BLACKROCK MUNICIPAL INCOME QUALITY TRUST
Form N-Q
July 28, 2011
UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM N-Q

QUARTERLY SCHEDULE OF PORTFOLIO HOLDINGS OF REGISTERED MANAGEMENT INVESTMENT COMPANY

Investment Company Act file number 811-21178

Name of Fund: BlackRock Municipal Income Quality Trust (BYM)

Fund Address: 100 Bellevue Parkway, Wilmington, DE 19809

Name and address of agent for service: John M. Perlowski, Chief Executive Officer, BlackRock Municipal Income Quality Trust, 55 East 52nd Street, New York, NY 10055

Registrant s telephone number, including area code: (800) 882-0052, Option 4

Date of fiscal year end: 08/31/2011

Date of reporting period: 05/31/2011

Item 1 Schedule of Investments

Schedule of Investments May 31, 2011 (Unaudited)

BlackRock Municipal Income Quality Trust (BYM)
(Percentages shown are based on Net Assets)

Municipal Bonds	Par (000)	Value
Alabama 3.8%		
Alabama State Docks Department, Refunding RB, 6.00%, 10/01/40	$ 3,800	$ 3,864,790
Birmingham Airport Authority, RB (AGM), 5.50%, 7/01/40	5,800	5,878,300
Birmingham Special Care Facilities Financing Authority, RB, Children s Hospital (AGC), 6.00%, 6/01/39	1,495	1,590,157
County of Jefferson Alabama, RB, Series A, 4.75%, 1/01/25	2,800	2,256,716
		13,589,963
Arizona 0.6%		
State of Arizona, COP, Department of Administration, Series A (AGM):		
5.00%, 10/01/27	1,500	1,519,275
5.25%, 10/01/28	650	664,027
		2,183,302
California 29.2%		
California Health Facilities Financing Authority, Refunding RB, St. Joseph Health System, Series A, 5.75%, 7/01/39	625	632,206
California Infrastructure & Economic Development Bank, RB, Bay Area Toll Bridges, First Lien, Series A (AMBAC), 5.00%, 1/01/28 (a)	10,100	12,106,769
Coast Community College District California, GO, Refunding, CAB, Election of 2002, Series C (AGM):		
5.58%, 8/01/31 (b)	7,450	6,439,780
5.40%, 8/01/36 (c)	4,200	799,764
Fresno Unified School District California, GO, Election of 2001, Series E (AGM), 5.00%, 8/01/30	1,100	1,098,581
Golden State Tobacco Securitization Corp. California, RB, Series 2003-A-1 (a):		
6.63%, 6/01/13	6,500	7,269,535
6.75%, 6/01/13	14,500	16,252,615

Los Angeles Municipal Improvement Corp., RB, Series B1 (NPFGC), 4.75%, 8/01/37	4,000	3,565,840
Metropolitan Water District of Southern California, RB, Series B-1 (NPFGC), 5.00%, 10/01/33	17,500	17,744,825
Monterey Peninsula Community College District, GO, CAB, Series C (AGM) (c):		
5.15%, 8/01/31	13,575	3,595,203
5.16%, 8/01/32	14,150	3,447,223

Municipal Bonds	Par (000)	Value
California (concluded)		
Orange County Sanitation District, COP, Series B (AGM), 5.00%, 2/01/31	$ 2,500	$ 2,583,225
Sacramento Unified School District California, GO, Election of 2002 (NPFGC), 5.00%, 7/01/30	2,700	2,730,672
San Diego Unified School District California, GO, CAB, Election of 2008, Series C, 6.85%, 7/01/38 (c)	2,000	337,400
San Francisco City & County Public Utilities Commission, Refunding RB, Series A (AGM), 5.00%, 11/01/31	15,000	15,034,500
San Joaquin Hills Transportation Corridor Agency California, Refunding RB, CAB, Series A (NPFGC), 5.50%, 1/15/31 (c)	53,000	8,496,960
San Jose Unified School District Santa Clara County California, GO, Election of 2002, Series B (NPFGC), 5.00%, 8/01/29	2,350	2,395,825
		104,530,923
Colorado 0.3%		
Regional Transportation District, COP, Series A, 5.38%, 6/01/31	960	990,749
District of Columbia 2.4%		
District of Columbia Tobacco Settlement Financing Corp., Refunding RB, Asset-Backed, 6.75%, 5/15/40	9,500	8,745,795
Florida 15.4%		
Broward County School Board Florida, COP, Series A (AGM), 5.25%, 7/01/33	2,000	2,017,560
City of Tallahassee Florida, RB (NPFGC), 5.00%, 10/01/32	3,000	3,027,360
County of Broward Florida, RB, Series A, 5.25%, 10/01/34	6,750	6,986,048

County of Duval Florida, COP, Master Lease Program (AGM), 5.00%, 7/01/33	2,800	2,770,348
County of Miami-Dade Florida, RB:		
CAB, Sub-Series A (NPFGC), 5.25%, 10/01/38 (c)	25,520	3,800,438
Jackson Health System (AGC), 5.75%, 6/01/39	2,300	2,366,171
Water & Sewer System (AGM), 5.00%, 10/01/39	10,100	10,144,238

Portfolio Abbreviations

To simplify the listings of portfolio holdings in the Schedule of Investments, the names and descriptions of many of the securities have been abbreviated according to the following list:

AGC	Assured Guaranty Corp.
AGM	Assured Guaranty Municipal Corp.
AMBAC	American Municipal Bond Assurance Corp.
BHAC	Berkshire Hathaway Assurance Corp.
CAB	Capital Appreciation Bonds
COP	Certificates of Participation
EDA	Economic Development Authority
ERB	Education Revenue Bonds
GO	General Obligation Bonds
IDA	Industrial Development Authority
ISD	Independent School District
NPFGC	National Public Finance Guarantee Corp.
PSF-GTD	Permanent School Fund Guaranteed
RB	Revenue Bonds
SBPA	Stand-by Bond Purchase Agreements
VRDN	Variable Rate Demand Notes

Schedule of Investments (continued)

BlackRock Municipal Income Quality Trust (BYM)
(Percentages shown are based on Net Assets)

Municipal Bonds	Par (000)	Value
Florida (concluded)		
County of Miami-Dade Florida, Refunding RB (AGM), 5.00%, 7/01/35	$ 1,300	$ 1,296,334
Florida Housing Finance Corp., RB, Homeowner Mortgage, Series 3, 5.45%, 7/01/33	4,020	4,087,536
Florida State Department of Environmental Protection, RB, Series B (NPFGC), 5.00%, 7/01/27	7,500	7,715,850
Miami-Dade County School Board, COP, Refunding, Series B (AGC), 5.25%, 5/01/31	2,135	2,172,042
Orange County School Board, COP, Series A (AGC), 5.50%, 8/01/34	6,090	6,242,433
Sarasota County Public Hospital District, RB, Sarasota Memorial Hospital Project, Series A, 5.63%, 7/01/39	300	296,850
Tohopekaliga Water Authority, RB Refunding, Series A, 5.25%, 10/01/36	2,000	2,056,080
		54,979,288
Georgia 2.6%		
City of Atlanta Georgia, Refunding RB, General, Series C, 6.00%, 1/01/30	7,500	8,336,775
Gwinnett County Hospital Authority, Refunding RB, Gwinnett Hospital System Series D (AGM), 5.50%, 7/01/41	900	899,955
		9,236,730
Hawaii 1.4%		
Hawaii State Harbor, RB, Series A, 5.50%, 7/01/35	5,000	5,081,900
Illinois 4.7%		
Chicago Board of Education Illinois, GO, Refunding, Chicago School Reform Board, Series A (NPFGC), 5.50%, 12/01/26	2,500	2,578,875
Chicago Park District, GO, Harbor Facilities, Series C, 5.25%, 1/01/40	600	610,368

City of Chicago Illinois, RB, Series A (AGC), 5.00%, 1/01/38	7,310	7,245,964
County of Cook Illinois, GO, Refunding, Series A, 5.25%, 11/15/33	1,475	1,503,586
Illinois Municipal Electric Agency, RB, Series A (NPFGC), 5.25%, 2/01/27	2,500	2,591,450
Railsplitter Tobacco Settlement Authority, RB, 6.00%, 6/01/28	710	712,116
State of Illinois, RB, Build Illinois, Series B, 5.25%, 6/15/34	1,400	1,409,086
		16,651,445
Indiana 2.1%		
Indiana Municipal Power Agency, RB:		
Series A (NPFGC), 5.00%, 1/01/37	2,050	2,000,759
Series B, 5.75%, 1/01/34	450	457,299

Municipal Bonds	**Par (000)**	**Value**
Indiana (concluded)		
Indianapolis Local Public Improvement Bond Bank, Refunding RB, Waterworks Project, Series A:		
(AGC), 5.50%, 1/01/38	$ 2,000	$ 2,064,920
(NPFGC), 5.50%, 7/01/20	2,630	3,013,059
		7,536,037
Iowa 1.4%		
Iowa Finance Authority, RB, Series A (AGC), 5.63%, 8/15/37	5,000	5,116,550
Kentucky 0.4%		
Kentucky State Property & Buildings Commission, Refunding RB, Project No. 93 (AGC), 5.25%, 2/01/29	1,500	1,575,150
Louisiana 2.2%		
State of Louisiana, RB, Series A (AGM), 5.00%, 5/01/31	7,500	7,723,500
Michigan 2.9%		
City of Detroit Michigan, RB:		
Senior Lien, Series A (NPFGC), 5.00%, 7/01/30	1,000	939,080
Senior Lien, Series A (NPFGC), 5.00%, 7/01/34	2,480	2,240,878
System, Second Lien, Series A (BHAC), 5.50%, 7/01/36	2,900	2,945,704
System, Second Lien, Series B (NPFGC), 5.00%, 7/01/36	100	92,596
City of Detroit Michigan, Refunding RB, Second Lien, Series E (BHAC), 5.75%, 7/01/31	3,000	3,136,320

Kalamazoo Hospital Finance Authority, RB, Bronson Methodist Hospital (AGM), 5.25%, 5/15/36	465	456,114
Lansing Board of Water & Light, RB, Series A, 5.50%, 7/01/41 (d)	400	417,604
		10,228,296
Nebraska 1.2%		
Nebraska Investment Finance Authority, Refunding RB, Series A:		
5.90%, 9/01/36	2,450	2,545,256
6.05%, 9/01/41	1,805	1,855,359
		4,400,615
Nevada 1.6%		
County of Clark Nevada, RB:		
Las Vegas-McCarran International Airport, Series A (AGC), 5.25%, 7/01/39	4,100	3,988,316
System, Subordinate Lien, Series C (AGM), 5.00%, 7/01/26	1,650	1,668,513
		5,656,829
New Jersey 0.8%		
New Jersey Transportation Trust Fund Authority, RB, Transportation System, Series A, 5.50%, 6/15/41	3,000	3,067,260

Schedule of Investments (continued)

BlackRock Municipal Income Quality Trust (BYM)
(Percentages shown are based on Net Assets)

Municipal Bonds	Par (000)	Value
New York 2.4%		
New York City Transitional Finance Authority, RB, Fiscal 2009, Series S-4, 5.50%, 1/15/33	$ 1,950	$ 2,060,370
New York State Dormitory Authority, ERB, Series B, 5.75%, 3/15/36	1,300	1,426,256
Port Authority of New York & New Jersey, Refunding RB, Consolidated, 140th Series, 5.00%, 12/01/34	5,000	5,122,250
		8,608,876
North Carolina 0.7%		
North Carolina Medical Care Commission, RB, Novant Health Obligation, Series A, 4.75%, 11/01/43	2,875	2,388,809
Ohio 0.5%		
County of Lucas Ohio, Refunding RB, Promedica Healthcare, Series A, 6.50%, 11/15/37	610	668,676
Ohio Higher Educational Facility Commission, Refunding RB, Summa Health System, 2010 Project (AGC), 5.25%, 11/15/40	1,125	1,070,190

	Third Quarter (through September 15, 2004)	$33.06	$23.07
	Second Quarter	$33.57	$23.01
	First Quarter	$24.95	$13.47
2003:			
	Fourth Quarter	$17.00	$ 9.15
	Third Quarter	$ 9.37	$ 5.46
	Second Quarter	$ 7.01	$ 4.48
	First Quarter	$ 6.00	$ 4.10
2002:			
	Fourth Quarter	$ 7.35	$ 4.35
	Third Quarter	$11.96	$ 6.78
	Second Quarter	$10.80	$ 7.28
	First Quarter	$ 8.50	$ 6.06

On September 15, 2004, the last reported sale price of our common stock on the Nasdaq National Market was $28.52 per share. As of September 15, 2004, there were approximately 362 stockholders of record of our common stock.

COMMON STOCK DIVIDENDS

The holders of our common stock are entitled to dividends in such amounts and at such times, if any, as may be declared by our board of directors out of legally available funds. We do not pay dividends on our common stock and do not anticipate paying any cash dividends on our common stock in the foreseeable future.

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CAPITALIZATION

The following table sets forth our actual cash and cash equivalents and capitalization as of June 30, 2004, and as adjusted to give effect to the issuance of 2,460,000 shares of our common stock being offered hereby and the application of the estimated net proceeds of the offering. The capitalization information set forth in the table below is qualified by the more detailed consolidated financial statements and notes thereto incorporated by reference in this prospectus.

	As of June 30, 2004	
	Actual	As Adjusted
	(Unaudited) (Dollars in thousands)	
Cash and cash equivalents	$22,279	$ 85,909
Debt and capital lease obligations:		
Long-term debt, including current portion	$ 4,796	$ 4,796
Capital lease obligations, including current portion	942	942
Total debt and capital lease obligations	5,738	5,738
Stockholders equity:		
Common stock, $0.001 par value per share; 30,000,000 shares authorized, 12,387,940 (actual) and 14,847,940 (as adjusted) shares issued and outstanding	12	15
Additional paid-in capital	58,980	122,608
Treasury stock	(25)	(25)
Retained earnings	5,129	5,129
Total stockholders equity	64,096	127,727
Total capitalization	$69,834	$133,465

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SELECTED FINANCIAL DATA

The following table presents our selected financial information, which you should read in conjunction with, and is qualified in its entirety by reference to, our historical consolidated financial statements, the notes to those financial statements, and Management s Discussion and Analysis of Financial Condition and Results of Operations included in the documents incorporated by reference in this prospectus. The selected financial information set forth below as of and for the years ended December 31, 2001, 2002 and 2003 has been derived from our audited consolidated financial statements. The selected financial information as of and for the six months ended June 30, 2003 and 2004 has been derived from unaudited financial statements, which include all adjustments consisting of normal recurring accruals that we consider necessary for a fair presentation of the financial position and the results of operations for these periods. Historical results are not necessarily indicative of future performance.

	Years ended December 31,			Six months ended June 30,	
	2001	2002	2003	2003	2004
		(Audited)		(Unaudited)	
	(In thousands, except per share amounts)				
Selected Historical Statements of Operations					
Net service revenue	$110,174	$129,424	$142,473	$63,326	$104,235
Cost of service revenue (excluding amortization and depreciation)	49,046	58,244	58,554	26,009	43,093
Gross margin	61,128	71,180	83,919	37,317	61,142
General/administrative expenses	53,665	64,700	69,581	32,577	46,154
Operating income	7,463	6,480	14,338	4,740	14,988
Other (expense), net	(2,167)	(9,013)	(711)	(451)	(135)
Income tax (expense) benefit	(220)	3,285	(5,220)	(1,626)	(5,671)
Income before discontinued operations	5,076	752	8,407	2,663	9,182
Discontinued operations:					
Loss from discontinued operations, net of income tax	(566)				
Gain on dispositions, net of income tax	876				
Net income	$ 5,386	$ 752	$ 8,407	$ 2,663	$ 9,182
Weighted average common shares used in computing basic net income per share	5,941	8,499	9,808	9,402	12,144
Weighted average common shares used in computing diluted income per share	7,980	9,007	10,074	9,583	12,683
Basic earnings per share					
Net income before discontinued operations	$ 0.85	$ 0.09	$ 0.86	$ 0.28	$ 0.76
Loss from discontinued operations, net of income tax	(0.10)				
Gain on dispositions, net of income tax	0.15				
Net income	$ 0.90	$ 0.09	$ 0.86	$ 0.28	$ 0.76
Diluted earnings per share					
	$ 0.64	$ 0.08	$ 0.83	$ 0.28	$ 0.72

Net income before discontinued operations					
Loss from discontinued operations, net of income tax	(0.07)				
Gain on dispositions, net of income tax	0.11				
Net income	$ 0.68	$ 0.08	$ 0.83	$ 0.28	$ 0.72

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	Years ended December 31,			Six months ended June 30,	
	2001	2002	2003	2003	2004
		(Audited)			(Unaudited)
		(In thousands, except per share amounts)			
Selected Historical Balance Sheet Data					
Cash and cash equivalents	$ 3,515	$ 4,861	$29,779	$12,801	$ 22,279
Patient accounts receivable, net of allowances for doubtful accounts	23,682	14,102	15,185	9,424	19,841
Total current assets	28,263	23,223	49,596	26,954	45,511
Goodwill and other assets, net	22,301	25,768	35,658	25,737	57,383
Total assets	60,854	58,959	92,473	60,069	111,015
Total current liabilities	46,623	31,755	34,018	31,056	40,574
Net working capital (deficit) surplus	(18,360)	(8,532)	15,578	(4,102)	4,937
Total long-term obligations	10,856	10,241	7,056	7,874	6,345
Total stockholders equity	3,309	16,963	51,399	21,139	64,096

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OUR BUSINESS

We are one of the nation s largest providers of home nursing services to Medicare beneficiaries. We deliver a wide range of health-related services in the home to individuals who may be recovering from surgery, have a chronic disability or terminal illness, or need assistance with the essential activities of daily living. The services we provide include skilled nursing and home health aide services; physical, occupational, and speech therapy; and medically oriented social work to eligible individuals who require ongoing care that cannot be provided effectively by family and friends. In addition, we have developed and offer clinically focused nursing programs in high-cost disease categories, such as diabetes, coronary artery disease, congestive heart failure, orthopedics, wound care, geriatric surgical recovery, and behavioral health. As of July 31, 2004, we operated 94 Medicare-certified home health care nursing locations in the Southern and Southeastern United States consisting of 53 main locations and 41 branch locations. We also operate Medicare-certified hospice locations in two markets and may add hospice locations on a selective basis in the future. We believe our services are attractive to payors and physicians because they combine clinical quality with cost-effectiveness and are accessible 24 hours a day, seven days a week. Our objective is to be the leading provider of high-quality, low-cost home nursing services in each market in which we operate.

Since 2002, we have generated significant increases in revenue and earnings by focusing on internal growth in our existing markets, opening home nursing locations in new markets, and selectively acquiring home nursing operations. For the six months ended June 30, 2004, we reported net service revenue of $104.2 million, net income of $9.2 million, and earnings per diluted share of $0.72 compared to net service revenue of $63.3 million, net income of $2.7 million, and earnings per diluted share of $0.28 for the same period in 2003. For the year ended December 31, 2003, we reported net service revenue of $142.5 million, net income of $8.4 million, and earnings per diluted share of $0.83 compared to net service revenue of $129.4 million, net income of $0.8 million, and earnings per diluted share of $0.08 for 2002.

Our Market and Opportunity

Segments within the $45.3 billion home health care industry include: (1) home nursing services, (2) infusion therapy, (3) respiratory therapy, and (4) home medical equipment. Home nursing is by far the largest industry segment, accounting for $33.2 billion, or 73.3% of total market spending, according to 2001 figures from CMS. There are approximately 7,000 Medicare-certified home nursing agencies currently in operation. The home nursing industry is comprised of facility-based and hospital-based agencies owned by publicly-traded and privately-held companies, visiting nurse associations, and nurse registries. Of these, 68% are freestanding agencies and approximately half operate as for-profit entities. The bulk of the home nursing industry is made up of thousands of relatively small local or regional providers, most of which are not well capitalized. The industry remains highly fragmented, and we believe it represents an attractive consolidation opportunity. Although a small number of large, for-profit companies exist, none has a dominant market presence.

Medicare is the largest single home nursing payor, accounting for $11.4 billion or 34.3% of total home health nursing spending, and this amount is expected to increase substantially, growing to $20.7 billion by 2011, according to 2002 statistics from CMS Office of the Actuary. Among other factors, we believe that industry growth primarily is being driven by:

Patient Preference. When possible, patients prefer the convenience and comfort of receiving treatment in their homes. Studies have shown that patients actually respond to treatment more aggressively if they are comfortable in the environment in which they receive care. Continuing advances in pharmaceutical development and medical technology are enabling a growing number of patients to receive treatment in lower intensity settings and, in many cases, to self-administer medications or to do so under the supervision of a qualified caregiver in their home.

Payor Incentives. Continuing economic pressures within the health care industry have led both public and private sector payors to implement strategies that create incentives for providers to deliver care more efficiently and in the most appropriate setting. This dynamic, combined with the

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substantial cost savings that can be realized through treatment at home, has led to increased utilization of home care over the past ten years.

Demographic Changes. The population of older Americans is growing at an increasing rate and life expectancies in the United States are increasing. The U.S. Census Bureau estimates the population aged 65 and older will grow 50.8% from its estimated 2003 level of 35.6 million (12.6% of the total population) to 53.7 million (16.5% of the total population) by 2020. In addition, people over the age of 85 currently comprise the fastest growing subset of the population. The U.S. Census Bureau projects an increase in the over-85 population from an estimated 4.7 million in 2003 to 5.9 million in 2011. Over the same period, the over-85 population is expected to increase as a percentage of the over-65 population from 13.2% to 14.6%. The growth in the elderly population and continued aging of these individuals is expected to continue to drive demand for home health services.

Increases in Chronic Disease Prevalence. Prolonged life expectancy often results in a higher incidence of chronic conditions and disease. For example, the invention of modern-day antibiotics markedly reduced death due to infectious causes, which in turn has led to an increase in the prevalence of chronic, non-infectious conditions such as coronary artery disease and diabetes. Other examples include success with preventive measures such as the treatment of vascular disease and ability to intervene effectively during acute events such as myocardial infarctions. These interventions have decreased the incidence of death resulting from acute episodes, which has led to the emergence of chronic conditions associated with long-term disease.

Use of home nursing services is increasing due to the rising demand for skilled nursing and related services by an aging population combined with patient and payor preferences for treatment in the home setting when possible. Home nursing spending grew rapidly in the early and mid-1990s, from $3.3 billion in 1990 to $18.8 billion in 1997. BBA was the first of a series of legislative and administrative actions designed to rationalize the growth of home health benefit spending by transitioning from a cost-based reimbursement system to PPS. Under home health PPS, which was fully implemented in October 2000, home health agencies are paid a fixed amount for providing an episode of care to a beneficiary. Payments to providers are adjusted to account for differences in individual care plans and for geographic differences in home health agency costs. Episodes of care begin with a patient s admission and end up to 60 days later, after which most patients complete their course of care and are discharged in one payment episode. If a patient s care is not completed within 60 days, Medicare allows another episode to begin without a break in care upon recertification by the referring physician. For a fixed episode of care payment, the home health agency provides therapy, skilled nursing, medically oriented social service, and home health aide visits to patients in their homes. Home health providers face the risk of loss if their costs exceed these payments, while providers that furnish care for less than the fixed payment rate retain the difference. To earn profits or avoid losses, agencies can control the number of visits, per-visit costs, or both. This new system encourages efficient delivery of care.

Our Competitive Strengths

We believe the following competitive strengths contribute to our strong market share in each of our markets and will enable us to grow our business successfully and increase our profitability:

Primary Focus on Medicare Home Nursing. Our primary focus is on providing home nursing services to Medicare beneficiaries, and we derive approximately 92% of our revenues from Medicare. We recruit and retain caregivers who are attentive to, and familiar with, the specialized needs of the elderly population. We have deployed specialized nursing programs that focus on the high-cost diseases and conditions prevalent in the 65 and older demographic segment. We believe these efforts position us as a potential partner for CMS should we be chosen to participate in programs like the Chronic Care Improvement program, a recent CMS initiative focused on introducing disease management services and protocols to Medicare-eligible individuals. Finally, there are other benefits to our Medicare focus. For example, our billing and collections are

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somewhat simplified compared with other health care industry providers because of our emphasis on Medicare and the PPS reimbursement process.

Proven Operating Model. Our home nursing model balances the benefits of promoting local agency responsibility and accountability for quality of care and operating results with the efficiencies gained from centralizing key administrative functions. Our home health agencies carry locally recognized branding and tailor their respective marketing efforts to address the specific needs of the communities, referral sources, and Medicare beneficiaries they serve. Agency management teams work to establish strong relationships in their communities and with referral sources. To support our local management teams, we have centralized accounting, regulatory, marketing, payroll, intake, billing, collections, risk management, and quality assurance. We have implemented standardized clinical programs across our system and believe this initiative has improved care quality through the implementation of best practices and helps us actively manage risk by ensuring clinical compliance across all of our home health agencies. In addition, our operations typically have access to more resources and financial management expertise than locally-owned competitors.

Focused Clinical, Operational, and Financial Management. We have invested in information technology and real-time management and monitoring capabilities that allow us to standardize the care delivered across our system and monitor the status of the patients we treat. Under PPS, the majority of our revenue is pre-determined at admission based on an initial patient assessment and adjusted for patient resource needs, their functional severity and therapy requirements, and the local wage index. Monitoring and controlling the time and costs associated with the care we provide is essential to maintaining our operating margins and profitability. We have generated significant recent admissions growth and have been able to manage that growth due in large part to our real-time monitoring capability. We believe that most competing providers lack the resources to implement similar systems. In addition, we believe that our focus helps us develop important relationships and extensive referral networks within our markets and to attract and retain qualified health care professionals.

Demonstrated Ability to Identify and Integrate Acquisitions. We have a demonstrated track record of identifying, evaluating, acquiring, and integrating companies in the home nursing market. We have integrated successfully the home health agencies we acquired in 2001, 2002 and 2003 and are in the process of integrating recent acquisitions, including the ten home health agencies and two hospices we acquired from Tenet. We attribute part of our success in integrating these agencies to our rigorous due diligence review prior to completing the acquisitions. We employ a disciplined strategy based on defined acquisition criteria including high service quality, a strong referral base, a compatible payor mix, and opportunities for cost savings and significant internal growth. We also develop a comprehensive post-acquisition strategic plan to facilitate the integration of acquired agencies that includes improving agency operations; recruiting qualified nurses and account executives; expanding relationships with local physicians and discharge planners; expanding the breadth and quality of services offered by the agencies; and transitioning acquired operations onto our information technology platform.

Significant Cash Flow from Operations and Relatively Low Capital Expenditures. We generate significant cash flow from operations due to the profitable operation of our business, our relatively low capital expenditure requirements, and the active management of our working capital. Our capital expenditure requirements are low because our services do not require the purchase and replacement of expensive medical equipment. Historically, our capital expenditures have amounted to less than 2.0% of our revenue.

Patient-Oriented Company Culture. We believe that we have developed a strong patient-oriented culture that emphasizes quality of care. We communicate frequently with our employees and provide education opportunities along with competitive benefits. We reinforce our culture through an orientation program for new employees and by an ongoing emphasis on the importance of high-quality patient care and the need to remain productive while keeping our costs low. We

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communicate actively with our employees to keep them informed about corporate events and to solicit feedback regarding ways to improve our services and their working environment. We also provide extensive sales and compliance training for our employees as part of their ongoing education.

Our Strategy

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

Focus on Medicare-eligible patients. Medicare beneficiaries represent a growing and profitable market for home nursing service providers. Implementation of PPS in the home health care industry has created a relatively stable reimbursement environment that favors companies such as ours that focus on providing high-quality, low-cost home nursing services.

Emphasize internal growth. We emphasize the internal growth of Medicare patient admissions, which increased approximately 28% for the six months ended June 30, 2004 and 8% for the calendar year ended 2003. We drive internal growth by: (1) maintaining our emphasis on high-quality home nursing care; (2) expanding and enhancing referral relationships in our local and regional markets; (3) continuing to educate referral sources regarding our specialized nursing programs that focus on high-cost diseases; (4) developing strategic partnerships with large hospital systems to increase admission volume; (5) expanding our service coverage areas by developing new locations; and (6) expanding the size and improving the quality of our team of sales executives.

Grow through strategic acquisitions. We believe our focus on Medicare beneficiaries provides us with a strategic advantage when assessing potential acquisitions. The home nursing market is highly fragmented with approximately 7,000 Medicare-certified home nursing agencies across the country. The majority of these home nursing agencies are owned either by hospitals or independent operators. We employ a disciplined strategy based on defined acquisition criteria including high-quality service, a strong referral base, and compatible payor mix. We have completed six acquisitions with twenty-one locations over the past twelve months, and we plan to evaluate and pursue additional hospital-based and multi-site home health agency acquisitions in our target markets. Attractive acquisitions offer prospects for cost efficiencies within our existing markets, opportunities to expand service coverage into contiguous geographic markets, and the ability to achieve economies of scale associated with large, concentrated patient volumes.

Leverage our cost-efficient operating structure. We believe the size and scale of our infrastructure and operating systems offer the opportunity to achieve operating leverage on two levels. At the agency level, we have developed a cost-efficient operating structure for our home nursing locations that focuses on nurse productivity, per episode utilization, and clinical outcomes, among other measures. To manage our diverse network of locations, we use a proprietary information system that reduces administrative and operating costs through the integration of clinical, financial, and operating functions. We manage all patient care and utilization on a real-time basis from both a clinical and financial perspective through a system of exception reporting. We believe our operating structure and information systems have facilitated our ability to generate and manage strong internal growth in admissions. At the corporate level, our geographic focus and investment in infrastructure and information systems enable us to leverage our regional and senior management resources and add new nursing locations without proportionate increases in corporate expense.

Continue to develop and deploy specialized nursing programs for chronic diseases and conditions. We have developed specialty nursing services and programs that focus on high-cost diseases and have successfully launched programs for diabetes, coronary artery disease, congestive heart failure, orthopedics, wound care, geriatric surgical recovery, and behavioral health. Our specialty nursing programs represent an attractive growth opportunity because they combine clinical quality and 24-hour access, which is appealing to patients and physicians, with cost-effective delivery of high-quality care to patients who have high-cost or chronic conditions.

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Our Home Health Agencies

As of July 31, 2004, we operated 94 Medicare-certified home health care nursing locations in the Southern and Southeastern United States consisting of 53 main locations and 41 branch locations. A director and team of administrative professionals lead each agency and have primary responsibility for the day-to-day operations. Our agencies are staffed with experienced clinical home health professionals who provide a wide range of patient care services. Our operations are organized into twelve regions, each of which provides clinical, operational, and sales support. To support our local agencies, we have centralized accounting, regulatory, marketing, payroll, intake, billing, collections, risk management, and quality assurance. All of our agencies are accredited or in the process of seeking accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), with the exception of five agencies, which are accredited by the Community Health Accreditation Program.

We deliver a wide range of health-related services in the home to eligible individuals who require ongoing skilled nursing and associated care that cannot be provided effectively by family and friends. Our patients are typically recovering, disabled, or chronically or terminally ill persons in need of medical, nursing, social, or therapeutic treatment and assistance with the essential activities of daily living.

We provide a wide variety of home health care services including:

registered nursing services such as infusion therapy, skilled monitoring, assessments, and patient education, many of whom have advanced certifications;

licensed practical (vocational) nursing services, including performance of technical procedures, administration of medications, and changing of surgical and medical dressings;

physical and occupational therapy to strengthen muscles, restore range of motion and help patients perform the activities of daily living;

speech pathology/ therapy to restore communication and oral skills;

social work to help families address the problems associated with acute and chronic illnesses;

home health aid services to perform personal care such as bathing or assistance in walking; and

private duty services such as continuous hourly nursing care and sitter services.

Sales and Marketing

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

Technology

The development and enhancement of our information technology systems has been, and continues to be a key component of our strategy. We have invested significant time and resources enhancing the capabilities of our technology platform in recent years to gain a strategic advantage over our competitors. We have standardized and are automating most of the critical components of the operational, clinical,

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financial, and compliance-related processes at our locations. We implemented a wide area network in 2001 in order to connect all of our agencies to a central corporate system. This infrastructure allows us to introduce standardized programs to all of our locations in a highly-efficient manner and to centrally monitor and manage critical clinical and financial aspects of patient care and utilization on a real-time basis.

We have developed and utilize a proprietary windows-based clinical software system to collect assessment data, schedule and log patient visits, generate medical orders, and monitor treatments and outcomes in accordance with established medical standards. The systems integrate billing and collections functionality, as well as accounting, human resource, payroll, and employee benefits programs provided by third parties. Because our home care software has been developed internally, we believe our programmers can add programming enhancements and functionality and integrate software programs from outside vendors more quickly and less expensively than would be the case were our system purchased or leased from a third party. We exchange data electronically with many third party organizations, and all of our information processes use best practices for security and are in compliance with HIPAA guidelines.

We use document recognition software developed by Healthcare Quality Systems (HQS) that enables our agencies to scan assessment forms into our clinical system, which reduces the amount of time spent on data entry, standardizes the data collection process, and significantly reduces the occurrence of data entry errors. Each assessment from our agencies is sent electronically to HQS, which uses proprietary software to review and verify the quality of the assessments via a system of smart edits to flag inconsistencies and errors in order to enable our nurses to make necessary corrections. Assessments are then provided to us electronically by HQS and automatically uploaded to our clinical and operational system. Once the data is integrated into our clinical system, it is used in all of our processing functions. Finally, we are in the process of consolidating our various agency databases into an enterprise-wide system that will improve the accuracy, reliability, and efficiency of processing and management reporting. This project is in the parallel testing phase. Following the successful completion of this phase, we will begin an enterprise-wide roll-out.

We believe that building and enhancing our information systems provides us with a competitive advantage that will allow us to grow our business in a more cost efficient manner.

Compliance and Quality Improvement

We are a health care services business, and the quality and reputation of our personnel and operations are critical to our success. We develop, implement, and maintain comprehensive compliance and quality improvement programs as a component of the centralized corporate services provided to our 94 home care locations. Our compliance program includes a code of ethical conduct for our employees and affiliates and a process for reporting regulatory or ethical concerns to our Chief Compliance Officer, including a toll-free telephone hotline. We have a Compliance Committee, which is chaired by the Chief Compliance Officer and is comprised of our Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, the Senior Vice President of Clinical Operations, and the Senior Vice President of Human Resources. This Corporate Compliance Committee reviews and recommends appropriate courses of action for the handling of compliance issues.

The effectiveness of our compliance program is directly related to the legal and ethical training that we provide to our employees. Compliance education for new hires is initiated immediately upon employment with corporate video training and reinforced through regional corporate orientation within one month of an employee s hire date, when the Chief Compliance Officer conducts a comprehensive compliance training seminar. All newly hired sales employees receive additional training from the Chief Compliance Officer in conjunction with business development orientation. In addition, all of our employees are required to receive continuing compliance education and training each year.

We conduct periodic compliance surveys of all of our agencies, which include audits of patient charts and documentation to ensure compliance with Medicare regulations. Audit findings and corresponding action plans are routed to both the Chief Compliance Officer and the Senior Vice President of Operations.

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An internal auditor provides a second compliance review function to ensure the legality and propriety of our activities and to report any finding of fraud or abuse that is uncovered in the course of the audits. Our quality improvement reinforces our compliance program by improving the quality of field staff education, performing competency assessments, conducting separate agency quality audits, and visiting patients to ensure compliance guidelines are met.

Our proprietary disease management programs and clinical tracks ensure that consistent quality of care is delivered across the organization. These programs are a critical component of improving patient outcomes. We utilize the federal government s Outcome Based Quality Improvement Scores and the Home Health Outcome Compare Scores to measure the quality of our services and to monitor the effectiveness of our quality improvement initiatives. We also use outside consultants to provide independent data and analysis to support our quality improvement initiatives. One such consulting firm benchmarks clinical activities and outcomes for all of our agencies against state, regional, and national averages and provides individual agency rankings across a host of categories that enable us to identify trends in the delivery of care to our patients. Another independent firm provides computer software systems that analyze Company billings to ensure that assessment forms are completed properly and that internally mandated assessment methodologies and coding procedures are followed. This software system identifies any assessment or billing trends that are exceptions to corporate guidelines.

We believe our compliance and quality improvement programs ensure that our employees are well trained so that they can deliver consistent high quality service to our patients. We incorporate compliance staffing and oversight into our growth plans and believe our consistent focus on compliance and quality improvement provides us with a competitive advantage in the market.

Reimbursement

Patient Eligibility

Medicare is a federally funded and administered health insurance program, primarily for individuals entitled to social security benefits who are 65 or older or who are disabled. The Medicare home health benefit is available to patients who need care following discharge from a hospital, as well as patients who suffer from chronic conditions that require ongoing but intermittent care. The services received need not be rehabilitative or of a finite duration, however, patients who require full-time skilled nursing for an extended period of time generally do not qualify for Medicare home health benefits. As a condition of participation under Medicare, beneficiaries must: (1) be homebound in that they are unable to leave their home without considerable effort; (2) require intermittent skilled nursing, physical therapy, or speech therapy services that are covered by Medicare; and (3) receive treatment under a plan of care that is established and periodically reviewed by a physician. Qualifying patients also may receive reimbursement for occupational therapy, medical social services, and home health aide services if these additional services are part of a plan of care prescribed by a physician. There is no limit to the number of episodes a beneficiary may receive as long as they remain eligible.

Provider Eligibility

To participate in the Medicare program and receive a Medicare payment, our agencies must comply with regulations promulgated by the Department of Health and Human Services. Among other things, these regulations, known as conditions of participation, relate to personnel qualifications, patient rights, standards of medical care, financial reporting, and compliance with state and local laws and regulations. The requirements for certification under Medicare are subject to change, and failure to comply with these requirements could lead to termination of our participation in the Medicare program.

Provider Reimbursement

Revenue from our home nursing services are paid by Medicare, Medicaid, private insurance carriers, managed care organizations, individuals, and other health insurance programs. Medicare is a federally funded program available to persons with certain disabilities and persons 65 years of age or older.

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Medicaid, a program jointly funded by federal, state, and local governmental health care programs, is designed to pay for certain health care and medical services provided to low income individuals without regard to age. We have several contracts for negotiated fees with insurers and managed care organizations. We submit all home health Medicare claims to a single fiscal intermediary for the federal government.

During the 1990s, reimbursement for home nursing services was one of the fastest growing expenditures in Medicare. According to the Medicare Payment Advisory Commission (MedPAC), from 1990 to 1997, the number of home health visits reimbursed under the Medicare system nearly doubled, and Medicare home health spending grew at an average annual rate of 25.0%, peaking at approximately $18.0 billion in 1997. The escalating costs and the rapidly growing use of home health services provided a catalyst for legislative action. BBA significantly reduced Medicare reimbursement to home health agencies by eliminating the industry s cost-based reimbursement methodology and mandating the establishment of PPS, which commenced in October 2000.

Under PPS, we receive a standard prospective Medicare payment for delivering care over a base 60-day period, or episode of care. Most patients complete treatment within one payment episode, though multiple continuous episodes are allowed. The base payment, which is established through federal legislation, is a flat rate that is adjusted upward or downward to account for differences in the expected resource needs of individual patients as indicated by clinical severity, functional severity, and service utilization. The adjustment is derived from each patient s categorization into one of 80 payment groups, known as home health resource groups, and the costliness of care for patients in each group relative to the average patient. Our payment is also adjusted for differences in local prices using the hospital wage index.

We bill and are reimbursed for services in two stages: an initial claim when the episode commences and a final claim when it is completed. We receive 60% of the estimated payment for a patient s initial episode up-front (after the initial assessment is completed and upon initial billing) and the remaining 40% upon completion of the episode and all final treatment orders are signed by the physician. In the event of subsequent episodes, reimbursement timing is 50% up-front and 50% upon completion of the episode. Final payments may reflect one of five retroactive adjustments to ensure the adequacy and effectiveness of the total reimbursement: (1) an outlier payment if the patient s care was unusually costly; (2) a low utilization adjustment if the number of visits was fewer than five; (3) a partial payment if the patient transferred to another provider before completing the episode; (4) a change-in-condition adjustment if the patient s medical status changes significantly, resulting in the need for more or less care; or (5) a payment adjustment based upon the level of therapy services required in the population base. We submit all Medicare claims through a single fiscal intermediary for the federal government.

The current base payment for Medicare home nursing is $2,213. Since implementation of PPS in October 2000, the base episode payment has varied due to both the impact of annual market basket based increases and Medicare-related legislation. In December 2000, Congress passed the Benefits Improvement and Protection Act, which delayed a BBA-mandated 15.0% reduction until October 1, 2002, restored an annual market basket increase to the base payment, and included a 10.0% add-on payment for services provided in a rural area. Since that time, MedPAC has focused its recommendations on the market basket update and the rural add-on as a primary means for controlling Medicare expenditures for home health services. In December 2003, MMA mandated a reduction in the annual payment increase, resetting the annual payment increase equal to the market basket less 0.8% effective April 1, 2004 through December 31, 2006. MMA also reinstated a rural add-on of 5.0% effective April 1, 2004 through March 31, 2005. In its most recent recommendation to Congress, MedPAC advised the elimination of the annual rate increase based on factors that it believes indicate improving access to home health care, favorable economics for providers, and improving quality of care. The applicability of a change is dependent upon the completion date of the episode, and therefore changes in reimbursement will impact our financial results up to 60 days in advance of the effective rate.

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Government Regulation

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

Our agencies are subject to federal, state and local laws dealing with issues such as occupational safety, employment, medical leave, insurance, civil rights, discrimination, building codes, and other environmental issues. Federal, state and local governments are expanding the regulatory requirements on businesses. The imposition of these regulatory requirements may have the effect of increasing our operating costs and reducing the profitability of our operations.

We cannot predict what additional government regulations affecting our business, if any, may be enacted in the future or how existing or future laws and regulations might be interpreted. If we, or any of our agencies, fail to comply with applicable laws, it might have a material adverse effect on our business.

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

Home health care agencies have licenses granted by the health authorities of their respective states. Additionally, some state health authorities require a certificate of need or permit of approval. Tennessee, Georgia, Mississippi, Alabama, North Carolina, and South Carolina require a CON to establish and operate a home health care agency, while Arkansas requires a POA. Louisiana, Oklahoma, Virginia, Texas, and Florida currently do not have such requirements. In every state where required each location license and/or CON or POA issued by the state health authority determines the service areas for the home health care agency. Currently, JCAHO accreditation of home health care agencies is voluntary.

States with CON and POA laws place limits on the (1) construction and acquisition of health care facilities and operations and (2) the expansion of existing facilities and services. In these states, approvals are required for capital expenditures exceeding amounts that involve certain facilities or services, including home care agencies.

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

Typically, the provider of services submits an application to the appropriate state agency with information concerning the area and population to be served, the anticipated demand for the facility or service to be provided, the amount of capital expenditure, the estimated annual operating costs, the relationship of the proposed facility or service to the overall state health plan and the cost per patient day for the type of care contemplated. The issuance of a certificate of need is based upon a finding of need by the state agency in accordance with criteria set forth in certificate of need laws and state and regional health facilities plans. If the proposed facility or service is found to be necessary and the applicant to be the appropriate provider, the state agency will issue a certificate of need containing a maximum amount of expenditure and a specific time period for the holder of the certificate of need to implement the approved project. The specific CON or POA application process varies from state to state, and in many jurisdictions the process is competitive, which frequently requires administrative appeals and litigation to reach an ultimate resolution. Where we seek to expand through the CON or POA process, we may incur substantial fees related to the preparation, presentation, and legal defense of our applications.

Medicare Participation

Approximately 91% of our revenue during 2003 was received from Medicare and we expect to continue to receive the majority of our revenues from serving Medicare beneficiaries. Medicare is a

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federally funded and administered health insurance program, primarily for individuals entitled to social security benefits who are 65 or older or who are disabled. To participate in the Medicare program and receive Medicare payment, our agencies must comply with regulations promulgated by the Department of Health and Human Services. Among other things, these regulations, known as conditions of participation, relate to the type of facility, its personnel and its standards of medical care, as well as compliance with state and local laws and regulations. Although we intend to continue to participate in these reimbursement programs, we cannot assure you that our agencies will continue to qualify for participation.

Federal and State Anti-Kickback Laws

As a provider under the Medicare and Medicaid systems, we are subject to the various anti-fraud and abuse laws, including the federal health care programs anti-kickback statute and, where applicable, their state law counterparts. These laws prohibit any offer, payment, solicitation, or receipt of any form of remuneration to induce the referral of business reimbursable under a federal health care program or in return for the purchase, lease, order, arranging for, or recommendation of items or services covered by any federal health care programs or any health care plans or programs that are funded by the United States government (other than certain federal employee health insurance benefits) and certain state health care programs that receive federal funds under various programs, such as Medicaid. A related law forbids the offer or transfer of any item or service for less than fair market value, or certain waivers of co-payment obligations, to a beneficiary of Medicare or a state health care program that is likely to influence the beneficiary s selection of health care providers. Violations of the anti-fraud and abuse laws can result in the imposition of substantial civil and criminal penalties and, potentially, exclusion from furnishing services under any federal health care programs. In addition, the states in which we operate generally have laws that prohibit certain direct or indirect payments or fee-splitting arrangements between health care providers where they are designed to obtain the referral of patients to a particular provider.

Stark Laws

Congress adopted legislation in 1989, known as the Stark Law, that generally prohibits a physician from ordering clinical laboratory services for a Medicare beneficiary where the entity providing that service has a financial relationship (including direct or indirect ownership or compensation relationships) with the physician (or a member of his/her immediate family), and prohibits such entity from billing for or receiving reimbursement for such services, unless a specified exception is available. Additional legislation, known as Stark II, became effective January 1, 1993. That legislation extends the Stark law prohibitions to services under state Medicaid programs, and beyond clinical laboratory services to all designated health services, including, but not limited to, home health services, durable medical equipment and supplies, and parenteral and enteral nutrients, equipment, and supplies. Violations of the Stark Law may also trigger civil monetary penalties and program exclusion. Pursuant to Stark II, physicians who are compensated by us will be prohibited from seeking reimbursement for designated health services rendered to such patients unless an exception applies. One such exception we use is a safe harbor that allows us to contract with certain physicians at fair market value to provide consulting work to our agencies. Several of the states in which we conduct business have also enacted statutes similar in scope and purpose to the federal fraud and abuse laws and the Stark laws.

Various federal and state laws impose criminal and civil penalties for submitting false claims for Medicare, Medicaid or other health care reimbursements. We believe that we bill for our services under such programs accurately, although, the rules governing coverage of, and reimbursement for, our services are complex. There can be no assurance that these rules will be interpreted in a manner consistent with our billing practices.

HIPAA

HIPAA was enacted August 21, 1996 to assure health insurance portability, reduce health care fraud and abuse, guarantee security and privacy of health information and enforce standards for health information. Organizations were required to be in compliance with certain HIPAA provisions relating to

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security and privacy beginning April 14, 2003. Organizations are subject to significant fines and penalties if found not to be compliant with the provisions outlined in the regulations. Regulations issued pursuant to HIPAA impose ongoing obligations relative to training, monitoring and enforcement, and management has implemented processes and procedures to ensure continued compliance with these regulations.

Pursuant to the provisions of HIPAA, covered health care providers are required to be compliant with the regulation s electronic Health Care Transactions and Code Sets Requirements. In conformity with these federal regulations, we are now capable of transmitting in the new standard format.

Insurance

We maintain liability insurance in amounts that we believe are appropriate for our operations, including professional and general liability insurance, business interruption insurance, property damage insurance, and an additional umbrella liability insurance policy. Coverage under certain of these policies is contingent upon the policy being in effect when a claim is made regardless of when the events that caused the claim occurred. The cost and availability of such coverage has varied widely in recent years. While we believe that our insurance policies are adequate in amount and coverage for our anticipated operation, we cannot assure you that the insurance coverage is sufficient to cover all future claims or will continue to be available in adequate amounts or at a reasonable cost.

From December 31, 1998 to November 9, 2000, we were covered by Reliance Insurance Company of Illinois (Reliance) for risks associated with professional and general liability. We became aware of the deteriorating stability and rating of Reliance during the latter part of 2000 and thus, secured coverage with another insurer on November 9, 2000 for occurrences after that date. Reliance is currently in liquidation and may not be in a position to pay or defend claims we incurred during the period stated above. We have two open claims relating to this period, which we are now defending, and we do not believe that the ultimate resolution of these claims will be materially different from reserves we established for those claims. We are unaware of, and do not expect, any material claims that may be made based on occurrences during the period, but there is no assurance that additional claims will not be brought against us relating to incidents which occurred during the time period stated above or that any such claims will not be material.

Legal Proceedings

We are involved in legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which may not be covered by our insurance. These actions, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our financial position, results of operations, or cash flows.

Alliance Home Health, Inc.

Alliance, one of our wholly-owned subsidiaries, was acquired in 1998 and ceased operations in 1999. Alliance filed for Chapter 7 federal bankruptcy protection with the United States Bankruptcy Court in the Northern District of Oklahoma on September 29, 2000. A trustee was appointed for Alliance in 2001. Until the contingencies associated with the liabilities are resolved, our consolidated financial statements continue to consolidate Alliance, which has net liabilities of $4.2 million.

Class Action Suits

On August 23 and October 4, 2001, two class action lawsuits were filed against us and three of our executive officers on behalf of all purchasers of our common stock between November 15, 2000 and June 13, 2001. These suits, which were filed in the United States District Court for the Middle District of Louisiana, have been consolidated and seek damages based on the decline in our stock price following an announced restatement of earnings for the fourth quarter of 2000 and first quarter of 2001. The suits allege that we knew or were reckless in not knowing the facts giving rise to the restatement. No trial date has been set and pre-trial discovery is ongoing. We are vigorously defending these lawsuits, which have been certified as class actions, although we are appealing such determination.

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We believe our existing insurance is sufficient to cover any amounts that may be awarded, and we have not recorded any liabilities in excess of such coverage in our financial statements. Though we believe that the ultimate outcome of these lawsuits will not exceed our insurance coverage, the maximum amount that could potentially be claimed in these suits substantially exceeds the amount of our coverage; under certain circumstances, a finding of liability could have a material adverse effect on our business.

Corporate Integrity Agreement

In 1999 we uncovered certain improprieties stemming from the unauthorized conduct of an agency director in a previously-acquired agency in Monroe, Louisiana. We disclosed these improprieties to the OIG. Following an extensive series of audits, we and the OIG reached a settlement in August 2003. As part of this settlement, we agreed to repay approximately $1.2 million to the government in three annual payments, the last of which we will make in 2005. We also executed a three-year CIA which requires that we:

maintain our current compliance program;

specify additional training requirements;

conduct annual, independent audits of the agency; and

make timely disclosure of and repay overpayments resulting from any potential fraud or abuse of which we become aware.

There are stipulated penalties for violations of the CIA. Egregious violations of the CIA could result in our exclusion from further participation in government-funded health programs. We have designated a Chief Compliance Officer to ensure ongoing compliance with the terms and conditions of the CIA as well as compliance with all other applicable laws, rules, and regulations. Any acquired businesses will be subject to the provisions of the CIA.

We believe that we are in compliance with all state and federal fraud and abuse provisions and all other applicable government laws and regulations. Our compliance with these laws and regulations may be subject to future government review and interpretation and possible regulatory actions currently unknown or unasserted. If we are found to be in violation of any of these provisions, it could have a material adverse effect on our business.

We operate our agencies under licenses issued and regulated by the respective states in which they are located. Each agency is subject to periodic surveys and complaint-based surveys. If a survey identifies violations of state standards, the agency typically is afforded a grace period in which to comply or otherwise lose its license to operate. We use a Clinical Operations Department, staffed by regional personnel, to prepare each agency for these surveys and respond when those surveys identify potential problems or when plans-of-correction are required to bring the agency back into compliance. If we are found to be in violation of any of these state standards, it could have a material adverse effect on our business.

NPF VI

In November 2002, we elected to terminate our asset financing facility with NPF VI, Inc. (NPF VI) and advised our payors that payments should be directed to our bank accounts rather than bank accounts controlled by NPF VI under collateral arrangements for the facility. NPF VI has filed for Chapter 11 bankruptcy protection. We are taking legal and other action to recover Company funds from JP Morgan, as trustee for NPF VI, that have not been released to us. During the fourth quarter of 2002, we recorded a reserve for the full amount of approximately $7.1 million related to our funds held by JP Morgan. During the quarter ended June 30, 2004, we received an unfavorable verdict in our suit against JP Morgan. We are appealing this decision to the U.S. Circuit Court of Appeals. No assessment of the likelihood of an outcome favorable to us can be made at this time.

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Competition

We compete with local, regional, and national home nursing providers for referrals based primarily on scope and quality of services, geographic coverage, outcomes data, and, in selected instances, pricing. The impact of this competition is best determined on a market-by-market basis. We believe our generally favorable competitive position is attributable to our reputation for consistent, high-quality care, comprehensive range of services, state-of-the-art information management systems, and widespread service network.

Employees

At June 30, 2004, we had 3,260 employees, of which 2,016 were full-time employees. None of our employees are represented by a collective bargaining agreement. We believe that we have a good relationship with our employees.

Properties

Our corporate headquarters are located in Baton Rouge, Louisiana in a total of 36,869 square feet of leased office space, under four separate lease agreements, each of which expires December 31, 2006. Typically, our home health agencies are located in leased facilities. Generally, the leases have initial terms of three years, but range from one to six years. Most of the leases contain options to extend the lease period for up to five additional years.

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PRINCIPAL AND SELLING STOCKHOLDERS

The following table sets forth information about the beneficial ownership of our common stock on August 27, 2004, and as adjusted, which assumes the sale of a total of 150,000 shares of common stock by certain selling stockholders and 150,000 shares of common stock by us in this offering pursuant to the exercise of the underwriters over-allotment option. The underwriters will draw upon such shares from us and the selling stockholders on a pro rata basis.

We have determined beneficial ownership in accordance with the rules of the SEC. Except as indicated by the footnotes below, we believe, based on the information furnished to us, that the persons and entities named in the table below have sole voting and investment power with respect to all shares of common stock that they beneficially own, subject to applicable community property laws. We have based our calculation of the percentage of beneficial ownership on 12,387,940 shares of common stock outstanding on August 27, 2004, and 15,147,940, assuming the underwriters exercise their over-allotment option in full shares of common stock outstanding upon completion of this offering.

In computing the number of shares of common stock beneficially owned by a person and the percentage ownership of that person, we deemed to be outstanding any shares of common stock subject to options held by that person that currently are exercisable or exercisable within 60 days after August 27, 2004. We did not deem these shares outstanding, however, for the purpose of computing the percentage ownership of any other person.

Unless otherwise noted below, the address of each beneficial owner listed in the table below is c/o Amedisys, Inc., 11100 Mead Road, Suite 300, Baton Rouge, Louisiana 70816.

	Before Offering			After Offering	
Name and Address of Beneficial Owner:	Number of Shares of Common Stock Beneficially Owned(1)	Percentage of Common Stock Beneficially Owned	Number of Shares of Common Stock Offered	Number of Shares of Common Stock Beneficially Owned(1)	Percentage of Common Stock Beneficially Owned
William F. Borne, Chief Executive Officer and Chairman of the Board(2)	537,687	2.7	88,450	449,237	2.2
Larry R. Graham, President and Chief Operating Officer(3)	100,833	*	10,000	90,833	*
Gregory H. Browne, Chief Financial Officer	36,726	*	10,000	26,726	*
Jeffrey Jeter, Senior Vice President of Compliance and Corporate Counsel	8,425	*		8,425	*
John H. Linden, Chief Information Officer	5,667	*		5,667	*
Peter F. Ricchiuti, Director	51,060	*	13,000	38,060	*
Jake L. Netterville, Director	60,805	*	10,000	50,805	*
Ronald A. LaBorde, Director	55,805	*	8,550	47,255	*
David R. Pitts, Director	53,805	*	10,000	43,805	*
Donald A. Washburn, Director	3,000	*		3,000	*
All officers and directors as a group (10 persons)	913,813	3.4	150,000	763,813	2.9

(*) Less than one percent.

(1) The amounts in this column include shares of common stock with respect to which certain persons had the right to acquire beneficial ownership within 60 days after August 18, 2004, pursuant to the exercise of options: William F. Borne: 208,400 shares; Larry R. Graham: 36,306 shares; Gregory H. Browne: 34,666 shares; Jeffrey Jeter: 5,333 shares; John H. Linden: 667 shares; Peter F. Ricchiuti: 44,455 shares; Jake L. Netterville: 53,805 shares; Ronald A. LaBorde: 53,805 shares; David R. Pitts: 53,805 shares; and executive officers and directors as a group: 491,242 shares.

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(2) Includes 20,000 shares of common stock owned by his wife, 25,000 shares of common stock owned by a trust on behalf of Mr. Borne s children, and 25,100 shares of common stock owned by his father.

(3) Includes 4,156 shares owned jointly with his wife, and 7,698 shares of common stock owned by his wife.

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UNDERWRITING

Subject to the terms and conditions of the underwriting agreement dated September 15, 2004, the underwriters named below, for whom Raymond James & Associates, Inc. is acting as representative, have severally agreed to purchase from us the respective number of shares of our common stock set forth opposite their names below:

Underwriters	Number of Shares
Raymond James & Associates, Inc.	1,291,500
Jefferies & Company, Inc.	799,500
Legg Mason Wood Walker, Incorporated	369,000
Total	2,460,000

The underwriting agreement provides that the obligations of the several underwriters to purchase and accept delivery of the common stock offered by this prospectus are subject to the terms and conditions set forth in the underwriting agreement. The underwriters are obligated to purchase and accept delivery of all of the shares of common stock offered by this prospectus, if any are purchased, other than those covered by the over-allotment option described below.

The underwriters propose to offer the common stock directly to the public at the public offering price indicated on the cover page of this prospectus and to various dealers at that price less a concession not to exceed $0.90 per share, of which $0.10 may be re-allowed to other dealers. After this offering, the public offering price, concession and re-allowance to dealers may be reduced by the underwriters. No reduction will change the amount of proceeds to be received by us as indicated on the cover page of this prospectus. The shares of common stock are offered by the underwriters as stated in this prospectus, subject to receipt and acceptance by them and subject to their right to reject any order in whole or in part.

We have granted to the underwriters an option, exercisable within 30 days after the date of this prospectus, to purchase from time to time up to an aggregate of 150,000 additional shares of common stock to cover over-allotments, if any, at the public offering price less the underwriting discount; and the selling stockholders have granted to the underwriters an option, exercisable within 30 days after the date of this prospectus, to purchase from time to time up to an aggregate of 150,000 additional shares of common stock to cover over-allotments, if any, at the public offering price less the underwriting discount. If the underwriters exercise their over-allotment option to purchase any of these additional 300,000 shares of common stock, each underwriter, subject to several conditions, will become obligated to purchase its pro rata portion of these additional shares based on the underwriter s percentage purchase commitment in this offering as indicated in the table above. If purchased, these additional shares will be sold by the underwriters on the same terms as those on which the shares offered by this prospectus are being sold. The underwriters may exercise the over-allotment option only to cover over-allotments made in connection with the sale of the shares of common stock offered in this offering.

The following table summarizes the underwriting compensation to be paid to the underwriters by us. These amounts assume both no exercise and full exercise of the underwriters over-allotment option to purchase additional shares. We estimate that the total expenses payable by us in connection with this offering, other than the underwriting discount referred to below, will be approximately $300,000.

	Per Share	Without Option	With Option
Underwriting discount payable by us	$1.512	$3,719,520	$3,946,320
Underwriting discount payable by selling stockholders	$1.512	$ 0	$ 226,800

We and the selling stockholders have agreed to indemnify the underwriters against various liabilities, including liabilities under the Securities Act of 1933, or to contribute to payments the underwriters may be required to make because of any of those liabilities.

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Subject to specified exceptions, each of our directors and our executive officers has agreed, for a period of 90 days after the date of this prospectus, without the prior written consent of Raymond James & Associates, Inc., not to offer, sell, contract to sell, pledge, grant any option to purchase or otherwise dispose of any shares of our common stock or securities convertible into or exercisable or exchangeable for any shares of our common stock. This agreement also precludes any hedging, collar or other transaction designed or reasonably expected to result in a disposition of our common stock or securities convertible into or exercisable or exchangeable for our common stock.

In addition, we have agreed that, for 90 days after the date of this prospectus, we will not, directly or indirectly, without the prior written consent of Raymond James & Associates, Inc., issue, sell, contract to sell, or otherwise dispose of or transfer, any of our common stock or securities convertible into, exercisable for or exchangeable for our common stock, or enter into any swap or other agreement that transfers, in whole or in part, the economic consequences of ownership of our common stock or securities convertible into, exercisable for or exchangeable for our common stock, except for our sale of common stock in this offering, and the issuance of options or shares of common stock under our currently outstanding warrants, and our existing stock option plans.

Until the offering is completed, the rules of the SEC may limit the ability of the underwriters and selling group members to bid for and purchase shares of our common stock. As an exception to these rules, the underwriters may engage in some types of transactions that stabilize the price of our common stock. These transactions may include short sales, stabilizing transactions, purchases to cover positions created by short sales and passive market making. Short sales involve the sale by the underwriters of a greater number of shares of our common stock than they are required to purchase in the offering. Stabilizing transactions consist of bids or purchases made for the purpose of preventing or retarding a decline in the market price of our common stock while the offering is in progress. In passive market making, the underwriter, in its capacity as market maker in the common stock, may, subject to limitations, make bids for or purchases of our common stock until the time, if any, at which a stabilizing bid is made.

The underwriters also may impose a penalty bid. This occurs when a particular underwriter repays to the other underwriters a portion of the underwriting discount received by it because the representatives have repurchased shares sold by or for the account of such underwriter in stabilizing or short covering transactions.

These activities by the underwriters may stabilize, maintain or otherwise affect the market price of our common stock. As a result, the price of our common stock may be higher than the price that otherwise might exist in the open market. If these activities are commenced, they may be discontinued by the underwriters without notice at any time. These transactions may be effected on the Nasdaq National Market or otherwise.

Some of the underwriters or their affiliates, including Raymond James & Associates, Inc. and Jefferies & Company, Inc., have in the past and may in the future perform investment banking and other financial services for us and our affiliates for which they may receive advisory or transaction fees, as applicable, plus out-of-pocket expenses, of the nature and in amounts customary in the industry for these financial services.

LEGAL MATTERS

The validity of the issuance of the shares of common stock offered hereby will be passed upon for us by Correro Fishman Haygood Phelps Walmsley & Casteix, L.L.P., New Orleans, Louisiana. Morrison & Foerster LLP, New York, New York, will pass upon legal matters relating to the offering for the underwriters.

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EXPERTS

The consolidated financial statements of Amedisys, Inc. as of December 31, 2002 and 2003 and for each of the years in the two-year period ended December 31, 2003, have been incorporated by reference herein and in the registration statement in reliance upon the report of KPMG LLP, independent accountants, incorporated by reference herein, and upon the authority of said firm as experts in accounting and auditing.

KPMG s report refers to its audit of transitional disclosures for 2001 required by Statement of Financial Accounting Standards No. 142 Goodwill and Other Intangible Assets , which was adopted by Amedisys, Inc. on January 1, 2002 to revise the 2001 consolidated financial statements, as more fully described in Note 1 to the consolidated financial statements. However, KPMG was not engaged to audit, review, or apply any procedures to the 2001 consolidated financial statements other than with respect to such reclassification and disclosures.

The combined Statement of Direct Revenues and Direct Operating Expenses of the Acquired Entities for the year ended December 31, 2003, have been incorporated by reference herein and in the registration statement in reliance upon the report of KPMG LLP, independent accountants, incorporated by reference herein, and upon the authority of said firm as experts in accounting and auditing.

NOTICE REGARDING ARTHUR ANDERSEN LLP

Arthur Andersen LLP audited our financial statements for the five years ended December 31, 2001. We have included information derived from these financial statements in this prospectus through incorporation by reference of certain documents filed by us with the SEC. On June 15, 2002, Arthur Andersen was convicted of obstruction of justice by a federal jury in Houston, Texas in connection with Arthur Andersen s work for Enron Corp. On September 15, 2002, a federal judge upheld this conviction. Arthur Andersen ceased its audit practice before the SEC on August 31, 2002. Effective April 30, 2002, we terminated the engagement of Arthur Andersen as our independent auditors and engaged KPMG LLP to serve as our independent auditors. KPMG LLP has audited our financial statements for the years ended December 31, 2002 and 2003. Because of the circumstances currently affecting Arthur Andersen LLP, as a practical matter it may not be able to satisfy any claims arising from the provision of auditing services to us, including claims holders of notes may have that are available to security holders under applicable securities laws.

WHERE YOU CAN FIND MORE INFORMATION

This prospectus is part of a registration statement we filed with the SEC. You should rely only on the information contained herein or incorporated by reference. The SEC allows us to incorporate by reference certain information that we file with it, which means that we can disclose important information to you by referring you to those documents. The information incorporated by reference is considered to be part of this prospectus, and information that we file later with the SEC will update automatically, supplement and/or supersede this information. Any statement in a document incorporated or deemed to be incorporated by reference herein shall be deemed to be modified or superseded for purposes of this prospectus to the extent that a statement contained herein or in any other document which also is or is deemed to be incorporated by reference herein modifies or supersedes such statement. Any such statement so modified or superseded shall not be deemed, except as so modified or superseded, to constitute a part hereof. You should read the following summary together with the more detailed information regarding our Company, our common stock and our financial statements and notes to those statements appearing elsewhere in this prospectus or incorporated herein by reference.

We have not authorized anyone else to provide you with different information. We are not making an offer of these securities in any state where the offer is not permitted. You should not assume that the information herein is accurate as of any date other than the date on the front page of this prospectus, regardless of the time of delivery of this prospectus or any sale of common stock.

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We file annual, quarterly and special reports, proxy statements and other information with the SEC. You may read, without charge, and copy the documents we file at the SEC s public reference rooms in Washington, D.C., New York, New York and Chicago, Illinois, under SEC File No. 000-24260. You can request copies of these documents by writing to the SEC and paying a fee for the copying cost. Please call the SEC at 1-800-SEC-0330 for further information on the public reference rooms. Our SEC filings are also available to the public at no cost from the SEC s website at http://www.sec.gov.

We incorporate by reference the filed documents listed below, except as superseded, supplemented or modified by this prospectus, and any future filings we will make with the SEC under Sections 13(a), 13(c), 14 or 15(d) of the Securities Exchange Act of 1934 (the Exchange Act):

our Annual Report on Form 10-K for the fiscal year ended December 31, 2003;

our Quarterly Report on Form 10-Q for the quarter ended March 31, 2004;

our Quarterly Report on Form 10-Q for the quarter ended June 30, 2004;

our Current Report on Form 8-K/ A, filed July 15, 2004;

our Current Report on Form 8-K, filed July 22, 2004;

our Current Report on Form 8-K, filed August 3, 2004;

our Current Report on Form 8-K, filed August 9, 2004;

our Current Report on Form 8-K, filed August 11, 2004;

our Current Report on Form 8-K, filed August 23, 2004;

our Current Reports on Form 8-K, filed September 9, 2004; and

our definitive proxy statement filed April 29, 2004.

The reports and other documents that we file after the date hereof will update, supplement and supersede the information in this prospectus. You may request and obtain a copy of these filings, at no cost, by writing or telephoning us at the following address or phone number:

Amedisys, Inc.
11100 Mead Road, Suite 300
Baton Rouge, Louisiana 70816
(800) 467-2662
Attn: Gregory H. Browne

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You should rely only on the information contained in this prospectus. We have not authorized anyone to provide you with information different from that contained in this prospectus or any prospectus supplement. This prospectus is not an offer of these securities in any jurisdiction where an offer and sale is not permitted. The information contained in this prospectus is accurate only as of the date of this prospectus, regardless of the time of delivery of this prospectus or any sale of our common stock.

2,460,000 Shares

Amedisys, Inc.

Common Stock

PROSPECTUS

RAYMOND JAMES

JEFFERIES &

COMPANY, INC.

LEGG MASON WOOD WALKER

Incorporated

September 15, 2004