AMEDISYS INC
Form 10-Q
May 09, 2012
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington D.C. 20549

FORM 10-Q

(Mark One)

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

For the quarterly period ended March 31, 2012

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)	**(I.R.S. Employer Identification No.)**

5959 S. Sherwood Forest Blvd., Baton Rouge, LA 70816

(Address of principal executive offices, including zip code)

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

(Registrant s telephone number, including area code)

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 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 Exchange Act). Yes ¨ No x

The number of shares outstanding of each of the issuer s classes of common stock, as of the latest practicable date, is as follows: Common stock, $0.001 par value, 30,127,046 shares outstanding as of May 3, 2012.

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SPECIAL CAUTION CONCERNING FORWARD-LOOKING STATEMENTS

When included in this Quarterly Report on Form 10-Q, 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 our Annual Report on Form 10-K for the year ended December 31, 2011, filed with the SEC on February 28, 2012, particularly Part I, Item 1A. Risk Factors therein, which are incorporated herein by reference and Part II, Item 1A. Risk Factors of this Quarterly Report on Form 10-Q. Additional risk factors may also be described in reports that we file from time to time with the SEC.

Available Information

Our company website address is www.amedisys.com. We use our website as a channel of distribution for important company information. Important information, including press releases, analyst presentations and financial information regarding our company, is routinely posted on and accessible on the Investor Relations subpage of our website, which is accessible by clicking on the tab labeled Investors on our website home page. We also use our website to expedite public access to time-critical information regarding our company in advance of or in lieu of distributing a press release or a filing with the SEC disclosing the same information. Therefore, investors should look to the Investor Relations subpage of our website 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, Quality of Care and Nominating and Corporate Governance 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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PART I. FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

AMEDISYS, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATED BALANCE SHEETS

(Amounts in thousands, except share data)

(Unaudited)

	March 31, 2012	December 31, 2011
ASSETS		
Current assets:		
Cash and cash equivalents	$ 41,290	$ 48,004
Patient accounts receivable, net of allowance for doubtful accounts of $18,607, and $17,438	161,834	148,061
Prepaid expenses	12,765	11,321
Other current assets	22,072	24,630
Total current assets	237,961	232,016
Property and equipment, net of accumulated depreciation of $101,941 and $94,266	143,965	148,536
Goodwill	334,695	334,695
Intangible assets, net of accumulated amortization of $21,314 and $20,611	49,364	50,067
Deferred tax asset	65,674	68,649
Other assets, net	23,721	24,322
Total assets	$ 855,380	$ 858,285
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 20,532	$ 25,475
Payroll and employee benefits	87,334	82,130
Accrued expenses	65,845	68,493
Current portion of long-term obligations	68,513	33,888
Current portion of deferred income taxes	10,193	11,748
Total current liabilities	252,417	221,734
Long-term obligations, less current portion	68,376	111,551
Other long-term obligations	4,613	4,852
Total liabilities	325,406	338,137
Commitments and Contingencies - Note 5		
Equity:		
Preferred stock, $0.001 par value, 5,000,000 shares authorized; none issued or outstanding		
Common Stock, $0.001 par value, 60,000,000 shares authorized; 31,443,152, and 31,017,363 shares issued; and 30,730,529 and 30,328,549 shares outstanding	31	30
Additional paid-in capital	437,024	432,390
Treasury Stock at cost 712,623, and 688,814 shares of common stock	(16,044)	(15,770)
Accumulated other comprehensive income	15	13
Retained earnings	107,625	102,205

Total Amedisys, Inc. stockholders equity	528,651	518,868
Noncontrolling interests	1,323	1,280
Total equity	529,974	520,148
Total liabilities and equity	$ 855,380	$ 858,285

The accompanying notes are an integral part of these condensed consolidated financial statements.

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AMEDISYS, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATED INCOME STATEMENTS

(Amounts in thousands, except per share data)

(Unaudited)

	For the Three-Month Periods Ended March 31,	
	2012	2011
Net service revenue	$ 370,833	$ 359,314
Cost of service, excluding depreciation and amortization	208,506	187,304
General and administrative expenses:		
Salaries and benefits	87,077	83,388
Non-cash compensation	2,482	1,910
Other	44,394	44,296
Provision for doubtful accounts	5,863	3,114
Depreciation and amortization	10,054	9,180
Operating expenses	358,376	329,192
Operating income	12,457	30,122
Other (expense) income:		
Interest income	15	118
Interest expense	(2,074)	(2,252)
Equity in earnings from equity investments	305	323
Miscellaneous, net	429	(295)
Total other expense, net	(1,325)	(2,106)
Income before income taxes	11,132	28,016
Income tax expense	(4,620)	(11,058)
Income from continuing operations	6,512	16,958
Discontinued operations, net of tax	(1,049)	(1,634)
Net income	5,463	15,324
Net (income) attributable to noncontrolling interests	(43)	(36)
Net income attributable to Amedisys, Inc.	$ 5,420	$ 15,288
Basic earnings per common share:		
Income from continuing operations attributable to Amedisys, Inc. common stockholders	$ 0.22	$ 0.60
Discontinued operations, net of tax	(0.04)	(0.06)
Net income attributable to Amedisys, Inc. common stockholders	$ 0.18	$ 0.54
Weighted average shares outstanding	29,389	28,366
Diluted earnings per common share:		
Income from continuing operations attributable to Amedisys, Inc. common stockholders	$ 0.22	$ 0.59

Discontinued operations, net of tax	(0.04)	(0.06)
Net income attributable to Amedisys, Inc. common stockholders	$ 0.18	$ 0.53
Weighted average shares outstanding	29,780	28,867
Amounts attributable to Amedisys, Inc. common stockholders:		
Income from continuing operations	$ 6,469	$ 16,922
Discontinued operations, net of tax	(1,049)	(1,634)
Net income	$ 5,420	$ 15,288

The accompanying notes are an integral part of these condensed consolidated financial statements.

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AMEDISYS, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

(Amounts in thousands)

(Unaudited)

	For the Three-Month Periods Ended March 31,	
	2012	**2011**
Cash Flows from Operating Activities:		
Net income	$ 5,463	$ 15,324
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	10,166	9,355
Provision for doubtful accounts	5,913	3,162
Non-cash compensation	2,482	1,910
401(k) employer match	2,347	1,403
Loss on disposal of property and equipment	505	656
Deferred income taxes	1,421	399
Equity in earnings of equity investments	(305)	(323)
Amortization of deferred debt issuance costs	394	394
Return on equity investment	150	240
Changes in operating assets and liabilities, net of impact of acquisitions:		
Patient accounts receivable	(19,686)	(3,536)
Other current assets	1,335	5,112
Other assets	(39)	(493)
Accounts payable	(87)	2,889
Accrued expenses	2,051	17,605
Other long-term obligations	(239)	(1,543)
Net cash provided by operating activities	11,871	52,554
Cash Flows from Investing Activities:		
Proceeds from sale of deferred compensation plan assets	230	853
Purchases of deferred compensation plan assets	(47)	(219)
Purchases of property and equipment	(10,236)	(16,580)
Net cash used in investing activities	(10,053)	(15,946)
Cash Flows from Financing Activities:		
Proceeds from issuance of stock upon exercise of stock options and warrants		96
Proceeds from issuance of stock to employee stock purchase plan	962	1,578
Tax benefit from stock option exercises	(944)	(82)
Principal payments of long-term obligations	(8,550)	(9,627)
Net cash used in financing activities	(8,532)	(8,035)
Net (decrease) increase in cash and cash equivalents	(6,714)	28,573
Cash and cash equivalents at beginning of period	48,004	120,295
Cash and cash equivalents at end of period	$ 41,290	$ 148,868

Supplemental Disclosures of Cash Flow Information:				
Cash paid for interest	$	3,388	$	3,490
Cash paid for income taxes, net of refunds received	$	1,150	$	2,793

The accompanying notes are an integral part of these condensed consolidated financial statements.

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AMEDISYS, INC AND SUBSIDIARIES

NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(Unaudited)

1. NATURE OF OPERATIONS, CONSOLIDATION AND PRESENTATION OF FINANCIAL STATEMENTS

Amedisys, Inc., a Delaware corporation, and its consolidated subsidiaries (Amedisys, we, us, or our) are a multi-state provider of home heal and hospice services with approximately 83% and 85% of our revenue derived from Medicare for the three months ended March 31, 2012 and 2011, respectively. As of March 31, 2012, we had 437 Medicare-certified home health care centers, 88 Medicare-certified hospice care centers and two hospice inpatient units in 38 states within the United States, the District of Columbia and Puerto Rico.

Basis of Presentation

In our opinion, the accompanying unaudited condensed consolidated financial statements contain all adjustments (consisting solely of normal recurring adjustments) necessary to present fairly our financial position, our results of operations and our cash flows in accordance with U.S. Generally Accepted Accounting Principles (U.S. GAAP). Our results of operations for the interim periods presented are not necessarily indicative of results of our operations for the entire year and have not been audited by our independent auditors.

Certain information and footnote disclosures normally included in financial statements prepared in accordance with U.S. GAAP have been condensed or omitted from the interim financial information presented. This report should be read in conjunction with our consolidated financial statements and related notes included in our Annual Report on Form 10-K for the year ended December 31, 2011 as filed with the Securities and Exchange Commission (SEC) on February 28, 2012 (the Form 10-K), which includes information and disclosures not included herein.

Use of Estimates

Our accounting and reporting policies conform with U.S. GAAP. In preparing the unaudited condensed consolidated financial statements, we are required to make estimates and assumptions that impact the amounts reported in the condensed consolidated financial statements and accompanying notes. Actual results could materially differ from those estimates.

Reclassifications and Comparability

Certain reclassifications have been made to prior periods financial statements in order to conform to the current period s presentation. During the quarter ended March 31, 2012 and the year ended December 31, 2011, management committed to exit three and 29 care centers, respectively. In accordance with applicable accounting guidance the results of operations for these care centers are presented in discontinued operations in our condensed consolidated financial statements. See Note 3 for additional information regarding our discontinued operations.

Principles of Consolidation

These unaudited condensed consolidated financial statements include the accounts of Amedisys, Inc., and our wholly owned subsidiaries. All significant intercompany accounts and transactions have been eliminated in our accompanying unaudited condensed consolidated financial statements, and business combinations accounted for as purchases have been included in our unaudited condensed consolidated financial statements from their respective dates of acquisition. In addition to our wholly owned subsidiaries, we also have certain equity investments that are accounted for as set forth below.

Equity Investments

We consolidate subsidiaries and/or joint ventures when the entity is a variable interest entity and we are the primary beneficiary or if we have controlling interests in the entity, which is generally ownership in excess of 50%. Third party equity interests in our consolidated joint ventures are reflected as noncontrolling interests in our condensed consolidated financial statements.

For subsidiaries or joint ventures in which we do not have a controlling interest or for which we are not the primary beneficiary, we record such investments under the equity method of accounting.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Revenue Recognition

We earn net service revenue through our home health and hospice care centers by providing a variety of services almost exclusively in the homes of our patients. This net service revenue is earned and billed either on an episode of care basis, on a per visit basis or on a daily basis depending upon the payment terms and conditions established with each payor for services provided. We refer to home health revenue earned and billed on a 60-day episode of care as episodic-based revenue.

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AMEDISYS, INC AND SUBSIDIARIES

NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(Unaudited)

When we record our service revenue, we record it net of estimated revenue adjustments and contractual adjustments to reflect amounts we estimate to be realizable for services provided, as discussed below. We believe, based on information currently available to us and based on our judgment, that changes to one or more factors that impact the accounting estimates (such as our estimates related to revenue adjustments, contractual adjustments and episodes in progress) we make in determining net service revenue, which changes are likely to occur from period to period, will not materially impact our reported consolidated financial condition, results of operations, cash flows or our future financial results.

Home Health Revenue Recognition

Medicare Revenue

Net service revenue is recorded under the Medicare prospective payment system (PPS) 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 (capped at 10% of total reimbursement per provider number); (b) a low utilization payment 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 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 a patient, regardless of whether the same home health provider provided care for the entire series of episodes; (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.

The Centers for Medicare and Medicaid Services (CMS) added two new regulations to PPS that became effective April 1, 2011: (1) a face-to-face encounter requirement and (2) changes to the 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.

We make adjustments to Medicare revenue on completed episodes to reflect differences between estimated and actual payment amounts, an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. We estimate the impact of such adjustments based on our historical experience, which primarily includes a historical collection rate of over 99% on Medicare claims, and record this estimate during the period in which services are rendered as an estimated revenue adjustment and a corresponding reduction to patient accounts receivable. In addition, management evaluates the potential for revenue adjustments and, when appropriate, provides allowances based upon the best available information. Therefore, we believe that our reported net service revenue and patient accounts receivable will be the net amounts to be realized from Medicare for services rendered.

In addition to revenue recognized on completed episodes, we also recognize a portion of revenue associated with episodes in progress. Episodes in progress are 60-day episodes of care that begin during the reporting period, but were not completed as of the end of the period. We estimate this revenue on a monthly basis based upon historical trends. The primary factors underlying this estimate are the number of episodes in progress at the end of the reporting period, expected Medicare revenue per episode and our estimate of the average percentage complete based on visits performed. As of March 31, 2012 and 2011, the difference between the cash received from Medicare for a request for anticipated payment (RAP) on episodes in progress and the associated estimated revenue was immaterial and, therefore, the resulting credits were recorded as a reduction to our outstanding patient accounts receivable in our condensed consolidated balance sheets for such periods.

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AMEDISYS, INC AND SUBSIDIARIES

NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(Unaudited)

Non-Medicare Revenue

Episodic-based Revenue. We recognize revenue in a similar manner as we recognize Medicare revenue for episodic-based rates that are paid by other insurance carriers, including Medicare Advantage programs; however, these rates can vary based upon the negotiated terms.

Non-episodic Based Revenue. Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to our established or estimated per-visit rates, as applicable. Contractual adjustments are recorded for the difference between our standard rates and the contracted rates to be realized from patients, third parties and others for services provided and are deducted from gross revenue to determine net service revenue and are also recorded as a reduction to our outstanding patient accounts receivable. In addition, we receive a minimal amount of our net service revenue from patients who are either self-insured or are obligated for an insurance co-payment.

Hospice Revenue Recognition

Hospice Medicare Revenue

Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are daily or hourly rates for each of the four levels of care we deliver. The four main levels of care are routine care, general inpatient care, continuous home care and respite care. Routine care accounts for 98% of our total net Medicare hospice service revenue for the three months ended March 31, 2012 and 2011. We make adjustments to Medicare revenue for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. We estimate the impact of these adjustments based on our historical experience, which primarily includes our historical collection rate on Medicare claims, and record it during the period services are rendered as an estimated revenue adjustment and as a reduction to our outstanding patient accounts receivable.

Additionally, as Medicare hospice revenue is subject to an inpatient cap limit and an overall payment cap for each provider number, we monitor these caps and estimate amounts due back to Medicare if a cap has been exceeded. We record these adjustments as a reduction to revenue and an increase in other accrued liabilities. We have settled our Medicare hospice reimbursements for all fiscal years through October 31, 2009. For the Federal cap years ended October 31, 2010 through October 31, 2012, we have $3.8 million recorded for estimated amounts due back to Medicare in other accrued liabilities as of March 31, 2012 and $3.1 million recorded as of December 31, 2011. As a result of our adjustments, we believe our revenue and patients accounts receivable are recorded at amounts that will be ultimately realized.

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 Revenue

We record gross revenue on an accrual basis based upon the date of service at amounts equal to our established rates or estimated per visit rates, as applicable. Contractual adjustments are recorded for the difference between our established rates and the amounts estimated to be realizable from patients, third parties and others for services provided and are deducted from gross revenue to determine our net service revenue and patient accounts receivable.

Patient Accounts Receivable

Our patient accounts receivable are uncollateralized and consist of amounts due from Medicare, Medicaid, other third-party payors and patients. There is no single payor, other than Medicare, that accounts for more than 10% of our total outstanding patient receivables, and thus we believe

there are no other significant concentrations of receivables that would subject us to any significant credit risk in the collection of our patient accounts receivable. We fully reserve for accounts which are aged at 365 days or greater. We write off accounts on a monthly basis once we have exhausted our collection efforts and deem an account to be uncollectible.

We believe the credit risk associated with our Medicare accounts, which represent 64% and 73% of our net patient accounts receivable at March 31, 2012 and December 31, 2011, respectively, is limited due to (i) our historical collection rate of over 99% from Medicare and (ii) the fact that Medicare is a U.S. government payor. Accordingly, we do not record an allowance for doubtful accounts for our Medicare patient accounts receivable, which are recorded at their net realizable value after recording estimated revenue adjustments as discussed above. During the three months ended March 31, 2012 and 2011, we recorded $2.7 million and $2.3 million, respectively, in estimated revenue adjustments to Medicare revenue.

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AMEDISYS, INC AND SUBSIDIARIES

NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(Unaudited)

We believe there is a certain level of credit risk associated with non-Medicare payors. To provide for our non-Medicare patient accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying amount to its estimated net realizable value.

Medicare Home Health

For our home health patients, our pre-billing process includes verifying that we are eligible for payment from Medicare for the services that we provide to our patients. Our Medicare billing begins with a process to ensure that our billings are accurate through the utilization of an electronic Medicare claim review. We submit a RAP for 60% of our estimated payment for the initial episode at the start of care or 50% of the estimated payment for any subsequent episodes of care contiguous with the first episode for a particular patient. The full amount of the episode is billed after the episode has been completed (final billed). The RAP received for that particular episode is then deducted from our 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.

Medicare Hospice

For our hospice patients, our pre-billing process includes verifying that we are eligible for payment from Medicare for the services that we provide to our patients. Once each patient has been confirmed for eligibility, we will bill Medicare on a monthly basis for the services provided to the patient.

Non-Medicare Home Health and Hospice

For our non-Medicare patients, our pre-billing process primarily begins with verifying a patient s eligibility for services with the applicable payor. Once the patient has been confirmed for eligibility, we will provide services to the patient and bill the applicable payor. Our review and evaluation of non-Medicare accounts receivable includes a detailed review of outstanding balances and special consideration to concentrations of receivables from particular payors or groups of payors with similar characteristics that would subject us to any significant credit risk. We estimate an allowance for doubtful accounts based upon our assessment of historical and expected net collections, business and economic conditions, trends in payment and an evaluation of collectibility based upon the date that the service was provided. Based upon our best judgment, we believe the allowance for doubtful accounts adequately provides for accounts that will not be collected due to credit risk.

Fair Value of Financial Instruments

The following details our financial instruments where the carrying value and the fair value differ (amounts in millions):

		Fair Value at Reporting Date Using		
Financial Instrument	**As of March 31, 2012**	**Quoted Prices in Active Markets for Identical Items (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**
Long-term obligations, excluding capital leases	$136.9	$	$142.0	$

The estimates of the fair value of our long-term debt are based upon a discounted present value analysis of future cash flows. Due to the existing uncertainty in the capital and credit markets the actual rates that would be obtained to borrow under similar conditions could materially differ from the estimates we have used.

The fair value hierarchy is based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value. The three levels of inputs are as follows:

Level 1 Quoted prices in active markets for identical assets and liabilities.

Level 2 Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities.

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For our other financial instruments, including our cash and cash equivalents, patient accounts receivable, accounts payable and accrued expenses we estimate the carrying amounts approximate fair value due to their short term maturity. Our deferred compensation plan assets are recorded at fair value.

Weighted-Average Shares Outstanding

Net income per share attributable to Amedisys, Inc. common stockholders, calculated on the treasury stock method, is based on the weighted average number of shares outstanding during the period. The following table sets forth, for the periods indicated, shares used in our computation of the weighted-average shares outstanding, which are used to calculate our basic and diluted net income attributable to Amedisys, Inc. common stockholders (amounts in thousands):

	For the Three-Month Periods Ended March 31,	
	2012	**2011**
Weighted average number of shares outstanding - basic	29,389	28,366
Effect of dilutive securities:		
Stock options	16	91
Non-vested stock and stock units	375	410
Weighted average number of shares outstanding - diluted	29,780	28,867
Anti-dilutive securities	340	

3. DISCONTINUED OPERATIONS

As part of our ongoing management of our portfolio of care centers, we conducted a review of our operating performance during the first quarter of 2012. Our review considered our current financial performance, market penetration, forecasted market growth and the impact of the proposed 2012 CMS payment revision. As a result of our review, we committed to a plan to exit three home health care centers during the first quarter of 2012.

During 2011, we consolidated 27 home health care centers and five hospice care centers with care centers servicing the same markets, closed 27 home health care centers and two hospice care centers and discontinued the start-up process associated with two prospective unopened home health care centers.

In accordance with applicable accounting guidance, the care centers which were closed in 2012 (three home health care centers) and closed in 2011 (27 home health care centers and two hospice care centers) are presented as discontinued operations in our condensed consolidated financial statements.

Net revenues and operating results for the periods presented for the care centers closed is as follows (dollars in millions):

	For the Three-Month Periods Ended March 31,

	2012	2011
Net revenues	$ 0.2	$ 5.0
(Loss) before income taxes	(1.8)	(2.7)
Income tax benefit	0.8	1.1
Discontinued operations, net of tax	$ (1.0)	$ (1.6)

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4. LONG-TERM OBLIGATIONS

Long-term debt consisted of the following for the periods indicated (amounts in millions):

	March 31, 2012	December 31, 2011
Senior Notes:		
$35.0 million Series A Notes: semi-annual interest only payments; interest rate at 6.07% per annum; due March 25, 2013	$ 35.0	$ 35.0
$30.0 million Series B Notes: semi-annual interest only payments; interest rate at 6.28% per annum; due March 25, 2014	30.0	30.0
$35.0 million Series C Notes: semi-annual interest only payments; interest rate at 6.49% per annum; due March 25, 2015	35.0	35.0
$150.0 million Term Loan; $7.5 million principal payments plus accrued interest payable quarterly; interest rate at ABR Rate plus applicable percentage or Eurodollar Rate plus the applicable percentage (1.25% at March 31, 2012); due March 26, 2013	30.0	37.5
Promissory notes	6.9	7.9
	136.9	145.4
Current portion of long-term obligations	(68.5)	(33.9)
Total	$ 68.4	$ 111.5

Our weighted average interest rate for our five year Term Loan was 1.1% and 1.0% for the three months ended March 31, 2012 and 2011, respectively.

As of March 31, 2012, our total leverage ratio (used to compute the margin and commitment fees, described above) was 1.1 and our fixed charge coverage ratio was 1.6.

As of March 31, 2012, our availability under our $250.0 Revolving Credit Facility was $229.5 million as we had $20.5 million outstanding in letters of credit.

5. COMMITMENTS AND CONTINGENCIES

Legal Proceedings

We are involved in the following legal actions:

United States Senate Committee on Finance Inquiry

On May 12, 2010, we received a letter of inquiry from the United States Senate Committee on Finance (the Committee) requesting documents and information relating to our policies and practices regarding home therapy visits and therapy utilization trends. A similar letter was sent to the other major publicly traded home health care companies. We cooperated with the Committee with respect to this inquiry.

On October 3, 2011, the Committee publicly issued a report titled Staff Report on Home Health and the Medicare Therapy Threshold. The Committee recommended that the CMS must move toward taking therapy out of the payment model. We believe that the issuance of the report concludes the Committee s inquiry, but are not in a position to speculate on the potential for future legislative or oversight action by the Committee.

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Securities Class Action Lawsuits

On June 7, 2010, a putative securities class action complaint was filed in the United States District Court for the Middle District of Louisiana against the Company and certain of our current and former senior executives. Additional putative securities class actions were filed in the United States District Court for the Middle District of Louisiana on July 14, July 16, and July 28, 2010.

On October 22, 2010, the Court issued an order consolidating the putative securities class action lawsuits and the Federal Derivative Actions (described immediately below) for pre-trial purposes. In the same order, the Court appointed the Public Employees Retirement System of Mississippi and the Puerto Rico Teachers Retirement System as co-lead plaintiffs (together, the Co-Lead Plaintiffs) for the putative class. On December 10, 2010, the Court also consolidated the ERISA class action lawsuit (described below) with the putative securities class actions and Federal Derivative Actions for pre-trial purposes.

On January 18, 2011, the Co-Lead Plaintiffs filed an amended, consolidated class action complaint (the Securities Complaint) which supersedes the earlier-filed securities class action complaints. The Securities Complaint alleges that the defendants made false and/or misleading statements and failed to disclose material facts about our business, financial condition, operations and prospects, particularly relating to our policies and practices regarding home therapy visits under the Medicare home health prospective payment system and the related alleged impact on our business, financial condition, operations and prospects. The Securities Complaint seeks a determination that the action may be maintained as a class action on behalf of all persons who purchased the Company s securities between August 2, 2005 and September 28, 2010 and an unspecified amount of damages. All defendants have moved to dismiss the Securities Complaint. That motion is fully briefed and remains pending before the court.

Derivative Actions

On July 2, 2010, an alleged shareholder of the Company filed a derivative lawsuit in the United States District Court for the Middle District of Louisiana, purporting to assert claims on behalf of the Company against certain of our current and former officers and directors. Three similar derivative suits were filed in the United States District Court for the Middle District of Louisiana on July 15, July 21, and August 2, 2010 (together, the Federal Derivative Actions). We are named as a nominal defendant in all of those actions. As noted above, on October 22, 2010, the United States District Court for the Middle District of Louisiana issued an order consolidating the Federal Derivative Actions with the putative securities class action lawsuits and for pre-trial purposes.

On January 18, 2011, the plaintiffs in the Federal Derivative Actions filed a consolidated, amended complaint (the Derivative Complaint) which supersedes the earlier-filed derivative complaints. The Derivative Complaint alleges that certain of our current and former officers and directors breached their fiduciary duties to the Company by making allegedly false statements, by allegedly failing to establish sufficient internal controls over certain of our home health and Medicare billing practices, by engaging in alleged insider trading, and by committing unspecified acts of waste of corporate assets and unjust enrichment. All defendants in the Federal Derivative Actions, including the Company as a nominal defendant, have moved to dismiss the Derivative Complaint. That motion is fully briefed and remains pending before the court.

On July 23, 2010, a derivative suit was filed in the Nineteenth Judicial District Court, Parish of East Baton Rouge, State of Louisiana. That action also purports to assert claims on behalf of the Company against certain of our current and former officers and directors. On December 8, 2010, the Court entered an order staying the action in deference to the earlier-filed derivative actions pending in federal court.

ERISA Class Action Lawsuit

On September 27, 2010 and October 22, 2010, separate putative class action complaints were filed in the United States District Court for the Middle District of Louisiana against the Company, certain of our current and former senior executives and members of our 401(k) Plan Administrative Committee. The suits allege violations of the Employee Retirement Income Security Act (ERISA) since January 1, 2006 and July 1, 2007, respectively. The plaintiffs brought the complaints on behalf of themselves and a class of similarly situated participants in our 401(k) plan. The plaintiffs assert that the defendants breached their fiduciary duties to the 401(k) Plan s participants by causing the 401(k) plan to

offer and hold Amedisys common stock during the respective class periods when it was an allegedly unduly risky and imprudent retirement investment because of our alleged improper business practices. The complaints seek a determination that the actions may be maintained as a class action, an award of unspecified monetary damages and other unspecified relief. As noted above, on December 10, 2010, the Court consolidated the putative ERISA class actions with the putative securities class actions and derivative actions for pre-trial purposes. In addition, on December 10, 2010, the Court appointed interim lead counsel and interim liaison counsel in the ERISA class action.

On March 10, 2011, Wanda Corbin, Pia Galimba and Linda Trammell (the Co-ERISA Plaintiffs), filed an amended, consolidated class action complaint (the ERISA Complaint), which supersedes the earlier-filed ERISA class action complaints. The ERISA Complaint seeks a determination that the action may be maintained as a class action on behalf of themselves and a class of similarly situated participants in our 401(k) plan from January 1, 2008 through present. All of the defendants have moved to dismiss the ERISA Complaint. That motion is fully briefed and remains pending before the court.

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SEC Investigation

On June 30, 2010, we received notice of a formal investigation from the SEC and received 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 are cooperating with the SEC with respect to this investigation.

U.S. Department of Justice Civil Investigative Demand (CID)

On September 27, 2010, we received a CID issued by the U.S. Department of Justice pursuant to the federal False Claims Act. The CID requires the delivery of a wide range of documents and information to the United States Attorney s Office for the Northern District of Alabama, relating to the Company s clinical and business operations, including reimbursement and billing claims submitted to Medicare for home health services, and related compliance activities. The CID generally covers the period from January 1, 2003. On April 26, 2011, we received a second CID related to the CID issued in September 2010, which generally covers the same time period as the previous CID and requires the production of additional documents. Such CIDs are often associated with previously filed qui tam actions, or lawsuits filed under seal under the False Claims Act (FCA), 31 U.S.C. § 3729 et seq. Qui tam actions are brought by private plaintiffs suing on behalf of the federal government for alleged FCA violations. Subsequently, the Company and certain current and former employees have received CIDs for testimony. We are cooperating with the Department of Justice with respect to this investigation and the requests for testimony.

Stark Law

In May 2012, the Company made a disclosure to CMS under the agency s Stark Law Self-Referral Disclosure Protocol relating to certain services agreements between a subsidiary of the Company and a large physician group. During some period of time since December 2007, the arrangements appear not to have complied in certain respects with an applicable exemption to the Stark Law referral prohibition. The Company intends to cooperate with CMS in its review of this matter

We are unable to assess the probable outcome or reasonably estimate the potential liability, if any, arising from the SEC investigation, the U.S. Department of Justice CIDs, the matter we have disclosed to CMS and the securities, shareholder derivative and ERISA litigation described above given the preliminary stage of these matters. The Company intends to continue to vigorously defend itself in the securities, shareholder derivative and ERISA litigation matters. No assurances can be given as to the timing or outcome of the SEC investigation, the U.S. Department of Justice CIDs, the matter we have disclosed to CMS or the securities, shareholder derivative and ERISA litigation matters described above or the impact of any of the inquiry, investigation or litigation matters on the Company, its consolidated financial condition, results of operations or cash flows, which could be material, individually or in the aggregate.

We recognize that additional putative securities class action complaints and other litigation could be filed, and that other investigations and actions could be commenced, relating to matters involving our home therapy visits and therapy utilization trends or other matters.

In addition to the matters referenced in this note, we are involved in legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages. We do not believe that these normal course actions, when finally concluded and determined, will have a material impact on our consolidated financial condition, results of operations or cash flows.

Third Party Audits

From time to time, in the ordinary course of business, we are subject to audits under various governmental programs in which third party firms engaged by CMS conduct extensive review of claims data to identify potential improper payments under the Medicare program.

In January 2010, our subsidiary that provides home health services in Dayton, Ohio received from a Medicare Program Safeguard Contractor (PSC) a request for records regarding 137 claims submitted by the subsidiary paid from January 2, 2008 through November 10, 2009 (the Claim

Period) to determine whether the underlying services met pertinent Medicare payment requirements. Based on the PSC s findings for 114 of the claims, which were extrapolated to all claims for home health services provided by the Dayton subsidiary paid during the Claim Period, on March 9, 2011, the Medicare Administrative Contractor (MAC) for the subsidiary issued a notice of overpayment seeking recovery from our subsidiary of an alleged overpayment of approximately $5.6 million. Our Dayton subsidiary made requests for redetermination to the MAC, which subsequently issued a series of redetermination decisions (Redetermination Decisions), 110 of which were unfavorable. Our subsidiary appealed 85 of the unfavorable Redetermination Decisions to MAXIMUS Federal Services, the qualified independent contractor (QIC) designated to process appeals from the MAC s decisions. In November 2011, the QIC affirmed those Redetermination Decisions. We dispute the QIC s findings and have requested appeal hearings before an administrative law judge (ALJ) in which we will seek to have those findings overturned. The ALJ hearings have not been scheduled, and no assurances can be given as to the timing or outcome of the ALJ appeal. As of March 31, 2012, we have recorded no liability with respect to the pending appeals.

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In July 2010, our subsidiary that provides hospice services in Florence, South Carolina received from a Zone Program Integrity Contractor (ZPIC) a request for records regarding a sample of 30 beneficiaries who received services from the subsidiary during the period of January 1, 2008 through March 31, 2010 (the Review Period) to determine whether the underlying services met pertinent Medicare payment requirements. We acquired the hospice operations subject to this review on August 1, 2009; the Review Period covers time periods both before and after our ownership of these hospice operations. Based on the ZPIC s findings for 16 beneficiaries, which were extrapolated to all claims for hospice services provided by the Florence subsidiary billed during the Review Period, on June 6, 2011, the MAC for the subsidiary issued a notice of overpayment seeking recovery from our subsidiary of an alleged overpayment of approximately $5.5 million. Our Florence subsidiary made requests for redetermination to the MAC, which subsequently issued a series of redetermination decisions (Florence Redetermination Decisions), which were favorable for 4 beneficiaries and unfavorable for 12 beneficiaries. The MAC communicated these decisions to the ZPIC, which re-extrapolated the findings and established a new alleged extrapolated overpayment of $6.3 million. Our subsidiary appealed all of the unfavorable Florence Redetermination Decisions to MAXIMUS Federal Services, the QIC designated to process appeals from the MAC s decisions. On March 13, 2012, the QIC issued a favorable decision for one beneficiary and unfavorable decisions for 11 beneficiaries. We dispute these findings and intend to vigorously seek to have these findings overturned, but no assurances can be given as to the timing or outcome of any appeal. In the event we pay any amount of this alleged overpayment, we are indemnified by the prior owners of the hospice operations for amounts relating to the period prior to August 1, 2009. As of March 31, 2012, we have recorded no liability for this claim.

In July 2009, Beacon Hospice, Inc., a subsidiary we acquired on June 7, 2011 (Beacon), received from Massachusetts Peer Review Organization, Inc. (MassPro), an entity contracted with the Massachusetts Office of Medicaid, a request for records regarding 25 beneficiaries in Boston, Framingham and Plymouth, Massachusetts, who received hospice services from Beacon during the period of August 1, 2007 through July 31, 2008 (the Review Period) to determine whether the underlying services met pertinent MassHealth Program regulations. Based on Masspro s findings for 89 of the 112 claims submitted in connection with these beneficiaries, which were extrapolated to all MassHealth claims for hospice services provided by Beacon billed during the Review Period, on February 15, 2012, MassPro issued a notice of overpayment seeking recovery from Beacon of an alleged overpayment of approximately $6.6 million. The Review Period covers a time before our ownership of Beacon, and in the event we pay any amount of this alleged overpayment, we are indemnified by the prior owners of Beacon for such amounts. We dispute these findings and intend to vigorously seek to have these findings overturned, but no assurances can be given as to the timing or outcome of any appeal. As of March 31, 2012, we have recorded no liability for this claim.

Insurance

We are obligated for certain costs associated with our insurance programs, including employee health, workers compensation and professional liability. While we maintain various insurance programs to cover these risks, we are self-insured for a substantial portion of our potential claims. We recognize our obligations associated with these costs in the period in which a claim is incurred, including with respect to both reported claims and claims incurred but not reported, up to specified deductible limits. These costs have generally been estimated based on historical data of our claims experience. Such estimates, and the resulting reserves, are reviewed and updated by us on a quarterly basis.

Our health insurance has a retention limit of $0.8 million, our workers compensation insurance has a retention limit of $0.4 million and our professional liability insurance has a retention limit of $0.3 million.

6. SEGMENT 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 surgery, have a chronic disability or terminal illness or need assistance with the essential activities of daily living. Our hospice segment provides palliative care and comfort to terminally ill patients and their families. The other column in the following tables consists of costs relating to corporate support functions that are not directly attributable to a specific segment.

During the three-month period ended March 31, 2012 and during 2011, we closed three and 29 care centers, respectively, which are reflected as discontinued operations in accordance with applicable accounting guidance. See Note 3 for additional information. Prior periods have been

reclassified to conform to the current presentation.

Management evaluates performance and allocates resources based on the operating income of the reportable segments, which excludes corporate expenses, but includes revenues and all other costs directly attributable to the specific segment. Segment assets are not reviewed by the company s chief operating decision maker and therefore are not disclosed below (amounts in millions).

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	For the Three-Month Periods Ended March 31,2012			
	Home Health	Hospice	Other	Total
Net service revenue	$ 301.4	$ 69.4	$	$ 370.8
Cost of service, excluding depreciation and amortization	172.0	36.5		208.5
General and administrative expenses	70.4	12.7	50.8	133.9
Provision for doubtful accounts	5.1	0.8		5.9
Depreciation and amortization	3.2	0.3	6.5	10.0
Operating expenses	250.7	50.3	57.3	358.3
Operating (loss) income	$ 50.7	$ 19.1	$ (57.3)	$ 12.5

	For the Three-Month Periods Ended March 31,2011			
	Home Health	Hospice	Other	Total
Net service revenue	$ 320.8	$ 38.5	$	$ 359.3
Cost of service, excluding depreciation and amortization	167.1	20.2		187.3
General and administrative expenses	73.5	7.9	48.2	129.6
Provision for doubtful accounts	3.1			3.1
Depreciation and amortization	3.0	0.1	6.1	9.2
Operating expenses	246.7	28.2	54.3	329.2
Operating (loss) income	$ 74.1	$ 10.3	$ (54.3)	$ 30.1

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ITEM 2. 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 the three month period ended March 31, 2012. This discussion should be read in conjunction with the condensed consolidated financial statements and notes thereto included herein, and the consolidated financial statements and notes and the related Management s Discussion and Analysis of Financial Condition and Results of Operations in our Annual Report on Form 10-K for the year ended December 31, 2011 filed with the Securities and Exchange Commission (SEC) on February 28, 2012 (the Form 10-K), which are incorporated herein by this reference.

Unless otherwise provided, Amedisys, we, our, and the Company refer to Amedisys, Inc. and our consolidated subsidiaries.

Overview

We are a leading provider of high-quality, low-cost home health services to the chronic, co-morbid, aging American population with approximately 83% and 85% of our revenue derived from Medicare for the three-month periods ended March 31, 2012 and 2011, respectively. During the three-month period ended March 31, 2012, we had $370.8 million in net service revenue, earnings per diluted share of $0.18 and cash flow from operations of $11.9 million.

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 March 31, 2012, we owned and operated 437 Medicare-certified home health care centers, 88 Medicare-certified hospice care centers and two hospice inpatient units in 38 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, 2011	439	87
Start-ups	1	1
Closed/Consolidated	(3)	
At March 31, 2012	437	88

In accordance with applicable accounting guidance, the care centers which were closed in 2012 (three home health care centers) and closed in 2011 (27 home health care centers and two hospice care centers) are presented as discontinued operations in our condensed 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.

Recent Developments

Governmental Inquiries and Investigations and Stockholder Litigation

See Note 5 to our condensed 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.

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.

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Results of Operations

Consolidated

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

	For the Three-Month Periods Ended March 31,	
	2012	**2011**
Net service revenue	$ 370.8	$ 359.3
Gross margin	162.3	172.0
% of revenue	*43.8%*	*47.9%*
Other operating expenses	149.8	141.9
% of revenue	*40.4%*	*39.5%*
Operating income	12.5	30.1
Income tax expense	(4.6)	(11.1)
Effective income tax rate	*41.5%*	*39.5%*
Income from continuing operations	6.5	17.0
Net loss from discontinued operations	(1.0)	(1.6)
Net income attributable to Amedisys, Inc.	$ 5.4	$ 15.3

Our operating income from continuing operations, declined $17.6 million from 2011. Approximately $11 million of the decrease resulted from the 2012 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 $9 million increase in operating income from our hospice division. Our hospice division benefitted from the acquisition of Beacon Hospice, Inc. (Beacon) which added approximately $22 million in revenue. Additionally, we had an increase of $3 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.

Discontinued operations include the three and 29 care centers we closed during the three-month period ended March 31, 2012 and during 2011, respectively. Their results are detailed below (dollars in millions):

	For the Three-Month Periods Ended March 31,	
	2012	**2011**
Net revenues	$ 0.2	$ 5.0
(Loss) before income taxes	(1.8)	(2.7)
Income tax benefit	0.8	1.1
Discontinued operations, net of tax	$ (1.0)	$ (1.6)

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Home Health Division

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

	For the Three-Month Periods Ended March 31,					
	2012			2011		
	Same Store	Start-ups/ Acquisitions	Total	Same Store	Other (1)	Total
Financial Information (in millions):						
Episodic-based revenue	$ 275.9	$ 1.5	**$ 277.4**	$ 295.7	$ 7.0	**$ 302.7**
Non-episodic revenue	23.8	0.2	**24.0**	18.0	0.1	**18.1**
Net service revenue	299.7	1.7	**301.4**	313.7	7.1	**320.8**
Episodic-based revenue growth (2)	**(7%)**		**(8%)**			
Cost of service	170.9	1.1	**172.0**	163.0	4.1	**167.1**
Gross margin	128.8	0.6	**129.4**	150.7	3.0	**153.7**
Other operating expenses	77.8	0.9	**78.7**	74.9	4.7	**79.6**
Operating income	$ 51.0	$ (0.3)	**$ 50.7**	$ 75.8	$ (1.7)	**$ 74.1**
Key Statistical Data:						
Admissions:						
Episodic-based	59,458	416	**59,874**	59,796	1,611	**61,407**
Non-episodic	14,368	103	**14,471**	10,405	141	**10,546**
Total admissions	73,826	519	**74,345**	70,201	1,752	**71,953**
Episodic-based admission growth (2)	**(1%)**		**(2%)**			
Recertifications:						
Episodic-based	40,648	151	**40,799**	42,535	726	**43,261**
Non-episodic	4,707	19	**4,726**	4,204	37	**4,241**
Total recertifications	45,355	170	**45,525**	46,739	763	**47,502**
Episodic-based recertification growth (2)	**(4%)**		**(6%)**			
Completed Episodes:						
Episodic-based	94,297	426	**94,723**	95,768	2,248	**98,016**
Visits:						
Episodic-based	1,870,919	9,233	**1,880,152**	1,865,242	43,553	**1,908,795**
Non-episodic	248,046	1,673	**249,719**	195,981	1,827	**197,808**
Total visits	2,118,965	10,906	**2,129,871**	2,061,223	45,380	**2,106,603**
Cost per Visit	$ 80.65	$ 101.94	**$ 80.76**	$ 79.05	$ 91.25	**$ 79.31**
Average episodic-based revenue per completed episode (3)	$ 2,853	$ 3,061	**$ 2,854**	$ 3,025	$ 3,178	**$ 3,028**

Episodic-based visits per completed episode (4)	18.7	17.9	**18.7**	18.5	19.4	**18.5**

(1) Care centers for the prior period which are not considered same store care centers (i.e., care centers consolidated in prior period or unopened startups).
(2) Episodic-based revenue, admissions or recertifications growth is the percent increase in our episodic-based revenue, admissions or recertifications for the period as a percent of the 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.

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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 the three month period ended March 31, 2012, we experienced declines in all of these revenue metrics which contributed to a $19 million decline in our home health net service revenue. Approximately $14 million of the decline in revenue is due to the 2012 CMS rate cut and the impact of the CMS face-to-face requirements and therapy assessment regulations.

We experienced a decline in episodic-based admissions and recertifications, which accounted for approximately $11 million of the decline in total episodic-based revenue. We believe our admission volumes have been negatively impacted by the CMS face-to-face requirements which were effective April 1, 2011. While our episodic recertifications as a percentage of completed episodes decreased approximately 1%, we experienced a 4% 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 during 2011.

Our revenue per episode decline of 6% has resulted in approximately a $14 million decrease in revenue with approximately $11 million as a result of the CMS rate cut for 2012 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 experienced continued improvement in our management of this regu