GENESIS HEALTH VENTURES INC /PA
Form 10-K
December 28, 2001

SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

|X| ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 2001

|_| TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 Commission File Number 1-11666

GENESIS HEALTH VENTURES, INC.

(Exact name of Registrant as specified in its charter)

Pennsylvania	101 East State Street Kennett Square, PA 19348	06-1132947
(State or other jurisdiction of incorporation or organization)	(Address of principal executive offices including zip code)	(I.R.S. Employer Identification Number)

(610) 444-6350

(Registrant's telephone number, including area code)

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

NONE

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

Title of each class

Common Stock, par value $.02 per share

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

Indicate by check mark whether the Registrant (i) 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, and (ii) has been subject to such filing requirements for the past 90 days.

YES X NO
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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. |_|

The aggregate market value of voting and non-voting common stock held by non-affiliates of the Registrant is $676,395,579(1). As of December 26, 2001, 39,671,279 shares of Common Stock were outstanding and 1,328,721 are to be

issued in connection with a plan confirmed by a court.

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

YES X NO
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DOCUMENTS INCORPORATED BY REFERENCE

NONE

(1) The aggregate dollar amount of the voting stock set forth equals the number of shares of the Company's Common Stock outstanding, reduced by the amount of Common Stock held by officers, directors and shareholders owning in excess of 10% of the Company's Common Stock, multiplied by the last reported sale price for the Company's Common Stock on December 26, 2001. The information provided shall in no way be construed as an admission that any officer, director or 10% shareholder in the Company may or may not be deemed an affiliate of the Company or that he/it is the beneficial owner of the shares reported as being held by him/it, and any such inference is hereby disclaimed. The information provided herein is included solely for record keeping purposes of the Securities and Exchange Commission.

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Cautionary Statements Regarding Forward Looking Statements

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

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

- statements contained in "Risk Factors";
- certain statements in "Management's Discussion and Analysis of Financial Condition and Results Of Operations," such as our ability or inability to meet our liquidity needs, scheduled debt and interest payments and expected future capital expenditure requirements, and to control costs, sell assets and the expected effects of government regulation on reimbursement for services provided;
- certain statements contained in "Business" concerning strategy,

corporate integrity programs, government regulations and the Medicare and Medicaid programs;

- certain statements in the Notes to Consolidated Financial Statements concerning pro forma adjustments; and

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

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

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

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

- changes in pharmacy legislation and payment formulas;

- the expiration of enactments providing for additional governmental funding;

- efforts of third party payors to control costs;

- the impact of federal and state regulations;

- changes in payor mix and payment methodologies;

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

- competition in our business;

- litigation regarding our NeighborCare(R)pharmacy operations' provision of service to HCR Manor Care;

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

- competition for qualified staff in the healthcare industry;

- our ability to control operating costs, return to profitability and generate sufficient cash flow to meet operational and financial requirements; and

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

Risk Factors

Set forth below are risks that we believe are material to our business operations. Additional risks and uncertainties not known to us or that we

currently deem immaterial may also impair our business operations.

Changes in the reimbursement rates or methods of payment from Medicare and Medicaid, or the implementation of other measures to reduce the reimbursement for our services may adversely affect our revenues and operating margins.

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

Legislative and regulatory action has resulted in continuing changes in the Medicare and Medicaid reimbursement programs which have impacted us, including the following:

- the adoption of the Medicare Prospective Payment System pursuant to the Balanced Budget Act of 1997, as modified by the Medicare Balanced Budget Refinement Act ("BBRA");

- adoption of the Benefits Improvement Protection Act of 2000 ("BIPA"); and

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

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

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

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

It is not possible to fully quantify the effect of recent legislation, the interpretation or administration of such legislation or any other governmental initiatives on our business. Accordingly, there can be no assurance that the impact of these changes or any future healthcare legislation will not adversely affect our business. These changes may also adversely affect long-term care

facilities which are customers of our specialty medical businesses, such as pharmacy and rehabilitation therapy services, which may, in turn, adversely affect such businesses. There can be no assurance that payments under governmental and private third party payor programs will be timely, will remain at levels comparable to present levels or will, in the future, be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to such programs. Our financial condition and results of operations may be affected by the revenue reimbursement process, which in our industry is complex and can involve lengthy delays between the time that revenue is recognized and the time that reimbursement amounts are settled. See "Business - Revenue Sources" and "Management's Discussion and Analysis of Financial Condition and Results of Operations."

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

Changes in pharmacy legislation and payment formulas could impact our NeighborCare(R) pharmacy operations.

Pharmacy coverage and cost containment are important policy debates at both the federal and state levels. The federal government has considered proposals to expand Medicare coverage for outpatient pharmacy services. Enactment of such legislation could affect institutional pharmacy services. Likewise, a number of states have proposed cost containment initiatives pending. Changes in payment formulas and delivery requirements could impact our NeighborCare pharmacy operations.

Our revenues will be adversely affected if enactments providing for additional funding expire as currently scheduled.

A number of provisions of the BBRA and BIPA enactments providing additional funding for Medicare participating skilled nursing facilities expire on September 30, 2002. Expiring provisions are estimated to, on average, reduce our per beneficiary per diems by $30. Moreover, the Centers for Medicare and Medicaid Services ("CMS") has indicated its desire to complete refinements to the case mix classification system as part of the Fiscal 2003 rule-making. Under the law, when these revisions are implemented, the add-on's authorized by the BBRA and BIPA will expire. As a result of the combination of these factors, the Medicare skilled nursing facility sector is faced with an 18% reduction in the average median per diems. If we were to experience an 18% decline in our current average Medicare rate per patient day, the estimated annual reduction in Medicare revenues of approximately $67,000,000 would have a material adverse effect on our financial position, results of operations and cash flows.

Efforts of third party payors to control cost may adversely affect our revenues and operating margins.

We receive approximately 40% of our revenues from private insurance, long-term care facilities which utilize our specialty medical services, self-pay eldercare facility residents, and other third party payors. These private third party payors are continuing their efforts to control healthcare costs through direct contracts with healthcare providers, increased utilization review and greater

enrollment in managed care programs and preferred provider organizations. These private payors increasingly are demanding discounted fee structures and the assumption by healthcare providers of all or a portion of the financial risk.

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

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

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

We believe that our eldercare centers and other sites of service are in substantial compliance with the various Medicare, Medicaid and state regulatory requirements applicable to us. However, in the ordinary course of our business, we receive notices of deficiencies for failure to comply with various regulatory requirements. We review such notices and take appropriate corrective action. In most cases, we and the reviewing agency will agree upon the measures to be taken to bring the center into compliance with regulatory requirements. In some cases or upon repeat violations, the reviewing agency may take various adverse actions against a provider, including but not limited to:

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

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

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

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

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

State and federal governments are devoting increasing attention and resources to anti-fraud initiatives against health care providers. The Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 expanded the penalties for health care fraud, including broader provisions for the exclusion of providers from the Medicaid program. We have established policies and procedures that we believe are sufficient to ensure that our facilities will operate in substantial compliance with these anti-fraud and abuse requirements. While we believe that our business practices are consistent with Medicaid criteria, those criteria are often vague and subject to change and interpretation. Aggressive anti-fraud actions, however, could have an adverse effect on our financial position, results of operations and cash flows.

State laws and regulations could affect our ability to grow.

Many states in which we operate have adopted Certificate of Need or similar laws which generally require that a state agency approve certain acquisitions and determine that the need for certain bed additions, new services, and capital expenditures or other changes exist prior to the acquisition or addition of beds or services, the implementation of other changes, or the expenditure of capital. State approvals are generally issued for a specified maximum expenditure and require implementation of the proposal within a specified period of time. Failure to obtain the necessary state approval can result in the inability to provide the service, to operate the centers, to complete the acquisition, addition or other change, and can also result in the imposition of sanctions or adverse action on the center's license and adverse reimbursement action.

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

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

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

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

We face intense competition in our business.

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

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

Our NeighborCare(R) pharmacy operations are involved in arbitration and litigation with HCR Manor Care regarding certain service contracts whereby an unfavorable decision would have a material adverse effect on our financial position, results of operations and cash flows.

Certain service contracts permit our NeighborCare pharmacy operations to provide services to HCR Manor Care which constitute approximately ten percent and four percent of the net revenues of our NeighborCare pharmacy operations and us, respectively. These Service Contracts are the subject of certain arbitration and litigation. We are not able to predict the results of such arbitration and litigation. However, if the outcome is unfavorable to us, it would have a

material adverse effect on our financial position, results of operations and cash flows.

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

We have experienced an adverse effect on operating cash flow beginning in the third quarter of 2000 due to an increase in the cost of certain of our insurance programs and the timing of funding new policies. Rising costs of eldercare malpractice litigation, losses stemming from these malpractice lawsuits, and a constriction of insurers has caused many insurance carriers to raise the cost of insurance premiums or refuse to write insurance policies for nursing homes. Also, a tightening of the reinsurance market has affected property, auto, and excess liability insurance carriers. Accordingly, the costs of all insurance premiums have increased.

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

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

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

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

If we are unable to control operating costs, return to profitability and generate sufficient cash flow to meet operational and financial requirements,

including servicing our reduced indebtedness, our business operations may be adversely affected.

Cost containment and lower reimbursement levels by third party payors, including the federal and state governments, have had a significant impact on the healthcare industry as a whole and on our cash flows. Even with reduced indebtedness, our operating margins may continue to be under pressure because of continuing regulatory scrutiny and growth in operating expenses, such as labor costs and insurance premiums. In addition, as a result of competitive pressures, our ability to maintain operating margins through price increases to private patients is limited. Additionally, in connection with our emergence from bankruptcy, we entered into new senior loan obligations. If we are unable to service our reduced indebtedness, our business operations may be adversely affected. Therefore, we will have to find ways to control increasing operating costs, return to profitability and generate sufficient cash flow to meet operational and financing requirements, which includes servicing our reduced indebtedness. If we are unable to do so, our business operations and revenues may be materially adversely affected. See "Management's Discussion and Analysis of Financial Condition and Results of Operation - Liquidity and Capital Resources."

We rely on certain markets and the recent economic downturn or changes in the laws affecting our business in those markets could have a material adverse effect on our operating results.

Our business depends on its eldercare facilities, which are located in 15 states. As of November 15, 2001, 19% of the Company's eldercare facility beds were located in Pennsylvania, 18% were located in New Jersey, 16% were located in Massachusetts and 13% were located in Maryland. The economic condition of these markets could affect the ability of our customers and third party payors to reimburse the Company for our services through a reduction of disposable household income or the ultimate reduction of the tax base used to generate state funding of their respective Medicaid programs. An economic downturn, or changes in the laws affecting our business, in these markets and surrounding markets could have a material adverse effect on our financial position, results of operations and cash flows.

PART I

ITEM 1: BUSINESS

General

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

We are a leading provider of healthcare and support services to the elderly. Our operations are comprised of two primary business segments, inpatient services and pharmacy and medical supply services. These segments are complemented by an array of other service capabilities through the Genesis ElderCare(R) delivery model of integrated healthcare networks.

We provide inpatient services through networks of skilled nursing and assisted living centers primarily located in the eastern United States. The networks currently include 276 owned, leased, managed and jointly-owned eldercare centers

with approximately 33,000 beds.

We provide pharmacy and medical supply services nationwide through our NeighborCare(R) integrated pharmacy and medical supply operation consisting of 60 institutional pharmacies of which two are jointly-owned. Our NeighborCare pharmacy operations serve approximately 253,000 institutional beds; 22 medical supply and home medical equipment distribution centers of which four are jointly-owned and serve over 1,000 eldercare centers with over 80,000 beds; 29 community-based pharmacies of which two are jointly-owned and infusion therapy services.

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

In order to achieve operating efficiencies, economies of scale and significant market share, Genesis has concentrated its eldercare networks in five geographic regions: New England Region (Massachusetts / Connecticut / New Hampshire / Vermont / Rhode Island); Midatlantic Region (Greater Philadelphia / Delaware Valley / New Jersey); Chesapeake Region (Southern Delaware / Eastern Shore of Maryland / Baltimore, Maryland / Washington D.C. / Virginia); Southern Region (Central Florida); and Allegheny / Midwest Region (West Virginia / Western Pennsylvania / Illinois / Wisconsin).

Reorganization

On October 2, 2001, the effective date, we and The Multicare Companies, Inc., referred to as Multicare, consummated a joint plan of reorganization (the "Plan") under Chapter 11 of the Bankruptcy Code (the "Reorganization") pursuant to a September 20, 2001 order entered by the U.S. Bankruptcy Court for the District of Delaware approving the Plan proposed by us and Multicare.

The principal provisions of the Plan are as follows:

- Multicare became our wholly-owned subsidiary. We previously owned 43.6% of Multicare and managed its skilled nursing and assisted living facilities under the Genesis Eldercare brand name;

- New senior notes, new convertible preferred stock, new common stock and new warrants were issued to the Companies' creditors. Approximately 93% of our common stock, also referred to as the new common stock, $242,600,000 in senior notes and preferred stock with a liquidation preference of $42,600,000 were issued to our and Multicare senior secured creditors. Approximately 7% of the new common stock is to be issued to our and Multicare unsecured creditors as well as one year warrants to purchase an additional 11% of the new common stock;

- Holders of our and Multicare pre-Chapter 11 preferred and common stock received no distribution and those instruments were canceled;

- Claims between us and Multicare were set-off against one another and any remaining claims were waived and released; and

- The following persons were designated to comprise our board of directors: Michael R. Walker, our chief executive officer and chairman; James H. Bloem of Humana Inc.; Edwin M. Crawford of Caremark Rx; James E. Dalton, Jr.; James D. Dondero of HCMLP; Robert H. Fish of Sonoma-Seacrest, LLC; Dr. Philip P. Gerbino of the University of the Sciences in Philadelphia; and Joseph A. LaNasa III of Goldman Sachs &

Co.

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

Description of Business

Inpatient Services

We own, lease, manage or jointly-own 276 eldercare centers, including 34 standalone assisted living facilities and 24 transitional care units, located in 15 states.

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

Our skilled nursing centers offer three levels of care for their customers: skilled, intermediate and personal. Skilled care provides 24-hour per day professional services of a registered nurse; intermediate care provides less intensive nursing care; and personal care provides for the needs of customers requiring minimal supervision and assistance. Each eldercare center is supervised by a licensed healthcare administrator and engages the services of a medical director to supervise the delivery of healthcare services to residents and a director of nursing to supervise the nursing staff. We maintain a corporate quality assurance program to monitor regulatory compliance and to enhance the standard of care provided in each center.

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

The following table sets forth, for the periods indicated, information regarding our average number of beds in service and the average occupancy levels at our eldercare centers during the respective fiscal years.

	2001	2000	1999
Average Beds in Service: (1)			
Owned and Leased Facilities	24,783	14,286	15,522

Managed and Jointly-Owned Facilities	9,215	23,779	23,984
Occupancy Based on Average Beds in Service:			
Owned and Leased Facilities	91%	91%	91%
Managed and Jointly-Owned Facilities	88%	91%	90%

(1) In connection with the consummation of the Plan, 10,702 Multicare beds previously classified as "Managed and Jointly-Owned Facilities" were reclassified as "Owned and Leased Facilities." See "Business - Reorganization."

Pharmacy and Medical Supply Services

We provide pharmacy and medical supply services in 41 states through our NeighborCare pharmacy operations. Our NeighborCare pharmacy operations consist of long-term care and retail pharmacies, medical supply centers, infusion services and home medical equipment facilities and serve over 250,000 customers in long-term care settings and more than 1,000,000 covered lives in home care settings.

Included in pharmacy and medical supply service revenues are institutional pharmacy revenues, which include the provision of prescription and non-prescription pharmaceuticals, infusion therapy, and medical supplies and equipment provided to eldercare centers operated by us, as well as to independent healthcare providers by contract. The pharmacy services provided in these settings are tailored to meet the needs of the institutional customer. These services include highly specialized packaging and dispensing systems, computerized medical records processing and 24-hour emergency services. We provide institutional pharmacy products and services to the elderly, chronically ill and disabled in long-term care and alternate sites settings, including skilled nursing facilities, assisted living facilities, residential and independent living communities and the home. We also provide pharmacy consulting services to assure proper and effective drug therapy. We provide these services through 60 institutional pharmacies (two are jointly-owned) and 22 medical supply and home medical equipment distribution centers (four are jointly-owned) located in our various market areas.

In addition, we operate 29 community-based pharmacies (two are jointly-owned) which are located in or near medical centers, hospitals and physician office complexes. The community-based pharmacies provide prescription and over-the-counter medications and certain medical supplies as well as personal service and consultation by licensed professional pharmacists.

Approximately 91% of the sales attributable to all pharmacy operations in the twelve months ended September 30, 2001 were generated through external contracts with independent healthcare providers with the balance attributable to centers owned or leased by us.

Other Services

Rehabilitation Therapy. We provide an extensive range of rehabilitation therapy services, including speech pathology, physical therapy and occupational therapy, through 12 certified rehabilitation agencies in all five of our regional market concentrations. These services are provided by approximately 3,300 licensed rehabilitation therapists and assistants employed or contracted by us to substantially all of the eldercare centers we operate, as well as by contract to healthcare facilities operated by others.

Management Services. We provide management services to 84 eldercare centers pursuant to management agreements that provide generally for the day-to-day responsibility for the operation and management of the centers. In turn, we receive management fees, depending on the agreement, computed as either an overall fixed fee, a fixed fee per customer, a percentage of net revenues of the center plus an incentive fee, or a percentage of gross revenues of the center with some incentive clauses. The various management agreements, including renewal option periods, are scheduled to terminate between 2002 and 2011.

Tidewater Group Purchasing. We own and operate The Tidewater Healthcare Shared Services Group, Inc., referred to as Tidewater, one of the largest long-term care group purchasing companies in the country. We have negotiated contracts with 65 national and 170 regional vendors. Tidewater provides purchasing and shared service programs specially designed to meet the needs of eldercare centers and other long-term care facilities. Tidewater's services are contracted to approximately 3,300 members with over 322,000 beds in 45 states and the District of Columbia.

Other Services. We employ or have consulting arrangements with approximately 81 physicians, physician assistants and nurse practitioners who are primarily involved in designing and administering clinical programs and directing patient care. We also provide an array of other specialty medical services in certain parts of our eldercare network, including portable x-ray and other diagnostic services; home healthcare services; adult day care services; consulting services; respiratory health services and hospitality services such as dietary, housekeeping, laundry, plant operations and facilities management services. We also provide healthcare consulting services.

The following table sets forth the amount of our total net revenue contributed by our segments for the periods presented (in thousands):

	2001	2000	1999
Inpatient services	$ 1,360,230	$ 1,320,151	$ 704,105
Pharmacy and medical supply services	1,040,051	952,350	927,334
Other revenue	169,656	161,357	234,987

Revenue Sources

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

The sources and amounts of our patient revenues will be determined by a number of factors, including licensed bed capacity and occupancy rates of our centers, the mix of patients and the rates of reimbursement among payors. Likewise, payment for ancillary medical services, including the institutional pharmacy services of NeighborCare and therapy services provided by our rehabilitation

therapy services business, will vary based upon payor and payment methodologies. Changes in the case mix of the patients as well as payor mix among private pay, Medicare, and Medicaid will significantly affect our profitability.

The following table reflects the allocation of customer service revenues among these sources of revenue.

	2001	2000	1999	1998	1997
Private pay and other	39%	41%	47%	45%	39%
Medicaid	43	43	39	35	37
Medicare	18	16	14	20	24
Total	100%	100%	100%	100%	100%

See "Business - Government Regulation."

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

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

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

We are subject to periodic audits by the Medicare and Medicaid programs, which

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

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

Under the 1997 Act, participating skilled nursing facilities are reimbursed under a prospective payment system ("PPS") for inpatient Medicare covered services. The PPS system commenced with a facility's first cost reporting period beginning on or after July 1, 1998. Under PPS, nursing facilities are paid a predetermined amount per patient, per day ("per diem") based on the anticipated costs of treating patients. The per diem rate is determined by classifying each patient into one of forty-four resource utilization groups ("RUG") using the information gathered during the minimum data set ("MDS") assessment. There is a separate per diem rate for each of the RUG classifications. The per diem rate also covers rehabilitation and non-rehabilitation ancillary services. The law phased in PPS over a three-year period. The final phase in period for Genesis began October 1, 2001 and is expected to result in a decline in Medicare revenues of approximately $7,000,000. PPS reimbursement is based largely on a nursing facility's costs for the services it provided to Medicare beneficiaries in the 1994-1995 base year.

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

In November 1999, the BBRA was passed in Congress. This enactment provided relief for certain reductions in Medicare reimbursement caused by the 1997 Act. For covered skilled nursing facility services furnished on or after April 1, 2000, the federal per diem rate was increased by 20% for 15 RUG payment categories. While this provision was initially expected to adjust payment rates for only six months, CMS withdrew proposed RUG refinement rules. These payment add-ons will continue until CMS completes certain mandated recalculations of current RUG weightings. For fiscal years 2001 and 2002, the BBRA mandated federal per diem rates for all RUG categories be increased by an additional 4% over the required market basket adjustment. The law provided that certain specific services (such as prostheses and chemotherapy drugs) would be reimbursed separately from and in addition to the federal per diem rate. A provision was included that provided for cost report years beginning on or after January 1, 2000, skilled nursing facilities could waive the PPS transition period and elect to receive 100% of the federal per diem rate. The enactment also lifted for two years a $1,500 cap on rehabilitation therapy services

provided under Medicare Part B.

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

A number of the provisions of the BBRA and BIPA enactments providing additional funding for Medicare participating skilled nursing facilities expire on September 30, 2002, referred to as the Medicare Rate Cliff. Expiring provisions are estimated to, on average, reduce per beneficiary per diems by $30. Moreover, CMS has indicated its desire to complete refinements to the case mix classification system ("RUG refinements") as part of the Fiscal 2003 rule-making. Under the law, when these revisions are implemented, the add-on's authorized by the BBRA and BIPA will expire. The combined effect of the Medicare Rate Cliff and RUG refinements on the Medicare skilled nursing facility sector will be an 18% reduction in the average median per diems. If we were to experience an 18% decline in our current average Medicare rate per patient day, the estimated annual reduction in Medicare revenues of approximately $67,000,000 would have a material adverse affect on our financial position, results of operations and cash flows. Trade organizations representing the skilled nursing facility sector are aggressively pursuing strategies to minimize the potential impact of the Medicare Rate Cliff.

The Company's average Medicare rate per patient day in Fiscal 1997, prior to the implementation of PPS, was over $400. In Fiscal 1998, 1999, 2000 and 2001, the average Medicare rate per patient day was $390, $302, $294 and $323 respectively.

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

The 1997 Act included several provisions affecting Medicaid. The 1997 Act repealed the "Boren Amendment" federal payment standard for Medicaid payments to nursing facilities effective October 1, 1997. The Boren Amendment required that Medicaid payments to certain healthcare providers be reasonable and adequate in order to cover the costs of efficiently and economically operated healthcare facilities. Under the 1997 Act, states must now use a public notice and comment period in order to determine rates and provide interested parties a reasonable opportunity to comment on proposed rates and the justification for and the methodology used in calculating such rates. With the repeal of the federal payment standards, there can be no assurances that budget constraints or other factors will not cause states to reduce Medicaid reimbursement to nursing facilities and pharmacies or that payments to nursing facilities and pharmacies will be made on timely basis. The 1997 Act also grants greater flexibility to

states to establish Medicaid managed care projects without the need to obtain a federal waiver. Although these projects generally exempt institutional care, including nursing facilities and institutional pharmacy services, no assurances can be given that these projects ultimately will not change the reimbursement methodology for nursing facility services or institutional pharmacy services from fee-for-service to managed care negotiated or capitated rates. We anticipate that federal and state governments will continue to review and assess alternative health care delivery systems and payment methodologies.

The BIPA enactment mandates a phase out of intergovernmental transfer transactions by states whereby states artificially inflate the payments to certain public facilities to increase federal matching funds. This action may reduce federal support for a number of state Medicaid plans. The reduced federal payments may impact aggregate available funds requiring states to further contain payments to providers. Genesis operates in several of the states that will experience a contraction of federal matching funds.

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

The reimbursement rates for pharmacy services under Medicaid are determined on a state-by-state basis subject to review by CMS and applicable federal law. In most states, pharmacy services are priced at the lower of "usual and customary" charges or cost (which generally is defined as a function of average wholesale price and may include a profit percentage) plus a dispensing fee. Certain states have "lowest charge legislation" or "most favored nation provisions" which require our institutional pharmacy and medical supply operation to charge Medicaid no more than its lowest charge to other consumers in the state. During 2000, Federal Medicaid requirements establishing payment caps on certain drugs were revised ("Federal Upper Limits"). The final rule relating to Federal Upper Limits was substantially modified, reducing the impact of the new rules on NeighborCare operations.

Pharmacy coverage and cost containment are important policy debates at both the federal and state levels. Congress has considered proposals to expand Medicare coverage for outpatient pharmacy services. Enactment of such legislation could affect institutional pharmacy services. Likewise, a number of states have proposed cost containment initiatives pending. Changes in payment formulas and delivery requirements could impact NeighborCare.

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

Legal Proceedings Potentially Affecting Revenues. Certain service contracts permit our NeighborCare pharmacy operations to provide services to HCR Manor Care, Inc. constituting approximately ten percent and four percent of the net revenues of NeighborCare and us, respectively, or approximately $116,000,000 for the twelve months ended September 30, 2001. These service contracts with HCR Manor Care are the subject of certain litigation. See "Business - Competition,"

"Legal Proceedings" and "Management's Discussion and Analysis of Financial Condition and Results of operations - Certain Transactions and Events - Vitalink Transaction."

Our NeighborCare pharmacy operations provide services to 58 centers operated by Mariner Post-Acute Network, Inc., referred to as Mariner, that represent four percent and two percent of net revenues of our NeighborCare pharmacy operations and us, respectively, or approximately $49,000,000, for the twelve months ended September 30, 2001. On January 18, 2000, Mariner filed voluntary petitions under Chapter 11 with the Bankruptcy Court, giving Mariner certain rights under the protection of the Bankruptcy Court. We participate as a member of the official Mariner unsecured creditors committee.

Effective November 1, 2001, the Mariner Bankruptcy Court approved a settlement agreement between NeighborCare and Mariner relating to these Mariner service contracts, whereby, among other things, (1) the form of the contracts were restated and new pricing was implemented; (2) the terms of the contracts were extended for eighteen months through April 30, 2003, except that Mariner has the right to terminate a limited number of service contracts in the event of the disposition or closure of the subject facility; (3) NeighborCare waived all claims against Mariner in the Mariner bankruptcy with respect to these contracts except for an allowed $6,000,000 pre-petition unsecured claim and (4) Mariner "assumed" the service contracts, as modified, in the Bankruptcy Court.

See "Risk Factors," "Business - Government Regulation" and "Management's Discussion and Analysis of Financial Condition and Results of Operations - Revenue Sources."

Marketing

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

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

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

We operate our core business under the name Genesis ElderCare(R). The Genesis ElderCare logo, trademarks and service marks have been featured in a series of print advertisements in publications serving the regional markets in which we operate. Our marketing of Genesis ElderCare is aimed at increasing awareness among decision makers in key professional and business audiences. We are using advertising, including our toll free Genesis ElderCare lines, to promote our brand name in trade, professional and business publications and to promote services directly to consumers.

Personnel

At November 30, 2001, we employed over 46,000 people, including approximately 33,000 full-time and 13,000 part-time employees. Approximately 19% of these employees are physicians, nurses and clinical professional staff.

We currently have 68 facilities that are covered by, or are negotiating, collective bargaining agreements. The agreements expire at various dates from 2002 through 2005 and cover approximately 5,100 employees. We believe that our relationship with our employees is generally good.

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

Employee Training and Development

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

In addition, we have established an internal training and development program for both nurse assistants and nurses. Employee training is emphasized through a variety of in-house programs as well as a tuition reimbursement program. We have established, company-wide, the Genesis Nursing Assistant Specialist Program. Classes are held on the employee's time, at our cost, last for approximately six months and provide advanced instruction in nursing care. When all of the

requirements for class participation have been met, the nurse aides graduate and are awarded the title of Geriatric Nursing Assistant Specialist ("GNAS") and they are given a salary adjustment. The GNAS then takes on additional responsibilities, acting in an enhanced, leadership roll in the center. As a GNAS continues along their career path, we provide further incentives.

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

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

Government Regulation

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

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

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

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

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

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

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

During the past year, several states have passed legislation altering their CON requirements. Virginia is expected to phase out its CON requirement, and Maryland is studying a similar action. These changes are not expected to materially alter our business opportunities.

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

- the "anti-kickback" provisions of the federal Medicare and Medicaid programs, which prohibit, among other things, knowingly and willfully soliciting, receiving, offering or paying any remuneration (including any kickback, bribe or rebate) directly or indirectly in return for or to induce the referral of an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under Medicare or Medicaid; and

- the "Stark laws" which prohibit, with limited exceptions, the referral of patients by physicians for certain services, including home health services, physical therapy and occupational therapy, to an entity in which the physician has a financial interest.

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

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

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

Although HIPAA was intended to ultimately reduce administrative expenses and burdens faced within the healthcare industry, we believe that implementation of this law will result in additional costs. We have approximately two years to comply with the regulation. We have established a HIPAA task force consisting of clinical, financial and information services professionals focused on HIPAA compliance.

Corporate Integrity Program

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

We have a corporate compliance officer responsible for administering the Integrity Program. The corporate compliance officer, with the approval of the chief executive officer or the board of directors, may use any of our resources to evaluate and resolve compliance issues. The corporate compliance officer reports significant compliance issues to the Board of Directors, including the results of investigations and any subsequent disciplinary or remedial actions

taken.

In December 1998, we established the Corporate Integrity hotline (the "Hotline"), which offers a toll-free number available to all of our employees to report non-compliance issues. Employee calls to the Hotline may be kept anonymous. All calls reporting alleged non-compliance are logged, investigated, addressed and remedied by appropriate company officials.

In 1999, the corporate integrity subcommittee (the "CIS") was established to ensure a mechanism exists for us to monitor compliance issues. Potential compliance issues are referred by the corporate compliance officer to members of the CIS for investigation. The CIS members are senior members of the reimbursement, risk management, human resources, legal, clinical practices and internal audit departments.

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

Competition in the Healthcare Services Industry

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

We operate eldercare centers in 15 states. In each market, our eldercare centers may compete for customers with rehabilitation hospitals; subacute units of hospitals; skilled or intermediate nursing centers; and personal care or residential centers.

Certain of these providers are operated by not-for-profit organizations and similar businesses which can finance capital expenditures on a tax-exempt basis or receive charitable contributions unavailable to us. In competing for customers, a center's local reputation is of paramount importance. Referrals typically come from acute care hospitals; physicians; religious groups; health maintenance organizations; the customer's families and friends; and other community organizations.

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

Genesis competes in providing pharmacy, medical supply and other specialty medical services with a variety of different companies. Generally, this competition is national, regional and local in nature. The primary competitive factors in the specialty medical services business are similar to those in the eldercare center business and include reputation; the cost of services; the quality of clinical services; responsiveness to customer needs and the ability

to provide support in other areas such as third party reimbursement, information management and patient record-keeping.

HCR Manor Care is a publicly traded owner of eldercare centers that competes with us in certain markets. Pursuant to certain service contracts, our NeighborCare pharmacy operations provide services to HCR Manor Care constituting approximately four percent and ten percent of the consolidated net revenues of Genesis and our NeighborCare pharmacy operations, respectively in fiscal 2001. These service contracts are the subject of certain litigation. See "Legal Proceedings."

See "Risk Factors."

Insurance

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

We have experienced an adverse effect on operating cash flow beginning in the third quarter of 2000 due to an increase in the cost of certain of our insurance programs and the timing of funding new policies. Rising costs of eldercare malpractice litigation, losses stemming from these malpractice lawsuits, and a constriction of insurers have caused many insurance carriers to raise the cost of insurance premiums or refuse to write insurance policies for nursing homes. Also, a tightening of the reinsurance market has affected property, auto, and excess liability insurance carriers. Accordingly, the costs of all insurance premiums have increased.

Prior to June 1, 2000, we purchased general and professional liability insurance coverage ("GL/PL") from various commercial insurers on a first dollar coverage basis. Beginning with the June 1, 2000 policy, we have purchased GL/PL coverage from a commercial insurer subject to per claim retentions. These retentions are insured by our wholly-owned captive insurance company, Liberty Health Corp., LTD, referred to as LHC. LHC is currently insuring workers' compensation and GL/PL retentions.

Workers' compensation insurance has been maintained as statutorily required, or in certain jurisdictions for certain periods, we have qualified as exempt or self-insured. Most of the commercial insurance purchased is loss sensitive in nature. As a result, we are responsible for adverse loss development or, in some cases, may be entitled to refunds if losses are below certain levels. We believe that adequate reserves are in place to cover the ultimate liability related to workers' compensation.

We provide several health insurance options to our employees, including a self-insured 80/20 indemnity plan and several fully insured health maintenance organizations.

See "Risk Factors."

ITEM 2: PROPERTIES

Eldercare Facilities

The following table provides information by state as of November 15, 2001 regarding the eldercare centers we own, lease and manage and the independently owned facilities that, for a fee, have access to many of the resources and capabilities of the Genesis Eldercare(R) Network ("Member Centers"). Member Centers typically purchase an array of services from us and have access to managed care contracts, preferred provider arrangements and group purchasing arrangements. Included in the center count are 34 standalone assisted living facilities with 3,323 units and 19 skilled nursing facilities with 632 assisted living units. Certain properties are leased by the respective operating entities from third parties. If we are unable to make rental payments under these leases it could result in loss of the leased property through eviction or other proceedings. Certain leases do not provide for non-disturbance from the mortgagee of the fee interest in the property and consequently each such lease is subject to termination in the event that the mortgage is foreclosed following a default by the owner. Also included in Managed centers are 24 transitional care units with 621 beds located in hospitals principally in the state of Massachusetts.

	Wholly-Owned Centers		Leased Centers		Managed Centers		
	Centers	Beds	Centers	Beds	Centers	Beds	Cent
Maryland	13	1,711	6	843	12	1,683	
Pennsylvania	29	3,778	7	688	11	1,824	
New Jersey	22	3,230	12	1,970	8	747	
Massachusetts	13	1,742	3	370	41	3,162	
Florida	12	1,556	3	321	-	-	
West Virginia	15	1,331	5	394	4	270	
Connecticut	9	1,381	1	130	2	168	
New Hampshire	9	920	3	260	1	85	
Delaware	4	502	-	-	3	319	
Virginia	5	709	1	240	-	-	
Illinois	9	919	-	-	-	-	
Wisconsin	5	720	-	-	-	-	
Rhode Island	3	373	-	-	-	-	
North Carolina	-	-	-	-	2	340	
Vermont	3	314	-	-	-	-	
District of Columbia	-	-	-	-	-	-	
Totals	151	19,186	41	5,216	84	8,598	

Pharmacy and Medical Supply Facilities

The following table provides information by state regarding the pharmacy and medical supply locations operated by our NeighborCare(R) pharmacy operations as of November 15, 2001.

All but two of these sites are leased. Our inability to make rental payments

under these leases could result in loss of the leased property through eviction or other proceedings. Certain leases do not provide for non-disturbance from the mortgagee of the fee interest in the property and consequently each such lease is subject to termination in the event that the mortgage is foreclosed following a default by the owner.

	Institutional Pharmacies	Medical Supply / Home Medical Equipment Sites	Communi Based Pharmac
Maryland	6	5	27
Pennsylvania	7	4	2
California	5	1	-
Florida	3	3	-
New Jersey	4	1	-
Virginia	3	2	-
Wisconsin	5	-	-
Illinois	3	1	-
South Carolina	3	1	-
Indiana	3	-	-
Connecticut	1	1	-
Massachusetts	1	1	-
New Hampshire	1	1	-
New York	2	-	-
North Carolina	2	-	-
Oklahoma	1	1	-
Oregon	2	-	-
Colorado	1	-	-
Iowa	1	-	-
Kentucky	1	-	-
Michigan	1	-	-
Ohio	1	-	-
Rhode Island	1	-	-
Texas	1	-	-
West Virginia	1	-	-
Totals	60	22	29

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

ITEM 3: LEGAL PROCEEDINGS

On October 2, 2001, we and Multicare consummated a joint plan of reorganization (the "Plan") under Chapter 11 of the Bankruptcy Code pursuant to a September 20, 2001 order entered by the U.S. Bankruptcy Court for the District of Delaware approving the Plan. See "Business - Reorganization."

An individual prepetition bond holder has filed a notice of appeal of the order confirming the Plan of Reorganizaton in the United States District Court for the

District of Delaware. The appeal is pending. The Company has filed a motion to dismiss.

We are a party to litigation arising in the ordinary course of business. With exception to the discussion which follows, we do not believe the results of such litigation, even if the outcome is unfavorable to us, would have a material adverse effect on our financial position. See "Cautionary Statements Regarding Forward Looking Statements."

NeighborCare Pharmacy Services, Inc. v. HCR Manor Care, Inc., Manor Care, Inc. and ManorCare Health Services, Inc.

On May 7, 1999, NeighborCare Pharmacy Services, Inc. ("NeighborCare"), our wholly-owned subsidiary, filed a demand for arbitration under the commercial arbitration rules of the American Arbitration Association (the "AAA Arbitration") against HCR Manor Care, Inc., Manor Care, Inc. and ManorCare Health Services, Inc (collectively, the "respondents"). The AAA Arbitration principally concerns two long-term master service agreements between NeighborCare(R) and ManorCare Health Services, Inc. ("the Master Service Agreements"). Pursuant to one of these agreements (the "Master Pharmacy Agreement"), NeighborCare provides pharmacy services to long-term care facilities owned or operated by Manor Care, Inc., formerly known as HCR Manor Care, Inc. ("Manor Care"). Pursuant to the other agreement (the "Master Infusion Therapy Agreement"), NeighborCare provides infusion therapy products and services to Manor Care long-term care facilities.

In the AAA Arbitration, NeighborCare seeks injunctive relief and compensatory damages estimated to be approximately $34,000,000, plus interest, in connection with (1) respondents' attempts to terminate the Master Service Agreements, and (2) respondents' failure to provide NeighborCare with the right to serve as the preferred provider of pharmacy and infusion therapy services to all Manor Care long-term care facilities pursuant to the Master Service Agreements. Respondents have filed counterclaims requesting declaratory relief approving the purported termination of the Master Service Agreements, as well as counterclaims seeking compensatory damages of at least $21,000,000, plus interest, in connection with alleged overcharges under the two agreements.

The AAA Arbitration incorporates causes of action that NeighborCare originally pleaded in a complaint filed on May 7, 1999 in the Circuit Court for Baltimore City in an action captioned Vitalink Pharmacy Services, Inc. v. HCR Manor Care, Inc., Manor Care, Inc., and ManorCare Health Services, Inc., Case No. 24-C-99-002179. At first, the AAA Arbitration only addressed claims relating to the Master Pharmacy Agreement, which, as amended, contained an arbitration clause. However, by letter agreement dated May 13, 1999 between NeighborCare and the defendants in the state court case, the litigants agreed to address the claims relating to the Master Infusion Therapy Agreement in the AAA Arbitration. The parties further agreed to stay respondents' attempted termination of both Master Service Agreements until ten days after a final decision is reached in the AAA Arbitration. As a result, the Master Service Agreements remain in full force and effect today.

The parties selected former federal judge Charles Renfrew to serve as the Arbitrator. The parties briefed a motion by Manor Care to dismiss NeighborCare's claims relating to its right to service all of Manor Care's facilities. In connection with that motion, the Arbitrator, on May 17, 2000, declined to dismiss NeighborCare's claims for money damages for breach of its contractual right to serve as the preferred provider to all Manor Care long-term care facilities. However, the Arbitrator did dismiss, without prejudice, NeighborCare's claim for specific performance of that right.

On June 15, 2000, in anticipation of our possible bankruptcy filing, the Arbitrator stayed the AAA Arbitration. In connection with this stay, the parties agreed that respondents may pay NeighborCare 90% of the face amount of all invoices for pharmaceutical and infusion therapy goods and services that NeighborCare renders to respondents under the Master Service Agreements. The parties agreed, however, that respondents must continue to pay NeighborCare the full face amount of all invoices for pharmacy consulting services under the Master Service Agreement. We subsequently filed for protection under chapter 11 of the United States Bankruptcy Code in the United States Bankruptcy Court for the District of Delaware (the "Bankruptcy Court") on June 22, 2000. Upon that filing, the AAA Arbitration became subject to the automatic stay provisions of 11 U.S.C. ss. 362.

On December 8, 2000, Manor Care renewed a previously filed motion seeking to lift the automatic stay in the AAA Arbitration. On February 6, 2001, the Bankruptcy Court granted the motion, allowing the AAA Arbitration to continue. The hearing in the AAA Arbitration began in Washington, D.C. on July 30, 2001 and was completed on August 16, 2001. Post-hearing briefing has been completed. The Arbitrator's decision is pending.

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

On January 16, 2001, NeighborCare filed a motion with the United States Bankruptcy Court for the District of Delaware seeking to assume the Master Service Agreements in its chapter 11 case. This motion was heard at the same time the Bankruptcy Court considered Manor Care's motion to lift the automatic stay. The Bankruptcy Court postponed any decision on the motion to assume pending the outcome of the AAA Arbitration. This issue is still pending.

Genesis Health Ventures, Inc. v. HCR Manor Care, Inc., Manor Care, Inc., Paul A. Ormond, and Stewart Bainum, Jr.

On May 7, 1999, we filed an action in the United States District Court for the District of Delaware against HCR Manor Care, Inc., Manor Care, Inc., Paul A. Ormond, and Stewart Bainum, Jr. (the "Genesis Delaware Action"). In this action, we seek compensatory and punitive damages exceeding $200,000,000 for federal securities fraud, common-law fraud, negligent misrepresentation and controlling person liability in connection with material misrepresentations and omissions made by defendants during the course of our acquisition of Vitalink. We further seek injunctive relief with respect to Manor Care's failure to dispose of its ownership interests in Heartland Healthcare Services, a competitor of NeighborCare, pursuant to a non-competition provision found in a Side Agreement between Genesis, Vitalink and the entity formerly known as Manor Care, Inc., and now known as Manor Care of America, Inc. ("MCAI").

Defendants filed a motion to dismiss or stay this action pending the resolution of the AAA Arbitration. On March 22, 2000, the Court denied the defendants' motion to dismiss, but granted the motion to stay the case pending resolution of the AAA Arbitration. As a result, the case remains stayed.

NeighborCare Pharmacy Services, Inc. v. Omnicare, Inc. and Heartland Healthcare Services

On July 26, 1999, NeighborCare filed an action in the Circuit Court for Baltimore County, Maryland against Omnicare, Inc. and Heartland Healthcare Services, a joint venture between Omnicare and Manor Care. In this action, NeighborCare seeks injunctive relief, and compensatory and punitive damages of not less than $200,000,000, in connection with defendants' tortious interference

with the Master Service Agreements.

The two defendants each filed motions to dismiss, or, in the alternative, to stay this action pending the resolution of the AAA Arbitration. On November 12, 1999, the Court granted the motions to stay, and set a January 31, 2000 hearing date for the motions to dismiss. Defendants subsequently withdrew their motions to dismiss prior to the hearing date. As a result, the case remains stayed.

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

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

We filed a motion to dismiss this action. On September 29, 2000, the Court granted that motion in part and denied it in part. Specifically, the Court dismissed plaintiff's allegations regarding purportedly fraudulent statements concerning: our knowledge as to certain legislative changes to the Medicare program; the effect of our affiliate Multicare on Genesis' earnings; our intent with respect to the issuance of preferred stock; and our ability to declare dividends on the Series G Preferred Stock. Accordingly, the only allegations that were not dismissed from this action concern our alleged failure to include certain financial information on the Registration Statement it filed in connection with our acquisition of Vitalink, and allegedly fraudulent statements concerning our labor relations. Our motion to consolidate this action with the Genesis Delaware Action described above has been denied.

On October 22, 2001, plaintiff filed a motion to reconsider the Court's decision to dismiss this action in part, and we filed an opposition to that motion. On December 5, 2001, Genesis filed a motion to dismiss the entire action pursuant to our Joint Plan of Reorganization and the Bankruptcy Court's order confirming that Plan, which extinguish plaintiff's claims against us except to the extent that those claims may be repled as set-off or recoupment against claims brought by us. The parties have agreed that plaintiff has until January 14, 2002 to respond to that motion.

Manor Care of America, Inc. v. Genesis Health Ventures, Inc., the Cypress Group L.L.C., TPG Partners II, L.P., and Nazem, Inc.

On December 22, 1999, MCAI filed a lawsuit in the United States District Court for the Northern District of Ohio against us, the Cypress Group L.L.C., TPG Partners II, L.P., and Nazem, Inc. In this action, MCAI brings claims of federal securities fraud in connection with alleged misrepresentations and omissions made by us in connection with our issuance of Series H Preferred Stock and Series I Preferred Stock (the "Senior Preferred Stock") on or about November 15, 1999. In connection with the issuance of the Senior Preferred Stock, MCAI also brings state law breach-of-contract claims with respect to our purported obligations under (1) a Rights Agreement entered into between us and MCAI at the time of our acquisition of Vitalink from MCAI, and (2) the terms of the Series G Preferred Stock issued to MCAI in connection with the Vitalink transaction. MCAI

seeks rescission of the Senior Preferred Stock and unspecified monetary damages.

On February 29, 2000, we filed a motion to dismiss this action on the ground, among others, that the sole federal claim alleged fails to state a cause of action under federal securities laws. That motion has been fully briefed. In response to our chapter 11 filing, the Court, on July 19, 2000, stayed this action and ordered the case closed subject to reopening upon written motion. The case remains closed.

We are not able to predict the results of such litigation. However, if the outcome is unfavorable to us, and the claims of HCR Manor Care are upheld, such results would have a material adverse effect on our financial position, results from operations and cash flows. See "Cautionary Statement Regarding Forward-Looking Statements" and "Risk Factors."

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

In this action, brought in United States District Court for the District of New Jersey on March 16, 2000, the plantiff alleges that a pharmacy purchased by NeighborCare failed to process Medicaid credits for returned medications. The allegations are vaguely alleged for other jurisdictions. While the action was under seal in United States District Court, we fully cooperated with the Department of Justice's evaluation of the allegations. On or about March 2001, the Department of Justice declined to intervene in the suit and prosecute the allegations. The plantiff filed a proof of claim in our bankruptcy proceedings initially for approximately $650,000,000 and more recently submitted an amended claim in the amount of approximately $325,000,000. We believe the allegations have no merit and have objected to the proof of claim. We intend to defend the suit.

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

Not applicable

PART II

ITEM 5: MARKET FOR THE REGISTRANT'S COMMON EQUITY AND RELATED STOCKHOLDER MATTERS

The following table indicates the range of prices per share of the our common stock that was cancelled as a result of the Plan, as reported on the New York Stock Exchange through June 22, 2000 and on the OTC Bulletin Board thereafter.

Fiscal Year Ending	High	Low
September 30, 2001		
First Quarter	$0.20	$0.03
Second Quarter	$0.41	$0.11
Third Quarter	$0.36	$0.02
Fourth Quarter	$0.08	$0.01
September 30, 2000		
First Quarter	$2.94	$1.94
Second Quarter	$3.50	$0.56
Third Quarter	$0.75	$0.02
Fourth Quarter	$0.31	$0.06

Our new common stock was issued on October 2, 2001 and currently trades on the

OTC Bulletin Board under the symbol "GHVE". We have applied to have the new common stock traded on the Nasdaq National Market. The range of prices from October 2, 2001 through December 26, 2001 of the new common stock was $19.20 to $26.00. As of December 26, 2001, there were 39,671,279 shares of the new common stock outstanding and entitled to vote. As of December 26, 2001, there were 5,199 stockholders of record of the new common stock.

The Senior Credit Facility and Senior Secured Note agreements restrict our ability to pay dividends. See "Management's Discussion and Analysis of Financial Condition and Results of Operations - Liquidity and Capital Resources". Management does not anticipate the payment of cash dividends on the new common stock in the foreseeable future.

ITEM 6: SELECTED FINANCIAL DATA

	Predecessor Com		
	2001	2000	1999
Statement of Operations Data (in thousands, except per share data)			
Net revenues	$ 2,569,937	$ 2,433,858	$ 1,866,426
Operating income (loss) before capital costs (1)	133,135	(138,280)	85,879
Earnings (loss) before extraordinary items, cumulative effect of accounting change and after preferred dividends	(1,277,814)	(873,043)	(287,950)
Net income (loss) attributable to common shareholders	247,009	(883,455)	(290,050)
Per common share data (Diluted):			
Earnings (loss) before extraordinary items and cumulative effect of accounting change	(26.27)	(18.55)	(8.11)
Net income (loss) attributable to common shareholders	$ 5.08	$ (18.77)	$ (8.17)
Weighted average shares of common stock and equivalents	48,641	47,077	35,485
Other Financial Data			
Capital expenditures (in thousands)	$ 43,721	$ 51,981	$ 77,943
Operating Data			
Payor Mix			
Private pay and other	39%	41%	47%
Medicare	18%	16%	14%
Medicaid	43%	43%	39%
Average owned/leased eldercare center beds (2)	24,783	14,286	15,522
Occupancy Percentage	90.8%	90.7%	90.7%
Average managed eldercare center beds (2)	9,215	23,779	23,984
Average institutional pharmacy beds served	253,224	244,409	245,277
Average full-time equivalent personnel	40,425	40,450	40,500

	Successor Company	Predece	
	2001	2000	1999
Balance Sheet Data (in thousands)			
Working capital	$ 298,515	$ 304,241	$ 235,704

Total assets	1,834,580	|	3,127,899	2,429,914
Liabilities subject to compromise	-	|	2,446,673	-
Long-term debt	603,268	|	10,441	1,484,510
Redeemable preferred stock	42,600	|	442,820	-
Shareholders' equity (deficit)	$ 834,858	|	$ (246,926)	$ 587,890

(1) Capital costs include depreciation and amortization, lease expense, interest expense, the Multicare joint venture restructuring cost incurred in 2000, and debt restructuring and reorganization costs incurred in 2000 and 2001.

(2) In connection with the consummation of the Plan, 10,702 Multicare beds previously classified as "Managed and Jointly-Owned Facilities" were reclassified as "Owned and Leased Facilities." See "Business - Reorganization."

Please refer to "Management's Discussion and Analysis of Financial Condition and Results of Operations - Certain Transactions and Events" for a description of significant transactions, including the definition of Successor Company, which is defined under "Reorganization - Fresh-Start Reporting."

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

General

Since we began operations in July 1985, we have focused our efforts on providing an expanding array of specialty medical services to elderly customers. We generate revenues primarily from two sources: inpatient services and pharmacy and medical supply services. However, we also derive revenue from other sources.

Inpatient service revenue includes all room and board charges and ancillary service revenue for our eldercare customers at our 192 owned and leased eldercare centers.

We provide pharmacy and medical supply services through our NeighborCare(R) pharmacy operations. Included in pharmacy and medical supply service revenues are institutional pharmacy revenues, which include the provision of infusion therapy, medical supplies and equipment provided to eldercare centers operated by Genesis, as well as to independent healthcare providers by contract. We provide these services through 60 institutional pharmacies (two are jointly-owned) and 22 medical supply and home medical equipment distribution centers (four are jointly-owned) located in our various market areas. In addition, we operate 29 community-based pharmacies (two are jointly-owned) which are located in or near medical centers, hospitals and physician office complexes. The community-based pharmacies provide prescription and over-the-counter medications and certain medical supplies, as well as personal service and consultation by licensed professional pharmacists.

We include the following service revenue in other revenues: rehabilitation therapy services, management fees, capitation fees, consulting services, homecare services, physician services, transportation services, diagnostic services, hospitality services, group purchasing fees, respiratory health services and other healthcare related services.

Certain Transactions and Events

Reorganization

On October 2, 2001, the effective date, we and Multicare consummated a joint plan of reorganization (the "Plan") under Chapter 11 of the Bankruptcy Code (the "Reorganization") pursuant to a September 20, 2001 order entered by the U.S. Bankruptcy Court for the District of Delaware approving the Plan proposed by us and Multicare.

The principal provisions of the Plan are as follows:

- Multicare became our wholly-owned subsidiary. We previously owned 43.6% of Multicare and managed its skilled nursing and assisted living facilities under the Genesis Eldercare(R) brand name;

- New senior notes, new convertible preferred stock, new common stock and new warrants were issued to the companies' creditors. Approximately 93% of our common stock, referred to as the new common stock, $242,600,000 in senior notes and preferred stock with a liquidation preference of $42,600,000 were issued to our and Multicare senior secured creditors. Approximately 7% of the new common stock is to be issued to our and Multicare unsecured creditors as well as one year warrants to purchase an additional 11% of the new common stock;

- Holders of our and Multicare pre-Chapter 11 preferred and common stock received no distribution and those instruments were canceled;

- Claims between us and Multicare were set-off against one another and any remaining claims were waived and released; and

- The following persons were designated to comprise our board of directors: Michael R. Walker, our chief executive officer and chairman; James H. Bloem of Humana Inc.; Edwin M. Crawford of Caremark Rx; James E. Dalton, Jr.; James D. Dondero of HCMLP; Robert H. Fish of Sonoma-Seacrest, LLC; Dr. Philip P. Gerbino of the University of the Sciences in Philadelphia; and Joseph A. LaNasa III of Goldman Sachs & Co.

Our financial difficulties were attributed to a number of factors. First, the federal government made fundamental changes to the reimbursement for medical services provided to individuals. These changes had a significant adverse impact on the healthcare industry as a whole and on our cash flows. Second, the federal reimbursement changes have exacerbated a long-standing problem of inadequate reimbursement by the states for medical services provided to indigent persons under the various state Medicaid programs. Third, numerous other factors have adversely affected our cash flows, including increased labor costs, increased professional liability and other insurance costs, and increased interest rates. Finally, as a result of declining governmental reimbursement rates and in the face of rising inflationary costs, we were too highly leveraged to service our debt, including our long-term lease obligations. See Business - "Revenue Sources," "Personnel," "Government Regulation," and "Insurance." Also see "Fiscal 2000 Compared to Fiscal 1999."

On October 2, 2001, the effective date, and in connection with the consummation of the Plan, we entered into a Senior Credit Facility consisting of the following: (1) a $150,000,000 revolving line of credit (the "Revolving Credit Facility"); (2) a $285,000,000 term loan (the "Term Loan") and (3) an $80,000,000 delayed draw term loan (the "Delayed Draw Term Loan") (collectively

the "Senior Credit Facility"). The proceeds from the Term Loan were utilized to repay $196,000,000 of the then outstanding amounts under the $250,000,000 Genesis debtor-in-possession financing facility (the "Genesis DIP Facility") and $50,000,000 of the then outstanding synthetic lease facility, with the remaining $39,000,000 provided to fund restructuring related costs in accordance with the Plan.

On October 2, 2001, the effective date, and in connection with the consummation of the Plan, we also entered an indenture agreement in the principal amount of $242,605,000 (the "Senior Secured Notes").

Fresh-Start Reporting

Upon emergence from our Chapter 11 proceedings, we adopted fresh-start reporting in accordance with the American Institute of Certified Public Accountants Statement of Position 90-7, "Financial Reporting By Entities in Reorganization Under the Bankruptcy Code" ("SOP 90-7"). In connection with the adoption of fresh start reporting, a new entity has been deemed created for financial reporting purposes. For financial reporting purposes, we adopted the provisions of fresh-start reporting effective September 30, 2001. Consequently, the consolidated balance sheet and related information at September 30, 2001 is labeled "successor company," and reflects the Plan and the principles of fresh start reporting. Periods presented prior to September 30, 2001 have been designated "predecessor company."

In adopting the requirements of fresh-start reporting as of September 30, 2001, we were required to value our assets and liabilities at their estimated fair value and eliminate our accumulated deficit at September 30, 2001. With the assistance of financial advisors in reliance upon various valuation methods, including discounted projected cash flow analysis, price/earnings ratios, and other applicable ratios and economic industry information relevant to our operations, and through negotiations with the various creditor parties in interest, we determined our reorganization value, before consideration of post-filing current and long term liabilities or minority interests, to be $1,525,000,000.

The adjustments to reflect the adoption of fresh-start reporting, including the adjustments to record property, plant and equipment, other long-term assets, investments in unconsolidated affiliates and identifiable intangible assets, at their fair values, have been reflected in the consolidated balance sheet as of September 30, 2001. In addition, the successor company's consolidated balance sheet was further adjusted to eliminate existing liabilities subject to compromise, minority interest with Multicare and consolidated shareholders' deficit; and to reflect the aforementioned $1,525,000,000 reorganization value, which includes the establishment of $320,953,000