BEVERLY ENTERPRISES INC
Form 10-K
March 15, 2005

Table of Contents

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

(Mark One)

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

For the fiscal year ended December 31, 2004

or

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

Commission file number: 1-9550
Beverly Enterprises, Inc.
(Exact name of Registrant as specified in its charter)

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

One Thousand Beverly Way
Fort Smith, Arkansas 72919
(Address of principal executive offices)
Registrant s telephone number, including area code: (479) 201-2000
Registrant s website: www.beverlycorp.com
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Name of each exchange on which registered**
Common Stock, $.10 par value, and attached Rights to Purchase Series A Junior Participating Preferred Stock, $1.00 par value	New York Stock Exchange and Pacific Exchange

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

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

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

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

The aggregate market value of the voting and non-voting common stock held by nonaffiliates of Registrant was $908,046,901 as of June 30, 2004.

108,787,095

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

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

TABLE OF CONTENTS

Table of Contents

FORWARD-LOOKING STATEMENTS

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

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

Table of Contents

PART I

ITEM 1. BUSINESS.

Operations and Services

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

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

Nursing Facilities. Our Nursing Facilities operations provide long-term healthcare and rehabilitation services through the operation of skilled nursing facilities and assisted living centers and accounted for approximately 90% of our revenues from continuing operations for the year ended December 31, 2004. Our facilities provide residents with routine long-term care services, including daily nursing, dietary, social and recreational services and a full range of pharmacy services and medical supplies. Our skilled nursing staff also provides complex and intensive medical services to residents with higher acuity needs outside the traditional acute-care hospital setting. We have designed our assisted living centers to provide residents with a greater degree of independence while still offering routine services and, if required, limited medical care.

Aegis. Aegis is one of the largest contract therapy companies in the United States, providing rehabilitation therapy services under contract to our nursing facilities as well as 585 third-party customers as of December 31, 2004, and accounted for approximately 6% of our revenues for the year ended December 31, 2004. Aegis offers occupational, physical and speech therapy services designed to maximize function and independence, assist in recovery from medical conditions and compensate for remaining disabilities.

AseraCare. Our AseraCare operations primarily provide hospice services within nursing facilities and patients homes and accounted for approximately 3% of our revenues for the year ended December 31, 2004. Our hospice services include palliative care for terminally ill patients, as well as pastoral, counseling and bereavement services for the families of hospice patients.

Revenue Sources

Overview

We receive payments for services provided to patients from:

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

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

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

Table of Contents

The following table sets forth for the periods indicated:

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

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

	Medicaid		Medicare		Private and Other	
	Patient Days	Revenues	Patient Days	Revenues	Patient Days	Revenues
Years Ended:						
December 31, 2004	71%	55%	12%	28%	17%	17%
December 31, 2003	70%	56%	12%	26%	18%	18%
December 31, 2002	70%	55%	11%	27%	19%	18%

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

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

Reimbursement by Medicaid Programs

Medicaid programs currently exist in all of the 23 states, and the District of Columbia, in which we operate nursing facilities. These programs differ in certain respects from state to state, but they are all subject to federally imposed requirements. At least 50% of the funds available under these programs is provided by the federal government under a matching program.

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

State Medicaid reimbursement programs vary as to the level of allowable costs that are reimbursed to operators. In some states, cost-based reimbursement is subject to retrospective adjustment through cost report settlement. In other states, reimbursements made to a facility that are subsequently determined to be less than or in excess of allowable costs may be adjusted through future reimbursements to the facility. Still other states reimburse facilities based upon costs from a prior base year, adjusted for inflation.

More than 50% of the states we currently operate in have enacted reimbursement programs that are adjusted to reflect patient acuity, similar to the methodology utilized in Medicare s prospective payment system (PPS). Many other states are actively developing reimbursement systems based on patient acuity. We are unable to estimate the ultimate impact of any changes in state reimbursement programs on our future consolidated financial position, results of operations or cash flows.

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

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

Table of Contents

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

We have experienced increases in our state Medicaid rates averaging 6.1%, 4.6% and 3.5% for the years ended December 31, 2004, 2003 and 2002, respectively. While federal regulations do not provide states with grounds to curtail funding of their Medicaid cost reimbursement programs due to state budget deficiencies, states have done so in the past. No assurance can be given that states will not do so in the future or that the future funding of Medicaid programs will remain at levels comparable to the present levels.

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

Reimbursement by Medicare

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

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

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

a 6.7% add-on for all 14 rehabilitation RUG categories.

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

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

Table of Contents

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

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

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

The proposed Federal Budget that was released in February 2005 contains provisions to cut Medicare funding for skilled nursing facilities by more than $1.5 billion for fiscal year 2006 by issuing regulations implementing RUG refinements and then eliminating the two add-ons described above. In addition, the Federal Budget proposes to reduce by 30 percent the amount that Medicare reimburses skilled nursing facilities and other non-hospital providers for bad debts arising from uncollectible Medicare coinsurance and deductibles. The proposal is to phase in the reduction over a three-year period at 10 percent per year. Based on our current volume of Medicare bad debts, this proposed rule would reduce our revenues by $1.9 million, $3.8 million and $5.7 million for the first, second and third year, respectively. We cannot currently determine if, or when, this proposal will be implemented.

Government Regulation

Survey, Certification and Licensure

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

Table of Contents

CMS survey and certification regulations regarding implementation of the Medicare and Medicaid provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) were revised significantly in March 1999. Among the provisions that CMS adopted are requirements that:

surveys focus on residents outcomes;

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

penalties will result for certain types of deficiencies.

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

installation of temporary management;

denial of payment for new admissions;

denial of payment for all patients;

civil money penalties of $50 to $3,000 per day for deficiencies that do not put a resident in immediate jeopardy and $3,050 to $10,000 per day for deficiencies that have caused or are likely to cause serious injury or death or alternatively, penalties of $1,000 to $10,000 per instance;

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

directed plans of correction; and

directed in-service training.

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

the imposition of fines;

temporary suspension of admission of new patients to the facility;

decertification from participation in the Medicare or Medicaid programs; or

in extreme circumstances, revocation of a facility s license.

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

In February 2000, as part of the settlement of an investigation by the federal government into our allocation of certain costs to the Medicare program, we entered into a Corporate Integrity Agreement with the United States Department of Justice and the Office of Inspector General (the OIG), which was subsequently revised in 2002 and 2004. This agreement requires that we monitor our activities, on an ongoing basis, to ensure our compliance with the requirements of participation in federal healthcare programs. It also includes functional and training obligations, audit

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

Table of Contents

to all of our nursing facilities and to reflect a modification of the requirements under the agreement with respect to training and education. We believe that we are generally in compliance with the requirements of the Corporate Integrity Agreement and file annual reports with the OIG documenting our compliance. Failure to comply with the Corporate Integrity Agreement may result in penalties or exclusion from the Medicare and Medicaid programs.

Nursing Facility Quality Initiative

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

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

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

Regulations Governing Healthcare Fraud and Abuse

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

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

Table of Contents

ventures, space and equipment rentals, management and personal services contracts, and certain investment arrangements among providers may be subject to increased regulatory scrutiny.

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

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

denial of payment for services provided;

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

refunds of any amounts collected;

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

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

exclusion from the Medicare and Medicaid programs.

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

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

The Budget Act also contained a significant number of new fraud and abuse provisions. For example, civil money penalties may also be imposed for violations of the Antifraud Amendments (previously, exclusion or criminal

prosecution were the only actions under the Antifraud Amendments), as well as for contracting with an individual or entity that a provider knows or should know is excluded from a federal healthcare program. A person is subject to mandatory exclusion from participation in federal healthcare programs upon conviction for

Table of Contents

certain defined healthcare offenses. The Budget Act provides a minimum ten-year period for exclusion from participation in federal healthcare programs for providers convicted of a prior healthcare offense. The Budget Act also provides for civil money penalties of up to $50,000 and damages of not more than three times the amount of payment received from the prohibited activity.

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

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

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

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

In addition to laws addressing referral relationships, several federal laws impose criminal and civil sanctions for fraudulent and abusive billing practices. The Federal False Claims Act imposes sanctions, consisting of monetary penalties of up to $11,000 for each claim and three times the amount of damages, on entities and persons who knowingly present or cause to be presented to the federal government a false or fraudulent claim for payment. Also, the statute allows private parties to bring *qui tam* whistleblower lawsuits alleging false claims. Some states have adopted similar whistleblower and/or false claims provisions. The Social Security Act prohibits the knowing and willful making of a false statement or misrepresentation of a material fact with respect to the submission of a claim for payment under government health programs (including the Medicare and Medicaid programs). Violations of this provision are a felony offense punishable by fines and imprisonment. Government prosecutors are increasing their use of the Federal False Claims Act to prosecute quality of care deficiencies in healthcare facilities. Their theory behind this is that the submission of a claim for services provided in a manner that falls short of quality of care standards can constitute the submission of a false claim.

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

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

Regulation Governing the Privacy and Transmission of Healthcare Information

In addition to its antifraud provisions, HIPAA also includes regulations which standardize electronic data interchange and protect the privacy and security of health data. More specifically, HIPAA calls for:

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

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

Table of Contents

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

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

Final regulations, and modifications to these regulations, establishing standards for electronic data transactions and code sets, as required under HIPAA, have been released. These standards are designed to allow entities within the healthcare industry to exchange medical, billing and other information and to process transactions in a more timely and cost effective manner. Congress has granted extensions to providers whose Medicare and Medicaid trading partners are not ready to implement these standards. We are already complying with the transactions standards where possible. We will begin operating in a compliant manner with the remaining trading partners as they become ready.

The HIPAA privacy standards are designed to protect the privacy of certain individually identifiable health information. The privacy standards have required us to make certain updates to our policies and procedures and conduct training for our employees surrounding these standards. The HIPAA employer identification standard is designed to ensure industry uniformity when reporting this data element in standardized transactions and required no changes in our operations. We believe we are generally compliant with the privacy and employer identification standards.

We must comply with the HIPAA security standards by April 20, 2005. We must comply with the provider identification standard by May 23, 2007. We continue to evaluate and update our processes and procedures to meet the requirements of the new standards; however, we cannot assure you that all of the parties with whom we do business are in compliance with HIPAA. We do not believe our ongoing implementation to comply with HIPAA will have a material impact on our consolidated financial position, results of operations or cash flows.

Competitive Conditions

Our nursing facilities compete primarily on a local and regional basis with other long-term care providers, some of whom may own as few as a single nursing facility. Our primary national competitors include Manor Care, Inc., Kindred Healthcare, Inc., Genesis HealthCare Corporation, Extendicare Health Services, Inc. and Mariner Health Care, Inc. Our ability to compete successfully with other long-term healthcare providers varies from location to location and depends on a number of factors, which include:

the number of competitors in the local market;

the types of services available;

quality of care;

reputation, age and appearance of each nursing facility; and

the cost of care in each locality.

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

the number of competitors in the local market;

price relative to perceived value;

employee retention and training;

quality of care; and

referral sources.

11

Table of Contents

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

Employees and Labor Relations

At December 31, 2004, we, primarily through our operating subsidiaries, had approximately 34,300 full and part-time employees. Approximately 10% of our employees, employed in 93 of our nursing facilities, are represented by various labor unions. Although our facilities have never experienced any material work stoppages and we believe that our relations with employees and labor organizations are generally good, we cannot predict the effect continued union representation or organizational activities would have on our future operations.

A national shortage of nurses, therapists and other trained personnel, as well as general inflationary pressures, have required us to adjust our wage and benefits packages in order to compete for qualified personnel. In 2004, labor costs accounted for approximately 52% of the operating expenses of our Nursing Facilities segment, 91% of our Aegis segment and 59% of our AseraCare segment. We compete with other healthcare providers to attract and retain qualified or skilled personnel. We also compete with various industries for lower-wage employees.

We are not currently facing a staffing shortage in all markets where we operate; however, in certain markets with shortages of healthcare workers we have used high cost temporary help to supplement staffing levels. We are addressing our staffing challenges through innovative recruiting and retention programs and training initiatives. However, these programs and initiatives may not stabilize or improve our ability to attract and retain these personnel. Our inability to control labor availability and costs could have an adverse effect on our future operating results.

Risks Relating to Our Company

Our substantial indebtedness could adversely affect our financial health.

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

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

increase our vulnerability to general adverse economic and industry conditions;

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

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

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

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

limit our ability to borrow additional funds.

In addition, the indentures relating to our publicly traded notes contain restrictive covenants and our senior credit facility contains financial and other restrictive covenants that limit our ability to engage in activities that may be in our long-term best interest. Our failure to comply with those covenants could result in

Table of Contents

an event of default, which, if not cured or waived, could result in the acceleration of a substantial amount of our debt.

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

We may be able to incur substantial additional indebtedness in the future, including indebtedness to finance potential acquisitions and expansions. The terms of our existing debt instruments and the indentures relating to our public notes allow us to incur additional indebtedness if certain conditions and financial tests are met. We have $90.0 million of revolving credit under our senior credit facility ($15.0 million of which availability at December 31, 2004 was being used for letters of credit) and can draw up to $40.0 million of letters of credit under our letter of credit facility ($21.5 million of which was available at December 31, 2004). If new indebtedness is added to our current debt levels, the related risks could increase.

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

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

At December 31, 2004, we had cash and cash equivalents totaling $215.7 million and availability of $75.0 million under our revolving credit facility and $21.5 million under our letter of credit facility. We currently anticipate that cash on hand, cash flows from operations and availability under our banking arrangements will be adequate to repay our debts due within one year of $12.2 million, to make normal recurring annual capital additions and improvements estimated to be $100.0 million, to make operating lease and other contractual obligation payments, to make selective acquisitions, including the purchase of previously leased facilities, and to meet working capital requirements for the twelve months ending December 31, 2005.

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

The price of our common stock may fluctuate significantly.

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

future announcements concerning us or our competitors;

quarterly variations in operating results;

business acquisitions or divestitures;

changes in earnings estimates;

changes in third-party reimbursement practices;

regulatory developments;

changes in the number of outstanding shares; or

fluctuations in the economy or general market conditions.

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

13

Table of Contents

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

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

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

Holders of our $115.0 million of 2.75% convertible subordinated notes are entitled to convert the notes into our common stock if the closing sale price of our common stock for at least 20 consecutive trading days in the 30 consecutive trading day period ending on the last day of the immediately preceding fiscal quarter is more than 120% of the conversion price (or $8.94 per share) in effect on that 30th trade day, among other circumstances. Given the recent trading activity in our common stock, we believe it is likely that the notes will become convertible at the beginning of the second quarter of 2005, but we are unable to predict the impact the conversion would have on the price of our common stock. The shares underlying the notes, since their issuance in October 2003, are included in the calculation of our diluted earnings per share in accordance with Emerging Issues Task Force Issue No. 04-8, *The Effect of Contingently Convertible Debt on Diluted Earnings per Share.*

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

For the year ended December 31, 2004, 55%, 28% and 17% of our nursing facility revenues from continuing operations were derived from Medicaid, Medicare and private and other sources, respectively. For the year ended December 31, 2004, 97% of our AseraCare revenues were derived from Medicare. Although Aegis revenues are provided by non-governmental customers, these customers obtain their revenues primarily from government programs. Changes in the reimbursement policies of the Medicare or Medicaid programs as a result of budget cuts by federal and state governments or other legislative and regulatory actions could have an adverse effect on our consolidated financial position, results of operations and cash flows.

Governmental payment programs are subject to statutory and regulatory changes, retroactive rate adjustments, administrative or executive orders and government funding restrictions, all of which may materially decrease the rate of government program payments to us for our services. Our financial condition and results of operations may be adversely affected by reductions in reimbursement levels and the reimbursement process in general, which in the healthcare industry is complex and can involve lengthy delays between the time that revenue is recognized and the time that reimbursement amounts are settled (see Revenue Sources *Reimbursement by Medicaid Programs* and *Reimbursement by Medicare).*

Our industry is heavily regulated by the government, which requires our compliance with a variety of laws.

The operation of our facilities and the services we provide are subject to periodic inspection by governmental authorities to ensure that we are complying with standards established for continued licensure under state law and certification for participation under the Medicare and Medicaid programs. Additionally, in certain states, certificates of need or other similar approvals are required for expansion of our operations. We

Table of Contents

could be adversely affected if we are unable to obtain these approvals, if the standards applicable to approvals or the interpretation of those standards change and by possible delays and expenses associated with obtaining approvals. Our failure to obtain, retain or renew any required regulatory approvals, licenses or certificates could prevent us from being reimbursed for certain of our services (see Government Regulation *Survey, Certification and Licensure*).

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

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

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

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

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

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

damage to our reputation in various markets.

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

cost reporting and billing practices;

Medicare hospice reimbursement caps;

quality of care;

average length of stay in hospice locations;

financial relationships with referral sources; and

proper documentation of medical necessity for services provided.

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

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

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

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

Table of Contents

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

Healthcare reform legislation may adversely affect our business.

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

We are subject to expensive and unpredictable general and professional liability costs.

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

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

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

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

Table of Contents

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

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

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

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

the purchase, construction or expansion of healthcare facilities, agencies or locations;

capital expenditures exceeding a prescribed amount; or

changes in services or bed capacity.

To the extent that we are required to obtain a CON or other similar approvals to expand our operations (either by acquiring facilities, agencies or locations or expanding or providing new services or other changes), our expansion could be adversely affected by our failure or inability to obtain the necessary approvals, changes in the standards applicable to those approvals, and possible delays and expenses associated with obtaining those approvals. We cannot assure you that we will be able to obtain CON approval for all future projects requiring this approval.

Our civil settlement agreement with the United States Government with respect to alleged violations of cost allocations under Medicare negatively impacts our cash flows and subjects us to a Corporate Integrity Agreement.

On February 3, 2000, we entered into a series of separate agreements with the OIG of HHS. Under the civil settlement agreement, we paid the federal government $25.0 million during the first quarter of 2000 and agreed to reimburse the federal government an additional $145.0 million through withholdings from our biweekly Medicare periodic interim payments. As of December 31, 2004, the present value of the remaining obligation was $48.8 million. As a result of such withholdings, our cash flows from operations were negatively impacted by $18.1 million in 2004, and are expected to be negatively impacted at an annual rate of $18.1 million, ending in the first quarter of 2008.

As part of this series of agreements, we entered into a Corporate Integrity Agreement with the OIG, which was subsequently revised in 2002 and 2004. This agreement requires that we monitor our activities, on an ongoing basis, to ensure our compliance with the requirements of participation in federal healthcare programs. It also includes functional and training obligations, audit and review requirements and record keeping and reporting requirements. The revisions were made to provide an independent quality monitor to all of our nursing facilities and to modify the requirements under the agreement with respect to training and education.

We believe that we are generally in compliance with the requirements of our Corporate Integrity Agreement and file annual reports with the OIG documenting our compliance. If we fail to comply with our Corporate Integrity Agreement, we may be subject to penalties or exclusion from the Medicare and Medicaid programs, which could have an adverse effect on our financial condition and results of operations.

Table of Contents

We are subject to material litigation.

We are, and may in the future be, subject to litigation which, if determined adversely against us, could have a material adverse effect on our business, financial condition, results of operations and cash flows (see Item 3).

If we fail to cultivate new, or maintain existing, relationships with the physicians or other referral sources in the communities in which we operate, our patient base may decrease.

Our Nursing Facilities and AseraCare patient bases depend in part upon the admissions and referral practices of the physicians in the communities in which we operate and our ability to cultivate and maintain relationships with these physicians or other referral sources. Physicians or other sources referring patients to us are not our employees and are free to refer their patients to other providers. If we are unable to successfully cultivate and maintain strong relationships with these physicians, our patient population may decline, which, if significant, could have an adverse effect on our financial condition and results of operations.

Changes in the acuity of the patients and the mix of our patient population among the Medicare, Medicaid and private categories may significantly affect our nursing facility revenues and profitability.

The sources and amounts of our nursing facility revenues are determined by a number of factors, including licensed bed capacity and census of our nursing facilities, average length of stay of our residents, the mix of our patients by payor type (for example, Medicare versus Medicaid or private) and the acuity level of our patients. Changes in the acuity of patients, the mix of patients by payor type and payment methodologies may significantly affect our profitability. In particular, changes which increase the percentage of Medicaid residents within our nursing facilities could have an adverse effect on our financial condition and results of operations due to Medicaid rates being generally lower than Medicare and private pay rates.

Certain trends in the healthcare industry are putting pressure on our ability to maintain nursing facility census.

Over the past decade, a number of trends have developed that impact our nursing facility census. These trends include:

overbuilding of nursing facilities in states that have eliminated the CON process for new construction;

creation of nursing facilities by acute-care hospitals to keep discharged patients within their complex;

rapid growth of assisted living centers, which sometimes are more attractive to less medically complex patients; and

the availability of eldercare services delivered to the home.

The negative impact of these trends on nursing facility census varies from facility to facility, from community to community and from state to state, and if we are not successful in responding to them, these trends could have an adverse effect on our Nursing Facilities segment.

Our executive officers and other key personnel are critical to our business, and if they choose to leave, it could harm our business.

The loss of the services of one or more of our executive officers or key employees, or the decision of one or more such officers or employees to join a competitor or otherwise compete directly or indirectly with us, could disrupt our business and could have an adverse effect on our financial condition and results of operations.

Table of Contents

A group including Arnold Whitman, the Chief Executive Officer of Formation Capital, LLC and Appaloosa Management, LP, a New Jersey based hedge fund, among others, has expressed an interest in purchasing all or a part of our Company. This interest could be disruptive to our business and could threaten to adversely affect our operations and results.

Our results of operations, financial condition and cash flows may be adversely impacted by the unsolicited indications of interest in an acquisition of us in January 2005, by a group including Arnold Whitman, the Chief Executive Officer of Formation Capital, LLC and Appaloosa Management, LP, a New Jersey based hedge fund, among others, and related actions taken by this group, including the nomination of candidates for election to our Board of Directors. These actions may materially impact our ability to attract and retain customers, management and employees and may result in the incurrence of significant advisory fees, litigation costs and other expenses. In addition, some of our key employees may seek other employment opportunities as a consequence of the uncertainty surrounding our future. Any such impact from the actions of the Whitman/Appaloosa group could have a material adverse effect on our business and results of operations. In addition, the actions of the Whitman/Appaloosa group may lead to a diversion on management s attention from other ongoing business concerns.

Provisions in our charter documents, under Delaware law, and in our stockholder rights plan could discourage a takeover that stockholders may consider favorable.

Our restated certificate of incorporation, as amended, and bylaws may discourage, delay or prevent a merger or acquisition that a stockholder may consider favorable because they:

authorize the issuance by the Board of Directors of preferred stock without the requirement of stockholder approval, which could make it more difficult for a third party to acquire a majority of our outstanding voting stock;

prohibit cumulative voting in the election of directors;

prohibit our stockholders from acting by written consent;

limit the persons who may call special meetings of stockholders;

establish advance notice requirements for nominations for election to the Board of Directors or for proposing matters to be approved by stockholders at stockholder meetings; and

require an 80% vote to approve certain business combinations with persons holding 10% or more of our common stock, unless certain conditions are met.

Delaware law may also discourage, delay or prevent someone from acquiring or merging with us. Under Delaware law, a corporation may not engage in a business combination with any holder of 15% or more of its capital stock until the holder has held the stock for three years unless, among other possibilities, the Board of Directors approves the transaction. Our Board of Directors will not approve takeovers that are not reasonably believed to be in the best interest of the stockholders, and therefore, certain acquisitions may be prevented or delayed.

As permitted by our charter, our Board of Directors approved a Rights Plan on January 25, 2005, which awards one one-thousandth of a preferred share purchase right for each share of our common stock. These rights are triggered in the event that any individual or entity acquires 10% or more of our outstanding common stock without the approval of our Board of directors. These purchase rights will cause substantial dilution to any person or group that attempts to acquire us without obtaining the approval of the Board of Directors.

These provisions could discourage potential acquisition proposals and could delay or prevent a change of control transaction. As a result, they may limit the price investors may be willing to pay for our stock in the future.

Table of Contents

Available Information

Our website, *www.beverlycorp.com,* provides access, free of charge, to our SEC reports, including our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and amendments to these reports, as soon as reasonably practicable. In addition, our corporate governance guidelines, code of conduct, code of ethics for senior financial officers, and charters for each key committee of the Board of Directors will be available on this website and in print to any stockholder who requests them.

You may read and copy any materials we file with the SEC at the SEC s Public Reference Room at 450 Fifth Street, NW, Washington, DC 20549. You may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. The SEC maintains a website that contains reports, proxy and information statements, and other information regarding issuers that file electronically with the SEC, including us, at *http: //www.sec.gov.*

Table of Contents

ITEM 2. PROPERTIES.

On December 31, 2004, we operated 351 nursing facilities, 18 assisted living centers, 52 hospice and home health locations and 10 outpatient clinics in 25 states and the District of Columbia. As of December 31, 2004, we had 27 nursing facilities (2,572 beds) and 10 outpatient clinics classified as held for sale (see Item 8. Note 15 regarding the sale of the 10 outpatient clinics in February 2005). Most of our 87 leased nursing facilities are subject to net leases which require us to pay all taxes, insurance and maintenance costs. Most of these leases have original terms from ten to fifteen years and contain at least one renewal option. Renewal options typically extend the original terms of the leases by five to fifteen years. Many of these leases also contain purchase options. We consider our physical properties to be in good operating condition and suitable for the purposes for which they are being used. Certain of our nursing facilities and assisted living centers are included in the collateral securing our obligations under various debt agreements (see Item 8. Note 9).

The following is a summary of our nursing facilities, assisted living centers, hospice and home health locations and outpatient clinics at December 31, 2004:

	Nursing Facilities		Assisted Living Centers			
Location	Number	Total Licensed Beds	Number	Total Units	Hospice and Home Health Locations	Outpatient Clinics
Alabama	14	1,692			11	
Arkansas	19	2,270	1	16		
California	24	2,306			2	
District of Columbia	1	355				
Georgia	13	1,595	2	72	1	
Illinois	3	275				
Indiana	26	3,064			1	
Iowa					1	
Kansas	19	1,175				
Kentucky	8	1,039				
Maryland	4	585	1	19		
Massachusetts	18	2,048			1	
Minnesota	28	2,324	1	16		
Mississippi	10	1,148			7	
Missouri	18	1,723	3	109	2	
Nebraska	24	2,037	1	16	4	
New Jersey	1	140				
North Carolina	10	1,278			1	10
Ohio	9	1,252				
Pennsylvania	41	4,659	3	72	9	
South Dakota	17	1,165	1	36		
Tennessee	5	555	2	55	5	
Texas					4	
Virginia	13	1,720	3	84		
West Virginia	3	310				

Wisconsin	23	2,280			3	
	351	36,995	18	495	52	10
Classification						
Owned	264	27,448	17	426		
Leased	87	9,547	1	69	52	10
	351	36,995	18	495	52	10

Table of Contents

ITEM 3. LEGAL PROCEEDINGS.

(a) On January 26, 2005, a putative class action complaint brought on behalf of all shareholders of the Company was filed against the Company and each of its directors in the Delaware Chancery Court in New Castle County. The complaint, captioned *Chaya Perlstein v. William R. Floyd, et. al*., Civil Action No. CA1050-N, asserts a claim for breach of fiduciary duty in connection with our response to an unsolicited expression of interest by a group of investors that collectively had purchased 8.1% of our common stock on the open market prior to January 24, 2005. A second, substantially identical, putative class action complaint was filed in the same court on February 1, 2005, bearing the caption *Robert Strougo v. Beverly Enterprises, Inc., et. al*., Civil Action No. CA1067-N. On February 23, 2005, the Delaware Chancery Court consolidated these cases under the caption *In re Beverly Shareholders Litigation,* Civil Action No. CA1050-N, and designated the *Floyd* complaint as operative. In addition, the Chancery Court extended the defendants time to respond to the operative complaint to May 9, 2005. The plaintiffs seek preliminary and permanent injunctive relief, an unspecified amount of compensatory damages, an accounting, as well as an award of attorneys fees, expert fees, and costs. Due to the preliminary state of these actions, we are unable to assess the probable outcome and can give no assurance of the ultimate impact on our financial position, results of operations and cash flows.

(b) As previously reported, on October 31, 2002, a shareholder derivative action entitled *Paul Dunne and Helene Dunne, derivatively on behalf of nominal defendant Beverly Enterprises, Inc. v. Beryl F. Anthony, Jr., et. al.* was filed in the Circuit Court of Sebastian County, Arkansas, Fort Smith Division (No. CIV-2002-1241). This case was purportedly brought derivatively on our behalf against various current and former officers and directors. The complaint alleges causes of action for breach of fiduciary duty against the defendants based on: (1) allegations that defendants failed to establish and maintain adequate accounting controls such that we failed to record adequate reserves for general and professional liability costs; and (2) allegations that certain defendants sold Company stock while purportedly in possession of material non-public information. On May 16, 2003, two additional derivative complaints (*Holcombe v. Floyd, et. al. and Flowers v. Floyd, et. al.*) were filed and subsequently transferred to the Circuit Court of Sebastian County, Arkansas, Fort Smith Division and consolidated with the Dunne action as *Holcomb v. Beverly Enterprises, Inc.* The Dunnes were subsequently dismissed as plaintiffs. On November 19, 2004, Beverly moved to dismiss these actions on the grounds that the plaintiffs failed to make a pre-suit demand upon Beverly s Board of Directors and did not show that the failure to make such demand was excused as futile. The other defendants also moved to dismiss the actions for failure to state a claim upon which relief can be granted. Plaintiffs have opposed both motions. The court has scheduled oral argument on the motions to dismiss for June 17, 2005. Due to the preliminary state of this action, we are unable to assess the probable outcome of the case and can give no assurance of the ultimate impact on our financial position, results of operations and cash flows.

(c) In 2002, we notified federal and California healthcare regulatory authorities (CMS, OIG, the California Attorney General s office and the California Department of Health) of our intent to conduct an internal investigation of past billing practices relating to MK Medical, our former medical equipment business unit based in Fresno, California. An independent accounting firm has reviewed MK Medical s government payor billings since October 1, 1998, the date Beverly acquired the business unit. Deficiencies identified by the accounting firm primarily relate to inadequate documentation supporting Medicare and Medi-Cal claims for reimbursement for drugs, wheelchairs, and other durable medical equipment distributed by MK Medical. Specifically, the review identified instances of missing or incomplete certificates of medical necessity, treatment authorization requests, prescriptions and other documentation MK Medical is required to maintain in order to be entitled to reimbursement from government payors. Based on the results of the accounting firm s review, we established a reserve in 2002, included in Other accrued liabilities on the consolidated balance sheets in the amount of $18.0 million to cover potential overpayments from government payors for the period from October 1, 1998 to 2002. We have advised regulatory authorities of the results of the accounting firm s review. On September 15, 2003, we received a subpoena from the United States Attorney s Office in Oakland, California, requesting the production of additional documents relating to MK Medical s operations and our review of MK Medical s claims. We have produced documents in response to this subpoena and continue to cooperate with the government s request for information. Our liability with respect to this matter could exceed the reserved amount,

which continues to be the best estimate of our exposure in this matter. We are actively

Table of Contents

cooperating with the government in this matter and expect to fund or resolve this liability within 12 months. We can give no assurance of the final outcome of this matter or its impact on our financial position, results of operations and cash flows.

(d) We are a party to various legal matters relating to patient care, including claims that our services have resulted in injury or death to residents of our facilities. Over the past few years, we have experienced an increasing trend in the number and severity of the claims asserted against us. We believe that there has been, and will continue to be, an increase in governmental investigations of long-term care providers. Adverse determinations in legal proceedings or governmental investigations, whether currently asserted or arising in the future, could have a material adverse effect on us.

(e) There are various other lawsuits and regulatory actions pending against us arising in the normal course of business, some of which seek punitive damages that are generally not covered by insurance. We do not believe that the ultimate resolution of such other matters will have a material adverse effect on our consolidated financial position, results of operations or cash flows.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS.

There were no matters submitted to a vote of our security holders during the last quarter of our fiscal year ended December 31, 2004.

Table of Contents

PART II

ITEM 5. MARKET FOR THE COMPANY S COMMON EQUITY AND RELATED STOCKHOLDER MATTERS.

Our common stock is listed on the New York Stock Exchange and the Pacific Exchange under the symbol BEV. The table below sets forth, for the periods indicated, the range of high and low sales prices of our common stock as reported on the New York Stock Exchange composite tape.

	Prices	
	High	Low
2003		
First Quarter	$ 3.00	$ 1.63
Second Quarter	4.30	1.80
Third Quarter	6.99	3.71
Fourth Quarter	8.60	5.06
2004		
First Quarter	$ 8.96	$ 5.84
Second Quarter	8.92	5.83
Third Quarter	8.70	6.78
Fourth Quarter	9.41	7.49
2005		
First Quarter (through March 7)	$ 12.32	$ 8.33

On March 7, 2005, there were 4,838 record holders of our common stock.

We are subject to certain restrictions under our long-term debt agreements related to the payment of cash dividends on our common stock. We have not paid any cash dividends on our common stock since 1987, and no future cash dividends are currently planned. In deciding whether to propose a cash dividend and determining the dividend amount, our Board of Directors would take into account such matters as the availability of funds for dividends, general business conditions, our financial results, other capital requirements, contractual, legal and regulatory restrictions on the payment of cash dividends to our stockholders and such other factors as our Board of Directors may deem relevant (see Item 7. Liquidity and Capital Resources).

During 2004 and 2003, we did not purchase any of our common stock. We did not make any unregistered sales of equity securities during 2004.

Table of Contents

ITEM 6. SELECTED FINANCIAL DATA.

The following table of selected financial data should be read along with our consolidated financial statements and related notes for 2004, 2003 and 2002 included in Item 8. Consolidated Financial Statements and Supplementary Data.

	At or For the Years Ended December 31,				
	2004(1)	**2003(1)**	**2002(1)**	**2001(1)**	**2000(1)**
	(Dollars in thousands, except per share data)				
Consolidated Statement of Operations Data:					
Revenues	$ 1,988,852	$ 1,802,026	$ 1,766,726	$ 1,953,084	$ 1,908,173
Costs and expenses:					
Wages and related	1,147,743	1,078,548	1,068,629	1,203,932	1,188,908
Provision for insurance and related items	127,653	109,377	84,161	75,385	102,237
Other operating and administrative	522,603	462,144	458,311	503,951	542,539
Depreciation and amortization	62,166	58,807	62,906	63,549	70,667
Florida insurance reserve adjustment			22,179		
Special charge and adjustment related to California investigation settlement		(925)	6,300		
Special charge and adjustments related to settlements of federal government investigations			(9,441)	77,495	
Asset impairments, workforce reductions and other unusual items	448	3,825	46,287	180,000	16,895
Total costs and expenses	1,860,613	1,711,776	1,739,332	2,104,312	1,921,246
Income (loss) before other income (expenses)	128,239	90,250	27,394	(151,228)	(13,073)
Other income (expenses):					
Interest expense	(45,637)	(63,314)	(62,652)	(74,447)	(75,119)
Costs related to early extinguishments of debt	(40,935)	(6,634)			(354)
Interest income	5,485	5,363	4,688	2,911	2,485
Net gains on dispositions	396	422	2,142	988	2,433
Gains on sales of equity investments		6,686		256	1,477
Total other expenses, net	(80,691)	(57,477)	(55,822)	(70,292)	(69,078)
Income (loss) before provision for income taxes, discontinued	47,548	32,773	(28,428)	(221,520)	(82,151)

operations and cumulative effect of change in accounting for goodwill					
Provision for (benefit from) income taxes	4,890	5,069	6,085	60,432	(25,791)
Income (loss) before discontinued operations and cumulative effect of change in accounting for goodwill	42,658	27,704	(34,513)	(281,952)	(56,360)
Discontinued operations, net of taxes of 2004 $55; 2003 $3,378; 2002 $0; 2001 $956; and 2000 $3,529	(14,637)	52,764	(34,406)	(19,320)	1,858
Cumulative effect of change in accounting for goodwill, net of income taxes of $0(2)			(77,171)		
Net income (loss)	$ 28,021	$ 80,468	$ (146,090)	$ (301,272)	$ (54,502)
Net income (loss) per share of common stock:					
Basic:					
Before discontinued operations and cumulative effect of change in accounting for goodwill	$ 0.40	$ 0.26	$ (0.33)	$ (2.71)	$ (0.55)
Discontinued operations, net of taxes	(0.14)	0.49	(0.32)	(0.19)	0.02
Cumulative effect of change in accounting for goodwill, net of taxes			(0.74)		
Net income (loss) per share of common stock	$ 0.26	$ 0.75	$ (1.39)	$ (2.90)	$ (0.53)
Shares used to compute per share amounts	107,749	106,582	104,726	104,037	102,452
Diluted:(3)					
Before discontinued operations and cumulative effect of change in accounting for goodwill	$ 0.37	$ 0.26	$ (0.33)	$ (2.71)	$ (0.55)
Discontinued operations, net of taxes	(0.12)	0.48	(0.32)	(0.19)	0.02
Cumulative effect of change in accounting for goodwill, net of taxes			(0.74)		
	$ 0.25	$ 0.74	$ (1.39)	$ (2.90)	$ (0.53)

Net income (loss) per share of common stock					
Shares used to compute per share amounts	124,334	109,922	104,726	104,037	102,452

Table of Contents

	At or For the Years Ended December 31,				
	2004(1)	2003(1)	2002(1)	2001(1)	2000(1)
	(Dollars in thousands, except per share data)				
Other Financial Data:					
Cash flows from operations	$ 75,660	$ 69,861	$ 116,633	$ 220,897	$ 37,010
EBITDA(4)	190,801	156,165	92,442	(86,435)	61,504
EBITDA Margin %(4)	9.59%	8.67%	5.23%	(4.43)%	3.22%
Capital expenditures	62,718	43,984	100,103	89,401	76,027
Consolidated Balance Sheet Data:					
Total assets	$ 1,361,385	$ 1,346,421	$ 1,349,895	$ 1,681,070	$ 1,875,993
Current portion of long-term debt	12,240	13,354	41,463	64,231	227,111
Long-term debt, excluding current portion	545,943	552,873	588,714	677,442	564,247
Total stockholders equity	272,413	238,186	153,472	296,497	583,993
Other Data:					
Average occupancy(5)	88.9%	88.2%	88.2%	86.6%	86.5%

(1) The operations of Matrix, MK Medical, Care Focus, 125 nursing facilities and eight assisted living centers have been reclassified as discontinued operations for all periods presented, including 27 nursing facilities and 10 outpatient clinics classified as held for sale during the year ended December 31, 2004, since they met the applicable criteria under Statement of Financial Accounting Standards No. 144, *Accounting for the Impairment or Disposal of Long-Lived Assets (see Item 8 Note 6).*

(2) Includes a $77.2 million goodwill impairment charge relating to the 2002 adoption of Statement of Financial Accounting Standards No. 142, *Goodwill and Other Intangible Assets*.

(3) Assumes the conversion of our 2.75% convertible subordinated notes since their issuance in October 2003, on an if-converted basis, in accordance with Emerging Issues Task Force Issue No. 04-8, *The Effect of Contingently Convertible Debt on Diluted Earnings per Share* (see Item 8. Note 1 *Earnings Per Share*).

(4) We define EBITDA as earnings from continuing operations before interest expense (including costs related to early extinguishments of debt), interest income, income taxes, depreciation and amortization. EBITDA margin is EBITDA as a percentage of revenues. EBITDA is commonly used by our lenders and investors to assess our leverage capacity, debt service ability and liquidity, and we use EBITDA to evaluate financial performance and to design incentive compensation for management. EBITDA is not considered a measure of financial performance under U.S. generally accepted accounting principles (GAAP), and the items excluded from EBITDA are significant components in understanding and assessing our financial performance. EBITDA should not be considered as an alternative to net income, cash flows provided by or used in operating, investing or financing activities or other financial statement data presented in our consolidated financial statements as an indicator of financial performance or liquidity. Since EBITDA is not a measure determined in accordance with GAAP and is thus susceptible to varying calculations, EBITDA, as presented, may not be comparable to other similarly titled measures of other companies.

EBITDA has limitations as an analytical tool, and you should not consider it in isolation or as a substitute for analysis of our results as reported under GAAP. Some of these limitations are:

EBITDA does not reflect our cash expenditures, or future requirements, for capital expenditures or contractual commitments;

EBITDA does not reflect changes in, or cash requirements for, our working capital needs;

EBITDA does not reflect interest expense, or the cash requirements necessary to service interest or principal payments, on our debt; and

although depreciation and amortization are non-cash charges, the assets being depreciated and amortized will often have to be replaced in the future, and EBITDA does not reflect any cash requirements for such replacements.

Because of these limitations, EBITDA should not be considered as a measure of discretionary cash available to us to invest in the growth of our business. We compensate for these limitations by relying primarily on our GAAP results and using EBITDA only supplementally. See our Consolidated Statements of Cash Flows included in Item 8. The following table provides a reconciliation from our pre-tax income (loss) from continuing operations, which is the most directly comparable financial measure presented in accordance with GAAP for the periods indicated (in thousands):

	2004	2003	2002	2001	2000
Income (loss) before provision for income taxes, discontinued operations and cumulative effect of change in accounting for goodwill	$ 47,548	$ 32,773	$ (28,428)	$ (221,520)	$ (82,151)
Plus:					
Depreciation and amortization	62,166	58,807	62,906	63,549	70,667
Interest expense(a)	86,572	69,948	62,652	74,447	75,473
Minus:					
Interest income	5,485	5,363	4,688	2,911	2,485
EBITDA	$ 190,801	$ 156,165	$ 92,442	$ (86,435)	$ 61,504

(a) Includes $40.9 million, $6.6 million and $354,000, respectively, for the years ended December 31, 2004, 2003 and 2000 of costs related to the early extinguishments of debt.

(5) Calculated by dividing the nursing facilities actual patient days by available patient days from continuing operations. Available patient days are calculated by multiplying total calendar days by the number of beds that are operationally ready for use.

Table of Contents

ITEM 7. MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS.

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

Overview

We are a much stronger company than we were just a few years ago with better operating units, a solid financial position, and a more disciplined culture. On any given day, we have 34,000 dedicated associates providing high quality care and generating annual revenues totaling approximately $2 billion. In just a few years we have made dramatic progress in transforming us into a leading provider of eldercare services. Just for example, since the end of 2000 we have:

decreased our balance sheet debt from $791 million to less than $560 million;

eliminated off-balance sheet debt of $184 million;

increased our cash balance from $26 million to $216 million; and

cut our Nursing Facilities patient receivables by 64% to $179 million and less than 35 days sales outstanding; and

substantially completed the divestiture program begun in 2001.

In 2004, we successfully delivered the profitable growth we had expected, through strong performance by all three of our principal business segments. Our EBITDA for the year ended December 31, 2004 was $190.8 million exceeding the high end of our guidance for 2004 by $5.8 million. For purposes of generally accepted accounting principles (GAAP), EBITDA is most directly comparable to pre-tax income from continuing operations of $47.5 million (see Item 6 for a reconciliation of EBITDA to pre-tax income from continuing operations and a definition of, and discussion of why we use EBITDA). We reported diluted earnings per share from continuing operations of 37 cents, a 42% increase from 2003, despite a $40.9 million refinancing charge and an increase in the shares used to compute diluted earnings per share of approximately 14.4 million, primarily due to the effect of our 2.75% convertible subordinated notes.

A key to our success was the focused execution of our strategic plan by our seasoned leadership team. Critical measures of our 2004 success in terms of our four core strategies are as follows:

Strengthen and grow our Nursing Facilities segment

6.8% revenue growth;

45.9% pre-tax income growth; and

divested 18 non-strategic facilities, substantially completing our divestiture strategy.

Table of Contents

Accelerate the growth of our service businesses

61.4% revenue growth, including:

58.2% from Aegis and

67.5% from AseraCare;

75 new Aegis customers, net;

70% growth in hospice average daily census; and

30 new hospice locations (including the acquisition of Hospice USA).

Lead innovation in eldercare

completed construction on 29 Alzeheimer s units; and

Aegis Freedom Through Functionality program added in 33 locations.

Continually re-engineer our Company

$17.7 million or 27.9% drop in interest expense; and

new technologies implemented to improve the documentation of resident care and to effectively manage labor costs at the local level (resulting in a weighted average wage rate increase of 3.7%).

Revenues consistently grew quarter over quarter during 2004. We generated a 45% increase in pre-tax income from continuing operations on a 10% increase in revenues (dollars in millions):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total
Revenues:					
2004	$ 481	$ 488	$ 503	$ 517	$ 1,989
2003	$ 433	$ 442	$ 457	$ 470	$ 1,802
% change	*11%*	*10%*	*10%*	*10%*	*10%*
Pre-tax income (loss) from continuing operations:					
2004	$ 23	$ (14)	$ 22	$ 17	$ 48
2003	$ 4	$ 7	$ 10	$ 12	$ 33
% change	*475%*		*120%*	*42%*	*45%*

As further discussed in *Results of Operations Continuing Operations*, we strategically incurred $40.9 million of costs related to the refinancing of high-cost debt, primarily during the second quarter of 2004. We believe it was the right thing to do because it improved our capital structure by:

increasing the maturities on 36% of our long-term debt by more than five years;

providing greater covenant flexibility;

lowering our interest rate 175 basis points on that layer of debt; and

providing additional financing capacity and flexibility by refinancing with subordinated debt.

Our solid operating and financial performance was further demonstrated by our increase in cash flows from operations to $75.7 million in 2004, from $69.9 million in 2003. Our 2004 cash flows from operations were negatively impacted by approximately $82 million due to the reconsolidation of Beverly Funding Corporation (BFC). BFC was reconsolidated in the second quarter of 2004, as a result of the repayment of its outstanding obligations (see Item 8 Note 1 *Transfers of Financial Assets*). Excluding this one-time impact, our cash flows from operations would have been approximately $157.7 million for 2004, a 126% increase over 2003. Our significant cash generation during 2004

enabled us to strategically invest $62.7 million in capital expenditures and $71.4 million for acquisitions.

Table of Contents

We expect that our momentum in 2004, together with diligent and focused attention to our strategic plan, will drive further profitable growth in 2005 and beyond.

Critical Accounting Policies

The accompanying consolidated financial statements have been prepared in conformity with U.S. generally accepted accounting principles (GAAP). The accounting policies detailed below are considered by management to be critical to an understanding of our financial statements, and are discussed annually with the Audit and Compliance Committee of our Board of Directors, because their application requires significant judgment and reliance on estimations of matters that are inherently uncertain. Certain risks related to these critical accounting policies are described in the following paragraphs.

Revenue Recognition, Accounts Receivable and Allowance for Doubtful Accounts

Our revenues are derived primarily from providing long-term healthcare services. Approximately 80% of our current revenues is derived from federal and state healthcare programs (primarily Medicare and Medicaid). All providers participating in the Medicare and Medicaid programs are required to meet certain financial cost reporting requirements. Federal and state regulations generally require the submission of annual cost reports covering revenues, costs and expenses associated with the services provided to Medicare beneficiaries and Medicaid recipients. Annual cost reports are subject to routine audits and retroactive adjustments. These audits often require several years to reach the final determination of amounts due to, or by, us under these programs.

Compliance with laws and regulations governing the Medicare and Medicaid programs is subject to government review and interpretation, as well as significant regulatory action including fines, penalties, and possible exclusion from the Medicare and Medicaid programs. In addition, under the Medicare program, if the federal government makes a formal demand for reimbursement, even related to contested items, payment must be made for those items before the provider is given an opportunity to appeal and resolve the issue.

Revenue Assumptions and Approach Used. As discussed more fully in Item 8 Note 1, we record revenues when services are provided at standard charges, adjusted to amounts estimated to be received under governmental programs or other third-party contractual arrangements based on contractual terms and historical experience. On an annual basis, state Medicaid programs may adjust their plan reimbursement rates in accordance with state specific guidelines and calculations. In addition, our reimbursement rates are adjusted based on information we file in annual cost reports to each state. Using these state plans, and filed cost report data, we estimate rate adjustments and record revised per diem rates beginning in the period the rate adjustment would apply according to state plans.

As adjustments to recorded revenues become known or as cost reporting years are no longer subject to audits, reviews or investigations, the amounts of our revenues and receivables are revised. Our revenues are reported at their estimated net realizable amounts, and we believe adequate provision has been made to reflect any adjustments that could result from audits of cost reports. However, due to the complexity of the laws and regulations governing the Medicare and Medicaid programs, there is at least a possibility that recorded estimates will change by a material amount in the near term. Changes in estimates related to third-party receivables due to retroactive rate adjustments and cost report settlements resulted in an increase in revenues from continuing operations of approximately $8.0 million, $8.7 million and $948,000 for the years ended December 31, 2004, 2003 and 2002, respectively.

Allowance Assumptions and Approach Used. We record bad debt expense monthly as a percentage of revenue reflecting our historical experience. Each quarter we adjust the allowance for doubtful accounts according to the aging and payor mix of the receivables. These adjustments are based on our weighted average collection experience by payor type, and recognize the relative risk depending on the source of the expected payment. Private pay accounts usually represent our highest collectibility risk. In addition, specific accounts that are determined to be uncollectible (due to bankruptcy, insufficient documentation, lack of third-party coverage or financial resources and the like) are fully reserved when such determinations are made. We write off uncollectible accounts receivable after all collection efforts have been exhausted and we determine they

Table of Contents

will not be collected. If circumstances change (including, but not limited to: economic downturn; higher than expected defaults or denials; reduced collections; and changes in our payor mix), our estimates of the recoverability of our receivables could be reduced by a material amount. For our Nursing Facilities segment, the aging of our receivables has improved over the past three years and our cash collections continue to be in line with, or ahead of, our generated revenues. These factors have led to a decrease in our total provision for bad debts and a reduction in our total allowance for doubtful accounts.

The following table provides an analysis of our allowance and provision for doubtful accounts (from continuing and discontinued operations) at or for the years ended December 31 (dollars in thousands):

	2004	2003	2002
Allowance for doubtful accounts	$ 26,320	$ 31,615	$ 44,536
As a % of accounts receivable	10.1%	16.1%	20.2%
As a % of accounts over 180 days old	190.5%	119.6%	115.5%
Provision for doubtful accounts	$ 8,898	$ 22,743	$ 54,558
As a % of revenues	0.4%	1.3%	3.1%

Sensitivity Analysis. We believe adequate provision has been made for receivables that may prove to be uncollectible. During 2004, our Nursing Facilities segment weighted average collection experience improved 21 basis points when compared to 2003. As a result of the improved collection rates, we reduced our recorded allowance for doubtful accounts by approximately $4.0 million. However, changes in collection rates or payment patterns could affect the assumptions used to estimate the current level of allowance for doubtful accounts. If our collection rates increase or decrease by ten basis points, the impact on pre-tax income from continuing operations on the consolidated statement of operations would be approximately $2.0 million.

General and Professional Liabilities and Other Insurance Risks

General and professional liability costs for the long-term healthcare industry have become expensive and difficult to estimate. In addition, insurance coverage for general and professional liability and certain other risks, for nursing facilities specifically and companies in general, has become increasingly difficult to obtain. When obtained, insurance carriers are often requiring companies to significantly increase their liability retention levels and pay substantially higher premiums for reduced terms of coverage. The majority of our workers compensation and auto liability risks are insured through loss-sensitive insurance policies with affiliated and unaffiliated insurance companies.

For our general and professional liabilities, we are responsible for the first dollar of each claim, up to a self-insurance limit determined by the individual policies, subject to aggregate limits in certain prior policy years, and accrue liabilities for claims when they are probable and can be reasonably estimated. We evaluate our purchased insurance coverage for risk transfer and we exercise care in selecting companies from which we purchase insurance, including review of published ratings by recognized rating agencies, advice from national brokers and consultants and review of trade information sources. There exists a risk that any of these insurance companies may become insolvent and unable to fulfill their obligation to defend, pay or reimburse us when that obligation becomes due. In several prior policy years, losses exceed our self-insurance aggregate limits. For claims relating to these years, our insurers have assumed their obligations for defense and payment of covered claims, and we expect them to continue to meet these obligations. Although we believe the companies we have purchased insurance from are solvent, in light of the dramatic changes occurring in the insurance industry in recent years, we cannot assure you that they will remain solvent and able to fulfill their obligations.

Assumptions and Approach Used. Our outstanding liabilities for general and professional liability risks and workers compensation risks are estimated by our independent actuaries twice a year using the most recent historical trends of data, including frequency and severity of claims, settlements and other relevant data. On an undiscounted basis, these liabilities totaled $209.8 million at December 31, 2004. On our financial statements, these liabilities are discounted at 8.5% to their present value using actuarially determined loss payment timing patterns. The discount rate

is based upon our best estimate of the incremental borrowing rate that would be required to fund these liabilities with incremental uncollateralized debt. We continually evaluate the discount

Table of Contents

rate utilized to measure our outstanding insurance liabilities. Due to changes in our capital structure and the overall interest rate environment, we decreased our discount rate from 10% to 8.5% and recorded a pre-tax charge of $6.0 million on these liabilities during the fourth quarter of 2004.

Sensitivity Analysis. A reduction in the discount rate by one-half of a percentage point would have resulted in an additional pre-tax charge of $1.9 million for the year ended December 31, 2004. Based on information provided by our independent actuaries, we estimate our range of discounted exposure for these liabilities to be $163.8 million to $189.7 million. At December 31, 2004, our recorded reserves for these liabilities totaled $172.7 million. We believe adequate provision has been made in the financial statements for liabilities that may arise out of patient care and other services.

Tax Valuation Allowance

In 2001, based upon our operating results in previous years, our reported cumulative losses, and the inherent uncertainty associated with the realization of future income, we provided a full valuation allowance on our net deferred tax assets. During 2004 and 2003, our valuation allowance decreased by $10.8 million and $30.1 million, respectively, primarily due to the reversal of temporary differences and the utilization of net operating loss carryforwards, partially offset by increases in general business tax credits and state tax credits. During 2004, the decrease in the valuation allowance was further offset by the generation of alternative minimum tax credits. During 2002, our valuation allowance increased by $45.5 million primarily due to the generation of net operating loss carryforwards and increases in general business tax credits and state tax credits, partially offset by the reversal of temporary differences.

Assumptions and Approach Used. We assess the need for, and amount of, a valuation allowance for deferred tax assets in accordance with Statement of Financial Accounting Standards No. 109, *Accounting for Income Taxes* (SFAS No. 109). A valuation allowance is required when it is more likely than not that all, or a portion, of a deferred tax asset will not be realized. Realization of deferred tax assets ultimately depends on the existence of sufficient taxable income, which may be derived from future reversals of existing temporary differences, taxable income in prior carryback years, tax planning strategies or future taxable income, exclusive of reversing temporary differences and carryforwards. We believe a significant cumulative pre-tax loss for the current and two preceding years is significant evidence to warrant a full valuation allowance on our net deferred tax assets.

Sensitivity Analysis. Currently we have a $158.3 million valuation allowance on our net deferred tax assets and any change in net deferred tax assets resulting from the reversal of existing temporary differences, the origination of future temporary differences, and the utilization/ generation of net operating losses is being applied against the valuation allowance, and, therefore, does not affect the provision for income taxes. All available evidence has been, and will continue to be, considered at least quarterly in assessing the need to maintain a full valuation allowance.

We expect to maintain a valuation allowance on our net deferred tax assets until an appropriate level of profitability is sustained for the current and two preceding years, or we are able to develop and implement tax strategies enabling us to conclude it is more likely than not that our net deferred tax assets will be realized.

Asset Impairments

Long-Lived Assets. We recorded pre-tax asset impairment charges from continuing operations of $3.5 million, $2.1 million and $41.4 million for the years ended December 31, 2004, 2003 and 2002, respectively. We evaluate our long-lived assets for impairment whenever indicators of impairment exist, in accordance with Statement of Financial Accounting Standards No. 144, *Accounting for the Impairment or Disposal of Long-Lived Assets* (SFAS No. 144). These indicators of impairment can include, but are not limited to, the following:

a history of operating losses, with expected future losses;

changes in the regulatory environment affecting reimbursement;

Table of Contents

decreases in cash flows or cash flow deficiencies;

changes in the way an asset is used in the business; and

commitment to a plan to sell or otherwise dispose of an asset.

SFAS No. 144 Assumptions and Approach Used. A history of operating losses, with expected future losses, and cash flow deficiencies led to impairments in our Nursing Facilities segment on seven facilities in 2004 and three facilities in 2003. During 2002, changes in the regulatory environment affecting Medicare reimbursement led to a long-lived asset impairment analysis on each facility within our Nursing Facilities segment.

These impairment analyses included:

estimating the undiscounted cash flows to be generated by each facility or property, primarily over the remaining life of the primary asset; and

reducing the carrying value of the asset to the estimated fair value when the total estimated undiscounted cash flows was less than the carrying value of the facility or property.

In order to estimate the fair values of the nursing facilities, we used a discounted cash flow approach, supplemented by public resource information on valuations of nursing facility sales transactions by region of the country. Where the estimated undiscounted cash flows were negative, we estimated the fair values based on discounted public resource information, sales values or estimated salvage values.

SFAS No. 144 Sensitivity Analysis. In estimating the undiscounted cash flows for our nursing facilities, we primarily used our internally prepared budgets and forecast information, with certain probability adjustments, including, but not limited to, the following items: Medicare and Medicaid funding; overhead costs; capital expenditures; and general and professional liability costs. A change in the estimated future cash flows could change our estimated fair values resulting in additional impairments.

Indefinite-Lived Intangible Assets. We also recorded impairments of goodwill of $77.2 million in 2002 as the cumulative effect of an accounting change in accordance with Statement of Financial Accounting Standards No. 142, *Goodwill and Other Intangible Assets* (SFAS No. 142). In July 2001, SFAS No. 142 was issued, which established new rules on the accounting for goodwill and other intangible assets.

SFAS No. 142 Assumptions and Approach Used. In accordance with this standard, we performed the initial screening for potential impairments of our indefinite-lived intangible assets by reporting unit as of January 1, 2002. We determined the estimated fair values of each reporting unit using discounted cash flow analyses, along with independent source data related to recent transactions. Based on this determination, we identified potential goodwill impairments at our former Matrix segment and at Care Focus, a former reporting unit within our AseraCare segment. The fair values of the reporting units were derived from a five-year projection of revenues and expenses plus residual value, with the resulting projected cash flows discounted at an appropriate weighted average cost of capital. The analysis was completed in the fourth quarter of 2002, and led to the recording of goodwill impairment charges as the cumulative effect of an accounting change of $77.2 million as of January 1, 2002, including $70.6 million for Matrix and $6.6 million for Care Focus. The outpatient therapy clinic operations and the managed care network of Matrix were sold during January 2003. The Care Focus unit was sold in June 2003. We perform assessments of goodwill for all reporting units on an annual basis during the fourth quarter. Based on these analyses, there have been no additional impairments of goodwill since 2002.

SFAS No. 142 Sensitivity Analysis. Our estimated future cash flows by reporting unit would have to decline by nearly 50% to result in additional impairments of goodwill and other intangible assets.

Off-Balance Sheet Arrangements

On June 15, 2004, $70.0 million of off-balance sheet medium-term notes (Medium-Term Notes) were repaid. These notes were obligations of Beverly Funding Corporation (BFC), a bankruptcy remote, qualifying special purpose entity, which was not consolidated with us prior to the repayment of the notes. Upon

Table of Contents

repayment of the Medium-Term Notes, BFC no longer had third-party beneficial owners and no longer met the conditions of a qualifying special purpose entity. Therefore, during the second quarter of 2004, BFC was reconsolidated with us (see Item 8. Note 1 *Transfer of Financial Assets*).

As of December 31, 2004, we were contingently liable for approximately $11.8 million of long-term debt maturing on various dates through 2019, as well as annual interest on that debt. These contingent liabilities principally arose from previous sales of nursing facilities. We also guarantee certain third-party operating leases. Those guarantees arose from our dispositions of leased facilities and, as of December 31, 2004, the underlying leases have $54.8 million of minimum rental commitments remaining through the initial lease terms. In accordance with the FASB s Interpretation No. 45, *Guarantor s Accounting and Disclosure Requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others*, we have recorded approximately $627,000, included in Other accrued liabilities on the consolidated balance sheet at December 31, 2004, as the estimated fair value of our guarantees initiated in 2003 and 2004.

Operating Results

General

Our business consists principally of providing healthcare services, including the operation of nursing facilities, assisted living centers, hospice and home health locations and rehabilitation therapy services. We are one of the largest operators of nursing facilities in the United States. As of December 31, 2004, we operated 351 nursing facilities (36,995 licensed beds) that range in capacity from 34 to 355 licensed beds. As of December 31, 2004, we also operated 18 assisted living centers containing 495 units, 52 hospice and home health locations and 10 outpatient clinics. Our operations include rehabilitation therapy services in 37 states and the District of Columbia. As of December 31, 2004, we had 27 nursing facilities (2,572 beds) and 10 outpatient clinics classified as held for sale (see Item 8. Note 15 regarding the sale of the 10 outpatient clinics in February 2005). See Item 1. Business Operations and Services for a more detailed description of our operations by segment.

Reclassification

Results of operations for the years ended December 31, 2004, 2003 and 2002, reflect asset dispositions during 2004 and 2003, and assets classified as held for sale, as discontinued operations. The following discussions reflect this reclassification.

Results of Operations Continuing Operations

We reported a 45% increase in pre-tax income from continuing operations to $47.5 million for the year ended December 31, 2004, compared to $32.8 million for the same period in 2003. In 2002, we reported a pre-tax loss of $28.4 million from continuing operations. The year-over-year comparisons of our financial results are affected by material special pre-tax charges (adjustments) discussed below. Excluding these special pre-tax charges (adjustments), we would have more than doubled our pre-tax income from continuing operations for the year ended December 31, 2004, compared to the same period in 2003. Before we discuss and analyze our operating performance year-over-year, we have included on the following table, and in the discussion below, the items that affect comparability of our operating results:

	2004	2003	2002
Costs related to early extinguishments of debt	40,935	6,634	
Florida insurance reserve adjustment			22,179
Charge and adjustment related to California investigations		(925)	6,300
Adjustments related to settlements of federal government investigations			(9,441)
Asset impairments, workforce reductions and other unusual items	448	3,825	46,287
Gain on sale of equity investment		(6,686)	

Table of Contents

Pre-tax income from continuing operations for 2004 included the following special pre-tax charges (adjustments):

$40.9 million for costs related to the early extinguishments of debt. During the second quarter 2004, we issued $215.0 million of 7^{7}/8% senior subordinated notes. The proceeds from the senior subordinated notes, together with cash on hand, were used to purchase $190.6 million of our 9^{5}/8% senior notes and to pay related fees and expenses. In conjunction with these transactions, we paid a prepayment premium of $36.1 million, wrote off $3.7 million of related deferred financing costs and paid $681,000 in fees and expenses related to the early extinguishment of the 9^{5}/8% senior notes. We also wrote off $505,000 of deferred financing costs related to early extinguishments of certain other debt;

$3.5 million for asset impairments, primarily related to seven nursing facilities (see *Asset Impairments* in our Critical Accounting Policies above);

$422,000 for net workforce reduction charges, including $1.3 million resulting from operational reorganizations, net of a $536,000 reversal of workforce reduction charges which were no longer needed. The charge is partially offset by $362,000 primarily due to the cancellation of restricted stock. During 2004, we notified 53 associates that their positions would be eliminated. The $1.3 million for workforce reductions was an all cash expense, $500,000 of which was paid during the year ended December 31, 2004; partially offset by

$3.4 million gain due to the sale or settlement of previously impaired assets above carrying value.

Pre-tax income from continuing operations for 2003 included the following special pre-tax charges (adjustments):

$6.6 million for costs related to the early extinguishment of debt. During the fourth quarter of 2003, we entered into a $210.0 million senior credit facility and issued $115.0 million of 2.75% convertible subordinated notes. The net proceeds from these transactions were used to pay off our 9% senior notes and certain mortgages, bonds and other debt obligations. In conjunction with these transactions, we wrote off $3.9 million of deferred financing costs and paid a prepayment premium of $2.7 million;

$2.1 million for asset impairments, primarily related to three nursing facilities (see *Asset Impairments* in our Critical Accounting Policies above);

$2.5 million for net workforce reduction charges, including $2.9 million resulting from operational reorganizations, net of a $395,000 reversal of workforce reduction charges which were no longer needed. During 2003, we notified 67 associates that their positions would be eliminated. The charge included the following:

- $2.8 million of cash expenses, $1.8 million and $900,000 of which was paid during the years ended December 31, 2003 and 2004, respectively; and
- non-cash expenses of approximately $84,000 related to the issuance of 108,230 shares under our Stock Grant Plan (the Stock Grant Plan), less approximately $400,000 due to the cancellation of restricted stock;

partially offset by a $6.7 million gain on the sale of a publicly traded equity security that was acquired in 1995;

a $1.0 million reversal of previously recorded exit costs and $447,000 primarily resulting from the settlement of a previously impaired asset above carrying value; and

the reversal of $925,000 of costs originally accrued for the settlement, recorded in 2002, related to the investigation of patient care issues at certain California nursing homes (the California investigation settlement).

Table of Contents

Pre-tax loss from continuing operations for 2002 included the following special pre-tax charges (adjustments):

$41.4 million for the write-down of property and equipment on certain assets of the Nursing Facilities segment (see *Asset Impairments* in our Critical Accounting Policies above);

$22.2 million for an insurance reserve adjustment related to Florida facilities sold in 2002;

$7.9 million of net workforce reduction charges, including $8.5 million resulting from an operational reorganization required to support the implementation of our three-year strategic plan, net of a $585,000 reversal of workforce reduction charges recorded in 2001, which were no longer needed. During 2002, we notified 133 associates that their positions would be eliminated. The charge included the following:

$8.0 million of cash expenses, $4.1 million, $2.8 million and $1.1 million of which was paid during the years ended December 31, 2002, 2003 and 2004, respectively; and

non-cash expenses of approximately $500,000 related to the issuance of 124,212 shares under our Stock Grant Plan;

$6.3 million for the California investigation settlement and related costs (see Item 8. Note 3); partially offset by

$9.4 million adjustment to reserves established in conjunction with previous settlements of federal government investigations (see Item 8. Note 4); and

$3.0 million gain primarily related to the sale of previously impaired assets above carrying value.

We estimate the annual cost savings of these workforce reductions for 2004, 2003 and 2002 to be approximately $3.4 million, $5.0 million and $11.2 million, respectively. The following table summarizes activity in our estimated workforce reductions and exit costs for the years ended December 31 (in thousands):

	2004		2003		2002	
	Workforce Reductions	Exit Costs	Workforce Reductions	Exit Costs	Workforce Reductions	Exit Costs
Balance beginning of year	$ 3,029	$ 7,270	$ 5,418	$ 4,991	$ 7,631	$ 15,030
Charged to continuing operations	1,320	185	2,902	(884)	8,454	
Charged to discontinued operations		4,251		26,599		2,633
Cash payments	(2,647)	(7,134)	(4,896)	(22,579)	(9,074)	(10,313)
Stock transactions					(1,008)	
Reversals	(536)		(395)	(857)	(585)	(2,359)
Balance end of year	$ 1,166	$ 4,572	$ 3,029	$ 7,270	$ 5,418	$ 4,991

Workforce reductions and exit costs accruals are included in Accrued wages and related liabilities and Other accrued liabilities on our consolidated balance sheets.

Table of Contents

Revenues

Revenues by operating segment for the years ended December 31 (in thousands) are as follows:

				Change			
				2004 vs. 2003		2003 vs. 2002	
	2004	2003	2002	$	%	$	%
Nursing Facilities	$ 1,794,471	$ 1,680,420	$ 1,677,892	$ 114,051	6.8%	$ 2,528	0.2%
Aegis	121,846	77,007	52,871	44,839	58.2%	24,136	45.7%
AseraCare	65,604	39,164	34,315	26,440	67.5%	4,849	14.1%
Other	6,931	5,435	1,648	1,496	27.5%	3,787	
Total revenues	$ 1,988,852	$ 1,802,026	$ 1,766,726	$ 186,826	10.4%	$ 35,300	2.0%

2004 Compared to 2003. Approximately 90% and 93% of our revenues for the years ended December 31, 2004 and 2003, respectively, were derived from services provided by our Nursing Facilities segment. The increase in total revenues of $186.8 million for the year ended December 31, 2004, as compared to the same period in 2003, is primarily due to the following, by operating segment:

Nursing Facilities:

an increase of $57.8 million, $33.9 million and $11.4 million in Medicaid, Medicare and private payment rates, respectively;

an increase of $18.1 million due to Medicare Part B revenues, primarily due to increased therapy-related services;

an increase of $4.4 million due to one additional calendar day during 2004 as compared to the same period in 2003; partially offset by

a decrease of $11.8 million due to a decline in census;

Aegis:

an increase of $44.8 million from growth in Aegis external therapy business, including a 14.7% increase in the number of contracts and a 28% growth in average revenue per contract;

AseraCare:

an increase of $19.5 million due to the Hospice USA acquisition (see Item 8. Note 7) and the opening of 14 hospice locations; and

an increase of $6.9 million primarily due to a 29% increase in average daily census in our core AseraCare business.

2003 Compared to 2002. Approximately 93% and 95% of our revenues for the years ended December 31, 2003 and 2002, respectively, were derived from services provided by our Nursing Facilities segment. The increase in total revenues of $35.3 million for the year ended December 31, 2003, as compared to the same period in 2002, is primarily due to the following, by operating segment:

Nursing Facilities:

an increase of $41.3 million and $12.0 million in Medicaid and private payment rates, respectively;

an increase of $7.7 million due to adjustments related to favorable prior year cost report settlements;

an increase of $6.8 million due to a shift in our patient mix, primarily from private to Medicare; partially offset by

a decrease of $47.3 million due to 2002 dispositions;

Table of Contents

a decrease of $11.4 million due to a decline in census; and

a decrease of $6.6 million due to various other items;

Aegis:

an increase of $24.1 million from growth in Aegis external therapy business, including a 32.5% increase in the number of contracts;

AseraCare:

an increase of $3.6 million primarily due to a 21% increase in average daily census in our core AseraCare business; and

an increase of $1.2 million due to the opening of three hospice locations.

Costs and Expenses

The following table details costs and expenses excluding special pre-tax charges (adjustments) for the years ended December 31 (in thousands):

				Change			
				2004 vs. 2003		2003 vs. 2002	
	2004	2003	2002	$	%	$	%
Wages and related	$ 1,147,743	$ 1,078,548	$ 1,068,629	$ 69,195	6.4%	$ 9,919	0.9%
Provision for insurance and related items	127,653	109,377	84,161	18,276	16.7%	25,216	30.0%
Other operating and administrative	522,603	462,144	458,311	60,459	13.1%	3,833	0.8%
Depreciation and amortization	62,166	58,807	62,906	3,359	5.7%	(4,099)	(6.5)%
Total costs and expenses excluding special pre-tax charges (adjustments)	$ 1,860,165	$ 1,708,876	$ 1,674,007	$ 151,289	8.9%	$ 34,869	2.1%

2004 Compared to 2003. Excluding special pre-tax charges (adjustments) discussed above, our total costs and expenses increased $151.3 million, primarily due to the following:

an increase of $34.1 million related to Aegis wages and related expenses due to increased staffing related to the increased volume of new contracts. This increase also includes a $5.6 million, or 49%, increase in Aegis contract therapy cost;

an increase of $32.6 million related to our Nursing Facilities wages and related expenses, primarily due to a 3.7% increase in our weighted average wage rate and an increase in nursing hours per patient day, partially offset by an adjustment in reserves related to revised employee benefit programs;

an increase of $12.6 million in contracted services, primarily due to outsourcing certain dietary and laundry services in our Nursing Facilities segment;

an increase in our provision for insurance and related items. We adjust our reserves for current and prior year general, professional, and workers compensation liabilities based primarily on actuarial studies conducted twice per year. Adjustments to premiums and other costs are recorded as incurred. The provision increase included the following:

- $12.3 million due to an increase in the estimate of outstanding general, professional and workers compensation liabilities, net of a decrease in insurance premiums and related program costs; and

Table of Contents

$6.0 million due to a change in the discount rate used to estimate the present value of our insurance liabilities (from 10% to 8.5%) due to a decrease in our incremental borrowing rate resulting from changes in our capital structure and the overall interest rate environment;

an increase of $17.1 million due to the Hospice USA acquisition, the opening of 14 hospice locations and two start-up businesses;

an increase of $10.0 million in state-imposed provider taxes in our Nursing Facilities segment; and

an increase in depreciation and amortization expense, primarily due to an increase in capital expenditures in our Nursing Facilities segment.

2003 Compared to 2002. Excluding special pre-tax charges (adjustments) discussed above, our total costs and expenses increased $34.9 million, primarily consisting of the following:

an increase in our provision for insurance and related items due to an increase in the estimate of outstanding general, professional and workers compensation liabilities and increased insurance premiums and related program costs;

an increase of $18.3 million related to Aegis wages and related expenses, which includes a $2.6 million, or 29%, increase in Aegis contract therapy cost;

an increase of $21.6 million related to Nursing Facilities wages and related expenses, primarily due to a 4.6% increase in our weighted average wage rate and an increase in nursing hours per patient day;

an increase of $14.5 million in contracted services, primarily due to outsourcing certain housekeeping, laundry and dietary services in our Nursing Facilities segment;

an increase of $3.5 million due to the opening of three hospice locations and two start-up businesses; partially offset by

a decrease of $21.4 million in our provision for reserves on accounts and notes receivable due to improvements in the timing and amount of account collections, as well as the collection of certain accounts that had previously been fully reserved;

a decrease of $22.7 million primarily due to 2002 dispositions; and

a decrease in depreciation and amortization expense, primarily due to the impact of asset impairments recorded in the fourth quarter of 2002.

Other Income and Expenses, Net

Other income and expenses for the years ended December 31 (in thousands) are as follows:

				Change			
				2004 vs. 2003		2003 vs. 2002	
	2004	2003	2002	$	%	$	%
Other income (expenses):							
Interest expense	$ (45,637)	$ (63,314)	$ (62,652)	$ 17,677	(27.9)%	$ (662)	1.1%
Costs related to early extinguishments of debt(1)	(40,935)	(6,634)		(34,301)		(6,634)	

Interest income	5,485	5,363	4,688	122	2.3%	675	14.4%
Net gains on dispositions	396	422	2,142	(26)	(6.2)%	(1,720)	(80.3)%
Gain on sale of equity investment(1)		6,686		(6,686)		6,686	

(1) See *Results of Operations Continuing Operations* for a discussion of special pre-tax charges for 2004 and 2003.

Table of Contents

Interest Expense

Interest expense decreased 28% to $45.6 million for the year ended December 31, 2004, as compared to $63.3 million for the year ended December 31, 2003. This was primarily due to the October 2003 refinancing of both our credit facility and our 9% senior notes as well as the reduction of debt using the proceeds from sales of facilities, clinics and other assets in 2003.

Results of Operations Discontinued Operations

The results of operations of disposed facilities, clinics and other assets during the years ended December 31, 2004 and 2003, as well as the results of operations of held-for-sale assets as of December 31, 2004, have been reported as discontinued operations for all periods presented in the consolidated statements of operations.

A summary of discontinued operations by operating segment for the years ended December 31 is as follows (in thousands):

	2004				2003			
	Matrix	Home Care	Nursing Facilities	Total	Matrix	Home Care	Nursing Facilities	Total
Revenues	$ 14,021	$ 148	$ 163,745	$ 177,914	$ 18,550	$ 20,395	$ 515,008	$ 553,953
Operating income (loss)(1)	$ 1,106	$ 110	$ (10,335)	$ (9,119)	$ 749	$ (2,446)	$ (2,817)	$ (4,514)
Gain (loss) on sales and exit costs	(49)	369	(1,441)	(1,121)	11,120	1,557	67,113	79,790
Impairments and other unusual items(2)			(4,342)	(4,342)		(540)	(18,594)	(19,134)
Pre-tax income (loss)	$ 1,057	$ 479	$ (16,118)	(14,582)	$ 11,869	$ (1,429)	$ 45,702	56,142
Provision for state income taxes				55				3,378
Discontinued operations, net of taxes				$ (14,637)				$ 52,764

	2002			
	Matrix	Home Care	Nursing Facilities	Total
Revenues(3)	$ 86,109	$ 20,894	$ 644,811	$ 751,814
Operating income (loss)(1)(3)	$ 810	$ (31,057)	$ 35,435	$ 5,188

Gain (loss) on sale and exit costs	(1,001)	(1,257)	(107)	(2,365)
Impairments and other unusual items(4)	230	(4,239)	(33,220)	(37,229)
Pre-tax income (loss)	$ 39	$ (36,553)	$ 2,108	(34,406)
Provision for income taxes				
Discontinued operations, net of taxes				$ (34,406)

(1) Includes net interest expense of $143,000, $2.8 million and $4.1 million for 2004, 2003 and 2002, respectively, and depreciation and amortization expense of $2.1 million, $10.9 million and $26.0 million for 2004, 2003 and 2002, respectively. Also includes an $8.6 million charge in 2004 primarily due to an increase in the estimate of outstanding general and professional liability reserves and related program costs.

(2) Includes an accrual in 2003 for the purchase of incremental general and professional liability insurance on disposed nursing facilities.

(3) Includes an adjustment of $18.0 million in 2002 for estimated overpayments to MK Medical by government payors. MK Medical was part of our former Home Care segment.

(4) Includes an accrual of $1.0 million in 2002 for legal and related fees associated with the MK Medical estimated overpayment issue, and asset impairment charges related to certain nursing facilities and MK Medical.

Table of Contents

We recognized net gains on sales of $67.1 million in discontinued operations related to divestitures of certain nursing facilities and assisted living centers during the year ended December 31, 2003. During 2002, we recognized asset impairment charges on certain of these divested facilities, amounting to $33.2 million. These impairments were precipitated by an estimated decline in future cash flows, primarily associated with Medicare funding reductions. Of the divested nursing facilities that incurred impairment charges in 2002, we recognized net losses on sales of $5.3 million.

Income Taxes

Our provision for income taxes of $4.9 million for the year ended December 31, 2004, primarily related to state income taxes. We decreased the valuation allowance on our deferred tax assets by $10.8 million during 2004 to $158.3 million as of December 31, 2004, primarily due to the reversal of temporary differences and the utilization of net operating loss carryforwards, partially offset by increases in general business tax credits, state tax credits and alternative minimum tax credits (see *Tax Valuation Allowance* in our Critical Accounting Policies above).

At December 31, 2004, for income tax purposes, we had federal net operating loss carryforwards of $60.8 million which expire in years 2018 through 2020; general business tax credit carryforwards of $39.0 million which expire in years 2006 through 2024; and alternative minimum tax credit carryforwards of $23.0 million which do not expire. Future tax benefits associated with these carryforwards are not recorded in our 2004 and 2003 consolidated financial statements as a result of the valuation allowance recorded in 2001.

Cumulative Effect of Accounting Change (see *Asset Impairments* in our Critical Accounting Policies above.)

New Accounting Standard

In December 2004, the Financial Accounting Standards Board (FASB) issued Statement of Financial Accounting Standards No. 123 (revised), *Share-Based Payment* (SFAS No. 123R). SFAS No. 123R eliminates the intrinsic value method as an alternative method of accounting for stock-based awards. SFAS No. 123R also revises the fair value-based method of accounting for share-based payment liabilities, forfeitures and modifications of stock-based awards and clarifies SFAS No. 123 s guidance in several areas, including measuring fair value, classifying an award as equity or as a liability and attributing compensation cost to reporting periods. In addition, SFAS No. 123R amends Statement of Financial Accounting Standards No. 95, *Statement of Cash Flows,* to require that excess tax benefits be reported as a financing cash inflow rather than as a reduction of taxes paid. We are required to adopt SFAS No. 123R for the interim period beginning July 1, 2005 and expect to use the modified version of prospective application. Based on the estimated value of current unvested stock options, we expect wages and related expenses to increase $1.5 million in the last six months of 2005.

Liquidity and Capital Resources

At December 31, 2004, we had $215.7 million in cash and cash equivalents and $5.0 million of investments with maturities between three and six months. We anticipate that $67.8 million of our cash balance, while not legally restricted, will be utilized primarily to fund certain general and professional liabilities and workers compensation claims and expenses. In addition, at December 31, 2004, we had approximately $16.0 million in funds that are restricted for the payment of insured claims and are included in Prepaid expenses and other on our consolidated balance sheet. At December 31, 2004, we had positive working capital of $175.3 million reflected on our consolidated balance sheet, an increase of 73% over the prior year. Also at December 31, 2004, we had $75.0 million of borrowing capacity under our $90.0 million revolving credit facility and $21.5 million availability under our $40.0 million letter of credit facility.

Table of Contents

Cash Flows. Our cash flows consisted of the following for the years ended December 31 (in thousands):

	2004	2003	2002
Net cash provided by operating activities	$ 75,660	$ 69,861	$ 116,633
Net cash provided by (used for) investing activities	(69,979)	219,188	62,335
Net cash used for financing activities	(48,831)	(145,679)	(152,866)
Net increase (decrease) in cash and cash equivalents	$ (43,150)	$ 143,370	$ 26,102

Net cash provided by operating activities, under the direct method, consists of the following for the years ended December 31 (in thousands):

	2004	2003	2002
Cash received from patients and third-party payors	$ 2,094,684	$ 2,342,011	$ 2,526,436
Interest received	5,521	5,524	4,748
Cash paid to suppliers and employees	(1,972,340)	(2,217,620)	(2,352,598)
Interest paid	(46,356)	(67,710)	(65,658)
Income tax (paid) refunds received	(5,849)	7,656	3,705
Net cash provided by operating activities	$ 75,660	$ 69,861	$ 116,633

With the termination of daily purchases of receivables by BFC from Beverly Health and Rehabilitation Services, Inc. on March 1, 2004, accounts receivable on our consolidated balance sheet have increased and resulted in an $82.0 million detriment to cash from operating activities on our consolidated statement of cash flows for the year ended December 31, 2004.

For the year ended December 31, 2004, proceeds from dispositions and collections on notes receivable totaling $53.6 million, as well as cash generated from operations and cash on hand, were used to acquire Hospice USA, LLC and its affiliates for $69.1 million and to fund capital expenditures of $62.7 million, including $54.7 million related to our Nursing Facilities segment.

Debt Transactions. At December 31, 2004, we had $75.0 million of availability under our $90.0 million revolving credit facility, with $15.0 million being utilized for standby letters of credit primarily in support of certain insurance programs, security deposits, and debt or guaranteed debt obligations. During October 2004, we entered into a $40.0 million letter of credit facility, of which $18.5 million was utilized for standby letters of credit as of December 31, 2004. As of January 31, 2005, we had transferred all outstanding letter of credit commitments under our revolving credit facility to the new letter of credit facility, thereby increasing our availability under the revolving credit facility to the full $90.0 million.

During June 2004, we commenced a cash tender offer to purchase any and all of our $200.0 million principal amount outstanding of 9^{5}/8% senior notes due 2009 at an offer price of $1,190 per $1,000 principal amount tendered, plus accrued and unpaid interest, and a solicitation of consents to amend the indenture under which the 9^{5}/8% senior notes were issued. Holders of $190.6 million of the 9^{5}/8% senior notes tendered their notes and delivered consents. During June 2004, we issued $215.0 million of 7^{7}/8% senior subordinated notes due June 15, 2014 (the Senior Subordinated Notes). The Senior Subordinated Notes were issued at a discount (98.318% of par) to yield 8.125%. The Senior Subordinated Notes are general unsecured obligations subordinated in right of payment to our existing and future senior unsubordinated indebtedness and are guaranteed by certain of our subsidiaries. The Senior Subordinated

Notes were issued through a private placement; however during February 2005, we completed an exchange of these notes for publicly tradable notes.

The proceeds from the Senior Subordinated Notes, together with cash on hand, were used to purchase $190.6 million of our 9^{5}/8% senior notes tendered, as well as to pay related fees and expenses. We recorded a pre-tax charge of $40.4 million related to this transaction, including $36.1 million for the prepayment premium, $3.7 million for the write-off of deferred financing costs, as well as $681,000 for fees and expenses related to the cash tender offer. Approximately $36.1 million of the pre-tax charge and $4.1 million of deferred

Table of Contents

financing costs related to the Senior Subordinated Notes were paid out in cash, using $20.6 million of net proceeds from the issuance of the Senior Subordinated Notes and $19.6 million of cash on hand.

During the second quarter of 2004, we entered into two amendments to our senior credit facility which, among other things, permitted the issuance of the Senior Subordinated Notes and the purchase of our 9^{5}/8% senior notes, reduced the interest rate on the term loan portion of the senior credit facility, increased the size of our revolving credit facility from $75.0 million to $90.0 million and modified certain financial covenant levels.

Our revolving credit and term loan agreements contain a number of financial covenants, such as a limit on the ratio of total debt and senior secured debt to earnings before interest, taxes, depreciation, and amortization (see Item 6). Other covenants limit our ability to incur additional debt, to pledge/sell assets and to make substantial payments in connection with our common stock. The revolving credit and term loan agreements allow for $80.0 million of annual capital expenditures, plus a provision to carry forward any unused availability from the previous year. Our outstanding indentures contain customary covenants, including limits on liens, subsidiary debt and payments in connection with our common stock. None of these covenants are presently considered restrictive to our operations. We are currently in compliance with all of our debt covenants.

A credit rating reflects an assessment by the rating agency of the credit risk associated with particular securities we issue, based on information provided by us and other sources. Credit ratings are not recommendations to buy, sell or hold securities and are subject to revision or withdrawal at any time by the assigning rating agency. Each rating agency may have different criteria for evaluating company risk, and therefore ratings should be evaluated independently for each rating agency. Lower credit ratings generally result in higher borrowing costs and reduced access to capital markets. Our credit ratings are below investment grade. Any credit downgrade could affect our ability to enter into and maintain certain contracts on favorable terms and increase our cost of borrowing.

Our credit ratings as of December 31, 2004, are as follows:

Rating Agency	Senior Implied/ Corporate Rating	2.75% Convertible Subordinated Notes and 7^{7}/8% Senior Subordinated Notes
Standard & Poor s(a)	BB-	B
Moody s(a)	Ba3	B2
Fitch(a)	BB-	B+

(a) Ratings outlook is stable.

Acquisitions, Divestitures and Other. On July 30, 2004, we purchased substantially all of the assets of Hospice USA, LLC and its affiliates, which were privately held companies providing hospice services in Mississippi, Alabama and Tennessee, for cash of approximately $69.1 million. At the time of acquisition, Hospice USA, LLC and its affiliates operated 18 hospice locations and had an additional 16 locations under development. The acquisition was part of our ongoing strategy to expand our service businesses.

In 2003, we completed a full evaluation of our Nursing Facilities segment portfolio, which included the identification of non-strategic facilities and facilities that account for a disproportionately high share of projected general and professional liability costs. As a result of this analysis, we have divested a significant portion of our nursing facility capacity. During the years ended December 31, 2004 and 2003, we sold, closed or terminated the leases on 103 nursing facilities, nine assisted living centers, of which 89 nursing facilities and seven assisted living centers were part of this divestiture strategy. We received net cash proceeds of $290.6 million from the sales of these nursing facilities, our former Matrix outpatient therapy clinics and managed care network, certain assets of our

AseraCare segment and other assets.

As of December 31, 2004, we had 27 nursing facilities classified as held for sale that met the criteria set forth in SFAS No. 144 to be classified as held for sale and we expect to dispose of them within the first half of 2005. The 10 outpatient clinics classified as held for sale at December 31, 2004, were sold in February 2005 (see Item 8. Note 15).

Table of Contents

Our financial condition, results of operations and cash flows may be adversely impacted by the unsolicited indication of interest in acquiring us by a group including Arnold Whitman, the Chief Executive Officer of Formation Capital, LLC and Appaloosa Management, LP, a New Jersey based hedge fund, among others, and related actions taken by this group, including the nomination of candidates for election to our Board of Directors. These actions may impact our ability to attract and retain customers, management and employees and may result in the incurrence of significant advisory fees, litigation costs and other expenses.

Summary. We currently anticipate that cash on hand, cash flows from operations and availability under our banking arrangements will be adequate to repay our debts due within one year of $12.2 million, to make capital additions and improvements of approximately $100.0 million, to make operating lease and other contractual obligation payments, to make selective acquisitions, including previously leased facilities and to meet working capital requirements for the twelve months ending December 31, 2005.

Our ability to make payments on, and to refinance, our indebtedness, as well as to fund planned capital expenditures, including strategic acquisitions, and research and development efforts, will depend on our ability to generate cash in the future. This, to a certain extent, is subject to general economic, financial, competitive, legislative, regulatory and other factors that are beyond our control. However, based on our current level of operations and anticipated cost savings and operating improvements, we believe our cash flows from operations, current cash and cash equivalents and available borrowings will be adequate to meet our future liquidity needs for at least the next five years.

We cannot assure you, however, that our business will generate sufficient cash flows from operations, that currently anticipated cost savings and operating improvements will be realized on schedule or that future borrowings will be available to us in an amount sufficient to enable us to pay our indebtedness or to fund our other liquidity needs. We may need to refinance all or a portion of our indebtedness on or before maturity. We cannot assure you that we will be able to refinance any of our indebtedness on commercially reasonable terms or at all. If cash flows from operations or availability under our existing banking arrangements fall below expectations, we may be required to utilize cash on hand, delay capital expenditures, dispose of certain assets, issue additional debt securities, or consider other alternatives to improve liquidity. (See Item 1. Business Risks Relating to our Company *To service our indebtedness, we will require a significant amount of cash. Our ability to generate cash depends on many factors, some of which are beyond our control*.)

Obligations and Commitments

As of December 31, 2004, we have off-balance sheet debt guarantees of $11.8 million that primarily arose from our sales of nursing facilities. We also guarantee certain third-party operating leases. Those guarantees arose from our dispositions of leased nursing facilities, and the underlying leases have $54.8 million of minimum rental commitments remaining through the initial lease terms, with the latest termination date being February 2019. We have recorded approximately $627,000, included in Other accrued liabilities on the consolidated balance sheet at December 31, 2004, as the estimated fair value of guarantees in accordance with FASB Interpretation No. 45, *Guarantor s Accounting and Disclosure Requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others.*

Table of Contents

We are party to many contractual obligations involving commitments to make payments to third parties. A summary of our long-term contractual obligations and commitments in future years as of December 31, 2004, including principal and interest, is shown below (in thousands):

	Payments Due by Period				
	Total	2005	2006-2007	2008-2009	After 2009
Contractual obligations:					
Long-term debt(a)	$ 874,595	$ 48,287	$ 129,517	$ 175,824	$ 520,967
Capital lease obligations	7,799	530	906	820	5,543
Operating leases	95,488	37,362	30,315	14,913	12,898
Federal government settlement obligations	55,769	18,125	36,250	1,394	
Unconditional purchase obligations(b)	8,277	4,273	4,004		
Total contractual cash obligations	$ 1,041,928	$ 108,577	$ 200,992	$ 192,951	$ 539,408

	Amount of Commitment Expiration Per Period				
	Total Amounts Committed	2005	2006-2007	2008-2009	After 2009
Other commercial commitments:					
Letters of credit	$ 33,455	$ 33,455	$	$	$
Guarantees	11,822		950	2,002	8,870
Total commercial commitments	$ 45,277	$ 33,455	$ 950	$ 2,002	$ 8,870

(a) For variable-rate debt, we estimated future interest payments based on published forward yield curve analyses. The long-term debt amounts exclude $3.5 million of unamortized discounts related to our 7⅞% senior subordinated notes.

(b) We have unconditional purchase obligations totaling $8.3 million primarily due to our outsourcing of certain information technology functions, as well as contracts relative to our frame relay network and certain office equipment. These contracts involve future minimum commitments that are noncancelable or impose a penalty if these agreements are cancelled prior to expiration.

Excluded from the contractual obligations and commitments table are payments we may make for general and professional liabilities and workers compensation risks. Our recorded reserves for these liabilities primarily includes estimated reserves for losses retained by us and not covered by insurance (see Item 8 Note 2).

The expected timing and amount of payments for obligations and commitments discussed above are estimated based on currently available information. The actual timing and amount of payments may be different.

Table of Contents

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK.

We are exposed to market risk because we utilize financial instruments. The market risks inherent in these instruments are attributable to the potential loss from adverse changes in the general level of United States interest rates. We manage our interest rate risk exposure by maintaining a mix of fixed and variable rates for debt. The following table provides information regarding our market sensitive financial instruments and constitutes a forward-looking statement. The actual results of our mix of financial instruments could differ materially from the outlook set forth below.

	Expected Maturity Dates							Fair Value December 31, 2004	Fair Value December 31, 2003
	2005	2006	2007	2008	2009	Thereafter	Total		
	(Dollars in thousands)								
Total long-term debt:(1)									
Fixed rate	$ 10,740	$ 8,755	$ 14,652	$ 8,057	$ 16,180	$ 368,757	$ 427,141	$ 503,776	$ 503,923
Average interest rate	6.73%	6.74%	6.73%	6.69%	6.68%	6.58%			
Variable rate	$ 1,500	$ 1,510	$ 33,583	$ 97,381	$ 193	$ 369	$ 134,536	$ 134,536	$ 136,800
Average interest rate	5.98%	6.28%	6.62%	6.90%	8.36%	8.86%			
Total notes receivable:									
Fixed rate	$ 2,269	$ 427	$ 329	$ 208	$ 216	$ 1,709	$ 5,158	$ 5,158	$ 27,459
Average interest rate	9.46%	9.42%	9.67%	9.73%	9.25%	9.75%			
Variable rate	$ 38	$ 40	$ 43	$ 45	$ 48	$ 163	$ 377	$ 377	$ 414
Average interest rate	6.25%	6.25%	6.25%	6.25%	6.25%	6.25%			

(1) See Item 8-Note 9 for a discussion of our 2004 and 2003 refinancings. For variable-rate debt, we estimate future interest rates based on published forward yield curve analyses. The long-term debt amounts exclude $3.5 million of unamortized discounts related to our 7 7/8% senior subordinated notes.

Table of Contents

ITEM 8. CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA.

Table of Contents

REPORT OF ERNST & YOUNG LLP,
INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
Beverly Enterprises, Inc.

We have audited the accompanying consolidated balance sheets of Beverly Enterprises, Inc. as of December 31, 2004 and 2003, and the related consolidated statements of operations, stockholders equity, and cash flows for each of the three years in the period ended December 31, 2004. Our audits also included the financial statement schedule listed in the Index at Item 15(a). These financial statements and schedule are the responsibility of the Company s management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Beverly Enterprises, Inc. at December 31, 2004 and 2003, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2004, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

As discussed in Note 1 to the consolidated financial statements, in 2002 the Company changed its method of accounting for goodwill.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the effectiveness of Beverly Enterprises, Inc. s internal control over financial reporting as of December 31, 2004, based on criteria established in Internal Control Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated March 8, 2005, expressed an unqualified opinion thereon.

Fort Smith, Arkansas
March 8, 2005

Table of Contents

REPORT OF ERNST & YOUNG LLP,
INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
Beverly Enterprises, Inc.

We have audited management s assessment, included in the accompanying Management s Report on Internal Control Over Financial Reporting, that Beverly Enterprises, Inc. (the Company) maintained effective internal control over financial reporting as of December 31, 2004, based on criteria established in Internal Control Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). The Company s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting. Our responsibility is to express an opinion on management s assessment and an opinion on the effectiveness of the Company s internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, evaluating management s assessment, testing and evaluating the design and operating effectiveness of internal control, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company s internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company s internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company s assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, management s assessment that Beverly Enterprises, Inc. maintained effective internal control over financial reporting as of December 31, 2004, is fairly stated, in all material respects, based on the COSO criteria. Also, in our opinion, Beverly Enterprises, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2004, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Beverly Enterprises, Inc. as of December 31, 2004 and 2003, and the related consolidated statements of operations, stockholders equity, and cash flows for each of the three years in the period ended December 31, 2004 of Beverly Enterprises, Inc. and our report dated March 8, 2005 expressed an unqualified opinion thereon.

Fort Smith, Arkansas
March 8, 2005

Table of Contents

BEVERLY ENTERPRISES, INC.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2004	**2003**
	(Dollars in thousands)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 215,665	$ 258,815
Accounts receivable less allowance for doubtful accounts: 2004 $26,320; 2003 $31,615	235,477	164,635
Notes receivable, less allowance for doubtful notes: 2004 $1,686 ; 2003 $3,336	2,786	13,724
Operating supplies	9,181	10,425
Assets held for sale	14,898	3,498
Investment in Beverly Funding Corporation		31,342
Prepaid expenses and other	37,266	33,377
Total current assets	515,273	515,816
Property and equipment, net	653,656	694,220
Other assets:		
Goodwill, net	124,066	57,102
Other, less allowance for doubtful accounts and notes: 2004 $1,538; 2003 $2,120	68,390	79,283
Total other assets	192,456	136,385
	$ 1,361,385	$ 1,346,421
LIABILITIES AND STOCKHOLDERS EQUITY		
Current liabilities:		
Accounts payable	$ 67,778	$ 67,572
Accrued wages and related liabilities	104,037	116,717
Accrued interest	3,602	6,896
General and professional liabilities	54,216	93,736
Federal government settlement obligations	14,359	13,125
Liabilities held for sale	676	672
Other accrued liabilities	83,097	102,289
Current portion of long-term debt	12,240	13,354
Total current liabilities	340,005	414,361
Long-term debt	545,943	552,873
Other liabilities and deferred items	203,024	141,001
Commitments and contingencies		
Stockholders equity:		
Preferred stock, shares authorized: 25,000,000		

Common stock, shares issued: 2004 116,621,715; 2003 115,594,806	11,662	11,559
Additional paid-in capital	902,053	895,950
Accumulated deficit	(532,804)	(560,825)
Treasury stock, at cost: 8,283,316	(108,498)	(108,498)
Total stockholders equity	272,413	238,186
	$ 1,361,385	$ 1,346,421

See accompanying notes.

Table of Contents

BEVERLY ENTERPRISES, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS

	Years Ended December 31,		
	2004	**2003**	**2002**
	(In thousands, except per share amounts)		
Revenues	$ 1,988,852	$ 1,802,026	$ 1,766,726
Costs and expenses:			
Wages and related	1,147,743	1,078,548	1,068,629
Provision for insurance and related items	127,653	109,377	84,161
Other operating and administrative	522,603	462,144	458,311
Depreciation and amortization	62,166	58,807	62,906
Florida insurance reserve adjustment			22,179
Special charge and adjustment related to California investigation settlement		(925)	6,300
Adjustment related to settlements of federal government investigations			(9,441)
Asset impairments, workforce reductions and other unusual items	448	3,825	46,287
Total costs and expenses	1,860,613	1,711,776	1,739,332
Income before other income (expenses)	128,239	90,250	27,394
Other income (expenses):			
Interest expense	(45,637)	(63,314)	(62,652)
Costs related to early extinguishments of debt	(40,935)	(6,634)	
Interest income	5,485	5,363	4,688
Net gains on dispositions	396	422	2,142
Gain on sale of equity investment		6,686	
Total other expenses, net	(80,691)	(57,477)	(55,822)
Income (loss) before provision for income taxes, discontinued operations and cumulative effect of change in accounting for goodwill	47,548	32,773	(28,428)
Provision for income taxes	4,890	5,069	6,085
Income (loss) before discontinued operations and cumulative effect of change in accounting for goodwill	42,658	27,704	(34,513)
Discontinued operations, net of taxes: 2004 $55; 2003 $3,378; 2002 $0	(14,637)	52,764	(34,406)
Cumulative effect of change in accounting for goodwill, net of income taxes of $0			(77,171)
Net income (loss)	$ 28,021	$ 80,468	$ (146,090)

Net income (loss) per share of common stock:			
Basic:			
Before discontinued operations and cumulative effect of change in accounting for goodwill	$ 0.40	$ 0.26	$ (0.33)
Discontinued operations, net of taxes	(0.14)	0.49	(0.32)
Cumulative effect of change in accounting for goodwill, net of taxes			(0.74)
Net income (loss) per share of common stock	$ 0.26	$ 0.75	$ (1.39)
Shares used to compute basic net income (loss) per share	107,749	106,582	104,726
Diluted:			
Before discontinued operations and cumulative effect of change in accounting for goodwill	$ 0.37	$ 0.26	$ (0.33)
Discontinued operations, net of taxes	(0.12)	0.48	(0.32)
Cumulative effect of change in accounting for goodwill, net of taxes			(0.74)
Net income (loss) per share of common stock	$ 0.25	$ 0.74	$ (1.39)
Shares used to compute diluted net income (loss) per share	124,334	109,922	104,726

See accompanying notes.

Table of Contents

BEVERLY ENTERPRISES, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS EQUITY

	Common Stock	Additional Paid-In Capital	Accumulated Deficit	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total
			(Dollars in thousands)			
Balances at January 1, 2002	$ 11,281	$ 887,668	$ (495,203)	$ 2,029	$ (109,278)	$ 296,497
Employee stock transactions related to 436,038 shares of common stock, net	44	3,680				3,724
Reissuance of 124,212 shares of common stock from treasury		434			419	853
Comprehensive income (loss):						
Unrealized losses on securities, net of income taxes of $0				(1,464)		(1,464)
Foreign currency translation adjustments, net of income taxes of $0				(48)		(48)
Net loss			(146,090)			(146,090)
Total comprehensive loss						(147,602)
Balances at December 31, 2002	11,325	891,782	(641,293)	517	(108,859)	153,472
Employee stock transactions related to 2,345,465 shares of common stock, net	234	4,274				4,508
Reissuance of 108,230 shares of common stock from treasury		(106)			361	255
Comprehensive income (loss):						
Unrealized losses on securities, net of income taxes of $0				(512)		(512)

Foreign currency translation adjustments, net of income taxes of $0				(5)		(5)
Net income			80,468			80,468
Total comprehensive income						79,951
Balances at December 31, 2003	11,559	895,950	(560,825)		(108,498)	238,186
Employee stock transactions related to 1,026,909 shares of common stock, net	103	6,103				6,206
Net income and total comprehensive income			28,021			28,021
Balances at December 31, 2004	$ 11,662	$ 902,053	$ (532,804)	$	$ (108,498)	$ 272,413

See accompanying notes.

Table of Contents

BEVERLY ENTERPRISES, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Years Ended December 31,		
	2004	2003	2002
	(In thousands)		
Cash flows from operating activities:			
Net income (loss)	$ 28,021	$ 80,468	$ (146,090)
Adjustments to reconcile net income (loss) to net cash provided by operating activities, including discontinued operations:			
Depreciation and amortization	64,301	69,663	88,943
Provision for reserves on patient, notes and other receivables, net	8,815	21,605	55,570
Amortization of deferred financing costs	2,754	4,474	3,096
Florida insurance reserve adjustment			22,179
Special charge and adjustment related to California investigation settlement		(925)	6,300
Adjustment related to settlements of federal government investigations			(9,441)
Asset impairments, workforce reductions and other unusual items	4,790	7,459	85,773
Costs related to early extinguishments of debt	40,935	6,634	
Cumulative effect of change in accounting for goodwill			77,171
Losses (gains) on dispositions of facilities and other assets, net	725	(81,508)	(1,855)
Insurance related accounts	6,523	(32,727)	8,411
Changes in operating assets and liabilities, net of acquisitions and dispositions:			
Accounts receivable	(72,082)	(13,968)	7,896
Operating supplies	352	1,467	3,081
Prepaid expenses and other receivables	5,155	(2,502)	988
Accounts payable and other accrued expenses	(8,584)	117	(85,335)
Income taxes payable	(904)	16,103	9,790
Other, net	(5,141)	(6,499)	(9,844)
Total adjustments	47,639	(10,607)	262,723
Net cash provided by operating activities	75,660	69,861	116,633
Cash flows from investing activities:			
Capital expenditures	(62,718)	(43,984)	(100,103)
Proceeds from dispositions of facilities and other assets, net	15,557	275,039	169,471
Payments for acquisitions, net of cash acquired	(71,352)	(459)	
Collections on notes receivable	38,089	8,689	1,616
Payments for designated funds, net	(1,009)	(5,183)	(260)

Proceeds from Beverly Funding Corporation investment	28,956		
Other, net	(17,502)	(14,914)	(8,389)
Net cash provided by (used for) investing activities	(69,979)	219,188	62,335
Cash flows from financing activities:			
Proceeds from issuance of long-term debt	211,384	250,000	5,000
Repayments of long-term debt	(219,428)	(313,352)	(116,496)
Repayments of off-balance sheet financing		(69,456)	(42,901)
Proceeds from exercise of stock options	3,592	1,108	1,699
Deferred financing and other costs (including those related to early extinguishments of debt)	(44,379)	(13,979)	(168)
Net cash used for financing activities	(48,831)	(145,679)	(152,866)
Net increase (decrease) in cash and cash equivalents	(43,150)	143,370	26,102
Cash and cash equivalents at beginning of year	258,815	115,445	89,343
Cash and cash equivalents at end of year	$ 215,665	$ 258,815	$ 115,445
Supplemental schedule of cash flow information:			
Cash paid (received) during the year for:			
Interest, net of amounts capitalized	$ 46,356	$ 67,710	$ 65,658
Income tax payments (refunds), net	5,849	(7,656)	(3,705)

See accompanying notes.

Table of Contents

BEVERLY ENTERPRISES, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
Years ended December 31, 2004, 2003, and 2002

1. Summary of Significant Accounting Policies

Basis of Presentation

References herein to the Company include Beverly Enterprises, Inc. and its wholly owned subsidiaries.

On December 31, 2004, we operated 351 nursing facilities (of which 27 were held for sale), 18 assisted living centers, 52 hospice and home health locations and 10 outpatient clinics (all of which were held for sale see Note 15) in 25 states and the District of Columbia. Our operations also included rehabilitation therapy services in 37 states and the District of Columbia. Our consolidated financial statements include the accounts of the Company and all of its wholly owned subsidiaries. All significant intercompany accounts and transactions have been eliminated.

Restatement

The accompanying consolidated financial statements have been restated to report facilities, clinics and other assets which have been sold, closed or classified as held for sale during the year ended December 31, 2004, as discontinued operations. See *Earnings Per Share* below for a change in the calculated 2003 diluted earnings per share to include our convertible subordinated notes, on an if-converted basis, since their issuance in October 2003, in accordance with Emerging Issues Task Force Issue No. 04-8, *The Effect of Contingently Convertible Debt on Diluted Earnings Per Share* (EITF 04-8).

Use of Estimates

Generally accepted accounting principles require management to make estimates and assumptions when preparing financial statements that affect:

the reported amounts of assets and liabilities at the date of the financial statements; and

the reported amounts of revenues and expenses during the reporting period.

They also require management to make estimates and assumptions regarding contingent assets and liabilities at the date of the financial statements. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include time deposits and certificates of deposit with original maturities of three months or less.

Receivables and Concentration of Credit Risk

We have significant accounts receivable whose collectibility or realizability is dependent upon the performance of certain governmental programs, primarily Medicare and Medicaid. Approximately 70% and 56% of our net patient accounts receivable at December 31, 2004 and 2003, respectively, are due from such programs. These receivables represent our primary concentration of credit risk. We do not believe there are significant credit risks associated with these governmental programs. We believe that an adequate provision, based on historical experience, has been made for the possibility of a portion of these and other receivables becoming uncollectible and we continually monitor and adjust these allowances as necessary. In establishing our estimate of uncollectible accounts, we consider our historical collection experience, the aging of the account, and the payor classification. Private pay accounts usually represent our highest collectibility risk. We write off uncollectible accounts receivable after all collection efforts have been exhausted and we determine they will not be collected.

Table of Contents

BEVERLY ENTERPRISES, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)
Years ended December 31, 2004, 2003, and 2002

1. Summary of Significant Accounting Policies (Continued)

Our allowance for doubtful accounts represented approximately 10% and 16% of accounts receivable at December 31, 2004 and 2003, respectively. We believe adequate provision has been made for receivables that may prove to be uncollectible. During 2004, our Nursing Facilities segment s weighted average collection experience improved 21 basis points when compared to 2003. As a result of the improved collection rates, we reduced our recorded allowance for doubtful accounts by approximately $4.0 million. Changes in collection rates or payment patterns could affect the assumptions used to estimate the current level of allowance for doubtful accounts.

Certain interest-bearing notes receivable are placed on a nonaccrual basis when uncertainty arises as to the collectibility of principal or interest. Notes receivable of $4.6 million and $6.7 million at December 31, 2004 and 2003, respectively, were on a nonaccrual basis. After considering the estimated collateral values, specific collectibility allowances of $2.5 million and $3.7 million, respectively, have been recorded on these nonaccrual notes.

Property and Equipment, net

Property and equipment is stated at the lower of carrying value or fair value, or where appropriate, the present value of the related capital lease obligations less accumulated amortization. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the assets.

Intangible Assets

Following is a summary of our goodwill and other indefinite-lived intangible assets and related accumulated amortization, included in Other assets, at December 31 (in thousands):

	Cost Basis		Accumulated Amortization		Carrying Value	
	2004	2003	2004	2003	2004	2003
Goodwill	$ 145,430	$ 78,609	$ 21,364	$ 21,507	$ 124,066	$ 57,102
Other indefinite-lived intangible assets	10,020	9,546	4,569	4,547	5,451	4,999
	$ 155,450	$ 88,155	$ 25,933	$ 26,054	$ 129,517	$ 62,101

In July 2004, we purchased substantially all of the assets of Hospice USA, LLC and its affiliates (Hospice USA) which led to the recording of $67.6 million of goodwill, of which all is expected to be deductible for income tax purposes, $725,000 of other indefinite-lived intangible assets and $1.3 million of operating rights and licenses.

In July 2001, Statement of Financial Accounting Standards No. 142, *Goodwill and Other Intangible Assets* (SFAS No. 142) was issued, which established new rules on the accounting for goodwill and other intangible assets. Under SFAS No. 142, goodwill and intangible assets with indefinite lives are no longer amortized; however, they are subject to annual impairment tests as prescribed by the Statement. Intangible assets with definite lives continue to be amortized over their estimated useful lives. With respect to our goodwill and intangible assets, SFAS No. 142 was effective for us beginning January 1, 2002.

In accordance with this standard, we performed the initial screening for potential impairments of our indefinite-lived intangible assets by reporting unit as of January 1, 2002. We determined the estimated fair values of each reporting unit using discounted cash flow analyses, along with independent source data related

Table of Contents

BEVERLY ENTERPRISES, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)
Years ended December 31, 2004, 2003, and 2002

1. Summary of Significant Accounting Policies (Continued)

to recent transactions. Based on this determination, we identified potential goodwill impairments at our former Matrix and Home Care Services Care Focus reporting units.

The fair values of the reporting units were derived from a five-year projection of revenues and expenses plus residual value, with the resulting projected cash flows discounted at an appropriate weighted average cost of capital. The analysis was completed in the fourth quarter of 2002, and led to the recording of goodwill impairment charges as the cumulative effect of an accounting change of $77.2 million as of January 1, 2002, including $70.6 million for Matrix and $6.6 million for Care Focus.

Following is a summary of our finite-lived intangible assets and related accumulated amortization, by major classification, which are included in Other assets, at December 31 (in thousands):

	Cost Basis		Accumulated Amortization		Carrying Value	
	2004	2003	2004	2003	2004	2003
Operating rights and licenses	$ 3,091	$ 1,801	$ 451	$ 203	$ 2,640	$ 1,598
Leasehold interests	349	439	349	389		50
	$ 3,440	$ 2,240	$ 800	$ 592	$ 2,640	$ 1,648

The acquisition of Hospice USA caused our weighted-average amortization period for operating rights and licenses to decrease to approximately 6 years due to the estimated useful lives of the acquired intangibles. Amortization expense related to these intangibles for the years ended December 31, 2004, 2003 and 2002 was approximately $300,000, $100,000 and $300,000, respectively. Our estimated aggregate annual amortization expense for these intangibles for each of the next five years is approximately $300,000.

On an ongoing basis, we review the carrying value of our finite-lived intangibles in light of any events or circumstances that indicate they may be impaired or that the amortization period may need to be adjusted and make any necessary adjustments. As of December 31, 2004, we do not believe there are any indications that the carrying values, or the useful lives, of these assets need to be adjusted. We have no residual values assigned to our finite-lived intangible assets.

Insurance

We record our provisions for insurance based on estimates of projected claims cost, premiums, and program related expenses. We discount our insurance reserves using our incremental borrowing rate. See Note 2 for a discussion of our insurance liabilities and related items.

We are primarily self-insured for employee medical and dental insurance programs. During the second quarter of 2004, we recorded a change in estimate relative to reserves established for these insurance programs of $6.1 million. This change in estimate was primarily due to a reduction in claims experience resulting from a change in our medical insurance programs in 2003.

Income Taxes

We follow the liability method in accounting for income taxes in accordance with Statement of Financial Accounting Standards No. 109, *Accounting for Income Taxes* (SFAS No. 109). Under the liability method, deferred tax assets and liabilities are recorded at currently enacted tax rates based on the difference between the tax basis of assets and liabilities and their carrying amounts for financial reporting purposes, referred to as temporary differences.

Due to uncertainties surrounding the generation of sufficient future

Table of Contents

BEVERLY ENTERPRISES, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)
Years ended December 31, 2004, 2003, and 2002

1. Summary of Significant Accounting Policies (Continued)

income in the near term necessary to realize certain deferred tax benefits, primarily relating to net operating loss carryforwards, we have established a full valuation allowance on our net deferred tax assets (see Note 12).

Transfers of Financial Assets

Through February 29, 2004 and during 2003 and 2002, the Company, through its wholly owned subsidiary Beverly Health and Rehabilitation Services, Inc. (BHRS), sold on a revolving basis certain Medicaid and Veterans Administration patient accounts receivable to a non-consolidated bankruptcy remote, qualifying special purpose entity (QSPE), Beverly Funding Corporation (BFC), at a discount of 1%. These daily transactions constituted true sales of receivables for which BFC bore the risk of collection. The Company accounted for the transfers of receivables as sales in accordance with Statement of Financial Accounting Standards No. 140, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities* (SFAS No. 140).

In accordance with its medium-term notes agreement, BFC ceased purchasing receivables from BHRS on March 1, 2004. Cash collections on and after March 1, 2004, on receivables purchased by BFC prior to March 1, 2004, were accumulated by BFC to repay its $70.0 million of medium-term notes on June 15, 2004. Upon repayment of the medium-term notes on June 15, 2004, BFC no longer had third-party beneficial owners and, therefore, no longer met the conditions of a qualifying special purpose entity, in accordance with SFAS No. 140. Therefore, during the second quarter of 2004, we reconsolidated the remaining balances of BFC with us. Activities related to the revolving sales structure with BFC were as follows for the years ended December 31 (in thousands):

	2004	2003	2002
New receivables sold	$ 119,360	$ 824,475	$ 867,772
Cash collections remitted	197,123	830,457	857,731
Fees received for servicing	658	2,142	2,119
Loss on sale of receivables	(1,194)	(8,245)	(8,678)

BHRS provided invoicing and collection services related to the receivables owned by BFC for a market-based servicing fee. BHRS recognized a loss for the 1% discount at the time of sale which is included in Other operating and administrative costs and expenses and in Net cash provided by operating activities in our consolidated financial statements.

At December 31, 2003, we had an investment in BFC of approximately $31.3 million. The investment was recorded at its estimated fair value and was subjected to periodic review for other than temporary impairment. Prior to consolidation, we received $29.0 million of cash from BFC as a return on our investment. The remaining investment balance was recovered through cash collections on the reconsolidated receivables owned by BFC.

Under the revolving sales structure, BFC purchased receivables for cash on a daily basis from BHRS. When BFC ceased its purchases on March 1, 2004, accounts receivable began to increase on our condensed consolidated balance sheet. Our cash flows from operating activities in 2004 have temporarily been negatively impacted since the timing of collections of these receivables is longer than when the receivables were being sold to BFC daily.

Table of Contents

BEVERLY ENTERPRISES, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)
Years ended December 31, 2004, 2003, and 2002

1. Summary of Significant Accounting Policies (Continued)

Revenues

Our revenues are derived primarily from providing long-term healthcare services. Approximately 80% of our revenues in 2004 was derived from federal (Medicare) and state (Medicaid) medical assistance programs. We record revenues when services are provided at standard charges adjusted to amounts estimated to be received under governmental programs and other third-party contractual arrangements based on contractual terms and historical experience. These revenues and receivables are reported at their estimated net realizable amounts and are subject to audit and retroactive adjustment.

Retroactive adjustments are estimated in the recording of revenues in the period the related services are rendered. These amounts are adjusted in future periods as adjustments become known or as cost reporting years are no longer subject to audits, reviews or investigations. Due to the complexity of the laws and regulations governing the Medicare and Medicaid programs, there is at least a possibility that recorded estimates will change by a material amount in the near term. See Note 4 for a discussion of a settlement with the federal government related to Medicare cost reimbursement issues and Note 10 for the estimated potential overpayment from government programs resulting from an internal investigation of our former MK Medical business unit. Excluding these items, changes in estimates related to third-party receivables resulted in an increase in revenues of approximately $8.0 million, $8.7 million and $948,000 for the years ended December 31, 2004, 2003 and 2002, respectively.

Stock-Based Awards

On December 31, 2002, the Financial Accounting Standards Board (FASB) issued Statement of Financial Accounting Standards No. 148, *Accounting for Stock-Based Compensation Transition and Disclosure* (SFAS No. 148). SFAS No. 148 amends Statement of Financial Accounting Standards No. 123, *Accounting for Stock-Based Compensation* (SFAS No. 123) to provide methods of transition for an entity that changes to the fair value method of accounting for stock-based employee compensation. In addition, SFAS No. 148 amends the disclosure provisions of SFAS No. 123 and Accounting Principles Board Opinion No. 28, *Interim Financial Reporting* (APB 28) to require expanded disclosure of the effects of an entity s accounting policy with respect to stock-based employee compensation on reported net income and earnings per share in annual and interim financial statements and allows companies to continue to use the intrinsic value method.

We continue to use the intrinsic value method to account for our stock options. Accordingly, we do not recognize compensation expense for our stock option grants, which are issued at fair market value on the date of grant. However, we recognize compensation expense for our restricted stock grants at the fair market value of our common stock on the date of grant over the respective vesting periods on a straight-line basis. See Note 11 for other disclosures required by SFAS No. 148 and for the pro forma effects on our reported net income (loss) and diluted net income (loss) per share if we recognized compensation expense on all stock-based awards using estimated fair values over the vesting periods and other disclosures required by SFAS No. 148.

In December 2004, the FASB issued Statement of Financial Accounting Standards No. 123 (revised), *Share-Based Payment* (SFAS No. 123R). SFAS No. 123R prospectively eliminates the intrinsic value method as an alternative method of accounting for stock-based awards. SFAS No. 123R also revises the fair value-based method of accounting for share-based payment liabilities, forfeitures and modifications of stock-based awards and clarifies SFAS No. 123 s guidance in several areas, including measuring fair value, classifying an award as equity or as a liability and attributing compensation expense to reporting periods. In addition, SFAS No. 123R amends Statement of Financial Accounting Standard No. 95, *Statement of Cash*

Table of Contents

BEVERLY ENTERPRISES, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)
Years ended December 31, 2004, 2003, and 2002

1. Summary of Significant Accounting Policies (Continued)

Flows, (SFAS No. 95) to require the reporting of excess tax benefits as a financing cash inflow rather than as a reduction of taxes paid. We are required to adopt SFAS No. 123R for the interim period beginning July 1, 2005 and expect to use the modified version of prospective application. Based on the number of current unvested stock options, we expect wages and related expenses to increase $1.5 million in the last six months of 2005.

Impairment of Long-Lived Assets

In August 2001, the FASB issued Statement of Financial Accounting Standards No. 144, *Accounting for the Impairment or Disposal of Long-Lived Assets* (SFAS No. 144), which addresses financial accounting and reporting for the impairment of long-lived assets (other than goodwill and indefinite-lived intangibles). We adopted the provisions of SFAS No. 144 in the fourth quarter of 2002. SFAS No. 144 requires impairment losses to be recognized for long-lived assets used in operations when other than temporary indicators of impairment are present and the estimated undiscounted cash flows are not sufficient to recover the assets carrying amounts. The impairment loss is measured by comparing the estimated fair value of the asset, usually based on discounted cash flows, to its carrying amount. In accordance with SFAS No. 144, we assess the need for an impairment write-down when indicators of impairment are present (see Note 5).

Discontinued Operations

SFAS No. 144 also addresses the accounting for and disclosure of long-lived assets to be disposed of by sale. Under SFAS No. 144, when a long-lived asset or group of assets (disposal group) meets the criteria set forth in the Statement:

the long-lived asset (disposal group) will be measured and reported at the lower of its carrying value or fair value less costs to sell and classified as held for sale on the consolidated balance sheet; and

the related operations of the long-lived asset (disposal group) will be reported as discontinued operations in the consolidated statement of operations, with all comparable periods restated.

SFAS No. 144 also addresses the accounting for and disclosure surrounding the disposal of long-lived assets. Our consolidated statements of operations have been restated for all periods presented to report as discontinued operations 125 nursing facilities, eight assisted living centers, our Matrix outpatient therapy clinics, our MK Medical business unit and our Care Focus business unit. At December 31, 2004, 27 nursing facilities and 10 outpatient clinics had met the criteria set forth in SFAS No. 144 to be classified as held for sale and, therefore, are reported in discontinued operations (see Note 6).

Table of Contents

BEVERLY ENTERPRISES, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)
Years ended December 31, 2004, 2003, and 2002

1. Summary of Significant Accounting Policies (Continued)

Earnings Per Share

The following table sets forth the calculation of basic and diluted earnings per share from continuing operations for the years ended December 31 (in thousands, except per share data):

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