AMERIPATH INC
Form 10-K
March 18, 2005
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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, 2004

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	**(I.R.S. Employer**
Incorporation or Organization)	**Identification No.)**

7111 Fairway Drive, Suite 400, Palm Beach Gardens, Florida 33418

(Address of Principal Executive Offices)

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

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

(Former Address of Principal Executive Offices)

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

All of the voting and non-voting common equity of the Registrant is held by affiliates.

The number of shares of Common Stock of the Registrant outstanding as of March 17, 2005 was 100.

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PART I

ITEM 1. BUSINESS

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 2004, 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 2004, we generated net revenue and income from operations of $507.3 million and $52.5 million, respectively.

We service an extensive referring physician base through our 14 regional laboratories and 31 satellite laboratories, and we provide inpatient diagnostic and medical director services at more than 200 hospitals. We have operations in 22 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 our formation as a Delaware corporation in 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 32 million and 128 million individuals, respectively, which represents more than half of all individuals covered by managed care in the United States.

Company History

On December 8, 2002, Amy Holding Company and its wholly-owned subsidiary, Amy Acquisition Corp., entered into a merger agreement with the predecessor of AmeriPath, Inc. (AmeriPath or the Company) pursuant to which Amy Acquisition Corp. merged with and into the predecessor, with AmeriPath continuing as the surviving corporation (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). Amy Holding Company and Amy Acquisition Corp. were Delaware corporations formed at the direction of Welsh, Carson, Anderson & Stowe IX, L.P. (WCAS). WCAS, its related investors and several employees or affiliates of the Company currently own 100% of the outstanding common stock of Holdings. The March 2003 Transaction was approved by the Company s stockholders and subsequently consummated on March 27, 2003. References herein to our predecessor refer to the activities, financial position and results of operations of AmeriPath prior to 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 AmeriPath s 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.

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The address of our principal executive office is 7111 Fairway Drive, Suite 400, Palm Beach Gardens, Florida 33418. Our phone number is (561) 712-6200. Our Internet website address is www.ameripath.com.

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 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 $4.4 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 14%, 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.

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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 22 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 $4.4 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, 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 2004, we generated operating income of $52.5 million, or 10.3% of net revenues. In addition, during 2004 we had cash flow from operating activities less capital expenditures, or free operating cash flow, of $41.2 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. In addition, we have recently signed a multi-year agreement to provide anatomic pathology and esoteric testing for CIGNA HealthCare effective March 1, 2005. Under the agreement, we will be a participating provider in CIGNA HealthCare s HMO, POS, PPO and indemnity health plans and may actively market our services to CIGNA HealthCare members and physicians in certain states. 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 2004, 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.

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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 14 regional laboratories, 31 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 our Center for Advanced Diagnostices, or 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.

Continue to focus on organic growth. We are focused on generating internal revenue growth. For 2004, we generated annual same store sales growth of 5.8% 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 who are locally, nationally and/or internationally renowned. In 2004, we successfully recruited 38 pathologists. 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. In addition, we expect to make additional acquisitions, as opportunities arise, in order to strategically enter new markets or further penetrate existing regional markets, such as the facilities we acquired in Utah, Kansas City and New York.

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.

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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 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 89 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 69 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 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 are primarily 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.

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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 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 2004, 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 payors, such as government programs and managed care organizations. Our provision for doubtful accounts for the year 2004 was 15.1% of net revenues, with net revenues from outpatient and inpatient services having a provision for doubtful accounts of 9.8% and 23.8%, 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 80% of our revenue in 2004 was billed through five separate billing systems. We plan to integrate substantially all of our operations into two systems by the end of 2007, utilizing an in-house system and a single outsourced system.

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.

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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 focused on providing dedicated service and support along five distinct specialty lines.

- the dermatopathology specialty line, 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, and podiatrists. This specialty line is supported by two distinct Institutes; The Institute for Podiatric Pathology, focusing on providing specialized service to Podiatrists and The Institute for Immunofluorescence focusing on providing esoteric testing services to Dermatologists.

- the general anatomic specialty line, which markets itself under the name AmeriPath , is sub-divided into four different specialty lines; Women s Health, Urology, Gastroenterology and Oncology. These specialty lines focus on servicing and growing our business with gynecologists, urologists, gastroenterologists, clinics and freestanding surgery centers, outpatient oncology offices and hospitals that provide specialized anatomic pathology testing. The general anatomic pathology specialty line is supported by 4 distinct Institutes; The GI Institute, focusing on providing specialized services to gastroenterologists; The GU Institute, focusing on providing specialized services to urologists and The Center for Advanced Diagnostics and AmeriPath Esoteric Institute, focusing on providing esoteric testing services to oncologists, hospitals and gynecologists.

Our sales force markets all the services that fall under each respective specialty line area. We believe these specialty lines are structured to best identify and take advantage of the buying patterns within the markets we serve. Each sales representative is supported by regional sales managers, each of whom work closely with their regional president and 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 team of managed care contracting representatives to support all five specialty lines in marketing our services to managed care organizations.

We also employ product managers in each of our specialty lines. The product managers report directly to our vice president of marketing. The primary responsibility of each product manager is to work in conjunction with our pathologists and sales and operational teams to develop and market new tests and to assist in training the sales force on the technical attributes of any new test or product within their specialty line.

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:

	Year Ended December 31,		
	2002	2003	2004
Source of cash collections:			
Government programs	22%	22%	22%
Third party (including managed care organizations)	57%	58%	56%
Private payors	10%	12%	14%
National clinical laboratories	7%	2%	1%
Other	4%	6%	7%

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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 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 in two facilities that will provide redundancy of all our key components in order to improve the overall uptime of all our applications,
- the creation of a Physician s WEB Portal that gives AmeriPath clients the ability to view Pathology reports on the WEB and to print populated requisitions with information interfaced from their practice management system,
- the development of a state of the art laboratory information system that will be utilized by all AmeriPath laboratories and will include advanced features for specimen tracking, document scanning, voice recognition, image reporting, as well as facilitate standardization of data input for consistent management reporting,

the development of a state of the art billing information system that is specifically designed to meet AmeriPath s unique billing needs in the Anatomic Pathology business, as well as provide complete control of system enhancements necessary to accommodate ever changing regulatory requirements.

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.

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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, 2004, we employed 405 pathologists. In addition, we employed 825 laboratory technicians, 656 billing, marketing, transcription and administrative staff and 843 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 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. 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 the period of July 1, 2003 through June 30, 2004, our medical malpractice costs were approximately $13.5 million, representing an increase of $1.1 million from fiscal year 2003. 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.

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

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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 22%, 22%, and 20% of our net revenues for the years 2004, 2003 and 2002, 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 levels 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 reductions 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 enacted legislation that 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 laws. 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 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

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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.

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 exemptions do 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 interpreted 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.

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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, 2004. 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.

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

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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 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 adjustment 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 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.

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.

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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 chief compliance officer reports to our Vice President of Legal and monitors our compliance plan and audit process. The chief compliance officer reports compliance issues directly to the audit committee of our board of directors as he deems appropriate.

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 regarding antitrust violations, 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.

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 inspections. 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.

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 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 HIPAA provisions is in its early stages, and we currently are unable to predict their ultimate impact on us.

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.

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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 believe 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 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

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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 believe 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, and 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.

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.

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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.

ITEM 2. PROPERTIES

We lease our executive offices located in Palm Beach Gardens, Florida (approximately 22,500 square feet), our billing offices in Pompano Beach, Florida (approximately 27,000 square feet) and Addison, Texas (approximately 10,300 square feet), and, including our managed operations, lease 89 other facilities: 23 in Florida, 22 in Texas, six in Tennessee, four in Ohio, three in each of Mississippi, New York, Oklahoma, Pennsylvania, Kentucky, Wisconsin and Georgia, two in each of Alabama, South Carolina and Colorado and one each in Arizona, North Carolina, Indiana, West Virginia, Massachusetts, Michigan 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 545,000 square feet, have an aggregate annual rent of approximately $7.6 million and have lease terms expiring from 2005 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. In addition, certain of our affiliates received subpoenas from the Florida Attorney General Medicaid Fraud Control Unit requesting copies of agreements that we have with certain hospitals and certain patient records. To our knowledge, numerous other hospitals and facilities have received similar subpoenas, which may indicate a state-wide audit of pathology operations. We are providing information to both the United States Attorney s office and the Florida Attorney General s office and intend to cooperate in the investigations. It is not possible at this point in either 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 these investigations. Any action against us by the government 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 federal or state government agency will not reach a different conclusion.

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 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.

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

On November 23, 2004, the sole stockholder of the Company approved by written consent the election of Brett P. Brodnax to the Company s Board of Directors effective as of January 1, 2005. The term of office of all other directors of the Company continued after such election, such directors being Donald E. Steen, Jeffrey A. Mossler, M.D., Clay J. Cockerell, M.D., D. Scott Mackesy, Paul B. Queally, Raymond A. Ranelli, C. Arnold Renschler, M.D., and Sean M. Traynor.

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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, there is no established public trading market for our Common Stock. As of March 17, 2005, 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 and indenture restrict 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, 2004, for the period from March 28, 2003 through December 31, 2003 for the period from January 1, 2003 through March 27, 2003, and for the year ended December 31, 2002 have been audited by Ernst & Young LLP, our independent auditors. Our consolidated audited financial statements for the years ended December 31, 2001 and 2000 have been audited by Deloitte & Touche LLP. We have restated the historical information below for the year ended December 31, 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.

STATEMENTS OF INCOME DATA:

YEAR ENDED DECEMBER 31,

(dollars in thousands)

	Predecessor				Successor	
	Year Ended December 31,			(1)	(1)	
	2000	2001	2002	Period from January 1, 2003 through March 27, 2003	Period from March 28, 2003 through December 31, 2003	Year Ended December 31, 2004
Net revenues	$ 330,094	$ 418,732	$ 478,818	$ 118,957	$ 366,046	$ 507,271
Operating costs and expenses:						

Cost of services	163,390	200,102	238,573	62,145	189,771	270,959
Selling, general and administrative expenses	58,411	71,856	84,868	21,726	65,579	95,688
Provision for doubtful accounts	34,040	48,287	58,170	14,997	56,376	76,463
Amortization expense	16,172	18,659	11,389	3,107	8,352	11,100
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	611
Total operating costs and expenses	287,784	349,816	398,589	113,181	324,951	454,821
Income from operations	42,310	68,916	80,229	5,776	41,095	52,450
Interest expense	(15,376)	(16,350)	(4,016)	(1,180)	(34,469)	(44,797)
Termination of interest rate swap agreement		(10,386)				
Change in value of derivative [5]						(1,015)
Write-off of Genomics investment [6]			(1,000)			
Write-off of deferred financing costs [7]		(1,574)		(957)		(3,829)
Other income, net	226	145	548	33	318	66
Income before income taxes	27,160	40,751	75,761	3,672	6,944	2,875
Provision for income taxes	14,068	17,399	31,120	2,131	3,090	1,361
Net income	13,092	23,352	44,641	1,541	3,854	1,514
Induced conversion and accretion of preferred stock [8]	(1,604)					
Net income available to common shareholders	$ 11,488	$ 23,352	$ 44,641	$ 1,541	$ 3,854	$ 1,514

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CONSOLIDATED BALANCE SHEET DATA:

DECEMBER 31,

(dollars in thousands)

	2000	2001	2002	2003	2004
Cash and cash equivalents	$ 2,418	$ 3,208	$ 964	$ 23,536	$ 20,980
Total assets	562,166	604,462	708,460	912,753	964,309
Long-term debt, including current portion	201,747	93,322	116,253	492,458	497,853
Stockholder s equity	249,665	399,190	451,326	338,675	358,092

(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.

(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. During 2004, we recorded a pre-tax, non-cash charge of approximately $0.6 million in connection with the sale of a practice in Michigan.

(5) During 2004, we entered into a swap agreement, and recorded its change in market value as of December 31, 2004.

(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 in connection with the March 2003 Transaction, and two voluntary paydowns on our current credit facility in 2004.

(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.

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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.

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 14 regional laboratories and 31 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 year financial information has been restated to reflect the Inform DX merger.

Because the laws of many states restrict corporations 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 2004, 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, Amy Holding Company and its wholly-owned subsidiary, Amy Acquisition Corp., entered into a merger agreement with the predecessor of AmeriPath, pursuant to which Amy Acquisition Corp. merged with and into the predecessor, with AmeriPath continuing as

the surviving corporation (the March 2003 Transaction). Amy Holding Company and Amy Acquisition Corp. were Delaware corporations formed at the direction of WCAS. WCAS, its related investors and several employees or affiliates of the Company currently own 100% of the outstanding common stock of Holdings. The March 2003 Transaction was approved by the Company s stockholders and subsequently consummated on March 27, 2003. References herein to our predecessor refer to the activities, financial position and results of operations of AmeriPath prior to 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 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 i