AMEDISYS INC
Form 10-K
February 22, 2011
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-K

x **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended: December 31, 2010

OR

¨ **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.)**

5959 S. Sherwood Forest Blvd.

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 Act:

Title of Each Class	**Name of Each Exchange on Which Registered**
Common Stock, par value $0.001 per share	**The NASDAQ Global Select Market**
(Title of each class)	**(Name of each exchange on which registered)**

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

Indicate by check mark whether the issuer is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes x No ¨

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

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes x No ¨

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes x No ¨

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. x

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

Large accelerated filer x	Accelerated filer ¨	Non-accelerated filer ¨ (Do not check if a smaller reporting company)	Smaller reporting company ¨

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

The aggregate market value of the voting and non-voting common stock held by non-affiliates of the registrant, based on the last sale price as quoted by the NASDAQ Global Select Market on June 30, 2010 (the last business day of the registrant s most recently completed second fiscal quarter) was $1,245,717,579. For purposes of this determination shares beneficially owned by executive officers, directors and ten percent stockholders have been excluded, which does not constitute a determination that such persons are affiliates.

As of February 18, 2011, the registrant had 29,489,289 shares of Common Stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant s definitive Proxy Statement for its 2011 Annual Meeting of Stockholders (the 2011 Proxy Statement) to be filed pursuant to the Securities Exchange Act of 1934 with the Securities and Exchange Commission within 120 days of December 31, 2010 are incorporated herein by reference into Part III of this Annual Report on Form 10-K.

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SPECIAL CAUTION CONCERNING FORWARD-LOOKING STATEMENTS

When included in this Annual Report on Form 10-K, or in other documents that we file with the Securities and Exchange Commission (SEC) or in statements made by or on behalf of the Company, words like believes, belief, expects, plans, anticipates, intends, projects, estimates, may, might, would, should and similar expressions are intended to identify forward-looking statements as defined by the Private Securities Litigation Reform Act of 1995. These forward-looking statements involve a variety of risks and uncertainties that could cause actual results to differ materially from those described therein. These risks and uncertainties include, but are not limited to the following: changes in Medicare and other medical payment levels, our ability to open agencies, acquire additional agencies and integrate and operate these agencies effectively, changes in or our failure to comply with existing Federal and state laws or regulations or the inability to comply with new government regulations on a timely basis, competition in the home health industry, changes in the case mix of patients and payment methodologies, changes in estimates and judgments associated with critical accounting policies, our ability to maintain or establish new patient referral sources, our ability to attract and retain qualified personnel, changes in payments and covered services due to the economic downturn and deficit spending by Federal and state governments, future cost containment initiatives undertaken by third-party payors, our access to financing due to the volatility and disruption of the capital and credit markets, our ability to meet debt service requirements and comply with covenants in debt agreements, business disruptions due to natural disasters or acts of terrorism, our ability to integrate and manage our information systems, changes in or developments with respect to any litigation or investigations relating to the Company, including the United States Senate Committee on Finance inquiry, the SEC investigation and the U.S. Department of Justice Civil Investigative Demand and various other matters, many of which are beyond our control.

Because forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified, you should not rely on any forward-looking statement as a prediction of future events. We expressly disclaim any obligation or undertaking and we do not intend to release publicly any updates or changes in our expectations concerning the forward-looking statements or any changes in events, conditions or circumstances upon which any forward-looking statement may be based, except as required by law. For a discussion of some of the factors discussed above as well as additional factors, see Part I, Item 1A Risk Factors and Part II, Item 7 Critical Accounting Policies within Management s Discussion and Analysis of Financial Condition and Results of Operations.

Unless otherwise provided, Amedisys, we, us, our, and the Company refer to Amedisys, Inc. and our consolidated subsidiaries and when we refer to 2010, 2009 and 2008, we mean the twelve month period then ended December 31, unless otherwise provided.

A copy of this Annual Report on Form 10-K for the year ended December 31, 2010 as filed with the SEC, including all exhibits, is available on our internet website at http://www.amedisys.com on the Investors page under the SEC Filings link.

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PART I

ITEM 1. BUSINESS

Overview

Amedisys, Inc. (NASDAQ: AMED) is a leading health care company focused on bringing home the continuum of care. We deliver personalized health care services to patients and their families in the comfort of patients homes, with approximately 10 million patient care and education encounters per year.

Our state-of-the-art advanced chronic care management programs and leading-edge technology enable us to deliver quality care based upon the latest evidence-based best practices. Amedisys is a recognized innovator, being one of the first in the industry to equip its clinicians with point-of-care laptop technology and its referring physicians with an internet portal that enables real-time coordination of patient care. Amedisys also has the industry s first-ever nationwide Care Transitions program. Amedisys Care Transitions is designed to reduce unnecessary hospital readmissions through patient and caregiver health coaching and care coordination, which starts in the hospital and continues through completion of the patient s home health plan of care.

As of December 31, 2010, we owned and operated 486 Medicare-certified home health agencies and 67 Medicare-certified hospice agencies in 45 states within the United States, the District of Columbia and Puerto Rico. The following is our geographic footprint including the number of home health and hospice agencies by state:

Our services are primarily paid for by Medicare due to the age demographics of our patient base (average age 83). Medicare represented approximately 86%, 88%, and 87% of our net service revenue in 2010, 2009 and 2008, respectively. We plan to diversify our sources of payment and become less reliant upon Medicare in response to the needs of our aging population, uncertainty surrounding health care reform and new health care models currently in development, such as accountable care organizations (ACOs).

We were originally incorporated in Louisiana in 1982 by William F. Borne, our founder, Chief Executive Officer and Chairman of the Board; transferred our operations to a Delaware corporation, which was incorporated in 1994; and became a publicly traded company in August of that year. Our common stock is currently traded on the NASDAQ Global Select Market under the trading symbol AMED .

Home Health Care:

There is no place like home to provide a healing, relaxing environment when recovering from an illness, injury or surgical procedure. It is the place where family, friends and familiar surroundings make patients feel most

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comfortable and recover faster. Amedisys home care services are provided by highly trained and skilled home health care professionals dedicated to the care and comfort of our patients.

Home care services offered are:

- Skilled Nursing
- Home Health Aides
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Social Workers
- Specialized nursing programs such as cardiac, diabetes, pain management, wound care, infusion therapy, oncology and psychiatric services

Our Home Health Care division also provides a portfolio of advanced chronic care clinical programs designed from evidence-based best practices for patients with chronic diseases. These programs incorporate national clinical standards and use patient education to empower patients and their caregivers with self care management skills.

Our Clinical Program Portfolio:

Hospice Care:

Hospice is a special form of care that is designed to provide comfort and support for those who are facing a life-limiting illness. It is a compassionate form of care that promotes dignity and affirms quality of life for the patient, family members and other loved-ones.

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Individuals with a terminal illness such as heart disease, pulmonary disease, dementia, Alzheimer s, HIV/AIDS or cancer are considered eligible for hospice care, if they have a life expectancy of six months or less.

Amedisys specialized team of hospice professionals works with the patient, family members and attending physician to develop a plan of care that will best meet the patient s and family s needs.

The Hospice Care Team is a dedicated support network for the patient and includes:

- The Patient and Family
- Attending Physician
- Hospice Physician
- Nurses
- Social Workers
- Home Health Aides
- Physical, Speech and Occupational Therapists
- Volunteers
- Bereavement Counselors
- Spiritual Counselors

Financial Information:

Financial information for our home health and hospice segments can be found in our consolidated financial statements included in this Annual Report on Form 10-K.

Vision, Mission and Strategy

Our Vision: To be the premier home health care company in the communities we serve.

Our Mission: To provide cost-efficient, quality health care services to the patients entrusted to our care.

Our Strategy: To offer low-cost, outcome-driven health care at home.

In order to deliver on our vision, mission and strategy, we believe a focus on clinical excellence, growth and efficiency will continue to be the keys to our success.

Clinical Excellence

Deliver high quality patient outcomes. We believe the clinical outcomes we have achieved for our home health patients are among the best in the industry. This can be seen in quality data collected and reported by the Centers for Medicare and Medicaid Services (CMS), which shows for 2009, we met or exceeded all of the measurement categories in the footprint we serve and 11 out of the 12 measurement categories when compared to the national average.

Deploy best-in-class technology to better coordinate and standardize care for our patients across the continuum. Amedisys was one of the first in the home health services industry to adopt technology to provide better, more efficient care for patients, including a patient call center (Encore) and a laptop point-of-care (POC)

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system that enable us to provide a uniform standard of high quality care. Amedisys was also one of the first to design a method of communicating electronically with patients supervising physicians to provide better, more responsive care (MercuryDoc).

Provide evidence-based clinical care programs with an industry-leading high-skilled clinical team. Amedisys has led, and intends to continue to lead, the industry in clinical care and we believe our team members are the best in the industry at delivering care to our patients. We were one of the first home health care companies to:

- Develop and bring to market a multidisciplinary approach to fall prevention with our Balanced for Life program;
- Design evidence-based advanced chronic care management programs for diabetes, cardiac disease, wound care, COPD, stroke and seven other illnesses;
- Design and launch a national hospital care transitions and readmission reduction program (called Care Transitions); and
- Combine all the resources listed above into a comprehensive care coordination and management delivery model CCM : Comprehensive, Continuous, Chronic Care Management.

Growth

Emphasize internal growth. We believe the rapidly growing population of aging Americans, particurlary the baby boomer population, creates a significant need for home health and hospice providers to deliver cost-effective, quality health care for complex chronic conditions. We intend to focus on the internal growth of our episodic-based patient admissions by: continued development and deployment of our specialty programs, continued referral source communication enhancements, targeted start-ups, clinical differentiation and health system and hospital partnerships.

Pursue acquisition opportunities. We believe our focus on evidence-based, high quality health care, our strong infrastructure, including our people, processes and technology, as well as our financial strength provide us with a strategic advantage when assessing potential acquisitions. The majority of home health and hospice agencies are owned either by hospitals or small independent operators. We believe recent and other potential changes to Medicare home health and hospice payment rates will continue to pressure the home health and hospice industry to consolidate, which will give us a strategic opportunity to pursue and close acquisitions. In evaluating strategic acquisitions, we strive to employ a disciplined strategy based on defined criteria, which include, but are not limited to, high-quality service, a sound compliance track record, a strong referral base and a compatible payor mix.

Efficiency

Proven, cost-efficient operating model. Our size allows us to take advantage of certain economies of scale in billing, accounting, marketing, training and information technologies. Additionally, our size allows us to negotiate favorable contracts with suppliers. We have developed an operating model that we believe provides a successful balance between the roles and responsibilities undertaken by our agencies and the roles and responsibilities undertaken by our consolidated corporate operations. We have deployed standardized clinical programs and believe this initiative has improved our quality of care and risk management systems and helps us actively manage clinical compliance across all of our home health agencies.

Integrated technology and management systems. We have invested significant time and resources to improve our information technology and real-time management and monitoring capabilities. For example, we have developed and deployed POC laptop devices, developed and deployed a proprietary, Windows -based clinical

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software system and implemented an electronic physician communication system (MercuryDoc), which together are used to collect assessment data, schedule and log patient visits, communicate with our patients physicians regarding plans of care and monitor treatments and outcomes in accordance with established medical standards. With these integrated technologies, we believe we are able to standardize the care delivered across our network of agencies and that we are more effectively able to monitor the patients we treat. We believe that our investments in technology have helped us achieve significant operating efficiencies, enhance our internal financial and compliance controls, and most importantly improve the quality of care we provide to our patients, permitting our patients to achieve better outcomes more rapidly than before.

Best in class operational infrastructure. At the agency level, we have strived to develop a cost-efficient operating model. We manage all patient care and utilization on a real-time basis from both a clinical and financial perspective through a system of exception reporting. At the corporate level, our geographic focus and investment in infrastructure and information systems enable us to leverage regional and senior management resources and add new locations without proportionate increases in corporate overhead. We believe we have been successful at integrating acquisitions. Initial integration activities include converting agencies to our information systems and implementing standardized operational and clinical processes. Further integration efforts generally take 18-24 months to complete and include: improving operating efficiencies; recruiting qualified nurses and account executives as necessary; expanding relationships with local physicians and discharge planners; and expanding the breadth and quality of services offered to patients.

Our Employees

At January 31, 2011, we employed approximately 16,300 employees, consisting of approximately 13,800 home health care employees, 1,400 hospice care employees and 1,100 corporate and divisional support employees. We compensate our visiting staff, which includes our home health care and hospice care employees, predominately on a pay per visit model. We believe paying clinicians in this manner maximizes efficiency and is the most equitable means of compensating them.

Payment for Our Services

Home Health Medicare

The Medicare home health benefit is available both for patients who need care following discharge from a hospital and patients who suffer from chronic conditions that require ongoing but intermittent care. As a condition of participation under Medicare, beneficiaries must be homebound (meaning that the beneficiary is unable to leave his/her home without a considerable and taxing effort), require intermittent skilled nursing, physical therapy or speech therapy services, and receive treatment under a plan of care established and periodically reviewed by a physician. Medicare rates are based on the severity of the patient s condition, his or her service needs and other factors relating to the cost of providing services and supplies, bundled into 60-day episodes of care. An episode starts with the first day a billable visit is furnished and ends 60 days later or upon discharge, if earlier. If a patient is still in treatment on the 60th day, a recertification assessment is undertaken to determine whether the patient needs additional care. If the patient s physician determines that further care is necessary, another episode begins on the 61st day (regardless of whether a billable visit is rendered on that day) and ends 60 days later. The first day of a consecutive episode, therefore, is not necessarily the new episode s first billable visit. Annually, the Medicare program base episodic rates are set through Federal legislation, as follows:

Period	Base episode payment
January 1, 2008 through December 31, 2008	$ 2,270
January 1, 2009 through December 31, 2009	2,272
January 1, 2010 through December 31, 2010	2,313
January 1, 2011 through December 31, 2011	2,192

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Payments can be adjusted for: (a) an outlier payment if our patient s care was unusually costly; (b) a low utilization payment adjustment (LUPA) if the number of visits during the episode was fewer than five; (c) a partial payment if our patient transferred to another provider or we received a patient from another provider before completing the episode; (d) a payment adjustment based upon the level of therapy services required (thresholds set at 6, 14 and 20 therapy visits); (e) the number of episodes of care provided to the patient (episodes three or greater are paid at higher rates compared to the first two episodes, even if the episodes of care are provided by different home health providers); (f) changes in the base episode payments established by the Medicare program; (g) adjustments to the base episode payments for case mix and geographic wages; and (h) recoveries of overpayments. In addition, Medicare can also make various adjustments to payments received if we are unable to produce appropriate billing documentation or acceptable authorizations.

Home Health Non-Medicare

Payments from Medicaid and private insurance carriers are based on episodic-based rates or per visit rates (non-episodic based) depending upon the terms and conditions established with such payors. Episodic-based rates paid by our non-Medicare payors are paid in a similar manner and subject to the same adjustments as discussed above for Medicare; however, these rates can vary based upon negotiated terms.

Hospice Medicare

The Medicare hospice benefit is also available to Medicare-eligible patients with terminal illnesses, certified by a physician, where life expectancy is six months or less. Medicare rates are based on standard prospective rates for delivering care over a base 90-day or 60-day period (90-day episodes of care for the first two episodes and 60-day episodes of care for any subsequent episodes). Payments are based on daily rates for each day a beneficiary is enrolled in the hospice benefit. Rates are set based on specific levels of care, are adjusted by a wage index to reflect health care labor costs across the country and are established annually through Federal legislation. The levels of care are routine care, general inpatient care, continuous home care and respite care. For 2010, our Medicare routine care revenue accounted for approximately 99% of our total net Medicare hospice service revenue and our average Medicare reimbursement was $135 per routine care day.

We bill Medicare for hospice services on a monthly basis and our payments are subject to two fixed annual caps, which are assessed on a provider number basis. Generally, each hospice agency has its own provider number. However, where we have created branch agencies to help our parent agencies serve a geographic location, the parent and branch may have the same provider number. The annual caps per patient, known as hospice caps, are calculated and published by the Medicare fiscal intermediary on an annual basis and cover the twelve month period from November 1 through October 31. The caps can be subject to annual and retroactive adjustments, which can cause providers to owe money back to Medicare if such caps are exceeded.

The two caps are detailed below:

Inpatient Cap. This cap limits the number of days of inpatient care (both respite and general) under a provider number to 20% of the total number of days of hospice care (both inpatient and in-home) furnished to all patients served. The daily payment rate for any inpatient days of service in excess of the cap amount is calculated at the routine home care rate, with excess amounts due back to Medicare; and

Overall Payment Cap. This cap is calculated by the Medicare fiscal intermediary at the end of each hospice cap period to determine the maximum allowable payments per provider number. On a monthly and quarterly basis, we estimate our potential cap exposure using information available for both inpatient day limits as well as per beneficiary cap amounts. The total cap amount for each provider is calculated by multiplying the number of beneficiaries electing hospice care during the period by a statutory amount that is indexed for inflation. The per beneficiary cap amount was $23,875 for the twelve-month period ended October 31, 2010 and $23,015 for the twelve month period ended October 31, 2009. Any amounts received in excess of the beneficiary cap amount must be refunded to Medicare.

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Our ability to stay within these limitations depends on a number of factors, each determined on a provider number basis, including the average length of stay and mix in level of care.

Hospice Non-Medicare

Non-Medicare payors pay at rates different from established Medicare rates for hospice services, which are based on separate, negotiated agreements. We bill and are paid based on these agreements.

Controls over Our Business System Infrastructure

We establish and maintain processes and controls over coding, clinical operations, billing, patient recertifications and compliance to help monitor and promote compliance with Medicare requirements.

Coding Specified diagnosis codes are assigned to each of our patients based on their particular health condition and ailment (such as diabetes, coronary artery disease or congestive heart failure). Because coding regulations are complex and are subject to frequent change, we maintain controls surrounding our coding process. In order to reduce associated risk, we provide coding training for new agency directors and clinical managers; provide annual coding update training for agency directors and clinical managers; provide coding training during orientation for new employees; provide monthly specialized coding education; circulate a clinical operations quality newsletter; obtain outside expert coding instruction; utilize coding software in our POC system; and have automated coding edits based on pre-defined compliance metrics in our POC system.

Clinical Operations Regulatory requirements allow patients to be admitted to home health care if they are considered homebound and require certain clinical services. These clinical services include: educating the patient about their disease; an assessment of observation skills; wound care; administering injections or intravenous fluids; and management and evaluation of a patient s plan of care. In order to help monitor and promote compliance with regulatory requirements, we complete audits of patient charts; we use risk forecasting methodologies; we administer survey guideline education; we hold recurrent homecare regulatory education; we utilize outside expert regulatory services; and we have a toll-free hotline to offer additional assistance.

Billing We maintain controls over our billing processes to help promote accurate and complete billing. In order to promote the accuracy and completeness of our billing, we have annual billing compliance testing; use formalized billing attestations; limit access to billing systems; use risk forecasting methodologies; perform direct line supervisor audits; hold weekly operational meetings; use automated daily billing operational indicators; and take prompt corrective action with employees who knowingly fail to follow our billing policies and procedures in accordance with a well-publicized Zero Tolerance Policy .

Patient Recertification In order to be recertified for an additional episode of care, a patient must be diagnosed with a continuing medical need. This could take the form of a continuing skilled clinical need or could be caused by changes to the patient s medical regimen or by modified care protocols within the episode of care. As with the initial episode of care, a recertification requires approval of the patient s physician. Before any employee recommends recertification to a physician, we conduct an agency level, multidisciplinary care team conference. We also monitor centralized automated compliance recertification metrics to identify, monitor, and, where appropriate, audit agencies that have relatively high recertification levels.

Compliance The quality and reputation of our personnel and operations are critical to our success. We develop, implement and maintain ethics, compliance and quality improvement programs as a component of the centralized corporate services provided to our home health and hospice agencies. Our ethics and compliance program includes a Code of Ethical Business Conduct for our employees, officers, directors and affiliates and a process for reporting regulatory or ethical concerns to our Chief

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Compliance Officer through a confidential hotline. We promote a culture of compliance within our company through persistent messages from our senior leadership concerning the necessity of strict compliance with legal requirements and company policies and procedures, and through publicizing and enforcing our Zero Tolerance Policy. We also employ a comprehensive compliance training program that includes: annual compliance testing; new hire compliance training; new acquisition compliance training; sales compliance training; new employee orientation compliance training; billing compliance training; and compliance presentations at company functions.

Our Regulatory Environment

We are highly regulated by Federal, state and local authorities. Regulations and policies frequently change, and we monitor changes through trade and governmental publications and associations. We also meet regularly with a group of financial, legal and regulatory consultants to discuss emerging issues that may affect our business. Our home health and hospice subsidiaries are certified by CMS and therefore are eligible to receive payment for services through the Medicare system.

We are also subject to Federal, state and local laws and regulations dealing with issues such as occupational safety, employment, medical leave, insurance, civil rights, discrimination, building codes, environmental issues and adverse event reporting and recordkeeping. Federal, state and local governments are expanding the number of regulatory requirements on businesses.

We have set forth below a discussion of the regulations that we believe most significantly affect our home health and hospice businesses.

Licensure, Certificates of Need (CON) and Permits of Approval (POA)

Home health and hospice agencies operate under licenses granted by the health authorities of their respective states. Additionally, certain states, including a number in which we operate, carefully restrict new entrants into the market based on demographic and/or competitive changes. In such states, expansion by existing providers or entry into the market by new providers is permitted only where a given amount of unmet need exists, resulting either from population increases or a reduction in competing providers. These states ration the availability of markets through a CON process, which is periodically evaluated. Currently, state health authorities in 17 states and the District of Columbia and Puerto Rico require a CON or, in the State of Arkansas, a POA, in order to establish and operate a home health agency, and state health authorities in 13 states and the District of Columbia require a CON to operate a hospice agency.

We operate home health agencies in the following CON states: Alabama, Arkansas (POA), Georgia, Kentucky, Maryland, Mississippi, New Jersey, New York, North Carolina, South Carolina, Tennessee, Washington and West Virginia, as well as the District of Columbia and Puerto Rico. We provide hospice related services in the following CON states: Alabama, Maryland, North Carolina, Tennessee, Washington and West Virginia.

In every state where required, our locations possess a license and/or CON or POA issued by the state health authority that determines the local service areas for the home health or hospice agency. In general, the process for opening a home health or hospice agency begins by a provider submitting an application for licensure and certification to the state and Federal regulatory bodies, which is followed by a testing period of transmitting data from the applicant to CMS. Once this process is complete, the agency receives a provider agreement and corresponding number and can begin billing for services that it provides. For those states that require a CON or POA, the provider must also complete a separate application process before billing can commence. In addition, states with CON and POA laws place limits on the construction and acquisition of health care facilities and operations and the expansion of existing facilities and services. In these states, approvals are required for capital expenditures exceeding amounts above the prescribed thresholds.

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State CON and POA laws generally provide that, prior to the addition of new capacity, the construction of new facilities or the introduction of new services, a designated state health planning agency must determine that a need exists for those beds, facilities or services. The process is intended to promote comprehensive health care planning, assist in providing high-quality health care at the lowest possible cost and avoid unnecessary duplication by ensuring that only those health care facilities and operations that are needed will be built and opened.

Medicare Participation

As we expect to continue to receive the majority of our revenue from serving Medicare beneficiaries, our agencies must comply with regulations promulgated by the United States Department of Health and Human Services in order to participate in the Medicare program and receive Medicare payments. Among other things, these regulations, known as conditions of participation, relate to the type of facility, its personnel and its standards of medical care, as well as its compliance with state and local laws and regulations. CMS has indicated that it will be revising the current home health conditions of participation but has not yet announced the publication date of such revisions.

CMS has engaged a number of third party firms, including Recovery Audit Contractors (RACs), Program Safeguard Contractors (PSCs), Zone Program Integrity Contractors (ZPICs) and Medicaid Integrity Contributors (MICs), to conduct extensive reviews of claims data and state and Federal government health care program laws and regulations applicable to companies that operate home health and hospice agencies. These audits will evaluate the appropriateness of billings submitted for payment. In addition to identifying overpayments, audit contractors can refer suspected violations of law to government enforcement authorities.

Federal and State Anti-Fraud and Anti-Kickback Laws

As a provider under the Medicare and Medicaid systems, we are subject to various anti-fraud and abuse laws, including the Federal health care programs anti-kickback statute and, where applicable, its state law counterparts. Subject to certain exceptions, these laws prohibit any offer, payment, solicitation or receipt of any form of remuneration to induce or reward the referral of business payable under a government health care program or in return for the purchase, lease, order, arranging for, or recommendation of items or services covered under a government health care program. Affected government health care programs include any health care plans or programs that are funded by the United States government (other than certain Federal employee health insurance benefits/programs), including certain state health care programs that receive Federal funds, such as Medicaid. A related law forbids the offer or transfer of anything of value, including certain waivers of co-payment obligations, to a beneficiary of Medicare or Medicaid that is likely to influence the beneficiary s selection of health care providers, again subject to certain exceptions. 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 government health care program. In addition, the states in which we operate 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 from a particular provider.

Stark Laws

Congress adopted legislation in 1989, known as the Stark Law, that generally prohibited 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 further prohibits such entity from billing for or receiving payment for such services, unless a specified exception is available. The Stark Law was amended through additional legislation, known as Stark II, which became effective January 1, 1993. That legislation extended the Stark Law prohibitions beyond clinical laboratory services to a more extensive list of statutorily defined designated health services, which includes, among other things, home health services, durable medical

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equipment and outpatient prescription drugs. Violations of the Stark Law result in payment denials and may also trigger civil monetary penalties and program exclusion. An exception from the Stark Law that we rely upon is a safe harbor allowing us to lease office space from certain physicians at fair market value for legitimate and commercially reasonable business purposes. Several of the states in which we conduct business have also enacted statutes similar in scope and purpose to the Federal fraud and abuse laws and the Stark Laws. These state laws may mirror the Federal Stark Laws or may be different in scope. The available guidance and enforcement activity associated with such state laws varies considerably.

Federal and State Privacy and Security Laws

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), directed that the Secretary of the U.S. Department of Health and Human Services (HHS) promulgate regulations prescribing standard requirements for electronic health care transactions and establishing protections for the privacy and security of individually identifiable health information, known as protected health information. The HIPAA transactions regulations establish form, format and data content requirements for most electronic health care transactions, such as health care claims that are submitted electronically. The HIPAA privacy regulations establish comprehensive requirements relating to the use and disclosure of protected health information. The HIPAA security regulations establish minimum standards for the protection of protected health information that is stored or transmitted electronically. Violations of the privacy and security regulations are punishable by civil and criminal penalties.

The American Recovery and Economic Reinvestment Act of 2009 (ARRA), signed into law by President Obama on February 17, 2009, contained significant changes to the privacy and security provisions of HIPAA, including major changes to the enforcement provisions. Among other things, ARRA significantly increased the amount of civil monetary penalties that can be imposed for violations of HIPAA. ARRA also authorized state attorneys general to bring civil enforcement actions under HIPAA. These enhanced penalties and enforcement provisions went into effect immediately upon enactment of ARRA. ARRA also required that HHS promulgate regulations requiring that certain notifications be made to individuals, to HHS and potentially to the media in the event of breaches of the privacy of protected health information. These breach notification regulations went into effect on September 23, 2009, and HHS began to enforce violations on February 22, 2010. Violations of the breach notification provisions of HIPAA can trigger the increased civil monetary penalties described above.

ARRA s numerous other changes to HIPAA have delayed effective dates and require the issuance of implementing regulations by HHS. The changes to HIPAA enacted as part of ARRA reflect a Congressional intent that HIPAA s privacy and security provisions be more strictly enforced. It is likely that these changes will stimulate increased enforcement activity and enhance the potential that health care providers will be subject to financial penalties for violations of HIPAA.

In addition to the Federal HIPAA regulations, most states also have laws that protect the confidentiality of health information. Also, in response to concerns about identity theft, many states have adopted so-called security breach notification laws that may impose requirements regarding the safeguarding of personal information, such as social security numbers and bank and credit card account numbers, and that impose an obligation to notify persons when their personal information has or may have been accessed by an unauthorized person. Some state security breach notification laws may also impose physical and electronic security requirements. Violation of state security breach notification laws can trigger significant monetary penalties.

The False Claims Act

The Federal False Claims Act gives the Federal government an additional way to police false bills or requests for payment for health care services. Under the False Claims Act, the government may fine any person who knowingly submits, or participates in submitting, claims for payment to the Federal government which are false or fraudulent, or which contain false or misleading information. Any person who knowingly makes or uses a

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false record or statement to avoid paying the Federal government, or knowingly conceals or avoids an obligation to pay money to the Federal government, may also be subject to fines under the False Claims Act. Under the False Claims Act, the term person means an individual, company, or corporation. The Federal government has widely used the False Claims Act to prosecute Medicare and other governmental program fraud in areas such as violations of the Federal anti-kickback statute or the Stark Laws, coding errors, billing for services not provided, and submitting false cost reports. The False Claims Act has also been used to prosecute people or entities that bill services at a higher reimbursement rate than is allowed and that bill for care that is not medically necessary. In addition to government enforcement, the False Claims Act authorizes private citizens to bring qui tam or whistleblower lawsuits, greatly extending the practical reach of the False Claims Act. The penalty for violation of the False Claims Act is a minimum of $5,500 for each fraudulent claim plus three times the amount of damages caused to the government as a result of each fraudulent claim.

The Fraud Enforcement and Recovery Act of 2009 (FERA), effective May 20, 2009, amended the False Claims Act with the intent of enhancing the powers of government enforcement authorities and whistleblowers to bring False Claims Act cases. In particular, FERA attempts to clarify that liability may be established not only for false claims submitted directly to the government, but also for claims submitted to government contractors and grantees. FERA also seeks to clarify that liability exists for attempts to avoid repayment of overpayments, including improper retention of Federal funds. FERA also included amendments to False Claims Act procedures, expanding the government s ability to use the Civil Investigative Demand process to investigate defendants, and permitting government complaints in intervention to relate back to the filing of the whistleblower s original complaint. FERA is likely to increase both the volume and liability exposure of False Claims Act cases brought against health care providers.

In addition to the False Claims Act, the Federal government may use several criminal statutes to prosecute the submission of false or fraudulent claims for payment to the Federal government. Many states have similar false claims statutes that impose liability for the types of acts prohibited by the False Claims Act. As part of the Deficit Reduction Act of 2005 (the DRA), Congress provided states an incentive to adopt state false claims acts consistent with the Federal False Claims Act. Additionally, the DRA required providers who receive $5 million or more annually from Medicaid to include information on Federal and state false claims acts, whistleblower protections and the providers own policies on detecting and preventing fraud in their written employee policies.

Civil Monetary Penalties

The United States Department of Health and Human Services may impose civil monetary penalties upon any person or entity who presents, or causes to be presented, certain ineligible claims for medical items or services. The amount of penalties varies, depending on the offense, from $2,000 to $50,000 per violation. In addition, persons who have been excluded from the Medicare or Medicaid program and still retain ownership in a participating entity, or who contract with excluded persons, may be penalized. Penalties also are applicable in certain other cases, including violations of the Federal anti-kickback statute, payments to limit certain patient services and improper execution of statements of medical necessity.

FDA Regulation

The U.S. Food and Drug Administration (FDA) regulates medical device user facilities, which include home health care providers. FDA regulations require user facilities to report patient deaths and serious injuries to FDA and/or the manufacturer of a device used by the facility if the device may have caused or contributed to the death or serious injury of any patient. FDA regulations also require user facilities to maintain files related to adverse events and to establish and implement appropriate procedures to ensure compliance with the above reporting and recordkeeping requirements. User facilities are subject to FDA inspection, and noncompliance with applicable requirements may result in warning letters or sanctions including civil monetary penalties, injunction, product seizure, criminal fines and/or imprisonment.

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Patient Protection and Affordable Care Act

In March 2010, comprehensive health care reform legislation was signed into law in the United States through the passage of the Patient Protection and Affordable Health Care Act and the Health Care and Education Reconciliation Act (collectively, PPACA). However, it is difficult to predict the full impact of PPACA due to the law s complexity and current lack of implementing regulations or interpretive guidance, as well our inability to foresee how CMS and other participants in the health care industry will respond to the choices available to them under the law. Many provisions in PPACA are scheduled to become effective over the next several years, but the implementing regulations for these statutory provisions have not yet been published. It is also possible that implementation of some or all of the PPACA s provisions could be delayed or even blocked due to court challenges, and efforts to repeal or amend the law. PPACA makes a number of changes to Medicare payment rates and also calls for a rebasing of the home health payment system beginning in 2014 that will be phased in over a four-year period. These reimbursement changes are described in detail in Part II, Item 7, Recent Developments. PPACA also has established a number of new requirements impacting our business operations, and promises to give rise to other changes that could significantly impact our businesses in the future. See Part 1, Item IA, Risk Factors, Risks Related to Laws and Government Regulations for a more complete discussion of PPACA and the risks it presents to our businesses.

Our Competitors

There are few barriers to entry in home health and hospice markets that do not require certificates of need or permits of approval. Our primary competition comes from local privately-owned and hospital-owned health care providers. We compete based on the availability of personnel; the quality of services, expertise of visiting staff and value of our services; and in certain instances, on the price of our services. In addition, we compete with a number of non-profit organizations that finance acquisitions and capital expenditures on a tax-exempt basis or receive charitable contributions that are unavailable to us.

Available Information

Our company website address is www.amedisys.com. We use our website as a channel of distribution for important company information. Important information, including press releases, analyst presentations and financial information regarding our company, is routinely posted on and accessible on the Investor Relations subpage of our website, which is accessible by clicking on the tab labeled Investors on our website home page. We also use our website to expedite public access to time-critical information regarding our company in advance of or in lieu of distributing a press release or a filing with the SEC disclosing the same information. Therefore, investors should look to the Investor Relations subpage of our web site for important and time-critical information. Visitors to our website can also register to receive automatic e-mail and other notifications alerting them when new information is made available on the Investor Relations subpage of our website. In addition, we make available on the Investor Relations subpage of our website (under the link SEC filings) free of charge our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, ownership reports on Forms 3, 4 and 5 and any amendments to those reports as soon as practicable after we electronically file such reports with the SEC. Further, copies of our Certificate of Incorporation and Bylaws, our Code of Ethical Business Conduct, our Corporate Governance Guidelines and the charters for the Audit, Compensation, Nominating and Corporate Governance and Quality of Care Committees of our Board are also available on the Investor Relations subpage of our website (under the link Corporate Governance).

Additionally, the public may read and copy any of the materials we file with the SEC at the SEC s Public Reference Room at 100 F Street, NE, Room 1580, Washington, D.C. 20549. Information on the operation of the Public Reference Room may be obtained by calling the SEC at (800) SEC-0330. Our electronically filed reports can also be obtained on the SEC s internet site at http://www.sec.gov.

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ITEM 1A. RISK FACTORS

The risks described below, and risks described elsewhere in this Form 10-K, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows and the actual outcome of matters as to which forward-looking statements are made in this Form 10-K. The risk factors described below and elsewhere in this Form 10-K are not the only risks faced by Amedisys. Our business and consolidated financial condition, results of operations and cash flows may also be materially adversely affected by factors that are not currently known to us, by factors that we currently consider immaterial or by factors that are not specific to us, such as general economic conditions.

If any of the following risks are actually realized, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected. In that case, the trading price of our common stock could decline.

You should refer to the explanation of the qualifications and limitations on forward-looking statements under Special Caution Concerning Forward-Looking Statements. All forward-looking statements made by us are qualified by the risk factors described below.

Risks Related to Reimbursement

Because a high percentage of our revenue is derived from Medicare, reductions in Medicare rates, rate increases that do not cover cost increases and/or significant changes to the Medicare payment methodology could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our net service revenue is primarily derived from Medicare, which accounted for 86%, 88% and 87% of our revenue during 2010, 2009 and 2008, respectively. Payments received from Medicare are subject to changes made through Federal legislation. These changes, as further detailed in Item 1, Payment for Our Services, can include changes to base episode payments and adjustments for home health services and changes to cap limits and per diem rates for hospice services. When such changes are implemented, we must also modify our internal billing processes and procedures accordingly, which can require significant time and expense. Any similar changes, including retroactive adjustments, adopted in the future by CMS could have a material adverse effect on our business and our consolidated financial condition, results of operations and cash flows.

There are continuing efforts to reform governmental health care programs that could result in major changes in the health care delivery and reimbursement system on a national and state level, including changes directly impacting the reimbursement systems for our home health and hospice agencies. Though we cannot predict what, if any, reform proposals will be adopted, health care reform and legislation may have a material adverse effect on our business and our financial condition, results of operations and cash flows through decreasing payments made for our services. We could be affected adversely by the continuing efforts of governmental and private third party payors to contain health care costs. We cannot assure you that reimbursement payments under governmental and private third party payor programs, including Medicare supplemental insurance policies, will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to these programs. These changes could have a material adverse effect on our business, our consolidated financial condition, results of operations and cash flows.

Our hospice operations are subject to two annual Medicare caps. If such caps were to be exceeded by any of our hospice providers, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

With respect to our hospice operations, overall payments made by Medicare to each provider number (generally corresponding to a hospice agency) are subject to an inpatient cap amount and an overall payment cap, which are calculated and published by the Medicare fiscal intermediary on an annual basis covering the period from

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November 1 through October 31. If payments received by any one of our hospice provider numbers exceeds either of these caps, we may be required to reimburse Medicare for payments received in excess of the caps, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

The economic downturn, any deepening of the economic downturn, continued deficit spending by the Federal government or state budget pressures may result in a reduction in payments and covered services.

Adverse developments in the United States and global economies, continued deficit spending due to economic conditions, bailout programs directed at specific industries or other governmental measures, could lead to a reduction in Federal government expenditures, including governmentally funded programs in which we participate, such as Medicare and Medicaid. Reductions in expenditures for these programs could have a material adverse effect on our business and our consolidated financial condition, results of operations and cash flows.

Historically, state budget pressures have resulted in reductions in state spending. Given that Medicaid outlays are a significant component of state budgets, we can expect continuing cost containment pressures on Medicaid outlays for our services. In addition, continued unfavorable economic conditions may affect the number of patients enrolled in managed care programs and the profitability of managed care companies, which could result in reduced payment rates and could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Future cost containment initiatives undertaken by private third party payors may limit our future revenue and profitability.

Our non-Medicare revenue and profitability are affected by continuing efforts of third party payors to maintain or reduce costs of health care by lowering payment rates, narrowing the scope of covered services, increasing case management review of services and negotiating pricing. There can be no assurance that third party payors will make timely payments for our services, and there is no assurance that we will continue to maintain our current payor or revenue mix. Any changes in payment levels from third party payors could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Risks Related to Laws and Government Regulations

We are the subject of a number of inquiries by the Federal government, any of which could result in substantial penalties against us.

We are the subject of a number of inquiries by the Federal government. We have received a letter of inquiry from the United States Senate Committee on Finance requesting documents and information relating to our policies and practices regarding home therapy visits and therapy utilization trends. A similar letter was sent to the other major publicly traded home health care companies. In addition, we as well as the other major publicly traded home health care companies received a notice of formal investigation from the SEC accompanied by a subpoena for documents relating to the matters under review by the United States Senate Committee on Finance and other matters involving our operations. We have also received a Civil Investigative Demand (CID) issued by the U.S. Department of Justice pursuant to the Federal False Claims Act, requiring the delivery of a wide range of documents and information relating to our clinical business operations, including reimbursement and billing claims submitted to Medicare for home health services, and related compliance activities. We are cooperating with these investigations and are responding to these requests. However, we cannot predict when these investigations will be resolved, the outcome of these investigations or their impact on our business. An adverse outcome in these investigations could include the commencement of civil and/or criminal proceedings, substantial fines, penalties and/or administrative remedies, including the loss of the right to participate in the Medicare program. In addition, resolution of these matters could involve the imposition of additional and costly compliance obligations. Finally, if these investigations continue over a long period of time, they could divert the attention of management from the day-to-day operations of our business and impose significant administrative

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burdens on us. These potential consequences, as well as any adverse outcome from these investigations or other investigations initiated by the government at any time, could have a material adverse effect on our business and our consolidated financial condition, results of operations and cash flows.

Pending civil litigation could have a material adverse effect on the Company.

We and certain of our current and former directors, senior executives and other employees are defendants in a Federal securities class action, an ERISA class action and a shareholder derivative action. See Part I, Item 3, Legal Proceedings for a more detailed description of these proceedings. These actions remain in preliminary stages and it is not yet possible to assess their probable outcome or our potential liability, if any. We cannot provide any assurances that the legal and other costs associated with the defense of these actions, the amount of time required to be spent by management on these matters and the ultimate outcome of these actions will not have a material adverse effect on our business, financial condition and results of operations.

We are subject to extensive government regulation. Any changes to the laws and regulations governing our business, or to the interpretation and enforcement of those laws or regulations, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our industry is subject to extensive Federal and state laws and regulations. See Part I, Item 1, Our Regulatory Environment for additional information on such laws and regulations. Federal and state laws and regulations impact how we conduct our business, the services we offer and our interactions with patients, our employees and the public and impose certain requirements on us such as:

- licensure and certification;
- adequacy and quality of health care services;
- qualifications of health care and support personnel;
- quality and safety of medical equipment;
- confidentiality, maintenance and security issues associated with medical records and claims processing;
- relationships with physicians and other referral sources;
- operating policies and procedures;
- polices and procedures regarding employee relations;
- addition of facilities and services;

billing for services; and

reporting and maintaining records regarding adverse events.

These laws and regulations, and their interpretations, are subject to change. Changes in existing laws and regulations, or their interpretations, or the enactment of new laws or regulations could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows by:

increasing our administrative and other costs;

increasing or decreasing mandated services;

causing us to abandon business opportunities we might have otherwise pursued;

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

requiring us to implement additional or different programs and systems.

Additionally, we are subject to various routine and non-routine reviews, audits and investigations by the Medicare and Medicaid programs and other Federal and state governmental agencies, which have various rights and remedies against us if they assert that we have overcharged the programs or failed to comply with program

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requirements. 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, and the termination of our rights to participate in Federal and state-sponsored programs and/or 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, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

We face periodic and routine reviews, audits and investigations under our contracts with Federal and state government agencies and private payors, and these audits could have adverse findings that may negatively impact our business.

As a result of our participation in the Medicare and Medicaid programs, we are subject to various governmental reviews, audits and investigations to verify our compliance with these programs and applicable laws and regulations. We also are subject to audits under various government programs, including the RAC, ZPIC, PSC and MIC programs, in which third party firms engaged by CMS conduct extensive reviews of claims data and medical and other records to identify potential improper payments under the Medicare program. Private pay sources also reserve the right to conduct audits. Our costs to respond to and defend reviews, audits and investigations may be significant and could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Moreover, an adverse review, audit or investigation could result in:

- required refunding or retroactive adjustment of amounts we have been paid pursuant to the Federal or state programs or from private payors;
- state or Federal agencies imposing fines, penalties and other sanctions on us;
- loss of our right to participate in the Medicare program, state programs, or one or more private payor networks; or
- damage to our business and reputation in various markets.

These results could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

If an agency fails to comply with the conditions of participation in the Medicare program, that agency could be terminated from the Medicare program.

Each of our agencies must comply with required conditions of participation in the Medicare program. If we fail to meet the conditions of participation at an agency, we may receive a notice of deficiency from the applicable state surveyor. If that agency then fails to institute an acceptable plan of correction to remediate 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 agencies from the Medicare program for failure to satisfy the program s conditions of participation could have a material adverse effect on our business and reputation and our consolidated financial condition, results of operations and cash flows. CMS has announced that it is currently revising the Medicare conditions of participation for home health agencies across the industry, with an unknown publication date. We do not know at this time what effect the revisions will have on our operations, and there can be no assurances that the revisions will not have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

We are subject to Federal and state laws that govern our financial relationships with physicians and other health care providers, including potential or current referral sources.

We are required to comply with Federal and state laws, generally referred to as anti-kickback laws, that prohibit certain direct and indirect payments or other financial arrangements between health care providers that are designed to encourage the referral of patients to a particular provider for medical services. In addition to these

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anti-kickback laws, the Federal government has enacted specific legislation, commonly known as the Stark Law, that prohibits certain financial relationships, specifically including ownership interests and compensation arrangements, between physicians (and the immediate family members of physicians) and providers of designated health services, such as home health agencies, to whom the physicians refer patients. Some of these same financial relationships are also subject to additional regulation by states. Although we believe we have structured our relationships with physicians and other potential referral sources to comply with these laws where applicable we cannot assure you that courts or regulatory agencies will not interpret state and Federal anti-kickback laws and/or the Stark Law and similar state laws regulating relationships between health care providers and physicians in ways that will adversely implicate our practices. Violations of these laws could lead to criminal or civil fines or other sanctions, including denials of government program reimbursement or even exclusion from participation in governmental health care programs that could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

We may face significant uncertainty in the industry due to government health care reform.

The health care industry in the United States is subject to fundamental changes due to ongoing health care reform efforts and related political, economic and regulatory influences. In March 2010, comprehensive health care reform legislation was signed into law in the United States through the passage of the Patient Protection and Affordable Health Care Act and the Health Care and Education Reconciliation Act (collectively, PPACA). However, it is difficult to predict the full impact of PPACA due to the law s complexity and current lack of implementing regulations or interpretive guidance, as well our inability to foresee how CMS and other participants in the health care industry will respond to the choices available to them under the law. Many provisions in PPACA are scheduled to become effective over the next several years, but the implementing regulations for these statutory provisions have not yet been published. It is also possible that implementation of some or all of the PPACA s provisions could be delayed or even blocked due to court challenges and efforts to repeal or amend the law.

PPACA makes a number of changes to Medicare payment rates and also calls for a rebasing of the home health payment system beginning in 2014 that will be phased in over a four-year period. These reimbursement changes are described in detail in Part II, Item 7 Recent Developments.

In November of 2010, CMS issued a final payment rule that established Medicare home health rates for 2011 and implemented new PPACA requirements regarding face-to-face encounters for both home health and hospice services and regarding assessments needed to support therapy utilization. These new operational changes were originally slated to become effective January 1, 2011, but CMS announced that it would delay enforcement of these requirements until April 1, 2011 due to a concern that some providers may need additional time to prepare. For the home health face-to-face encounter, before certifying a patient for home health services, the certifying physician must document that the physician (or a non-physician practitioner under the direction of the physician) has had a face-to-face encounter with the patient, during a timeframe starting 90 days prior to the home health start of care and ending 30 days after the start of care. For the hospice face-to-face encounter, a hospice physician or nurse practitioner must have a face-to-face encounter with the patient during the 30-day period prior to the 180th-day recertification (i.e., the third benefit period) and each subsequent recertification. These new face-to-face requirements may increase our costs associated with home health certifications and hospice recertifications, and may also impact utilization of home health and hospice services by Medicare beneficiaries. In addition, the November 2010 final rule introduced additional therapy assessment requirements. A professional qualified therapist assessment must take place at least once every 30 days during a therapy patient s course of treatment. Subject to certain exceptions, for those patients needing 13 or 19 therapy visits, a qualified therapist must perform the therapy services required, assess the patient, and measure and document effectiveness of the therapy both on the 13th visit and the 19th visit, for all therapy disciplines caring for the patient. These and other regulations implementing the provisions of the PPACA may similarly increase our costs, decrease our revenues, expose us to expanded liability or require us to revise the ways in which we conduct our business.

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PPACA also calls for a number of other changes to be made over time that will likely have a significant impact upon the health care delivery system. For example, PPACA mandates creation of a home health value-based purchasing program, the development of quality measures, and decreases in home health reimbursement rates, as further described in Part II, Item 7 Recent Developments. In addition, PPACA requires the Secretary of Health and Human Services to test different models for delivery of care, some of which will involve home health services. It also requires the Secretary to establish a national pilot program for integrated care for patients with certain conditions, bundling payment for acute hospital care, physician services, outpatient hospital services (including emergency department services) and post-acute care services, which would include home health. PPACA further directs the Secretary to conduct a study to evaluate cost and quality of care among efficient home health agencies and specifically focusing on access to care and treating Medicare beneficiaries with varying severity levels of illness, and provide a report to Congress no later than March 1, 2014. At this time, it is not possible to predict with any certainty how these initiatives will be implemented and what impact they may have on our business.

In addition, various health care reform proposals similar to the Federal reforms described above have also emerged at the state level, including in several states in which we operate. Moreover, in January 2011, the Medicare Payment Advisory Commission voted to recommend to Congress that it make additional changes to the home health payment system noting that such recommendations may include further payment reductions and/or a beneficiary copayment obligation. We cannot predict with certainty what health care initiatives, if any, will be implemented at the state level, or what the ultimate effect of Federal health care reform or any future legislation or regulation may have on us or on our business, financial condition or results of operations.

Finally, in addition to impacting our Medicare businesses, PPACA may also significantly affect our non-Medicare businesses. PPACA makes many changes to the underwriting and marketing practices of private payors. The resulting economic pressures could prompt these payors to seek to lower their rates of reimbursement for the services we provide. At this time, it is not possible to estimate what impact PPACA may have on our non-Medicare businesses.

Risks Related to our Growth Strategy

Our growth strategy depends on our ability to open agencies, acquire additional agencies on favorable terms and integrate and operate these agencies effectively. If our growth strategy is unsuccessful or we are not able to successfully integrate newly acquired or opened agencies into our existing operations, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

We expect to continue to open agencies in 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 professionals; and

obtain adequate financing to fund growth.

We focus significant time and resources on acquisitions of agencies, or on assets of agencies, in targeted markets. Not only do we face competition for acquisition candidates, but we may also be unable to identify, negotiate and complete suitable acquisition opportunities on favorable terms. 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. 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. Additionally, acquisitions involve significant risks and uncertainties, including difficulties in recouping partial episode payments and other types of misdirected payments for services from the previous owners; difficulties integrating acquired personnel and business practices into our business; the potential loss of key employees, referral sources or patients of acquired agencies; the delay in payments

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associated with change in ownership, control and the internal process of the Medicare fiscal intermediary; and the assumption of liabilities and exposure to unforeseen liabilities of acquired agencies. We may not be able to fully integrate the operations of the acquired businesses with our current business structure in an efficient and cost-effective manner. The failure to effectively integrate any of these businesses could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Start-up agencies can be delayed from opening in a timely manner due to processing of regulatory approvals.

There can be delays associated with opening a start-up agency. These delays are the result of processing delays with the state regulatory bodies as well as processing delays by the associated fiscal intermediaries that serve as billing liaisons between the agency and CMS. In order to initiate operations at a start-up agency we must submit the necessary applications along with the required documentation to the appropriate state and Federal regulatory bodies. However, CMS has issued a memorandum which prioritizes the initial surveys for new Medicare providers as lowest priority for the state regulatory bodies. Moreover, depending on state requirements, the fiscal intermediary may need to receive the state license before the approval process can move forward. Once the necessary application and documentation has been submitted to the state and Federal regulatory bodies, there is a testing period of transmitting data from the applicant to CMS. Once complete, the agency receives a provider agreement and corresponding number and can begin billing. If we are unable to obtain regulatory approval for our start-up agencies in a timely manner, such delays could have a material adverse effect on our business and our consolidated financial condition, results of operations and cash flows.

State efforts to regulate the establishment or expansion of health care providers could impair our ability to expand our operations.

Some states require health care providers (including skilled nursing facilities, hospice agencies, home health agencies and assisted living facilities) to obtain prior approval, known as a CON or POA in order to commence operations. See Part I, Item 1, Our Regulatory Environment for additional information on CONs and POAs. If we are not able to obtain such approvals, our ability to expand our operations could be impaired, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Federal regulation may impair our ability to consummate acquisitions or open new agencies.

Changes in Federal laws or regulations may materially adversely impact our ability to acquire agencies or open new start-up agencies. For example, the recently enacted PPACA authorized CMS to impose temporary moratoria on the enrollment of new Medicare providers, if deemed necessary to combat fraud, waste or abuse under government programs. The moratoria on new enrollments may be applied to categories of providers or to specific geographic regions. If a moratorium is imposed on the enrollment of new home health or hospice providers in a geographic area we desire to service, it could have a material impact on our ability to open new agencies. Additionally, CMS recently adopted and amended a regulation known as the 36 Month Rule that is applicable to home health agency acquisitions. Subject to certain exceptions, the 36 Month Rule prohibits buyers of certain home health agencies those that either enrolled in Medicare or underwent a change in ownership fewer than 36 months prior to the acquisition from assuming the Medicare billing privileges of the acquired agency. Instead, the acquired agencies must enroll as new providers with Medicare. One of the exceptions for the 36 Month Rule applies to home health agencies that have submitted two consecutive years of Medicare full cost reports. We believe that this exception applies to the majority of potential acquisition targets. Nonetheless, the rule may apply to some acquisition targets, the rule may be changed, or it may be interpreted differently by CMS going forward and could therefore have a material detrimental impact on our acquisition strategy. It may further increase competition for acquisition targets that are not subject to the rule, and may cause significant Medicare billing delays for the purchasers of agencies that are subject to the rule.

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We may not succeed in our efforts to evolve from a home health care company to a post acute chronic care company.

Our long-term strategy is to develop from a home health care to a post acute chronic care company to better serve the needs of our nation s seniors and diversify our sources of payment so as to become less reliant upon Medicare. To this end, we are working to develop new products and business lines that will complement our existing home care and hospice business, and help seniors manage their health more effectively and stay in their home longer. Developing new product offerings and lines of business can be time consuming and expensive, and there can be no certainty that our efforts in these areas will ultimately be successful.

Risks Related to our Operations

Because we are limited in our ability to control rates received for our services, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected if we are not able to maintain or reduce our costs to provide such services.

As Medicare is our primary payor and rates are established through Federal legislation, we have to manage our costs of providing care to achieve a desired level of profitability. Additionally, non-Medicare rates are difficult for us to negotiate as such payors are under pressure to reduce their own costs. As a result, we manage our costs in order to achieve a desired level of profitability including, but not limited to, centralization of various processes, the use of technology and management of the number of employees utilized. If we are not able to continue to streamline our processes and reduce our costs, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

Our industry is highly competitive, with few barriers to entry.

There are few barriers to entry in home health markets that do not require a CON or POA. Our primary competition comes from local privately-owned and hospital-owned health care providers. We compete based on the availability of personnel; the quality of services, expertise of visiting staff and value of our services; and in certain instances, on the price of our services. Increased competition in the future may limit our ability to maintain or increase our market share.

Further, the introduction of new and enhanced service offerings by others, 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.

Managed care organizations and other third party payors continue to consolidate to enhance their ability to influence the delivery of health care services. Consequently, the health care needs of patients in the United States are increasingly served by a smaller number of managed care organizations. These organizations generally enter into service agreements with a limited number of providers. Our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected if these organizations terminate us as a provider and/or engage our competitors as a preferred or exclusive provider. In addition, should private payors, including managed care payors, seek to negotiate additional discounted fee structures or the assumption by health care providers of all or a portion of the financial risk through prepaid capitation arrangements, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

If we are unable to react competitively to new developments, our operating results may suffer. We cannot assure you that we will be able to compete successfully against current or future competitors, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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If we are unable to maintain relationships with existing patient referral sources or to establish new referral sources, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

Our success depends on referrals from physicians, hospitals and other sources in the communities we serve and on our ability to maintain good relationships with existing referral sources. Our referral sources are not contractually obligated to refer patients to us and may refer their patients to other providers. Our growth and profitability depends, in part, on our ability to establish and maintain close working relationships with these patient referral sources and to increase awareness and acceptance of the benefits of home health and hospice care by our referral sources and their patients. Our loss of, or failure to maintain, existing relationships or our failure to develop new referral relationships could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

Our business depends on effective, secure and operational information systems which include software that is developed in-house and systems provided by external contractors and other service providers. We have developed and use a proprietary Windows -based clinical software system with our POC system to collect assessment data, schedule and log patient visits, communicate with patients physicians regarding their plan of care and monitor treatments and outcomes in accordance with established medical standards. Our clinical software system integrates billing and collections functionality; accounting; human resources; payroll; and employee benefits programs provided by third parties. Problems with, or the failure of, our technology and systems or any system upgrades or programming changes associated with such technology and systems that have problems or fail to function properly could have a material adverse effect on data capture, billing, collections, assessment of internal controls and management and reporting capabilities. Any such problems or failures and the costs incurred in correcting any such problems or failures, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. To the extent these external contractors or other service providers become insolvent or fail to support the software or systems we have licensed from them, our operations could be materially adversely affected.

Our agencies also depend upon our information systems for accounting, billing, collections, risk management, quality assurance, human resources, 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 materially 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.

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, including unauthorized access to patient data and personally identifiable information stored in our information systems, and the introduction of computer viruses to our systems. Our security measures may be inadequate to prevent security breaches and our business operations could be materially adversely affected by Federal and state fines and penalties, cancellation of contracts and loss of patients if security breaches are not prevented.

We have installed privacy protection systems and devices on our network and POC laptops in an attempt to prevent unauthorized access to information in our database. However, our technology may fail to adequately secure the confidential health information and personally identifiable information we maintain in our databases.

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In such circumstances, we may be held liable to our patients and regulators, which could result in fines, litigation or adverse publicity that could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Even if we are not held liable, any resulting negative publicity could harm our business and distract the attention of management.

Further, our information systems are vulnerable to damage or interruption from fire, flood, power loss, telecommunications failure, break-ins and similar events. A failure to restore our information systems after the occurrence of any of these events could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Because of the confidential health information we store and transmit, loss of electronically stored information for any reason could expose us to a risk of regulatory action and litigation and possible liability and loss.

We believe we have all of the necessary licenses from third parties to use technology and software that we do not own. A third party could, however, allege that we are infringing its rights and we may not be able to obtain licenses on commercially reasonable terms from the third party, if at all, or the third party may commence litigation against us. In addition, we may find it necessary to initiate litigation to protect our trade secrets, to enforce our intellectual property rights and to determine the scope and validity of any proprietary rights of others. Any such litigation, or the failure to obtain any necessary licenses or other rights, could materially and adversely affect our business.

Possible changes in the case mix of patients, as well as payor mix and payment methodologies, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our revenue is determined by a number of factors, including our mix of patients and the rates of payment among payors. Changes in the case mix of our patients, payment methodologies or the payor mix among Medicare, Medicaid and private payors could have a material adverse effect on our business and our consolidated financial condition, results of operations and cash flows.

A write off of a significant amount of intangible assets or long-lived assets could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Because we have grown in part through acquisitions, goodwill and other acquired intangible assets represent a substantial portion of our assets. Goodwill was approximately $791.4 million as of December 31, 2010 and if we make additional acquisitions, it is likely that we will record additional intangible assets in our consolidated financial statements. We also have long-lived assets consisting of property and equipment and other identifiable intangible assets of $191.9 million as of December 31, 2010, which we review both on a periodic basis as well as when events or circumstances indicate that the carrying amount of an asset may not be recoverable. If a determination that a significant impairment in value of our unamortized intangible assets or long-lived assets occurs, such determination could require us to write off a substantial portion of our assets. A write off of these assets could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

A shortage of qualified registered nursing staff and other clinicians, such as therapists, could materially impact our ability to attract, train and retain qualified personnel and could increase operating costs.

We compete for qualified personnel with other providers of home health and hospice services. Our ability to attract and retain clinicians depends on several factors, including our ability to provide these personnel with attractive assignments and competitive salaries and benefits. We cannot be assured we will succeed in any of these areas. In addition, there are shortages of qualified health care personnel in some of our markets. As a result, we may face higher costs of attracting clinicians and providing them with attractive benefit packages than we originally anticipated which could have a material adverse effect on our business and consolidated financial

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condition, results of operations and cash flows. In addition, if we expand our operations into geographic areas where health care providers historically have been unionized, or if any of our agency employees become unionized, being subject to a collective bargaining agreement may have a negative impact on our ability to timely and successfully recruit qualified personnel and may increase our operating costs. Generally, if we are unable to attract and retain clinicians, the quality of our services may decline and we could lose patients and referral sources, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

As a result of operating in the home health industry, our business entails an inherent risk of claims, losses and potential lawsuits alleging incidents involving our employees that are likely to occur in a patient s home. We maintain professional liability insurance to provide coverage to us and our subsidiaries against these risks. However, we cannot assure you claims will not be made in the future in excess of the limits of our insurance, 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 business and consolidated financial condition, results of operations and cash flows. Our insurance coverage also includes fire, property damage and general liability with varying limits. We cannot assure you that the insurance we maintain will satisfy claims made against us or 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.

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. As of January 31, 2011, we had approximately 16,300 employees (13,800 home health, 1,400 hospice and 1,100 corporate employees). In addition, we employ direct care workers on a contractual basis to support our existing workforce. Due to the nature of our business, we, through our employees and caregivers who provide services on our behalf, may be the subject of medical malpractice claims. A court could find these individuals should be considered our agents, and, as a result, we could be held liable for their 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. While we maintain malpractice liability coverage that we believe is appropriate given the nature and breadth of our operations, any claims against us in excess of insurance limits could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

If we are unable to maintain our corporate reputation, our business may suffer.

Our success depends on our ability to maintain our corporate reputation, including our reputation for providing quality patient care and for compliance with Medicare requirements and the other laws to which we are subject. Adverse publicity surrounding any aspect of our business, including the death or disability of any of our patients due to our failure to provide proper care, or due to any failure on our part to comply with Medicare requirements or other laws to which we are subject, could negatively affect our Company s overall reputation and the willingness of referral sources to refer patients to us.

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

Our success depends upon the continued employment of members of our senior management team, including our Chairman and Chief Executive Officer, William F. Borne, our Chief Operating Officer, Michael D. Snow, our Chief Financial Officer, Dale E. Redman, our Chief Medical Officer, Dr. Michael O. Fleming, our Chief Development Officer, T.A. Tim Barfield, Jr., our Executive Vice President of Human Resources and Chief Information Officer, G. Patrick Thompson, Jr., our Chief Compliance Officer, Jeffrey D. Jeter, and our General

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Counsel and Secretary, David R. Bucey. The loss or departure of any one of these executives could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our operations could be impacted by natural disasters.

The occurrence of natural disasters in the markets in which we operate could not only impact the day-to-day operations of our agencies, but could also disrupt our relationships with patients, employees and referral sources located in the affected areas and, in the case of our corporate office, our ability to provide administrative support services, including billing and collection services. In addition, any episode of care that is not completed due to the impact of a natural disaster will generally result in lower revenue for the episode. For example, our corporate office and a number of our agencies are located in the southeastern United States and the Gulf Coast Region, increasing our exposure to hurricanes. Future hurricanes or other natural disasters may have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Risks Related to Liquidity

Delays in payment may cause liquidity problems.

Our business is characterized by delays from the time we provide services to the time we receive payment for these services. If we have difficulty in obtaining documentation, such as physician orders, experience information system problems or experience other issues that arise with Medicare or other payors, we may encounter additional delays in our payment cycle.

In addition, timing delays may cause working capital shortages. Working capital management, including prompt and diligent billing and collection, is an important factor in achieving our financial results and maintaining liquidity. It is possible that documentation support, system problems, Medicare or other provider issues or industry trends may extend our collection period, which may materially adversely affect our working capital, and our working capital management procedures may not successfully mitigate this risk.

Additionally, our hospice operations may experience payment delays. We have experienced payment delays when attempting to collect funds from state Medicaid programs in certain instances. Delays in receiving payments from these programs may also materially adversely affect our working capital.

The volatility and disruption of the capital and credit markets and adverse changes in the United States and global economies could impact our ability to access both available and affordable financing, and without such financing, we may be unable to achieve our objectives for strategic acquisitions and internal growth.

The United States and global capital and credit markets have recently experienced extreme volatility and disruption at unprecedented levels. Many financial institutions have recorded significant write-downs of asset values and these write-downs have caused many financial institutions to seek additional capital, to merge with larger and stronger institutions and, in some cases, to fail. Many lenders and institutional investors have reduced, and in some cases, ceased to provide funding to borrowers, including other financial institutions, or have increased their rates significantly.

While we intend to finance strategic acquisitions and internal growth with cash flows from operations and borrowings under our revolving credit facility, we may require sources of capital in addition to those presently available to us. Uncertainty in the capital and credit markets may impact our ability to access capital on terms acceptable to us (i.e. at attractive/affordable rates) or at all, and this may result in our inability to achieve present objectives for strategic acquisitions and internal growth. Further, in the event we need additional funds, and we are unable to raise the necessary funds on acceptable terms, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

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Our indebtedness could impact our financial condition and impair our ability to fulfill other obligations.

As of December 31, 2010, we had total outstanding indebtedness of approximately $181.9 million, comprised mainly of indebtedness incurred in March 2008, in connection with the TLC Health Care Services, Inc. (TLC) acquisition. Our level of indebtedness could have a material adverse effect on our business and consolidated financial position, results of operations and cash flows and impair our ability to fulfill other obligations in several ways, including:

- it could require us to dedicate a portion of our cash flow from operations to payments on our indebtedness, which could reduce the availability of cash flow to fund acquisitions, start-ups, working capital, capital expenditures and other general corporate purposes;
- it could limit our ability to borrow money or sell stock for working capital, capital expenditures, debt service requirements and other purposes;
- it could limit our flexibility in planning for, and reacting to, changes in our industry or business;
- it could make us more vulnerable to unfavorable economic or business conditions; and
- it could limit our ability to make acquisitions or exploit other business opportunities.

In the event we incur additional indebtedness, the risks described above could increase.

The agreements governing our indebtedness contain various covenants that limit our discretion in the operation of our business and our failure to satisfy requirements in these agreements could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

The agreements governing our indebtedness (the Debt Agreements) contain restrictive covenants that require us to comply with or maintain certain financial covenants and ratios and restrict our ability to:

- incur additional debt;
- redeem or repurchase stock, pay dividends or make other distributions;
- make certain investments;
- create liens;
- enter into transactions with affiliates;

make acquisitions;

merge or consolidate;

invest in foreign subsidiaries;

amend acquisition documents;

enter into certain swap agreements;

make certain restricted payments;

transfer, sell or leaseback assets; and

make fundamental changes in our corporate existence and principal business.

In addition, events beyond our control could affect our ability to comply with and maintain the financial covenants and ratios. Any failure by us to comply with or maintain all applicable financial covenants and ratios and to comply with all other applicable covenants could result in an event of default with respect to the Debt Agreements. If we are unable to obtain a waiver from our lenders in the event of any non-compliance, our lenders could accelerate the maturity of any outstanding indebtedness and terminate the commitments to make further extensions of credit (including our ability to borrow under our revolving credit facility). Any failure to comply with these covenants could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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Risks Related to Ownership of Our Common Stock

The price of our common stock may be volatile.

The price at which our common stock trades may be volatile. The stock market from time to time experiences significant price and volume fluctuations that impact the market prices of securities, particularly those 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 by the Company or large stockholders or the perception that such sales could occur;
- investor, analyst and media perception of our business and our prospects;
- developments relating to litigation or 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;
- departure of key personnel;
- changes in the Medicare, Medicaid and private insurance payment rates for home health and hospice;
- announcements by us or our competitors of significant contracts, acquisitions, strategic partnerships, joint ventures or capital commitments; or
- general economic and stock market conditions.

In addition, the stock market in general, and the NASDAQ Global Select Market (NASDAQ) in particular, has experienced price and volume fluctuations that we believe 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. Securities class-action cases have often been brought against companies following periods of volatility in the market price of their securities.

The activities of short sellers could reduce the price or prevent increases in the price of our common stock. Short sale is defined as the sale of stock by an investor that the investor does not own. Typically, investors who sell short believe the price of the stock will fall, and anticipate

selling shares at a higher price than the purchase price at which they will buy the stock. As of December 31, 2010, investors held a short position of approximately 5.4 million shares of our common stock which represented 19.0% of our outstanding common stock. The anticipated downward pressure on our stock price due to actual or anticipated sales of our stock by some institutions or individuals who engage in short sales of our common stock could cause our stock price to decline.

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

The following table presents information about our outstanding common and preferred stock and our outstanding securities exercisable for or convertible into shares of common stock:

	As of December 31, 2010
Common stock outstanding	29,232,807
Preferred stock outstanding	
Common stock available under 2008 Omnibus Incentive Compensation Plan	1,452,943
Stock options outstanding and exercisable	298,679
Non-vested stock outstanding	408,350
Non-vested stock units outstanding	46,894

If we were to sell substantial amounts of our common stock in the public market or if there was a public perception that substantial sales could occur, the market price of our common stock could decline. These sales or the perception of substantial future sales may also make it difficult for us to sell common stock in the future to raise capital.

Our Board of Directors may use anti-takeover provisions or issue stock to discourage a change of control.

Our certificate of incorporation currently authorizes us to issue up to 60,000,000 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 our company. For example, shares of stock could be sold to purchasers who might support our Board of Directors in a control contest or to dilute the voting or other rights of a person seeking to obtain control. In addition, our 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.

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 advance notice requirements for director nominations and stockholder proposals. These provisions, and others that our 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 1B. UNRESOLVED STAFF COMMENTS

None.

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ITEM 2. PROPERTIES

Our corporate headquarters are located in Baton Rouge, Louisiana in an 110,000 square feet building that we own. As of December 31, 2010, we had adequate space to accommodate our corporate staff located in the Baton Rouge area; however, we believe this headquarters facility may not be adequate in the future as we continue to grow. We are currently evaluating how best to meet our growing needs, which may include adding to our corporate offices and/or leasing additional office space.

In addition to our corporate headquarters, we also lease facilities for our home health and hospice agencies. Generally, these leases have an initial term of three years, but range from one to seven years. Most of these leases also contain an option to extend the lease period as deemed necessary. The following table shows the location of our 486 Medicare-certified home health and 67 hospice agencies at December 31, 2010:

State	Home Health	Hospice	State	Home Health	Hospice
Alaska	2		New Jersey	1	
Alabama	30	6	Nevada	1	
Arkansas	6		New Mexico	2	
Arizona	6		New York	5	
California	12		New Hampshire	2	1
Colorado	2		North Carolina	8	4
Connecticut	4		Ohio	12	1
Delaware	3		Oklahoma	9	
Florida	47		Oregon	5	1
Georgia	67	5	Pennsylvania	12	7
Idaho	1	1	Rhode Island	1	
Iowa	1				