AMEDISYS INC
Form 10-K
February 28, 2012
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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, 2011

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, 2011 (the last business day of the registrant s most recently completed second fiscal quarter) was $780,740,204. 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 23, 2012, the registrant had 30,003,342 shares of Common Stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant s definitive Proxy Statement for its 2012 Annual Meeting of Stockholders (the 2012 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, 2011 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 care centers, acquire additional care centers and integrate and operate these care centers 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, and changes in or developments with respect to any litigation or investigations relating to the Company, including the SEC investigation and the U.S. Department of Justice Civil Investigative Demands 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 2011, 2010 and 2009, 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, 2011 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 11 million visits per year.

Our mission is to help lead the patient-centered revolution by providing state-of-the-art, innovative health care at home. This means rethinking how America views aging and health issues related to growing older. It requires a monumental shift, from different providers managing one disease at a time in a vacuum, to managing a patient s disease process through communication, technology, care transition and education from the very beginning of one disease to subsequent age-related illnesses through the end of life.

We believe we are well-positioned to provide this comprehensive, patient-centered care and have a nationwide care network and the technological capability to link patients, doctors, pharmacists and caregivers improving patient outcomes, reducing costs and keeping our loved ones where they want to be, at home, enjoying life.

Our chronic care management programs and innovative technology infrastructure enable us to deliver quality care based upon the latest evidence-based best practices. We are a recognized innovator, being one of the first in the industry to equip our clinicians with point-of-care laptop technology and our referring physicians with an internet portal that enables seamless real-time coordination of patient care. We also have one of the industry s first nationwide Care Transitions program. Our 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, 2011, we owned and operated 440 Medicare-certified home health care centers, 87 Medicare-certified hospice care centers and two hospice inpatient units in 41 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 care centers by state:

Our services are primarily paid for by Medicare due to the age demographics of our patient base (average age 81). Medicare represented approximately 85%, 86%, and 88% of our net service revenue in 2011, 2010 and 2009, respectively. We are working to diversify our sources of payment by contracting with an increasing number of managed care providers. In 2011, we became an in-network home healthcare provider for 71 managed care plans across 24 states, which included three national agreements, and a hospice care provider for 27 managed care plans across 12 states. We now have agreements with 240 managed care providers across the country and are focused on adding to our network.

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 comfortable and recover faster. The Medicare home health benefit is available to homebound patients who require ongoing intermittent skilled care. Our services are provided by highly trained and skilled home health care professionals dedicated to the care and comfort of our patients.

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The Home Health Care Team includes:

- Skilled Nursing
- Nurse Practitioners
- Home Health Aides
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Social Workers

Our chronic care clinical programs incorporate 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 chronic care programs include programs for cardiovascular, respiratory, diabetes, behavioral health, rehabilitative and medical surgical conditions.

Hospice Care:

Hospice is a special form of care that is designed to provide comfort and support for those who are facing a terminal 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.

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

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 and hospice care company in the communities we service.

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

Our Strategy: To focus on clinical excellence, operational excellence, and differentiated growth.

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 that for the twelve month period ending September 2011 we met or exceeded all of the measurement categories in the footprint we serve and 6 out of the 8 measurement categories when compared to the national average.

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Effective October 2012, Medicare will impose a financial penalty upon hospitals that have excessive rates of patient readmissions within 30 days from hospital discharge. We believe this new regulation provides significant opportunities for us and other post-acute providers who can demonstrate the ability to reduce or maintain patient acute care hospital readmission rates at or below an acceptable level. We are working to take advantage of this opportunity by striving to further improve the quality of care we provide, as well as implementing disease management programs designed to be responsive to the needs of patients served by the hospitals we call upon, so as to expand our business by garnering more referrals from hospitals.

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 telemonitoring and a laptop point-of-care (POC) 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 seamless, real-time access to patient data (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 some of 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 cardiovascular, respiratory, diabetes, behavioral health, rehabilitative and medical-surgical conditions; and
- Design and launch a national hospital care transitions and readmission reduction program (called Care Transitions).

Operational Excellence

Proven, cost-efficient operating model. Our size allows us to take advantage of certain economies of scale in billing, accounting, marketing, training, purchasing and information technologies. We have developed an operating model that we believe provides a successful balance between the roles and responsibilities undertaken by our care centers 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 care centers.

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 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. We believe that our investments in technology have helped us achieve 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 care center level, we have strived to develop a cost-efficient operating model and are currently working towards sharing resources amongst our care centers that are located within a reasonable proximity to one another to further improve our 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. Initial integration activities include converting care centers to our information systems and implementing standardized operational and clinical processes. We believe that we have developed a financial and clinical infrastructure that will allow us the scalability needed to grow our home health and hospice operations.

Differentiated Growth

Emphasize internal growth. We believe the rapidly growing population of aging Americans, particularly the baby boomer population currently ages 48 to 66, will create a significant need for home health and hospice providers to deliver cost-effective, quality health care for complex

chronic conditions. We plan to target growth in markets in which we already have a significant market presence. We believe this strategy will offer more efficiencies as we look to share resources among our care centers that are located within a reasonable proximity to one another. 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, pursuing targeted start-ups, achieving clinical differentiation, and entering into new managed care contracts and health system and hospital partnerships.

Pursue strategic 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. In evaluating strategic acquisitions, we strive to employ a disciplined strategy based on defined criteria, which include, but are not limited to, clinical excellence, high-quality service, a sound compliance track record, a strong referral base and a compatible payor mix. In addition to our pure acquisition strategy, we are currently pursuing partnerships or joint ventures with health systems and hospitals.

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Our Employees

At January 31, 2012, we employed approximately 16,500 employees, consisting of approximately 12,800 home health care employees, 2,400 hospice care employees and 1,300 corporate and divisional support employees.

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.

In addition to the items noted above, CMS added two new regulations that became effective April 1, 2011: (1) a face-to-face encounter requirement for home health and hospice services and (2) changes to the home health therapy assessment schedule, which require additional patient evaluations and certifications. As a condition for Medicare payment, the first new regulation mandates that prior to certifying a patient s eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed non-physician practitioner, has had a face-to-face encounter with the patient. The encounter must occur in the timeframe of 90 days prior to the start of care or 30 days after the start of care. Documentation regarding these encounters must be present on certifications. Under the second new regulation, CMS imposed additional therapy assessment requirements. An assessment by a professional qualified therapist must take place at least once every 30 days during a therapy patient s course of treatment. Additionally, for those qualified patients that require greater than 13 or 19 therapy visits, a qualified therapist must perform the therapy service required, assess the patient, and measure and document potential effectiveness of additional visits. This requirement applies to each therapy discipline caring for the patient, and the assessment must be performed by each discipline close to, but no later than, the 13th and 19th visits. Management evaluates the potential for revenue adjustments as a result of these regulations and, when appropriate, provides allowances based upon the best available information.

Annually, the Medicare program base episodic rates are set through Federal legislation, as follows:

Period	Base episode payment
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
January 1, 2012 through December 31, 2012	2,139

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 (with various incremental adjustments made for additional visits, with larger payment increases associated with the sixth, fourteenth and twentieth visit thresholds); (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.

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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 2011, our Medicare routine care revenue accounted for approximately 99% of our total Medicare hospice service revenue and our average Medicare reimbursement was $142 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 care center has its own provider number. However, where we have created branch care centers to help our parent care centers 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 $24,528 for the twelve-month period ended October 31, 2011 and $23,875 for the twelve month period ended October 31, 2010. Any amounts received in excess of the beneficiary cap amount must be refunded to Medicare.

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.

Effective April 1, 2011, CMS implemented its hospice regulation requiring that a hospice physician or nurse practitioner have a face-to-face encounter with hospice patients during the 30 day period prior to the 180th-day recertification (third benefit period) and each subsequent recertification, to gather clinical findings to determine continued eligibility for hospice care, and that the certifying hospice physician or nurse practitioner attest that such a visit took place. Management evaluates the potential for revenue adjustments due to these regulations and when appropriate provides allowances based upon the best available information.

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 care center directors and clinical managers; provide annual coding update training for care center 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.

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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; assessment and observation of disease status; delivery of clinical skills such as wound care; administration of 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; 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 continue to meet qualifying criteria and have a continuing medical need. This could be caused by changes to the patient s medical regimen or by modified care protocols within the episode of care. The patient s progress towards goals is evaluated prior to recertification. 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 a care center level, multidisciplinary care team conference. We also monitor centralized automated compliance recertification metrics to identify, monitor, and, where we deem appropriate, audit care centers 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 care centers. 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 Compliance Officer through a confidential hotline, which is augmented by exit interviews of departing employees and monthly interviews with randomly-selected, current employees. 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. We also employ a comprehensive compliance training program that includes mandatory compliance training and testing for all new employees upon hire and annually for all staff thereafter. In addition to our compliance training, we also conduct numerous proactive, compliance audits based on key risk metrics, which are conducted by clinical auditors who work for our Compliance Department.

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. 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 care centers 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 care center, and state health

authorities in 12 states and the District of Columbia and Puerto Rico require a CON to operate a hospice care center.

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We operate home health care centers in the following CON states: Alabama, Alaska, 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 care center. In general, the process for opening a home health or hospice care center 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 care center 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.

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

Our care centers 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 care centers. These audits 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,

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which includes, among other things, home health services, durable medical equipment and outpatient prescription drugs. Violations of the Stark Law result in payment denials and may also trigger civil monetary penalties and program exclusion. 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. On July 14, 2010, the HHS Office for Civil Rights (OCR) published proposed regulations designed to implement a number of changes called for by ARRA, but the proposed regulations have not yet been finalized. 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 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

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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.

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 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 full 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 many of 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 the home health and hospice jurisdictions that do not require certificates of need or permits of approval. Our primary competition in these jurisdictions 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, 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.

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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 or eligibility requirements 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 85%, 86% and 88% of our revenue during 2011, 2010 and 2009, 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, changes to cap limits and per diem rates for hospice services and changes to Medicare eligibility requirements or changes designed to restrict utilization. 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 consolidated financial condition, results of operations and cash flows.

CMS added two new regulations that became effective April 1, 2011: (1) a face-to-face encounter requirement for home health and hospice services and (2) changes to the home health therapy assessment schedule, which requires additional patient evaluations and certifications. As a condition for Medicare payment, the first new regulation mandates that prior to certifying a patient s eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed non-physician practitioner, has had a face-to-face encounter with the patient. The encounter must occur in the timeframe of 90 days prior to the start of care or 30 days after the start of care. Documentation regarding these encounters must be present on certifications. For the hospice face-to-face encounter requirement, 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. Under the second new regulation, CMS imposed additional therapy assessment requirements. An assessment by a professional qualified therapist must take place at least once every 30 days during a therapy patient s course of treatment. Additionally, for those qualified patients that require greater than 13 or 19 therapy visits, a qualified therapist must perform the therapy service required, assess the patient, and measure and document potential effectiveness of additional visits. This requirement applies to each therapy discipline caring for the patient, and the assessment must be performed by each discipline close to, but no later than, the 13th and 19th visits. 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. The new therapy assessment requirement similarly may increase our costs associated with the provision of home health therapy services and affect therapy utilization. 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.

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 care centers. 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 and consolidated financial condition, results of operations and cash flows.

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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 care center) 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 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 could lead to a reduction in Federal government expenditures, including governmentally funded programs in which we participate, such as Medicare and Medicaid. In addition, if at any time the Federal government is not able to meet its debt payments unless the Federal debt ceiling is raised, and legislation increasing the debt ceiling is not enacted, the Federal government may stop or delay making payments on its obligations, including funding for government programs in which we participate, such as Medicare and Medicaid. Failure of the government to make payments under these programs could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Further, any failure by the United States Congress to complete the Federal budget process and fund government operations may result in a Federal government shutdown, potentially causing us to incur substantial costs without reimbursement under the Medicare program, which could have a material adverse effect on our business and 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. We are continuing our efforts to develop our non-Medicare sources of revenue and any changes in payment levels from current or future 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. On May 12, 2010, the United States Senate Committee on Finance (the Senate Finance Committee) launched an inquiry of us and the other major publicly traded home health corporations, relating to our policies and practices regarding home therapy visits and therapy utilization trends. On October 3, 2011, the Senate Finance Committee publicly issued a report titled Staff Report on Home Health and the Medicare Therapy Threshold, which recommended that CMS must move toward taking therapy out of the payment model. Following the initiation of the Senate Finance Committee inquiry, 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 also received Civil Investigative Demands (CIDs) 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 and business operations, including reimbursement and billing claims submitted to Medicare for home health services, and related compliance activities. Subsequently, the Company and certain current and former employees have received CIDs for testimony. 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

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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 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 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 IV, Item 15, Note 9, Commitments and Contingencies 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 and consolidated financial condition, results of operations and cash flows.

Our insurance may not cover all of the costs associated with defending the pending Federal securities class action, ERISA class action and shareholder derivative action and the ongoing Federal government investigation, and any potential liability costs associated with such matters.

With respect to the pending securities and ERISA class actions, the shareholder derivative action and the ongoing Federal government investigations, we maintain directors and officers liability insurance that we believe should cover a portion of the legal costs and potential liability costs associated with certain of these matters. However, the insurance coverage does not extend to all of these expenditures, and the insurance limits may be insufficient even with respect to expenditures that would otherwise be covered. In addition, we may be obligated to indemnify (and advance legal expenses to) both current and former officers, employees and directors in connection with these matters. Furthermore, our insurance carriers may seek to deny coverage in some or all of these matters, in which case we may have to fund the indemnification amounts owed to such directors and officers ourselves. If our insurance coverage for any or some of these matters is denied or is not adequate, it may have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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;

policies and procedures regarding employee relations;

addition of facilities and services;

billing for services;

requirements for utilization of services; and

reporting and maintaining records regarding adverse events.

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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;
- decreasing utilization of services;
- 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 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. If billing errors are identified in the sample of reviewed claims, the billing error can be extrapolated to all claims filed which could result in a larger overpayment than originally identified in the sample of reviewed claims. 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 a care center fails to comply with the conditions of participation in the Medicare program, that care center could be terminated from the Medicare program.

Each of our care centers must comply with required conditions of participation in the Medicare program. If we fail to meet the conditions of participation at a care center, we may receive a notice of deficiency from the applicable state surveyor. If that care center then fails to institute an acceptable plan of correction to remediate the deficiency within the correction period provided by the state surveyor, that care center could be terminated from the Medicare program. Any termination of one or more of our care centers 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 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 care centers 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.

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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 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 care centers, 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 Management s Discussion and Analysis of Financial Condition and Results of Operations: Recent Developments.

CMS added two new regulations that became effective April 1, 2011: (1) a face-to-face encounter requirement for home health and hospice services and (2) changes to the home health therapy assessment schedule, which requires additional patient evaluations and certifications. As a condition for Medicare payment, the first new regulation mandates that prior to certifying a patient s eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed non-physician practitioner, has had a face-to-face encounter with the patient. The encounter must occur in the timeframe of 90 days prior to the start of care or 30 days after the start of care. Documentation regarding these encounters must be present on certifications. For the hospice face-to-face encounter requirement, 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. Under the second new regulation, CMS imposed additional therapy assessment requirements. An assessment by a professional qualified therapist must take place at least once every 30 days during a therapy patient s course of treatment. Additionally, for those qualified patients that require greater than 13 or 19 therapy visits, a qualified therapist must perform the therapy service required, assess the patient, and measure and document potential effectiveness of additional visits. This requirement applies to each therapy discipline caring for the patient, and the assessment must be performed by each discipline close to, but no later than, the 13th and 19th visits. 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. The new therapy assessment requirement similarly may increase our costs associated with the provision of home health therapy services and affect therapy utilization. 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.

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, including rebasing, as further described in Part II, Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations: 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. In advance of the national pilot program, the newly created

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CMS Innovation Center is launching the Bundled Payments for Care Improvement initiative designed to encourage doctors, hospitals and other health care providers, including home health providers, to work together to better coordinate care for patients both when they are in the hospital and after they are discharged. In October 2011 CMS published final accountable care organization (ACO) regulations establishing a shared savings program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. PPACA further directs the Secretary to conduct a study to evaluate cost and quality of care among efficient home health care centers 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 which we operate. Moreover, in January 2011, the Medicare Payment Advisory Commission voted to recommend to Congress 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 and consolidated financial condition, results of operations and cash flows.

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 Strategies

We may not succeed in our efforts to evolve from a traditional home health and hospice care company to a company focused on bringing home a continuum of care whereby we play a key role in managing our patients age-related disease processes from onset through the end of life. If this strategy is not successful, our financial performance could be adversely affected.

Our long-term strategy is to evolve from a traditional home health and hospice care company to a company focused on bringing home a continuum of care 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 or acquire new business lines that will complement our existing home care and hospice business and help seniors manage their health more effectively and stay in their homes longer. We are also working to develop or acquire new business lines that are focused on managing our patients age-related disease processes from onset through the end of life. These new business lines will focus on expanding the range of health care services provided within patients homes, including through utilization of house call physician or nurse practitioners and developing technology that assists with coordinating patient care, developing new care transition processes and promoting patient education. Developing or acquiring new lines of business can be time consuming and expensive, and there can be no assurance that our efforts in these areas will ultimately be successful. Further, the development or acquisition of new lines of business requires significant attention from our management team, and if events occur that distract our management s attention and resources, our business performance could be negatively impacted. In addition, we may expend significant resources to acquire or develop and introduce new business lines that are ultimately not accepted by patients, payors or referral sources for multiple reasons, including, but not limited to, a failure to successfully market the new business lines to patients, payors and referral sources, competition from existing and new competitors and a failure to introduce new business lines in a timely manner. These results could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our internal growth strategies depend on our ability to maintain and build upon our market positions in geographic areas where we currently have a significant market presence. If our internal growth strategies are unsuccessful, or if we are not able to maintain and build upon our market presence in our leading markets, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

We have made a decision to emphasize internal growth by maintaining and building upon our market positions in geographic areas where we currently have a significant market presence. This will likely involve sharing resources among geographically proximate care centers, the continued development and deployment of our specialty programs, continued referral source communication enhancements, opening targeted start-up care centers in existing leading markets and entering into relationships or joint ventures with health systems and hospitals. If these strategies are unsuccessful or if we are unsuccessful in building upon our current leading market positions, this could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Further, in areas where we currently have a significant market presence, partnering or entering into joint ventures with health systems and hospitals is one way to increase that presence. We face competition for potential partnership and joint venture candidates, which may limit the number of partnership and joint venture opportunities available to us. Further, we may not be able to identify

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suitable partnership or joint venture opportunities in the future or any such opportunities, if identified, may not be consummated on favorable terms, if at all. Without successful partnerships or joint ventures in markets where we already have a significant market presence, our future growth rates could decline. In addition, any future partnerships or joint ventures, if consummated, may not be successful in achieving further growth and market penetration.

Our external growth strategies depend on our ability to pursue targeted acquisition opportunities. If such opportunities are not available on favorable terms, or if we are not able to successfully integrate newly-acquired care centers into our existing operations, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

As part of our external growth strategies, we will continue to pursue the acquisition of care centers, or assets of care centers, in targeted markets. We cannot guarantee that we will be able to identify, negotiate and complete suitable acquisition opportunities on favorable terms. We also face competition for acquisition candidates. Further, pursuing acquisitions 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 care centers; the delay in payments 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 care centers. 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.

A component of our internal growth strategies is opening targeted start-up care centers. If we are not able to open start-up care centers, integrate them into our existing operations and operate them effectively, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected. Further, start-up care centers can be delayed from opening in a timely manner due to processing of regulatory approvals, which delay could impact the success of our growth strategies.

One of our growth strategies is to open care centers in existing and new targeted markets. However, our ability to open start-up care centers will depend on several factors, including our ability to:

obtain locations for care centers in markets where need exists;

identify and hire a sufficient number of appropriately trained professionals; and

obtain adequate financing to fund growth.

Further, there can be delays associated with opening a start-up care center. 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 care center and CMS. In order to initiate operations at a start-up care center 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 care center receives a provider agreement and corresponding number and can begin billing. If we are unable to obtain regulatory approval for our start-up care centers in a timely manner, such delays could impact the success of our growth strategies and could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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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 care centers, home health care centers 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 care centers.

Changes in Federal laws or regulations may materially adversely impact our ability to acquire care centers or open new start-up care centers. For example, 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 care centers. Additionally, CMS recently adopted and amended a regulation known as the 36 Month Rule that is applicable to home health care center acquisitions. Subject to certain exceptions, the 36 Month Rule prohibits buyers of certain home health care centers those that either enrolled in Medicare or underwent a change in majority ownership fewer than 36 months prior to the acquisition from assuming the Medicare billing privileges of the acquired care center. These changes in Federal laws and regulations, and similar future changes, may further increase competition for acquisition targets and could have a material detrimental impact on our acquisition strategy.

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 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 which enhances 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.

If we are unable to provide consistently high quality of care, our business will be adversely impacted.

Providing quality patient care is the cornerstone of our business. Hospitals, physicians and other referral sources refer patients to us in large part because of the quality of care we provide. Clinical quality is becoming increasingly important within our industry. Effective October 2012, Medicare will impose a financial penalty upon hospitals that have excessive rates of patient readmissions within 30 days from hospital discharge. We believe this new regulation provides a competitive advantage to home health providers who can differentiate themselves based upon quality, particularly by achieving low patient acute care hospitalization readmission rates and by implementing disease management programs designed to be responsive to the needs of patients served by referring hospitals. We are focused intently upon improving our patient outcomes, particularly our patient acute care hospitalization readmission rates. If we should fail to attain our goals regarding acute care hospitalization readmission rates and other quality metrics, we expect our ability to generate referrals would be adversely impacted, which could have a material adverse effect upon our business and consolidated financial condition, results of operations and cash flows .

We may close additional underperforming care centers in the future.

During 2010 and 2011, we reviewed the performance of our portfolio of care centers. Our review considered the current financial performance, market penetration, forecasted market growth and current and future CMS payment revisions. As a result of this review we closed or consolidated a total of 146 care centers and ceased operations at another 49 unopened start-up centers. We incurred exit activity costs of $19.8 million in connection with these closures, including lease termination payments, relocation costs, severance costs and asset and intangible write-offs.

We will continue to monitor the performance of our existing care centers on an ongoing basis and anticipate that additional closures may from time to time occur in the future. We will incur costs and expenses with any additional closures, which may require us to book significant charges in future periods. While any such closures would be part of our efforts to improve our profitability, they would have a negative impact on our revenue and possibly our operating results over the short-term.

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 care centers 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.

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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. 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 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 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.

During the third and fourth quarter and of 2011, we determined that goodwill and other intangible assets related to our home health reporting unit were impaired and we recorded an estimated non-cash goodwill and other intangible assets impairment charge of $579.9 million for the home health reporting unit. In addition, a further significant and sustained decline in our stock price and market capitalization, a significant decline in our expected future cash flows, a significant adverse change in the business climate or slower growth rates could result in the need to perform an impairment analysis under Accounting Standard Codification (ASC) Topic 350 Intangibles Goodwill and Other in future periods. If we were to conclude that a future write down of goodwill is necessary, then we would record the appropriate charge, which could result in material charges that are adverse to our consolidated financial condition and results of operations. See Note 5 Goodwill and Other Intangible Assets, Net to our consolidated financial statements for additional information on the impairment.

Because we have grown in part through acquisitions, goodwill and other acquired intangible assets represent a substantial portion of our assets. Goodwill was approximately $334.7 million as of December 31, 2011 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 $198.6 million as of December 31, 2011, 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 and results of operations.

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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 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 care center 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, 2012, we had approximately 16,500 employees (12,800 home health, 2,400 hospice and 1,300 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 acts or omissions. 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, or multiple claims requiring us to pay deductibles 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 President and Chief Financial Officer, Ronald A. LaBorde, our Executive Vice President of Home Health and Hospice, Jim Robinson, our Chief Medical Officer, Dr. Michael O. Fleming, our Executive Vice President of Administration/Human Resources and Chief Information Officer, G. Patrick Thompson, Jr., our Chief Compliance Officer, Jeffrey D. Jeter, and our General Counsel and Secretary, David R. Bucey. The loss or departure of any one of these executives or key employees could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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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 care centers, 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 care centers 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.

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

As of December 31, 2011, we had total outstanding indebtedness of approximately $145.4 million, comprised mainly of indebtedness incurred for acquisitions. 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 take advantage of other business opportunities.

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

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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;

enter into joint ventures;

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.

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.

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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, 2011, investors held a short position of approximately 3.9 million shares of our common stock which represented 12.9% 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.

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, 2011
Common stock outstanding	30,328,549
Preferred stock outstanding	
Common stock available under 2008 Omnibus Incentive Compensation Plan	915,646
Stock options outstanding and exercisable	268,007
Non-vested stock outstanding	568,850
Non-vested stock units outstanding	28,428

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, 2011, we believe we have adequate space to accommodate our corporate staff located in the Baton Rouge area for the foreseeable future.

In addition to our corporate headquarters, we also lease facilities for our home health and hospice care centers and own one hospice inpatient unit and lease one hospice inpatient unit. 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. The following table shows the location of our 440 Medicare-certified home health, 87 hospice care centers and two hospice inpatient units at December 31, 2011:

State	Home Health	Hospice	State	Home Health	Hospice
Alaska	1		Missouri	6	
Alabama	30	7	New Jersey	2	2*
Arkansas	6		New Mexico	1	
Arizona	6		New York	5	
California	10		New Hampshire	2	5*
Colorado	2		North Carolina	8	4
Connecticut	4	1	Ohio	6	1
Delaware	2		Oklahoma	9	
Florida	40		Oregon	4	1
Georgia	67	6	Pennsylvania	10	6
Idaho	2	1	Rhode Island	1	2
Iowa	1		South Carolina	19	9
Illinois	5		Tennessee	51	10
Indiana	10	2	Texas	17	1
Kansas	2	1	Virginia	22	1
Kentucky	25		Washington	1	1
Louisiana	12	4	West Virginia	12	5
Massachusetts	9	10	Wisconsin	2	
Maine	2	5	Wyoming	3	3
Maryland	9	1	Washington, D.C.	1	
Minnesota	1		Carolina, Puerto Rico	1	
Mississippi	11		Total	440	89

* Includes one hospice inpatient unit

ITEM 3. LEGAL PROCEEDINGS

See Part IV, Item 15, Note 10, Commitments and Contingencies for information concerning our legal proceedings.

ITEM 4. MINE SAFETY DISCLOSURES.

Not applicable

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PART II

ITEM 5. MARKET FOR REGISTRANT S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Information and Holders

Our common stock trades on the NASDAQ under the trading symbol AMED. The following table presents the range of high and low sales prices for our common stock for the periods indicated as reported on NASDAQ:

	Price Range of Common Stock	
	High	Low
Year Ended December 31, 2011:		
First Quarter	$ 38.87	$ 30.26
Second Quarter	35.59	24.90
Third Quarter	27.76	12.64
Fourth Quarter	14.74	9.12
Year Ended December 31, 2010:		
First Quarter	$ 62.72	$ 49.09
Second Quarter	64.28	42.21
Third Quarter	40.00	22.82
Fourth Quarter	34.40	22.93

As of February 23, 2012, there were approximately 557 holders of record of our common stock.

Dividend Policy

We have not declared or paid any cash dividends on our common stock or any other of our securities and do not expect to pay cash dividends for the foreseeable future. We currently intend to retain our future earnings, if any, to fund the development and growth of our business. Future decisions concerning the payment of dividends will depend upon our results of operations, financial condition, capital expenditure plans and debt service requirements, as well as such other factors as our Board of Directors, in its sole discretion, may consider relevant. In addition, our outstanding indebtedness restricts, and we anticipate any additional future indebtedness may restrict, our ability to pay cash dividends.

Purchases of Equity Securities

The following table provides the information with respect to purchases made by us of shares of our common stock during each of the months during the three-month period ended December 31, 2011:

Period	(a) Total Number of Share (or Units) Purchased	(b) Average Price Paid per Share (or Unit)	(c) Total Number of Shares (or Units) Purchased as Part of Publicly Announced Plans or Programs	(d) Maximum Number (or Approximate Dollar Value) of Shares (or Units) That May Yet Be Purchased Under the Plans or Programs
October 1, 2011 to October 31, 2011	307	$ 13.84		$
November 1, 2011 to November 30, 2011		$		

December 1, 2011 to December 31, 2011	264	$	11.65
	571 (1)		12.82

(1) Includes shares of common stock surrendered to us by certain employees to satisfy tax withholding obligations in connection with the vesting of non-vested stock previously awarded to such employees under our 2008 Omnibus Incentive Compensation Plan.

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Stock Performance Graph

The Performance Graph below compares the cumulative total stockholder return on our common stock, $0.001 par value per share, for the five-year period ended December 31, 2011, with the cumulative total return on the NASDAQ composite index and an industry peer group over the same period (assuming the investment of $100 in our common stock, the NASDAQ composite index and the industry peer group) on December 31, 2006 and the reinvestment of dividends. The peer group we selected is comprised of: Gentiva Health, Inc. (GTIV), LHC Group, Inc. (LHCG) and Almost Family, Inc. (AFAM). The cumulative total stockholder return on the following graph is historical and is not necessarily indicative of future stock price performance. No cash dividends have been declared on our common stock.

	12/31/2006	12/31/2007	12/31/2008	12/31/2009	12/31/2010	12/31/2011
Amedisys, Inc.	$ 100.00	$ 147.61	$ 125.77	$ 147.86	$ 101.92	$ 33.19
NASDAQ Composite	$ 100.00	$ 110.26	$ 65.65	$ 95.19	$ 112.10	$ 110.81
Peer Group	$ 100.00	$ 93.35	$ 146.81	$ 134.79	$ 128.04	$ 44.51

This stock performance information is furnished and shall not be deemed to be soliciting material or subject to Regulation 14A, shall not be deemed filed for purposes of Section 18 of the Securities Exchange Act of 1934 (the Exchange Act) or otherwise subject to the liabilities of that section, and shall not be deemed incorporated by reference in any filing under the Securities Act of 1933, as amended, or the Exchange Act, whether made before or after the date of this report and irrespective of any general incorporation by reference language in any such filing, except to the extent we specifically incorporate the information by reference.

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ITEM 6. SELECTED FINANCIAL DATA

The selected consolidated financial data presented below is derived from our audited consolidated financial statements for the five-year period ended December 31, 2011, based on our continuing operations. The financial data for the years ended December 31, 2011, 2010 and 2009 should be read together with our consolidated financial statements and related notes included in Part IV, Item 15 Exhibits and Financial Statement Schedules and the information included in Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations herein.

	2011 (1)(2)(3)(4)	2010 (1)(2)(3)(5)	2009	2008 (6)(7)	2007 (8)(9)
	(Amounts in thousands, except per share data)				
Income Statement Data:					
Net service revenue	$ 1,470,358	$ 1,603,849	$ 1,484,376	$ 1,169,441	$ 692,152
Operating (loss) income from continuing operations	$ (470,866)	$ 210,588	$ 238,114	$ 161,015	$ 98,060
Net (loss) income from continuing operations attributable to Amedisys, Inc.	$ (375,499)	$ 122,925	$ 140,102	$ 89,084	$ 66,058
Net (Loss) income from continuing operations attributable to Amedisys, Inc per basic share	$ (13.09)	$ 4.39	$ 5.15	$ 3.37	$ 2.56
Net (Loss) income from continuing operations attributable to Amedisys, Inc per diluted share	$ (13.09)	$ 4.32	$ 5.05	$ 3.31	$ 2.51

(1) During 2011 and 2010, we received CMS bonus payments as the result of a pay for performance demonstration which amounted to $4.7 million ($2.9 million, net of tax) and $3.6 million ($2.2 million, net of tax), respectively.

(2) During 2011 and 2010, we incurred certain costs associated with the realignment of our operations and legal expenses related to the United States Senate Committee on Finance inquiry and SEC and DOJ investigations. These certain costs amounted to $10.1 million ($6.1 million, net of tax) and $9.6 million ($5.8 million, net of tax), respectively.

(3) During 2011 and 2010, we incurred certain costs associated with our exit activities of $3.4 million ($2.0 million, net of tax) and $11.4 million ($7.0 million, net of tax), respectively (see Part IV, Item 15, Note 13, Exit Activity for further details).

(4) During 2011, we recorded a $579.9 million charge ($438.4 million, net of tax) for the impairment of goodwill and other intangibles. We also released a valuation allowance related to specific deferred tax assets which amount to $1.9 million.

(5) During 2010, we settled our Georgia indigent care liability for the years 2007 through 2009 for $3.7 million ($2.2 million, net of tax).

(6) On March 26, 2008, we acquired 100% of the stock of TLC Health Care Services, Inc. (TLC), a privately-held provider of home nursing services with 92 home health and 11 hospice care centers located in 22 states and the District of Columbia, and on February 28, 2008, we acquired the stock of Family Home Health Care, Inc. and Comprehensive Home Healthcare Services, Inc. (HMA), a home health provider with 24 care centers in Tennessee and Kentucky. The results of these acquisitions have been included in our consolidated results as of the dates of purchase (see Part IV, Item 15, Note 3, Acquisitions for further details).

(7) During 2008, certain TLC integration costs were incurred primarily for the payment of severance for TLC employees and for the conversion of the acquired TLC care centers to our operating systems, including our POC network. The costs were included in general and administrative expenses and amounted to $4.0 million ($2.4 million, net of tax) for 2008.

(8) During the third quarter of 2007, a Chapter 7 Federal bankruptcy protection case for Alliance Home Health, Inc. (Alliance), one of our wholly owned subsidiaries concluded. As a result, the remaining $4.2 million of liabilities of Alliance were extinguished and we were not liable for any of these obligations.

(9) During the third and fourth quarters of 2007, we acquired certain assets and certain liabilities of Integricare, Inc. (Integricare) a home health and hospice care service provider with 15 home health and nine hospice care centers in nine states. The results of Integricare have been included in our consolidated results as of the dates of the purchase.

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	2011	2010	2009	2008	2007
			(Amounts in thousands)		
Balance Sheet Data:					
Total assets	$ 858,285	$ 1,299,863	$ 1,172,386	$ 1,070,303	$ 587,075
Total debt, including current portion	$ 145,439	$ 181,866	$ 215,153	$ 328,574	$ 24,040
Total Amedisys, Inc. stockholders equity	$ 518,868	$ 877,857	$ 735,166	$ 561,335	$ 446,971
Cash dividends declared per common share	$	$	$	$	$

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ITEM 7. MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion and analysis provides information we believe is relevant to an assessment and understanding of our results of operations and financial condition for 2011, 2010 and 2009. This discussion should be read in conjunction with our audited financial statements included in Part IV, Item 15, Exhibits and Financial Statement Schedules and Part I, Item 1, Business of this Annual Report on Form 10-K. The following analysis contains forward-looking statements about our future revenues, operating results and expectations. See Special Caution Concerning Forward-Looking Statements for a discussion of the risks, assumptions and uncertainties affecting these statements as well as Part I, Item 1A, Risk Factors.

Overview

We are a leading provider of high-quality, low-cost home health services to the chronic, co-morbid, aging American population with approximately 85%, 86%, and 88% of our revenue derived from Medicare for 2011, 2010 and 2009, respectively. During 2011, we had $1,470.3 million in net service revenue, recorded a net loss per diluted share of $(13.33) and had cash flow from operations of $141.6 million. During 2011, we recorded a $579.9 million impairment charge of goodwill and other intangibles as a result of the decline in our market capitalization and operating forecasts during 2011 see Goodwill Impairment below for additional information.

Our operations involve servicing patients through our two reportable business segments: home health and hospice. Our home health segment delivers a wide range of services in the homes of individuals who may be recovering from an illness, injury or surgical procedure. Our hospice segment provides care that is designed to provide comfort and support for those who are facing a terminal illness. As of December 31, 2011, we owned and operated 440 Medicare-certified home health care centers, 87 Medicare-certified hospice care centers and two hospice inpatient units in 41 states within the United States, the District of Columbia and Puerto Rico as detailed below:

	Owned and Operated Care Centers	
	Home Health	Hospice
At December 31, 2009	521	65
Acquisitions	3	1
Start-ups	40	8
Closed/Consolidated	(78)	(7)
At December 31, 2010	486	67
Acquisitions		23
Start-ups	8	4
Closed/Consolidated	(54)	(7)
At December 31, 2011	440	87

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During 2011 and 2010, we performed an extensive review of our portfolio of care centers which resulted in the closure and/or consolidation of several care centers. Our review considered the current financial performance, market penetration, forecasted market growth and current and future CMS payment revisions. As a result of these reviews, we consolidated certain care centers, closed certain care centers, and discontinued the startup process with certain care centers. The number of care centers impacted and the related costs are detailed below:

	2011 Exit Activities			2010 Exit Activities		
	Home Health	Hospice	Total	Home Health	Hospice	Total
Number of care centers:						
Consolidations	27	5	32	59	3	62
Closures	27	2	29	19	4	23
Unopened start-ups	2		2	41	6	47
Total	56	7	63	119	13	132
Exit activity costs (in millions):						
Lease termination	$ 2.9	$ 0.1	$ 3.0	$ 9.7	$ 1.3	$ 11.0
Relocation costs				0.6	0.1	0.7
Severance	0.7		0.7	0.6	0.1	0.7
Asset and intangible write-off	1.1	0.4	1.5	2.1	0.1	2.2
Total	$ 4.7	$ 0.5	$ 5.2	$ 13.0	$ 1.6	$ 14.6

In accordance with applicable accounting guidance, the care centers which were closed in 2011 (27 operating home health care centers and two operating hospice care centers) and closed in 2010 (19 operating home health care centers and four operating hospice care centers) are presented as discontinued operations in our consolidated financial statements.

When we refer to same store business, we mean home health and hospice care centers that we have operated for at least the last twelve months; when we refer to acquisitions, we mean home health and hospice care centers that we acquired within the last twelve months; and when we refer to start-ups, we mean any home health or hospice care center opened by us in the last twelve months. Once a care center has been in operation for a twelve month period, the results for that particular care center are included as part of our same store business from that date forward. When we refer to episodic-based revenue, admissions, recertifications or completed episodes, we mean home health revenue, admissions, recertifications or completed episodes of care for those payors that pay on an episodic-basis, which includes Medicare and other insurance carriers including Medicare Advantage programs.

Goodwill Impairment

As of September 30, 2011, we concluded that impairment indicators existed including our decline in market capitalization, third quarter results and recent forecasts which prompted us to perform an interim impairment test. As a result of our preliminary assessment we recorded an estimated non-cash goodwill and other intangible assets impairment charge of $574.1 million during the third quarter of 2011. We finalized our interim impairment test of goodwill during the fourth quarter of 2011 and recorded an additional $5.8 million non-cash goodwill impairment charge. The final non-cash goodwill and other intangible assets impairment charge was $579.9 million. In addition, a further significant and sustained decline in our stock price and market capitalization, a significant decline in our expected future cash flows, a significant adverse change in the business climate or slower growth rates could result in the need to perform an impairment analysis under Accounting Standard Codification (ASC) Topic 350 Intangibles Goodwill and Other in future periods. See Note 5 to our consolidated financial statements for additional information on the impairment charge.

Recent Developments

Executive Leadership

During 2011, we announced the departure of our former Chief Operating Officer and the transition of our Chief Financial Officer to the role of Executive Vice President and Treasurer in anticipation of his planned retirement during the first quarter of 2012. The responsibilities for the Company s operations formerly overseen by the Chief Operating Officer have been assumed by our Chief Executive Officer, William F. Borne,

and Ronald A. LaBorde, who has served as our Lead Director since February 2003 and as a member of our Board of Directors since 1997, has been appointed as President and Chief Financial Officer.

Governmental Inquiries and Investigations and Stockholder Litigation

See Note 10 to our consolidated financial statements for a discussion of the recent governmental inquiry, investigations and subsequent stockholder litigation we are involved in. No assurances can be given as to the timing or outcome of these items.

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Health Care Reform

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA), which amends the PPACA (collectively, the Health Care Reform Bills). The Health Care Reform Bills make a number of changes to Medicare payment rates, including the reinstatement of the 3% home health rural add-on, which began on April 1, 2010 (expiring January 1, 2016). The Health Care Reform Bills also include a systematic rebasing of the amount Centers for Medicare and Medicaid Services (CMS) reimburses for home health services, to be phased in over four years, beginning in 2014. We anticipate that many of the provisions of the Health Care Reform Bills may be subject to further clarification and modification through the rule-making process. It is uncertain at this time the effect that rebasing will have on our future results of operations or cash flows.

Face-to-Face and Therapy Requirements

In November 2010, CMS issued a rule which finalized two new regulations under the PPACA which ultimately were implemented April 1, 2011: (1) a face-to-face encounter requirement for home health and hospice services and (2) changes in the home health therapy assessment schedule. As a condition for Medicare payment, the PPACA mandates that prior to certifying a patient s eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed non-physician practitioner, has had a face-to-face encounter with the patient. The encounter must occur in the timeframe of 90 days prior to the start of care or 30 days after the start of care. Documentation regarding these encounters must be present on certifications.

The hospice regulation for the implementation of a PPACA provision requires that a hospice physician or nurse practitioner have a face-to-face encounter with hospice patients during the 30 day period prior to the 180th-day recertification (third benefit period) and each subsequent recertification, and that the certifying hospice physician attest that such a visit took place.

In addition, the rule imposed additional home health therapy assessment requirements. An assessment by a professional qualified therapist must take place at least once every 30 days during a therapy patient s course of treatment. Additionally, for those qualified patients that require 13 or 19 therapy visits, a qualified therapist must perform the therapy service required, assess the patient, and measure and document the potential effectiveness of additional therapy visits. This requirement applies to each therapy discipline caring for the patient and the assessment must be performed by each discipline close to, but no later than, the 13th and 19th visits.

Payment

On October 31, 2011, CMS issued a final rule to update and revise Medicare home health rates for calendar year 2012. The final rule includes a 1.4% market basket increase which includes the 1% reduction mandated by the Health Care Reform Bills and a negative 3.79% nominal change in case-mix adjustment. The net effect of these changes decreases the base rate by 2.4% to $2,139. Based on our 2011 fourth quarter revenues, the decrease in the 2012 base rate would reduce home health revenue by approximately $30.0 million. The final rule also shifts case mix points from high case mix and high therapy episodes to low case mix and non-therapy episodes. The shift from high therapy episodes will also negatively impact our revenues in 2012 in addition to the base rate decrease. The reduction will be dependent upon our therapy mix at the time the new rule is effective. In addition, the final rule states that the Medicare home health rates for calendar year 2013 will include an additional negative 1.32% nominal change in case-mix adjustment.

In August 2011, CMS issued a final rule to update and revise the Medicare hospice wage index for fiscal year 2012. The final rule includes a 3.0% market basket update, a 0.1% increase for the updated wage index data and the third year of the 7-year phase out of the budget neutrality adjustment factor of 0.6%. The net effect of the final rule, effective October 1, 2011, increases the base rate for 2012 by 2.5%. Based on our 2011 revenues, the increase in the base rate would increase hospice revenue by approximately $5 million.

The failure of the 2011 Joint Select Committee to meet its Deficit Reduction goal will result in an automatic reduction to Medicare home health and hospice payments of 2% in 2013. These cuts in addition to the 1.32% discussed above will go into effect unless a new law is enacted that specifically addresses these cuts.

In July 2011, CMS issued a proposed rule that revised the Medicaid home health definition to add a requirement, similar to the finalized Medicare home health requirement, that a physician or non-physician practitioner perform a face-to-face encounter with the Medicaid eligible individual and the physician must document that the face-to-face encounter occurred. Under the proposed rule, the face-to-face encounter must occur no more than 90 days prior to the start of services under the Medicaid home health benefit or, in certain circumstances, within 30 days after the start of home health services. CMS has not issued a final rule as of the date of this filing.

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Results of Operations

Year Ended December 31, 2011 Compared to the Year Ended December 31, 2010

During 2011 and 2010, we incurred certain costs associated with the realignment of operations and legal expenses related to the United States Senate Committee on Finance inquiry and SEC and DOJ investigation discussed in Note 10 to the consolidated financial statements and incurred costs associated with our exit activities as discussed in Note 13 to the consolidated financial statements. In addition during 2011, we recorded a $579.9 million impairment charge of goodwill and other intangibles as a result of the decline in our market capitalization and recent results and forecasts. During 2011 and 2010, we received bonus payments from CMS as the result of a pay for performance demonstration during those years. In addition, during 2010, we settled our Georgia indigent care liability for the years 2007 through 2009 for less than previously accrued.

The following details these items (amounts in millions, except per share data):

	CMS Bonus	GA Indigent Care liability	Goodwill and Other Intangibles Impairment Charge	Valuation Allowance Adjustment	Exit Activities	Certain Costs (1)	Total
For the Year-Ended December 31, 2011:							
Net service revenue	$ 4.7	$	$	$	$	$	$ 4.7
Operating expenses			(579.9)		(3.2)	(10.1)	(593.2)
Other income (expense)					(0.2)		(0.2)
Income tax benefit	(1.8)		141.5	1.9	1.4	4.0	147.0
(Loss) income from continuing operations	2.9		(438.4)	1.9	(2.0)	(6.1)	(441.7)
Discontinued operations, net of tax					(1.8)		(1.8)
Net (loss) income attributable to Amedisys, Inc.	$ 2.9	$	$ (438.4)	$ 1.9	$ (3.8)	$ (6.1)	$ (443.5)
Diluted earnings per common share:							
(Loss) income from continuing operations	$ 0.10	$	$ (15.25)	$ 0.07	$ (0.07)	$ (0.21)	$ (15.36)
Discontinued operations, net of tax					(0.06)		(0.06)
Net (loss) income attributable to Amedisys, Inc.	$ 0.10	$	$ (15.25)	$ 0.07	$ (0.13)	$ (0.21)	$ (15.42)
For the Year-Ended December 31, 2010:							
Net service revenue	$ 3.6	$ 3.7	$	$	$	$	$ 7.3
Operating expenses					(11.4)	(7.8)	(19.2)
Other income (expense)						(1.8)	(1.8)
Income tax benefit	(1.4)	(1.5)			4.4	3.8	5.3
(Loss) income from continuing operations	2.2	2.2			(7.0)	(5.8)	(8.4)
Discontinued operations, net of tax					(1.3)		(1.3)
Net (loss) income attributable to Amedisys, Inc.	$ 2.2	$ 2.2	$	$	$ (8.3)	$ (5.8)	$ (9.7)
Diluted earnings per common share:							
(Loss) income from continuing operations	$ 0.08	$ 0.08	$	$	$ (0.24)	$ (0.21)	$ (0.29)
Discontinued operations, net of tax					(0.05)		(0.05)
Net (loss) income attributable to Amedisys, Inc.	$ 0.08	$ 0.08	$	$	$ (0.29)	$ (0.21)	$ (0.34)

(1) Certain costs include acquisitions and related integration costs and legal expenses related to the United States Senate Committee on Finance inquiry and the SEC and DOJ investigations.

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Consolidated

The following table summarizes our consolidated results of operations (amounts in millions):

	For the Years Ended December 31, 2011	2010
Net service revenue	$ 1,470.3	$ 1,603.8
Gross margin	688.0	807.4
% of revenue	*46.8%*	*50.3%*
Other operating expenses	1,158.9	596.8
% of revenue	*78.8%*	*37.2%*
Operating (loss) income	(470.9)	210.6
Income tax benefit (expense)	103.4	(78.9)
Effective income tax rate	*(21.6%)*	*39.0%*
(Loss) income from continuing operations	(375.4)	123.6
Net loss from discontinued operations	(7.0)	(10.3)
Net (loss) income attributable to Amedisys, Inc.	$ (382.5)	$ 112.6

Our operating income from continuing operations, excluding the $579.9 million goodwill and other intangibles impairment charge, declined $101.6 million from 2010. Approximately $70 million of the decrease resulted from the 2011 CMS rate cut impacting the home health division. In addition, our home health division experienced declines in episodic volumes and declines in revenue per episode in excess of the rate cut which further impacted our performance. We were able to partially mitigate this impact by a $24.1 million increase in operating income from our hospice division and a $51.0 million reduction in other operating expenses in our home health division during 2011. Approximately $34 million of the $51.0 million reduction in other operating expenses in our home health division relates to care centers we consolidated during 2010 or 2011. Our hospice division benefitted from the acquisition of Beacon Hospice, Inc. (Beacon) which added approximately $50 million in revenue. Additionally, we had an increase of $20.7 million in our corporate support functions primarily related to additional salary costs, depreciation and amortization, legal fees and growth in our corporate services related to our Beacon acquisition.

During 2011, we recorded a $579.9 million impairment charge of goodwill and other intangibles as a result of the decline in our market capitalization and forecasts during the third quarter. We recognized a deferred tax benefit of $141.5 million as a result of the impairment charges.

In addition to the $141.5 million deferred tax benefit discussed above, income tax expense included a one-time favorable adjustment of $1.9 million related to the release of a valuation allowance on specific deferred tax assets related to the utilization of state net operation losses during the third quarter of 2011.

Discontinued operations include the 29 and 23 operating care centers we closed in 2011 and 2010, respectively. Their results are detailed below (dollars in millions):

	$00.00	$00.00
	For the Years Ended December 31, 2011	2010
Net revenues	$ 15.4	$ 30.5
(Loss) before income taxes	(11.4)	(16.9)
Income tax benefit	4.4	6.6

Discontinued operations, net of tax	$ (7.0)	$ (10.3)

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Home Health Division

The following table summarizes our home health segment results from continuing operations:

	For the Years Ended December 31,					
	2011			2010		
	Same Store	Start-ups/ Acquisitions	Total	Same Store	Other (1)	Total
Financial Information (in millions):						
Episodic-based revenue	$ 1,161.2	$ 17.3	**$ 1,178.5**	$ 1,354.0	$ 37.5	**$ 1,391.5**
Non-episodic revenue	72.8	1.3	**74.1**	70.8	2.9	**73.7**
Net service revenue	1,234.0	18.6	**1,252.6**	1,424.8	40.4	**1,465.2**
Same store episodic-based revenue growth (2)	**(14%)**					
Cost of service	654.9	10.8	**665.7**	692.3	30.0	**722.3**
Gross margin	579.1	7.8	**586.9**	732.5	10.4	**742.9**
Other operating expenses excluding impairment charge (5)	308.6	8.3	**316.9**	326.9	41.0	**367.9**
Operating income before impairment charge (5)	$ 270.5	$ (0.5)	**$ 270.0**	$ 405.6	$ (30.6)	**$ 375.0**
Key Statistical Data:						
Admissions:						
Episodic-based	230,183	3,538	**233,721**	240,115	7,674	**247,789**
Non-episodic	42,354	761	**43,115**	38,276	1,610	**39,886**
Total admissions	272,537	4,299	**276,836**	278,391	9,284	**287,675**
Same store episodic-based admission growth (2)	**(4%)**					
Recertifications:						
Episodic-based	171,690	1,645	**173,335**	181,481	4,563	**186,044**
Non-episodic	17,282	158	**17,440**	18,117	333	**18,450**
Total recertifications	188,972	1,803	**190,775**	199,598	4,896	**204,494**
Same store episodic-based recertification growth (2)	**(5%)**					
Completed Episodes:						
Episodic-based	386,959	4,815	**391,774**	402,910	13,269	**416,179**
Visits:						
Episodic-based	7,436,394	94,225	**7,530,619**	7,877,580	211,168	**8,088,748**
Non-episodic	791,823	13,051	**804,874**	780,284	30,074	**810,358**

Total visits	8,228,217	107,276	**8,335,493**	8,657,864	241,242	**8,899,106**
Cost per Visit	$ 79.59	**$** 100.98	**$ 79.87**	**$** 79.97	**$** 124.20	**$ 81.17**
Average episodic-based revenue per completed episode (3)	$ 3,003	**$** 3,126	**$ 3,005**	**$** 3,315	**$** 3,216	**$ 3,312**
Episodic-based visits per completed episode (4)	18.8	18.0	**18.8**	19.2	17.7	**19.1**

(1) Care centers for the prior period which are not considered same store care centers (i.e. care centers consolidated in current or prior period or unopened startups).

(2) Same store episodic-based revenue, admissions or recertifications growth is the percent increase (decrease) in our same store episodic-based revenue, admissions or recertifications for the period as a percent of the same store episodic-based revenue, admissions or recertifications of the prior period.

(3) Average episodic-based revenue per completed episode is the average episodic-based revenue earned for each episodic-based completed episode of care.

(4) Episodic-based visits per completed episode are the home health episodic-based visits on completed episodes divided by the home health episodic-based episodes completed during the period.

(5) Other operating expenses and operating loss totaled $896.8 million and $309.9 million, respectively including the $579.9 million impairment charge of goodwill and other intangibles for the year ended December 31, 2011

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Net Service Revenue

Our home health revenue is driven by the volume of admissions and recertifications and the revenue per episode on episodes completed and in progress. During 2011, we experienced significant declines in all of these revenue metrics which contributed to a $208.9 million decline in our home health net service revenue excluding the $3.7 million for the settlement of our Georgia indigent care liability we recognized during 2010. Approximately $70 million of the decline in revenue is due to the 5.2% CMS rate cut for 2011 and approximately $3.4 million is related to the 2012 CMS rate cut on our episodes in progress at December 31, 2011.

We experienced a decline in episodic-based admissions and recertifications during 2011, which accounted for approximately $65 million of the decline in same store episodic-based revenue and $89 million of the decline in total episodic-based revenue. We believe our admission volumes were negatively impacted by the CMS face-to-face requirements. While we cannot fully measure the impact of lower admissions due to the unwillingness of physicians to refer to home health as a result of this regulation, we do believe that it has impacted current admissions and it could impact future admissions. While our episodic recertifications as a percentage of completed episodes decreased less than 1%, we experienced a 5% decline in same store episodic-based recertifications. The primary reason for the decrease is the overall decline in our patient census driven by the decline in admission volumes.

Our revenue per episode decline of 9% has resulted in approximately a $125 million decrease in revenue with approximately $70 million as a result of the 5.2% CMS rate cut for 2011 with the remainder due to a reduction in therapy utilization and the impact of the new CMS therapy assessment regulations effective April 1, 2011. We performed approximately 64,000 therapy visits which became non-billable due to our failure to meet the requirements of the regulation resulting in an estimated $11 million reduction in revenue for 2011. This regulation was in effect for three quarters of 2011, but will be in effect for all of 2012. We expect this regulation to continue to have a negative impact in 2012; however, we expect continued improvement in our management of this regulation through continued training, process improvement and system enhancements.

Cost of Service, excluding Depreciation and Amortization

The decrease in cost of service is due to the decline in visit volume which corresponds to our decline in admission and recertification volume in 2011 and a decrease in our cost per visit. We performed approximately 564,000 fewer visits in 2011, which accounted for $45.7 million of the decrease. The remainder is due to the decline in cost per visit which is due primarily to our conversion of therapists to our pay per visit models, our focus on productivity and a decline in therapy visits. The factors that are expected to impact our 2012 cost per visit metric are wage inflation and any change in our mix of visits.

Other Operating Expenses

Our other operating expenses, excluding the goodwill and other intangibles impairment charge decreased $51.0 million primarily as a result of reductions in salaries and benefits, rent and bad debt expense. A significant portion of the reduction is due to the consolidation of 27 operating care centers during 2011.

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Hospice Division

The following table summarizes our hospice segment results from continuing operations:

	For the Year Ended December 31,					
	2011			2010		
	Same Store	Start-ups/ Acquisitions	Total	Same Store	Other (1)	Total
Financial Information (in millions):						
Medicare revenue	$ 151.6	$ 52.9	**$ 204.5**	$ 127.6	$ 3.4	**$ 131.0**
Non-Medicare revenue	10.0	3.2	**13.2**	7.4	0.2	**7.6**
Net service revenue	161.6	56.1	**217.7**	135.0	3.6	**138.6**
Same store Medicare revenue growth (2)	**19%**					
Cost of service	83.5	33.1	**116.6**	70.2	3.9	**74.1**
Gross margin	78.1	23.0	**101.1**	64.8	(0.3)	**64.5**
Other operating expenses	30.9	13.9	**44.8**	28.3	4.0	**32.3**
Operating income	$ 47.2	$ 9.1	**$ 56.3**	$ 36.5	$ (4.3)	**$ 32.2**
Key Statistical Data:						
Hospice admits	12,203	3,686	**15,889**	10,903	372	**11,275**
Hospice days	1,200,201	331,764	**1,531,965**	1,007,364	26,196	**1,033,560**
Average daily census	3,288	909	**4,197**	2,760	72	**2,832**
Revenue per day	$ 134.66	$ 169.20	**$ 142.14**	$ 133.99	$ 137.61	**$ 134.09**
Cost of service per day	$ 69.36	$ 99.35	**$ 75.85**	$ 69.69	$ 147.04	**$ 71.65**
Average length of stay	91	78	**88**	88		