VISTACARE INC
Form S-1/A
May 01, 2003

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**As filed with the Securities and Exchange Commission on May 1, 2003**

**Registration No. 333-104801**

# SECURITIES AND EXCHANGE COMMISSION

**Washington, D.C. 20549**

**Amendment No. 1**
**to**

# Form S-1

**REGISTRATION STATEMENT UNDER**
**THE SECURITIES ACT OF 1933**

# VistaCare, Inc.

*(Exact Name of Registrant as Specified in its Charter)*

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

**8125 North Hayden Road, Suite 300,**

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

**Richard R. Slager**

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

***Copies to:***

| **Robert V. Jahrling, Esq.** | **Alejandro E. Camacho, Esq.** |
|---|---|
| **Choate, Hall & Stewart** | **Clifford Chance US LLP** |
| **Exchange Place, 53 State Street** | **200 Park Avenue** |
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| **Telephone: (617) 248-5000** | **Telephone: (212) 878-8000** |
| **Telecopy: (617) 248-4000** | **Telecopy: (212) 878-8375** |

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

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

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

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

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

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

**CALCULATION OF REGISTRATION FEE**

| Title of each Class of Securities to be Registered | Amount to be Registered(1) | Proposed Maximum Offering Price Per Share(2) | Proposed Maximum Aggregate Offering Price | Amount of Registration Fee |
|---|---|---|---|---|
| Class A Common Stock, $.01 par value | 5,290,000 shares | $18.08 | $95,643,198 | 7,738(3) |

(1) Includes 690,000 shares which may be sold if the Underwriters over-allotment option is exercised.

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

(3) $7,401 was previously paid in connection with the original filing of this registration statement on April 29, 2003. The remainder of the currently due filing fee, $337, is being offset against a balance of $1,094 resulting from an overpayment made by the registrant in connection with the filing of a registration statement on Form S-1 (Registration No. 333-98033) initially filed with the Securities and Exchange Commission on August 13, 2002.

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

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

Subject to Completion, dated May 1, 2003

PROSPECTUS

# 4,600,000 Shares

# Class A Common Stock

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

Our shares are quoted on the Nasdaq National Market under the symbol VSTA . On April 30, 2003, the last sale price of our common stock as reported on the Nasdaq National Market was $20.20 per share.

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

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

The selling stockholders have granted the underwriters a 30-day option to purchase up to an aggregate of 690,000 additional shares of common stock on the same terms and conditions as set forth above to cover over-allotments, if any.

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

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

**LEHMAN BROTHERS** **SG COWEN**

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

, 2003

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

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

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## PROSPECTUS SUMMARY

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

### VistaCare, Inc.

**Overview of Our Business**

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

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

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

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

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

**Overview of the Hospice Care Industry**

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

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**Market Opportunity**

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

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

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

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

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

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

**Our Competitive Strengths**

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

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

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

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

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

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

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**Our Business Strategy**

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

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

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

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

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

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

**Corporate Information**

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

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**THE OFFERING**

| | |
|---|---|
| Common stock offered by the selling stockholders | 4,600,000 shares |
| Common stock to be outstanding after the offering | 15,604,035 shares |
| Nasdaq National Market symbol | VSTA |
| Use of proceeds | We will not receive any of the proceeds from this offering |

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

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

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

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

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## SUMMARY CONSOLIDATED FINANCIAL AND OPERATING DATA

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

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

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

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

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

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

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

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

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

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

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## RISK FACTORS

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

### Risks Relating to Our Business

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

manage a large and geographically diverse group of hospice programs;

become Medicare and Medicaid certified in new markets;

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

compete effectively with existing hospice programs in new markets.

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

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

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

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

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

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

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

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

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

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

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

potential difficulties in obtaining required regulatory approvals; and

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

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

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

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

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

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

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

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

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

community-based hospice providers;

national and regional companies;

hospital-based hospice and palliative care programs;

nursing homes; and

home health agencies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Risks Relating to Our Industry

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Risks Related to This Offering

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

Immediately following this offering, our executive officers, directors and their affiliates will together own approximately 16.9% of our outstanding common stock. As a result, those stockholders, if they act together, could influence the outcome of the vote on any matter requiring stockholder approval, including the election of directors and the approval of significant corporate transactions. This concentration of ownership may have

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

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

Sales of a substantial number of shares of common stock in the public market by our current stockholders, or the threat that substantial sales may occur, could cause the market price of our common stock to decrease significantly or make it difficult for us to raise additional capital by selling stock. In connection with this offering, our directors, including Barry M. Smith, who is also a selling stockholder in this offering, together with our executive officers and some of our significant stock and option holders, entered into 90-day lock-up agreements at the request of the underwriters. On the day that is 91 days after the completion of this offering, those stockholders will be able to sell an aggregate of 1,713,409 shares of our common stock they will hold after this offering pursuant to Rule 144 or Rule 701 under the Securities Act of 1933, or the Securities Act. In addition, our directors, officers and some of our significant stockholders, including each of the selling stockholders in this offering, entered into 180-day lock-up agreements in connection with our initial public offering, but the selling stockholders, other than Barry M. Smith, and some of our other significant stockholders did not enter into the 90-day lock-up referred to above in connection with this offering. Those 180-day lock-up agreements will expire on June 16, 2003. At that time, the stockholders who signed a 180-day lock-up agreement, but did not sign a 90-day lock-up agreement will be entitled to sell an aggregate of 2,207,391 shares of our common stock pursuant to Rule 144 or Rule 701 under the Securities Act. The underwriters may also consent to the release of some or all of these shares for sale prior to that time. See the section of this prospectus entitled Shares Eligible for Future Sale for further details regarding the number of shares eligible for sale in the public market after this offering.

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

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

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

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

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

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

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

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

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

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

- actual or anticipated fluctuations in our operating results or our competitors operating results;
- actual or anticipated changes in our growth rates or our competitors growth rates;
- actual or anticipated changes in healthcare policy in the United States and internationally;
- conditions in the financial markets in general or changes in general economic conditions;
- our ability to raise additional capital;
- hospice industry trends, such as variations in patient length of stay; and
- changes in stock market analyst recommendations regarding our common stock, other comparable companies or the hospice industry generally.

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## SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS

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

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

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

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## USE OF PROCEEDS

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

## MARKET PRICE OF COMMON STOCK

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

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

On April 30, 2003, the last reported sale of our common stock on the Nasdaq National Market was $20.20. On April 25, 2003, there were 65 holders of record of our common stock.

## DIVIDEND POLICY

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

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## CAPITALIZATION

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

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

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

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## SELECTED CONSOLIDATED FINANCIAL AND OPERATING DATA

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

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

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

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| | Year Ended December 31, | | | Three Months Ended March 31, | |
|---|---|---|---|---|---|
| | 2000 | 2001 | 2002 | 2002 | 2003 |
| | (dollars in thousands) | | | | |
| **Operating Data:** | | | | | |
| Number of hospice programs(2) | 38 | 38 | 38 | 38 | 39 |
| Admissions(3) | 9,455 | 10,330 | | | |