AMEDISYS INC
Form 10-K
February 27, 2008

# 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, 2007**

**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 (Title of each class) | The NASDAQ Global Select Market (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 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, 2007 (the last business day of the registrant s most recently completed second fiscal quarter) was $795,638,662. For purposes of this determination shares beneficially owned by officers, directors and ten percent stockholders have been excluded, which does not constitute a determination that such persons are affiliates.

As of February 20, 2008, registrant had 26,470,599 shares of Common Stock outstanding.

**DOCUMENTS INCORPORATED BY REFERENCE**

Portions of the registrant s definitive Proxy Statement for its 2008 Annual Meeting of Stockholders (the 2008 Proxy Statement ) to be filed pursuant to the Securities Exchange Act of 1934 are incorporated herein by reference into Part III of this Annual Report on Form 10-K for the year ended December 31, 2007.

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**SPECIAL CAUTION CONCERNING FORWARD-LOOKING STATEMENTS**

*When included in this Annual Report on Form 10-K or in the information incorporated by reference, words like believes , belief, expects, plans, anticipates, intends, projects, estimates, may, might, would 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 projected therein. These risks and uncertainties include, but are not limited to: general economic and business conditions, changes in or failure to comply with existing regulations or the inability to comply with new government regulations on a timely basis, changes in Medicare and other medical reimbursement levels, our ability to complete acquisitions we announce from time to time, and any financing related thereto, our ability to meet debt service requirements, adverse changes in federal and state laws relating to the health care industry, demographic changes, availability and terms of capital, our ability to attract and retain qualified personnel, ongoing development and success of new start-ups, our ability to successfully integrate newly acquired agencies, changes in estimates and judgments associated with critical accounting policies, business disruption due to natural disasters or acts of terrorism, 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. 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 below.*

*Unless otherwise provided, Amedisys, we, us, our, and the Company refer to Amedisys, Inc. and our consolidated subsidiaries and when we refer to 2007, 2006 and 2005, 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, 2007 as filed with the Securities and Exchange Commission, including all exhibits, is available on our internet website at http://www.amedisys.com on the Investors page under the SEC Filings link.*

**PART I**

**ITEM 1. BUSINESS**
**Overview**

We are a leading provider of high-quality, low-cost home health services to the chronic, co-morbid, aging American population. We were originally incorporated in Louisiana in 1982, 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 . The services that we provide on a multi-state basis include both home health and hospice services with over 8,900 employees and approximately 89% of our revenue derived from Medicare. As of December 31, 2007, we owned and operated 325 Medicare-certified home health agencies, 29 Medicare-certified hospice agencies and managed the operations of four Medicare-certified home health and two Medicare-certified hospice agencies in 30 states within the United States. Our typical home health patient is Medicare eligible, 80 to 84 years old and takes approximately eight different medications on a daily basis. For our home health patients, we typically receive a 60-day episodic-based payment from Medicare that averages $2,666 for each episode of care that we provide. Our care for each home health patient focuses on improving the quality of life by evaluating the health condition of each patient; developing a doctor approved plan of care for each episode of care to achieve certain goals for each individual patient, which can be followed up with additionally paid episodes of care, if deemed necessary; and educating each patient on how to either maintain or continue to improve upon their health on an ongoing basis after they leave our care.

During 2007, we completed the acquisition of 38 home health and 11 hospice agencies. Our asset purchase of IntegriCare, Inc. during the third and fourth quarters of 2007, accounted for a substantial number of these locations with a total of 15 home health and nine hospice agencies in nine states. In addition, subsequent to December 31, 2007, we signed two definitive stock purchase agreements for the acquisition of all of the outstanding shares of TLC Health Care Services, Inc. and the holding company that operates Family Home Health Care, Inc. and Comprehensive Home Healthcare Service, Inc. We also closed the acquisition of a home health location in Carolina, Puerto Rico. When these acquisitions close in 2008, we will add a total of 117 home health and 11 hospice agencies to our operations and we will be located in five new states within the United States and we will also then be located in Puerto Rico and the District of Columbia.

Through our home health agencies, we deliver a wide range of services in the homes of individuals who may be recovering from surgery, have a chronic disability or terminal illness or need assistance with the essential activities of daily living. The services we provide include skilled nursing and home health aide services; physical, occupational and speech therapy; and medically oriented social work to eligible individuals who require ongoing care that cannot be provided effectively by family and friends. In addition, we have developed and offer clinically focused programs for high cost chronic conditions and various diseases, such as diabetes, coronary artery disease, congestive heart failure, complex wound care, chronic obstructive pulmonary disease ( COPD ), geriatric surgical recovery, behavioral health, and stroke recovery, as well as various rehabilitative programs. In each case, we focus on improving the functional ability of our geriatric population and enhancing patient self-management through compliance tracking and behavioral modification. As an organization, we continue to focus on enhancing the delivery of services to geriatric patients with chronic co-morbid conditions. We believe our services are attractive to payors and physicians because we combine clinical quality with cost-effectiveness; we provide clinical consistencies in the care we provide in each of our agencies; and we are accessible 24 hours a day, seven days a week to answer our patients questions and to provide for their medical needs with such services as our Encore nurse call center.

Through our hospice agencies, we provide palliative care and comfort to terminally ill patients and their families. We provide hospice services to each patient using an interdisciplinary care team comprised of a physician, a patient care manager, registered nurses, certified home health aides, social workers, a chaplain, a homemaker and specially trained volunteers. This team then collectively assesses the clinical, psychosocial and

spiritual needs of the patients and their families and manages that care accordingly. Although we expect Medicare home health to remain our primary focus over the near and intermediate term, we believe home health and hospice are complementary services and we expect to continue to expand our home health and hospice networks through acquisitions and start-up activities.

**Our Market and Opportunity**

*Home Health*

On January 1, 2008, the first member of the baby boomer generation became eligible to receive early retirement benefits from Social Security at age 62. With Medicare eligibility commencing at age 65, the United States is only three years away from realizing the start of that generation s demands on the Medicare system. It is estimated by the United States Census Bureau that approximately 8,000 Americans will become Medicare eligible each day beginning in 2011, and by 2030, 57.8 million baby boomers will be eligible for Medicare benefits. With the expected increase in the number of Medicare beneficiaries and continuing expected increases in life expectancies, home health expenditures in the United States are estimated to surpass the $53.4 billion that was spent in 2005, as reported by the National Association of Home Care and Hospice. In addition, according to the Office of the Actuary of the Center for Medicare and Medicaid Services ( CMS ), Medicare currently is the largest single home health payor, accounting for $12.5 billion of total home health spending during 2005.

We believe these additional demands on the Medicare system will cause CMS to continue its search for lower cost alternatives for providing care to the aging American population. As CMS looks for alternative solutions, we believe it most likely will continue to make changes to the Prospective Payment System ( PPS ). For instance, on August 22, 2007, CMS issued its final rule to redefine and update the Home Health PPS, which included changes in the base rate calculation and case mix adjustment model, implementation of refinements to the payment system and imposed new quality of care data collection requirements, among other requirements. We believe these and other such changes will cause smaller, less profitable operators to exit the industry as their ability to remain profitable and competitive declines, thus continuing to present attractive consolidation opportunities for us. We believe that as these opportunities present themselves, we will be successful at improving their day-to-day operations and the level of care provided to their patients thus increasing our own operating results, primarily due to the efficiencies that would be gained by successfully integrating these opportunities into our corporate, centralized network. In addition, the home health industry remains highly fragmented with both facility-based and hospital-based agencies owned by publicly traded and privately held companies, visiting nurse associations and nurse registries. According to the Medicare Payment Advisory Commission ( MedPAC ), there were approximately 8,800 Medicare-certified home health agencies in operation in the United States at the end of 2006. We view this industry fragmentation as a further opportunity for consolidation.

*Hospice*

According to CMS, Medicare, with $9.8 billion of expenditures in 2006, is the largest payor in the hospice industry. We believe many of the same growth dynamics in the home health sector are driving growth in the hospice industry. According to CMS, the number of Medicare beneficiaries utilizing hospice is projected to increase at an average rate of 9% per year from 2004 to 2015, and according to the National Association for Home Care & Hospice, there were approximately 3,000 Medicare-certified hospice agencies in operation in the United States at the end of 2006. We believe that the hospice industry is similar to home health in that it is highly fragmented and has a relatively small number of companies of significant size. We believe it represents an attractive growth opportunity for us.

**Payment for Our Services**

*Patient Eligibility and Payors*

Medicare is a federally funded and administered health insurance program, primarily for individuals entitled to Social Security benefits who are 65 years of age or older or who are disabled. The Medicare home health

benefit is available to patients who need care following discharge from a hospital, as well as patients who suffer from chronic conditions that require ongoing but intermittent care. The services received need not be rehabilitative or of a finite duration; however, patients who require full-time skilled nursing for an extended period of time generally do not qualify for Medicare home health benefits. As a condition of participation under Medicare, beneficiaries must: be homebound, which means that they are unable to leave their home without considerable effort; require intermittent skilled nursing, physical therapy or speech therapy services that are covered by Medicare; and receive treatment under a plan of care that is established and periodically reviewed by a physician. Qualifying patients also may receive payment for occupational therapy, medical social services and home health aide services if these additional services are part of a plan of care prescribed by a physician. There is no limit to the number of episodes a beneficiary may receive as long as they remain eligible. The Medicare hospice benefit is available to Medicare-eligible patients who have advanced illnesses and are certified by a physician as having a life expectancy of six months or less. Net service revenue from our home health and hospice services is derived from Medicare, Medicaid, private insurance carriers, managed care organizations, individuals and other health insurance programs, including Medicare Advantage programs. Medicaid, a program jointly funded by federal, state and local governmental health care programs, is designed to pay for certain health care and medical services provided to low income individuals without regard to age. We also have contracts with negotiated fees with insurers and managed care organizations.

*Home Health*

We are paid for home health services from Medicare, Medicaid and other insurance carriers, including Medicare Advantage programs, for patients who have chosen not to be Medicare beneficiaries. The payment received from these other insurance carriers can either be paid by an episodic-based rate or by a per visit rate depending upon the payment terms and conditions established with such payors.

Medicare

Payment under the Medicare program (PPS) is based on a 60-day episode payment rate that is subject to adjustment based on certain variables including, but not limited, to: (a) an outlier payment if our patient s care was unusually costly; (b) a low utilization adjustment ( LUPA ) if the number of visits 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 change-in-condition adjustment if our patient s medical status changed significantly, resulting in the need for more or less care; (e) a payment adjustment based upon the level of therapy services required; (f) changes in the base episode payments established by the Medicare program; (g) adjustments to the base episode payments for case mix, geographic wages and low utilization; 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.

As we provide care to Medicare beneficiaries, we are able to pre-bill Medicare a portion of the estimated payment for each 60-day episode of care in the form of a request for anticipated payment ( RAP ). We submit a RAP for 60% of the estimated payment for the initial 60-day episode at the start of care. The full amount of the episode is then billed and paid after the episode has been completed ( final billed ). The RAP received for that particular episode is then deducted from the final payment. If a final bill is not submitted within the greater of 120 days from the start of the episode, or 60 days from the date the RAP was paid, any RAPs received for that episode will be recouped by Medicare from any other claims in process for that particular provider number. The RAP and final claim must then be re-submitted. For any subsequent 60-day episodes of care contiguous with the first episode for a particular patient ( recertification ), we submit a RAP for 50% instead of 60% of the estimated episodic payment.

On August 22, 2007, CMS issued its final rule to redefine and update the Home Health PPS for calendar year 2008 ( final rule ). The final rule included changes in the base rate calculation, case mix adjustment model, implementation of refinement to the payment system and imposed new quality of care data collection

requirements, among other requirements. CMS also included a 3.0% increase to Medicare home health rates ( market basket ) for calendar year 2008 as its suggestion to the United States Congress ( Congress ) for its final review and approval.

Non-Medicare

For a portion of our non-Medicare patients, we receive payment based on episodic-based rates by insurance carriers, including Medicare Advantage programs that pay for home health services in a similar manner as Medicare. For all other non-Medicare patients, we are paid on per visit rates. We receive these non-episodic based payments from other payor sources, which primarily consist of private insurance companies and private payors. We typically enter into agreements with such third party payors, generally on a per visit basis.

*Hospice*

Hospice services became a covered benefit under Medicare in 1983. Medicare distinguishes between four levels of hospice care: routine home care; general inpatient care; continuous home care; and respite care. Medicare pays for services based on a standard prospective rate for delivering care over a base 90-day or 60-day period (90-day episode of care for the first two hospice episodes of care and a 60-day episode of care for any subsequent episodes).

We are paid for services provided on a weekly basis for patients who leave our care and on a monthly basis for patients who receive ongoing care. Each of our hospice provider numbers is subject to payment caps for inpatient services; the cap is based on inpatient days, which cannot exceed 20% of all Medicare hospice days. In addition, our overall Medicare payment is also subject to a cap amount calculated by the Medicare fiscal intermediary at the end of each hospice cap period. The per beneficiary cap amount was $21,410 for the twelve-month period ended October 31, 2007 and $20,585 for the twelve month period ended October 31, 2006. For the twelve-month period ended October 31, 2008, the per beneficiary cap amount will not be established by the Medicare fiscal intermediary until the second half of 2008.

**Our Philosophy**

As one of the leading providers of home health care and hospice services, we strive to maintain our vision, purpose, strategy and mission:

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

*Our Purpose.* To assist patients in maintaining and improving their quality of life.

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

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

**Our Operations**

*Home Health*

Our home health operations focus on providing low-cost, outcome driven health care to the homebound patients we serve in the United States within the comfort of their own homes through our 325 agencies. We believe that there truly is no place like home for a healing, relaxing environment for patients recovering from illness, injury or surgical procedures. The home is the place where family, friends and familiar surroundings make patients generally feel most comfortable. It also generally provides an environment that allows medical professionals greater access to family members who can participate in their loved one s care, while allowing the caregivers to make recommendations based on each individual patient s needs.

By providing care to our patients in their homes, we believe we offer a low-cost alternative to acute inpatient hospitals. As the aging American population continues to grow and become Medicare eligible, we believe CMS and Medicare will continue to implement cost saving initiatives to more efficiently respond to the growing needs of the Medicare beneficiaries. Examples of initiatives currently in place include, but are not limited to the following:

- Health care facilities must provide intensive rehabilitation services to 60% of their patients who cannot be served in other, less intensive rehabilitation settings in order to qualify for payment by Medicare under the Inpatient Rehabilitation Facility Prospective Payment System, thus encouraging health care facilities to refer beneficiaries with lower acuity cases to seek care in settings that are both less intensive and costly, such as home health care;

- Effective January 1, 2008, payment for outpatient therapy services was capped at a rate of $1,810 per patient per calendar year, which further encourages health care providers to refer their patients to alternative care choices, such as home health care facilities; and

- Medicare denies payment to health care facilities for events that occur to the beneficiary while they are under the care of the facility, which events are commonly referred to as never events . With these denied claims, CMS and Medicare avoid paying for unnecessary costs and health care facilities are encouraged to treat only more severe cases due to potential denial for reimbursement for services provided.

We believe these and other cost containment initiatives will continue and thus require companies in the home health care industry to focus their efforts on providing care in the most efficient and cost effective way possible. We believe that we are well positioned to succeed in such a regulated industry that demands these cost efficiencies. Our home health care delivery platform is centralized, which allows us to effectively manage our multi-state operations. We believe that our proprietary technologies, including our Point of Care ( PoC ) laptop computer system, which allows our healthcare professionals to have real-time access to patient information and input patient data on a standardized basis, coupled with our Encore nurse call center, which tracks patient progress after discharge to ensure that care needs are being met, and our evidence-based, best practice clinical algorithms are the right prescription for providing complete care management to the aging, chronic, co-morbid American population. We believe that this infrastructure uniquely positions us to become the leading provider of complex care coordination and disease management services.

The services that we provide through our home health operations are paid primarily by Medicare, which represents approximately 89% of our net service revenue for 2007 and 93% for both 2006 and 2005. The remainder of our home health net service revenue is paid by either Medicaid or other insurance carriers, including Medicare Advantage programs, for patients who have chosen not to be Medicare beneficiaries.

As we care for our patients, we focus our efforts on the continuum of care, our disease management programs, our referral process and our commitment to providing the best plan of care based on individual patient needs.

Our Continuum of Care

Our home health care team works closely with our patients and their physicians to coordinate all aspects of each individual patient s care. With skill, efficiency and compassion, we strive to provide a seamless transition from an institutional setting to the individual patient s home, while keeping in mind the needs of our patients. Our continuum of care includes the following services:

- ***Skilled Nursing:*** includes skilled observation and assessment, disease specific patient/caregiver education, wound management, infusion management, infusion therapy, catheter, including, tracheotomy and ostomy care, and nutritional assessment/education;

- ***Therapy services:*** includes physical therapy, occupational therapy and speech therapy assessment/education;

***Assistance:*** includes an assessment of and education regarding health challenges faced by each patient, in each case provided by certified nursing assistants; and

***Additional services:*** includes care provided by medical social workers and registered dieticians.

Our Disease Management Programs

We provide several disease management programs that offer documented diagnosis driven, evidenced based protocols for effective patient management. Our disease management programs include the following innovative approaches to care:

Heart @ Home;

Diabetes @ Home;

Partners in Wound Care®;

Surgical Recovery @ Home;

Behavioral Health @ Home;

COPD @ Home;

Stroke Recovery @ Home;

Chronic Kidney Disease @ Home;

Pain Management @ Home;

Rehab @ Home;

Orthopedic Recovery @ Home;

Dysphagia @ Home;

Wound Care  a Therapy Approach; and

Balance for Life (in select markets only).

Our Referral Process

We have developed a referral process, utilized by all of our 325 home health agencies, that is designed to be the most efficient, best-practice approach for the processing of patient referrals. When we receive a referral at one of our agencies, our interdisciplinary care team coordinates the entire process. Initially, our team evaluates the needs of each individual referral at the patient s home. Once our initial evaluation is completed, we work with the patient and his/her referring physician to design a plan of care to provide the most optimal outcome. We focus on being an advocate for each of our individual patients, and accordingly, we make every effort to review each service that may benefit the patient and improve his/her quality of life.

Our Commitment

We are committed to each one of our patients and understand that they depend on us to help them achieve an optimal quality of life. We are committed to providing the highest quality of care to our patients by acting as an extension of each physician practice to whose patients we provide care. Additionally, we recognize that we cannot succeed in our endeavors if we are not also committed to and, therefore, receive a commitment from each one of our approximate 7,800 home health employees.

Our Outcomes

Through our continuum of care, our disease management programs, our referral process and our commitment to patient care, we strive to achieve the best possible outcome for each of our patients. From our

initial evaluation, to our carefully developed plan of care, to our final discharge and to our follow up through our Encore call center with patients after discharge, we believe that we have achieved outcomes that exceed those experienced by our competitors in the markets that we serve. According to CMS, we have exceeded the regional average in all ten measurement categories for outcomes in the markets that we serve and we have improved upon six of these ten measurement categories since the last reporting period. These ten measurement categories are tracked by CMS through responses received by home health providers as part of their clinical assessment process and consist of the following measurements:

- Improvement in ability to walk;
- Improvement of time in/out of bed;
- Improvement in bladder control;
- Decrease in pain experienced while moving around;
- Improvement in bathing;
- Decrease in the number of oral medications;
- Improvement in shortness of breath;
- Decrease in number of hospital readmissions;
- Decrease in number of emergency room visits; and
- Decrease in number of patients remaining at home after care has been completed.

Despite the current levels of success reported by CMS, we strive to continue to improve upon the outcomes of our patients. We believe that with successful patient outcomes, we will continue to build upon our reputation within the industry of being one of the leading providers of home health care.

Our Competitors

We compete with local, regional and national home health providers based primarily on the scope and quality of services, geographic coverage, outcome data and, in select instances, pricing. The majority of our competition is from hospital-based home health agencies, local home health agencies and visiting nurse associations. We compete with these institutions based on availability of personnel, quality of services, expertise of visiting staff employees and the value and price of services. In addition, with the exception of states that require certificates of need ( CON ) or permits of approval ( POA ), there are relatively few barriers to entry in the markets in which we operate. Despite these various competitive forces, we believe that our consistent, high-quality care, comprehensive range of services, state-of-the-art information management systems and widespread service network give us a competitive advantage over most of our competitors.

*Hospice*

Our hospice operations focus on providing a special form of care that is designed to provide comfort and support for our patients who are facing terminal illnesses, such as heart disease, pulmonary disease, dementia, Alzheimer s, HIV/AIDS or cancer through our 29 hospice agencies. We

believe that early involvement of hospice care is beneficial to patients, as well as their loved ones. Our services provided are designed to be a compassionate form of care that promotes patient dignity and supports family members. We strive to develop a relationship of trust, which allows time for all who are involved to more fully understand the needs of each patient and family member, which we believe results in greater comfort and quality of life.

Our services are paid for by Medicare, Medicaid or other third party payors, with Medicare representing 93%, 91% and 89% of our total hospice net service revenue for 2007, 2006 and 2005, respectively.

Our Comprehensive Approach

As we provide hospice services to each one of our patients, our specialized team of over 550 hospice care professionals works with each patient, family member and attending physician to develop a plan of care that we believe will best meet the individual needs of each patient. At each of our 29 hospice agencies, our specialized team of hospice care professionals includes the following:

- Hospice physician;
- Nurses;
- Home health aides;
- Social workers;
- Therapists;
- Volunteers;
- Counselors and chaplains; and
- Bereavement coordinators.

Our Offered Services

We know how important our hospice care is to our patients, their family members and physicians that we service. Therefore, our hospice services are available 24 hours a day, 7 days a week to patients and their family members. The services that we offer include, but are not limited to, the following:

- Providing all medicines, medical equipment and supplies related to the hospice diagnosis;
- Medication management to control pain and symptoms;
- Physician services to manage medications;
- Nursing and home health aide visits to provide direct care;
- Social work, counseling and chaplain services to provide support;

Volunteer services to provide companionship; and

Bereavement services for a minimum of 13 months following a loss.

Our Competitors

Unlike our home health operations, where referrals come directly from physicians, we receive referrals for hospice services from physicians as well as friends or family members of potential patients who need our services. In our markets, we compete with local, regional and national hospice providers for such referrals based primarily on the scope and quality of services, geographic coverage and pricing. With the exception of states that require CONs or POAs, there are relatively few barriers to entry in our markets, thus allowing for additional potential competition to enter our markets. We strive to differentiate ourselves from the competition through providing what we believe is the highest practicable quality care.

**Our Competitive Strengths**

We believe that we have certain competitive strengths that help to differentiate us as a leading provider in most of our markets. We believe that the following strengths will continue to help grow our business successfully and to continue our trend of increased earnings:

***Primary Emphasis on Medicare Home Health.*** Our primary focus is providing quality home health services to Medicare beneficiaries, and we derive approximately 89% of our revenue from Medicare. As

we provide these services, we focus on improvements to our continuum of care, continued development of our disease management programs, the development and growth of our referral network, improvements to the processing of referrals and an ongoing commitment to our patients and employees. We believe that our continued efforts in improving efficiencies and quality of care differentiate us from our competition. We also believe that these efforts will enable us to adapt to any future CMS changes to PPS for Medicare beneficiaries.

***Proven Operating Model.*** We have developed an operating model that we believe provides a successful balance between the roles and responsibilities existing at our agency locations and the roles and responsibilities existing at our consolidated corporate operations. For example, we have centralized our billing and collection efforts to reduce overhead expense. In addition to billing and collections, we also have centralized our accounting, regulatory, marketing, payroll, intake, risk management and quality assurance functions. With our proven operating model, we have been able to better integrate acquisitions onto our platform as quickly as possible. In addition, each of our agencies carry both locally and nationally recognized branding and each tailor their respective marketing efforts to address the specific needs of the communities, referral sources and Medicare beneficiaries they serve. Each agency has a management team that works to establish strong relationships within their communities and with referral sources. Finally, we have deployed standardized clinical programs and believe this initiative has improved the quality of care and risk management, which helps us actively manage clinical compliance across all of our home health agencies.

***Integrated Technology and Management Systems.*** We have invested significant time and resources to improve our information technology and real-time management and monitoring capabilities. For instance, we have developed a proprietary, Windows-based clinical software system and have deployed PoC laptop devices, which together are used to collect assessment data, schedule and log patient visits, generate medical orders and monitor treatments and outcomes in accordance with established medical standards. With this integrated technology, we believe that we are able to standardize the care delivered across our network of over 325 home health agencies in 30 states and that we are effectively able to monitor the patients we treat. This integrated technology also allows us to be efficient, thus reducing the need for additional administrative staff and related expenses, which enables us to continue to be a low-cost provider. Our integrated technology also provides a care coordination platform unlike any other in the home health industry.

***Proven Clinical Outcomes.*** We believe that our clinical outcomes are among the best in the industry. According to CMS, we have exceeded the regional average in all ten measurement categories for outcomes in our markets and we have improved upon six of these ten measurement categories from the last reporting period. With that track record of documented success in clinical outcomes, we are poised to continue to grow not only through acquisitions, but through internal growth in admissions at our existing locations as we continue to receive a growing number of referrals from existing sources and continue to increase our number of new referral sources.

***Demonstrated Ability to Identify and Integrate Acquisitions.*** We believe that we have been successful at identifying and integrating acquisitions that fit into our vision, purpose, strategy and mission. As we acquire agency locations, we strive to integrate these locations to our proven operating platform, including our PoC technology, as soon as possible, so that these agencies can share in the same efficiencies that benefit our existing agencies. Our integration efforts, post-acquisition, include: improving earnings; recruiting, as necessary, qualified nurses and account executives; expanding relationships with local physicians and discharge planners; and expanding the breadth and quality of services. When potential acquisition targets come to our attention, we complete an intense review process to determine whether the acquisition fits our overall business model. We employ a disciplined strategy based on defined acquisition criteria, including high service quality, a strong referral base, a compatible payor mix and opportunities for cost savings and significant internal growth.

***Significant Cash Flow from Operations and Relatively Low Capital Expenditures.*** We generate significant cash flow from operations due to the profitable operation of our business and active

management of our working capital. Our capital expenditure requirements are low because of the nature of our services, which include providing services at the patient s homes, thus not requiring significant office space and or expensive medical equipment. Historically, our routine capital expenditures have amounted to approximately 2% of our net service revenue.

***Patient-Oriented Company Culture.*** We believe that we have developed a strong patient-oriented culture that emphasizes quality of care. We communicate frequently with our employees and provide educational opportunities along with competitive benefits. We reinforce our culture not only through an orientation program for new employees, but also through an ongoing emphasis on the importance of high-quality patient care and the need to remain productive while keeping our costs low. We strive to keep our employees informed about corporate events and solicit feedback regarding ways to improve our services and the employee working environment. We also provide extensive sales and compliance training for our employees as part of their ongoing education.

***Sales and Marketing.*** Our sales and marketing efforts are directed primarily at physicians and hospital discharge planners, who are responsible for referring patients to home health and hospice agencies. Marketing activities are coordinated locally by the individual agency and are supplemented by regional sales management and specified corporate personnel. These activities generally emphasize the benefits offered by our home health and hospice agencies as compared to other providers in the market, such as our focus on addressing the unique needs of Medicare beneficiaries; our specialized programs and our focus on specific disease and chronic conditions such as diabetes, coronary artery disease and congestive heart failure, orthopedics and wound care; our ability to schedule and coordinate patient assessment and admission, when appropriate, with little to no inconvenience to the patient; and our size and scale. Although the agency director is the primary point of contact, physicians who utilize our agencies are important sources of recommendations to other physicians regarding the benefits of using our services. Each agency director develops a target list of physicians and discharge planners, and we continually review these marketing lists and our progress in contacting and successfully attracting additional local referral sources.

**Our Strategy**

Our objective is to be the leading provider of high-quality, low-cost home health services in each market in which we operate. To achieve this objective, we intend to:

***Focus on Medicare-Eligible Patients.*** The rapidly growing population of potential Medicare beneficiaries represents a compelling market for home health and hospice providers. We believe that implementation of PPS in the home health industry has created a relatively stable payment environment favoring companies such as ours that focus on providing high-quality, low-cost home health and hospice services.

***Prioritize Internal Growth.*** We emphasize the internal growth of our episodic-based patient admissions, which approximated 12% during 2007. We drive internal growth by: maintaining an emphasis on high-quality care; expanding and enhancing referral relationships in our local and regional markets; continuing to educate referral sources regarding our specialized programs that focus on high-cost chronic conditions and diseases; developing strategic relationships with large hospital systems to increase admission volume; expanding our service coverage areas by developing new locations; and attracting and retaining highly skilled and experienced employees through communication, education, empowerment and competitive benefits.

***Grow Through Strategic Acquisitions.*** We believe our focus on Medicare beneficiaries and our size and national reputation provides us with a strategic advantage when assessing potential acquisitions. The majority of home health agencies and hospice programs are owned either by hospitals or independent operators. We believe that recent CMS changes to reimbursement and other potential, future changes to reimbursement will continue to pressure the home health industry to consolidate. As

we pursue strategic acquisitions, we employ a disciplined acquisition strategy based on defined acquisition criteria, which include, but are not limited to, high-quality service, a strong referral base and compatible payor mix.

***Leverage our Cost-Efficient Operating Structure.*** We believe the size and scale of our infrastructure and operating systems offer the opportunity to achieve operating leverage at both the agency and corporate level. At the agency level, we have strived to develop a cost-efficient operating model. To manage our diverse network of locations, we use a proprietary information system that reduces administrative and operating costs through the integration of clinical, financial and operating functions. 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 enables us to leverage regional and senior management resources and add new locations without proportionate increases in corporate overhead. We also believe that this cost-efficient operating structure coupled with the recent changes in payment by Medicare under PPS, which went into effect on January 1, 2008, will allow us to successfully integrate and keep increasing our overall profitability as we acquire additional agencies that cannot function as effectively under the adjusted PPS.

***Continue to Develop and Deploy Specialized Programs for Chronic Diseases and Conditions.*** We have developed specialized services that focus on high-cost diseases and chronic conditions and have successfully launched programs for diabetes, coronary artery disease, congestive heart failure, orthopedics, complex wound care, geriatric surgical recovery and behavioral health, among others. Our specialty programs represent an attractive growth opportunity because they combine clinical quality and 24-hour, seven days a week access, which is appealing to patients and physicians, with cost-effective delivery of high-quality nursing care to patients who have high-cost or chronic conditions.

***Continue to Develop our Care Coordination Platform.*** Due to our data and infrastructure being centralized, we are able to closely focus on our chronic care coordination programs. Our typical patient currently is 80 to 84 years old and receives eight medications per day. With these types of patients, we experience multiple co-morbidities and a higher risk for unplanned emergent events, thus we recognize the need to manage this population much more comprehensively than the traditional home care model.

**Our View of the Future of Health Care and the Home Health Solution**

A healthcare crisis in our country is on the horizon. According to the United States Congressional Budget Office, 43% of Medicare costs can be attributed to 5% of Medicare s most costly beneficiaries. Further, Medicare beneficiaries with four or more chronic conditions are 99 times more likely to experience one or more potentially preventable hospitalizations as compared to those without chronic conditions. The American Geriatric Society estimates that approximately 20% of Medicare beneficiaries have five or more chronic conditions and these individuals account for almost 70% of all Medicare spending. When Medicare was first established in 1965, it was based on a health insurance model, which focused on acute care and not chronic conditions; however, as the baby boomer generation of the United States reaches the age of Medicare eligibility at age 65, we believe this model will be unable to provide necessary care for a growing population of chronic, co-morbid, aging Americans. According to the Board of Trustees of Medicare, Medicare is projected to run out of funds to care for its beneficiaries in 2019, if significant changes are not made to the current health care system.

Currently, we believe that the delivery of care and the associated reimbursement by Medicare does not provide an adequate incentive to physicians and other health care providers to coordinate care for Medicare beneficiaries who have chronic care conditions. There is clearly a disconnect between the care coordination for this portion of the population and the related reimbursement through the Medicare system. We believe that a growing population of elderly Medicare recipients is receiving disjointed care through multiple visits to different doctors at an unnecessarily high cost.

The United States has recognized this problem and has tried to focus efforts on resolving the issue through the completion of various studies, models, proposed legislation and panel discussions by health care professionals. On August 1, 2005, CMS began Phase 1 of its Medicare Health Support Program ( MHS ), which was a three year pilot program designed to test a variety of disease management interventions to invited fee-for-service Medicare beneficiaries with chronic conditions. The goal of Phase 1 was to show improvements in clinical quality and beneficiary satisfaction, while achieving savings targets through the utilization of disease management programs. Preliminary results of MHS indicate that Phase 1 has not succeeded in meeting the statutory requirements necessary to expand it into the next stage. If these preliminary results are confirmed, then MHS could be cancelled and these particular efforts of CMS would have failed to resolve the problem of caring for the growing chronic, co-morbid, aging American population.

Despite the lack of a defined solution to the approaching problem and the potential exhaustion of Medicare funds in 2019, there are others within both the health care industry and the United States Congress working diligently on viable alternative solutions that could revolutionize the health care industry. One of the potential solutions is to overhaul the current health care system to provide for the development of care coordination plans.

The concept of care coordination plans put the patient at the center of care. These plans take a complete view of each patient s physical, cognitive and care needs to help develop a plan of care that is designed to address all of the medical conditions of a patient and takes into account the patient s ability to self-manage his or her health care, and functional issues in each patient s personal support system. If properly organized and designed, a successful care coordination program oversees the implementation of a patient-specific, individualized plan of care. This coordination could involve consultation with various health care providers, monitoring and managing of medications and providing education and counseling to both the patient and the patient s caregivers. The benefits associated with care coordination plans include, but are not limited to, the avoidance of negative medication interactions associated with the prescription of too many medications by various doctors who have historically not communicated with one another, the prevention of hospital stays as the care provided through these programs would be designed to be preventive in nature, which may reduce the likelihood of inflammations of chronic conditions of beneficiaries and an increase in the potential for a beneficiary to experience more independence for an extended period of time as the need for services provided by assisted living or nursing home communities may be postponed to a later date.

Examples of services provided by care coordination programs are as follows:

- General assessment of each patient s various illnesses and of their overall health, which would be used to develop an overall plan of care;
- Multidisciplinary care conferences;
- Coordination and consultation with other health care providers;
- Monitoring and management of the medications consumed by each patient to help avoid the likelihood of complications associated with negative medication interactions; and
- Education and counseling of the beneficiary and his or her caregivers.

The concept of care management has also gained momentum within the health care community. There have been groups of professionals who have developed research programs to test if such programs could be a viable solution for caring for the growing chronic, co-morbid, aging American population. For instance, Oregon Health and Science University has been working on research associated with the integration of information technology with the overall care of older adults with complex chronic illnesses in a program called Care Management Plus. The program consists of a care manager who educates and guides patients through their health care options. It integrates a tested information technology system with trained care managers in primary care clinics to treat older adults with complicated conditions respectfully and effectively. In the initial testing, information reported by Oregon Health and Science University suggested that the plan saved lives and improved health care outcomes by

reducing hospitalizations by 24%, improved the patient s experience with care who participated in the study and improved the disease status. As of the second quarter of calendar year 2007, the plan was in the process of expanding from seven clinics to more than 40 clinics.

As we look to the future, the development of care management programs could be a viable solution for the United States to care for the growing chronic, co-morbid, aging American population. With this vision of the future of the health care industry, we are evaluating ways to broaden our present service offerings to include not only home health care and hospice services, but also other services within a care management program that we believe could successfully provide for the health care needs of all of our current patients as well as other Medicare beneficiaries. We believe that if we are able to provide an infrastructure that can disseminate a nationwide standard of care through our continuing growing network of home health and hospice agencies, our services will not only be attractive to health care providers who need these services for their patients, but we will be an attractive partner for health care professionals who are caring for Medicare beneficiaries who need assistance in managing their overall care.

As we work to develop a care management program, we are well positioned with our network of 442 home health and 40 hospice agencies throughout 35 states, Puerto Rico and the District of Columbia, after considering our recently announced, pending definitive stock purchase agreements, that have occurred during 2008. In addition, as a result of our current business practices, we believe that we obtain the most comprehensive, real-time clinical information by way of an assessment that is currently available for these patients in an electronic format, which could be utilized to help manage all of the necessary care of each of our patients. These assessments are CMS developed and mandated and are referred to as Outcome Assessment Information Set ( OASIS ) forms. As a care management coordinator, we could utilize these assessments as a starting point to the development of a repository of real-time health care information for each patient as these