

ACHIEVEMENT REHAB ("Achieve")

INTRODUCTION

In October 1988, Larry Garatoni, the owner of Achievement Rehab, had hired Scott Frazier to turn around the financially failing business. Scott turned losses into profits in a little over one year and continued to find ways to improve operations in a heavily regulated industry plagued by employee turnover rates between 35% and 40%. In 1993, in the face of an uncertain future with expected downward pressure on margins and revenue, Scott and Larry considered selling the company and wondered how to get the highest possible price.

INDUSTRY OVERVIEW

The contract rehab industry provides physical, occupational and speech therapy services under contract to Long Term Care facilities (LTCs) and other institutions. In 1992, approximately \$15 billion was spent on rehabilitation in the United States, \$3 billion of which was spent on therapy in nursing homes. From 1990 to 1992, contract rehab in nursing homes was the fastest growing segment of the medical rehabilitation industry doubling in size to approximately \$2.7 billion. The market size and growth rate was constrained only by the growth rate in the supply of therapists.

Physical, occupational, and speech therapists treat a wide range of disabilities resulting from accidental injuries and disease. Disabilities commonly treated include traumatic brain injury, spinal cord trauma and limb amputation; orthopedic and other skeletal diseases; strokes and other debilitating neurological disorders; disabilities associated with aging, such as arthritis; and cancer related disabilities. Although there is crossover among the three categories of therapy, physical therapy primarily focuses on rebuilding muscle tissue; occupational therapy reteaches patients how to do simple daily tasks such as eating or making a bed; and speech therapy not only works with speech and hearing, but all aspects of the mouth and throat, e.g. helping someone learn how to swallow.

Approximately 1,000 contract therapy companies operate in the United States. Most are small and service only a few contracts. NovaCare and Continental Medical Systems (Exhibits 1—NovaCare Value Line Report, Exhibit 2—"The Hillary Correction," Exhibit 2a—Continental Medical S&P Stock Report), two large competitors, had grown to substantial size through acquisitions and through agreements with national LTC chains. Achieve belongs to an intermediate tier consisting of mid-size regionally dominant firms.

HISTORY OF ACHIEVEMENT REHAB

Lise C. Taylor prepared this case under the supervision of Professor Hal Heaton as the basis for class discussion rather than to illustrate either effective or ineffective handling of an administrative situation. Copyright © 1998 Marriott School of Management, BYU.

In 1986, Larry Garatoni, owner of a chain of nursing homes, purchased Rehabilitation Specialist, Inc. for \$2.3 million from its founder, also a physical therapist. Larry changed the name to Achievement Rehab and retained the founder as President and CEO. The founder had started the business in 1976 after graduating from physical therapy school. He had decided to sell in 1986 because proposed legislation in Minnesota, where the company had 80% of its business, would greatly reduce company revenues and margins by altering Medicare and Medicaid payment systems.

In 1987, after the sale, Achieve lost \$2 million. In 1988, Achieve lost \$2.7 million on revenues of approximately \$10 million. The monthly financial statements showed Achieve making significant profits while the year end income statements showed losses. Unhappy with these results, Larry replaced the founder with Scott Frazier, a Harvard MBA graduate of 1978.

Scott soon discovered that Achieve had been using its invoices to record revenues, but only one third of the bills sent out to private insurance companies and Medicaid were actually paid in full. These payers would mark down the invoice to the extent it exceeded their "reasonable and customary" charges.

The differences between recorded revenues and payments remained as accounts receivable and were only written off as bad debt at the end of the year. In 1988, uncollectable accounts totaled \$1,531,224. Previously, based on the assumption Achieve was profitable as reported in the monthly financial statements, management had also worsened Achieve's cost structure by giving therapists raises and acquiring new contracts on questionable terms (i.e., low rate per unit of therapy, low volume of therapy, hard-to-staff locations, and extended payment terms). Scott fixed these problems by analyzing contracts and terminating the unprofitable ones; raising charges to nursing homes across the board; implementing proper accounting practices; demanding higher productivity of higher paid therapists or negotiating lower wages; and finally cutting back on some overhead and administrative costs.

Before 1989, Medicaid and private insurers accounted for about half Achieve's revenue. These payers had a fixed price schedule which they would pay for therapy. In 1989, the price was \$12 per fifteen minute "unit" of therapy. These payers were billed directly by Achieve and they submitted payment to Achieve.

Medicare accounted for the other half of Achieve's revenues. Achieve billed the nursing home for therapy services and the nursing home paid Achieve. For Medicare patients the nursing home was on a "cost based" reimbursement system which meant that the nursing home would expense all ancillary services, including therapy, and Medicare reimbursed nursing homes for these expenses plus a mark-up to cover nursing home overhead. Medicare was willing to reimburse the nursing home for all therapy delivered as long as the cost was deemed "reasonable" for the area, and as long as the patients continued to make progress. From 1989 to 1993, Achieve's Medicare revenues increased from 50% to 95% of total revenues.

For many years Medicare placed a restriction on reimbursement for Physical Therapy called "salary equivalency" out of concern that a therapist might work with several

patients at one time and receive full payment for each. Under salary equivalency, if reimbursement to the therapy provider exceeded an amount (equal to \$30 in 1989) times the number of hours the physical therapist worked, then the provider was paid the lesser amount. This restriction did not apply to occupational or speech therapy. Because of salary equivalency, therapy providers considered physical therapy to be a "loss leader."

Therapists were trained to increase their productivity by searching for new patients in the nursing homes who might need therapy. For example, a speech therapist might observe individuals in the dining room and look for patients who had difficulty swallowing. As the nursing homes utilized more speech and occupational therapy, these therapies increased from 20% to 60% of the total billed to the nursing homes.

COMPETITION AMONG PROVIDERS

Federal regulations effectively eliminated price competition. Nursing homes had little incentive to select a low priced contract rehab provider since the charges, so long as they were "reasonable and customary," were passed on from the nursing home to Medicare, with a percentage markup by the nursing home. In the absence of price competition other forms of competition emerged including patient referrals, terms of payment, extensive rehab programs, and occasionally in "kickbacks" or "bribes."

Patient Referral

As an example, one smaller contract rehab provider owned by a group of Neurologists offered to admit their neurology patients to a particular nursing home if the home would use their contract rehab company to provide therapy at the home. This constituted "selling" medical referrals, an illegal practice. A competitor documented this practice and referred it to federal authorities resulting in closure of the contract rehab company.

Various hospitals and hospital chains, which controlled the flow of large numbers of patients to nursing homes, started subsidiaries to offer contract rehab to nursing homes. Scott stated that in effect they were saying to the nursing home, "Use us for contract rehab or lose your major source of patients." As long as the hospital was discrete this was not challenged as illegal. Fortunately, no hospitals in Achieve's market area had started contract rehab subsidiaries.

In addition, Medicare reduced the incentive for nursing homes to own their own therapy provider through the Related Party Rule. In an attempt to control costs, Medicare stipulated that therapy providers owned by a nursing home would have the "profit" component of their charges removed if more than about 30% of the therapy company's revenue came from "related" nursing homes.

Terms of Payment

Contract rehab companies competed by offering very loose collection terms, payment in 90 to 150 days.

“Kickbacks”

Some contract rehab companies would provide the nursing home with a van and a driver, ostensibly for rehab related transportation, but really used more widely. High-end copiers were purchased "for the rehab department," but the other nursing home staff used them. The nursing home was given an "advertising allowance," to advertise the rehab services available, but there was a large spill-over effect into other non-rehab areas. A large contract rehab company had a cooperative advertising arrangement with one of the largest nursing home chains which made that chain impervious to competing rehab companies.

“Bribes”

It was reported that some contract rehab companies would provide the nursing home administrator with a car. A more subtle, and perhaps legal, method was to offer the administrator employment as a sales representative of the contract rehab company should he lose his job with the nursing home. With administrator turnover of perhaps 50% per year this was very attractive. He might even succeed in persuading a friend to switch contract rehab providers.

Extensive Rehab Programs

Achieve competed by offering more and more extensive rehab programs. Achieve's entire marketing effort was centered around providing services which were far more extensive than any competitor.

For example, a less extensive program might employ two FTE (full-time equivalent) therapists and generate \$20,000 in revenue. An extensive program increased FTEs to ten and generated approximately \$100,000 in revenue. Nursing homes benefited from the administrative mark-up on \$100,000, and also were able to market themselves as a "rehab facility." These facilities served more patients who required extensive care, or the kind of patients who generated more revenue for therapy providers.

Achieve provided therapists certified in various rehab specialties, as well as specialized rehab equipment. Regular consultations from a rehab physician were given and Achieve extended rehab sessions to Saturdays and Sundays. More highly skilled clinicians were used in the nursing homes, e.g. more therapists, and less assistants and aides. On-site rehab managers also helped to extend services. Achieve employed no marketing representatives because they felt that the extensiveness of their services largely spoke for itself and that line managers could better represent the company in a sales situation. Line manager representation was important because the nursing home had to be convinced to set aside occupied space for a more extensive program.

"Quality" of patient care never really emerged as a competitive arena. This was due, in part, to the fact that measuring quality in health care was very difficult. Scott stated, "To continue therapy, a patient was required to show 'progress,' but that didn't necessarily mean that the patient was restored to health." Also, the nursing home

administrator or chain administrator essentially had no financial incentive to push for the highest quality rehab program.

Scott commented, "Weaker and newer competitors occasionally resorted to the illegal forms of competition mentioned above. Even large and well established competitors used 'sanitized' variations of these forms of competition." Yet Scott did not see these forms of competition as a major threat to Achieve. "The means of competition used by most of our competitors was costly and reduced their profits. However, when we competed by offering a much more extensive rehab program, the added costs were more than offset by a greatly increased volume of therapy in each nursing home."

OPERATIONS

Recruiting

Since the nursing home had the incentive to provide as much therapy as possible to Medicare patients, growth was constrained primarily by the number of available therapists. In 1993, Achieve employed a staff of fourteen full-time domestic recruiters capable of recruiting at least 300 therapists per year. In addition to domestic recruiters Achieve employed a six member international recruiting and processing staff in the United States, as well as a full-time immigration attorney, capable of bringing approximately 300 qualified therapists per year to the US. Achieve used local recruiting agents in the Philippines, Canada, Australia, Colombia, India, Israel, England, and the Netherlands. Achieve brought more international therapists to the US than any other company by a wide margin.

International therapists reduced Achieve's cost structure because they did not command similar salaries as those clinicians trained in the US. However, salaries for international therapists were higher than what they would have received at home, plus they received training with the most modern equipment. The only way to make a profit on physical therapy was to employ low paid therapists and Achieve was perhaps the only therapy provider who made a profit on physical therapy.

A recent study which estimated future supply and demand for physical therapists and assistants projected a significant demand surplus through at least the year 1995. Demand in the United States was projected to exceed supply for physical therapists and assistants by approximately 15%. Physical therapist supply for 1995 was projected at 99,294 while demand was projected at 114,137. Therapist assistant supply was projected at 27,469 while demand was projected at 31,509.

Investing heavily in recruiting and training, Achieve had not only created a qualified staff providing quality service, but also skilled potential competition. Because Achieve's clients were attached primarily to the individual therapists and less so to Achieve, the therapists could potentially earn for themselves the margins that went to Achieve. However, Achieve managed to keep their average turnover rate lower than the industry average—26% as compared to 35%-40%.

On-site Management

Part of the low turnover rate was due to on-site management by an RSD (Rehab Services Director). The RSD, also a therapist, coordinated the three individual therapies and acted as a single point of contact with the nursing facility. The RSD was also responsible for marketing the rehab program at the facility. After implementation of this position, nursing home customers reported better integration and higher satisfaction with Achieve's services. Productivity increased, staff morale rose from already good levels, and Medicare census (the number of Medicare patients using therapy per nursing home) improved.

Systems

Another important aspect of Achieve's operations was the computer system which linked each Achieve therapy office with the division and corporate offices. The computer system had automated several time consuming procedures such as

- Tracking patient treatments and associated billing functions
- Therapy documentation such as Plan of Care, Discharge Summary, etc.
- Therapist time keeping and associated Medicare salary equivalency computations
- Tracking productivity statistics
- Tracking clinical summary data used in analysis of case mix, patient outcomes, etc.

The system had improved therapist productivity through tighter management. It also helped Achieve bill facilities more accurately and timely and made available patient outcome data for marketing use.

A system designed to measure patient outcomes, developed by the Rehab Institute of Chicago, was instigated by Achieve in June of 1993. Outcomes measurement, which documents the value of services delivered on a case by case and a diagnosis by diagnosis level, was important because as Scott stated, "Melding such outcomes data with cost data would produce a value measurement that would both justify therapy and provide a means of discriminating between different providers." However, a basis for comparison had not yet been established in the industry.

Start-up in New States

All of these operational components, along with the willingness of one third of Achieve's management team to relocate, lent themselves to yet one more capability—the ability to extend quickly operations into new states.

ACHIEVEMENT REHAB IN 1993

Achieve employed a staff of approximately 800 people with sizable operations in Minnesota, Florida and Indiana, and start-up operations in Ohio and Tennessee. LTC contract therapy made up 80% of the company's revenue and was growing rapidly. Of the 800 employees, half were therapists with four to six years of post secondary training. Therapists earned approximately \$50 to \$60 thousand a year. Achieve employed 100 assistants who generally had two years of post secondary training and earned \$20 to \$30 thousand a year. The 200 untrained aides usually earned \$8 to \$10 an hour.

Because Achieve provided top quality and intensive service to nursing homes, it was generally regarded as the best provider wherever it operated. In 1993, Achieve provided the full complement of rehab staffing, an average of seven clinicians per facility. NovaCare, its largest competitor, identified an average staff of 1.8 clinicians per facility in its 1992 annual report.

As a result, Achieve grew rapidly and profitably. From 1990 to 1993, revenues grew at an annually compounded rate of 55%. Achieve earned profit margins of 15.1% in 1992 and 16.2% in 1993 (Exhibits 3 and 4, Income Statement and Balance Sheet).

Clinton's 1993 Health Care Reform Proposal and Future Uncertainty

In 1992, Medicare spending totaled \$132 billion, while the nation as a whole spent approximately \$820 billion on health care. "Medicare beneficiaries have virtually unlimited access to fee-for-service medicine provided by the physician of their choice, with the federal government paying most of their costs of coverage."¹ Escalating health care costs prompted the Clinton administration to find new methods of controlling those costs, while still serving a growing population.

Three basic plans for the rehabilitation sector included the salary equivalency payment plan, the prospective payment plan, and the managed care payment plan. The salary equivalency plan would limit reimbursement for occupational and speech therapy to a fixed rate per hour as was already done with physical therapy. However, it was expected that Medicare would raise the limit for physical therapy and would set reasonable limits for occupational and speech therapy allowing at least a minimal profit to be earned on all three.

The prospective payment plan would cap the rate Medicare would pay for a nursing home patient per day. From this amount, the nursing home would need to cover all ancillary services including therapy. Any amount spent on therapy would limit the money available for room and board, drugs, profit for the nursing home, etc.

The managed care plan proposed payment of a fixed fee for the entire stay of the patient based on the patient's diagnosis. For example, if the patient required a knee replacement surgery, the nursing home would receive a fixed fee, but the patient could be discharged as soon as he or she met a certain wellness criteria. Each of these plans would change the future cash flows of Achieve's business.

Amidst the uncertainty, managed-care companies grew. One editorial stated, "Managed competition may be the reform concept *du jour*, but it's not a magic elixir that will guarantee medical cost containment and make health care accessible for all Americans. What it will do is force hospitals and other providers to compete on the basis of price and quality."² Another article commented, "The latest move in anticipation of reform is designed to keep the industry competitive by moving the delivery of traditional fee-for-service acute rehabilitation into less costly sub-acute and outpatient care."³

¹ "Medicare Meets Reform." *Hospitals*, April 20, 1993 p42

² "Will all the talk of reform turn out to be just talk?" *Modern Healthcare*. Jan.

The Sale

Faced with the possibility of a divergent, uncertain future, Larry and Scott decided to sell the company to Integrated Health Service (IHS), a medium size nursing home chain with approximately 150 nursing homes (Exhibit 5, IHS S&P Stock Report). Scott commented, "IHS's stated reason for acquiring their own contract rehab facility was to control service delivery and to minimize the cost of rehab in their nursing homes." Previously, IHS had negotiated to purchase another contract rehab provider, but the parties had been unable to reach an agreeable price.

IHS's homes were spread across the entire US, while Achieve's service area was in the central and south US. Approximately half of the IHS homes could be serviced by Achieve immediately and it was considered relatively easy for Achieve to service homes outside its normal area of operations. Achieve had very strong operations in Florida and this was also the area of greatest interest to IHS. In early negotiations, IHS had said that Achieve may service any IHS home it wants to and had specifically agreed to a list of 25 homes. These homes each had approximately \$100,000 per month of rehab, were in Achieve's current service area, and Achieve could commence services within 60 days after the acquisition was completed. IHS was traded on the NYSE and was a relatively "hot" health care stock with a PE of 22 at the time of the acquisition discussions. The stock price was \$28.38 per share with 13.53 million shares outstanding. Long Term Debt totaled 388.4 million with sales projected to grow from \$195.26 million in '92 to \$282.16 million in '93. 1993 EBITDA was projected to be \$42.86 million with a net income of \$15.47 million. IHS employed almost 11,000 with assets over \$767 million (Exhibit 6, comparative data).

Since everyone else involved in health care industry was aware of the proposed legislation, Scott and Larry were unsure how to appropriately value Achieve. Even though profits were above three million, those profits might be significantly reduced due to unfavorable legislation. Scott and Larry also knew that because of Medicare's bureaucracy, an unfavorable legislative decision would take two to three years to be implemented.

4, 1993. p28.

³ "Providers Position for Reform." *Modern Healthcare*, Jun 21, 1993 v23 n25 p11.

The Hillary Correction

Continental Medical Systems' stock was flying high. Then came talk of health care reform.

BY JOHN KIMELMAN

You'd think that Rocco Ortenzio would be happy. After all, Continental Medical Systems, the medical rehabilitation services company he founded seven years ago, has been on a growth tear.

For the past five years, earnings at the Mechanicsburg, Pa.-based company providing rehab services to people who have suffered such things as strokes, spinal cord damage, and work-related injuries have grown 49% a year.

So why isn't this man smiling? Blame it on the Hillary factor, and the tiring pace that comes from expanding this rapidly.

Within the past year, shares of Continental Medical have fallen from a high of \$21.50 to a recent \$12, less than 12 times projected 1993 earnings of \$1.04 per share, primarily because of concern about pending health care reform. Medicare reimbursement accounts for 40% of Continental's rehabilitation business, and investors are worried that any governmental effort to contain the costs of subsidized health care could cut into profits.

"It's the uncertainty of not knowing what Congress will do that has people a little nervous," says Ortenzio, with a bit of understatement.

Ortenzio, 60, confesses the possibility of Medicare cost containment has influenced his decision to slow down Continental Medical's expansion plans.

Until now, Continental has grown sales and earnings mostly through a market share grabbing strategy of acquiring smaller US. rehabilitation service companies, in addition to building its own facilities. The company is now the biggest provider of medical rehab services in the US.

Douglas Thomas, the director of research at Emerald Asset Management, a Lancaster, Pa.-based investment management company, says Continental Medical picks a give area and then gains a dominant market share through what he calls a "hub-and-spoke" approach. It rings its inpatient hospital facilities (the hubs) with outpatient sites (the spokes), and supports both with its contract services, where Continental sends a therapist to make "house" calls to companies, health clubs or hospital it does not own.

This aggressive strategy has led to sales growth from \$51 million in fiscal (June) 1987 to \$659 million in 1992. For the first six months of fiscal 1993, the company's net profits increased 335, to \$18.2 million, on revenues that rose 40% to \$415 million. Today, Continental operates 32 rehab hospitals with 2,352 beds in 14 states.

However, the company's strategy has been as costly as it has been successful: From June 1990 to June 1992, Continental more than doubled its assets from \$209 million to \$468 million, pushing long-term debt to 56% of total capital.

Given the debt, and the uncertainty surrounding what recommendations will come from the federal task force on health care reform that is being chaired by Hillary Rodham Clinton, Ortenzio plans, in the coming years to concentrate on getting more revenues out of the existing facilities.

"I wouldn't have slowed up on hospital expansion this much [to two or three hospitals a year] if there weren't concern about health care reform," says Ortenzio, who started his career as a physical therapist in the late 1950's.

When will Continental's stock price turn around? Ortenzio's careful forecast: "Once you can glean from the health care reform proposal that our particular niche of the health care industry will be okay, then maybe the cloud will come off."

				Exhibit 3
INCOME STATEMENT				
	Year End 12/31/90	Year End 12/31/91	Year End 12/31/92	8 Months Ending 08/31/93
<i>Operating Revenues</i>				
Physical Therapy	\$3,622,968	\$3,831,777	\$6,394,226	\$7,700,427
Occupational Therapy	3,617,261	4,415,306	6,716,218	7,606,771
Speech Therapy	1,511,876	1,868,991	2,846,040	3,669,648
Other Therapy	27,813	0	508,646	534,512
Other Income	48,691	35,964	(9,473)	(82,049)
	\$8,828,609	\$10,152,038	\$16,455,657	\$19,429,309
<i>Cost of Sales</i>				
Physical Therapy	2,270,851	2,483,086	4,180,242	5,686,375
Occupational Therapy	2,046,730	2,387,642	3,226,340	3,564,510
Speech Therapy	923,400	1,159,067	1,665,564	1,957,109
Other Therapy	30,466	690	371,184	397,024
	5,271,447	6,030,485	9,443,330	11,605,018
<i>Gross Profit</i>	\$3,557,162	\$4,121,553	\$7,012,327	\$7,824,291
<i>General & Administrative Expenses:</i>				
Administrative Payroll	973,318	906,580	1,419,099	1,667,039
Taxes & Benefits	697,880	849,027	1,279,885	1,414,025
Office Operations	485,872	618,889	1,118,564	1,629,227
Travel & Entertainment	89,131	94,255	213,550	323,920
Bad Debt Expense	282,737	419,620	385,972	878,096
Depreciation	85,243	67,215	109,338	112,212
	\$2,614,181	\$2,955,586	\$4,526,408	\$6,024,519
<i>*Add back: Contract start expenses</i>				1,009,971
<i>Medicare B Payback</i>				335,209
<i>Net Income</i>	\$942,981	\$1,165,967	\$2,485,919	\$3,144,952
<i>Net Income as a Percent of Revenue</i>	10.7%	11.5%	15.1%	16.2%
Note--Adjustments have been made to remove the following:				
1. Health Quest Group overhead and interest charges.				
2. Amortization of goodwill.				
3. Income & loss from joint ventures discontinued in 1991.				
4. Long term debt interest				
*One time expenses incurred in 1993				

				Exhibit 4
BALANCE SHEET				
	Year End	Year End	Year End	8 Months Ending
	12/31/88	12/31/91	12/31/92	08/31/93
Cash	1,077,679	196,295	541,022	602,261
Accounts Receivable	1,780,909	2,270,312	4,680,841	7,247,295
Less Allowance for Bad Debt	0	(459,279)	(660,543)	(1,272,694)
Other Assets & Prepaid Expenses	98,180	89,105	515,554	1,093,633
Total Current Assets	2,956,768	2,096,433	5,076,874	7,670,495
Property and Equipment	462,976	320,884	690,578	811,998
Accumulated Depreciation	(143,417)	(88,932)	(192,922)	(264,435)
Total Fixed Assets	319,559	231,952	497,656	547,563
Goodwill	64,716	-	-	-
Service Agreements & Employee Contracts	905,954	-	-	-
Other Assets	236,335	-	-	-
Total Long Term Assets	1,207,005	182,047	131,614	117,142
TOTAL ASSETS	4,483,332	2,510,432	5,706,144	8,335,200
Accounts Payable	533,469	342,176	772,383	829,064
Short Term Borrowings	2,129,319	-	-	-
Accrued Payroll & Taxes	-	598,152	1,079,148	1,605,549
Current Liabilities	2,662,788	940,328	1,851,531	2,434,613
Long Term Liabilities	-	1,087,330	1,748,991	3,628,517
Owner's Equity	1,821,104	482,774	2,105,622	2,272,070
TOTAL LIABILITIES & EQUITY	4,483,892	2,510,432	5,706,144	8,335,200

	Exhibit 6					
	IHS		CONTINENTAL MED.		NOVACARE	
	1992	1993*	1992	1993*	1992	1993*
PRICE Per Share	\$24.75	\$28.38	\$16.88	\$8.63	\$23.75	\$15.25
<i>Following in millions</i>						
Shares	11.38	13.53	35.53	37.55	49.13	49.65
Debt (LT)	\$140.50	\$388.40	\$133.50	\$382.60	N/A	\$193.50
Other LT Liabilities	\$3.30	\$70.30	\$11.60	\$7.60		\$4.20
Sales	\$195.26	\$282.16	\$681.83	\$901.40	N/A	\$582.34
EBITDA	\$24.58	\$42.86	\$74.09	\$113.82	N/A	\$98.64
Net Income	\$9.14	\$15.47	\$27.09	\$19.35	N/A	\$47.64
Assets	\$312.00	\$767.70	\$468.20	\$772.20	N/A	\$611.60
Employees (in thousands)	6,483	10,900	N/A	13,500	N/A	7,750
Sales/Employee	\$30.12	\$25.89	N/A	\$66.77	N/A	\$75.14
Assets/Employee	\$48.12	\$70.43	N/A	\$57.20	N/A	\$78.91
Net Income/ Employee	\$1.41	\$1.42	N/A	\$1.43	N/A	\$6.15
		1993				
90 Day Treasury		3.10%				
30 Year Treasury		5.92%				
S&P 500 P/E Ratio		21.70				
Corporate Bond Yields Aaa		6.72%				
Corporate Bond Yields Bbb		9.50%				
*Casewriter estimates						

ACHIEVE REHAB-FIVE FORCES

