

EXHIBITOR PROSPECTUS

2008 Hoosier Home Care, Hospice & HME Conference

April 29 & 30, 2008

With a special holdover opportunity for Hospice vendors on May 1

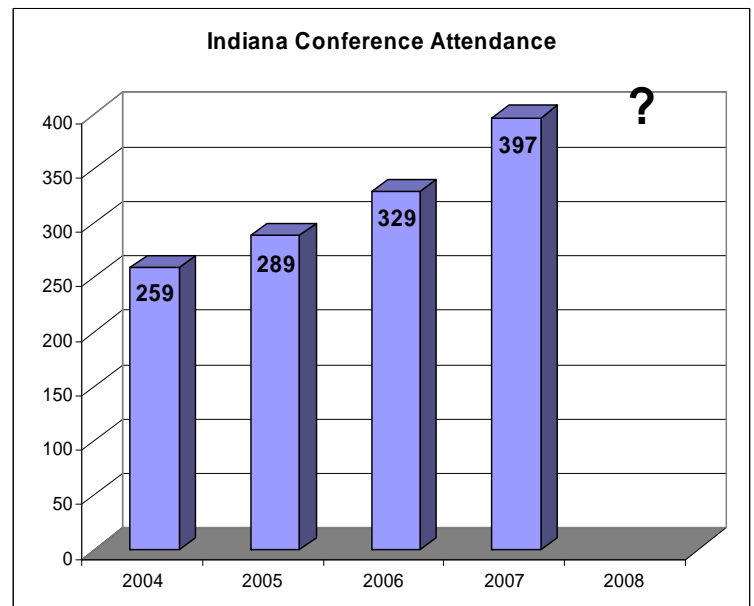
Marriott East Conference Center ~ Indianapolis, Indiana

One of America's Best Attended State Home Care Trade Shows!

The 2007 Hoosier Home Care, Hospice & HME Conference topped all our previous events with a record attendance by owners, administrators, managers, and professionals. Attendance grew by over 20%!

This year's Conference will provide several new features for our Exhibitors:

- Choose from 4 different booth sizes & prices
- Request your preferred booth location
- Optional third exhibit day on May 1



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EXHIBITING INFORMATION

Set-up and tear-down of exhibits: Shipments, set-up and tear-down of exhibits will take place on the dates and times specified by IAHC/AIHMS. Set-up and tear-down may not begin until the times indicated below (*these times are subject to change*):

EXHIBIT SCHEDULE Tuesday, April 29, 2008 - Liberty Hall	
10:00 am - 12:00 pm	Exhibitor Registration & Set-up
11:30 am	Lunch Served for Exhibitors ONLY
12:00 - 1:30 pm	Lunch (<i>Exhibits Open</i>)
3:00 pm - 3:30 pm	Break (<i>Exhibits Open</i>)
4:30 - 6:30 pm	Cocktail Reception in Exhibit Hall (<i>Exhibits Open</i>)
Wednesday, April 30, 2008 - Liberty Hall	
7:30 am	Exhibits Open
8:00 - 9:30 am	IAHC/AIHMS Recognition Breakfast (<i>Vendors Welcome</i>)
11:00 am	Lunch Served for Exhibitors ONLY
11:30 - 1:00 pm	Lunch (<i>Exhibits Open</i>)
1:00 pm	Exhibit Hall Closes (<i>Breakdown & Relocate Booths for May 1</i>)
OPTIONAL - May 1 is targeted to Hospice Market Thursday, May 1, 2008	
7:30 - 9:00 am	Exhibits Open/Continental Breakfast
12:30 - 2:00 pm	Lunch (<i>Exhibits Open</i>)
2:00 pm	<i>Exhibits Close (Breakdown Booths)</i>

2008 Exhibiting Information

Booth Fees	IAHC / AIHMS Member	Nonmember
Premium 8 x 10 feet	\$800	\$1000
Preferred 8 x 8 feet	\$700	\$900
Standard 6 x 8 feet	\$600	\$800
Economy 6 x 6 feet	\$500	\$750

What is included with booth fee: All booths include draped table with two chairs, wastebasket, and a header sign with company name and booth number beginning with set-up on April 29, 2008 and ending at 1:00 pm on April 30, 2008. Exhibitors should provide a logo in electronic format. Exhibitors may attend any educational sessions of interest to them.

In response to vendor requests, meals for one person will be included with the exhibit fee and additional meals may be purchased. Exhibitors may request a list of pre-conference marketing contacts prior to conference and will receive a final roster of participants after the conference.

Optional Third Exhibit Day on May 1: In response to participant requests, we are now offering the opportunity for a small number of vendors to exhibit on May 1. This day's programming is

traditionally targeted to Hospice professionals. Due to space limitations at the facility, exhibits will be relocated after the 1:00 pm breakdown of Liberty Hall on April 30, 2008. All exhibits be on 6-foot tables with drapes equivalent to economy booth.

Additional Cost: \$100.

Registering / Selecting Your Booth: Registrations are limited to 70 booths and will be accepted on a "first paid - first assigned" basis. This Exhibit Hall has sold out the past two years. Exhibitors may request their booth from the Exhibit Hall Floor Plan included in this booklet. Indicate your top three choices of booths. Booth assignments will be made when payment is received in the form of check or successful credit card transaction and every effort will be made to award your preferred choice. If none of your choices are available, we will contact you to select an alternative.

Exhibit Hall Location and Conference Hotel: The Exhibit Hall will be in the **Liberty Hall** at the **Marriott Hotel and Conference Center**, 7202 East 21st Street, Indianapolis, IN 46219. Phone (317) 352-1231, Fax (317) 352-9775. Overnight rooms are \$104 for single and double. The phone number to call for reservations is (317) 352-1231. The cut off date is March 31. Be sure to ask for the Indiana Association for Home and Hospice Care rate in order to get the corporate rate. You can reserve a room online at www.marriott.com. Use group code **HOSHOSA**.

Exhibitor Registration Deadline: The deadline for registrations is Friday, April 6, 2008. After April 6th, if you would like to attend and have not sent in your information please call (317) 844-6630 for availability.

Cancellation of Booth Space: Should an exhibitor cancel on or before Friday, April 6, 2008, there will be a cancellation fee of \$100. After Friday, April 6 2008, IAHC reserves the right to retain the entire exhibit fee.

Show Contractor: IAHC/AIHMS has an official full-service show contractor for the Hoosier Home Care, Hospice & HME Conference. Several weeks before the exposition you will receive an exhibitor kit from the show contractor for you to order any additional equipment or supplies you might need for your exhibit booth for additional charge. Some additional equipment or supplies include shipping and handling of materials, furniture, labor, drayage, additional signs, carpeting, etc. may be ordered from the show contractor.

Liability: The exhibitor assumes the entire responsibility and liability for losses, damages and claims arising out of injury or damage to exhibitor's displays, equipment and other property brought upon the premises of the hotel and shall indemnify and hold harmless the Marriott Hotel and Conference Center and the Indiana Association for Home and Hospice Care and any representative, agent, or employee of the foregoing of any and all losses, damages and claims.

Contact Information: For questions contact the Indiana Association for Home and Hospice Care at (317) 844-6630 or at staff@iahc.org.

Scheduled Payment: Full payment is due no later than April 6, 2008 – booth space WILL NOT be assigned until payment is received.

Door Prize: Each exhibitor will be asked to provide a door prize to be awarded throughout the conference. Conference attendees will need to register at a percentage of booths to be eligible for a door prize.

CONFERENCE SPONSORSHIP OPPORTUNITIES

Sponsorships offer you opportunities to gain valuable visibility to build better relationships in the home care, hospice and HME industries. All Hoosier Home Care, Hospice and HME Conference sponsors receive the following great promotional benefits:

- ✓ Recognition on sponsorship signage placed near the location of your sponsored event.
- ✓ Recognition in the official Hoosier Home Care, Hospice and HME Conference Program.
- ✓ Special mention on the IAHHC and AIHMES websites.
- ✓ Opportunity to place pre-printed materials in participant bags.
- ✓ Pre-Show participant mailing list

Below are the sponsorships available. All sponsors will receive the above listed benefits plus the additional benefits listed below.

Conference Grand Sponsor - \$5,000

- Premium exhibit booth
- Full-page ad in conference program
- Logo on conference banner & participant bags
- Special recognition & speaker introduction privileges

Keynote or Closing Speaker - \$3,000

- Premium exhibit booth
- Full-page ad in conference program
- Special recognition before introduction of speaker
- Opportunity to introduce the Keynote or Closing Speaker

Exhibit Hall Reception - \$2,000

- Preferred exhibit booth
- Half-page ad in conference program
- Special recognition at the Opening Reception

Day One or Two Lunch - \$1,500

- Half-page ad in conference program
- Special recognition during the lunch

General Session Speaker - \$1,000

- Half-page ad in conference program
- Special recognition before introduction of speaker
- Opportunity to introduce the General Session Speaker

Day Two IAHHC or AIHMES

Recognition Breakfast - \$1,000

- Quarter-page ad in conference program
- Special recognition during the breakfast

Day Three Luncheon - \$1,000

- Quarter-page ad in conference program
- Special recognition during the luncheon

Lanyard - \$1,000 RESERVED

- Quarter-page ad in conference program
- Name and/or logo on conference lanyard

President's Dessert Reception - \$750

- Quarter-page ad in conference program
- Special recognition during the dessert reception

Breakout Session Speaker - \$500

- Quarter-page ad in conference program
- Special recognition before introduction of speaker
- Opportunity to introduce the Breakout Session Speaker

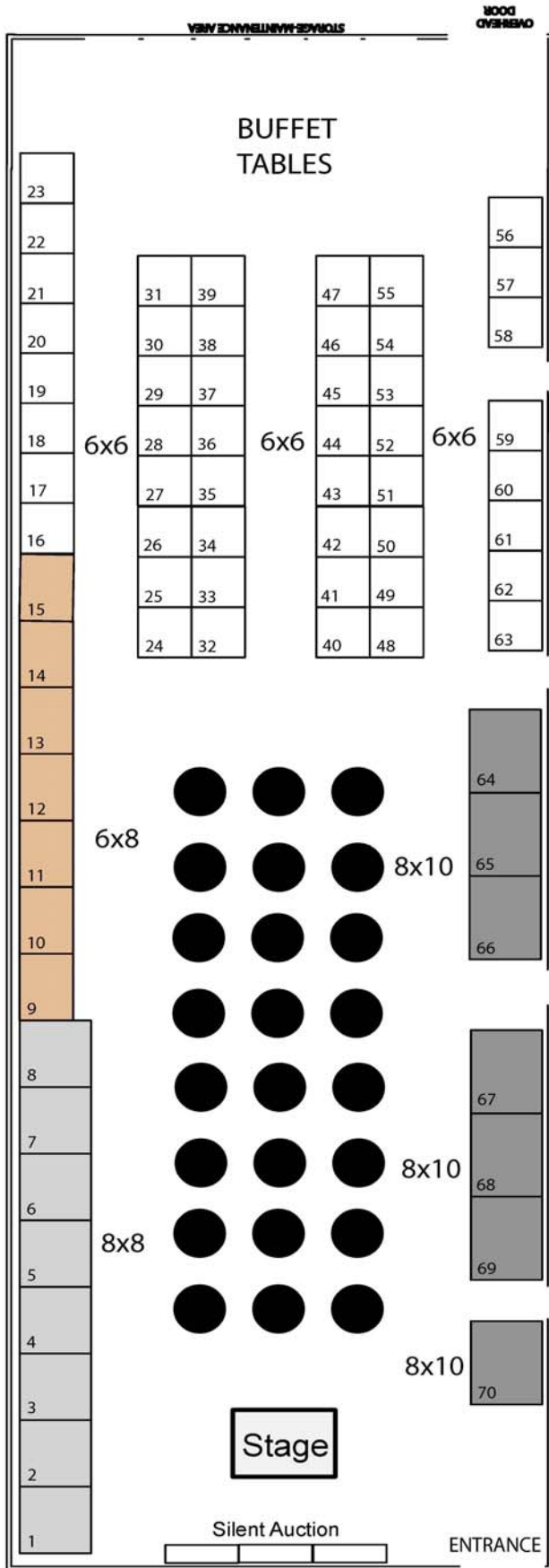
Day One or Three Continental Breakfast - \$500

- Quarter-page ad in conference program

Refreshment Break - \$500

- Quarter-page ad in conference program

Proposed Exhibit Hall Layout - *(this layout is subject to change)*



- ✓ Booth will be assigned on "1st paid, 1st assigned" basis.
- ✓ Exhibitor will get to choose from 4 different booth sizes and prices.
- ✓ Each booth will include one 6 foot draped table with two chairs and a header sign with company name and booth number.
- ✓ Participants must enter Exhibit Hall for lunch and breaks.
- ✓ Exhibit Hall has sold out in 2006 & 2007.

Program Advertising

Your company's name will leave a lasting impression in the annual program booklet, which serves as the exclusive guide to daily workshops and events. Market your products and services by utilizing this cost-effective advertising vehicle. Space is limited - please complete the application/contract and send your reservation today!

You can email your camera ready artwork to sue@iahhc.org in a JPEG, PDF, or EPS format. All sponsors and exhibitors receive free advertising. Sponsors will receive up to one page of advertising. Exhibitors will receive a line ad with logo. Rates are for those companies unable to attend the conference or for exhibitors wishing to increase their ad space.

Official Program: Size 8 1/2" by 11"

SPACE	WIDTH	LENGTH	PRICE
Full Page	7 1/4	9 1/2	\$500
Half Page	7 1/4	4 1/2	\$300
Quarter Page	3 3/4	4 1/12	\$250
Business Card Size	3 1/2	2	\$100
Participant Bag Stuffer	N/A	N/A	\$100



2008 Hoosier Home Care, Hospice & HME Conference
April 29 – May 1, 2008
Exhibitor/Sponsorship Registration Form



Exhibitor Booth Fee:

IAHHC/AIHMS MEMBER

- Premium 8 x 10 ft \$800
- Preferred 8 x 8 ft \$700
- Standard 6 x 8 ft \$600
- Economy 6 x 6 ft \$500

NONMEMBER

- Premium 8 x 10 ft \$1,000
- Preferred 8 x 8 ft \$900
- Standard 6 x 8 ft \$800
- Economy 6 x 6 ft \$750

Meals are provided for one person with exhibitor booth fee. Additional meals are \$25 each.

Marketing and Sponsorship Opportunities:

- Conference Grand Sponsor \$5,000
- Keynote or Closing Speaker \$3,000
- Exhibit Hall Reception \$2,000
- Day One/Two Lunch (2) \$1,500
- General Session Speaker \$1,000
- Day Two Breakfast (2) \$1,000
- Day Three Luncheon \$1,000
- Lanyard **RESERVED**
- President's Dessert Reception \$ 750
- Breakout Session Speaker \$ 500
- Day One/Three Breakfast (2) \$ 500
- Refreshment Break (3) \$ 500

UNABLE TO EXHIBIT? ADVERTISE!

***Official Program Advertising:**

- Full Page \$ 500
- Half Page \$ 300
- Quarter Page \$ 250
- Business Card Size \$ 100
- Participant Bag Stuffer \$ 100

ALL Logos and ads are due into the IAHHC office in JPG/EPS/PDF format no later than April 6, 2008.

**All sponsors and exhibitors receive free advertising. Sponsors will receive no more than one page of advertising. Exhibitors will receive a line ad with logo. Rates are for those companies unable to attend the conference or for exhibitors wishing to increase their ad space.*

Please print or type, complete, and return to address below

Company _____
 Contact _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 Email _____ Website _____

REPRESENTATIVE(S) STAFFING EXHIBIT (Name as they should appear on nametag and in printed materials):

1. _____ Email _____
 2. _____ Email _____

Provide a 25 word company or product description to be printed in the official program. Entries over 25 words may be edited. **Submission deadline: 4/06/08.** Unless otherwise specified, your company, name, address, phone number and website will appear in the official program.

BOOTH REQUEST: 1st Choice _____ 2nd Choice _____ 3rd Choice _____

DOOR PRIZE:

Will your company be furnishing a door prize? Yes No
 If so, please describe: _____

ELECTRICITY/INTERNET:

For an additional fee, the hotel provides electricity/internet for your exhibit. If you require electricity/internet, please check the box above and the forms will be faxed or emailed immediately.

Exhibit Booth Fee \$ _____
 Optional Stay over for
 Hospice Program May 1st \$ _____
 Additional Meals ____ X \$25 \$ _____
 Sponsorship Cost \$ _____
 Program Advertising \$ _____
Total Amount Enclosed: \$ _____

Make checks payable to/Mail registration to:
IAHHC
 6320-G Rucker Road
 Indianapolis, IN 46220
 Phone: (317) 844-6630
FAX: (317) 575-8751

Method of Payment

Check Credit Card: Visa MasterCard
 Card # _____ Expiration Date _____
 Authorized Signature: _____

Signature: _____

CONFIRMATIONS WILL BE SENT UPON RECEIPT OF PAYMENT

For office use ONLY
 Date Paid _____
 Check Check Number _____
 Credit Card Authorization # _____

IF YOU ARE NOT ALREADY A MEMBER BOTH ORGANIZATIONS AND



IAHHC represents 180 Home Health, Hospice and Personal Care Companies 2008 Associate Membership Application

Step One: Company Information

Contact Person (Person designated to receive mailings): _____

Provider/Company Name: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (_____) _____ **Fax:** (_____) _____

Toll Free Phone: (_____) _____ **Individual E-Mail:** _____

Company E-Mail: _____ **Website:** _____

Please check the type of products/services available to home health agencies:

- | | | |
|---|--|--|
| <input type="checkbox"/> Accounting | <input type="checkbox"/> Affiliated | <input type="checkbox"/> Advertising Specialties |
| <input type="checkbox"/> Billing Services | <input type="checkbox"/> Clinical Laboratory | <input type="checkbox"/> Collections/Recovery |
| <input type="checkbox"/> Compliance Programs | <input type="checkbox"/> Consulting | <input type="checkbox"/> Employee Benefits |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Information Technology/ Information Systems | <input type="checkbox"/> IV Support |
| <input type="checkbox"/> Legal | <input type="checkbox"/> License Pending | <input type="checkbox"/> Medical Supplies |
| <input type="checkbox"/> Medical Bill Review | <input type="checkbox"/> Medical Social Services | <input type="checkbox"/> OASIS/Clinical Pathways |
| <input type="checkbox"/> Patient Charting Equipment | <input type="checkbox"/> Pediatric Products | <input type="checkbox"/> Pharmaceuticals |
| <input type="checkbox"/> Printing & Forms | <input type="checkbox"/> Risk Management | <input type="checkbox"/> Software & Support |
| <input type="checkbox"/> Staff Development & Training | <input type="checkbox"/> Staff Leasing | <input type="checkbox"/> Therapy Services |
| <input type="checkbox"/> Other _____ | | |

Note: If consulting firm please check what type of consulting services your company provides:

- | | | | |
|--|---|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Accreditation | <input type="checkbox"/> Billing | <input type="checkbox"/> Clinical | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Information Technology/Information Systems | <input type="checkbox"/> Legal | <input type="checkbox"/> Management |
| <input type="checkbox"/> Other _____ | | | |

Step Two: Dues Schedule

- Associate Membership:** A business that supplies goods and/or services for compensation to home care agencies, hospices, \$ 550.00 or their patients, but does not supply in-home personnel. Associate Members shall not have voting rights, shall not hold office or service as an officer or Director of the Corporation nor chair any standing committee of the Corporation.

Step Three: Sign and Submit Application with Payment

Signature Required

By this signature, I verify that the information provided on this application form is, to the best of my knowledge, correct. I understand that the membership benefits that we receive are only to be used by the company/ provider listed in Step One and its employees. Furthermore, I understand that these benefits may not be transferred to another licensed agency or business, which does not hold membership in this association. Any misuse of membership rights and benefits may result in the termination of our membership. I am aware that information on contacting my company will be available for viewing by the public on the IAHC website. **FCC Communication Consent:** I understand that by providing my mailing address, email address, telephone number, and fax number, I consent to receive communications via regular mail, email, telephone, and/or fax sent by or on behalf of Indiana Association for Home & Hospice Care (IAHC).

Administrator or Contact Person

Date

Payment Information

Total amount enclosed of 2008 Membership Dues _____ .

Please make checks payable to:
IAHHC
6320 G-Rucker Road
Indianapolis, IN 46220
Phone: (317) 844-6630
FAX: (317) 575-8751

For office use ONLY

Date Paid _____

Check **Check Number** _____

Credit Card **Authorization Number** _____

OF IAHHC OR AIHMES, JOIN EITHER OR QUALIFY FOR THE MEMBER RATE



AIHMES Represents 70 DME/HME Companies 2008 Membership Application

Step One: Company Information

Contact Person (Person designated to receive mailings): _____

Provider/Company Name: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (_____) _____ **Fax:** (_____) _____

Toll Free Phone: (_____) _____ **Individual E-Mail:** _____

Company E-Mail: _____ **Website:** _____

Please check the type of products/services available to home health agencies:

- | | | |
|---|--|--|
| <input type="checkbox"/> Accounting | <input type="checkbox"/> Affiliated | <input type="checkbox"/> Advertising Specialties |
| <input type="checkbox"/> Billing Services | <input type="checkbox"/> Clinical Laboratory | <input type="checkbox"/> Collections/Recovery |
| <input type="checkbox"/> Compliance Programs | <input type="checkbox"/> Consulting | <input type="checkbox"/> Employee Benefits |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Information Technology/ Information Systems | <input type="checkbox"/> IV Support |
| <input type="checkbox"/> Legal | <input type="checkbox"/> License Pending | <input type="checkbox"/> Medical Supplies |
| <input type="checkbox"/> Medical Bill Review | <input type="checkbox"/> Medical Social Services | <input type="checkbox"/> OASIS/Clinical Pathways |
| <input type="checkbox"/> Patient Charting Equipment | <input type="checkbox"/> Pediatric Products | <input type="checkbox"/> Pharmaceuticals |
| <input type="checkbox"/> Printing & Forms | <input type="checkbox"/> Risk Management | <input type="checkbox"/> Software & Support |
| <input type="checkbox"/> Staff Development & Training | <input type="checkbox"/> Staff Leasing | <input type="checkbox"/> Therapy Services |
| <input type="checkbox"/> Other _____ | | |

Note: If consulting firm please check what type of consulting services your company provides:

- | | | | |
|--|---|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Accreditation | <input type="checkbox"/> Billing | <input type="checkbox"/> Clinical | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Information Technology/Information Systems | <input type="checkbox"/> Legal | <input type="checkbox"/> Management |
| <input type="checkbox"/> Other _____ | | | |

Step Two: Dues Schedule

- Associate Membership:** A business that supplies goods and/or services to home medical equipment companies or their patients. \$ 400.00

Step Three: Sign and Submit Application with Payment

Signature Required

By this signature, I verify that the information provided on this application form is, to the best of my knowledge, correct. I understand that the membership benefits that we receive are only to be used by the company/provider listed in Step One and Two and its employees. Furthermore, I understand that these benefits may not be transferred to another licensed agency or business, which does not hold membership in this association. Any misuse of membership rights and benefits may result in the termination of our membership. I am aware that information on contacting my company will be available for viewing by the public on the AIHMES website. **FCC Communication Consent:** I understand that by providing my mailing address, email address, telephone number, and fax number, I consent to receive communications via regular mail, email, telephone, and/or fax sent by or on behalf of Association of Indiana Home Medical Equipment Services (AIHMES).

Administrator or Contact Person

Date

A. **Payment Information**

Total amount enclosed of 2007 Membership Dues \$ _____

Make checks payable to:

AIHMES

8605 Allisonville Road, Suite 112

Indianapolis, IN 46250

Phone: (866) 225-6335

FAX: (678) 264-4748

For office use ONLY

Date Paid _____

Check **Check Number** _____

Credit Card **Authorization Number** _____



6320-G Rucker Road
 Indianapolis, IN 46220
 (317) 844-6630

**Your 2008 Conference
 Exhibitor and Sponsorship
 Information is Enclosed!**

MAP TO INDIANAPOLIS MARRIOTT EAST



EXHIBITOR CONFERENCE SCHEDULE

Subject To Change

EXHIBIT SCHEDULE	
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