AMEDISYS INC
Form 10-K/A
April 18, 2005
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-K/A

(Amendment No. 1)

x ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the Fiscal Year Ended: December 31, 2004

OR

¨ 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: 0-24260

AMEDISYS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**11-3131700**
(State or other jurisdiction of incorporation or organization)	**(IRS Employer Identification No.)**

11100 Mead Road, Suite 300

Baton Rouge, Louisiana 70816

(Address of principal executive offices, including zip code)

(225) 292-2031 or (800) 467-2662

(Registrant s telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Exchange Act: None

Securities registered pursuant to Section 12(g) of the Exchange Act:

Common Stock, par value $.001 per share

Check whether the issuer: (1) filed all reports required to be filed by Section 13 or 15(d) of the Exchange Act during the past 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 past 90 days. Yes x No ¨

Check if there is no disclosure of delinquent filers in response to Item 405 of Regulation S-K in this form, and if no disclosure will 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. ¨

Check whether the registrant is an accelerated filer (as defined in Rule 12b-2 of the Act). Yes x No ¨

The aggregate market value of the voting stock held by non-affiliates of the registrant, based on the last sale price as quoted by the Nasdaq National Market System on June 30, 2004 was $319,111,124. For purposes of this determination shares beneficially owned by officers, directors and ten percent shareholders have been excluded, which does not constitute a determination that such persons are affiliates.

As of March 10, 2005, the registrant had 15,359,941 shares of Common Stock outstanding.

Documents incorporated by reference: Registrant s definitive Proxy Statement for its 2005 Annual Meeting of Stockholders to be filed pursuant to the Securities Exchange Act of 1934 is incorporated herein by reference into Part III hereof.

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Explanatory Note

Amedisys, Inc. (the Company) is filing this Amendment No. 1 on Form 10-K/A (the Amendment) to its Annual Report on Form 10-K for the year ended December 31, 2004, which was filed with the Securities and Exchange Commission on March 17, 2005 (the Original Filing), pursuant to an Exemptive Order issued by the Securities and Exchange Commission (SEC Release No. 34-50754) (the Exemptive Order). In accordance with the Exemptive Order, the Company may include management s annual report on internal control over financial reporting and the related report of the Company s independent registered public accounting firm in an amendment to its Annual Report on Form 10-K not later than 45 days after the end of the prescribed period for filing such Form 10-K.

In compliance with the Exemptive Order, the Company is filing this Amendment to:

include management s annual report on internal control over financial reporting; and

include a Report of Independent Registered Public Accounting Firm relating to the Company s assessment of internal control over financial reporting and the effectiveness of internal control over financial reporting.

This Amendment also reflects a correction to a typographical error contained in the Company s Consolidated Statements of Cash Flows for the year ended December 31, 2004. As reported in the Original Filing, Net cash used in investing activities was $34,951,000. The correct amount is $(34,951,000). Finally, this Amendment reflects correction of certain nonsubstantive errors in the List of Exhibits in Item 15 of the Original Filing.

As a result of this Amendment, (1) the certifications pursuant to Section 302 and Section 906 of the Sarbanes-Oxley Act of 2002, filed and furnished, respectively, as exhibits to the Original Filing, have been re-executed and re-filed as of the date of this Amendment; and (2) a Consent of Independent Registered Public Accounting Firm to cover its report related to our internal control over financial reporting is being filed.

Except for the matters described above, this Amendment does not modify or update the Company s previously reported financial statements and other financial disclosures in, or exhibits to, the Original Filing. In order to provide a full, integrated document, the complete Form 10-K, but not the exhibits thereto (except as noted above), has been presented in this Amendment.

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PART I

Forward Looking Statements

When included in the Annual Report on Form 10-K or in documents incorporated herein by reference, the words expects , intends , anticipates , believes , estimates , and analogous expressions are intended to identify forward-looking statements. Such statements inherently are subject to a variety of risks and uncertainties that could cause actual results to differ materially from those projected. Such risks and uncertainties include, among others, general economic and business conditions, current cash flows, debt service needs, adverse changes in federal and state laws relating to the health care industry, competition, regulatory initiatives and compliance with governmental regulations, customer preferences and various other matters, some of which are described under the caption Risk Factors herein, many of which are beyond the Company s control. These forward-looking statements speak only as of the date of the Annual Report on Form 10-K. The Company expressly disclaims any obligation or undertaking to release publicly any updates or any changes in the Company s expectations with regard thereto or any changes in events, conditions or circumstances on which any statement is based.

ITEM 1. BUSINESS

General

Amedisys, Inc., a Delaware corporation (Amedisys , We , Our , or the Company), is a multi-state provider of home health care nursing services. The Company operated 108 home care nursing offices, two hospice offices and two corporate offices in the southern and southeastern United States at December 31, 2004.

The Company plans to strengthen its market position in the southern and southeastern United States by expanding its referral base using a trained sales force, offering specialized Disease Management programs such as wound care, and completing selective acquisitions.

Industry Overview

As national health care spending continues to outpace the rate of inflation and the population of older Americans increases at a faster rate, the Company believes that alternatives to costly hospital stays will be in even greater demand. Managed care, Medicare, Medicaid and other payor pressures continue to drive patients through the continuum of care until they reach a setting where the appropriate level of care can be provided most cost effectively. Over the past several years, home health care has evolved as an acceptable and often preferred alternative in this continuum. In addition to patient comfort and convenience, substantial cost savings can usually be realized through treatment at home as an alternative to traditional institutional settings. The continuing economic pressures within the health care industry and the Medicare payment system have forced providers of home health care services to closely examine and often modify the manner in which they provide patient care and services. Those companies that successfully operate with effective business models can provide quality patient care and manage costs under the current reimbursement system.

Traditionally, the home health care industry has been highly fragmented, comprised primarily of smaller local home health agencies offering limited services. These local providers often do not have the necessary capital to expand their operations or services and are often not able to

achieve the efficiencies necessary to compete effectively. With the implementation of the Medicare Prospective Payment System (PPS) on October 1, 2000, and other legislation, the home health care industry experienced major consolidation for the first time in its history, with industry reports suggesting a reduction from approximately 11,000 agencies in 1997 to approximately 7,000 agencies in 2004.

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Strategy

The Company s business objective is to enhance its market position as a leading provider of high quality, low cost home health nursing services. In order to accomplish this objective, the Company intends to pursue the following strategies:

Internal Growth Strategy

Focus on Its Employees. Because the Company is engaged in a service business, the essence of the Company is its people. The Company s emphasis on communication, education, empowerment, and competitive benefits allows it to attract and retain highly skilled and experienced people in its markets.

Expand Its Service Base. The Company has targeted selected markets in the southern and southeastern United States. Through the expansion of its services and development of niche programs, it plans to increase market share in these markets, to increase utilization of its services by payors and referral sources, and to enhance its overall market position.

The Company has opened thirteen new locations, two of which were merged into existing locations, in the twelve months ended December 31, 2004, and plans to accelerate the opening of new offices in selected markets.

Expand Its Referral Base. It is anticipated that revenue growth will be spurred by the Company s strategy to employ sales account executives whose sole focus will be to expand its referral base, so that the Company is not dependent on a relatively few physician groups for patient referrals in any given market.

Manage Costs Through Disease Management. Payors are focusing on the management of patients who suffer from chronic diseases, which correlate with substantial long-term costs. In 1999, the Company introduced Disease Management programs for wound care, cardiac, and diabetes. In 2000, the Company introduced other Disease Management programs, such as pulmonary/respiratory, pneumonia, cardiovascular, and cancer. The Company s Disease Management programs include patient and family education and empowerment, frequent monitoring and coordinated care with other medical professionals involved in the care of the patient.

Manage Costs Through Technology. The Company utilizes an internally-developed software system which reduces its operating costs and integrates a number of clinical, financial and operating functions into a single entry system. The Company sold the software system to an affiliate of CareSouth Home Health Services, Inc. (CareSouth) in 1998. In October 2001, the Company entered into a licensing agreement with CareSouth to use the software. This licensing agreement expired in May 2004. The agreement contained a bargain purchase option, which the Company exercised upon expiration of the agreement. The software has been enhanced extensively by the Company, particularly with respect to clinical management, and has been supplemented by other externally sourced software. By enhancing its operations through the use of information technology and expanded computer applications, the Company is positioned to not only operate more efficiently, but to compete in an environment increasingly influenced by cost containment.

External Growth Strategy

The Company s external growth strategy is to continue its expansion through selected acquisitions. The Company believes that home health nursing companies are currently undervalued and provide excellent opportunities to gain additional market share. The Company s acquisition strategy includes the following key elements:

Focus on Large Hospital Systems with Internal Home Health Agencies. PPS, which was implemented in October 2000, eliminates the opportunities for cost shifting by hospitals. Many hospitals can no longer compete effectively in the home health business. As a result, many hospitals have made the decision, or are considering, to sell their agencies or alternatively, partner with a reputable company to provide these services. This not only provides the Company with the opportunity to acquire quality agencies, but to acquire agencies with a strong base of physician referrals.

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Target Large, Multi-Site Agencies. By acquiring multi-site agencies and eliminating their corporate structure, the Company hopes to rapidly dominate a market by layering the new business into its current agencies, enhancing current market share or expanding its coverage to markets that are contiguous to existing markets.

Target Metropolitan Areas. Metropolitan-based agencies are principal targets due to the synergies created by large patient populations located in close proximity to each other.

Focus on Medicare Eligible Patients. The Company targets its marketing activities toward Medicare eligible patients. Approximately 93% of the Company s net service revenue was derived from Medicare for the year ended December 31, 2004.

Hospice Services

The Company also operates two hospice locations as of December 31, 2004, which accounted for approximately 2% of the Company s net service revenues in fiscal year 2004, and has plans to open at least two additional hospice locations during 2005.

Hospice care became a covered benefit under the Medicare program in 1983. Unlike home health care, which focuses on the curative treatment of patients, hospice care focuses primarily on improving the quality of life of terminally ill patients and their families.

At the center of hospice care is an interdisciplinary team that provides comprehensive management of the healthcare services and products needed by hospice patients and their families. An interdisciplinary team is typically comprised of a physician, a patient care manager, registered nurses, certified home health aides, social workers, a chaplain, a homemaker and specially trained volunteers.

We assign each of our hospice patients to an interdisciplinary team, which assesses the clinical, psychosocial and spiritual needs of the patient and their family, develops a plan of care, and delivers, monitors and coordinates that plan with the goal of providing appropriate care for the patient and their family. This interdisciplinary team approach offers significant benefits to hospice patients, their families and payors.

Home Health Care Services

Services provided in home health care include four broad categories: (1) home health nursing services, (2) infusion therapy, (3) respiratory therapy and, (4) home medical equipment. According to statistics from the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, total expenditures by payors on home health nursing services were approximately $40 billion in 2003. Medicare is the largest single payor, accounting for $13 billion in 2003, and this is projected to grow to $28 billion by 2014, according to the Home Health Care Spending projections by CMS, Office of the Actuary.

The Company operated 108 home care nursing offices, two hospice offices and two corporate offices in the southern and southeastern United States at December 31, 2004. The Company has built its reputation based on providing quality care and specialty nursing services. Because its services are comprehensive, cost-effective and accessible 24 hours a day, seven days a week, the Company s home health care nursing services are attractive to both payors and physicians. Over 84% of the Company s offices are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or by the Community Health Accreditation Program. The Company intends to seek accreditation for all remaining non-accredited offices. The Company provides a wide variety of home health care services including:

Registered nurses that provide specialty services such as skilled monitoring, assessments and patient education. Many of the Company s nurses have advanced certifications.

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Licensed practical (vocational) nurses that perform technical procedures, administer medications and change surgical and medical dressings.

Physical and occupational therapists that work to strengthen muscles, restore range of motion and help patients perform the activities of daily living.

Speech pathologists/therapists that work to restore communication and oral skills.

Social workers that help families address the problems associated with acute and chronic illnesses.

Home health aides that perform personal care such as bathing or assistance in walking.

Private duty services that provide continuous hourly nursing care and sitter services.

Billing and Reimbursement

Revenue generated from the Company s home health care services are paid by Medicare, Medicaid, private insurance carriers, managed care organizations, individuals and other local health insurance programs. Medicare is a federally funded program available to persons with certain disabilities and persons 65 years of age or older. The Company submits all home health Medicare claims to a single fiscal intermediary for the federal government. Medicaid, a program jointly funded by federal, state, and local governmental health care programs, is designed to pay for certain health care and medical services provided to low income individuals without regard to age. The Company has several contracts for negotiated fees with insurers and managed care organizations.

Medicare Reimbursement for Home Health Nursing

The Company derived approximately 93% and 91% of its net service revenue from the Medicare system for the years ended December 31, 2004 and 2003, respectively.

Since October 2000, with the implementation of PPS, the Company has been paid by Medicare based on episodes of care. An episode of care is defined as a length of care up to 60 days with multiple continuous episodes allowed. A base episode payment is established by the Medicare Program through federal legislation for all episodes of care ended on or after the applicable time periods detailed below:

Period Beginning	Base episode payment

October 1, 2000 through March 31, 2001	$2,115 per episode
April 1, 2001 through September 30, 2001	$ 2,264 per episode
October 1, 2001 through September 30, 2002	$ 2,274 per episode
October 1, 2002 through September 30, 2003	$ 2,159 per episode
October 1, 2003 through March 31, 2004	$ 2,231 per episode
April 1, 2004 through December 31, 2004	$ 2,213 per episode
January 1, 2005 through December 31, 2005	$ 2,264 per episode

The provision in the Benefits Improvement and Protection Act (BIPA) whereby home health providers received a 10% increase in reimbursement that began April 2001 for serving patients in rural areas expired March 31, 2003, however, in April 2004, a 5% increase in reimbursement was reinstated for a one-year period. The Company cannot predict with reasonable certainty whether or not this rural patient reimbursement add-on will be extended, and, if so, what the applicable add-on rate. Patients in rural areas account for approximately 28% of the Company s patient population as of December 31, 2004.

Medicare reimbursement rates are subject to change. The applicability of a reimbursement change depends upon the completion date of the episode and generally applies to all episodes ending after the effective date of the change. Therefore, any change in Medicare reimbursement, positive or negative, will impact the financial results of the Company up to sixty days in advance of the effective date of such change, and the impact of a change could be material.

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The base episode payment as shown above is adjusted by a number of factors including, but not limited to, the following: a case mix adjuster consisting of 80 home health resource groups (HHRG), the applicable geographic wage index (to give effect to geographic differences in wage levels), low utilization (either expected or unexpected), intervening events, such as a significant change in the patient s condition and other factors. The episode payment is also adjusted in the event that a patient is either readmitted by the Company, or admitted to another home health agency, prior to the expiration of 60 days from the original admission date these reimbursement adjustments are known as partial episode payments. As a result, the actual payment to the Company is different from the base episode payments listed above, but generally, a decrease in a base episode payment will result in a decrease in actual episode payment. The episode payment will be made to providers regardless of the cost to provide care. The services covered by the episode payment include all disciplines of care, in addition to medical supplies, within the scope of the home health benefit.

A portion of the cash reimbursement from each Medicare episode is typically received before all services are rendered. The estimated episodic payment is billed at the commencement of the episode. Medicare reimburses 60% of the estimated reimbursement at the initial billing for the initial episode of care per patient and the remaining reimbursement is received upon completion of the episode and upon final billing. Medicare reimburses 50% at initial billing for any subsequent episodes of care for a previously admitted patient immediately following the first episode of care for a patient. The remaining 50% reimbursement is received upon completion of the episode and upon final billing.

Revenue is recorded as services are provided to a patient. Amounts billed and/or received in advance of services performed are recorded as deferred revenue. The amount of deferred revenue at December 31, 2004 and 2003 was $14.9 million and $8.7 million, respectively. These deferred revenue amounts have been recorded as a reduction to accounts receivable in the accompanying Consolidated Balance Sheets since only a nominal amount of deferred revenue represents cash collected in advance of providing services. For episodes of care that are completed, all of the revenue expected to be received for that episode is recognized. The amount of revenue recognized for episodes of care which are incomplete at period end is based on an estimate of the portion of the episode which applies to the period, and is calculated based upon total visits performed to date as a percentage of total expected visits for a particular episode. Management believes that this is a reasonable estimate for revenue with respect to services provided for incomplete episodes, and for which reimbursement will be ultimately received. Because of the potential for changes in base episode payments referred to above and the complexity of the regulations noted above, the estimated amounts originally recorded as net patient revenue and accounts receivable may be subject to revision as additional information becomes known.

During 2003, CMS informed home health care providers that it intended to make certain recoveries of amounts overpaid to providers for the periods dating from the implementation of PPS on October 1, 2000 through particular dates in 2003 and 2004. The first of these amounts related to partial episode payments (PEPs), whereby a patient was readmitted to a home health care agency prior to the passing of 60 days from the previous admission date at another home health agency. In such instances, reimbursement for the first agency is reduced. CMS advised the industry that CMS had implemented changes to its computer system such that the proper adjustment would be made at the time of claim submission on an ongoing basis, and that recovery for prior overpayments would commence in the summer of 2003 and extend over a two-year period. The Company reserved, based on information supplied by CMS, approximately $0.9 million in 2003 for all claims dating from October 1, 2000. During the twelve months ended December 31, 2004, CMS recouped approximately $51,000 of the above estimated overpayments. The Company cannot predict the actual timing of future collections initiated by CMS. Secondly, CMS advised the industry that it would seek recovery of overpayments that were made for patients who had, within 14 days of such admission, been discharged from inpatient facilities, including hospitals, rehabilitation and skilled nursing units, and that these recoveries would commence in April 2004. This date was subsequently extended to 2005. CMS will provide at least five weeks notice of any impending recovery. To date no notice has been received by the Company. The Company conducted an analysis of a sample of claims where and when these events had occurred, and estimated that, for all periods dating from October 1, 2000

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through December 31, 2003, a reserve in the amount of approximately $1.5 million was appropriate. This reserve is recorded in current portion of Medicare liabilities in the accompanying Consolidated Balance Sheets.

Prior to the implementation of PPS on October 1, 2000, reimbursement for home health care services to patients covered by the Medicare program was based on reimbursement of allowable costs subject to certain limits. Final reimbursement was determined after submission of annual cost reports and audits thereof by the fiscal intermediaries. Retroactive adjustments have been accrued on an estimated basis in the period the related services were rendered and will be adjusted in future periods, as final settlements are determined. Estimated settlements for cost report years ended 1997 and subsequent years, which are still subject to audit by the intermediary and the Department of Health and Human Services, are recorded in current Medicare liabilities in the accompanying Consolidated Balance Sheets. Under the new PPS rules, annual cost reports are still required as a condition of participation in the Medicare program. However, there are no final settlements or retroactive adjustments based on the submitted annual cost reports.

Information Technology

Effective October 1, 2001, the Company entered into a Software License Agreement (License Agreement) with CareSouth for the use of a home health care billing and collections software system. The License Agreement, which expired in May 2004, contained a bargain purchase option that the Company exercised upon expiration. The Company has extensively enhanced this software, utilizing employed development staff. This billing and collection software is combined with both internally developed clinical management software, and other externally sourced software, and is used throughout the Company s operations. The Company intends to continue this development process in order to improve the efficiency of its operations. In particular, the Company, in January 2005, commenced an important modification to the underlying database for the software. This modification implements a Sequel database, which management believes will allow the Company significantly more system capacity, and therefore, ensuring system capacity for growth opportunities.

Furthermore, the Company plans to commence making certain modules of its clinical software available on mobile computers in the second half of 2005, and to provide such mobile computers to an increasing proportion of its clinical staff. Management believes that a successful implementation of this application will enhance the Company s efficiency by having more accurate nursing notes available in a more timely manner. Such an implementation could provide additional benefits for the quality of medical records.

Quality Control and Improvement

As a medical service business, the quality and reputation of the Company s personnel and operations are critical to its success. The Company has implemented quality management and improvement programs, a corporate compliance program, and policies and procedures at both the corporate and field levels. The Company strives to meet regulations set forth by state licensure, federal guidelines for Medicare and Medicaid, and JCAHO standards.

The Company has an active quality management team that makes periodic on-site inspections of field offices to review systems, operations, and clinical procedures. During the second six months of 2004, the Company increased the size of this team, and expanded the range of the inspections undertaken by the personnel. An educational division is also part of this quality management team and is responsible for conducting educational and training sessions at the field offices, as well as disseminating continuing education materials to the Company s employees. Additionally, the quality management team works in conjunction with the Company s Corporate Compliance Officer to perform compliance audits and conduct education to enhance the knowledge of the field staff and to ensure compliance with state and federal laws and regulations.

Recruiting and Training

The Company s Recruiting Department, assisted by specialists, coordinates recruiting efforts for corporate and field personnel. Employees are recruited through newspaper advertising, professional recruiters, the Internet, the Company s web page, networking, participation in job fairs, and word-of-mouth referrals. The Company

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believes it is competitive in the industry and offers its employees upward mobility, health insurance, an Employee Stock Purchase Plan, a 401(k) plan with Company matching contributions, and a cafeteria plan.

Uniform procedures for screening, testing, and verifying references, including criminal background checks where appropriate, have been established.

The Company s Training and Development department provides education and development opportunities to employees throughout the Company. Through the orientation program, new employees are introduced to the Company s mission, vision, strategy, purpose and core beliefs, and receive compliance education from the Company s Chief Compliance Officer. During the fourth quarter of 2004, the Company provided a one-day orientation program to all employees of the Company who had not previously received this training. A training certification program for clinicians assures that clinical staff are prepared for their responsibilities in providing care in patients homes. In addition, leadership development efforts help to assure that managers are well prepared to meet the challenges of their day-to-day management responsibilities.

The Company believes that it is in compliance with all material Department of Labor regulations.

Government Regulation

The Company s home health care business is highly regulated by federal, state and local authorities. Regulations and policies frequently change, and the Company monitors changes through trade and governmental publications and related associations. The Company s home health care subsidiaries are certified by CMS and are therefore eligible to receive reimbursement for services provided through the Medicare program. As a provider under the Medicare and Medicaid systems, the Company is subject to the various anti-fraud and abuse laws, including the federal health care programs anti-kickback statute. This law prohibits any offer, payment, solicitation or receipt of any form of remuneration to induce the referral of business reimbursable under a federal health care program or in return for the purchase, lease, order, arranging for, or recommendation of items or services covered by any federal health care programs or any health care plans or programs that are funded by the United States government (other than certain federal employee health insurance benefits) and certain state health care programs that receive federal funds under various programs, such as Medicaid. A related law forbids the offer or transfer of any item or service for less than fair market value, or certain waivers of co-payment obligations, to a beneficiary of Medicare or a state health care program that is likely to influence the beneficiary s selection of health care providers. Violations of the anti-fraud and abuse laws can result in the imposition of substantial civil and criminal penalties and, potentially, exclusion from furnishing services under any federal health care programs. In addition, the states in which the Company operates generally have laws that prohibit certain direct or indirect payments or fee-splitting arrangements between health care providers where they are designed to obtain the referral of patients to a particular provider.

Congress adopted legislation in 1989, known as the Stark Law , that generally prohibits a physician from ordering clinical laboratory services for a Medicare beneficiary where the entity providing that service has a financial relationship (including direct or indirect ownership or compensation relationships) with the physician (or a member of his/her immediate family), and prohibits such entity from billing for or receiving reimbursement for such services, unless a specified exception is available. Additional legislation became effective as of January 1, 1993, known as Stark II, that extends the Stark law prohibitions to services under state Medicaid programs, and beyond clinical laboratory services to all designated health services, including, but not limited to, home health services, durable medical equipment and supplies, and parenteral and enteral nutrients, equipment, and supplies. Violations of the Stark Law may also trigger civil monetary penalties and program exclusion. Pursuant to Stark II, physicians who are compensated by the Company will be prohibited from seeking reimbursement for designated health services rendered to such patients unless an exception applies. Several of the states in which the Company conducts business have also enacted statutes similar in scope and purpose to the federal fraud and abuse laws and the Stark laws.

Various federal and state laws impose criminal and civil penalties for submitting false claims for Medicare, Medicaid or other health care reimbursements. The Company believes that it bills for its services under such programs accurately, although the rules governing coverage of, and reimbursements for, the Company s services

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are complex. There can be no assurance that these rules will be interpreted in a manner consistent with the Company s billing practices.

The Health Insurance Portability and Accountability Act (HIPAA) was enacted August 21, 1996 to assure health insurance portability, reduce health care fraud and abuse, guarantee security and privacy of health information and enforce standards for health information. Organizations were required to be in compliance with certain HIPAA provisions relating to security and privacy beginning April 14, 2003. The Company believes that it was in compliance as of April 14, 2003, and is currently in compliance. Organizations are subject to significant fines and penalties if found not to be compliant with the provisions outlined in the regulations. Regulations issued pursuant to HIPAA impose ongoing obligations relative to training, monitoring and enforcement, and management has implemented processes and procedures to ensure continued compliance with these regulations.

Pursuant to the provisions of HIPAA, covered health care providers were required to comply with the statute s electronic Health Care Transactions and Code Sets. The Company is now capable of transmitting electronic information in HIPAA-compliant format to any vendor who is also 100 percent HIPAA-compliant. The Company s largest trading partner, as defined by HIPAA, processes claims on behalf of CMS, is our fiscal intermediary, who is using the HIPAA-compliant specifications. However, the Virginia Medicaid program, one of the Company s smaller trading partners, has elected to utilize HIPAA-compliant specifications with non-standard coding specifications, which has required the Company to integrate this new format, which is presently pending, but which will not materially impair the Company s operations or finances. New HIPAA electronic security regulations also become effective in April of 2005, with which the Company intends to be fully compliant.

Home health care offices have licenses granted by the health authorities of their respective states. Additionally, some state health authorities require a Certificate of Need (CON) or Permit of Approval (POA). Tennessee, Georgia, Alabama, North Carolina, South Carolina, Mississippi, and Maryland require a CON to establish and operate a home health care agency, while Arkansas requires a POA. Louisiana, Oklahoma, Virginia, Texas and Florida currently do not have such requirements. However, Louisiana remains subject to a legislative moratorium on the award of new home health licenses that has been in place for several years, and will continue for the foreseeable future. In every state, each location license and/or CON or POA issued by the state health authority determines the service areas for the home health care agency.

The Company strives to comply with all federal, state and local regulations, and has passed all federal and state inspections and surveys, subject to current surveys of nine operating locations that have certain identified deficiencies. In the event that these deficiencies, for which the Company has submitted appropriate plans of corrections, are not resolved within the specified period, regulatory consequences may result, including in the case of one location revocation of Medicare participation. The ability of the Company to operate properly and fulfill its business objective will depend on the Company s ability to comply with all applicable healthcare regulations.

In 1999, the Company discovered questionable conduct involving the former owner of one of its smaller agencies, which occurred between 1994 and 1997. The Company conducted an initial audit (using an independent auditor) and voluntarily disclosed the irregularities to the Department of Health and Human Services Office of the Inspector General (OIG). Thereafter, the government examined the disclosed activities, and during the second quarter of 2002, the Company conducted a further audit of relevant claims that was initiated at the request of the OIG, which was completed during the third quarter of 2002. In February 2003, the OIG offered a settlement that included certain penalties not previously anticipated by the Company, as the Company self-reported the matter. On August 8, 2003, the Company signed both a Settlement Agreement and a Corporate Integrity Agreement with the OIG and Department of Justice. The Settlement Agreement provides for payment of a financial settlement in three equal annual payments of $386,000, with the first payment made on the date of execution and the second payment made on August 6, 2004. This agreement also obligates the Company to amend previously filed cost reports to deduct costs incurred by the Company for audit and investigation of this matter, and the Company has taken the necessary steps to re-open the applicable cost reports.

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The Corporate Integrity Agreement, which is binding for a three-year period, requires that the Company maintain its existing compliance program and provides for enhanced training requirements, annual claims audits of the subject agency by an independent reviewer, and regular reporting to the OIG. This agreement provides for stipulated penalties in the event of non-compliance by the Company, including the possibility of exclusion from the Medicare program. The Company believes that these obligations will not materially affect the Company s operations or financial performance over the period of the agreement, although no assurances can be provided that the ultimate cost will not be materially different. Management believes the Company is in compliance with the Corporate Integrity Agreement as of December 31, 2004.

Competition

The services provided by the Company are also provided by competitors at the local, regional and national levels. Home health care providers compete for referrals based primarily on scope and quality of services, geographic coverage, pricing, and outcomes data. The impact of competitors is best determined on a market-by-market basis.

The Company believes its generally favorable competitive position in its markets is attributable to its reputation for over a decade of consistent, high quality care, its comprehensive range of services, its state-of-the-art information management and technology systems, and its widespread service network.

Seasonality

The demand for the Company s home health care nursing is slightly lower from April through September of each year, although the variation is generally less than 5% from the monthly average.

Employees

As of December 31, 2004, the Company had 2,534 full-time employees, and 1,060 part-time employees, including part-time field nurses and other professionals in the field. The Company currently employs the following classifications of personnel: administrative level employees which consist of a senior management team (Chief Executive Officer President and Chief Operating Officer, Chief Financial Officer, Chief Information Officer and Chief Compliance Officer), senior vice presidents and vice presidents, office administrative staff, clinical managers and nursing directors, accountants, sales executives, licensed and certified professional staff (RNs, LPNs, therapists and therapy assistants), and non-licensed care givers (aides). The Company s labor force is not unionized or subject to any collective bargaining agreements.

The Company complies with the Fair Labor Standards Act in establishing compensation methods for its employees. Select positions within the Company are eligible for bonuses based on the achievement of pre-determined budgeted performance measures. The Company sponsors and contributes toward the cost of a group health insurance program for its eligible employees and their dependents. The group health insurance program is self-funded by the Company; however, there is a re-insurance policy in place to limit the liability for the Company. In addition, the Company provides a group term life insurance policy and a long-term disability policy for eligible employees. The Company also offers a 401(k) retirement plan, a Cafeteria Section 125 plan, an Employee Stock Purchase Plan, supplemental benefit programs, and paid time-off benefits for eligible employees.

The Company believes its employee relations are good. It successfully recruits employees and a significant number of its employees are shareholders.

Insurance

The Company maintains casualty coverages for all of its operations, including professional and general liability, workers compensation, automobile, property, fiduciary liability, and directors and officers. The insurance program is reviewed periodically throughout the year and thoroughly on an annual basis to ensure adequate coverage is in place. For the years ended December 31, 1995 through December 31, 1998, the Company was approved through the State of Louisiana to self-insure its workers compensation program. All other states

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were covered on a fully insured basis through A+ rated insurers. In January 1999, the Company changed from the self-insured workers compensation plan to a fully-insured, guaranteed cost plan, and in January 2003, the Company reverted to a high deductible plan with a $250,000 deductible per claim which the Company currently maintains. All of the Company s employees are bonded. The Company is self-insured for its employee health benefits, with reinsurance in place for individual claims in excess of $100,000. In 2005, the reinsurance was increased to individual claims in excess of $125,000.

From December 31, 1998 to November 9, 2000, the Company was covered by Reliance Insurance Company of Illinois (Reliance) for risks associated with professional and general liability. The Company became aware of the deteriorating stability and rating of Reliance during the latter part of 2000 and thus, secured coverage with another insurer on November 9, 2000 for occurrences after that date. Reliance is currently in liquidation and may not be in a position to pay or defend claims incurred by the Company during the period stated above. The Company has two open claims relating to the above period, which it is now defending and does not believe that the ultimate resolution of these claims will be materially different from reserves established for those claims. The Company is unaware of, and does not expect, any material claims that may be made based on occurrences during the period, but there is no assurance that additional claims will not be brought against the Company relating to incidents which occurred during the time period stated above or that any such claims will not be material.

Risk Factors

Risks Related to Our Industry

Our profitability depends principally on the level of government-mandated payment rates. Reductions in rates or rate increases that do not cover cost increases may adversely affect our business.

We generally receive fixed payments from Medicare for our services based on the level of care that we provide patients. Consequently, our profitability largely depends upon our ability to manage the cost of providing services. Although Medicare currently provides for an annual adjustment of the various payment rates based on the increase or decrease of the medical care expenditure category of the Consumer Price Index, these Medicare payment rate increases may be less than actual inflation or could be eliminated or reduced in any given year. Alternatively, if our cost of providing services, which consists primarily of labor costs, increases more than the annual Medicare price adjustment, our profitability could be impacted negatively.

If any of our agencies fails to comply with the conditions of participation in the Medicare program, that agency could be terminated from the Medicare program, which would adversely affect our net patient service revenue and profitability.

Each of our home care agencies must comply with the extensive conditions of participation in the Medicare program. If any of our agencies fails to meet any of the Medicare conditions of participation, that agency may receive a notice of deficiency from the applicable state surveyor. If that agency then fails to institute a plan of correction to correct the deficiency within the correction period provided by the state surveyor, that agency could be terminated from the Medicare program. Any termination of one or more of our home care agencies from the Medicare program for failure to satisfy the program s conditions of participation could adversely affect our net service revenue and profitability.

We are subject to extensive government regulation. Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

The federal government and the states in which we operate regulate our industry extensively. The laws and regulations governing our operations, along with the terms of participation in various government programs, regulate how we do business, the services we offer, and our interactions with patients and the public. These laws

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and regulations, and their interpretations, are subject to frequent change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations could reduce our profitability by:

increasing our liability;

increasing our administrative and other costs;

increasing or decreasing mandated services;

requiring us to restructure our relationships with referral sources and providers; or

requiring us to implement additional or different programs and systems.

For example, Congress enacted the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which mandates that provider organizations enhance privacy protections for patient health information. This requires companies like us to add new administrative, information, and security systems to prevent inappropriate release of protected health information. Compliance with this law has added, and will continue to add, costs that affect our profitability.

In addition, we are subject to various routine and non-routine governmental reviews, audits, and investigations. Violation of the laws governing our operations, or changes in interpretations of those laws, could result in the imposition of fines, civil or criminal penalties, the termination of our rights to participate in federal and state-sponsored programs, and the suspension or revocation of our licenses. If we become subject to material fines or if other sanctions or other corrective actions are imposed on us, we might suffer a substantial reduction in profitability.

If we are unable to maintain relationships with existing patient referral sources or to establish new referral sources, our growth and profitability could be adversely affected.

Our success depends significantly on referrals from physicians, hospitals, and other patient referral sources in the communities that our home care agencies serve, as well as on our ability to maintain good relationships with these referral sources. Our referral sources are not contractually obligated to refer home care patients to us and may refer their patients to other home care providers. Our growth and profitability depend on our ability to establish and maintain close working relationships with these patient referral sources and to increase awareness and acceptance of the home care benefit by our referral sources and their patients. We cannot assure you that we will be able to maintain our existing referral source relationships or that we will be able to develop and maintain new relationships in existing or new markets. Our loss of, or failure to maintain, existing relationships or our failure to develop new relationships could adversely affect our ability to expand our operations and operate profitably.

We may be subject to substantial malpractice or other similar claims.

The services we offer involve an inherent risk of professional liability and related substantial damage awards. On any given day, we have several hundred nurses and other direct care personnel driving to and from patients homes where they deliver medical and other care. Due to the nature of our business, we and the caregivers who provide services on our behalf may be the subject of medical malpractice claims. These caregivers could be considered our agents and, as a result, we could be held liable for their medical negligence. We cannot predict the effect that any claims of this nature, regardless of their ultimate outcome, could have on our business or reputation or on our ability to attract and retain patients and employees. We maintain malpractice liability insurance and are responsible for amounts in excess of the limits of our coverage.

Delays in reimbursement may cause liquidity problems.

Our business is characterized by delays in reimbursement from the time we provide services to the time we receive reimbursement or payment for these services. If we have information system problems or issues that arise

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with Medicare, we may encounter delays in our payment cycle. Such a timing delay may cause working capital shortages. As a result, working capital management, including prompt and diligent billing and collection, is an important factor in our results of operations and liquidity. We cannot assure you that industry trends will not extend our collection period, adversely impact our working capital, or that our working capital management procedures will successfully negate this risk.

Our industry is highly competitive.

We compete with local and regional home health care companies, hospitals, nursing homes, and other businesses that provide home nursing services, some of which are large established companies that have significantly greater resources than we do. Our primary competition comes from local companies in each of our markets, and these privately owned or hospital-owned health care providers vary by region and market. We compete based on the availability of personnel; the quality, expertise, and value of our services; and in select instances, on the price of our services. Increased competition in the future from existing competitors or new entrants may limit our ability to maintain or increase our market share. We cannot assure you that we will be able to compete successfully against current or future competitors or that competitive pressures will not have a material adverse impact on our business, financial condition, or results of operations.

Some of our existing and potential new competitors may enjoy greater name recognition and greater financial, technical, and marketing resources than we do. This may permit our competitors to devote greater resources than we can to the development and promotion of services. These competitors may undertake more far-reaching and effective marketing campaigns and may offer more attractive opportunities to existing and potential employees and services to referral sources.

We expect our competitors to develop new strategic relationships with providers, referral sources, and payors, which could result in increased competition. The introduction of new and enhanced service offerings, in combination with industry consolidation and the development of strategic relationships by our competitors, could cause a decline in revenue or loss of market acceptance of our services or make our services less attractive. Additionally, we compete with a number of non-profit organizations that can finance acquisitions and capital expenditures on a tax-exempt basis or receive charitable contributions that are unavailable to us.

We expect that industry forces will continue to have an impact on our business and that of our competitors. In recent years, the health care industry has undergone significant changes driven by efforts to reduce costs. For example, the Medicare Modernization Act of December 2003 (MMA) allocated significant additional funds to Medicare managed care providers in order to promote greater participation in those plans by Medicare beneficiaries. If these increased funding levels have the intended result, the rate of growth in the Medicare fee-for-service market, where we have generated the majority of our historical revenue, could decline. The frequent changes in our industry have increased competition among home health care providers. If we are unable to react competitively to new developments, our operating results may suffer.

A shortage of qualified registered nursing staff and other caregivers could adversely affect our ability to attract, train and retain qualified personnel and could increase operating costs.

We rely significantly on our ability to attract and retain caregivers who possess the skills, experience, and licenses necessary to meet the requirements of our patients. We compete for home health care personnel with other providers of home nursing services. Our ability to attract and retain caregivers depends on several factors, including our ability to provide these caregivers with attractive assignments and competitive benefits and salaries. We cannot assure you that we will succeed in any of these areas. The cost of attracting caregivers and providing them with attractive benefit packages may be higher than anticipated and, if that occurs, our profitability could decline. If we are unable to attract and retain caregivers, the quality of our services may decline, and we could lose patients and referral sources.

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Risks Related to Our Business

We depend on Medicare for substantially all of our revenues.

For the years ended December 31, 2004, 2003 and 2002, we received 93%, 91% and 88%, respectively, of our revenue from Medicare. Reductions in Medicare reimbursement could have an adverse impact on our profitability. Such reductions in payments to us could be caused by:

- administrative or legislative changes to the base episode rate;
- the elimination or reduction of annual rate increases based on medical inflation;
- the imposition by Medicare of co-payments or other mechanisms shifting responsibility for a portion of payment to beneficiaries;
- adjustments to the relative components of the wage index;
- changes to our case mix or therapy thresholds; or
- other adverse changes to the way we are paid for delivering our services.

Our non-Medicare revenues and profitability also are affected by the continuing efforts of third-party payors to contain or reduce the costs of health care by lowering reimbursement rates, narrowing the scope of covered services, increasing case management review of services, and negotiating reduced contract pricing. Any changes in reimbursement levels from these third-party payor sources and any changes in applicable government regulations could have a material adverse effect on our revenues and profitability. We can provide no assurance that we will continue to maintain the current payor or revenue mix.

We are operating under a Corporate Integrity Agreement. Violations to that agreement could result in penalties or exclusion from participation in the Medicare program.

In 1999 we uncovered certain improprieties stemming from the unauthorized conduct of an agency director in our Monroe, Louisiana location, an agency we had acquired previously. We disclosed these improprieties to the Office of the Inspector General (OIG). Following an extensive series of audits, we and the OIG reached a settlement in August 2003, whereby we agreed to repay approximately $1.2 million to the government in three annual payments, the last of which we will make in August 2005. As part of the settlement, we also executed a three-year Corporate Integrity Agreement (CIA) which requires that we:

- maintain our current compliance program;

specify additional training requirements;

conduct annual, independent audits of the agency; and

make timely disclosure of, and repay, overpayments resulting from any potential fraud or abuse of which we become aware.

There are stipulated penalties for violations of the CIA. Egregious violations of the CIA could result in our exclusion from further participation in government-funded health programs. We have designated a Chief Compliance Officer to ensure ongoing compliance with the terms and conditions of the CIA as well as compliance with all other applicable laws, rules, and regulations. Any acquired businesses are subject to the provisions of the CIA.

We believe that we are in compliance with all state and federal fraud and abuse provisions and all other applicable government laws and regulations. Our compliance with these laws and regulations may be subject to future government review and interpretation and possible regulatory actions currently unknown or unasserted. If we are found to be in violation of any of these provisions, it could have a material adverse effect on our business.

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We operate our agencies under licenses issued and regulated by the respective states in which they are located. Each agency is subject to periodic surveys and complaint-based surveys. If a survey identifies violations of state standards, the agency typically is afforded a grace period in which to comply or otherwise lose its license to operate. We use a Clinical Operations Department, staffed by regional personnel, to prepare each agency for these surveys and respond when those surveys identify potential problems or when plans-of-correction are required to bring the agency back into compliance. If we are found to be in violation of any of these state standards, it could have a material adverse effect on our business.

Our growth strategy depends on our ability to manage growing and changing operations.

Our business has grown significantly in size and complexity in recent years. Our internal growth rate for Medicare patient admissions was 28% for calendar year 2004 and 8% for calendar year 2003. This growth has placed, and will continue to place, significant demands on our management systems, internal controls, and financial and professional resources. In addition, we will need to further develop our financial controls and reporting systems to accommodate future growth. This could require us to incur expenses for hiring additional qualified personnel, retaining professionals to assist in developing the appropriate control systems, and expanding our information technology infrastructure. Our inability to manage growth effectively could have a material adverse effect on our financial results.

Our growth strategy depends on our ability to develop and to acquire additional home care agencies on favorable terms and to integrate and operate these agencies effectively. If we are unable to do so, our future growth and operating results could be negatively impacted.

Developments. We expect to continue to open agencies in our existing and new markets. Our new agency growth, however, will depend on several factors, including our ability to:

- obtain locations for agencies in markets where need exists;
- identify and hire a sufficient number of appropriately trained home care and other health care professionals;
- obtain adequate financing to fund growth; and
- operate successfully under applicable government regulations.

Acquisitions. We are focusing more time and resources on the acquisition of small to medium-sized home health providers, or of certain of their assets, in targeted markets. We may be unable to identify, negotiate, and complete suitable acquisition opportunities on reasonable terms. We may incur future liabilities related to acquisitions. Should any of the following problems, or others, occur as a result of our acquisition strategy, the impact could be material:

- difficulties integrating acquired personnel and other corporate cultures into our business;
- difficulties integrating information systems;

the potential loss of key employees or referral sources of acquired companies or a reduction in patient referrals by hospitals from which we have acquired home health care agencies;

the assumption of liabilities and exposure to undisclosed liabilities of acquired companies;

the acquisition of an agency with undisclosed compliance problems;

the diversion of management attention from existing operations; or

an unsuccessful claim for indemnification rights from previous owners for acts or omissions arising prior to the date of acquisition.

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Our acquisitions may impose strains on our existing resources.

As a result of our past and current acquisition strategy, we have grown significantly over the last two years. As we continue to add acquisition-related revenue and expand our markets, our growth could strain our resources, including management, information systems, regulatory compliance, logistics, and other controls. We cannot assure you that our resources will keep pace with our anticipated growth. If we do not manage our expected growth effectively, our future results could be adversely affected.

We may face increasing competition for acquisition candidates.

We intend to grow significantly through the continued acquisition of additional home nursing agencies. We face competition for acquisition candidates, which may limit the number of acquisition opportunities available to us and may lead to higher acquisition prices. Recently, we have observed an increase in acquisition prices for mid-sized and larger regional home health care companies. We cannot assure you that we will be able to identify suitable acquisitions in the future or that any such opportunities, if identified, will be consummated on favorable terms, if at all. In the absence of completing successful acquisitions, our future growth rate would decline. In addition, we cannot assure you that any future acquisitions, if consummated, will result in further growth.

We may require additional capital to pursue our acquisition strategy.

At December 31, 2004, we had cash and cash equivalents of approximately $90 million. Based on our current plan of operations, including acquisitions, we cannot assure you that this amount will be sufficient to support current growth strategies. We cannot readily predict the timing, size, and success of our acquisition efforts and the associated capital commitments. If we do not have sufficient cash resources, our growth could be limited unless we obtain additional equity or debt financing. Effective as of April 28, 2004, we entered into a credit agreement with General Electric Capital Corporation for a $15.0 million revolving credit facility, with $10.0 million of additional borrowing capacity, upon the satisfaction of certain conditions as defined in the credit agreement, for a total borrowing capacity of $25.0 million.

Our business depends on our information systems. Our inability to effectively integrate, manage, and keep secure our information systems could disrupt our operations.

Our business depends on effective and secure information systems that assist us in, among other things, monitoring utilization and other cost factors, processing claims, reporting financial results, measuring outcomes and quality of care, managing regulatory compliance controls, and maintaining operational efficiencies. These systems include software developed in-house and systems provided by external contractors and other service providers. To the extent that these external contractors or other service providers become insolvent or fail to support the software or systems, our operations could be affected negatively. Our agencies also depend upon our information systems for accounting, billing, collections, risk management, quality assurance, payroll, and other information. If we experience a reduction in the performance, reliability, or availability of our information systems, our operations and ability to produce timely and accurate reports could be adversely affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Our acquisition activity requires transitions and integration of various information systems. We regularly upgrade and expand our information systems capabilities. If we experience difficulties with the transition and integration of information systems or are unable to implement, maintain, or expand our systems properly, we could suffer from, among other things, operational disruptions, regulatory problems, and increases

in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography or other events or developments could result in compromises or breaches of our security systems and patient data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in our services or operations. The Internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been

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distributed and have rapidly spread over the Internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations or make our systems inaccessible to our providers or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of patients if security breaches are not prevented.

Our clinical software system has been developed in-house. Failure of, or problems with, our system could harm our business and operating results.

We have developed and utilize a proprietary Windows-based clinical software system to collect assessment data, schedule and log patient visits, generate medical orders, and monitor treatments and outcomes in accordance with established medical standards. The system integrates billing and collections functionality as well as accounting, human resource, payroll, and employee benefits programs provided by third parties. Problems with, or the failure of, our technology and systems could negatively impact data capture, billing, collections, and management and reporting capabilities. Any such problems or failures could adversely affect our operations and reputation, result in significant costs to us, and impair our ability to provide our services in the future. The costs incurred in correcting any errors or problems may be substantial and could adversely affect our profitability.

We may experience difficulties implementing a new information system.

We are in the process of consolidating our various agency databases into an enterprise-wide system to improve the accuracy, reliability, and efficiency of processing and management reporting. We are engaged in transitioning from our current database system to a Sequel database. However, if any problems emerge in connection with this transition, our ability to manage our operations would be impaired from both a clinical and financial perspective, which could have a material adverse effect on our business.

We depend on outside software providers.

We depend on the proper functioning and availability of our information systems in operating our business, some of which are provided by outside software providers. These information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. If our providers are unable to maintain or expand our information systems properly, we could suffer from operational disruptions and an increase in administrative expenses, among other things.

Our insurance liability coverage may not be sufficient for our business needs.

We maintain professional liability insurance for Amedisys and our subsidiaries. However, we cannot assure you that claims will not be made in the future in excess of the limits of such insurance, if any, nor can we assure you that any such claims, if successful and in excess of such limits, will not have a material adverse effect on our ability to conduct business or on our assets. Our insurance coverage also includes fire, property damage, and general liability with varying limits. Although we maintain insurance consistent with industry practice, we cannot assure you that the insurance we maintain will satisfy claims made against us. In addition, we cannot assure you that insurance coverage will continue to be available to us at commercially reasonable rates, in adequate amounts or on satisfactory terms.

Any claims made against us, regardless of their merit or eventual outcome, could damage our reputation and business. From December 31, 1998 to November 9, 2000, we were insured for risks associated with professional and general liability by an insurance company that currently is in liquidation under federal bankruptcy laws and may not be able to pay or defend claims incurred by us during this period, and our current insurance does not

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cover any such claims. We do not, however, believe that the ultimate resolution of current claims will be materially different from reserves established for them or that any material claims will be made in the future based on occurrences during that period.

We have established reserves for Medicare liabilities that may be payable by us in the future. These liabilities may be subject to audit or further review, and we may owe additional amounts beyond what we expect and have reserved for.

As of December 31, 2004, we have estimated an aggregate payable to Medicare of $9.3 million, all of which is reflected as a current liability in our Consolidated Balance Sheets. The $9.3 million liability has two components: a cost report adjustments reserve ($6.8 million), and a PPS payment adjustments reserve ($2.5 million). If actual amounts exceed our reserves, we may incur additional costs that may affect adversely our results of operations. We describe these adjustments below.

Cost Report Adjustments Reserve. Prior to the implementation of PPS on October 1, 2000, we recorded Medicare revenue at the lower of (1) actual costs, (2) the per-visit cost limit, or (3) a per-beneficiary cost limit on an individual provider basis. We determined ultimate reimbursement upon review of annual cost reports.

The recorded $6.8 million payable includes a $3.7 million reserve for open cost reports through periods ended October 2000. At the time when these audits are completed and final assessments are issued, we may apply to Medicare for repayment over a 36-month period, although there is no assurance that this application will be accepted by Medicare. These amounts relate to the Medicare payment system in effect until October 2000, under which Medicare provided us with periodic interim payments, subject to an audit of cost reports submitted by us and repayment of any overpayments by Medicare to us. The fiscal intermediary, acting on behalf of CMS, has not yet issued finalized audits with respect to 1999 and 2000, and is entitled to reopen settled cost reports for up to three years after issuing final assessments.

The payable to Medicare also includes a $3.1 million reserve related to amounts owed to Medicare as overpayments for Alliance Home Health, Inc. (Alliance), a subsidiary that is in bankruptcy proceedings under Chapter 7 of the U.S. Bankruptcy Code. It is uncertain at this time whether we will have any responsibility for that amount if the debt of the subsidiary is discharged in bankruptcy.

PPS Payment Adjustments Reserve. The remaining balance of $2.5 million is related to notice from CMS that it intended to make certain recoveries of amounts overpaid to providers for the periods dating from the implementation of PPS on October 1, 2000 through particular dates in 2003 and 2004. The first of these amounts related to partial episode payments whereby a patient was readmitted to home health care prior to the expiration of 60 days from the previous admission date at another home health agency. In such instances, reimbursement for the first agency is reduced. CMS advised the industry that CMS had recently implemented changes to its computer system such that these instances would be adjusted at the time of claim submission on an ongoing basis, and that recovery for prior overpayments would commence in the summer of 2003 and extend over a two-year period. We reserved, based on information supplied by CMS, approximately $1.0 million in 2003 for all claims dating from October 1, 2000. Second, CMS advised the industry that CMS would seek recovery of overpayments that were made for patients who had, within 14 days of such admission, been discharged from inpatient facilities, including hospitals, rehabilitation, and skilled nursing units, and that these recoveries would commence in April 2004, subsequently delayed until 2005. We conducted an analysis of a representative sample of claims where these events had occurred, and estimated that, for periods dating from October 1, 2000 through December 31, 2003, a reserve in the amount of approximately $1.5 million was appropriate.

We depend on the services of our executive officers and other key employees.

Our success depends upon the continued employment of certain members of our senior management team, including our Chairman and Chief Executive Officer, William F. Borne, our President and Chief Operating

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Officer, Larry R. Graham, our Chief Financial Officer, Gregory H. Browne, and our Chief Information Officer, Alica A. Schwartz. We also depend upon the continued employment of the Senior Vice Presidents that manage several of our key functional areas, including operations, business development, accounting, finance, human resources, marketing, information systems, contracting, and compliance.

We maintain key employee life insurance of $4.5 million on Mr. Borne s life and have entered into employment agreements with each of Mr. Borne, Mr. Graham and Mr. Browne. The departure of any member of our senior management team may materially adversely affect our operations.

We are defending class action lawsuits that may require us to pay substantial damage awards.

On August 23 and October 4, 2001, two class action lawsuits were filed, on behalf of all purchasers of our common stock between November 15, 2000 and June 13, 2001, against the Company and three of our executive officers. These suits, which were filed in the United States District Court for the Middle District of Louisiana, have now been consolidated. In May of 2003, the trial court certified the class, and the Company appealed that decision. On February 17, 2005, the United States Court of Appeals for the Fifth Circuit vacated the trial court s certification order and remanded the case for further proceedings relative to class certification. The parties have agreed to a stay of all depositions and other discovery (subject to certain limited exceptions) pending a ruling on class certification.

The suit seeks damages based on the decline in our stock price following an announced restatement of earnings for the fourth quarter of 2000 and first quarter of 2001. The suits allege that management of the Company knew or were reckless in not knowing the facts giving rise to the restatement. The Company is vigorously defending these lawsuits. The Company has directors and officers insurance coverage for an amount in excess of $100,000 up to $4 million, in respect of this period. The Company is not able to estimate at this time the potential amounts that could be awarded to the plaintiffs in this matter. Although management believes our insurance coverage is sufficient in respect to any amounts that may be awarded, the Company cannot assure you that the final resolution will fall within the Company s insurance coverage amounts. The Company has met our deductible with the legal fees that have been incurred to date. Additional legal fees will be paid by the insurer up to our policy limits.

There is a risk that we will be held responsible for some or all of the $4.2 million liability of a bankrupt subsidiary.

We consolidate the net liabilities of Alliance, a bankrupt subsidiary that is no longer in operation, in our consolidated financial statements. It is possible that we could be held responsible for some or all of this amount, and depending upon the outcome of the bankruptcy proceedings, a potentially larger amount.

Arthur Andersen LLP may not be able to satisfy any claims arising from their provision of auditing services to us, including claims that you may have under applicable securities laws.

Arthur Andersen LLP audited our financial statements for the five years ended December 31, 2001. On June 15, 2002, Arthur Andersen was convicted of obstruction of justice by a federal jury in Houston, Texas in connection with Arthur Andersen s work for Enron Corp. On September 15, 2002, a federal judge upheld this conviction. Arthur Andersen ceased its audit practice before the Securities and Exchange Commission (SEC) on August 31, 2002. Because of the circumstances currently affecting Arthur Andersen LLP, as a practical matter it may not be able to satisfy any claims arising from the provision of auditing services to us, including claims that you may have under applicable securities laws.

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Risks Related to Ownership of Our Common Stock

The price of our common stock may be volatile and this may adversely affect our stockholders.

The price at which our common stock trades may be volatile. The stock market has from time to time experienced significant price and volume fluctuations that have affected the market prices of securities, particularly securities of health care companies. The market price of our common stock may be influenced by many factors, including:

- our operating and financial performance;
- variances in our quarterly financial results compared to research analyst expectations;
- the depth and liquidity of the market for our common stock;
- future sales of common stock or the perception that sales could occur;
- investor perception of our business and our prospects;
- developments relating to litigation and governmental investigations;
- changes or proposed changes in health care laws or regulations or enforcement of these laws and regulations, or announcements relating to these matters; or
- general economic and stock market conditions.

In addition, the stock market in general, and the Nasdaq National Market in particular, has experienced price and volume fluctuations that have often been unrelated or disproportionate to the operating performance of health care provider companies. These broad market and industry factors may materially reduce the market price of our common stock, regardless of our operating performance. In the past, securities class-action litigation has often been brought against companies following periods of volatility in the market price of their respective securities. We may become involved in this type of litigation in the future. Litigation of this type is often expensive to defend and may divert our management team s attention as well as resources from the operation of our business.

Sales of substantial amounts of our common stock, or the availability of those shares for future sale, could adversely affect our stock price and limit our ability to raise capital.

At December 31, 2004, 15,310,547 shares of our common stock are outstanding. There are 171,058 shares of our common stock that may be issued under our 1998 employee stock purchase plan. As of December 31, 2004, 374,354 shares of our common stock were issuable upon the exercise of stock options which were outstanding but not exercisable, 525,636 shares of our common stock were issuable upon the exercise of stock options which were outstanding and exercisable, and 38,000 shares of our common stock were issuable upon the exercise of outstanding warrants. The market price of our common stock could decline as a result of sales of substantial amounts of our common stock in the public market or the perception that substantial sales could occur. These sales also may make it more difficult for us to sell common stock in the future to raise capital.

We do not anticipate paying dividends on our common stock in the foreseeable future, and you should not expect to receive dividends on shares of our common stock.

We do not pay dividends and intend to retain all future earnings to finance the continued growth and development of our business. In addition, we do not anticipate paying cash dividends on our common stock in the foreseeable future. Any future payment of cash dividends will depend upon our financial condition, capital requirements, earnings, and other factors deemed relevant by our board of directors. As of December 31, 2004, the terms of our Senior Credit Facility restricts us from paying cash dividends and making other cash distributions to our stockholders.

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Our Board of Directors may utilize anti-takeover provisions or issue stock to discourage control contests.

Our Certificate of Incorporation authorizes us to issue up to 30,000,000 shares of common stock and 5,000,000 shares of undesignated Preferred Stock. Our Board of Directors may cause us to issue additional stock to discourage an attempt to obtain control of the Company. For example, shares of stock could be sold to purchasers who might support the Board of Directors in a control contest or to dilute the voting or other rights of a person seeking to obtain control. In addition, the Board of Directors could cause us to issue Preferred Stock entitling holders to:

vote separately on any proposed transaction;

convert preferred stock into common stock;

demand redemption at a specified price in connection with a change in control; or

exercise other rights designed to impede a takeover.

In addition, the issuance of additional shares may, among other things, dilute the earnings and equity per share of our common stock and the voting rights of common stockholders.

We have implemented other anti-takeover provisions or provisions that could have an anti-takeover effect, including (1) advance notice requirements for director nominations and stockholder proposals and (2) a stockholder rights plan, also known as a poison pill . These provisions, and others that the Board of Directors may adopt hereafter, may discourage offers to acquire us and may permit our Board of Directors to choose not to entertain offers to purchase us, even if such offers include a substantial premium to the market price of our stock. Therefore, our stockholders may be deprived of opportunities to profit from a sale of control.

ITEM 2. PROPERTIES

The Company operates 108 home care nursing offices, two hospice offices and two corporate offices in the southern and southeastern United States. The Company presently leases approximately 22,337 square feet located at 11100 Mead Road, Baton Rouge, Louisiana, and 15,963 square feet located at 3029 South Sherwood Forest Boulevard, Baton Rouge, Louisiana, representing the corporate offices. The Mead Road lease provides for a basic annual rental rate of approximately $15.50 per square foot through the expiration date on December 31, 2006. The South Sherwood Forest lease provides for a basic annual rental rate of approximately $14.43 per square foot through the expiration date on December 31, 2006. The Company has an aggregate of 473,350 square feet of leased space for nursing and regional offices pursuant to leases that expire between January 2005 and November 2009. Rental rates for these regional offices range from $2.09 per square foot to $43.20 per square foot with an average of $13.09 per square foot. In late 2002 the Company advised that it had abandoned space in several locations, as well as negotiated buyouts of certain leases, with the objective of reducing the overall cost of leased space.

As of January 2005, the Company has entered into a conditional agreement to purchase and placed a conditional deposit on land and a building in Baton Rouge for the purpose of consolidating its corporate offices into one location, and providing additional space for further growth (See Note 15 to the Consolidated Financial Statements for further information).

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The following is a list of the Company s offices, including corporate offices, at December 31, 2004. Subsequent to this date, the Company has acquired or opened offices in South Carolina and Maryland.

Alabama (17)

Anniston

Bay Minette

Birmingham (3)

Demopolis

Fairhope

Fayette

Huntsville

Mobile

Montgomery

New Hope

Reform

Selma

Thomasville

Tuscaloosa

Walker

Arkansas (1)

Van Buren

Florida (9)

Boynton Beach

Bradenton

Brandon

Fort Lauderdale

Miami Lakes

Georgia (30)

Atlanta

Augusta

Blue Ridge

Cartersville

Cedartown

Clayton

College Park

Commerce

Covington

Cumming

Dalton

Decatur

Demorest

Douglasville

Fayetteville

Ft. Oglethorpe

Gainesville

Griffin

Hiawassee

Jasper

Kennesaw

Lavonia

Lawrenceville

Louisiana (15)

Alexandria

Baton Rouge (3)

Chalmette

Cutoff

Gonzales

Hammond

Houma (2)

Lafayette

Mandeville

Metairie

Monroe

Slidell

Mississippi (2)

Biloxi

Vicksburg

North Carolina (2)

Chapel Hill

Winston-Salem

Oklahoma (6)

Claremore

Gore

Grove

Oklahoma City

South Carolina (1)

Charleston

Tennessee (18)

Athens

Bristol

Chattanooga

Clarksville

Dickson

Gordonsville

Jamestown

Johnson City

Kingsport

Livingston

McMinnville

Memphis (2)

Nashville

O Neida

Pikeville

Portland

Winchester

Texas (6)

Corpus Christi

Dallas (2)

Fort Worth

Virginia (5)

Chesterfield

Duffield

Goochland

Jeterville

Lebanon

Lakeland	Macon	Stilwell	Houston (2)
Tampa	Madison	Tulsa	
West Palm Beach	Milledgeville		
Winter Haven	Rome		
	Summerville		
	Toccoa		
	Valdosta		

The Company entered into three leases on or before December 31, 2004 for the purpose of initiating new agency locations, but the agencies had not begun operations by the end of the 2004 fiscal year.

ITEM 3. LEGAL PROCEEDINGS

From time to time, the Company and its subsidiaries are defendants in lawsuits arising in the ordinary course of the Company s business. Based on currently available information, management believes that the resolution of these matters will not have a material adverse effect on the Company s financial condition or results of operations.

Alliance Home Health, Inc. (Alliance), a wholly-owned subsidiary of the Company (which was acquired in 1998 and ceased operations in 1999), filed for Chapter 7 Federal bankruptcy protection with the United States Bankruptcy Court in the Northern District of Oklahoma on September 29, 2000. A trustee was appointed for Alliance in 2001. Until the contingencies associated with the bankruptcy are resolved, the accompanying consolidated financial statements continue to consolidate Alliance, which has net liabilities of $4.2 million as of December 31, 2004.

On August 23 and October 4, 2001, two suits were filed against the Company and three of its executive officers in the United States District Court for the Middle District of Louisiana by individuals purportedly as class actions on behalf of all purchasers of Amedisys stock between November 15, 2000 and June 13, 2001. The suits, which have now been consolidated, seek damages based on the decline in Amedisys stock price following an announced restatement of earnings for the fourth quarter of 2000 and first quarter of 2001, claiming that the

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defendants knew or were reckless in not knowing the facts giving rise to the restatement. In February 2005, the United States Fifth Circuit Court of Appeals vacated the trial court s certification of the suit as a class action, and remanded the case to the trial court for further proceedings. The Company intends to vigorously defend these lawsuits, and has insurance coverage for an amount in excess of $100,000 up to $4 million. While the Company believes that insurance coverage is sufficient in respect to any amounts that may be awarded, there can be no assurance that the final resolution will be within the coverage amounts carried by the Company.

In 1999, the Company discovered questionable conduct involving the former owner of one of its smaller agencies, which occurred between 1994 and 1997. The Company conducted an initial audit (using an independent auditor) and voluntarily disclosed the irregularities to the Department of Health and Human Services OIG. Thereafter, the government examined the disclosed activities; and during the second quarter of 2002, the Company conducted a further audit of relevant claims at the request of the OIG, which was completed during the third quarter of 2002. In February 2003, the OIG offered a settlement that included certain penalties not previously anticipated by the Company, as the Company self reported the matter. On August 8, 2003, the Company signed both a Settlement Agreement and a Corporate Integrity Agreement with the OIG and Department of Justice. The Settlement Agreement provides for payment of a financial settlement in three equal annual payments of $386,000, with the first payment made on the date of execution and the second payment was made on August 6, 2004. This agreement also obligates the Company to amend previously filed cost reports to deduct costs incurred by the Company for audit and investigation of this matter. The Corporate Integrity Agreement, which is binding for a three-year period, requires that the Company maintain its existing Compliance Program and provides for enhanced training requirements, annual claims audits of the subject agency by an independent reviewer, and regular reporting to the OIG. This agreement provides for stipulated penalties in the event of non-compliance by the Company, including the possibility of exclusion from the Medicare program. The Company believes that these obligations will not materially affect the Company s operations, or financial performance, over the period of the agreement, although no assurances can be provided that the ultimate cost will not be materially different. Management believes the Company is in compliance with the Corporate Integrity Agreement as of December 31, 2004.

As discussed in Management s Discussion and Analysis of Financial Condition and Results of Operations , the Company has approximately $7.1 million in funds held by NPF VI and/or the Trustee for NPF VI bondholders, JP Morgan Chase, which have not been released to the Company. NPF VI has filed for Chapter 11 bankruptcy. The Company has instituted legal action against JP Morgan Chase, and others, in order to recover these funds. No assurance can be made as to the likelihood of a recovery, or the amount of such recovery, if any, by the Company.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

No matters were submitted to a vote of the Company s stockholders during the fourth quarter of 2004.

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PART II

ITEM 5. MARKET FOR REGISTRANT S COMMON STOCK AND RELATED STOCKHOLDER MATTERS

From September 1998 to April 2002, the Company s common stock traded on the Over the Counter (OTC) Bulletin Board. In April 2002 the Company s common stock was admitted to the NASDAQ Small Cap Market, and in September 2002, admitted to the NASDAQ National Market. As of March 10, 2005, there were approximately 484 holders of record of the Company s common stock and the Company believes there are approximately 4,574 beneficial holders. The Company has not paid any dividends on its common stock since inception and expects to retain any future earnings for use in its business development for the foreseeable future.

The following table provides the high and low prices of the Company s Common Stock during 2003 and 2004 as quoted by NASDAQ.

	High	Low
1st Quarter 2003	$ 6.00	$ 4.10
2nd Quarter 2003	7.01	4.48
3rd Quarter 2003	9.37	5.46
4th Quarter 2003	17.00	9.15
1st Quarter 2004	$ 24.95	$ 13.47
2nd Quarter 2004	33.57	23.01
3rd Quarter 2004	33.06	23.07
4th Quarter 2004	36.80	28.57

On September 28, 2004, the Company completed an equity offering of 2,460,000 shares of its Common Stock at $27.50 per share, providing net proceeds after expenses to the Company of approximately $67.4 million. The Company engaged Raymond James & Associates, Inc., Jefferies & Company, Inc. and Legg Mason Wood Walker, Incorporated, as underwriters for the transaction pursuant to which the underwriters received approximately 5.5% of the gross proceeds in cash. Additionally, the underwriters exercised their option to purchase an additional 300,000 shares of Amedisys, Inc. Common Stock at the offering price to cover over-allotments. The over-allotment included 150,000 shares offered by existing stockholders and 150,000 shares offered by the Company, and resulted in additional net proceeds to the Company of approximately $3.9 million. Approximately $21 million of the proceeds have been used through March 16, 2005 for acquisitions. The Company intends to use the balance of the proceeds from this offering for general corporate purposes, including potential acquisitions.

On November 26, 2003, the Company completed a private placement of 1,900,000 shares of Common Stock with private investors at a price of $12.00 per share. This placement provided net proceeds to the Company of approximately $21.3 million. The Company engaged Jefferies & Company, Inc. and Raymond James & Associates, Inc. as placement agents for the transaction pursuant to which the placement agents received approximately 6% of the gross proceeds in cash and warrants to purchase up to 95,000 shares of common stock exercisable at $14.40 per share. Exemption is claimed for the issuance of the common stock under Section 4(2) of the Securities Act of 1933 and Rule 506 thereunder. Approximately $4.3 million of the net proceeds of the offering were used to prepay Medicare debt and the remainder was used to reduce the Company s working capital deficit.

In 2004, holders of 306,720 warrants to purchase common stock exercised their warrants. Exemption is claimed for the issuance of the common stock under Section 4(2) of the Securities Act of 1933.

The information required under Regulation SK 201 (d) is shown in the Notes to the Consolidated Financial Statements beginning on page F-1.

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ITEM 6. SELECTED FINANCIAL DATA

The selected consolidated financial data presented below are derived from audited financial statements for each of the years ended December 31, 2000 through December 31, 2004. The financial data for the years ended December 31, 2004, 2003 and 2002 should be read in conjunction with the consolidated financial statements and related notes attached hereto, the information set forth under Management s Discussion and Analysis of Financial Condition and Results of Operations and other financial information included herein.

Selected Historical Statement of Income Data

	2004	2003	2002	2001	2000(a)
	(Dollar amounts in thousands, except per share amounts)				
Net service revenue	$ 227,089	$ 142,473	$ 129,424	$ 110,174	$ 88,155
Cost of service revenue (excluding amortization and depreciation)	96,078	58,554	58,244	49,046	41,468
Gross margin	131,011	83,919	71,180	61,128	46,687
General/administrative expenses	97,633	69,581	64,700	53,665	49,251
Operating income (loss)	33,378	14,338	6,480	7,463	(2,564)
Other income (expense), net	(19)	(711)	(9,013)	(2,167)	4,729
Income tax benefit (expense)	(12,855)	(5,220)	3,285	(220)	202
Income before discontinued operations	20,504	8,407	752	5,076	2,367
Discontinued operations:					
Loss from discontinued operations, net of income tax				(566)	(3,281)
Gain on dispositions, net of income tax				876	4,684
Net income	$ 20,504	$ 8,407	$ 752	$ 5,386	$ 3,770
Weighted avg. common shares outstanding basic	13,057	9,808	8,499	5,941	4,336
Weighted avg. common shares outstanding diluted	13,543	10,074	9,007	7,980	4,336
Basic earnings per common share(b)					
Net income before discontinued operations	$ 1.57	$ 0.86	$ 0.09	$ 0.85	$ 0.55
(Loss) from discontinued operations, net of income tax				(0.10)	(0.76)
Gain on dispositions, net of income tax				0.15	1.08
Net income	1.57	0.86	0.09	0.90	0.87
Diluted earnings per common share(b)					
Net income before discontinued operations	$ 1.51	$ 0.83	$ 0.08	$ 0.64	$ 0.55
(Loss) from discontinued operations, net of income tax				(0.07)	(0.76)
Gain on dispositions, net of income tax				0.11	1.08
Net income	1.51	0.83	0.08	0.68	0.87