U S PHYSICAL THERAPY INC /NV
Form 10-K
March 10, 2011

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
Form 10-K

(Mark One)

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
FOR THE FISCAL YEAR ENDED DECEMBER 31, 2010

OR

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

COMMISSION FILE NUMBER 1-11151

U.S. PHYSICAL THERAPY, INC.
(EXACT NAME OF REGISTRANT AS SPECIFIED IN ITS CHARTER)

NEVADA	**76-0364866**
(STATE OR OTHER JURISDICTION OF INCORPORATION OR ORGANIZATION)	*(I.R.S. EMPLOYER IDENTIFICATION NO.)*
1300 WEST SAM HOUSTON PARKWAY SOUTH, SUITE 300, HOUSTON, TEXAS	**77042**
(ADDRESS OF PRINCIPAL EXECUTIVE OFFICES)	*(ZIP CODE)*

REGISTRANT S TELEPHONE NUMBER, INCLUDING AREA CODE:
(713) 297-7000

SECURITIES REGISTERED PURSUANT TO SECTION 12(b) OF THE EXCHANGE ACT:

Title of Each Class	**Name of Each Exchange on Which Registered**
Common Stock, $.01 par value	**The Nasdaq Stock Market LLC**

SECURITIES REGISTERED PURSUANT TO SECTION 12(g) OF THE EXCHANGE ACT: none

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes o No þ

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. Yes o No þ

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes o No o

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

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

Large accelerated filer o	Accelerated filer þ	Non-accelerated filer o	Smaller reporting company o

(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes o No þ

The aggregate market value of the shares of the registrant s common stock held by non-affiliates of the registrant at June 30, 2010 was $149,121,600 based on the closing sale price reported on the Nasdaq Global Select Market for the registrant s common stock on June 30, 2010, the last business day of the registrant s most recently completed second fiscal quarter. For purposes of this computation, all executive officers, directors and 5% or greater beneficial owners of the registrant were deemed to be affiliates. Such determination should not be deemed an admission that such executive officers, directors and beneficial owners are, in fact, affiliates of the registrant.

As of March 9, 2011, the number of shares outstanding of the registrant s common stock, par value $.01 per share, was: 11,788,846.

DOCUMENTS INCORPORATED BY REFERENCE

DOCUMENT	PART OF FORM 10-K
Portions of Definitive Proxy Statement for the 2011 Annual Meeting of Shareholders	PART III

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FORWARD LOOKING STATEMENTS

We make statements in this report that are considered to be forward-looking statements within the meaning under Section 21E of the Securities Exchange Act of 1934. These statements contain forward-looking information relating to the financial condition, results of operations, plans, objectives, future performance and business of our Company. These statements (often using words such as believes , expects , intends , plans , appear , should and similar wor involve risks and uncertainties that could cause actual results to differ materially from those we project. Included among such statements are those relating to opening new clinics, availability of personnel and the reimbursement environment. The forward-looking statements are based on our current views and assumptions and actual results could differ materially from those anticipated in such forward-looking statements as a result of certain risks, uncertainties, and factors, which include, but are not limited to:

- changes in Medicare guidelines and reimbursement or failure of our clinics to maintain their Medicare certification status;
- revenue and earnings expectations;
- general economic conditions;
- business and regulatory conditions including federal and state regulations;
- changes as the result of government enacted national healthcare reform;
- availability and cost of qualified physical therapists;
- personnel productivity;
- competitive, economic or reimbursement conditions in our markets which may require us to reorganize or close certain clinics and thereby incur losses and/or closure costs including the possible write-down or write-off of goodwill and other intangible assets;
- changes in reimbursement rates or payment methods from third party payors including government agencies and deductibles and co-pays owed by patients;
- maintaining adequate internal controls;
- availability, terms, and use of capital;
- acquisitions and the successful integration of the operations of the acquired businesses; and
- weather and other seasonal factors.

Many factors are beyond our control. Given these uncertainties, you should not place undue reliance on our forward-looking statements. Please see the other sections of this report and our other periodic reports filed with the Securities and Exchange Commission (the SEC) for more information on these factors. Our forward-looking statements represent our estimates and assumptions only as of the date of this report. Except as required by law, we are under no obligation to update any forward-looking statement, regardless of the reason the statement is no longer accurate.

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PART I

ITEM 1. *BUSINESS.*

GENERAL

Our company, U.S. Physical Therapy, Inc. (the Company), through its subsidiaries, operates outpatient physical therapy clinics that provide pre- and post-operative care and treatment for orthopedic-related disorders, sports-related injuries, preventative care, rehabilitation of injured workers and neurological-related injuries. We also provide physician services to third parties and operate two clinics which specialize in the outpatient, non-surgical treatment of osteo arthritis degenerative joint disease and other musculoskeletal conditions. We primarily operate through subsidiary clinic partnerships in which we generally own a 1% general partnership interest and a 64% limited partnership interest and the managing therapist(s) of the clinics owns the remaining limited partnership interest in the majority of the clinics (hereinafter referred to as Clinic Partnerships). To a lesser extent, we operate some clinics through wholly-owned subsidiaries under profit sharing arrangements with therapists (hereinafter referred to as Wholly-Owned Facilities). Unless the context otherwise requires, references in this Annual Report on Form 10-K to we , our or us includes the Company and all of its subsidiaries.

Our strategy is to develop and acquire outpatient clinics on a national basis. At December 31, 2010, we operated 392 outpatient physical therapy clinics in 42 states. The average age of the 392 clinics in operation at December 31, 2010 was 7.5 years. There were 292 clinics operated under Clinic Partnerships and 100 were operated as Wholly-Owned Facilities. Of the 392 clinics, we developed 287 and acquired 105. During 2010, we opened 19 clinics, acquired 25, closed 15 and sold 5. Our highest concentration of clinics are in the following states Tennessee, Texas, Michigan, Georgia, Maryland, New Jersey, Wisconsin, Oklahoma, Virginia, Florida, and Indiana. In addition to our 392 clinics, at December 31, 2010, we also managed 15 physical therapy practices for third parties, including physicians.

During 2010, we acquired a majority interest in 25 clinics in three separate transactions. On February 26, 2010, we acquired a 70% interest in five clinics in the northeast (Northeast Acquisition). On December 21, 2010, we acquired a 70% interest in a six clinic physical therapy group in the mid-Atlantic region (Mid-Atlantic Acquisition). On December 31, 2010, we acquired a 65% interest in a 14 clinic physical therapy group located in the southeast (Southeast Acquisition).

We continue to seek to attract physical therapists who have established relationships with physicians and other referral sources by offering therapists a competitive salary and a share of the profits or an ownership interest in the clinic operated by that therapist. In addition, we have developed satellite clinic facilities of existing clinics, with the result that many clinic groups operate more than one clinic location. Of the 19 clinics opened in 2010, seven were with new partners and 12 were satellites of existing partnerships. In 2011, we intend to continue to focus on developing new clinics and on opening satellite clinics where appropriate along with increasing our patient volume through marketing and new programs. In addition, we will evaluate acquisition opportunities.

Therapists at our clinics initially perform a comprehensive evaluation of each patient, which is then followed by a treatment plan specific to the injury as prescribed by the patient s physician. The treatment plan may include a number of procedures, including therapeutic exercise, manual therapy techniques, ultrasound, electrical stimulation, hot packs, iontophoresis, education on management of daily life skills and home exercise programs. A clinic s business primarily comes from referrals by local physicians. The principal sources of payment for the clinics services are managed care programs, commercial health insurance, Medicare and workers compensation insurance.

Our Company was re-incorporated in April 1992 under the laws of the State of Nevada and has operating subsidiaries organized in various states in the form of limited partnerships and wholly-owned corporations. This description of our business should be read in conjunction with our financial statements and the related notes contained elsewhere in this Annual Report on Form 10-K. Our principal executive offices are located at 1300 West Sam Houston Parkway South, Suite 300, Houston, Texas 77042. Our telephone number is (713) 297-7000. Our website is www.usph.com.

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OUR CLINICS

Most of our clinics are Clinic Partnerships in which we own the general partnership interest and a majority of the limited partnership interests. The managing therapists of the clinics own a portion of the limited partnership interests. Historically, the therapist partners had no interest in the net losses of Clinic Partnerships, except to the extent of their capital accounts. Since we also develop satellite clinic facilities of existing clinics, Clinic Partnerships may consist of more than one clinic location. As of December 31, 2010, through wholly-owned subsidiaries, we owned a 1% general partnership interest in all the Clinic Partnerships, except for one partnership in which we own a 6% general partnership interest. Our limited partnership interests range from 64% to 99% in the Clinic Partnerships, but with respect to the majority of our Clinic Partnerships, we own a limited partnership interest of 64%. For the great majority of the Clinic Partnerships, the managing therapist of each clinic owns the remaining limited partnership interest in the Clinic Partnerships.

In the majority of the Clinic Partnership agreements, the therapist partner begins with a 20% interest in their Clinic Partnership earnings which increases by 3% at the end of each year thereafter up to a maximum interest of 35%.

Typically each therapist partner or director enters into an employment agreement for a term of up to three years with their Clinic Partnership. Each agreement typically provides for a covenant not to compete during the period of his or her employment and for up to two years thereafter. Under each employment agreement, the therapist partner receives a base salary and may receive a bonus based on the net revenues or profits generated by his or her Clinic Partnership. In the case of Clinic Partnerships, the therapist partner receives earnings distributions based upon his or her ownership interest. Upon termination of employment, the Company typically has the right, but is not obligated, to purchase the therapist s partnership interest in Clinic Partnerships. In connection with several of our acquired clinics, in the event that a limited minority partner s employment ceases at any time after three years from the acquisition date, we have agreed to repurchase that individual s noncontrolling interest at a predetermined multiple of earnings before interest and taxes.

Each Clinic Partnership maintains an independent local identity, while at the same time enjoying the benefits of national purchasing, negotiated third-party payor contracts, centralized support services and management practices. Under a management agreement, one of our subsidiaries provides a variety of support services to each clinic, including supervision of site selection, construction, clinic design and equipment selection, establishment of accounting systems and billing procedures and training of office support personnel, processing of accounts payable, operational direction, auditing of regulatory compliance, payroll, benefits administration, accounting services, quality assurance and marketing support.

Our typical clinic occupies approximately 1,500 to 3,000 square feet of leased space in an office building or shopping center. We attempt to lease ground level space for patient ease of access to our clinics. We also attempt to make the decor in our clinics less institutional and more aesthetically pleasing than traditional hospital clinics. Typical minimum staff at a clinic consists of a licensed physical therapist and an office manager, as well as, if appropriate, a medical advisor. As patient visits grow, staffing may also include additional physical therapists, occupational therapists, therapy assistants, aides, exercise physiologists, athletic trainers and office personnel. Therapy services are performed under the supervision of a licensed therapist.

We provide services at our clinics on an outpatient basis. Patients are usually treated for approximately one hour per day, two to three times a week, typically for two to six weeks. We generally charge for treatment on a per procedure basis. Medicare patients are charged based on prescribed time increments and Medicare billing standards. In addition, our clinics will develop, when appropriate, individual maintenance and self-management exercise programs to be continued after treatment. We continually assess the potential for developing new services and expanding the methods of providing our existing services in the most efficient manner while providing high quality patient care.

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FACTORS INFLUENCING DEMAND FOR THERAPY SERVICES

We believe that the following factors, among others, influence the growth of outpatient physical therapy services:

Economic Benefits of Therapy Services. Purchasers and providers of healthcare services, such as insurance companies, health maintenance organizations, businesses and industries, continuously seek cost savings for traditional healthcare services. We believe that our therapy services provide a cost-effective way to prevent short-term disabilities from becoming chronic conditions and to speed recovery from surgery and musculoskeletal injuries.

Earlier Hospital Discharge. Changes in health insurance reimbursement, both public and private, have encouraged the earlier discharge of patients to reduce costs. We believe that early hospital discharge practices foster greater demand for outpatient physical therapy services.

Aging Population. In general, the elderly population has a greater incidence of disability compared to the population as a whole. As this segment of the population grows, we believe that demand for rehabilitation services will expand.

MARKETING

We focus our marketing efforts primarily on physicians, including orthopedic surgeons, neurosurgeons, physiatrists, internal medicine physicians, podiatrists, occupational medicine physicians and general practitioners. In marketing to the physician community, we emphasize our commitment to quality patient care and regular communication with physicians regarding patient progress. We employ personnel to assist clinic directors in developing and implementing marketing plans for the physician community and to assist in establishing relationships with health maintenance organizations, preferred provider organizations, industry and case managers and insurance companies.

SOURCES OF REVENUE

Payor sources for clinic services are primarily managed care programs, commercial health insurance, Medicare/Medicaid and workers compensation insurance. Commercial health insurance, Medicare and managed care programs generally provide coverage to patients utilizing our clinics after payment by the patients of normal deductibles and co-insurance payments. Workers compensation laws generally require employers to provide, directly or indirectly through insurance, costs of medical rehabilitation for their employees from work-related injuries and disabilities and, in some jurisdictions, mandatory vocational rehabilitation, usually without any deductibles, co-payments or cost sharing. Treatments for patients who are parties to personal injury cases are generally paid from the proceeds of settlements with insurance companies or from favorable judgments. If an unfavorable judgment is received, collection efforts are generally not pursued against the patient and the patient s account is written-off against established reserves. Bad debt reserves relating to all receivable types are regularly reviewed and adjusted as appropriate.

The following table shows our payor mix for the years ended:

	December 31, 2010		December 31, 2009		December 31, 2008	
Payor	Net Patient Revenue	Percentage	Net Patient Revenue	Percentage	Net Patient Revenue	Percentage
	(Net Patient Revenues in Thousands)					
Managed Care Program	63,993	31.4%	61,819	31.6%	61,775	33.8%

Commercial Health Insurance	50,243	24.6%	49,150	25.2%	45,866	25.1%
Medicare/Medicaid	46,165	22.6%	40,765	20.9%	35,203	19.2%
Workers Compensation Insurance	34,185	16.7%	34,458	17.6%	35,212	19.2%
Other	9,523	4.7%	9,130	4.7%	4,883	2.7%
Total	204,109	100.0%	195,322	100.0%	182,939	100.0%

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Our business depends to a significant extent on our relationships with commercial health insurers, health maintenance organizations, preferred provider organizations and workers compensation insurers. In some geographical areas, our clinics must be approved as providers by key health maintenance organizations and preferred provider plans to obtain payments. Failure to obtain or maintain these approvals would adversely affect financial results.

During the year ended December 31, 2010, approximately 24% of our visits and 21% of our net patient revenues were from patients with Medicare program coverage. To receive Medicare reimbursement, a facility (Medicare Certified Rehabilitation Agency) or the individual therapist (Physical/Occupational Therapist in Private Practice) must meet applicable participation conditions set by the Department of Health and Human Services (HHS) relating to the type of facility, equipment, record keeping, personnel and standards of medical care, and also must comply with all state and local laws. HHS, through Centers for Medicare & Medicaid Services (CMS) and designated agencies, periodically inspects or surveys clinics/providers for approval and/or compliance. We anticipate that newly developed clinics will generally become certified as Medicare providers. However, we cannot assure you that newly developed clinics will be successful in becoming certified as Medicare providers.

Since 1999, reimbursement for outpatient therapy services provided to Medicare beneficiaries has been made according to a Medicare Physician Fee Schedule (MPFS) published by the Department of Health and Human Services (HHS). Under the Balanced Budget Act of 1997, the total amount paid by Medicare in any one year for outpatient physical therapy or occupational therapy (including speech-language pathology) to any one patient is subjected to a stated dollar amount (the Medicare Cap or Limit), except for services provided in hospitals. Outpatient therapy services rendered to Medicare beneficiaries by the Company s therapists are subject to the Medicare Cap, except to the extent these services are rendered pursuant to certain management and professional services agreements with inpatient facilities. In 2006, Congress passed the Deficit Reduction Act (DRA), which allowed the Centers for Medicare & Medicaid Services (CMS) to grant exceptions to the Medicare Cap for services provided during the year, as long as those services met certain qualifications. The exception process initially allowed for automatic and manual exceptions to the Medicare Cap for medically necessary services. The Temporary Extension Act of 2010, enacted on March 2, 2010, extended the therapy cap exceptions process through March 31, 2010, retroactive to January 1, 2010. With respect to the MPFS, in April 2010, the Continuing Extension Act of 2010 was signed into law which extended the zero percent update through May 31, 2010. On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (PPACA), which extended the exceptions process for the outpatient therapy Medicare Cap. Outpatient therapy service providers may continue to submit claims when an exception is appropriate beyond the allotted Medicare Cap for services furnished on or after January 1, 2010 through December 31, 2010. For physical therapy and speech language pathology service combined, and for occupational therapy services, the Medicare Cap for 2010 was $1,860. On June 25, 2010, the President signed into law the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act (PACMBPRA). The legislation increased reimbursement to providers of outpatient physical therapy for Medicare patients by 2.2% effective June 1, 2010 through November 30, 2010.

On November 2, 2010 CMS released a final ruling on the Multiple Procedure Payment Reduction (MPPR) that includes changes to the reimbursement for Medicare related therapy services that will become effective January 1, 2011. Under MPPR, the practice expense of second and subsequent therapy codes billed in a single day will be reduced by 25%. This reduction will result in an estimated 7% rate reduction for therapy services provided in calendar year 2011 for Medicare. In addition, CMS will make changes to the Relative Value Units (RVUs) and the Geographic Practice Costs Index (GPCI) to the Resource Based Relative Value System (RBRVS) that would potentially mitigate the 7% rate reduction, assuming that Congress acts with regard to the pending Sustainable Growth Rate (SGR) Physician Fee Schedule reduction.

On December 15, 2010, the President signed into law the Medicare and Medicaid Extenders Act of 2010 (MMEA) which tabled for one year the scheduled Medicare rate reduction for physicians, physical therapists and various other healthcare service providers. Further, under the Physician Fee Schedule, during the week of December 27, 2010, CMS

released corrected payment amounts for 2011 that incorporates the changes included in the MMEA. Effective January 1, 2011 pursuant to CMS s ruling on the MPPR, the practice expense of

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second and subsequent therapy codes billed in a single day will be reduced by 20% to 25%. This reduction will result in an estimated 5% to 7% rate reduction for our reimbursement for therapy services provided in calendar year 2011 for Medicare patients. For physical therapy and speech language pathology service combined, and for occupational therapy services, the Medicare Cap for 2011 is $1,870

Since the Medicare Cap was implemented, patients who have been impacted by the cap and those who do not qualify for an exception may choose to pay for services in excess of the cap themselves; however, the Medicare Cap may have resulted in some lost revenues to the Company.

Medicare regulations require that a physician or non-physician practitioner certify the need for skilled therapy services for each patient and that these services be provided under an established plan of treatment, which is periodically revised.

Medicaid has not been a material payor for us, constituting less than 2% of historical revenue.

REGULATION AND HEALTHCARE REFORM

Numerous federal, state and local regulations regulate healthcare services and those who provide them. Some states into which we may expand have laws requiring facilities employing health professionals and providing health-related services to be licensed and, in some cases, to obtain a certificate of need (that is, demonstrating to a state regulatory authority the need for, and financial feasibility of, new facilities or the commencement of new healthcare services). Only one of the states in which we currently operate requires a certificate of need for the operation of our physical therapy business functions. Our therapists and/or clinics, however, are required to be licensed, as determined by the state in which they provide services. Failure to obtain or maintain any required certificates, approvals or licenses could have a material adverse effect on our business, financial condition and results of operations.

Regulations Controlling Fraud and Abuse. Various federal and state laws regulate financial relationships involving providers of healthcare services. These laws include Section 1128B(b) of the Social Security Act (42 U.S. C. § 1320a-7b[b]) (the Fraud and Abuse Law), under which civil and criminal penalties can be imposed upon persons who, among other things, offer, solicit, pay or receive remuneration in return for (i) the referral of patients for the rendering of any item or service for which payment may be made, in whole or in part, by a Federal health care program (including Medicare and Medicaid); or (ii) purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, ordering any good, facility, service, or item for which payment may be made, in whole or in part, by a Federal health care program (including Medicare and Medicaid). We believe that our business procedures and business arrangements are in compliance with these provisions. However, the provisions are broadly written and the full extent of their specific application to specific facts and arrangements to which the Company is a party is uncertain and difficult to predict. In addition, several states have enacted state laws similar to the Fraud and Abuse Law, which may be more restrictive than the federal Fraud and Abuse Law.

In 1991, the Office of the Inspector General (OIG) of the HHS issued the first of its regulations describing compensation financial arrangements that fall within a Safe Harbor and, therefore, are not viewed as illegal remuneration under the Fraud and Abuse Law. Failure to fall within a Safe Harbor does not mean that the Fraud and Abuse Law has been violated; however, the OIG has indicated that failure to fall within a Safe Harbor may subject an arrangement to increased scrutiny under a facts and circumstances test.

Our business of managing physician-owned physical therapy facilities is regulated by the Fraud and Abuse Law. However, the manner in which we contract with such facilities often falls outside the complete scope of available Safe Harbors. We believe our arrangements comply with the Fraud and Abuse Law, even though federal courts provide limited guidance as to the application of the Fraud and Abuse Law to these arrangements. If our management

contracts are held to violate the Fraud and Abuse Law, it could have an adverse effect on our business, financial condition and results of operations.

In February 2000, the OIG issued a special fraud alert regarding the rental of space in physician offices by persons or entities to which the physicians refer patients. The OIG s stated concern in these arrangements is that rental payments may be disguised kickbacks to the physician-landlords to induce referrals. We rent

clinic space for a few of our clinics from referring physicians and have taken the steps that we believe are necessary to ensure that all leases comply to the extent possible and applicable with the space rental Safe Harbor to the Fraud and Abuse Law.

In April 2003, the OIG issued a special advisory bulletin addressing certain complex contractual arrangements for the provision of items and services that were previously identified as suspect in a 1989 special fraud alert. This special advisory bulletin identified several characteristics commonly exhibited by suspect arrangements, the existence of one or more of which could indicate a prohibited arrangement to the OIG. Generally, the indicia of a suspect contractual joint venture as identified by the special advisory bulletin and Opinion 04-17 include the following:

New Line of Business. A provider in one line of business (Owner) expands into a new line of business that can be provided to the Owner s existing patients, with another party who currently provides the same or similar item or service as the new business (Manager/Supplier).

Captive Referral Base. The arrangement predominantly or exclusively serves the Owner s existing patient base (or patients under the control or influence of the Owner).

Little or No Bona Fide Business Risk. The Owner s primary contribution to the venture is referrals; it makes little or no financial or other investment in the business, delegating the entire operation to the Manager/Supplier, while retaining profits generated from its captive referral base.

Status of the Manager/Supplier. The Manager/Supplier is a would-be competitor of the Owner s new line of business and would normally compete for the captive referrals. It has the capacity to provide virtually identical services in its own right and bill insurers and patients for them in its own name.

Scope of Services Provided by the Manager/Supplier. The Manager/Supplier provides all, or many, of the new business key services.

Remuneration. The practical effect of the arrangement, viewed in its entirety, is to provide the Owner the opportunity to bill insurers and patients for business otherwise provided by the Manager/Supplier. The remuneration from the venture to the Owner (i.e., the profits of the venture) takes into account the value and volume of business the Owner generates.

Exclusivity. The arrangement bars the Owner from providing items or services to any patients other than those coming from Owner and/or bars the Manager/Supplier from providing services in its own right to the Owner s patients.

Due to the nature of our business operations, many of our management service arrangements exhibit one or more of these characteristics. However, the Company believes it has taken steps regarding the structure of such arrangements as necessary to sufficiently distinguish them from these suspect ventures, and to comply with the requirements of the Fraud and Abuse Law. However, if the OIG believes the Company has entered into a prohibited contractual joint venture, it could have an adverse effect on our business, financial condition and results of operations.

Stark Law. Provisions of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. § 1395nn) (the Stark Law) prohibit referrals by a physician of designated health services which are payable, in whole or in part, by Medicare or Medicaid, to an entity in which the physician or the physician s immediate family member has an investment interest or other financial relationship, subject to several exceptions. Unlike the Fraud and Abuse Law, the Stark Law is a strict liability statute. Proof of intent to violate the Stark Law is not required. Physical therapy services are among the designated health services . Further, the Stark Law has application to the Company s management contracts with

individual physicians and physician groups, as well as, any other financial relationship between us and referring physicians, including any financial transaction resulting from a clinic acquisition. The Stark Law also prohibits billing for services rendered pursuant to a prohibited referral. Several states have enacted laws similar to the Stark Law. These state laws may cover all (not just Medicare and Medicaid) patients. Many federal healthcare reform proposals in the past few years have attempted to expand the Stark Law to cover all patients as well. As with the Fraud and Abuse Law, we consider the Stark Law in planning our clinics, marketing and other activities, and believe that our operations

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are in compliance with the Stark Law. If we violate the Stark Law, our financial results and operations could be adversely affected. Penalties for violations include denial of payment for the services, significant civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

HIPAA. In an effort to further combat healthcare fraud and protect patient confidentially, Congress included several anti-fraud measures in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA created a source of funding for fraud control to coordinate federal, state and local healthcare law enforcement programs, conduct investigations, provide guidance to the healthcare industry concerning fraudulent healthcare practices, and establish a national data bank to receive and report final adverse actions. HIPAA also criminalized certain forms of health fraud against all public and private payors. Additionally, HIPAA mandates the adoption of standards regarding the exchange of healthcare information in an effort to ensure the privacy and electronic security of patient information and standards relating to the privacy of health information. Sanctions for failing to comply with HIPAA include criminal penalties and civil sanctions. In February of 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law. Title XIII of ARRA, the Health Information Technology for Economic and Clinical Health Act (HITECH), provided for substantial Medicare and Medicaid incentives for providers to adopt electronic health records (EHRs) and grants for the development of health information exchange (HIE). Recognizing that HIE and EHR systems will not be implemented unless the public can be assured that the privacy and security of patient information in such systems is protected, HITECH also significantly expanded the scope of the privacy and security requirements under HIPAA. Most notable are the new mandatory breach notification requirements and a heightened enforcement scheme that includes increased penalties, and which now apply to business associates as well as to covered entities. In addition to HIPAA, a number of states have adopted laws and/or regulations applicable in the use and disclosure of individually identifiable health information that can be more stringent than comparable provisions under HIPAA.

We believe that our operations fully comply with applicable standards for privacy and security of protected healthcare information. We cannot predict what negative effect, if any, HIPAA/HITECH or any applicable state law or regulation will have on our business.

Other Regulatory Factors. Political, economic and regulatory influences are fundamentally changing the healthcare industry in the United States. Congress, state legislatures and the private sector continue to review and assess alternative healthcare delivery and payment systems. Potential alternative approaches could include mandated basic healthcare benefits, controls on healthcare spending through limitations on the growth of private health insurance premiums and Medicare and Medicaid spending, the creation of large insurance purchasing groups, and price controls. Legislative debate is expected to continue in the future and market forces are expected to demand only modest increases or reduced costs. For instance, managed care entities are demanding lower reimbursement rates from healthcare providers and, in some cases, are requiring or encouraging providers to accept capitated payments that may not allow providers to cover their full costs or realize traditional levels of profitability. We cannot reasonably predict what impact the adoption of any federal or state healthcare reform measures or future private sector reform may have on our business.

COMPETITION

The healthcare industry, including the physical therapy business, is highly competitive. The physical therapy business is highly fragmented with no company having as much as six percent of the market share nationally. We believe that our Company ranks third nationally in outpatient rehabilitation providers.

Competitive factors affecting our business include quality of care, cost, treatment outcomes, convenience of location, and relationships with, and ability to meet the needs of, referral and payor sources. Our clinics compete, directly or indirectly, with the physical therapy departments of hospitals, private therapy clinics, physician-owned therapy clinics,

and chiropractors. We may face more intense competition as consolidation of the therapy industry continues.

We believe that our strategy of providing key therapists in a community with an opportunity to participate in ownership or clinic profitability provides us with a competitive advantage by helping to ensure the commitment of local management to the success of the clinic.

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We also believe that our competitive position is enhanced by our strategy of locating our clinics, when possible, on the ground floor of buildings and shopping centers with nearby parking, thereby making the clinics more easily accessible to patients. We offer convenient hours. We also attempt to make the decor in our clinics less institutional and more aesthetically pleasing than traditional hospital clinics.

ENFORCEMENT ENVIRONMENT

In recent years, federal and state governments have launched several initiatives aimed at uncovering behavior that violates the federal civil and criminal laws regarding false claims and fraudulent billing and coding practices. Such laws require providers to adhere to complex reimbursement requirements regarding proper billing and coding in order to be compensated for their services by government payors. Our compliance program requires adherence to applicable law and promotes reimbursement education and training; however, a determination that our clinics billing and coding practices are false or fraudulent could have a material adverse effect on us.

We and our clinics are subject to federal and state laws prohibiting entities and individuals from knowingly and willfully making claims to Medicare, Medicaid and other governmental programs and third party payors that contain false or fraudulent information. The federal False Claims Act encourages private individuals to file suits on behalf of the government against healthcare providers such as us. As such suits are generally filed under seal with a court to allow the government adequate time to investigate and determine whether it will intervene in the action, the implicated healthcare providers often are unaware of the suit until the government has made its determination and the seal is lifted. Violations or alleged violations of such laws, and any related lawsuits, could result in (i) exclusion from participation in Medicare, Medicaid and other federal healthcare programs, or (ii) significant financial or criminal sanctions, resulting in the possibility of substantial financial penalties for small billing errors that are replicated in a large number of claims, as each individual claim could be deemed a separate violation. The recently enacted Fraud Enforcement and Recovery Act of 2009 (FERA) simplified and expanded the principal liability provisions of the False Claims Act and appropriated over $500 million for federal law enforcement authorities to combat financial fraud in 2010 and 2011. Some states also have enacted similar statutes, which may include criminal penalties, substantial fines, and treble damages.

COMPLIANCE PROGRAM

Our Compliance Program. The ongoing success of our Company depends upon our reputation for quality service and ethical business practices. Our Company operates in a highly regulated environment with many federal, state and local laws and regulations. We take a proactive interest in understanding and complying with the laws and regulations that apply to our business.

Our Board of Directors (the Board) has adopted a Code of Business Conduct and Ethics to clarify the ethical standards under which the Board and management carry out their duties. In addition, the Board has created a Corporate Compliance Sub-Committee of the Board s Audit Committee (Compliance Committee) whose purpose is to assist the Board and its Audit Committee (Audit Committee) in discharging their oversight responsibilities with respect to compliance with federal and state laws and regulations relating to healthcare.

We have issued an Ethics and Compliance Manual, created a compliance DVD, hand-outs and an on-line testing program. These tools were prepared to ensure that each clinic as well as every employee of our Company and subsidiaries has a clear understanding of our mutual commitment to high standards of professionalism, honesty, fairness and compliance with the law in conducting business. These standards are administered by our Compliance Officer (CO), who has the responsibility for the day-to-day oversight, administration and development of our compliance program. The CO, internal and external counsel, management and the Compliance Committee review our policies and procedures for our compliance program from time to time in an effort to improve operations and to ensure

compliance with requirements of standards, laws and regulations and to reflect the on-going compliance focus areas which have been identified by the

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Compliance Committee. We also have established systems for reporting potential violations, educating our employees, monitoring and auditing compliance and handling enforcement and discipline.

Committees. Our Compliance Committee, appointed by the Board, consists of four independent directors. The Compliance Committee has general oversight of our Company s compliance with the legal and regulatory requirements regarding healthcare operations. The Compliance Committee relies on the expertise and knowledge of management, the CO and other compliance and legal personnel. The CO regularly communicates with the Chairman of the Compliance Committee. The Compliance Committee meets at least four times a year or more frequently as necessary to carry out its responsibilities and reports regularly to the Board regarding its actions and recommendations.

In addition, management has appointed a team to address our Company s compliance with HIPAA. The HIPAA team consists of a security officer and employees from our legal, information systems, finance, operations, compliance, business services and human resources departments. The team prepares assessments and makes recommendations regarding operational changes and/or new systems, if needed, to comply with HIPAA.

Each clinic certified as a Medicare Rehabilitation Agency has a formally appointed governing body composed of a member of management of the Company and the director/administrator of the clinic. The governing body retains legal responsibility for the overall conduct of the clinic. The members confer regularly and discuss, among other issues, clinic compliance with applicable laws and regulations. In addition, there are Professional Advisory Committees which serve as Infection Control Committees. These committees meet in the facilities and function as advisors.

The Company has in place a Risk Management Committee consisting of the CO, the Corporate in-house Legal Counsel and the Corporate Vice President of Administration. This committee reviews and monitors all employee and patient incident reports and provides clinic personnel with actions to be taken in response to the reports.

Reporting Violations. In order to facilitate our employees ability to report in confidence, anonymously and without retaliation any perceived improper work-related activities, accounting irregularities and other violations of our compliance program, we have set up an independent national compliance hotline. The compliance hotline is available to receive confidential reports of wrongdoing Monday through Friday (excluding holidays), 24 hours a day. The compliance hotline is staffed by experienced third party professionals trained to utilize utmost care and discretion in handling sensitive issues and confidential information. The information received is documented and forwarded timely to the CO, who, together with the Compliance Committee, has the power and resources to investigate and resolve matters of improper conduct.

Educating Our Employees. We utilize numerous methods to train our employees in compliance related issues. The directors/administrators of each clinic are responsible to conduct the initial training sessions on compliance with existing employees. Training is based on our Ethics and Compliance Manual, inclusive of HIPAA information, and our compliance DVD. The directors/administrators also provide periodic refresher training for existing employees and one-on-one comprehensive training with new hires. The corporate compliance group responds to questions from clinic personnel and will conduct frequent teleconference meetings on topics as deemed necessary.

When a clinic opens, the CO provides a package of compliance materials containing manuals and detailed instructions for meeting Medicare Conditions of Participation Standards and other compliance requirements. During follow up training with the director/administrator of the clinic, the CO explains various details regarding requirements and compliance standards. The CO and the compliance staff will remain in contact with the director/administrator while the clinic is implementing compliance standards and will provide any assistance required. All new office managers receive training (including Medicare, regulatory and corporate compliance, insurance billing, charge entry and transaction posting and coding, daily, weekly and monthly accounting reports) from the training staff at the corporate

office. The corporate compliance group will assist in continued compliance, including guidance to the clinic staff with regard to Medicare certifications, state survey requirements and responses to any inquiries from regulatory agencies.

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Monitoring and Auditing Clinic Operational Compliance. Our Company has in place audit programs and other procedures to monitor and audit clinic operational compliance with applicable policies and procedures. We employ internal auditors who, as part of their job responsibilities, conduct periodic audits of each clinic. Each clinic is audited at least once every 18 months and additional focused audits are performed as deemed necessary. During these audits, particular attention is given to compliance with Medicare and internal policies, Federal and state laws and regulations, third party payor requirements, and patient chart documentation, billing, reporting, record keeping, collections and contract procedures. The audits are conducted on site and include interviews with the employees involved in management, operations, billing and accounts receivable. Formal audit reports are prepared and reviewed with corporate management and the Compliance Committee. Each clinic director/administrator receives a letter instructing them of any corrective measures required. Each clinic director/administrator then works with the compliance team and operations to ensure such corrective measures are achieved.

Handling Enforcement and Discipline. It is our policy that any employee who fails to comply with compliance program requirements or who negligently or deliberately fails to comply with known laws or regulations specifically addressed in our compliance program should be subject to d