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

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

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

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

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

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

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

Securities registered pursuant to Section 12(g) of the Exchange Act:
None
Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ¨ No ý
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ¨ No ý
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ý No ¨
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ý No ¨
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (117 CFR 229.405) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ý
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

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

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

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

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

DOCUMENTS INCORPORATED BY REFERENCE

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

LHC GROUP, INC.
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PART I

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

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

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

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

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

the Private Securities Litigation Reform Act of 1995.

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

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

Item 1. Business.

Overview

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

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

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

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

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

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

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

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

Business Strategy

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

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

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

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

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

Services

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

Home Health Services

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

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

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

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

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

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

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

Hospice Services

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

Community-Based Services

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

Facility-Based Services

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

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

Operations

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

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

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

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

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

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

Joint Ventures

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

Equity Joint Ventures

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

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

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

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

License Leasing Agreements

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

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

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

Management Services Agreements

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

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

Competition

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

Quality Control

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

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

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

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

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

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

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

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

Compliance

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

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

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

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

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

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

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

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

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

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

Technology and Intellectual Property

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

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

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

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

Reimbursement

Medicare

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

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

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

Home Health

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

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

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

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

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

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

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

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

Hospice

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

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

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

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

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

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

Long-Term Acute Care Hospitals

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

Adjustments to MS-LTC-DRG payments might include:

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

component will increase.

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

Freestanding, HwH and Satellite LTACHs

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

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

Fiscal Year 2015 Rates

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

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

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

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

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

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

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

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

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

Fiscal Year 2016 Rates

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

Medicaid

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

Non-Governmental Payors

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

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

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

Government Regulations

General

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

- Medicare and Medicaid participation and reimbursement regulations;

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

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

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

Medicare Participation

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

Federal Anti-Kickback Statute

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

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

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

Stark Law

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

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

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

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

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

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

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

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

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

False Claims

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

Anti-fraud Provisions of the HIPAA

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

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

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

Administrative Simplification Provisions of HIPAA

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

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

Civil Monetary Penalties

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

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

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

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

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

Environmental, Health and Safety Laws

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

Licensing

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

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

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

Certificate of Need and Permit of Approval Laws

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

Accreditations

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

Employees

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

Insurance

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

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

Available Information

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

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

Item 1A. Risk Factors.

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

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

Risk Factors Related to Reimbursement and Government Regulation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

management procedures may not successfully mitigate this risk.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Risk Factors Related to Capital and Liquidity

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Delays in reimbursement may cause liquidity problems.

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

Risk Factors Related to Operations and our Growth Strategy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We may close additional underperforming agencies in the future.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Risk Factors Related to our Ownership and Management

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Item 1B. Unresolved Staff Comments.

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

Item 2. Properties.

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

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

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

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

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

Item 3. Legal Proceedings.

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

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

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

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

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

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

Item 4. Mine Safety Disclosures.

Not applicable.

PART II

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

Sales of Unregistered Common Stock

None

Market Information and Holders

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

Dividend Policy

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

Price Range of Common Stock

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

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

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

Performance Graph

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

Issuer Purchases of Equity Securities

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

Item 6. Selected Financial Data.

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

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

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

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

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

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

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

Overview

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

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

Segments

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

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

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

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

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

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

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

Development Activities

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

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

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Recent Developments

Home-Based Services

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

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

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

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

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

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

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

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

Hospice

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

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

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

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

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

Community-Based Services

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

Facility-Based Services

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

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

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

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

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

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

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

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

2015 and 2014 Operational Data

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

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

Consolidated Results of Operations

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

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

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

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

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

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

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

Net Service Revenue

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

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

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

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

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

	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	
Home health 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 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 approximately $46.1 million, or 10.6%; however, as a percentage of net service revenue, it is 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 %	

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Community-based services						
Salaries, wages and benefits	28,525	69.2	%	$19,287	69.63	%
Transportation	263	0.6		170	0.61	
Supplies and services	288	0.7		154	0.56	
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	20.1	
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 approximately $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 have 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 accounts receivable in our home health services and community-based services increased by $0.8 million due to a legacy system transition for prior year acquisitions. The remainder of the aged accounts receivable continues to be reviewed and submitted to payors for collection. All aged accounts receivable have been reserved for any estimated uncollectible accounts.

General and Administrative Expenses

Consolidated general and administrative expenses for the year ended December 31, 2015 were $248.6 million compared to $233.9 million for the same period in 2014, an increase of approximately $14.7 million, or 6.3%; 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	$182,651	29.8	%	$180,364	31.9	%
Depreciation and amortization	8,484	1.4		6,917	1.2	
Total	$191,135	31.2	%	$187,281	33.1	%
Hospice services						
General and administrative	$24,973	29.1	%	$17,796	26.3	%
Depreciation and amortization	1,544	1.8		1,086	1.6	
Total	$26,517	30.9	%	$18,882	27.9	%
Community-based services						
General and administrative	$8,350	20.3	%	$6,445	23.3	%
Depreciation	156	0.4		106	0.4	
Total	$8,506	20.7	%	$6,551	23.7	%
Facility-based services						
General and administrative	$20,702	27.2	%	$19,769	27.0	%
Depreciation and amortization	1,769	2.3		1,462	2.0	
Total	$22,471	29.5	%	$21,231	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 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 those 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 an other intangible asset impairment of $0.6 million in 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 name 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 joint ventures. 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.

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

Net Service Revenue

Consolidated net service revenue for the year ended December 31, 2014 was $733.6 million compared to $658.3 million for the same period in 2013, an increase of $75.3 million, or 11.4%. Consolidated net service revenue growth in 2014 was primarily due from our acquisition of 52 agencies during 2014 and an increase in admits. Consolidated net service revenue was comprised of the following for the periods ending December 31:

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

Revenue derived from Medicare represented 75.9% and 79.8% of our consolidated net service revenue for the years ended December 31, 2014 and 2013, 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, 2014 and the related change for the same period in 2013 (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	$530,640	$—	$530,640	1.4 %	$34,404	$565,044	7.9 %
Revenue Medicare	$412,544	—	$412,544	(0.4)	$25,940	$438,484	5.9
New admissions	123,659	—	123,659	1.6	9,395	133,054	9.3
New Medicare admissions	84,489	—	84,489	1.2	6,001	90,490	8.4

Average census	32,891	—	32,891	(3.5	)	2,408	35,299	3.6
Average Medicare census	24,774	—	24,774	(4.1	)	1,562	26,336	1.9
Episodes	172,472		172,472	0.9		10,424	182,896	7.0
Hospice services								
Revenue	$63,502	$—	$63,502	13.1		$4,119	$67,621	20.4
Revenue Medicare	$58,687	—	$58,687	12.7		$3,841	$62,528	20.1
New admissions	5,159	—	5,159	4.9		387	5,546	12.8
New Medicare admissions	4,506	—	4,506	6.8		350	4,856	15.1
Average census	1,262	—	1,262	10.5		81	1,343	17.5
Average Medicare census	1,158	—	1,158	11.0		77	1,235	18.3
Patient days	460,798	—	460,798	10.5		29,454	490,252	17.5
Community-based services								
Revenue	$3,902	$273	4,175	30.2		$23,523	27,698	763.7
Billable hours	910,964	34	910,998	493.3		219	911,217	493.4
Facility-based services								
LTACHs								
Revenue	$70,442	$—	$70,442	(2.0	)		$70,442	(2.0	)
Patient days	62,352	—	62,352	0.8		—	62,352	0.8	

(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 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, 2014 was $434.8 million compared to $383.5 million for the same period in 2013, an increase of $51.3 million, or 13.4%. The following table summarizes cost of service revenue (amounts in thousands, except percentages, which are percentages of the segment's respective net service revenue):

	2014			2013		
Home health services						
Salaries, wages and benefits	$295,340	52.3	%	$269,016	51.4	%
Transportation	21,463	3.8		21,443	4.1	
Supplies and services	13,053	2.3		12,130	2.3	
Total	$329,856	58.4	%	$302,589	57.8	%
Hospice services						
Salaries, wages and benefits	$27,263	40.3	%	$23,512	41.9	%
Transportation	3,027	4.5		2,745	4.9	
Supplies and services	9,514	14.1		7,955	14.1	
Total	$39,804	58.9	%	$34,212	60.9	%
Community-based services						
Salaries, wages and benefits	$19,287	69.6	%	$2,339	72.9	%
Transportation	170	0.6		39	1.2	
Supplies and services	154	0.6		20	0.6	

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Total	$19,611	70.8	%	$2,398	74.7	%
Facility-based services						
Salaries, wages and benefits	$30,047	41.0	%	$28,772	38.2	%
Transportation	281	0.4		301	0.4	
Supplies and services	15,176	20.1		15,192	20.2	
Total	$45,504	62.0	%	$44,265	58.7	%

The increase in cost of service revenue was related to the acquisitions of Deaconess and Elk Valley, and Life Care Home Health, Inc., which was offset by productivity improvements and efficiencies gained from our POC technology.

Provision For Bad Debts

Consolidated provision for bad debts for the year ended December 31, 2014 was $15.8 million compared to $13.9 million for the same period in 2013, an increase of $1.9 million, or 13.7%. On a consolidated basis, provision for bad debts as a percentage of net service revenue remained consistent. For home health services, provision for bad debts increased due to an increase in collection risks identified on certain commercial insurance claims and self pay claims. For hospice services, a decrease occurred due to the recognition of a Change in Ownership ("CHOW") by CMS for two agencies acquired in 2013. These CHOWs allowed previously "at risk" patient claims to be billed and collected, thereby reducing provision for bad debts during 2014. For facility-based services, the decrease was due to the recoverability of accounts receivable that were previously reserved.

General and Administrative Expenses

Consolidated general and administrative expenses for the year ended December 31, 2014 was $233.9 million compared to $213.6 million for the same period in 2013, an increase of $20.3 million, or 9.5%. The following table summarizes general and administrative expenses (amounts in thousands, except percentages, which are percentages of the segment's respective net service revenue):

	2014			2013		
Home health services						
General and administrative	$180,364	31.9	%	$168,881	32.3	%
Depreciation and amortization	6,917	1.2		6,175	1.2	
Total	$187,281	33.1	%	$175,056	33.4	%
Hospice services						
General and administrative	$17,796	26.3	%	$15,335	27.3	%
Depreciation and amortization	1,086	1.6		875	1.6	
Total	$18,882	27.9	%	$16,210	28.9	%
Community-based services						
General and administrative	$6,445	23.3	%	$972	30.3	%
Depreciation and amortization	106	0.4		46	1.4	
Total	$6,551	23.7	%	$1,018	31.7	%
Facility-based services						
General and administrative	$19,769	27.0	%	$20,121	26.7	%
Depreciation and amortization	1,462	2.0		1,228	1.6	
Total	$21,231	28.9	%	$21,349	28.3	%

The increase in general and administrative expenses were related to the acquisitions of Deaconess and Elk Valley, and Life Care Home Health, Inc., which was offset by staffing efficiencies gained through our POC technology. Depreciation increased due to the increase in POC devices and licenses utilized in our locations.

Impairment of intangibles and other

Consolidated impairment of intangibles and other for the year ended December 31, 2014 was $3.6 million compared to $0.5 million for the same period in 2013. The increase relates to the consolidation of a limited number of locations

in service area overlap markets and the closure of underperforming providers. Goodwill and other intangible asset disposal costs for these closures were $1.6 million. In addition, there was $2.0 million related to the impairment of intangible trade name in the home health services segment.

Interest Expense

Consolidated interest expense for the year ended December 31, 2014 was $2.5 million compared to $2.0 million for the same period in 2013, an increase of approximately $0.5 million, or 25%. The increase relates directly to balances outstanding on our revolving credit facility in each year, respectively.

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, 2014, noncontrolling interest was $6.9 million compared to $6.8 million for the same period in 2013, an increase of approximately $0.1 million, or 1.5%.

Liquidity and Capital Resources

Cash at December 31, 2015 was $6.1 million, compared to $0.5 million at December 31, 2014. 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 flows decline 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,	
	2015	2014
Net cash provided by (used in):		
Operating activities	$59,934	$38,657
Investing activities	(83,855)	(82,038)
Financing activities	29,529	29,898

The acquisitions of Halcyon Healthcare, LLC and Nurses Registry and Home Health Corporation, LLC affected operating cash flows for 2015.

Accounts Receivable days sales outstanding (“DSO”) for the year ended December 31, 2015 was 46 days compared to 47 days for the same period in 2014.

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, 2015 and 2014, outstanding letters of credit were $9.8 million and $7.1 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, 2015, 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, 2015 (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	$98,784	$241	$516	$98,027	$—
Operating leases	55,232	25,207	17,832	6,661	5,532
Total contractual cash obligations	$154,016	$25,448	$18,348	$104,688	$5,532

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.

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 controlled entities controlled. We define control as ownership of a majority of the voting interest of an entity. 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	2015		2014		2013	
Wholly owned subsidiaries	55.2	%	53.5	%	48.8	%
Equity joint ventures	42.9		43.9		48.5	
License leasing arrangements	1.0		1.8		1.9	
Management services	0.9		0.8		0.8	
	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.

The following describes the Company's consolidation policy with respect to its various ventures excluding wholly owned subsidiaries:

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.

License Leasing Arrangements

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.

Management Services

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	2015	2014	2013

Medicare	74.5	%	75.9	%	79.8	%
Medicaid	1.5		1.4		1.4	

Other	24.0		22.7		18.8	
	100.0	%	100.0	%	100.0	%

The percentage of net service revenue contributed from each reporting segment was as follows for the respective years ending December 31:

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

Medicare

Home Health Services

Our 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 one of four retroactive 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 before completing the episode; or (d) a payment adjustment based upon the level of therapy services required in the population base. Management estimates the impact of these payment adjustments based on historical experience and records this estimate during the period the services are rendered. Our payment is also adjusted for geographic wage differences. In calculating our reported net service revenue from home nursing services, we adjust the prospective Medicare payments by an estimate of the adjustments.

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 we furnish to the patient. We record net service revenue from hospice services based on the daily or hourly rate and recognize revenue as hospice services are provided.

Hospice payments are also subject to an inpatient cap and an overall Medicare payment cap. 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 twelve-month period ending on October 31 of each year. We monitor our limits on a provider-by-provider basis and record an estimate of its liability for reimbursements received in excess of the cap amount. Beginning with the 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 or inpatient rehabilitation facility. 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 agreements.

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. In compliance with the provisions of Accounting Standards Codification 740 and based on our assessment of probable outcomes, we recorded an unrecognized tax position of $3.2 million.

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 55% of our patient accounts receivable at December 31, 2015 and 2014, 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, 2015, our allowance for uncollectible accounts, as a percentage of patient accounts receivable, was approximately 19.5%, or $26.7 million, compared to 16.0%, or $18.6 million, at December 31, 2014.

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

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, 2014, 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	$51,919	$7,945	$6,142	$2,131	$68,137
Medicaid	2,039	761	666	250	3,716
Other	27,375	6,253	6,164	4,435	44,227
Total	$81,333	$14,959	$12,972	$6,816	$116,080

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:				
2015	$18,582	$19,243	$11,113	$26,712
2014	14,334	15,780	11,532	18,582
2013	11,863	13,929	11,458	14,334

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. 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 2015, 2014 or 2013 related to the annual impairment testing; however, we did recognize a disposal of $0.4 million and $0.2 million related to goodwill associated with the closure of underperforming locations in 2015 and 2014, respectively.

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. Software licenses are amortized over a three year period and 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. Lower revenue expectations caused primarily by changes in payor contracts and Medicare reimbursement cuts may reduce the fair values of certain intangible assets below their carrying values. Based on our analysis, we recorded an intangible asset charge of $0.6 million, $2.0 million and $0.5 million for the twelve months ended December 31, 2015, 2014 and 2013, respectively. We recognized a disposal of $0.3 million and $1.4 million related to other indefinite-lived intangible assets associated with the closure of underperforming locations in 2015 and 2014, respectively.
As a result of these respective impairment charges, the carrying values of the related intangible assets were adjusted to their estimated fair values as of December 31, 2015 and 2014. Any further decline in the estimated fair values of these intangibles could result in

additional impairment charges being recorded. We determined that, except for the impairment charges described above, there were no indicators that any other intangible assets were impaired as a result of the impairment analysis conducted as of November 30, 2015.

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 $0.6 million for the year ended December 31, 2015.

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 management, including its Chief Executive Officer and Chief Financial Officer, management evaluated the effectiveness of the Company's disclosure controls and procedures as of December 31, 2015. 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, 2015.

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 management, including the Chief Executive Officer and Chief Financial Officer, the Company 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, 2015.

Under guidelines established by the SEC, companies are allowed to exclude acquisitions from their assessment of internal control over financial reporting during the first year of an acquisition while integrating the acquired company. Accordingly, our assessment of the internal controls excluded Halcyon Healthcare, LLC which was acquired on October 1, 2015. Halcyon Healthcare's operations represented approximately 1% of both total assets and total revenues as of and for the year ended December 31, 2015.

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.

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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, 2015 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, 2015, 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, 2015, 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. acquired Halcyon Healthcare, LLC ("Halcyon") on October 1, 2015, and management excluded from its assessment of the effectiveness of LHC Group, Inc.'s internal control over financial reporting as of December 31, 2015, Halcyon's internal control over financial reporting associated with approximately 1% of both total assets and total revenues included in the consolidated financial statements of LHC Group, Inc. and subsidiaries as of and for the year ended December 31, 2015. Our audit of internal control over financial reporting of LHC Group, Inc. also excluded an evaluation of the internal control over financial reporting of Halcyon.

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, 2015 and 2014, 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, 2015, and our report dated March 3, 2016 expressed an unqualified opinion on those

consolidated financial statements.
/s/ KPMG LLP
Baton Rouge, Louisiana
March 3, 2016

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 2016 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 2016 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 2016 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 2016 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 2016 Annual Meeting of Stockholders.

Equity Compensation Plan Information

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)
Equity compensation plans approved by Stockholders:	5,500	$20.09	704,797
Equity compensation plans not approved by Stockholders:	—	—	—
Total	5,500	$20.09	704,797

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

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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 2016 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 2016 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, 2015 and 2014, 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, 2015. 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, 2015 and 2014, and the results of their operations and their cash flows for each of the years in three-year period ended December 31, 2015, 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, 2015, 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 3, 2016 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 3, 2016

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

	As of December 31,	
	2015	2014
ASSETS		
Current assets:		
Cash	$6,139	$531
Receivables:		
Patient accounts receivable, less allowance for uncollectible accounts of $26,712 and $18,582, respectively	110,350	97,498
Other receivables	2,093	1,334
Amounts due from governmental entities	1,081	1,164
Total receivables, net	113,524	99,996
Deferred income taxes	—	11,381
Prepaid income taxes	1,949	3,093
Prepaid expenses	10,833	8,724
Other current assets	5,835	3,777
Receivable due from insurance carrier	550	7,850
Total current assets	138,830	135,352
Property, building and equipment, net of accumulated depreciation of $38,907 and $44,683, respectively	38,096	34,787
Goodwill	290,694	240,019
Intangible assets, net of accumulated amortization of $8,496 and $6,560, respectively	96,405	79,685
Other assets	2,029	1,896
Total assets	$566,054	$491,739
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and other accrued liabilities	$24,586	$19,278
Salaries, wages and benefits payable	28,098	22,466
Self insurance reserves	9,636	6,559
Current portion of long-term debt	241	230
Amounts due to governmental entities	7,055	4,459
Legal settlement payable	550	7,850
Total current liabilities	70,166	60,842
Deferred income taxes	23,729	33,592
Income tax payable	3,415	3,415
Revolving credit facility	98,000	60,000
Long-term debt, less current portion	543	778
Total liabilities	195,853	158,627
Noncontrolling interest-redeemable	12,408	11,517
Stockholders' equity:		
LHC Group, Inc. stockholders' equity:		
Common stock – $0.01 par value: 40,000,000 shares authorized; 22,224,423 and 22,015,211 shares issued in 2015 and 2014, respectively	222	220
Treasury stock – 4,776,560 and 4,734,363 shares at cost, respectively	(37,139)	(35,660)
Additional paid-in capital	113,793	108,708

Retained earnings	277,706	245,371
Total LHC Group, Inc. stockholders' equity	354,582	318,639
Noncontrolling interest – non-redeemable	3,211	2,956
Total stockholders' equity	357,793	321,595
Total liabilities and stockholders' equity	$566,054	$491,739

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,		
	2015	2014	2013
Net service revenue	$816,366	$733,632	$658,283
Cost of service revenue	480,878	434,775	383,464
Gross margin	335,488	298,857	274,819
Provision for bad debts	19,243	15,780	13,929
General and administrative expenses	248,629	233,945	213,633
Impairment of intangibles and other	1,273	3,646	520
Operating income	66,343	45,486	46,737
Interest expense	(2,302)	(2,486)	(1,995)
Non-operating income	457	265	263
Income from continuing operations before income taxes and noncontrolling interests	64,498	43,265	45,005
Income tax expense	22,848	14,513	15,859
Income from continuing operations	41,650	28,752	29,146
Less net income attributable to noncontrolling interests	9,315	6,915	6,804
Net income attributable to LHC Group, Inc.’s common stockholders	$32,335	$21,837	$22,342
Earnings per share - basic:			
Net income attributable to LHC Group, Inc.’s common stockholders	$1.86	$1.27	$1.31
Earnings per share - diluted:			
Net income attributable to LHC Group, Inc.’s common stockholders	$1.84	$1.26	$1.30
Weighted average shares outstanding:			
Basic	17,405,379	17,229,026	17,049,794
Diluted	17,547,531	17,315,333	17,132,751

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, 2012	$216	21,578,772	(33,846)	4,653,039	$100,619	$201,192	$4,033	$272,214	$11,426	
Net income	—	—	—	—	—	22,342	1,244	23,586	5,560	29,146
Transfer of noncontrolling interest							(1,342)	(1,342)	1,342	
Noncontrolling interest	—	—	—	—	—	—	—	—	608	
Noncontrolling interest distributions	—	—	—	—	—	—	(1,060)	(1,060)	(7,066)	
Purchase of additional controlling interest	—	—	—	—	(1,267)	—	—	(1,267)	(612)	
Nonvested stock compensation	—	—	—	—	3,886	—	—	3,886	—	
Issuance of vested stock	—	184,403	—	—	—	—	—	—	—	
Treasury shares redeemed to pay income tax	—	—	(869)	40,608	—	—	—	(869)	—	
Excess tax benefits-vesting nonvested stock	—	—	—	—	(50)	—	—	(50)	—	
Issuance of common stock under Employee Stock Purchase Plan	2	38,459	—	—	784	—	—	786	—	
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	—	
Purchase of additional controlling interest	—	—	—	—	(275)	—	—	(275)		
Noncontrolling interest distributions	—	—	—	—	—	—	(1,637)	(1,637)	(6,687)	
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	2	22,723	—	—	780	—	—	782		

Stock Purchase Plan Balances at December 31, 2015	$222	22,224,423	$(37,139)	4,776,560	$113,793	$277,706	$3,211	$357,793	$12,408

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,		
	2015	2014	2013
Operating activities			
Net income	$41,650	$28,752	$29,146
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization expense	11,955	9,571	8,325
Provision for bad debts	19,243	15,780	13,929
Stock-based compensation expense	4,225	4,094	3,886
Deferred income taxes	1,518	2,402	2,351
Impairment of intangibles and other	1,990	3,650	520
Changes in operating assets and liabilities, net of acquisitions:			
Receivables	(27,951)	(16,372)	(18,961)
Prepaid expenses and other assets	(3,793)	191	(749)
Prepaid income taxes	441	911	3,299
Accounts payable and accrued expenses	10,526	(10,460)	4,395
Net amounts due to/from governmental entities	130	138	(226)
Net cash provided by operating activities	59,934	38,657	45,915
Investing activities			
Cash paid for acquisitions, primarily goodwill and intangible assets	(70,572)	(73,933)	(26,920)
Purchases of property, building and equipment	(13,283)	(8,105)	(8,343)
Net cash (used in) investing activities	(83,855)	(82,038)	(35,263)
Financing activities			
Proceeds from line of credit	83,000	75,000	73,000
Payments on line of credit	(45,000)	(37,000)	(70,500)
Excess tax benefits from vesting of restricted stock	914	124	18
Proceeds from issuance of common stock under ESPP	782	782	786
Proceeds from debt issuance	—	—	1,212
Payments on debt	(233)	(202)	—
Noncontrolling interest distributions	(8,324)	(6,843)	(8,126)
Payment of deferred financing fees	—	(852)	—
Purchase of additional controlling interest	(275)	(359)	(1,879)
Sale of noncontrolling interest	—	193	—
Redemption of treasury stock to pay income tax	(1,479)	(945)	(869)
Proceeds from exercise of stock options	144	—	—
Net cash provided by (used in) financing activities	29,529	29,898	(6,358)
Change in cash	5,608	(13,483)	4,294
Cash at beginning of period	531	14,014	9,720
Cash at end of period	$6,139	$531	$14,014
Supplemental disclosures of cash flow information			
Interest paid	$1,870	$2,461	$1,961
Income taxes paid	$20,361	$11,781	$21,606
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, 2015, the Company, through its wholly and majority-owned subsidiaries, equity joint ventures and controlled affiliates, operated 363 service providers in 25 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 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. 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. Control is defined by the Company as ownership of a majority of the voting interest of an entity. 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	2015		2014		2013	
Wholly owned subsidiaries	55.2	%	53.5	%	48.8	%
Equity joint ventures	42.9		43.9		48.5	
License leasing arrangements	1.0		1.8		1.9	
Management services	0.9		0.8		0.8	
	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.

The following discussion describes the Company’s consolidation policy with respect to its various ventures excluding wholly owned subsidiaries:

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.

License Leasing Arrangements

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.

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Management Services

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	2015		2014		2013	
Medicare	74.5	%	75.9	%	79.8	%
Medicaid	1.5		1.4		1.4	
Other	24.0		22.7		18.8	
	100.0	%	100.0	%	100.0	%

The percentage of net service revenue contributed from each reporting segment was as follows for the years ending December 31:

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

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 one of four retroactive 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 before completing the episode; or (d) a payment adjustment based upon the level of therapy services required in the population base. Management estimates the impact of these payment adjustments based on historical experience and records this estimate during the period the services are rendered. The Company’s payment is also adjusted for geographic wage differences. In calculating the Company’s reported net service revenue from home nursing services, the Company adjusts the prospective Medicare payments by an estimate of the adjustments.

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 exceed 55.0% 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 2015, 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 2015, 2014 or 2013 related to the annual impairment testing. During the twelve months ended December 31, 2015 and 2014, the Company recognized a disposal of $0.4 million and $0.2 million, respectively, of goodwill associated with the closure of underperforming locations.

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, 2015, 2014 and 2013, the Company recorded impairment charges related to indefinite-lived intangible assets of $0.6 million, $2.0 million and $0.5 million, respectively. During the twelve months ended December 31, 2015 and 2014, the Company recognized $0.3 million and $1.4 million, respectively, of disposal costs related to other indefinite-lived intangible assets associated with the closure of underperforming locations.

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 stated 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. 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, 2015, 2014 or 2013.

The following table describes the Company’s components of property, building and equipment for the years ended December 31, 2015 and 2014 (amounts in thousands):

	2015	2014

Land	$2,033	$543
Building and improvements	10,026	9,238
Transportation equipment	6,912	6,191
Fixed equipment	3,373	3,661
Office furniture and medical equipment	54,659	59,837
	77,003	79,470
Less accumulated depreciation	38,907	44,683
	$38,096	$34,787

Depreciation expense for the years ended December 31, 2015, 2014 and 2013 was $10.0 million, $7.5 million and $6.9 million, respectively, which was recorded in general and administrative expenses.

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, 2015, 2014 and 2013:

	2015	2014	2013
Weighted average number of shares outstanding for basic per share calculation	17,405,379	17,229,026	17,049,794
Effect of dilutive potential shares:			
Options	3,663	4,284	4,058
Nonvested restricted stock	138,488	82,023	78,899
Adjusted weighted average shares for diluted per share calculation	17,547,531	17,315,333	17,132,751
Antidilutive shares	200,525	173,360	182,225

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 the Company on January 1, 2017. Early adoption is not permitted. The standard permits the use of either the retrospective or cumulative effect transition method. The Company is evaluating the effect that ASU 2014-9 will have on its consolidated financial statements and related disclosures. The Company has not yet selected a transition method nor has it determined the effect of the standard on its ongoing financial reporting.

On November 20, 2015, the FASB issued ASU No. 2015-17, Income Taxes: Balance Sheet Classification of Deferred Taxes, ("ASU 2015-17") which requires an entity with a classified balance sheet to present all deferred tax assets and

liabilities as noncurrent. The new standard is effective for the Company on January 1, 2017; however, early adoption is permitted. The Company is electing to early adopt the new standard effective December 31, 2015. The standard permits the use of prospective transition and, as such, prior periods were not adjusted in the Company's financial statements.

3. Acquisitions and Disposals

2015 Acquisitions

On October 1, 2015, the Company acquired 100% of the membership interests of Halcyon Healthcare, LLC ("Halcyon"). Halcyon has 16 hospice locations throughout Alabama, Mississippi, and South Carolina. On November 11, 2015, the Company acquired 100% of the assets of Nurses' Registry and Home Health Corporation, LLC ("Nurses Registry"). Nurses Registry has five locations, four home health agencies and one community-based services agency, located in Kentucky. The goodwill associated with Halcyon and Nurses Registry was $47.2 million.

In addition, the Company acquired the majority-ownership of five home health agencies, one hospice agency, and one community-based services agency during the twelve months ended December 31, 2015.

The total aggregate purchase prices for the Company's acquisitions were $71.4 million, of which $70.1 million was paid in cash. The purchase prices are determined based on the Company's analysis of comparable acquisitions and the target market's potential future cash flows. The Company paid $0.4 million in acquisition-related costs, which was recorded in general and administrative expenses.

The Company’s home health services segment, hospice services segment, and community-based services segment recognized aggregate goodwill of $7.1 million, $43.3 million, and $0.6 million, respectively. 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	$70,123
Fair value of total consideration transferred	70,123
Recognized amounts of identifiable assets acquired and liabilities assumed	
Trade name	6,530
Certificates of needs/licenses	11,609
Other identifiable intangible assets	953
Cash	700
Accounts receivable	4,202
Fixed assets	521
Accounts payable	(1,389)
Other assets and (liabilities), net	(3,937)
Total identifiable assets	19,189
Noncontrolling interest	152
Goodwill, including noncontrolling interest of $36	$51,086

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 a preliminary assessment of deferred income tax accounting and the calculation of the final net working capital adjustment and has recognized provision amounts in it is initial accounting for the acquisition of Halcyon for all identified liabilities in accordance with the requirements of ASC Topic 805. However, the Company is continuing its review of these matters during the measurement period, and if new information obtained about facts and circumstances that existed at the acquisition date identified adjustments to the assets and liabilities initially recognized, the acquisition accounting will be revised to reflect the resulting adjustments to the provisional amounts initially recognized.

The following table contains unaudited pro forma consolidated income statement information assuming the 2015 acquisitions closed January 1, 2014 (amount in thousands, except earnings per share):

	2015	2014
Net service revenue	$ 868,075	$ 789,761
Operating income	67,520	45,671
Net income	33,044	21,949
Basic earnings per share	1.90	1.27
Diluted earnings per share	1.88	1.27

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.

2014 Acquisitions

The total aggregate purchase price for the Company’s acquisitions, which closed in the twelve months ended December 31, 2014, was $75.5 million, of which $73.9 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 paid $1.0 million in acquisition-related costs, which was recorded in general and administrative expenses.

The Company’s home health services segment, hospice services segment, and community-based services segment recognized aggregate goodwill of $22.9 million, $5.3 million, and $17.1 million, respectively. 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.

4. Goodwill and Other Intangibles, Net

The following table summarizes changes in goodwill by reporting unit during the twelve months ended December 31, 2015 and 2014 (amounts in thousands):

	Home health reporting unit	Hospice reporting unit	Community-based reporting unit	Facility-based reporting unit	Total
Balance as of December 31, 2013	$173,574	$9,463	$265	$ 11,591	$194,893
Goodwill from acquisitions	22,809	5,330	17,074	—	45,213
Goodwill related to noncontrolling interests	113	—	—	—	113
Goodwill related to disposal	(200)	—	—	—	(200)
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

The Company determined that there was no impairment for the goodwill of any reporting units as of December 31, 2015, 2014 and 2013 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 to determine the fair values as of November 30, 2015 and 2014. Lower revenue expectations caused by payor contract changes and projected Medicare reimbursement cuts reduced the fair values of certain intangible assets below their carrying values. Based on that analysis, the Company recorded an impairment charge of $0.6 million, $2.0 million, and $0.5 million for the years ended December 31, 2015, 2014 and 2013, respectively, which was recorded in impairment of intangibles and other.

The following tables summarize the changes in intangible assets during the twelve months ended December 31, 2015 and 2014 (amounts in thousands):

	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

	December 31, 2014			
	Remaining useful life	Gross carrying amount	Accumulated amortization	Net carrying amount
Indefinite-lived assets:				
Trade names	Indefinite	$54,732	$—	$54,732
Certificates of need/licenses	Indefinite	19,058	—	19,058
Total		$73,790	$—	$73,790
Amortizing assets:				
Trade names	2 months – 5 years	$8,230	$(2,797)	$5,433
Non-compete agreements	3 months – 3 years	4,225	(3,763)	462
Total		12,455	(6,560)	5,895
Balance at December 31, 2014		$86,245	$(6,560)	$79,685

Intangible assets of $66.4 million, net of accumulated amortization, related to the home health services segment, $21.8 million related to the hospice segment, $7.3 million related to the community-based services segment and $0.9 million related to the facility-based services segment as of December 31, 2015. Amortization for the years ended December 31, 2015, 2014 and 2013 was $1.9 million, $2.1 million and $1.5 million, respectively, which was recorded in general and administrative expenses.

Disposal of Intangible Assets in Company’s Subsidiary

During the twelve months ended December 31, 2015 and 2014, the Company disposed of intangible assets for underperforming providers in the home health segment. The loss on the disposal of these providers was $0.3 million and $1.4 million, respectively, which was recorded in impairment of intangibles and other.

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, 2015 and 2014 were as follows (amounts in thousands):

	2015	2014
Deferred tax assets:		
Allowance for uncollectible accounts	$9,048	$6,397
Accrued employee benefits	5,260	4,195

Stock compensation	1,068	1,228
Accrued self-insurance	2,517	2,526
Acquisition costs	1,651	1,510
Net operating loss carry forward	983	927
Intangible asset impairment	43	49
Uncertain tax position—state tax portion	215	215