

FIVE STAR QUALITY CARE INC

Form 10-K

March 07, 2007

## **UNITED STATES**

**SECURITIES AND EXCHANGE COMMISSION**

**WASHINGTON, DC 20549**

**FORM 10-K**

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

**For the fiscal year ended December 31, 2006**

**OR**

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

**Commission File Number 001-16817**



# FIVE STAR QUALITY CARE, INC.

(Exact Name of Registrant as Specified in its Charter)

**Maryland**  
(State of Incorporation)

**04-3516029**  
(IRS Employer Identification No.)

**400 Centre Street, Newton, Massachusetts 02458**

(Address of Principal Executive Offices)

**617-796-8387**

(Registrant's Telephone Number)

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

**Title of each class**  
Common Stock

**Name of each exchange on which registered**  
American Stock Exchange

Securities to be registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.

Yes ☐ No ☒

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.

Yes ☐ No ☒

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer or a non-accelerated filer. See definition of large accelerated filer and accelerated filer in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐ Accelerated filer ☒ Non-accelerated filer ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes ☐ No ☒

The aggregate market value of the voting shares of the registrant held by non-affiliates was \$343.4 million based on the \$11.07 closing price per common share on the American Stock Exchange on June 30, 2006. For purposes of this calculation, an aggregate of 557,582.6 shares of common stock are held by the directors and officers of the registrant and have been included in the number of shares of common stock held by

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affiliates, which includes 35,000 shares of common stock held by Senior Housing Properties Trust.

Number of the registrant's shares of common stock outstanding as of March 5, 2007: 31,684,134.

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In this Annual Report on Form 10-K, the terms the Company, Five Star, FVE, we, us or our include Five Star Quality Care, Inc., and its consolidated subsidiaries, unless the context indicates otherwise.

### **DOCUMENTS INCORPORATED BY REFERENCE**

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Certain information required in Items 10, 11, 12, 13 and 14 of Part III of this Annual Report on Form 10-K is incorporated by reference from our definitive Proxy Statement for the Annual Meeting of Shareholders scheduled to be held on May 15, 2007, or our definitive Proxy Statement.

### **WARNING CONCERNING FORWARD LOOKING STATEMENTS**

THIS ANNUAL REPORT CONTAINS STATEMENTS WHICH CONSTITUTE FORWARD LOOKING STATEMENTS WITHIN THE MEANING OF THE PRIVATE SECURITIES LITIGATION REFORM ACT OF 1995 AND OTHER FEDERAL SECURITIES LAWS. ALSO, WHENEVER WE USE WORDS SUCH AS BELIEVE , EXPECT , ANTICIPATE , INTEND , PLAN , ESTIMATE OR SIMILAR EXPRESSIONS, WE ARE MAKING FORWARD LOOKING STATEMENTS. THESE FORWARD LOOKING STATEMENTS ARE BASED UPON OUR PRESENT INTENT, BELIEFS OR EXPECTATIONS, BUT FORWARD LOOKING STATEMENTS ARE NOT GUARANTEED TO OCCUR AND MAY NOT OCCUR. ACTUAL RESULTS MAY DIFFER MATERIALLY FROM THOSE CONTAINED IN OR IMPLIED BY OUR FORWARD LOOKING STATEMENTS AS A RESULT OF VARIOUS FACTORS.

IMPORTANT FACTORS THAT COULD CAUSE ACTUAL RESULTS TO DIFFER MATERIALLY FROM THOSE IN OUR FORWARD LOOKING STATEMENTS ARE:

- THE TERMINATION OF OUR MANAGEMENT AGREEMENTS WITH SUNRISE SENIOR LIVING SERVICES, INC., OR SLS, MAY NOT IMPROVE OUR FINANCIAL RESULTS OR MAY CAUSE US TO EXPERIENCE OPERATING LOSSES. ALTHOUGH OUR EXPECTATION IS OTHERWISE, WE MAY BE UNABLE TO OPERATE THE COMMUNITIES SLS MANAGED FOR US AS PROFITABLY AS THEY WERE OPERATED BY SLS; AND
- OPERATING MARGINS FOR OUR TWO REHABILITATION HOSPITALS MAY BE LOWER THAN WE CURRENTLY ANTICIPATE OR MAY DECLINE. WE MAY BE UNABLE TO OPERATE THESE HOSPITALS PROFITABLY AND WE MAY EXPERIENCE LOSSES FROM OUR OPERATION OF THESE HOSPITALS. ALSO, THE PERCENTAGE OF PATIENTS AT THESE HOSPITALS WHICH MEET CERTAIN MEDICARE REQUIREMENTS MAY NOT BE AS HIGH AS WE CURRENTLY ANTICIPATE OR MAY DECLINE AND, AS A RESULT, THESE HOSPITALS MAY RECEIVE LOWER MEDICARE RATES THAN WE CURRENTLY ANTICIPATE.

OTHER RISKS MAY ADVERSELY IMPACT US, AS DESCRIBED MORE FULLY IN THIS ANNUAL REPORT UNDER ITEM 1A. RISK FACTORS.

YOU SHOULD NOT PLACE UNDUE RELIANCE UPON FORWARD LOOKING STATEMENTS.

EXCEPT AS REQUIRED BY LAW, WE UNDERTAKE NO OBLIGATION TO UPDATE OR REVISE ANY FORWARD LOOKING STATEMENTS AS A RESULT OF NEW INFORMATION, FUTURE EVENTS OR OTHERWISE.

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**FIVE STAR QUALITY CARE, INC.  
2006 ANNUAL REPORT ON FORM 10-K**

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## PART I

### Item 1. Business

#### GENERAL

We operate senior living communities, including independent living and congregate care communities, assisted living communities and nursing homes. As of December 31, 2006, we operated 162 communities containing 18,117 living units, including 113 primarily independent and assisted living communities containing 13,701 living units and 49 nursing homes containing 4,416 living units. Of our 113 primarily independent and assisted living communities, we leased 97 communities containing 12,498 living units from Senior Housing Properties Trust, or Senior Housing, our former parent, and we own or lease from parties other than Senior Housing 16 communities containing 1,203 living units. We lease all but two of our nursing homes from Senior Housing. Our 162 communities include 5,601 independent living apartments, 6,541 assisted living suites and 5,975 skilled nursing beds. We also operate six institutional pharmacies, one of which provides mail order pharmaceuticals to the general public, and we operate two rehabilitation hospitals that we lease from Senior Housing. Our two rehabilitation hospitals contain 342 beds available for inpatient services and 21 affiliated outpatient clinics. Our principal executive offices are located at 400 Centre Street, Newton, Massachusetts 02458, and our telephone number is (617) 796-8387.

#### OUR HISTORY

##### Spin off from Senior Housing

We were created by Senior Housing in April 2000 to operate nursing homes repossessed or acquired from two former Senior Housing tenants. We were incorporated in Delaware in April 2000 and reincorporated in Maryland on September 17, 2001. On December 31, 2001, Senior Housing distributed substantially all of our outstanding shares to its shareholders and we became a separate publicly owned company listed on the American Stock Exchange, or AMEX. Pursuant to the transaction agreement governing this spin off:

- Senior Housing capitalized us with approximately \$50.0 million of equity, consisting of cash and working capital, primarily operating receivables, net of operating payables;
- we agreed to lease 31 primarily independent and assisted living communities then operated by Marriott Senior Living Services, Inc., or MSLS, a wholly owned subsidiary of Marriott International Inc., or Marriott, upon their acquisition by Senior Housing which occurred in 2002, as described below;
- we leased 53 nursing homes and two assisted living communities from Senior Housing;
- we assumed one lease from the town of Campbell, Nebraska; and
- we agreed to acquire FSQ, Inc., or FSQ, the former operating company of the healthcare business we owned in order to acquire the personnel, systems and assets necessary for our business.

In 2002, we commenced operations at 51 senior living communities, including the 31 communities then operated by MSLS, and subsequently operated by SLS, a wholly owned subsidiary of Sunrise Senior Living, Inc., or Sunrise, and 20 additional communities. In 2003, we commenced operations at three senior living communities which we lease from Senior Housing.

##### Acquisitions

In November 2004, we acquired 100% of the capital stock of LTA Holdings, Inc., or LTA, for approximately \$211.0 million, excluding closing costs. LTA owned, leased and operated 47 senior living communities with 2,636 living units, which primarily offer assisted living services, located in seven states. In addition, LTA had two management contracts with third parties for 12 assisted living communities. We terminated one contract for 11 of these communities on March 1, 2005.



In March 2005, we acquired a 62 unit assisted living community located in Georgia for approximately \$6.9 million. In June 2005, we acquired six assisted living communities for approximately \$59.0 million. In order to finance this acquisition, we sold four senior living communities to Senior Housing in June 2005 for \$24.0 million and Senior Housing leased these communities back to us for initial rent of \$2.2 million per year. In August 2005, we sold the six communities to Senior Housing for net proceeds of \$56.7 million and Senior Housing leased these communities back to us for initial rent of \$5.2 million per year.

Between September and December 2006, we agreed to lease from Senior Housing 11 senior living communities with 1,284 units that Senior Housing acquired from third parties. Six of these communities are assisted living communities (three of which offer some skilled nursing services), three are independent living communities and two are continuing care retirement communities which offer independent living, assisted living and skilled nursing services. Our rent payable to Senior Housing for these 11 communities is \$9.0 million per year, plus future increases calculated as a percentage of the revenue increases at these communities after 2007. We added these communities to our existing lease with Senior Housing which has a current term ending in 2020, plus renewal options thereafter. Residents pay substantially all of our charges at these communities from their private resources.

#### Pharmacies

Between September 2003 and November 2006, we acquired a total of six institutional pharmacies located in Wisconsin, Nebraska, California, South Carolina and Virginia.

#### Rehabilitation Hospitals

In February 2006, we agreed to lease two rehabilitation hospitals from Senior Housing. We commenced operations at these two hospitals on October 1, 2006. Our lease with Senior Housing for these two hospitals expires on June 30, 2026, subject to our right to extend the term of the lease for an additional 20 years. These two hospitals provide health rehabilitation services and are located in Braintree and Woburn, Massachusetts. Our rent payable to Senior Housing for these hospitals is \$10.3 million per year. These hospitals offer extensive inpatient and outpatient services that we believe are similar to services we currently provide in many of our senior living communities.

#### Termination of SLS Management Agreements

During 2005 and 2006, we terminated management agreements for the 30 senior living communities that SLS managed for us and began to directly operate these communities for our own account. In connection with these terminations, we paid SLS termination fees totaling \$216.1 million. We no longer pay management fees to SLS.

#### Discontinued Operations

During 2003 and 2004, we ceased operations at one skilled nursing facility which we previously leased from Senior Housing and seven assisted living facilities, one of which we previously leased from Senior Housing.

During 2005, we ceased operations at one assisted living community in Los Angeles, California, and one skilled nursing facility in Milwaukee, Wisconsin. We leased this community and this facility from Senior Housing. Senior Housing sold the assisted living community in California in December 2005 for net proceeds of approximately \$2.6 million, which caused a \$260,000 reduction in the annual minimum rent we pay to Senior Housing in accordance with our lease terms. Senior Housing sold the skilled nursing facility located in Wisconsin in December 2006 for net proceeds of approximately \$1.3 million, which caused a \$130,000 reduction in the annual minimum rent we pay to Senior Housing in accordance with our lease terms.

During 2006, we ceased operations at two skilled nursing facilities located in Connecticut that we leased from Senior Housing. Senior Housing sold these facilities in November 2006 for net proceeds of approximately \$5.6 million, which caused a \$559,000 reduction in the annual minimum rent we pay to Senior Housing in accordance with our lease terms.





### Equity and Debt Financings

In 2002, we issued 3,823,000 shares of our common stock, or common shares, in an underwritten public offering raising net proceeds of \$26.1 million. In December 2004 and January 2005, we issued 3,620,000 common shares in an underwritten public offering raising net proceeds of \$28.8 million. In 2005, we issued 7,750,000 common shares in an underwritten public offering raising net proceeds of \$55.6 million. In 2006, we issued 11,500,000 common shares in an underwritten public offering raising net proceeds of \$114.1 million and we issued in a private placement \$126.5 million principal amount of our 3.75% Convertible Senior Notes due 2026. The notes bear interest at 3.75% per annum, payable semi-annually, and will mature on October 15, 2026, but are redeemable by us beginning on October 20, 2011. In addition, we may be required by the note holders to redeem the notes on each of October 15, 2013, October 15, 2016 and October 15, 2021.

### **OUR GROWTH STRATEGY**

We believe that the aging of the U.S. population will increase demand for independent living properties, assisted living communities, nursing homes and pharmacy and rehabilitation services. Our principal growth strategy is to profit from this increasing demand by operating properties that provide high quality services to senior residents who pay with private resources and by acquiring and operating pharmacy and rehabilitation health service providers.

We seek to improve the profitability of our existing operations by increasing revenues and improving margins. We attempt to increase revenues by increasing rates and utilization of our facilities and services. We attempt to improve margins by limiting increases in expenses and improving operating efficiencies.

In addition to managing our existing operations, we intend to continue to grow our business through acquisitions of independent and assisted living communities where residents' private resources account for a large majority of revenues. Since we became a public company in late 2001, we have acquired 112 primarily independent and assisted living communities which in 2006 generated approximately 89% of their revenue from residents' private resources, rather than from Medicare or Medicaid. We prefer to acquire communities which have achieved or are close to stabilized operations. We also seek to make acquisitions where we can realize cost savings by combining acquired operations with our existing operations.

We also intend to expand our institutional pharmacy business. We acquired our first pharmacy in Wisconsin in 2003. Between 2004 and 2006, we acquired five additional pharmacies: two located in Nebraska, one located in California, one located in South Carolina and one located in Virginia. One of our pharmacies provides mail order pharmaceuticals to the general public. Whenever we buy an institutional pharmacy business, we seek to grow its business by providing pharmacy services at our senior living communities within the same service area. We are currently interested in acquiring pharmacies in other areas where we own senior living communities.

In October 2006, we began to operate two rehabilitation hospitals located in Braintree and Woburn, Massachusetts. These hospitals offer extensive inpatient and outpatient services that are similar to services we currently provide in many of our senior living communities. We may seek to acquire additional rehabilitation hospitals, as well as expand our rehabilitation business at our existing senior living communities.

Although expansion of our nursing home business is not our primary growth strategy, we have in the past considered acquiring additional nursing homes. Most nursing homes are financially dependent upon the Medicare and Medicaid programs. Accordingly, we believe the potential for profitable operations of nursing homes is limited by government rate settings. In these circumstances, we are only interested in expanding our nursing home operations at prices which we believe take into account the risks inherent in government funding. In the past few years, we have been unable to buy nursing homes at prices we consider appropriate, but we may continue to investigate such opportunities in the future.

### **TYPES OF PROPERTIES**

Our present business plan contemplates the ownership, leasing and management of independent living apartments or congregate care communities, assisted living communities, nursing homes and rehabilitation hospitals.



Some of our properties combine more than one type of service in a single building or campus. We operate most of our pharmacies and several of our outpatient rehabilitation clinics from leased commercial spaces.

*Independent Living Apartments or Congregate Care Communities.* Independent living apartments, or congregate care communities, provide high levels of privacy to residents and require residents to be capable of relatively high degrees of independence. An independent living apartment usually bundles several services as part of a regular monthly charge. For example, one or two meals per day in a central dining room, weekly maid service or services of a social director may be included in the base charge. Additional services are generally available from staff employees on a fee for service basis. In some independent living properties, separate parts of the community are dedicated to assisted living or nursing services. As of March 5, 2007, our business includes 5,601 independent living apartments in 43 communities.

*Assisted Living Communities.* Assisted living communities are typically comprised of one bedroom units which include private bathrooms and efficiency kitchens. Services bundled within one charge usually include three meals per day in a central dining room, daily housekeeping, laundry, medical reminders and 24 hour availability of assistance with the activities of daily living such as dressing and bathing. Professional nursing and healthcare services are usually available at the community on call or at regularly scheduled times. As of March 5, 2007, our business includes 6,541 assisted living suites in 103 communities.

*Nursing Homes.* Nursing homes generally provide extensive nursing and healthcare services similar to those available in hospitals, without the high costs associated with operating theaters, emergency rooms or intensive care units. A typical purpose built nursing home includes mostly two bed rooms with a separate bathroom in each room and shared dining and bathing facilities. Some private rooms are available for those residents who pay higher rates or for residents whose medical conditions require segregation. Nursing homes are staffed by licensed nursing professionals 24 hours per day. As of March 5, 2007, our business includes 5,975 skilled nursing beds in 76 communities.

*Rehabilitation Hospitals.* Rehabilitation hospitals, also known as inpatient rehabilitation facilities, or IRFs, provide intensive physical therapy, occupational therapy and speech language pathology services. Patients in IRFs generally receive a minimum of three hours of rehabilitation services daily. IRFs also provide onsite pharmacy, radiology, laboratory, telemetry, hemodialysis and orthotics/prosthetics services. Outpatient satellite clinics are often included as part of the services offered by IRFs. The two rehabilitation hospitals that we began operating in 2006 have 341 beds available for inpatient services and provide extensive outpatient services from the hospitals premises. In addition, these two hospitals operate 21 affiliated outpatient clinics where patients discharged from the hospitals can continue their therapy programs, and receive amputee, brain injury, cardio-pulmonary, orthopedic, spinal cord injury, stroke and neurorehabilitation rehabilitation services.

*Pharmacies.* Our institutional pharmacies are located in six leased commercial spaces and one owned commercial space containing approximately 41,114 square feet plus parking areas for our delivery vehicles.

## **OPERATING STRUCTURE**

We have four divisional offices which are located throughout the country. Each divisional office is responsible for multiple regions and is headed by a divisional vice president with extensive experience in the senior living and health rehabilitative industries. We have several regional offices within each division. Each regional office is responsible for multiple communities and is headed by a regional director of operations with extensive experience in the senior living industry. Each regional office is typically supported by a clinical or wellness director, a rehabilitation services director, a regional accounts manager, a human resources specialist and a sales and marketing specialist. Regional staffs are responsible for all our community operations within the region, including:

- resident services;

- marketing and sales;
- hiring of community personnel;
- compliance with applicable legal and regulatory requirements; and
- supporting our development and acquisition plans within their region.

Our home office staff performs the following tasks:

- general oversight of our regional staff, pharmacy and rehabilitation hospital operations;
- the establishment of company wide policies and procedures relating to resident care;
- human resources policies and procedures;
- information technology;
- Medicare and Medicaid billing;
- licensing and certification maintenance;
- legal services;
- central purchasing;
- budgeting and supervision of maintenance and capital expenditures;
- implementation of our growth strategy; and
- accounting and finance functions, including operations budgeting, portions of accounts receivable and collections, accounts payable, portions of payroll, financial reporting, and tax planning and compliance.

#### **STAFFING**

***Independent and assisted living community staffing.*** Each of the independent and assisted living communities we operate for our own account has an executive director responsible for the day to day operations of the community, including quality of care, resident services, sales and marketing, financial performance and staff supervision. The executive director is supported by department heads, who oversee the care and service of the residents, a wellness director, who is responsible for coordinating the services necessary to meet the health care needs of our residents and a marketing director, who is responsible for selling our services. Other important staff include the dining services coordinator, the activities coordinator and the property maintenance coordinator.

***Nursing home staffing.*** Each of our nursing homes is managed by a state licensed administrator who is supported by other professional personnel, including a director of nursing, an activities director, a marketing director, a social services director, a business office manager, and physical, occupational and speech therapists. Our directors of nursing are state licensed nurses who supervise our registered nurses, licensed practical nurses and nursing assistants. Staff size and composition vary depending on the size and occupancy of each nursing home and on the type of care provided by the nursing home. Our nursing homes also contract with physicians who provide certain medical services.

***Pharmacy operations and staffing.*** Our institutional pharmacy operation provides prescriptions, medical supplies, equipment and services to operators and residents of senior living communities. We do not sell over the counter to the public, but our mail order business provides prescriptions and medical supplies to the general public. Each of our

pharmacies is managed by an executive director, who is responsible for the day to day operations of each pharmacy and our mail order business, including billings, sales and marketing, financial performance, compliance with regulatory codes regarding the dispensing of controlled substances and staff supervision. Other pharmacy personnel include licensed dispensing pharmacists, a director of pharmacy consultation, a medical records director, a nurse consultant, pharmacy technicians and billing personnel.

***Rehabilitation hospital staffing.*** Each IRF is operated under the leadership of a hospital based chief executive officer with the support of senior staff, including a medical director, chief financial officer, director of patient care services, director of rehabilitation and director of case management. The hospitals are also staffed with board certified physicians who primarily specialize in internal medicine, neurology or psychiatry, as well as other licensed professionals, including rehabilitation nurses, physical therapists, occupational therapists, speech and language pathologists, nutrition counselors, neuropsychologists and pharmacists. Each outpatient clinic associated with our IRFs is managed by an outpatient director who is a registered occupational or physical therapist.

## EMPLOYEES

As of March 5, 2007, we had approximately 17,108 employees, including 11,960 full time equivalents. Approximately 93 employees, including approximately 78 full time equivalents, are represented under two collective bargaining agreements, which have remaining terms of approximately 3 years. Except for seven contracts entered into with former owner operators of certain pharmacies which we acquired, we have no employment agreements with our employees. We believe our relations with our union and non-union employees are good.

## GOVERNMENT REGULATION AND REIMBURSEMENT

Our operations must comply with numerous federal, state and local statutes and regulations. Also, the healthcare industry depends significantly upon federal and state programs for revenues and, as a result, is vulnerable to the budgetary policies of both the federal and state governments.

*Independent Living Communities.* Government benefits generally are not available for services at independent living communities and the resident charges in these communities are paid from private resources. However, a number of Federal Supplemental Security Income program benefits pay housing costs for elderly or disabled residents to live in these types of residential communities. The Social Security Act requires states to certify that they will establish and enforce standards for any category of group living arrangement in which a significant number of Supplemental Security Income residents reside or are likely to reside. Categories of living arrangements which may be subject to these state standards include independent living apartments and assisted living communities. Because independent living communities usually offer common dining facilities, in many locations they are required to obtain licenses applicable to food service establishments in addition to complying with land use and life safety requirements. In many states, independent living communities are licensed by state or county health departments, social service agencies or offices on aging with jurisdiction over group residential communities for seniors. To the extent that independent living communities include units in which assisted living or nursing services are provided, these units are subject to applicable state licensing regulations, and if the communities receive Medicaid or Medicare funds, to certification standards. In some states, insurance or consumer protection agencies regulate independent living communities in which residents pay entrance fees or prepay for services.

*Assisted Living Communities.* According to the National Academy for State Health Policy, or the National Academy, a majority of states provide or are approved to provide Medicaid payments for services to residents, but not room and board, in some assisted living communities under waivers granted by the Federal Centers for Medicare and Medicaid Services, or CMS, or under Medicaid state plans. Certain other states are planning some Medicaid funding by preparing state plan amendments or requesting waivers to fund assisted living demonstration projects. Because rates paid to assisted living community operators are generally lower than rates paid to nursing home operators, some states use Medicaid funding of assisted living as a means of lowering the cost of services for residents who may not need the higher intensity of health related services provided in nursing homes. States that administer Medicaid programs for services in assisted living communities are responsible for monitoring the services at, and physical conditions of, the participating communities. Different states apply different standards in these matters, but generally we believe these monitoring processes are similar to the concerned states' inspection processes for nursing homes.

As a result of the large number of states using Medicaid to purchase services at assisted living communities and the growth of assisted living in recent years, a majority of states have adopted licensing standards applicable to assisted living communities. A majority of states have licensing statutes or standards specifically using the term "assisted living" and have requirements for communities servicing people with Alzheimer's disease or dementia. The majority of states have revised their licensing regulations recently or are reviewing their policies or drafting or revising their regulations. State regulatory models vary; there is no national consensus on a definition of assisted living, and no uniform approach by the states to regulating assisted living communities. Most state licensing standards apply to assisted living communities whether or not they accept Medicaid funding. Also, according to the National Academy, a few states require certificates of need from state health planning authorities before new assisted living communities may be developed. Based on our analysis of current economic and regulatory trends, we believe that assisted living communities that become dependent upon Medicaid or other public payments for a majority of their revenues may decline in value because Medicaid rates may fail to keep up with increasing costs. We also believe that assisted living communities located in states that



adopt certificate of need requirements or otherwise restrict the development of new assisted living communities

may increase in value because these limitations upon development may help ensure higher occupancy and higher non-governmental rates.

The US. Department of Health and Human Services, the Government Accountability Office, or GAO, and the Senate Special Committee on Aging have recently studied and reported on the development of assisted living and its role in the continuum of long term care and as an alternative to nursing homes. In 2003, the GAO recommended that CMS strengthen its oversight of state quality assurance in Medicaid home and community-based services waiver programs. Since then, CMS has commenced a series of actions to increase its oversight of state quality assurance programs for assisted living facilities and has provided guidance and technical assistance to the states to improve their ability to monitor and improve the quality of services paid for through Medicaid waiver programs. Also in 2003, a working group of assisted living providers, consumers and regulatory organizations made recommendations to the Senate Special Committee on Aging on a range of subjects, including staffing, funding and regulation of assisted living. We cannot predict whether these studies and reports will result in governmental policy changes or new legislation, or what impact any changes may have. Based upon our analysis of current economic and regulatory trends, we do not believe that the federal government is likely to have a material impact upon the current regulatory environment in which the assisted living industry operates unless it also undertakes expanded funding obligations. Although CMS is implementing provisions of the Deficit Reduction Act of 2005, or the DRA, enacted in February 2006, that encourage state Medicaid programs to expand their use of home and community based services as alternatives to institutional services, we do not believe a materially increased financial commitment from the federal government to fund assisted living is presently likely. However, we do anticipate that assisted living communities will increasingly be licensed and regulated by the various states, and that, in the absence of federal standards, the states' policies will continue to vary widely.

*Nursing Homes-Reimbursement.* About 62% of all nursing home revenues in the U.S. in 2005 (the most recent date for which information is publicly available) came from publicly funded programs, including about 44% from Medicaid programs and 16% from the Medicare program. Nursing homes are among the most highly regulated businesses in the Country. The federal and state governments regularly monitor the quality of care provided at nursing homes. State health departments conduct surveys of resident care and inspect the physical condition of nursing home properties. These periodic inspections and occasional changes in life safety and physical plant requirements sometimes require nursing home operators to make significant capital improvements. These mandated capital improvements have in the past usually resulted in Medicare and Medicaid rate adjustments, albeit on the basis of amortization of expenditures over expected useful lives of the improvements. A Medicare prospective payment system, or the PPS, was phased in over three years beginning with cost reporting years starting on or after July 1, 1998. Under the PPS, capital costs are part of the prospective rate and are not community specific. The PPS and other recent legislative and regulatory actions with respect to state Medicaid rates are limiting the reimbursement levels for some nursing home services. At the same time, federal and state enforcement and oversight of nursing homes have been increasing, making licensing and certification of these communities more rigorous.

The PPS was established by the Balanced Budget Act of 1997, and was intended to reduce the rate of growth in Medicare payments for skilled nursing communities. Before the current Medicare payment system, Medicare rates were community specific and cost based. Under the current Medicare payment system, skilled nursing facilities receive a fixed payment for each day of care provided to residents who are Medicare beneficiaries. Each resident is assigned to a care group depending on that resident's medical characteristics and service needs. These care groups are known as Resource Utilization Groups, or RUGs. Per diem payment rates are established for each of these care groups. Medicare payments cover substantially all services provided to Medicare residents in skilled nursing communities, including ancillary services such as rehabilitation therapies. The PPS is intended to provide incentives to providers to furnish only necessary services and to deliver those services efficiently. During the three year phase in period, Medicare rates for skilled nursing communities were based on a blend of community specific costs and rates established by the new Medicare payment system. According to the GAO, between fiscal year 1998 and fiscal year 1999, the first full year of the changed Medicare payment system phase in, the average Medicare payment per day declined by about 9%.

From November 1999 to January 2006, Congress and CMS have provided some periodic relief from the impact of the Balanced Budget Act of 1997 through temporary increases in skilled nursing facility payment rates and temporary moratoria on some therapy limitations for skilled nursing residents covered under Medicare Part B. Effective January 1, 2006, CMS implemented changes to the payment categories it uses to set daily payment rates for Medicare beneficiaries in skilled nursing facilities. CMS introduced nine new payment categories for medically complex patients, increasing the



number of categories from 44 to 53, and made revisions to its payment rates for current RUGS. Also effective January 1, 2006, these RUG changes caused the elimination of certain temporary additional payments for certain skilled nursing care and rehabilitation groups. The financial impact of these changes to the Medicare rates on our operations was to effectively eliminate an October 2005 Medicare 3% rate increase; but then in October 2006, the Medicare rates were increased by 3%.

Under the DRA, the federal government is slowing the growth of Medicare and Medicaid payments for nursing home services by several methods. Medicare bad debt reimbursement has been reduced from 100% to 70% for uncollected cost sharing payments from Medicare beneficiaries who are not eligible for Medicaid. Limits on Medicare payments were also implemented for outpatient therapies in 2006, with an exception process under which beneficiaries could request an exemption from the cap and be granted the amount of services deemed medically necessary by Medicare. Under the Tax Relief and Health Care Act of 2006, enacted in December 2006, the exemption process has been extended an additional year through 2007. In addition, the DRA increased the "look-back" period for prohibited asset transfers that disqualify individuals from Medicaid nursing home benefits from three to five years. The period of Medicaid ineligibility begins on the date of the prohibited transfer or the date an individual has entered the nursing home and would otherwise be eligible for Medicaid coverage, whichever occurs later, rather than on the date of the prohibited transfer, effectively extending the Medicaid penalty period and placing added burdens on nursing homes to collect charges from residents and their transferees. The DRA includes a demonstration project that will award competitive grants to states to provide home and community based long term care services to qualified individuals relocated from nursing homes, providing an increased federal medical assistance percentage for 12 months for each qualifying beneficiary, during a grant period of at least two years. The DRA also includes a post acute payment reform demonstration program that will compare and assess costs and outcomes of services at different long term care sites over three years. Effective January 1, 2007, states may include home and community based services as optional services under their Medicaid state plans, rather than only pursuant to waivers or demonstration projects, and permits such states to cap enrollment, maintain waiting lists and offer the services in only some regions of a state, as they may with waivers. These initiatives will likely decrease the demand for nursing home services and nursing home occupancy and services may decline.

*Nursing Homes-Survey and Enforcement.* In July 1998, GAO issued a report which found inadequate care in a significant proportion of California nursing homes. Since 1999, the U.S. Department of Health and Human Services, Office of Inspector General has issued several reports concerning quality of care in nursing homes, and the GAO has issued several reports recommending that CMS and the states strengthen their compliance and enforcement practices, including federal oversight of state actions, to better ensure that nursing homes provide adequate care and states act more consistently. The Senate Special Committee on Aging also held hearings on these issues. As a result, CMS has undertaken an initiative to increase the effectiveness of Medicare and Medicaid nursing home survey and enforcement activities. CMS is taking steps to focus more survey and enforcement efforts on nursing homes with findings of substandard care or repeat violations of Medicare and Medicaid standards and to identify chain operated communities with patterns of noncompliance. CMS is increasing its oversight of state survey agencies and requiring state agencies to use enforcement sanctions and remedies more promptly when substandard care or repeat violations are identified, to investigate complaints more promptly, and to survey communities more consistently. In addition, CMS adopted regulations expanding federal and state authority to impose civil money penalties in instances of noncompliance. Medicare survey results, including fire safety reports, and average nursing staff hours per resident for each nursing home are posted on the Medicare website at [www.medicare.gov](http://www.medicare.gov). CMS issued a proposed rule in 2006 that would require older nursing homes to install sprinklers and to install battery powered smoke detectors in the interim. When deficiencies under state licensing and Medicare and Medicaid standards are identified, sanctions and remedies such as denials of payment for new Medicare and Medicaid admissions, civil monetary penalties, state oversight and loss of Medicare and Medicaid participation or licensure may be imposed on nursing home operators. Our communities incur sanctions and penalties from time to time. If we are unable to cure deficiencies which have been identified or that are identified in the future, additional sanctions may be imposed, and if imposed, may adversely affect our ability to meet our financial obligations and negatively affect our financial condition and results of operations.

In 2000 and 2002, the Department of Health and Human Services and CMS issued reports linking nursing staffing levels with quality of care. The Bush administration has indicated that it does not intend to impose minimum staffing levels or to increase Medicare or Medicaid rates to cover the costs of increased staffing at this time; however, CMS is publishing the nurse staffing level at each nursing home on the internet ([www.medicare.gov](http://www.medicare.gov)) to create market pressure to improve nursing home operations.



*Rehabilitation Hospital Regulations and Rate Setting.* The two rehabilitation hospitals that we began operating in 2006 are subject to federal, state and local regulation that affect their business activities and determine the rates they receive for services. These facilities are subject to periodic inspection by governmental and non-governmental agencies to ensure continued compliance with various licensure and accreditation standards. In addition, these facilities are certified by CMS to participate in the Medicare program and receive a significant portion of their revenues from that program.

On May 7, 2004, CMS issued a rule establishing revised Medicare standards that rehabilitation hospitals are required to meet in order to participate as IRFs in the Medicare program, known as the 75% Rule. The 75% Rule generally provides that, to be considered an IRF and receive reimbursement for services under the IRF-prospective payment system, at least 75% of a facility's total inpatient population must require intensive rehabilitation services associated with treatment of at least one of 13 designated medical conditions. This means that to maintain their current levels of revenues many rehabilitation hospitals may need to reduce the number of non-qualifying patients treated and replace them with qualifying patients, establish other sources of revenues or both. The 75% Rule is being phased in over a four year period that began on July 1, 2004. For cost reporting periods starting on and after July 1, 2006, 60% of a facility's inpatient population must require intensive rehabilitation services for one of CMS designated medical conditions. For cost reporting periods starting on and after July 1, 2007, the requirement is 65%, and for cost reporting periods starting on and after July 1, 2008, the requirement is 75%. An IRF that fails to meet the requirements of the 75% Rule is subject to reclassification as a different type of healthcare provider; and the effect of such reclassification would be to lower Medicare payment rates. We believe our hospitals are operating in compliance with the current requirements of the 75% Rule and we are taking actions to assure continued compliance with this rule during its full phase in; however, we can provide no assurance that we will be able to continue to comply with these intensifying rules.

*Certificates of Need.* Most states limit the number of nursing homes and hospitals by requiring developers to obtain certificates of need before new communities may be built and a few states also limit the number of assisted living facilities by requiring certificates of need. Also, states such as California and Texas that have eliminated certificate of need laws often have retained other means of limiting new development, such as the use of moratoria, licensing laws or limitations upon participation in the state Medicaid program. We believe that these governmental limitations may make existing nursing homes and hospitals more valuable by limiting competition.

*Other Matters.* Federal efforts to target fraud and abuse and violations of anti;

Director

March 7, 2007

Barbara D. Gilmore

/s/ Arthur G. Koumantzelis

Director

March 7, 2007

Arthur G. Koumantzelis

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