LHC Group, Inc
Form 10-K
March 09, 2017

UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
Form 10-K
ýANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2016
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 filerý 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, 2016, the aggregate market value of the registrant's common stock held by non-affiliates of the registrant was $655.2 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 18,153,486 shares of common stock, $0.01 par value, issued and outstanding as of March 6, 2017.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's Annual Report to Stockholders for the fiscal year ended December 31, 2016 are incorporated by reference in Part II of this Annual Report on Form 10-K. Portions of the Registrant's Proxy Statement for its 2017 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, 2016;
- 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 regulatory changes under the new presidential administration;
- the effect of any changes in market rates on our operations 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;
- 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, 2016, through our wholly- and majority-owned subsidiaries, equity joint ventures and controlled affiliates, we operated in 372 service providers in 26 states within the continental United States. We operate in four segments: home health services, hospice services, community-based services, and facility-based services.

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, 2016, we operated 283 home health service locations, of which 164 are wholly-owned by us, 114 are majority-owned by us through equity joint ventures, three are under license lease arrangements, and the operations of the remaining two 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, 2016, we operated 65 hospice locations, of which 49 are wholly-owned by us, 14 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, 2016, we operated 11 locations, of which 10 are wholly-owned by us and one 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, 2016, our LTACHs had 189 licensed beds. We own and operate six LTACHs with eight locations, of which all but one are located within host hospitals. As part of our facility-based services segment, we also own and operate a pharmacy, a family health center, a family health clinic, and physical therapy clinics. Of these 13 facility-based services locations, seven are wholly-owned by us and six are majority-owned by us through equity joint ventures.

Our net service revenue by segment for the years ended December 31, 2016, 2015 and 2014 was as follows (amounts in thousands):

	Year Ended December 31,		
	2016	2015	2014
Home health services	$665,896	$613,188	$564,966
Hospice services	134,948	85,854	67,621
Community-based services	43,891	41,202	27,698
Facility-based services	70,088	76,122	73,347
Consolidated net service revenue	$914,823	$816,366	$733,632

For further information regarding the financial performance of our segments, see Note 11 to the Consolidated Financial Statements included in this Annual Report on Form 10-K.

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 continue acquiring 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 will 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, as well as other non-related facilities. We also operate a family health center, a family health clinic, and physical therapy providers that staff both facilities and outpatient clinics.

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, 2016, 2015 and 2014, 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, 2016, 267 of our 283 home health service locations and 36 of our 65 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, through our LTACHs, 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.

Equity Joint Ventures

As of December 31, 2016, we had 72 equity joint ventures including 62 with hospitals, four with physicians, and six with other parties.

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 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.

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, 2016, 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	2016 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	2016 with a 1 year automatic renewal
1	Based on net quarterly projections with an annual cap of $208,000.	None	2016 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, 2016, we had two 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 management services agreement we are reimbursed for operating expenses and receive a percentage of the operating net income of the agency. The term of these management services agreements is five years, with an option to renew for an additional five-year term. Both 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 12,416 Medicare-certified home nursing agencies in the United States in 2014. 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 Assurance & Performance Improvement

The LHC Group Quality Assurance and Performance Improvement Department, overseen 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:

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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 third party data; 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.

In December 2014, CMS introduced the Five-Star Quality Rating System to help consumers, their families, and the caregivers compare home health agencies more easily. The Five-Star Quality Rating System gives each home health agency a rating of between one and five based upon a number of quality measures associated with such agency, such as timely initiation of care, medication education provided to patients/caregivers, improvements in ambulation, bed transferring, and bathing, and acute care hospitalization, among others.

The Quality of Patient Care Start 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, we continue to strive to improve our results. As of December 31, 2016, 151 of our 283 home health agencies were rated 4 stars or greater.

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;
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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

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.

On January 4, 2017, the Office of Inspector General of the Department of Health and Human Services acknowledged that the Company had completed its Corporate Integrity Agreement requirements and the Company has since been removed from the current listing of Corporate Integrity Agreements.

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, 2016, 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, 2016, 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%, 74.5% and 75.9% of our net service revenue for the years ended

December 31, 2016, 2015 and 2014, 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 skilled 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 adjustments to ensure the adequacy and effectiveness of the total reimbursement: (a) an outlier payment if the patient's care was unusually costly; (b) a low utilization adjustment if the number of visits was fewer than five; (c) a partial payment if the patient transferred to another provider or transferred from another provider before completing the episode; (d) a payment adjustment based upon the level of therapy services required; (e) base payment adjustments for case-mix and geographic wage differences; and (f) 2% sequestration reduction for episodes beginning after March 31, 2013. 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 $2,965.12 per 60-day episode for the year ended December 31, 2016. The base payment rate does not take into consideration the 2% sequestration payment reduction 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 basis 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, 2016, we had a total of eight LTACH facilities, with 189 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 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.

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 did 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.

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 2017 Rates

On August 2, 2016, CMS released the final rule to update fiscal year 2017 LTACH reimbursement and policies under the LTACH PPS, which affects discharges occurring in cost reporting periods beginning on or after October 1, 2016. CMS projects that overall LTACH PPS spending would decrease by 7.1%, compared to fiscal year 2016 payments. This estimated decrease is 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, 2016. Cases that do qualify for higher LTACH PPS rates will see a payment rate increase of 0.7% (including a market basket update of 2.8% reduced by a multi-factor productivity adjustment of 0.3%, minus an additional adjustment of 0.75 percentage point in accordance with the PPACA, for a net market basket of 1.75%). The LTACH PPS standard federal payment rate for fiscal year 2017 is $42,476.41 (increased from $41,762.85 in fiscal year 2016). Site-neutral discharges will have a 23% reduction in payments. CMS also proposes to begin enforcement of the 25 Percent rule which will cap the number of patients treated at an LTACH who have been referred from all locations of a hospital. Grandfathered LTACH facilities are exempt from the 25 Percent rule, while rural LTACHs will have a threshold of 50% and MSA-dominant hospitals will have a threshold between 25% and 50%. The 25 Percent rule will apply to discharges occurring after October 1, 2016. CMS will have two separate outlier pools and thresholds for LTACH-appropriate patients and for site-neutral patients. For 2017, CMS finalized an increase of its fixed-loss threshold to $21,943 from 2016's $16,432, to limit outlier spending at no more than 8% of total LTACH spending (2016 outlier payments may reach 9.0%). CMS is applying the proposed inpatient fixed-loss threshold of $23,570 for site neutral patients. CMS also finalized four new measures for the LTACH Quality Reporting Program to meet the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. For the fiscal year 2018 LTACH Quality Reporting Program, CMS added quality measures for Medicare spending per beneficiary, discharge to community and potentially-preventable 30-day post-discharge readmissions. For the fiscal year 2020 LTACH Quality Reporting Program, CMS adopted a new drug regimen review measure.

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 based rates 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, 2016, our managed care contracts included 181 different payors between all of our divisions. 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, 2016, 2015 and 2014, 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.

Governmental Review, Audits and Investigations

CMS, DOJ and other federal and state agencies continue to impose intensive enforcement policies and conduct random and directed audits, reviews and investigations designed to insure compliance with applicable healthcare program participation and payment laws and regulations. As a result, we are routinely the subject of such audits, reviews and investigations.

In addition, CMS has engaged a number of third party firms, including Zone Program Integrity Contractors ("ZPICs") and Recovery Audit Contractors ("RACs") to conduct extensive reviews of claims data and state and Federal Government health care program laws and regulations applicable to healthcare providers. These audits evaluate the appropriateness of billings submitted for payment. Audit contractors identify overpayments resulting from incorrect payment amounts, non-covered services, medically unnecessary services,

incorrectly coded services, and duplicate services and are paid on a contingency basis. In addition to identifying overpayments, audit contractors can refer suspected violations of law to government enforcement authorities.

The findings of these audits, reviews and investigations may result in citations of regulatory deficiencies, sanctions and other criminal, civil, and regulatory penalties. They may also result in the refund of overpayments, a retroactive adjustment to amounts previously paid, termination from the Medicare and Medicaid programs, bars on Medicare and Medicaid payments for new admissions, and civil monetary penalties.

The Company's costs to respond to and defend any such audits, reviews and investigations could be significant and are likely to increase in the current enforcement environment. These enforcement activities and policies and resulting fines, recoupments and penalties could have a material adverse effect on our business and financial condition.

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 2016.

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, 2016.

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 2017.

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, 2016, the Joint Commission had accredited 267 of our 283 home health

agencies and 36 of our 65 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, 2016, we had 11,598 employees, of which 7,299 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, crime 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.

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.

Significant developments resulting from the recent U.S. presidential election could have a material effect on our business.

On January 30, 2017, President Trump issued an Executive Order entitled "Reducing Regulation and Controlling Regulatory Costs" that, among other things, will require federal agencies to cut two existing regulations for every new regulation they implement. The impact of any such changes to health care regulations on our financial performance and business prospects cannot be estimated at this time. It remains unclear what regulations might change, and whether any regulatory changes might affect, positively or negatively, our home health services, hospice services, community-based services, or facility-based services. Additionally, the new Executive Order also required a suspension of the implementation of any new planned regulations for a review period, which calls into question whether the implementation of changes to Conditions of Participation (CoPs) recently issued by CMS will be halted. Substantive changes to the regulations applicable to our businesses, in particular changes in compliance requirements or in reimbursement rates under Medicare, could have a material effect on our businesses and our financial performance.

Additionally, as a candidate, President Trump vowed to repeal and replace the PPACA. Significant changes to or the repeal of the PPACA could shift the U.S. health care system away from government reimbursement toward private business. It remains unclear which provisions of the PPACA will change, and whether any changes will affect our businesses or financial performance.

The appointment of Representative Tom Price as the new head of the Department of Health and Human Services (HHS) may also affect our businesses. During his confirmation hearings, Rep. Price expressed his personal opinions concerning health care priorities and the PPACA. Rep. Price spoke about the possibility of incentivizing home health care providers, if such support resulted in improved and more accessible health care for home health patients. Rep. Price has also been a vocal opponent of the home health Pre-Claim Review Demonstration, which requires the submission of documentation for affirmation of compliance with Medicare certification and coverage requirements prior to the submission of final claims for reimbursement. The Pre-Claim Review was rolled-out in Illinois on August 1, 2016, with delayed roll-out in Florida (estimated April 1, 2017), Texas, Michigan, and Massachusetts. The Pre-Claim Review has largely been criticized by the home health care industry as causing unnecessary increases in costs and errors and delays in reimbursement. With the appointment of Rep. Price to head HHS, the continued implementation of the Pre-Claim Review remains in doubt. While the future of the Pre-Claim Review process remains uncertain, the elimination or significant alteration of the Pre-Claim Review process could have a material effect on our business and financial performance.

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, 2016, 2015 and 2014, we received 74.5%, 74.5% and 75.9%, 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.

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 face reviews, audits and investigations under our contracts with federal and state government agencies and private payors, and these audits could have adverse findings that may negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits and investigations. These audits include those conducted through the recovery audit contractor program ("RAC") and the zone program integrity contractor program ("ZPIC"), 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.

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 additional costs associated with compliance with such changes.

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 effect 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 began 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 began 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, 2016, 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 may experience significant disruptions, which could impact 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. 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 position, 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, 2016, our facilities in Louisiana, Mississippi, Tennessee, Alabama, and Arkansas accounted for approximately 58.4% 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 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. 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.

We will continue to monitor the performance of our agencies on an ongoing basis, and 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 hospice agencies 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.

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 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

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 14.9% of our outstanding shares of common stock as of December 31, 2016. 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:

- staggered terms for our 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 March 1, 2017 was approximately 128,094 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.

Seven 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, 2016:

	Home health services	Hospice services	Community-based services	Facility-based services
Louisiana	40	7	—	12
Mississippi	34	9	—	—
Alabama	27	8	—	—
Tennessee	29	2	1	—
Arkansas	21	8	1	1
Kentucky	28	—	2	—
West Virginia	17	3	—	—
Georgia	8	11	—	—
Washington	10	4	1	—
Missouri	6	5	2	—
Maryland	10	—	1	—
Illinois	9	—	—	—
Texas	8	—	—	—

Idaho	4	2	—	—
North Carolina	2	1	3	—
Arizona	4	1	—	—
California	5	—	—	—

South Carolina	1	4	—	—
Colorado	4	—	—	—
Florida	4	—	—	—
Oregon	4	—	—	—
Virginia	3	—	—	—
Ohio	2	—	—	—
Oklahoma	1	—	—	—
Rhode Island	1	—	—	—
Wisconsin	1	—	—	—
	283	65	11	13

Item 3. Legal Proceedings.

We provide services in a highly regulated industry and are a party to various proceedings and regulatory and other governmental and internal audits and investigations in the ordinary course of business (including audits by Zone Program Integrity Contractors ("ZPICs") and Recovery Audit Contractors ("RACs") and investigations resulting from our obligation to self-report suspected violations of law). We cannot predict the ultimate outcome of any regulatory and other governmental and internal audits and investigations. The DOJ, CMS, or other federal and state enforcement and regulatory agencies may conduct additional investigations related to our businesses in the future. These matters could potentially subject us to sanctions, damages, recoupments, fines, and other penalties (some of which may not be covered by insurance), which may, either individually or in the aggregate, have a material adverse effect on our business and financial condition.

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 October 7, 2015, the parties entered into a Stipulation of Settlement in the consolidated case styled In re LHC Group, Inc. Derivative Litigation, Case No. 6:13-cv-02899-JTT-CBW. 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 Preliminarily 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 settlement amount, which was immediately releasable to Plaintiffs' counsel on January 11, 2016. The time for appeal has passed and no appeals were filed. This matter is now concluded. At December 31, 2015, the Company's balance sheet reflected the entire settlement in current assets as a receivable due from insurance carrier and correspondingly reflected 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 March 6, 2017, there were approximately 167 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 2016 and 2015 as quoted by NASDAQ:

	High	Low
2016		
Fourth Quarter	$45.70	$32.48
Third Quarter	46.51	34.90
Second Quarter	43.67	35.05
First Quarter	44.10	33.55
	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

The closing price of our common stock as reported by NASDAQ on March 6, 2017 was $48.86.
Performance Graph
This item is incorporated by reference from our Annual Report to Stockholders for the fiscal year ended December 31, 2016.
Issuer Purchases of Equity Securities
None.

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, 2016. The financial data for the years ended December 31, 2016, 2015 and 2014 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).

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Year Ended December 31,	2016	2015	2014	2013	2012
Consolidated Statements of Operations Data:					
Net service revenue	$914,823	$816,366	$733,632	$658,283	$637,569
Gross margin	357,173	335,488	298,857	274,819	271,817
Operating income	70,562	66,343	45,486	46,737	54,305
Income from continuing operations	45,942	41,650	28,752	29,146	35,428
Net income attributable to LHC Group, Inc.'s common stockholders	36,583	32,335	21,837	22,342	27,440
Net income attributable to LHC Group, Inc.'s common stockholders:					
Basic	$2.08	$1.86	$1.27	$1.31	$1.54
Diluted	$2.07	$1.84	$1.26	$1.30	$1.53
Weighted average shares outstanding:					
Basic	17,559,477	17,405,379	17,229,026	17,049,794	17,853,321
Diluted	17,682,820	17,547,531	17,315,333	17,132,751	17,899,195

As of December 31,	2016	2015	2014	2013	2012
Consolidated Balance Sheet Data:					
Cash	$3,264	$6,139	$531	$14,014	$9,720
Total assets	614,071	566,054	491,739	422,226	386,894
Total debt	87,796	98,784	61,008	23,212	19,500
Total LHC Group, Inc. stockholders' equity	395,126	354,582	318,639	293,009	268,181

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. Our net service revenue increased $98.4 million to $914.8 million for the year ending December 31, 2016 from $816.4 million for the year ending December 31, 2015. During 2016, we acquired 23 agencies, such that, as of December 31, 2016, we operated 372 locations in 26 states within the continental United States.

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, 2016, we operated 283 home health service locations, of which 164 are wholly-owned by us, 114 are majority-owned or controlled by us through equity joint ventures, three are controlled by us through license lease arrangements and the remaining two are only managed by us.

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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, 2016, we operated 65 hospice locations, of which 49 are wholly-owned by us, 14 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, 2016, we operated 11 community-based services locations, of which 10 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, 2016, 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, family health clinic, and physical therapy clinics. Of these 13 facility-based services locations as of December 31, 2016, seven are wholly-owned by us and six 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, 2016, 2015 and 2014 was as follows:

Type of Segment	2016	2015	2014
Home health services	72.8 %	75.1 %	77.0 %
Hospice services	14.8	10.5	9.2
Community-based services	4.8	5.1	3.8
Facility-based services	7.6	9.3	10.0
	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, 2014 through December 31, 2016. This table does not include the two management services agreements under which we manage the operations of two home nursing agencies, through our home health services segment, nor does it include our pharmacy, family health center, family health clinic, and physical therapy clinics through our facility-based services segment.

	Home Health Agencies	Hospice Agencies	Community-based Agencies	Long-Term Acute Care Hospitals
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
Developed	5	1	—	—
Acquired	12	10	1	—
Divested/Merged	(16)	(2)	(3)	—
Total at December 31, 2016	281	65	11	8

Recent Developments

Home Health Services

On April 14, 2015, legislation was passed which limits any increase in home health payments to 1% for fiscal year 2018 and extended 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 increased to $2,965.12 for 2016. The rural rate is

$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%, resulting in 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.

On October 31, 2016, CMS released a Final Rule (effective January 1, 2017) regarding payment rates for home health services provided during calendar year 2017. The national, standardized 60-day episode payment rate will increase to $2,989.97 for 2017. The rural rate is $3,079.67. The Final Rule implements the final year of the four year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment rate and the decrease of 0.97% to account for nominal case-mix growth between calendar year 2012 and calendar year 2014, which was not accounted for in the rebasing adjustments finalized in calendar year 2014. The Final Rule also contains minor adjustments to the HHVBP program and to the home health quality reporting program. CMS estimates the overall economic impact of the proposed rule's policy changes and payment rate update is an estimated aggregate decrease of 0.7% in payments to home health agencies, which decrease will vary based on each agency's wage index and patient mix weight.

Hospice

On July 31, 2015, CMS released a Final Rule that updated the Medicare hospice payment rates and wage index for fiscal year 2016, which resulted in an increase in payment rates of 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 $27,820.75 for the 2016 hospice 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 ended September 30, 2016:

Description	Rate per patient day
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

On July 29, 2016, CMS issued a final rule updating Medicare payment rates and the wage index for hospices for fiscal year 2017, which will result in 2.1% increase in payment rates. The 2.1% increase is based on 2.7% inpatient hospital market basket update, reduced by a 0.3% productivity adjustment, and a 0.3% adjustment set by the Patient Protection and Affordable Care Act ("PPACA"). The hospice cap amount for the 2017 hospice cap year will be $28,404.99. The following table shows the hospice Medicare payment rates for fiscal year 2017, which began on October 1, 2016 and

will end September 30, 2017:

Description	Rate per patient day
Routine Home Care days 1-60	$190.55
Routine Home Care days 60+	$149.82
Continuous Home Care	$964.63
Full Rate = 24 hours of care	
$40.19 = hourly rate	
Inpatient Respite Care	$170.97
General Inpatient Care	$734.94

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 80% 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 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 became effective for cost reporting periods that began 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.
- 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.

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 August 2, 2016, CMS released the final rule to update fiscal year 2017 LTACH reimbursement and policies under the LTACH PPS, which affects discharges occurring in cost reporting periods beginning on or after October 1, 2016. CMS projects that overall LTACH PPS spending would decrease by 7.1%, compared to fiscal year 2016 payments. This estimated decrease is 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, 2016. Cases that do qualify for higher LTACH PPS rates will see a payment rate increase of 0.7% (including a market basket update of 2.8% reduced by a multi-factor productivity adjustment of 0.3%, minus an additional adjustment of 0.75 percentage point in accordance with the PPACA, for a net market basket of 1.75%). The LTACH PPS standard federal payment rate for fiscal year 2017 is $42,476.41 (increased from $41,762.85 in fiscal year 2016). Site-neutral discharges will have a 23% reduction in payments. CMS also proposes to begin enforcement of the 25 Percent rule which will cap the number of patients treated at an LTACH who have been referred from all locations of a hospital. Grandfathered LTACH facilities are exempt from the 25 Percent rule, while rural LTACHs will have a threshold of 50% and MSA-dominant hospitals will have a threshold between 25% and 50%. The 25 Percent rule will apply to discharges occurring after October 1, 2016. CMS will have two separate outlier pools and thresholds for LTACH-appropriate patients and for site-neutral patients. For 2017, CMS finalized an increase of its fixed-loss threshold to $21,943 from 2016’s $16,423, to limit outlier spending at no more than 8% of total LTACH spending (2016 outlier payments may reach 9.0%). CMS is applying the proposed inpatient fixed-loss threshold of $23,570 for site neutral patients. CMS also finalized four new measures for the LTACH Quality Reporting Program to meet the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. For the fiscal year 2018 LTACH Quality Reporting Program, CMS added quality measures for Medicare spending per beneficiary, discharge to community and potentially-preventable 30-day post-discharge readmissions. For the fiscal year 2020 LTACH Quality Reporting Program, CMS adopted a new drug regimen review measure.

On December 7, 2016, Congress passed the 21st Century Cures Act ("Cures"), which boosts funding for medical research, eases the development and approval of experimental treatments and reforms federal policy on mental health care. Included in the bill was relief for LTACHs under a one year moratorium on the 25 Percent Rule, which would otherwise penalize LTACHs that admit more than 25% of their patients from a particular acute care hospital. As modified by Cures, implementation of the 25 Percent Rule will be suspended during federal fiscal year 2017 (October 1, 2016 through September 30, 2017).

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.

2016 and 2015 Operational Data

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

	Three Months Ended March 31, 2016	Three Months Ended June 30, 2016	Three Months Ended September 30, 2016	Three Months Ended December 31, 2016
Home Health Services:				
Average census	38,218	38,357	38,511	39,407
Average Medicare census	28,246	28,046	27,983	28,381
Admissions	39,124	38,949	40,657	41,184

Medicare admissions	26,136	25,817	26,810	26,812
Hospice Services:				
Average census	2,425	2,615	2,736	2,713
Average Medicare census	2,248	2,431	2,547	2,520
Admissions	2,463	2,523	2,554	2,607
Medicare admissions	2,152	2,246	2,266	2,218
Patient days	220,694	237,968	251,753	249,608
Community-based Services:				
Billable hours	304,487	330,350	354,998	349,053
LTACHs:				
Patient days	15,537	13,929	13,499	13,257

	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

Consolidated Results of Operations

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

	Year Ended December 31,		
	2016	2015	2014
Consolidated Services Data:			
Net service revenue	$914,823	$816,366	$733,632
Cost of service revenue	557,650	480,878	434,775
Gross margin	357,173	335,488	298,857
Provision for bad debts	14,790	19,243	15,780
General and administrative expenses	270,622	247,919	233,898
Impairment of intangibles and other	—	1,273	3,646
Loss on disposal of assets	1,199	710	47
Operating income	70,562	66,343	45,486
Interest expense	(2,936)	(2,302)	(2,486)
Non-operating income	492	457	265
Income tax expense	22,176	22,848	14,513
Income attributable to noncontrolling interests	9,359	9,315	6,915
Net income available to LHC Group, Inc.'s common stockholders.	$36,583	$32,335	$21,837

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,		
	2016	2015	2014
Consolidated Services Data:			
Cost of service revenue	61.0 %	58.9 %	59.3 %
Gross margin	39.0	41.1	40.7
Provision for bad debts	1.6	2.4	2.2
General and administrative expenses	29.6	30.4	31.9
Impairment of intangibles and other	—	0.2	0.5
Loss on disposal of assets	0.1	0.1	—

Operating income	7.7	8.1	6.2
Interest expense	(0.3)	(0.3)	(0.3)
Non-operating income	0.1	0.1	—

Income tax expense	37.7	41.4	39.9
Income attributable to noncontrolling interests	1.0	1.1	0.9
Net income attributable to LHC Group, Inc.'s common stockholders	4.0	4.0	3.0

Year Ended December 31, 2016 Compared to Year Ended December 31, 2015

Net Service Revenue

Consolidated net service revenue for the year ended December 31, 2016 was $914.8 million compared to $816.4 million for the same period in 2015, an increase of $98.4 million, or 12.1%. Consolidated net service revenue growth in 2016 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	2016	2015
Home health services	72.8 %	75.1 %
Hospice services	14.8	10.5
Community-based services	4.8	5.1
Facility-based services	7.6	9.3
	100.0%	100.0%

Revenue derived from Medicare represented 74.5% of our consolidated net service revenue for both years ended December 31, 2016 and 2015.

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, 2016 and the related change from the same period in 2015 (amounts in thousands, except admissions, census, episode data and patient days):

	Same Store (1)	De Novo (2)	Organic (3)	Organic Growth (Loss)%	Acquired (4)	Total	Total Growth (Loss) %
Home Health Services							
Revenue	$651,015	$1,158	$652,173	6.4 %	$13,723	$665,896	8.6 %
Revenue Medicare	$494,378	$921	$495,299	4.7	$10,775	$506,074	6.9
New admissions	156,359	159	156,518	9.3	3,396	159,914	11.7
New Medicare admissions	103,175	106	103,281	6.6	2,294	105,575	8.9
Average census	37,344	265	37,609	2.3	978	38,587	5.0
Average Medicare census	27,226	188	27,414	0.4	732	28,146	3.1
Home health episodes	195,057	303	195,360	2.2	3,875	199,235	4.2
Hospice Services							
Revenue	$95,095	$2,028	$97,123	13.1	$37,825	$134,948	57.2
Revenue Medicare	$88,852	$1,985	$90,837	13.8	$35,047	$125,884	57.7
New admissions	7,392	55	7,447	9.7	2,700	10,147	49.5
New Medicare admissions	6,493	48	6,541	10.6	2,342	8,883	50.2
Average census	1,668	68	1,736	3.6	887	2,623	56.6
Average Medicare census	1,547	66	1,613	3.9	824	2,437	57.0
Patient days	687,853	14,564	702,417	14.9	257,606	960,023	57.0
Community-based Services							
Revenue	$43,734	$—	$43,734	6.1 %	$157	$43,891	6.5 %
Billable hours	1,331,448	—	1,331,448	9.7 %	7,734	1,339,182	10.3 %
Facility-Based Services							

LTACHs						
Revenue	$64,607	$—	$64,607	(11.1)	$—	$64,607 (10.3)%
Patient days	56,224	—	56,224	(8.5)	—	56,224 (8.5)

(1) Same store - location that has been in service with us for greater than 12 months.
(2) De Novo - internally developed location that has been in service for 12 months or less.
(3) Organic - combination of same store and de novo.
(4) Acquired - purchased location that has been in service with us 12 months or less.

Total organic revenue and patient days decreased in our facility-based services segment due to the negative impact from the reduction of 18 beds in one LTACH location. In addition, patient criteria changes went into effect for two of our LTACH locations on June 1, 2016 and six of our LTACH locations on September 1, 2016. The criteria changes are reflective in our decrease of revenue per patient day.

Organic growth is primarily generated by population growth in areas covered by mature agencies and by increased market share in acquired and developing agencies. Historically, acquired agencies have the highest growth in admissions and average census in the first 24 months after acquisition, and have the highest contribution to organic growth, measured as a percentage of growth, in the second full year of operation after the acquisition.

Cost of Service Revenue

Consolidated cost of service revenue for the year ended December 31, 2016 was $557.7 million compared to $480.9 million for the same period in 2015, an increase of approximately $76.8 million, or 16.0%.

The following table summarizes cost of service revenue (amounts in thousands, except percentages, which are percentages of the segment's respective net service revenue):

	2016		2015	
Home health services				
Salaries, wages and benefits	$360,378	54.1%	$320,548	52.3%
Transportation	22,252	3.3	21,056	3.4
Supplies and services	15,820	2.4	13,146	2.1
Total	$398,450	59.8%	$354,750	57.9%
Hospice services				
Salaries, wages and benefits	$58,094	43.0%	$35,022	40.8%
Transportation	5,384	4.0	3,638	4.2
Supplies and services	19,881	14.7	12,246	14.3
Total	$83,359	61.8%	$50,906	59.3%
Community-based services				
Salaries, wages and benefits	$32,086	73.1%	$28,525	69.2%
Transportation	263	0.6	263	0.6
Supplies and services	254	0.6	288	0.7
Total	$32,603	74.3%	$29,076	70.5%
Facility-based services				
Salaries, wages and benefits	$28,802	41.1%	$29,898	39.3%
Transportation	233	0.3	240	0.3
Supplies and services	14,203	20.3	16,008	21.0
Total	$43,238	61.7%	$46,146	60.6%

Consolidated cost of service revenue variances were as follows:

- Home Health Segment -- Cost of service increased as a percentage of net service revenue due in part to 1.5% Medicare reimbursement cuts recognized in 2016. Additionally, acquisitions accounted for $7.0 million of the $76.8 million increase, with the remaining difference caused by the growth in our same store agencies.
- Hospice Segment -- Acquisitions accounted for $26.3 million of the $76.8 million increase.

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- Community-Based Services Segment -- Cost of service revenue increased as a percentage of net service revenue due to an increase in labor costs related to providing a higher level of care for our current patient mix.
- Facility-Based Services Segment -- Cost of service revenue increased as a percentage of net service revenue due to the reduction of LTACH licensed beds and lower revenue per patient day for the period caused by patient criteria changes that went into effect in June and September of 2016.

Provision for Bad Debts

Consolidated provision for bad debts for the year ended December 31, 2016 was $14.8 million, or 1.6% of net service revenue, compared to $19.2 million, or 2.4% of net service revenue, for the same period in 2015, a decrease of approximately $4.5 million, or 23.1%. The decrease in provision for bad debts was primarily due to continued process improvements in our revenue cycle department that were implemented during 2015 and improved cash collections. In addition, provisions for bad debts in 2015 was higher due to claims associated with two payors in our home health services segment and delayed payment issues related to our transition to a new billing system for our community-based services segment. These issues were resolved.

General and Administrative Expenses

Consolidated general and administrative expenses for the year ended December 31, 2016 were $270.6 million compared to $247.9 million for the same period in 2015, an increase of approximately $22.7 million, or 9.2%; however, as a percentage of net service revenue, it is a decrease of 0.8%. Of the $22.7 million increase: acquisitions accounted for $14.0 million; a severance package of $1.1 million was recorded due to the resignation of our prior Chief Financial Officer; the remainder of the increase was due to growth in our same store agencies.

The following table summarizes general and administrative expenses (amounts in thousands, except percentages, which are percentages of the segment's respective net service revenue):

	2016		2015	
Home health services				
General and administrative	$195,591	29.4%	$182,107	29.7%
Depreciation and amortization	7,827	1.1	8,484	1.4
Total	$203,418	30.5%	$190,591	31.1%
Hospice services				
General and administrative	$35,046	26.0%	$24,893	29.0%
Depreciation and amortization	2,161	1.6	1,544	1.8
Total	$37,207	27.6%	$26,437	30.8%
Community-based services				
General and administrative	$8,380	19.1%	$8,309	20.2%
Depreciation	405	0.9	156	0.4
Total	$8,785	20.0%	$8,465	20.6%
Facility-based services				
General and administrative	$19,445	27.7%	$20,657	27.1%
Depreciation and amortization	1,767	2.5	1,769	2.3
Total	$21,212	30.2%	$22,426	29.5%

Loss on disposal of assets

The loss on disposal of assets increased during the twelve months ended December 31, 2016 due to the sale of an aircraft. The aircraft incurred damage and was subsequently sold at a price below the aircraft's net book value. The sale generated a loss of $0.9 million, which was realized during the twelve months ended December 31, 2016.

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 $82.7 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 the growth or loss of each of our segment's revenue and patient statistical data for the twelve months ended December 31, 2015 and the related change for the same period in 2014 (revenue amounts are in thousands):

	Same Store (1)	De Novo (2)	Organic (3)	Organic Growth (Loss)%	Acquired (4)	Total	Total Growth (Loss) %
Home health services							
Revenue	$588,003	$2,105	$590,108	4.5 %	$23,080	$613,188	8.5 %
Revenue Medicare	$452,136	$1,542	$453,678	3.5	$19,515	$473,193	7.9
New admissions	137,041	507	137,548	3.4	5,649	143,197	7.6
New Medicare admissions	92,290	339	92,629	2.4	4,282	96,911	7.1
Average census	35,216	132	35,348	0.1	1,404	36,752	4.1
Average Medicare census	26,114	92	26,206	(0.5)	1,091	27,297	3.6
Episodes	184,774	610	185,384	1.4	5,824	191,208	4.5
Hospice services							
Revenue	$71,620	$1,809	$73,429	8.6	$12,425	$85,854	27.1
Revenue Medicare	$66,378	$1,783	$68,161	9.0	$11,685	$79,846	27.8
New admissions	5,952	46	5,998	8.2	789	6,787	22.4
New Medicare admissions	5,191	45	5,236	7.8	679	5,915	21.8
Average census	1,284	34	1,318	(1.9)	357	1,675	24.7
Average Medicare census	1,184	33	1,217	(1.5)	336	1,553	25.8
Patient days	514,496	12,440	526,936	7.5	84,557	611,493	24.7
Community-based services							
Revenue	$31,797	$180	$31,977	15.4	$9,225	$41,202	48.8
Billable hours	947,395	5,844	953,239	4.6	260,630	1,213,869	33.2
Facility-based services							
LTACHs							
Revenue	$72,668	$—	$72,668	—	$—	$72,668	3.2
Patient days	61,427	—	61,427	—	—	61,427	(1.5)

(1) Same store - location that has been in service with us for greater than 12 months.
(2) De Novo - internally developed location that has been in service for 12 months or less.
(3) Organic - combination of same store and de novo.
(4) Acquired - purchased location that has been in service with us 12 months or less.

Organic growth is primarily generated by population growth in areas covered by mature agencies and by increased market share in acquired and developing agencies. Historically, acquired agencies have the highest growth in admissions and average census in the first

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24 months after acquisition, and have the highest contribution to organic growth, measured as a percentage of growth, in the second full year of operation after the acquisition.

Cost of Service Revenue

Consolidated cost of service revenue for the year ended December 31, 2015 was $480.9 million compared to $434.8 million for the same period in 2014, an increase of $46.1 million, or 10.6%; however, as a percentage of net service revenue, it was a decrease of 0.4%. Of the $46.1 million increase, acquisitions purchased during 2015 accounted for $8.7 million. The remainder of the increase was due to the accretion of same store agencies. The following table summarizes cost of service revenue (amounts in thousands, except percentages, which are percentages of the segment's respective net service revenue):

	2015		2014	
Home health services				
Salaries, wages and benefits	$320,548	52.3%	$295,340	52.3%
Transportation	21,056	3.4	21,463	3.8
Supplies and services	13,146	2.1	13,053	2.3
Total	$354,750	57.9%	$329,856	58.4%
Hospice services				
Salaries, wages and benefits	$35,022	40.8%	$27,263	40.3%
Transportation	3,638	4.2	3,027	4.5
Supplies and services	12,246	14.3	9,514	14.1
Total	$50,906	59.3%	$39,804	58.9%
Community-based services				
Salaries, wages and benefits	$28,525	69.2%	19,287	69.6%
Transportation	263	0.6	170	0.6
Supplies and services	288	0.7	154	0.6
Total	$29,076	70.5%	$19,611	70.8%
Facility-based services				
Salaries, wages and benefits	$29,898	39.3%	$30,047	41.0%
Transportation	240	0.3	281	0.4
Supplies and services	16,008	21.0	15,176	20.7
Total	$46,146	60.6%	$45,504	62.0%

Provision For Bad Debts

Consolidated provision for bad debts for the year ended December 31, 2015 was $19.2 million compared to $15.8 million for the same period in 2014, an increase of $3.4 million, or 21.5%. Provision for bad debts increased in the home health services segment due to additional reserves being recorded for patient claims related to prior period patient care associated with commercial payors. Accounts receivable that are aged over 365 days increased during the period by $4.5 million. For home health services and facility-based services, an increase of $2.1 million was due to the continued backlog of Medicare Administrative Contractor audit claims awaiting appeal hearing. Appeals have historically experienced a substantial success rate in claim recovery. In addition, aged account receivable in our home health services increased by $0.8 million due to a legacy system transition for prior year acquisitions.

General and Administrative Expenses

Consolidated general and administrative expenses for the year ended December 31, 2015 was $247.9 million compared to $233.9 million for the same period in 2014, an increase of $14.0 million, or 6.0%; however, as a percentage of net service revenue, it is a decrease of 1.5%. The following table summarizes general and administrative expenses (amounts in thousands, except percentages, which are percentages of the segment's respective net service revenue):

	2015		2014	
Home health services				
General and administrative	$182,107	29.7%	$180,363	31.9%
Depreciation and amortization	8,484	1.4	6,917	1.2

Total	$190,591	31.1%	$187,280	33.1%
Hospice services				

General and administrative	$24,893	29.0%	$17,789	26.3%
Depreciation and amortization	1,544	1.8	1,086	1.6
Total	$26,437	30.8%	$18,875	27.9%
Community-based services				
General and administrative	$8,309	20.2%	$6,445	23.3%
Depreciation and amortization	156	0.4	106	0.4
Total	$8,465	20.6%	$6,551	23.7%
Facility-based services				
General and administrative	$20,657	27.1%	$19,730	26.9%
Depreciation and amortization	1,769	2.3	1,462	2.0
Total	$22,426	29.5%	$21,192	28.9%

For home health services, hospice services, and community-based services, $6.9 million of the increase was from agencies acquired during 2015. The remainder of the increase was due to growth in our same store agencies. This increase was partially offset with savings associated with prior year closures of underperforming providers. For the facility-based services segment, general and administrative expenses increased due to the implementation of management roles in sales and administrative support staff.

Depreciation and amortization expense increased in the home health services segment and hospice services segment due to the capitalization of point of care licenses. In 2014, we successfully completed the roll out of our point of care technology. These licenses are amortized over their estimated useful life of 36 months. Depreciation in the facility-based services segment increased due to the purchase of patient care equipment, which occurred during the latter part of 2014.

Prior to 2015, the Company's principal executive offices were located in three properties. During 2015, the Company consolidated its corporate headquarters into one property. Depreciation expense associated with leasehold improvements and office furniture in the original three properties was accelerated during 2015 as the Company terminated these leases and disposed of the assets; the depreciation expense related to this was $1.3 million.

Impairment of intangibles and other

Consolidated impairment of intangibles and other for the year ended December 31, 2015 was $1.3 million compared to $3.6 million for the same period in 2014. During 2015, goodwill and other intangible asset disposal costs for underperforming providers that were closed was $0.7 million and as other intangible asset impairment of $0.6 million in the home health segment was recorded. In 2014, goodwill and other intangible asset disposal costs for closures were $1.6 million. In addition, there was $2.0 million related to the impairment of intangible trade names in the home-health segment.

Net Income Attributable to Noncontrolling Interest

Consolidated net income attributable to noncontrolling interest represents the minority owners' allocable share of income in the equity joint venture partners. For the year ended December 31, 2015, noncontrolling interest was $9.3 million compared to $6.9 million for the same period in 2014, an increase of approximately $2.4 million, or 34.8%. Noncontrolling interest increased due to the overall growth in same store agencies, and overall operational efficiencies gained through the joint ventures' use of our point of care platform.

Liquidity and Capital Resources

Cash at December 31, 2016 was $3.3 million, compared to $6.1 million at December 31, 2015. Based on our current plan of operations, including acquisitions, we believe this amount, 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.

Liquidity

Our principal source of liquidity needed to fund our operating activities is the collection of patient accounts receivable, most of which are collected from governmental and third-party commercial payors. We also have the ability to obtain additional liquidity, if necessary, through our revolving credit facility, which provides for aggregate borrowings, including outstanding letters of credit, up to $225 million.

Our reported cash flows are affected by various external and internal factors, including the following:

- Operating Results – Our net income has a significant effect on our operating cash flows. Any significant increase or decrease in our net income could have a material effect on our operating cash flows.

- Timing of Acquisitions – We use a portion of our operating and/or financing cash flows for acquisitions. When the acquisitions occur at or near the end of a period, our cash outflows significantly increase.

- Timing of Payroll – Our employees are paid bi-weekly on Fridays. Operating cash outflows increase in reporting periods that end on a Friday.

- Self Insurance Plan Funding – We are self-funded for health insurance and workers compensation insurance. Any significant changes in the amount of insurance claims submitted could have a direct effect on our operating cash flows.

Cash used in investing activities primarily relates to acquisitions of home nursing and hospice agencies, while cash used by financing activities primarily relates to payments on outstanding debt agreements and payments to our noncontrolling interest partners.

The following table summarizes changes in cash flows (amounts in thousands):

	Year Ended December 31,	
	2016	2015
Net cash provided by (used in):		
Operating activities	$ 67,472	$ 59,934
Investing activities	(50,380)	(83,855)
Financing activities	(19,967)	29,529

Cash provided by operating activities changed due to acquisitions purchased in 2016 and the accretion of agencies purchased in 2015.

Cash used in investing activities and financing activities changed due to the difference in volume of acquisition activity occurring between 2016 and 2015. We paid $34.6 million for acquisitions in 2016 compared to $70.6 million for acquisitions in 2015. The acquisition activity in 2015 caused us to draw more on our line of credit compared to 2016.

Credit Facility

Our revolving credit facility with Capital One, National Association is unsecured and provides for a maximum aggregate principal borrowing of $225 million (with a letter of credit sub-limit equal to $15 million), and is scheduled to expire on June 18, 2019. We are required to pay a commitment fee for the unused commitments at rates ranging from 0.225% to 0.375% per annum depending upon the Company's consolidated Leverage Ratio, as defined in the Credit Agreement.

A letter of credit fee equal to the applicable Eurodollar rate multiplied by the face amount of the letter of credit is charged upon issuance and on each anniversary date while the letter of credit is outstanding. The agent’s standard up-front fee and other customary administrative charges are also due upon issuance of the letter of credit, along with a renewal fee on each anniversary date while the letter of credit is outstanding. At December 31, 2016 and 2015, outstanding letters of credit were $11.0 million and $9.8 million, respectively, which are issued as collateral on our workers’ compensation insurance.

Borrowings accrue interest under the Credit Agreement at either the Base Rate or Eurodollar rate are subject to the applicable margins as set forth below:

Leverage Ratio	Eurodollar Margin	Base Rate Margin	Commitment Fee Rate
≤ 1.00:1.00	1.75 %	0.75 %	0.225 %
>1.00:1.00 ≤ 1.50:100	2.00 %	1.00 %	0.250 %
>1.50:1.00 ≤ 2.00:1.00	2.25 %	1.25 %	0.300 %

>2.00:1.00	2.50 %	1.50 %	0.375 %

Our Credit Agreement contains customary affirmative, negative and financial covenants. For example, without prior approval of our bank group, we are restricted in incurring additional debt, disposing of assets, making investments, allowing fundamental changes to our business or organization and making certain payments in respect of stock or other ownership interests, such as dividends and stock repurchases, up to $50.0 million. Under our Credit Agreement, we are also required to meet certain financial covenants with respect to minimum fixed charge coverage and leverage ratios.

Our Credit Agreement contains customary events of default, including bankruptcy and other insolvency events, cross-defaults to other debt agreements, a change in control involving us or any subsidiary guarantor and the failure to comply with certain covenants.

At December 31, 2016, we were in compliance with all covenants contained in the Credit Agreement governing our credit facility.

Contractual Obligations

The following table discloses aggregate information about our contractual obligations and the periods in which payments are due as of December 31, 2016 (amounts in thousands):

	Payment Due by Period				
Contractual Cash Obligation	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
Long-term debt	$87,796	$ 252	$87,544	$ —	$ —
Operating leases	51,276	17,785	19,056	8,808	5,627
Total contractual cash obligations	$139,072	$ 18,037	$106,600	$ 8,808	$ 5,627

Off-Balance Sheet Arrangements

We currently do not have any off-balance sheet arrangements with unconsolidated entities, financial partnerships or entities often referred to as structured finance or special purpose entities, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. In addition, we do not engage in trading activities involving non-exchange traded contracts. As such, we are not materially exposed to any financing, liquidity, market or credit risk that could arise if we had engaged in these relationships.

Recently Issued Accounting Pronouncements

For a discussion of recently issued accounting pronouncements, see Note 2 of the Notes to Condensed Consolidated Financial Statements, which is incorporated herein by reference.

Critical Accounting Policies

The following discussions describe our critical accounting policies, which we believe require the most significant judgments and estimates used in the preparation of our consolidated financial statements.

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported revenue and expenses during the reporting period. Changes in the accounting estimates are reasonably likely to occur from period to period. Accordingly, actual results could differ materially from our estimates. To the extent that there are material differences between these estimates and actual results, our financial condition or results of operations will be affected. We base our estimates on past experience and other assumptions that we believe are reasonable under the circumstances and we evaluate these estimates on an ongoing basis.

Principles of Consolidation

The consolidated financial statements include all subsidiaries and entities controlled by us through our direct ownership of a majority interest or controlling member ownership of such entities. The consolidated financial statements include entities in which we have the obligation to absorb losses of the entities or the right to receive benefits from the entities and have voting control over the entities or both, as a result of ownership, contractual or other financial interests in the entities.

The following table summarizes the percentage of net service revenue earned by type of ownership or relationship we had with the operating entity:

Ownership type	2016	2015	2014
Wholly owned subsidiaries	57.2 %	55.2 %	53.5 %
Equity joint ventures	41.2	42.9	43.9

Other	1.6	1.9	2.6
	100.0%	100.0%	100.0%

All significant inter-company accounts and transactions have been eliminated in consolidation. Business combinations accounted for as purchases have been included in the consolidated financial statements from the respective dates of acquisition.

Equity Joint Ventures

Our equity joint ventures are structured as limited liability companies in which we typically own a majority equity interest ranging from 51% to 91%. Each member of all but one of our equity joint ventures participates in profits and losses in proportion to their equity interests. We have one equity joint venture partner whose participation in losses is limited; otherwise, earnings and losses are based on ownership interest. We consolidate these entities as we have voting control over the entities.

Other (License Leasing Arrangements and Management Services)

Through our wholly owned subsidiaries, we lease home health licenses necessary to operate certain of our home nursing agencies. We own 100% of the equity of these entities and consolidate them based on such ownership, as well as our obligation to absorb losses of the entities and the right to receive benefits from the entities.

We have various management services agreements under which we manage certain operations of agencies and facilities. We do not consolidate these agencies or facilities, as we do not have an ownership interest and do not have an obligation to absorb losses of the entities or the right to receive the benefits from the entities other than our management fee.

Revenue Recognition

For a detailed discussion of revenue recognition, see Item 1, which is incorporated here by reference.

We report net service revenue at the estimated net realizable amount due from Medicare, Medicaid, commercial insurance, managed care payors, patients and others for services rendered. All payors contribute to the home health services, hospice services, community-based services and facility-based services.

The following table sets forth the percentage of net service revenue earned by category of payor for the respective years ending December 31:

Payor	2016	2015	2014
Medicare	74.5 %	74.5 %	75.9 %
Medicaid	1.8	1.5	1.4
Other	23.7	24.0	22.7
	100.0%	100.0%	100.0%

Medicare

Home Health Services

The Company’s home nursing Medicare patients are classified into one of 153 home health resource groups prior to receiving services. Based on this home health resource group, we are entitled to receive a standard prospective Medicare payment for delivering care over a 60-day period referred to as an episode. We recognize revenue based on the number of days elapsed during an episode of care within the reporting period.

Final payments from Medicare may reflect adjustments to ensure the adequacy and effectiveness of the total reimbursement: (a) an outlier payment if the patient’s care was unusually costly; (b) a low utilization adjustment if the number of visits was fewer than five; (c) a partial payment if the patient transferred to another provider or transferred from another provider before completing the episode; (d) a payment adjustment based upon the level of therapy services required; (e) base payment adjustments for case-mix and geographic wage differences; and (f) 2% sequestration reduction for episodes beginning after March 31, 2013. Management estimates the adjustments outlined above based on historical experience and as changes become known, and records these adjustments during the period in which the services are provided to the patient. Net service revenue and related patient accounts receivable are recorded at amounts estimated to be realized from Medicare for services rendered.

Hospice Services

We are paid by Medicare under a per diem payment system. We receive one of four predetermined daily or hourly rates based upon the level of care the Company furnished. We record net service revenue from hospice services based on the daily or hourly rate and recognizes revenue as hospice services are provided.

Hospice payments are subject to an inpatient cap and an overall Medicare payment cap. The inpatient cap relates to individual programs receiving more than 20% of its total Medicare reimbursement from inpatient care services and the

overall Medicare payment cap relates to individual programs receiving reimbursements in excess of a “cap amount,” calculated by multiplying the number of beneficiaries during the period by a statutory amount that is indexed for inflation. The determination for each cap is made annually based on the 12 -month period ending on October 31 of each year. We monitor its limits on a provider-by-provider basis and record an estimate of its

liability for reimbursements received in excess of the cap amount. Annually, we receive notification of whether any of our hospice providers have exceeded either cap. Beginning with cap year October 1, 2014, CMS implemented a new process requiring hospice providers to self-report their cap liabilities and remit applicable payment by March 31 of the following year.

Facility-Based Services

Long-Term Acute Care Services. We are reimbursed by Medicare for services provided under the LTACH-PPS, which was implemented on October 1, 2002. Each patient is assigned a long-term care diagnosis-related group. We are paid a predetermined fixed amount intended to reflect the average cost of treating a Medicare patient classified in that particular long-term care diagnosis-related group. For selected patients, the amount may be further adjusted based on length-of-stay and facility-specific costs, as well as in instances where a patient is discharged and subsequently re-admitted, among other factors. We calculate the adjustment based on a historical average of these types of adjustments for claims paid. Similar to other Medicare prospective payment systems, the rate is also adjusted for geographic wage differences. Revenue is recognized for our LTACHs as services are provided.

Medicaid, managed care and other payors

Our Medicaid reimbursement is based on a predetermined fee schedule applied to each service provided. Therefore, revenue is recognized for Medicaid services as services are provided based on this fee schedule. Our managed care payors and other payors reimburse us, and we recognize revenue, in a manner similar to our Medicare and Medicaid reimbursements.

Management Services

We record management services revenue as services are provided in accordance with the various management services agreements to which we are a party. As described in the agreements, we provide billing, management and other consulting services suited to and designed for the efficient operation of the applicable home nursing agency. We are responsible for the costs associated with the locations and personnel required for the provision of services. We are compensated based on a percentage of cash collections for one management services agreement and reimbursed for operating expenses plus a percentage of operating net income for the remaining management services agreement.

Income Tax

We operate in numerous tax jurisdictions and recognize income tax expense based on the revenue and expenses earned in those jurisdictions, which requires us to apportion and allocate revenue and expenses in all taxable jurisdictions. During 2011, we entered into a settlement with the United States of America which we believe is fully deductible for income tax purposes. As of December 31, 2016, $1.3 million was recorded in income tax payable as an unrecognized tax benefit which, if recognized, would decrease the our effective tax rate. All of the unrecognized tax benefit is due to the settlement with the United States of America, which was announced September 30, 2011. On July 31, 2014, the Internal Revenue Service ("IRS") issued a notice of proposed adjustment asserting that a portion of the original tax deduction claimed by us associated with the settlement of the United States of America should be disallowed. In December 2016, we signed a final settlement offer from the IRS that reduced the unrecognized tax benefit from $3.4 million to $1.3 million. We received approval from Joint Committee Review in February 2017 to finalize the settlement. Due to the approval being received subsequent to year-end, we continue to show the amount as an uncertain tax position as of December 31, 2016.

Accounts Receivable and Allowances for Uncollectible Accounts

We report accounts receivable net of estimated allowances for uncollectible accounts and adjustments. Accounts receivable are uncollateralized and primarily consist of amounts due from Medicare, other third-party payors and patients. To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for uncollectible accounts to reduce the carrying amount of such receivables to their estimated net realizable value. The amount of the provision for uncollectible accounts is based upon our assessment of historical and expected net collections, business and economic conditions and trends in government reimbursement. Uncollectible accounts are written off after exhausting collection efforts and we have concluded that the account will not be collected. Because Medicare is our primary payor, the credit risk associated with receivables from other payors is limited. We believe the credit risk associated with our Medicare accounts, which represent over 60% of our patient accounts receivable at December 31, 2016 and 2015, respectively, is limited due to (a) our historical collections experience with Medicare

and (b) the fact that Medicare is a U.S. government payor. We do not believe that there are any other significant concentrations of receivables from any particular payor that would subject it to any significant credit risk in the collection of accounts receivable.

A portion of the estimated Medicare prospective payment system reimbursement from each submitted home nursing episode is received in the form of a request for anticipated payment ("RAP"). We submit a RAP for 60% of the estimated reimbursement for the initial episode at the start of care. The full amount of the episode is billed after the episode has been completed. The RAP received for that particular episode is deducted from the final payment. If a final bill is not submitted within the greater of 120 days from the start of the episode, or 60 days from the date the RAP was paid, any RAPs received for that episode will be recouped by Medicare from any other Medicare claims in process for that particular provider. The RAP and final claim must then be resubmitted. For subsequent episodes of care contiguous with the first episode for a particular patient, we submit a RAP for 50% instead of 60% of the estimated reimbursement.

Our Medicare population is paid at a prospectively set amount that can be determined at the time services are rendered. Our Medicaid reimbursement is based on a predetermined fee schedule applied to each individual service we provide. Our managed care contracts are structured similar to the Medicare and Medicaid payment methodologies. Because of our payor mix, we are able to more accurately calculate our actual amount due at the patient level and adjust the gross charges to the actual amount at the time of billing. This negates the need to record an estimated allowance for uncollectible accounts, similar to a contractual adjustment, when reporting the majority of our net service revenue for each reporting period.

At December 31, 2016, our allowance for uncollectible accounts, as a percentage of patient accounts receivable, was approximately 18.9%, or $29.0 million, compared to 19.5%, or $26.7 million, at December 31, 2015. Accounts Receivable days sales outstanding ("DSO") for the year ended December 31, 2016 was 49 days compared to 46 days for the same period in 2015. Increased accounts receivable from acquisitions, an increase in managed care accounts receivable, and collection delays resulting from reviews, audits and investigations from ZPICs, RACs, and additional development requests have each contributed to the increase in days sales outstanding.

The following table sets forth, as of December 31, 2016, the aging of accounts receivable (based on the end of episode date) (amounts in thousands):

Payor	0-90	91-180	181-365	Over 365	Total
Medicare	$71,386	$9,590	$5,547	$5,720	$92,243
Medicaid	4,600	1,470	1,380	268	7,718
Other	33,084	5,943	7,179	7,672	53,878
Total	$109,070	$17,003	$14,106	$13,660	$153,839

For home health services, hospice services, and community-based services, we calculate the allowance for uncollectible accounts as a percentage of total patient receivables. The percentage changes depending on the payor and increases as the patient receivables age. For facility-based services, we calculate the allowance for uncollectible accounts based on a claim by claim review.

The following table sets forth, as of December 31, 2015, the aging of accounts receivable (based on the end of episode date) (amounts in thousands):

Payor	0-90	91-180	181-365	Over 365	Total
Medicare	$65,910	$8,244	$4,971	$4,960	$84,085
Medicaid	2,994	1,033	903	561	5,491
Other	26,794	7,248	7,699	5,745	47,486
Total	$95,698	$16,525	$13,573	$11,266	$137,062

The following table summarizes the activity and ending balances in the allowance for uncollectible accounts (amounts in thousands):

	Beginning of Year Balance	Additions	Deductions	End of Year Balance
Year ended December 31:				
2016	$ 26,712	$ 14,790	$ 12,466	$ 29,036
2015	18,582	19,243	11,113	26,712
2014	14,334	15,780	11,532	18,582

Goodwill and Intangible Assets

We have a significant amount of goodwill on our balance sheet that resulted from the numerous business acquisitions we have made in prior years. We review goodwill and other intangible assets with indefinite lives annually for impairment or more frequently if circumstances indicate impairment may have occurred. We evaluate goodwill for impairment by comparing the current fair value of each of our reporting units to their carrying value, including goodwill. Our business is comprised of four reporting units: home health, hospice, community-based, and LTACH. To

the extent the carrying value of a reporting unit exceeds the fair value of the reporting unit, the Company would be required to perform the second step of the impairment test. Our impairment analysis is performed on November 30th of each year.

We performed a qualitative assessment to determine if it is more likely than not that the fair value of the reporting units are less than its carrying value. We evaluated relevant events and circumstances, such as market conditions, financial performance, and share price to determine if any goodwill impairment is indicated. Based on our analysis, an impairment of goodwill was not indicated.

We have not recognized any goodwill impairment charges in 2016, 2015 or 2014 related to the annual impairment testing.

Included in intangible assets are definite-lived assets subject to amortization such as software licenses, non-compete agreements and defensive assets, which are defined as trade names that are not actively used. Amortization of the definite-lived intangible assets is calculated on a straight-line basis over the estimated useful lives of the related assets. Non-compete agreements are amortized over the life of the agreement, usually ranging from one to three years.

We also have indefinite-lived assets that are not subject to amortization expense such as actively used trade names, certificates of need and licenses to conduct specific operations within geographic markets. Such trade names, certificates of need and licenses have indefinite lives because there are no legal, regulatory, contractual, economic or other factors that would limit the useful life of these intangible assets and we intend to renew and operate the certificates of need and licenses and use these trade names indefinitely. These indefinite-lived intangibles are reviewed annually for impairment or more frequently if circumstances indicate impairment may have occurred. To determine whether an indefinite-lived intangible asset is impaired, we perform a qualitative assessment to support the conclusion that the indefinite-lived intangible asset is not impaired. Based on the results of that qualitative assessment, we may perform a quantitative test. The quantitative impairment test on trade names uses the relief-from-royalty method. Under this method, the fair value of the trade name is determined by calculating the present value of the after-tax cost savings associated with owning the trade names and, therefore, not having to pay royalties for use over its estimated useful life. The quantitative impairment test for certificates of need and licenses applies the cost approach. Under this method, assumptions are made about the cost to replace the certificates of need and licenses. Based on our analysis, there were no indicators that any other intangible assets were impaired and no impairment charge was recorded for the year ended December 31, 2016. We did record impairment charges of $0.6 million and $2.0 million for the twelve months ended December 31, 2015 and 2014, respectively.

Self Insurance Reserves

We maintain insurance programs, which include employee health insurance and workers' compensation. Our employee health insurance program is self-funded, with stop-loss coverage on claims that exceed $0.2 million for any individually covered employee or employee family member. We are responsible for workers' compensation claims up to $0.5 million per individual incident. The self insurance reserve payable reflects the current estimate of incurred but not reported losses, historical claims experience, and expected costs to settle unpaid claims. We record amounts due from insurance policies in other current assets while recording the estimated liability in self insurance reserves.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

Our exposure to market risk relates to fluctuations in interest rates from borrowings under the credit facility. Our letter of credit fees and interest accrued on our debt borrowings are subject to the applicable Eurodollar rate or Base Rate. A hypothetical 100 basis point increase in interest rates on the average daily amounts outstanding under the credit facility would have increased interest expense by $1.6 million and $0.6 million for the years ended December 31, 2016 and 2015, respectively.

Item 8. Financial Statements and Supplementary Data.

The consolidated financial statements and financial statement schedules in Part IV, Item 15 of this Annual Report on Form 10-K are incorporated by reference into this Item 8.

Item 9. Changes In and Disagreements with Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Disclosure Controls and Procedures.

Evaluation of Disclosure Control and Procedures

The Company maintains disclosure controls and procedures that are designed to ensure that information required to be disclosed by the Company in the reports we file or submit under the Exchange Act is recorded, processed,

summarized and reported within the time periods specified in the SEC's rules and forms, and that such information is accumulated and communicated to the Company's

management, including its Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosure.

Under the supervision and with the participation of the Company's Chief Executive Officer and Chief Financial Officer, the Company's management evaluated the effectiveness of the Company's disclosure controls and procedures as of December 31, 2016. Based on that evaluation, the Company's Chief Executive Officer and its Chief Financial Officer concluded that the Company's disclosure controls and procedures (as such term is defined under Rule 13a-15(e) promulgated of the Exchange Act) were effective as of December 31, 2016.

Management's Annual Report on Internal Control Over Financial Reporting

The Company's management is responsible for establishing and maintaining adequate internal control over financial reporting, as that term is defined in Rule 13a-15(f) of the Exchange Act. Under the supervision and with the participation of the Company's Chief Executive Officer and Chief Financial Officer, the Company's management conducted an evaluation of its internal control over financial reporting based on the framework in Internal Control – Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Based on management's testing and evaluation under the framework in Internal Control – Integrated Framework (2013), management concluded that our internal control over financial reporting was effective as of December 31, 2016.

The attestation report of KPMG LLP, the independent registered public accounting firm that audited the financial statements included in this Annual Report on Form 10-K, is included herein.

Changes in Internal Control Over Financial Reporting

There have not been any changes in the Company's internal control over financial reporting, as such term is defined in Rule 13a-15(f) of the Exchange Act, during the Company's fiscal quarter ended December 31, 2016 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders

LHC Group, Inc.:

We have audited LHC Group, Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control – Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). LHC Group, Inc.'s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Annual Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, LHC Group, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control – Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of LHC Group, Inc. and subsidiaries as of December 31, 2016 and 2015, and the related consolidated statements of income, changes in equity, and cash flows for each of the years in the three-year period ended December 31, 2016, and our report dated March 9, 2017 expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP

Baton Rouge, Louisiana

March 9, 2017

Item 9B. Other Matters.
None noted.

PART
III

Item 10. Directors, Executive Officers and Corporate Governance.

The information required by this Item regarding our directors and executive officers is incorporated by reference from the information contained under the heading “Information About Directors, Nominees and Management” in the definitive Proxy Statement relating to the Company’s 2017 Annual Meeting of Stockholders.

The information required by this Item regarding compliance with Section 16(a) of the Exchange Act is incorporated by reference from the information contained under the heading “Section 16(a) Beneficial Ownership Reporting Compliance” in the definitive Proxy Statement relating to the Company’s 2017 Annual Meeting of Stockholders.

The information required by this Item regarding our corporate governance Nominating Committee and Audit Committee is incorporated by reference from the information contained under the heading “The Board of Directors and Corporate Governance” in the definitive Proxy Statement relating to the Company’s 2017 Annual Meeting of Stockholders.

Code of Conduct and Ethics

We have adopted a code of ethics that applies to all of our directors, officers and employees. This code is publicly available in the investor relations area of our website at www.lhcgroup.com. Any substantive amendments to this code, or any waivers granted for any directors or executive officers, including our principal executive officer, principal financial officer, principal accounting officer or controller, will be disclosed on our website and remain available there for at least 12 months. This code of ethics is not incorporated in this report by reference. Copies of our code of ethics will also be provided, without charge, upon written request to Investor Relations at LHC Group, Inc., 901 Hugh Wallis Road South, Lafayette, Louisiana, 70508.

Item 11. Executive Compensation.

The information required by this Item regarding our executive compensation and Compensation Committee is incorporated by reference from the information contained under the heading “Executive Officer Compensation” in the definitive Proxy Statement relating to the Company’s 2017 Annual Meeting of Stockholders.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

The information required by this Item regarding our securities authorized for issuance under equity compensation plans and security ownership of certain beneficial owners and management is incorporated by reference from the information contained under the headings “Security Ownership of Certain Beneficial Owners and Management” in the definitive Proxy Statement relating to the Company’s 2017 Annual Meeting of Stockholders.

Equity Compensation Plan Information

The following table provides information as of December 31, 2016, regarding shares of common stock that may be issued under the Company's existing equity compensation plans:

Plan Category	(a) Number of Shares to be Issued Upon Exercise of Outstanding Options, Warrants, and Rights	(b) Weighted-Average Exercise Price of Outstanding Price of Outstanding Rights	(c) Number of Shares Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column a) (1)
	—	$ —	666,740

Equity compensation plans approved by Stockholders:			
Equity compensation plans not approved by Stockholders:	—	—	—
Total	—	$	— 666,740

(1) Includes 477,129 shares remaining available for issuance under the LHC Group, Inc. 2010 Long-Term Incentive Plan (all of which are available for issuance pursuant to grants of full-value stock awards) and 189,611 shares remaining available for issuance under the Amended and Restated LHC Group, Inc.'s 2006 Employee Stock Purchase Plan.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

The information required by this Item regarding transactions with related persons is incorporated by reference from the information contained under the heading “Certain Relationships and Related Transactions” in the definitive Proxy Statement relating to the Company’s 2017 Annual Meeting of Stockholders.

Item 14. Principal Accounting Fees and Services.

The information required by this Item regarding accounting and audit fees is incorporated by reference from the information contained under the heading “Principal Accounting Fees and Services” in the definitive Proxy Statement relating to the Company’s 2017 Annual Meeting of Stockholders.

PART
IV

Item 15. Exhibits, Financial Statement Schedules.
(a) Documents to be filed with Form 10-K:
(1) Financial Statements

(2) Financial Statement Schedules
There are no financial statement schedules included in this report.
(3) Exhibits
The Exhibits are listed in the Index of Exhibits required by Item 601 of Regulation S-K included herewith, which is incorporated by reference.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders

LHC Group, Inc.:

We have audited the accompanying consolidated balance sheets of LHC Group, Inc. and subsidiaries as of December 31, 2016 and 2015, and the related consolidated statements of income, changes in equity, and cash flows for each of the years in three-year period ended December 31, 2016. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of LHC Group, Inc. and subsidiaries as of December 31, 2016 and 2015, and the results of their operations and their cash flows for each of the years in three-year period ended December 31, 2016, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), LHC Group, Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control – Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated March 9, 2017 expressed an unqualified opinion on the effectiveness of the LHC Group, Inc.'s internal control over financial reporting.

/s/ KPMG LLP

Baton Rouge, Louisiana

March 9, 2017

LHC GROUP, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(Amounts in thousands, except share data)

	As of December 31,	
	2016	2015
ASSETS		
Current assets:		
Cash	$3,264	$6,139
Receivables:		
Patient accounts receivable, less allowance for uncollectible accounts of $29,036 and $26,712, respectively	124,803	110,350
Other receivables	5,115	2,093
Amounts due from governmental entities	942	1,081
Total receivables, net	130,860	113,524
Prepaid income taxes	—	1,949
Prepaid expenses	9,821	10,833
Other current assets	5,796	5,835
Receivable due from insurance carrier	—	550
Total current assets	149,741	138,830
Property, building and equipment, net of accumulated depreciation of $35,226 and $38,907, respectively	43,251	38,096
Goodwill	307,317	290,694
Intangible assets, net of accumulated amortization of $10,968 and $8,496, respectively	102,006	96,405
Other assets	11,756	2,029
Total assets	$614,071	$566,054
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and other accrued liabilities	$26,805	$24,586
Salaries, wages and benefits payable	34,265	28,098
Self insurance reserves	10,691	9,636
Current portion of long-term debt	252	241
Amounts due to governmental entities	4,955	7,055
Income tax payable	3,499	—
Legal settlement payable	—	550
Total current liabilities	80,467	70,166
Deferred income taxes	31,941	23,729
Income tax payable	—	3,415
Revolving credit facility	87,000	98,000
Long-term debt, less current portion	544	543
Total liabilities	199,952	195,853
Noncontrolling interest-redeemable	12,567	12,408
Stockholders' equity:		
LHC Group, Inc. stockholders' equity:		
Common stock – $0.01 par value: 40,000,000 shares authorized; 22,429,041 and 22,224,423 shares issued in 2016 and 2015, respectively	224	222
Treasury stock – 4,828,679 and 4,776,560 shares at cost, respectively	(39,135)	(37,139)
Additional paid-in capital	119,748	113,793
Retained earnings	314,289	277,706

Total LHC Group, Inc. stockholders' equity	395,126	354,582
Noncontrolling interest – non-redeemable	6,426	3,211
Total stockholders' equity	401,552	357,793
Total liabilities and stockholders' equity	$614,071	$566,054

See accompanying Notes to the Consolidated Financial Statements

LHC GROUP, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF INCOME
(Amounts in thousands, except share and per share data)

	For the year ended December 31,		
	2016	2015	2014
Net service revenue	$914,823	$816,366	$733,632
Cost of service revenue	557,650	480,878	434,775
Gross margin	357,173	335,488	298,857
Provision for bad debts	14,790	19,243	15,780
General and administrative expenses	270,622	247,919	233,898
Impairment of intangibles and other	—	1,273	3,646
Loss on disposal of assets	1,199	710	47
Operating income	70,562	66,343	45,486
Interest expense	(2,936)	(2,302)	(2,486)
Non-operating income	492	457	265
Income from continuing operations before income taxes and noncontrolling interests	68,118	64,498	43,265
Income tax expense	22,176	22,848	14,513
Income from continuing operations	45,942	41,650	28,752
Less net income attributable to noncontrolling interests	9,359	9,315	6,915
Net income attributable to LHC Group, Inc.’s common stockholders	$36,583	$32,335	$21,837
Earnings per share - basic:			
Net income attributable to LHC Group, Inc.’s common stockholders	$2.08	$1.86	$1.27
Earnings per share - diluted:			
Net income attributable to LHC Group, Inc.’s common stockholders	$2.07	$1.84	$1.26
Weighted average shares outstanding:			
Basic	17,559,477	17,405,379	17,229,026
Diluted	17,682,820	17,547,531	17,315,333

See accompanying Notes to the Consolidated Financial Statements

LHC GROUP, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CHANGES IN EQUITY
(Amounts in thousands, except share data)

	LHC Group, Inc. Common Stock Issued Amount	Shares	Treasury Amount	Shares	Additional paid-in capital	Retained earnings	Noncontrolling interest - redeemable	Total non-equity	Non controlling interest - redeemable	Net income
Balances at December 31, 2013	$218	21,801,634	(34,715)	4,693,647	$103,972	$223,534	$2,875	$295,884	$11,258	
Net income	—	—	—	—	—	21,837	1,214	23,051	5,701	28,752
Acquired noncontrolling interest	—	—	—	—	—	—	138	138	130	
Sale of noncontrolling interest	—	—	—	—	161	—	—	161	—	
Noncontrolling interest distributions	—	—	—	—	—	—	(1,271)	(1,271)	(5,572)	
Purchase of additional controlling interest	—	—	—	—	(359)	—	—	(359)	—	
Nonvested stock compensation	—	—	—	—	4,094	—	—	4,094	—	
Issuance of vested stock	—	177,272	—	—	—	—	—	—	—	
Treasury shares redeemed to pay income tax	—	—	(945)	40,716	—	—	—	(945)	—	
Excess tax benefits-vesting nonvested stock	—	—	—	—	60	—	—	60	—	
Issuance of common stock under Employee Stock Purchase Plan	2	36,305	—	—	780	—	—	782	—	
Balances at December 31, 2014	$220	22,015,211	$(35,660)	4,734,363	$108,708	$245,371	$2,956	$321,595	$11,517	
Net income	—	—	—	—	—	32,335	1,737	34,072	7,578	41,650
Acquired noncontrolling interest	—	—	—	—	—	—	155	155	—	
Noncontrolling interest	—	—	—	—	—	—	(1,637)	(1,637)	(6,687)	

distributions										
Purchase of additional controlling interest	—	—	—	—	(275)	—	—	(275)	—	
Stock options exercised	—	9,500	—	—	144	—	—	144	—	
Nonvested stock compensation	—	—	—	—	4,225	—	—	4,225	—	
Issuance of vested stock	—	176,989	—	—	—	—	—	—	—	
Treasury shares redeemed to pay income tax	—	—	(1,479)	42,197	—	—	—	(1,479)	—	
Excess tax benefits-vesting nonvested stock	—	—	—	—	211	—	—	211	—	
Issuance of common stock under Employee Stock Purchase Plan	2	22,723	—	—	780	—	—	782	—	
Balances at December 31, 2015	$222	22,224,423	$(37,139)	4,776,560	$113,793	$277,706	$3,211	$357,793	$12,408	
Net income	—	—	—	—	—	36,583	1,373	37,956	7,986	45,942
Acquired noncontrolling interest	—	—	—	—	—	—	1,783	1,783	—	
Sale of noncontrolling interest	—	—	—	—	(931)	—	1,400	469		
Noncontrolling interest distributions	—	—	—	—	—	—	(1,341)	(1,341)	(7,827)	
Stock options exercised	—	5,500	—	—	109	—	—	109		
Nonvested stock compensation	—	—	—	—	4,872	—	—	4,872		
Issuance of vested stock	2	174,969	—	—	(2)	—	—	—		
Treasury shares redeemed to pay income tax	—	—	(1,996)	52,119		—	—	(1,996)		
Excess tax benefits-vesting nonvested stock	—	—	—	—	995	—	—	995		
Issuance of common stock under Employee Stock Purchase	—	24,149	—	—	912	—	—	912		

Plan Balances at December 31, 2016	$224	22,429,041	$(39,135)	4,828,679	$119,748	$314,289	$6,426	$401,552	$12,567

See accompanying Notes to the Consolidated Financial Statements

LHC GROUP, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(Amounts in thousands)

	For the Year Ended December 31,		
	2016	2015	2014
Operating activities			
Net income	$45,942	$41,650	$28,752
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization expense	12,160	11,955	9,571
Provision for bad debts	14,790	19,243	15,780
Stock-based compensation expense	4,872	4,225	4,094
Deferred income taxes	7,402	1,518	2,402
Loss on disposal of assets	1,199	710	47
Impairment of intangibles and other	—	1,280	3,603
Changes in operating assets and liabilities, net of acquisitions:			
Receivables	(28,873)	(27,951)	(16,372)
Prepaid expenses and other assets	1,034	(3,793)	191
Prepaid income taxes	1,641	441	911
Accounts payable and accrued expenses	9,182	10,526	(10,460)
Income tax payable	84	—	—
Net amounts due to/from governmental entities	(1,961)	130	138
Net cash provided by operating activities	67,472	59,934	38,657
Investing activities			
Cash paid for acquisitions, primarily goodwill and intangible assets	(23,156)	(70,572)	(73,933)
Purchases of property, building and equipment	(16,009)	(13,283)	(8,105)
Advanced payments on acquisitions	(11,488)	—	—
Other	273	—	—
Net cash (used in) investing activities	(50,380)	(83,855)	(82,038)
Financing activities			
Proceeds from line of credit	38,000	83,000	75,000
Payments on line of credit	(49,000)	(45,000)	(37,000)
Excess tax benefits from vesting of stock awards	1,303	914	124
Proceeds from employee stock purchase plan	912	782	782
Payments on debt	(238)	(233)	(202)
Noncontrolling interest distributions	(9,413)	(8,324)	(6,843)
Payment of deferred financing fees	—	—	(852)
Purchase of additional controlling interest	—	(275)	(359)
Sale of noncontrolling interest	356	—	193
Withholding taxes paid on stock-based compensation	(1,996)	(1,479)	(945)
Proceeds from exercise of stock options	109	144	—
Net cash (used in) provided by financing activities	(19,967)	29,529	29,898
Change in cash	(2,875)	5,608	(13,483)
Cash at beginning of period	6,139	531	14,014
Cash at end of period	$3,264	$6,139	$531
Supplemental disclosures of cash flow information			
Interest paid	$3,123	$1,870	$2,461

Income taxes paid	$11,533	$20,361	$11,781

Supplemental disclosure of non-cash transactions:

2014 non-cash transaction. $2.7 million of licenses associated with the Company's point of care technology were capitalized as additions to property, building and equipment upon placing associated equipment in service. These licenses were purchased during the twelve months ended December 31, 2010 and previously recorded in other assets on the balance sheet.

See accompanying Notes to the Consolidated Financial Statements

LHC GROUP, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Organization

LHC Group, Inc. (the “Company”) is a health care provider specializing in the post-acute continuum of care primarily for Medicare beneficiaries. The Company provides home health services, hospice services, community-based services, and facility-based services, the latter primarily through long-term acute care hospitals ("LTACHs"). As of December 31, 2016, the Company, through its wholly and majority-owned subsidiaries, equity joint ventures and controlled affiliates, operated 372 service providers in 26 states within the continental United States.

2. Summary of Significant Accounting Policies

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (“US GAAP”) requires management to make estimates and assumptions that affect the reported amounts in the Company's accompanying consolidated financial statements and notes to the consolidated financial statements. Actual results could differ from those estimates.

The most significant estimates relate to revenue recognition, collectability of accounts receivable and impairment tests of goodwill and other indefinite-lived intangible assets. A description of the significant accounting policies and a discussion of the significant estimates and judgments associated with such policies are described below.

Principles of Consolidation

The consolidated financial statements include all subsidiaries and entities controlled by the Company through direct ownership of majority interest or controlling member ownership of such entities. Third party equity interests in the consolidated joint ventures are reflected as noncontrolling interests in the Company’s consolidated financial statements.

The following table summarizes the percentage of net service revenue earned by type of ownership or relationship the Company had with the operating entity for the periods presented for the years ending December 31:

Ownership type	2016	2015	2014
Wholly owned subsidiaries	57.2 %	55.2 %	53.5 %
Equity joint ventures	41.2	42.9	43.9
Other	1.6	1.9	2.6
	100.0%	100.0%	100.0%

All significant inter-company accounts and transactions have been eliminated in consolidation. All business combinations accounted for as purchases have been included in the consolidated financial statements from the respective dates of acquisition.

Equity Joint Ventures

A majority of the Company’s equity joint ventures are structured as limited liability companies in which the Company typically owns a majority equity interest ranging from 51% to 91%. Each member of all but one of the Company’s equity joint ventures participates in profits and losses in proportion to their equity interests. The Company has one equity joint venture partner whose participation in losses is limited. The Company consolidates these entities as the Company has the obligation to absorb losses of the entities and the right to receive benefits from the entities and generally has voting control over the entities.

Other (License Leasing Arrangements and Management Services)

The Company, through wholly owned subsidiaries, leases home health licenses necessary to operate certain of its home nursing and hospice agencies. As with wholly owned subsidiaries, the Company owns 100% of the equity of these entities and consolidates them based on such ownership.

The Company has various management services agreements under which the Company manages operations of certain agencies and facilities. The Company does not consolidate these agencies or facilities, as the Company does not have an ownership interest and does not have an obligation to absorb losses of the entities or the right to receive the benefits

from the entities other than management fees.

Revenue Recognition

The Company reports net service revenue at the estimated net realizable amount due from Medicare, Medicaid and others for services rendered. The Company assesses the patient's ability to pay for their healthcare services at the time of patient admission based on the Company's verification of the patient's insurance coverage under the Medicare, Medicaid and other commercial or managed care insurance programs. All such payors contribute to the net service revenue of the Company's home health services, hospice services and facility-based services.

The following table sets forth the percentage of net service revenue earned by category of payor for the years ending December 31:

Payor	2016	2015	2014
Medicare	74.5 %	74.5 %	75.9 %
Medicaid	1.8	1.5	1.4
Other	23.7	24.0	22.7
	100.0%	100.0%	100.0%

Medicare

Home Health Services

The Company’s home nursing Medicare patients are classified into one of 153 home health resource groups prior to receiving services. Based on this home health resource group, the Company is entitled to receive a standard prospective Medicare payment for delivering care over a 60-day period referred to as an episode. The Company recognizes revenue based on the number of days elapsed during an episode of care within the reporting period.

Final payments from Medicare may reflect adjustments to ensure the adequacy and effectiveness of the total reimbursement: (a) an outlier payment if the patient’s care was unusually costly; (b) a low utilization adjustment if the number of visits was fewer than five; (c) a partial payment if the patient transferred to another provider or transferred from another provider before completing the episode; (d) a payment adjustment based upon the level of therapy services required; (e) base payment adjustments for case-mix and geographic wage differences; and (f) 2% sequestration reduction for episodes beginning after March 31, 2013. Management estimates the adjustments outlined above based on historical experience and as changes become known, and records these adjustments during the period in which the services are provided to the patient. Net service revenue and related patient accounts receivable are recorded at amounts estimated to be realized from Medicare for services rendered.

Hospice Services

The Company is paid by Medicare under a per diem payment system. The Company receives one of four predetermined daily or hourly rates based upon the level of care the Company furnished. The Company records net service revenue from hospice services based on the daily or hourly rate and recognizes revenue as hospice services are provided.

Hospice payments are subject to an inpatient cap and an overall Medicare payment cap. The inpatient cap relates to individual programs receiving more than 20% of its total Medicare reimbursement from inpatient care services and the overall Medicare payment cap relates to individual programs receiving reimbursements in excess of a “cap amount,” calculated by multiplying the number of beneficiaries during the period by a statutory amount that is indexed for inflation. The determination for each cap is made annually based on the 12 -month period ending on October 31 of each year. The Company monitors its limits on a provider-by-provider basis and records an estimate of its liability for reimbursements received in excess of the cap amount. Annually, the Company receives notification of whether any of its hospice providers have exceeded either cap. Beginning with cap year ended October 1, 2014, CMS implemented a new process requiring hospice providers to self-report their cap liabilities and remit applicable payment by March 31 of the following year.

Facility-Based Services

Long-Term Acute Care Services. The Company is reimbursed by Medicare for services provided under the long-term acute care hospital (“LTACH”) prospective payment system. Each patient is assigned a long-term care diagnosis-related group. The Company is paid a predetermined fixed amount intended to reflect the average cost of treating a Medicare patient classified in that particular long-term care diagnosis-related group. For selected patients, the amount may be further adjusted based on length-of-stay and facility-specific costs, as well as in instances where a patient is

discharged and subsequently re-admitted, among other factors. The Company calculates the adjustment based on a historical average of these types of adjustments for claims paid. Similar to other Medicare prospective payment systems, the rate is also adjusted for geographic wage differences. Revenue is recognized for the Company's LTACHs as services are provided.

Medicaid, managed care and other payors

The Company's Medicaid reimbursement is based on a predetermined fee schedule applied to each service provided. Therefore, revenue is recognized for Medicaid services as services are provided based on this fee schedule. Managed care and other payors reimburse the

Company in a manner similar to either Medicare or Medicaid. Accordingly, the Company recognizes revenue from managed care and other payors in the same manner as the Company recognizes revenue from Medicare or Medicaid.

Management Services

The Company records management services revenue as services are provided in accordance with the various management services agreements to which the Company is a party. As described in the management services agreements, the Company provides billing, management and other consulting services suited to and designed for the efficient operation of the applicable home nursing agency. The Company is responsible for the costs associated with the locations and personnel required for the provision of services. The Company is compensated based on a percentage of cash collections for one management service agreement and reimbursed for operating expenses plus a percentage of operating net income for two management service agreements.

Accounts Receivable and Allowances for Uncollectible Accounts

The Company reports accounts receivable net of estimated allowances for uncollectible accounts and adjustments. Accounts receivable are uncollateralized and primarily consist of amounts due from Medicare, Medicaid, other third-party payors, and patients. To provide for accounts receivable that could become uncollectible in the future, the Company establishes an allowance for uncollectible accounts to reduce the carrying amount of such receivables to their estimated net realizable value. Because Medicare is the Company's primary payor, the credit risk associated with receivables from other payors is limited. The Company believes the credit risk associated with its Medicare accounts, which have historically exceeded 60.0% of its patient accounts receivable, is limited due to (i) the historical collection rate from Medicare and (ii) the fact that Medicare is a U.S. government payor. The Company does not believe that there are any other significant concentrations of receivables from any particular payor that would subject it to any significant credit risk in the collection of accounts receivable.

The amount of the provision for bad debts is based upon the Company's assessment of historical and expected net collections, business and economic conditions, and trends in government reimbursement. Uncollectible accounts are written off when the Company has determined that the account will not be collected.

A portion of the estimated Medicare prospective payment system reimbursement from each submitted home nursing episode is received in the form of a request for anticipated payment ("RAP"). The Company submits a RAP for 60% of the estimated reimbursement for the initial episode at the start of care. The full amount of the episode is billed after the episode has been completed. The RAP received for that particular episode is deducted from the final payment. If a final bill is not submitted within the greater of 120 days from the start of the episode, or 60 days from the date the RAP was paid, any RAPs received for that episode will be recouped by Medicare from any other Medicare claims in process for that particular provider. The RAP and final claim must then be resubmitted. For subsequent episodes of care contiguous with the first episode for a particular patient, the Company submits a RAP for 50% instead of 60% of the estimated reimbursement.

The Company's Medicare population is paid at a prospectively set amount that can be determined at the time services are rendered. The Company's Medicaid reimbursement is based on a predetermined fee schedule applied to each individual service we provide. The Company's managed care contracts are structured similar to either the Medicare or Medicaid payment methodologies. Because of its payor mix, the Company is able to calculate its actual amount due at the patient level and adjust the gross charges down to the actual amount at the time of billing. This negates the need to record an estimated contractual allowance when reporting net service revenue for each reporting period.

Business Combination

The Company accounts for business combinations using the acquisition method. The assets typically acquired consist primarily of Medicare licenses, trade names, certificates of need and/or a non-compete agreement. The assets acquired and liabilities assumed, if any, are measured at fair value on the acquisition date using the appropriate valuation method. The noncontrolling interest associated with joint venture acquisitions is also measured and recorded at fair value as of the acquisition date. The residual purchase price is recorded as goodwill. The operations of the acquisitions are included in the consolidated financial statements from their respective dates of acquisition.

Goodwill and Intangible Assets

The Company performs its annual impairment review of goodwill at November 30, and when a triggering event occurs between annual impairment tests. For 2016, the Company performed a qualitative assessment of goodwill and determined that it is not more likely than not that the fair values of its reporting units are less than the carrying amounts. The Company has not recognized any goodwill impairment charges in 2016, 2015 or 2014 related to the annual impairment testing.

Included in intangible assets are definite-lived assets subject to amortization such as non-compete agreements and defensive assets, which are defined as trade names that are not actively used. Amortization of definite-lived intangible assets is calculated on a straight-line basis over the estimated useful lives of the related assets, ranging from two to five years. The Company also has indefinite-lived

assets that are not subject to amortization expense such as trade names, certificates of need and licenses to conduct specific operations within geographic markets. The Company has concluded that trade names, certificates of need and licenses have indefinite lives, because there are no legal, regulatory, contractual, economic or other factors that would limit the useful life of these intangible assets and the Company intends to renew and operate the certificates of need and licenses and use the trade names indefinitely. These indefinite-lived intangible assets are reviewed annually for impairment or more frequently if circumstances indicate impairment may have occurred. To determine whether an indefinite-lived intangible asset is impaired, the Company performs a qualitative assessment to support the conclusion that the indefinite-lived intangible asset is not impaired. Based on the results of that qualitative assessment, the Company may perform a quantitative test. The Company utilizes a relief-from-royalty method in its quantitative impairment test of trade names. Under this method, the fair value of the trade name is determined by calculating the present value of the after-tax cost savings associated with owning the trade names and, therefore, not having to pay royalties for use over its estimated useful life. The Company utilizes the replacement cost approach in its quantitative impairment test for certificates of need and licenses. Under this method, assumptions are made about the cost to replace the certificates of need and licenses. During the twelve months ended December 31, 2016, the Company did not record an impairment charge related to indefinite-lived intangible assets. During the twelve months ended December 31 2015 and 2014, the Company recorded impairment charges related to indefinite-lived intangible assets of $0.6 million and $2.0 million, respectively.

Due to/from Governmental Entities

The Company’s LTACHs are reimbursed for certain activities based on tentative rates. The amounts recorded in due to/from governmental entities on the Company’s consolidated balance sheets relate to settled and open cost reports that are subject to the completion of audits and the issuance of final assessments. Final reimbursement is determined based on submission of annual cost reports and audits by the fiscal intermediary. Adjustments are accrued on an estimated basis in the period the related services were rendered and further adjusted as final settlements are determined. These adjustments are accounted for as changes in estimates. Additionally, reimbursements received in excess of hospice cap amounts are recorded in this account.

Property, Building and Equipment

Property, building and equipment are recorded at cost. Depreciation is computed using the straight-line method over the estimated useful lives of the individual assets. The estimated useful life of buildings is 39 years, while the estimated useful lives of transportation equipment and furniture and other equipment range from 3 to 10 years. The useful life for leasehold improvements is the shorter of the lease term or the expected life of the leasehold improvement. Expenditures that increase capacities or extend useful lives are capitalized to the appropriate property, building and equipment accounts. Costs and related accumulated depreciation associated with assets that are sold or retired are written off and any gain or losses are recorded in operating income. Routine repairs and maintenance costs are expensed as incurred.

Property, building and equipment are reviewed whenever events or changes in circumstances occur that indicate possible impairment. There were no impairments recognized during the periods ended December 31, 2016, 2015 and 2014.

The following table describes the Company’s components of property, building and equipment for the years ended December 31, 2016 and 2015 (amounts in thousands):

	2016	2015
Land	$2,033	$2,033
Building and improvements	11,363	10,026
Transportation equipment	11,220	6,912
Fixed equipment	1,090	3,373
Office furniture and medical equipment	52,771	54,659
	78,477	77,003
Less accumulated depreciation	35,226	38,907
	$43,251	$38,096

Depreciation expense for the years ended December 31, 2016, 2015 and 2014 was $12.2 million, $12.0 million and $9.6 million, respectively, which was recorded in general and administrative expenses. Amortization expense related to definite-lived intangible assets is included in depreciation expense.

Self Insurance Reserves

The Company maintains insurance programs, which include employee health insurance and workers' compensation. The Company's employee health insurance program is self-funded, with stop-loss coverage on claims that exceed $0.2 million for any individually covered employee or employee family member. The Company is responsible for workers' compensation claims up to $0.5 million per

individual incident. The self insurance reserve payable reflects the current estimate of incurred but not reported losses, historical claims experience, and expected costs to settle unpaid claims. The Company records amounts due from insurance policies in other current assets while recording the estimated liability in self insurance reserves.

Noncontrolling Interest

The nonredeemable interest held by third parties in subsidiaries owned or controlled by the Company is reported on the consolidated balance sheets as noncontrolling interest as a component of stockholders' equity. Redeemable interest held by third parties in subsidiaries owned or controlled by the Company is reported on the consolidated balance sheets outside of permanent equity. All noncontrolling interest reported in the consolidated statements of income reflects the respective interests in the income or loss after income taxes of the subsidiaries attributable to the other parties, the effect of which is removed from the net income attributable to the Company.

Stock-Based Compensation

The Company grants restricted stock or restricted stock units to employees and members of its Board of Directors as a form of compensation. The expense for such awards is based on the grant date fair value of the award and is recognized on a straight-line basis over the requisite service period. See Note 7 to these consolidated financial statements.

Earnings Per Share

The following table sets forth shares used in the computation of basic and diluted per share information for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
Weighted average number of shares outstanding for basic per share calculation	17,559,477	17,405,379	17,229,026
Effect of dilutive potential shares:			
Options	863	3,663	4,284
Nonvested restricted stock	122,480	138,489	82,023
Adjusted weighted average shares for diluted per share calculation	17,682,820	17,547,531	17,315,333
Antidilutive shares	219,855	200,525	173,360

Recently Adopted Accounting Pronouncements

In April 2015, the FASB issued ASU No. 2015-3, Simplifying the Presentation of Debt Issuance Costs, ("ASU 2015-3") which requires an entity to present debt issuance costs related to a recognized debt liability as a direct deduction from that liability. The Company adopted this standard during the year ended December 31, 2016. In August 2015, the FASB issued ASU No. 2015-15, Interest - Imputation of Interest, which stated ASU No. 2015-3 does not address presentation or subsequent measurement of debt issuance costs related to line-of-credit arrangements; therefore, ASU No. 2015-3 will not have an effect on the Company's consolidated financial statements and related disclosures.

Recently Issued Accounting Pronouncements

On May 28, 2014, the FASB issued ASU No. 2014-9, Revenue from Contracts with Customers, ("ASU 2014-9") which requires an entity to recognize the amount of revenue to which it expects to be entitled for the transfer of promised goods or services to customers. ASU 2014-9 will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. The new standard is effective for reporting periods beginning after December 15, 2017, with early adoption permitted for reporting periods beginning after December 15, 2016. The standard permits the use of either the retrospective or cumulative effect transition method. As the Company progresses with evaluating the effect that ASU 2014-9 will have on its consolidated financial statements and related disclosures, the Company does not expect a material impact on its consolidated financial statements upon implementation on January 1, 2018. The Company has not yet selected a transition method.

In February 2016, the FASB issued ASU No. 2016-2, Leases, ("ASU 2016-2") which requires lessees to recognize qualifying leases on the statement of financial position. Qualifying leases will be classified as right-of-use assets and lease liabilities. The new standard is effective on January 1, 2019. Early adoption is permitted. ASU 2016-2 mandates a modified retrospective transition method for all entities. The Company anticipates that the adoption of ASU 2016-2 will result in a material increase in total assets and total liabilities. The Company continues to evaluate the effect that ASU 2016-2 will have on its related disclosures.

In March 2016, as part of its Simplification Initiative, the FASB issued ASU No. 2016-9, Compensation - Stock Compensation (ASU 2016-09), which finalizes Proposed ASU No. 2015-270 of the same name, and seeks to reduce complexity in accounting standards. The areas for simplification in ASU 2016-09 involve several aspects of the accounting for share-based payment transaction, including (1) accounting for income taxes, (2) classification of excess tax benefits on the statement of cash flows, (3) forfeitures, (4) minimum statutory tax withholding requirements, (5) classification of employee taxes paid on the statement of cash flows when an employer withholds shares for tax withholding purposes, (6) the practical expedient for estimating the expected term, and (7) intrinsic value. The new standard is effective on January 1, 2017. The adoption of this standard is not expected to have a material impact on the Company's consolidated financial statements.

3. Acquisitions and Disposals

2016 Acquisitions

The total aggregate purchase price for the acquired 23 locations that occurred in 2016 was $24.1 million, of which $23.1 million was paid in cash. These providers conduct home health operations in Alabama, Arizona, Arkansas, Florida, Louisiana, and Oklahoma; hospice operations in Alabama, Arizona, Arkansas, Georgia, and Missouri; and physical therapy clinics in Arkansas.

The fair values assigned to certain assets acquired and liabilities assumed in relation to the Company’s acquisition that occurred during the fourth quarter of 2016 have been prepared on a preliminary basis with information currently available and are subject to change. Specifically, the Company is further assessing the valuation of certain tangible and intangible assets acquired and obligations assumed pending the final appraisals. The Company expects to finalize its analysis during 2017.

Goodwill generated from the acquisitions was recognized based on the expected contributions of each acquisition to the overall corporate strategy. The Company expects its portion of goodwill to be fully tax deductible. The acquisitions were accounted for under the acquisition method of accounting, and, accordingly, the accompanying financial information includes the results of operations of the acquired entities from the dates of acquisition.

The following table summarizes the aggregate consideration paid for the acquisitions and the amounts of the assets acquired and liabilities assumed at the acquisition dates, as well as their fair value at the acquisition dates and the noncontrolling interest acquired (amounts in thousands):

Consideration	
Cash	$23,082
Fair value of total consideration transferred	23,082
Recognized amounts of identifiable assets acquired and liabilities assumed	
Trade name	4,113
Certificates of needs/licenses	3,520
Other identifiable intangible assets	262
Other assets and (liabilities), net	(865)
Total identifiable assets	7,030
Noncontrolling interest	1,784
Goodwill, including noncontrolling interest of $1,275	$17,836

Trade names, certificates of need and licenses are indefinite-lived assets and, therefore, not subject to amortization. Acquired trade names that are not being used actively are amortized over the estimated useful life on the straight line basis. Trade names are valued using the relief from royalty method, a form of the income approach. Certificates of needs are valued using the replacement cost approach based on registration fees and opportunity costs. Licenses are

valued based on the estimated direct costs associated with recreating the asset, including opportunity costs based on an income approach. In the case of states with a moratorium in place, the licenses are valued using the multi period excess earnings method. The other identifiable assets include non-compete agreements that are amortized over the life of the agreements, ranging from one to three years. Noncontrolling interest is valued at fair value by applying a discount to the value of the acquired entity for lack of control.

The Company has conducted an assessment of deferred income tax accounting and the calculation of the final net working capital adjustment and has recognized provision amounts in it is accounting for the acquisition of Halcyon for all identified liabilities in accordance with the requirements of ASC Topic 805. During the twelve months ended December 31, 2016, a decrease to net working capital adjustment of $2.0 million and an increase to deferred tax liabilities of $0.8 million were recorded in goodwill.

The following table contains unaudited pro forma consolidated income statement information assuming the 2016 acquisitions closed January 1, 2015 (amount in thousands, except earnings per share):

	2016	2015
Net service revenue	$936,621	$907,941
Operating income	71,977	64,547
Net income	37,521	31,217
Basic earnings per share	2.14	1.79
Diluted earnings per share	2.12	1.78

The pro forma information presented above includes adjustments for (i) depreciation expense, (ii) amortization of identifiable intangible
assets, (iii) income tax provision using the Company's effective tax rate and (iv) estimate of additional costs to provide administrative costs for these locations. This pro forma information is presented for illustrative purposes only and may not be indicative of the results of operations that would have actually occurred. In addition, future results may vary significantly from the results reflected in the pro forma information.

2015 Acquisitions

The total aggregate purchase price for the Company's acquisitions, which closed in the twelve months ended December 31, 2015, was $71.4 million, of which $70.1 million was paid in cash. The purchase prices are determined based on an analysis of comparable acquisitions and the target market's potential future cash flows. The Company expects its portion of goodwill to be fully tax deductible. The company paid $0.4 million in acquisition-related costs, which was recorded in general and administrative expenses.

4. Goodwill and Other Intangibles, Net

The following table summarizes changes in goodwill by reporting unit during the twelve months ended December 31, 2016 and 2015 (amounts in thousands):

	Home health reporting unit	Hospice reporting unit	Community-based reporting unit	Facility-based reporting unit	Total
Balance as of December 31, 2014	$196,296	$14,793	$ 17,339	$ 11,591	$240,019
Goodwill from acquisitions	7,069	43,343	638	—	51,050
Goodwill related to noncontrolling interests	14	—	22	—	36
Goodwill related to disposal	(384)	—	(27)	—	(411)
Balance as of December 31, 2015	$202,995	$58,136	$ 17,972	$ 11,591	$290,694
Goodwill from acquisitions	6,760	7,460	848	1,493	16,561
Goodwill related to noncontrolling interests	580	355	—	340	1,275
Goodwill related to prior period net working capital adjustments	504	(1,717)	—	—	(1,213)
Balance as of December 31, 2016	$210,839	$64,234	$ 18,820	$ 13,424	$307,317

The Company determined that there was no impairment for the goodwill of any reporting units as of December 31, 2016, 2015 and 2014 based on the Company's annual impairment testing; however, the Company did record $0.4 million and $0.2 million of disposal of goodwill during the years ended December 31, 2015 and 2014, respectively, due to the closure of underperforming locations. This was recorded in impairment of intangibles and other.

The Company performed an impairment analysis on its indefinite-lived intangible assets related to the Company's trade names, licenses and certificates of need and determined that it is not more likely than not that the fair values of the indefinite-lived intangible assets are less than its carrying amount as of November 30, 2016. During the years ended December 31, 2015 and 2014, an impairment charge of $0.6 million and $2.0 million, respectively, was recorded in impairment of intangibles and other.

The following tables summarize the changes in intangible assets during the twelve months ended December 31, 2016 and 2015 (amounts in thousands):

	December 31, 2016			
	Remaining useful life	Gross carrying amount	Accumulated amortization	Net carrying amount
Indefinite-lived assets:				
Trade names	Indefinite	$64,672	$ —	$64,672
Certificates of need/licenses	Indefinite	33,327	—	33,327
Total		97,999	—	97,999
Amortizing assets:				
Trade names	8 months – 9 years	9,294	(5,991)	3,303
Non-compete agreements	2 months – 3 years	5,681	(4,977)	704
Total		14,975	(10,968)	4,007
Balance at December 31, 2016		$112,974	$ (10,968)	$102,006

	December 31, 2015			
	Remaining useful life	Gross carrying amount	Accumulated amortization	Net carrying amount
Indefinite-lived assets:				
Trade names	Indefinite	$60,762	$ —	$60,762
Certificates of need/licenses	Indefinite	29,807	—	29,807
Total		$90,569	$ —	$90,569
Amortizing assets:				
Trade names	2 months – 5 years	$8,985	$ (4,385)	$4,600
Non-compete agreements	3 months – 2 years	5,347	(4,111)	1,236
Total		14,332	(8,496)	5,836
Balance at December 31, 2015		$104,901	$ (8,496)	$96,405

Intangible assets of $69.4 million, net of accumulated amortization, related to the home health services segment, $23.7 million related to the hospice segment, $7.4 million related to the community-based services segment and $1.5 million related to the facility-based services segment as of December 31, 2016. Amortization for the years ended December 31, 2016, 2015 and 2014 was $2.5 million, $1.9 million and $2.1 million, respectively, which was recorded in general and administrative expenses.

The estimated intangible asset amortization expense for each of the five years subsequent to December 31, 2016 is as follows (amounts in thousands):

Year	Amortization amount
2017	$ 2,037
2018	1,366
2019	353
2020	153
2021	22
Total	$ 3,931

5. Income Taxes

The Company accounts for income taxes using the asset and liability method. Under the asset and liability method, deferred taxes are determined based on differences between the financial reporting and tax bases of assets and liabilities and are measured using the enacted tax laws that will be in effect when the differences are expected to

reverse.

Significant components of the Company’s deferred tax assets and liabilities as of December 31, 2016 and 2015 were as follows (amounts in thousands):

	2016	2015
Deferred tax assets:		
Allowance for uncollectible accounts	$9,735	$9,048
Accrued employee benefits	5,532	5,260
Stock compensation	1,004	1,068
Accrued self-insurance	2,762	2,517
Acquisition costs	1,781	1,651
Net operating loss carry forward	1,880	983
Intangible asset impairment	38	43
Uncertain tax position—state tax portion	63	215
Uncertain tax position - interest expense	90	254
Other	155	93
Capital loss carryforward	154	—
Valuation allowance	(44)	(44)
Deferred tax assets	$23,150	$21,088
Deferred tax liabilities:		
Amortization of intangible assets	(45,622)	(35,355)
Tax depreciation in excess of book depreciation	(8,397)	(8,201)
Prepaid expenses	(817)	(655)
Non-accrual experience accounting method	(255)	(606)
Deferred tax liabilities	(55,091)	(44,817)
Net deferred tax liability	$(31,941)	$(23,729)

Based on the Company’s historical pattern of taxable income, the Company believes it will produce sufficient income in the future to realize its deferred income tax assets. Management provides a valuation allowance for any net deferred tax assets when it is more likely than not that a portion of such net deferred tax assets will not be recovered.

The components of the Company’s income tax expense from continuing operations, less noncontrolling interest, were as follows (amounts in thousands):

	2016	2015	2014
Current:			
Federal	$12,563	$18,094	$10,195
State	2,371	3,232	1,916
	14,934	21,326	12,111
Deferred:			
Federal	6,223	1,389	2,187
State	1,019	133	215
	7,242	1,522	2,402
Total income tax expense	$22,176	$22,848	$14,513

A reconciliation of the difference between the federal statutory tax rate and the Company's effective tax rate for income taxes for each period is as follows:

	2016	2015	2014
Federal statutory tax rate	35.0 %	35.0%	35.0 %
State income taxes, net of federal benefit	3.8	3.9	3.5
Nondeductible expenses	2.6	2.5	2.3
Uncertain tax position	(3.3)	—	—
Credits and other	(0.4)	—	(0.9)
Effective tax rate	37.7 %	41.4%	39.9 %

The Company is subject to both federal tax and state income tax for jurisdictions within which it operates. Within these jurisdictions, the Company is open to examination for tax years ended after December 31, 2012. Tax year ending December 31, 2011 is still open due to being under current examination.

As of December 31, 2016, $1.3 million was recorded in income tax payable as an unrecognized tax benefit which, if recognized, would decrease the Company's effective tax rate. All of the Company's unrecognized tax benefit is due to the settlement with the United States of America, which was announced September 30, 2011. On July 31, 2014, the Internal Revenue Service ("IRS") issued a notice of proposed adjustment asserting that a portion of the original tax deduction claimed by the Company associated with the settlement of the United States of America should be disallowed. In December 2016, the Company signed a final settlement offer from the IRS that reduced the unrecognized tax benefit from $3.4 million to $1.3 million. The Company received approval from Joint Committee Review in February 2017 to finalize the settlement. Due to the approval being received subsequent to year-end, the Company will continue to show the amount as an uncertain tax position as of December 31, 2016. A reconciliation of the total amounts of unrecognized tax benefits follows (amounts in thousands):

Total unrecognized tax benefits as of December 31, 2015	$3,415
Increases (decreases) in unrecognized tax benefits as a result of:	
Tax positions taken during the current period	(2,100)
Total unrecognized tax benefits as of December 31, 2016	$1,315

The Company recognizes interest and penalties related to uncertain tax positions in interest expense and general and administrative expenses, respectively. During the year ended December 31, 2016, the Company recognized a decrease of $0.4 million in interest expense and associated liability due to the decrease in the overall uncertain tax position. During the years ended December 31, 2015 and 2014, the Company recognized $0.2 million each year in interest expense, and recorded an accrued liability of interest payments related to uncertain tax positions.

6. Debt

Credit Facility

On June 18, 2014, the Company entered into a Credit Agreement (the “Credit Agreement”) with Capital One, National Association, which provides a senior, secured revolving line of credit commitment with a maximum principal borrowing limit of $225.0 million and a letter of credit sub-limit equal to $15.0 million. The expiration date of the Credit Agreement is June 18, 2019. Revolving loans under the Credit Agreement bear interest at either a (1) Base Rate, which is defined as a fluctuating rate per annum equal to the highest of (a) the Federal Funds Rate in effect on such day plus 0.5% (b) the Prime Rate in effect on such day and (c) the Eurodollar Rate for a one month interest period on such day plus 1.0%, plus a margin ranging from 0.75% to 1.5% per annum or (2) Eurodollar rate plus a margin ranging from 1.75% to 2.5% per annum. Swing line loans bear interest at the Base Rate. Borrowings under a Base Rate or Eurodollar Rate may be outstanding at any time; however, there shall not be more than 15 Eurodollar borrowings outstanding at any given time. The Company is required to pay a commitment fee for the unused commitments at rates ranging from 0.225% to 0.375% per annum depending upon the Company’s consolidated Leverage Ratio, as defined in the Credit Agreement. The Base Rate at December 31, 2016 was 4.75% and the Eurodollar rate was 3.02%. As of December 31, 2016, the interest rate on outstanding borrowings was 3.02%.

As of December 31, 2016 the Company had $87.0 million drawn and letters of credit in the amount of $11.0 million outstanding under the credit facility. At December 31, 2015, the Company had $98.0 million drawn and letters of credit in the amount of $9.8 million outstanding under the credit facility.

The scheduled principal payments on long-term debt for each of the five years subsequent to December 31, 2016 is as follows (amounts in thousands):

Year	Principal payment amount
2017	$252

2018	267
2019	87,277
2020	—
2021	—
Total	$ 87,796

7. Stockholders' Equity

Equity Based Awards

At the Company's 2010 Annual Meeting of Stockholders, the stockholders of the Company approved the Company's 2010 Long Term Incentive Plan (the "2010 Incentive Plan"). The 2010 Incentive Plan is administered by the Compensation Committee of the Company's Board of Directors (the "Compensation Committee"). A total of 1,500,000 shares of the Company's common stock are reserved and 477,129 shares are available for issuance pursuant to awards granted under the 2010 Incentive Plan. A variety of discretionary awards for employees, officers, directors and consultants are authorized under the 2010 Incentive Plan, including incentive or non-qualified statutory stock options and nonvested stock. All awards must be evidenced by a written award certificate which will include the provisions specified by the Compensation Committee. The Compensation Committee will determine the exercise price for non-statutory stock options, which cannot be less than the fair market value of the Company's common stock as of the date of grant.

In the event of a change of control as defined in the 2010 Incentive Plan, all restricted periods and restrictions imposed on non-performance based restricted stock awards will lapse and outstanding options will become immediately exercisable in full.

Share Based Compensation

Stock Options

During the twelve months ended December 31, 2016, 5,500 options were exercised with an exercise price of $19.75. There were no options granted or forfeited during the twelve months ended December 31, 2016, and no options were issued or exercisable as of December 31, 2016. No compensation expense related to stock options grants was recorded in the years ended December 31, 2016, 2015 and 2014.

Nonvested Stock

The Company issues stock-based compensation to employees in the form of nonvested stock, which is an award of common stock subject to certain restrictions. The awards, which the Company calls nonvested shares, generally vest over a five year period, conditioned on continued employment for the full incentive period. Compensation expense for the nonvested stock is recognized for the awards that are expected to vest. The expense is based on the fair value of the awards on the date of grant recognized on a straight-line basis over the requisite service period, which generally relates to the vesting period.

During 2016, 2015 and 2014, respectively, 220,800, 182,865 and 172,545 nonvested shares were granted to employees pursuant to the 2010 Incentive Plan.

The Company also issues nonvested stock to its independent directors of the Company's Board of Directors. During 2016, 2015 and 2014, respectively, 15,300, 16,200 and 26,900 nonvested shares of stock were granted to the independent directors under the 2005 Director Compensation Plan. The shares issued under the 2005 Director Compensation Plan were drawn from the 1,500,000 shares reserved for issuance under the 2010 Incentive Plan. The shares fully vest one year from the date of the grant, except for grants provided to new directors, which one-third on each of the first three anniversaries of the grant date.

The fair value of nonvested shares is determined based on the closing trading price of the Company's shares on the grant date. The weighted average grant date fair values of nonvested shares granted during the years ended December 31, 2016, 2015 and 2014 were $37.99, $34.06 and $23.59, respectively.

The following table represents the nonvested stock activity for the year ended December 31, 2016:

	Number of Shares	Weighted Average Grant Date Fair Value
Nonvested shares outstanding at January 1, 2016	527,091	$ 26.64
Granted	236,100	37.99
Vested	(174,969)	25.72
Forfeited	(13,511)	25.27
Nonvested shares outstanding at December 31, 2016	574,711	$ 31.61

As of December 31, 2016, there was $11.9 million of total unrecognized compensation cost related to non-vested shares granted. That cost is expected to be recognized over the weighted average period of 3.16 years. The total fair value of shares vested in the year ended December 31, 2016 was $4.5 million and the total fair value of shares vested in the years December 31, 2015 and 2014 was $4.1 million and $3.9 million, respectively. The Company records compensation expense related to non-vested share awards at the grant date for shares that are awarded fully vested and over the vesting term on a straight line basis for shares that vest over time. The Company has recorded $4.9 million, $4.2 million and $4.1 million in compensation expense related to non-vested stock grants in the years ended December 31, 2016, 2015 and 2014, respectively.

Employee Stock Purchase Plan

In 2006, the Company adopted the Employee Stock Purchase Plan allowing eligible employees to purchase the Company's common stock at 95% of the market price on the last day of each calendar quarter. There were 250,000 shares reserved for the plan.

On June 20, 2013, the Amended and Restated Employee Stock Purchase Plan was approved by the Company's stockholders. As a result of the amendment, the Employee Stock Purchase Plan was modified as follows:

- An additional 250,000 shares of common stock were authorized for issuance over the term of the Employee Stock Purchase Plan.
- The term of the Employee Stock Purchase Plan was extended from January 1, 2016 to January 1, 2023.

The following table represents the shares issued during 2016, 2015 and 2014 under the Employee Stock Purchase Plan:

	Number of Shares	Weighted Average Per Share Price
Shares available as of December 31, 2013	272,788	
Shares issued in 2014	36,305	$ 21.49
Shares issued in 2015	22,723	$ 34.37
Shares issued in 2016	24,149	$ 37.79
Shares available as of December 31, 2016	189,611	

Treasury Stock

In conjunction with the vesting of the non-vested shares of stock, recipients incur personal income tax obligations. The Company allows the recipients to turn in shares of common stock to satisfy those personal tax obligations. The Company redeemed 52,119, 42,197 and 40,716 shares of common stock related to these tax obligations during the years ended December 31, 2016, 2015 and 2014, respectively.

8. Leases

In certain instances, state laws may prohibit the sale of a home nursing agency or hospitals may be reluctant to sell their home health agencies. In these instances, the Company, through its wholly owned subsidiaries, enters into a lease agreement for a Medicare and Medicaid license, as well as the associated provider number to provide home health or hospice services. As of December 31, 2016, the Company had three license lease arrangements to operate four home nursing agencies and three hospice agencies.

One of the leases was entered into in 2007 and expires in 2017. Expense related to this lease was $0.2 million for each of the years ended December 31, 2016, 2015, and 2014, respectively. Payment due under this lease is $0.2 million in 2017.

Two of the leases were amended during 2010 to extend the lease terms to one year with an automatic renewal clause for additional consecutive one year terms. Expense related to these leases was $0.4 million, $0.5 million, and $0.4 million for the years ended December 31, 2016, 2015 and 2014, respectively. The lease payments associated with these leases are based on a percentage of quarterly net profits; therefore, the future payments will vary with the future profits.

The Company leases office space and equipment at its various locations. Many of the leases contain renewal options with varying terms and conditions. Management expects that in the normal course of business, expiring leases will be renewed or, upon making a decision to relocate, replaced by leases for new locations. Operating lease terms range from three to ten years. Rent expense includes insurance, maintenance, and other costs as required by the lease. Total rental expense was $20.8 million, $20.7 million and $21.1 million for the years ended December 31, 2016, 2015 and 2014, respectively.

The Company began participating in a fleet program during 2014. The program allows employees that drive over 12,000 miles on an annual basis to qualify for a vehicle; all participation is voluntary. The individual operating leases

are for a minimum of 12 months. Fleet expense was $5.3 million, $7.2 million and $3.6 million for the years ended December 31, 2016, 2015 and 2014, respectively.

Future minimum rental commitments under non-cancelable operating leases are as follows (amounts in thousands):

Year	Total
2017	$17,785
2018	11,439
2019	7,617
2020	5,064
2021	3,744

Thereafter	5,627
	$51,276

9. Employee Benefit Plan

Defined Contribution Plan

The Company sponsors a 401(k) plan for all eligible employees. The plan allows participants to contribute up to $18,000 in 2016, tax deferred (subject to IRS guidelines). The plan also allows discretionary Company contributions as determined by the Company's Board of Directors. Effective January 1, 2006, the Company implemented a discretionary match of up to two percent of participating employee contributions. The employer contribution will vest 20% after two years and 20% each additional year until it is fully vested in year six. Contribution expense to the Company was $6.3 million, $5.4 million and $4.7 million in the years ended December 31, 2016, 2015 and 2014, respectively.

10. Commitments and Contingencies

Contingencies

The Company provides services in a highly regulated industry and is a party to various proceedings and regulatory and other governmental and internal audits and investigations in the ordinary course of business (including audits by Zone Program Integrity Contractors ("ZPICs") and Recovery Audit Contractors ("RACs") and investigations resulting from the Company's obligation to self-report suspected violations of law). Management cannot predict the ultimate outcome of any regulatory and other governmental and internal audits and investigations. The DOJ, CMS, or other federal and state enforcement and regulatory agencies may conduct additional investigations related to the Company's businesses in the future. These matters could potentially subject the Company to sanctions, damages, recoupments, fines, and other penalties (some of which may not be covered by insurance), which may, either individually or in the aggregate, have a material adverse effect on the Company's business and financial condition.

The Company is 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, after considering the effect of the Company's insurance coverage, on the Company's interim financial information.

On October 7, 2015, the parties entered into a Stipulation of Settlement in the consolidated case styled In re LHC Group, Inc. Derivative Litigation, Case No. 6:13-cv-02899-JTT-CBW. 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 Preliminarily 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 settlement amount, which was immediately releasable to Plaintiffs' counsel on January 11, 2016. The time for appeal has passed and no appeals were filed. This matter is now concluded. At December 31, 2015, the Company's balance sheet reflected the entire settlement in current assets as a receivable due from insurance carrier and correspondingly reflected the entire settlement in current liabilities as a legal settlement payable.

Joint Venture Buy/Sell Provisions

Most of the Company's joint ventures include a buy/sell option that grants to the Company and its joint venture partners the right to require the other joint venture 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 interest, 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 is based on a multiple of the historical or future earnings before income taxes and 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 and subject to a fair market valuation process. The Company has not received notice from any joint venture partners of their intent to exercise the terms of the buy/sell agreement nor has the Company notified any joint venture partners of its intent to exercise the terms of the buy/sell agreement.

Compliance

The laws and regulations governing the Company's operations, along with the terms of participation in various government programs, regulate how the Company does business, the services offered and its interactions with patients and the public. These laws and regulations, and their interpretations, are subject to frequent change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations could materially and adversely affect the Company's operations and financial condition.

The Company is subject to various routine and non-routine governmental reviews, audits and investigations. 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 referral practices, cost reporting, billing practices, joint ventures and other financial relationships among health care providers.

Violation of the laws governing the Company's operations, or changes in the interpretation of those laws, could result in the imposition of fines, civil or criminal penalties, and/or termination of the Company's rights to participate in federal and state-sponsored programs and suspension or revocation of the Company's licenses. The Company believes that it is in material compliance with all applicable laws and regulations.

11. Segment Information

The Company's segments consist of home health services, hospice services, community-based services, and facility-based services. The accounting policies of the segments are the same as those described in the summary of significant accounting policies.

The following tables summarize the Company's segment information for the twelve months ended December 31, 2016, 2015 and 2014 (amounts in thousands):

	Year Ended December 31, 2016				
	Home health services	Hospice services	Community-based services	Facility-based services	Total
Net service revenue	$665,896	$134,948	$ 43,891	$ 70,088	$914,823
Cost of service revenue	398,450	83,359	32,603	43,238	557,650
Provision for bad debts	9,609	3,401	797	983	14,790
General and administrative expenses	203,418	37,207	8,785	21,212	270,622
Loss (gain) on disposal of assets	857	338	49	(45)	1,199
Operating income	53,562	10,643	1,657	4,700	70,562
Interest expense	(2,216)	(317)	(144)	(259)	(2,936)
Non-operating income	422	25	14	31	492
Income from continuing operations before income taxes and noncontrolling interests	51,768	10,351	1,527	4,472	68,118
Income tax expense	16,505	3,485	651	1,535	22,176
Income from continuing operations	35,263	6,866	876	2,937	45,942
Less net income (loss) attributable to noncontrolling interests	6,876	1,867	(58)	674	9,359
Net income attributable to LHC Group, Inc.'s common stockholders	$28,387	$4,999	$ 934	$ 2,263	$36,583
Total assets	$427,782	$116,090	$ 33,520	$ 36,679	$614,071

	Year Ended December 31, 2015				
	Home health services	Hospice services	Community-based services	Facility-based services	Total
Net service revenue	$613,188	$85,854	$ 41,202	$ 76,122	$816,366
Cost of service revenue	354,750	50,906	29,076	46,146	480,878
Provision for bad debts	15,736	1,002	1,816	689	19,243
General and administrative expenses	190,591	26,437	8,465	22,426	247,919
Impairment of intangibles and other	1,245	—	28	—	1,273
Loss on disposal of assets	544	80	41	45	710
Operating income	50,322	7,429	1,776	6,816	66,343
Interest expense	(1,819)	(253)	(23)	(207)	(2,302)
Non-operating income	397	38	3	19	457

Income from continuing operations before income taxes and noncontrolling interests	48,900	7,214	1,756	6,628	64,498
Income tax expense	17,173	2,541	787	2,347	22,848
Income from continuing operations	31,727	4,673	969	4,281	41,650

Less net income (loss) attributable to noncontrolling interests	7,424	1,077	(144)	958	9,315
Net income attributable to LHC Group, Inc.'s common stockholders	$24,303	$3,596	$1,113	$3,323	$32,335
Total assets	$394,392	$101,641	$31,235	$38,786	$566,054

	Year Ended December 31, 2014				
	Home health services	Hospice services	Community-based services	Facility-based services	Total
Net service revenue	$564,966	$67,621	$ 27,698	$ 73,347	$733,632
Cost of service revenue	329,856	39,804	19,611	45,504	434,775
Provision for bad debts	13,072	909	873	926	15,780
General and administrative expenses	187,280	18,875	6,551	21,192	233,898
Impairment of intangibles and other	3,269	202	—	175	3,646
Loss on disposal of assets	1	7	—	39	47
Operating income	31,488	7,824	663	5,511	45,486
Interest expense	(1,969)	(249)	(19)	(249)	(2,486)
Non-operating income	201	43	2	19	265
Income from continuing operations before income taxes and noncontrolling interests	29,720	7,618	646	5,281	43,265
Income tax expense	10,999	1,955	105	1,454	14,513
Income from continuing operations	18,721	5,663	541	3,827	28,752
Less net income attributable to noncontrolling interests	5,121	1,122	(36)	708	6,915
Net income attributable to LHC Group, Inc.'s common stockholders	$13,600	$4,541	$ 577	$ 3,119	$21,837
Total assets	$386,511	$34,847	$ 34,027	$ 36,354	$491,739

12. Fair Value of Financial Instruments

The carrying amounts of the Company's cash, receivables, accounts payable and accrued liabilities approximate their fair values. The estimated fair value of intangible assets was calculated using level 3 inputs based on the present value of anticipated future benefits. For the year ended December 31, 2016, the carrying value of the Company's long-term debt approximates fair value as the interest rates approximates current rates.

13. Allowance for Uncollectible Accounts

The following table summarizes the activity and ending balances in the allowance for uncollectible accounts for the twelve months ended December 31, 2016, 2015 and 2014 (amounts in thousands):

Year	Beginning of Year Balance	Additions	Deductions	End of Year Balance
2016	$ 26,712	$ 14,790	$ 12,466	$ 29,036
2015	18,582	19,243	11,113	26,712
2014	14,334	15,780	11,532	18,582

14. Concentration of Risk

The Company's Louisiana facilities accounted for approximately 18.5%, 21.0% and 22.7% of net service revenue during the years ended December 31, 2016, 2015 and 2014, respectively. Any material change in the current economic or competitive conditions in Louisiana could have a disproportionate effect on the Company's overall business results.

15. Unaudited Summarized Quarterly Financial Information

The following table represents the Company's unaudited quarterly results of operations (amounts in thousands, except share data):

	First Quarter 2016	Second Quarter 2016	Third Quarter 2016	Fourth Quarter 2016
Net service revenue	$ 222,552	$ 226,031	$ 230,797	$ 235,443
Gross margin	86,951	88,903	89,965	91,354
Net income attributable to LHC Group, Inc.’s common stockholders	7,686	9,464	9,616	9,817
Net income attributable to LHC Group' Inc.'s common stockholders				
Basic earnings per share:	$ 0.44	$ 0.54	$ 0.55	$ 0.56
Diluted earnings per share:	$ 0.44	$ 0.54	$ 0.54	$ 0.55
Weighted average shares outstanding:				
Basic	17,485,766	17,566,097	17,588,163	17,597,190
Diluted	17,633,549	17,685,147	17,719,473	17,764,066

	First Quarter 2015	Second Quarter 2015	Third Quarter 2015	Fourth Quarter 2015
Net service revenue	$ 193,079	$ 200,172	$ 204,122	$ 218,993
Gross margin	78,653	83,533	83,249	90,053
Net income attributable to LHC Group, Inc.’s common stockholders	6,805	8,950	8,845	7,735
Net income attributable to LHC Group' Inc.'s common stockholders				
Basic earnings per share:	$ 0.39	$ 0.51	$ 0.51	$ 0.44
Diluted earnings per share:	$ 0.39	$ 0.51	$ 0.50	$ 0.44
Weighted average shares outstanding:				
Basic	17,322,791	17,410,971	17,436,731	17,447,691
Diluted	17,489,483	17,529,100	17,610,953	17,647,483

Because of the method used to calculate per share amounts, quarterly per share amounts may not necessarily total to the per share amounts for the entire year.

16. Subsequent Event

On November 1, 2016, the Company entered into a definitive agreement to form a joint venture with LifePoint Health, Inc. ("LifePoint"). LifePoint will contribute all of its existing home health and hospice agencies to the joint venture and the Company will contribute certain existing home health agencies to the joint venture in areas serviced by LifePoint hospitals. The first phase of the contributions occurred on January 1, 2017 and the remaining phases will occur over 2017 and 2018. When the contributions are complete, the joint venture will operate 39 home health agencies and 12 hospice agencies. On December 30, 2016, the Company contributed $11.5 million to the joint venture in relation to the first phase. This was recorded in Other Assets on the Company's Consolidated Balance Sheets.

SIGNATURES

Pursuant to the requirements of Section 13 or 15 (d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

LHC GROUP, INC.

March 9, 2017 /s/ KEITH G. MYERS
Keith G. Myers
Chief Executive Officer

F-23

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that each person whose signature appears below constitutes and appoints Keith G. Myers and Joshua L. Proffitt and either of them (with full power in each to act alone) as true and lawful attorneys-in-fact with full power of substitution, for him and in his name, place and stead, in any and all capacities, to sign any and all amendments to this Annual Report on Form 10-K and to file the same, with all exhibits thereto and other documents in connection therewith, with the Securities and Exchange Commission, hereby ratifying and confirming all that said attorneys-in-fact, or their substitute or substitutes, may lawfully do or cause to be done by virtue hereof.

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ KEITH G. MYERS Keith G. Myers	Chief Executive Officer and Chairman of the Board of Directors	March 9, 2017
/s/ JOSHUA L. PROFFITT Joshua L. Proffitt	Executive Vice President, Chief Financial Officer, Principal Accounting Officer	March 9, 2017
/s/ MONICA F. AZARE Monica F. Azare	Director	March 9, 2017
/s/ JOHN B. BREAUX John B. Breaux	Director	March 9, 2017
/s/ JOHN L. INDEST John L. Indest	Director	March 9, 2017
/s/ GEORGE A. LEWIS George A. Lewis	Director	March 9, 2017
/s/ RONALD T. NIXON Ronald T. Nixon	Director	March 9, 2017
/s/ CHRISTOPHER S. SHACKELTON Christopher S. Shackelton	Director	March 9, 2017
/s/ W.J. “BILLY” TAUZIN W.J. “Billy” Tauzin	Director	March 9, 2017
/s/ KENNETH E. THORPE Kenneth E. Thorpe	Director	March 9, 2017
/s/ BRENT TURNER Brent Turner	Director	March 9, 2017
/s/ DAN S. WILFORD Dan S. Wilford	Director	March 9, 2017

EXHIBIT INDEX

Exhibit Number	Description of Exhibits
3.1	Certificate of Incorporation of LHC Group, Inc. (previously filed as Exhibit 3.1 to LHC Group's Form S-1/A (File No. 333-120792) filed on February 14, 2005).
3.2	Bylaws of LHC Group, Inc., as amended on December 3, 2007 (previously filed as Exhibit 3.2 to LHC Group's Form 10-Q for the quarterly period ended March 31, 2008, filed on May 9, 2008).

4.1	Specimen Stock Certificate of LHC Group's Common Stock, par value $0.01 per share (previously filed as Exhibit 4.1 to LHC Group's Form S-1/A (File No. 333-120792) filed on February 14, 2005).
10.1+	LHC 2003 Key Employee Equity Participation Plan (previously filed as Exhibit 10.3 to LHC Group's Form S-1 (File No. 333-120792) filed on November 26, 2004).
10.2+	LHC Group, Inc. 2005 Long-Term Incentive Plan (previously filed as Exhibit 10.4 to the Form S-1/A (File No. 333-120792) filed on February 14, 2005).
10.3+	LHC Group, Inc. 2010 Long-Term Incentive Plan (previously filed as Exhibit 10.1 to LHC Group's Form 10-Q for the quarterly period ended June 30, 2010, filed on August 6, 2010).
10.4+	LHC Group, Inc. Second Amended and Restated 2005 Non-Employee Directors Compensation Plan (previously filed as Exhibit 10.4 to LHC Group's Form 10-K for the year ended December 31, 2014, filed on March 11, 2015).
10.5+	Form of Indemnity Agreement between LHC Group and directors and certain officers (previously filed as Exhibit 10.10 to the Form S-1/A (File No. 333-120792) filed on February 14, 2005).
10.6+	LHC Group, Inc. 2006 Employee Stock Purchase Plan (previously filed as Exhibit 99.2 to LHC Group's Form 8-K filed on June 16, 2006).
10.7	Credit Agreement, dated as of June 18, 2014, among LHC Group, Inc., Capital One, National Association, as administrative agent, sole bookrunner, sole lead arranger, and a lender, JPMorgan Chase Bank, N.A., Regions Bank and Compass Bank, as co-syndication agents and lenders, and Whitney Bank, as a lender (previously filed as Exhibit 10.1 to LHC Group's Form 8-K filed on June 23, 2014).
10.8+	Amended and Restated Employment Agreement between Keith G. Myers and LHC Group, Inc. dated April 1, 2014 (previously filed as Exhibit 10.1 to the Form 8-K filed April 4, 2014).
10.9+	Amended and Restated Employment Agreement between Donald D. Stelly and LHC Group, Inc. dated June 1, 2016 (previously filed as Exhibit 10.1 to the Form 8-K filed June 3, 2016).
10.10+	Amended and Restated Employment Agreement between Joshua L. Proffitt and LHC Group, Inc. dated September 12, 2016 (previously filed as Exhibit 10.2 to the Form 8-K filed November 3, 2016).
10.11+	Amendment to LHC Group, Inc. Second Amended and Restated 2005 Non-Employee Directors Compensation Plan, effective January 20, 2015. (previously filed as Exhibit 10.1 to LHC Group's Form 10-Q filed on May 7, 2015).
21.1	Subsidiaries of the Registrant.
23.1	Consent of KPMG LLP.
31.1	Certification of Keith G. Myers, Chief Executive Officer pursuant to Rule 13a- 14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Joshua L. Proffitt, Chief Financial Officer pursuant to Rule 13a- 14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.

32.1*	Certification of the Chief Executive Officer and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Instance Document

101.SCH XBRL Schema Document

101.CAL XBRL Calculation Linkbase Document

101.DEF XBRL Definition Linkbase Document

101.LAB XBRL Label Linkbase Document

101.PRE XBRL Presentation Linkbase Document

Attached as Exhibit 101 to this report are documents formatted in XBRL (Extensible Business Reporting Language). Users of this data are advised pursuant to Rule 406T of Regulation S-T that the interactive data file is deemed not filed or part of a registration statement or prospectus for purposes of section 11 or 12 of the Securities Act of 1933, is deemed not filed for purposes of section 18 of the Securities Exchange Act of 1934, and otherwise not subject to liability under these sections. The financial information contained in the XBRL-related documents is “unaudited” or “unreviewed.”

+Indicates a management contract or compensatory plan.