receiving traditional medical services.

The American Population is Aging. In 2002, 82.5% of our patients were over the age of 65. This segment of the American population is expected to grow at a rate three times greater than the rate of the general population through the year 2022.

Hospice Services are Underutilized. Recent studies have found that in 2000 only 25% of decedents received hospice care, 75% of Americans were not aware that hospice care can be provided in the home and 90% of Americans did not know that hospice care is covered by Medicare.

In addition, we believe that there will be consolidation within the fragmented hospice industry and that large, well managed hospice care providers are best positioned to grow by affiliating with or acquiring small hospice care providers.

Our Competitive Strengths

We believe a number of factors differentiate us from our competitors and provide us with important competitive advantages.

We Benefit from Being One of the Nation s Largest Hospice Care Providers. Because we are one of the nation s largest hospice care providers, we are able to negotiate volume discounts on the purchase of pharmaceuticals, durable medical equipment and medical supplies and spread our fixed costs over a large patient population. In addition, the geographic scope of our operations gives us a competitive advantage in developing referral relationships with national and regional nursing home and assisted living companies.

We Have Implemented a Highly Effective Pharmacy Cost Control System. Our comprehensive pharmacy cost management system has enabled us to achieve an average daily pharmacy cost per patient that is significantly lower than the industry average.

We Have Developed an Advanced, Proprietary Technology Infrastructure. Our proprietary technology infrastructure enables us to manage our costs effectively while allowing us to deliver a consistently high level of care across our organization. We intend to continue to invest in our technology infrastructure to streamline our decision-making and drive efficiencies in our operations.

We Provide Open Access to Hospice-Eligible Patients. Our service philosophy is to provide hospice care to all adult patients who are eligible to receive hospice care under Medicare guidelines, regardless of the complexity of their illness. We call this philosophy open access . Operating with this service philosophy enables us to build strong relationships with our referral sources, encourages earlier utilization of our services and increases the average length of stay of our patients.

We Have an Experienced Management Team. We have assembled a management team at both the corporate and program level with financial, regulatory and operating experience. Our corporate executive officers, half of whom have joined us since January 1, 2001, have significant experience operating publicly traded healthcare companies and growing businesses both organically and through acquisitions.

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Our Business Strategy

We intend to enhance our position as a market leader in the hospice care industry by pursuing the following strategies:

Continue to Drive Same-Store Census Growth. We have more than doubled our patient census over the past three years through same-store growth. We intend to continue to increase our same-store growth by:

- continuing to provide superior quality of care;
- building relationships that enhance our presence in local markets;
- focusing on our formal marketing initiatives; and
- building relationships with national and regional nursing homes, assisted living facilities and managed care organizations.

Expand Through Strategic Acquisitions and New Program Development. We believe we will have significant opportunities to acquire or enter into strategic alliances with other hospice programs, including not-for-profit providers. In attractive markets where there are no suitable acquisition or strategic alliance opportunities, we may develop new hospice programs.

Build Market Share in Non-Urban Markets. Hospice care usage by Medicare beneficiaries in non-urban areas has increased dramatically in recent years. A significant portion of our current business involves providing care in those markets. We plan to continue to focus on building market share in non-urban markets.

Become the Employer of Choice in the Hospice Care Industry. We are committed to maintaining a superior work environment consisting of competitive compensation, proper staffing, useful management tools and extensive internal training.

Corporate Information

Our principal executive offices are located at 8125 North Hayden Road, Suite 300, Scottsdale, Arizona 85258 and our main telephone number is (480) 648-4545. Our website address is www.vistacare.com. **Information contained on our website does not constitute part of this prospectus.**

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THE OFFERING

Common stock offered by the selling stockholders	4,400,000 shares
Common stock to be outstanding after the offering	15,604,035 shares
Nasdaq National Market symbol	VSTA
Use of proceeds	We will not receive any of the proceeds from this offering

The number of shares of common stock that will be outstanding after this offering is based on the number of shares of common stock outstanding on March 31, 2003. This number does not include:

- 20,000 shares of common stock issuable upon the exercise of a warrant outstanding on March 31, 2003 with an exercise price of $0.025 per share;
- 1,981,900 shares of common stock issuable upon the exercise of stock options outstanding on March 31, 2003 with exercise prices ranging from $1.68 to $15.17 per share and a weighted average exercise price of $6.62 per share; and
- an aggregate of 1,335,700 additional shares of common stock reserved for future issuance under our stock option and stock purchase plans.

Except as otherwise specified in this prospectus, all information in this prospectus assumes:

- the conversion of all 58,096 outstanding shares of our Class B Common Stock, which are convertible at any time at the option of the holder into an equal number of shares of our common stock; and
- the underwriters do not exercise the over-allotment option that the selling stockholders have granted to them to purchase additional shares in this offering, as described in the section of this prospectus entitled Underwriting .

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SUMMARY CONSOLIDATED FINANCIAL AND OPERATING DATA

You should read this summary information with the discussion in Management s Discussion and Analysis of Financial Condition and Results of Operations and our financial statements and notes to those statements included elsewhere in this prospectus.

	Year Ended December 31,			Three Months Ended March 31,	
	2000	2001	2002	2002	2003
	(dollars in thousands, except per share data)				
Consolidated Statement of Operations Data:					
Net patient revenue	$ 81,595	$ 91,362	$ 132,947	$ 27,674	$ 42,001
Operating expenses:					
Patient care	55,256	63,950	79,752	17,269	24,085
General and administrative (exclusive of stock-based compensation charges reported below)	23,541	30,666	42,535	8,911	13,352
Depreciation and amortization	1,797	1,990	1,349	272	344
Stock-based compensation		50	427	50	1,047
Total operating expenses	80,594	96,656	124,063	26,502	38,828
Operating (loss) income	1,001	(5,294)	8,884	1,172	3,173
Non-operating income (expense):					
Interest income	202	52	25	2	101
Interest expense	(1,497)	(1,157)	(935)	(201)	(48)
Other expense	(8)	(163)	(137)	(28)	(16)
Net (loss) income before income taxes	(302)	(6,562)	7,837	945	3,210
Income tax expense	81	150	281	36	386
Net (loss) income	(383)	(6,712)	7,556	909	2,824
Accrued preferred stock dividends(1)	3,482	3,839	4,052	1,032	
Net (loss) income to common stockholders	$ (3,865)	$ (10,551)	$ 3,504	(123)	2,824
Net (loss) income per common share:					
Basic	$ (0.76)	$ (2.07)	$ 0.63	$ (0.02)	$ 0.18
Diluted	$ (0.76)	$ (2.07)	$ 0.52	$ (0.02)	$ 0.17
Weighted average shares outstanding:					
Basic	5,098,000	5,098,000	5,580,000	5,100,000	15,500,000
Diluted	5,098,000	5,098,000	6,776,000	5,100,000	16,656,000
Operating Data:					
Number of hospice programs(2)	38	38	38	38	39
Admissions(3)	9,455	10,330	12,745	2,893	3,734

Days of care(4)	823,885	948,001	1,227,787	258,980	371,253
Average daily census(5)	2,251	2,597	3,364	2,878	4,125
Other Data:					
Adjusted EBITDA(6)	$ 2,790	$ (3,417)	$ 10,523	$ 1,466	$ 4,548
Net cash provided by (used in) operating activities	$ 2,080	$ 3,164	$ 6,142	$ (3,390)	$ 1,347
Net cash used in investing activities	$ (2,266)	$ (2,051)	$ (6,008)	$ (314)	$ (1,160)
Net cash (used in) provided by financing activities	$ (2,190)	$ (2,277)	$ 37,587	$ 3,194	$ 220

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	March 31, 2003
	(in thousands)
Consolidated Balance Sheet Data:	
Cash and cash equivalents	$ 39,511
Working capital	44,756
Total assets	99,735
Capital lease obligations, including current portion	156
Long-term debt, including current portion	250
Accumulated deficit(1)	(26,693)
Total stockholders equity	73,338

(1) Reflects accrued dividends on the Series B Preferred Stock, Series C Preferred Stock and Series D Preferred Stock at the rate of 10.0% per annum, compounded semi-annually. This preferred stock was converted into common stock upon the closing of our initial public offering, and the accrued preferred stock dividends, which were not payable in the event of a conversion into common stock, were reclassified as additional paid-in-capital.

(2) Number of hospice programs at end of period.

(3) Represents the total number of patients admitted into our hospice programs during the period.

(4) Represents the total days of care provided to our patients during the period.

(5) Represents the average number of patients for whom we provided hospice care each day during the period and is computed by dividing days of care by the number of days during the period.

(6) Adjusted EBITDA consists of net (loss) income before accrued preferred stock dividends, excluding net interest, taxes, depreciation and amortization and stock-based compensation charges. We present adjusted EBITDA to enhance the understanding of our operating results. Adjusted EBITDA is not a measure of financial performance under generally accepted accounting principles. Items excluded from adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA is a key measure we use to evaluate our operations. In addition, we provide our adjusted EBITDA because we believe that investors and securities analysts will find adjusted EBITDA to be a useful measure for evaluating our cash flows from operations, for comparing our operating performance with that of similar companies that have different capital structures and for evaluating our ability to meet our future debt service, capital expenditures and working capital requirements. Adjusted EBITDA should not be considered in isolation or as an alternative to net (loss) income, cash flows generated by operating, investing or financing activities, or other financial statement data presented in the consolidated financial statements as indicators of financial performance or liquidity. Because adjusted EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, adjusted EBITDA as presented may not be comparable to other similarly titled measures of performance of other companies. For a reconciliation of net (loss) income to adjusted EBITDA, see Management s Discussion and Analysis of Financial Condition and Results of Operations Adjusted EBITDA .

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RISK FACTORS

An investment in our common stock represents a high degree of risk. There are a number of factors, including those specified below, which may adversely affect our business, financial results or stock price. Additional risks that we do not know about or that we currently view as immaterial may also impair our business or adversely impact our financial results or stock price. You should carefully consider the risks described below, together with the other information in this prospectus, before making a decision to invest in our common stock.

Risks Relating to Our Business

We are dependent on payments from Medicare and Medicaid. Changes in the rates or methods governing these payments for our services could adversely affect our net patient revenue and profitability.

Approximately 92.1%, 98.9%, 96.6% and 95.9% of our net patient revenue for the years ended December 31, 2000, 2001 and 2002 and for the three months ended March 31, 2003, respectively, consisted of payments from Medicare and Medicaid programs. Because we generally receive fixed payments for our hospice care services based on the level of care provided to our hospice patients, we are at risk for the cost of services provided to our hospice patients. We cannot assure you that Medicare and Medicaid will continue to pay for hospice care in the same manner or in the same amount that they currently do. Reductions in amounts paid by government programs for our services or changes in methods or regulations governing payments, which would likely result in similar changes by private third-party payors, could adversely affect our net patient revenue and profitability.

Our profitability may be adversely affected by limitations on Medicare payments.

Medicare payments for hospice services are subject to an annual per-beneficiary cap, which for the twelve months ended October 31, 2002 was $17,391. Medicare has not yet announced the per-beneficiary cap amount that will be effective for services performed during the twelve months ending October 31, 2003. Medicare may not announce the new cap amount until the third quarter of 2003. Once announced, the new cap amount will become effective retroactively for all services performed since November 1, 2002. Compliance with the cap is measured by calculating the annual Medicare payments received by a hospice program with respect to services provided to all Medicare hospice care beneficiaries and comparing the result with the product of the per-beneficiary cap amount and the number of Medicare beneficiaries electing hospice care for the first time from that program during that year. We reflected as a reduction to net patient revenue of approximately $1.1 million in 2001, $0.9 million in 2002 and $0.4 million in the three-month period ended March 31, 2003 as a result of estimated reimbursements in excess of the per-beneficiary cap in those periods. Our ability to comply with this limitation depends on a number of factors relating to a given hospice program, including the rate at which our patient census increases, the average length of stay and the mix in level of care. Our profitability may be adversely affected if, in the future, we are unable to comply with this and other Medicare payment limitations.

If our costs were to increase more rapidly than the fixed payment adjustments we receive from Medicare and Medicaid for our hospice services, our profitability could be negatively impacted.

We generally receive fixed payments for our hospice services based on the level of care that we provide to patients and their families. Accordingly, our profitability is largely dependent on our ability to manage costs of providing hospice services and to maintain a patient base with a sufficiently long length of stay to attain profitability. We are susceptible to situations, particularly because of our open access philosophy, where we may be referred a disproportionate share of patients requiring more intensive and therefore more expensive care than other providers. Although Medicare and Medicaid currently provide for an annual adjustment of the various hospice payment rates based on the increase or decrease of the medical care expenditure category of the Consumer Price Index, these hospice care increases have historically been less

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than actual inflation. If these annual adjustments were eliminated or reduced, or if our costs of providing hospice services, over one-half of which consist of labor costs, increased more than the annual adjustment, our profitability could be negatively impacted. In addition, cost pressures resulting from shorter patient lengths of stay and the use of more expensive forms of palliative care, including drugs and drug delivery systems, could negatively impact our profitability.

We may be adversely affected by governmental decisions regarding our nursing home patients.

For our patients receiving nursing home care under certain state Medicaid programs, the applicable Medicaid program pays us an amount equal to no more than 95% of the Medicaid per diem nursing home rate for room and board services furnished to the patient by the nursing home in addition to the applicable Medicare or Medicaid hospice per diem payment. We, in turn, are generally obligated to pay the nursing home for these room and board services at a rate between 95% and 100% of the full Medicaid per diem nursing home rate. In the past, we have experienced situations where both we and the Medicaid program have paid a nursing home for the same room and board service and the Medicaid program has imposed on us the burden of recovering the amount we previously paid to the nursing home. There can be no assurance these situations will not recur in the future or that if they do, we will be able to fully recover from the nursing home.

In addition, many of our patients residing in nursing homes are eligible for both Medicare and Medicaid benefits. In these cases, the patients state Medicaid program pays their nursing home room and board charges and Medicare pays their hospice services benefits. Government audits conducted in the last several years have suggested that the reimbursement levels for these dual-eligible hospice patients as well as for Medicare-only patients living in nursing homes may be excessive. Specifically, the government has expressed concerns that hospice programs may provide fewer services to patients who reside in nursing homes than to patients living in other settings due to the presence of the nursing home s own staff to address problems that might otherwise be handled by hospice personnel. Because hospice programs are paid a fixed daily amount, regardless of the volume or duration of services provided, the government is concerned that by shifting the responsibility and cost for certain patient care or counseling services to the nursing home, hospice programs may inappropriately increase their profitability. In the case of these dual-eligible patients, the government s concern is that the cost of providing both the room and board and hospice services may be significantly less than the combined reimbursement paid to the nursing homes and hospice programs as a result of the overlap in services.

From time to time, there have been legislative proposals to reduce or eliminate Medicare reimbursement for hospice patients residing in nursing homes and to require nursing homes to provide end-of-life care, or alternatively to reduce or eliminate the Medicaid reimbursement of room and board services provided to hospice patients. The likelihood of this type of change may be greater when federal and state governments experience budgetary shortfalls. If any such proposal were adopted, it could significantly affect our ability to obtain referrals from and continue to serve patients residing in nursing homes.

Medical reviews and audits by governmental and private payors could result in material payment recoupments and payment denials, which could negatively impact our business.

Medicare fiscal intermediaries and other payors periodically conduct pre-payment or post-payment medical reviews or other audits of our reimbursement claims. In order to conduct these reviews, the payor requests documentation from us and then reviews that documentation to determine compliance with applicable rules and regulations, including the eligibility of patients to receive hospice benefits, the appropriateness of the care provided to those patients, and the documentation of that care. We cannot predict whether medical reviews or similar audits by federal or state agencies or commercial payors of our hospice programs reimbursement claims will result in material recoupments or denials, which could have a material adverse effect on our financial condition and results of operations.

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We have a limited history of profitability and may incur substantial net losses in the future.

We began operations in November 1995. For 1999, 2000 and 2001, we recorded net losses before accrued preferred stock dividends of $0.8 million, $0.4 million and $6.7 million, respectively. Although we recorded net income before accrued preferred stock dividends of $7.6 million for 2002 and $2.8 million for the three months ended March 31, 2003, we had an accumulated deficit of $26.7 million at March 31, 2003. We cannot assure you that we will operate profitably in the future. In addition, we may experience significant quarter-to-quarter variations in operating results. We are pursuing a growth strategy focused primarily on same-store growth but also involving the development of new programs and acquisitions. Our growth strategy may involve, among other things, increased marketing expenses, significant cash expenditures, debt incurrence and other expenses that could negatively impact our profitability on a quarterly and an annual basis. Our net patient revenue could be adversely impacted by a number of factors, in particular, reductions in Medicare payment rates and patient lengths of stay, which may not be within our control.

If we are unable to attract qualified nurses and other healthcare professionals at reasonable costs, it could limit our ability to grow, increase our operating costs and negatively impact our business.

We rely significantly on our ability to attract and retain qualified nurses and other healthcare professionals who possess the skills, experience and licenses necessary to meet the Medicare certification requirements and the requirements of the hospitals, nursing homes and other healthcare facilities with which we work. We compete for qualified nurses and other healthcare professionals with hospitals, nursing homes, other hospices and other healthcare organizations. Currently, there is a shortage of qualified nurses in most areas of the United States. Competition for nursing personnel is increasing, and nurses salaries and benefits have risen.

Our ability to attract and retain qualified nurses and other healthcare professionals depends on several factors, including our ability to provide attractive assignments and competitive benefits and wages. We cannot assure you that we will be successful in any of these areas. Because we operate in a fixed reimbursement environment, increases in the wages and benefits that we must provide to attract and retain qualified nurses and other healthcare professionals or increases in our reliance on contract nurses or temporary healthcare professionals could negatively affect our profitability. We may be unable to continue to increase the number of qualified nurses and other healthcare professionals that we recruit, decreasing the potential for growth of our business. Moreover, if we are unable to attract and retain qualified nurses and other healthcare professionals, we may have to limit the number of patients for whom we can provide hospice care to maintain the quality of our hospice services.

We may not be able to attract and retain a sufficient number of volunteers to grow our business or maintain our Medicare certification.

Medicare requires certified hospice programs to recruit and train volunteers to provide patient care services or administrative services. Volunteer services must be provided in an amount equal to at least five percent of the total patient care hours provided by all paid hospice employees and contract staff of a hospice program. If we are unable to attract and retain volunteers, it could limit our potential for growth and our hospice programs could lose their Medicare certifications, which would make those hospice programs ineligible for Medicare reimbursement.

If we fail to cultivate new or maintain established relationships with existing patient referral sources our net patient revenue may decline.

Our success is heavily dependent on referrals from physicians, nursing homes, assisted living facilities, hospitals, managed care companies, insurance companies and other patient referral sources in the communities that our hospice programs serve. Because we and many of our referral sources are dependent upon Medicare, we are limited in our ability to engage in business practices that are commonplace among referring businesses in other industries such as referral fees, or bonuses and long-term exclusive contracts.

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Our growth and profitability depend significantly on our ability to establish and maintain close working relationships with patient referral sources and to increase awareness and acceptance of hospice care by our referral sources and their patients. We cannot assure you that we will be able to maintain our existing referral source relationships or that we will be able to develop and maintain new relationships in existing or new markets. Our loss of existing relationships or our failure to develop new relationships could adversely affect our ability to expand our operations and operate profitably. Moreover, we cannot assure you that awareness or acceptance of hospice care will increase.

Our growth strategy may not be successful, which could adversely impact our growth and profitability.

The primary focus of our growth strategy is same-store growth. To achieve this growth, we intend to increase our marketing and other expenditures. If our resources are not deployed effectively and we do not achieve the same-store growth we seek, it could adversely impact our profitability.

Our growth strategy also involves the development of new programs. When we develop new programs, we first engage a small staff and obtain office space, contracts and referral sources. Then we admit a small number of patients and request a Medicare certification survey. Following Medicare certification, we spend significant management and financial resources in an effort to increase patient census of that program. This aspect of our growth strategy may not be successful, which could adversely impact our growth and profitability. In this regard, we cannot assure you that we will be able to:

identify markets that meet our selection criteria for new hospice programs;

hire and retain a qualified management team to operate each of our new hospice programs;

manage a large and geographically diverse group of hospice programs;

become Medicare and Medicaid certified in new markets;

generate sufficient hospice admissions in new markets to operate profitably in these new markets; or

compete effectively with existing hospice programs in new markets.

Competition for acquisition opportunities may restrict our future growth by limiting our ability to make acquisitions at reasonable valuations.

In addition to same-store growth and the development of new programs, our business strategy includes increasing our market share and presence in the hospice care industry through strategic acquisitions of companies that complement or enhance our business. We have historically faced competition for acquisitions. In the future, this could limit our ability to grow by acquisitions or could raise the prices of potential acquisition targets and make them less attractive to us.

Our ability to grow through acquisitions may be limited by increasing government oversight and review of sales of not-for-profit healthcare providers.

Approximately 73% of hospice programs in the United States are not-for-profit programs. Accordingly, it is likely that a substantial number of acquisition opportunities will involve hospice programs operated by not-for-profit entities. In recent years, several states have increased review and oversight of transactions involving the sale of healthcare facilities by not-for-profit entities. Although the level of oversight varies from state to state, the current trend is to provide for increased governmental review, and in some cases approval, of transactions in which a not-for-profit entity sells a healthcare facility or business to a for profit entity. This increased scrutiny may increase the difficulty of completing or prevent the completion of acquisitions in some states in the future.

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As with our past acquisitions, we may face difficulties integrating businesses that we may acquire in the future. Our efforts to acquire other businesses may be unsuccessful, involve significant cash expenditures or expose us to unforeseen liabilities.

Our 1998 acquisitions, which were closed nearly simultaneously and increased our patient census approximately five-fold, presented significant integration difficulties. Due to the size and complexity of these transactions, immediately following the transactions our resources available for integration efforts were limited. In time, as we were able to focus on the integration of the acquired businesses, we spent substantial resources on projects such as:

implementing consistent billing and payroll systems across a large number of new programs;

instituting standard procedures for ordering pharmaceuticals, medical equipment and supplies; and

re-training staff from the acquired businesses to complete properly our standard claim documentation and to conform to our service philosophy and internal compliance procedures.

Our future acquisitions could require that we spend significant resources on some of the same types of projects. In addition, our future acquisitions could present other challenges such as:

potential loss of key employees or referral sources of acquired businesses;

potential difficulties in obtaining required regulatory approvals; and

assumption of liabilities and exposure to unforeseen liabilities of acquired businesses, including liabilities for their failure to comply with healthcare regulations.

Our future acquisitions may also involve significant cash expenditures, debt incurrence and integration expenses that could have a material adverse effect on our financial condition and results of operations. Any acquisition may ultimately have a negative impact on our business and financial condition.

The loss of key senior management personnel could adversely affect our ability to remain competitive.

We believe that the success of our business strategy and our ability to operate profitably depends on the continued employment of our senior management team. If key members of our senior management team become unable or unwilling to continue in their present positions, our business and financial results could be materially adversely affected. In particular, we believe the continued employment of each of Richard R. Slager, our Chief Executive Officer, Mark E. Liebner, our Chief Financial Officer, and Carla Davis Hughes, our Senior Vice President of Operations, is important to our future growth and competitiveness. We have entered into management agreements with Messrs. Slager and Liebner and Ms. Hughes to provide them with incentives to remain employed by us, all as more fully described in the section of this prospectus entitled Management Employment and Compensation Arrangements . However, there can be no assurance that any of these individuals will continue to be employed by us.

If any of our hospice programs fail to comply with the Medicare conditions of participation, that hospice program could lose its Medicare certification, thereby adversely affecting our net patient revenue and profitability.

Each of our hospice programs must comply with the extensive conditions of participation to remain certified under Medicare guidelines. If any of our hospice programs fails to meet any of the Medicare conditions of participation, that hospice program may receive a notice of deficiency from a state surveyor designated by Medicare to measure the hospice program s level of compliance. The notice may require the hospice program to prepare a plan of correction and undertake other steps to ensure future compliance with the conditions of participation. If a hospice program fails to correct the deficiencies or develop an adequate plan of correction, the hospice program may be required to suspend admissions or may have its Medicare or Medicaid provider agreement terminated. In June 2000, the Medicare provider agreement for our Odessa, Texas hospice program was terminated. In July 1999, our Las Vegas, Nevada hospice program received a Medicare termination notice asserting that the program was not in compliance with the Medicare conditions

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of participation. Following an internal review, we determined that it would not be cost-effective to protest the termination or to attempt to bring the program into compliance. Accordingly, the Medicare certification for that program was terminated in August 1999. We cannot assure you that we will not lose our Medicare certification at one or more of our other hospice programs in the future. Any such loss could adversely affect our net patient revenue and profitability as well as our reputation within the hospice care industry. For more information, see the section of this prospectus entitled Business Government Regulation Medicare Conditions of Participation for Hospice Programs .

We may not be able to compete successfully against other hospice care providers, and competitive pressures may limit our ability to maintain or increase our market position and adversely affect our profitability.

Hospice care in the United States is competitive. In many areas in which we maintain hospice programs, we compete with a large number of organizations, including:

community-based hospice providers;

national and regional companies;

hospital-based hospice and palliative care programs;

nursing homes; and

home health agencies.

Our largest competitors include Odyssey Healthcare, Inc., SouthernCare Hospice, Inc. and Vitas Healthcare Corporation.

Some of our current and potential competitors have or may obtain significantly greater financial and marketing resources than us. Various healthcare companies have diversified into the hospice market. Relatively few regulatory barriers to entry exist in our local markets. Accordingly, other companies, including hospitals and other healthcare organizations that are not currently providing hospice care, may expand their services to include hospice care. We may encounter increased competition in the future that could negatively impact patient referrals to us, limit our ability to maintain or increase our market position and adversely affect our profitability.

A significant reduction in the carrying value of our goodwill could have a material adverse effect on our profitability.

A substantial portion of our total assets consists of intangible assets, primarily goodwill. Goodwill, net of accumulated amortization, accounted for approximately 20.6% of our total assets as of March 31, 2003. Effective January 1, 2002, we adopted Statement of Financial Accounting Standards No. 142, *Goodwill and Other Intangible Assets*. As a result, we no longer amortize goodwill and indefinite lived intangible assets. Instead, we review them at least annually to determine whether they have become impaired. If they have become impaired, we charge the impairment as an expense in the period in which the impairment occurred.

Any event which results in the significant impairment of our goodwill, such as closure of a hospice program or sustained operating losses, could have a material adverse effect on our profitability.

We are dependent on the proper functioning of our information systems to efficiently manage our business.

We are dependent on the proper functioning of our information systems in operating our business. Critical information systems used in daily operations perform billing and accounts receivable functions. Our information systems are vulnerable to fire, storm, flood, power loss, telecommunications failures, physical or software break-ins and similar events. If our information systems fail or are otherwise unavailable, these functions would have to be accomplished manually, which could impact our ability to identify business

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opportunities quickly, to maintain billing and clinical records reliably, to pay our staff in a timely fashion and to bill for services efficiently.

We may experience difficulties in transitioning to a new billing software system which may result in delays and errors in billing for our services.

We are in the process of replacing our billing software, which we believe to be inadequate to support our growth, with our proprietary software running on our CareNation operating platform. Accurate billing is crucial to reimbursement from third-party payors. If any unforeseen problems emerge in connection with our migration to the new billing software, billing delays and errors may occur, which could significantly increase the time that it takes for us to collect payments from payors and in some cases, our ability to collect at all. Any such increase in collection time or inability to collect could have a material adverse effect on our cash flows or result in a financial loss.

A material write-off of our capitalized software development costs and costs and problems related to the implementation of new software applications could have a material adverse effect on our profitability.

As of March 31, 2003, our capitalized software development costs, net of amortization, was approximately $4.3 million, most of which amount related to the development of CareNation, our proprietary software platform, and related application modules. We anticipate that the development work on several application modules will be completed in the near term. If one or more of the application modules do not function as anticipated, we may be required to write off a significant amount of capitalized software development costs and we may experience significant disruptions in our operations, all of which could have a material adverse effect on our profitability. In addition, the costs associated with training our employees to use these new applications effectively and errors arising from being unfamiliar with the new applications could have a material adverse effect on our operations and profitability.

We may need to raise additional capital in the future to fund our operations and finance our growth, which may be unavailable or which may result in dilution to our stockholders and restrict our operations.

We may seek to sell additional equity or debt securities or obtain new credit facilities in order to finance our operations, which we may not be able to do on favorable terms or at all. If we are unable to obtain financing, we may be unable to continue with our strategy to increase same-store growth, develop new hospice programs and acquire existing hospice programs. The sale of additional equity or convertible debt securities could result in dilution to our stockholders. If additional funds are raised through the issuance of debt securities or preferred stock, these securities could have rights that are senior to the our common stock and any debt securities could contain covenants that would restrict our and our subsidiaries operations.

Risks Relating to Our Industry

We operate in a regulated industry and changes in regulations or violations of regulations may result in increased costs or sanctions that could reduce our revenues and profitability.

The healthcare industry is subject to extensive and complex federal and state laws and regulations related to professional licensure, conduct of operations, payment for services and payment for referrals. If we fail to comply with the laws and regulations that are directly applicable to our business, we could suffer civil and/or criminal penalties, be subject to injunctions or cease and desist orders or become ineligible to receive government program payments.

In recent years, Congress and some state legislatures have introduced an increasing number of proposals to make significant changes in the United States healthcare system. Changes in law and regulatory interpretations could reduce our net patient revenue and profitability. Recently, there have been heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to

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the healthcare industry. There has also been an increase in the filing of actions by private individuals on behalf of the federal government against healthcare companies alleging the filing of false or fraudulent healthcare claims. This heightened enforcement activity increases our potential exposure to damaging lawsuits, investigations and other enforcement actions. Any such action could divert management resources and adversely affect our business reputation and profitability.

In the future, different interpretations or enforcement of laws, rules and regulations governing the healthcare industry could subject our current business practices to allegations of impropriety or illegality or could require us to make changes in our operations and personnel and distract our management. If we fail to comply with these extensive laws and government regulations, we could become ineligible to receive government program payments, suffer civil and criminal penalties or be required to make significant changes to our operations. In addition, we could be forced to expend considerable resources responding to an investigation or other enforcement action under these laws or regulations. For a more detailed discussion of the regulatory environment in which we operate, see Business Government Regulation .

A pending review of the hospice industry could result in decreased Medicare hospice reimbursements for nursing home patients, which could adversely affect our profitability.

The Office of the Inspector General for the Department of Health and Human Services, or the OIG, has recently called for a review of the hospice sector. The review is expected to consider whether Medicare should decrease hospice reimbursements for patients in nursing homes on the theory that nursing homes provide some of the same services that hospice providers provide. Approximately 40% of our patients reside in nursing homes. If, as a result of this review, Medicare decreases hospice reimbursement rates for nursing home patients, our profitability could be adversely affected.

Many states have certificate of need laws or other regulatory provisions that may adversely impact our ability to expand into new markets and thereby limit our ability to grow and to increase our net patient revenue.

Many states have enacted certificate of need laws that require prior state approval to open new healthcare facilities or expand services at existing facilities. Currently, fourteen states have certificate of need laws that apply to hospice programs. Those laws require some form of state agency review or approval before a hospice may add new services or undertake significant capital expenditures. In addition, two states in which we do not currently operate, Florida and New York, have additional barriers to entry. Florida places restrictions on the ability of for-profit corporations to own and operate hospices, and New York places restrictions on the corporate ownership of hospices. Accordingly, our ability to operate in Florida and New York and the states with certificate of need laws is restricted. The laws in these states could affect our ability to expand into new markets and to expand our services and facilities in existing markets.

To comply with new laws and regulations regarding the confidentiality of patient medical information, we may be required to expend substantial sums on acquiring and implementing new information systems, which could negatively impact our profitability.

There are currently numerous legislative and regulatory initiatives at both the state and federal levels that address patient privacy concerns. In particular, the Health Insurance Portability and Accountability Act of 1996, or HIPAA, contains provisions that may require us to implement expensive new computer systems and business procedures designed to protect the privacy of each of our hospice patient s individual health information. The United States Department of Health and Human Services published final regulations addressing patient privacy in December 2000. Those regulations subsequently were modified in March 2002 and again in August 2002. We have been subject to the privacy regulations since April 14, 2003. Final regulations addressing the security of patient health information were modified and published in final form on February 20, 2003. We must be in compliance with these regulations by April 21, 2005. We have not fully evaluated and cannot fully predict the total financial or other impact of these regulations on us. Compliance with these rules could require us to spend substantial sums, which could negatively impact our profitability.

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Our net patient revenue and profitability may be constrained by cost containment initiatives undertaken by payors.

Initiatives undertaken by private insurers, managed care companies and federal and state governments to contain healthcare costs may affect the profitability of our hospice programs. We have a number of contractual arrangements with private insurers and managed care companies to provide hospice care for a fixed fee. These payors often attempt to control healthcare costs by contracting with hospices and other healthcare providers to obtain services on a discounted basis. We believe that this trend may continue and may limit payments for healthcare services, including hospice services in the future. In addition, there may be changes made to the Medicare program s Medicare HMO component, which could result in managed care companies becoming financially responsible for providing hospice care. Currently, Medicare pays for hospice services outside of the Medicare HMO per-member per-month fee so that managed care companies do not absorb the cost of providing these services. If such changes were to occur, a greater percentage of our net patient revenue could come from managed care companies and these companies would be further incentivized to reduce hospice costs. As managed care companies attempt to control hospice-related costs, they could reduce payments to us for hospice services. In addition, states, many of which are operating under significant budgetary pressures, may seek to reduce hospice payments under their Medicaid programs or Medicaid managed care programs may opt not to continue providing hospice coverage. These developments could negatively impact our net patient revenue and profitability.

Professional and general liability claims may have an adverse effect on us either because our insurance coverage may be inadequate to cover the losses or because claims against us, regardless of merit or eventual outcome, may adversely affect our reputation, our ability to obtain patient referrals or our ability to expand our business.

In recent years, participants in the healthcare industry have become subject to an increasing number of lawsuits, including allegations of medical malpractice. Many of these lawsuits involve large claims and substantial defense costs. The medical malpractice claims we have faced relate to our patients in inpatient facilities where we were named as a defendant together with the operator of the inpatient facility.

We maintain general liability insurance coverage on an occurrence basis with limits of $1.0 million per occurrence and $3.0 million in the aggregate. We maintain healthcare professional liability insurance coverage on a claims-made basis with limits of $1.0 million per occurrence and $3.0 million in the aggregate. We also maintain umbrella coverage with a limit of $10.0 million excess over both general and healthcare professional liability coverage. Nevertheless, some risks and liabilities, including claims for punitive damages or claims based on the actions of third parties, may not be covered by insurance. In addition, we cannot assure you that our coverage will be adequate to cover potential losses. While we have generally been able to obtain liability insurance in the past, insurance can be expensive and may not be available in the future on terms acceptable to us, or at all. For example, our insurance relating to automobiles not owned by us but used by our employees and volunteers in connection with their employment recently expired. To date, we have not been able to secure replacement coverage except on prohibitively expensive terms. Moreover, claims, regardless of their merit or eventual outcome, may also adversely affect our reputation, our ability to obtain patient referrals or our ability to expand our business, as well as divert management resources from the operation of our business.

Risks Related to This Offering

The concentration of ownership of our common stock will limit your ability to influence corporate actions.

Immediately following this offering, our executive officers, directors and their affiliates will together own approximately % of our outstanding common stock. As a result, those stockholders, if they act together, could influence the outcome of the vote on any matter requiring stockholder approval, including the election of directors and the approval of significant corporate transactions. This concentration of ownership may have

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the effect of delaying, preventing or deterring a change in control of our company, could deprive our stockholders of an opportunity to receive a premium for their common stock as part of a sale of our company and may negatively affect the market price of our common stock.

Future sales of our common stock by existing stockholders could depress the market price of our common stock.

Sales of a substantial number of shares of common stock in the public market by our current stockholders, or the threat that substantial sales may occur, could cause the market price of our common stock to decrease significantly or make it difficult for us to raise additional capital by selling stock. In connection with this offering, the selling stockholders, together with our directors, executive officers and some of our significant stock and option holders, entered into 90-day lock-up agreements at the request of the underwriters. On the day that is 91 days after the completion of this offering, those stockholders will be able to sell an aggregate of shares of our currently outstanding common stock pursuant to Rule 144 or Rule 701 under the Securities Act of 1933, or the Securities Act. In addition, our directors, officers and some of our significant stockholders entered into 180-day lock-up agreements in connection with our initial public offering, but did not enter into the 90-day lock-up referred to above in connection with this offering. Those agreements will expire on June 16, 2003. At that time, those stockholders will be entitled to sell an aggregate of shares of our common stock pursuant to Rule 144 or Rule 701 under the Securities Act. The underwriters may also consent to the release of some or all of these shares for sale prior to that time. See the section of this prospectus entitled Shares Eligible for Future Sale for further details regarding the number of shares eligible for sale in the public market after this offering.

Some provisions of our charter and by-laws may delay or prevent transactions that many stockholders may favor, and may have the effect of entrenching management.

Some provisions of our certificate of incorporation and by-laws may discourage, delay or prevent a merger or acquisition that our stockholders may consider favorable, including transactions in which stockholders might otherwise receive a premium for their shares. These provisions include:

authorization of the issuance of blank check preferred stock without the need for stockholder approval;

provision for a classified board of directors with staggered three-year terms;

elimination of the ability of stockholders to call special meetings of stockholders or act by written consent; and

advance notice requirements for proposing matters that can be acted on by stockholders at stockholder meetings.

In addition, some provisions of Delaware law may also discourage, delay or prevent someone from acquiring us or merging with us. Such provisions of Delaware law and the provisions of our certificate of incorporation may have the effect of entrenching management by making it more difficult to remove directors. See the section of this prospectus entitled Description of Capital Stock Delaware Anti-Takeover Law and Certain Charter and By-Law Provisions for more detailed information regarding these provisions.

Our stock price may be volatile and your investment in our common stock could suffer a decline in value.

With the current uncertainty about healthcare policy, reimbursement and coverage in the United States, there has been significant volatility in the market price and trading volume of securities of healthcare and other companies, which is unrelated to the financial performance of these companies. These broad market fluctuations may negatively affect the market price of our common stock.

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Some specific factors that may have a significant effect on our common stock market price include:

actual or anticipated fluctuations in our operating results or our competitors operating results;

actual or anticipated changes in our growth rates or our competitors growth rates;

actual or anticipated changes in healthcare policy in the United States and internationally;

conditions in the financial markets in general or changes in general economic conditions;

our ability to raise additional capital;

hospice industry trends, such as variations in patient length of stay; and

changes in stock market analyst recommendations regarding our common stock, other comparable companies or the hospice industry generally.

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SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS

This prospectus includes forward-looking statements within the meaning of Section 27A of the Securities Act and Section 21E of the Securities Exchange Act of 1934, or the Exchange Act. All statements other than statements of historical facts contained in this prospectus, including statements regarding our future financial position, business strategy and plans and objectives of management for future operations, are forward-looking statements. The words believe, may, will, estimate, continue, anticipate, intend, expect and similar expressions, as us, are intended to identify forward-looking statements. We have based these forward-looking statements largely on our current expectations and projections about future events and financial trends that we believe may affect our financial condition, results of operations, business strategy and financial needs. These forward-looking statements are subject to a number of risks, uncertainties and assumptions described in Risk Factors including, among other things:

- reductions in amounts paid to us by the Medicare and Medicaid programs;
- changes in healthcare regulation and payment methods;
- our ability to identify suitable hospices to acquire on favorable terms;
- our ability to integrate effectively the operations of acquired hospices;
- our ability to develop new hospice locations in new markets or markets that we currently serve;
- our ability to attract and retain key personnel and skilled employees; and
- our dependence on patient referrals.

In light of these risks, uncertainties and assumptions, the forward-looking events and circumstances discussed in this prospectus may not occur and actual results could differ materially from those anticipated or implied in the forward-looking statements.

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USE OF PROCEEDS

We will not receive any proceeds from the sale of shares of common stock by the selling stockholders in this offering. The selling stockholders will receive all of the net proceeds from this offering.

MARKET PRICE OF COMMON STOCK

Our common stock has been quoted on the Nasdaq National Market under the symbol VSTA since December 18, 2002. Prior to that time, there was no public market for our common stock. The following table sets forth for the indicated periods the high and low sale prices of our common stock on the Nasdaq National Market.

	High	Low
2002		
Fourth Quarter (from December 18)	$16.83	$13.00
2003		
First Quarter	$18.90	$13.90

On April 28, 2003, the last reported sale of our common stock on the Nasdaq National Market was $19.25. On April 25, 2003, there were 65 holders of record of our common stock.

DIVIDEND POLICY

We have never declared or paid any cash dividends on our capital stock and do not anticipate paying cash dividends in the foreseeable future. We are prohibited under our credit facility from paying any dividends if there is a default under the facility or if the payment of any dividends would result in a default. We currently intend to retain future earnings, if any, to fund the expansion and growth of our business.

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CAPITALIZATION

The following table sets forth our capitalization as of March 31, 2003. No adjustments to the balance sheet to reflect this offering are shown because we will not be selling any shares or receiving any of the proceeds. You should read this information in conjunction with our consolidated financial statements and the notes to those statements appearing elsewhere in this prospectus.

	As of March 31, 2003
Long-term debt, including current portion	$ 250
Stockholders (deficit) equity:	
Class A common stock, $0.01 par value; 33,000,000 shares authorized, 15,545,939 issued and outstanding	155
Class B common stock, $0.01 par value; 200,000 shares authorized, 58,096 shares issued and outstanding	1
Additional paid-in capital[(1)]	101,216
Deferred compensation	(1,341)
Accumulated deficit	(26,693)
Total stockholders equity	73,338
Total capitalization	$ 73,588

(1) Reflects approximately $45.2 million of accrued dividends on our Series B Preferred Stock, Series C Preferred Stock and Series D Preferred Stock. The preferred stock was converted into common stock upon the closing of our initial public offering, and the accrued dividends, which were not payable upon conversion into common stock, were reclassified as additional paid-in capital.

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SELECTED CONSOLIDATED FINANCIAL AND OPERATING DATA

The selected financial data set forth below should be read in conjunction with our consolidated financial statements and the notes to those statements and Management s Discussion and Analysis of Financial Condition and Results of Operations appearing elsewhere in this prospectus. The consolidated statement of operations data for the years ended December 31, 1998 and 1999 and the consolidated balance sheet data as of December 31, 1998, 1999 and 2000 are derived from our audited financial statements not included in this prospectus. The consolidated statement of operations data for the years ended December 31, 2000, 2001 and 2002 and the consolidated balance sheet data as of December 31, 2001 and December 31, 2002 are derived from our audited financial statements included elsewhere in this prospectus. The financial data for the three-month periods ended March 31, 2002 and March 31, 2003 were derived from our unaudited financial statements included elsewhere in this prospectus. The unaudited financial statements include all adjustments, consisting of normal recurring accruals, which we consider necessary for a fair presentation of our financial position and results of operations for the period. The historical results of operations are not necessarily indicative of the operating results to be expected in the future.

	Year Ended December 31,					Three Months Ended March 31,	
	1998	1999	2000	2001	2002	2002	2003
	(dollars in thousands, except per share data)						
Consolidated Statement of Operations Data:							
Net patient revenue	$ 39,697	$ 78,768	$ 81,595	$ 91,362	$ 132,947	$ 27,674	$ 42,001
Operating expenses:							
Patient care	26,845	50,693	55,256	63,950	79,752	17,269	24,085
General and administrative (exclusive of stock-based compensation charges below)	17,104	25,500	23,541	30,666	42,535	8,911	13,352
Depreciation and amortization	992	1,677	1,797	1,990	1,349	272	344
Restructuring costs	2,539						
Stock-based compensation				50	427	50	1,047
Total operating expenses	47,480	77,870	80,594	96,656	124,063	26,502	38,828
Operating (loss) income	(7,783)	898	1,001	(5,294)	8,884	1,172	3,173
Non-operating income (expense):							
Interest income	298	69	202	52	25	2	101
Interest expense	(686)	(1,542)	(1,497)	(1,157)	(935)	(201)	(48)
Other expense	(155)	(202)	(8)	(163)	(137)	(28)	(16)
Net (loss) income before income taxes	(8,326)	(777)	(302)	(6,562)	7,837	945	3,210
Income tax expense		68	81	150	281	36	386
Net (loss) income	(8,326)	(845)	(383)	(6,712)	7,556	909	2,824
Accrued preferred stock dividends(1)	1,797	2,879	3,482	3,839	4,052	1,032	

Net (loss) income to common stockholders	$ (10,123)	$ (3,724)	$ (3,865)	$ (10,551)	$ 3,504	$ (123)	$ 2,824
Net (loss) income per common share:							
Basic	$ (2.67)	$ (0.98)	$ (0.76)	$ (2.07)	$ 0.63	$ (0.02)	$ 0.18
Diluted	$ (2.67)	$ (0.98)	$ (0.76)	$ (2.07)	$ 0.52	$ (0.02)	$ 0.17
Weighted average shares outstanding:							
Basic	3,782,000	3,798,000	5,098,000	5,098,000	5,580,000	5,100,000	15,500,000
Diluted	3,782,000	3,798,000	5,098,000	5,098,000	6,776,000	5,100,000	16,656,000

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	Year Ended December 31,			Three Months Ended March 31,	
	2000	2001	2002	2002	2003
	(dollars in thousands)				
Operating Data:					
Number of hospice programs(2)	38	38	38	38	39
Admissions(3)	9,455	10,330	12,745	2,893	3,734
Days of care(4)	823,885	948,001	1,227,787	258,980	371,253
Average daily census(5)	2,251	2,597	3,364	2,878	4,125
Other Data:					
Adjusted EBITDA(6)	$ 2,790	$ (3,417)	$ 10,523	$ 1,466	$ 4,548
Net cash provided by (used in) operating activities	$ 2,080	$ 3,164	$ 6,142	$ (3,390)	$ 1,347
Net cash used in investing activities	$ (2,266)	$ (2,051)	$ (6,008)	$ (314)	$ (1,160)
Net cash provided by (used in) financing activities	$ (2,190)	$ (2,277)	$ 37,587	$ 3,194	$ 220

	As of December 31,					As of
	1998	1999	2000	2001	2002	March 31, 2003
	(in thousands)					
Consolidated Balance Sheet Data:						
Cash and cash equivalents	$ 4,792	$ 4,923	$ 2,547	$ 1,383	$ 39,104	$ 39,511
Working capital	9,141	9,933	6,548	(1,261)	41,502	44,756
Total assets	44,926	49,343	46,019	40,997	94,943	99,735
Redeemable (non-convertible and convertible) preferred stock(1)	32,099	38,228	41,710	45,249		
Capital lease obligations, including current portion				250	176	156
Long-term debt, including current portion	14,600	13,487	11,955	10,131	250	250
Accumulated deficit(1)	(14,881)	(18,605)	(22,470)	(33,021)	(29,517)	(26,693)
Total stockholders deficit	(14,787)	(17,215)	(21,587)	(32,088)	69,247	73,338

(1) Reflects accrued dividends on the Series B Preferred Stock, Series C Preferred Stock and Series D Preferred Stock at the rate of 10.0% per annum, compounded semi-annually. This preferred stock was converted into common stock upon the closing of our initial public offering, and the accrued preferred stock dividends, which were not payable in the event of a conversion into common stock, were reclassified as additional paid-in capital.

(2) Number of hospice programs at end of period.

(3) Represents the total number of patients admitted into our hospice programs during the period.

(4) Represents the total days of care provided to our patients during the period.

(5) Represents the average number of patients for whom we provided hospice care each day during the period and is computed by dividing days of care by the number of days during the period.

(6) Adjusted EBITDA consists of net (loss) income before accrued preferred stock dividends, excluding net interest, taxes, depreciation and amortization and stock-based compensation charges. We present adjusted EBITDA to enhance the understanding of our operating results. Adjusted EBITDA is not a measure of financial performance under generally accepted accounting principles. Items excluded from adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA is a key measure we use to

evaluate our operations. In addition, we provide our adjusted EBITDA because we believe that investors and securities analysts will find adjusted EBITDA to be a useful measure for evaluating our cash flows from operations, for comparing our operating performance with that of similar companies that have different capital structures and for evaluating our ability to meet our future debt service, capital expenditures and working capital requirements. Adjusted EBITDA should not be considered in isolation or as an alternative to net (loss) income, cash flows generated by operating, investing or financing activities, or other financial statement data presented in the consolidated financial statements as indicators of financial performance or liquidity. Because adjusted EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, adjusted EBITDA as presented may not be comparable to other similarly titled measures of performance of other companies. For a reconciliation of net (loss) income to adjusted EBITDA, see Management s Discussion and Analysis of Financial Condition and Results of Operations Adjusted EBITDA .

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MANAGEMENT S DISCUSSION AND ANALYSIS OF

FINANCIAL CONDITION AND RESULTS OF OPERATIONS

You should read the following discussion of our financial condition and results of operations together with the audited consolidated financial statements and notes to the financial statements included elsewhere in this prospectus. This discussion contains forward-looking statements that involve risks and uncertainties. The forward-looking statements are not historical facts, but rather are based on current expectations, estimates, assumptions and projections about our industry, business and future financial results. Our actual results could differ materially from the results contemplated by these forward-looking statements due to a number of factors, including those discussed in the sections of this prospectus entitled Risk Factors and Special Note Regarding Forward-Looking Statements .

Overview

We are a leading provider of hospice services in the United States. We began operations in November 1995. Through the development of new programs and two significant acquisitions in 1998, we now provide service through 39 hospice programs serving patients in 14 states. Since our 1998 acquisitions, we have more than doubled our patient census primarily as a result of same-store growth. Our patient census at March 31, 2003 was approximately 4,300 patients. In 2002, our net patient revenue was $132.9 million, which represents a 45.4% increase over our 2001 net patient revenue of $91.4 million. For the year ended December 31, 2002, we recorded net income before accrued preferred stock dividends of $7.6 million, as compared to a net loss before accrued preferred stock dividends of $6.7 million for the year ended December 31, 2001. For the three months ended March 31, 2003, we recorded net income before accrued preferred stock dividends of $2.8 million, as compared to net income before accrued preferred stock dividends of $0.9 million for the three months ended March 31, 2002.

On December 23, 2002, we completed our initial public offering of common stock. We sold 4.5 million shares at an offering price of $12.00 per share. We received net proceeds of approximately $48.1 million after deducting the underwriting discount and offering expenses. Use of the offering proceeds included repayment of $11.0 million of outstanding principal and accrued interest on our credit facility and $0.3 million to redeem all of the shares of our Series A-2 Preferred Stock that were outstanding prior to the offering.

Net Patient Revenue

Net patient revenue is the amount we believe we are entitled to collect for our services, adjusted as described below. The amount we believe we are entitled to collect for our services varies depending on the level of care provided, the payor and the geographic area where the services are rendered. Net patient revenue includes adjustments for:

- estimated payment denials and contractual adjustments;
- patients who do not have insurance coverage and who are deemed financially in need of charity care;
- amounts we estimate we could be required to repay to Medicare, such as amounts that we would be required to repay if any of our programs exceed the annual per-beneficiary cap, as described below under Critical Accounting Policies and Significant Estimates Adjustments to Net Patient Revenue for Exceeding the Medicare Per-Beneficiary Cap ; and
- subsequent changes to initial level of care determinations.

We adjust our estimates from time to time based on our billing and collection experience. Only after a patient s hospice eligibility has been determined, a payment source has been identified and services have been provided do we recognize net patient revenue for services that we provide to that patient.

We derive net patient revenue from billings to Medicare, Medicaid, private insurers, managed care providers, patients and others. We operate under arrangements with those payors pursuant to which they

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reimburse us for services we provide to hospice eligible patients they cover, subject only to our submission of adequate and timely claim documentation. Our patient intake process screens patients for hospice eligibility and identifies whether their care will be covered by Medicare, Medicaid, private insurance, managed care or self-pay. Medicare reimbursements account for the majority of our net patient revenue. Our net patient revenue is determined primarily by the number of billable patient days, the level of care provided and reimbursement rates. The number of billable patient days is a function of the number of patients admitted to our programs and the number of days that those patients remain in our care (length of stay). We exceeded the industry average in achieving an average length of stay of 86 days and 84 days for the year ended December 31, 2002 and the three months ended March 31, 2003, respectively. We attribute our ability to exceed the industry average in terms of length of stay to several factors. First, a significant proportion of our patients are non-cancer patients, who tend to have a higher average length of stay than cancer patients. Second, we believe that our open access philosophy and our efforts to educate referral sources about hospice care is encouraging earlier transfers of patients to hospice care. Finally, a significant amount of our growth in recent periods has been in rural markets where more patients turn to hospital care because access to intensive care hospitals or other alternative sites for hospice-eligible patients is more difficult.

The table below sets forth the percentage of our net patient revenue in 2000, 2001 and 2002 and the three-month periods ended March 31, 2002 and 2003 derived from Medicare, Medicaid, private insurers and managed care payors.

	Year Ended December 31,			Three Months Ended March 31,	
	2000	2001	2002	2002	2003
Medicare	89.6%	97.4%	93.4%	93.6%	92.3%
Medicaid	2.5%	1.5%	3.2%	2.9%	3.6%
Private insurers and managed care	7.9%	1.1%	3.4%	3.5%	4.1%

Medicare, Medicaid and most private insurers and managed care providers pay for hospice care at a daily or hourly rate that varies depending on the level of care provided. For a discussion of those levels of care established by Medicare and the current applicable Medicare reimbursement rates, see Business Overview of the Hospice Care Industry Funding Hospice Care: Medicare, Medicaid and other Sources and Business Government Regulation Overview of Government Payments Medicare . The table below sets forth the percentage of our net patient revenue generated under each of the four Medicare levels of care for the periods indicated:

	Year Ended December 31,			Three Months Ended March 31,	
Level of Care	2000	2001	2002	2002	2003
Routine Home Care	90.6%	92.6%	93.9%	93.2%	93.1%
General Inpatient Care	8.9%	7.1%	5.7%	6.6%	6.3%
Continuous Home Care	0.3%	0.1%	0.2%	0.1%	0.1%
Respite Inpatient Care	0.2%	0.2%	0.2%	0.1%	0.5%

Typically, each October, Medicare adjusts its base hospice care reimbursement rates for the following year based on inflation and other economic factors. Effective October 1, 2000, the Medicare base rates were increased 2.9% over the base rates then in effect. Such rates were further increased by 5.0% effective April 1, 2001, 3.2% effective October 1, 2001 and 3.4% effective October 1, 2002. These increases have favorably impacted our net patient revenue. Medicare s base rates are subject to regional adjustments based on local wage levels. These regional adjustments are not necessarily proportional to adjustments in the base rates.

Medicaid reimbursement rates and hospice care coverage rates for private insurers and managed care plans tend to approximate Medicare rates.

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Because we generally receive fixed payments for our hospice care services based on the level of care provided to our hospice patients, we are at risk for the cost of services provided to our hospice patients. We cannot assure you that Medicare and Medicaid will continue to pay for hospice care in the same manner or in the same amount that they currently do. Reductions in amounts paid by government programs for our services or changes in methods or regulations governing payments, which would likely result in similar changes by private third-party payors, could adversely affect our net patient revenue and profitability.

Expenses

We recognize expenses as incurred. Our primary expenses include those we classify as either patient care expenses or general and administrative expenses.

Patient care expenses consist primarily of salaries, benefits, payroll taxes and travel costs associated with our hospice care providers and program level administrative and marketing personnel. Patient care expenses also include the cost of pharmaceuticals, durable medical equipment, medical supplies, inpatient arrangements, nursing home costs, net, and purchased services such as ambulance, infusion and radiology. We incur inpatient facility costs primarily through per diem lease arrangements with hospitals and skilled nursing facilities where we provide our services. We also operate a 12-bed, stand-alone inpatient hospice facility and a 10-bed, hospital-based inpatient facility. Patient length of stay impacts our patient care expenses as a percentage of net patient revenue. Patient care expenses are generally higher during the initial and latter days of care. In the initial days of care, expenses tend to be higher because of the initial purchases of pharmaceuticals, medical equipment and supplies and the administrative costs of determining the patient s hospice eligibility, registering the patient and organizing the plan of care. In the latter days of care, expenses tend to be higher because patients generally require more services, such as pharmaceuticals and nursing care, due to their deteriorating medical condition. Accordingly, if lengths of stay decline, those higher costs are spread over fewer days of care, which increases patient care expenses as a percentage of net patient revenue and negatively impacts profitability. Patient care expenses are also impacted by the geographic concentration of patients. Labor expenses, which represent the single largest category of patient care expenses, tend to be less if patients are geographically concentrated and hospice care providers are required to spend less time traveling and can care for more patients.

For our patients who receive nursing home care under state Medicaid programs in states other than Arizona, Oklahoma, Pennsylvania and South Carolina, the applicable Medicaid program pays us an amount equal to no more than 95% of the Medicaid per diem nursing home rate for room and board services furnished to the patient by the nursing home in addition to the Medicare or Medicaid routine home care per diem payment. We pay the nursing home for these room and board services at a rate between 95% and 100% of the full Medicaid per diem nursing home rate, depending on the terms of the contract between us and the nursing home. We include the difference between the amount we pay the nursing home and the amount we receive from Medicaid in patient care expenses. We refer to this difference as nursing home costs, net . Our nursing home costs, net, were $0.6 million in 2000, $1.0 million in 2001 and $1.3 million in 2002, respectively. Our nursing home costs, net, were $0.2 million and $0.4 million for the three months ended March 31, 2002 and 2003, respectively.

General and administrative expenses primarily include salaries, payroll taxes, benefits and travel costs associated with our staff that is not directly involved with patient care (other than program level administrative and marketing personnel), bonuses for all employees, marketing, office leases and professional services.

In April 2003, we increased employee salaries by an average of 3.3% per employee, which will impact both patient care expenses and general and administrative expenses.

Stock-Based Compensation

Certain employee stock options which we granted in 2001 and 2002 have resulted in and will continue to result in stock-based compensation charges. In accordance with Accounting Principles Board Opinion No. 25 and related interpretations, if an employee stock option is granted with an exercise price which is less than the deemed fair value of the underlying stock, the difference is treated as a compensation charge that

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must be recognized ratably over the vesting period for the option. As a result of employee option grants made in 2001 and 2002 with exercise prices determined to be less than the deemed fair value of our common stock on the respective grant dates, we recognized stock-based compensation expense of $50,000 in 2001, $427,000 in 2002, $50,000 in the three-month period ended March 31, 2002 and $94,000 in the three-month period ended March 31, 2003. In addition, a stock option granted to our Chief Executive Officer in November 2002 was subject to variable accounting due to the vesting provisions contained in the option. We accelerated the vesting on this option in February 2003, and we recorded stock-based compensation expense in relation to this option of $9,000 in 2002 and $953,000 in the three months ended March 31, 2003. As of December 31, 2002, we had accrued a total of $2.6 million of deferred stock-based compensation relating to the foregoing options, of which $1.2 million related to the option grant to our Chief Executive Officer.

Capitalized Software Development Costs

We have capitalized certain internal costs related to the development of software used in our business. We capitalize all qualifying internal costs incurred during the application development stage. Costs incurred during the preliminary project stage and post-implementation/operation stage are expensed as incurred. As of March 31, 2003, we had total capitalized software development costs, net of amortization, of approximately $4.3 million. We amortize the capitalized software development costs related to particular software over a three-year period commencing when that software is substantially complete and ready for its intended use.

Goodwill

Goodwill from our 1998 and 2002 acquisitions, net of accumulated amortization of $2.4 million, was $20.6 million as of December 31, 2002 and March 31, 2003. Prior to 2002, we were amortizing the goodwill from our 1998 acquisitions over 30 years. New rules issued by the Financial Accounting Standards Board, effective for 2002, require that we no longer amortize goodwill. These rules require that we analyze our goodwill for impairment annually, or more often if events or circumstances arise that indicate that the carrying value of our goodwill exceeds its fair market value. We applied these rules beginning January 1, 2002. Application of the non-amortization provisions of the new rules in 2001 would have resulted in a decrease in amortization expense of $0.7 million. We have concluded that no basis for impairment of our goodwill exists as of the date of this prospectus.

Adjusted EBITDA

Adjusted EBITDA consists of net (loss) income before accrued preferred stock dividends, excluding net interest, taxes, depreciation and amortization and stock-based compensation charges. We present adjusted EBITDA to enhance the understanding of our operating results. Adjusted EBITDA is not a measure of financial performance under generally accepted accounting principles. Items excluded from adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA is a key measure we use to evaluate our operations. In addition, we provide our adjusted EBITDA because we believe that investors and securities analysts will find adjusted EBITDA to be a useful measure for evaluating our cash flows from operations, for comparing our operating performance with that of similar companies that have different capital structures and for evaluating our ability to meet our future debt service, capital expenditures and working capital requirements. Adjusted EBITDA should not be considered in isolation or as an alternative to net (loss) income, cash flows generated by operating, investing or financing activities, or other financial statement data presented in the consolidated financial statements as indicators of financial performance or liquidity. Because adjusted EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, adjusted EBITDA as presented may not be comparable to other similarly titled measures of performance of other companies.

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The following table reconciles our net (loss) income before accrued preferred stock dividends to adjusted EBITDA and also shows cash flows from operating, investing and financing activities for the periods indicated:

	Year Ended December 31,			Three Months Ended March 31,	
	2000	2001	2002	2002	2003
			(in thousands)	(unaudited)	
Net (loss) income before accrued preferred stock dividends	$ (383)	$(6,712)	$ 7,556	$ 909	$ 2,824
Add:					
Interest income	(202)	(52)	(25)	(2)	(101)
Interest expense	1,497	1,157	935	201	48
Income tax expense	81	150	281	36	386
Depreciation and amortization	1,797	1,990	1,349	272	344
Stock-based compensation		50	427	50	1,047
Adjusted EBITDA	$ 2,790	$(3,417)	$10,523	$ 1,466	$ 4,548
Net cash provided by (used in) operating activities	$ 2,080	$ 3,164	$ 6,142	$(3,390)	$ 1,347
Net cash used in investing activities	$(2,266)	$(2,051)	$ (6,008)	$ (314)	$(1,160)
Net cash (used in) provided by financing activities	$(2,190)	$(2,277)	$37,587	$ 3,194	$ 220

Critical Accounting Policies and Significant Estimates

To understand our financial position and results of operations, you should read carefully the description of our significant accounting policies set forth in note 1 to our financial statements appearing elsewhere in this prospectus. You should also be aware that application of our significant accounting policies requires that we make certain judgments and estimates, which are subject to an inherent degree of uncertainty.

Adjustments to Net Patient Revenue for Estimated Payment Denials

Approximately 96% of our net patient revenue is derived from Medicare and Medicaid programs. The balance of our net patient revenue is derived primarily from private insurers and managed care programs. We operate under arrangements with these payors pursuant to which they reimburse us for services we provide to hospice-eligible patients they cover, subject only to our submission of adequate and timely claim documentation. In some cases, these payors deny our claims for reimbursement for reasons such as:

our claim documentation is incomplete or contains incorrect patient information;

the payor deems the patient ineligible for insurance coverage; or

we have failed to provide timely written physician certifications as to patient eligibility.

We adjust our net patient revenue to the extent we estimate these payors will deny our claims. This estimate is subject to change based on information we receive or data we compile concerning factors such as:

our experience of claim denials by payor class;

the strength and reliability of our billing practices; and

changes in the regulatory environment.

We reflected reductions to net patient revenue for estimated claim denials of $6.2 million, $2.3 million, $0.6 million and $0.9 million for the years ended December 31, 2001 and 2002 and the three months ended March 31, 2002 and 2003, respectively.

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Adjustments to Net Patient Revenue for Exceeding the Medicare Per-Beneficiary Cap

Each of our hospice programs is subject to the annual Medicare per-beneficiary cap, as more fully described in the section of this prospectus entitled Business Government Regulation Overview of Government Payments Medicare . In effect, the per-beneficiary cap imposes a limit on the amount of payments per beneficiary that we can receive from Medicare with respect to services provided during the twelve-month period between November 1 of one year and October 31 of the following year. To determine whether we have exceeded the per-beneficiary cap at any of our programs, Medicare first multiplies the number of Medicare hospice beneficiaries in that program who have elected Medicare hospice coverage for the first time in that twelve-month period by the annual per-beneficiary cap amount. If actual Medicare reimbursements to that program with respect to services provided during the period exceed that amount, Medicare requires that we repay the difference to Medicare.

We actively monitor each of our programs to determine whether they are likely to exceed the Medicare per-beneficiary cap. If we determine that a program is likely to exceed the cap, we attempt to institute corrective action, such as a change in patient mix. However, to the extent we believe our corrective action will not be successful, we estimate the amount that we could be required to repay to Medicare and accrue that amount as a reduction to net patient revenue. Factors that impact our estimate include:

- our success in implementing corrective measures; and
- possible enrollment of beneficiaries in our programs who, without our knowledge, may have previously elected Medicare hospice coverage through another hospice provider.

We recorded reductions to net patient revenue of $1.0 million, $1.1 million, $0.9 million and $0.4 million for years ended December 31, 2000, 2001 and 2002, and the three months ended March 31, 2003, respectively, for exceeding the per-beneficiary cap in those periods.

Goodwill Impairment

On January 1, 2002, we adopted Statement of Financial Accounting Standards No. 142, *Goodwill and Other Intangible Assets*, which requires that we conduct a review to determine whether the carrying value of the goodwill associated with our acquired businesses exceeds its fair market value. We are required to conduct such a review annually, or more often if events or circumstances arise that indicate the fair market value of such goodwill may have materially declined. Such events or circumstances could include:

- significant under-performance of our acquired businesses relative to historical or projected operating results;
- significant negative industry trends; or
- significant changes in regulations governing hospice reimbursements from Medicare and state Medicaid programs.

To determine the fair market value of our goodwill, we make estimates regarding future cash flows and the potential sale and liquidation values of our acquired businesses.

In the event we determine that the value of our goodwill has become impaired, we are required to write down the value of the goodwill to its fair market value on our balance sheets and to reflect the extent of the impairment as an expense on our statements of operations. We have not recorded any impairment of goodwill for any accounting period presented in this prospectus.

Income Taxes and Deferred Tax Assets

As of December 31, 2002, we had net operating tax loss carryforwards to offset future taxable income of approximately $5.9 million for federal income tax purposes and $6.3 million for state income tax purposes. These carryforwards begin to expire in 2011 for federal income tax purposes and began to expire in 2002 for

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state income tax purposes. Future utilization of our net operating tax loss carryforwards may be limited under Internal Revenue Code Section 382 based upon changes in ownership that may occur in the future. We had net deferred tax assets of $6.1 million as of December 31, 2002, of which approximately $2.4 million related to net operating tax loss carryforwards, which were partially offset by a valuation allowance of $3.9 million and further by net deferred tax liabilities of $2.2 million. We recorded a valuation allowance to reduce our net deferred tax assets to the amount that we believe is more likely than not to be realized based upon our recent operating results. At present, we intend to recognize the benefits as the net operating tax loss carryforwards are utilized in the future. However, we will continue to evaluate the necessity of maintaining the valuation allowance based upon current and future profitable operating results.

Results of Operations

The following table sets forth selected consolidated financial information as a percentage of net patient revenue for the periods indicated:

	Year Ended December 31,			Three Months Ended March 31,	
	2000	2001	2002	2002	2003
Net patient revenue	100%	100%	100%	100%	100.0%
Operating Expenses:					
Patient care:					
Salaries, benefits and payroll taxes	40.7%	44.3%	39.6%	40.6%	37.9%
Pharmaceuticals	7.9%	8.0%	5.9%	6.2%	6.0%
Durable medical equipment and supplies	5.3%	5.7%	4.9%	5.3%	4.5%
Other (including inpatient arrangements, nursing home costs, net, purchased services and travel)	13.8%	12.0%	9.6%	10.3%	8.9%
Total	67.7%	70.0%	60.0%	62.4%	57.3%
General and administrative (exclusive of stock-based compensation charges reported below):					
Salaries, benefits and payroll taxes	15.6%	18.1%	16.1%	15.6%	15.4%
Office leases	2.9%	3.0%	2.4%	2.5%	2.2%
Other (including severance, travel, marketing and charitable contributions)	10.4%	12.5%	13.5%	14.0%	14.2%
Total	28.9%	33.6%	32.0%	32.1%	31.8%
Depreciation and amortization	2.2%	2.2%	1.0%	1.0%	0.8%
Stock-based compensation	0.0%	0.0%	0.3%	0.2%	2.5%
Operating (loss) income	1.2%	(5.8)%	6.7%	4.2%	7.6%
Non-operating income (expense)	(1.6)%	(1.4)%	(0.8)%	(0.8)%	0.1%
Income tax expense	0.1%	0.1%	0.2%	0.1%	0.8%
Net (loss) income before accrued dividends to preferred stockholders	(0.5)%	(7.3)%	5.7%	3.3%	6.7%
Adjusted EBITDA(1)	3.4%	(3.7)%	7.9%	5.4%	10.9%

(1) Adjusted EBITDA consists of net (loss) income before accrued preferred stock dividends excluding net interest, taxes, depreciation and amortization and stock-based compensation charges. We present adjusted EBITDA to enhance the understanding of our operating results. Adjusted EBITDA is not a measure of financial performance under generally accepted accounting principles. Items excluded from adjusted EBITDA are significant components in understanding and assessing financial performance. Adjusted EBITDA is a key measure we use to evaluate our operations. In addition, we provide our adjusted

EBITDA because we believe that investors and securities analysts will find adjusted EBITDA to be a useful measure for evaluating our cash flows from operations, for comparing our operating performance with that of similar companies that have different capital structures and for evaluating our ability to meet our future debt service, capital expenditures and working capital requirements. Adjusted EBITDA should not be considered in isolation or as an alternative to net (loss) income, cash flows generated by operating, investing or financing activities, or other financial statement data presented in the consolidated financial statements as indicators of financial performance or liquidity. Because adjusted EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, adjusted EBITDA as presented may not be comparable to other similarly titled measures of performance of other companies.

Three Months Ended March 31, 2003 Compared to Three Months Ended March 31, 2002

Net Patient Revenue

Net patient revenue increased $14.3 million, or 51.6%, from $27.7 million for the three months ended March 31, 2002 to $42.0 million for the three months ended March 31, 2003. This increase was due to an increase in billable patient days of 112,273, or 43.4%, and the Medicare reimbursement rate increase that went into effect on October 1, 2002. Net patient revenue per day of care was approximately $107 and $113 for the three months ended March 31, 2002 and 2003, respectively. This increase was due primarily to the Medicare rate increase, an increase in the number of patients receiving care in geographic regions where reimbursement rates are relatively higher and an increase in the number of general inpatient days of service. Our average daily census of patients increased from 2,878 for the three months ended March 31, 2002 to 4,125 for the three months ended March 31, 2003. Medicare and Medicaid payments represented 96.5% and 95.9% of net patient revenue for the three months ended March 31, 2002 and 2003, respectively.

Patient Care Expenses

Patient care expenses increased $6.8 million, or 39.3%, from $17.3 million for the three months ended March 31, 2002 to $24.1 million for the three months ended March 31, 2003. Of this increase, 69.1% was due to a $4.7 million increase in salaries, benefits, payroll taxes and travel costs of hospice care providers. The remainder of the increase was due to an increase in pharmaceuticals, durable medical equipment and other costs associated with providing services to our increased census of patients. As a percentage of net patient revenue, patient care expenses decreased from 62.4% for the three months ended March 31, 2002 to 57.3% for the three months ended March 31, 2003. This decrease was primarily due to the increase in net patient revenue coupled with a decrease in the average cost per patient, per day of purchased services, durable medical equipment and supplies, and greater productivity of our workforce as patient census increased in a number of our programs.

General and Administrative Expenses (Exclusive of Stock-Based Compensation)

General and administrative expenses increased $4.5 million, or 50.6%, from $8.9 million for the three months ended March 31, 2002 to $13.4 million for the three months ended March 31, 2003. As a percentage of net patient revenue, general and administrative expenses decreased from 32.1% for the three months ended March 31, 2002 to 31.8% for the three months ended March 31, 2003. Of the overall increase in general and administrative expenses, 48.8% was due to a $2.1 million increase in salaries, payroll taxes, benefits. The remainder of the increase was primarily due to increases in insurance expenses, program facility leases and audit and legal professional service fees.

Depreciation and Amortization

Depreciation and amortization expense remained constant at $0.3 million for each of the three months ended March 31, 2002 and the three months ended March 31, 2003. As a percentage of net patient revenue, depreciation and amortization expense declined from 1.0% for the three months ended March 31, 2002 to 0.8% for the three months ended March 31, 2003.

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Stock-Based Compensation

Stock-based compensation expense increased approximately $1.0 million, from approximately $50,000 for the three months ended March 31, 2002 to $1,047,000 for the three months ended March 31, 2003. Of the total stock-based compensation expense we incurred in the three-month period ended March 31, 2003, $953,000 related to the acceleration of the vesting of a stock option.

Non-Operating Income (Expense)

Non-operating income (expense) increased $264,000 from $(227,000) for the three months ended March 31, 2002 to $37,000 for the three months ended March 31, 2003. This increase was due to an increase in interest income that we derived from our investment of the net proceeds we received from our initial public offering of common stock in December 2002.

Income Tax

Our income tax expense for the three months ended March 31, 2003 was $386,000, compared to $36,000 for the three months ended March 31, 2002.

For the year ended December 31, 2002, we did not have any federal income tax liability, and our state income tax liability was partially offset, as the result of our use of net operating loss carryforwards from prior periods. We expect to fully utilize those carryforwards for federal income tax purposes in 2003, and accordingly, to experience an increase in our effective tax rate for the year.

Year Ended December 31, 2002, Compared to Year Ended December 31, 2001

Net Patient Revenue

Net patient revenue increased $41.6 million, or 45.5%, from $91.4 million in 2001 to $132.9 million in 2002. This increase was due to an increase in billable patient days and the Medicare reimbursement rate increases effective April 1, 2001, October 1, 2001 and October 1, 2002. Net patient revenue per day of care was approximately $96 and $108 for 2001 and 2002, respectively. This increase was due primarily to the Medicare rate increases and an increase in the number of patients receiving care in geographic regions where reimbursement rates are relatively higher. Our average daily census of patients increased from 2,597 in 2001 to 3,364 in 2002. Medicare and Medicaid payments represented 98.9% and 96.6% of net patient revenue for 2001 and 2002, respectively.

The increase in net patient revenue was also attributable to a reduction in the adjustment for estimated payment denials from $6.2 million, or 6.8% of recorded net patient revenue in 2001, to $2.7 million, or 2.0% of recorded net patient revenue in 2002. The greater adjustment for payment denials in 2001 reflected various billing issues encountered in that period including most significantly our failure to provide certain Medicaid programs and private insurance carriers with adequate or timely claim documentation. In 2002, we took several steps to improve our billings and collections efforts, including:

- implementing a web-based application that enables us to verify whether our patients are eligible to receive Medicare and Medicaid benefits;
- establishing a committee consisting of members of our corporate financial services and operations departments to manage billing and collection issues;
- increasing training at the program level in billing practices and procedures; and
- adopting more stringent procedures for determining alternative payment sources.

Patient Care Expenses

Patient care expenses increased $15.8 million, or 24.7%, from $64.0 million in 2001 to $79.8 in 2002. Of this increase, 77.2% was due to a $12.2 million increase in salaries, benefits and payroll taxes and travel costs of hospice care providers, including pay increases for our existing care providers and costs associated with additional personnel hired to provide care to our increased census of patients. The remainder of the

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increase was due to an increase in purchased services, durable medical equipment and medical supplies required to provide care to our increased census of patients. As a percentage of net patient revenue, patient care expenses decreased from 70.0% in 2001 to 60.0% in 2002. This decrease was primarily due to the increase in net patient revenue coupled with reductions in average daily per patient pharmaceutical expenses and purchased services.

General and Administrative Expenses (Exclusive of Stock-Based Compensation)

General and administrative expenses increased $11.8 million, or 38.4%, from $30.7 million in 2001 to $42.5 million in 2002. As a percentage of net patient revenue, general and administrative expenses decreased from 33.6% in 2001 to 32.0% in 2002. Of the overall increase in general and administrative expenses $4.8 million or 40.7% was due to increases in salaries, payroll taxes, benefits and travel costs of staff not directly involved with patient care and $3.0 million or 25.4% was due to increases in employee bonuses for all employees. The remainder of the increase was due to expenses incurred in connection with increases in the number of marketing staff as well as increased training, human resources, charitable contributions and other expenditures required to support growth in overall staffing.

Depreciation and Amortization

Depreciation and amortization expense decreased $0.6 million, or 32.2%, from $2.0 in 2001 to $1.3 million in 2002. As a percentage of net patient revenue, depreciation and amortization expense decreased from 2.2% in 2001 to 1.0% in 2002. These decreases were due to our ceasing to amortize goodwill in 2002 as a result of SFAS No. 142. See note 1 to our financial statements included elsewhere in this prospectus.

Stock-Based Compensation

The stock-based compensation charge of $0.4 million for 2002 related primarily to employee stock options granted in 2001 and 2002 with exercise prices determined to be less than the fair value of our common stock on the respective dates of grant. For more information, see Stock-Based Compensation above.

Non-Operating Income (Expense)

Non-operating income (expense) decreased $0.2 million to $(1.0) million in 2002 primarily due to reduced interest expenses resulting from less borrowings and lower interest rates.

Income Tax

In 2002, we had no federal income tax expense and only $0.3 million of state income tax expense due to our ability to utilize net operating tax loss carryforwards. We expect our income tax expense to increase significantly in 2003 as such tax loss carryforwards are exhausted or expire.

Year Ended December 31, 2001, Compared to Year Ended December 31, 2000

Net Patient Revenue

Net patient revenue increased $9.8 million, or 12.0%, from $81.6 million in 2000 to $91.4 million in 2001. This increase was due to an increase in billable patient days and the Medicare reimbursement rate increases effective April 1 and October 1, 2001. Net patient revenue per day of care declined from $99 in 2000, to $96 in 2001 as the Medicare reimbursement rate increases were offset by a decrease in the percentage of patients receiving general inpatient care. Our average daily census of patients increased from 2,251 in 2000 to 2,597 in 2001. Medicare and Medicaid payments represented 92.1% of net patient revenue in 2000 and 98.9% of net patient revenue in 2001.

The increase in net patient revenue from 2000 to 2001 was reduced by an increase in the adjustment for estimated payment denials from $3.3 million, or 4.1% of recorded net patient revenue in 2000, to $6.2 million, or 6.8% of recorded net patient revenue in 2001.

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Patient Care Expenses

Patient care expenses increased $8.7 million, or 15.7%, from $55.3 million in 2000 to $64.0 million in 2001. As a percentage of net patient revenue, patient care expenses increased from 67.7% in 2000 to 70.0% in 2001. Of the overall increase in patient care expenses, 84.0% was due to a $7.3 million increase in salaries, payroll taxes, benefits and travel costs of patient care staff. The remainder of the increase was due to increased expenditures for items such as durable medical equipment and pharmaceuticals required to provide care to our increased census of patients. This increase in expenses was partially offset by a $0.4 million decrease in nursing home costs, net.

General and Administrative Expenses

General and administrative expenses increased $7.1 million, or 30.3%, from $23.5 million in 2000 to $30.7 million in 2001. As a percentage of net patient revenue, general and administrative expenses increased from 28.9% in 2000 to 33.6% in 2001. Of the overall increase in general and administrative expenses, 53.5% was due to a $3.8 million increase in salaries, payroll taxes, benefits and travel costs of staff not directly involved with patient care, including costs associated with the hiring and relocation of new management personnel. The remainder of the increase was due to expenses incurred in connection with increased training, human resources and other expenditures required to support growth in overall staffing. These increased expenses were partially offset by a $0.5 million reversal we recorded as the result of a reduction in the lease termination charge described below.

In 1999 we recorded a charge of $1.1 million related to our termination of an inpatient facility lease. The charge was equal to the rent due for the balance of the lease term. As a result of negotiations with the landlord, in 2000 we were able to reduce the lease termination charge by $0.5 million and, accordingly, reduced general and administrative expenses in 2000 by that amount.

Depreciation and Amortization

Depreciation and amortization expense increased $0.2 million, or 10.7%, from $1.8 million in 2000 to $2.0 million in 2001. This increase was due to increased capital expenditures, primarily technology equipment for our hospice programs. As a percentage of net patient revenue, depreciation and amortization expense remained constant at 2.2% in 2000 and 2001.

Stock-Based Compensation

The stock-based compensation charge of $50,000 in 2001 related to employee stock options granted in 2001 with exercise prices determined to be less than the deemed fair value of our common stock on the respective dates of grant. For more information, see Stock-Based Compensation above.

Non-Operating Income (Expense)

Non-operating income (expense) remained constant at $(1.3) million in 2000 and 2001.

Liquidity and Capital Resources

Our principal liquidity requirements have been for working capital, debt service and capital expenditures. We have financed these requirements primarily with cash flow from operations, borrowings under our credit facility and proceeds from the issuance of preferred and common stock. In December 2002, we completed our initial public offering of common stock in which we raised net proceeds of approximately $48.1 million. As of March 31, 2003, we had cash and cash equivalents of $39.5 million, working capital of $44.8 million and the ability to borrow $19.0 million under our revolving credit facility described below.

Net cash provided by operating activities for 2002 was $6.1 million and resulted from the increase in our overall profitability and increases in our accounts payable and accrued expenses due to timing of receipts and payments, partially offset by the $10.1 million increase in our patient accounts receivable from census growth and timing of scheduled receipts. Net cash provided by operating activities for the three months ended

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March 31, 2003 was $1.3 million and resulted from increased profitability, and was offset by the timing of scheduled receipts.

Net cash used in investing activities was $6.0 million for 2002. This was due primarily to the acquisition of a hospice program with approximately 85 patients in Albuquerque, New Mexico for cash consideration of $2.5 million as well as the continued investment in internally developed software and capital expenditures. Net cash used in investing activities was $1.2 million for the three months ended March 31, 2003. This was due primarily to the continued investment in internally developed software and expenditures relating to its implementation.

Net cash provided by financing activities was $37.6 million for 2002. This resulted from net proceeds of $48.1 million from our initial public offering in December 2002, reduced by our repayment of $10.5 million of our credit facility. Net cash provided by financing activities was $0.2 million for the three months ended March 31, 2003, which resulted from the exercise of employee stock options.

We currently maintain a revolving line of credit with Healthcare Business Credit Corporation, or HBCC, under which we may borrow, repay and re-borrow from time to time up to $30 million, based on the amount of our eligible accounts receivable. As of March 31, 2003, there were no borrowings under this facility and there was $19.0 million available for borrowing.

Advances under the HBCC revolving line of credit bear interest at an annual rate equal to, at our option, either the prime rate in effect from time to time, as reported in the Money Rates section of the *Wall Street Journal*, plus 1.5%, or the one-month London Interbank Borrowing Rate in effect from time to time, plus 3.0%. The applicable interest rate increases by 3.5% if there is an event of default. Accrued interest is due and payable weekly on advances under the revolving line of credit bearing interest at the prime rate. Accrued interest on advances bearing interest at the London Interbank Offering Rate is due and payable on the last business day of the month. The maturity date for the revolving line of credit is April 30, 2005. As of March 31, 2003, the effective interest rate for borrowings under this facility was 4.31% per annum.

The HBCC credit facility is collateralized by substantially all of our assets. In addition, our credit agreement with HBCC contains customary covenants including covenants restricting our ability to incur additional indebtedness, permit liens on property or assets, make capital expenditures, make certain investments, pay dividends or make restricted payments, and prepay or redeem debt or amend certain agreements relating to our indebtedness. As of December 31, 2001 and March 31, 2002 we were not in compliance with certain covenants set forth in the credit agreement. In July 2002, we entered into an agreement with HBCC pursuant to which HBCC agreed to waive our past failure to comply with such covenants and to amend certain financial covenants for future periods. As of March 31, 2003, we were in compliance with all the terms of our credit facility.

In August 2002, we completed the acquisition of a hospice program in Albuquerque, New Mexico with approximately 85 patients for $2.5 million in cash and an unsecured promissory note in the original principal amount of $250,000. The integration of the operations of the acquired program with our existing hospice program in the same market was completed in 2002.

In April 2003, we made a $1.9 million prepayment of our estimated workers compensation claim liabilities for the period March 31, 2003 to March 31, 2004.

Each of our hospice programs is subject to the annual Medicare per-beneficiary cap, as more fully described in the section of this prospectus entitled Business Government Regulation Overview of Government Payments Medicare . If we are found by Medicare to have exceeded the per-beneficiary cap, Medicare will require that we make restitution for payments made to us in excess of the per-beneficiary cap. We were required to repay Medicare $0.6 million in 2000 and $1.0 million in 2001 for exceeding the per-beneficiary cap in those years. We have not been assessed any amount for exceeding the per-beneficiary cap for the assessment periods that began on November 1, 2001 and November 1, 2002. We believe adequate reserves have been established for potential assessments for exceeding the per-beneficiary cap for the assessment periods that began on November 1, 2001 and November 1, 2002. We actively monitor each of our programs to determine whether they are likely to exceed the per-beneficiary cap and attempt corrective action

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when necessary. However, we cannot assure you that we will not be assessed for exceeding the per-beneficiary cap in future periods.

We expect that our principal liquidity requirements will be for working capital, the development of new hospice programs, the acquisition of other hospice programs and capital expenditures. We expect that our existing funds, cash flows from operations and borrowing capacity under our credit agreement will be sufficient to fund our principal liquidity requirements for at least the next twelve months. Our future liquidity requirements and the adequacy of our available funds will depend on many factors, including payment for our services, regulatory changes and compliance with new regulations, expense levels, capital expenditures and future development of new hospice programs and acquisitions.

Interest Rate and Foreign Exchange Risk

Interest Rate Risk

We do not expect our cash flow to be affected to any significant degree by a sudden change in market interest rates. We have not implemented a strategy to manage interest rate market risk because we do not believe that our exposure to this risk is material at this time. We invest excess cash balances in money market accounts with average maturities of less than 90 days.

Foreign Exchange

We operate our business within the United States and execute all transactions in U.S. dollars.

Payment, Legislative and Regulatory Changes

We are highly dependent on payments from the Medicare and Medicaid programs. These programs are subject to statutory and regulatory changes, possible retroactive and prospective rate adjustments, administrative rulings, rate freezes and funding reductions. Reductions in amounts paid by these programs for our services or changes in methods or regulations governing payments for our services could materially adversely affect our net patient revenue and profitability.

Inflation

The healthcare industry is labor intensive. Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. In addition, suppliers pass along rising costs to us in the form of higher prices. We have implemented control measures designed to curb increases in operating expenses. To date, reimbursement rate increases and our increasing patient census have offset increases in operating costs. However, we cannot predict our ability to cover or offset future cost increases.

Recent Accounting Pronouncements

In April 2002, FASB issued SFAS No. 145, *Rescission of FASB Statements No. 4, 44 and 64, Amendment of FASB Statement No. 13 and Technical Corrections.* This statement eliminates corresponding treatment for reporting gains or losses on debt extinguishment and amends certain other existing accounting pronouncements. SFAS No. 145 is effective for fiscal years beginning after May 15, 2002. The adoption of this standard is not expected to have a material effect on our financial position or results of operations.

In June 2002, FASB issued SFAS No. 146, *Accounting for Costs Associated with Exit or Disposal Activities*. SFAS No. 146 nullifies the guidance in EITF Issue No. 94-3, *Liability Recognition for Certain Employee Termination Benefits and Other Costs to Exit an Activity.* Under EITF No. 94-3, an entity recognized a liability for an exit cost on the date that the entity committed itself to an exit plan. In SFAS No. 146, the FASB acknowledges that an entity s commitment to a plan does not, by itself, create a present obligation to the other parties that meets the definition of a liability and requires that a liability for a cost that is associated with an exit or disposal activities be recognized when the liability is incurred. It also establishes that fair value is the objective for the initial measurement of the liability. SFAS No. 146 will be effective for

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exit or disposal activities that are initiated after December 31, 2002. The adoption of this standard is not expected to have a material effect on our financial position or results of operations.

In November 2002, FASB issued Interpretation No. 45, *Guarantor s Accounting and Disclosure Requirements for Guarantees, Including Indirect Guaranteed of Indebtedness of Others.* FIN 45 requires certain guarantees to be recorded at fair value. FIN 45 also requires a guarantor to make certain disclosures about guarantees even when the likelihood of making any payments under the guarantee is remote. FIN 45 is effective for financial statements of interim or annual periods ending after December 15, 2002. The adoption of this interpretation is not expected to have a material effect on our financial position or results of operations.

In December 2002, FASB issued SFAS No. 148, *Accounting for Stock-Based Compensation Transition and Disclosure.* SFAS No. 148 amends SFAS No. 123, *Accounting for Stock-Based Compensation* and provides alternative methods of transition for a voluntarily change to the fair value based method of accounting for stock-based employee compensation. SFAS No. 148 also amends the disclosure requirements of SFAS No. 123 to require prominent disclosures in both annual and interim financial statements about the method of accounting for stock-based compensation and the effect of the method used on reported results. SFAS No. 148 is effective for fiscal years ending after December 15, 2002. Accordingly, we have adopted the disclosure provisions of SFAS No. 148 as of December 31, 2002. We have continued to follow APB No. 25, *Accounting for Stock Issued to Employees*, in accounting for employee stock options.

In January 2003, FASB issued Interpretation No. 46, *Consolidation of Variable Interest Entities.* FIN 46 addressed the consolidation and financial reporting of variable interest entities. FIN 46 is effective for financial statements of interim or annual periods beginning after June 15, 2002 for variable interest entities created before February 1, 2003, or immediately for variable interest entities created after February 1, 2003. The adoption of this interpretation is not expected to have a material effect on our financial position or results of operations.

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BUSINESS

Overview of Our Business

We are a leading provider of hospice services in the United States. Through interdisciplinary teams of physicians, nurses, home healthcare aides, social workers, spiritual and other counselors and volunteers, we provide care primarily designed to reduce pain and enhance the quality of life of terminally ill patients, most commonly in their home or other residence of choice. Our mission is to provide superior and financially responsible care for the physical, spiritual and emotional needs of our patients and their families, while maintaining a supportive environment for our employees.

We have grown rapidly since commencing operations in 1995. By the end of 1997, our operations consisted of seven programs in four states. In 1998, we completed two significant acquisitions that increased our census from approximately 350 patients to approximately 1,750 patients. Since then, we have more than doubled our patient census primarily through same-store growth. As of March 31, 2003, we had 39 hospice programs serving patients in 14 states with a census of approximately 4,300 patients. Our net patient revenue was $132.9 million in 2002. For the three months ended March 31, 2003, our net patient revenue was $42.0 million, a 51.6% increase over our net patient revenue of $27.7 million for the three months ended March 31, 2002. We recorded net income before accrued preferred stock dividends of $7.6 million for 2002 and $2.8 million for the three months ended March 31, 2003.

Our rapid growth has presented challenges. For example, our 1998 acquisitions required us to spend considerable time and resources integrating our systems and operating methods with those of the acquired businesses. Our efforts to improve our same-store growth required us to invest in the development of extensive referral relationships. As a result of these and other challenges, we incurred net losses before accrued preferred stock dividends of $0.4 million and $6.7 million in 2000 and 2001, respectively.

We plan to continue our expansion through same-store growth and the development of new hospice programs, as well as through strategic alliances, partnerships and acquisitions. We expect that our growth strategy will present challenges similar to those we have faced in the past. However, as a result of the experience of our management team and our investment in information technology infrastructure, employee training and regulatory compliance programs, we believe we have developed a solid platform for future growth.

Our operations are built around a mission-oriented philosophy that emphasizes superior care and open access to our services. We believe our high care standards, distinctive service philosophy and expertise in cost-effective care management help us develop strong relationships with the medical and consumer communities we serve and give us a competitive advantage in obtaining patient referrals.

Our predecessor corporation, Vista Hospice Care, Inc., a Delaware corporation, was formed in 1995. In 1998, in connection with our two significant acquisitions, we reorganized our corporate structure by establishing VistaCare, Inc., a Delaware corporation, as the parent holding company of Vista Hospice Care, Inc. and our other operating subsidiaries.

Overview of the Hospice Care Industry

Development of the Industry

Over the past century, care for terminally ill patients in the United States focused primarily on curative treatment, with only secondary regard for patient comfort and immediate quality of life concerns. The 1960s and 1970s saw the emergence of a grass roots movement in the United States that advocated a shift in attitude from strictly providing curative care for terminally ill patients to providing a greater degree of physical, emotional and spiritual comfort and care for patients and their families at the end-of-life. Hospice programs provide these services. According to the National Hospice and Palliative Care Organization, or NHPCO, since the 1970s, hospice care in the United States has grown into a multi-billion dollar industry that

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served approximately 700,000 patients in 2000 through more than 3,100 hospice care programs in the United States and its territories.

Funding Hospice Care: Medicare, Medicaid and Other Sources

Today, Medicare is the largest payor for hospice services. To be eligible to receive the Medicare hospice benefit, a patient must have two physicians certify that, if the patient s terminal illness were to run its usual course, the patient would have a life expectancy of six months or less. Hospice care is also covered by most private insurance plans, and 43 states and the District of Columbia provide hospice coverage to their Medicaid beneficiaries. The NHPCO reports that in 2000, at the time of admission, approximately 79% of hospice patients claimed Medicare as their payment source, 13% private insurance, 5% Medicaid, 3% alternative sources and 1% self-pay.

Medicare has provided benefits for hospice care since 1983. According to the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration), or CMS, between 1984 and 2000, the number of hospice programs certified by Medicare increased from 31 to 2,273. In addition, CMS estimates that Medicare hospice expenditures will reach $5.0 billion in 2003.

The Medicare hospice benefit covers four distinct levels of care, each of which is subject to a different per diem reimbursement rate. The table below sets forth a brief description of each of the four levels of care and the base Medicare per diem reimbursement rates in effect for the periods indicated:

		Base Medicare Per Diem Reimbursement Rates	
Level of Care	**Care Description**	**October 1, 2001 through September 30, 2002**	**October 1, 2002 through September 30, 2003**
Routine Home Care	Provided through visits by members of the interdisciplinary team to the patient s home or other residence	$110.42	$114.20
General Inpatient Care	Provided in a hospital or other inpatient facility when pain or other symptoms cannot be managed effectively in a home setting	$491.19	$508.01
Continuous Home Care	Provided in the patient s home or other residence to manage acute pain or other medical symptoms for a minimum of eight hours per day, with nursing care accounting for more than half of the care provided	$644.45	$666.52
Respite Inpatient Care	Provided for up to five days in a hospital or other inpatient facility to relieve the patient s family or other caregivers	$114.22	$118.13

These reimbursement rates are Medicare s base rates and vary from region to region depending on local salary levels. In 2000, routine home care services accounted for 96.0% of all Medicare hospice days while general inpatient care services, continuous home care services and respite inpatient care services accounted for 3.0%, 0.3% and 0.3% of Medicare hospice days, respectively. Effective each October 1, and occasionally

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at other times, Medicare establishes new base hospice care reimbursement rates. The table below sets forth the Medicare hospice base rate increases since October 1, 1999:

Effective Date of Rate Increase	Percentage Increase in Medicare Hospice Base Rates
October 1, 1999	1.9%
October 1, 2000	2.9%
April 1, 2001	5.0%
October 1, 2001	3.2%
October 1, 2002	3.4%

Medicaid reimbursement rates and hospice care coverage rates for private insurance plans tend to approximate Medicare rates.

Market Opportunity

We believe the hospice care industry is poised for substantial growth over the next several years due to the following factors:

Awareness and Acceptance of Hospice Care Services is Expanding. Over the past several years, there has been expanding awareness and acceptance of hospice care evidenced by:

- according to the NHPCO, between 1992 and 2000 the number of patients receiving hospice care increased from approximately 246,000 to approximately 700,000 annually;
- according to CMS, between 1988 and 2000 Medicare reimbursements for hospice care increased by approximately $2.8 billion;
- although hospice care has been traditionally associated with end-stage cancer patients, Medicare records from 1992 to 1998 show a 338% increase in the number of Medicare beneficiaries using the Medicare hospice benefit for conditions other than cancer;
- according to CMS, the number of Medicare certified hospice programs increased by 89% between 1992 and 2002; and
- a significant percentage of commercial insurers now provide coverage for hospice care services.

Hospice Care Provides Significant Cost Savings Over Traditional Care. Recent estimates by CMS have concluded that the cost of care for hospice patients is substantially less than the cost of care for similarly situated patients receiving traditional medical services, often in high acuity settings such as hospitals. Reasons for those cost savings include:

- hospice care patients in long-term care facilities are hospitalized fewer days in their last month of life than long-term care facility residents not enrolled in hospice programs, according to a March 2000 report commissioned by the United States Department of Health and Human Services;
- hospice care patients are often transitioned from expensive treatments, such as chemotherapy and radiation, to less expensive forms of palliative care; and
- hospice care patients generally require less emergency care, which typically involves costly transportation, paramedics, emergency room and other charges.

We believe that government and other payors will continue to encourage the use of hospice care because of such cost savings.

The American Population is Aging. In 2002, 82.5% of our patients were over the age of 65 at the time of admission. Data from the United States Census Bureau indicate that this segment of the American population is expected to grow at a rate three times greater than the rate of the general population between 2002 and 2022. According to the United States Census Bureau, the number of Americans over the age of 65

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will increase from 35 million in 2000 to 54 million in 2020. We expect that as this segment of the population grows, the demand for end-of-life services, including hospice care, will increase accordingly.

Hospice Services Are Underutilized. Although the number of hospice patients has increased rapidly in recent years, we believe that a significant number of hospice-eligible patients do not take advantage of hospice care. The NHPCO estimates that only 25% of decedents in 2000 received hospice care. A 1999 study by The National Hospice Foundation concluded that 75% of Americans were not aware that hospice care can be provided in the home and 90% did not know that hospice care is covered by Medicare. We believe that the following factors contribute to the current underutilization of hospice care:

- resistance to or misunderstanding of the benefits of hospice care; and
- restrictive eligibility criteria on the part of some hospice care providers, including denying enrollment to patients who wish to continue to maintain certain forms of aggressive treatment or patients who do not have a principal caregiver.

We believe that as awareness and acceptance of hospice care grows and hospice programs develop a reputation for consistent, high quality care, utilization of hospice services will increase.

Industry Consolidation and Government Initiatives

In addition to favorable industry growth conditions, we believe that consolidation in the hospice care industry will provide significant opportunities for us to grow our business. Today, the hospice care industry is dominated by small, not-for-profit providers in non-urban areas. According to the NHPCO, in 2000, 73% of all hospice programs were run by not-for-profit entities and only 13% of all hospice programs were located in urban areas. In 1999, the GAO found that approximately 57% of hospice programs had fewer than 100 admissions annually. Demanding market conditions are making it difficult for smaller providers to offer cost-effective, quality care. We believe that the fragmented hospice care industry is poised for consolidation and that large, well managed hospice providers are best positioned to affiliate with or acquire smaller hospice care providers.

Notwithstanding the recent increase in awareness and acceptance of hospice care, we believe that most Americans still lack a basic understanding of the benefits that hospice care offers and are unaware that Medicare, Medicaid and private insurers provide coverage for hospice care. In an effort to increase awareness and acceptance, medical societies, patient advocacy groups, private foundations and the hospice care industry have all undertaken campaigns in recent years to educate physicians and the public about the benefits of hospice care:

- in March 2003, CMS published an article urging physicians to raise awareness of hospice care among their patients and to recommend hospice care to qualified beneficiaries;
- in May 2002, the United States Department of Health and Human Services urged members of the physician community and other health care professionals to consider hospice care for their terminally ill patients;
- in April 2002, CMS placed paid advertisements in prominent publications aimed at physicians stressing the benefits of hospice care and advising physicians that hospice care is a benefit reimbursable by Medicare; and
- in September 2001, United States congressional hearings addressed the need for greater public awareness of end-of-life care options, including hospice care.

Our Competitive Strengths

We believe a number of factors differentiate us from our competitors and provide us with important competitive advantages.

We Benefit from Being One of the Nation s Largest Hospice Care Providers. As a result of having a patient census among the highest of any hospice provider in the United States, we are able to negotiate

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volume discounts on the purchase of pharmaceuticals, durable medical equipment and medical supplies, to enter into favorable contracts with private insurers and pharmacy benefit managers and to spread certain fixed costs, particularly corporate overhead, information technology and marketing spending, over a large patient population. In addition, the geographic scope of our operations gives us a competitive advantage in developing referral relationships with national and regional nursing home and assisted living companies who, we believe, often seek the administrative and service consistency benefits resulting from working with a limited number of providers.

We Have Implemented a Highly Effective Pharmacy Cost Control System. Pharmaceuticals represent our second largest category of patient care expenses. To manage those expenses, we have developed and implemented a comprehensive pharmacy cost management system. Using this system, in 2002 we were able to achieve an average daily pharmacy cost per patient that is significantly lower than the industry average. Our pharmacy cost management system involves:

a flexible, proprietary, disease and symptom-specific drug formulary that emphasizes the use of generic drugs, if as effective as the brand-name alternative;

the use of our proprietary software applications to streamline the enrollment of our patients in a nationwide network of pharmacies;

the commitment of our clinical staff to reducing our patients use of treatments that are needlessly expensive or clinically ineffective; and

an education program for our physicians and nurses that emphasizes both clinical and cost effectiveness.

We Have Developed an Advanced, Proprietary Technology Infrastructure. We have developed a proprietary technology infrastructure consisting of a highly-scalable, Linux-based operating platform we call CareNation and a variety of hospice specific applications. Because we own our core technology, we believe we will be able to minimize our payment of third-party licensing or maintenance and support fees that would likely increase as we grow. We believe that our web-based platform provides a level of secure, rapid and remote access from a wide variety of sources that is not currently available from third-party vendors. In addition, as we deploy additional applications, we anticipate improvements in our operating efficiency and ability to deliver a consistently high level of care across our organization. Our systems currently enable us to:

track patient admission and certification;

enroll our patients in a nationwide network of pharmacies;

monitor patient census and length of stay data; and

automate our bereavement communications.

In addition to ongoing efforts to refine our existing applications, we are in the process of developing additional applications, including a new billing program (scheduled for testing and release in 2003) and applications that will allow us to better monitor and produce timely and detailed reports on key expenses, such as labor and pharmaceuticals. We expect to be able to deploy our existing and new technologies rapidly in hospice programs that we develop or acquire in the future. We intend to continue to invest in our technology infrastructure to streamline our decision making and drive efficiencies in our operations, while providing further support and functionality to our care providers. In the future, we may consider commercializing these technologies.

We Provide Open Access to Hospice-Eligible Patients. Our service philosophy is to provide hospice care to all adult patients who are eligible to receive hospice care under Medicare guidelines, regardless of the complexity of their illness. We call this philosophy open access . In a May 2002 report to Congress, the Medicare Payment Advisory Commission, or MedPAC, concluded that many patients who meet Medicare hospice eligibility requirements currently have problems accessing hospice care because of restrictive eligibility criteria on the part of some hospice care providers. Operating with an open access philosophy

enables us to remove these barriers to hospice care access and to achieve important competitive advantages, including:

Strong relationships with our referral sources. We believe that our open access service philosophy helps us build strong relationships with our referral sources because we will accept all hospice-eligible adult patients they refer to us.

Greater utilization of our services, resulting in lower direct care costs. Patient care expenses are generally higher during the initial and latter days of care. In the initial days of care, expenses tend to be higher because of the initial purchases of pharmaceuticals, medical equipment and supplies and the administrative costs of determining the patient s hospice eligibility, registering the patient and organizing the plan of care. In the latter days of care, expenses tend to be higher because patients generally require more services, especially pharmaceuticals and nursing care, due to their deteriorating medical condition. Therefore, when we increase the number of days a patient stays in our care, we increase the number of lower cost days over which our costs are spread. Our open access philosophy involves a commitment on the part of all our staff to encourage patients to use our services, and referral sources to refer patients, at the earliest stage of hospice eligibility. We believe this philosophy has contributed to our 2002 average length of stay of approximately 86 days per patient, which we believe to be well in excess of the industry average.

We Have an Experienced Management Team. We have assembled a management team at both the corporate and program level with the financial, regulatory and operating experience to grow our company. Our corporate executive officers, half of whom have joined us since January 1, 2001, have significant experience operating publicly traded healthcare companies and growing businesses both organically and through acquisitions.

Our Business Strategy

We intend to enhance our position as a market leader in the hospice care industry by pursuing the following strategies:

Continue to Drive Same-Store Census Growth

An important aspect of our growth strategy involves increasing patient census within our existing programs. Since the end of 1998, following the completion of our last material acquisition, through March 31, 2003, we grew our same-store patient census by approximately 168%, from 1,579 to 4,227 patients. We intend to continue to increase our same-store growth by:

Continuing to provide superior quality of care. We have driven our same-store growth to date largely through word of mouth recommendations based on the quality of our care. Consistent with our mission, we will continue to focus our efforts on providing superior care to our patients and their families.

Building relationships that enhance our presence in local markets. We intend to increase our presence in local markets by fostering relationships with physicians, discharge planners, local faith-based and other community organizations and their leaders, and by providing educational workshops on hospice care and other end-of-life issues.

Focusing on our formal marketing initiatives. In September 2001, we initiated our first ever company-wide marketing program with the goal of expanding awareness and acceptance of hospice care and increasing our market share. Since then, we have added to our team of professional relations representatives and revised our employee compensation structure to include bonus incentives for increasing census at the program level. Our same-store census has grown 88% since the inception of this program, from 2,245 patients as of September 1, 2001 to 4,227 patients as of March 31, 2003. We believe that a continued commitment to these initiatives will help us continue growing.

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Building relationships with national and regional nursing homes, assisted living facilities and managed care organizations. By building relationships with nursing home chains, assisted living providers, and managed care organizations, we hope to develop steady referral sources, that have the ability to provide multiple referrals on an on-going basis.

Expand Through Strategic Acquisitions and New Program Development

We intend to expand our services in existing and new markets. Factors we consider when examining expansion opportunities include the following:

hospice utilization and the number of eligible beneficiaries in the community who are not receiving hospice care;

proximity to our existing programs and our ability to leverage our local resources through regional density;

existing competition;

the potential profitability of the target hospice program; and

the regulatory environment.

After we identify a market that fits our criteria for expansion, we may choose to develop or acquire a new hospice program or enter into a strategic alliance with an existing hospice program. Because small, non-urban, not-for-profit hospice providers dominate the United States hospice care industry, and because demanding market conditions have made it more difficult for small providers to offer cost-effective quality care, we believe that there will be significant opportunities for us to acquire or enter into strategic alliances with existing programs. We believe that because of the quality of our care, our management capabilities and our dedication to open access, many smaller hospice programs, including not-for-profit providers, will look favorably on combining their operations with ours.

In markets where there are no suitable acquisition or strategic alliance opportunities, we may develop a new program. When we develop a new program, we first deploy a small staff and acquire necessary office space, contracts and referral sources. Then we admit a small number of patients and request a Medicare certification survey. Following Medicare certification, we employ robust recruiting, training, community education and marketing efforts to build census.

Build Market Share in Non-Urban Markets

Hospice care usage by Medicare beneficiaries in non-urban areas has increased dramatically in recent years. A significant portion of our current business involves providing care in these areas. We plan to continue to focus on building market share in the non-urban markets in which we currently operate and in new markets. We find these markets particularly attractive because:

we tend to encounter less competition from larger healthcare institutions devoted to aggressive curative care; and

we are able to develop a dominant market share by quickly building relationships and brand identity with local referral sources.

Become the Employer of Choice in the Hospice Care Industry

We are committed to maintaining a superior work environment consisting of competitive compensation, proper staffing, useful management tools and extensive internal training. All of our full-time employees participate in a performance-based cash bonus program that rewards them based on a combination of factors including quality of care, compliance, profitability and census growth. We analyze current data from each of our programs in order to adjust staffing levels in response to or in anticipation of fluctuations in patient census so that we can minimize staff turnover. We have also initiated the development of technology tools designed to reduce administrative paperwork and enable our clinical staff to focus on patient care. As a result

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of these initiatives, our turnover rate for full-time employees with at least one year of service has steadily decreased from approximately 41.0% for the year ended December 31, 1999 to approximately 21.0% for the year ended December 31, 2002. We calculate our turnover rates for any period on a monthly basis by dividing the number of full-time employees with at least one year of service whose employment terminated during the month by the average number of full-time employees employed during such month.

Our Services

We provide a full range of hospice services, from pain and symptom control to emotional and spiritual support, tailored to the individual needs of our patients and their families. Each patient who enrolls in one of our programs is assigned an interdisciplinary care team consisting of, depending on the patient s needs, a physician, a nurse, a home health aide, a social worker, occupational and speech pathology therapists, a spiritual counselor, a dietary counselor, a volunteer, a homemaker and a bereavement coordinator. Below is a list of the key services we provide:

- pain and symptom management;
- emotional and spiritual support;
- special palliative modalities such as radiation therapy, chemotherapy and infusion therapy;
- diagnostic testing;
- inpatient and respite care;
- physician visits;
- nursing care;
- personal care by home health aides;
- homemaker services;
- social worker visits;
- spiritual counseling;
- bereavement counseling for up to 13 months after the patient s death;
- dietary counseling;
- physical, occupational and speech therapy;
- medical equipment and supplies; and
- medications.

Our services are available twenty-four hours a day, seven days a week and can be provided in a patient s home or other residence of choice, such as a nursing home or assisted living facility, or in a hospital or other inpatient facility. We currently operate two inpatient facilities, a 12-bed, stand-alone facility in Cincinnati, Ohio, and a 10-bed hospital-based facility in Albuquerque, New Mexico.

Marketing and Referral Relationships

The primary focus of our marketing activities is on increasing patient referrals from existing referral sources and establishing new referral sources. Our referral sources include:

nursing homes;

assisted living facilities;

hospitals;

physicians;

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home health care organizations;

managed care companies;

community social service organizations; and

religious organizations.

Historically, we have dedicated relatively few resources to formal marketing activities. Most of our referrals have been the result of word of mouth among referral sources about the high quality of our care. We have recently, however, implemented a standardized marketing strategy. A key element of our marketing strategy is training our professional relations representatives and providing them with the tools to communicate effectively to a variety of different types of referral sources, including referral sources with which an individual professional relations representative may not have had significant prior experience.

Each of our hospice care programs has a marketing team led by the program director who is assisted by at least one director of professional relations. Each program employs between one and four professional relations representatives. At March 31, 2003, we employed 94 professional relations representatives company-wide. Consistent with our belief that marketing is a team effort, each program s marketing team is supported by other program employees, including admissions coordinators, patient care managers, medical directors, chaplains, social workers, counselors and nurses. Each professional relations representative seeks to develop patient referral sources located in the representative s territory by regularly calling on those referral sources and educating them regarding our services and hospice care generally. Our professional relations representatives provide feedback to those sources regarding the status of referred patients when appropriate and with the patient s consent. Our marketing efforts also include educational seminars for physicians and hospital personnel and community-based events.

Information Technology

We believe that information technology can significantly enhance our financial, operational, clinical, and compliance performance, and that by building our own information technology infrastructure and software, we can achieve important cost efficiencies as we grow. We employ an in-house software development team of experienced professionals capable of developing solutions in a complex data environment. We believe that by building our own information technology solutions, we can reduce or eliminate outside training costs, expensive third-party applications, and many third-party license or other fees which typically increase when the number of transactions processed or number of users increases.

In addition to the proprietary applications already in place, we are in the process of developing applications we believe will reduce paperwork and travel costs for our nurses, aides and other clinicians in the field, and allow for the automated transfer of enrollment information to suppliers, which we expect to lead to faster delivery of items needed to appropriately care for patients. We are also developing applications designed to monitor and produce timely reports on key expenses such as labor and pharmaceuticals, which we anticipate will enable us to make better staffing, procurement and budgetary decisions. In the second half of 2003, we expect to begin testing a new billing system that will operate on our CareNation platform. We expect to complete the conversion to this new billing system in the second half of 2003 after all technical components have passed all critical criteria tests and once we have completed the training, compliance and reporting systems associated with the new system.

Compliance

We have a strong commitment to operating our business in a manner that adheres to all regulatory requirements, internal company policies and procedures and our corporate philosophy. We have adopted a proactive approach to compliance that includes:

developing information systems that allow us to continuously monitor our performance in key areas;

performing internal compliance audits;

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implementing a continuous quality improvement process designed to ensure regulatory compliance and improve patient care; and

developing a priority index that enables us to shift compliance resources to those hospice programs more likely to experience compliance-related issues before they arise.

Education and Training

We have devoted substantial time and resources to the development of a comprehensive education and training program. We have contracted with a national provider of healthcare educational resources to develop company and industry specific written materials, videos and on-line training and educational resources. We believe these resources will help us deliver consistently high quality service and increase employee confidence, satisfaction and retention.

Competition

Hospice care in the United States is competitive. The hospice care industry is highly fragmented and we compete with a large number of organizations, some of which may have significantly greater financial and marketing resources than we have. Based on industry data, we estimate that approximately 73% of existing hospice programs in 2000 were local, not-for-profit hospice programs. Most hospice programs are small and community-based. We also compete with other multi-program hospice companies including Odyssey Healthcare Inc., SouthernCare Hospice, Inc. and Vitas Healthcare Corporation.

In addition, we compete with a number of hospitals, nursing homes, home health agencies and other health care providers which offer home care to patients who are terminally ill, or market palliative care and hospice-like programs. In addition, various health care companies have diversified into the hospice market, including Beverly Enterprises, Inc. and Manor Care, Inc.

Relatively few barriers to entry exist in the markets we serve. Accordingly, other companies that are not currently providing hospice care may enter these markets and expand the variety of services they offer.

Insurance

We maintain general liability insurance coverage on an occurrence basis with limits of $1.0 million per occurrence and $3.0 million in the aggregate. We maintain healthcare professional liability insurance coverage on a claims-made basis with limits of $1.0 million per occurrence and $3.0 million in the aggregate. We also maintain umbrella coverage with a limit of $10.0 million excess over both general and healthcare professional liability coverage. While we believe our insurance coverage is adequate for our current operations, we cannot assure you that it will cover all future claims or will be available in adequate amounts or at a reasonable cost.

Offices

Our principal executive office is located in Scottsdale, Arizona. Although the lease for this facility does not expire until December 2006, we entered into an agreement with the landlord in January 2003 to terminate it in the second quarter of 2003. We have entered into a seven year lease for a new principal executive office, which is also located in Scottsdale, Arizona, and we expect to relocate to this new office in the second quarter of 2003.

As of March 31, 2003, we operated 39 hospice care programs, including one stand-alone inpatient facility and one hospital-based inpatient facility, serving patients in 14 states from leased program offices in 13 states. We believe that our properties are adequate for our current business needs. In addition, we believe that adequate space can be obtained to meet our foreseeable business needs. With the exception of our principal executive office leases, we have no material operating leases.

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Government Regulation

General

As a provider of healthcare services, we are subject to extensive federal, state and local statutes and regulations. These laws and regulations significantly affect the way in which we operate various aspects of our business. For example, we must comply with federal, state and local laws relating to hospice care eligibility, the development and maintenance of plans of care, and the coordination of services with nursing homes or assisting living facilities where many of our patients live. In addition, each state in which we operate has its own licensing requirements with which we must comply.

We also must comply with regulations and conditions of participation to be eligible to receive payments from various federal and state government-sponsored healthcare programs, such as Medicare and Medicaid. Medicare is a federally funded and administered health insurance program, primarily for individuals entitled to Social Security benefits who are 65 years of age or older or who are disabled. Medicaid is a medical assistance program, jointly funded by the states and the federal government that provides certain medical and psychiatric care services to qualifying low-income persons. States are not required to provide Medicaid coverage for hospice services, but 43 states and the District of Columbia currently do so. All fourteen states in which we currently provide services offer coverage for Medicaid hospice services. Those states in which we operate that do provide a Medicaid benefit may limit the days for which hospice service will be covered, establish pre-authorization processes that can deny or delay access to hospice care, or establish Medicaid managed care programs that include only limited forms of hospice care coverage.

In the future, we may choose to provide hospice care services in one of the few states that do not provide Medicaid coverage for hospice services. All of our current hospice programs have been certified as Medicare providers and are eligible to receive payments from applicable state Medicaid programs.

Medicare Conditions of Participation for Hospice Programs

Federal regulations established as part of the Medicare program require that every hospice program continue to satisfy various conditions of participation to be certified and receive payment for the services it provides. Compliance with the conditions of participation is monitored by state survey agencies designated by the Medicare program. In some cases, failure to comply with the conditions may result in payment denials, the imposition of fines or penalties, or the implementation of a corrective action plan. In extreme cases or cases where there is a history of repeat violations, a state survey agency may recommend a suspension of new admissions to the program or termination of the program in its entirety.

The Medicare conditions of participation for hospice programs include the following:

Governing Body. Each hospice must have a governing body that assumes full responsibility for the policies and the overall operation of the hospice and for ensuring that all services are provided in a manner consistent with accepted standards of practice. The governing body must designate one individual who is responsible for the day-to-day administrative operations of the hospice.

Direct Provision of Core Services. Medicare limits those services for which the hospice may use individual independent contractors or contract agencies to provide care to patients. Specifically, substantially all nursing, social work, and counseling services must be provided directly by hospice employees meeting specific educational and professional standards. During periods of peak patient loads or under extraordinary circumstances, the hospice may be permitted to use contract workers, but the hospice must agree in writing to maintain professional, financial and administrative responsibility for the services provided by those individuals or entities.

Medical Director. Each hospice must have a medical director who is a physician and who assumes responsibility for overseeing the medical component of the hospice s patient care program.

Professional Management of Non-Core Services. A hospice may arrange to have non-core services such as therapy services, home health aide services, medical supplies or drugs provided by a non- employee or outside entity. If the hospice elects to use an independent contractor to provide non-core

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services, however, the hospice must retain professional management responsibility for the arranged services and ensure that the services are furnished in a safe and effective manner by qualified personnel, and in accordance with the patient s plan of care.

Plan of Care. The patient s attending physician, the medical director or designated hospice physician, and the interdisciplinary team must establish an individualized written plan of care prior to providing care to any hospice patient. The plan must assess the patient s needs and identify services to be provided to meet those needs and must be reviewed and updated at specified intervals.

Continuation of Care. A hospice may not discontinue or reduce care provided to a Medicare beneficiary if the individual becomes unable to pay for that care.

Informed Consent. The hospice must obtain the informed consent of the hospice patient, or the patient s representative, that specifies the type of care services that may be provided as hospice care.

Training. A hospice must provide ongoing training for its employees.

Quality Assurance. A hospice must conduct ongoing and comprehensive self-assessments of the quality and appropriateness of care it provides and that its contractors provide under arrangements to hospice patients.

Interdisciplinary Team. A hospice must designate an interdisciplinary team to provide or supervise hospice care services. The interdisciplinary team develops and updates plans of care, and establishes policies governing the day-to-day provision of hospice services. The team must include at least a physician, registered nurse, social worker and spiritual or other counselor. A registered nurse must be designated to coordinate the plan of care.

Volunteers. Hospice programs are required to recruit and train volunteers to provide patient care services or administrative services. Volunteer services must be provided in an amount equal to at least five percent of the total patient care hours provided by all paid hospice employees and contract staff.

Licensure. Each hospice and all hospice personnel must be licensed, certified or registered in accordance with applicable federal, state and local laws and regulations.

Central Clinical Records. Hospice programs must maintain clinical records for each hospice patient that are organized in such a way that they may be easily retrieved. The clinical records must be complete and accurate and protected against loss, destruction, and unauthorized use.

In addition to the conditions of participation governing hospice services generally, Medicare regulations also establish conditions of participation related to the provision of various services and supplies that many hospice patients receive from us. These services include therapy services (physical therapy, occupational therapy, speech-language pathology), home health aide and homemaker services, pharmaceuticals, medical supplies, short-term inpatient care and respite inpatient care, among other services.

Surveys and Audits

Hospice programs are subject to periodic survey by federal and state governmental authorities to ensure compliance with various licensing and certification requirements. Regulators conduct periodic surveys of hospice programs and provide reports containing statements of deficiencies for alleged failure to comply with various regulatory requirements. Survey reports and statements of deficiencies are common in the healthcare industry. In most cases, the hospice program and reviewing agency will agree upon the steps to be taken to bring the hospice into compliance with applicable regulatory requirements. In some cases, however, a state or federal agency may take a number of adverse actions against a facility, including:

the imposition of fines;

temporary suspension of admission of new patients to the hospice s service;

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in extreme circumstances, de-certification from participation in the Medicaid or Medicare programs; or

in extreme circumstances, revocation of the hospice s license.

From time to time we receive survey reports containing statements of deficiencies. We review these reports, prepare responses, work with the relevant regulator and take appropriate corrective action, if required. In June 2000, the Medicare provider agreement for our Odessa, Texas hospice program was terminated and we voluntarily surrendered our state hospice license for that program. In July 1999, our Las Vegas, Nevada hospice program was given a Medicare termination notice. We elected to voluntarily terminate our provider status for that program. We believe that each of our current hospice programs is in material compliance with Medicare and Medicaid certification requirements and state licensure requirements.

Billing Audits/ Claims Reviews. Medicare fiscal intermediaries and other payors periodically conduct pre-payment or post-payment medical reviews or other audits of our claims. In order to conduct these reviews, the payor requests documentation from us and then reviews that documentation to determine compliance with applicable rules and regulations, including the eligibility of patients to receive hospice benefits, the appropriateness of the care provided to those patients, and the documentation of that care.

Certificate/ Determination of Need Laws and Other Restrictions. Approximately 14 states continue to have certificate/determination of need laws that seek to limit the number or size of hospice care providers. These states require some form of state agency review or approval before a hospice may add new services or undertake significant capital expenditures. Approval under these certificate of need laws is generally conditioned on the showing of a demonstrable need for services in the community. In the future we may seek to develop or acquire hospice programs in states having certificate of need laws. To the extent that state agencies require us to obtain a certificate of need or other similar approvals to expand services at our existing hospice programs or to make acquisitions or develop hospice programs in new or existing geographic markets, our plans could be adversely affected by a failure to obtain a certificate or approval.

Limitations on For-Profit Ownership. A few states have laws that restrict the development and expansion of for-profit hospice programs. For example, Florida does not permit the operation of a hospice by a for-profit corporation unless it was operated in that capacity on or before July 1, 1978, although the law might permit us to purchase a grandfathered for-profit hospice and continue to operate it. New York law states that a hospice cannot be owned by a corporation that has another corporation as a stockholder. These types of additional state law restrictions could affect our ability to expand into New York or Florida, or other locations with similar restrictions.

Limits on the Acquisition or Conversion of Non-Profit Health Care Corporations. An increasing number of states have enacted laws that restrict the ability of for-profit entities to acquire or otherwise assume the operations of a non-profit health care provider. Some states may require government review, public hearings, and/or government approval of transactions in which a for-profit entity proposes to purchase a non-profit healthcare facility or insurer. Heightened scrutiny of these transactions may significantly increase the costs associated with future acquisitions of non-profit hospice programs in some states, otherwise increase the difficulty in completing those acquisitions, or prevent them entirely. We cannot assure you that we will not encounter regulatory or governmental obstacles in connection with our acquisition of non-profit hospice programs in the future.

Professional Licensure and Participation Agreements. Many of our employees are subject to federal and state laws and regulations governing the ethics and practice of their chosen profession, including physicians, physical, speech and occupational therapists, social workers, home health aides, pharmacists, and nurses. In addition, those professionals who are eligible to participate in the Medicare, Medicaid or other federal health care programs as individuals must not have been excluded from participation in those programs at any time.

Overview of Government Payments General

Payments from Medicare and Medicaid are subject to legislative and regulatory changes as well as susceptible to budgetary pressures. Our revenues and profitability are therefore subject to the effect of those changes and to possible reductions in coverage or payment rates by private third-party payors. For the year

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ended December 31, 2002 and the three months ended March 31, 2003, 96.6% and 95.9%, respectively, of our net patient revenue was attributable to Medicare and Medicaid payments. As a result, any changes in the regulatory, payment or enforcement landscape may significantly affect our operations.

Overview of Government Payments Medicare

Medicare Eligibility Criteria. To receive Medicare payment for hospice services, the hospice medical director and, if the patient has one, the patient s attending physician, must certify that the patient has a life expectancy of six months or less if the illness runs its normal course. This determination is made based on the physician s clinical judgment. Due to the uncertainty of such prognoses, however, it is likely that some percentage of our patients will not die within six months of entering the hospice program. The Medicare program (among other third-party payors) recognizes that terminal illnesses often do not follow an entirely predictable course, and therefore the hospice benefit remains available to beneficiaries so long as the hospice physician or the patient s attending physician continues to certify that the patient s life expectancy remains six months or less. Specifically, the Medicare hospice benefit provides for two initial 90-day benefit periods followed by an unlimited number of 60-day periods. A Medicare beneficiary may revoke his or her election of the Medicare hospice benefit at any time and resume receiving regular Medicare benefits. The patient may elect the hospice benefit again at a later date so long as he or she remains eligible.

Levels of Care. Medicare pays for hospice services on a prospective payment system basis under which we receive an established payment for each day that we provide hospice services to a Medicare beneficiary, depending upon the level of service provided. These rates are then subject to annual adjustments for inflation and may also be adjusted based upon the location where the services are provided due to variability in labor costs the greatest single expense for hospice programs. The rate we receive will vary depending on which of the following four levels of care is being provided to the beneficiary:

Routine Home Care. We are paid the routine home care rate for each day that a patient is in our program and is not receiving one of the other categories of hospice care or when a patient is receiving hospital care for a condition that is not related to his or her terminal illness. We are paid the same daily rate regardless of the volume or intensity of the services provided to the patient and his or her family or caregivers.

General Inpatient Care. General inpatient care is provided when a patient requires inpatient services for a short period for pain control or symptom management that typically cannot be provided in other settings. General inpatient care services must be provided in a Medicare or Medicaid certified hospital or long-term care facility or at a freestanding inpatient hospice facility with the required registered nurse staffing.

Continuous Home Care. Continuous home care is provided only during periods of crisis when a hospice patient requires predominantly nursing care to achieve palliation or management of acute medical problems while at home. Medicare requires that at least eight hours of services be provided (licensed nursing care must be provided for more than one half of the time) within a single day in order to qualify for reimbursement under the continuous home care provisions. While the Medicare published continuous home care rates are daily rates, Medicare actually pays for continuous home care services on an hourly basis. This hourly rate can be obtained by dividing the daily rate by 24.

Respite Care. Respite care permits a hospice patient to receive services on an inpatient basis for a short period of time in order to relieve the patient s family or other caregivers from the demands of caring for the patient. We can receive payment for respite care provided to a patient for up to five consecutive days at a time on an occasional basis. Any additional consecutive days of respite care will be reimbursed at the routine home care rate.

Program Limits on Hospice Care Payments. Medicare payments for hospice services are subject to two additional limits or caps, both of which are assessed on a provider-wide basis. The first of these two caps is commonly known as the 80-20 rule and applies only to Medicare inpatient services. Specifically, the 80-20 rule states that if the number of inpatient care days any of our hospice programs provides to Medicare

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beneficiaries exceeds 20.0% of the total days of hospice care it provides, those days in excess of the 20.0% figure may be reimbursed only at the routine home care rate. Compliance with the 80-20 rule is measured by examining all claims submitted by a hospice program between November 1 and the following October 31.

None of our hospice programs has exceeded the cap on inpatient care services. However, we cannot assure you that on