

Kevin: Good morning. My name is Kevin LeBlanc and I'm the Director of Investor Relations at Amedisys. I would like to thank everyone for joining us today for our first investor analyst day. We hope that after our presentation that you will be able to takeaway some useful information and a better understanding of Amedisys.

Presenting today will be Bill Borne, who is our founder, Chairman, and Chief Executive Officer and who started the company in 1982. Next up on the list will be Larry Graham, who is our President and Chief Operating Officer who started with the company in 1996. Alice Ann Schwartz is also going to be presenting today and she is our Chief Information Officer and she started with the company in 1997. Jeffrey Jeter started with the company in 2001 and is our Chief Compliance Officer. And the last person who will be presenting today will be Dale Redman, who is our Chief Financial Officer who started with the company in February of 2007.

We have a break scheduled on our agenda today and we will observe the timeframes as noted on our agendas to make sure we have ample time for the question and answer session at the end of the presentations. Beverage services will be in the room next door where you had breakfast, which is to my right. And the restrooms are located right outside the \_\_\_\_\_ room in the lobby area.

Before we get started, I would like to remind everyone that any statements made today, which express a belief, expectation, or intent, as well as those that are not historical facts are considered forward-looking statements and are protected under the Safe Harbor of the Private Securities Litigation Reform Act. These forward-looking statements are based on information available to Amedisys today and the company assumes no obligations to update these statements as circumstances change. These forward-looking statements may involve a number of risks and uncertainties, which may cause the company's result to differ materially from such statements. These risks and uncertainties include factors detailed in our SEC filings including our Forms 10-K and 10-Q. Also, the company urges caution in considering any current trends or guidance that may be discussed in these presentations. The home health and hospice industry is highly competitive and trends and guidance are subject to numerous factors, risks, and influences, which are described in the company's reports and registration statements filed with the SEC. The company disclaims any obligations to update information on trends or targets other than in its periodic filings with the SEC.

Our company website address is [www.amedisys.com](http://www.amedisys.com). We use our website as a channel of distribution for important company information including press releases, analyst presentations, and financial information regarding the company. This information is routinely posted on the Investor Relations subpage of our website, which is accessible by clicking the tab labeled Investors. We also use our

website to expedite public access to time-critical information regarding the company in advance of or in lieu of distributing a press release or a filing with the SEC, which is 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, as required by SEC Regulation G, a reconciliation of any non-GAAP measures mentioned during our presentation today to the most comparable GAAP measures will be available on our website.

Thank you and now we'll start our presentations with Bill Borne. Please go ahead Bill.

Bill: Thank you. Well, thank you, Kevin, and good morning. We appreciate everybody coming this morning to listen to our story. I have the distinct privilege of leading our session this morning and everybody knows who I am. I'm Bill Borne. I'm the founder. I'm a nurse. I've been here from the beginning and when we talk about home healthcare and we look at the focus of the company and where we've been, where we're at, and where we're going, I can get really excited. Today, I'm going to spend a few minutes talking about the future of home healthcare and how it will evolve into what we feel will be one of the most significant providers in the nation in reference to healthcare delivery for the chronic population.

Before I go into that, I wanted to take just a snapshot of the quick past. If you at the last five years of Amedisys' growth, both in top line and bottom line, we've experienced right over 700 percent growth in revenue over the last five years, from basically 150 million to 1.2 billion. And I want to remind you that that's in the face of all the regulatory reimbursement changes, case mix changes, everything that's occurred over the last five years, we've still been able to etch out a little over 700 percent top line growth. If you take a look at the bottom line or the net income, we've been able to etch out between 900 and 1000 percent growth and that really shows leverage, in my opinion. So, we were able to take an industry, which is basically a commodity, and consolidate it and to show pretty extraordinary growth.

Now, growth is a result of many things. One is new program, design and development, and you see that with our rehab programs. You see startups as we continue to do startups in markets, multiple startups as compared to anybody else in our space. You see it through consolidation. And one of the things about consolidation and the roll up is (1) is can you acquire it, (2) is can you acquire it at a good price, (3) is can you integrate it and can you be effective. If you take a look at TLC, which is the largest integration or acquisition that we made to date,

about 102 agencies, we made that acquisition early last year around March. In six months we integrated that organization. We brought in 103 offices approximately to the 350 that existed and integration went quite well. So, we have the capabilities, we have the discipline, we have the skill set, we have the infrastructure, we have the management capabilities to continue to grow through all the vehicles that I've just mentioned.

If you take a look at what's really growing or driving our industry, and not Amedisys specifically, one is the overall patient preference. The AARP came out with a study not long ago that said more than 90 percent of the population where applicable would prefer to be treated in their home versus a facility-based setting. Makes a whole lot of sense.

Over the last few years the government has enacted several changes in reimbursement on not only for the hospitals in reference to their DRGs, but for the subacute and skilled facilities. In many instances they eliminated certain diagnoses from being able to be cared in rehab facilities and in many instances they reduced the length of stay for both rehab and hospitals. As a natural fallout that population is going to go to the community and home health agencies will pick that up. And if you take an Amedisys, who is really targeting the more acute complex population, it's natural to assume that our case mix or our acuity level would go up simply as a result of this population leaving the facilities quicker and sicker with a higher acuity. Couple that with our focus of us looking at, through our special disease management programs, the more complex population, it's a natural curve to see the acuity mix of our patients going up.

Technology helps us do that, as well. Being a nurse and working in a hospital ICU for many years, we're caring for patients and using certain technology that in some instances we use in the home now. We have the ability to monitor patients through telehealth or telemonitoring from afar and really follow many of the metrics on patients that are significant to managing them and keeping them stable. It allows us to focus in on when we should do a visit versus just putting visits in a CAD(?) algorithm and visiting patients according to the algorithm.

Demographics are undeniable. 2011, for the next 20 years we're going to add 58 million Americans to the Medicare rolls. Now, our sweet spot is the 75 to 90-year-old population, but this bolus of population that's going to move into the Medicare arena over the next few years will create some huge opportunities for Amedisys, not only in near term, but in the long-term.

I think the most fundamental issue that we're dealing with and the challenges that we have as a nation from the perspective of healthcare and Medicare is the growing chronicity of the population, the comorbidity. Our population is very

sick, very chronic, very comorbid, using a lot of medications, and consuming a lot of healthcare dollars. It would make sense for a company such as Amedisys to leverage its core competencies to really position itself to evolve into that chronic care manager of the future and to be best positioned to care for this population in the comfort of their own home eliminating the risk of facility-based care and getting better outcomes. And would you believe it, for less cost. That's the opportunity that we have with Amedisys and that's what makes me so excited to get up here and talk about the future of healthcare.

We have to start with the Medicare benefit. You're looking at inpatient hospitalizations are right at 30 percent and outpatients at six percent. Hospitals drive most of the attention in the communities. I want you to pay attention to the physician benefit at 13 percent of all Medicare funding, and more specifically look at the drug benefit as a result of the MMA that President Bush passed. The pharmacological benefit is equal to what all the physicians receive to care for all the Medicare populations in the nation and that just evolved over the last two to three years with the new legislation. If you look at the home health at three percent and the hospice benefit at two percent, it's cumulative five. So, to give you a snapshot and perspective of how we spend our healthcare dollars as it relates to Medicare, this is kind of a global perspective. You just read in the paper about President Obama's new legislation and changes in that they're going to make a reduction in some of the reimbursements for some of the providers. Well, not some of them, all of them. And we're going to be affected just like them, but in our opinion, something that's very manageable and they're going to take that money and redeploy it in healthcare.

But Medicare has got a problem; it's got a major problem. And just to highlight how bad of a problem that is, is anybody out here 58 years of age? Raise your hand if you're 58. There we go. Dale, are you 58? We actually had some other people raise their hand. That's good. Well, let me ask you all. Who else raised their hand? Do you want to live to be 80 or 90? 90. 58-90. All right. So, if you're 58 years of age, in 2016 you'll be 65 and at 65 years of age, if you live to be 90, you're going to need in your savings \$409,000 just to pay for the supplemental insurance for Medicare. This is not your Medicare cost. This is just to pay for your supplemental, Medicare supplemental insurance. You're going to need \$409,000 if you live to the age of 90. It doesn't count your cost of living, all the other expenses you will incur, your lifestyle. Think about it. Think about how dysfunctional our Medicare system has become and how costly it's become and what a burden it's placed on our society, on our children.

Let's take a real look at what we're looking at. Twenty-five percent of the Medicare beneficiaries consume 85 percent of the costs. Stated another way, 12 percent of the Medicare beneficiaries consume 69 percent of the costs. Stated

another way, five percent of the Medicare beneficiaries consume 43 percent of the costs. Stated another way, each beneficiary, the chronically ill, see 14 physicians over a year, fill an average of 50 prescriptions, which account for 76 percent of all hospital admissions, 88 percent of all prescriptions filled, and 72 percent of physicians visits. And you know that high, high Medicare drug benefit cost? Well, this is the way it's being spent right here. Remember the hospital costs? This is where it's being spent. Four percent of the Medicare healthy population or 50 percent of the Medicare healthy population only consume four percent of the spending. So, if I was focusing on the company and looking into the future and trying to position the company to have a great opportunity and involved for the next generation of healthcare providers and chronic care management, I would certainly look to Medicare. I would certainly look to Medicare and I would look to this population that's consuming all the resources and I would come up with a clinical system using technology and a new delivery model to be able to focus on caring for this population across the nation. To standardize the way we assess this population, to standardize the care algorithms that we care for this population, to standardize the outcomes, and to drive the cost down in a more friendly environment. That's what I would do if I was planning on positioning a company for the future.

If you take a look at the influences of the changes that has to happen in order for us to move into that direction because the question is oh yeah well thank you. Now we know what you want to do, how are you going to do it and how are you going to get paid for it? Well, as I mentioned, the public has a deep-rooted desire to be cared for at home and it's safer. No \_\_\_\_\_ issues, no cognitive issues, cheaper cost of care. If you would look the referral sources prefer Amedisys, Larry will show you that we get more of our patients directly from physicians than discharged from facilities. And we do that because we market a very sophisticated high tech approach using disease management programs to be able to show physicians the type of care that we're capable of in the communities for the patients that we serve.

Fiscal intermediaries are always over and reviewing what we do and when they see something it's the first sign of a problem that they see usual trends they like to come right in. And we have very little fiscal intermediary interface with our organization. Alice Ann will talk about that.

And then we get to talk about the administrative burdens. We get to talk about CMS, MedPAC, and we get to talk about the GAO. Well, I'm going to tell you there's a lot of initiatives going on with MedPAC right now, but I truly believe the way they're looking at things, they're not including all the costs, what we call the Medicare profits. It's not a total profit to the organization. You would think that CMS is not friendly to the industry from the things that you've seen, case mix

adjustments, the creep that you're talking about. What I'm telling you, CMS is very friendly to our industry and through the alliance that I'll talk about near term, we've created a lot of initiatives that has made us friendly to CMS and we're working with them in many initiatives that are very sensitive to them and for their overall success. GAO report \_\_\_\_\_ and everybody's heard about the impending GAO report that's out there. And these are all issues or factors and influences that we have to deal with and that we have to manage. I will tell you that CMS, MedPAC, and the GAO have always been around since the Balanced Budget Act of '97 that Clinton put forward and we've decided to be the first home nursing public pure play company. They were always there. And through the last five years they've been there and through the last five years MedPAC has reported market basket holds or reduction in reimbursement and CMS has changed reimbursement and GAO has mentioned margins and activities with the home care industry. I mean we reported the home care industry down in Miami Dade for years and years and years and finally the GA took a good look at it and found that ten percent of the Medicare benefit was being spent in those two counties alone. Well, yeah there are some problems in the industry, but we're not the problem. We're part of the solution of not only the industry and reform for the industry, but also the healthcare industry in reference to chronic care. And then you have the policy makers and everything we're doing is slated to influence policy and policy makers.

If you take a look at what our real mission is, is to really convert Amedisys from the commodity, which is a consolidating company to a value added company. And the way we have been able to succeed and be so successful in the past with growth of both top line and bottom line is our size, use of technology, our performance metrics, and our financial strength. And it's undeniable the leverage that we have been able to create and how effective we've been in consolidating startups and growing new programs. We feel that that's for today. For tomorrow we would like to leverage these core competencies, the technologies, the ability to outreach to the patient during and after an episode of care and put a new design for a new medical model and it has reference to do with chronic care. And we feel that all the policy makers right now are talking about it. You see Bachus and his bill, President Obama; they're all talking about care coordination, they're talking about care management for the chronic population, for the costly population. Well, home health nurses and nursing has the infrastructure to be able to provide that services. Let me give you a few examples.

If you take a look at the home health value market drivers of the past and as we see it today, everything is driven by the payor and in this instance we're talking about Medicare so it's part of the federal part. It also works with the private insurances. Community by community healthcare is driven by hospitals. In many of the smaller communities the hospital is the dominant player. They're the

largest providers. They have the most employees in the whole community so they drive it. All the doctors are oriented around the hospitals. Doctors come next, then subacute, custodial care facilities, and at the very bottom of the healthcare continuum, the value pyramid, is community-based services. And because we provide services this way, the patients and a lot of times the employees are victims of the system. If you look at hospitals 20, 30, 40 years ago and 20 years ago when I was in the hospitals, it worked well. Hospitals take care of patients who have trauma, OB/GYN, first time diagnosis, surgeries. A lot of this population needs to be treated by hospitals, but 50 percent of your hospital population right now is this complex chronic comorbid population. We already know what's wrong with them. The mission is to stabilize them and to manage them and teach them how to manage themselves in the comfort of their own home.

So, a new continuum of healthcare as far as value and community-based care, we feel the payor is still at the top, but the physician needs to drive care. And you saw in the recent CCIP support where they failed that chronic care demonstration. The physicians were out of the loop. The physicians not only need to drive care, but they need to be responsible for the care. Imagine if we have a system where the physicians were responsible for the outcome of care, how things would change, how they would focus and redirect where care needs to be provided, and who gives the care. But medical physicians to provide that care such as in the medical home that you're hearing about, they need a care management infrastructure, the exact infrastructure that Amedisys has already put together and is using on thousands and hundreds of thousands of patients over the last few years. So, physicians come second, care management comes third. For the chronic and complex patients there should be community-based services first. A patient should only be admitted to a hospital when community-based care fails. In essence, we should be discharging to hospitals versus hospitals discharging to us in the community care arena. If that happens, then you're going to see that five percent that consumes 44 percent of the resources flip over immediately and would gain share in the proper distribution and outcome focus care. You would see a radical change overnight not only in the outcomes of care, but the independence and quality of life for the people we're caring for but also a dramatic decrease in the cost. That money can be redeployed into the benefit to cover other needs that the government has, uninsured and underinsured.

So, why do we need it? Obviously the cost I just went over in the slides earlier, all the dollars that we're spending, 85 percent of the Medicare resources and 25 percent of the population or 69 percent of the Medicare resources and 12 percent. That 12 percent is the population we care for every day. We bring them in. We do a comprehensive assessment and analysis. We do a care plan. We look at medication reconciliation. We look at environmental issues. We look at social

issues. We tie in the collaborative issues. And then again, we look at the caregiver, the patient, who is caring for them. We educate them. We help them migrate through the medical maze. We treat the patient holistically instead of as body parts. And after we reach outcome with this chronic patient who will cost our system a lot of money over the years to come, we discharge them and we forget about them. Wouldn't it make sense if the home care benefit could follow that patient for years and drive the cost down and get into a gain sharing opportunity?

The potential solution's VNA, VA has right now 130 facilities. It's called the home-based primary care and they've been doing this for many years and it's a model almost identical to the model we're providing our patients today except we don't provide the aftercare. And what is shown in the VA model that's in 48 states and in Puerto Rico that it's actually saved a lot of dollars; 62 percent in hospital days, 88 percent in Medicare nursing home days, and around I think it's 26 percent in total overall cost savings. So, the VA model, which is a care management chronic care model has been very successful and if you look at Amedisys' infrastructure, it's almost a mirror image of what's going on there. The home health infrastructure, as I stated earlier, is perfectly designed for leverage to be that complex care manager of the future. Amedisys' information and communication technology allows us to do that. It is the new model of care and we believe it is the future of healthcare for the chronic and complex population.

If you look at some of the initiatives we're doing to forge policy changes, very important, the large public privately held companies, as well as the two associations, the National Association of Home Care and Hospice, as well as the Visiting Nurses Association of America, have all come together accumulatively and collectively to look at the value proposition that home care provides for all of healthcare. And I can tell you it's the first time in the history of our industry that we have come together collectively for a common purpose and a common focus. And that's to share with the policy makers the value that home health can provide, not only in the benefit as it is today and the cost savings and the reduction of hospitalization, but in the benefit that we can evolve to tomorrow in that complex chronic care management.

If you look at some of the things that we're doing, we're finalizing our messaging. Right now there is not a clear understanding about the home care benefit. Many policy makers still today think it's a custodial benefit and it's not. Many think that it's a transitional benefit. That it's convalescent, from a patient being discharged from the hospital into the home sicker and quicker. But in actuality it's an alternative in many instances to avoid hospitalization. It's an alternative to some of the \_\_\_\_\_ units or subacute care, and it's a cheaper and more valuable and better and more humane alternative.

If you take a look at some of the other things we're doing, currently in legislation we're revitalizing the Home Health Working Group. We're getting members of Congress to represent us on the hill internally in reference to the value proposition that home care brings. We've just basically retained Avalere to look at a cost effective analysis in reference to home care and one of the main focus points is the reduction of rehospitalization. Even Obama's plan that he's talking about, he's focusing on patients that are rehospitalized. It's a major issue.

Right now we're working with the QIOs and they're represented by the AHQA in reference to care transitions. We have patients that literally presents in an emergency room outside of the direction of their primary care, get admitted to the hospital, get treated by hospitalists, get discharged back into the community, primary care still doesn't know they were in the hospital, goes back to the emergency room and gets readmitted without primary care knowing about it. Right now we're working in two demonstrations with QIOs and possibly three with three different states in reference to care transition talking about how when a patient gets discharged from the hospital they're better prepared to manage their illness so they don't have that rehospitalization.

We're also looking at many issues with CMS and working with them on a quality forum, The National Quality Forum, which helps to drive policy for Medicare reform. We're working very closely with that group. We've already made some recommendations that have been accepted. So, home care is sitting at the table on all the quality forums that exist. Postacute care demonstration on the care management \_\_\_\_\_ is a very vital transition application for our industry. We're working very closely. And I can tell you if you would talk to the quality managers of CMS and you ask them about the alliance and you ask them about an opinion if you thought that the alliance and the home health industry was friendly to their initiatives and their objectives, I can promise you they would say yes. We've been very cooperative. We've been working with them very effectively over the last six to eight months and we feel that these efforts will allow us to forge policy changes that will allow us to be effective in the future and create some legislation.

If you take a look at what that legislation might look like, one is taking the home care benefit and offering a couple different alternatives. One is an episode extension where we follow our patient through the episode. We discharge the patient, but then we follow the patient postdischarge of that episode for a certain period of time; for a year, two years, or even for the rest of their life. In that application we look for some gain sharing where the government would actually give us, once they took out their portion of the profit, a certain percentage of the profits for managing that patient.

There's legislation that was introduced last year and getting introduced again this year. It's called the Independence at Home. It's the house call physician from the Academy of Home Care Physicians. The legislation is well received. It takes that five percent of the population that consumes 44 percent of the healthcare Medicare dollars and it allows the physicians, in conjunction with other providers inclusive of home care, to manage this population more cost effectively. The first five percent of the savings would go back to Medicare and then it would be an 80/20 gains sharing split where the providers would get 80 percent of the savings to be distributed according to proportionate application in the system. We're excited about that because we think it gives us one of the greater opportunities to expand our benefit and participate in another realm, which is Medicare reimburse for the exact populations that we care for.

The Medical Home(?) is legislation that's already been passed. It's several years old. It's gone into a demonstration or pilot program this year. It's basically focused on office-based practices, but the intent is to focus on the sickest of the sick in the very expensive population. Home health has a wonderful opportunity in many instances to align with those physicians, target the populations that are sick and costing a lot of money, and being able to participate in gain share and opportunity with that, as well.

I can tell you I'm excited not only about what Amedisys has accomplished in its base services, but the opportunities we have to evolve in being the care management entity of the future focusing on the most complex patient that are costing our Medicare system a lot of money and the demographics are only going to drive that higher. So, we're excited about what we're doing. I appreciate the opportunity to be sharing the information today. I'm sure you have a lot of questions in reference to what I've said, but the format of this will allow the questions at the end.

I'm pleased and privileged to introduce Mr. Larry Graham to come up and give his portion of the presentation. Thank you all.

Larry: Thank you, Bill. Good morning, everybody. You know today Amedisys will do 20,000 home care visits. That means RNs, LPNs, physical therapists, physical therapists' assistants, occupational therapists and their assistants, speech therapists, social workers. Our home health aides will be driving in their car in 37 different states in 500 and some-odd locations and providing care. And we'll talk about our patient age is usually between 75 and 85, one in four live alone, one in four live with someone almost as sick as they are, many of them have sons and daughters or neighbors that come by and assist in their care, and when our nurse shows up on that first visit, we're going to sit at that patient's bedside or kitchen table along with those caregivers and we're going to talk about their illness. And

it's typically an illness that they've had for years or multiple illnesses in most cases. We will pull out every medication that they have, both over the counter and prescription. We will educate them on those medications and what they will do for that patient. If there's any conflicting information or diagnoses related to the prescriptions, we will call the physicians and go over that. It's one of the few times, and if you talk to your parents, it's one of the few times someone sits down and goes over all of the medication profiles at one time. It's one of the few times that you literally have up to two hours to talk to a clinician in your home about what's going on with your illness with the whole goal of stabilizing that geriatric patient so they do not show back up at the emergency room or at the hospital. We take care of patients that have hip and knee transplants. We take care of patients that are so bedridden they develop what's called pressure ulcers and we have heal wounds. We take care of patients that are so fragile that they're scared of falling in their home. And we have programs that are proven to work if you educate that patient and the caregivers on what they're supposed to know and what they're supposed to be able to do. And we will not discharge a patient until they can do two things; verbalize what's wrong with them and what they should be doing, and demonstrate that they can do it with the goal of they know that they're going to have to take care of themselves independently. It's an awesome service to say that you help people stay in their home longer.

Those of you that have listened to me present over the years, I like to keep things very basic and very simple. We have a three-pronged strategy and it's been consistent since I've been here. We're going to grow aggressively through acquisitions and through startups, we're going to figure out ways to do what we do more efficiently, and we're going to constantly strive to improve our outcome. We've done a very good job in all three of these areas and we will continue to do so no matter what happens with reimbursement. If we figure out how to do things more efficiently, grow aggressively, I think we can push through future reimbursement cuts and Bill articulated how we've lived in that environment for the last decade.

If you look at this graph, it just shows that we've grown the number of locations quarter-over-quarter for the last 12 quarters. We're up to 528 locations, 48 of which are hospice locations. If you look at the time period from 2005 to 2008, we've acquired about 303 home care locations and hospice locations. We've started 141 locations from scratch. So, we have a phenomenal track record of doing acquisitions and doing startups and we will continue to do so. To put that in perspective, a home care or hospice agency covers about a 50-mile radius. Obviously in urban areas you will need multiple agencies to cover that area. If you were to add up all the home care agencies in the United States, both provider number and a branch, it's going to come to around 20,000 locations. If you were to do the same for hospice, it's going to come to about 8,000 locations. We have

528. There are 3,141 counties in the United States. We have ample room over the next foreseeable future to continue to grow through startups and acquisitions. And it's interesting that when we do an acquisition, we're going to bring the efficiencies that we've already brought to our mature agencies to that acquisition. Stating another way, if I buy something that's not performing at the level that Amedisys agencies are performing and I bring those efficiencies over the first year or two years of an acquisition, that is a strategy to offset reimbursement cuts going forward to continue your earnings per share growth.

On the internal growth side, in 2008, we grew revenue 28 percent. Growth in revenue dollars is made up of growth in admissions, growth in recertifications, and growth in how much you're getting paid per patient or we call it revenue per episode. Those three components in 2008 totaled 28 percent. In April of this year, TLC, which Bill mentioned had 103 locations, does about 300 million in revenue, will become internal for us. We have told the market that we expect to grow at least 15 percent internally in terms of revenue dollars. It's more of a metric of size than anything else, but it's also if you were to take our guidance of about 1,475,000,000 on the high end, backout the annualized acquisition revenue in '08, you come to about 15 percent internal growth rate to hit those targets.

These lines, the top line or the red line, which ends last quarter at 30 percent, is our quarter-by-quarter internal revenue growth rate in terms of dollars. The green line and the blue line -- the green line being recertifications and the blue line being admissions -- are volume related. Now, these percentages are a little misleading because while the market may talk about some of these metrics as financial metrics, we look at a recertification rate as a clinical metric. Meaning when you get ready to discharge that patient at the end of an episode can they demonstrate what they're supposed to demonstrate, can they verbalize what's wrong with them, do we feel like they're going to be stable, do we feel like they're going to be able to take care of themselves, and if the answer is yes, we discharge them. Sixty-five percent of the time we discharge our patients with one episode. But we do have, keep in mind, 82-year-old patients, 13 medications, multiple things wrong with them, some of them are going to stay on service more than one episode and correctly be recertified.

If you look at the recertifications and admissions and how they track each other, these bottom two lines, with the blue line being just the raw number of admissions and the green line being the raw number of recertifications, you can see over the years they've gone together and tracked pretty closely. The top line is just on a quarterly basis the number of episodes that get completed on any given month. You can see the spike up in the second quarter of last year, which is when we did the TLC acquisition.

On the case mix or the revenue per episodes, those of you that have followed this industry are familiar that in 2008, CMS implemented a new reimbursement methodology. We went from 80 home health resource groups to 153 home health resource groups. We went from only mattering the primary diagnosis to determine what you get reimbursed to the primary and secondary diagnosis now matters. We went from it matters which episode of care you're in and all those factors work together to determine how much you're going to get reimbursed for an episode of care. If I break it down to its simplest level, the sicker the patient the higher you're going to get reimbursed, and it matters where the patient lives. If you live in New York or California, you're revenue per episode is going to be higher than if you live in Baton Rouge, Louisiana, just because of the wage index. As a note, TLC has locations in New York and California. Their revenue per episode was higher than Amedisys' historical revenue per episode, and their acuity level was slightly lower so it was due to their wage index.

This kind of maps out what I just said. You can see in the second quarter is when revenue per episode had a spike up. Two things happened. Number one, was the TLC acquisition. They had a higher revenue per episode. In the first quarter you were transitioning from the old reimbursement methodology to the new reimbursement methodology. During that transition your revenue per episode was slightly lower. And you can see that as we rolled out Balanced for Life -- which I'll go over in a minute, we did about 40 per quarter -- our revenue per episode climbed during the year and it ended the year at 2,981. While I do not forecast the components of the 15 percent internal growth rate, I will state that we will be rolling out Balanced for Life at the rate of about 40 per quarter through 2009. We will also roll that out to a lot of TLC agencies that are just now getting enough traction that we feel confident to roll that program out to them.

Bill mentioned that I would talk about the referral source and where our patients, the majority of our patients are coming from. Basically patients come from three areas. They either go to the emergency room, get admitted to the hospital, and then get discharged to home care. They show up at their doctor's office, the doctor admits them to home care, or they may be living in an assisted living facility, which is their home and they get home care services provided inside the assisted living facility. Not a nursing home, but an assisted living facility.

We have about 800 sales people that call mainly on hospital discharge planners and physicians. And what we're doing with the physicians is educating them on the type of illnesses that we care for and why home care is appropriate and the circumstances by which one of their patients may qualify for home care. We've done that since we got into home care years ago. And we try to take the most clinically challenging patient they have. So, we were going to a doctor's office and say doctor do you have a patient that is bedridden that has a wound that you

have not been able to get healed? And if they say yes, they say I know you use other home care providers, would you give Amedisys the opportunity to service that one patient. And we go in there with our advanced clinical protocols, our advanced wound dressings, and we educate that doctor on what we're doing differently. And we've been very successful at healing wounds.

Or we say doctor do you have patients that you're scared that might fall in their home and break a leg? And, of course, they all do. And then we educate them on our Balanced for Life program and we say not only are we going to provide therapists to strengthen the muscles in their legs, but we're going to do a series of tests to determine why they have a risk of falling. And it could be that they've lost feeling or sensory in their legs and in their feet, which has a lot to do with your balance. It could have to do with their vision. It could have to do with the way things are laid out in their home. It could have to do with three bones in the inner ear that can get stuck in certain locations inside the ear canals or get crystals that form around them and cause them to get dizzy and there's a set of exercises you can do to help break that up and make that person more balanced. I've just described falling is one of the major risks and reasons why patients end up in the hospital, geriatric patients. So, if you articulate that to a physician he's going to be very interested in providing that service to his 82-year-old patient population. So, a lot of our patients come directly from the physicians.

Years ago when someone would tell me that if a patient comes from the hospital into the home setting they're actually more stable and better off than if they come directly from the physician office. The reason being, and it makes sense, is you've stayed in the hospital three to five days. You've had round the clock care, you've had somebody monitoring your diet, and you are stabilized versus if you just show up in the physician's office and we come straight to your home. You haven't had that stabilization period. So, the acuity level for our patients is higher than a lot of our competitors because as you can see 41 percent of our patients comes from physicians versus the national norm, 27 percent.

This is a list of our care management programs. All of them are based on evidence-based care. Meaning if you're a diabetic patient there's lot of literature on how you should educate and treat that diabetic patient. There's lots of literature of how they monitor their blood sugar, what they should and shouldn't eat, what their exercise program should be. And we base the visits that we perform based on these evidence-base protocols and we have physicians that have reviewed our care protocols and said yes if you do those things for this type of patient you should get the outcome that you're desiring. And the utilization that we prescribe, 16 to 18 visits, has more to do with the illness and what we're doing on each visit than it does about an individual person making a decision on how many visits he or she is going to do on that patient.

This is the acquisition slide. I mentioned from 2005 to 2008, we have acquired 303 locations. We've actually done 33 transactions during that timeframe. And if you totaled up, it's about \$760 million we've spent on acquisitions during that timeframe. Now, there are two that make up a bulk of that. We did TLC, which is about 395 million last year, and in 2005, we did Housecall, which is about 100 million. So, in any given year we're going to do a number of transactions and that combination of the acquisitions and the startups is why quarter-over-quarter our locations have increased.

I wanted to talk about the acquisition process. You guys will be familiar that we will -- there are a lot of different avenues we hear about acquisitions. If it's something we're interested in at some point we're going to entertain a letter of interest. And then when we start getting close to we know we're going to do this deal, we sign an LOI, we're working on a purchase agreement. Most of our acquisitions allow us to talk to the leadership of the agencies prior to us owning them, usually the month before we own them. And we start educating those leaders on what they need to do to prepare for us coming in. And we all know we're going to give them all new computer equipment, that their clinicians are all going to get laptops, we're going to put Amedisys processes and protocols inside their agency, and they need to get all of their backlog, all their visits, everything up to date in their system so at least they're starting from a clean point. What you may not know is the first 30 days of an acquisition we audit every patient that is on service when we buy that agency. So, if they've got a patient census of 200 people or patients, we audit 200 charts, which is one reason you will see a delay in our billing when we do an acquisition, not to mention the change of ownership and the regulatory stuff we talk about, but the processes that we put in place. And during that audit we learn very specifically what they're doing, whether they're up to speed, whether their documentation is appropriate, and we use those results to educate those clinicians on the Amedisys processes and protocols. Stating another way, it is not unusual, and it will happen, that our DSO will increase when we do an acquisition. It's built into our process and then it will come down over time and Dale will articulate that very well in his presentation.

Once we get through getting new computers, getting laptops, auditing the charts, the next three to six months we are making sure that they are staffed appropriately. You can imagine if you go from a paper system to an automated system your job changes a little bit. Maybe you ordered supplies via paper in the agency and now you do it over the Internet. And we staff people appropriately. We usually staff more efficiently than they are currently staffed. We need less clerical people in the agency than they needed and we get that staffing model inline over the first six months.

There's a discussion on what's called a pay per visit model. It's very common in the home care industry. You pay a clinician a fixed dollar amount every time they do a home care visit. A majority of our clinicians are paid per visit. A majority of the industry is paid per visit. We have clinicians that are salaried. We have clinicians that are per visit. Keeping in mind that when they're paid per visit we expect the clinician to do five to six home care visits a day. So, if they do 25 to 30 home care visits a week they're going to make, on a per visit model, what they would make working full time in a hospital. Productive home care clinicians prefer to be paid per visit because if they end up doing 31, 32, 33, they end up making a little bit more. So, it's a very common pay methodology in our industry.

So, we do those things and then we start educating them and telling them that we can connect their referral sources through a Mercury Doc program, which just means that the doctor can review the plan of care, sign the plan of care over the Internet, automated. I'm going to give a stat that no one else in the industry can touch of size. Sixteen percent. Sixteen percent of our admissions are done over the Internet with physicians. A year ago that stat was one percent. Do you want to talk about customer loyalty or tying into a referral source, when they understand the ease of being able to transact home care and review those care plans and protocols and sign off on the plan of care via the Internet, so we use that with our referral sources as an education tool to better facilitate and time manage the physician's time in the practice because a typical physician may see 35 patients a day, they may refer eight to ten home care patients a month. They're very interested in making that process as smooth and as time convenient as possible and getting the information they need. Then on the back end, 6 to 12 to 18 months, we start educating them on our specific programs like Balanced for Life, and we start educating referral sources now that we've put the processes in place, which is one reason why we talk about growth of acquisitions happening in the second and third year because the first year is just radical change.

On the startup slide, if you were to add up the startups we've done from 2005 to 2008, it would come to 141 startups. And I've articulated over the years that it costs us somewhere in the neighborhood of \$250,000 to \$350,000 all in to do a startup. That's any salaries you're covering before you breakeven, any equipment you need, laptops, computers; those types of expenses. Typically by month nine they're breakeven on a monthly basis. But what's interesting is about a year and a half to two years out on average they're producing 1.5 million to 2 million in revenue at a 20 percent contribution margin. Those of you that follow our conference calls, I talk about mature agencies typically have a contribution margin of around 30-31 percent. So, even after that two-year period of a startup, they have future room to grow both on the revenue side and the contribution margin side. If you were to take \$2 million times 141 agencies times the 20 percent contribution margin, if you were to take 141 agencies times \$300,000,

you would clearly understand the accretion story inside of our startup strategy. You would clearly understand that us being able to do this is going to help offset future reimbursement cuts.

Let's say that CMS decided no more startups in the industry. Well, all that would mean is we would go into a county and buy a provider number. There's 20,000 locations out there. There's probably close to 9,000 provider numbers. Instead of \$300,000, it may cost us \$500,000 or \$600,000 to get into that location. There's a lot of small provider numbers out there so it wouldn't stop our strategy. It would just change the direction, although I don't believe that that's going to happen, but I like to bring that point to some people that have asked me about that.

The last think I want to talk to you about is efficiencies. We made the decision years ago to tie all of our offices together via T1 lines. And then we made the decision to rollout laptop technology. We have over 14,000 laptops in the hands of our clinicians. We have standardized our care protocols above and beyond what is required by Medicare regulations of what you're supposed to document. So, now if the clinician goes into a patient home and a certain clinical question is answered a certain way, we have popup boxes or algorithms that say okay now you need to ask this patient these set of things and you need to document those things because each visit needs to tie back into your first admission and what you said was wrong with the patient. Because if you start performing something outside of that, one it's denied if it's not medically necessary because you didn't identify it as an issue on the front end. If you identify it in week three, you've got to call the physician and get a change order and get the doctor to sign off on that. And if you're doing that all manually, all paper-based, you can imagine the things that get missed or the visits that don't get put in the charts. But if you're doing it automated and when they go press send to update and you've left something blank or you don't have proper documentation, it pops up and says you missed this. You didn't fill this field in or these two conflict with each other. I have just articulated a major compliance strength of Amedisys, which Jeff Jeter will go over in detail.

What I'm excited about and what I want -- if you don't take anything away from this presentation other than this -- if we believe that we're not going to get a market basket increase in 2010, and CMS has already regulated the 2.75 percent cut, it would be inappropriate if you took our Medicare revenue, that what it is projected to be out in 2010, times 2.75 and said that's just going to be a raw cut to Amedisys, the reason being is we have known efficiencies that we are putting in place now that are going to help cut into and offset that reimbursement cut. We are going to grow through startups. We have acquisitions in our pipeline that we've already done that have significant room for contribution margin expansion. Now, while I'm not going to add up all of these initiatives, and there are more

than listed here, each individually is significant, so automated mileage or going to a paperless initiative. What we do is we hire Six Sigma experts to go into an area, say human resources, and they map out every process that we're currently doing manually, then they recommend technology to eliminate steps, and then we come up with a new staffing model based on that efficiency. And we do that area by area and we've done that over the years.

I'll give you another example. We went into the agencies and did a Six Sigma process and we studied what we call what a clinical manager does, who manages about 100 patients. And we figured out that clinical managers are wearing two different hats. They were doing a lot of transactional type work; making sure visits were entered into the system, make sure doctor's sign the plan of care, making sure the charts were audited, making sure a nurse came in when they were supposed to come in. But then they also did a lot of communication back and forth with the nurses and a lot of communication back and forth with physicians. So, we said we're going to split those into two different functions and we came up with what's called a quality care coordinator, it's a home-based job, and they do the transactional work. And there are certain clinicians that love transactional work. And then inside the agency we left the clinical manager that's going to do the communication with the field and with the clinicians and coordinate care. Those two positions combined are more efficient than just one person wearing one hat doing everything, so there's just a raw dollar savings by doing that. Your DSO over time will come down as a result of doing that because you'll have somebody focusing in on transactions.

This year we're going into our clerical steps and we're looking at our business office specialists and we're studying the steps they're doing through a Six Sigma process. And over the next year or two we will probably centralize some of their functions and have home-based jobs that work on transactions, that we can monitor remotely the number of transactions there to process. You become more efficient, you're not as worried about turnover in an individual agency because you have multiple people trained. You can turn an acquisition over to a centralized function that's been here for years. It makes all kinds of efficiency sense and provides better clinical care because it allows the clinicians inside the agency to focus on what they should be focused on, which is the care of the patient. I have just articulated a major efficiency structural difference of Amedisys from our next closest competitor. I've articulated a major reason why we will become even more efficient than we currently are.

I mentioned that we do our visits based on a plan of care and you have RNs and LPNs, physical therapists, physical therapists' assistants. Well, just like in a hospital, an RN doesn't come into your room every single time. Sometimes an LPN comes in to do certain functions. Just like on a home care visit, an RN is

going to come to your home the first time we do an assessment, but an LPN may come to your home to do basic functions that they're very qualified to do. This industry, and specifically Amedisys, has yet to study every single visit and make sure the appropriate discipline is providing care on each visit, which is the most efficient clinical appropriate thing to do. As we rollout that efficiency over the next couple of years, that individual efficiency will be significant. And we have several more that we can talk about. Again, I'm not articulating the difference, but I want you to keep in mind that all of these individually are significant and cumulatively they're very significant.

The outcomes, we're one of the few industries in Medicare that have to publicly report outcomes and in ours there's 12 of them. Ten of 12, we beat national averages. That's significant because our acuity level is higher. I've already articulated that we care for a sicker population and we've done a lot of acquisitions, a lot of startups; all of that data is inside these metrics. Over the years, we have sequentially improved our outcomes. So, you can't talk about one of our metrics. You can't talk about utilization or recertification or growth or any of those metrics without talking about outcomes because all of them have improved sequentially over the years.

My presentation to this point has been about home care. I'm going to spend a couple of minutes on hospice. We have 48 locations in hospice. Our annualized revenue in 2008 was 69 million. We opened five new hospice locations last year. In '09, we project to open at least five new hospice locations. If a standalone hospice acquisition became available that made sense to us, we would entertain that. We haven't done anything large on the hospice arena. Most of our hospice locations have come through buying a home care agency that also had hospice locations. I believe, my personal opinion, over the next three or four years there'll be a major reimbursement change in hospice and that may provide an inflection point for Amedisys to get more aggressively into hospice. But our bread and butter is home care and that's what we'll continue to do on the startup and acquisition side. But I can tell you all the things that we've learned over the years in home care, whether that's technology, the way we staff our agencies, the processes that we do, we are implementing within hospice. And we're much further along in hospice than we were in home care when we had 48 locations because we've learned from our mistakes, if you will, on the home care side.

I am very optimistic about our future. I'm comfortable in our reimbursement environment. While I can't predict what future reimbursement will be, I know that we are focused on a company on providing future efficiencies and growing aggressively and that will continue to be our story.

And I appreciate your time and it's my pleasure to introduce Miss Alice -- is it Alice Ann that's coming up. Alice Ann Schwartz -- Dale was getting jumpy there -- who will do the next presentation. Thank you guys very much.

Alice Ann: Thank you, Larry. We've talked a lot about home care. We talked to you a lot about the processes that we use in home care, but we thought it was best to show a short video to you before I begin my presentation and you'll really understand the essence of what we're doing in the home. So, with that, I'd ask someone to please kick off the video.

Video: A snapshot of the Amedisys admission process. Amedisys delivers community-based care to elderly patients who cannot readily leave their homes. The company currently provides care in 37 states and has serviced over 805,597 patients in the last five years. The home health process begins with our nurses or therapists performing what is known as an evaluation on a patient in their home. During this evaluation, the clinician is determining whether the patient qualifies to receive the benefit. What is Medicare criteria? The patient must have a medical condition that requires the skills of a licensed medical professional such as a registered nurse, physical therapist, or speech therapist. The patient must also be considered homebound. The homebound status is defined as being able to leave the home for short periods of time, but must require some level of assistance such as a walker, a cane, or the assistance of an individual. Medicare defines this as a taxing effort, so seniors who are without medical conditions, drive frequently, and can independently leave the home without a taxing effort do not qualify to receive Medicare home care services. If the evaluating clinician determines that the patient meets coverage requirements, then the admission process begins. Amedisys has deployed a laptop technology to all full time and part time clinicians who provide consistent service to our patients. Currently we have over 12,219 point of care laptops in the field. This technology is utilized in our patients' homes to ensure we capture all of the information electronically. The admission process itself lasts approximately one and a half to two hours. During that time, the admitting clinician reviews with the patients their home care rights and responsibilities, obtains the patient's consent and signature for treatment, reviews and documents all of the patient's current medications in order to get the most updated patient medication profile, inspects the home environment to ensure the home is safe and provides appropriate safety teaching, performs a physical assessment of the patient to determine what their clinical needs are, and begins to form the basis for what is known as the home health plan of care, which is what we're hoping to clinically accomplish with that patient. Once the plan of care is developed, it is sent to the physician for final approval and signature. Once the admission paperwork is completed, the nurse will transmit that information back to the Amedisys agency. Our technology is developed to support all modes of transmission such as wireless transmission, docking transmission, or DSL/modem

transmission. Back in the local agencies we have nurses employed and physicians known as clinical managers who are responsible for coordinating the care of a team of patients. Visiting nurses deliver the care in the patients' homes while our clinical managers are available to plan and coordinate with the physician. Once the admission is transmitted through the point of care system, our clinical managers utilize a clinical dashboard for care coordination. Even though a clinical manager is responsible for a large team of patients, the dashboard enables them to highlight in exception the patients on their team who are the sickest and require intervention with the physician. This type of dashboard exception-based clinical care coordination has many benefits for Amedisys. It elevates the standard of care delivery. Every morning a clinical manager will know who are her sicker patients that require her to contact the physician. It improves the communication between the clinical manager and the visiting clinician as the clinical manager can drill into the documentation notes and view patient graphical trends and recent visiting documentation. It also improves the organization's documentation standards prior to information coming through the dashboard. Electronic edits on the laptop ensure that all of our required information is completed thoroughly. And lastly, but most importantly, as the standard of patient care is heightened, communication is increased with the physician and required documentation is obtained, Amedisys clinical outcomes are improved, and their survey citations or regulatory risk is reduced. Once the admission process is complete, the patient is cared for over a two-month period. This is known as an episode of care. On average our clinicians may visit the patient's home between 16 to 18 times during this two-month period. During that time the clinicians are actively working to stabilize their patient's clinical condition. This could include adjusting and stabilizing a patient's medication regimen, assessing and stabilizing their cardiac condition, or performing wound care or other advanced clinical services. Nearing the end of a patient's 60-day episode of care a process known as a case conference is conducted. A case conference is a multidisciplinary clinical meeting conducted on all patients prior to the end of their care. It is during this time that the clinical team discusses the patient's conditions, evaluates if there is a continuing need, and if the patient is progresses or declining when compared against the original treatment goals as defined in the plan of care. If the patient has successfully progressed and no unstable medical condition remains, the agency will begin the discharge planning process. If the patient has not successfully progressed and has a continuing medical need that requires the ongoing skills of a nurse or a therapist, the agency will recertify that patient for another 60-day episode of care. In the recertification case, a new plan of treatment is developed and the physician authorizes a new plan of care. To review the Amedisys admission process, a visiting clinician does not make a discharge or recertification determination independently. All patients are evaluated by a local multidisciplinary clinical team to make a patient specific determination. If a patient is determined to have a continuing clinical need, a new plan of treatment is

developed and the physician must reauthorize a new subsequent episode of care. Thank you for allowing Amedisys to give you a glimpse into how we care for our patients.

Alice Ann: A couple of areas to touch on before I begin the presentation. We talked a lot and showed you a lot about the laptop in the home. Larry referenced the number of 14,000 laptops deployed. That's accurate in that through our system we have 14,000 laptops employed and our regional staff also have those laptops. A little over 12,000 are deployed to clinicians. That has a key compliance control for us and during my presentation and Jeffrey's presentation, I think you'll see a recurrent trend of the impact that that point of care system has on our controls.

This presentation is really to give you a clinical perspective of our patients, help you understand the platform that we currently use to deliver care. We will go a little bit into our survey results from outside regulators. We spend a lot of time in this area. Give you an overview of the care management programs and what we believe are our competitive clinical advantages. We'll also give you a little insight into what we believe will be coming in the next 24 to 36 months as far as the clinical platform and further clinical results.

A lot of this presentation is just visual for your benefit. You'll see in 2004, we serviced a little over 100,000 patients. That number in 2008, we ended servicing a little under 300,000 patients so you see that visual growth in patients served. Both Bill and Larry touched a little bit about our patient age. What's important to note is that the majority of our patients, we are not servicing the majority of newly benefit eligible Medicare recipients. Our sweet spot, if you will, is servicing between the 80 to 84-year-old patient. If you look between the age of 80 and 90, that's almost 50 percent of our whole population.

You will see through these trends, and we've reported these last year, that our average medication per patient is increasing on an annual basis. That is a statistic that we monitor closely because it's an independent outside variable that we don't control and it's a reflection of increased comorbidities, increased clinical conditions. Those physicians are prescribing more medications to treat more clinical conditions on our population. So, you will see, if you ask any researcher what's the most independent assessment of acuity, they will tell you the average medications that a patient is on. As you see these clinical complexities increase or these comorbidities increase, you will see over a longer period of time that your service levels will migrate and reflect that increased need. And I'll show you a little bit more data on that in a little bit.

We also routinely utilize independent third party benchmarking firms on the clinical side. We spend a lot of time risk stratifying our population to understand

the variables, their hospitalization events in relation to national statistics where we stand. And we spend a lot of time focused on care management protocol adjustments to focus on that high-risk patient population. This is data for the first half of 2008, it was stratified by a third party benchmark vendor, ranking our patients related to their very high probability of going into the hospital, high probability, moderate, low, and very low. And what you will see and what we've articulated in the past to our investors that we have a much higher degree of patients or higher percentage of patients that are ranked as very high risk for going into the hospital and high risk. When you combine those two numbers, it's over 51 percent when we admit our patients versus the national statistic of a little over one-third.

The video that we showed, showed that nurse completing that admission paperwork. We have a document in the admission process called Oasis. Any investors that are familiar with the sector probably heard of Oasis. It's a 40-page document. And when we complete that document, we have a very clear picture of that patient's functional status. What we mean by that is can they ambulate independently or do they need a lot of assistance? Can they get in and out of the bathtub independently? That is the statistic as far as functional trend. You will see, this is a four-year picture for you of the patient population that we serviced and their functional debility ranking. So, you'll see on the far right hand side that increase of servicing year-over-year more patients that are graded at maximum impairment levels. You'll see that on the flip side, a year-over-year decrease or tend down, if you will, of patients that have moderate impairment or no impairment. So, if you look at the organization's profile in totality, you're going to see a trend of increased medication use, polypharmacy needs, increased hospitalization risk compared to national benchmarks, and increased functional abilities of our patient population each year. And that really is the essence of our clinical challenge.

There are also some other trends that are going on that are at the diagnostic level. If you listened to Bill's presentation and Larry's presentation, they talked about that chronic subset that's only going to grow when we talk about Medicare beneficiaries. We are seeing, if we look at the last three years, we are seeing the trend of servicing patients that have more complex cardiac conditions. You've seen almost a four percent growth in our cardiac pool, a one percent growth in the wound population. It doesn't sound big, but those patients typically require much more intensive services. Our diabetic population has essentially stayed stable, hasn't grown by over a percentage. But the other interesting component is some pretty significant growth in the patients that we service, those elderly patients with stroke and debility. If our goal is to continue and we think our value proposition in the area of servicing that chronic subset, we anticipate over the next two to three years that we will continue to see these trends through a combination

of going to our referral sources, telling them this is what we specialize in, and naturally the migration of these chronic patients from acute care into the community-based setting.

This is our average episodes per patient trends. You will see this from 2006 to 2008. Major changes happened at the end of 2007, a couple of things. Obviously we had the addition of TLC into our data. That has affected the average episodes per patient. The average episodes per patient is more of a sensitive indicator to those clinical changes than you will see in just a moment a gross recertification trend. And I'll show you that information.

We published, I believe the last reporting period, this patient on service by days. That was 2007 data. This is new data from 2008. On a macro basis, a little under 85 percent of our patients received care in two episodes and are discharged. When we look at that third and fourth episode, there's about ten percent that require care into the third and fourth episode. And then we have a five percent, what we call chronic subset, patients with increased needs that continue on past that.

For your benefit we have – I have just given you this visual comparison. This is the 2007 length of stay data compared to the 2008 length of stay data. So, if you were to look at this graph, it doesn't really show you major trends or major swings in that length of stay of our patient population. But when you look at the diagnostic level and you look at the average episodes per patient, you will start to see those trends. What we are trying to telegraph to our investors is as we continue to build out our clinical competencies and our models and our technology to continue to focus on this chronic subset, even though you're not seeing a significant trend in patient length of stay from 2007 to 2008, we are seeing clinical variables that are much deeper than that that are reflecting trends. Reflecting trends at the diagnoses level of servicing more stroke patients, increase in the \_\_\_\_\_ population, increase in the cardiac population not showing in this length of stay data now, but it makes sense to us over the next two years as we continue to focus on that chronic subset that those data points will be impacted.

A little on the outcome side. Larry talked about the 12 publicly reported outcomes. We do focus a lot of time in that area. We also use outside third party experts to roll up our outcomes into one standardized score. We are very interested in showing improvement in those scores, but also aggregate improvement compared to national trends. This is just a visual example for you that shows where we are. The top line is Amedisys. The lower line is the national level. Where the nation has gone on this one standardized score versus where Amedisys is trended.

And I believe Larry already went over these. These are our 12 publicly reported outcomes. I'll touch a little bit on that on the back half of the presentation.

So, as a summary, more advanced age definitely a trend in the pharmaceutical use of our population, definitely a higher risk of hospitalization compared to external benchmark measures, a defined trend of admitting more patients into our service each year that have a higher functional debility level, if you will. We are seeing a baseline trend in the type of patients that we are servicing year-over-year at the diagnostic level. And I think we've given to you a pretty good visual of the improvement and quality trend.

I'm going to shift gears for just a moment and talk about the platform of care. We touched on it in the video. You've seen the point of care system. Larry and Bill both talked about the need to get all of that data in and have all of the variables that are required by Medicare to be on our clinical records. The point of care helps us standardize our care. It helps us to really identify the patients we need to focus on, the sickest of the sick so those clinical managers can intervene in the back office. And it helps us to continue to focus on delivering outcome-based care. I can tell you if your front end is not electronic, you have lost control of your ability to ensure that on your clinical notes within the episode that you're meeting those compliance measures or the conditions of participation measures every time. So, it's been a huge strategy for us.

Secondly, the way we interface with our physicians. Sixteen percent of our referrals do come through the Internet and our physicians are using what we call that Mercury Doc portal. Through that portal we're able to give them graphic trended data on their patient population, all of the updated medications, all of the most recent verbals orders that they've signed, the plans of care, and we can communicate with our physicians electronically. This is a huge strategy for us as it increases the level of care coordination and helps us standardize our care and our interventions more timely.

On the back end, after we discharge a patient, all of that data flows into our freestanding call center called Encore. We know exactly which disease management program that that patient was on. We know exactly what we focused on during that episode of care. We know when they're supposed to go visit their doctor's office again. And we follow those patients for a six-month time period.

It's during that time that we get our satisfaction surveys results from our patient population and we also use that data and we mine that data. Meaning when we contact those patients over that six-month period, we're asking them have you gone back into the hospital or have you gone back into the emergency room and why. And we track and trend rehospitalization rates at 30, 60, 90, and 120 days

and those root causes. We also track the same data for emergency room. We're very interested in why these elderly patients are having to go back into the hospital. A lot of our root cause analysis, just to give you one example, we found within the first 60 days that the number one reason why patients were having to go back into the hospital was because of a fall. Hence we started the development two years ago of our vestibular balance program or our Balanced for Life program and we rolled that our system wide and will continue to do that. So, that data is very valuable for us.

If you're a Medicare home care provider, we thought it was very useful for investors to understand the level of reviews that a home care provider goes through and the risk associated with those levels of reviews.

The first level is the state level. The state contracts state surveyors to come survey home care agencies based on what is known as the conditions of participation. These are our regulations that we have to follow to continue to participate in the Medicare program. There are certain levels of deficiency citation and I'll go into those in a moment, but essentially there's a condition level deficiency. If an agency shows a very poor trend, the state surveyors can put that provider number on what's called a condition level deficiency or a termination track. During that time they have either 30, 45, or up to 90 days where they have to turnaround their practice. The state surveyors then return after that time period and they reassess that location. If you're not in compliance or have not turned around those significant trends, the state has the regulatory authority to issue a termination of that individual provider number. So, that's the risk at the state level.

At the intermediary level, that is the individuals that process our billing or our claims, if you will, each year they put a varying number of sample edits. They do that on the home care industry and the hospice industry. If you go onto one of those edits, it will be at a quarter at a time duration and they'll look at your payment percentage of denials. If at the end of a quarter your denial percentage, the claims reviewed versus claims denied percentage, is less than 15 percent that provider will come off of that edit. The government assumes there's not major problems in that provider number. If you're still above 15 percent, you're going to continue into subsequent quarters of a review. Once you get to the fourth to fifth quarter of a review the intermediary has the regulatory authority to say obviously there are some significant problems with provider number and they have the authority to apply what's called a sampling methodology where they will look at the last year's revenue of that provider number and they will pull a sample of claims. Let's say that sample of claims said that you had a 20 percent denial rate and they say okay you have a 20 percent denial rate of your claims. We're going to assume that 20 percent of all of your revenue last year was not billed appropriately and then apply it to the annual revenue.

And then obviously the third level is the federal level. We have cost report reviews, RAC audit recoveries that touch primarily right now the acute care facilities, whistle blower allegations, and any federal investigation; all of which could result in recoupment of monies or sanctions or obviously market capitalization impacts.

At the state survey level, these are the three options that can come from a state survey. One is the deficiency free survey, meaning they didn't find anything wrong. Does not happen on a consistent basis in the home care industry. A standard level of deficiency is something where they found one area of documentation that wasn't wrong. Maybe you didn't have your insurance on file for that visiting nurse or maybe you didn't assess the patient's pain level. Standard level deficiencies are very common in the industry. And the third level that we talked about before is the condition level survey. That is a significant trend of standard levels combined. Then they start that termination process.

We spend a lot of time in the areas of clinical outcome improvements, care management and how we change our systems, and in this area. We mine all of our deficiencies on an annual basis. We look at the root cause of why we're getting those deficiencies and then we embed set clinical standards into our point of care system to reduce our regulatory risk over time.

These are just some visuals for you. When you talk about the outside regulators that come into our locations, in 2005 we averaged five surveys per month. With our growth, obviously, the number of surveys in the system has increased from 2006, 2007. This is the trend in 2008. We're now surveyed an average of 16 times per month by regulators. Stated another way, every other day at Amedisys we have an outside regulator auditing our locations and that's our current trend currently.

We also do extensive internal clinical audits on our locations. This is a graph for you that shows our trends of internal audits. This is a combination of quality audits, audits that we do through our operational line, and two times a year we also risk stratify on the clinical side all of the locations that we have. Those agencies that have a high-risk stratification will also be audited to be proactive. They might not have had a bad survey yet, but they're going to be audited based on that clinical oversight infrastructure. This past year we were a little under 18,000 clinical self-audits.

At the standard level survey citation level there are some national benchmarks in this area. These are the top 15 citations that outside regulators cite in home care and the national percentages of the deficiency citation rate. We look at this area

very closely. Amedisys, if you roll them up, out of the top 15 survey deficiency citations we're better than national averages or lower; in this case 13 out of the 15. This next year we have two focused initiatives in the areas where we aren't at -- where we are above the national average in that survey citation. So, this gives you an indication as the standard survey level citations for Amedisys as a system.

Deficiency free surveys, this is probably the biggest marker or trend of our overall quality improvement and the biggest marker of our technology improvement. In 2005, a little over a quarter of our surveys, when we were surveyed an average of five times per month, a little over a quarter of those were perfect, meaning the surveyors found nothing wrong. You'll see visually the impact that point of care has had on our clinical operations and our risk profile. When you look at 2008, perfect surveys, no deficiency citations referenced for almost half of our monthly surveys conducted by outside regulators. We will continue to focus a lot of effort in this area.

At the intermediary level -- these are the last three years of results -- how many individual provider numbers we have had placed on a specific edit. We talked about that quarterly process. We do not have any concerning trend to us of increased pre or post payment denials. In the history of Amedisys, we have never had a provider number actually go into a fourth quarter review and we've never had a provider number -- had a sampling methodology applied.

At the federal level, obviously at current, no known cost reporting impropriety inquires from the government, we are not experiencing any RAC audits, we have no whistle blower allegations, and no active federal investigations.

At the care management level, we have talked about our care management programs. I think Larry did a great job talking about the impact that it has on our clinical population. I wanted to touch briefly on what we do. We do use our Encore data to identify the root cause of why patients are going back into the hospital. In addition to that, we also do a market review of every one of our locations every year to understand the majority of the clinical population as it's coming out of the hospitals. In one location, we might need to roll out a cardiac program and in another location it might be a behavioral health program. So, we use all of the market data to understand what is the primary program that our agencies need to launch for that year.

We spend a lot of time in making sure that those programs are based on the research-based protocols. There is a big disconnect between proven research and entities that are implementing proven research and that's really where we believe a lot of our clinical strategies or value proposition centers around is our ability to

embed research into the standardized platform and implement it to facilitate a clinical change.

The sites that maybe select let's say a behavioral health at home program to implement, those clinicians will go through an advanced clinical credentialing process. We also think it's very important for our account executives to understand that clinical information so we require that they go through that same advanced clinical credentialing process before we go out and speak to our physicians.

Throughout the year we will track the clinical outcome growth of that subset of that disease management program, and we will track the growth of that diagnosis in that location.

And then agencies throughout the year that have proven that they can reduce their hospitalization rate based on a trend, that they have credentialed all of their staff and their sales force, and they're growing that population, they're awarded a center of clinical excellence within the company.

This gives you a snapshot of 2008. A little under 15,000 of our clinicians went through advanced credentialing. This is the breakdown of the clinical programs. We also awarded a little bit over 58,000 continuing education units.

What we believe are our competitive advantages is to remain the leader in clinical outcomes. You see a defined trend of improved quality and reduced survey risk. Those variables will continue over the next 24 to 36 months. We have a true commitment to embedding those research-based protocols into our practice. You will see our delivery model change significantly over the next 24 months. We have a significant clinical competency and credentialing infrastructure that we're committed to. We believe that they require advanced education for our clinicians to care for this sicker subset. We'll continue to build out our care management programs and we've been very successful to date at treating the complex patient.

We feel pretty confident in telling you that we are in the middle of this year with a major system redesign focused on improved regulatory results and improved care delivery models. Over the next 12, 24, to 36 months, you are going to see improvements in those publicly reported clinical outcomes. You will continue to see a trend of increased deficiency free surveys. You will continue to see a trend of a reduction in the hospitalization rate. If you look back at our hospitalization rate 36 months ago, you'll see defined basis point improvement and that is something that doesn't just flip on a quarterly basis, but you have to look over a multiyear period. We are spending a lot of time on our technical platform, morphing that technical platform into a chronic care delivery platform. And you

will see patient stratifications or predictive modeling more embedded to make sure that the care is more patient centered.

Last slide. I know it's been a long morning. We'll break after this. Our future clinical delivery model, once you are nationwide and once you have your front end all electronic and all of your data centralized, there is some phenomenal things that you have the ability to do related to your care model. A diabetic patient shouldn't just be treated the same way no matter what. A diabetic patient that has a 20 percent probability of going into the hospital should not be treated the same way as a diabetic patient that has an 80 or 90 percent probability of going into the hospital. You will see over the next 12 months that we will migrate our centralized platform to identify those patients using predictive modeling capabilities, stratify that subset that we know we're already taking care of, and deliver more advanced clinical services to that subset on top of the normal care delivery model that happens in home care. That is going to be the basis for our continued outcome improvement, the basis for our reduced regulatory risk, and the expansion of our clinical program.

So, with that, we are probably going to break at this point and then after the break Jeffrey Jeter, our Chief Compliance Officer, will return.

BREAK

Jeffery: Good morning. We're going to get started again so that we're mindful of your busy schedule. My name is Jeffery Jeter, I am the Chief Compliance Office for the company. And it's indeed a privilege this morning for me to be with you and share with you what I believe are one of the biggest strengths of our company, which is our compliance program.

I'd like to start by just giving you an overview of what the compliance infrastructure within the company looks like. Our entire compliance program is built around and modeled after the OIG's model compliance program guidance for both homecare providers and hospice providers. And as you'll see on this slide, this really shows you the continuum of compliance efforts that we undertake within the company. It begins even at the moment an employee applies for a position with our company with the screening that is done, with background checks, monitoring the OIG's exclusion list. And then from the moment they enter the organization, we take great steps to train employees. And then we monitor their performance throughout the duration of care that's provided to a patient. So there are both pre-billing audits that we undertake, as well as retrospective claims reviews, which is really after the occurrence of the event we are constantly auditing as well.

And then as part of any good compliance plan, you will note that we do put into place some pretty robust reporting mechanisms, as well as have a well defined system for addressing disciplinary action and enforcement of our policies. And all of this goes under the auspices of our corporate compliance department, which in turn reports up through a corporate compliance committee, comprised of the key executives in the organization, ultimately reporting to both our board of directors and our audit committee.

I want to spend the majority of our time this morning discussing what I think is really the backbone of our compliance program. And to articulate that, I would probably summarize it in terms of our training, our technology, and our testing. So we'll begin first with our compliance training. Within the company we have what I would classify as both a tiered and a targeted compliance training program. My fundamental belief is that most employees do not want to do the wrong thing. They don't set out to intentionally commit fraud. But we do live in a very highly regulated industry, and oftentimes the regulations that surround what we do are complex, and they're also very murky. And so the challenge for any provider is to be able to lay out the expectations and lay out the rules and lay out information that is consistent with the government's expectations for the providers. And so there needs to be a deliberate attempt to educate and train staff in such a way that the information is memorable and addresses all of their needs as they go out and do their day to day jobs.

And so we do this through a variety of formats. We require general compliance training of all employees in the organization upon their hire, and then we repeat that every year that they work for us. And that's at this point done online. And secondary to that, we feel that it's important to continue to emphasize compliance and its integration into employees' day to day job functions. And one of the ways we do that is through our new employee orientation. And when new employees come into the company, they attend a regional meeting that's held periodically, generally about every six weeks, at which time they spend the day with executive management. And we go through the expectations of the company and what it means to really be an Amedisys employee. Not in terms of one specific job function, but more along the lines of what is the company's value set? What are our principles? What are the things that we hold true to? And compliance is a constant theme that runs through all of our presentations.

Thereafter, once somebody is integrated into the organization, we also undertake a series of extensive training that is targeted to one specific role in the company. So for example, if an employee is involved in the billing and coding processes for our company, they must undergo separate compliance training that is tailored to the particular risk and to the particular policies, and to the particular concerns that are specific to their job functions. Additionally, if an employee is involved in

business development for us, so our sales staff, they have to participate in additional training that is geared toward preventing kickbacks, preventing bribes to referral sources, and those types of things that would be in violation of the Federal Anti-Kickback Statute and the Stark Law.

So as you'll see, here are a few examples of some of the training that we've done over the years with our staff. This just gives you a snapshot into how we do it and how we present the information. And what you'll see is there's an emphasis, both in terms of marketing, there's some that's targeting specifically our billing components, as well as just the overall general compliance training that we do for the company.

The next thing I'd like to do is discuss at length some of the very compliant centric technology that we employ that I think really sets us up and provides a lot of internal controls against fraud and abuse in how we conduct our business. And there are really three critical pieces of compliance technology that I would like to go through with you this morning. The first being our point of care system, secondly being our compliance scorecard, and then third being our physician consultant payment tracking system.

So to start with, I'd like to spend a lot of time talking about the compliance impact of our point of care system. And Alice Ann and Larry both spent a great deal of time showing you what that system does, how it functions. And I think there are some clear operational efficiencies that the point of care system brings.

But the real secret and the greatest impact to our point of care system is not so much in the operational efficiencies, but in the compliance controls that it brings, because I think fundamentally when you look at compliance problems that a healthcare provider undergoes, the common denominator for the vast majority of these kinds of problems is documentation issues. And I can tell you as a former healthcare fraud prosecutor, the vast majority of cases that I ever prosecuted turned on the fact that the provider did not have documentation to support what they did. And you would see that even reflected – there was a study done by The Cato Institute several years ago that looked at healthcare fraud prosecutions and the underlying cause of those. And their findings were in the majority of the cases it turned on insufficient documentation. So whether you're talking about allegations of billing for services you didn't provide, of up-coding, any of those types of allegations, which really form the bulk of healthcare fraud prosecutions in this country, your documentation is a make or break aspect to your billing and to the propriety of what you do. So because of that and because of those risks, if a provider can come up with a way to ensure that their documentation is more accurate and more consistent, and does not have errors in it, and is complete, then you dramatically reduce your risk for compliance problems. And we have really

found in our point of care system that this particular technology helps us in all of those regards. Because what it does is it requires our clinicians to document what they do. And they're not able to translate visit notes and by extension get paid unless they complete all aspects of their visit note. And then built into this point of care technology are certain smart edits that are looking for data inconsistencies and things that may not make sense that you would otherwise only catch in an audit, which may be too late, especially if it's being conducted by the government.

So beyond that then we've also built in some very important technologies that Alice Ann referenced, things such as our automated mileage calculation, our electronic patient signatures, and some time and date stamping capabilities, which really goes to address fraud that might occur on a micro level, meaning you have a clinician that wants to just go out and falsify a visit. And this technology allows us then to put in controls that will tell us when did a clinician show up at a patient's home? And how long did they stay in that home? And so while you'll never be able to guarantee that you won't have a clinician who attempts to falsify documentation, what you have done is you've created an environment in which it is so cumbersome for them to do and so risky for them to do, that if that's their mindset, they would just go work somewhere else rather than try and commit that in your organization. And then when they do, you have the tools and capabilities to follow-up on it.

The next major piece of compliance technology that we have employed is our compliance scorecard. And what this is, it's really a risk-based auditing format. And throughout the balance of my presentation this morning I'm going to go through and show you a lot of the things that we look at and how this particular scorecard is organized. And what it does is it focuses on those conditions that are suggestive of potential fraud within the organization. So a lot of times I will analogize it to perhaps a meteorologist who is going to tell you there is a chance of rain, or there is a chance of snow. And they do that based on certain diagnostic tools that they use that will tell them this is what the barometric pressure is, this is what the temperature is, this is what the wind speed is, this is the wind direction, this is the level of humidity, and so all of those things may be suggestive of a weather occurrence. But just because they say it doesn't mean that it's going to snow today or that it will definitely rain.

So along those same lines, this is the type of approach that we take. We're looking for conditions that suggest potential fraud. And when we see that, and we see a higher incidence of it, those are the agencies that we really focus on. And it allows us to draw on very specific risk measures that occur from across the organization. So we're looking not just from a purely compliance standpoint, but we're looking at how other groups within the organization assess risk. So you're

drawing on the risk assessments that our clinicians and our clinical division uses, that our operators use, our human resources division uses, which gives you a pretty clear and pretty good snapshot of where your problem areas could be.

And then lastly, we do this and we analyze it based on what I would consider to be pure abhorrence analysis when you're looking for agencies that perform better or worse than their peers. And this type of analysis is something that the government does all the time. That's how they identify where their risk areas are. So we've tried to mirror and mimic how the government views risk and how they assess risk, and build that within our organizational structure to focus our resources and our scrutiny in the most efficient manner possible.

Here is an example of the compliance scorecard from a rolled up comprehensive format that shows you kind of an example of what the company-wide scorecard metrics would look like. And the scorecard itself gives you some drill down capabilities that we will go through momentarily.

Then this brings us to the third fundamental piece of compliance technology that we employ, which is our physician consultant payment tracking system. More and more these days the government is concerned about the business of healthcare, particularly in how providers market to referral sources, so to, in our case, physicians and to hospital discharge planners. And one of the things that they really focus on is the use of medical directors, particularly by home care and hospice agencies because they want a way to ensure that you're not bribing doctors to send you business. And several years ago we developed this physician consultant payment tracking system to ensure the propriety of the payments that we make to physicians. So we have approximately 500 doctors that work for our different agencies on generally an hourly basis. And we have to ensure that the arrangements that we have with those doctors satisfy the Stark and Anti-Kickback Safe Harbors to the letter.

And then we additionally have to ensure that the payments that we make under those contractual arrangements are justified and warranted. And we do that by flowing this entire process through our compliance department. So the compliance department oversees the contract creation, the compliance department oversees the invoice approval, and it's through this technology. And this is a screenshot that will show you how that system is really laid out. But it allows us to keep track of contracts, determination dates. And what it does is it builds a failsafe into the system that will not allow an invoice to be processed if it doesn't meet all the requirements within the system. So the system is constantly scrubbing to make sure contracts are in place, that reimbursement caps have not been exceeded, and those types of things.

So we've talked momentarily about the technology and the training. Now I really want to go into the testing aspects of our compliance program, because I think this is really where you will see a key difference between us and a lot of other healthcare providers out there. We really employ a multi-focal compliance testing structure. In other words, we're trying to look and test and audit from a variety of different perspectives within the compliance department. And we do that in four major areas.

First, our compliance oversight audits, which are all the audits that we undertake based on the risk ranking that's done in our compliance scorecard. And we will spend some time momentarily going through the specifics of that.

And secondly, we do complaint audits. We have a number of systems in place for employees to report concerns. And where they do, then obviously we follow up and audit those complaints. So you see that through our compliance hotlines, through exit interviews that we do with staff who have left the organization, and then lastly through internal polling that we do through current and active employees.

Then the next audit focus from a compliance perspective that we undertake are the special types of audits that we do, what I would sometimes call our work plan audits that occur periodically throughout the year, and are driven mostly by emerging needs and trends that we see overall within home health, within hospice, within healthcare. So some examples for you might include an outlier audit that we did in the State of Florida that many of you probably read in the news about issues they were having in South Florida with provision of outlier payments to home health providers and how those payments were dramatically higher than they should be, and that there was a concern about fraud in South Florida. Well, in response to those articles and the enforcement actions that were taken against a handful of providers in South Florida, none of which were owned by Amedisys, we elected to do a very focused specialized audit on our outlier billings in the State of Florida.

Similarly, with a revenue impacting program like Balanced for Life, we will do compliance audits with respect solely to that program to make sure that we are very comfortable with the propriety and the compliance of what's being done in those areas. And then even in the last year we've done HIPAA security audits in our agencies in response to the government's announcement of more vigorous enforcement of the HIPAA security standards.

And then lastly, there is an advisory function that my department performs. Any time we have anybody within the organization that may have concerns about things either in their area, in their region, in their particular field of responsibility,

they will sometimes turn those matters over to the compliance department to review. So from time to time an operational leader may call and say I really have a concern about this market, would you mind auditing them? Or we may get a handful of referrals from our quality care coordinators who may see a trend with respect to a particular clinician or particular agency. And those would be handled by my department as well.

With respect to the testing that we do, I'm going to spend the balance of the presentation this morning really going through our compliance oversight audit process, which, again, are those audits that we now do based on our compliance scorecard. And there's been an evolution in that process that we've seen over the last several years. This compliance oversight audit process actually began in 2005 when we identified that there were certain high revenue events that if they were not done in the right way posed a greater compliance risk to the company. And we looked at three particular areas, most notably the provision of a large amount of therapy because, as you'll recall, prior to 2008, home health got additional reimbursement if we did in excess of 10 therapy visits. Then following January, 2008, they have changed the reimbursement structure, and you still get increased reimbursement for the more therapy you provide. But it's more flattened out. You see increases at the 6, 14, and 20 therapy visit level. But because of that, and because if you were so inclined to commit improprieties, that would be a good area that you would try to do it in because it's high revenue impacting. So we really focused on that.

Then we also looked at the provision of a lower amount of LUPAs. And the way home health is reimbursed, they're reimbursed on an episodic basis. And the government says we will pay you a flat amount of money to provide care for these patients for a period of 60 days. The exception to that is if you do not provide a sufficient number of visits, if you provide four or fewer visits, the government says you really have not done enough to earn that full episodic reimbursement rate. So at that point they issue what's called a LUPA, which is a Low Utilization Payment Adjustment, and they reduce your reimbursement rate to a per visit amount. And so if somebody was trying to inflate their financials, what they would do is make sure all of their visits do not become LUPAs. And they would make sure all of the episodes were billed at a full episodic rate rather than a lower rate. And so we were concerned with any agency that had an exceptionally low LUPA rate.

And then lastly, we were always looking at case mix, which a high case mix is potentially suggestive of up-coding. And so these are the three key areas that we were focused on in this audit – compliance oversight audit process. That changed then in 2008 with the launch of our compliance scorecard and the dashboard that we use to manage that. Because what we said is, yes, these three areas should

concern us, and they should be things that we focus on. But there are a lot of other data points that are suggestive of potential compliance risk in the company. And if we can find a way to integrate all of those, it may show us a better snapshot of where the true risk is. So really what we've done is we've morphed from three factors that we look at in terms of compliance risk to in excess of 40 factors. And here they are laid out for you in totality. And what you will see is these are spread across a wide variety of areas. So we really have been able to group these together in a way that is suggestive of the different risk areas that an agency may have.

So we've taken these 42 measures of risk, and they have been consolidated into subgroups. And there are six subgroups that represent revenue risk, operational risk, compliant risk, clinical risk, environmental risk, and regulatory risk. And within each of those subgroups are components that are these 42 different measures that we take into consideration. All of these can then be rolled up and can give you a consolidated risk ranking.

So with respect to the revenue risk subgroup, what you'll see is there are 12 factors that we look at. And again, these are things that we've identified to be key drivers of revenue within an agency. And so handling them in an inappropriate fashion presents greater risk for you. So we're still looking at things like the low LUPA rate, and we're looking at high provision of therapy. Now in the new reimbursement system, that has to take several views. We look at high therapy one, and high therapy two, which depends on the number of therapy visits that are being provided in an episode. Then we look at things like gross margin, doing(?) without orders, questionable recertifications, which is a reverse edit that we do where you look at particular requirements that you satisfy in order to justify recertification. And we know that there are a handful of those that the government says in these conditions, a recertification is appropriate. We have reversed that, and we look at recertifications that that occur when those conditions do not exist.

And then along the same lines, then our high revenue programs, for example Balanced for Life, we audit those separately because they would otherwise skew how you just judge therapy because obviously Balanced for Life has a greater provision of therapy within it. And then you also trend your LUPAs and your therapies over time to see patterns that may develop from there.

Within the clinical risk subgroup, this subgroup is comprised of a lot of the things that Alice Ann detailed in her presentation. And what we're trying to do is identify risks from a clinical standpoint that are suggestive of potential quality of care concerns, and that really get down to the provisioning of nuts and bolts nursing care within our agencies. So you'll see audit results that are done for conditions of participation, our PI audit results, and our clinical oversight risk stratification. These are all areas of information that our clinical operations

division has on hand that we think are very good to translate into our scorecard because they are measuring risk from a clinical perspective.

Then we also look at things such as patient satisfaction surveys. Obviously if you have patients that aren't happy with you, that means you're not doing something right. So we look at those, and agencies would get credit for excessively high scores in those areas, as well as things like focused medical review and ADRs.

Within the operational risk subgroup, these look at a series of metrics that are driven by the question are your agencies processes functioning properly? And are they doing what they are supposed to do in conformity with our company's policies. And so all of these are measures that our operators use to judge performance in the agencies, but they are also indicative of whether you have a breakdown in process. So the things like whether the agency is meeting the weekly frequency on their patients, whether they're locking their OASIS assessments late, whether they've got a high number of system holds preventing billing, whether they have outstanding orders that prevent billing, as well as any kind of discharge or recertifications that do not occur in a timely manner. All of these, while individually are not clearly a fraud incidence occurring, they do represent a condition that would potentially contribute to that.

The next major grouping that we look at is our environmental risk subgroup. And these are all conditions that describe the characteristics of an agency. And they tell you really what's going on behind the scenes and where you may have some heightened risk. So for example, we look at things like total turnover in an agency. The more people that leave an agency, it may be suggestive of problems in that agency, that people are trying to flee the ship for example. Then we also look at our employee to contractor ratio because we've found over time that agencies that have a high number of independent contractors have more problems with their documentation and more problems with people following processes because you have more people that don't necessarily report to you. And they won't do all the time what you want them to do.

Then we also look at changes in leadership. New leadership coming in gives a potential for things to fall through the cracks. It also tells you there may be a learning curve with somebody new coming in. Similar to what I call a working director of operations, this is somebody that is leading an agency that may not have a great deal of home health or hospice experience. And so because of that, then you anticipate there could be a learning curve and the propensity for something to fall through the cracks. Again, it doesn't necessarily mean that that occurs, it just means that it is more likely than what you would find in a seasoned veteran who has many years of home health experience.

Then also recognizing that when we do an acquisition or when we do a start up, we have new employees on board in larger numbers. We're putting in new processes, we're putting people through a lot of change. And so because of that, we just automatically say agencies that fit those profiles, we're going to raise them up on our list of risk. Not because we necessarily feel there's risk there, it is just that the conditions exist such that you may be more likely to have holes in processes and things as people try to overcome that learning curve.

And then via our complaint risk subgroup, this is just an amalgamation of all of the avenues through which we receive reports of problems in agencies. So it may come through our compliance hotline, it may come through our HIPAA privacy hotline, it may be as a result of a Sarbanes-Oxley complaint. And we would also open it up to exit interviews from employees, as well as polling that we do every month with our current employees. Any time an agency has a report of a problem, they really get a double whammy from the compliance department because we will go out and audit them and investigate the actual complaint, but just the mere existence of that complaint elevates their risk profile for us. Because ultimately when we drill down on the complaint, we may not find that there's a problem. It may not be substantiated. But you still have the perception of a person who thinks that there's a problem. So because of that, then your agency would get credit in their risk ranking just for the existence of the complaint.

And then lastly, the last subgroup that we look at is our regulatory risk subgroup. I think Alice Ann spent a pretty good deal of time detailing for you our state surveys. And we track those, and we fold back into our compliance scorecard. Again, because if a state surveyor is looking at you and they identify a problem, that to me is just an indication of potential risk. So we see that, and they get credit if they have a current survey with a deficiency. We also look at it trended over time. And then on the flip side, if an agency has had a deficiency-free survey, the agency actually gets credit in their favor, and we look at them as being less of a compliance risk because you've actually had a government auditor or government surveyor within your shop, and they looked at your practices and say everything appears shipshape.

The other nice aspect of our compliance scorecard are the drill down capabilities that it provides, both in terms of the risk that you look at, as well as the breadth of what you look at, so with respect to the risk, we are able with our scorecard to look at risk from a compliance standpoint in a consolidated format, meaning companywide in its totality. And then we can also look at risk in terms of particular risk subgroup. So we can look at it in terms of all environmental risks or all clinical risks. And then we could even drill down into the specific metrics. From a breadth standpoint, then the compliance scorecard allows us to drill down either company wide or below that based on regional authority, whether you're

talking about our senior vice presidents, our vice president level, or even at the area vice president level, and then all the way down, obviously, to the agency level. So all of this gives us a good perspective and allows us to slice and dice the data in such a way that we can find trends, that we isolate problems, and that we can really use this data in an effective format to improve what we do and to ensure the compliance and the propriety of our billings.

Now I would be remiss though if I were to lead you to believe that this is really the only auditing and the only testing that occurs within our company. Certainly we do a great deal of compliance auditing within the organization. But that's just one small part of an overall comprehensive audit universe that we undertake. And you see audits that occur within our organization almost on a daily and weekly basis from a variety of perspectives. And it clearly starts on the operations side on the clinical side with the oversight audits and quality care coordinator reviews that Alice Ann discussed with you previously, as well as kind of that intermediate level that we look at in terms of our quality management audits. We also have a very robust internal audit department that conducts their own reviews of our agencies and their practices. And they are independent of the compliance department. And I can tell you they even audit the compliance department. Then in addition to that, we have Sarbanes-Oxley audits, as well as quarterly and annual audits that are done by KPMG, who is the company's external auditor. And then you've got the folks from the outside who are constantly scrutinizing us, which would include the state surveys, which as Alice Ann indicated, occur on a weekly basis, as well as any kind of review that's done by our fiscal intermediaries. And we're topped of course by the compliance audit process that I've detailed for you this morning.

So I think all of this should telegraph to you that we have a lot of eyes looking at what we do, and we're looking at it from a wide variety of perspectives. But it's all driven by the notion of trying to find where risk is so that we can mitigate the risk and remediate problems where they're located.

And then lastly, compliance enforcement is important. We do have a company compliance plan. It is based on the OIG's model of compliance. And within that compliance plan, we have articulated very clearly a zero tolerance for fraud and abuse. So if somebody's going to commit fraud, if they're going to try and rip the system off, we're going to take disciplinary action against them and get them out of the organization.

But we also recognize that there will be times where employees do things that are not fraudulent per se, but they may be taking actions and doing things that increase the risk of fraud for us, such as circumventing controls that we have in place, not following key policies. So in 2006 we expanded our zero tolerance

policy to include instances where people were lifting system holds and doing other things to circumvent controls that we had deliberately set up that prevent us from committing fraud.

And lastly, we have a robust compliance reporting process that's driven by our compliance hotlines. We have a separate compliance hotline for both reporting fraud, as well as for reporting HIPAA concerns. And these are available to all of our employees 24 hours a day, seven days a week. We do give exit surveys to all of our employees that leave the company. Included within that are ten very specific compliance questions, and we follow up on those where indicated.

And then lastly, we do a monthly report where we poll current employees to find out if there's anything going on under the surface that we don't know about. So each month we reach out to 90 active employees to try and get a read on whether we have any compliance problems. And obviously we follow up on any reports with audits.

So in summary, our compliance program is really based on tiered and targeted training, as well as a very compliance centric technology platform, which we use to perform risk-based auditing that results where problems are identified in zero tolerance and we allow ample and varied reporting mechanisms for our employees.

With that, I thank you for your attention. It would be my pleasure now to turn the podium over to Mr. Dale Redman, our Chief Financial Officer.

Dale: Thanks, Jeff, and good morning. As an old journeyman bean counter, one of the things I particularly love about working for Amedisys, it is not only a good business, but it's personal. It's personal two different ways I think. One is sort of on a macro level we are all getting older. And as Bill has discovered this morning, there's some of us that are over 58 years old. And we view Amedisys and this industry as not part of the problem, but part of the solution to healthcare in America. Secondly, if you've ever had, as I have, a loved one treated by the caregivers in a home health agency, you get to see up close the benefits that this industry brings to a fragile population. And that's almost as personal as it gets. So having dealt with that issue, we are not only on a personal level, but on an operational compliance clinical level pretty good at what we do.

We talked about those other issues, so let's talk about it on a financial level. As most of you, I'm pretty sure, know last week we released our year end 2008 financial results. And what I want to do this morning is give you a little bit of an overview of that. There's some things I think you saw. We've seen strong revenue growth. Bill pointed out 700 percent, a 40 percent compounded return over the

last five years. Our EPS has grown over 20 percent per year for the last six years. Our margins have been relatively stable. We'll look at those in a minute. Our leverage is low and trending down. And we have high cash flow. Last year we collected over \$1.1 billion worth of cash.

Here's the revenue and EPS story. From 2004 when we had \$227 million in revenue and \$1.14 in EPS, our projected guidance for 2009 is \$4.10 to \$4.30, with a revenue story of \$1.425 billion to \$1.475 billion.

Here are some other metrics, from \$541 million in revenue in 2006 to \$1.187 billion in 2008. Gross margin has remained relatively stable at 52 to 53 percent. Our cash flow from operations has grown from \$43 million in 2006 to \$150 million in 2008. And our adjusted EBITDA from \$75 to \$181 million. And our EPS \$1.78 to \$3.31. And our EBITDA numbers have remained around a 15 percent level.

Here are some other statistics sort of across the company. As you can see, if you look at this, in practically every one of these statistics we have doubled that metric in the last two years. Agencies from 275 to 528, visits from 3.5 million to 7 million, same thing with admissions and completed episodes. And as Larry discussed, our revenue per episode from 2007 to 2008 has gone up almost \$200.

Here's the balance sheet story. In 2007, at the end of the year we had \$56 million in cash. When we completed the TLC transaction in March of 2008 we used most of that cash as a part of paying for that \$395 million acquisition. That acquisition also increased accounts receivable and goodwill, as well as debt. Our debt went from almost zero, \$24 million at the end of 2007 at a leverage ratio of again almost zero to \$417 million at the end of March is now down to \$328 million. That differential is almost \$90 million that we have paid down on that debt in the last three quarters of 2008 through cash flow. And our leverage ratio right now is about 1.58 percent.

Here's the story on DSO. As Larry, I think, talked to you about, when we do a major acquisition, or even a series of small, reasonable sized acquisitions, what tends to happen is our DSO tends to go up. Primarily those are operational issues, in some cases they're regulatory issues where we're trying to get change of ownership, trying to get sorted out with the financial intermediaries. In addition, we are training our personnel and getting them up to speed on our billing and operating systems. In the process of doing that, we tend to lose billing time. What then happens is once that integration process is complete and the regulatory issues are sorted out, you see DSO come down. In 2005 we did the Housecall acquisition, which to that point was our largest acquisition. And you see the DSO trend line coming down in the beginning of 2007. It comes back up in 2007

because we did a number of significant but relatively smaller transactions we call Dynacare, IntegraCare, etcetera. In March of 2008 was the TLC transaction. And DSO peaked at September of 2008 at 56 days on a gross basis and has come back down to 54 at the end of the year. In net down to 47.

We anticipate in 2009 that DSO will continue to trend positively. That's for a number of reasons. One is we've got about \$8 million in revenue that was stuck in Medicare in late fall of 2008. That's now resolved, it was an industry-wide issue. It's now resolved, and we have received the money. That's about two days of DSO for us.

In addition, our agencies that we acquired with the TLC transaction and getting more comfortable with our billing and our operational systems and the regulatory issues associated with change of ownership are pretty well getting sorted out. So we're optimistic the DSO will continue to trend down. Obviously with the exception of we do another large transaction or sizeable transaction in 2009. In addition, going forward, we will begin to talk about exclusively DSO on a net basis.

Here's the accounts receivable story. And as you have heard us talk about in the past, we look at our reserves on accounts receivable basically two different ways. We look at them on an aging basis, and we look at them on a percentage of revenue collected basis. In evaluating both of those approaches we then provide reserves against the accounts receivable that we don't believe we're going to collect. And there's two pieces to that. The first piece is on Medicare, we provide what we call an estimated revenue adjustment. That's simply the portion of Medicare revenue that we don't think we're going to collect. And that number nets against revenue and accounts receivable. That number was \$7 million at the end of 2008. On our non-Medicare revenue and receivables, we provide an allowance for doubtful accounts. That number is expensed and netted against accounts receivable. At the end of 2008 that number is \$27 million. Added together, that's \$34 million, or about 17 percent of our accounts receivable, 16 percent of our accounts receivable. At the end of 2007, that number was \$16.5 million, or about 15 percent of our accounts receivable.

As we mentioned to you before, we collect about 99, over 99 percent of our Medicare revenue. And on our non-Medicare revenue, we collect about 87 percent. On a blended rate basis, we collect about 97.5 percent of our total revenue. If you add the expense for 2008 of our estimated revenue adjustment on Medicare and our allowance for doubtful accounts on non-Medicare together, that's about \$30 million, or 2.6 percent of our revenue in 2008. 2007 that number is \$17 million, or 2.5 percent of revenue.

So here's another way to look at the adequacy of our reserves. We have, and it's published in our 10K, we have very little receivables that are over one year old, almost no Medicare, and about \$4 million of non-Medicare. That's about 2 percent of our receivables. So what we arguably need to have in reserves is about 2.5 percent of a trailing 12 month revenue number. So if you do that math, and the number is right there, if you do the math that number is about \$30 million. We have \$34 million in reserves already booked on our balance sheet.

From a liquidity standpoint, we have about \$160 million available under our lines of credit at year end 2008. That's part of the transaction that we did to finance the TLC transaction. It was a \$500 million raise, we have about \$160 million available under that line of credit. In addition, we project that in 2009 our cash flow from operations minus CAPEX that we think is going to be about \$30 million, and minus required debt payments, which are \$30 million, we're going to end up with about \$140 million from cash flow from operations.

To sum up then, you've seen a strong revenue and EPS growth, you've seen our stable margins, our leverage is low and continuing to decline, and we have high cash flow. Today we are reiterating and reaffirming our guidance for 2009. Revenue we project will be between \$1.425 billion and \$1.475 billion, EPS \$4.10 to \$4.30 based on diluted earnings per share, shares outstanding of 27.5 million.

Now we're going to go into a question and answer session. Kevin, I think you're going to give us that set up.

Kevin: Thank you, Dale. While our management team is moving to the front table, we would like to remind everybody this presentation is being webcast and we would like the people in the audience on the webcast to be able to hear the questions. So Casey and I will be walking up and down the sides. Please raise your hand and we'll come and give you the microphone. Be reminded that just ask one question with one follow-up and that will give us enough time to have everybody ask a question. And the other thing I ask is that you provide your name and the company you're with before you ask your question so they know who they're talking to. With that, let's go ahead and get started.

Q: Good morning. John Ransom, Raymond James. Two questions. The first question is on your episodes per admission. It looks like you're slightly over 1.8. Your biggest competitor or peer, Gentiva, is reporting the 1.4 range. I don't know what the benchmarking data would say for the industry. Could you talk about that difference? And do you have any idea kind of where the industry is on that number? Thanks.

Answer: Sure, I'll take a stab at that first. You mentioned Gentiva specifically of 1.4 or 1.5 episodes per patient, and we're at 1.8. That's why we tied the acuity level of our patient and the recertification process. It's interesting to note that the longer you keep a patient on service, the chance of them going in the hospital is greater under your watch. So hospitalization risk has a lot to do with how long we keep a patient on service. And if you watched the video, when we talked about case conferencing and discussing the patient and whether they've met their goals and protocols, and then if you listened to Jeff Jeter talking about doing an audit to make sure they've either had a change in medication, a variance on their clinical track, a change in doctor's orders, all are substantive reasons why you have recertifications. I can't speak to a competitor's exact number because I don't know their case mix, I don't know their acuity level. But I can say that because our acuity level is higher, our length of stay is longer, our average per episodes are longer. But then you circle back and you tie that into our outcomes, which we feel very strong about.

Q: Thank. Ralph Giacobbe, Credit Suisse. Can you talk about the difference in revenue per episode in your specialty, maybe even Balanced for Life relative to just non-specialty program? First question. And then second, just wanted to clarify, help us understand that -- did you say 16 percent of total admissions came in through the internet? Or was that 16 percent of the physician referral came in through the internet? And then maybe just help us understand sort of what exactly that entails?

Answer: Sure. The 16 percent number is Medicare admission. So the total number we do on a monthly basis, 16 percent of the Medicare admissions come through the Mercury Doc portal. And the revenue per episode I believe we reported around \$2960 in the fourth quarter. I think if you look at Gentiva's there is over 3,000 to put that in perspective on the revenue per episode. On a LUPA patient, the revenue may be \$400 or \$500, on a high utilizing patient it could be \$5,000, \$6,000. IT depends on whether a lot of different factors. It depends on their \_\_\_\_\_ level, it depends on which episode of care, it depends on how many therapy visits, every patient is uniquely reimbursed. Obviously Balanced for Life could be \$1,000 to \$2,000 higher than a normal episode.

Q: Hi. Art Henderson from Jefferies. Bill, I know you referenced disease management as an opportunity for Amedisys longer term. Could you elaborate a little bit more on what sort of timing you may have as far as a demonstration project or something that might monetize some of the work you've done there? And then secondarily, Dale or Larry, could you remind us what your rural exposure is and what the possibilities of a potential rural add-on benefit being legislated sometime this year would be? Thanks.

Answer: Art, there are a lot of initiatives that are going on in policy in general looking at the chronic complex population and the cost of that population. You've heard from the President in campaigning speeches through the Bachus Bill that care coordination or care management is important for this population. There's been a lot of initiative, most recently the chronic healthcare support, Medicare health support that really had some challenges with DM managing that population. Of the 15, 13 of them failed, two of them were successful. Those were reinitiated. The bottom line is if you look at the core competencies that are required to manage this population, they're embedded in the services that we provide from home health every day. So the question is, one, do we have the capabilities? Yes. Are we positioned for that? Yes. We incorporate the physicians in our plan of care. And it helps also engage the patient so they're more responsive to the behavior modification and compliance with medication. We have the ability to oversee the patient and to respond immediately into the patient's home to prevent an unwarranted event in the patient's condition. More importantly, there are a couple of pieces of legislation, one that's already passed under the Bush Administration, which is a medical home patients and a medical home. It's office based. But there's an incentive for physicians to follow the very complex patient. In order for them to do that, they have to put in a very expensive infrastructure to follow this very chronic and expensive patient. We feel that Amedisys has the care technology to link up with the office space physicians and provide care to this specific population, put them under care management, care coordination, a collaborative services, use our technology and our infrastructure, as well as our care management center to manage these patients. Currently there's legislation getting ready to be reintroduced called Independence at Home legislation. I urge everybody to pull it up and look at it. It was sponsored by Wyden on the Senate side, and Mackie on the House side. It's got a lot of traction. It focuses on the 5 percent of the population that consumes 44 percent of the dollars. There are many types of demonstrations that have proven successful and profitable. I mentioned the VA is one of them, Commonwealth in Virginia is another one. These are well publicized. Amedisys has those exact same capabilities. We believe that this legislation will get some wind in its sails this year, and has a good possibility of being placed and passed. And although it's not a direct benefit for home care, it's going to require the services of home care and care management to be able to support and follow those patients for a long period of time. So we think it's a wonderful opportunity. In addition, I think the association and the industry will introduce chronic care legislation itself this year, and it's going to be oriented around targeting those specific populations. It will also have a gain sharing benefit that's tied into it. And I do want to note just quickly as I close and turn it over to Larry and Dale that one of the challenges we had with the Medicare Health Support is that we took a control of patients, 10,000, against the patients that were followed, and we tried to manage large groups of patients. In this new legislation, we're actually looking at the actuarial cost expecting to look at what

costs the patient is going to incur over the period of a year, and we're weighing the cost that we provide care against against the patient's expected cost. So we think it's a much finer way to look at the cost of a patient and be able to evaluate if we've been productive in driving that cost down. So we think it offers a lot of opportunity to the industry.

Answer: About 27 percent of our revenue is rural based. If you take in the component all the different factors, if there's a 5 percent rural add-on, you can use about a 1 percent estimate for us.

Q: Hello. Kevin Ellich, RBC Capital Markets. I was hoping you guys could give us an outlook on reimbursement given the MedPAC recommendation, President Obama's budget coming out this morning, and the GAO report that's expected out relatively soon? And then the second question is given the specialty program rollout that you talked about this morning, I was wondering if you could quantify the contribution that you expect this year? Thanks.

Answer: I'll start with the back half of that. We talked about rolling out about 40 agencies per quarter on the Balance for Life, which should have an impact on revenue per episode, that's wrapped into my guidance of 15 percent growth(?), I'm not going to get into the area of predicting admission growth or recertification rates, or revenue per episode, I'll combine all three and talk about them in totality, and that's the 15 percent number. But you can see the trends though this year of the revenue per episode growth. On the first part, and you mentioned a lot of different things. You mentioned what you're reading in the papers today about Obama, you mentioned the GAO report, and you mentioned MedPAC, wrapping all of that out there, the honest answer is we don't know exactly what's going to happen, but we give an opinion. Our opinion is we'll get a market basket freeze, and by default you'll have a 2.7 percent case mix adjustment. We believe providers across the board may get a market basket freeze. We believe Medicare Advantage will probably be picked on disproportionately. But this may change ten times in the next ten months in the discussion going back and forth. But if I were modeling out and had that duty, I would do the market basket freeze and the 2.75 percent reduction, offset by the efficiencies I mentioned in my presentation in the growth.

Q: Dave MacDonald, SunTrust. Two questions, guys. On the specialty programs you've talked about others in development for a while now. Can you give us a sense of even some clinical areas where we can think about maybe seeing additional specialty programs? And then secondly, are you seeing in the market any increased reimbursement concerns in the liquidity issues potentially leading to opportunities to potentially lean on multiples for acquisitions on a go forward basis?

Answer: On the clinical side, we do spend a lot of time, like I said, in the presentation trying to understand that chronic subset. We believe that that chronic subset is going to be ultimately irrespective of the payment system best utilized for service at home. And we believe that's the way it's going to go. So isolating for us the subset that is requiring a lot of resources right now that currently are not serviced well in other areas, the stroke patient that requires multi-disciplines is not serviced well in the in-patient rehab setting, not serviced well on an outpatient setting. So that makes a good sense for us to expand that type of program. Not so much looking at the revenue of a program, but looking at areas, clinical areas that are underserved. We see the behavioral health diagnosis as an area that's underserved. Typically it requires special competencies. Those competencies are hard to obtain in certain markets. But it's a patient population that's currently not serviced well in the acute care facility, and then not serviced well on an outpatient basis. So without getting into specifics as far as launch date, we kind of use that methodology to understand where that subset is going and where that underserved need is.

Answer: On the multiple side, we have not seen major impacts on multiple expectations by sellers. We're seeing more sellers begin to come to the forefront and be interested in that process. Having said that, it's logical to assume that if there are reimbursement cuts and there's an ongoing dislocation in the availability of credit in the marketplace, that expectations will come down. One of the benefits, and it's sort of turn the world on its head kind of thing of a reimbursement cut, is we believe it will have a much more negative impact on other companies potentially than Amedisys, and that may counter intuitively give us a better opportunity to expand our acquisition activity at potentially better multiples than we've been able to do in the past. We do have a robust acquisition pipeline. And we're being very careful about the ones that we pursue.

Q: How you doing? Newton Juhng from BB&T Capital Markets. Larry, in your presentation you talked a lot about the growth in the agencies. And one of the things I was wondering about though was occasionally we see a closure of an agency. What are the factors that are driving that, whether it's that it's just not ramping up like you were looking for, or whether or not it's more of a mature agency that you just feel like you need to exit the marketplace?

Answer: Specifically from 2005 to 2008 there has been 26 what you would call closures. But none of those closures have we surrendered a provider number. And provider number gives you the opportunity to service up to a 50 mile radius. It's mainly when we've acquired something and we may have a provider number and two branches inside a 50 mile radius. So we'll just consolidate into one office. So it's more of a consolidation effort, too many offices and the demographics don't support it than it is hey, we're failing in this market, we want to go ahead and

close down the opportunity to service to this market. So we have not lost any geographic service area as a result of a closure. Typically we don't close underperforming offices. We'll change leadership and we'll add new salespeople, we'll roll out a disease management program. But we haven't abandoned a geographic territory, if you will.

Q: Thanks for the comments there, Larry. In terms of the state surveys, you pointed to, or it was pointed to that the numbers have been improving quite a bit over the last couple of years. And one of the things I was just wondering about was how you're doing relative to peers in each of the individual states? Any chance that you'd give us in the 37 states that you're operating in which states you're doing better than the peer group versus maybe not?

Answer: The data is not really out there to compare us to other peers. We gave you the national citation references. And that's the data, the external comparative data that is out there in the market. Obviously other providers aren't really forthcoming in rolling up and reporting all of their annual survey results. So that's information that we can glean from OIG studies of the state survey process that are imported in the literature. That national benchmark, the 15 top deficiency surveys that happen in home care, Amedisys versus the national, that's the benchmark that we have. Anecdotally I can tell you that perfect surveys are not the majority of the time. The state surveyors come in, that they're just very open to say everything's perfect. But I can't give you a benchmark of that unfortunately.

Q: Okay, so the states aren't giving the data that you could do it on a state by state basis?

Answer: We have not been able to find a national benchmark for those perfect survey ratings.

Q: Thank you.

Q: Thanks. It's Darren Lehigh with Deutsche Bank. I have a question just about the level of care that's being delivered by discipline. Larry, I think you talked about that as an opportunity to create some efficiencies. And I guess kind of a twofold question for you there. How are you measuring whether the caregiver is the right kind of caregiver to deliver that service? It sounds like you're trying to move some of the levels of care down in terms of the discipline. So if you would just share with us your thoughts on that. And then I guess to dovetail with that, how are those people trained? And are you doing anything organizationally to address training for those caregivers? Because I would imagine you want them to deliver the service at a certain level and they may not be able to do that.

Answer: Sure. Your first area, as far as identifying what services they can and should provide, on a macro basis, a registered nurse should provide – obviously the regulations state they have to do the admission assessment, they have to do any discharges. Beyond the regulations, you really need those registered nurses to provide advanced assessment in complex management skills. And typically your licensed practical nurses, or your PTAs will provide the lower services with technical skills. So for instance, if I was to give you an example, if you have a diabetic patient that you're going and you're checking blood sugar rates on, that's very appropriate for an LPN to do those functions. You'll see that in the acute care setting. From the registered nurse side, if you have a complex congestive heart failure patient that's been in the hospital multiple times, you would want that registered nurse to be able to provide that service because it requires advanced assessment skills. There are also other visits that we believe, although they're not in the regulations, but we believe are best suited for the registered nurse, complex wound patients, we've identified that as something we would prefer to have a registered nurse supervise that care. Psychiatric visits have to be provided by a certified psychiatric nurse. And IV infusion visits should be provided by a registered nurse. We have tagged in our system all of those type of high tech visits, meaning the IV visits, the psychiatric visits, and we have also tagged those type of visits that are technical skills in nature to give our directors a sense of if this is your visit population, these really are the technical visits that can be provided by an LPN versus you need to reserve these for the RN population. This is, in essence, you define this as a team nursing concept. So it's not an RN versus an LPN visit, but it's a structure of a pattern, a primary RN with disciplines of lower technical skills underneath them. So you will have a primary RN who has a team of two LPNs underneath them. So when you talk about rolling that out, you have to do a lot of due diligence work. You have to understand which visits and quantify which visits you believe are best suited to the level of care. Once you've done that process, you have to develop advanced credentialing for the LPN to ensure that they have competencies in those technical skills. So when we talk about those diabetic patients that require blood sugar monitoring, all of the LPNs went through advanced competency training related to those type of skilled visits. That is different than the competency training that I showed you on the screen that's in addition to that. So that is a change in practice. That's not something that happened over a month or six months. It's something that happens when you shift from primary nursing, I have one nurse and she takes care of these 20 patients and she does everything, versus team nursing. And that takes a while over a 12 to 24 month period.

Q: And then my other question here is just with regard to the episodes per beneficiary. And if you just talk a little bit more about how you see the rollout of the various specialty programs impacting that, would that increase that ratio or would that decrease that over time? And I guess the other part of the question is

just the recertification rate, what do you think is the right recertification rate given the reimbursement rules today and where you are with your population?

Answer: Well, in regards to the specialty programs, it's very hard for us to sit here and tell you, oh, the length of stay is going to increase because of specialty programs. Or the recert is going to increase because of specialty programs. We can tell you what we're seeing in the data. And the data shows us that we are growing that stroke subset. And that stroke subset has a higher episodes per patient. And we are growing that cardiac subset, and that cardiac subset has a higher episodes per patient. So that is not something that you're going to see shift similar to the initiative related to the disciplines or how we deliver care from RN to LPN. You're not going to see that shift over a six month period or a 12 month period. But that is going to be more driven by increasing the service levels based on those diagnostic categories. If we were to look out over the next 12 to 24 months and our percentage of wound patients has gone up by four percent, it makes total sense that you're going to see potential migrations in that recertification rate, and potential migrations in net episodes per patient. But it's very hard for us to quantify that we believe specialty programs within a year's point of time is going to increase the episode per patient from this to this.

Answer: If I could add something, too. We made a deliberate effort in the last earnings call to point out that there is a difference in financial metrics versus clinical metrics. So the number of episodes per patient is really driven more by the acuity of the patient and the needs of the patient. And so we can't really sit here and say we predict that the right level of service and from a financial standpoint should be four episodes per patient in this particular program because it's going to be driven entirely by how sick is this particular patient in this particular agency at this particular time. And so a lot of these metrics that we talk about are not, do not lend themselves to kind of the financial prediction. And so we've tried to spell out that you can't put it in that kind of financial box, that there are some clear financial metrics that we can give. But there are also some clinical metrics that are just not prone to prediction in that same manner.

Answer: It's also important to note that the lion's share of our patients only receive one episode of care. The majority of them.

Q: Good morning, guys. Greg Williams from Sidoti. Thanks from having us all here today. Just a question, Dale, you mentioned that acquisition multiples may come down in the face of rate cuts, rate cut uncertainties. And you're going to generate ample free cash flow, \$140 million in '09 projected. And with where your shares are trading at recently, would you guys entertain a share repurchasing program? Thanks.

Answer: I think the answer to that is that we feel like there is probably more accretion involved in spite of the current stock price involved in pursuing our three phase strategy, which is growing through acquisitions, start ups, and the Medicare beneficiary is going to grow by itself. So I don't know that that's necessarily on our radar screen. In these different times that we're living in now, or interesting time that we're living in now, you don't take anything off the table. But I think given the resources that we have, which is \$140 million or so in cash flow that we have available to spend for acquisitions in 2009 and the availability under our line of credit, probably makes more sense for us to pursue our acquisition strategy rather than a share repurchase program.

Male: Before we go to the next one we've got just a couple of more minutes left, so we're just going to go to a couple of more people after this.

Q: This is Cameron \_\_\_\_\_ at Athas Capital. I had a question about your LUPA rate, and does that trend down as your acuity case mix increases? And then kind of related is the diagnosis trend. You showed us an increase in stroke patients and wound patients. Which types of patients are declining if those patients are increasing?

Answer: I think with respect to the LUPA rate, that's driven more by oftentimes circumstances that are beyond our control. It may be that a patient dies during care or a patient may choose just to terminate services. So there are a lot of external factors that would impact that that are not driven so much by the particular DM program that you put them on. I think it important with respect to LUPAs, that there is an expectation that you're just naturally going to have a certain percentage of LUPAs. I think it's going to vary over time because it's driven by particular patient needs. I think you're talking somewhere in the range of four to five percent somewhere. And there's a relatively low number to begin with. But you get concerned obviously the lower it is. So it could migrate all over the board. But fundamentally you're going to have some LUPA. So the issue is not the number of LUPAs, the issue is which agencies have the lowest number of LUPAs relative to your company average.

Q: [inaudible]

Answer: From what I've been able to see generally yes. Again, there's not a whole lot of data out there for comparative purposes. But generally the vast majority of our agencies are all in the same range. So it's just where, again, it gets artificially low that it gives you pause.

Answer: And could you please repeat the –

Q: You said your stroke and wound patients are increasing, what type of patients are decreasing?

Answer: We see stability in the diabetes population. For the last three years that's escalated a little bit. But there's been no more than 1 percent growth within that population. We'll still service those patients. It's not a situation where we're declining those patients that have needs. But if we just look at our data, I don't see exponential growth in that area.

Q: [inaudible]

Answer: No, there's no trend.

Q: Alex Schmeltzer, Scoggin Capital. Does Medicare reimburse you per visit or per episode? In other words do you get more money if there are 20 visits instead of 10?

Answer: It's per episode. It's called The Home Health Resource Group, similar to a DRG in a hospital. Unless you do less than five visits, then it's per visit, which is called our LUPA rate. So it matters by diagnoses and wage index where they live, so it varies per episode of care. And our average all-in of all our episodes is at \$2,960.

Q: [inaudible]

Answer: The number of visits you do does not impact the revenue per episode except for the LUPA rate if you do less than five, therapy on the 6, 14, and 20 threshold impacts your revenue per episode, and less than probably 2 percent of our population is considered outliers. You're doing 70 or 80 visits, you're going every day, that will impact your revenue per episode. Other than that, the vast majority if you do 16 or 20 or 25, it doesn't have a revenue per episode impact.

Q: \_\_\_\_\_ 14, 20 therapy.

Answer: On the therapy side.

Q: What's that?

Answer: That's at both thresholds at six therapy visits you get additional reimbursement, and then you a dollar incremental for the seventh, eighth, and ninth. At 14 you get a dollar incremental, and at 20 you get a dollar incremental.

Q: Good morning, Eric Gommel, Stifel Nicolaus. You talked about the formation of the alliance with the other public and large private home health operators, which I

think is a very positive development from a lobbying perspective, quality perspective. What's the potential that you get together from maybe a financial reporting perspective to look at maybe the way each company, to standardize how you might report perhaps AR or how you might standardize reporting certain revenue numbers, for example the nursing homes, they talk about rates per day, patient days. Is that something you would have a positive bias for? Just would be interested in your thoughts on that.

Answer: Well, let me just take a quick stab and I'll let Dale go from there. But the intention of the alliance is not to get together and look at metrics or compare metrics. It's really about a value proposition. It's how the industry can get together and one, prove the value of the services as we provide them today as an alternative to hospitalization, and preventing readmissions to hospitals, also preventing patients visiting the emergency room. So we're working on that, we're working on the message to make sure a panelist understand the breadth of the benefit and the value of it. We're working on legislation, we're working on all the quality initiatives through three or four different organizations. When it comes down to operational things, we think that's something best for the CFOs to get together and communicate. And I'll let Dale maybe share a little bit about his dialogue with some of those CFOs.

Answer: The direct answer to your question, there have been discussions on that issue. Obviously if another company versus Amedisys is doing things differently, both of them may be absolutely appropriate. But the fact that they're different causes confusion, and that's not a good thing for any industry. So we have had discussions with the other public company CFOs, and the idea there is basically if there are things that we can do to report things on a common basis, and an easy example is I mentioned to you in the presentation that we are going to henceforth report DSO on a net basis. That's what primarily the rest of the industry does. And that's what we're going to do going forward. I think you will also see the aging buckets that we use on our accounts receivable conform. It's not good, bad, or indifferent for any particular company, it just makes the industry, the numbers more comparable. So I think you will see that as an effort that the industry takes on simply to eliminate the confusion of using different accounting methods to the extent that we can. So that process is underway and we hope to make some progress on it during 2009.

Q: Thanks, Whit Mayo with Robert Baird. There's been a lot of discussion lately about CMS attachment D pertaining to the secondary and tertiary diagnosis within the OASIS assessment. And we heard over the past couple of days that I think CMS has now acknowledged that a lot of the language that it put in its initial transmittal was flawed and it sounds like nothing is going to happen going forward. But could you, one, just kind of confirm where that issue lies right now?

And secondly, could you comment around whether or not you think the secondary and tertiary diagnosis has helped your, had any impact really on your revenue per episode at least in 2008?

Answer: On your first question, from our perspective, the coding guidelines were extremely vague and contradictory to prior guidelines. So our understanding at this point is your understanding. They've come out, they've said there might be some issues and it's kind of back at the table. We're continuing the same type of guidelines or coding instructions to our agencies at this point. We don't envision that any clarification on secondary diagnosing will change the financial estimates that we've given the market over the next year.

Q: Okay. And maybe just one other question for Jeff while he's here. It sounds like there's some HIPAA changes coming over the next year, and you guys have a lot of laptops and I find it hard to believe that maybe a nurse doesn't lose one here and there. So could you talk a little bit about the compliance programs, what you have in place right now just for breeches of information, whether or not you need to staff up at all just in anticipation of some of the HIPAA changes? Just any comments around that?

Answer: Yeah. I think actually the technology works in our favor with respect to HIPAA issues. If you can imagine a home care agency that is not electronic and doesn't have laptops, you run into the same kinds of problems where you have an inherently mobile workforce. They're out, they're doing visits, they have information in their cars. You frequently see maybe a clinician's care will get broken into, somebody would think they've got medications, drugs in it for example. And that would be a problem you would run into. But if you're entirely paper based, once those records are out of the vehicle and out into the stream of commerce, they're gone. And some things you would do is engage a private investigator and see if you can find that information. But at that point you lose control over it. The technology that we have that allows our clinicians to do all of their work electronically built into the laptop system, there's password security, so obviously they can't get into it. There's really no value in that point of care device other than using it for its intended purpose. They can't all the sudden use it and start doing their own personal computing on it. And then what we've also built into it is if we have a theft of one of the devices or just one of the clinicians loses it, we have the capability remotely to wipe the memory. So we basically throw a switch and the entire thing is disabled and it's of no use to anybody. So I really look at that more in light of the HIPAA security regs as a strength of ours as opposed to a weakness.

Male: With that, that will conclude our presentation today. On behalf of the senior management, I'd like to thank everybody for coming. And if you have any further questions, please get in contact with me at Amedisys. Thank you very much.

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