LHC Group, Inc
Form 10-K
March 03, 2016

UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
Form 10-K

ý ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2015
or
.. TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to

Commission file number: 001-33989
LHC GROUP, INC.
(Exact name of registrant as specified in its charter)

Delaware	71-0918189
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

901 Hugh Wallis Road South
Lafayette, Louisiana 70508
(Address of principal executive offices, including zip code)
(337) 233-1307
(Registrant's telephone number, including area code)
Securities registered pursuant to Section 12(b) of the Exchange Act:

Common Stock, par value $0.01 per share	NASDAQ Global Select Market
(Title of each class)	(Name of each exchange on which registered)

Securities registered pursuant to Section 12(g) of the Exchange Act:
None
Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ¨ No ý
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ¨ No ý
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 ý No ¨
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ý No ¨
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (117 CFR 229.405) 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. ý
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ¨	Accelerated filer ý	Non-accelerated filer ..	Smaller reporting company ¨

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ¨ No ý

As of June 30, 2015, the aggregate market value of the registrant's common stock held by non-affiliates of the registrant was $496.8 million based on the closing sale price as reported on the NASDAQ Global Select Market. For purposes of this determination shares beneficially owned by officers, directors and ten percent stockholders have been excluded, which does not constitute a determination that such persons are affiliates.

There were 17,972,512 shares of common stock, $0.01 par value, issued and outstanding as of February 29, 2016.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's Annual Report to Stockholders for the fiscal year ended December 31, 2015 are incorporated by reference in Part II of this Annual Report on Form 10-K. Portions of the Registrant's Proxy Statement for its 2016 Annual Meeting of Stockholders are incorporated by reference in Part III of this Annual Report on Form 10-K.

LHC GROUP, INC.
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PART I

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K and the information incorporated by reference herein contain certain statements and information that may constitute "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934 (the "Exchange Act"). Forward-looking statements relate to future plans and strategies, anticipated events or trends, future financial performance and expectations and beliefs concerning matters that are not historical facts or that necessarily depend upon future events. The words "may," "should," "could," "would," "expect," "plan," "anticipate," "believe," "foresee," "estimate," "predict," "potential," "intend," ar expressions are intended to identify forward-looking statements. Specifically, this Annual Report on Form 10-K contains, among others, forward-looking statements about:

- our expectations regarding financial condition or results of operations for periods after December 31, 2015;
- our critical accounting policies;
- our business strategies and our ability to grow our business;
- our participation in the Medicare and Medicaid programs;
- the reimbursement levels of Medicare and other third-party payors;
- the prompt receipt of payments from Medicare and other third-party payors;
- our future sources of and needs for liquidity and capital resources;
- the effect of any changes in market rates on our operating and cash flows;
- our ability to obtain financing;
- our ability to make payments as they become due;
- the outcomes of various routine and non-routine governmental reviews, audits and investigations;
- our expansion strategy, the successful integration of recent acquisitions and, if necessary, the ability to relocate or restructure our current facilities;
- the value of our proprietary technology;
- the impact of legal proceedings;
- our insurance coverage;
- the costs of medical supplies;
- our competitors and our competitive advantages;
- our ability to attract and retain valuable employees;
- the price of our stock;
- our compliance with environmental, health and safety laws and regulations;
- our compliance with health care laws and regulations;
- our compliance with Securities and Exchange Commission laws and regulations and Sarbanes-Oxley requirements;
- the impact of federal and state government regulation on our business; and
- the impact of changes in or future interpretations of fraud, anti-kickback or other laws.

The forward-looking statements included in this report reflect our current views and assumptions only as of the date this report is filed with the Securities and Exchange Commission. Except as required by law, we assume no responsibility and do not intend to release updates or revisions to forward-looking statements after the date they are made, whether as a result of new information, future events or otherwise. The occurrence of any of the events described in Part I, Item 1A. Risk Factors in this Annual Report on Form 10-K or incorporated by reference into this Annual Report on Form 10-K, and other events that we have not predicted or assessed, could have a material adverse effect on our earnings, financial condition and business, and any such forward-looking statements should not be relied on as a prediction of future events.

We qualify all of our forward-looking statements by this cautionary statement. In addition, with respect to all of our forward-looking statements, we claim the protection of the safe harbor for forward-looking statements contained in

the Private Securities Litigation Reform Act of 1995.

You should read this Annual Report on Form 10-K, the information incorporated by reference into this Annual Report on Form 10-K and the documents filed as exhibits to this Annual Report on Form 10-K completely and with the understanding that our actual future results or achievements may differ materially from what we expect or anticipate.

Unless otherwise indicated, “LHC Group,” “we,” “us,” “our” and “the Company” refer to LHC Group, Inc. and its consolidated subsidiaries.

Item 1. Business.

Overview

We provide post-acute health care services to patients through our home nursing agencies, hospice agencies, community-based services agencies, and long-term acute care hospitals ("LTACHs"). As of December 31, 2015, through our wholly- and majority-owned subsidiaries, equity joint ventures and controlled affiliates, we operated in 363 service providers in 25 states within the continental United States. We operate in four segments: home health services, hospice services, community-based services, and facility-based services, the latter through our LTACHs.

Our home health service locations offer a wide range of services, including skilled nursing, medically-oriented social services and physical, occupational, and speech therapy. The nurses, home health aides, and therapists in our home health agencies work closely with patients and their families to design and implement individualized treatment plans in accordance with a physician-prescribed plan of care. As of December 31, 2015, we operated 283 home health service locations, of which 168 are wholly-owned by us, 109 are majority-owned by us through equity joint ventures, three are under license lease arrangements, and the operations of the remaining three locations are managed by us.

Our hospices provide end-of-life care to patients with terminal illnesses through interdisciplinary teams of physicians, nurses, home health aides, counselors, and volunteers. We offer a wide range of services, including pain and symptom management, emotional and spiritual support, inpatient and respite care, homemaker services, and counseling. As of December 31, 2015, we operated 56 hospice locations, of which 43 are wholly-owned by us, 11 are majority-owned by us through equity joint ventures, and two are under license lease arrangements.

Our community-based service locations offer assistance with activities of daily living to elderly, chronically ill, and disabled patients. As of December 31, 2015, we operated 13 locations, of which 12 are wholly-owned by us and 1 is majority-owned by us through an equity joint venture.

Our LTACH locations provide services primarily to patients with complex medical conditions who have transitioned out of a hospital intensive care unit but whose conditions remain too severe for treatment in a non-acute setting. As of December 31, 2015, our LTACHs had 223 licensed beds. We own and operate six LTACHs with eight locations, of which all but one are located within host hospitals. We also own and operate a pharmacy, a family health center, and a family health clinic. Of these 11 facility-based services locations, six are wholly-owned by us and five are majority-owned by us through equity joint ventures.

Our net service revenue by segment for the years ended December 31, 2015, 2014 and 2013 was as follows (amounts in thousands):

	Year Ended December 31,		
	2015	2014	2013
Home health services	$613,188	$564,966	$523,512
Hospice services	85,854	67,621	56,172
Community-based services	41,202	27,698	3,207
Facility-based services	76,122	73,347	75,392
Consolidated net service revenue	$816,366	$733,632	$658,283

Our founders began operations in September 1994 as St. Landry Home Health, Inc. in Palmetto, Louisiana. After several years of expansion, our founders reorganized their business and began operating as Louisiana Healthcare Group, Inc. in June 2000. In March 2001, Louisiana Healthcare Group, Inc. reorganized and became a wholly owned subsidiary of The Healthcare Group, Inc., a Louisiana business corporation. In December 2002, The Healthcare Group, Inc. merged into LHC Group, LLC, a Louisiana limited liability company, with LHC Group, LLC being the surviving entity. In January 2005, LHC Group, LLC established a wholly owned Delaware subsidiary, LHC Group, Inc. and on February 9, 2005, LHC Group, LLC merged into LHC Group, Inc., a Delaware corporation with LHC Group, Inc. being the surviving entity. Our principal executive offices are located at 901 Hugh Wallis Road, South, Lafayette, Louisiana, 70508. Our telephone number is (337) 233-1307. Our website is www.lhcgroup.com. Information contained on our website is not part of or incorporated by reference into this Annual Report on Form 10-K.

Business Strategy

Our objective is to become the leading provider of home health, hospice, and community-based services in the United States. To achieve this objective, we intend to:

Drive internal growth in existing markets. We intend to drive internal growth in our current markets by increasing the number of health care providers from whom we receive referrals and by expanding the breadth of our services in each market. We intend to achieve this growth by: (1) continuing to educate health care providers about the benefits of our services, (2) reinforcing the position of our agencies and facilities as community assets, (3) maintaining our emphasis on high-quality medical care for our patients, (4) identifying related products and services needed by our patients and their communities, and (5) providing a superior work environment for our employees.

Achieve margin improvement through the active management of costs. The majority of our net service revenue is generated under the Medicare prospective payment systems ("PPS") through which we are paid pre-determined rates based upon the clinical condition and severity of the patients in our care. Because our profitability in a fixed payment system depends upon our ability to manage the costs of providing care, we continue to pursue initiatives to improve our margins and net income.

Expand into new markets. We intend to continue expanding into new markets by utilizing our point of care technology, developing de novo locations, and acquiring existing Medicare and/or Medicaid-certified agencies in attractive markets throughout the United States. We will also continue our unique strategy of partnering with hospitals and health systems, as these ventures provide significant return on investment. We also plan to acquire larger freestanding agencies that can serve as growth platforms in markets we do not currently serve in order to support our growth into new markets.

Pursue strategic acquisitions and develop joint ventures. We will continue to identify and evaluate opportunities for strategic acquisitions in new and existing markets that will enhance our market position, increase our referral base, and expand the breadth of services we offer. We endeavor to joint venture with hospitals to provide post-acute services, such as home health, hospice, and community-based services.

Services

We provide post-acute care services in the United States by providing quality cost-effective health care services to patients within the comfort and privacy of their home, place of residence, or long-term acute care hospital facility. Our services can be broadly classified into four principal categories: (1) home health services, (2) hospice services, (3) community-based services, and (4) facility-based services offered through our LTACHs.

Home Health Services

Our registered nurses and licensed practical nurses provide a variety of medically necessary services to homebound patients who are suffering from acute or chronic illness, recovering from injury or surgery, or who otherwise require caring, teaching or monitoring. These services include, but are not limited to:

- wound care and dressing changes,
- cardiac rehabilitation,
- infusion therapy,
- pain management,
- pharmaceutical administration,
- skilled observation and assessment, and
- patient education.

We have also designed proprietary guidelines to treat chronic diseases and conditions, including diabetes, hypertension, arthritis, Alzheimer's disease, low vision, spinal stenosis, Parkinson's disease, osteoporosis, complex wound care, and chronic pain. Through our medical social workers, we counsel patients and their families with regard to financial, personal, and social concerns that arise from a patient's health-related problems. We provide skilled nursing, ventilator and tracheotomy services, extended care specialties, medication administration and management, and patient and family assistance and education. We also provide management services to third-party home nursing agencies, often as an interim solution until proper state and regulatory approvals for an acquisition can be obtained.

Our physical, occupational and speech therapists provide therapy services to patients in their home. Our therapists coordinate multi-disciplinary treatment plans with physicians, nurses and social workers to restore basic mobility skills such as getting out of bed and walking safely with crutches or a walker. As part of the treatment and rehabilitation process, a therapist will stretch and strengthen muscles, test balance and coordination abilities, and teach home exercise programs. Our therapists assist patients and their families with improving and maintaining a patient's ability to perform functional activities of daily living, such as the ability to dress, cook, clean, and manage other activities safely in the home environment. Our speech and language therapists provide corrective and rehabilitative treatment to patients who suffer from physical or cognitive deficits or disorders that create difficulty with verbal communication or swallowing.

All of our home nursing agencies offer 24-hour personal emergency response system and support services through a third-party service provider ("PERS") for qualified patients who require intensive medical monitoring, but want to

maintain an independent lifestyle. These services consist principally of a communicator that connects to the telephone line in the patient’s home and a personal help button that is worn or carried by the individual patient that, when activated, initiates a telephone call from the patient’s communicator to PERS's central monitoring facilities. Their trained personnel identify the nature and extent of the patient’s particular need and notify the patient’s family members, neighbors, and/or emergency personnel, as needed.

We believe our use of this system increases patient satisfaction and loyalty by providing our patients a point of contact between scheduled nursing visits. As a result, we believe that we provide a more complete regimen of care management than our competitors in the markets in which we operate by offering this service to qualified patients as part of their home health plan of care.

Hospice Services

Our Medicare-certified hospice operations provide a full range of hospice services designed to meet the individual physical, spiritual, and psychosocial needs of terminally ill patients and their families. Our hospice services are primarily provided in a patient's home, but can also be provided in a nursing home, assisted living facility or hospital. The key services provided through our hospice agencies include pain and symptom management accompanied by palliative medication, emotional, and spiritual support, inpatient and respite care, homemaker services, dietary counseling, and family bereavement counseling and social worker visits for up to 13 months after a patient's death.

Community-Based Services

Our community-based service operations offer a wide range of services to patients in their home or in a medical facility. The services range from assistance with grooming, medication reminders, meal preparation, assistance with feeding, light housekeeping, respite care, transportation, and errand services.

Facility-Based Services

Long-term Acute Care Hospitals. Our LTACHs treat patients with severe medical conditions who require a high-level of care and frequent monitoring by physicians and other clinical personnel. Patients who receive our services in an LTACH have been diagnosed as being too medically unstable for treatment in a non-acute setting. For example, our LTACHs typically serve patients suffering from respiratory failure, neuromuscular disorders, cardiac disorders, non-healing wounds, renal disorders, cancer, head and neck injuries, and mental disorders. We also treat patients diagnosed with musculoskeletal impairments that restrict their ability to perform normal activities of daily living.

Other. As part of our facility-based services, we operate an institutional pharmacy, which focuses on providing a full array of services to our LTACHs, a family health center, and a family health clinic.

Operations

Financial information relating to the home health, hospice, community-based, and facility-based operating segments of our business, including their contributions to our net service revenue, operating income, and total assets for each of the twelve months ended December 31, 2015, 2014 and 2013, respectively, is found in Note 11 to the Consolidated Financial Statements included in this Annual Report on Form 10-K.

Our home health agencies are operated in one segment that is separated into four geographical regions and further separated into individual operating areas. Our hospice agencies are operated in one segment that is separated into four geographical regions. Our community-based agencies are operated in one segment within one geographic region. Each of our home health agencies is staffed with experienced clinical home health and administrative professionals who provide a wide range of patient care services. Each of our home health agencies, hospice agencies, and community-based agencies are licensed and certified by the state and federal governments. As of December 31, 2015, 268 of our 283 home health service locations and 34 of our 56 hospice service locations were accredited by the Joint Commission, a nationwide commission that establishes standards relating to the facilities, administration, quality of patient care, and operation of medical staffs of hospitals. Those not yet accredited are working towards achieving this accreditation, a process which can take up to six months. As we acquire companies, we apply for accreditation 12 to 18 months after completing the acquisition.

Our facility-based service locations are operated in one segment within one geographic region. Our facility-based services follow a clinical approach under which each patient is discussed in weekly, multidisciplinary team meetings. In these meetings, patient progress is assessed and compared to goals and future goals are set. We believe that this model results in higher quality care and more predictable discharge patterns and avoids unnecessary delays.

Our home health service locations use our Service Value Point system, a proprietary clinical resource allocation model and cost management system. The system is a quantitative tool that assigns a target level of resource units to a group of patients based upon their initial assessment and estimated skilled nursing and therapy needs. The Service Value Point system allows the Director of Nursing or Branch Manager to allocate adequate resources throughout the group of patients assigned to his or her care, rather than focusing on the profitability of an individual patient.

Patient care is coordinated on-site at the agency level of each home health service, hospice service, and community-based service location. All coding, medical records, case management, utilization review, and medical staff credentialing are provided on-site at the hospital level of each facility-based service location. Centralized functions such as payroll, accounting, financial reporting, billing, collections, regulatory and legal compliance, risk

management, pharmacy, information technology, and general clinical oversight accomplished by periodic on-site surveys are provided from our executive offices.

Joint Ventures

As of December 31, 2015, we had 64 equity joint ventures including 57 with hospitals, four with physicians, and three with other parties. We also operated three agency license leasing agreements.

Equity Joint Ventures

Our equity joint ventures are generally structured as limited liability companies in which we own a majority equity interest and our partner(s) own(s) a minority equity interest. At the time of formation, each party contributes capital to the equity joint venture in the form of cash or property. We believe that the amount contributed by each party to the equity joint venture represents their pro-rata portion of the fair market value of the equity joint venture, and we maintain processes to confirm and document those determinations. None of our equity joint venture partners are required to make or influence referrals to our equity joint ventures. In fact, agreements with our hospital joint venture partners, which make up 89% of our equity joint venture partners, require that they follow the same Medicare discharge planning regulations, that, among other things, require the hospitals to offer each Medicare patient a list of available Medicare-certified home nursing agency options and to allow the patient to choose his or her own provider.

We structure our equity joint ventures as either manager-managed or board-managed. We control our manager-managed joint ventures, since LHC Group, Inc. is typically designated as the manager to oversee the day-to-day operations of the joint venture. We control our board-managed joint ventures, since we typically hold a majority of the votes required to take board action and/or we control the senior officer positions, although a majority of our joint ventures require super majority board approval for certain actions. Our equity joint venture partners participate in the profits and losses of the joint venture in proportion to their equity interests. Distributions from our equity joint ventures are made pro-rata based on percentage ownership interests and are not based on referrals made to the equity joint venture by any of the partners.

The 64 equity joint ventures individually contribute between 0.02% and 3.46% of our consolidated net service revenue, with only two of the equity joint ventures accounting for greater than 3% of our consolidated net service revenue for the year ended December 31, 2015.

Most of our equity joint ventures include a buy/sell option that grants to us and our equity joint venture partners the right to require the other party to either purchase all of the exercising member’s membership interests or sell to the exercising member all of the non-exercising member’s membership interests, at the non-exercising member’s option, within 30 days of the receipt of notice of the exercise of the buy/sell option. In some instances, the purchase price under these buy/sell provisions is based on a multiple of the historical or future earnings before income taxes, depreciation and amortization of the equity joint venture at the time the buy/sell option is exercised. In other instances, the buy/sell purchase price will be negotiated by the parties but will be subject to a fair market valuation process.

License Leasing Agreements

As of December 31, 2015, we had three license leasing agreements, through our wholly-owned subsidiaries, granting us the right to use the lessors' home health licenses necessary to operate home nursing agencies and hospice agencies. These license leasing agreements are entered into when state law would otherwise prohibit the sale and transfer of the agency. The table below details the monthly fees and termination dates of the license leasing agreements.

Number of license leasing agreements	2015 Current Monthly Fee	Increase in Monthly Fee	Initial Termination Dates
1	$18,375	5% increase every three years	2017 with a 2 year automatic renewal
1	Based on net quarterly projections with an annual cap of $423,000.	None	2015 with a 1 year automatic renewal
1	Based on net quarterly projections with an annual cap of $208,000.	None	2015 with a 1 year automatic renewal

In all three license leasing agreements, we have a right of first refusal in the event that the lessor intends to sell the agency to a third party.

Management Services Agreements

As of December 31, 2015, we had three management services agreements under which we manage the operations of home nursing agencies. We do not have ownership interest in these home nursing agencies. Instead, for a fee, we provide billing, management, and other consulting services suited to and designed for the efficient operation of the home nursing agency. We are responsible for the costs associated with the locations and personnel required for the provision of services. Under one management services agreement, we are compensated based on a percentage of cash collections for the agency, and under the other two management services agreements we are reimbursed for operating expenses and receive a percentage of the operating net income of the agencies. The term of these management

services agreements is typically five years, with an option to renew for an additional five-year term. All management services agreements will automatically renew annually unless either party gives written notice of termination.
We record management services revenue as services are provided in accordance with the management services agreements.

Competition

The home health care market is highly fragmented. According to the Medicare Payment Advisory Commission, an independent agency that advises Congress on various Medicare issues ("MedPac"), there were approximately 12,613 Medicare-certified home nursing agencies in the United States in 2013. In 2015, MedPac estimated that approximately 16% of Medicare-certified home health agencies provided a majority of their services in rural areas, and 89% of agencies were proprietary. We believe we are well positioned to build and maintain long-term relationships with local hospitals, physicians, and other health care providers and to become the highest quality post-acute provider in our markets. In our experience, because most rural areas do not have the population size to support more than one or two general acute care hospitals, the local community hospital often plays a significant role in rural market health care delivery systems. Rural patients who require home nursing frequently receive care from a small home care agency or an agency that, while owned and run by the local community hospital, is not an area of focus for that hospital. Similarly, patients in these markets who require services typically offered by LTACHs are more likely to remain in the community hospital because it is often the only local facility equipped to deal with severe and complex medical conditions. We choose to enter these rural markets through affiliations with local hospitals, since we typically experience significantly less competition for the services we provide.
As we expand into new markets, we may encounter competitors that have greater resources or greater access to capital. Generally, competition in our home health service markets comes from small local and regional providers. These providers include facility- and hospital-based providers, visiting nurse associations, and nurse registries. We are unaware of any competitor offering our breadth of services and focusing on the needs of rural markets.
Although several publicly-held and privately-owned national and regional companies own or manage LTACHs, they generally do not operate in the rural markets that we serve. Generally, competition in our facility-based service markets comes from local health care providers. We believe our diverse service offerings, collaborative approach to working with health care providers, business experience gained from focusing on rural markets and patient-oriented operating model provide our principal competitive advantages over local providers.

Quality Control

The LHC Group Quality Department, led by our Chief Clinical Officer, is responsible for formulating quality of care indicators, identifying performance improvement priorities, and facilitating best-practices for quality care. Company-wide, we have adopted a "Plan, Do, Check, Act" methodology for our quality/performance improvement activities and initiatives. We also set forth a quality platform that reviews:

- performance improvement audits;
- Joint Commission accreditation;
- state and regulatory surveys;
- publicly reported quality data; and
- patient perception of care.

The Quality Department is also responsible for ensuring that the infrastructure of the quality initiatives throughout the Company is appropriate, for overseeing and evaluating the effectiveness of the quality plans and initiatives, and for recommending appropriate quality and performance improvement initiatives.
The Clinical Quality Committee of the Board of Directors is responsible for advising our clinical leadership, monitoring the performance of our locations based on internal and external benchmarks, overseeing and evaluating the effectiveness of the performance improvement and quality plans, facilitating best practices based on internal and external comparisons, and fostering enhanced awareness of clinical performance by the Board of Directors.
As part of our ongoing quality control, internal auditing, and monitoring programs, we conduct internal regulatory audits and mock surveys at each of our agencies and facilities at least once a year. If an agency or facility does not achieve a satisfactory rating, we require that it prepare and implement a plan of correction. We then follow-up to

verify that all deficiencies identified in the initial audit and survey have been corrected.

As required under the Medicare conditions of participation, we maintain a continuous quality improvement program, which involves:

- ongoing education of staff and quarterly continuous quality improvement meetings at each of our agencies, facilities and principal executive offices;

- monthly comprehensive audits of patient charts performed at each of our agencies and facilities;
- at least annually, a comprehensive survey readiness assessment on each of our agencies and facilities;
- review of Home Health Compare scores;
- assessment of patient's and/or family member's perception of care using Press Ganey, SHP and Deyta; and
- assessment of infection control practices and risk events.

We constantly expand and refine our continuous quality improvement programs. Specific written policies, procedures, training, and educational materials and programs, as well as auditing and monitoring activities, have been prepared and implemented to address the functional and operational aspects of our business. Our programs also address specific areas identified for improvement through regulatory interpretation and enforcement activities. We believe our consistent focus on continuous quality improvement programs provide us with a competitive advantage in the markets we serve.

Compliance

We have established and continually maintain a comprehensive compliance and ethics program that is designed to assist all of our employees to exceed applicable standards established by federal and state laws and regulations and industry practice. Our goal is to foster and maintain the highest standards of compliance, ethics, integrity, and professionalism in every aspect of our business dealings, and we utilize our compliance and ethics program to assist our employees toward achieving that goal.

The purpose of our compliance and ethics program is to promote and foster compliance with applicable legal and regulatory requirements, the requirements of the Medicare and Medicaid programs and other government healthcare programs, industry standards, our Code of Conduct and Ethics, and our other policies and procedures that support and enhance overall compliance within our Company. Our compliance and ethics program focuses on regulations related to the federal False Claims Act, the Stark Law, the federal Anti-Kickback Law, billing and overall adherence to health care regulations.

To ensure the independence of our compliance department staff, we have implemented the following:

- our Chief Compliance Officer reports to and has direct oversight by the Audit Committee of the Board of Directors;
- our compliance department has its own operating budget; and
- our compliance department has the authority to independently investigate any compliance or ethical concerns, including, when deemed necessary, the authority to interview any company personnel, access any company property (including electronic communications) and engage counsel to assist in any investigation.

Among other activities, our compliance department staff is responsible for the following activities:

- drafting and revising the Company's policies and procedures related to compliance and ethics issues;
- reviewing, making recommended revisions, disseminating and tracking attestations to our Code of Conduct and Ethics;
- measuring compliance with our policies and procedures, Code of Conduct and Ethics and legal and regulatory requirements related to the Medicare and Medicaid programs and other government healthcare programs, laws and regulations;
- developing and providing compliance-related training and education to all of our employees and, as appropriate, directors, contractors and other representatives and agents, including new-hire compliance training for all new employees, annual compliance training for all employees, sales compliance training to all members of our sales team, billing compliance training to all members of our billing and revenue cycle team and other job-specific and role-based compliance training of certain employees;
- performing an annual company-wide risk assessment;
- implementing an annual compliance auditing and monitoring work plan and performing and following up on various risk-based auditing and monitoring activities, including both clinical and non-clinical auditing and monitoring activities at the corporate level and at the local agency/facility level;
- developing, implementing and overseeing our Health Insurance Portability and Accountability Act of 1996 ("HIPAA") privacy and security compliance program;

- monitoring, responding to and overseeing the resolution of issues and concerns raised through our anonymous compliance hotline;
- monitoring, responding to and resolving all compliance and ethics-related issues and concerns raised through any other form of communication;
- ensuring that we take appropriate corrective and disciplinary action when noncompliant or improper conduct is identified; and
- monitoring, measuring and reporting on the Company's compliance with its corporate integrity agreement with the Office of Inspector General of the Department of Health and Human Services ("OIG"), including, without limitation, reviewing, revising and distributing the Code of Conduct and Ethics and compliance-related policies and procedures, reviewing revising and distributing all required training, assisting the independent review organization with its review procedures, overseeing the

timely repayment of any identified overpayments, overseeing the timely reporting of any reportable events and ensuring the timely submission of the Company's annual reports to the OIG.

All employees are required to report incidents, issues or other concerns that they believe in good faith may be in violation of our Code of Conduct and Ethics, our policies and procedures, applicable legal and regulatory requirements or the requirements of the Medicare and Medicaid programs and other government health care programs. All employees are encouraged to either contact our Chief Compliance Officer directly or to contact our 24-hour toll-free compliance hotline when they have questions or concerns about any compliance or ethics issues. All reports to our compliance hotline are kept confidential to the extent allowed by law, and employees have the option to remain anonymous. When cases reported to our compliance hotline involve a compliance or ethics issue or any possible violation of law or regulation, the matter is referred to the compliance department for investigation. Retaliation against employees in connection with reporting compliance or ethical concerns is considered a serious violation of our Code of Conduct and Ethics, and, if it occurs, will result in discipline, up to and including termination of employment.

We continually expand and refine our compliance and ethics programs. We promote a culture of compliance, ethics, integrity and professionalism within the Company through persistent messages from our senior leadership concerning the necessity of strict compliance with legal requirements and company policies and procedures. We believe our consistent focus on our compliance and ethics program provides us with a competitive advantage in the markets we serve.

Technology and Intellectual Property

Our Service Value Point system is a proprietary information system that assists us in, among other things, monitoring clinical utilization and other cost factors, supporting our health care management techniques, internal benchmarking, clinical analysis, outcomes monitoring and claims generation, revenue cycle management, and revenue reporting at our home nursing agencies. We were issued a patent for our Service Value Point system during 2009 by the U.S. Patent and Trademark Office. This proprietary home nursing clinical resource and cost management system is a quantitative tool that assigns a target level of resource units to each patient based upon our staff's initial assessment of the patient's estimated skilled nursing and therapy needs. We designed this system to empower our direct care employees to make appropriate day-to-day clinical care decisions while also allowing us to monitor and manage the quality and delivery of care across our system, including the cost of providing that care, on both a patient-specific and agency-specific basis.

In addition to our Service Value Point system, our business is substantially dependent on non-proprietary software. For example, we utilize a third-party software information system for billing and maintaining patient claim receivables for our LTACHs. Also, as of December 31, 2015, our home nursing and hospice agencies primarily utilized commercially-available billing and patient claim systems.

During 2014, we successfully completed the roll out of our point of care ("POC") strategy. Our POC system allows a visiting clinician to access records and other information from the patient's home or at the POC, complete required documentation at the POC and submit it electronically into our patient record system. As of December 31, 2015, all of our home nursing and hospice locations were utilizing our POC system.

Technology plays a key role in our ability to expand operations and maintain effective managerial control. The software we use is based on client-server technology and is highly scalable. We believe our software and systems are flexible, easy-to-use and allow us to accommodate further growth. We believe that our ability to build and enhance our information and software systems provides us with a competitive advantage that allows us to grow our business in a cost-efficient manner and provide better patient care.

Reimbursement

Medicare

The federal government's Medicare program, governed by the Social Security Act of 1965 (the "Social Security Act"), reimburses health care providers for services furnished to Medicare beneficiaries. These beneficiaries generally include persons age 65 and older and those who are chronically disabled. The program is primarily administered by the Department of Health and Human Services ("HHS") and the Centers for Medicare & Medicaid Services ("CMS"). Medicare payments accounted for 74.5%, 75.9% and 79.8% of our net service revenue for the years ended December 31, 2015, 2014 and 2013, respectively. Medicare reimburses us based upon the setting in which we provide

our services or the Medicare category in which those services fall.

In 2011, sequestration was implemented in the Budget Control Act of 2011(BCA, P.L. 112-25) as a tool in federal budget control. The sequestration cut to Medicare payments began on April 1, 2013, and reduced Medicare payments for patients whose service dates ended on or after April 1, 2013 by 2%. Absent any additional Congressional action, the 2% sequestration cuts are planned to continue through 2023.

Home Health

The Medicare home nursing benefit is available to patients who need care following discharge from a hospital, as well as patients who suffer from chronic conditions that require ongoing intermittent care. While the services received need not be rehabilitative or of a finite duration, patients who require full-time skilled nursing for an extended period of time generally do not qualify for Medicare home nursing benefits. As a condition of coverage under Medicare, beneficiaries must: (1) be homebound, meaning they are unable to leave

their home without a considerable and taxing effort; (2) require intermittent skilled nursing, physical therapy or speech therapy services that are covered by Medicare; and (3) receive treatment under a plan of care that is established and periodically reviewed by a physician. Qualifying patients also may receive reimbursement for occupational therapy, medical social services and home health aide services if these additional services are part of a plan of care prescribed by a physician.

We receive a standard prospective Medicare payment for delivering care over a 60-day episode of care. There is no limit to the number of episodes a beneficiary may receive as long as he or she remains eligible. The base episode payment is a flat rate that is adjusted upward or downward based upon differences in the expected resource needs of individual patients as indicated by clinical severity, functional severity and service utilization. The magnitude of the adjustment is determined by each patient's categorization into one of 153 payment groups, known as Home Health Resource Groups and the costliness of care for patients in each group relative to the average patient. Payment is further adjusted for differences in local labor costs using the hospital wage index. We bill and are reimbursed for services in two stages: an initial request for advance payment when the episode commences and a final claim when the episode is completed. We submit all Medicare claims through the Medicare Administrative Contractors for the federal government. We receive 60% of the estimated payment for a patient's initial episode up-front (after the initial assessment is completed and upon initial billing) and the remaining 40% upon completion of the episode and after all final treatment orders are signed by the physician. In the event of subsequent episodes, reimbursement timing is 50% up-front and 50% upon completion of the episode. Final payments may reflect one of four retroactive adjustments to ensure the adequacy and effectiveness of the total reimbursement: (1) an outlier payment if the patient's care was unusually costly; (2) a low utilization adjustment if the number of visits was fewer than five; (3) a partial payment if the patient transferred to another provider before completing the episode; or (4) a payment adjustment based upon the level of therapy services required in the population base. Because such adjustments are determined upon the completion date of the episode, retroactive adjustments could impact our financial results.

In 2011, CMS finalized two provisions of the Patient Protection and Affordable Care Act ("the PPACA") that substantially impact our business. First, as a condition for Medicare payment, the PPACA mandates that prior to certifying a patient's eligibility for home health services, the certifying physician must document that he or she, or allowed non-physician practitioner, had a face-to-face encounter with the patient that relates to the condition for which the patient receives home health services. The face-to-face encounter must occur within 90 days prior to the start of care or 30 days after the start of care. Documentation regarding these encounters must be present in the patient's home health medical record. In 2015, documentation supporting these encounters must be in the certifying physician's or hospital medical record.

Beginning in 2015, CMS also made important changes to therapy assessment requirements. A professional qualified therapist assessment must take place at least once every 30 days during a therapy patient's course of treatment.

We verify a patient's eligibility for home health benefits at the time of admission. Through the verification process we are able to determine the payor source and eligibility for reimbursement of each patient. Accordingly, we do not have material amounts of reimbursements pending approval based on the eligibility of a patient to receive reimbursement from the applicable payor program. Further, we provide only limited services to patients who are ineligible for reimbursement from a third party payor. Therefore, we do not have any material amounts of reimbursements due from patients who are self-pay.

The base payment rate for Medicare home nursing was $2,961.38 per 60-day episode for the year ended December 31, 2015. The base payment rate does not include the 2% reduction to Medicare payment through sequestration as mandated by the Budget Control Act of 2011.

Home health payment rates are updated annually by the home health market basket percentage as adjusted by Congress. CMS establishes the home health market basket index, which measures inflation in the prices of an appropriate mix of goods and services included in home health services.

Hospice

In order for a Medicare beneficiary to qualify for the Medicare hospice benefit, two physicians must certify that, in their clinical judgment, the beneficiary has less than six months to live, assuming the beneficiary's disease runs its normal course. In addition, the Medicare beneficiary must affirmatively elect hospice care and waive any rights to

other Medicare curative benefits related to his or her terminal illness. At the end of each benefit period (described below), a physician must recertify that the Medicare beneficiary's life expectancy is six months or less in order for the beneficiary to continue to qualify for and to receive the Medicare hospice benefit. The first two benefit periods are 90 days and subsequent benefit periods are 60 days. A Medicare beneficiary may revoke his or her election at any time and resume receiving traditional Medicare benefits. There is no limit on how long a Medicare beneficiary can receive hospice benefits and services, provided that the beneficiary continues to meet Medicare hospice eligibility criteria. Medicare reimburses for hospice care using one of four predetermined daily or hourly rates based upon the level of care we furnish to a beneficiary. These rates are subject to annual adjustments based on inflation and geographic wage considerations. The base Medicare rate for services that we provide to a beneficiary depends upon which of the following four levels of care we provide to that beneficiary:

- Routine Care. Care that is not classified under any of the other levels of care, such as the work of nurses, social workers or home health aides.
- General Inpatient Care. Pain control or acute or chronic symptom management that cannot be managed in a setting other than an inpatient Medicare certified facility, such as a hospital, skilled nursing facility or hospice inpatient facility.
- Continuous Home Care. Care for patients experiencing a medical crisis that requires nursing services to achieve palliation and symptom control, if the agency provides a minimum of eight hours of care within a 24-hour period.
- Respite Care. Short-term, inpatient care to give temporary relief to the caregiver who regularly provides care to the patient.

Medicare limits the reimbursement we may receive for inpatient care services (both respite and general care) for hospice patients. Under the "80-20 rule," if the number of inpatient care days of hospice care furnished by us to Medicare hospice beneficiaries under a unique provider number exceeds 20% of the total days of hospice care furnished by us to all Medicare hospice beneficiaries for both inpatient and in-home care, Medicare payments to us for inpatient care days exceeding the inpatient cap will be reduced to the routine home care rate, with excess amounts due back to Medicare. This determination is made annually based on the twelve-month period beginning on November 1 each year. Our Medicare hospice reimbursement is also subject to a cap amount calculated at the end of the hospice cap period, based on the twelve-month period beginning on November 1 each year, which determines the maximum allowable payments per provider.

In 2011, CMS finalized a face-to-face encounter requirement for hospice reimbursement, mandating that a physician or qualifying nurse practitioner must certify a face-to-face encounter with the patient no later than the 30-day period prior to the 180th-day recertification (beginning of the third benefit period) and each subsequent recertification in order to gather clinical findings that support continued hospice care.

In the fiscal year 2016 hospice payment rule, CMS established a new two-tiered payment system for routine home care hospice services, which replaces the former single per diem routine home care rate. Effective January 1, 2016, hospices will be reimbursed at a higher routine home care rate ($186.84) for days 1 through 60 of a hospice episode of care and a lower rate ($146.83) for days 61 and beyond of a hospice episode of care. In this rule, CMS also provided for a Service Intensity Add-on increasing payments for routine home care services provided directly by registered nurses and social workers to hospice patients during the final seven days of life.

Long-Term Acute Care Hospitals

All Medicare payments to our LTACHs are made in accordance with a PPS specifically applicable to LTACHs, referred to as "LTACH-PPS." The LTACH-PPS was established by CMS final regulations published in 2002, that require each patient discharged from an LTACH to be assigned a distinct long-term care diagnosis-related group ("MS-LTC-DRG"), which take into account (among other things) the severity of a patient's condition. Our LTACHs are paid a pre-determined fixed amount based upon the assigned MS-LTC-DRG (adjusted for area wage differences), which includes adjustments for short stay and high cost outlier patients (described in further detail below). The payment amount for each MS-LTC-DRG classification is intended to reflect the average cost of treating a Medicare patient assigned to that MS-LTC-DRG in an LTACH.

Adjustments to MS-LTC-DRG payments might include:

- Short Stay Outlier Policy. CMS has established a modified payment methodology for Medicare patients with a length-of-stay less than or equal to five-sixths of the geometric average length-of-stay for that particular MS-LTC-DRG, referred to as a short stay outlier, or "SSO." When LTACH-PPS was established, SSO cases were paid based on the lesser of (1) 120% of the average cost of the case; (2) 120% of the LTC-DRG specific per diem amount multiplied by the patient's length-of-stay; or (3) the full LTC-DRG payment. CMS modified the payment methodology for discharges occurring on or after July 1, 2006, which changed the limitation in clause (1) above to reduce payment for SSO cases to 100% (rather than 120%) of the average cost of the case, and also added a fourth limitation, potentially further limiting payment for SSO cases at a per diem rate derived from blending 120% of the MS-LTC-DRG specific per diem amount with a per diem rate based on the general acute care hospital inpatient prospective payment system, or "IPPS". Under this methodology, as a patient's length-of-stay increases, the percentage of the per diem amount based upon the IPPS component will decrease and the percentage based on the MS-LTC-DRG

component will increase.

- High Cost Outliers. Some cases are extraordinarily costly, producing losses that may be too large for healthcare providers to offset. Cases with unusually high costs, referred to as “high cost outliers,” receive a payment adjustment to reflect the additional resources utilized. CMS provides an additional payment if the estimated costs for the patient exceed the adjusted MS-LTC-DRG payment plus a fixed-loss amount that is established in the annual payment rate update.
- Interrupted Stays. An interrupted stay occurs when an LTACH patient is admitted upon discharge to a general acute care hospital, inpatient rehab facility (“IRF”), skilled nursing facility or a swing-bed hospital and returns to the same LTACH within a specified period of time. If the length-of-stay at the receiving provider is equal to or less than the applicable fixed period of time, it is considered to be an interrupted stay case and is treated as a single discharge for the purposes of payment to the LTACH.

Freestanding, HwH and Satellite LTACHs

LTACHs may be organized and operated as freestanding facilities or as a hospital within a hospital, or “HwH”. An HwH is an LTACH that is located on the "campus" of another hospital, meaning the physical area immediately adjacent to a hospital’s main buildings, other areas and structures that are not strictly contiguous to a hospital’s main buildings but are located within 250 yards of its main buildings, and any other determined, on an individual case bases by the applicable CMS regional office, to be part of a hospital's campus. An LTACH that uses the same Medicare provider number of an affiliated “primary site” LTACH is known as a “satellite.” Under Medicare policy, a satellite LTACH must be located within 35 miles of its primary site LTACH and be administered by such primary site LTACH. As of December 31, 2015, we had a total of eight LTACH facilities, with 223 licensed beds. Seven of our LTACH facilities were classified as HwHs and one was classified as freestanding. Of the seven HwH facilities, three were located in Metropolitan Statistical Area (“MSA”) or urban areas and four were located in non-MSA or rural areas. One of our HwH facilities was a satellite location of a parent hospital located in an MSA. Our single freestanding location was a remote campus site of a parent located in an MSA.

An LTACH must have an average inpatient length-of-stay for Medicare patients (including both Medicare covered and non-covered days) of greater than 25 days during each annual cost reporting period. LTACHs that fail to exceed an average length-of-stay of 25 days during any cost reporting period may be paid under the general acute care hospital IPPS. CMS clarified its policy on the calculation of the average length-of-stay by specifying that all data on all Medicare inpatient days, including Medicare Advantage days, must be included in the average length-of-stay calculation effective for cost reporting periods beginning on or after January 1, 2012.

Fiscal Year 2015 Rates

On August 4, 2014, CMS released its final rule for LTACH Medicare reimbursement for fiscal year 2015 (affecting discharges and cost reporting periods beginning on or after October 1, 2014 through September 30, 2015). In aggregate, payments for fiscal year 2015 increased by 1.1% over fiscal year 2014 rates. The 1.1% increase consists of a 2.9% inflationary market basket update, offset by a 0.5% reduction for the productivity adjustment, and a 0.2% reduction to the market basket as defined by PPACA. LTACH payment rates were also reduced by approximately 1.3% for the "one-time" budget neutrality adjustment factor under the last year of a three-year phase in and increased by 0.2% for wage index budget neutrality adjustment.

The Bipartisan Budget Act of 2013 “BBA 2013” included the following changes in LTACH policies:

LTACH Patient Criteria: Effective for cost reporting periods beginning on or after October 1, 2015, Medicare payment for LTACH services will change based on certain new patient criteria. To be paid at the full Medicare LTACH-PPS rate, a patient discharged from an LTACH must either (1) have a short-term acute care hospital stay including a three day length-of-stay in an intensive care unit during that hospitalization preceding the LTACH stay, or (2) receive ventilator services for more than 96 hours while hospitalized in the LTACH. In addition such patients cannot be hospitalized in an LTACH for a psychiatric or rehabilitation diagnosis.

Site Neutral Payment: Also effective for cost reporting periods beginning on or after October 1, 2015, all other Medicare discharges from LTACHs will be paid at a new “site neutral” rate, which is the lesser of: (1) the IPPS comparable per diem amount determined using the formula in the LTACH short-stay outlier regulation, plus applicable outlier payments, or (2) 100% of the cost of the services provided. The site neutral payment provision will be phased in over two years, so discharges receiving a “site neutral” rate get paid 50% based on current LTAC rate and 50% based on the “site neutral” rate. Our LTACHs have cost-reporting periods that begin in July or September of each year so we will not have any impact until the third quarter of 2016.

Twenty-five Day Average Length-of-stay: Patient stays paid the site neutral rate will not count toward calculation of the 25 day average length-of-stay requirement for LTACHs. Additionally, the law clarifies that patient stays paid by Medicare Advantage plans will also not count toward the 25 day average length-of-stay requirement for LTACHs. The BBA 2013 also included a provision that these exceptions to the 25 day average length-of-stay will not be used in calculating the length-of-stay for short-term acute care hospitals that seek to qualify as LTACHs as of December 10, 2013.

25 Percent Rule Relief: Prior relief from compliance with the 25 Percent Rule for freestanding LTACHs, HWHs and satellite facilities will be extended without interruption for cost reporting periods beginning through December 28,

2016. Grandfathered HWHs are permanently exempt from the 25 Percent Rule. CMS must report to Congress by December 18, 2015 on whether the 25 Percent Rule should continue to be applied through June 30, 2019.

Compliance With LTACH Patient Criteria: Effective for cost reporting periods beginning in federal fiscal year 2020, LTACHs with less than half of their discharges paid at the full LTACH-PPS rates will lose certification as LTACHs and will transition to payment under the IPPS for all discharges in subsequent cost reporting periods. However, CMS is required to establish a process for LTACHs to seek reinstatement of LTACH-PPS payments for applicable discharges.

Moratorium on LTACHs: The BBA 2013 enacted a moratorium on new LTACH beds and hospitals (including satellite locations) effective January 1, 2015 through September 30, 2017. The law clarifies that there will be no exceptions to the moratorium.

Fiscal Year 2016 Rates

On July 31, 2015, CMS issued a final rule to update fiscal year 2016 payment policies and rates under the IPPS and LTACH-PPS, which affects discharges occurring in cost reporting periods beginning on or after October 1, 2015. CMS projects that LTACH-PPS rates would decrease by 4.6%. This estimated decrease is primarily attributable to the statutory decrease in payment rates for site neutral LTACH-PPS cases that do not meet the clinical criteria to qualify for higher LTACH rates in cost reporting years beginning on or after October 1, 2015. Cases that do qualify for higher LTACH-PPS rates will see a payment rate increase of 1.7% (based on a market basket update of 2.4% adjusted by a multi-factor productivity adjustment of -0.5 percentage point and an additional adjustment of -0.2 percentage point in accordance with the Affordable Care Act). CMS also finalized its proposal to implement a transitional blended payment rate (50% site neutral rate and 50% LTACH-PPS rates) for site neutral discharges occurring in fiscal years 2016 and 2017.

Medicaid

Medicaid is a joint federal and state funded health insurance program for certain low-income individuals administered by the states. Medicaid reimburses health care providers using a number of different systems, including cost-based, prospective payment and negotiated rate systems. Rates are also subject to adjustment based on statutory and regulatory changes, administrative rulings, government funding limitations and interpretations of policy by individual state agencies.

Non-Governmental Payors

Payments from non-governmental payor sources are based on episodic-based rates or per visit basis depending upon the terms and conditions of the payor. This reimbursement category includes payors such as insurance companies, workers' compensation programs, health maintenance organizations, preferred provider organizations, other managed care companies and employers, as well as payments received directly from patients.

Patients are generally not responsible for any difference between customary charges for our services and amounts paid by Medicare and Medicaid programs and the non-governmental payors, but are responsible for services not covered by these programs or plans, as well as co-payments for deductibles and co-insurance obligations of their coverage. Patient out-of-pocket costs for the payment of deductibles and co-insurance have increased in recent years. Collection of amounts due from individuals is typically more difficult than collection of amounts due from government or business payors. Because the majority of our billed services are paid in full by Medicare, Medicaid or private insurance, co-payments from patients do not represent a material portion of our billed revenue and corresponding accounts receivable. To further reduce their health care costs, most commercial payors such as insurance companies, health maintenance organizations, preferred provider organizations and other managed care companies have negotiated discounted fee structures or fixed amounts for services performed, rather than paying health care providers the amounts normally billed.

In response to the challenges associated with collecting from commercial payors, we began negotiating higher reimbursement rates with a majority of our commercial payors. As of December 31, 2015, our managed care contracts included 177 different payors between all of our divisions, seven of which were national contracts, 25 were regional contracts and 145 were state and local contracts/standing letters of agreement. If we are unable to continue negotiating higher reimbursement rates with commercial payors or if commercial payors continue to reduce health care costs through reduction in home health reimbursement, it could have a material adverse impact on our financial results.

Government Regulations

General

The health care industry is highly regulated and we are required to comply with federal, state and local laws which significantly affect our business. These laws and regulations are extremely complex and, in many instances, the industry does not have the benefit of significant regulatory or judicial interpretation. Regulations and policies frequently change, and we monitor these changes through trade and governmental publications and associations. The significant areas of federal and state regulation that could affect our ability to conduct our business include the following:

- Medicare and Medicaid participation and reimbursement regulations;

- the federal Anti-Kickback Statute and similar state laws;
- the federal Stark Law and similar state laws;
- false claims laws and regulations;
- HIPAA;
- laws and regulations imposing civil monetary penalties;
- environmental health and safety laws;
- licensing laws and regulations; and
- laws and regulations governing certificates of need and permits of approval.

If we fail to comply with these applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in federal and state health care programs, which would materially adversely affect our

financial condition and results of operations. Although we believe we are in material compliance with all applicable laws and regulations, these are complex matters and a review of our practices by a court or law enforcement or regulatory authority could result in an adverse determination that could harm our business. Furthermore, the laws applicable to us are subject to change, interpretation and amendment, which could adversely affect our ability to conduct our business.

Medicare Participation

To participate in the Medicare program and receive Medicare payments, our agencies and facilities must comply with regulations promulgated by CMS. Among other things, these requirements, known as "conditions of participation," relate to the type of facility, its personnel and its standards of medical care. While we intend to continue to participate in the Medicare reimbursement programs, we cannot guarantee that our agencies, facilities and programs will continue to qualify for Medicare participation.

Federal Anti-Kickback Statute

Provisions of the Social Security Act of 1965, commonly referred to as the Anti-Kickback Statute, prohibit the payment or receipt of anything of value in return for the referral of patients or arranging for the referral of patients, or in return for the recommendation, arrangement, purchase, lease or order of items or services that are covered by a federal health care program such as Medicare and Medicaid. Violation of the Anti-Kickback Statute is a felony and sanctions include imprisonment of up to five years, criminal fines of up to $25,000, civil monetary penalties of up to $50,000 per act plus three times the amount claimed or three times the remuneration offered and exclusion from federal health care programs (including the Medicare and Medicaid programs). Many states have adopted similar prohibitions against payments intended to induce referrals of Medicaid and other third-party payor patients.

The OIG has published numerous "safe harbors" that exempt some practices from enforcement action under the Anti-Kickback Statute. These safe harbors exempt specified activities, including bona-fide employment relationships, contracts for the rental of space or equipment, personal service arrangements and management contracts, so long as all of the requirements of the safe harbor are met. The OIG has recognized that the failure of an arrangement to satisfy all of the requirements of a particular safe harbor does not necessarily mean that the arrangement violates the Anti-Kickback Statute. Instead, each arrangement is analyzed on a case-by-case basis, which is very fact specific. While we operate our business to comply with the prohibitions of the Anti-Kickback Statute, we cannot guarantee that all our arrangements will satisfy a safe harbor or will ultimately be viewed as being compliant with the Anti-Kickback Statute.

We endeavor to conduct our operations in compliance with federal and state health care fraud and abuse laws, including the Anti-Kickback Statute and similar state laws. However, our practices may be challenged in the future and the fraud and abuse laws may be interpreted in a way that finds us in violation of these laws. If we are found to be in violation of the Anti-Kickback Statute, we could be subject to civil and criminal penalties and we could be excluded from participating in federal health care programs such as Medicare and Medicaid. The occurrence of any of these events could significantly harm our business and financial condition.

Stark Law

Congress has passed significant prohibitions against physician self-referrals of patients for certain designated health care services, commonly known as the Stark Law, which prohibits a physician from making referrals for particular health care services (called designated health services) to entities with which the physician, or an immediate family member of the physician, has a financial relationship.

The term "financial relationship" is defined very broadly to include most types of ownership or compensation relationships. The Stark Law also prohibits the entity receiving the referral from seeking payment under the Medicare or Medicaid programs for services rendered pursuant to a prohibited referral. If an entity is paid for services rendered pursuant to a prohibited referral, it may incur civil penalties and could be excluded from participating in the Medicare or Medicaid programs. If an arrangement is covered by the Stark Law, the requirements of a Stark Law exception must be met for the physician to be able to make referrals to the entity for designated health services and for the entity to be able to bill for these services.

“Designated health services” under the Stark Law is defined to include home health services, inpatient and outpatient hospital services, clinical laboratory services, physical therapy services, occupational therapy services, radiology services (including magnetic resonance imaging, computerized axial tomography scans and ultrasound services), radiation therapy services and supplies, and the provision of durable medical equipment and supplies, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics and prosthetic devices and supplies, and outpatient prescription drugs. The Stark Law defines a financial relationship to include: (1) a physician’s ownership or investment interest in an entity and (2) a compensation relationship between a physician and an entity. Under the Stark Law, financial relationships include both direct and indirect relationships.

Physicians refer patients to us for several Stark Law designated health services, including home health services, inpatient and outpatient hospital services and physical therapy services. We have compensation arrangements with some of these physicians or their professional practices in the form of medical director and consulting agreements. We also have operations owned by joint ventures in which physicians have an investment interest. In addition, other physicians who refer patients to our agencies and facilities may own shares of our stock. As a result of these relationships, we could be deemed to have a financial relationship with physicians who refer patients to

our facilities and agencies for designated health services. If so, the Stark Law would prohibit the physicians from making those referrals and would prohibit us from billing for the services unless a Stark Law exception applies.

The Stark Law contains exceptions for certain physician ownership or investment interests and physician compensation arrangements. If an investment relationship or compensation agreement between a physician, or a physician's immediate family member, and the subject entity satisfies all requirements for a Stark Law exception, the Stark Law will not prohibit the physician from referring patients to the entity for designated health services. The exceptions for a physician investment relationship include ownership in an entire hospital and ownership in rural providers. The exceptions for compensation arrangements cover employment relationships, personal services contracts and space and equipment leases, among others. We believe our physician investment relationships and compensation arrangements with referring physicians meet the requirements as exceptions under the Stark Law and that our operations comply with the Stark Law.

The Stark Law also includes an exception for a physician's ownership or investment interest in certain entities through the ownership of stock that is listed on the New York Stock Exchange or NASDAQ. If the ownership meets certain other requirements, the Stark Law will not apply to prohibit the physician from referring to the entity for designated health services. For example, this Stark Law exception requires that the entity issuing the stock have at least $75.0 million in stockholders' equity at the end of its most recent fiscal year or on average during the previous three fiscal years. As of December 31, 2015, 2014 and 2013, we have in excess of $75.0 million in stockholders' equity.

If an entity violates the Stark Law, it could be subject to civil penalties of up to $15,000 per prohibited claim and up to $100,000 for knowingly entering into certain prohibited referral schemes. The entity also may be excluded from participating in federal health care programs (including Medicare and Medicaid). There are no criminal penalties for violations of Stark Law. If the Stark Law was found to apply to our relationships with referring physicians and those relationships did not meet the requirement of an exception under the Stark Law, we would be required to restructure these relationships or refuse to accept referrals for designated health services from these physicians. If we were found to have submitted claims to Medicare or Medicaid for services provided pursuant to a referral prohibited by the Stark Law, we would be required to repay any amounts we received from Medicare for those services and could be subject to civil monetary penalties. Further, we could be excluded from participating in Medicare and Medicaid. If we were required to repay any amounts to Medicare, subjected to fines, or excluded from the Medicare and Medicaid Programs, our business and financial condition would be harmed significantly.

Many states have physician relationship and referral statutes that are similar to the Stark Law. Some of these laws generally apply without regard to whether the payor is a governmental body (such as Medicare) or a commercial party (such as an insurance company). While we believe that our operations are structured to comply with applicable state laws with respect to physician relationships and referrals, any finding that we are not in compliance with these state laws could require us to change our operations or could subject us to penalties. This, in turn, could have a significantly negative impact on our operations.

False Claims

The submission of claims to a federal or state health care program for items and services that are "not provided as claimed" may lead to the imposition of civil monetary penalties, criminal fines and imprisonment and/or exclusion from participation in state and federally funded health care programs, including the Medicare and Medicaid programs, under false claims statutes such as the federal False Claims Act. Under the federal False Claims Act, actions against a provider can be initiated by the federal government or by a private party on behalf of the federal government. These private parties are often referred to as qui tam relators, and relators are entitled to share in any amounts recovered by the government. Both direct enforcement activity by the government and qui tam actions have increased significantly in recent years, increasing the risk that a health care company like us will have to defend a false claims action, pay fines or be excluded from the Medicare and Medicaid programs as a result of an investigation. Many states have enacted similar laws providing for the imposition of civil and criminal penalties for the filing of fraudulent claims. While we operate our business to avoid exposure under the federal False Claims Act and similar state laws, because of the complexity of the government regulations applicable to our industry, we cannot guarantee that we will not be the subject of an action under the federal False Claims Act or similar state law.

Anti-fraud Provisions of the HIPAA

In an effort to combat health care fraud, Congress included several anti-fraud measures in HIPAA. Among other things, HIPAA broadened the scope of certain fraud and abuse laws, extended criminal penalties for Medicare and Medicaid fraud to other federal health care programs and expanded the authority of the OIG to exclude persons and entities from participating in the Medicare and Medicaid programs. HIPAA also extended the Medicare and Medicaid civil monetary penalty provisions to other federal health care programs, increased the amounts of civil monetary penalties and established a criminal health care fraud statute.

Federal health care offenses under HIPAA include health care fraud and making false statements relating to health care matters. Under HIPAA, among other things, any person or entity that knowingly and willfully defrauds or attempts to defraud a health care benefit program is subject to a fine, imprisonment or both. Also under HIPAA, any person or entity that knowingly and willfully falsifies or conceals or covers up a material fact or makes any materially false or fraudulent statements in connection with the delivery of or

payment of health care services by a health care benefit plan is subject to a fine, imprisonment or both. HIPAA applies not only to governmental plans but also to private payors.

Administrative Simplification Provisions of HIPAA

HHS's final regulations governing electronic transactions involving health information are part of the administrative simplification provisions of HIPAA, commonly referred to as the Transaction Standards rule. The rule establishes standards for eight of the most common health care transactions by reference to technical standards promulgated by recognized standards publishing organizations. Under the rule, any party transmitting or receiving health transactions electronically must send and receive data in a single format, rather than the large number of different data formats currently used. This rule applies to us in connection with submitting and processing health claims, and also applies to many of our payors and to our relationships with those payors. We believe that our operations materially comply with the Transaction Standards rule.

These regulatory requirements impose significant administrative and financial obligations on companies like us that use or disclose electronic health information. We have modified our existing HIPAA privacy and security policies and procedures to comply with the HIPAA regulations.

Civil Monetary Penalties

The Secretary of HHS may impose civil monetary penalties on any person or entity that presents, or causes to be presented, certain ineligible claims for medical items or services. The severity of penalties varies depending on the offense, from $2,000 to $50,000 per violation, plus treble damages for the amount at issue and may include exclusion from federal health care programs such as Medicare and Medicaid.

HHS can also impose penalties on a person or entity who offers inducements to beneficiaries for program services, who violates rules regarding the assignment of payments, or who knowingly gives false or misleading information that could reasonably influence the discharge of patients from a hospital. Persons who have been excluded from a federal health care program and who retain ownership in a participating entity and persons who contract with excluded persons may be penalized.

HHS can also impose penalties for false or fraudulent claims and those that include services not provided as claimed. In addition, HHS may impose penalties on claims:

- for physician services that the person or entity knew or should have known were rendered by a person who was unlicensed, or by a person who misrepresented either their qualifications in obtaining their license, or their certification in a medical specialty;
- for services furnished by a person who was, at the time the claim was made, excluded from the program to which the claim was made; or
- that show a pattern of medically unnecessary items or services.

Penalties also are applicable in certain other cases, including violations of the federal Anti-Kickback Statute, payments to limit certain patient services and improper execution of statements of medical necessity.

Environmental, Health and Safety Laws

We are subject to federal, state and local regulations governing the storage, use and disposal of materials and waste products. Although we believe that our safety procedures for storing, handling and disposing of these hazardous materials comply with the standards prescribed by law and regulation, we cannot completely eliminate the risk of accidental contamination or injury from those hazardous materials. In the event of an accident, we could be held liable for any damages that result and any liability could exceed the limits or fall outside the coverage of our insurance. We may not be able to maintain insurance on acceptable terms, or at all. We could incur significant costs and the diversion of our management's attention to comply with current or future environmental laws and regulations. We are not aware of any violations related to compliance with environmental, health and safety laws through 2015.

Licensing

Our agencies and facilities are subject to state and local licensing regulations ranging from the adequacy of medical care to compliance with building codes and environmental protection laws. To assure continued compliance with these various regulations, governmental and other authorities periodically inspect our agencies and facilities. Additionally, health care professionals at our agencies and facilities are required to be individually licensed or certified under applicable state law. We operate our business to ensure that our employees and agents possess all necessary licenses and certifications.

The institutional pharmacy operations within our facility-based services segment are also subject to regulation by the various states in which we conduct the pharmacy business, as well as by the federal government. The pharmacies are regulated under the Food, Drug and Cosmetic Act and the Prescription Drug Marketing Act, which are administered by the United States Food and Drug Administration.

Under the Comprehensive Drug Abuse Prevention and Control Act of 1970, administered by the United States Drug Enforcement Administration, as a dispenser of controlled substances, our pharmacy operations must register with the Drug Enforcement Administration, file reports of inventories and transactions and provide adequate security measures. Failure to comply with such requirements could result in civil or criminal penalties. We are not aware of any violations of applicable laws relating to our institutional pharmacy operations through December 31, 2015.

Certificate of Need and Permit of Approval Laws

In addition to state licensing laws, some states require a provider to obtain a certificate of need or permit of approval prior to establishing, constructing, acquiring or expanding certain health services, operations or facilities. In these states, approvals are required for capital expenditures exceeding certain amounts that involve certain facilities or services, including home nursing agencies. The certificate of need or permit of approval issued by the state determines the service areas for the applicable agency or program. The following U.S. jurisdictions require certificates of need or permits of approval for home nursing agencies: Alabama, Alaska, Arkansas, Georgia, Hawaii, Kentucky, Maryland, Mississippi, Montana, New Jersey, New York, North Carolina, Rhode Island, South Carolina, Tennessee, Vermont, Washington, West Virginia and the District of Columbia. In addition, the state of Louisiana continues to have a moratorium on the issuance of new licenses for home nursing agencies that we expect to remain in effect for 2016. State certificate of need and permit of approval laws generally provide that, prior to the addition of new capacity, the construction of new facilities or the introduction of new services, a designated state health planning agency must determine that a need exists for those beds, facilities or services. The process is intended to promote comprehensive health care planning, assist in providing high quality health care at the lowest possible cost and avoid unnecessary duplication by ensuring that only needed health care facilities and operations will be built and opened.

Accreditations

The Joint Commission is a nationwide commission that establishes standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of health care organizations. Currently, Joint Commission accreditation of home nursing and hospice agencies is voluntary. However, some managed care organizations use Joint Commission accreditation as a credentialing standard for regional and state contracts. As of December 31, 2015, the Joint Commission had accredited 268 of our 283 home health agencies and 34 of our 56 hospice agencies. Those not yet accredited are working towards achieving this accreditation. As we acquire companies, we apply for accreditation 12 to 18 months after completing the acquisition.

Employees

As of December 31, 2015, we had 10,922 employees, of which 6,835 were full-time. None of our employees are subject to a collective bargaining agreement. We consider our relationships with our employees and independent contractors to be good.

Insurance

We are subject to claims and legal actions in the ordinary course of our business. To cover claims that may arise, we maintain commercial insurance for healthcare professional liability, general liability, automobile liability, employed lawyers liability, fiduciary liability, information security and privacy liabilities, and workers' compensation/employer's liability in amounts that we believe are appropriate and sufficient for our operations. We maintain claims-made healthcare professional liability and occurrence based general liability insurance that provides primary limits of $1.0 million per incident/ occurrence and $3.0 million in annual aggregate amounts. We maintain workers' compensation insurance that meets state statutory requirements and provides a primary employer liability limit of $1.0 million to cover claims that may arise in the states in which we operate, excluding Ohio and Washington. Coverage for workers compensation matters within Ohio and Washington is procured from each state's specific mandated programs and not through third party insurance payors. Under our workers' compensation insurance policies, the Company maintains a deductible of the first $0.5 million in workers compensation liability. We maintain automobile liability insurance for all owned, hired and non-owned autos with a primary limit of $1.0 million. In addition, we currently maintain multiple layers of umbrella coverage in the aggregate amount of $40.0 million that provides excess coverage for healthcare professional liability, general liability, automobile liability and employer's liability. We also maintain directors' and officers' liability insurance in the aggregate amount of $65.0 million. The cost and availability of insurance coverage has varied widely in recent years. While we believe that our insurance policies

and coverage are adequate for a business enterprise of our type, we cannot guarantee that our insurance coverage is sufficient to cover all future claims or that it will continue to be available in adequate amounts or at a reasonable cost.

Available Information

Our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, proxy statements and amendments to those reports are available free of charge on our internet website at www.lhcgroup.com as soon as reasonably practicable after such reports are electronically filed with or furnished to the Securities and Exchange Commission ("SEC"). The SEC also maintains an internet site at www.sec.gov that contains such reports, proxy and information statements and other information regarding issuers that file electronically with the SEC. These reports may also be obtained at the SEC's Public Reference Room at 100 F Street NE,

Washington, D.C. 20549. Information on the operation of the Public Reference Room is available by calling the SEC at (800) SEC-0330. Information contained on our website is not part of or incorporated by reference into this Annual Report on Form 10-K.

Item 1A. Risk Factors.

The risks and uncertainties described below and elsewhere in this Annual Report on Form 10-K could cause our actual results to differ materially from past or expected results and are not the only ones we face. Other risks and uncertainties that we have not predicted or assessed may also adversely affect us.

If any of the negative effects associated with the following risks occur, our earnings, financial condition or business could be materially harmed and the trading price of our common stock could decline, resulting in the loss of all or part of stockholders' investments.

Risk Factors Related to Reimbursement and Government Regulation

We cannot predict the effect that health care reform and other changes in government programs may have on our business, financial condition or results of operations.

The PPACA and the Health Care Education Reconciliation Act of 2010 (collectively, the "Acts") were signed into law by President Obama on March 23, 2010, and March 30, 2010, respectively. The Acts dramatically alter the United States' health care system and are intended to decrease the number of uninsured Americans and reduce overall health care costs. The Acts attempt to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding Medicare and Medicaid eligibility, reducing Medicare and Medicaid payments, and tying reimbursement to the satisfaction of certain quality criteria. The Acts also contain a number of measures that are intended to reduce fraud and abuse in the Medicare and Medicaid programs. Because a majority of the measures contained in the Acts have either just recently or not yet taken effect, it is difficult to predict the impact the Acts will have on our operations. However, depending on how they are ultimately interpreted and implemented, the Acts could have an adverse effect on our business and its financial condition and results of operations.

We derive a majority of our consolidated net service revenue from Medicare. If there are changes in Medicare rates or methods governing Medicare payments for our services, or if we are unable to control our costs, our results of operations and cash flows could decline materially.

For the years ended December 31, 2015, 2014 and 2013, we received 74.5%, 75.9% and 79.8%, respectively, of our net service revenue from Medicare. Reductions in Medicare rates or changes in the way Medicare pays for services could cause our net service revenue and net income to decline, perhaps materially. See Part I, Item 1. Reimbursement in this Annual Report on Form 10-K for additional information regarding reimbursements. Reductions in Medicare reimbursement could be caused by many factors, including:

- administrative or legislative changes to the base rates under the applicable prospective payment systems;
- the reduction or elimination of annual rate increases;
- the imposition or increase by Medicare of mechanisms shifting more responsibility for a portion of payment to beneficiaries, such as co-payments;
- adjustments to the relative components of the wage index used in determining reimbursement rates;
- changes to case mix or therapy thresholds;
- the reclassification of home health resource groups or long-term care diagnosis-related groups; or
- further limitations on referrals to long-term acute care hospitals from host hospitals.

We receive fixed payments from Medicare for our services based on the level of care provided to our patients. Consequently, our profitability largely depends upon our ability to manage the cost of providing these services. Medicare currently provides for an annual adjustment of the various payment rates, such as the base episode rate for our home nursing services, based upon the increase or decrease of the medical care expenditure, which may be less than actual inflation. This adjustment could be eliminated or reduced in any given year. Also beginning on April 1, 2013 Medicare reimbursement was cut an additional 2% through sequestration as mandated by the Congressional Budget Act. Further, Medicare routinely reclassifies home health resource groups and long-term care diagnosis-related

groups. As a result of those reclassifications, we could receive lower reimbursement rates depending on the case mix of the patients we service. If our cost of providing services increases by more than the annual Medicare price adjustment, or if these reclassifications result in lower reimbursement rates, our results of operations, net income and cash flows could be adversely impacted.

We are subject to extensive government regulation. Any changes in the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could require us to modify our operations and could negatively impact our operating results and cash flows.

As a provider of health care services, we are subject to extensive regulation on the federal, state and local levels, including with regard to:

- licensure and certificates of need and permits of approval;
- coding and billing for services;
- conduct of operations, including financial relationships among health care providers, Medicare fraud and abuse and physician self-referral;
- maintenance and protection of records, including HIPAA;
- environmental protection, health and safety;
- certification of additional agencies or facilities by the Medicare program; and
- payment for services.

The laws and regulations governing our operations, along with the terms of participation in various government programs, regulate how we do business, the services we offer and our interactions with patients and other providers. See Part I, Item 1. Government Regulations in this Annual Report on Form 10-K for additional information concerning applicable laws and regulations. These laws and regulations, and their interpretations, are subject to frequent change. Changes in existing laws, regulations, their interpretations or the enactment of new laws or regulations could increase our costs of doing business and cause our net income to decline. If we fail to comply with these applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in federal and state reimbursement programs.

The PPACA also amended the False Claims Act to provide that a provider must report and return overpayments within 60 days of identifying the overpayment or the claims for the services that generated the overpayments become false claims subject to the False Claims Act. Overpayments include payments for services for which the provider does not have proper documentation. If we were to identify documentation failures that could not be corrected we could be required to return payments received for those claims within the mandated 60-day time period. If we fail to identify and return overpayments within the required 60-day period we could be subject to suits under the False Claims Act by the government or relators (whistleblowers). On February 13, 2015, CMS announced that it will delay finalizing regulations that were intended to clarify when a payment is “identified” for purposes of the 60-day rule. Notwithstanding the delay, providers are still required to comply with the rule even though there is considerable uncertainty over exactly when the 60-day period begins. Due to this uncertainty, our continued compliance with the False Claims Act and its implementing regulations could have a material adverse impact on our business and operations.

On October 6, 2014, CMS issued a proposed rule that would revise the Medicare and Medicaid conditions of participation for home health agencies. The proposed rule would require home health agencies to develop, implement, and maintain an agency-wide, data-driven quality assessment and improvement program and a system of communication and integration to identify patient needs and coordinate care. The proposed rule also aims to clarify and expand current patient rights requirements and contains several other clarifications and updates largely focused on creating a more patient-centered, data-driven, outcome-oriented process for patient care. If the proposed rule is finalized, we expect to face costs associated with compliance with such changes.

On December 11, 2014, CMS proposed a star rating methodology for home health agencies to meet the PPACA’s call for more transparent, public information on provider quality. All Medicare-certified home health agencies would be eligible to receive a star rating (from one to five stars) based on a number of quality measures, such as timely initiation of care, drug education provided to patients, fall risk assessment, depression assessments, improvements in bed transferring, and bathing, among others. The “Quality of Patient Care Star Ratings” were first published in July, 2015, and are updated quarterly thereafter based upon new data that is published with the ratings on the “Home Health Compare” section of the medicare.gov website. While we are pleased with the initial ratings received by our home health agencies and are striving to improve our results, it is not clear at this time what impact, if any, the new rating system will have on our home health business.

We are also subject to various routine and non-routine governmental reviews, audits and investigations. These audits include those conducted through the recovery audit contractor program and the zone program integrity contractor program, in which third party firms engaged by CMS conduct extensive reviews of claims data and non-medical and other records to identify potential improper payments under the Medicare Program. In recent years, federal and state civil and criminal enforcement agencies have heightened and coordinated their oversight efforts related to the health care industry, including with respect to referral practices, cost reporting, billing practices, joint ventures and other financial relationships among health care providers. Although we have invested substantial time and effort in implementing policies and procedures to comply with laws and regulations, we could be subject to liabilities arising from violations. A violation of the laws governing our operations, or changes in the interpretation of those laws, could result in the imposition of fines, civil or criminal penalties, the termination of our rights to participate in federal and state-sponsored programs or the suspension or revocation of our licenses to operate. If we become subject to material fines or if other sanctions or other corrective actions are imposed upon us, we may suffer a substantial reduction in net income.

We are subject to federal and state laws that govern our employment practices. Failure to comply with these laws, or changes to these laws that increase our employment-related expenses, could adversely impact our operations.

We are required to comply with all applicable federal and state laws and regulations relating to employment, including occupational safety and health requirements, wage and hour requirements, employment insurance, and equal employment opportunity laws. These laws can vary significantly among states and can be highly technical. Costs and expenses related to these requirements are a significant operating expense and may increase as a result of, among other things, changes in federal or state laws or regulations requiring employers to provide specified benefits to employees, increases in the minimum wage and local living wage ordinances, increases in the level of existing benefits, or the lengthening of periods for which unemployment benefits are available. We may not be able to offset any increased costs and expenses. Furthermore, any failure to comply with these laws, including even a seemingly minor infraction, can result in significant penalties which could harm our reputation and have a material adverse effect on our business. Additionally, a number of states require that direct care workers receive state-mandated minimum wage and/or overtime pay. Opponents say that the new protections will make in-home care more expensive for government programs that pay for such services, and that these new rules and regulations could result in a reduction in covered services. We will continue to evaluate the effect of these various new rules and regulations on our operations.

Current economic conditions and continued decline in spending by the Federal and State governments could adversely affect our results of operations and cash flows.

Worldwide economic conditions have significantly declined and will likely remain depressed for the foreseeable future. While our services are not typically sensitive to general declines in the federal and state economies, the erosion in the tax base caused by the general economic downturn has caused, and will likely continue to cause, restrictions on the federal and state governments' ability to obtain financing and a decline in spending. As a result, we may face reimbursement rate cuts or reimbursement delays from Medicare and Medicaid and other governmental payors, which could adversely impact our results of operations and cash flows.

If any of our agencies or facilities fail to comply with the conditions of participation in the Medicare program, that agency or facility could be terminated from Medicare, which could adversely affect our net service revenue and net income.

Our agencies and facilities must comply with the extensive conditions of participation in the Medicare program. These conditions of participation vary depending on the type of agency or facility, but, in general, require our agencies and facilities to meet specified standards relating to personnel, patient rights, patient care, patient records, administrative reporting and legal compliance. If an agency or facility fails to meet any of the Medicare conditions of participation, that agency or facility may receive a notice of deficiency from the applicable state surveyor. If that agency or facility then fails to institute a plan of correction to correct the deficiency within the time period provided by the state surveyor, that agency or facility could be terminated from the Medicare program. We respond in the ordinary course to deficiency notices issued by state surveyors and none of our facilities or agencies have ever been terminated from the Medicare program for failure to comply with the conditions of participation. Any termination of one or more of our agencies or facilities from the Medicare program for failure to satisfy the Medicare conditions of participation could adversely affect our net service revenue and net income.

Our revenue may be negatively impacted by a failure to appropriately document services, resulting delays in reimbursement.

Reimbursement to us is conditioned upon providing the correct administrative and billing codes and properly documenting the services themselves, including the level of service provided, and the necessity for the services. If incorrect or incomplete documentation is provided or inaccurate reimbursement codes are utilized, this could result in nonpayment for services rendered and could lead to allegations of billing fraud. This could subsequently lead to civil and criminal penalties, including exclusion from government healthcare programs, such as Medicare and Medicaid. In addition, third-party payors may disallow, in whole or in part, requests for reimbursement based on determinations that certain amounts are not covered, services provided were not medically necessary, or supporting documentation was not adequate. In addition, timing delays may cause working capital shortages. Working capital management, including prompt and diligent billing and collection, is an important factor in achieving our financial results and maintaining liquidity. It is possible that documentation support, system problems, provider issues or industry trends may extend our collection period, which may materially adversely affect our working capital, and our working capital

management procedures may not successfully mitigate this risk.

The inability of our long-term acute care hospitals to maintain their certification as long-term acute care hospitals could have an adverse affect on our results of operations and cash flows.

If our LTACHs fail to meet or maintain the standards for Medicare certification as LTACHs, such as for average minimum patient length-of-stay and restrictions on sources of referral (e.g. 25 Percent rule), they will receive reimbursement under the prospective payment system applicable to general acute care hospitals rather than the system applicable to long-term acute care hospitals. Payments at rates applicable to general acute care hospitals would likely result in our LTACHs receiving less Medicare reimbursement than they currently receive for their patient services. If any of our LTACHs were subject to payment as general acute care hospitals, our net service revenue and net income would decline.

The implementation of new patient criteria for our LTACHs under the BBA 2013 will reduce the population of patients eligible for LTACH-PPS and change the basis upon which we are paid which could adversely affect our revenues and profitability.

The BBA 2013 creates new Medicare criteria and payment rules for our LTACHs. Under the new criteria, our LTACHs treating patients with at least a three-day prior stay in an acute care hospital intensive care unit and patients on prolonged mechanical ventilation admitted from an acute care hospital will continue to receive payment under LTACH-PPS rate. Other patients will continue to have access to LTACH care, but our LTACH will be paid at a "site-neutral rate" for these patients, based on the lesser of per diem Medicare rates paid for patients with the same diagnoses under IPPS or LTACH costs.

The effective date of the new patient criteria was October 1, 2015, followed by a two-year phase-in period tied to each LTACH's cost reporting period. During the phase-in period, payment for patients receiving the site-neutral rate will be based 50% on the current LTACH-PPS rate and 50% on the new site-neutral rate. For our two LTACHs that have a cost reporting period starting before July 1 of each year, the phase-in will begin on June 1, 2016. For our six LTACHs that have a cost reporting period starting on or after July 1 of each year, the phase-in will begin on September 1, 2016.

We continue to analyze Medicare and internal data to estimate the number of our cases that will continue to be paid under the LTACH-PPS rate. At this time, we estimate that less than one-third of our current LTACH patients will be paid at the site-neutral rate under the new criteria once it is fully phased-in. The site-neutral payment rates will be based on the lesser of per diem Medicare rates paid for patients with the same diagnoses under IPPS or our LTACHs costs. There can be no assurance that these site-neutral payments will not be materially less than the payments currently provided under LTACH-PPS rates.

The additional patient criteria imposed by the BBA 2013 will reduce the population of patients eligible for LTACH-PPS rates and change the basis upon which our LTACHs are paid for other patients. In addition, the BBA 2013 will generate additional governmental regulations, including interpretations and enforcement actions surrounding those regulations. These changes could have a material adverse effect on our business, financial position, results of operations and liquidity.

Our hospice operations are subject to two annual Medicare caps. If any of our hospice providers exceeds such caps, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

Overall payments made by Medicare to each hospice provider number (generally corresponding to each of our hospice agencies) are subject to an inpatient cap amount and an overall payment cap amount, which are calculated and published by the Medicare fiscal intermediary on an annual basis covering the period from November 1 through October 31. If payments received under any of our hospice provider numbers exceeds either of these caps, we may be required to reimburse Medicare for payments received in excess of the caps, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

If the structures or operations of our joint ventures are found to violate the law, it could have a material adverse impact on our financial condition and consolidated results of operations.

Several of our joint ventures are with hospitals and physicians, which are governed by the federal Anti-Kickback Statute and similar state laws. These anti-kickback statutes prohibit the payment or receipt of anything of value in return for referrals of patients or services covered by governmental health care programs, such as Medicare. The OIG has published numerous safe harbors that exempt qualifying arrangements from enforcement under the federal Anti-Kickback Statute. We have sought to satisfy as many safe harbor requirements as possible in structuring our joint ventures. For example, each of our equity joint ventures with hospitals and physicians is structured in accordance with the following principles:

- the investment interest offered is not based upon actual or expected referrals by the hospital or physician;
- our joint venture partners are not required to make or influence referrals to the joint venture;
- at the time the joint venture is formed, each hospital or physician joint venture partner is required to make an actual capital contribution to the joint venture equal to the fair market value of his or her investment interest and is at risk to lose his or her investment;
- neither we nor the joint venture entity lends funds to or guarantees a loan to the hospital or physician to acquire interests in the joint venture; and
- distributions to our joint venture partners are based solely on their equity interests and are not affected by referrals from the hospital or physician.

Despite our efforts to meet the safe harbor requirements where possible, our joint ventures may not satisfy all elements of the safe harbor requirements.

If any of our joint ventures were found to be in violation of federal or state anti-kickback or physician referral laws, we could be required to restructure them or refuse to accept referrals from the physicians or hospitals with which we have entered into a joint venture. We also could be required to repay to Medicare amounts we have received pursuant to any prohibited referrals, and we could suffer civil or

criminal penalties, including the loss of our licenses to operate and our ability to participate in federal and state health care programs. If any of our joint ventures were subject to any of these penalties, our business could be materially adversely affected. If the structure of any of our joint ventures were found to violate federal or state anti-kickback statutes or physician referral laws, we may be unable to implement our growth strategy, which could have an adverse impact on our future net income and consolidated results of operations.

The application of state certificate of need and permit of approval regulations and compliance with federal and state licensing requirements could substantially limit our ability to operate and grow our business.

Our ability to expand operations in a state will depend on our ability to obtain a state license to operate. States may have a limit on the number of licenses they issue. For example, Louisiana currently has a moratorium on the issuance of new home nursing agency licenses. We cannot predict whether this moratorium will be extended beyond this date or whether any other states in which we operate, or may wish to operate in the future, may adopt a similar moratorium.

As of December 31, 2015, we operated in 12 states that require health care providers to obtain prior approval, known as a certificate of need or a permit of approval, for the purchase, construction or expansion of health care facilities, to make certain capital expenditures or to make changes in services or bed capacity. The failure to obtain any requested certificate of need, permit of approval or other license could impair our ability to operate or expand our business.

Risk Factors Related to Capital and Liquidity

The condition of the financial markets, including volatility and weakness in the equity, capital and credit markets, could limit the availability and terms of debt and equity financing sources to fund the capital and liquidity requirements of our business.

Financial markets experienced significant disruptions over the past few years. These disruptions have impacted liquidity in the debt markets, making financing terms for borrowers less attractive and, in certain cases, significantly reducing the availability of certain types of debt financing. Despite the instability over the past few years within the financial markets nationally and globally, we have not experienced any individual lender limitations to extend credit under our revolving credit facility. However, the obligations of each of the lending institutions in our revolving credit facility are separate and the availability of future borrowings under our revolving credit facility could be impacted by further volatility and disruptions in the financial credit markets or other events. Our inability to access our revolving credit facility or refinance the revolving credit facility would have a material adverse effect on our business, financial positions, results of operations and liquidity.

Based on our current plan of operations, including acquisitions, we believe our existing cash balance, when combined with expected cash flows from operations and amounts available under our revolving credit facility, will be sufficient to fund our growth strategy and to meet our anticipated operating expenses, capital expenditures and debt service obligations for at least the next 12 months. If our future net service revenue or cash flow from operations is less than we currently anticipate, we may not have sufficient funds to implement our growth strategy. Further, we cannot readily predict the timing, size and success of our acquisition and internal development efforts and the associated capital commitments. If we do not have sufficient cash resources, our growth could be limited unless we are able to obtain additional equity or debt financing.

The agreement governing our revolving credit facility contains, and future debt agreements may contain, various covenants that limit our discretion in the operation of our business.

The agreement and instruments governing our revolving credit facility, and the agreements and instruments governing future debt agreements may contain various restrictive covenants that, among other things, require us to comply with or maintain certain financial tests and ratios that may restrict our ability to:

- incur more debt;
- redeem or repurchase stock, pay dividends or make other distributions;
- make certain investments;

- create liens;
- enter into transactions with affiliates;
- make unapproved acquisitions;
- merge or consolidate;
- transfer or sell assets; and/or
- make fundamental changes in our corporate existence and principal business.

In addition, events beyond our control could affect our ability to comply with and maintain such financial tests and ratios. Any failure by us to comply with or maintain all applicable financial tests and ratios and to comply with all applicable covenants could result in an event of default with respect to our revolving credit facility or any other future debt agreements. An event of default could lead to the acceleration of the maturity of any outstanding loans and the termination of the commitments to make further extensions of credit. Even if we are able to comply with all applicable covenants, the restrictions on our ability to operate our business at our sole discretion could

harm our business by, among other things, limiting our ability to take advantage of financing, mergers, acquisitions and other corporate opportunities.

Our net service revenue is concentrated in a small number of states, which makes us sensitive to regulatory and economic changes in those states.

For the year ended December 31, 2015, our facilities in Louisiana, Mississippi, Tennessee, Alabama, and Arkansas accounted for approximately 61.1% of our net service revenue. Accordingly, any changes in the current demographic, economic, competitive, or regulatory conditions in these states could have an adverse effect on our business, financial condition, results of operations and cash flows. Medicaid changes in these states could also have a material adverse effect on our results of operations and cash flows.

Hurricanes or other adverse weather events could negatively affect the local economies in which we operate or disrupt our operations, which could have an adverse effect on our business or results of operations.

Our operations along coastal areas in the southern United States are particularly susceptible to hurricanes. Such weather events can disrupt our operations, result in damage to our properties and negatively affect the local economies in which we operate. Future hurricanes could affect our operations or the economies in those market areas and result in damage to certain of our facilities, the equipment located at such facilities or equipment rented to patients in those areas. Our business or results of operations may be adversely affected by these and other negative effects of future hurricanes. Although we maintain insurance coverage, we cannot guarantee that our insurance coverage will be adequate to cover any losses or that we will be able to maintain insurance at a reasonable cost in the future. If our losses from business interruption or property damage exceed the amount for which we are insured, our results of operations and financial condition would be adversely affected.

We may be more vulnerable to the effects of a public health catastrophe than other businesses due to the nature of our patients.

The majority of our patients are older individuals and others with complex medical challenges, many of whom may be more vulnerable than the general public during a pandemic or in a public health catastrophe. Our employees are also at greater risk of contracting contagious diseases due to their increased exposure to vulnerable patients. For example, if a flu pandemic were to occur, we could suffer significant losses to our consumer population or a reduction in the availability of our employees and, at a high cost, be required to hire replacements for affected workers. Accordingly, certain public health catastrophes could have a material adverse effect on our financial condition and results of operations.

Delays in reimbursement may cause liquidity problems.

Our business is characterized by delays in reimbursement from the time we request payment for our services to the time we receive reimbursement or payment. A portion of our estimated reimbursement (60% for an initial episode of care and 50% for subsequent episodes of care) for each Medicare episode is billed at the commencement of the episode and we typically receive payment within approximately seven days. The remaining reimbursement is billed upon completion of the episode and is typically paid within 14 to 17 days from the billing date. If we have information system problems or issues arise with Medicare or other payors, we may encounter further delays in our payment cycle. For example, in the past we have experienced delays resulting from problems arising out of the implementation by Medicare of new or modified reimbursement methodologies or as a result of natural disasters, such as hurricanes. We have also experienced delays in reimbursement resulting from our implementation of new information systems related to our accounts receivable and billing functions. Any future timing delay may cause working capital shortages. As a result, working capital management, including prompt and diligent billing and collection, is an important factor in our consolidated results of operations and liquidity. Our working capital management procedures may not successfully negate this risk. Significant delays in payment or reimbursement could have an adverse impact on our liquidity and financial condition.

Risk Factors Related to Operations and our Growth Strategy

We could be required to record a material non-cash charge to income if our recorded goodwill or intangible assets are impaired.

Goodwill and other intangible assets represent a significant portion of the assets on our balance sheet and are assessed for impairment annually or whenever circumstances indicate potential impairment. The goodwill assessment includes

comparing the fair value of each reporting unit to the carrying value of the assets assigned to the reporting unit. If the carrying value of the reporting unit were to exceed our estimate of fair value of the reporting unit, we would be required to estimate the fair value of the assets and liabilities within the reporting unit to ascertain the fair value of goodwill. If we determine that the fair value is less than our book value, we could be required to record a non-cash impairment charge to our consolidated statements of operations, which could have a material adverse effect on our earnings, debt covenants and ability to access capital.

We assess other intangible assets, such as trade names and licenses, individually, based on expected revenue and cash flows to be generated by those assets. Specific economic factors and conditions attributed to local agencies could cause these expected revenue and cash flows to decrease. If we determine that the fair value is less than the carrying value, we could be required to record material non-cash impairment charges, which could have a material adverse effect on our earnings, debt covenants and ability to access capital.

Our allowance for contractual adjustments and doubtful accounts may not be sufficient to cover uncollectible amounts.

On an ongoing basis, we estimate the amount of Medicare, Medicaid and private insurance receivables that we will not be able to collect. This allows us to calculate the expected loss on our receivables for the period we are reporting. Our allowance for contractual adjustments and doubtful accounts may underestimate actual uncollectible receivables for various reasons, including:

- adverse changes in our estimates as a result of changes in payor mix and related collection rates;
- inability to collect funds due to missed filing deadlines or inability to prove that timely filings were made;
- adverse changes in the economy generally exceeding our expectations; or
- unanticipated changes in reimbursement from Medicare, Medicaid and private insurance companies.

If our allowance for contractual adjustments and doubtful accounts is insufficient to cover losses on our receivables, our business, financial position and results of operations could be materially adversely affected.

Changes in the case mix of patients, as well as payor mix and payment methodologies, may have a material adverse effect on our results of operations and cash flows.

The sources and amounts of our patient revenue are determined by a number of factors, including the mix of patients and the rates of reimbursement among payors. Generally, we receive higher reimbursement for services rendered under Medicare. Changes in the case mix of the patients, payment methodologies or payor mix among private pay, Medicare and Medicaid may significantly affect our results of operations and cash flows.

Shortages in qualified nurses and other health care professionals could increase our operating costs significantly or constrain our ability to grow.

We rely on our ability to attract and retain qualified nurses and other health care professionals. The availability of qualified nurses nationwide has declined in recent years and competition for these and other health care professionals has increased and, therefore, salary and benefit costs have risen accordingly. Our ability to attract and retain nurses and other health care professionals depends on several factors, including our ability to provide desirable assignments and competitive benefits and salaries. We may not be able to attract and retain qualified nurses or other health care professionals in the future. In addition, the cost of attracting and retaining these professionals and providing them with attractive benefit packages may be higher than anticipated which could cause our net income to decline. Moreover, if we are unable to attract and retain qualified professionals, the quality of services offered to our patients may decline or our ability to grow may be constrained.

If we are required to either repurchase or sell a substantial portion of the equity interests in our joint ventures, our capital resources and financial condition could be materially adversely impacted.

Upon the occurrence of fundamental changes to the laws and regulations applicable to our joint ventures, or if a substantial number of our joint venture partners were to exercise the buy/sell provisions contained in many of our joint venture agreements, we may be obligated to purchase or sell the equity interests held by us or our joint venture partners. In some instances, the purchase price under these buy/sell provisions is based on a multiple of the historical or future earnings before income taxes, depreciation and amortization of the equity joint venture at the time the buy/sell option is exercised. In other instances, the buy/sell purchase price will be negotiated by the partners but will be subject to a fair market valuation process. In the event the buy/sell provisions are exercised and we lack sufficient capital to purchase the interest of our joint venture partners, we may be obligated to sell our equity interest in these joint ventures. If we are forced to sell our equity interest, we will lose the benefit of those particular joint venture operations. If these buy/sell provisions are exercised and we choose to purchase the interest of our joint venture partners, we may be obligated to expend significant capital in order to complete such acquisitions. If either of these events occurs, our net service revenue and net income could decline or we may not have sufficient capital necessary to implement our growth strategy.

If we are unable to maintain relationships with existing referral sources or establish new referral sources, our growth and net income could be adversely affected.

Our success depends significantly on referrals from physicians, hospitals and other health care providers in the communities in which we deliver our services. Our referral sources are not obligated to refer business to us and may refer business to other health care providers. We believe many of our referral sources refer business to us as a result of the quality of patient care provided by our local employees in the communities in which our agencies and facilities are located. If we are unable to retain these employees, our referral sources may refer business to other health care providers. Our loss of, or failure to maintain, existing relationships or our failure to develop new relationships could adversely affect our ability to expand our operations and operate profitably.

We face competition, including from competitors with greater resources, which may make it difficult for us to compete effectively as a provider of post-acute health care services.

We compete with local and regional home nursing and hospice companies, hospitals and other businesses that provide post-acute health care services, some of which are large, established companies that have significantly greater resources than we do. Our primary competition comes from local operators in each of our markets. We expect our competitors to develop joint ventures with providers, referral sources and payors, which could result in increased competition. The introduction by our competitors of new and enhanced service offerings, in combination with industry consolidation and the development of competitive joint ventures, could cause a decline in net service revenue and loss of market acceptance of our services. Future increases in competition from existing competitors or new entrants may limit our ability to maintain or increase our market share. We may not be able to compete successfully against current or future competitors and competitive pressures may have a material adverse impact on our business, financial condition and results of operations.

We may close additional underperforming agencies in the future.

We regularly review the performance of our various agencies. Our review considers the current financial performance, market penetration, forecasted market growth and current and future reimbursement payment forecasts. During 2015, we incurred exit activity costs of $1.8 million in connection with the closure of certain underperforming agencies, including lease termination payments, relocation costs, severance costs and asset and intangible write-offs.

We will continue to monitor the performance of our agencies on an ongoing basis, and additional closures may from time to time occur in the future. If we take any further action to close agencies, we will incur additional costs and expenses, which may require us to record significant charges in future periods. While any such closures would be made in connection with our constant efforts to improve our profitability, associated charges would have a negative impact on our revenue and possibly our operating results during the short-term.

Future acquisitions may be unsuccessful and could expose us to unforeseen liabilities. Further, our acquisition and internal development activity may impose strains on our existing resources.

Our growth strategy involves the acquisition of home nursing agencies and facilities throughout the United States. These acquisitions involve significant risks and uncertainties, including difficulties integrating acquired personnel and other corporate cultures into our business, the potential loss of key employees or patients of acquired agencies and the assumption of liabilities and exposure to unforeseen liabilities of acquired agencies. We may not be able to fully integrate the operations of the acquired businesses with our current business structure in an efficient and cost-effective manner. The failure to effectively integrate any of these businesses could have a material adverse effect on our operations.

We generally structure our acquisitions as asset purchase transactions in which we expressly state that we are not assuming any pre-existing liabilities of the seller and obtain indemnification rights from the previous owners for acts or omissions arising prior to the date of such acquisitions. However, the allocation of liability arising from such acts or omissions between the parties could involve the expenditure of a significant amount of time, manpower and capital. Further, the former owners of the agencies and facilities we acquire may not have the financial resources necessary to satisfy our indemnification claims relating to pre-existing liabilities. If we were unsuccessful in a claim for indemnification from a seller, the liability imposed could materially adversely affect our operations.

In addition, as we continue to expand our markets, our growth could strain our resources, including management, information and accounting systems, regulatory compliance, logistics and other internal controls. Our resources may not keep pace with our anticipated growth. If we do not manage our expected growth effectively, our future prospects could be affected adversely.

We may face increased competition for attractive acquisition and joint venture candidates.

We intend to continue growing through the acquisition of additional home-based agencies and the formation of joint ventures with hospitals for the operation of home-based agencies. We face competition for acquisition and joint venture candidates, which may limit the number of acquisition and joint venture opportunities available to us or lead to the payment of higher prices for our acquisitions and joint ventures. We cannot guarantee that we will be able to identify suitable acquisition or joint venture opportunities in the future or that any such opportunities, if identified,

will be consummated on favorable terms, if at all. Without successful acquisitions or joint ventures, our future growth rate could decline. In addition, we cannot guarantee that any future acquisitions or joint ventures, if consummated, will result in further growth.

Federal regulation may impair our ability to consummate acquisitions or open new agencies.

Changes in federal laws or regulations may materially adversely impact our ability to acquire home nursing agencies or open new start-up home nursing agencies. For example, CMS has adopted a regulation known as the “36 Month Rule” that is applicable to home health agency acquisitions. Subject to certain exceptions, the 36 Month Rule prohibits buyers of certain home health agencies – those that either enrolled in Medicare or underwent a change in ownership fewer than 36 months prior to the acquisitions – from assuming the Medicare billing privileges of the acquired agency. Instead, the acquired home health agencies must enroll as new providers with Medicare. As a result, the 36 Month Rule may further increase competition for acquisition targets that are not subject to the rule, and may cause significant Medicare billing delays for the purchases of home health agencies that are subject to the rule.

We are subject to a corporate integrity agreement and could be subject to substantial monetary penalties or suspension of participation in federal health care programs for noncompliance.

On September 29, 2011, we entered into a corporate integrity agreement ("CIA") with the Office of Inspector General of the Department of Health and Human Services. The CIA imposes certain auditing, self-reporting and training requirements that we must comply with. Failure to comply with certain obligations may lead to the imposition of monetary penalties and/or exclusion from participation in the federal health care programs. The imposition of monetary penalties would adversely affect our profitability. An exclusion from participation in the federal health care programs would have a material adverse effect on our financial condition as a substantial portion of our net service revenue is attributable to payments received under the Medicare and Medicaid programs.

If we are subject to substantial malpractice or other similar claims, it could materially adversely impact our results of operations and financial condition.

The services we offer have an inherent risk of professional liability and substantial damage awards. We, and the nurses and other health care professionals who provide services on our behalf, may be the subject of medical malpractice claims. These nurses and other health care professionals could be considered our agents and, as a result, we could be held liable for their medical negligence. We cannot predict the effect that any claims of this nature, regardless of their ultimate outcome, could have on our business or reputation or on our ability to attract and retain patients and employees. We maintain malpractice liability insurance that provides primary coverage on a claims-made basis of $1.0 million per incident and $3.0 million in annual aggregate amounts. In addition, we maintain multiple layers of umbrella coverage in the aggregate amount of $40.0 million that provide excess coverage for professional malpractice and other liabilities. We are responsible for deductibles and amounts in excess of the limits of our coverage. Claims that could be made in the future in excess of the limits of such insurance, if successful, could materially adversely affect our financial condition. In addition, our insurance coverage may not continue to be available to us at commercially reasonable rates, in adequate amounts or on satisfactory terms.

Failure of, or problems with, our critical software or information systems could harm our business and operating results.

We depend upon reliable and secure information systems to provide valuable tools by which we manage our business, comply with legal requirements and provide services. In addition to our Service Value Point system, our business is also substantially dependent on non-proprietary software. We utilize a third-party software information system for billing and maintaining patient claim receivables for our LTACHs. Our systems require constant maintenance and upgrading to preserve and enhance system capabilities and security. Problems with, or the failure of, our information systems or software could negatively impact our clinical performance and our management and reporting capabilities. Any significant problems with or failures of our information systems or software could materially and adversely affect our operations and reputation, result in significant costs to us, cause delays in our ability to bill Medicare or other payors for our services, or impair our ability to provide our services in the future. The costs incurred in correcting any errors or problems with our proprietary and non-proprietary software may be substantial and could adversely affect our net income. Our agencies also depend upon our information systems for accounting, billing, collections, risk management, quality assurance, payroll, education tracking and operational performance. If we experience a reduction in the performance, reliability, availability or accuracy of our information systems, our operations and financial performance, and ability to report timely and accurate information, could be adversely affected.

Operations that we acquire must be integrated into our various information systems in an efficient and effective manner. For certain aspects, we rely upon third party contractors to assist us with those activities. If we are unable to integrate and transition any acquired business into our information systems, due to our failures or any failure of our third party contractors, we could incur unanticipated expenses, suffer disruptions in service, experience regulatory issues and lose revenue from the operation of such business.

Our information systems are networked via public network infrastructure and standards based encryption tools that meet regulatory requirements for transmission of protected health information over such networks. We have installed privacy protection systems on our network and point-of-care devices to prevent unauthorized access to proprietary, sensitive and legally protected information. However, threats from computer viruses, instability of the public network

on which our data transit relies, or other instances that might render those networks unstable or disabled would create operational difficulties for us, including difficulties effectively transmitting claims and maintaining efficient clinical oversight of our patients, as well as disrupting revenue reporting and billing and collections management, which could adversely affect our business or operations. If personal or protected information of our patients, employees or others with whom we do business is tampered with, stolen or otherwise improperly accessed, we may incur additional fines and penalties associated with the breach of security or take other action with respect to judicial or regulatory actions arising out of the incident, including under HIPAA or other judicial acts, as applicable.

Our information systems are also subject to damage or service interruption due to natural disasters, floods, fires, loss of power, loss of telecommunications connectivity, and other events that may be beyond our immediate control. While we maintain and test various disaster recovery plans and procedures, our failure to successfully implement and execute upon such plans and procedures, and restore the full operational capabilities of our information systems and software in an effective and efficient manner, could have a material adverse effect on the functionality of our information systems and our business, financial condition, results of operations and cash flows, and cause a possible significant disruption of our operations and services.

Our inability to effectively and timely transition to the new ICD-10 coding system could disrupt our operations.

CMS has mandated that all providers implement the use of new patient codes for medical coding, referred to as ICD-10 codes, on or before October 1, 2015. This mandate substantially increased the number of medical billing codes by which we will seek reimbursement, increasing the complexity of submitting claims for reimbursement. Claims that we submit to CMS after October 1, 2015 must use ICD-10 codes or such claims will not be paid. Transition to the new ICD-10 system required alterations to our clinical software systems, as well as training of our staff involved in the coding and billing processes. In addition to these upfront costs of transition to ICD-10, it is possible that we could experience disruption or delays in payment due to implementation issues, including software errors, coding errors or a decrease in the productivity of our staff involved in coding and billing processes. Any such delays in payment could disrupt our operations and materially and adversely affect our business.

Our failure to negotiate favorable managed care contracts, or our loss of existing favorable managed care contracts, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

One of our strategies is to diversify our payor sources by increasing the business we do with managed care companies, and we strive to secure favorable contracts with managed care payors. However, we may not be successful in these efforts. Additionally, there is a risk that any favorable managed care contracts that we can secure may be terminated on short notice, since managed care contracts typically permit the payor to terminate without cause, typically on 60 days notice. Such provisions can provide payors with leverage to reduce volume or obtain favorable pricing. Our failure to negotiate, secure and maintain favorable managed care contracts could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Risk Factors Related to our Ownership and Management

Start-up home nursing agencies can be delayed from opening in a timely manner due to processing or regulatory approvals.

There can be delays associated with opening a de novo home nursing agency. These delays are the result of processing delays with the state regulatory bodies as well as processing delays by the associated fiscal intermediaries that serve as billing liaisons between the home nursing agency and CMS. To initiate operations at a de novo home nursing agency, we must submit the necessary applications along with the required documentation to the appropriate state and federal regulatory bodies. However, CMS has issued a memorandum which prioritizes the initial surveys for new Medicare providers as lowest priority for the state regulatory bodies. Moreover, depending on state requirements, the fiscal intermediary may need to receive the state license before the approval process can move forward. Once the necessary application and documentation has been submitted to the state and federal regulatory bodies, there is a testing period of transmitting data from the applicant to CMS. Once complete, the home nursing agency receives a provider agreement and corresponding number and can begin billing. If we are unable to obtain regulatory approval for our de novo home nursing agencies in a timely manner, such delays could have a material adverse effect on our business and our consolidated financial condition, results of operations and cash flows.

As a holding company, we have no material assets or operations of our own.

We are a holding company, whereby our material assets and operations are held by our subsidiaries. Accordingly, our ability to service our debt, if any, is dependent upon the earnings from the business conducted by our subsidiaries. The distributions of those earnings or advances or other distributions of funds by these subsidiaries to us are contingent upon the subsidiaries' earnings and are subject to various business considerations. In addition, distributions by subsidiaries could be subject to statutory restrictions, including state laws requiring that the subsidiary be solvent, or contractual restrictions. If our subsidiaries are unable to make sufficient distributions or advances to us, we may not have the cash resources necessary to service our debt.

The loss of certain executive management or key employees could have a material adverse effect on our operations and financial performance.

Our success depends upon the continued employment of our executive management team and key employees and our ability to retain and motivate these individuals. If we lose the services of one or more of our executive officers or key employees, we may not be able to successfully manage our business, achieve our business goals or replace them with equally qualified personnel. The loss of any of our executive officers or key employees could have a material adverse effect on our operations and financial performance.

Our executive officers and directors and their affiliates hold a substantial portion of our outstanding shares of common stock and could exercise significant influence over matters requiring stockholder approval, regardless of the wishes of other stockholders.

Our executive officers and directors and individuals or entities affiliated with them, beneficially own an aggregate of approximately 18.6% of our outstanding shares of common stock as of December 31, 2015. The interests of these stockholders may differ from other stockholders' interests. If they were to act together, these affiliated stockholders would be able to significantly influence all matters that our stockholders vote upon, including the election of directors, business combinations, the amendment of our certificate of incorporation and other significant corporate actions.

Certain provisions of our charter, bylaws, and Delaware law may delay or prevent a change in control of the Company.

Delaware law and our governing documents contain provisions that may enable our Board of Directors to resist a change in control of the Company. These provisions include:

- a staggered Board of Directors;
- limitations on persons authorized to call a special meeting of stockholders;
- the authorization of undesignated preferred stock, the terms of which may be established and shares of which may be issued without stockholder approval; and
- advance notice procedures required for stockholders to nominate candidates for election as directors or to bring matters before an annual meeting of stockholders.

These anti-takeover defenses could discourage, delay or prevent a transaction involving a change in control of the Company. These provisions could also discourage proxy contests and make it more difficult for stockholders to elect directors or cause us to take other corporate actions.

We have implemented other anti-takeover provisions or provisions that could have an anti-takeover effect. These provisions and others that our Board of Directors may adopt hereafter, may discourage offers to acquire us and may permit our Board of Directors to choose not to entertain offers to purchase us, even if such offers include a substantial premium to the market price of our common stock. Therefore, our stockholders may be deprived of opportunities to profit from a sale of control.

Our common stock is traded infrequently, which may cause volatility in our stock price, including a decline in value.

We have a relatively low volume of daily trades in our common stock on the NASDAQ Global Select Market ("NASDAQ"). For example, the average daily trading volume of our common stock on NASDAQ over the three-month trading period ending February 25, 2016 was approximately 123,812 shares per day. Because our common stock is traded infrequently, the price per share of our common stock can fluctuate more significantly from day-to-day than a widely held stock that is actively traded on a daily basis. For example, trading of a large volume of our common stock may have a significant impact on the trading price of our common stock. In addition, future issuances of our common stock, including the exercise of any options or the vesting of any restricted stock that we may grant to directors, executive officers and other employees in the future and the issuance of our common stock in connection with acquisitions, could have an adverse effect on the market price of our common stock.

We do not anticipate paying dividends on our common stock in the foreseeable future and, consequently, your ability to achieve a return on your investment will depend solely on appreciation in the price of our common stock.

We do not pay dividends on our shares of common stock and intend to retain all future earnings to finance the continued growth and development of our business and for general corporate purposes. In addition, we do not anticipate paying cash dividends on our common stock in the foreseeable future. Any future payment of cash dividends will depend upon our financial condition, capital requirements, credit facility limitations, earnings and other factors deemed relevant by our board of directors.

If we identify deficiencies in our internal control over financial reporting, our business and our stock price could be adversely affected.

We are required to report on the effectiveness of our internal control over financial reporting as required by Section 404 of Sarbanes-Oxley. Under Section 404, we are required to assess the effectiveness of our internal control over financial reporting and report our conclusion in our Annual Report. Our independent registered public accounting firm is also required to report its conclusion regarding the effectiveness of our internal control over financial reporting. The existence of one or more material weaknesses could require us and our auditor to conclude that our internal control over financial reporting is not effective. If material weaknesses in our internal control over financial reporting are identified, we could be subject to regulatory scrutiny and a loss of public confidence in our financial reporting, which could have an adverse effect on our business and price of our common stock.

Item 1B. Unresolved Staff Comments.

We have no unresolved written comments from the staff of the SEC regarding our periodic or current reports filed under the Exchange Act.

Item 2. Properties.

Our principal executive office is located in Lafayette, Louisiana in a 66,846 square feet building that is leased. The lease agreement commenced on February 1, 2015 and will expire on March 30, 2025.

Of our operating service locations, three are owned by us and the remaining locations are in leased facilities. Most of our operating service locations are located in general commercial office space. Generally, the leases have initial terms of one year, but range from one to five years. Most of the leases either contain multiple options to extend the lease period in one-year increments or convert to a month-to-month lease upon the expiration of the initial term.

Eight of our LTACHs are HWHs, meaning we have a lease or sublease for space with the host hospital. Generally, our leases or subleases for LTACHs have initial terms of five years, but range from three to ten years. Most of our leases and subleases for our LTACHs contain multiple options to extend the term in one-year increments.

The following table shows our locations of our home health services, hospice services, community-based services, and facility-based services facilities as of December 31, 2015:

	Home health services	Hospice services	Community-based services	Facility-based services
Louisiana	43	7	—	11
Mississippi	34	10	—	—
Tennessee	32	2	1	—
Kentucky	30	—	5	—
Alabama	27	6	—	—
Arkansas	19	5	—	—
West Virginia	17	3	—	—
Illinois	9	—	—	—
Maryland	9	—	1	—
Texas	9	—	—	—
Washington	9	4	1	—
Georgia	8	9	—	—
Missouri	6	3	2	—
California	4	—	—	—
Colorado	4	—	—	—
Idaho	4	2	—	—
Oregon	4	—	—	—
Virginia	4	—	—	—
Arizona	2	—	—	—
Florida	2	—	—	—
North Carolina	2	1	3	—
Ohio	2	—	—	—
Rhode Island	1	—	—	—
South Carolina	1	4	—	—
Wisconsin	1	—	—	—
	283	56	13	11

Item 3. Legal Proceedings.

We are involved in various legal proceedings arising in the ordinary course of business. Although the results of litigation cannot be predicted with certainty, management believes the outcome of pending litigation will not have a material adverse effect on our condensed consolidated financial statements, after considering the effect of our insurance coverage.

On June 13, 2012, a putative shareholder securities class action was filed against the Company and its Chairman and Chief Executive Officer in the United States District Court for the Western District of Louisiana, styled City of Omaha Police & Fire Retirement System v. LHC Group, Inc., et al., Case No. 6:12-cv-1609-JTT-CMH. The action was filed on behalf of LHC shareholders who purchased shares of the Company’s common stock between July 30,

2008 and October 26, 2011, alleging violations of Section 10(b), 20(a), and 20A of the Securities Exchange Act of 1934, as amended. On June 16, 2014, following mediation, the parties entered a Stipulation of Settlement. On August 5, 2014, the District Court entered an Order Preliminarily Approving Settlement and Providing for Notice. On March 3, 2015, the District Court entered its Judgments adopting the Report and Recommendation previously issued and dismissing the action with prejudice. The time for appeal has passed and no appeals were filed. This matter is now concluded. The Company's insurance carrier funded the entire $7.9 million settlement amount.

On October 18, 2013, a derivative complaint was filed by a purported Company shareholder against certain of the Company's current and former executive officers, employees and members of its Board of Directors in the United States District Court for the Western District of Louisiana, styled Plummer v. Myers, et al., Case No. 6:13-cv-2899-JTT-CMH. The action was brought derivatively on behalf of the Company, which is also named as a nominal defendant. Plaintiff generally alleges that the individual defendants breached their fiduciary duties owed to the Company. The complaint also alleges claims for insider selling and unjust enrichment against the Company's Chairman and Chief Executive Officer and the Company's former President and Chief Operating Officer.

On December 30, 2013, a related derivative complaint was filed by a purported Company shareholder against certain of the Company's current and former executive officers, employees and members of its Board of Directors in the United States District Court of the Western District of Louisiana, styled McCormack v. Myers, et al., Case No. 6:13-cv-3301-JTT-CMH. The action was brought derivatively on the Company's behalf and the Company was also named as a nominal defendant. Plaintiff generally alleges that the individual defendants breached their fiduciary duties owed to the Company and wasted corporate assets. Plaintiff also alleges that the Company's Chairman and Chief Executive Officer caused false and misleading statements to be issued in violation of Section 10(b) of the Exchange Act and Rule 10b-5 promulgated thereunder and that the Company's Directors are control persons under Section 20(a) of the Exchange Act. The complaint also alleges claims for insider selling, misappropriation of information and unjust enrichment against the Company's Chairman and Chief Executive Officer and the Company's former President and Chief Operating Officer.

On March 25, 2014, the McCormack derivative action was consolidated with the Plummer derivative action described above and stayed. On October 7, 2015, the parties entered into a Stipulation of Settlement. On October 19, 2015, Plaintiffs filed an Unopposed Motion for Preliminary Approval of Proposed Derivative Settlement. On October 26, 2015, the District Court entered an Order Preliminary Approving Settlement in the amount of $0.6 million. On January 11, 2016, the District Court entered its Order and Final Judgment approving the settlement and dismissing the consolidated action with prejudice. The Company's insurance carrier has funded the entire amount, which was immediately releasable to Plaintiffs' counsel on January 11, 2016. The Company's balance sheet reflects the entire settlement in current assets as a receivable due from insurance carrier and correspondingly reflects the entire settlement in current liabilities as a legal settlement payable.

Item 4. Mine Safety Disclosures.

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Sales of Unregistered Common Stock

None

Market Information and Holders

Our common stock trades on the NASDAQ Global Select Market ("NASDAQ") under the symbol "LHCG." As of February 22, 2016, there were approximately 156 registered holders of record of our common stock.

Dividend Policy

We have not paid any dividends on our common stock since our initial public offering in 2005 and do not anticipate paying dividends in the foreseeable future. We currently intend to retain future earnings, if any, to support the development and growth of our business. Payment of future dividends, if any, will be at the discretion of our Board of Directors and subject to any requirements under our credit facility or any future debt instruments.

Price Range of Common Stock

The following table provides the high and low prices of our common stock during each quarter in 2015 and 2014 as quoted by NASDAQ:

	High	Low
2015		
Fourth Quarter	$49.16	$42.97
Third Quarter	51.12	36.95
Second Quarter	40.61	30.15
First Quarter	34.40	28.88
	High	Low
2014		
Fourth Quarter	$31.46	$22.74
Third Quarter	25.77	21.30
Second Quarter	22.30	19.90
First Quarter	24.59	21.80

The closing price of our common stock as reported by NASDAQ on March 1, 2016 was $37.43.

Performance Graph

This item is incorporated by reference from our Annual Report to Stockholders for the fiscal year ended December 31, 2015.

Issuer Purchases of Equity Securities

In October 2010, our Board of Directors authorized a program to repurchase shares of our common stock, par value $0.01 per share, from time to time, in an amount not to exceed $50.0 million ("Stock Repurchase Program"). During the twelve months ended December 31, 2015, 2014, and 2013, no shares were repurchased. In accordance with the terms of the Stock Repurchase Agreement, it expired on September 4, 2015.

Item 6. Selected Financial Data.

The selected consolidated financial data presented below is derived from our audited consolidated financial statements for each of the years in the five year period ended December 31, 2015. The financial data for the years ended December 31, 2015, 2014 and 2013 should be read together with our consolidated financial statements and related Notes included in Part II, Item 7. Management's

Discussion and Analysis of Financial Condition and Results of Operations and Item 8. Financial Statements and Supplementary Data included herein (amounts in thousands, except share and per share data).

Year Ended December 31,	2015	2014	2013	2012	2011
Consolidated Statements of Operations Data:					
Net service revenue	$816,366	$733,632	$658,283	$637,569	$633,872
Gross margin	335,488	298,857	274,819	271,817	281,526
Operating income (loss)	66,343	45,486	46,737	54,305	(6,382)
Income (loss) from continuing operations	41,650	28,752	29,146	35,428	(3,651)
Net income (loss) available to LHC Group, Inc.'s common stockholders	32,335	21,837	22,342	27,440	(13,244)
Net income (loss) attributable to LHC Group Inc.'s common stockholders per basic share:	$1.86	$1.27	$1.31	$1.54	$(0.73)
Net income (loss) attributable to LHC Group Inc.'s common stockholders per diluted share:	$1.84	$1.26	$1.30	$1.53	$(0.73)
Weighted average shares outstanding:					
Basic	17,405,379	17,229,026	17,049,794	17,853,321	18,265,118
Diluted	17,547,531	17,315,333	17,132,751	17,899,195	18,265,118

As of December 31,	2015	2014	2013	2012	2011
Consolidated Balance Sheet Data:					
Cash	$6,139	$531	$14,014	$9,720	$256
Total assets	566,054	491,739	422,226	386,894	396,376
Total debt	98,784	61,008	23,212	19,500	34,820
Total LHC Group, Inc. stockholders' equity	354,582	318,639	293,009	268,181	263,683

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

The following discussion and analysis contains forward-looking statements about future revenues, operating results, plans and expectations. Forward-looking statements are based on a number of assumptions and estimates that are inherently subject to significant risks and uncertainties and our results could differ materially from the results anticipated by our forward-looking statements as a result of many known or unknown factors, including, but not limited to, those factors discussed in Part I, Item 1A. Risk Factors. Also, please read the "Cautionary Statement Regarding Forward-Looking Statements" set forth at the beginning of this Annual Report on Form 10-K.

In addition, read the following discussion in conjunction with Part 1 of this Annual Report on Form 10-K as well as our Consolidated Financial Statements and the related Notes contained elsewhere in this Annual Report on Form 10-K.

Overview

We provide post-acute health care services primarily to Medicare beneficiaries throughout the United States, through our home health agencies, hospice agencies, community-based services agencies, and long-term acute care hospitals ("LTACHs"). Our net service revenue increased $82.8 million to $816.4 million for the year ending December 31, 2015 from $733.6 million for the year ending December 31, 2014. During 2015, we acquired 28 agencies, such that, as of December 31, 2015, we operated 363 locations in the following 25 states: Alabama, Arizona, Arkansas,

California, Colorado, Florida, Georgia, Idaho, Illinois, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Ohio, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia and Wisconsin.

Segments

Our services are classified into four segments: (1) home health services; (2) hospice services; (3) community-based services and (4) facility-based services offered primarily through our LTACHs.

Through our home health services segment we offer a wide range of services, including skilled nursing, medically-oriented social services, and physical, occupational and speech therapy. As of December 31, 2015, we operated 283 home health service locations, of which 168 are wholly-owned by us, 109 are majority-owned or controlled by us through equity joint ventures, three are controlled by us through license lease arrangements and the remaining three are only managed by us.

Through our hospice services segment, we offer a wide range of services, including pain and symptom management, emotional and spiritual support, inpatient and respite care, homemaker services, and counseling. As of December 31, 2015, we operated 56 hospice locations, of which 43 are wholly-owned by us, 11 are majority-owned by us through equity joint ventures and two are controlled by us through license lease arrangements.

Through our community-based services segment, our services are performed by paraprofessional personnel, and include assistance to the elderly, chronically ill, and disabled patients with activities of daily living. As of December 31, 2015, we operated 13 community-based services locations, of which 12 are wholly-owned and one is majority-owned through an equity joint venture.

We provide facility-based services principally through our LTACHs. As of December 31, 2015, we owned and operated six LTACHs with eight locations, of which all but one are located within host hospitals. We also operate a pharmacy, family health center, and family health clinic. Of these 11 facility-based services locations as of December 31, 2015, six are wholly-owned by us and five are controlled by us through equity joint ventures.

The percentage of net service revenue contributed from each reporting segment for the each of the periods ended December 31, 2015, 2014 and 2013 was as follows:

Type of Segment	2015		2014		2013	
Home health services	75.1	%	77.0	%	79.5	%
Hospice services	10.5		9.2		8.5	
Community-based services	5.1		3.8		0.5	
Facility-based services	9.3		10.0		11.5	
	100.0	%	100.0	%	100.0	%

Development Activities

The following table provides a summary of our acquisitions, divestitures and internal development activities from January 1, 2013 through December 31, 2015. This table does not include the three management services agreements under which we manage the operations of three home nursing agencies, through our home health services segment, nor does it include our pharmacy, family health center and family health clinic, through our facility-based services segment.

	Home Health Agencies	Hospice Agencies	Community-based Agencies	Long-Term Acute Care Hospitals
Total at January 1, 2013	233	32	6	9
Developed	—	—	1	—
Acquired	23	2	—	—
Divested/Merged	—	—	—	—
Total at January 1, 2014	256	34	7	9
Developed	3	1	—	—
Acquired	40	6	6	—
Divested/Merged	(22)	(3)	(1)	(1)
Total at January 1, 2015	277	38	12	8
Developed	—	2	—	—
Acquired	9	17	2	—
Divested/Merged	(6)	(1)	(1)	—
Total at December 31, 2015	280	56	13	8

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Recent Developments

Home-Based Services

When the Patient Protection and Affordable Care Act ("PPACA") was enacted in 2010, it changed a number of Medicare payment rates, including the reinstatement of the 3% home health rural add-on, which began on April 1, 2010 (expired on January 1, 2016). Other changes from PPACA that took effect on or after January 1, 2011 were:

- reduced the market basket adjustment to be determined by CMS for each of 2011, 2012 and 2013 by 1%;
- instituted a full productivity adjustment beginning in 2015; and
- re-based the base payment rate for Medicare beginning in 2014 and phasing in over a four year period.

On October 30, 2014, CMS issued a Final Rule (effective January 1, 2015) regarding payment rates for home health services provided during 2015. The net impact of all policies in the rule is a reduction in Medicare payments of 0.3%. CMS estimated that freestanding proprietary agencies would have a 0.9% reduction in Medicare reimbursement compared with 2014 levels. The final rule included the following elements:

- The national, standardized 60-day episode payment rate increased from $2,869.27 in 2014 to $2,961.38 in 2015. This is a net 3.2% increase in standardized rate, due to application of (1) a wage index budget neutrality factor (+.24%) and (2) a case mix budget neutrality factor (+3.66%) to the 2014 standard rate which is offset by a recalibration of the case mix, then subtracting the rebasing adjustment of -$80.95 (2.82% of 2014 rates), then applying the net market basket adjustment of +2.1% (Market Basket =+2.6%, Productivity Adjustment =-0.5%).
- The 2013 Office of Management and Budget ("OMB") core-based statistical area ("CBSA") designations for calculating wage indexes were adopted. The proposed rule updated the HHA wage index using a 50/50 blend of the existing CBSA designations and the new CBSA designations outlined in a February 28, 2013, Office of Management and Budget bulletin, respectively. Nationally, 37 counties shifted from urban to rural and 105 counties shifted from rural to urban.
- The face-to-face narrative requirement was eliminated. CMS will only consider medical records from the patient's certifying physician or discharging facility in determining initial eligibility for Medicare's home health benefit. Physician claims for certification/re-certification of eligibility (not the face-to-face encounter visit) will be considered a non-covered service if the HHA claim was non-covered because the patient was ineligible for the home health benefit.
- The scheduling and administration of therapy reassessments were modified to every 30 calendar days as opposed to tracking and counting therapy visits, especially for multiple-discipline therapy episodes.
- The 3% rural add-on will only apply to counties that are classified as rural under the 2013 CBSA designations. Nationally, 37 counties will shift from urban to rural and pick up the rural add-on, and 105 counties will shift from rural to urban and will lose the rural add-on, but may offset some of that loss by a positive increase in wage index.
- CMS also made several minor policy changes, which will not affect reimbursement.

On April 14, 2015, legislation was passed which limits any increase in home health payments to 1% for fiscal year 2018, and extends the 3% rural home health safeguard for two years through December 31, 2017.

On October 30, 2015, CMS released a Final Rule (effective January 1, 2016) regarding payment rates for home health services provided during calendar year 2016. The national, standardized 60-day episode payment rate will increase to $2,965.12 in 2016. The rural rate will be $3,054.07. This is a net 0.01% increase in the national, standardized 60-day episode payment rate, due to application of (1) rebasing decrease of $80.95, (2) case-mix adjustment decrease of 0.97%, (3) net market basket increase of 1.9%, (4) case-mix recalibration budget neutrality adjustment increase of 1.87%, and (5) wage index budget neutrality adjustment increase of 0.11%. The home health market basket percentage increase for 2016 is 2.3% and the multifactor productivity adjustment is 0.4% for a net home health market basket of 1.9%. CMS reduced its estimate of nominal case-mix growth between 2012 and 2014 from 3.41% to 2.88% (0.53%) and spread the adjustment over three years at 0.97% each year to account for nominal case-mix growth. The finalized

payment policies results in a 1.4% reduction in Medicare payments for all home health agencies.

In addition, CMS finalized its proposal to implement a Home Health Value-Based Purchasing ("HHVBP") program that is intended to incentivize the delivery of high-quality patient care. The HHVBP program would withhold 3% to 8% of Medicare payments, which would be redistributed to participating home health agencies depending on their performance relative to specified measures. The HHVBP would apply to all home health agencies in Arizona, Florida, Iowa, Massachusetts, Maryland, Nebraska, North Carolina, Tennessee, and Washington.

Hospice

On August 22, 2014, CMS released its Final Rule for hospice for fiscal year 2015, which increased Medicare reimbursement payments by 1.4% over fiscal year 2014. The 1.4% increase consists of a 2.9% inflationary market basket update offset by a 0.7% reduction related to the wage index changes and the sixth year of CMS's seven-year phase-out of its wage index budget neutrality adjustment

factor, a 0.5% reduction for the productivity adjustment, and a 0.3% reduction to the market basket as defined by PPACA. The following table shows the hospice Medicare payment rates for fiscal year 2014, which began on October 1, 2014 and ended September 30, 2015:

Description	Rate per patient day
Routine Home Care	$159.34
Continuous Home Care	$929.91
Full Rate = 24 hours of care	
$38.75 = hourly rate	
Inpatient Respite Care	$164.81
General Inpatient Care	$708.77

On July 31, 2015, CMS released a Final Rule that updated the Medicare hospice payment rates and wage index for fiscal year 2016, which is estimated to be an increase in payment rates of 1.1%. Beginning January, 1, 2016, CMS finalized its proposal for two routine home care rates, in a budget-neutral manner, to provide separate payment rates for the first 60 days of care and care beyond 60 days. In addition to the two routine home care rates, CMS is implementing a service intensity add-on payment that would help to promote and compensate for the provision of skilled visits at end of life. As finalized, fiscal year 2016 will be the seventh and final year of the Budget Neutrality Adjustment Factor for hospice. CMS updated the aggregate hospice cap to $27,382.63 for the cap year ending October 31, 2015 and to $27,820.75 for the 2016 cap year. CMS is also changing the hospice inpatient and aggregate cap year to coincide with the fiscal year (October 1 to September 30) beginning October 1, 2017. The following table shows the hospice Medicare payment rates for fiscal year 2016, which began on October 1, 2015 and will end September 30, 2016:

Description	Rate per patient day
Routine Home Care (October 1, 2015 through December 31, 2015)	$161.89
Routine Home Care days 1-60 (effective January 1, 2016)	$186.84
Routine Home Care days 60+ (effective January 1, 2016)	$146.83
Continuous Home Care	$944.79
Full Rate = 24 hours of care	
$39.37 = hourly rate	
Inpatient Respite Care	$167.45
General Inpatient Care	$720.11

Community-Based Services

Community-based services are in-home care services, which are primarily performed by paraprofessional personnel, and include assistance with activities of daily living to elderly, chronically ill, and disabled patients. Revenue is generated on an hourly basis. Our primary payors are TennCare Managed Care Organization and Medicaid. Approximately 82% of our net service revenue in this segment is generated in Tennessee.

Facility-Based Services

On December 26, 2013, President Obama signed into law the Bipartisan Budget Act of 2013 (Public Law 113-67). This new law prevents a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect on January 1, 2014. Included in the legislation are the following changes to LTACH reimbursement:

- Medicare discharges from LTACHs will continue to be paid at full LTACH-PPS rates if the patient spent at least three days in a short-term care hospital ("STCH") intensive care unit ("ICU") during a STCH stay that immediately preceded the LTACH stay, or

- the patient was on a ventilator for more than 96 hours in the LTACH (based on the MS-LTACH DRG assigned) and had a STCH stay immediately preceding the LTACH stay.
- Also, the LTACH discharge cannot have a principal diagnosis that is psychiatric or rehabilitation.
- All other Medicare discharges from LTACHs will be paid at a new “site neutral” rate, which is the lesser of:
- the IPPS comparable per diem amount determined using the formula in the short-stay outlier regulation at 42 C.F.R. § 412.529(d)(4) plus applicable outlier payments, or
- 100% of the estimated cost of the services involved.
- The above new payment policy will not be effective until LTACH cost reporting periods beginning on or after October 1, 2015, and the site neutral payment rate will be phased-in over two years.
- For cost reporting periods beginning on or after October 1, 2015, discharges paid at the site neutral payment rate or by a Medicare Advantage plan (Part C) will be excluded from the LTACH average length-of-stay (“ALOS”) calculation.
- For cost reporting periods beginning in fiscal year 2016 and later, CMS will notify LTACHs of their “LTACH discharge payment percentage” (i.e., the number of discharges not paid at the site neutral payment rate divided by the total number of discharges).
- For cost reporting periods beginning in fiscal year 2020 and later, LTACHs with less than 50% of their discharges paid at the full LTACH-PPS rates will be switched to payment under the IPPS for all discharges in subsequent cost reporting periods. However, CMS will set up a process for LTACHs to seek reinstatement of LTACH-PPS rates for applicable discharges.
- MedPAC will study the impact of the above changes on quality of care, use of hospice and other post-acute care settings, different types of LTACHs and growth in Medicare spending on LTACHs. MedPAC is to submit a report to Congress with any recommendations by June 30, 2019. The report is to also include MedPAC's assessment of whether the 25 Percent rule should continue to be applied.
- 25 Percent rule relief for freestanding LTACHs, HWHs and satellite facilities will be extended without interruption for cost reporting periods beginning on or after December 29, 2007. The 25 Percent rule is scheduled to become effective: (i) for freestanding LTACHs for cost reporting periods beginning on or after July 1, 2016, and (ii) for HWHs and satellite facilities for cost reporting periods beginning on or after October 1, 2016. Grandfathered HWHs will be permanently exempt from the 25 Percent rule. CMS must report to Congress by December 18, 2015 on whether the 25 Percent rule should continue to be applied.
- The moratorium on new LTACH facilities and increases in LTACH beds will be renewed for the period from April 1, 2014 to September 30, 2017. Although the introductory language only refers to a moratorium extension for LTACH bed increases, the amendment to the Medicare, Medicaid, and SCHIP Extension Act ("MMSEA") would extend both moratoriums. No exceptions will apply during this extension of the moratoriums. The original rule renewed the moratorium for the period beginning January 1, 2015; however, a provision with HR4302 accelerated the moratorium period beginning on April 1, 2014.
- Not later than October 1, 2015, CMS will establish a new functional status quality measure for change in mobility of ventilator patients.
- As part of the fiscal year 2015 or 2016 rulemaking, CMS is to study payment rates and regulations that apply to the special category of neoplastic disease LTACHs and may adjust such payment rates.

On August 4, 2014, CMS released its final rule for LTACH Medicare reimbursement for fiscal year 2015, which began on October 1, 2014 and ended on September 30, 2015. In the aggregate, payments for fiscal year 2015 increased by 1.1% over fiscal year 2014 rates. The 1.1% increase consisted of a 2.9% inflationary market basket update, offset by a 0.5% reduction for the productivity adjustment, and a 0.2% reduction to the market basket as defined by PPACA. LTACH payment rates were also reduced by approximately 1.3% for the "one-time" budget neutrality adjustment factor under the last year of a three-year phase-in and increased by 0.2% for wage index budget neutrality adjustment.

On July 31, 2015, CMS issued a Final Rule to update fiscal year 2016 payment policies and rates under the IPPS and LTACH PPS, which affects discharges occurring in cost reporting periods beginning on or after October 1, 2015.

CMS projects that LTACH PPS rates would decrease by 4.6%. This estimated decrease is preliminary attributable to the statutory decrease in payment rates for site neutral LTACH PPS cases that do not meet the clinical criteria to qualify for higher LTACH rates in cost reporting years beginning on or after October 1, 2015. Cases that do qualify for higher LTACH PPS rates will see a payment rate increase of 1.7% (based on a market basket update of 2.4% adjusted by a multi-factor productivity adjustment of -0.5 percentage point and an additional adjustment of -0.2 percentage point in accordance with the Affordable Care Act). CMS also finalized its proposal to implement a transitional blended payment rate (50% site neutral rate and 50% LTACH PPS rates) for site neutral discharges occurring in fiscal years 2016 and 2017.

On October 1, 2015, CMS ICD-10 requirements for electronic billing transactions went into effect. In preparation, we have formally trained coding staff, invested in technology system upgrades, and provided compliance education for all ICD-10 changes. At this early stage of implementation, we are not able to predict the financial impact that ICD-10 may have on our overall financial position due to the possible delays in reimbursement, underpayment for services, or possible denials of payments from payors.

None of the above described estimated changes to Medicare payments for home health, hospice and LTACHs include the deficit reduction sequester cuts to Medicare that began on April 1, 2013, which reduced Medicare payments by 2% for patients whose service dates ended on or after April 1, 2013.

2015 and 2014 Operational Data

The following table sets forth, for the period indicated, each of our segment's data regarding census, aggregate admissions, Medicare admissions, billable hours and patient days:

	Three Months Ended March 31, 2015	Three Months Ended June 30, 2015	Three Months Ended September 30, 2015	Three Months Ended December 31, 2015
Home Health Services:				
Average census	36,450	36,834	36,858	37,060
Average Medicare census	27,235	27,336	27,278	27,432
Admissions	35,965	35,211	35,772	36,249
Medicare admissions	24,875	23,862	24,114	24,060
Hospice Services:				
Average census	1,357	1,446	1,528	2,360
Average Medicare census	1,256	1,328	1,411	2,205
Admissions	1,481	1,497	1,584	2,225
Medicare admissions	1,285	1,316	1,379	1,935
Patient days	122,179	131,565	140,592	217,157
Community-based Services:				
Billable hours	294,016	316,598	318,995	307,781
LTACHs:				
Patient days	16,162	15,393	15,422	14,450
	Three Months Ended March 31, 2014	Three Months Ended June 30, 2014	Three Months Ended September 30, 2014	Three Months Ended December 31, 2014
Home Health Services:				
Average census	32,988	36,450	35,974	36,153
Average Medicare census	24,938	27,080	26,615	26,781
Admissions	30,913	33,850	33,962	34,329
Medicare admissions	21,141	22,975	22,970	23,404
Hospice Services:				
Average census	1,223	1,371	1,389	1,387
Average Medicare census	1,124	1,259	1,271	1,282
Admissions	1,232	1,426	1,476	1,412
Medicare admissions	1,065	1,267	1,272	1,252
Patient days	110,043	124,744	127,832	127,633
Community-based Services:				
Billable hours	41,064	274,234	291,301	304,618
LTACHs:				
Patient days	16,462	14,939	15,362	15,589

Consolidated Results of Operations

The following table sets forth, for the periods indicated, our consolidated results (amounts in thousands):

	Year Ended December 31,		
	2015	2014	2013
Consolidated Services Data:			
Net service revenue	$816,366	$733,632	$658,283
Cost of service revenue	480,878	434,775	383,464
Gross margin	335,488	298,857	274,819

Provision for bad debts	19,243	15,780	13,929
General and administrative expenses	248,629	233,945	213,633
Impairment of intangibles and other	1,273	3,646	520
Operating income	66,343	45,486	46,737
Interest expense	(2,302)	(2,486)	(1,995)

Non-operating income	457	265	263
Income tax expense	22,848	14,513	15,859
Income attributable to noncontrolling interests	9,315	6,915	6,804
Net income available to LHC Group, Inc.'s common stockholders.	$32,335	$21,837	$22,342

The following table sets forth our consolidated results as a percentage of net service revenue, except income tax expense, which is presented as a percentage of income attributable to LHC Group, Inc.'s common stockholders:

	Year Ended December 31,		
	2015	2014	2013
Consolidated Services Data:			
Cost of service revenue	58.9 %	59.3 %	58.3 %
Gross margin	41.1	40.7	41.7
Provision for bad debts	2.4	2.2	2.1
General and administrative expenses	30.5	31.9	32.5
Impairment of intangibles and other	0.2	0.5	0.1
Operating income	8.1	6.2	7.1
Interest expense	(0.3)	(0.3)	(0.3)
Non-operating income	0.1	—	—
Income tax expense	41.4	39.9	41.5
Income attributable to noncontrolling interests	1.1	0.9	1.0
Net income attributable to LHC Group, Inc.'s common stockholders	4.0	3.0	3.4

Year Ended December 31, 2015 Compared to Year Ended December 31, 2014

Net Service Revenue

Consolidated net service revenue for the year ended December 31, 2015 was $816.4 million compared to $733.6 million for the same period in 2014, an increase of $82.8 million, or 11.3%. Consolidated net service revenue growth in 2015 was primarily due to both our acquisitions of 28 agencies during 2015 and an increase in same store growth.

Consolidated net service revenue was comprised of the following for the periods ending December 31:

Type of Segment	2015	2014
Home health services	75.1 %	77.0 %
Hospice services	10.5	9.2
Community-based services	5.1	3.8
Facility-based services	9.3	10.0
	100.0 %	100.0 %

Revenue derived from Medicare represented 74.5% and 75.9% of our consolidated net service revenue for the years ended December 31, 2015 and 2014, respectively.

The following table sets forth each of our segment's revenue growth or loss, admissions, census, episodes and patient days for the twelve months ended December 31, 2015 and the related change from the same period in 2014 (amounts in thousands, except admissions, census, episode data and patient days):