Teaching Case

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VistaCare Healthcare

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INTRODUCTION

Since its founding in 1995 as a for-profit hospice entity, VistaCare had enjoyed tremendous growth. In 1997, VistaCare had grown from its initial 2 sites to 7 sites in 4 states. By the end of 2003, VistaCare operated 40 hospice sites in 14 states. And the stock price reflected this growth: From its IPO in December of 2002, where the stock debuted at $12, it had risen to over $40 by December of 2003. Recent operational issues negatively impacting revenue growth and profitability had left Chairman and CEO Rick Slager and his management team with the unenviable task of informing investors that the firm had recorded a net loss for the third quarter 2004 of $6.2 million. In December of 2004, just one year after the stock had achieved its all-time high; it now wallowed at less than half that value.

What had happened in just a year's time? VistaCare had continued to invest in future growth by implementing aggressive marketing plans geared to spur the recruitment of patients for its ever-expanding number of hospices. But admissions growth had slowed. To make matters worse, VistaCare was plagued by unexpectedly high reimbursement charges from its primary source of revenue, the federal Medicare system. In effect, VistaCare had to pay back large amounts of monies received from Medicare because they had failed to effectively manage their business to comply with Medicare guidelines.

Rick Slager and his CFO, Mark Leibner, were in need of a viable operations plan to turn VistaCare's business around quickly. More specifically, Slager and Leibner needed to decide whether or not to continue the aggressive spending on marketing programs in the face of deteriorating company financial performance.

OVERVIEW OF THE HOSPICE INDUSTRY

Hospice Care

Hospice care is defined by the Hospice Association of America as:

> "…comprehensive, palliative medical care (treatment to provide for the reduction or abatement of pain and other troubling symptoms, rather than treatment aimed at cure) and supportive social, emotional, and spiritual services to the terminally ill and their families, primarily in the patient's home. The hospice interdisciplinary team, composed of professionals and volunteers, coordinates an individualized plan of care for each patient and family." (Hospice Association of America website 2005)

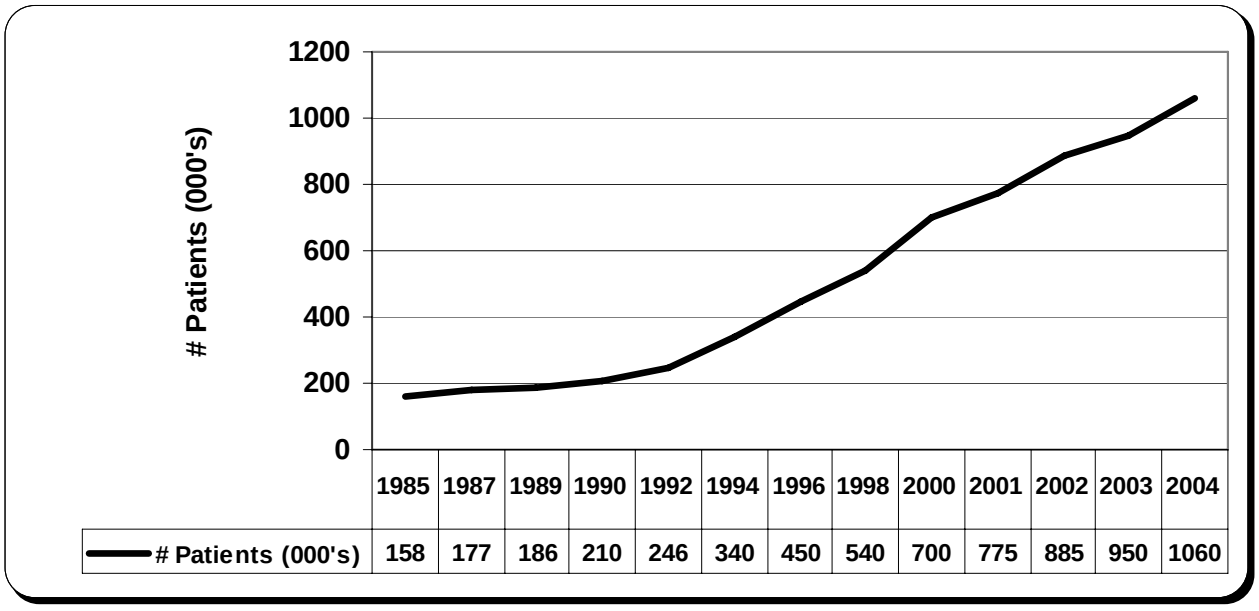
The palliative (pain-reducing) care provided by hospices differs from curative care which is traditionally provided by hospitals. A broad range of services, from traditional nursing care to respite care for family caregivers to bereavement services for family members is traditionally offered.

The Institution of the Medicare Hospice Benefit Spurs Industry Growth

In 2004, the hospice industry in the US was a relatively small and fragmented component of the overall healthcare industry, generating aggregate annual revenues of about $4.5 billion. Spending on hospice services amounted to less than one half of one percent of the $1.4 trillion annual US healthcare spending and only 1.5% of annual Medicare spending (Shattuck Hammond Partners 2004).

In 1982, Congress enacted the Medicare Hospice Benefit on a provisional basis. In 1986, the provisional law was made permanent. Each state was also given the option of including hospice care in their Medicaid program. In addition, hospice care was made available to terminally ill patients in nursing homes. A significant jump in usage of hospices occurred at this time.

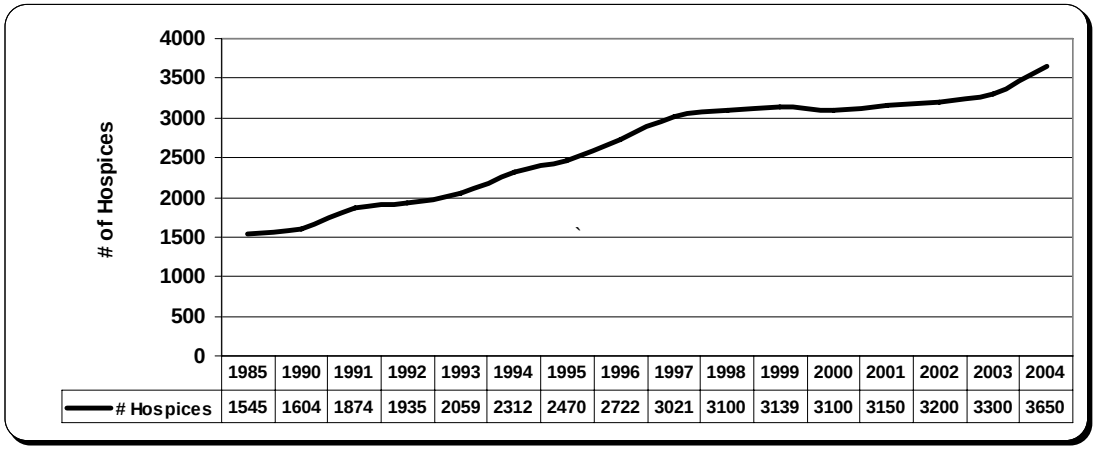
Figure 1: Number of Hospice Patients: 1985 – 2004 (000's)



(National Hospice and Palliative Care Organization (NHPCO) 2005)

In 1996, the federal government initiated a program ("Operation Restore Trust") focused on preventing Medicare fraud across all provider groups. This increased level of regulatory scrutiny, while probably needed, likely inhibited referrals of patients and reduced average and median lengths of stay industry-wide. The Balanced Budget Act of 1997 further negatively impacted reimbursement rates, further dampening the growth rate of hospice sites. By setting aside fewer funds for hospice care reimbursement, the government provided less incentive for hospice providers, particularly those driven by the profit incentive, to open new facilities.

Figure 2: Number of Hospices: 1985 – 2004



	1985	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
# Hospices	1545	1604	1874	1935	2059	2312	2470	2722	3021	3100	3139	3100	3150	3200	3300	3650

(NHPCO 2005)

Factors Driving the Growth in Hospice Care Services in the US

There were several factors driving growth in the hospice industry. Foremost was the overall aging trend in the US and the increasing size of the over 65 population. In addition, there had been an increasing role of advocacy groups in promoting hospice care over other end-of-life alternatives. Finally, The Center for Medicare and Medicaid Services (CMS) appeared to be promoting hospice care through its liberal policies for reimbursement. The CMS's favorable treatment of hospice care in their reimbursement policies was thought to be at least in part because hospice care was viewed as a lower cost alternative to traditional, hospital-based end-of-life care.

The Medicare Hospice Benefit

In 2003, Medicare and Medicaid accounted for 97% of all hospice industry payments. Private insurance paid for an additional 3%. (NHPCO 2004)

Medicare has 3 key eligibility criteria for hospice care. First, the patient must have Medicare A coverage. Second, the patient's doctor and the hospice's medical director must use their best clinical judgment to certify that the patient is terminally ill with a life expectancy of six months or less, if the disease runs its normal course. Third, the patient must choose to receive hospice care rather than curative treatments for their illness. That is, the patient agrees that the future course of action is not to recover from the illness, but to mitigate the pain and suffering related to the inevitable advancement of the illness.

Medicare then pays the hospice a per diem rate, which is intended to cover virtually all expenses related to addressing the patient's terminal illness. Because patients require differing levels of care as they progress in their diseases, Medicare provides for four levels of care to meet their changing needs. These levels are summarized in Figure 3.

LEVEL OF CARE	DESCRIPTION	DAILY RATE (2005)	% OF TOTAL MEDICARE PAYMENTS
Routine Home Care	Patient is at own home or nursing facility; hospice-led care-givers provide intermittent services.	$121.98	95%
Continuous Home Care	Patient is at own home or nursing facility; hospice employees are providing care for blocks of 8 – 24 hours per day.	$711.92	1%
Respite Care	Hospice employees relieve family member of certain care-giving duties for short periods of time to provide respite for the family care-giver.	$126.18	0%
Inpatient Care	Patient is at a hospice- run facility being cared for continuously.	$542.61	4%

Figure 3: Hospice Reimbursement Rates by Service (2005)
(CMS 2005)

Typically, each October, Medicare adjusts its base hospice care reimbursement rates for the following year based on inflation and other economic factors.

Medicare reimbursements are made along the following guidelines:

1) Medicare beneficiaries must pay limited coinsurance: the smallest of 5% or $5 for drugs and 5% of hospice payments for respite care.

2) Total annual co-payments for respite care cannot exceed the Medicare hospital deductible.

3) Medicare caps reimbursements to hospice programs in 2 ways:

   a. Inpatient care days may not exceed 20% of all patient care days per provider. If the cap is reached, reimbursement continues, but at a reduced rate. This is referred to as "The 20/80 Rule". This means that, when the government is reimbursing the hospice provider, they will not pay for inpatient days if they amount to more than 20% of the total number of days that the patient is under the care of the hospice provider. Since inpatient care is close to hospital care, and is the most expensive of the four forms of care, the government is vigilant about the potential abuse of this form of reimbursement.

In 2004, annual reimbursement per beneficiary was capped at $19,635.67. This rate, which is updated every year, is multiplied by the number of new beneficiaries enrolled by the program during the fiscal year. If actual Medicare reimbursements to a program during the period exceed the total, the provider must repay the difference to Medicare. This aggregate reimbursement cap effectively serves as a corrective mechanism to programs with very long lengths of stay. This version of the cap is applicable on a site to site basis, not for hospice operations overall.

For example, a typical hospice site may have 100 patients who are each receiving one of the 4 levels of care as previously described. For that given year, they are "capped" at receiving $1,963,567 for those 100 patients, or 100 X $19,635.67. If the hospice somehow exceeds this amount, for that particular site, they will not be reimbursed for the amount over $1,963,567.

The $19,635.67 amount, divided by 365 days in a year, comes to only $53.80 per day. But the government does not expect the patient at a hospice to have tenure much longer than 180 days (the six-month life expectancy requirement). This results in a daily reimbursement rate of $108.08, which is much closer to the daily reimbursement rate for routine home care, which accounts for 95% of the claims.

b. Prior to 1990, Medicare per-patient payments were limited to a 210 day maximum. From 1990-1997, payments were limited to a maximum of 4 6-month benefit periods, or roughly 720 days. Rules for maximum reimbursement have been further slackened: There are currently no limits to the number of days of care for which Medicare will pay. However, in order to continue to receive reimbursement a patient's prognosis must be reaffirmed at 90 days, at 180 days, and every 60 days thereafter.

Hospice Patient Trends

The typical patient in a hospice tended to be an older Caucasian who was most likely suffering from cancer. According to the National Hospice and Palliative Care Organization, 54% of all hospice patients were female, over 77% were Caucasian, and 65% were 75 years of age or older (NHPCO 2005).

Prior to 2004, the greatest increase had occurred in the number of beneficiaries with non-cancer diagnoses and those living in nursing homes and rural areas. Though cancer patients accounted for 46% of hospice admissions in 2004, this was down from 76% in 1992. Other ailments such as heart disease, dementia, debility, lung disease, kidney disease, and liver disease were becoming more common among patients admitted to hospice care.

Trends in Medicare-Certified Hospice Operations

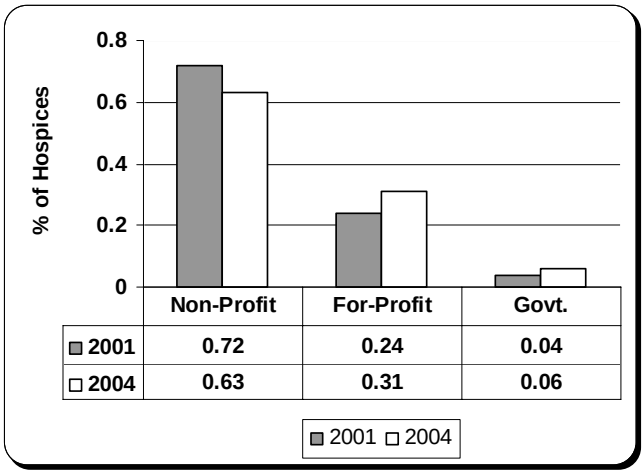
To be certified by Medicare, a hospice was required to provide a wide range of both core and non-core services. Core services, which include nursing services, medical social services, and bereavement, spiritual and dietary counseling, were to be provided by employees of the hospice. Non-core services, including home health aide or physician services, may be provided by hospice employees, or the hospice may have contracted to provide them. Medicare also required certified hospice programs to recruit and train volunteers to provide patient care or administrative services. Unpaid volunteers were required to provide a minimum of 5 % of total patient care hours provided by all paid hospice employees and contract staff of a hospice program.

Medicare regulations further specified that hospice providers could not make admission conditional on executed advanced directives, such as a "do not resuscitate" order, a living will, or a description of treatment desired or not desired. Beyond this specific stipulation, Medicare provided no other mandatory admission guidelines; hospice providers could provide care (or deny admission) to Medicare patients according to their individual philosophy of palliative care.

A hospice was allowed to refuse care to patients when the program was not equipped to provide the necessary services. For example, not all hospices had the ability to care for ventilator patients or to operate pediatric programs. Once a Medicare patient was admitted, the hospice could not discharge the eligible beneficiary at its own discretion, even if the care for the patient promised to be costly or inconvenient.

The hospice industry has traditionally been comprised of non-profit operations with an average of less than 50 patients at any given time. In 2004, nearly 63 % of all hospices were non-profit, with for-profit operations comprising 31%. However, as Figure 4 below shows, the trend had been toward growth in the for-profit area.

Figure 4: Trends in Hospice Profit Status (2001 – 2004)



(NHPCO 2005)

As of year-end 2003, 48% of hospices were free-standing entities, 30% were affiliated with hospitals and another 22% are affiliated with a home health agency or a nursing facility. The trend had been away from free-standing toward affiliation (NHPCO 2004).

The strategic rationale for a hospice to be a part of an integrated healthcare system was threefold. First, hospice was a critical and growing piece of the healthcare continuum and enabled acute care providers to offer patients an alternative to traditional end-of-life care situations. Second, hospice programs could act as a strong link to the community, given the large number of volunteers and the high level of emotional attachment. Finally, affiliated hospices offered "hard-wired" opportunities to transfer patients from high-cost acute care situations to the relatively lower-cost hospice environment, enhancing the financial performance of both entities.

Hospices had also traditionally skewed towards rural areas, most likely because of the relatively low penetration of other health-care alternatives in those areas. However, much of the growth in hospice care had been in the area of urban environments, where hospices were complementing other health care providers, such as hospitals. As of 2004, 38% of hospices were in rural areas, 24% in urban, and another 38% were considered to be operating in both urban and rural areas (NHPCO 2004).

For-Profit Hospices Grow in a Traditionally Non-Profit Industry

Up until the institution of the Medicare Hospice Benefit in 1982, there was little incentive for for-profit hospices to enter the industry. The Medicare Hospice Benefit, along with the dramatic growth trends in patients seeking hospice care, has attracted for-profit players. If one measures by average daily census (ADC), eight of the top nine hospice providers in the US are for-profit.

Figure 5: The Nine Largest Hospice Operations in the US (2004)

	PROVIDER	STATUS	EST. ADC	REV. ($MM)	INDUSTRY SHARE

1	Vitas Healthcare Corporation	Public; For-profit	8,500	$490	10.9%
2	Odyssey Healthcare Inc.	Public; For profit	7,700	$360	8.0%
3	VistaCare Inc.	Public; For profit	5,200	$192	4.3%
4	Manor Care, Inc	Public; For profit	4,500	376*	8.4%
5	SouthernCare Hospice, Inc.	Private; For profit	3,500	180 **	4.0%
6	Beverly Enterprises, Inc	Public; For profit	2,000	$87	1.9%
7	Trinity Hospice, Inc	Private; For profit	1,400	$72	1.6%
8	Life Path	Private; Not For Profit	1,300	$67	1.5%
9	Wellspring Hospice Care	Private; For profit	750	$38	.9%

(Based on market of $4.5 B)
* =Hospice and Home Health Care
** = estimated by Shattuck Hammond Partners LLC

VISTACARE

Origins and Growth

In 2004, VistaCare, Incorporated was the third largest provider of hospice services in the US. It was founded in 1995 by Barry Smith and Roseanne Berry in Phoenix, Arizona. Less than 10 years later, VistaCare had hospice operations in 45 facilities across 14 states, and served an overall average daily census of nearly 5,300 patients. Revenues had grown exponentially, approaching $200 million for 2003. In 2004, despite its expansion in hospice sites, revenues had receded to just over $150 million.

VistaCare's Overall Business Strategies

VistaCare's business strategies revolved around the following imperatives:

1) Controlling operating costs,
2) Managing patient length of stay,
3) Establishing scale and geographic breadth, and
4) The development of referral partners

Controlling Operating Costs

In November, 2003, VistaCare successfully completed a long-planned transition to a new billing system designed to streamline processes and prevent errors in applications for Medicare reimbursement which tend to delay timely payment. This system, called CareNation, had a number of hospice-specific applications which enabled them to track patient admission and certification, enroll patients in a nationwide network of pharmacies, monitor patient census and length of stay data, automate their bereavement communications, and process Medicare and private third-party payer reimbursement claims. Similarly, VistaCare also deployed a separate Pharmacy Cost Control System, which involved a flexible, proprietary disease and symptom-specific drug formulary that emphasized the use of generic drugs (if as effective as the brand-name alternative).

VistaCare maintained a commitment to reducing their patients' use of treatments that were needlessly expensive or clinically ineffective. Collectively, these internal systems helped VistaCare control operating costs.

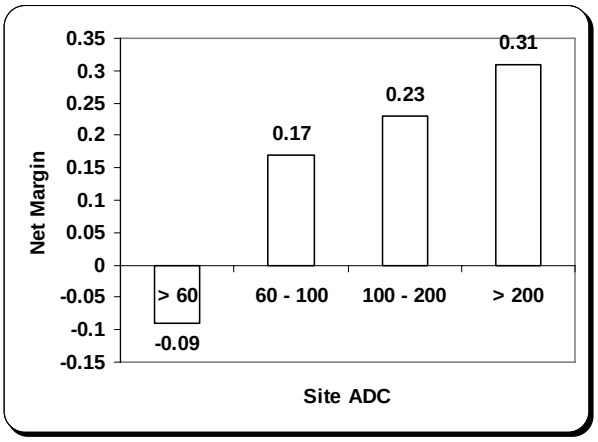
Managing Patient Length of Stay

Patient length of stay appeared to have the most impact on net patient revenue. Patient care expenses were usually higher during the initial and latter days of care. During the initial days of care, expenses tended to be higher due to initial purchases of pharmaceuticals, medical equipment, supplies, and administrative costs. In the latter days of care, expenses tended to be high because patients required more services due to their deteriorating medical condition. For each patient, if length of stay was only a few days, the high costs were spread over fewer days of care which increased patient care expenses as a percentage of net patient revenue. Consequently, profitability was negatively impacted. Clearly, the ideal scenario for a for-profit hospice was to have each patient stay as long as possible so that the patient care expenses were spread over more days, positively impacting profitability. Of course, managing the mix of services provided could also have a positive impact on profitability. As will be seen later, some for-profit firms also engaged in a strategy of enriching their product mixes. In particular, some hospices sought to increase the amount of inpatient care provided.

Establishing Scale and Geographic Breadth

The hospice business model was also highly sensitive to scale. Once the average daily census (ADC) breakeven point was reached (between 30 – 40 patients per month), operating margins in the 10% range were achievable and increased as the census rose. VistaCare's specific experience with scale effects are summarized in Figure 6 below.

Figure 6: The VistaCare Experience: Net Margins by ADC: 2004



(VistaCare Investor Day Presentation, May 17, 2005)

Hospice providers who achieved significant scale were able to negotiate volume discounts on the purchase of pharmaceuticals, durable medical equipment and medical

supplies. In addition, they were in a better position to enter into favorable contracts with private insurers, HMOs and pharmacy benefit managers. Finally, large hospice operations were better able to spread certain fixed costs (corporate overhead, IT infrastructure, and marketing spending) over large patient populations.

Having a broad footprint in a particular geography aided large for-profit hospices in receiving referrals from similarly broad-based health care providers. National and regional nursing home and assisted living communities often sought out the administrative and service consistency benefits resulting from working with a limited number of broad-based hospice service providers. Management at VistaCare referred to their geographic strategy as "building out regional density" (VistaCare Investor Day Presentation, May 17, 2005). A good example of this strategy could be found in the state of Georgia. VistaCare added 4 sites in Georgia in 2004 – 2005, essentially creating a cluster of sites around Atlanta covering 85% of the state population. VistaCare had similar clusters of operations throughout the Southeast, Southwest, Midwest and, to some degree, the East.

The Development of Referral Partnerships

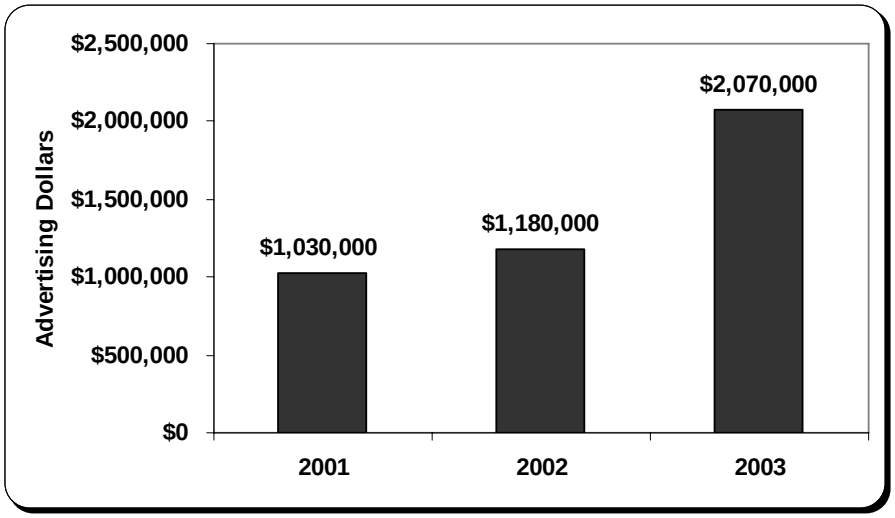
As previously mentioned, another trend toward aggressive marketing strategies in the hospice industry was to establish partnerships with hospitals and retirement communities. When these partnerships were established, the for-profit hospice relied on hospitals and retirement communities to generate referrals to their company. For example, when a person became terminally ill in a hospital or retirement community, a staff member from the organization would recommend that the patient seek hospice care with the partner hospice provider. These partnerships were a primary method used by for-profit hospices to increase admissions. For-profit hospices created marketing departments specifically designed to promote referral growth. As of May, 2005, VistaCare had over 150 hospital contracts, as well as similar relationships with long-term care providers and managed care providers. (VistaCare Investor Day Presentation, May 17, 2005).

THE EVOLUTION OF MARKETING PRACTICES AT VISTACARE

Advertising and Promotions

Traditionally, the marketing strategies of nonprofit hospices did not utilize many resources of the firm. However, the for-profit firms were dedicating increasing amounts of their budgets to marketing activities – particularly the recruitment of referral partners. Figure 7 below shows the increasing trend of advertising expenditures at VistaCare from 2001 – 2003.

Figure 7: VistaCare Expenditures for Advertising (2001 – 2003)



(VistaCare Annual Reports 2002, 2003, 2004)

As a point of differentiation from its larger competitors, VistaCare promoted their "Open Access Policy", which meant they would accept anyone who was eligible for hospice care, regardless of the complexity of their medical needs. This "open access" policy was actually dictated by Medicare policy, but had not been stressed as explicitly by VistaCare's leading competitors. The "Open Access Policy" had also been leveraged in the effort to convince patients and referrers to commit to hospice service in a more timely fashion (i.e., earlier in the progression of the terminal illness). Thus, the patient had a better chance of having a longer length of stay with the hospice, thereby augmenting the hospice's business model.

Personal Selling

As previously stated, VistaCare committed significant resources to establish personal selling teams to call on the various referring entities. Compensation plans were geared around numbers of referrals and types of patients obtained. In some cases, the teams specialized by type of client, such as nursing homes and oncology centers.

In June 2004, VistaCare created the new position of Vice President of Sales in their marketing department to further drive this critical aspect of their strategy. Through 2004, they continued to aggressively recruit qualified candidates to aid in the pursuit of future growth.

Products/Services Strategy

In order to be certified by Medicare, marketers of hospice services were required to offer specific core and non-core services. However, some hospices recognized the value of differentiating their services to appeal to certain types of referrers. For example, certain national or regional health care providers appreciated the ability to work with a larger partner who could offer a consistent level of care and administration over a larger geographical footprint.

Further, hospices were beginning to differentiate themselves by specializing in services for specific diagnoses. Vitas Healthcare, the leading for-profit hospice organization in the industry, distinguished itself by specifically targeting patients that required general inpatient care and continuous home care. This strategy held several advantages. First, it allowed Vitas to attract higher reimbursement rates, thereby achieving higher profitability. Second, due to the relatively short lengths of stay of these patients (as they tended to be cancer-related), it created a buffer against the Medicare Cap by admitting relatively short length of stay patients to offset their longer length of stay patients. Finally, the strategy of offering high value inpatient services differentiated Vitas from their major competitors in the eyes of potential referral partners. By 2004, VistaCare had seen the wisdom of offering inpatient facilities and had identified the establishment of IPUs (inpatient units) as a priority. In tandem with a regional density build-out strategy, VistaCare hoped to compete more effectively for referrals from large healthcare providers.

Distribution Strategy

The major for-profit competitors saw rapid expansion and share growth as critical to their long-term success. All were using the following three methods of expansion to one degree or another: 1) "same store" census growth in existing operations, 2) acquisitions, and 3) the construction of new facilities. Since most of hospice care is provided in the patients' places of residence and not a company-owned facility, capital costs to establish new facilities were relatively low. The acquisition costs for successful existing hospice operations far outstripped the roughly $500,000 cost of establishing a hospice operation from the ground up. Thus, in 2004, the rate of mergers and acquisitions in the hospice industry was slowing.

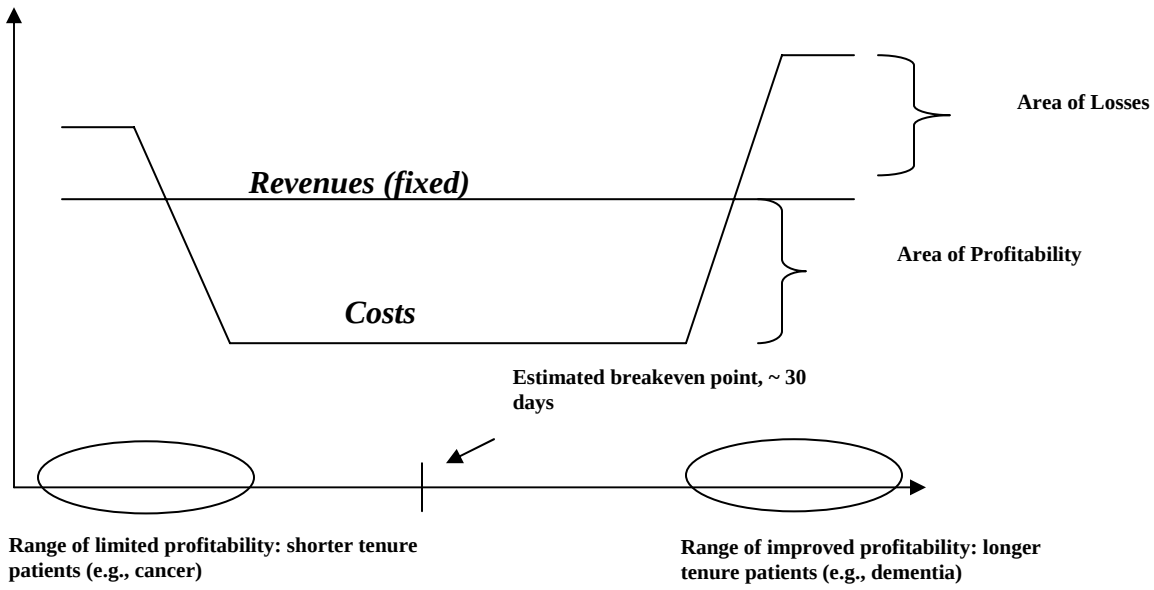
VistaCare was focusing on both rural areas and the fringes of metropolitan areas to expand their business. Prior to 2005, their strategy focused primarily on rural areas, where competition was relatively benign or non-existent, thereby improving the chances of ramping market share quickly.

Certification from Medicare was required to receive reimbursements from the government. Certification usually required that a hospice be up and running for a period of several months, after which time Medicare would inspect the operation and certify the hospice. This, of course, meant that a new hospice would have costs for several months with no income from Medicare, making the initial investment larger. To work around this issue, larger hospice operations made use of the stipulation that a hospice could operate within a 60 – mile radius of its certification. Thus, they used certified staff to establish hospices near the 60 – mile radius in order to operate under the other location's certification until the new operation could become certified. This insured consistent cash flow from Medicare. Once the new operation became certified, they could repeat the process to expand their operations into another 60-mile service area. Utilizing this process could cut the start-up costs for new hospices by up to 50%. VistaCare referred to this as their "leapfrog" strategy.

The Implications of a Fixed Pricing Environment

With over 90% of the revenues being obtained from Medicare and Medicaid, all hospice operators work under a fixed pricing system. Thus, the revenue function for a hospice operator is linear – a fixed per diem payment over time. The cost function, however, is not linear. The cost of a marginal day of care is relatively high at the onset of care, when there are initial costs of learning about the patient's background, and when developing a plan for facilitating the move to a hospice environment. Similarly, costs are relatively high in the days immediately prior to death. Between the high costs at the start and at the end of the period of care, costs are lower (Huskamp, et al). This pattern of cost is the same regardless of diagnoses. A chart depicting this unique revenue to expenses relationship over time can be found in Figure 8 on the following page:

Figure 8: Schematic of Fixed Revenue and U-Shaped Cost Function in Hospice Care



The primary implication of the linear revenue function and the U-shaped cost function is as follows: Given the most typical hospice scenario, whereby a patient is receiving routine home care which is reimbursed at roughly $120 per day, longer lengths of stay will yield higher profits.

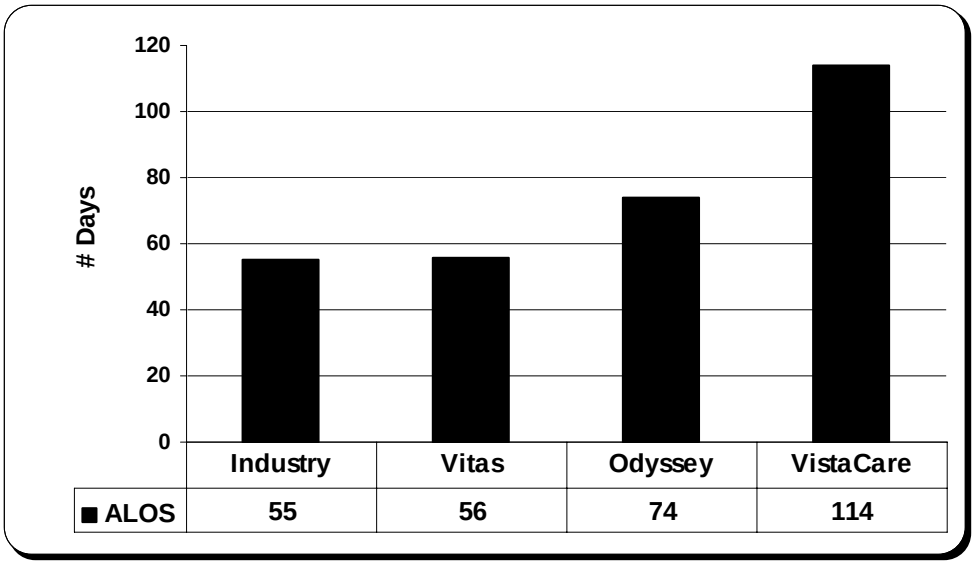
As previously discussed, another strategy being pursued by some hospice operations is to invest in the durable medical equipment that it utilized for inpatient care, which is

reimbursed at over $500 per day. While the durable equipment and full-time care drive the cost function up, these costs can be amortized and spread over many patients, making this portion of the business profitable. It also serves to differentiate the hospice provider as an entity that serves the full spectrum of care.

Further, a patient's diagnosis serves as a predictor of length of stay: Cancer patients tend to be referred late and have relatively short stays. In contrast, non-cancer patients tend to have longer lengths of stay. The cost/revenue dynamic is further complicated by the fact that the non-cancer patients tend to require more and more expensive types of medication and other services not traditionally used on a dying cancer patient.

Figure 9, on the following page, shows the average length of stay for VistaCare as well as for the other two major for-profit operations and the industry overall. It is interesting to note that VistaCare, which touts an "Open Access Policy", has experienced considerably longer average lengths of stay.

Figure 9: ALOS: Average Length of Patient Stay (2003)



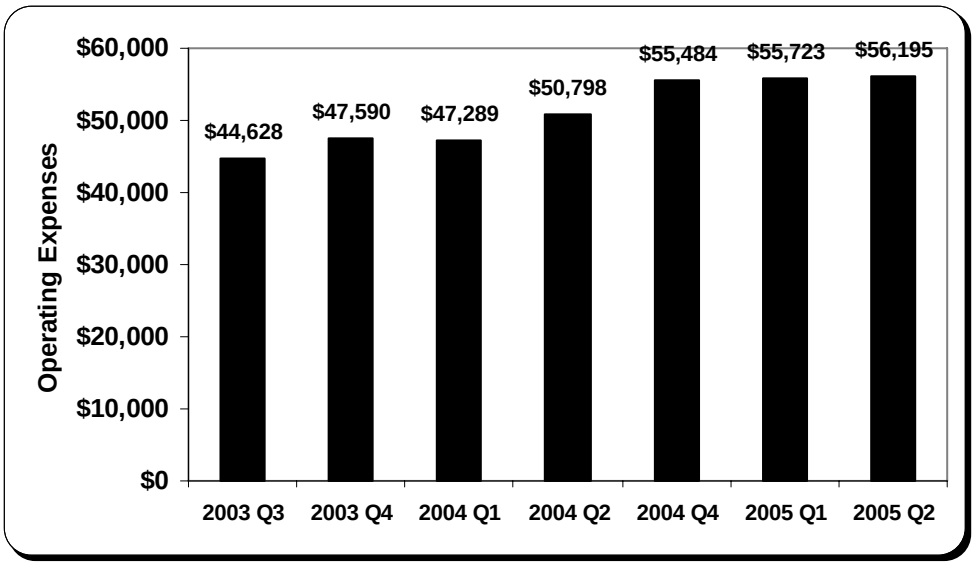
(NHPCO, Vitas, Odyssey, VistaCare Annual Reports 2004)

VistaCare must manage the type and number of patients in an environment where one is expected to take on all types of cases. This task is approached in the following two ways: First, marketing appeals are directed at the type of patients needed at the time to keep the mix of patients by diagnoses in an acceptable range. At times, this may mean directing efforts at oncology patients, but at other times it may mean directing efforts at non-cancer patients; Second, rapid census growth is viewed as a means of staying a step ahead of the Medicare Cap issue by attracting traditionally longer length of stay patients, and mitigating their impact by continuing to attract new patients with their inherently short tenures.

VISTACARE'S OPERATIONAL ISSUES

The year 2003 saw VistaCare seeking to expand its marketing activities with the expectation of increasing its admissions, particularly in some of the new sites it was launching. Among the key marketing initiatives was a hospital referral initiative: VistaCare was rapidly expanding its personal selling sales force and investing in training by retaining the services of an outside training agency. In addition, VistaCare revised its compensation structure for sales reps to provide incentives for enrollment at the program (local) level. This investment in personal selling continued into 2004. The number of personal sales reps expanded from 90 in 2003 to 141 in 2004: a 57% increase. Figure 10 shows the upward trend in operating expenses from 2003 to 2005.

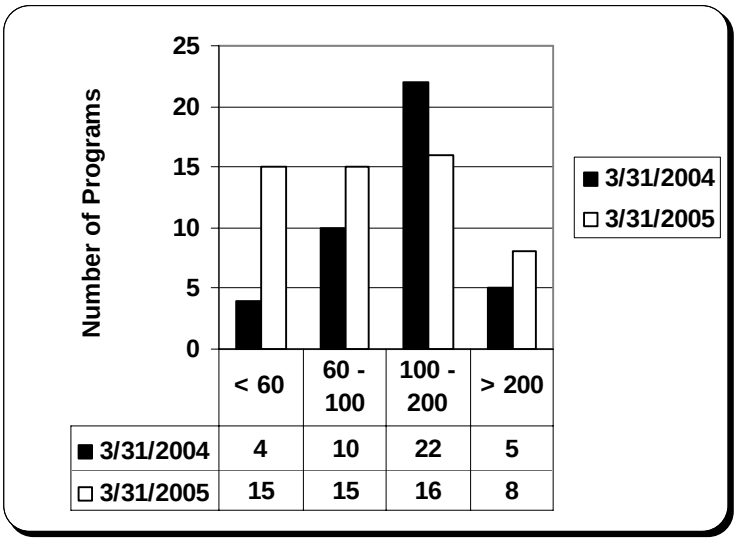
Figure 10: VistaCare Quarterly Operating Expenses (2003 - 2005)
($ 000's)



(VistaCare 10Q Reports, 2003 - 2005)

2004 also saw a significant number of new sites becoming certified. As of March 31, 2004, VistaCare had 41 active sites. By March of 2005, there were 54 sites up and running. This amounts to an increase of 32%. Unfortunately, many of these new sites were operating at relatively low patient count (ADC: Average Daily Census) levels, as Figure 11 below attests.

Figure 11: VistaCare Number of Sites by Site Size (2004 - 2005)



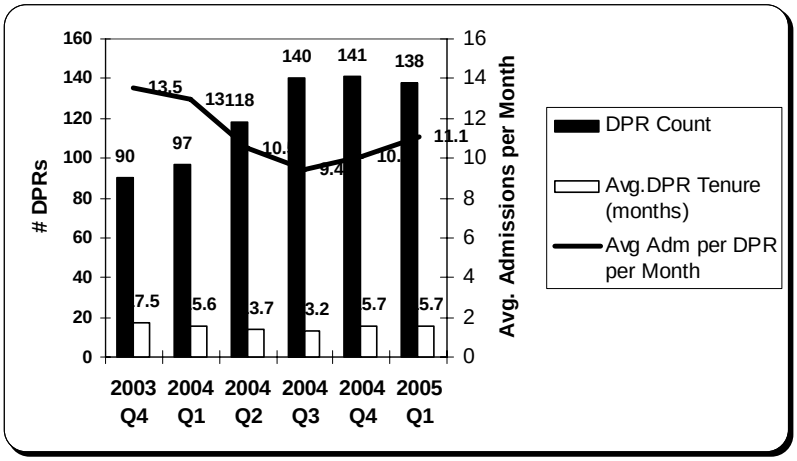
	< 60	60 - 100	100 - 200	> 200
3/31/2004	4	10	22	5
3/31/2005	15	15	16	8

(VistaCare Investor Day Presentation, May 17, 2005).

For example, in examining figure 10 above, note that the number of hospice sites with patient counts less than 60 grew from 4 to 15 from March 2004 to March 2005. These low patient counts place pressure on the business model.

In addition, the new sales reps (DPRs: Directors of Patient Referrals) were not as productive in gaining referrals, due to the learning curve and the long sales cycle of relationship selling. Figure 12 shows the productivity of VistaCare's DPRs based upon tenure in the job.

Figure 12: VistaCare Quarterly DPR Numbers, Tenure and Productivity (2005)

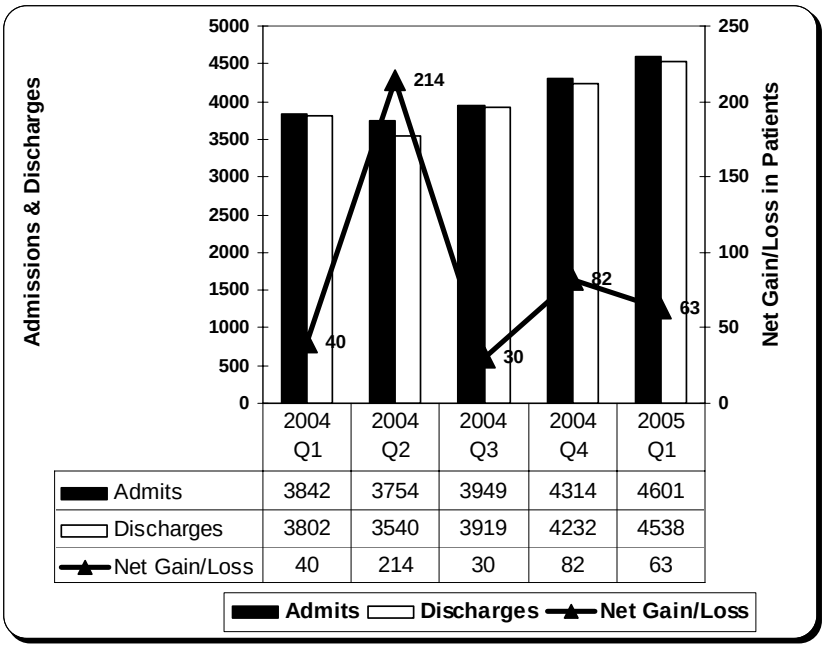


(VistaCare Investor Day Presentation, May 17, 2005).

Note that the average tenure of sales reps dipped from 7.5 months in Q4 2003 to 3.2 months in Q3 2004. Note also the swoon in average admissions per sales rep per month, which went from 13.5 per month in Q4 2003 to 8.4 per month in Q3 2004. In effect, VistaCare was bringing on new sales reps who, due to lack of experience, were less productive in obtaining referrals.

The result of this lack of sales force productivity resulted in a lack of net admissions growth in 2004, as is evidenced by Figure 13.

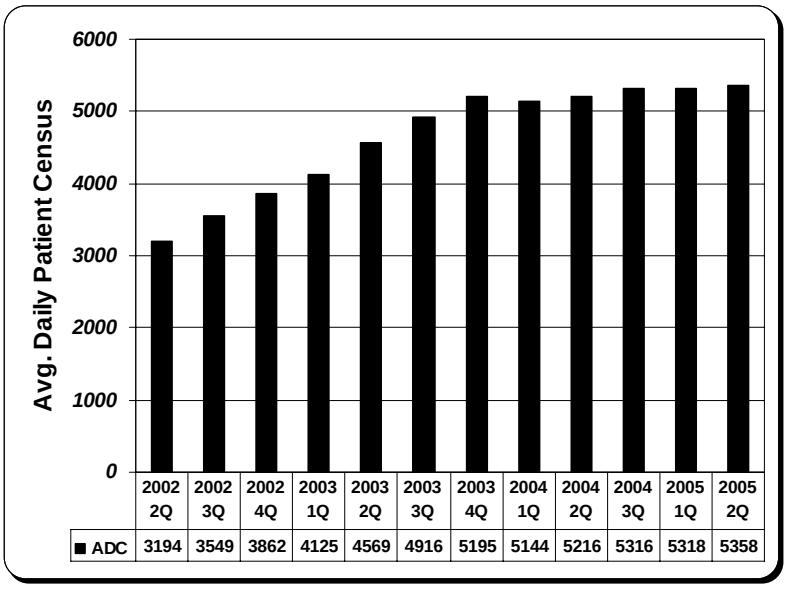
Figure 13: VistaCare Quarterly Admits, Discharges and Net Position (2004 - 2005)



(VistaCare Investor Day Presentation, May 17, 2005).

This dearth of net new admissions, in turn, led to a flattening of the Average Daily Census curve, as is shown by Figure 14.

Figure 14: VistaCare Quarterly ADC (2002 - 2005)

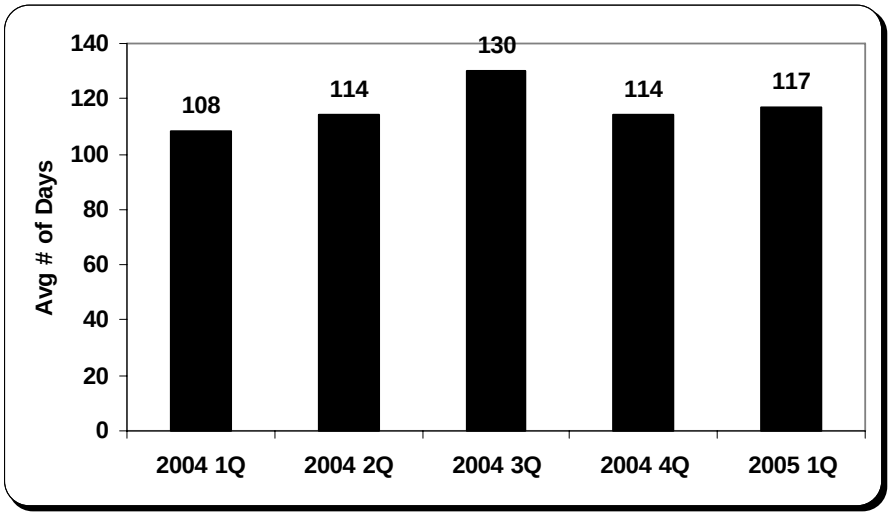


(VistaCare Investor Day Presentation, May 17, 2005)

To further exacerbate the situation, VistaCare had issues in regard to their patient mix. Whereas the industry average for cancer-related hospice patients in the patient mix was 49%, VistaCare's mix of patients with cancer was running at 30%. Traditionally, VistaCare would specifically target non-cancer patients, as they would typically have longer average lengths of stay (ALOS), thereby boosting profitability. However, in the scenario of low ADC growth, the longer lengths of stay would prove to have an adverse impact upon the new sites, where lack of patient turnover would lead to issues with the Medicare Cap requirement. That is, in some of the newer sites, the patient mix became heavily weighted with patients with longer lengths of stay. Without a balance in the mix of shorter length of stay patients (e.g., cancer patients), these sites became susceptible to the Medicare Cap reimbursement guidelines, and VistaCare was forced to reimburse Medicare for amounts billed over the allowable amount.

As Figure 15 depicts, in Q3 of 2004, the average length of stay at VistaCare was surging to a high of 130 days -- over twice the industry average of 55 days.

Figure 15: VistaCare Average Length of Stay (2004 - 2005)



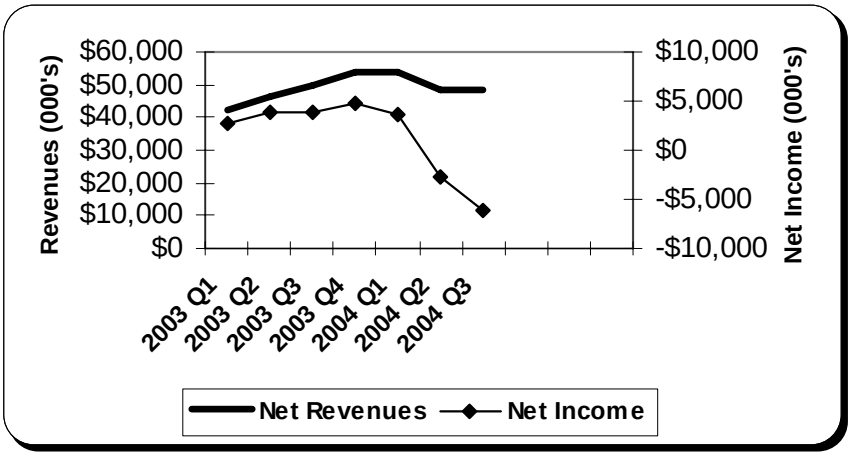
(VistaCare Investor Day Presentation, May 17, 2005).

VistaCare also faced a significant issue in the form of the Medicare Cap Accrual. Medicare caps reimbursements per patient per year at a fixed level (in 2004, that figure was $19,635.67). This rate, which is updated every year, is multiplied by the number of new beneficiaries enrolled by each individual site during the fiscal year. If actual Medicare reimbursements to an individual program during the period exceed the limit, the provider must repay the difference to Medicare. Since providers do not know if they have exceeded the limit until the end of the Medicare fiscal year (November 1), they must accrue accurately for this amount to avoid having an unexpected expense in the 4th quarter of the year. This can occur when hospices have patients with inordinately long lengths of stay. Assume the daily reimbursement rate for a typical hospice patient is about $125 (this is close to the routine care reimbursement rate). A hospice with a patient who has accumulated more than 157 days in a given year would be "capped" at receiving the $19,635.67 per the guideline. Any days beyond 157 would not be paid for by Medicare, and essentially come right off the bottom line of the hospice. The Medicare Cap is compiled in an aggregate manner for each individual hospice site, by simply dividing the total Medicare dollars reimbursed by the number of new patients admitted in the fiscal year. This means that the hospice can mitigate their cap accruals by taking on patients with relatively short lengths of stay. They can then dedicate the "unused" portion of the $19, 635.67 of a short length of stay patient as a "credit" of sorts against the patients who are over the cap amount. Thus, proper cap management entails strict attention to patient mix.

VistaCare ran into serious Medicare Cap accrual problems in 2004, brought upon by an imbalance in patient mix and the resulting inordinately high length of stay in some of their programs. VistaCare had Medicare Cap issues in 9 of their 44 programs in fiscal year 2004, or 20%. In 2Q 2004, they would surprise their stakeholders with an accrual of $6.2 million, over 7 times the "normal" level of the previous quarter. The troubles continued: In 3Q 2004 they were forced to book an accrual of $7.8 million. These expenses are essentially taken out of top-line revenues, severely impacting the bottom

line in those quarters, as Figure 16 attests. Refer to Appendix A for a more detailed profile of VistaCare's Income statement from 2000 – 2004.

Figure 16: VistaCare Quarterly Net Revenues & Net Income (2003 - 2004)



(VistaCare 10Q Reports, 2003 - 2004)

In December of 2004, CEO Rick Slager, CFO Mark Leibner and the rest of the VistaCare management team likely sat down to develop a plan to restore revenue growth and profitability to their operation. They would have been looking for the proper strategy to articulate to their potential customers, suppliers and investors that would renew their confidence in VistaCare's business going forward. In order to develop such a strategy, a number of issues were likely to be addressed:

1) What is the current situation in the industry? What is VistaCare's place in the industry? What imperatives, if any, exist for revenue growth and profitability in both the short term and the long term?

2) What factors, both internal and external, had led them to their current situation? Which were controllable, and which were not?

3) What elements of the marketing program were working effectively for them and which were not? Which should be retained or augmented? Which, if any, could be cut?

4) What is the best manner to move forward that will minimize the likelihood of a downside earnings surprise in the future?

It was clear that action must be taken immediately. The next few months might determine whether VistaCare returned to its high-growth, high-profitability glory days or languished in operational difficulty while competitors gobbled up share in the rapidly-growing hospice industry.

APPENDIX A: ANNUAL INCOME STATEMENTS FOR VISTACARE

VistaCare, Inc.
Annual Income Statements: 5 Year Trend
(Values in 000's)

	12/31/2004	12/31/2003	12/31/2002	12/31/2001	12/31/2000
Total Revenue	$207,051	$191,656	$132,947	$91,362	$81,595
Cost of Revenue	$135,204	$114,631	$79,752	$63,950	$55,256
Gross Profit	$71,847	$77,025	$53,195	$27,412	$26,339
Operating Expenses					
Sales, General and Admin.	$73,095	$55,784	$42,962	$30,716	$23,541
Other Operating Items	$4,060	$1,963	$1,349	$1,990	$1,797
Operating Income	$-4,402	$19,278	$8,884	($5,294)	$1,001
Add'l income/expense items	$967	$309	($112)	($111)	$194

Earnings Before Interest and Tax	$-5,369	$19,587	$8,772	($5,405)	$1,195
Interest Expense	0	$126	$935	$1,157	$1,497
Earnings Before Tax	-$5,369	$19,461	$7,837	($6,562)	($302)
Income Tax	($1,845)	$4,256	$281	$150	$81
Net Income-Cont. Operations	($3,524)	$15,205	$7,556	($6,712)	($383)
Net Income	($3,524)	$15,205	$7,556	($6,712)	($383)
Adjustments to Net Income	$0	$0	($4,052)	($3,839)	($3,482)
Net Income Applicable to Common Shareholders	($4,232)	$15,205	$3,504	($10,551)	($3,865)

(VistaCare Annual Report 2004)

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