AMERIPATH INC
Form 10-K
March 19, 2004
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SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-K

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

FOR THE YEAR ENDED DECEMBER 31, 2003

OR

¨ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

FOR THE TRANSITION PERIOD FROM _____ TO _____.

AMERIPATH, INC.

(Exact Name of Registrant as Specified in Its Charter)

Delaware	**65-0642485**
(State or Other Jurisdiction Incorporation or Organization)	**(I.R.S. Employer Identification No.)**

7289 Garden Road, Suite 200, Riviera Beach, Florida 33404

(Address of Principal Executive Offices)

Registrant s Telephone Number, Including Area Code: (561) 712-6200

Securities Registered Pursuant to Section 12(B) of the Act: None

Securities Registered Pursuant to Section 12(G) of the Act: None

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Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes x No ¨

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of Registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. x

Indicate by check mark whether the Registrant is an accelerated filer (as defined in Rule 12b-2 of the Exchange Act). Yes ¨ No x

The number of shares of Common Stock of the Registrant outstanding as of March 17, 2004 was 100.

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PART I

ITEM 1. BUSINESS

On December 8, 2002, Amy Holding Company and its wholly-owned subsidiary, Amy Acquisition Corp., entered into a merger agreement with AmeriPath, Inc. (Ameripath or the Company) pursuant to which Amy Acquisition Corp. merged with and into AmeriPath, with AmeriPath continuing as the surviving corporation (the March 2003 Transaction). The March 2003 Transaction was approved by the Company s stockholders and subsequently consummated on March 27, 2003. As a result of the March 2003 Transaction, AmeriPath became a wholly-owned subsidiary of Amy Holding Company, which was renamed AmeriPath Holdings, Inc. (Holdings).

Amy Holding Company and Amy Acquisition Corp. were Delaware corporations formed at the direction of Welsh, Carson, Anderson and Stowe LLP (WCAS). WCAS, its related investors and several employees of the Company own 100% of the outstanding common stock of Holdings after the March 2003 Transaction.

The funds necessary to consummate the March 2003 Transaction were approximately $804.0 million, including approximately $629.6 million to pay the stockholders and option holders of AmeriPath (other than WCAS and its affiliates) all amounts due under the merger agreement, approximately $127.5 million to refinance existing indebtedness and approximately $46.9 million to pay related fees and expenses. Prior to the merger, the 1,534,480 shares of AmeriPath common stock owned by WCAS and its affiliates were contributed to Holdings in exchange for shares of Holdings common stock. These shares were cancelled without payment of any merger consideration. The March 2003 Transaction was financed by a cash common equity investment by WCAS and its related equity investors of $296.2 million in Holdings, which funds were contributed by Holdings to AmeriPath in exchange for shares of AmeriPath s common stock, $225.0 million in term loan borrowings under its new senior credit facility, the issuance of $275.0 million in senior subordinated notes and existing AmeriPath cash.

The consolidated financial statements in this Annual Report on Form 10-K include the accounts of both the predecessor company Ameripath, Inc. (prior to the March 2003 Transaction) as well as the successor company (subsequent to the acquisition discussed above.) The financial position and results of operations of Ameripath, Inc. for periods prior to March 28, 2003 are referred to as that of our predecessor. The financial statements and financial data of the predecessor include the combined historical financial statements of the wholly owned subsidiaries of Ameripath that were acquired by Amy Acquisition Corp.

Unless otherwise noted, references to the Company, we, us, and our, refer to Ameripath, Inc. and its subsidiaries. Our fiscal year is the calendar year ending December 31. As noted in Note 1 to the consolidated financial statements, the March 2003 Transaction resulted in a new basis of accounting for the Company. In some cases, for ease of comparison purposes, financial data for the period from March 28, 2003, though December 31, 2003 has been added to financial data of the Predecessor for the period from January 1, 2003 through March 27, 2003, to arrive at a 12-month combined period ended December 31, 2003. This combined data may be referred to herein as fiscal year 2003, year 2003 or 2003.

The address of our principal executive office is 7289 Garden Road, Suite 200, Riviera Beach, Florida 33404. Our phone number is (561) 712-6200. Our Internet website address is www.ameripath.com.

We make available free of charge, on or through our Internet website, as soon as reasonably practical after they are electronically filed or furnished to the SEC, our annual reports on Form 10-K, quarterly reports on Form 10-Q, and current reports on Form 8-K.

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Our Company

We are one of the leading anatomic pathology laboratory companies in the United States. We offer a broad range of anatomic pathology laboratory testing and information services used by physicians in the detection, diagnosis, evaluation and treatment of cancer and other diseases and medical conditions. During 2003, we processed and diagnosed approximately four million tissue biopsies. We believe that we are the only anatomic pathology laboratory company with substantial operations in both the outpatient and inpatient sections of the anatomic pathology services market. For the year 2003, we generated net revenue and income from operations of $485.0 million and $46.9 million, respectively.

We service an extensive referring physician base through our 15 regional laboratories and 36 satellite laboratories, and we provide inpatient diagnostic and medical director services at more than 200 hospitals. We have operations in 21 states, providing us with a regional or local presence in 17 of the 30 most populous metropolitan areas of the United States. Our services are performed by over 400 pathologists, many of whom are leaders in their field. We have built our business by completing over 50 acquisitions of pathology laboratories and operations since 1996, enabling us to build regional density in attractive geographic markets and to establish a platform for organic growth. We also operate the Center for Advanced Diagnostics, or CAD, which is a leading specialty, or esoteric, testing laboratory.

Our fields of expertise include dermatopathology, in which we maintain a leading market position, women s health diagnostic services, urologic pathology and gastrointestinal pathology. We also believe that we are the leading anatomic pathology services provider to hospitals in the United States. Generally, we are the exclusive provider of anatomic pathology services for the hospitals we serve, which arrangements have historically provided us with a stable stream of revenue. In addition, through our managed care relationships, we contract with HMOs and PPOs that insure approximately 26 million and 83 million individuals, respectively, which represents more than half of all individuals covered by managed care in the United States.

Industry Overview

The practice of pathology consists of anatomic and clinical pathology. Anatomic pathology involves the diagnosis of cancer and other diseases and medical conditions through the examination of tissue and cell samples taken from patients. Generally, the anatomic pathology process involves the mounting of samples on slides by highly skilled technicians, which are then reviewed by anatomic pathologists. Anatomic pathologists are medical doctors who do not examine patients, but rather assist other physicians in determining the correct diagnosis of a patient s ailments. As a result, an anatomic pathologist is often referred to as a physician s physician. Clinical pathology, on the other hand, generally involves the chemical testing and analysis of body fluids utilizing standardized laboratory tests. The results of these standardized tests are provided to the referring physician for use in a patient s diagnosis. Clinical laboratory tests typically do not require the interpretive skills of a pathologist. The process is frequently routine, automated and performed by large national or regional clinical laboratory companies and hospital laboratories.

We believe the market for anatomic pathology services is approximately $7 billion per year, and we expect it to continue to grow for the following reasons:

- the aging of Americans should lead to more incidences of cancer and should result in greater demand for healthcare services, including those provided by anatomic pathologists,

the increasing reliance on pathology testing by physicians to aid in the identification of risk factors and symptoms of disease, the choice of therapeutic regimen and the evaluation of treatment results, and

the increasing awareness by physicians, patients and payors of the value of preventative testing to improve the effectiveness of medical services and reduce the overall cost of healthcare.

In addition to traditional anatomic pathology services, pathologists increasingly are performing highly

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complex esoteric tests. Traditionally performed in academic settings, technological advancements have provided large commercial laboratories with highly specialized equipment and the means to perform these advanced tests for patients in both outpatient and inpatient settings. As these tests typically require more advanced equipment and highly skilled personnel to perform, they are generally reimbursed at rates higher than more routine tests. We believe the market for esoteric testing services is approximately $2 billion per year. We also believe the growth in the esoteric testing services market benefits from demand factors similar to those in the traditional anatomic pathology services market. In addition, we believe that emerging technologies and tests, such as gene-based tests, or genomics, should drive growth in the esoteric testing services market at a rate that exceeds the growth rate for the traditional anatomic pathology services market.

According to the American Society for Clinical Pathologists, there are approximately 15,000 pathologists in the United States. Historically, the anatomic pathology industry has been highly fragmented with a majority of the services being performed by individual or small groups of pathologists working in independent laboratories, hospital laboratories or academic institutions. Recently, there has been a trend among pathologists to join larger laboratories in order to offer a broader range of outpatient and inpatient services, take advantage of economies of scale and reduce the burdens of managing the administrative aspects of their operations.

Competitive Strengths

We believe that we are distinguished by the following competitive strengths:

Leadership in anatomic pathology services. We are an established and experienced leader in the highly fragmented anatomic pathology services market. We believe that we are the only anatomic pathology laboratory company with substantial operations in both the outpatient and inpatient segments of the anatomic pathology services market. Our pathologist base comprises what we believe is the largest single group of pathologists in the nation, and provides us with the ability to offer services in all subspecialties of anatomic pathology. Within the subspecialty of dermatopathology, we estimate our market share to be approximately 10%, which we believe is the largest in the industry. In addition, we have expertise in esoteric testing as well as in the anatomic pathology subspecialties of women s health diagnostic services, urologic pathology and gastrointestinal pathology. We believe our broad service offerings provide us with an advantage over most of our competitors in maintaining and developing customer relationships.

National scale with regional and local density. We believe we have the broadest national footprint within the anatomic pathology services market. We have operations in 21 states, providing us with a regional or local presence in 17 of the 30 most populous metropolitan areas of the United States. We also have a presence in more than 200 hospitals, which we believe makes us the leading provider of anatomic pathology services in hospitals. Furthermore, we have contractual relationships with HMOs and PPOs whose members comprise more than half of the individuals covered by managed care in the United States. We have developed a substantial presence in our target markets by forming regional operations that deliver our services locally and enable our pathologists to establish strong relationships with our referring physician base. As a result of our regional coverage, we have been able to grow our revenues, enhance our laboratory utilization, offer a broader range of testing services and benefit from economies of scale and increased managed care contracting leverage.

Attractive industry dynamics. The demand for traditional anatomic pathology services and esoteric testing services has created significant and growing markets. We believe the market for traditional anatomic pathology services, excluding esoteric testing services, is approximately $7 billion per year, and the market for esoteric testing services is approximately $2 billion per year. We expect these markets to continue to grow primarily due to an aging population, increasing incidences of cancer and medical advancements that allow for more accurate and earlier diagnosis and treatment of diseases. According to the U.S. Census Bureau, the number of people aged 65 and older in the United States is expected to grow 19% over the next ten years. Generally, people aged 65 or older have a greater incidence of chronic health conditions such as cancer, diabetes,

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heart disease, arthritis or hypertension and are heavier users of healthcare services than people under age 65. For example, according to the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute, the average annual cancer incidence rate for people aged 65 to 74 is 2,007 per 100,000 people or approximately 14 times the incidence rate of people aged 20-49 and approximately 125 times the incidence rate of people aged 20 and under. Additionally, the National Cancer Institute estimates that incidences of melanoma, a type of skin cancer, in the United States will grow 11% from 2003 to 2007. We also believe that emerging technologies and tests, such as genomics, will further drive growth in the market for esoteric testing services.

Strong cash flow generation. We believe our strong cash flow substantially enhances our competitive position in the highly fragmented anatomic pathology services market. In 2003, we generated operating income of $46.9 million, or 9.7% of revenues. Although our 2003 operating income is down from 2002, the 2003 amount includes merger-related charges, restructuring costs, and an additional bad debt provision. In addition, during 2003 we had cash flow from operating activities less capital expenditures, or free operating cash flow, of $59.5 million. Historically, our strong operating cash flow has been a result of low capital expenditure requirements and our ability to increase the performance of acquired operations. Our attractive margins are a result of our enhanced laboratory utilization, our broad range of testing services, economies of scale and our success in contracting with managed care organizations. In addition, we believe our strong cash flow strengthens our ability to fund organic and external growth initiatives, which enhances our competitiveness relative to most of our smaller, regional competitors.

Favorable payor relationships. Currently, we have contractual relationships with HMOs and PPOs whose members comprise more than half of the individuals covered by managed care in the United States. These relationships provide us with access to a large number of current and potential patients. Our national scale and regional concentration have facilitated our entry into a growing number of relationships with managed care organizations, such as Blue Cross/Blue Shield, Aetna and United Healthcare. Since 1999, we have more than tripled the number of people covered under our managed care agreements, which we believe validates our managed care strategy. Furthermore, the overwhelming majority of our revenues from these relationships are generated from fee-for-service payments, rather than from fee-per-person, or capitated payments. In addition, our payments from government-sponsored programs, such as Medicare and Medicaid, are relatively limited. During 2003, we derived approximately 22% of our cash collections and net revenues from government-sponsored payors. We believe our diverse payor mix limits our exposure to the loss of any single source of payment for our services.

Business Strategy

We believe our business strategy will help us maintain our status as a leading provider of anatomic pathology services and increase our share of the markets in which we compete. The key elements of our strategy are to:

Capitalize on our leading market position. Through our 15 regional laboratories, 36 satellite laboratories and over 400 pathologists, we will continue to provide a comprehensive array of anatomic pathology services to primary care and specialty physicians and serve over 200 hospitals. We will further enhance our extensive expertise in the subspecialties of dermatopathology, women s health diagnostic services, urologic pathology and gastrointestinal pathology. In addition, through CAD, we will grow our esoteric testing capabilities in each of these subspecialties. We also plan to leverage our market position, regional model and broad range of services to further penetrate the markets we serve and expand our relationships with physicians, hospitals, managed care organizations and other customers.

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Continue to focus on organic growth. We are focused on generating internal revenue growth. For 2003, we generated annual same store sales growth of 3.4% without giving effect to the loss of revenues under our contracts with national laboratories, which are no longer a significant component of our business. We believe that our organic growth has been and will continue to be a result of the following initiatives:

increasing test volume by continuing to invest in a formal sales and marketing effort,

enhancing our payor mix by pursuing additional managed care contracts,

continuing to expand our service offerings, including the offering of new, higher revenue, esoteric tests, and

improving patient care and customer service by providing more specific, informative and timely reports through the development of a standardized pathology reporting system.

Collectively, these initiatives will provide us with the opportunity to grow our business organically.

Maintain quality leadership through a strong pathologist base. We believe that employing anatomic pathologists who provide accurate and efficient diagnoses is a key to our success. A pathologist s experience and reputation is critical to ensuring a successful relationship with local referring physicians. We actively recruit top anatomic pathologists by targeting practicing pathologists and medical students. In 2003, we successfully recruited 30 pathologists, each of whom is a graduate of an accredited United States pathology fellowship program. In addition, we operate one of the leading centers in the United States devoted to the diagnosis and instruction of diseases of the skin. Founded in 1999, this center provides fellowship programs that enable students to train in various aspects of dermatopathology. We also are affiliated with three leading dermatopathology fellowship programs in the United States. Collectively, these relationships enhance our ability to attract new pathologists and allow us to more easily transfer technical innovations to the anatomic pathology services market. We also believe our size and strength of reputation provide an attractive alternative for pathologists who are seeking to offer a broader range of services, take advantage of available economies of scale and reduce the burden of managing the administrative aspects of their operations.

Emphasize information technology capabilities and improve operational efficiencies. We invest in information technology enhancements to improve our services and increase efficiency. For example, in the subspecialty of women s health diagnostics, we offer customers enhanced pathology reports, including color micrographs that allow pathologists and referring physicians to more accurately view highly abnormal cell populations. In addition, to enhance efficiency, we are consolidating various internal billing systems and outsourced billing arrangements into two billing systems, which we believe will increase collections and reduce our days sales outstanding. We also are committed to increasing efficiencies and economies of scale by promoting best practices throughout our organization.

Selectively pursue strategic growth initiatives. We plan to invest in new outpatient laboratories and other strategic initiatives such as CAD. We believe these new facilities and programs drive revenue growth by providing national support for our existing regional and local operations and increasing our menu of testing services. We also plan to further penetrate our existing regional markets by opening new laboratory facilities, such as the new facilities we recently opened in South Carolina, Florida, Indiana and Pennsylvania. In addition, we expect to make additional acquisitions, as opportunities arise, in order to strategically enter new markets or further penetrate existing regional markets.

Operations

We serve both the outpatient and inpatient sections of the anatomic pathology services market. Outpatient services are provided to physician offices, clinics and freestanding surgery centers. Primary outpatient customers include dermatologists, gynecologists, urologists, gastroenterologists and oncologists. Inpatient pathology services generally are provided through our hospital-based operations. Primary inpatient customers include hospitals, staff physicians and surgeons who work in hospitals.

Outpatient Market. In the outpatient market, a patient will visit a physician s office or clinic for a medical problem or concern. Typically, the physician will determine whether a biopsy or Pap smear is necessary and perform the procedure to collect the necessary sample in the office or clinic. The sample, accompanied by an AmeriPath service requisition, is then sent, either by a land-based courier that we

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contract with or employ, or by a commercial overnight courier service, to one of our outpatient laboratories for diagnostic evaluation. If the test is a biopsy, the sample is prepared for review, generally overnight, by one of our histologists and examined by one of our pathologists the next day. The pathologist then renders a diagnosis and dictates a pathology report. The final report is reviewed and signed, manually or electronically, by the pathologist and sent to the referring physician s office. Reports can be delivered to the referring physician in numerous ways including by facsimile, courier service or mail or over the Internet. If the test is a Pap smear, the same process occurs except the sample is prepared for review and initially screened by a cytotechnologist who will issue a final report if the sample contains only normal cells. If the sample includes abnormal cells, then a pathologist s interpretation is performed to ensure accuracy. The referring physician, often in consultation with our pathologist, then determines the next steps for patient care.

Inpatient Market. We generally are the exclusive provider of all anatomic pathology services for the hospitals in which our pathologists work and as a result, our revenues from these services are directly related to the volume of patients in the hospitals we serve. In the hospital, the examination process is similar to that performed in the outpatient segment except, if the hospital has its own histology laboratory, samples are prepared for review within the hospital instead of by one of our histologists. As part of our inpatient services, we generally staff each hospital with at least one pathologist who serves as the medical director of the hospital s clinical laboratory, microbiology laboratory and blood banking operation and who facilitates the hospital s compliance with licensing requirements. The medical director is often responsible for the overall management of the laboratory, including quality of care, professional discipline and utilization review, and serves as a liaison to the hospital administrators, medical staff and the hospital s community.

Services

Anatomic pathology involves the diagnosis of disease through the examination of tissue and cell samples that have been processed and mounted on slides. We offer a broad range of anatomic pathology laboratory testing and information services used by physicians in the detection, diagnosis, evaluation and treatment of cancer and other medical diseases and conditions. Our services play an indispensable role in determining whether a patient s illness is benign, inflammatory or cancerous. We provide services in four primary subspecialties of anatomic pathology: dermatopathology, women s health diagnostics, urologic pathology and gastrointestinal pathology. In addition, we have significant esoteric testing capabilities that compliment these services.

Dermatopathology. Dermatopathology is the examination and diagnosis of skin biopsies taken by a dermatologist. Our dermatopathology services include physician-to-physician consultation, patient education materials, a dedicated sales and service team and quick turnaround to our customers. In addition to the routine microscopic examination of tissue, we offer a wide range of advanced testing, including B-cell and T-cell gene rearrangement, fungal cultures, frozen sections, immunohistochemistry profiles and indirect and direct immunoflourescence. Through our DermPath Diagnostics Division, we provide customers with access to approximately 70 board-certified dermatopathologists, which we believe is the largest group of dermatopathologists in our industry. Our customers typically include dermatologists, plastic surgeons, family practitioners, otolaryngologists and podiatrists.

Women s Health Diagnostics. Women s health diagnostic services, or gynecologic pathology, includes testing such as conventional and monolayer Pap smears, cervical and breast biopsy examination and testing for chlamydia, gonorrhea and HPV. We offer our customers enhanced pathology reports, including color photomicrographs, which allow pathologists to more accurately view highly abnormal cell populations. We have over 70 board-certified cytopathologists providing medical expertise in the women s health market. Our customers primarily include gynecologists and family practitioners.

Urologic Pathology. Urologic pathology relates to diseases of the male and female urinary tract and male reproductive systems. We offer services including the examination of the prostate, bladder and testicular biopsies, a kidney stone management program and recurrent bladder monitoring for cancer. We also offer prognostic testing including DNA analysis and tumor markers. Our kidney stone management

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program provides patients and referring physicians access to care through our strategic partnership with Mission Pharmacal, a San Antonio-based pharmaceutical company focused on treatment of kidney stones and other urological ailments. Our physicians include board-certified pathologists who specialize in urologic pathology. Our customers for these services primarily include urologists.

Gastrointestinal Pathology. We offer a comprehensive gastrointestinal, or GI, disease management program focusing on the digestive tract. We offer a broad range of GI tests, including routine gastric and liver biopsies, prognostic testing and more advanced molecular testing, including hereditary non-polyposis colorectal cancer testing. During 2002, we opened the AmeriPath Institute of Gastrointestinal Pathology and Digestive Disease, a national laboratory specializing in rendering specific diagnoses of GI biopsy specimens, providing second opinion surgical pathology interpretation, studying GI disease and educating both clinicians and pathologists. Our physicians include board-certified pathologists who specialize in gastrointestinal pathology. Our customers in this sub-specialty include endoscopy centers and gastroenterologists.

Esoteric Testing. Esoteric tests are highly complex tests, typically ordered when a physician requires additional information to establish a diagnosis or choose a therapeutic regimen. Esoteric tests require sophisticated instrumentation and highly skilled personnel to perform and analyze results and consequently have higher reimbursement rates than routine tests. Commonly ordered esoteric tests include flow cytometry (testing for leukemia and lymphoma), DNA analysis, molecular genetics and cytoegenetics. We offer all our pathologists and referring physicians access to these high-end diagnostics through our Center for Advanced Diagnostics, or CAD. CAD offers a full array of diagnostics for hematopoetic and solid tissue malignancies, including molecular genetics, cytogenetics, flow cytometry, specialized immunohistochemistry and minimal residual disease detection. The CAD staff includes doctoral scientists and pathologists who specialize in these areas of disease diagnosis.

Billing

Billing for laboratory services involves numerous parties and complex issues and procedures. Laboratories must bill various payors, such as patients, government programs, physicians, hospitals and managed care organizations, all of which have different requirements. Additionally, auditing for compliance with applicable laws and internal compliance policies adds further complexity to the billing process. See Government Regulation Reevaluations and Examination of Billing.

Current Procedural Terminology, or CPT, is a coding system that is applicable to medical services provided under government programs, including Medicare. In addition, most managed care organizations and other third-party payors utilize these codes in determining whether or not a particular service or treatment is a covered expense. During 2003, most of our net revenues resulted from procedures covered by a small number of CPT codes, which makes determination of which code to bill under easier for us than for most other healthcare companies. Upon completion of a pathology report, we generally bill a patient s insurance carrier, which may be a managed care organization, government program or other carrier, or a patient, if a patient does not have insurance. When billing for a test we use information contained in the service requisition form accompanying the test to obtain the appropriate CPT code for the anatomic pathology test performed. In the outpatient segment, we generally bill for both the technical processing and the professional interpretation of the sample, which we refer to as global billing. In the inpatient segment, we bill globally if we perform both the technical and professional component of the test, or we bill for the professional component only, if our pathologist performs the examination and interpretation and the hospital performs the technical processing of the sample. In hospitals where our pathologists also serve as the medical director, we often bill non-Medicare patients according to a fee schedule for what are referred to as clinical professional component, or CPC, charges. For Medicare patients at some hospitals, we are paid a medical director fee by the hospital for serving as their laboratory medical director.

Because substantially all of our revenues are derived from services for which our operations charge on a fee-for-service basis, we assume the financial risk related to collection. This includes potential write-offs of doubtful accounts and long collection cycles for accounts receivable, including reimbursements by third-party

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payors, such as government programs and managed care organizations. Our provision for doubtful accounts for the year 2003 was 14.7% of net revenues, with net revenues from outpatient and inpatient services having a provision for doubtful accounts of 4.7% and 21.9%, respectively. The difference between our provision for doubtful accounts in each segment is principally due to the lower recoverability of CPC fees in the inpatient segment. Each of these fees is typically a de minimus amount that is billed directly to the insurance carrier or the patient and, as a result, frequently go unpaid.

Billing for our operations currently is performed by multiple internal billing systems and other outsourced billing arrangements. Approximately 75% of our revenue in 2003 was billed through five separate billing systems. We plan to integrate substantially all of our operations into two systems by the end of 2005, utilizing an in-house system and a single outsourced system. We have installed a complete general ledger and financial reporting system to handle accounting for the operations and to consolidate all accounting and financial information.

Regional Business Model

Our strategy is to develop our resources nationally but remain in a position to deliver our services regionally and locally in order to strengthen our dialogue and relations with our referring physician base. We believe that this strategy benefits our company, our pathologists, referring physicians, third-party payors and patients. Our regional operations:

- have a substantial market presence,
- offer a broad range of services,
- have extensive physician contacts and
- possess complementary strengths and opportunities for enhanced operational efficiency.

We continue to integrate our operations administrative and technical support functions, including accounting, payroll, purchasing, risk management, billing and collections. We expect this integration to result in enhanced operational efficiencies. Our courier system for transporting samples enables our pathology operations to penetrate areas beyond their current markets and enhances the utilization of our laboratory facilities. We integrate and coordinate our sales and marketing efforts by targeting physicians, hospitals, managed care organizations and other customers on a national, regional and local basis. Our marketing efforts promote the broad geographic coverage, pathologist expertise and the extensive services offered by us. We believe that implementation of this regional model helps to increase the revenues and profitability of the operations in each of our regions.

Sales and Marketing

We employ formal sales and marketing techniques to capitalize on the medical reputations of our pathologists, which we believe distinguishes us from most independent pathologists. Our sales efforts are divided into three distinct sales divisions that provide dedicated service and support along specialty lines:

- the dermatopathology division, which markets itself under the name Dermpath Diagnostics, focuses on servicing and growing the national skin pathology market comprised of dermatologists, plastic surgeons, family practitioners, otolaryngologists and podiatrists,

- the general anatomic division, which markets itself under the name AmeriPath, focuses on servicing and growing our business with gynecologists, urologists, gastroenterologists, and clinics and freestanding surgery centers and

- the oncology division, which markets itself under the name AmeriPath Oncology focuses on servicing and growing our outpatient oncology business and business with hospitals that give specialized anatomic pathology testing.

Each sales division markets the services that fall under its respective specialty area. We believe these divisions are structured to best identify and take advantage of the buying patterns within the markets we serve. Each division is supported by regional sales managers, each of whom report directly to our vice president of sales. The regional sales managers supervise and coordinate the efforts of our field sales representatives. In addition, we utilize a specialized managed care contracting organization to support all three sales divisions in marketing our services to managed care organizations.

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We also employ product managers in our three principal specialty lines. The product managers report directly to our vice president of sales. The primary responsibility of each product manager is to work in conjunction with our pathologists to develop and market new tests and to train the sales force for the particular division on the technical attributes of any new test or product.

Payor Mix

Our services are provided to a wide variety of healthcare providers and payors including physicians, hospitals, managed care organizations and government programs. We consider a payor to be the party that actually pays for our services. Depending on the billing arrangement and applicable law, the payor may be the referring physician, the patient or a third party who pays the bill for the patient, such as a managed care organization or government program. The following table provides the percentages of our cash collections of our owned operations from the identified sources:

	Years Ended December 31,		
	2001	2002	2003
Source of cash collections:			
Government programs	21%	20%	22%
National clinical laboratories	8%	7%	2%
Management services	9%	6%	11%
Other	62%	67%	65%

Other sources of cash collections consist primarily of third-party payors, such as HMOs, PPOs and indemnity insurance companies. See Government Regulation for a discussion of amounts received from the Government.

Contracts and Relationships with Physicians

In connection with our owned operations, we either directly employ our pathologists or control a physician-owned entity that employs our pathologists. Each of our pathologists typically enters into an employment agreement with us or a company we control. Although these employment agreements typically have terms of three to five years, they generally can be terminated at any time, without penalty, upon 60 to 180 days notice. If the pathologist is terminated without cause, however, we may be contractually obligated to pay severance.

Our pathologists generally receive a base salary and fringe benefits and may be eligible for an incentive performance bonus. In addition to compensation, we provide our pathologists with uniform benefit plans, such as disability, supplemental retirement, life and group health insurance and medical malpractice insurance under our captive insurance arrangements. Our pathologists are each required to hold a valid license to practice medicine in the jurisdiction in which they practice and, with respect to inpatient services, to become a member of the medical staff at the contracting hospital with privileges in pathology.

Most of our employment agreements prohibit the pathologist from competing with our company within a defined geographic area and prohibit solicitation of other pathologists, other employees or clients for a period of one to two years after termination of employment. We attempt to structure all these contracts in accordance with applicable laws and to maintain and enforce these contracts as necessary. Agreements not to compete, however, are subject to many limitations under state law and these limitations may vary from state to state. We cannot predict whether a particular court will enforce the non-competition covenants in our employment agreements.

Information Technology

Information technology is used extensively in virtually all aspects of our business, including laboratory testing, billing, customer service, logistics and management of medical data. Through information technology initiatives, we believe we can improve efficiencies in our billing and collections and reporting systems. In addition, we believe our information technology initiatives will improve our

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services through enhanced utilization of our pathologists and more advanced and practical laboratory reporting. Among the initiatives currently being implemented by our information technology group are:

- the creation of a national data center to house the majority of our hardware and software platforms and standardize and streamline our computer maintenance and personnel costs,
- the creation of a data mart, which involves the consolidation of our laboratory information from numerous information systems to enhance our ability to report laboratory test results to customers,
- the development of a direct electronic system to system interface between our pathologists and referring clinician offices and
- the organization of a national billing system to increase the efficiencies in our collection of receivables.

Competition

The anatomic pathology services market is highly fragmented and competitive. We have numerous competitors, and competition can reasonably be expected to increase. Competitors include anatomic pathology practices, large physician group practices, hospital laboratories, specialized commercial laboratories and the anatomic pathology divisions of some national clinical laboratories. Moreover, companies in other healthcare segments, some of which have previously been customers of ours, such as hospitals, national clinical laboratories, managed care organizations and third party payors, may compete with us in the employment of pathologists and provision of anatomic pathology testing services. These companies also may have greater financial resources than we do.

We compete primarily on the basis of service capability, convenience of facilities, scope of testing services performed, accuracy, timeliness and consistency in reporting test results and reputation in the medical community. We believe that our principal competitive advantages are our leading market position, subspecialty focus and our regional business model. We compete for new pathologists and acquisitions on the basis of our reputation, management experience, status and focus on anatomic pathology.

Intellectual Property

We have registered the service marks AmeriPath, CAD-The Center for Advanced Diagnostics, Dermpath Diagnostics and the AmeriPath logo with the United States Patent and Trademark Office.

We are in the process of building brand equity in our trademarks and service marks. Other than the use of such marks, however, our business generally is not dependent upon any intellectual property and as a result, we do not rely on patents or licensed technology in operating our business.

Employees

At December 31, 2003, we employed 408 pathologists. In addition, we employed 805 laboratory technicians, 645 billing, marketing, transcription and administrative staff and 827 other full-time employees. None of these employees or any prospective employee is subject to any collective bargaining agreement.

Website Access to SEC Filings

AmeriPath makes its annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and any amendments to those reports, available free of charge on or through our Internet website, www.ameripath.com, as soon as reasonably practicable after they are electronically filed with or furnished to the SEC.

Insurance

We are at risk for being sued for acts or omissions of our pathologists, our laboratory personnel or hospital employees who are under the supervision of our hospital-based pathologists. We and our pathologists periodically become involved as defendants in medical malpractice and other lawsuits, some of which are currently ongoing, and are subject to the attendant risk of substantial damage awards. In June

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2002, we replaced our existing medical malpractice insurance coverage with third party insurance companies with a new self-insurance, or captive, arrangement. We entered into this self-insurance arrangement because we were unable to renew our existing coverage at acceptable rates, which we believe was an industry-wide situation. Under our self-insurance structure, we retain more risk for medical malpractice costs, including settlements and claims expense, than under our previous coverage. While we have obtained excess liability coverage for medical malpractice costs, we have no aggregate excess stop loss protection, meaning there is no aggregate limitation on the amount of risk we retain under these arrangements. For the period of July 1, 2002 through June 30, 2003, our medical malpractice costs were approximately $12.4 million, representing an increase of $1.3 million from fiscal year 2002. The determination of our medical malpractice costs is based on actuarial estimates of our medical malpractice settlement and claims expense and the costs of maintaining our captive insurance program and excess coverage. We periodically review and update the appropriateness of our accrued liability for medical malpractice costs. The terms of the purchase agreements relating to each of our past acquisitions generally contain certain limited rights of indemnification from the sellers of the practices. We also maintain property and general liability insurance policies and obtain indemnity agreements from third parties such as hospitals and national clinical laboratories.

While we believe we have a prudent risk management system for our company and our pathologists, pending or future claims may be successful and, if successful, may not be covered or may exceed the limitations of our risk management program, including the limits of our captive insurance arrangements, our excess liability coverage and applicable indemnification provisions. It is also possible that our excess liability and other insurance coverage will not continue to be available at acceptable costs or on favorable terms. In addition, our insurance does not cover all potential liabilities arising from governmental fines and penalties, indemnification agreements and certain other uninsurable losses. For example, from time to time we agree to indemnify third parties, such as hospitals and national clinical laboratories, for various claims that may not be covered by insurance. As a result we may become responsible for substantial damage awards that are uninsured. We are currently subject to indemnity claims, which if determined adversely to us or one or more of our pathologists or other persons whom we indemnify, could exceed the limitations of our risk management program. Such a result would have an adverse effect on our business, financial condition and results of operations.

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Government Regulation

Our business is subject to governmental and regulatory requirements relating to healthcare matters as well as laws and regulations relating to business corporations. We exercise care to structure our operations and arrangements with hospitals and physicians to comply with relevant federal and state laws. We believe our current arrangements and practices are in material compliance with applicable statutes and regulations. We have not received or applied, however, for legal opinions from counsel or from any federal or state regulatory authority to this effect, and many aspects of our business operations have not been the subject of federal or state regulatory interpretation. As a result, it is possible that our current or prior practices or arrangements could be found to be noncompliant with applicable laws and regulations, and any such occurrence could have an adverse effect on our business, financial condition and results of operations.

We derived approximately 21%, 20%, and 22% of our net revenues for the years 2001, 2002 and 2003, respectively, from payments made by government sponsored healthcare programs, principally Medicare and Medicaid. These programs are subject to substantial regulation by the federal and state governments. Any change in payment regulations, policies, practices, interpretations or statutes that places limitations on reimbursement amounts, or changes in reimbursement coding or practices could adversely affect our financial condition and results of operations. The medicare statute includes a methodology to adjust payments for services, including anatomic pathology services, under the physician fee schedule. This methodology is applied each year unless it is overridden by congressional action. The statutory methodology would have led to a 4.4% reduction in the physician fee schedule conversion factor in 2003 and a 4.5% reduction in 2004 if those reductions had not been blocked by Congress. Instead, Congress required a 1.6% increase in 2003 and a 1.5% increase in each of 2004 and 2005. In addition, because it was projected that the statutory methodology would result in additional reductions in the physician fee schedule conversion factor in future years, Congress revised the methodology through legislation enacted in December 2003. It is unclear how this revision in the methodology will affect the annual adjustments in the physician fee schedule conversion factor in future years and, if it will not prevent reductions, whether Congress will intervene to prevent decreases in the physician fee schedule conversion factor in future years.

Increasing budgetary pressures at both the federal and state level and concerns over the continued increase of the costs of healthcare have led, and may continue to lead, to significant reductions in healthcare payments and may lead to significant reduction in our revenue or our revenue for specific tests. State concerns over the growth in Medicaid costs also could result in payment reductions. Although governmental payment reductions have not materially affected us in the past, it is possible that such changes in the future could have an adverse effect on our financial condition and results of operations. In addition, Medicare, Medicaid and other government sponsored healthcare programs are increasingly shifting to some form of managed care. Some states have recently enacted legislation that will require that all Medicaid patients be converted to managed care organizations, and similar legislation may be enacted in other states, which could result in reduced payments to our company for such patients. In addition, a state-legislated shift in a Medicaid plan to managed care could cause the loss of some, or all, Medicaid business for us in that state if we were not selected as a participating provider. Additionally, funds received under all healthcare reimbursement programs are subject to audit with respect to the proper billing for physician services. Retroactive adjustments of revenue from these programs could occur. We expect that there will continue to be proposals to reduce or limit Medicare and Medicaid payment for services.

In connection with our past acquisitions, we performed due diligence investigations with respect to the potential liabilities of acquired operations and obtained indemnification with respect to some liabilities from the sellers of these operations. Nevertheless, there could be undiscovered claims. Further, despite our efforts to obtain adequate indemnification, liabilities for which we become responsible in respect of acquired operations could be material and may exceed either the limitations of any applicable indemnification provisions or the financial resources of the indemnifying parties. We regularly review compliance by our acquired businesses with federal and state healthcare laws and regulations and revise, as appropriate, the policies and procedures of our acquired businesses to conform to our policies and procedures and applicable law. Although we maintain an active compliance program, it is possible that the government might challenge some of our current practices as not being in full compliance with applicable laws and regulations. A violation of these laws could result in the government s recoupment of fees previously paid to us, forfeiture of revenues due to us, civil and criminal penalties, exclusion of the physician, the operation or our company from participation in Medicare and Medicaid programs and loss of a physician s license to practice medicine.

Anti-Kickback Laws

Federal anti-kickback laws and regulations prohibit any knowing and willful offer, payment, solicitation or receipt of

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any form of remuneration, either directly or indirectly, in return for, or to induce: (i) the referral of an individual for a service for which payment may be made by Medicare and Medicaid or certain other federal healthcare programs; or (ii) the purchasing, leasing, ordering or arranging for, or recommending the purchase, lease or order of, any service or item for which payment may be made by Medicare, Medicaid or certain other federal healthcare programs. Violations of federal anti-kickback laws and regulations are punishable by monetary fines, civil and criminal penalties and exclusion from participation in Medicare, Medicaid and other federal healthcare programs. Several states have similar laws.

The federal government has published regulations that provide safe-harbors from prosecution under federal anti-kickback laws for business transactions that meet certain requirements. Failure to meet the requirements of a safe harbor does not necessarily mean a transaction violates the anti-kickback law. Although many of our operations do not satisfy the requirements of the safe harbors, we believe our operations are in material compliance with applicable anti-kickback laws, and we seek to structure arrangements to comply with applicable safe harbors where reasonably possible. There is a risk, however, that the federal government might conclude that our arrangements violate the anti-kickback statute. If any of our arrangements were found to be illegal, our company and the individual physicians involved could be subject to government recoupment of fees paid to us, forfeiture of revenues due to us or civil and criminal penalties, including exclusion from the participation in government reimbursement programs, which could adversely affect our business, financial condition and results of operations.

The Office of Inspector General of the Department of Health and Human Services, or OIG, issues advisory opinions that provide advice on whether proposed business arrangements violate the anti-kickback law. In Advisory Opinion 99-13, the OIG opined that when prices for laboratory services for non-governmental patients are discounted below Medicare reimbursable rates, the anti-kickback law may be implicated. The OIG found prices discounted below the laboratory supplier s costs to be particularly problematic. In the same opinion, OIG suggested that a laboratory may be excluded from federal healthcare programs if it charges the Medicare or Medicaid programs amounts substantially in excess of discounted charges to other customers. In the OIG s opinion, charges are likely excessive if the profit margin for Medicare business exceeds the profit margin for non-federally reimbursed business.

The OIG also has addressed physician practice management arrangements in an advisory opinion. In Advisory Opinion 98-4, the OIG found that management fees based on a percentage of practice revenues may violate the anti-kickback statute. These Advisory Opinions suggest that OIG might challenge prices below Medicare reimbursement rates or arrangements based on a percentage of revenues. While we believe our arrangements are in material compliance with applicable law and regulations, OIG s advisory opinions suggest there is a risk of an adverse OIG finding relating to arrangements reviewed in the advisory opinions. Any such finding could adversely affect our business, financial condition and results of operations.

Self-Referral and Financial Inducement Laws

We are subject to federal and state statutes and regulations banning payments for referral of patients and referrals by physicians to healthcare providers with whom the physicians (or their immediate family members) have a financial relationship. The federal physician anti-self referral law, or the Stark Law, applies to Medicare and Medicaid and prohibits a physician from referring patients for certain designated health services, including laboratory services, to an entity with which the physician has a financial relationship. Financial relationships include both investment (and ownership) interests in an entity and compensation arrangements with an entity. If an arrangement or relationship is covered by the Stark Law, all of the requirements of a Stark Law exception must be satisfied. Most states have enacted some form of referral law. State statutes and regulations affecting the referral of patients to healthcare providers range from statutes and regulations that are substantially similar to the federal law to simple requirements that physicians and other healthcare professionals disclose to patients any financial relationship the physicians or healthcare professionals have with a healthcare provider to which the patient is referred. These laws and regulations are often vague and, in many cases, have not been interpreted by courts or regulatory agencies. The state statutes and regulations generally apply to services reimbursed by both governmental and private payors. Violations of these laws may result in prohibition of payment for services rendered, government recoupment of fees paid to us and forfeiture of revenues due to us, loss of licenses and fines and civil and criminal penalties. In addition, violation of the Stark Law may result in exclusion from Medicare and Medicaid and other federal and state healthcare programs. Adverse judicial or administrative interpretations of any of these laws could adversely affect our business, financial condition and results of operations. In addition, expansion of our operations to new jurisdictions, or new interpretations of laws in existing jurisdictions, could

require structural and organizational modifications of our relationships with physicians to comply with that jurisdiction s laws.

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The Stark Law exempts from its definition of a referral any request for diagnostic laboratory tests and pathological examination services when made by a pathologist pursuant to a consultation requested by another physician. Our business has been structured so that substantially all tests we perform on the basis of requests from our affiliated physicians will fall within this special pathology exemption. Certain referrals to us are however ineligible for this exemption and, if other Stark Law exemption does not apply (such as the in-office ancillary service exemption or exemptions for certain employment and personal services arrangements), the government may determine that we are in violation of these complex, constantly evolving Stark Law exemptions and rules. We have also attempted to design our business so that it is in material compliance with applicable state anti-referral laws and regulations, many of which are modeled after the federal statute. If our financial relationships with one or more pathologists were found to be non-exempt or if non-exempt referrals were found to have been made, or if our compensation to physicians were interrupted as violating a state s anti-referral laws, we and the affected pathologists could be subject to civil and criminal penalties, including fines, exclusions from participation in government and private payor programs, forfeiture of revenues due to us and requirements to refund amounts previously received from government and private payors.

False Claims Laws

Under the federal False Claims Act, the government may fine any person who knowingly submits, or participates in submitting, claims for payment to the federal government that are false or fraudulent or that contain false or misleading information. In addition, knowingly making or using a false record or statement to avoid paying the federal government is a violation. Entities found to have violated the False Claims Act may be required to make significant payments to the government, including damages, penalties, forfeiture of revenues due and reimbursements of amounts previously collected. Individuals associated with the entity may be subject to prison terms and large fines. In addition, entities and individuals may be excluded from participating in Medicare, Medicaid and other federal healthcare programs. Many states have similar false claims statutes.

In addition, private insurers may bring actions under false claim laws. In certain circumstances, federal and some state laws authorize private whistleblowers to bring false claim suits on behalf of the government against providers and reward the whistleblower with a portion of any final recovery. In addition, the federal government has engaged a number of nongovernmental-audit organizations to assist it in tracking and recovering false claims for healthcare services. The practices targeted include: billing for tests not performed, billing for tests not medically necessary or not ordered by the physician, unbundling, or billing for tests individually rather than as a group, upcoding tests to realize higher reimbursement than what is owed, offering inducements to physicians for testing referrals and duplicate billing. These practices have led to governmental investigations and whistleblower suits that have resulted in financially significant payments made by a number of healthcare providers in the past decade.

Since investigations relating to false claims have increased in recent years, it is more likely companies conducting business in the healthcare industry could become the subject of a federal or state civil or criminal investigation or action, be required to defend the results of such investigation, be subjected to civil and criminal fines, be sued by private payors and be excluded from Medicare, Medicaid or other federally funded healthcare programs. Although we monitor our billing practices for compliance with prevailing industry practice under applicable laws, such laws are complex and constantly evolving.

Government Investigations of Hospitals and Hospital Laboratories

Significant media and public attention has been focused on the healthcare industry due to ongoing federal and state investigations related to referral and billing practices, laboratory and home healthcare services and physician ownership and joint ventures involving hospitals. Most notably, HCA, Inc., or HCA, has been under investigation with respect to such practices. We provide medical director services for numerous hospital laboratories, including 27 HCA hospital laboratories as of December 31, 2003. The government s investigation of HCA could result in a governmental investigation of one or more of our operations that have arrangements with HCA. In addition, the OIG and the Department of

Justice have initiated hospital laboratory billing review projects in some states and are expected to extend such projects to additional states, including states in which we operate hospital laboratories. These projects increase the likelihood of governmental investigations of our operations. Although we monitor our billing practices and hospital arrangements for compliance with applicable laws, such laws are complex and constantly evolving. The government s investigations of entities with which we contract may have other effects, which could adversely affect us, including termination or amendment of one or more of our contracts or business relationships.

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Corporate Practice of Medicine Restrictions

We are not licensed to practice medicine. The practice of medicine is conducted solely by our licensed pathologists. The manner in which licensed physicians can be organized to perform and bill for medical services is governed by the laws of the state in which medical services are provided and by the medical boards or other entities authorized by these states to oversee the practice of medicine. Business corporations generally are not permitted under the laws of many states to exercise control over the medical judgments or decisions of physicians or engage in certain practices, such as fee-splitting, with physicians. In states where we are not permitted to directly own a medical practice, we perform only non-medical and administrative and support services, do not represent to the public or our clients that we offer medical services and do not exercise influence or control over the practice of medicine. In those states, we conduct our laboratory operations indirectly through one or more physician-owned entities that are controlled by us.

If the laws of a state restrict the direct employment of physicians or the practice of medicine by a company like ours, we conduct business in that state by contracting with an affiliated physician-owned entity that, in turn, employs the physicians who, in turn, practice medicine. In those states, we generally enter into a contract that restricts the owner of the affiliated entity from transferring his, her or its ownership interests in the affiliated entity and otherwise provides us or our designee with a controlling voting or financial interest in the affiliated entity and its laboratory operations. Our controlling financial interest is generally obtained pursuant to a long-term management service agreement between us and the affiliated physician-owned entity. Under the management services agreement we exclusively manage all aspects of the operation other than the provision of medical services. Generally, the affiliated entity has no operating assets because we acquired all of its operating assets at the time we acquired the related laboratory operations. As part of the management services agreements, each affiliated physician-owned entity is required to maintain medical malpractice insurance that names our company as an additional insured, and we are required to maintain general liability insurance that names the affiliated physician-owned entity as additional insured. Upon termination of the services agreement, each affiliated physician-owned entity is required to obtain continuing liability insurance coverage under either a tail policy or a prior acts policy.

We believe that we are currently in material compliance with the corporate practice laws in the states in which we operate. Regulatory authorities or other parties could assert, however, that we are engaged in the corporate practice of medicine. If such a claim were successfully asserted in any jurisdiction, our company and our pathologists could be subject to civil and criminal penalties under such jurisdiction s laws and could be required to restructure our contractual and other arrangements. Alternatively, some of our existing contracts could be found to be illegal and unenforceable. Any such occurrence could adversely affect our business, financial condition or results of operations. In addition, expansion of our operations to other states may require structural and organizational modification of our form of relationship with physicians or hospitals.

Restrictions on Fee-Splitting

Many states prohibit the splitting or sharing of fees between physicians and non-physicians. These laws vary from state to state and are enforced by courts and regulatory agencies, each with broad discretion. Most of the states with fee-splitting laws only prohibit a physician from sharing fees with a referral source. Some states, however, have interpreted management agreements between entities and physicians as unlawful fee-splitting.

We believe our arrangements with pathologists materially comply with the fee-splitting laws of the states in which we operate. Nevertheless, it is possible regulatory authorities or other parties could claim we are engaged in fee-splitting. If such a claim were successfully asserted in any jurisdiction, our company and our pathologists could be subject to civil and criminal penalties, and we could be required to restructure our contractual and other arrangements. Any restructuring of our contractual and other arrangements could result in lower revenues, increased expenses and reduced control over our operations. Alternatively, some of our existing contracts could be found to be illegal and unenforceable, which could result in the termination of those contracts and an associated loss of revenue. In addition, expansion of our operations to other states with fee-splitting prohibitions may require structural and organizational modification to the form of relationships that we currently have with

pathologists, affiliated operations and hospitals.

Medicare Fee Schedules for Diagnostic Laboratory Testing

Medicare reimburses hospitals for services performed for a patient based on location-specific fee schedules, which in

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part are based on Consumer Price Index, or CPI, related adjustments. At various times, Congress has implemented a national cap on Medicare laboratory fee schedules and has either limited or eliminated the annual CPI adjustments of the Medicare laboratory fee schedules.

The Medicare statute includes a methodology to adjust payments for services, including anatomic pathology services, under the physician fee schedule. This methodology is applied each year unless it is overridden by congressional action. The medicare statute includes a methodology to adjust payments for services, including anatomic pathology services, under the physician fee schedule. This methodology is applied each year unless it is overridden by congressional action. The statutory methodology would have led to a 4.4% reduction in the physician fee schedule conversion factor in 2003 and a 4.5% reduction in 2004 if those reductions had net been blocked by Congress. Instead, Congress required a 1.6% increase in 2003 and a 1.5% increase in each of 2004 and 2005. In addition, because it was projected that the statutory methodology would result in additional reductions in the physician fee schedule conversion factor in future years, Congress revised the methodology through legislation enacted in December 2003. It is unclear how this revision in the methodology will affect the annual adjustments in the physician fee schedule conversion factor in future years and, if it will not prevent reductions, whether Congress will intervene to prevent decreases in the physician fee schedule conversion factor in future years.

State Medicaid programs similarly pay in accordance with a fee schedule and may cap payments either in accordance with Medicare caps or state requirements. See Management s Discussion and Analysis of Financial Condition and Results of Operations Recent Trends and Events for additional discussion.

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Reevaluations and Examination of Billing

Payors periodically reevaluate the services they cover. In some cases, government payors such as Medicare also may seek to recoup payments previously made for services determined not to be covered. Moreover, recently the federal government has become more aggressive in examining laboratory billing and seeking repayments and penalties as the result of improper billing for services. The primary focus of this initiative has been on hospital laboratories and on clinical laboratory tests as opposed to anatomic pathology tests. The scope of this initiative, however, could expand. Furthermore, the Health Insurance Portability and Accountability Act of 1996, or HIPAA, and a joint governmental initiative commenced in 1995 called Operation Restore Trust have strengthened the powers of the OIG and increased the funding for Medicare and Medicaid audits and investigations. As a result, the OIG has expanded and continues to expand the scope of its healthcare audits and investigations. State enforcement actions are similarly expanding. Federal and state audits and inspections, whether on a scheduled or unannounced basis, are conducted from time to time at our facilities. We believe our practices are proper and do not include any allegedly improper practices now being examined.

Laboratory Compliance Plan

In February 1997, the OIG released a model compliance plan for laboratories based largely on the corporate integrity agreements negotiated with the laboratories against which government enforcement actions were brought under Operation Restore Trust. We adopted and maintain a compliance plan, which includes components of the OIG s model compliance plan, as we deem appropriate to the conduct of our business. Our president serves as our chief compliance officer and reports directly to the audit committee of our board of directors.

Antitrust Laws

In connection with state corporate practice of medicine laws discussed above, the physician-owned affiliates through which we operate are organized as separate legal entities. As such, the physician practice entities may be deemed to be persons separate both from our company and from one another under the antitrust laws and, accordingly, subject to a wide range of federal and state laws prohibiting anti-competitive conduct among separate legal entities. We believe we are in compliance with federal and state antitrust laws and intend to comply with any state and federal laws that may affect us. The government has increased its scrutiny, particularly with regard to healthcare providers. A review of our business and operations by courts or regulatory authorities may adversely affect our business, financial condition or results of operations.

HIPAA Criminal Penalties

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, established an array of new federal criminal authorities prohibiting the commission of fraud against any healthcare benefit program, theft, embezzlement involving healthcare and false statements in connection with the payment of any health benefits. HIPAA also provided broad prosecutorial subpoena authority and authorized property forfeiture upon conviction of a federal healthcare offense. Significantly, the HIPAA provisions apply both to federal programs and to private health benefit programs. HIPAA also broadened the authority of the OIG to exclude participants from federal healthcare programs. Enforcement of the new HIPPA provisions is in its early stages, and we currently are unable to predict their ultimate impact on us.

Licensing

The Clinical Laboratory Improvement Amendments program, or CLIA, extends federal oversight to virtually all healthcare laboratories by requiring that laboratories be certified by the government. Many laboratories also must meet governmental quality and personnel standards, undergo proficiency testing and biennial inspection. Rather than focusing on location, size or type of laboratory, oversight is based on the complexity of the test performed by the laboratory. The CLIA quality standards regulations divide all tests into three categories: waived, moderate complexity and high complexity. They also establish requirements depending upon the complexity of the test performed. Our outpatient laboratories are licensed by the Department of Health and Human Services, or HHS, under CLIA to perform high complexity testing. Generally, the HHS regulations require laboratories that perform high complexity or moderate complexity tests to implement systems that ensure the accurate performance and reporting of test results, establish quality control systems, conduct proficiency testing and perform biennial inspections. We also are subject to state regulation, and CLIA provides that a state may adopt more stringent regulations than federal law. For example, some states in which we operate require that laboratory personnel meet certain qualifications and quality controls, maintain certain records and undergo proficiency testing.

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Persons engaged in the practice of medicine must be licensed by each state in which they practice. The professional practice of physicians is regulated in each state by the state board of medicine. Each board of medicine has rules enumerating the activities that constitute unprofessional conduct. A board may sanction unprofessional conduct by suspending, restricting or revoking a physician s license. Other possible sanctions include restraining orders, injunctions, imprisonment and fines.

HIPAA Regulations Relating to Privacy, Security and Electronic Transactions and Code Sets

Among other things, HIPAA established several requirements regarding the privacy, security and electronic transmission of individually identifiable health information. HHS has issued several sets of regulations in accordance with its authority under HIPAA. In general, these regulations apply to healthcare providers, health plans, and healthcare clearinghouses, which the regulations refer to as covered entities. Our company and most of our operations are subject to the HIPAA regulations.

The HIPAA regulations include:

- regulations that protect individual privacy by limiting the uses and disclosures of individually identifiable health information, or the Privacy Regulations;
- regulations that prescribe specific transaction formats and data code sets for specified electronic healthcare transactions, or the TCS Regulations; and
- regulations that require covered entities to implement administrative, physical and technological safeguards to ensure the confidentiality, integrity and availability of individually identifiable health information in electronic form, or the Security Regulations.

Failure to comply with the HIPAA regulations may subject the company to civil monetary penalties and, in certain circumstances, criminal penalties. Under HIPAA, covered entities may be subject to civil monetary penalties in the amount of $100 per violation, capped at a maximum of $25,000 per year for violation of any particular standard. However, civil monetary penalties may not be assessed if a covered entity s failure to comply is based on reasonable cause and not willful neglect, and the failure to comply is remedied within 30 days, or a longer period determined to be appropriate by HHS. On April 17, 2003, HHS published an interim final rule regarding civil monetary penalties. The rule largely deals with procedural issues regarding imposition of penalties, and does not address substantive issues regarding what violations will result in the imposition of a civil monetary penalty and what factors will be taken into account in determining the amount of a penalty. The U.S. Department of Justice, or DOJ, may seek to impose criminal penalties for intentional violations of HIPAA. Criminal penalties under HIPAA vary depending upon the nature of the violation but could include fines of up to $250,000 and/or imprisonment.

At this time, we are not able to determine the full consequences of the HIPAA regulations to our business or the total cost of complying with these regulations. Although we are in material compliance with these HIPAA regulations with which compliance is currently required, the HIPAA regulations are expected to continue to impact us operationally and financially and will pose increased regulatory risk.

HIPAA Privacy Regulations

The Privacy Regulations establish comprehensive federal standards relating to the use and disclosure of individually identifiable health information, or protected health information. The Privacy Regulations establish limits on the use and disclosure of protected health information, provide for patients rights, including rights to access, request amendment of, and receive an accounting of certain disclosures of protected health information, and require certain safeguards to protect protected health information. In addition, each covered entity must contractually bind individuals and entities that furnish services to the covered entity or perform a function on its behalf, and to which the covered entity discloses protected health information, to restrictions on the use and disclosure of that information. The Privacy Regulations do not supersede state laws that are more stringent. Thus, we must reconcile the Privacy Regulations and other state privacy laws that are more stringent than the Privacy Regulations. Our operations that are regulated by HIPAA were required to be in compliance with the Privacy Regulations by April 14, 2003. We believe our operations are in material compliance with the Privacy Regulations. Because uncertainties

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remain regarding the application and interpretation of the Privacy Regulations, and because there is limited information currently available regarding civil enforcement activities by the HHS Office for Civil Rights, or OCR, and criminal enforcement activities by DOJ, there is no assurance that OCR or DOJ would find the company to be operating in compliance with the Privacy Regulations.

HIPAA TCS Regulations

The TCS Regulations establish uniform standards relating to data reporting, formatting and coding that covered entities must use in conducting certain transactions. The TCS Regulations presently apply to eight different transactions, including transactions relating to healthcare claims and healthcare payment and remittance advice. Upon the compliance date, healthcare providers must use these standards when electronically conducting a covered transaction with health plans. The compliance date for the TCS Regulations was October 16, 2002, although the Administrative Simplification Compliance Act granted a covered entity an additional one year to achieve compliance if it filed a compliance plan on or before October 15, 2002. We filed a compliance plan to extend the applicable compliance date for the TCS Regulations until October 16, 2003. Any of our operations acquired or formed after October 15, 2002 that did not file for an extension on or before that date were required to be in immediate compliance.

Many covered entities, including our company, were not fully compliant with the TCS Regulations as of October 16, 2003. However, we have deployed a contingency plan to continue to send and receive non-standard transactions, as contemplated in the Guidance on Compliance with HIPAA Transactions and Code Sets After the October 16, 2003 Implementation Deadline (which we refer to as the CMS Guidance) issued by the Centers for Medicare & Medicaid Services, or CMS, on July 24, 2003. In the CMS Guidance, CMS stated that covered entities are responsible for complying with the TCS Regulations following the October 16, 2003 compliance date. However, the CMS Guidance also provides that CMS s focus will be on obtaining voluntary compliance and that CMS will follow a complaint-driven approach to enforcement of the TCS Regulations. The CMS Guidance further indicates that CMS will consider a covered entity s good faith efforts to comply with the TCS Regulations in determining whether to seek civil monetary penalties against a non-compliant covered entity and whether to extend the time allowed for the covered entity to remedy the non-compliance.

In light of the CMS Guidance, we have taken a number of steps to update our systems and work with our trading partners to achieve compliance with the TCS Regulations. We have updated the software and information systems that we use to conduct electronic transactions with our trading partners to enable us to conduct those transactions in compliance with the TCS Regulations. Where our systems could not be updated to achieve compliance, we have engaged third party clearinghouses to conduct transactions for us. We have also established with most of our trading partners the electronic pathways necessary to process transactions in compliance with the TCS Regulations, and have conducted testing, re-testing and quality assurance processes related to such transactions. Currently, we are HIPAA compliant for those transactions that we conduct and with those trading partners that can conduct HIPAA compliant transactions.

Although we have taken these proactive steps, by deploying our contingency plan and conducting non-standard transactions, our company, like most covered entities, including CMS, was not in full compliance with the TCS Regulations as of and in the period immediately after October 16, 2003. Although the CMS Guidance indicated that CMS will follow a complaint-driven approach, we cannot provide any assurances regarding how CMS would apply the CMS Guidance in general or to our company in particular. In addition, we understand that CMS has received a limited number of complaints regarding covered entities compliance with the TCS Regulations, but are not currently aware of any complaint against our company. In the event of enforcement action by CMS, there can be no assurances that we will be able to establish our good faith efforts to CMS s satisfaction so as to avoid liability for civil monetary penalties. There also can be no assurances that CMS would be willing to extend the 30-day time period for us to remedy non-compliance, or that we would be able to remedy our non-compliance within the 30-day time period or any extended period granted by CMS.

We expect that in the near future CMS and other health plans are likely to end their contingency plans, and at that time will require healthcare providers like our company to operate in full compliance with the TCS Regulations. We cannot be sure that these health plans will provide us with sufficient notice to allow us to prepare to transition to operating in full compliance with the TCS Regulations. Since the healthcare system has not operated at full capacity using the newly-mandated standard electronic transactions, unforeseen errors may occur which could cause rejection of claims, extended payment cycles, and reduction of cash flow.

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As stated above, DOJ may seek to impose criminal penalties, including fines and imprisonment, in the event of a covered entity s knowing violation of HIPAA. It is not clear whether criminal penalties may be imposed for violations only of the Privacy Regulations, or also for violations of the TCS Regulations. To date, DOJ has not provided any formal guidance regarding when it would seek to impose criminal penalties for violations of the HIPAA regulations. While there can be no assurances that DOJ will not seek criminal penalties against us for our initial failure to fully comply with the TCS Regulations, we believe that, given the CMS Guidance, prosecution of technical violations of the TCS Regulations is unlikely.

HIPAA Security Regulations

The Security Regulations were finalized on February 20, 2003 and compliance will be required by April 21, 2005. The Security Regulations establish detailed requirements for safeguarding protected health information that is electronically transmitted or electronically stored. The Security Regulations establish 42 implementation specifications, 20 of which are required, meaning they must be implemented as specified in the Security Regulations, while the other 22 are addressable. Complying with addressable implementation specifications will require the Company to assess whether these specifications constitute a reasonable and appropriate safeguard for the particular business activity; if not, the Company must design and implement an alternative approach to satisfy the particular standard.

Some of the Security Regulations are technical in nature, while others may be addressed through policies and procedures. The Security Regulations may require us to incur significant costs in ensuring that our systems and facilities have in place all of the technical and physical safeguards to meet all of the implementation specifications. We are unable to predict what changes might be made to the Security Regulations, or what guidance might be provided by CMS, prior to the April 21, 2005 compliance deadline or how those changes or guidance might impact our business. The effect of the Security Regulations on our business is difficult to predict and there can be no assurances that we will adequately address the risks created by the Security Regulations and their implementation.

Other Regulations

In addition, our facilities and operations are subject to licensing and regulation under federal, state and local laws relating to the safety and health of laboratory employees and the collecting, storing, handling and disposal of medical specimens, infectious and hazardous waste and radioactive materials. We believe our laboratory operations are in material compliance with applicable federal and state laws and regulations relating to the generation, use, storage, treatment and disposal of all laboratory specimens and other biohazardous waste. We utilize licensed vendors for the disposal of such specimen and waste.

In addition to its comprehensive regulation of safety in the workplace, the federal Occupational Safety and Health Administration has established extensive requirements relating to workplace safety for healthcare employees, including clinical laboratories, whose workers may be exposed to blood-borne pathogens, such as HIV and the hepatitis B virus. These regulations require work practice controls, protective clothing and equipment, training, medical follow-up, vaccinations and other measures designed to minimize exposure to and transmission of, blood-borne pathogens. Regulations of the Department of Transportation, the Public Health Services and the U.S. Postal Service also apply to the transportation of laboratory specimens. We believe we are in material compliance with these regulations.

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ITEM 2. PROPERTIES

We lease our executive offices located in Riviera Beach, Florida (approximately 25,000 square feet) and our billing offices in Fort Lauderdale, Florida (approximately 66,400 square feet) and including our managed operations lease 93 other facilities: 27 in Florida, 22 in Texas, five in Tennessee, four in Ohio and Wisconsin, three in each of Mississippi, New York, Oklahoma, Pennsylvania, Kentucky and Georgia, two in each of Alabama, California and Colorado and one each in Arizona, North Carolina, Indiana, South Carolina, Virginia, Massachusetts and Utah. These facilities are used for laboratory operations, administrative and billing and collections operations and storage space. All the facilities encompass an aggregate of approximately 586,000 square feet, have an aggregate annual rent of approximately $7.6 million and have lease terms expiring from 2004 to 2019. As laboratory leases are scheduled to expire, we will consider whether to extend or renegotiate the existing lease or move the facility to another location within the defined geographic area of the operation.

ITEM 3. LEGAL PROCEEDINGS

From time to time, we receive subpoenas from government officials. While to date none of these investigations has resulted in liability, investigations are expensive and take valuable management time. For instance, we received subpoenas from the United States Attorney s office in Tampa, Florida to deliver Medicare billing records and other documents relating to alleged financial inducements received by a Florida physician who is not a pathologist with our company but is one of our clients. We are providing information to the United States Attorney s office and intend to cooperate in the investigation. We also are conducting our own internal investigation of the matter. It is not possible at this point in the investigation to determine whether the government will pursue action against us or to assess the merits of possible defenses we may have to any such action. Accordingly, no assurances can be given regarding the ultimate outcome of the investigation. Any action against us by the United States Attorney s office could result in fines or penalties being imposed upon us. Additionally, although we believe that we are in material compliance with federal and state fraud and abuse laws, there is no assurance that at a future time a United States Attorney, or other federal or state government agency will not reach a different conclusion.

During the fourth quarter of 2002, two civil actions were commenced in the Circuit Court of the 15th Judicial Circuit in and for Palm Beach County, Florida. The two actions were consolidated in February 14, 2003 and an Amended Complaint was filed on March 6, 2003. The Amended Complaint alleges a breach of duty to stockholders in connection with the March 2003 Transaction. The plaintiffs seek to represent a putative class consisting of the former public stockholders of AmeriPath, Inc. Named as defendants in the Amended Complaint are AmeriPath, Inc. and the members of the AmeriPath, Inc. board of directors. The plaintiffs allege, among other things, that the consideration was inadequate, that the announcement was improperly timed, that AmeriPath, Inc. was not properly auctioned, that the March 2003 Transaction was unfair, that the proxy statement omitted certain information that the plaintiffs contend was material and that such AmeriPath, Inc. directors breached their fiduciary duties. The Amended Complaint seeks injunctive relief against consummation of the merger, unspecified amounts of damages, costs and expenses related to their actions and other unspecified relief. We believe the Amended Complaint lacks merit and have moved to dismiss it. Notwithstanding this motion, the plaintiffs and us have agreed in principal to a non-class settlement that will be funded by our D&O insurance carrier, is in the range of future defense costs and will not materially impact our financial statements or operations. Upon consummation of the settlement, the litigation will be dismissed.

In addition, during the ordinary course of business, we have become and may in the future become subject to legal actions and proceedings. We may have liability with respect to our employees and our pathologists and with respect to hospital employees who are under the supervision of our hospital-based pathologists. The majority of these pending legal proceedings involve claims of medical malpractice. Based upon investigations conducted to date, we believe the outcome of any pending legal actions and proceedings, individually or in the aggregate, will not have a material adverse effect on our financial condition, results of operations or liquidity. There can be no assurance that our captive insurance arrangements and our excess liability insurance coverage will be adequate to cover all potential medical malpractice liabilities that we may incur. We have no aggregate excess stop loss protection, meaning once our claim limits have been reached, we are subject for any excess amounts. We also may, from time to time, be involved with legal actions related to the acquisition of anatomic pathology operations, the prior conduct of acquired operations or the employment and restriction on competition of physicians. There can be no assurance that any costs or liabilities for which we become responsible in connection with these claims or actions will not be material or will not exceed the limitations of

any applicable indemnification provisions or the financial resources of the indemnifying parties.

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ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

No matter was submitted to a vote of security holders during the fiscal quarter ended December 31, 2003.

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PART II

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

On December 8, 2002, AmeriPath Holdings, Inc. (Holdings), formerly known as Amy Holding Company, and its wholly-owned subsidiary Amy Acquisition Corp., entered into a merger agreement providing for the merger of Amy Acquisition Corp. with and into AmeriPath, with AmeriPath continuing as the surviving corporation and a wholly-owned subsidiary of Holdings. The merger was consummated on March 27, 2003. The Company refers to the merger as the March 2003 Transaction . As a result of the March 2003 Transaction, AmeriPath became a wholly-owned subsidiary of Amy Holding Company, which was renamed AmeriPath Holdings, Inc. (Holdings). As a result, there is no established public trading market for our Common Stock. As of March 10, 2004, there was one holder of our Common Stock. We have not declared any cash dividends on our Common Stock for our two most recent fiscal years, and we do not intend to pay cash dividends in the foreseeable future. In addition, our credit facility restricts the payment of dividends on our common stock.

ITEM 6. SELECTED FINANCIAL DATA

The following selected historical consolidated financial information should be read in conjunction with Management s Discussion and Analysis of Financial Condition and Results of Operations and our consolidated audited financial statements. The Statements of Income Data and Balance Sheet Data are derived from our audited financial statements. Our consolidated audited financial statements for the year ended December 31, 2002 and for the period from January 1, 2003 through March 27, 2003 and for the period from March 28, 2003 through December 31, 2003 have been audited by Ernst & Young LLP, our independent auditors. Our consolidated audited financial statements for the years ended December 31, 1999, 2000 and 2001 have been audited by Deloitte & Touche LLP. We have restated the historical information below for years ended December 31, 1999 and 2000 to reflect our combination with Pathology Consultants of America, Inc., also known as Inform DX, on November 30, 2000, which we accounted for as a pooling of interests.

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STATEMENTS OF INCOME DATA:

YEARS ENDED DECEMBER 31,

(dollars in thousands)

	Predecessor[1]					Successor
	Year Ended December 31				Period from January 1, 2003 through March	Period from March 28, 2003 through December
	1999	2000	2001	2002	27, 2003	31, 2003
Net revenue	$ 257,432	$ 330,094	$ 418,732	$ 478,818	$ 118,957	$ 366,046
Operating costs and expenses:						
Cost of services	122,685	163,390	200,102	238,573	62,145	189,771
Selling, general and administrative expenses	47,159	58,411	71,856	84,868	21,726	65,579
Provision for doubtful accounts	25,289	34,040	48,287	58,170	14,997	56,376
Amortization expense	12,827	16,172	18,659	11,389	3,107	8,352
Merger-related charges [2]		6,209	7,103	2,836	10,010	2,404
Restructuring costs [3]					1,196	2,044
Asset impairment and related charges [4]		9,562	3,809	2,753		425
Total operating costs	207,960	287,784	349,816	398,589	113,181	324,951
Income from operations	49,472	42,310	68,916	80,229	5,776	41,095
Interest expense	(9,573)	(15,376)	(16,350)	(4,016)	(1,180)	(34,469)
Termination of interest rate swap agreement [5]			(10,386)			
Write-off of Genomics investment [6]				(1,000)		
Write-off of deferred financing costs [7]			(1,574)		(957)	
Other income, net	286	226	145	548	33	318
Income before income taxes	40,185	27,160	40,751	75,761	3,672	6,944
Provision for income taxes	17,474	14,068	17,399	31,120	2,131	3,090
Net income	22,711	13,092	23,352	44,641	1,541	3,854
Induced conversion and accretion of preferred stock [8]	(131)	(1,604)				
Net income available to common shareholders	$ 22,580	$ 11,488	$ 23,352	$ 44,641	$ 1,541	$ 3,854

CONSOLIDATED BALANCE SHEET DATA:

DECEMBER 31,

(dollars in thousands)

	Predecessor [1]				Successor
	1999	2000	2001	2002	2003
Cash and cash equivalents	$ 1,713	$ 2,418	$ 3,208	$ 964	$ 23,536
Total assets	478,896	562,166	604,462	708,460	912,753
Long-term debt, including current portion	168,614	201,747	93,322	116,253	492,458
Redeemable equity securities	15,504				
Stockholder s equity	206,214	249,665	399,190	451,326	338,675

(1) Consolidated financial data as of December 31, 2003 and for the period from March 28, 2003 through December 31, 2003 reflect the fair value of assets acquired and liabilities assumed in connection with the merger. The comparability of the operating results for the periods presented is affected by the revaluation of the assets acquired and liabilities assumed on the date of the merger. The financial data for the periods prior to March 27, 2003 consists of the historical data and subsidiaries prior to the merger.

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(2) In connection with our combination with Inform DX, we recorded $6.2 million and $7.1 million in 2000 and 2001, respectively, of costs related to transaction fees, change in control payments and various exit costs associated with the consolidation of certain operations. In addition, in connection with the March 2003 Transaction, we recorded $2.8 million of transaction fees in the fourth quarter of 2002 and $12.4 million during 2003.

(3) Represents restructuring costs that were recognized based upon criteria set forth in SFAS 146 of (i) $1.2 million for employee severance costs in connection with a reduction in workforce at our Southern California, Philadelphia, Central Florida and North Texas laboratories, and (ii) $2.0 million incurred for remaining severance costs and the closure of our Southern California laboratory. The Southern California facility was closed as a result of a loss of revenue from Quest Diagnostics, which historically accounted for a significant portion of revenues for this individual lab.

(4) During 2000, we recorded the following asset impairment and related charges: (a) $3.3 million in connection with the termination of our services in South Florida by Quest, (b) $5.2 million in connection with a hospital system, where we provided services, filing for bankruptcy resulting in our loss of three hospital contracts and an ambulatory care facility contract and (c) $1.0 million in connection with the loss of a hospital contract in South Florida to a competitor. During 2001, we recorded an asset impairment charge of $3.8 million related to the closure of an Alabama laboratory. During 2002, we recorded charges consisting of approximately $2.1 million in connection with the write-off of our remaining Quest laboratory contract intangibles and approximately $0.7 million in connection with our termination of a management service agreement in Georgia. During 2003, we recorded a pre-tax, non-cash charge of approximately $0.4 million in connection with the sale of two hospital-based practices in Florida.

(5) In connection with the termination of a former credit facility during 2001, we made a one-time pre-tax payment of approximately $10.4 million to terminate our interest rate swap agreements.

(6) During 2002, we wrote off the $1.0 million carrying value of our interest in a genomics company as a result of a decline in the fair value of this investment.

(7) Consists of write-offs of deferred financing costs relating to the termination of then-existing credit facilities in 2001 and in connection with the March 2003 Transaction.

(8) During 2000, we recorded $1.5 million in connection with an induced conversion of preferred stock equal to 247,169 shares of common stock issued at a fair value of $6.22.

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

The consolidated financial statements contained in Item 8 include the accounts of Ameripath, Inc. and subsidiaries (collectively, Ameripath or the Company) subsequent to the March 2003 Transaction as well as the accounts of the Predecessor prior to the March 2003 Transaction. The financial statements and financial data of the Predecessor are presented for comparative purposes and include the combined historical financial statements of our wholly-owned subsidiaries. The Predecessor ceased operations as of the date of the merger.

The following discussion of our financial condition and results of operations should be read together with the Selected Financial Data and our consolidated financial statements and the accompanying notes included elsewhere in Item 8. Our fiscal year is the calendar year ending December 31. As noted in Note 1 to the Consolidated Financial Statements, the March 2003 Transaction resulted in a new basis of accounting for the Company. In some cases, for ease of comparison purposes, financial data for the period from March 28, 2003 through December 31, 2003 has been added to financial data for the period from January 1, 2003 through March 27, 2003, to arrive at a 12-month combined period ended December 31, 2003. This combined data may be referred to herein as fiscal year 2003, year 2003, 2003, or the 12-month combined period ended December 31, 2003.

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General

We are one of the leading anatomic pathology laboratory companies in the United States. We offer a broad range of anatomic pathology laboratory testing and information services used by physicians in the detection, diagnosis, evaluation and treatment of cancer and other diseases and medical conditions. We service an extensive referring physician base through our 15 regional laboratories and 36 satellite laboratories, and we provide inpatient diagnostic and medical director services at more than 200 hospitals. Our services are performed by over 400 pathologists.

Since our formation in 1996, we have completed over 50 acquisitions of pathology laboratories and operations. In 2000, we merged with Pathology Consultants of America, Inc., also known as Inform DX. The Inform DX merger was accounted for as a pooling of interests. All of our prior years financial information has been restated to reflect the Inform DX merger.

Because the laws of many states restrict corporations like us from directly employing physicians or owning corporations that employ physicians, we often conduct our business through affiliated entities that we manage and control but do not own. In states where we are under these restrictions, we perform only non-medical administrative and support services, do not represent to the public or our clients that we offer medical services and do not exercise influence or control over the practice of medicine by our physicians. Because of the degree of non-medical managerial control we exercise over our affiliated entities, we consolidate the financial results of these entities with those of our wholly-owned operations. We collectively refer to these consolidated entities and our wholly owned operations as our owned operations. In addition, we also have entered into management agreements with a few anatomic pathology laboratory operations over which we do not exercise non-medical managerial control and, accordingly, do not consolidate with our owned operations. We refer to these operations as our managed operations. For fiscal year 2003, our revenues from owned operations and managed operations accounted for 95.2% and 4.8% of our total net revenues, respectively.

The March 2003 Transaction

On December 8, 2002, Holdings and its wholly-owned subsidiary Amy Acquisition Corp., entered into a merger agreement providing for the merger of Amy Acquisition Corp. with and into AmeriPath, with AmeriPath continuing as the surviving corporation and a wholly-owned subsidiary of Holdings. The merger was consummated on March 27, 2003. As a result of the March 2003 Transaction, Ameripath became a wholly-owned subsidiary of Amy Holding Company, which was renamed Ameripath Holdings, Inc. (Holdings).

Amy Holding Company and Amy Acquisition Corp. were Delaware corporations formed at the direction of Welsh, Carson, Anderson & Stowe IX (WCAS). WCAS, its related investors and several employees of the Company own 100% of the outstanding common stock of Holdings.

The funds necessary to consummate the March 2003 Transaction were approximately $804.0 million, including approximately $629.6 million to pay the stockholders and option holders of AmeriPath (other than WCAS and its affiliates) all amounts due under the merger agreement, approximately $127.5 million to refinance existing indebtedness and approximately $46.9 million to pay related fees and expenses. Prior to the merger, the 1,534,480 shares of AmeriPath common stock owned by WCAS and its affiliates were contributed to Holdings in exchange for shares of Holdings common stock. These shares were cancelled without payment of any merger consideration. The March 2003 Transaction was financed by a cash common equity investment by WCAS and its related equity investors of $296.2 million in Holdings, which funds were contributed by Holdings to AmeriPath in exchange for shares of AmeriPath s common stock, $225.0 million in term loan borrowings under its new credit facility, the issuance of $275.0 million in senior subordinated notes and existing AmeriPath cash. Accordingly, our interest expense currently is and will continue to be higher than it was prior to the March 2003 Transaction.

The March 2003 Transaction has been accounted for under the purchase method of accounting prescribed in SFAS 141, with intangible assets recorded in accordance with SFAS No. 142. In accordance with the provisions of SFAS No. 142, no amortization of indefinite-lived intangible assets or goodwill is recorded.

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Financial Statement Presentation

The following paragraphs provide a brief description of the most important items that appear in our financial statements and general factors that impact these items.

Net Revenues. Net revenues consists of revenues received from patients, third-party payors and others for services rendered. Our same store net revenue is affected by changes in customer volume, payor mix and reimbursement rates. References to same store refer to operations that have been included in our financial statements throughout the periods compared.

Cost of Services. Cost of services consists principally of the compensation and fringe benefits of pathologists, medical malpractice insurance, licensed technicians and support personnel, laboratory supplies, shipping and distribution costs and facility costs. Historically, acquisitions, and the costs associated with additional personnel and facilities, have been the most significant factor driving increases in our cost of services. Also, increases in medical malpractice insurance have affected our cost of services.

Selling, General and Administrative Expense. Selling, general and administrative expense primarily includes the cost of field operations, corporate support, sales and marketing, information technology and billing and collections. As we have developed our national sales and marketing infrastructure, our selling, general and administrative expense has increased. In addition, spending on new information technology initiatives historically has contributed to increased expenses in this category.

Provision for Doubtful Accounts. The provision for doubtful accounts is affected by our mix of revenue from outpatient and inpatient services. The provision for doubtful accounts typically is higher for inpatient services than for outpatient services due primarily to a larger concentration of indigent and private pay patients, greater difficulty gathering complete and accurate billing information and longer billing and collection cycles for inpatient services. Management service revenue generally does not include a provision for doubtful accounts.

Amortization Expense. Our acquisitions have resulted in significant net identifiable intangible assets and goodwill. We record net identifiable intangible assets at fair value on the date of acquisition. Effective January 1, 2002, we adopted Statement of Financial Accounting Standards No. 142, Goodwill and Other Intangible Assets, which required us to cease amortizing goodwill and instead perform a transitional impairment test as of January 1, 2002 and an annual impairment analysis to assess the recoverability of goodwill. The results of the transitional and annual impairment tests indicated no impairment of goodwill or other indefinite lived intangible. We continually evaluate whether events or circumstances have occurred that may warrant revisions to the carrying values of our goodwill and other identifiable intangible assets or to the estimated useful lives assigned to such assets. Any significant impairment recorded on the carrying values of our goodwill or other identifiable intangible assets would be recorded as a charge to income from operations and a reduction of intangible assets and could materially reduce our profitability in the period in which the charge is recorded.

Recent Trends and Events

Acquisitions. During 2003, we acquired four anatomic pathology practices. The total consideration paid by us in connection with these acquisitions included cash of $4.8 million and additional purchase price consideration issued in the form of contingent notes. During 2002, we acquired seven anatomic pathology practices. The total consideration paid by us in connection with these acquisitions included cash of $44.0 million, 108,265 shares of common stock (aggregate value of $1.7 million based upon amounts recorded on our consolidated financial

statements). In addition, we issued additional purchase price consideration in the form of contingent notes. During 2001, we acquired one anatomic pathology operation. The total consideration paid by us in connection with the acquisition, which is deemed immaterial, included cash and issuance of common stock and subordinated debt. In addition, we issued additional purchase price consideration in the form of contingent notes.

Contingent Note Payments. During the 12-month combined period ended December 31, 2003, we made contingent note payments of $37.0 million. During the year ended December 31, 2002, we made contingent note payments of $39.9 million, issued $0.8 million of contingent stock, and made other purchase price adjustments of approximately $0.1 million in connection with certain post-closing adjustments and acquisition costs.

Medical Malpractice Costs. In June 2002, we replaced our existing medical malpractice insurance coverage with third

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party insurance companies with a new self-insurance, or captive, arrangement. We entered into this self-insurance arrangement because we were unable to renew our existing coverage at acceptable rates, which we believe was an industry-wide situation. Under our self-insurance structure, we retain more risk for medical malpractice costs, including settlements and claims expense, than under our previous coverage. While we have obtained excess liability coverage for medical malpractice costs, we have no aggregate excess stop loss protection, meaning there is no aggregate limitation on the amount of risk we retain under these arrangements. Our medical malpractice costs are based on actuarial estimates of our medical malpractice settlement and claims expense and the costs of maintaining our captive insurance program and excess coverage. We periodically review and update the appropriateness of our accrued liability for medical malpractice costs. Because we retain these risks, in addition to an actual increase in claims or related expenses, a change in the actuarial assumptions upon which our medical malpractice costs are based could materially affect results of operations in a particular period even if we do not experience an actual increase in claims or related expenses. For fiscal year 2003, our medical malpractice costs were approximately $12.4 million.

Quest Contracts. During 2002, Quest cancelled its contract with our Jacksonville laboratory, and Quest cancelled its contract with our Orlando laboratory effective March 31, 2003. Quest is in the process of internalizing the anatomic pathology work currently subcontracted to us. Our revenues from Quest in 2002 and 2003 were $23.3 million and $3.3 million, respectively. We expect the amount of revenue from our Quest contracts to continue to decline in 2004. As a result, we are attempting to broaden our customer base in these markets to mitigate the impact of the lost business. During the third quarter of 2002, we recorded a charge of approximately $2.1 million related to various contract terminations. We have no further identifiable intangible assets relating to Quest and therefore we do not anticipate any future charges related to Quest.

Medicare Reimbursement. The Medicare statute includes a methodology to adjust payments for services, including anatomic pathology services, under the physician fee schedule. This methodology is applied each year unless it is overridden by congressional action. The statutory methodology would have led to a 4.4% reduction in the physician fee schedule conversion factor in 2003 and a 4.5% reduction in 2004 if those reductions had not been blocked by Congress. Instead, Congress required a 1.6% increase in 2003 and a 1.5% increase in each of 2004 and 2005. In addition, because it was projected that the statutory methodology would result in additional reductions in the physician fee schedule conversion factor in future years, Congress revised the methodology through legislation enacted in December 2003. It is unclear how this revision in the methodology will affect the annual adjustments in the physician fee schedule conversion factor in future years and, if it will not prevent reductions, whether Congress will intervene to prevent decreases in the physician fee schedule conversion factor in future years.

Critical Accounting Policies and Estimates

The methods, estimates and judgments we use in applying our most critical accounting policies have a significant impact on the results we report in our consolidated financial statements. We evaluate our estimates and judgments on an ongoing basis. We base our estimates on historical experience and on assumptions that we believe to be reasonable under the circumstances. Our experience and assumptions form the basis for our judgments about the carrying value of assets and liabilities that are not readily apparent from other sources. Actual results may vary from what we anticipate and different assumptions or estimates about the future could change our reported results.

Intangible Assets. As of December 31, 2003, we had net identifiable intangible assets and goodwill of $186.6 million and $532.9 million, respectively. Our identifiable intangible assets include hospital contracts, laboratory contracts, management service contracts, employment and non-compete agreements, and trade names acquired by us in connection with acquisitions. We continually assess whether an impairment in the carrying value of our intangible assets has occurred. If the undiscounted future cash flows over the remaining amortization period of an intangible asset indicates that the value assigned to the intangible asset may not be recoverable, we reduce the carrying value of the intangible asset. We would determine the amount of any such impairment by comparing anticipated discounted future cash flows from acquired businesses with the carrying value of the related assets. In performing this analysis, we consider such factors as current results, trends and future prospects, in addition to other relevant factors. In September 2003, the Company finalized the recording of the fair value of the identifiable intangibles acquired and the amount of goodwill recorded as a result of the March 2003 Transaction. Fair value was determined based upon a valuation completed by an independent third-party valuation firm. As a result, in the third quarter of 2003, the Company recorded additional goodwill of approximately $12.4 million, recorded non-compete and employment agreements of $18.0 million, trade names of $27.2 million and payor contracts of $9.2 million. In addition, the Company also reduced the carrying value of its hospital contracts by $65.3 million, client lists by $70.8

million, and the carrying value of deferred taxes associated with previous acquisitions by $63.3 million. The change in the value of the Company s hospital contracts was

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primarily a result of changes in valuation assumptions that reflected lower projected profitability levels being received from these contracts, an increase in contributed capital as a result of an increase in the value of other separately identifiable intangibles and the utilization of a decay curve based on turnover statistics. Client lists were not valued because they did not meet the separability criteria as defined in EITF 02-17 *Recognition of Customer Relationship Intangible Assets Acquired in a Business Combination.* Prior to the March 2003 Transaction, the predecessor amortized hospital contracts over periods ranging from 25-40 years. As part of the valuation, the Company reviewed the lives of its intangible assets and estimated the remaining life of its hospital contracts to be 25 years and reduced the life of its management service agreements from 25 years to 20 years. The Company considered the effects of demand, competition, the expected useful life and other economic factors in determining the useful lives. The changes in the fair values of the Company s intangible assets as well as the changes in the estimated useful lives, discussed above, will reduce amortization expense in future periods by approximately $1.3 million annually.

Revenue Recognition. We recognize net patient service revenue at the time we perform services. We record unbilled receivables for services rendered during, but billed subsequent to, the reporting period. We report net patient service revenue at the estimated realizable amounts from patients, third-party payors and others for services rendered. Revenue under certain third-party payor agreements is subject to audit and retroactive adjustments. We estimate our provision for estimated third-party payor settlements and adjustments in the period the related services are rendered and adjust in future periods as final settlements are determined. We adjust the provision and the related allowance periodically, based upon our evaluation of historical collection experience with specific payors for particular services, anticipated collection levels with specific payors for new services, industry reimbursement trends and other relevant factors.

Captive Insurance Program. Through June 30, 2002, we were insured for medical malpractice risks on a claims made basis under traditional insurance policies. We formed a self-insurance, or captive, insurance company, on July 1, 2002 to partially self-insure for medical malpractice costs. The captive arrangement, combined with excess coverage, provides insurance on a per claim basis. We do not have any aggregate excess stop loss protection. We use actuarial estimates to determine accruals for settlement costs, claims expenses and incurred but not reported claims. Actual costs in future periods could differ materially from actuarial studies, depending on the frequency and severity of actual claims experienced.

Contingent Purchase Price. Our acquisitions generally have been accounted for using the purchase method of accounting. The aggregate consideration paid, and to be paid, by us in connection with our acquisitions is based on a number of factors, including the acquired operation s demographics, size, local prominence, position in the marketplace and historical cash flows from operations. Assessment of these and other factors, including uncertainties regarding the health care environment, results in our being unable to reach agreement on the final purchase price with sellers of acquired operations. As a result, when acquiring operations we generally have used as consideration a combination of cash, stock, assumed liabilities and contingent notes. Typically, the contingent notes have been structured to provide for payments to sellers upon the achievement of specified levels of operating income by the acquired operations over three to five year periods from the date of acquisition. Some of our contingent notes have been structured to provide for payments to sellers contingent on the retention of specified hospital contracts by the acquired operations. In either case, the contingent notes are not contingent on the continued employment by us of the sellers. If a contingent note payment is earned, we are required to pay the specified amount and interest on this amount. The amount of the payments under our contingent notes cannot be determined until final determination of the operating income levels or other performance targets during the relevant periods specified in the respective agreements. Pursuant to SFAS 141, principal and interest payments made in connection with the contingent notes are accounted for as additional purchase price, which increases our recorded goodwill and, in accordance with generally accepted accounting principles in the United States, are not reflected in our results of operations.

Provision for Doubtful Accounts and Related Allowance. We estimate our provision for doubtful accounts in the period the related services are rendered and adjust in future accounting periods as necessary. We base the estimates for the provision and the related allowance on our evaluation of historical collection experience, the aging profile of the accounts receivable, the historical doubtful account write-off percentages, revenue channel, in other words, inpatient as opposed to outpatient, and other relevant factors.

Principles of Consolidation

Our consolidated financial statements include our accounts and those of our owned operations. As part of the consolidation process, we have eliminated intercompany accounts and transactions. We do not consolidate the results of operations of our managed operations.

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Segments

Our two reportable segments are our owned operations and our managed operations. We determine our segments based upon the type of service performed and our customers. Our owned operations provide anatomic pathology services to hospitals and referring physicians, while our managed operations provide management services to the affiliated physician groups. We evaluate performance based on revenue and income before amortization of intangibles, merger-related charges, asset impairment related charges, interest expense, other income and expense and income taxes, which we refer to as segment operating income. In addition to the business segments above, there are charges that are not allocated to the business segments.

Results of Operations

The following table outlines, for the periods indicated, selected operating data as a percentage of net revenues.

	Year Ended December 31,				
	2001	2002	2003 Combined	Period from January 1, 2003 through March 27, 2003	Period from March 28, 2003 through December 31, 2003
	(Predecessor)	(Predecessor)		(Predecessor)	(Successor)
Net revenues	100.0%	100.0%	100.0%	100.0%	100.0%
Operating costs and expenses:					
Cost of services	47.8	49.8	51.9	52.2	51.8
Selling, general and administrative expenses	17.2	17.7	18.0	18.3	17.9
Provision for doubtful accounts	11.5	12.1	14.7	12.6	15.4
Amortization expense	4.4	2.5	2.3	2.6	2.3
Merger-related charges	1.7	0.6	2.6	8.4	0.7
Restructuring costs			0.7	1.0	0.6
Asset impairment and related charges	0.9	0.6	0.1		0.1
Total operating costs & expenses	83.5	83.3	90.3	95.1	88.8
Income from operations	16.5	16.7	9.7	4.9	11.2
Interest expense	(3.9)	(0.7)	(7.4)	(1.0)	(9.4)
Termination of interest rate swap agreement	(2.5)				
Write-off of deferred financing costs	(0.4)		(0.2)	(0.8)	
Write-off of Genomics investment		(0.2)			
Other income, net			0.1		0.1
Income before income taxes	9.7	15.8	2.2	3.1	1.9
Provision for income taxes	4.1	6.5	1.1	1.8	0.8
Net income	5.6%	9.3%	1.1%	1.3%	1.1%

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12-Month Combined Period Ended December 31, 2003 compared with year ended December 31, 2002

The 12-month combined period ended December 31, 2003 includes the period from January 1, 2003 through March 27, 2003 (predecessor) and the period from March 28, 2003 through December 31, 2003 (successor).

Net Revenues.

Net revenues increased by $6.2 million, or 1.3%, from $478.8 million for the year ended December 31, 2002 to $485.0 million for the 12-month combined period ended December 31, 2003. Revenues for 2003 were negatively impacted by a $4.5 million charge to revenues based on changes in our estimated contractual allowances resulting from the analysis of our managed care contracts. Same store net revenue decreased $3.7 million, or 0.8%, from $465.3 million for 2002 to $461.6 million for 2003. Same store net revenue, excluding revenue from national laboratory companies, for 2003 increased 3.4%, or $15.2 million, compared to the same period of 2002. For 2003, revenue from our contracts with national laboratory companies was $4.3 million, down from $23.3 million for the same period of 2002. These factors were offset by increased revenues from acquisitions made in late 2002 and during 2003. Our mix of revenue for 2003 was 50.8% outpatient, 44.4% inpatient (hospital based) and 4.8% management services.

Cost of Services.

Cost of services increased by $13.3 million, or 5.6%, from $238.6 million in 2002 to $251.9 million for the same period in 2003. The increase was due to an increase in medical malpractice costs of $3.5 million, excess lab capacity, increasing health insurance benefit costs, increase in physician costs and salaries, and acquisitions of $2.9 million. Cost of services, as a percentage of net revenues, increased from 49.8% for 2002 to 51.9% in the comparable period of 2003. Gross margin decreased from 50.2% in 2002 to 48.1% for the same period in 2003.

Selling, General and Administrative Expenses.

Selling, general and administrative expense increased by $2.4 million, or 2.9%, from $84.9 million for 2002 to $87.3 million for the same period of 2003. As a percentage of net revenues, selling, general and administrative expense increased from 17.7% for 2002 to 18.0% for the same period of 2003. The increase is primarily due to investments in information technology and the expansion of sales and marketing efforts.

Provision for Doubtful Accounts.

Our provision for doubtful accounts increased by $13.2 million, or 22.7%, from $58.2 million for 2002 to $71.4 million for the same period in 2003. The provision for doubtful accounts as a percentage of net revenues increased from 12.1% for 2002 to 14.7% for the same period in 2003. The provision for doubtful accounts for 2003 included charges of $6.5 million related to a change in the net realizable value of certain receivables based on our analysis of the ability to collect historical revenues and billings associated with clinical professional component services.

Amortization Expense.

Amortization expense increased by $0.1 million, or 0.9%, from $11.4 million for 2002 to $11.5 million for the same period of 2003, largely due to identifiable intangibles acquired in conjunction with acquisitions completed during the last quarter of 2002, partially offset by an adjustment to amortization expense of $0.7 million related to the final allocation of the purchase price of the March 2003 Transaction.

Merger-related Charges.

The merger-related charges of $12.4 million for 2003 relate to the March 2003 Transaction. These costs were primarily legal, accounting, advisory services and employee change in control payments related to the March 2003 Transaction. During 2002, we recorded acquisition-related costs totaling $2.8 million related to the March 2003 Transaction.

Restructuring Costs.

During 2003, we incurred certain restructuring costs as promulgated by SFAS No. 146 of approximately $1.2 million for employee severance costs in connection with a reduction in workforce at our Southern California, Philadelphia, Central Florida and North Texas laboratories. We also incurred an additional $2.0 million during 2003 for remaining severance costs and the closure of our Southern California laboratory. The Southern California laboratory was closed as a result of a loss of Quest revenues that historically accounted for a significant portion of revenues for this individual lab. It is estimated that these restructuring costs will rationalize excess capacity at certain laboratories.

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Asset Impairment and Related Charges.

During 2003, we sold two practices in Florida resulting in an impairment charge of approximately $425,000. In 2002, we recognized an impairment charge on the intangible asset value of our Quest lab contracts of approximately $2.1 million, due to the loss of these contracts. In addition, during 2002, the management service agreement contract with a managed practice in Georgia was terminated resulting in an impairment charge of approximately $700,000.

Income from Operations.

Income from operations decreased $33.3 million, or 41.5%, from $80.2 million for the year ended December 31, 2002 to $46.9 million for the 12-month combined period ended December 31, 2003. The decrease was primarily the result of an increase in the provision for doubtful accounts of $13.2 million, along with merger-related charges of $12.4 million and restructuring costs of $3.2 million incurred in 2003.

Write-off of Deferred Financing Costs.

In March 2003, we wrote off the $1.0 million remaining balance of deferred financing costs related to the termination of our former credit facility as part of the March 2003 Transaction.

Interest Expense.