LHC Group, Inc
Form 10-K
February 28, 2019

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, 2018
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 ý Accelerated filer ¨ Non-accelerated filer ¨ Smaller reporting company ¨
Emerging growth company ¨
Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ¨ No ý

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ¨

As of June 30, 2018, the aggregate market value of the registrant's common stock held by non-affiliates of the registrant was $2.5 billion 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 31,406,171 shares of common stock, $0.01 par value, issued and outstanding as of February 25, 2019.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's Annual Report to Stockholders for the fiscal year ended December 31, 2018 are incorporated by reference in Part II of this Annual Report on Form 10-K. Portions of the Registrant's Proxy Statement for its 2019 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," an 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, 2018;
- our critical accounting policies;
- our business strategies and our ability to grow our business;
- our participation in the Medicare and Medicaid programs;
- the reimbursement levels of Medicare and other third-party payors;
- the prompt receipt of payments from Medicare and other third-party payors;
- our future sources of and needs for liquidity and capital resources;
- the effect of any regulatory changes or anticipated regulatory changes;
- the effect of any changes in market rates on our operations and cash flows;
- our ability to obtain financing;
- our ability to make payments as they become due;
- the outcomes of various routine and non-routine governmental reviews, audits, and investigations;
- our expansion strategy, the successful integration of recent acquisitions and, if necessary, the ability to relocate or restructure our current facilities;
- the value of our proprietary technology;
- the impact of legal proceedings;
- our insurance coverage;
- our competitors and our competitive advantages;
- our ability to attract and retain valuable employees;
- the price of our stock;
- our compliance with environmental, health and safety laws and regulations;
- our compliance with health care laws and regulations;
- our compliance with Securities and Exchange Commission laws and regulations and Sarbanes-Oxley requirements;
- the impact of federal and state government regulation on our business;
- the impact of changes in or future interpretations of fraud, anti-kickback or other laws;
- that the businesses of the Company and Almost Family will not be integrated successfully;
- that the cost savings, synergies, growth and other benefits from the Almost Family Merger, which may not be fully realized or may take longer to realize than expected; and
- that costs associated with the integration of the businesses of the Company and Almost Family are higher than anticipated.

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 (i) 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 or, (ii) with respect to the risks associated with the proposed transaction with Almost Family, under the heading “Risk Factors” in the definitive joint proxy statement/prospectus that is included in the registration statement on Form S-4 that was filed by the Company with the SEC in connection with the proposed transaction, 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 consolidate subsidiaries.

Item 1. Business.

Overview

We provide post-acute health care services to patients through our home nursing agencies, hospice agencies, home and community-based services agencies, long-term acute care hospitals (“LTACHs”) and healthcare innovations services. As of December 31, 2018, through our wholly- and majority-owned subsidiaries, equity joint ventures and controlled affiliates, we operated 757 service providers in 36 states within the continental United States. We provide services through five segments: (1) home health, (2) hospice, (3) home and community-based (4) facility-based, and (5) healthcare innovations.

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, 2018, we operated 543 home health service locations, of which 302 are wholly-owned by us, 232 are majority-owned by us through equity joint ventures, three are under license lease arrangements, and the operations of the remaining six 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, 2018, we operated 104 hospice locations, of which 57 are wholly-owned by us, 45 are majority-owned by us through equity joint ventures, and two are under license lease arrangements.

Our home and community-based service locations offer assistance with activities of daily living to elderly, chronically ill, and disabled patients, performed by skilled nursing and paraprofessional personnel. As of December 31, 2018, we operated 81 locations, of which 71 are wholly-owned by us and ten are majority-owned by us through equity joint ventures.

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, 2018, our LTACHs had 310 licensed beds. We operated 10 LTACHs with 12 locations, of which all but two are located within host hospitals. As part of our facility-based services segment, we also own and operate two pharmacies, a family health center, a rural health clinic, and two physical therapy clinics. Of these 17 facility-based services locations, eight are wholly-owned by us and nine are majority-owned by us through equity joint ventures.

Our healthcare innovations ("HCI") segment reports on our developmental activities outside its other business segments. The HCI segment includes (a) Imperium Health Management, LLC, an ACO enablement and management company, (b) Long Term Solutions, Inc., an in-home assessment company serving the long-term care insurance industry, (c) certain assets operated by Advance Care House Calls, which provides primary medical care for patients with chronic and acute illnesses who have difficulty traveling to a doctor's office, and (d) a cost basis investment in Care Journey (formerly NavHealth, Inc.), a population-health analytics company. These activities are intended ultimately, whether directly or indirectly, to benefit our patients and/or payors through the enhanced provision of services in our other segments. The activities all share a common goal of improving patient experiences and quality outcomes, while lowering costs. They include, but are not limited to, items such as: technology, information, population health management, risk-sharing, care-coordination and transitions, clinical advancements, enhanced patient engagement and informed clinical decision and technology enabled in-home clinical assessments. We have 12 HCI locations, 11 of which are wholly-owned and one is controlled by us through equity joint ventures.

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Our net service revenue by segment for the years ended December 31, 2018, 2017 and 2016 was as follows (amounts in thousands):

	Year Ended December 31,		
	2018	2017	2016
Home health	$1,291,457	$777,583	$656,287
Hospice	199,118	157,287	131,547
Home and community-based	172,501	46,159	43,094
Facility-based	113,784	81,573	69,105
Healthcare innovations	33,103	—	—
Consolidated net service revenue	$1,809,963	$1,062,602	$900,033

For further information regarding the financial performance of our segments, see Note 12 to the Consolidated Financial Statements included in this Annual Report on Form 10-K.

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

Merger with Almost Family

On November 15, 2017, we announced the execution of an Agreement and Plan of Merger (the “Merger Agreement”) entered into among the Company, Almost Family, Inc. (“Almost Family”), and Hammer Merger Sub, Inc. (“Merger Sub”), a wholly owned subsidiary of the Company, providing for a “merger of equals” business combination of the Company and Almost Family (the "Merger"). The Merger closed on April 1, 2018, with the approval of both companies’ stockholders and the satisfaction of other customary closing conditions. See Note 3 to the Consolidated Financial Statement and Part I, Item 1A. Risk Factors in this Annual Report on Form 10-K for additional information on the Merger.

Business Strategy

Our objective is to become the leading provider of in-home healthcare services in the United States, while also providing a complementary suite of other post acute healthcare service offerings through our facility-based and HCI segments. 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. In addition, we plan to continue acquiring freestanding agencies that can serve as growth platforms in markets we do not currently serve in order to support our growth into new markets.

Pursue strategic acquisitions and develop joint ventures. We will continue to identify and evaluate opportunities for strategic acquisitions in new and existing markets that will enhance our market position, increase our referral base, and expand the breadth of services we offer. We will aim to continue entering into joint ventures with hospitals to provide our current post-acute care services to their patients upon discharge from the hospital setting.

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 five principal categories: (1) home health services, (2) hospice services, (3) home and community-based services, (4) facility-based services offered through our LTACHs, and (5) healthcare innovations services.

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 care, 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 clinical pathways to treat chronic diseases and conditions, including diabetes, hypertension, arthritis, Alzheimer’s disease, low vision, spinal stenosis, Parkinson’s disease, osteoporosis, complex wounds, 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 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.

Home and Community-Based Services

Our home and 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

Our long-term acute care hospitals (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. As part of our facility-based services, we operate an institutional pharmacy, which focuses on providing a full array of services to our LTACHs, as well as other non-related facilities. We also operate a family health center, a rural health clinic, two physical therapy providers that staff both facilities and outpatient clinics, and one retail pharmacy.

Healthcare Innovations Services

Our HCI segment reports on our developmental activities outside our other business segments. The HCI segment includes (a) Imperium Health Management, LLC, an ACO enablement and management company, (b) Long Term Solutions, Inc., an in-home assessment company serving the long-term care insurance industry, (c) certain assets operated by Advanced Care House Calls, which provides primary medical care for patients with chronic and acute illnesses who have difficulty traveling to a doctor's office, and (d) a cost basis investment in Care Journey (formerly NavHealth, Inc.), a population-health analytics company. These activities are intended ultimately, whether directly or indirectly, to benefit our patients and/or payors through the enhanced provision of services in our other segments. The activities all share a common goal of improving patient experiences and quality outcomes, while lowering costs. They include, but are not limited to, items such as: technology, information, population health management, risk-sharing, care-coordination and transitions, clinical advancements, enhanced patient engagement and informed clinical decision and technology enabled in-home clinical assessments.

Operations

Financial information relating to the home health, hospice, home and community-based, facility-based, and healthcare innovations 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, 2018, 2017 and 2016, respectively, is found in Note 12 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 multiple geographical regions and further separated into individual operating markets or clusters. Our hospice agencies are operated in one segment that is separated into multiple geographical regions. Our home and community-based agencies are operated in one segment separated into multiple geographic regions. Each of our home health agencies are 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 home and community-based agencies are licensed and certified by the state and federal governments. As of December 31, 2018, 459 of our 543 home health service locations and 88 of our 104 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 separated into multiple geographic regions. Our facility-based services, through our LTACHs, follow a clinical approach under which each patient is discussed in weekly, multidisciplinary team meetings. In these meetings, patient progress is assessed and compared to goals and future goals are set. We believe that this model results in higher quality care and more predictable discharge patterns and avoids unnecessary delays.

Our home health service locations use our Service Value Point system, a proprietary clinical resource allocation model and cost management system. The system is a quantitative tool that assigns a target level of resource units to a group of patients based upon their initial assessment and estimated skilled nursing and therapy needs. The Service Value Point system allows

the Director of Nursing or Branch Manager to allocate adequate resources throughout the group of patients assigned to his or her care, rather than focusing on the profitability of an individual patient.

Patient care is coordinated on-site at the agency level of each home health service, hospice service, and home 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.

Our healthcare innovations business lines primarily provide assessments and related services to the long term care insurance industry and management services to ACOs with over 400,000 Medicare lives under management.

Equity Joint Ventures

As of December 31, 2018, we had 79 equity joint ventures including 71 with hospital and health systems, which are comprised of 330 hospitals, four with physicians, and four with other parties.

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

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

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

License Leasing Agreements

As of December 31, 2018, 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	2018 Current Monthly Fee	Increase in Monthly Fee	Initial Termination Dates

1	$20,258	5% increase every three years	2018 with a 2 year automatic renewal
1	Based on net quarterly projections with an annual cap of $423,000.	None	2018 with a 1 year automatic renewal
1	Based on net quarterly projections with an annual cap of $208,000.	None	2018 with a 1 year automatic renewal

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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, 2018, we had six management services agreements under which we manage the operations of six home nursing agencies. We do not have ownership interest in these providers. Instead, for a fee, we provide billing, management, and other consulting services suited to and designed for the efficient operation of the providers. We are responsible for the costs associated with the locations and personnel required for the provision of services.

We have three different types of agreements. One management services agreement provides compensation based on a percentage of cash collections for the agency. Another agreement mandates that we are reimbursed for operating expenses and receive a percentage of the operating net income of the agency. The final agreement provides a base monthly fee in addition to reimbursement for operating expenses.

The terms of these agreements vary. Two of the management service agreements have a term of five years, with an option to renew for an additional five-year term. Renewal for same agreement is automatic unless either party gives written notice of termination. The term of the remaining agreement is for an initial three year period with an automatic renewal for successive one year terms unless terminated by either party. The final agreement expires upon the earlier of (i) the effective date of the proposed acquisition, (ii) cancellation of the proposed acquisition, or (iii) termination at any time by mutual written consent of the parties.

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 ("MedPac"), an independent agency that advises Congress on various Medicare issues, there were approximately 12,204 Medicare-certified home nursing agencies in the United States in 2016. MedPac estimated that in 2015 approximately 17% of Medicare-certified home health agencies provided a majority of their services in rural areas, and 78% 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.

We believe our diverse service offerings, collaborative approach to working with health care providers, densification house of brands market strategy, our size as one of the nation's largest home care providers, business experience gained from focusing on rural markets, and patient-oriented operating model provide our principal competitive advantages over local providers.

Quality Assurance & Performance Improvement

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

- performance improvement audits,
- Joint Commission accreditation,

- state and regulatory surveys,
- publicly reported quality data, and
- patient perception of care.

The Quality Department is also responsible for ensuring that the infrastructure of the quality initiatives throughout the Company is appropriate, overseeing and evaluating the effectiveness of the quality plans and initiatives, and 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 patients' and/or family members' perception of care using third party data, and
- assessment of infection control practices and risk events.

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

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

The Quality of Patient Care 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 ratings received by our home health agencies, we continue to strive to improve our results. As of December 31, 2018, 99% of our same store home health agencies were rated 4 stars or greater when excluding recent acquisitions.

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, and
- ensuring that we take appropriate corrective and disciplinary action when noncompliant or improper conduct is identified.

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.

As of December 31, 2018, all of our home nursing and hospice locations utilize our point of care ("POC") system. 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.

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 65.4%, 71.7% and 75.5% of our net service revenue for the years ended December 31, 2018, 2017 and 2016, respectively. Medicare reimburses us based upon the setting in which we provide our services or the Medicare category in which those services fall.

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

Home Health

The Medicare home nursing benefit is available to patients who need care following discharge from a hospital, as well as patients who suffer from chronic conditions that require skilled intermittent care. While the services received need not be rehabilitative or of a finite duration, patients who require full-time skilled nursing for an extended period of time generally do not qualify for Medicare home nursing benefits. As a condition of coverage under Medicare, beneficiaries must: (1) be homebound, meaning they are unable to leave their home without a considerable and taxing effort; (2) require intermittent skilled nursing, physical therapy, or speech therapy services that are covered by Medicare; and (3) receive treatment under a plan of care that is established and periodically reviewed by a physician. Qualifying patients also may receive reimbursement for occupational therapy, medical social services, and home health aide services if these additional services are part of a plan of care prescribed by a physician.

We receive a standard prospective Medicare payment for delivering care over a 60-day episode of care. There is no limit to the number of episodes a beneficiary may receive as long as he or she remains eligible. The base episode payment is a flat rate that is adjusted upward or downward based upon differences in the expected resource needs of individual patients as indicated by clinical severity, functional severity and service utilization. The magnitude of the adjustment is determined by each patient's categorization into one of 153 payment groups, known as Home Health Resource Groups and the costliness of care for patients in each group relative to the average patient. Payment is further adjusted for differences in local labor costs using the hospital wage index. We bill and are reimbursed for services in two stages: an initial request for advance payment when the episode commences and a final claim when the episode is completed. We submit all Medicare claims through the Medicare Administrative Contractors for the federal government. We receive 60% of the estimated payment for a patient's initial episode up-front (after the initial assessment is completed and upon initial billing) and the remaining 40% upon completion of the episode and after all final treatment orders are signed by the physician. In the event of subsequent episodes, reimbursement timing is 50% up-front and 50% upon completion of the episode. Final payments may reflect base payment adjustments for case-mix and geographic wage differences and 2% sequestration reduction for episodes beginning after March 31, 2013. In addition, final adjustments 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 or transferred from another provider before completing the episode; (d) a payment adjustment based upon the level of therapy services required. 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 $3,039.64 per 60-day episode for the year ended December 31, 2018. The base payment rate does not take into consideration the 2% sequestration payment reduction mandated by the Budget Control Act of 2011.
Home health payment rates are updated annually by the home health market basket percentage as adjusted by Congress. CMS establishes the home health market basket index, which measures inflation in the prices of an appropriate mix of goods and services included in home health services.
Effects of the Bipartisan Budget Act of 2018 on Home Health
On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018 (the “BBA 2018”), which included the following provisions impacting our home health business:

- A new case mix model
- Mandates the development of a new case mix model in a transparent process involving Centers for Medicare and Medicaid Services ("CMS"), the home health industry, and the Congressional committees of jurisdiction.
- The new model will use a 30-day payment period (leaving intact the 60-day assessment and order process), and must be implemented in a budget-neutral manner beginning in 2020 and will not include the use of therapy visits as a determinant. Congressional Budget Office ("CBO") scored this at zero savings and zero cost due to the budget-neutrality requirement.
- CMS is specifically instructed to consider the use of alternative payment reform recommendations like the “Risk Based Grouper Model” proposed in lieu of the Home Health Groupings Model ("HHGM") proposed in the preliminary rule.
- The new model must be developed on a budget-neutral basis as opposed to the HHGM, which was proposed on a non-budget-neutral basis in the preliminary rule. Further, any behavioral adjustments must now be transparent and subject to public notice, comment, and the rule-making process. The HHGM, as proposed, footnoted a reference to behavioral adjustments that were not defined and not transparent in its underlying assumptions period in 2017.
- Restoration of the 3% rural add-on
- Restores the 3% home health rate add-on for home health patients who reside in rural geographies, effective January 1, 2018. The add-on rate will be phased downward over a five-year period following a formula specified in the legislation.
- Restores an important protection of access to Medicare home health care for rural America, and provides sufficient time for the industry to produce additional compelling evidence to demonstrate the positive impact of the rural add-on payment to rural Medicare beneficiaries.
- Since its inception, the rural rate has been repeatedly renewed by Congress in recognition of the continued need.
- Face-to-face documentation improvements allowing the home health medical record in its entirety to be used in support of the physician’s attestation of medical necessity.
- A study is to be conducted by the GAO (Government Accounting Office) on Medicare improvements to address the needs of the chronically ill through healthcare services provided at home, including interdisciplinary care management, tele-health, and tele-monitoring for Medicare Advantage plans, requiring states to better integrate Medicare and Medicaid services for the dually-eligible, and the extension and expansion of the Independence at Home Demonstration Program.

- A specific market basket update percentage of 1.5% for fiscal year 2020, leaving intact the full market basket update (generally expected to be between 2-3%) for fiscal year 2019. Suspends the productivity adjustment in 2020.
- Repeal of the Independent Payment Advisory Board, effective upon passage.
- Payment rate feasibility study to be conducted concerning the feasibility of a higher payment rate for providers, including home health providers that engage in the management of patients' chronic conditions.

In addition, for certifications and recertifications that commence on or after January 1, 2020, CMS will implement the Patient Driven Groupings Model ("PDGM") prospective payment system, as mandated by the Bipartisan Budget Act of 2018. Under PDGM, the initial certification of patient eligibility, plan of care, and comprehensive assessment will remain valid for 60-day episodes of care, but payments for home health services will be made based upon 30-day payment periods. For low utilization payment adjustments ("LUPAs") under PDGM, the threshold will vary for a 30-day period depending on the PDGM payment group. Further, PDGM eliminates the use of the number of therapy visits in determining the calculation of payments. Under PDGM, the national standardized rate will be budget neutral and will be set in the 2020 proposed rule. While CMS has proposed to make adjustments totaling -6.42% for assumptions on changes in provider behavior affecting reimbursement, which relate to clinical group coding, comorbidity coding, and achievement of LUPA thresholds, without providing backup data to support a full understanding of the assumptions that CMS used in determining these adjustments. LHC Group intends to continue its advocacy efforts to eliminate or reduce the amount of the behavioral adjustments.

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 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.

Effective October 1, 2018, hospices will be reimbursed at a higher routine home care rate ($196.25) for days 1 through 60 of a hospice episode of care and a lower rate ($154.21) 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.

Effects of BBA 2018 on Hospice

The BBA 2018 included the following provisions impacting our hospice business:

- Hospice included in Hospital Post-Acute Transfer Policy for early discharges to hospice care. Hospice will be included as a post-acute service subject to the transfer DRG policy, in which acute-care hospitals receive a reduction in payments if they transfer a patient to post-acute care prior to achieving the mean length of stay for the DRG. Currently, home health, skilled nursing facilities, and LTACHs are included within the policy, and the BBA 2018 adds hospice as a post-acute provider subject to the policy.
- Physician Assistants recognized as attending physicians to serve hospice patients, effective January 1, 2019.

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 predetermined 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 area determined, on an individual case basis by the

applicable CMS regional office, to be part of a hospital's campus. An LTACH that uses the same Medicare provider number of an affiliated “primary site” LTACH is known as a “satellite”. Under Medicare policy, a satellite LTACH must be located within 35 miles of its primary site LTACH and be administered by such primary site LTACH. As of December 31, 2018, we had a total of 12

LTACH facilities, with 310 licensed beds. Ten of our LTACH facilities were classified as HwHs and two were classified as freestanding. Of the 12 facilities, seven were located in Metropolitan Statistical Area ("MSA") or urban areas and five 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. One of our freestanding locations is a remote campus site of a parent located in an MSA, and the latter freestanding location is located adjacent to a tertiary care facility.

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.

Fiscal Year 2019 Rates

On August 2, 2018, CMS posted a display copy of the Final Rule for the annual update to Medicare payment rates and policies for the fiscal year 2019 inpatient hospitals prospective payment system and the LTACH PPS. The final rule will be effective for discharges occurring on or after October 1, 2018 through September 30, 2019. CMS finalized a 0.9% overall increase in payments under the LTACH PPS in fiscal year 2019 based upon a 1% increase in payments for standard Federal payment rate cases and a 0.4% increase in payments for site neutral payment cases. On October 3, 2018, CMS published a correction to the final rule revising the fiscal year 2019, the LTACH PPS standard Federal payment rate to $41,558.68 (instead of $41,579.65 as published in the final rule on August 2, 2018). CMS also finalized elimination of the 25 Percent Rule, but implemented a one-time budget neutrality adjustment of approximately 0.9% for fiscal year 2019 to cover the cost of elimination of the rule.

CMS also finalized LTACH policy changes effective for cost reporting periods beginning on or after October 1, 2019, permitting LTACHs to establish psychiatric and rehabilitation units, and to co-locate with other IPPS-exempt hospitals to provide LTACH, psychiatric and rehabilitative care on the same campus. CMS also increased flexibility for co-located satellite LTACH facilities clarifying that such co-located satellites do not need to comply with some of the separateness and control requirements of a co-located hospital. The proposed rule also makes some changes to the LTACH quality reporting program by removing three quality measures and refraining from adding additional measures.

Effects of BBA 2018 on LTACHS

The impact of BBA 2018 on our LTACH business includes a two-year extension of site-neutral blended payments rates for certain long-term care hospital discharges, based upon a 4.6% reduction in site-neutral payments over 7 years.

Medicaid

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

Non-Governmental Payors

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

Patients are generally not responsible for any difference between customary charges for our services and amounts paid by Medicare and Medicaid programs and the non-governmental payors, but are responsible for services not covered by these programs or plans, as well as co-payments for deductibles and co-insurance obligations of their coverage. Patient out-of-pocket costs for the payment of deductibles and co-insurance have increased in recent years. Collection of amounts due from individuals is typically more difficult than collection of amounts due from government or business payors. Because the majority of our billed services are paid in full by Medicare, Medicaid or private

insurance, co-payments from patients do not represent a material portion of our billed revenue and corresponding accounts receivable. To further reduce their health care costs, most commercial payors such as insurance companies, health maintenance organizations, preferred provider organizations and other managed care companies have negotiated discounted fee structures or fixed amounts for services performed, rather than paying health care providers the amounts normally billed.

In response to the challenges associated with collecting from commercial payors, we began negotiating higher reimbursement rates with a majority of our commercial payors. As of December 31, 2018, our managed care contracts included over 320 different payors between all of our divisions. If we are unable to continue negotiating higher reimbursement rates with commercial payors or if commercial payors continue to reduce health care costs through reduction in home health reimbursement, it could have a material adverse impact on our financial results.

Government Regulations

General

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

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

If we fail to comply with these applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in federal and state health care programs, which would materially adversely affect our financial condition and results of operations. Although we believe we are in material compliance with all applicable laws and regulations, these are complex matters and a review of our practices by a court or law enforcement or regulatory authority could result in an adverse determination that could harm our business. Furthermore, the laws applicable to us are subject to change, interpretation, and amendment; which could adversely affect our ability to conduct our business.

Medicare Participation

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

Federal Anti-Kickback Statute

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

The OIG has published numerous “safe harbors” that exempt some practices from enforcement action under the Anti-Kickback Statute. These safe harbors exempt specified activities, including bona-fide employment relationships, contracts for the rental of space or equipment, personal service arrangements, and management contracts, so long as all of the requirements of the safe harbor are met. The OIG has recognized that the failure of an arrangement to satisfy all of the requirements of a particular safe harbor does not necessarily mean that the arrangement violates the

Anti-Kickback Statute. Instead, each arrangement is analyzed on a case-by-case basis, which is very fact specific. While we operate our business to comply with the prohibitions of the Anti-Kickback Statute, we cannot guarantee that all our arrangements will satisfy a safe harbor or will ultimately be viewed as being compliant with the Anti-Kickback Statute.

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

Stark Law

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

The term “financial relationship” is defined very broadly to include most types of ownership or compensation relationships. The Stark Law 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. 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.

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, 2018, 2017 and 2016, 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, as well as persons who contract with excluded persons may be penalized.

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

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

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

Governmental Review, Audits, and Investigations

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

In addition, CMS engages third party contractors to conduct Additional Documentation Requests ("ADR") and other third party firms, including Zone Program Integrity Contractors (“ZPICs”) and Recovery Audit Contractors (“RACs”), to conduct extensive reviews of claims data and state and Federal Government health care program laws and regulations applicable to healthcare providers. These audits evaluate the appropriateness of billings submitted for payment. Audit contractors identify overpayments resulting from incorrect payment amounts, non-covered services, medically unnecessary services, incorrectly coded services, and duplicate services, and are paid on a contingency basis. In addition to identifying overpayments, audit contractors can refer suspected violations of law to government enforcement authorities.

We cannot predict the ultimate outcome of any regulatory and other governmental audits and investigations. While such audits and investigations are the subject of administrative appeals, the appeals process, even if successful, may take several years to resolve. The Company’s costs to respond to and defend any such audits, reviews and investigations could be significant and are likely to increase in the current enforcement environment.

The Department of Justice, CMS, or other federal and state enforcement and regulatory agencies may conduct additional investigations related to the Company's businesses in the future. These audits and investigations have caused and could potentially continue to cause delays in collections, recoupments, retroactive adjustment to amounts previously paid from governmental payors. Currently, the Company has recorded $16.9 million in other assets, which are from government payors related to the disputed finding of pending ZPIC audits. Additionally, these audits and investigations may subject the Company to sanctions, damages, extrapolation of damage findings, additional recoupments, fines, and other penalties (some of which may not be covered by insurance), termination from the Medicare and Medicaid programs, bars on Medicare and Medicaid payments for new admissions, any of which may, either individually or in the aggregate, have a material adverse effect on the Company's business and financial condition.

Environmental, Health, and Safety Laws

We are subject to federal, state, and local regulations governing the storage, use, and disposal of materials and waste products. Although we believe that our safety procedures for storing, handling, and disposing of these hazardous materials comply with the standards prescribed by law and regulation, we cannot completely eliminate the risk of accidental

contamination or injury from those hazardous materials. In the event of an accident, we could be held liable for any damages that result, and any liability could exceed the limits or fall outside the coverage of our insurance. We may not be able to maintain insurance on acceptable terms, or at all. We could incur significant costs and the diversion of our management's attention to comply with current or future environmental laws and regulations. We are not aware of any violations related to compliance with environmental, health and safety laws through 2018.

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, 2018.

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 states of Louisiana and Mississippi continue to have state issued moratorium on the issuance of new licenses for home nursing agencies that we expect to remain in effect for 2019.

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 are 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, 2018, the Joint Commission had accredited 459 of our 543 home health agencies and 88 of our 104 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, 2018, we had 30,985 employees, of which 14,598 were full-time. None of our employees are subject to a collective bargaining agreement. We consider our relationships with our employees and independent contractors to be good.

Insurance

We are subject to claims and legal actions in the ordinary course of our business. To cover claims that may arise, we maintain commercial insurance for healthcare professional liability, general liability, automobile liability, employed lawyers liability, fiduciary liability, crime liability, information security and privacy liabilities, and workers' compensation/employer's liability

in amounts that we believe are appropriate and sufficient for our operations. We maintain claims-made healthcare professional liability and occurrence based general liability insurance that provides primary limits of $1.0 million per incident/ occurrence and $3.0 million in annual aggregate amounts. We maintain workers' compensation insurance that meets state statutory requirements and provides a primary employer liability limit of $1.0 million to cover claims that may arise in the states in which we operate, excluding Ohio and Washington. Coverage for workers' compensation matters within Ohio and Washington is procured from each state's respective 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 former President Obama on March 23, 2010, and March 30, 2010, respectively. The Acts dramatically alter the United States' health care system and are intended to decrease the number of uninsured Americans and reduce overall health care costs. The Acts attempt to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding Medicare and Medicaid eligibility, reducing Medicare and Medicaid payments, and tying reimbursement to the satisfaction of certain quality criteria. The Acts also contain a number of measures that are intended to reduce fraud and abuse in the Medicare and Medicaid programs. Because a majority of the measures contained in the Acts have either just recently or not yet taken effect, it is difficult to predict the impact the Acts will have on our operations. However, depending on how they are ultimately interpreted and implemented, the Acts could have an adverse effect on our business and its financial condition and results of operations.

The PPACA also amended the False Claims Act to provide that a provider must report and return overpayments within 60 days of identifying the overpayment or the claims for the services that generated the overpayments become false claims subject to the False Claims Act. Overpayments include payments for services for which the provider does

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

Significant developments from the U.S. President could have a material effect on our business.

On January 30, 2017, President Trump issued an Executive Order entitled “Reducing Regulation and Controlling Regulatory Costs” that, among other things, will require federal agencies to cut two existing regulations for every new regulation they implement. The impact of any such changes to health care regulations on our financial performance and business prospects

cannot be estimated at this time. It remains unclear what regulations might change, and whether any regulatory changes might affect, positively or negatively, our home health services, hospice services, community-based services, or facility-based services. Additionally, the new Executive Order also required a suspension of the implementation of any new planned regulations for a review period, which calls into question whether the implementation of changes to Conditions of Participation (CoPs) recently issued by CMS will be halted. Substantive changes to the regulations applicable to our business, in particular changes in compliance requirements or in reimbursement rates under Medicare, could have a material effect on our business and our financial performance.

The appointment of Alex Azar as the Secretary of the Department of Health and Human Services (HHS) may also affect our business. During his confirmation hearings, Mr. Azar expressed his personal opinions concerning the need to continue moving toward value-based payments, saying it represents a shift from "paying for procedures to paying for outcomes." While we continue to work with Secretary Azar and HHS under his leadership, we cannot anticipate the effect that the appointment of Secretary Azar will have on HHS policy and/or Medicare or Medicaid reimbursements.

The impact of the recent significant federal tax reform on the combined company is uncertain and may significantly affect the operations of the combined company.

On December 22, 2017, President Trump signed the Tax Cuts and Jobs Act (the “Tax Act”) into law. The Tax Act is the most comprehensive tax legislation signed into law in over three decades and makes broad and complex changes to the U.S. tax code. The Tax Act will significantly change how our earnings are taxed, including, among other items, (1) reducing the U.S. federal corporate tax rate from 35 percent to 21 percent, (2) repealing the corporate alternative minimum tax (“AMT”) and changing how existing AMT credits can be utilized, (3) temporarily providing for elective immediate expensing for certain depreciable property, (4) creating a new limitation on deductible interest expense, and (5) changing rules related to uses and limitations of net operating loss carryforwards created in tax years beginning after December 31, 2017. While we currently expect the Tax Act to have a long-term positive impact on our net income, we are continuing to evaluate the impact of the Tax Act on our current and prospective business. Furthermore, our financial results may be negatively impacted should tax rates be increased in the future or otherwise adversely affected by changes in allowable expense deductions.

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, 2018, 2017 and 2016, we received 65.4%, 71.7% and 75.5%, respectively, of our net service revenue from Medicare. Reductions in Medicare rates or changes in the way Medicare pays for services could cause our net service revenue and net income to decline, perhaps materially. See Part I, Item 1. Reimbursement in this Annual Report on Form 10-K for additional information regarding reimbursements. Reductions in Medicare reimbursement could be caused by many factors, including:

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

We receive fixed payments from Medicare for our services based on the level of care provided to our patients. Consequently, our profitability largely depends upon our ability to manage the cost of providing these services. Medicare currently provides for an annual adjustment of the various payment rates, such as the base episode rate for

our home nursing services, based upon the increase or decrease of the medical care expenditure, which may be less than actual inflation. This adjustment could be eliminated or reduced in any given year. Also beginning on April 1, 2013 Medicare reimbursement was cut an additional 2% through sequestration as mandated by the Congressional Budget Act. Further, Medicare routinely reclassifies home health resource groups and long-term care diagnosis-related groups. As a result of those reclassifications, we could receive lower reimbursement rates depending on the case mix of the patients we service. If our cost of providing services increases by more than the annual Medicare price adjustment, or if these reclassifications result in lower reimbursement rates, our results of operations, net income and cash flows could be adversely impacted.

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

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

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

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

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

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

We are subject to various routine and non-routine governmental reviews, audits and investigations. CMS engages third party contractors to conduct Additional Documentation Requests ("ADR") and other third party firms, including Zone Program Integrity Contractors ("ZPICs") and Recovery Audit Contractors ("RACs"), to 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 of such policies argue 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' abilities to obtain financing and a decline in spending. As a result, we may face reimbursement rate cuts or reimbursement delays from Medicare and Medicaid and other governmental payors, which could adversely impact our results of operations and cash flows.

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

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

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

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

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

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

If our LTACHs fail to meet or maintain the standards for Medicare certification as LTACHs, such as for average minimum patient length-of-stay and restrictions on sources of referral (e.g. the 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 25 Percent rule will not be applied to LTACHs for discharges occurring on or before September 30, 2018.

The implementation of new patient criteria for our LTACHs under the BBA 2018 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 2018 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 the LTACH-PPS rate. Other patients will continue to have access to LTACH care, but our LTACH will be paid at a "site-neutral rate" for these patients, based on the lesser of per diem Medicare rates paid for patients with the same diagnoses under IPPS or LTACH costs.

The effective date of the new patient criteria was October 1, 2015, followed by a two-year phase-in period tied to each LTACH's cost reporting period. During the phase-in period, payment for patients receiving the site-neutral rate will be based 50% on the current LTACH-PPS rate and 50% on the new site-neutral rate. For our two LTACHs that have a cost reporting period starting before July 1 of each year, the phase-in began on June 1, 2016. For our six LTACHs that have a cost reporting period starting on or after July 1 of each year, the phase-in began on September 1, 2016. As described in Part I, Item 1. Reimbursement in this Annual Report on Form 10-K, the BBA 2018 extended the site neutral phase-in period for an additional two years, based upon a 4.6% reduction in site neutral payments over seven years.

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 2018 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 2018 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 the moratorium in Louisiana will be extended. In addition, we cannot predict 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, 2018, we operated in 17 states that require health care providers to obtain prior approval, known as a certificate of need or a permit of approval, for the purchase, construction or expansion of health care facilities, to make certain capital expenditures or to make changes in services or bed capacity. The failure to obtain any requested certificate of need, permit of approval or other license could impair our ability to operate or expand our business.

Risk Factors Related to Capital and Liquidity

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

Financial markets may experience significant disruptions, which could impact liquidity in the debt markets, making financing terms for borrowers less attractive and, in certain cases, significantly reducing the availability of certain types of debt financing. We have not experienced any individual lender limitations to extend credit under our revolving credit facility. However, the obligations of each of the lending institutions in our revolving credit facility are separate and the availability of future borrowings under our revolving credit facility could be impacted by further volatility and disruptions in the financial credit markets or other events. Our inability to access our revolving credit facility or refinance the revolving credit facility would have a material adverse effect on our business, financial position, results of operations and liquidity.

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

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

The agreement and instruments governing our revolving credit facility contain, 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.

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 United States are particularly susceptible to adverse weather events, such as 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 and 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 other 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, at the applicable market or component level based on expected revenue and cash flows to be generated by those assets or collection of assets. Specific economic factors and conditions attributed to local markets or underlying 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 implicit price concessions 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 implicit price concessions 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 implicit price concessions are insufficient to cover losses on our receivables, our business, financial position and results of operations could be materially adversely affected.

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

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

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

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

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

Upon the occurrence of fundamental changes to the laws and regulations applicable to our joint ventures, or if a substantial number of our joint venture partners were to exercise the buy/sell provisions contained in many of our joint venture agreements, we may be obligated to purchase or sell the equity interests held by us or our joint venture partners. In some instances, the purchase price under these buy/sell provisions is based on a multiple of the historical or future earnings before income taxes, depreciation and amortization of the equity joint venture at the time the buy/sell option is exercised. In other instances, the buy/sell purchase price will be negotiated by the partners but will be subject to a fair market valuation process. In the event the buy/sell provisions are exercised and we lack sufficient capital to purchase the interest of our joint venture partners, we may be obligated to sell our equity interest in these joint ventures. If we are forced to sell our equity interest, we will lose the benefit of those particular joint venture operations. If these buy/sell provisions are exercised and we choose to purchase the interest of our joint venture

partners, we may be obligated to expend significant capital in order to complete such acquisitions. If either of these events occurs, our net service revenue and net income could decline or we may not have sufficient capital necessary to implement our growth strategy.

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

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

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

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

We may close additional underperforming agencies in the future.

We regularly review the performance of our various agencies. Our review considers the current financial performance, market penetration, forecasted market growth and current and future reimbursement payment forecasts.

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

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

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

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

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

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

We intend to continue growing through the acquisition of additional home-based agencies and the formation of joint ventures with hospitals for the operation of home-based agencies. We face competition for acquisition and joint venture candidates, which may limit the number of acquisition and joint venture opportunities available to us or lead to the payment of higher

prices for our acquisitions and joint ventures. We cannot guarantee that we will be able to identify suitable acquisition or joint venture opportunities in the future or that any such opportunities, if identified, will be consummated on favorable terms, if at all. Without successful acquisitions or joint ventures, our future growth rate could decline. In addition, we cannot guarantee that any future acquisitions or joint ventures, if consummated, will result in further growth.

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

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

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

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

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

We depend upon reliable and secure information systems to provide valuable tools by which we manage our business, comply with legal requirements and provide services. In addition to our Service Value Point system, our business is also substantially dependent on non-proprietary software. We utilize third-party software information systems for billing and maintaining patient claim receivables. Our systems require constant maintenance and upgrades 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 ability to maintain the security of patient, employee, third-party or company information could have an impact on our reputation and our results.

We have been, and likely will continue to be, subject to computer hacking, acts of vandalism or theft, malware, computer viruses or other malicious codes, phishing, employee error or malfeasance, catastrophes, unforeseen events or other cyber-attacks. To date, we have seen no material impact on our business or operations from these attacks or events. Any future significant compromise or breach of our data security, whether external or internal, or misuse of patient, employee, third-party or Company data, could result in significant costs, lost sales, fines, lawsuits, and damage to our reputation. However, the ever-evolving threats mean we and our third-party service providers and vendors must continually evaluate and adapt our respective systems and processes and overall security environment, as well as those of any companies we acquire. There is no guarantee that these measures will be adequate to safeguard against all data security breaches, system compromises, or misuses of data. In addition, as the regulatory environment related to information security, data collection and use, and privacy becomes increasingly rigorous, with new and constantly changing requirements applicable to our business, compliance with those requirements could also result in additional costs.

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

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

Risk Factors Related to our Ownership and Management

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

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

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

Our success depends upon the continued employment of our executive management team and key employees and our ability to retain and motivate these individuals. If we lose the services of one or more of our executive officers or key employees, we may not be able to successfully manage our business, achieve our business goals or replace them with equally qualified

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

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

Our executive officers and directors and individuals or entities affiliated with them, beneficially own an aggregate of approximately 4.3% of our outstanding shares of common stock as of December 31, 2018. 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 us. These provisions include:

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

These anti-takeover defenses could discourage, delay, or prevent a transaction involving a change in control of us. 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 the Company.

We do not anticipate paying dividends on our common stock in the foreseeable future and, consequently, our stockholders' ability to achieve a return on 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 material weaknesses 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 on Form 10-K. 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.

Risk Factors Related to the Merger with Almost Family

The company may fail to realize all of the anticipated benefits of the Merger or those benefits may take longer to realize than expected. The combined company may also encounter significant difficulties in integrating the two businesses.

The ability of the combined company to realize the anticipated benefits of the Merger will depend, to a large extent, on the combined company's ability to successfully integrate the two businesses. The combination of two independent businesses is

a complex, costly, and time-consuming process. As a result, the combined company will be required to devote significant management attention and resources to integrating our business practices and operations with the business practices and operations of Almost Family. The integration process may disrupt the business of the combined company and, if implemented ineffectively, would restrict the full realization of the anticipated benefits. The failure to meet the challenges involved in integrating the two businesses and to realize the anticipated benefits of the transaction could cause an interruption of, or a loss of momentum in, the activities of the combined company and could adversely impact the business, financial condition, and results of operations of the combined company. In addition, the overall integration of the businesses may result in material unanticipated problems, expenses, liabilities, loss of customers, and diversion of the attention of the combined company's management and employees. The challenges of combining the operations of the companies include, among others:

- difficulties in achieving anticipated cost savings, synergies, business opportunities, and growth prospects from the combination;
- difficulties in the integration of operations and systems, including information technology systems;
- difficulties in establishing effective uniform controls, standards, systems, procedures, and accounting and other policies; business cultures and compensation structures between the two companies;
- difficulties in the acculturation of employees;
- difficulties managing the expanded operations of a larger and more complex company;
- challenges in keeping existing customers and obtaining new customers;
- challenges in attracting new joint venture partners and acquisition targets;
- challenges in attracting and retaining key personnel, including personnel that are considered key to the future success of the combined company; and
- challenges in keeping key business relationships in place.

Many of these factors are outside of the control of the combined company, and any one of them could result in increased costs and liabilities, decreases in the amount of expected revenue and earnings, and diversion of management's time and energy, which could have a material adverse effect on the business, financial condition, and results of operations of the combined company. In addition, even if the operations of our business and the business of Almost Family are integrated successfully, the full benefits of the transaction may not be realized, including the synergies, cost savings, growth opportunities, or cash flows that are expected, and the combined company will also be subject to additional risks that could impact future earnings. These benefits may not be achieved within the anticipated time frame, or at all. Further, additional unanticipated costs may be incurred in the integration of our business with the business of Almost Family. All of these factors could cause dilution of the earnings per share of the combined company, decrease or delay the expected accretive effect of the Merger, negatively impact the price of the combined company's stock, impair the ability of the combined company to return capital to its stockholders, or have a material adverse effect on the business, financial condition, and results of operations of the combined company.

The future results of the combined company will suffer if the combined company does not effectively manage its expanded operations following the Merger.

Following the Merger, the size of the business of the combined company increased significantly beyond the current size of either our business or Almost Family's business. The combined company's future success depends, in part, upon its ability to manage this expanded business, which will pose substantial challenges for the management of the combined company, including challenges related to the management and monitoring of new operations and associated increased costs and complexity. There can be no assurances that the combined company will be successful or that it will realize the expected operating efficiencies, cost savings, revenue enhancements, and other benefits currently anticipated from the Merger.

Furthermore, we have incurred and expect to incur significant costs, expenses and fees for professional services and other transaction costs in connection with the Merger. In addition, the continued integration of the two businesses

could result in additional costs and expenses that were not expected or anticipated, and such costs and expenses could have a material adverse effect on the financial condition and results of operations of the combined company.

Portions of our Healthcare Innovations (HCI) segment compete in relatively new and developing markets, face larger more well-capitalized competitors, and rely on small numbers of relatively large customers.

The Company's HCI segment is used to report on the Company's developmental activities other than home health, hospice, home and community-based services, and facility-based services. The HCI segment includes (a) Imperium Health Management, LLC, an ACO enablement and management company, (b) Long Term Solutions, Inc., an in-home assessment company serving the long-term care insurance industry, (c) certain assets operated by Advanced Care House Calls, which

provides primary medical care for home-bound or home-limited patients with chronic and acute illnesses who have difficulty traveling to a doctor's office, and (d) a cost basis investment in Care Journey (formerly NavHealth, Inc.), a population-health analytics company. Portions of our HCI segment compete in new and developing markets with new competitors or solutions developed and introduced to the market regularly. Such new products may capture market share more quickly or may have access to more capital than the capital we have allocated for such projects. Our efforts to bring new solutions to the market may prove unsuccessful, may prove to be unprofitable, or may prove to be costlier to bring to market than anticipated. Our investments in these activities are highly speculative in nature and subject to loss. Specifically, our assessment subsidiary competes with larger, better capitalized competitors, while also being particularly reliant on a small number of large customers, the loss of which could significantly and adversely impact its results.

We have invested in development stage companies which may require further funding to support their respective business plans, which may ultimately prove unsuccessful.

In conjunction with the Merger, we obtained controlling interests in (a) Imperium Health Management, LLC, an ACO enablement and management company, (b) Long Term Solutions, Inc., a provider of in-home nursing assessments for the long-term care insurance industry, (c) certain assets operated by Advanced Care House Calls, which provides primary medical care for home-bound or home-limited patients with chronic and acute illnesses who have difficulty traveling to a doctor's office, as well as (d) a cost basis interest in Care Journey (formerly NavHealth, Inc.), a development stage analytics and software company. These investments are highly speculative, at risk and we may choose to make further investments, all of which may ultimately provide no return and could lead to a total loss of our investment.

Our HCI segment provides strategic health management services to Accountable Care Organizations (“ACOs”) that have been approved to participate in the Medicare Shared Savings Program (“MSSP”). ACOs are entities that contract with CMS to serve the Medicare fee-for-service population with the goal of better care for individuals, improved health for populations and lower costs. ACOs share savings with CMS to the extent that the actual costs of serving assigned beneficiaries are below certain trended benchmarks of such beneficiaries and certain quality performance measures are achieved. In addition to our ownership interests in ACOs, we also have management service agreements with ACOs that provide for sharing of MSSPs received by the ACOs, if any.

Notwithstanding our efforts, our ACOs may be unable to meet the required savings rates or may not satisfy the quality measures and efforts to drive other revenue may not cover operating costs of these investments. In addition, as the MSSP is a young program, it presents challenges and risks associated with the timeliness and accuracy of data and interpretation of complex rules, which may have a material adverse effect on our ability to recoup any of our investments. Further, there can be no assurance that we will maintain positive relations with our ACO partners or significant customers, which could result in a loss of our investment.

In addition, CMS, the OIG, the Internal Revenue Service, the Federal Trade Commission, US Department of Justice, and various states have adopted or are considering adopting new legislation, rules, regulations and guidance relating to formation and operation of ACOs. Such laws may, among other things, require ACOs to become subject to financial regulation such as maintaining deposits of assets with the states in which they operate, the filing of periodic reports with the insurance department and/or department of health, or holding certain licenses or certifications in the jurisdictions in which the ACOs operate. Failure to comply with legal or regulatory restrictions may result in CMS terminating the ACO's agreement with CMS and/or subjecting the ACO to loss of the right to engage in some or all business in a state, payments fines or penalties, or may implicate federal and state fraud and abuse laws relating to anti-trust, physician fee-sharing arrangements, anti-kickback prohibitions, prohibited referrals, any of which may adversely affect our operations and/or profitability.

We develop portions of our clinical software system in-house. Failure of, or problems with, our system could harm our business and operating results.

We develop and utilize a proprietary clinical software system to collect assessment data, log patient visits, generate medical orders, and monitor treatments and outcomes in accordance with established medical standards. The system integrates billing and collections functionality as well as accounting, human resource, payroll, and employee benefits programs provided by third parties. Problems with, or the failure of, our technology and systems could negatively impact data capture, billing, collections, and management and reporting capabilities. Any such problems or failures could adversely affect our operations and reputation, result in significant costs to us, and impair our ability to provide our services in the future. The costs incurred in correcting any errors or problems may be substantial and could adversely affect our profitability.

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 foot building, which was originally leased. During 2018, the Company purchased the land, building and adjacent parcels of land for approximately $19.3 million. The purchase was the first steps in the total $70.0 million home office campus expansion project expected to be completed in late 2020.

In addition, the Company leases two off-campus office buildings in Lafayette, Louisiana, where we occupy 22,571 and 15,833 square feet. We anticipate consolidating activities currently conducted in these two off-campus sites to the principal executive office location once the home office campus expansion project is completed.

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.

Ten 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.

We believe that our properties and facilities are well maintained and are generally suitable and adequate for the purposes for which they are used.

The following table shows the locations of our home health, hospice, home and community-based services, facility-based services, and healthcare innovations facilities by state as of December 31, 2018:

	Home health services	Hospice services	Home and community-based services	Facility-based services	HCI
Tennessee	59	11	8	—	—
Florida	58	2	10	—	1
Louisiana	38	12	—	14	4
Kentucky	53	—	9	—	1
Mississippi	37	13	—	—	—
Ohio	18	1	19	—	1
Alabama	31	7	—	—	—
Arkansas	23	7	5	2	1
Pennsylvania	24	6	2	—	—
Georgia	19	8	—	—	—
West Virginia	18	4	—	—	1
Texas	18	2	1	1	—
Illinois	18	1	—	—	—
Virginia	12	5	1	—	—
North Carolina	9	4	3	—	1
Connecticut	4	—	12	—	—
Washington	11	4	1	—	—
Indiana	13	—	—	—	1
Missouri	6	5	2	—	—

Maryland	10	—	1	—	1
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New York	5	—	7	—	—
South Carolina	4	6	—	—	—
Arizona	8	1	—	—	—
New Jersey	9	—	—	—	—
Michigan	4	3	—	—	—
Idaho	4	2	—	—	—
Massachusetts	6	—	—	—	—
Colorado	5	—	—	—	—
Oklahoma	5	—	—	—	—
Oregon	4	—	—	—	—
California	2	—	—	—	—
Nevada	1	—	—	—	—
New Mexico	1	—	—	—	—
New Hampshire	1	—	—	—	—
Rhode Island	1	—	—	—	—
Wisconsin	4	—	—	—	—
	543	104	81	17	12

Item 3. Legal Proceedings.

We provide services in a highly regulated industry and are a party to various proceedings (regulatory and other governmental), and internal audits and investigations in the ordinary course of business (including audits by Zone Program Integrity Contractors ("ZPICs"), Recovery Audit Contractors ("RACs"), and investigations resulting from our obligation to self-report suspected violations of law). We cannot predict the ultimate outcome of any regulatory and other governmental and internal audits and investigations. While such audits and investigations are the subject of administrative appeals, the appeals process, even if successful, may take several years to resolve. The Department of Justice, CMS, or other federal and state enforcement and regulatory agencies may conduct additional investigations related to our businesses in the future. These audits and investigations have caused and could potentially continue to cause delays in collections and recoupments from governmental payors. Currently, the Company has recorded $16.9 million in other assets, which are from government payors related to the disputed finding of pending ZPIC audits. Additionally, these audits may subject us to sanctions, damages, extrapolation of damage findings, additional recoupments, fines, and other penalties (some of which may not be covered by insurance), which may, either individually or in the aggregate, have a material adverse effect on our business and financial condition.

On January 18, 2018, Jordan Rosenblatt, a purported shareholder of Almost Family, Inc. (“Almost Family”) filed a Complaint for Violations of the Securities Exchange Act of 1934 (the "1934 Act") in the United States District Court for the Western District of Kentucky, styled Rosenblatt v. Almost Family, Inc., et al., Case No. 3:18-cv-40-TBR (the “Rosenblatt Action”). The Rosenblatt Action was filed against the Company, Almost Family, Almost Family’s board of directors, and Hammer Merger Sub, Inc. ("Merger Sub"). The complaint in the Rosenblatt Action (“Complaint”) asserts that the Form S-4 Registration Statement (“Registration Statement”) filed on December 21, 2017 contains false and misleading statements with respect to the Merger. The Complaint asserted claims against Almost Family and its board of directors for violations of Section 14(a) of the 1934 Act in connection with the dissemination of the Registration Statement, and asserted claims against the Almost Family board of directors and the Company for violations of Section 20(a) of the 1934 Act as controlling persons of Almost Family. The Rosenblatt Action sought, among other things, an injunction enjoining the Merger from closing and an award of attorneys’ fees and costs.

In addition to the Rosenblatt Action, two additional complaints were filed against Almost Family and the Almost Family board of directors in the United States District Court for the District of Delaware (the "Delaware Actions") alleging similar violations as the Rosenblatt Action. These Delaware Actions also sought, among other things, an injunction enjoining the closing of the Merger and an award of attorneys’ fees and costs.

On February 22, 2018, one of the plaintiffs in the Delaware Actions moved for a preliminary injunction to enjoin the merger of Almost Family and Merger Sub. Then, on March 2, 2018, the Delaware Actions were transferred to the

United States District Court for the Western District of Kentucky. Shortly thereafter, on March 12, 2018, Almost Family, LHC and Merger

Sub opposed the plaintiff's motion for a preliminary injunction, and the court heard oral argument on the plaintiff's motion for a preliminary injunction on March 19, 2018. On March 22, 2018, the court denied the plaintiff's motion for preliminary injunction.

The next day, on March 23, 2018, one of the plaintiffs in the Delaware Actions moved to consolidate the Delaware Actions with the Rosenblatt Action and for the appointment of a lead plaintiff. On December 19, 2018, the Court granted the motion to consolidate, appointed Leonard Stein, a purported Almost Family shareholder, as the lead plaintiff, and approved Stein's selection of Lead Counsel.

On February 1, 2019, the lead plaintiff filed his Consolidated Amended Class Action Complaint (the "Consolidated Complaint"). The Consolidated Complaint asserts claims against Almost Family, LHC and the Almost Family board of directors for violations of Section 14(a) of the 1934 Act in connection with the dissemination of the Registration Statement, and asserts breach of fiduciary duty claims and claims for violations of Section 20(a) of the 1934 Act against the Almost Family board of directors. The Consolidated Complaint seeks, among other things, monetary damages and an award of attorneys' fees and costs.

We believe that the claims asserted in these lawsuits are entirely without merit and intend to defend these lawsuits vigorously.

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

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

On July 1, 2018, the Company acquired all noncontrolling membership interests in Imperium Health Management, LLC ("Imperium") then-held by non-affiliated owners (the "Imperium Sellers"), which equated to approximately 29.4% of the membership interests of Imperium outstanding in such time, for an aggregate purchase price equal to $7.1 million. Upon the closing, Imperium became a wholly-owned indirect subsidiary of the Company. At the closing, the Company issued an aggregate of 90,032 shares of its unregistered common stock to the Imperium Sellers as consideration of their noncontrolling membership interests in Imperium. The shares were issued pursuant to an exemption from registration under Section 4(2) of the Securities Act of 1933 (the "Securities Act") in a privately-negotiated transaction not involving a public offering to the Imperium Sellers, each of which is an "accredited investor" as defined in Regulation D promulgated under the Securities Act.

Market Information and Holders

Our common stock trades on the NASDAQ Global Select Market (“NASDAQ”) under the symbol “LHCG.” As of February 22, 2019, there were approximately 455 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 2018 and 2017 as quoted by NASDAQ:

	High	Low
2018		
Fourth Quarter	$104.99	$85.06
Third Quarter	102.99	85.17
Second Quarter	86.87	62.98
First Quarter	66.13	60.09
	High	Low
2017		
Fourth Quarter	$72.07	$59.70
Third Quarter	70.92	57.72
Second Quarter	68.35	51.76
First Quarter	54.10	44.64

The closing price of our common stock as reported by NASDAQ on February 26, 2019 was $107.35.

Performance Graph

This item is incorporated by reference from our Annual Report to Stockholders for the fiscal year ended December 31, 2018.

Issuer Purchases of Equity Securities

None.

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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, 2018. The financial data for the years ended December 31, 2018, 2017 and 2016 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,	2018	2017	2016	2015	2014
Consolidated Statements of Operations Data:					
Net service revenue (1)	$1,809,963	$1,062,602	$900,033	$797,123	$717,852
Gross margin	653,606	386,792	342,383	316,245	283,077
Operating income	111,001	74,682	70,562	66,343	45,486
Net income	78,923	60,386	45,942	41,650	28,752
Net income attributable to LHC Group, Inc.'s common stockholders	63,574	50,112	36,583	32,335	21,837
Net income attributable to LHC Group, Inc.'s common stockholders:					
Basic	$2.31	$2.83	$2.08	$1.86	$1.27
Diluted	$2.29	$2.79	$2.07	$1.84	$1.26
Weighted average shares outstanding:					
Basic	27,498,351	17,715,992	17,559,477	17,405,379	17,229,026
Diluted	27,773,396	17,961,018	17,682,820	17,547,531	17,315,333

As of December 31,	2018	2017	2016	2015	2014
Consolidated Balance Sheet Data:					
Cash	$49,363	$2,849	$3,264	$6,139	$531
Total assets	1,928,715	793,702	614,071	566,054	491,739
Total debt	243,703	144,286	87,796	98,784	61,008
Total LHC Group, Inc. stockholders' equity	1,316,925	448,868	395,126	354,582	318,639

Footnote 1: The Company adopted ASU No. 2014-09, Revenue from Contracts with Customers, ("ASU 2014-09") on January 1, 2018 on a full retrospective basis, which required the Company to present the prior comparable periods as adjusted. The adoption of the standard did not have a material impact on the Company's financial statements. All amounts previously classified as provision for bad debts were reclassified within the Company's net service revenue.

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, home and community-based services agencies, long-term acute care hospitals, and healthcare innovations services. Our net service revenue increased $747.4 million to $1.8 billion for the year ending December 31, 2018 from $1.1 billion for the year ending December 31, 2017 largely as a result of the merger with Almost Family, Inc. During 2018, we acquired 355 agencies, such that, as of December 31, 2018, we operated 757 locations in 36 states within the continental United States.

On April 1, 2018, we completed our Merger with Almost Family, whereby Almost Family became a wholly owned subsidiary of the Company. The accompanying audited results of operations for the year ended December 31, 2018 includes the results of operations for Almost Family for the period April 1, 2018 to December 31, 2018, affecting comparability of fiscal 2018 and 2017 amounts. See Note 3 to the Consolidated Financial Statement for additional information about the Merger.

Segments

Our services are classified into five segments: (1) home health, (2) hospice, (3) home and community-based, (4) facility-based services offered primarily through our LTACHs, and (5) healthcare innovations.

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, 2018, we operated 543 home health service locations, of which 302 are wholly-owned by us, 232 are majority-owned or controlled by us through equity joint ventures, three are controlled by us through license lease arrangements and the remaining six 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, 2018, we operated 104 hospice locations, of which 57 are wholly-owned by us, 45 are majority-owned by us through equity joint ventures and two are controlled by us through license lease arrangements.

Through our home and community-based services segment, our services are performed by paraprofessional personnel, and include assistance to elderly, chronically ill, and disabled patients with activities of daily living. As of December 31, 2018, we operated 81 community-based services locations, of which 71 are wholly-owned and ten are majority-owned through an equity joint venture.

We provide facility-based services principally through our LTACHs. As of December 31, 2018, we operated 11 LTACHs with 12 locations, of which all but two are located within host hospitals. We also operate two pharmacies, a family health center, a rural health clinic, and two physical therapy clinics. Of these 17 facility-based services locations as of December 31, 2018, eight are wholly-owned by us and nine are controlled by us through equity joint ventures.

Our HCI segment reports on our developmental activities outside its other business segments. The HCI segment includes

(a) Imperium Health Management, LLC, an ACO enablement and management company, (b) Long Term Solutions, Inc., an in-home assessment company serving the long-term care insurance industry, (c) certain assets operated by Advanced Care House Calls, which provides primary medical care for patients with chronic and acute illnesses who have difficulty traveling to a doctor’s office, and (d) a cost basis investment in Care Journey (formerly NavHealth, Inc.), a population-health analytics company. These activities are intended ultimately, whether directly or indirectly, to benefit our patients and/or payors through the enhanced provision of services in our other segments. The activities all share a common goal of improving patient experiences and quality outcomes, while lowering costs. They include, but are not limited to, items such as: technology, information, population health management, risk-sharing, care-coordination and transitions, clinical advancements, enhanced patient engagement and informed clinical decision and technology enabled inhome clinical assessments. We have 12 HCI locations, of 11 which are wholly-owned and one is 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, 2018, 2017 and 2016 was as follows:

Type of Segment	2018	2017	2016

Home health	71.4%	73.1%	72.8%
Hospice	11.0	14.8	14.8
Home and community-based	9.5	4.4	4.8
Facility-based	6.3	7.7	7.6
Healthcare innovations	1.8	—	—

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, 2016 through December 31, 2018. This table does not include the six management services agreements under which we manage the operations of six home nursing agencies, through our home health services segment, nor does it include our pharmacies, family health center, rural health clinic, physical therapy clinics through our facility-based services segment.

	Home Health Agencies	Hospice Agencies	Community-based Agencies	Long-Term Acute Care Hospitals	HCI
Total at January 1, 2016	280	56	13	8	—
Developed	5	1	—	—	—
Acquired	12	10	1	—	—
Divested/Merged	(16)	(2)	(3)	—	—
Total at December 31, 2016	281	65	11	8	—
Developed	3	1	—	—	—
Acquired	43	27	1	6	—
Divested/Merged	(12)	(2)	—	—	—
Total at December 31, 2017	315	91	12	14	—
Developed	—	1	4	(2)	—
Acquired	260	18	65	—	12
Divested/Merged	(38)	(6)	—	—	—
Total at December 31, 2018	537	104	81	12	12

Recent Developments

Home Health Services

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

On November 1, 2017, CMS released the final rule (effective January 1, 2018) regarding payment rates for home health services provided during calendar year 2018. The national, standardized 60-day episode payment rate will increase to $3,039.64 in 2018. The final rule estimates an impact of 0.5% reduction in payments due to the expiration of the rural add-on provision, a 1% home health payment update percentage, and 0.97% adjustment for case mix (the third year of a three year adjustment). CMS also estimates a reduction in regulatory reporting due to the removal of a number of quality measures and OASIS items. CMS estimates the overall economic impact of the final rule's changes and payment rate update is an estimated decrease of 0.4% in payments to home health agencies. In addition, CMS decided not to finalize its rule on the Home Health Groupings Model ("HHGM") as was proposed, but instead will take additional time to further engage with stakeholders to move towards a system that shifts the focus from volume of services to a more patient-centered model.

The BBA 2018 included the following provisions impacting our home health business:

- A new case mix model
- Mandates the development of a new case mix model in a transparent process involving CMS, the home health industry, and the Congressional committees of jurisdiction.
- The new model will use a 30-day payment period (leaving intact the 60-day assessment and order process), and must be implemented in a budget-neutral manner beginning in 2020 and will not include the use of therapy visits as a determinant. Congressional Budget Office ("CBO") scored this at zero savings and zero cost due to the budget-neutrality requirement.
- CMS is specifically instructed to consider the use of alternative payment reform recommendations like the “Risk Based Grouper Model” proposed in lieu of the Home Health Groupings Model ("HHGM") proposed in the preliminary rule.

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- The new model must be developed on a budget-neutral basis as opposed to the HHGM, which was proposed on a non-budget-neutral basis in the preliminary rule. Further, any behavioral adjustments must now be transparent and subject to public notice, comment, and the rule-making process. The HHGM, as proposed, footnoted a reference to behavioral adjustments that were not defined and not transparent in its underlying assumptions period in 2017.
- Restoration of the 3% rural add-on
Restores the 3% home health rate add-on for home health patients who reside in rural geographies, effective January 1, 2018. The add-on rate will be phased downward over a five-year period following a formula specified in the legislation.
Restores an important protection of access to Medicare home health care for rural America, and provides sufficient time for the industry to produce additional compelling evidence to demonstrate the positive impact of the rural add-on payment to rural Medicare beneficiaries.
- Since its inception, the rural rate has been repeatedly renewed by Congress in recognition of the continued need.
- Face-to-face documentation improvements allowing the home health medical record in its entirety to be used in support of the physician’s attestation of medical necessity.
- A study is to be conducted by the GAO (Government Accounting Office) on Medicare improvements to address the needs of the chronically ill through healthcare services provided at home, including interdisciplinary care management, tele-health, and tele-monitoring for Medicare Advantage plans, requiring states to better integrate Medicare and Medicaid services for the dually-eligible, and the extension and expansion of the Independence at Home Demonstration Program.
- A specific market basket update percentage of 1.5% for fiscal year 2020, leaving intact the full market basket update (generally expected to be between 2-3%) for fiscal year 2019. Suspends the productivity adjustment in 2020.
- Repeal of the Independent Payment Advisory Board, effective upon passage.
- Payment rate feasibility study to be conducted concerning the feasibility of a higher payment rate for providers, including home health providers that engage in the management of patients’ chronic conditions.

On October 31, 2018, CMS released the final rule regarding payment rates for home health services provided during calendar year 2019. The national, standardized 60-day episode payment rate will increase to $3,154.27 in 2019. The rule
estimates an impact of 2.2% increase in payments due to the rate and policy changes proposed in the rule. The rule implements a modified rural safeguard payment varying between 1.5% and 4.0% beginning in 2019 as prescribed by the Bipartisan Budget Act of 2018. The final rule prescribed scores for various case-weights and made minor changes to the wage indices, both in a budget neutral manner. The final rule also establishes policy changes to the home health quality reporting program, the home health value based purchasing demonstration, the home health high cost outlier policy, and simplifies certification and recertification requirements beginning January 1, 2019.

In addition, for certifications and recertifications that commence on or after January 1, 2020, CMS will implement the Patient Driven Groupings Model ("PDGM") prospective payment system, as mandated by the Bipartisan Budget Act of 2018. Under PDGM, the initial certification of patient eligibility, plan of care, and comprehensive assessment will remain valid for 60-day episodes of care, but payments for home health services will be made based upon 30-day payment periods. For LUPAs under PDGM, the threshold will vary for a 30-day period depending on the PDGM payment group. Further, PDGM eliminates the use of the number of therapy visits in determining the calculation of payments. Under PDGM, the national standardized rate will be budget neutral and will be set in the 2020 proposed rule. While CMS has proposed to make adjustments totaling -6.42% for assumptions on changes in provider behavior affecting reimbursement, which relate to clinical group coding, comorbidity coding, and achievement of LUPA thresholds, without providing backup data to support a full understanding of the assumptions that CMS used in determining these adjustments. LHC Group intends to continue its advocacy efforts to eliminate or reduce the amount of the behavioral adjustments.

Hospice

On August 1, 2017, CMS issued a final rule updating Medicare payment rates and the wage index for hospices for fiscal year 2018. The result will be a 1.0% increase in payment rates due to the provisions of Section 411 (d) of the Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114-10) ("MACRA"). The hospice cap will be $28,689.04, which is a 1% increase. The Final Rule finalizes eight measures from Consumer Assessment of Healthcare Providers and Systems ("CAHPS") Hospice Survey data already submitted by hospices. The rule also finalizes the extension of the exception for quality reporting purposes from 30 calendar days to 90 calendar days after the date that an extraordinary circumstance occurred. CMS began public reporting Hospice Quality Reporting Program ("HQRP") data via a Hospice Compare Site in

August 2017 to help customers make informed choices. Hospices that fail to meet quality reporting requirements will receive a two percentage point reduction to their payments. The following table shows the hospice Medicare payment rates for fiscal year 2018, which began on October 1, 2017 and ended September 30, 2018:

Description	Rate per patient day
Routine Home Care days 1-60	$192.78
Routine Home Care days 60+	$151.41
Continuous Home Care	$976.42
Full Rate = 24 hours of care	
$40.19 = hourly rate	
Inpatient Respite Care	$172.78
General Inpatient Care	$743.55

On August 1, 2018, CMS posted a display copy of the final rule for the annual update to Medicare hospice payment rates for fiscal year 2019. In this final rule, hospices will receive a 1.8% increase in Medicare payments for fiscal year 2019. The hospice payment update percentage for fiscal year 2019 is based on a 2.9% inpatient hospital market basket update, reduced by a 0.8% point multifactor productivity adjustment, and reduced by a 0.3 percentage point adjustment required by law. Hospices that fail to meet quality reporting requirements receive a 2.0 percentage point reduction to their payments. The hospice aggregate cap amount for fiscal year 2019 will be $29,205.44 (2018 cap amount of $28,689.04 increased by 1.8%). Additionally, this rule finalizes conforming regulations text changes so that effective January 1, 2019, physician assistants will be recognized as designated hospice attending physicians, in addition to physicians and nurse practitioners. This rule also finalizes changes to the HQRP.

The following table shows the hospice Medicare payment rates for fiscal year 2019, which began on October 1, 2018 and will end September 30, 2019:

Description	Rate per patient day
Routine Home Care days 1-60	$196.25
Routine Home Care days 61+	$154.21
Continuous Home Care	$997.38
Full Rate = 24 hours of care	
$41.56 = hourly rate	
Inpatient Respite Care	$176.01
General Inpatient Care	$758.07

The BBA 2018 included the following provisions impacting our hospice business:

- Hospice included in Hospital Post-Acute Transfer Policy for early discharges to hospice care. Hospice will be included as a post-acute service subject to the transfer DRG policy, in which acute-care hospitals receive a reduction in payments if they transfer a patient to post-acute care prior to achieving the mean length of stay for the DRG. Currently, home health, skilled nursing facilities, and LTACHs are included within the policy, and the BBA 2018 adds hospice as a post-acute provider subject to the policy.

Home and Community-Based Services

Home and community-based services are in-home care services, which are primarily performed by skilled nursing and paraprofessional personnel, and include assistance with activities of daily living to elderly, chronically ill, and disabled patients. Revenue is generated on an hourly basis and our current primary payors are TennCare Managed Care Organization and Medicaid.

Facility-Based Services

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

- Medicare discharges from LTACHs will continue to be paid at full LTACH PPS rates if:
the patient spent at least three days in a short-term care hospital (“STCH”) intensive care unit (“ICU”) during a STCH stay that immediately preceded the LTACH stay, or
the patient was on a ventilator for more than 96 hours in the LTACH (based on the MS-LTACH DRG assigned) and had a STCH stay immediately preceding the LTACH stay.
Also, the LTACH discharge cannot have a principal diagnosis that is psychiatric or rehabilitation.
- All other Medicare discharges from LTACHs will be paid at a new “site neutral” rate, which is the lesser of the ("IPPS") comparable per diem amount determined using the formula in the short-stay outlier regulation at 42 C.F.R. § 412.529(d)(4) plus applicable outlier payments, or 100% of the estimated cost of the services involved.
- The above new payment policy will be effective for 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.

On August 2, 2016, CMS released the final rule to update fiscal year 2017 LTACH reimbursement and policies under the LTACH PPS, which affects discharges occurring in cost reporting periods beginning on or after October 1, 2016. CMS projects that overall LTACH PPS spending will decrease by 7.1% compared to fiscal year 2016 payments. This estimated decrease is attributable to the statutory decrease in payment rates for site neutral LTACH PPS cases that do not meet the clinical criteria to qualify for higher LTACH rates in cost reporting years beginning on or after October 1, 2016. Cases that do qualify for higher LTACH PPS rates will see a payment rate increase of 0.7% (including a market basket update of 2.8% reduced by a multi-factor productivity adjustment of 0.3%, minus an additional adjustment of 0.75 percentage point in accordance with the PPACA, for a net market basket of 1.75%). The LTACH PPS standard federal payment rate for fiscal year 2017 is $42,476.41 (increased from $41,762.85 in fiscal year 2016). Site-neutral discharges will have a 23% reduction in payments. CMS also proposes to begin enforcement of the 25 Percent Rule which will cap the number of patients treated at an LTACH who have been referred from all locations of a hospital. Grandfathered LTACH facilities are exempt from the 25 Percent Rule, while rural LTACHs will have a threshold of 50% and MSA-dominant hospitals will have a threshold between 25% and 50%. The 25 Percent Rule will apply to discharges occurring after October 1, 2016. CMS will have two separate outlier pools and thresholds for LTACH-appropriate patients and for site-neutral patients. For 2017, CMS finalized an increase of its fixed-loss threshold to $21,943 from 2016’s $16,423, to limit outlier spending at no more than 8% of total LTACH spending (2016 outlier payments may reach 9.0%). CMS is applying the proposed inpatient fixed-loss threshold of $23,570 for site neutral patients. CMS also finalized four new measures for the LTACH Quality Reporting Program to meet the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. For the fiscal year 2018 LTACH Quality Reporting Program, CMS added quality measures for Medicare spending per beneficiary, discharge to community and potentially-preventable 30-day post-discharge readmissions. For the fiscal year 2020 LTACH Quality Reporting Program, CMS adopted a new drug regimen review measure.

On August 2, 2017, CMS posted a display copy of its final rule for the annual update to Medicare payment rates and policies for the fiscal year 2018 inpatient hospitals prospective payment system and the LTACH PPS. CMS estimates the impact of the proposed rule will result in a 2.4% overall reduction in LTACH spending. The LTACH standard federal rate is reduced to $41,430.56 from $42,476.41. CMS is also proposing a 12 month administrative moratorium on application of the 25 Percent Rule beginning with the expiration of the statutory moratorium after September 30, 2017. The 25 Percent Rule will not be applied to LTACHs for discharges occurring on or before September 30, 2018. CMS also adopted certain adjustments to high cost outlier and short stay outlier policies. CMS finalized its proposal for a new severe wound exception to be paid at standard Federal LTACH rates instead of site neutral payments for grandfathered LTACHs. CMS changed the separateness and control restrictions for certain co-located IPPS-exempt hospitals. The final rule also adds three new quality measures and

discontinues two quality measures. CMS also finalized its proposal to implement collection of standardized patient assessment data under the IMPACT Act on functional status, cognitive function, cancer treatments, respiratory treatments, transfusions and other special services effective for admissions on/after April 1, 2019.

Effects of BBA 2018 on LTACHS

The impact of BBA 2018 on our LTACH business includes a two-year extension of site-neutral blended payments rates for certain long-term care hospital discharges, based upon a 4.6% reduction in site-neutral payments over 7 years.

On August 2, 2018, CMS posted a display copy of the final rule for the annual update to Medicare payment rates and policies for the fiscal year 2019 inpatient hospitals prospective payment system and the LTACH PPS. The final rule will be effective for discharges occurring on or after October 1, 2018 through September 30, 2019. CMS finalized a 0.9% overall increase in payments under the LTACH PPS in fiscal year 2019 based upon a 1% increase in payments for standard Federal payment rate cases and a 0.4% increase in payments for site neutral payment cases. On October 3, 2018, CMS published a correction to the final rule revising the fiscal year 2019 LTACH PPS standard Federal payment rate to $41,558.68 (instead of $41,579.65 as published in the final rule on August 2, 2018). CMS also finalized elimination of the 25 Percent Rule, but implemented a one-time budget neutrality adjustment of approximately 0.9% for fiscal year 2019 to cover the cost of elimination of the rule.

CMS also finalized LTACH policy changes effective for cost reporting periods beginning on or after October 1, 2019, permitting LTACHs to establish psychiatric and rehabilitation units, and to co-locate with other IPPS-exempt hospitals to provide LTACH, psychiatric and rehabilitative care on the same campus. CMS also increased flexibility for co-located satellite LTACH facilities clarifying that such co-located satellites do not need to comply with some of the separateness and control requirements of a co-located hospital. The proposed rule also makes some changes to the LTACH quality reporting program by removing three quality measures and refraining from adding additional measures.

None of the aforementioned 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.

Medicare Accountable Care Organizations (ACOs)

The Affordable Care Act established ACOs as a tool to improve quality and lower costs through increased care coordination in the Medicare fee-for-service ("FFS) program, also known as "Original Medicare." The Medicare FFS program covers approximately 70% of the Medicare recipients or approximately 36 million eligible Medicare beneficiaries. ACOs are typically formed as legal entities by groups of doctors and other healthcare providers who endeavor to work together to provide high quality services and care for their patients through three-year contracts with CMS. Provider and beneficiary participation in an ACO is purely voluntary and Medicare beneficiaries retain their current ability to seek treatment from any provider they wish. Beneficiaries are assigned to ACOs using an "attribution" model based on a plurality of services provided by the primary care physician. Beneficiaries retain the right to use any doctor or hospital who accepts Medicare, at any time.

CMS established the Medicare Shared Savings Program ("MSSP") to facilitate coordination and cooperation among providers to improve the quality of care for Medicare FFS beneficiaries and to reduce costs. Eligible providers, hospitals, and suppliers may participate in the MSSP by creating, participating in or contracting with an ACO. The MSSP is designed to improve beneficiary outcomes and increase value of care by (1) promoting accountability for the care of Medicare FFS beneficiaries, (2) requiring coordinated care for all services provided under Medicare FFS, and (3) encouraging investment in infrastructure and redesigned care processes. The MSSP will reward ACOs that provide healthcare services at a cost for the ACO's patients during a relevant measurement year that is below the ACO's

benchmark costs established by CMS, while also meeting performance standards on quality of care. Under the final MSSP rules, Medicare is to reimburse individual providers and suppliers for specific items and services as Medicare currently does under the FFS payment methodologies. MSSP rules require CMS to develop a benchmark for savings to be achieved by each ACO, if the ACO is to receive shared savings or for ACOs that have elected to accept responsibility for losses. An ACO that meets the program's quality performance standards will be eligible to receive a share of the savings to the extent its assigned beneficiary medical expenditures are below its own medical expenditure benchmark provided by CMS. The Company's HCI services provides specialized management services to ACOs, and in return, the Company shares in any MSSP payments received by the ACO.

2018 and 2017 Operational Data

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

	Three Months Ended March 31, 2018	Three Months Ended June 30, 2018	Three Months Ended September 30, 2018	Three Months Ended December 31, 2018
Home Health:				
Average census	45,156	76,708	75,479	75,869
Average Medicare census	30,362	51,279	49,948	49,858
Admissions	53,123	93,905	92,643	92,168
Medicare admissions	33,028	59,012	57,118	56,919
Hospice:				
Average census	3,136	3,659	3,804	3,823
Average Medicare census	2,910	3,372	3,491	3,502
Admissions	4,054	4,528	4,557	4,558
Medicare admissions	3,549	3,942	3,931	3,995
Patient days	282,220	332,978	346,153	322,197
Home and community-based:				
Billable hours	478,952	2,227,831	2,284,980	2,257,127
LTACHs:				
Patient days	22,560	19,983	21,617	18,409
	Three Months Ended March 31, 2017	Three Months Ended June 30, 2017	Three Months Ended September 30, 2017	Three Months Ended December 31, 2017
Home Health:				
Average census	41,874	43,395	43,450	44,362
Average Medicare census	29,244	29,743	29,691	29,925
Admissions	47,375	47,625	47,841	49,668
Medicare admissions	29,957	29,868	29,964	30,745
Hospice:				
Average census	2,861	3,031	3,108	3,180
Average Medicare census	2,650	2,803	2,888	2,959
Admissions	3,112	3,227	3,438	3,655
Medicare admissions	2,657	2,791	2,967	3,199
Patient days	257,474	275,866	285,971	351,742
Home and community-based:				
Billable hours	344,186	342,337	369,700	469,963
LTACHs:				
Patient days	13,732	13,075	14,599	21,719

Consolidated Results of Operations

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

	Year Ended December 31,		
	2018	2017	2016
Consolidated Services Data:			
Net service revenue	$1,809,963	$1,062,602	$900,033
Cost of service revenue	1,156,357	675,810	557,650
Gross margin	653,606	386,792	342,383
General and administrative expenses	537,916	310,539	270,622
Impairment of intangibles and other	4,689	1,571	1,199

Operating income	111,001	74,682	70,562
Interest expense	(9,679)	(3,352)	(2,444)
Income tax expense	22,399	10,944	22,176
Income attributable to noncontrolling interests	15,349	10,274	9,359

Net income available to LHC Group, Inc.’s common stockholders	$63,574	$50,112	$36,583

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,		
	2018	2017	2016
Consolidated Services Data:			
Cost of service revenue	63.9 %	63.6 %	62.0 %
Gross margin	36.1	36.4	38.0
General and administrative expenses	29.7	29.2	30.1
Impairment of intangibles and other	0.3	0.1	0.1
Operating income	6.1	7.0	7.8
Interest expense	(0.5)	(0.3)	(0.3)
Income tax expense	26.1	17.9	37.7
Income attributable to noncontrolling interests	0.8	1.0	1.0
Net income attributable to LHC Group, Inc.’s common stockholders	3.5	4.7	4.1

Year Ended December 31, 2018 Compared to Year Ended December 31, 2017

Consolidated net service revenue for the year ended December 31, 2018 was $1.8 billion compared to $1.1 billion for the same period in 2017, an increase of $747.4 million, or 70.3%. Consolidated net service revenue growth in 2018 was primarily due to both our acquisitions during 2018 and an increase in same store growth. Consolidated net service revenue was comprised of the following for the periods ending December 31:

Segment	2018	2017
Home health	71.4 %	73.1 %
Hospice	11.0	14.8
Home and community-based	9.5	4.4
Facility-based	6.3	7.7
Healthcare innovations	1.8	—
	100.0%	100.0%

Revenue derived from Medicare represented 65.4% and 71.7% of our consolidated net service revenue for the years ended December 31, 2018 and 2017, respectively.

The following table sets forth each of our segment's revenue growth or loss, along with key applicable statistical data, for the twelve months ended December 31, 2018 and the related change from the same period in 2017 (amounts in thousands, except statistical data, and revenue excludes implicit price concessions):

	Same Store (1)	De Novo (2)	Organic (3)	Organic Growth (Loss)%	Acquired (4)	Total	Total Growth (Loss) %
Home Health							
Revenue	$834,644	$5,603	$840,247	8.5 %	$468,124	$1,308,371	67.0 %
Revenue Medicare	$572,777	$4,896	$577,673	4.0	$354,112	$931,785	65.7
New admissions	204,398	1,217	205,615	8.2	126,224	331,839	72.7
New Medicare admissions	123,527	930	124,457	4.8	81,620	206,077	71.5
Average census	43,555	257	43,812	2.9	32,134	75,946	76.2
Average Medicare census	28,681	214	28,895	(0.9)	21,595	50,490	71.1
Home health episodes	211,563	1,431	212,994	1.1	125,253	338,247	58.6
Hospice							

Revenue	$158,792	$—	$158,792	3.4	$43,182	$201,974	26.9
Revenue Medicare	$144,606	$—	$144,606	0.1	$37,022	$181,628	23.5
New admissions	13,195	—	13,195	7.2	4,502	17,697	32.4
New Medicare admissions	11,594	—	11,594	6.0	3,823	15,417	33.4
Average census	2,726	—	2,726	(9.4)	877	3,603	18.6
Average Medicare census	2,516	—	2,516	(9.9)	800	3,316	17.7
Patient days	1,068,659	—	1,068,659	(2.6)	245,922	1,314,581	18.6
Home and community-based							
Revenue	$49,471	$3,454	$52,925	12.8	$122,517	$175,442	274.0
Billable hours	1,510,258	156,410	1,666,668	1.4	5,592,523	7,259,191	341.5
Facility-Based							
LTACHs							
Revenue	$80,334	$—	$80,334	10.4	$26,117	$106,451	46.3
Patient days	63,671	—	63,671	0.8	20,218	83,889	32.8
Other facility-based							
Revenue	$9,818	$—	9,818	1.2	$—	$9,818	1.2 %
Healthcare Innovations							
Revenue	$—	$—	—	—	$33,422	$33,422	100.0%
Consolidated							
Revenue	$1,133,059	$9,057	$1,142,116	36.3 %	$693,362	$1,835,478	515.4%

(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, including all legacy Almost Family locations for the period after April 1, 2018.

Total home health organic revenue and patient metrics increased due to market share growth in service areas where we have quality scores greater than 4 stars. Total organic revenue and patient days increased in our facility-based services segment due to a higher percentage of LTACH patients meeting patient criteria requirements.

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.

The following table sets forth the reconciliation of total revenue disclosed above, which excludes implicit price concessions, to net service revenue recognized for the twelve months ended December 31, 2018 and 2017 (amounts in thousands):

	2018	% of Net Service Revenue	2017	% of Net Service Revenue
Revenue	$1,835,478		$1,072,086	
Less: Implicit price concessions	25,515	1.4 %	9,484	0.9 %
Net service revenue	$1,809,963		$1,062,602	

Cost of Service Revenue

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

2018 2017

Home health				
Salaries, wages, and benefits	$733,432	56.8%	$438,856	56.4%
Transportation	40,760	3.2	24,550	3.2
Supplies and services	27,814	2.2	18,773	2.4
Total	$802,006	62.1%	$482,179	62.0%
Hospice				
Salaries, wages, and benefits	$94,966	47.7%	$73,621	46.8%
Transportation	7,330	3.7	6,146	3.9
Supplies and services	28,695	14.4	24,202	15.4
Total	$130,991	65.8%	$103,969	66.1%
Home and community-based				
Salaries, wages, and benefits	$128,124	74.3%	$34,642	75.0%
Transportation	1,797	1.0	335	0.7
Supplies and services	739	0.4	267	0.6
Total	$130,660	75.7%	$35,244	76.3%
Facility-based				
Salaries, wages, and benefits	$53,920	47.4%	$38,303	47.0%
Transportation	310	0.3	267	0.3
Supplies and services	22,669	19.9	15,848	19.4
Total	$76,899	67.6%	$54,418	66.7%
Healthcare Innovations				
Salaries, wages, and benefits	$15,101	45.6%	$—	— %
Transportation	551	1.7	—	—
Supplies and services	149	0.5	—	—
Total	$15,801	47.8%	$—	— %
Consolidated				
Total	$1,156,357	63.9%	$675,810	63.6%

Consolidated cost of service revenue for the year ended December 31, 2018 was $1,156.4 million compared to $675.8 million for the same period in 2017, an increase of approximately $480.5 million, or 71.1%. Substantially all of the change in consolidated cost of service revenue was a result of the Merger and other acquisitions purchased during the latter part of 2017 and 2018.

General and Administrative Expenses

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

	2018		2017	
Home health				
General and administrative	$368,761	28.6%	$220,509	28.4%
Depreciation and amortization	9,363	0.7	8,755	1.1
Total	$378,124	29.3%	$229,264	29.5%
Hospice				
General and administrative	$58,655	29.5%	$43,102	27.4%
Depreciation and amortization	2,278	1.1	2,414	1.5
Total	$60,933	30.6%	$45,516	28.9%
Home and community-based				
General and administrative	$39,847	23.1%	$9,491	20.6%
Depreciation	620	0.4	455	1.0
Total	$40,467	23.5%	$9,946	21.6%
Facility-based				

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General and administrative	$36,732	32.3%	$24,015	29.4%
Depreciation and amortization	2,906	2.6	1,798	2.2
Total	$39,638	34.9%	$25,813	31.6%
Healthcare Innovations				
General and administrative	$17,559	53.0%	$—	— %
Depreciation	1,195	3.6	—	—
Total	$18,754	56.6%	$—	— %
Consolidated				
Total	$537,916	29.7%	$310,539	29.2%

Consolidated general and administrative expenses for the year ended December 31, 2018 were $537.9 million compared to $310.5 million for the same period in 2017, an increase of approximately $227.4 million, or 73.2%. Substantially all of the change in consolidated general and administrative expenses was a result of the Merger and other acquisitions purchased during the latter part of 2017 and 2018. The increase in general and administrative expenses in the facility-based services segment was due in part to the closure of two LTACH locations and the relocation of two other LTACH locations.

Income Tax Expense

Consolidated income tax expense for the year ended December 31, 2018 was $22.4 million compared to $10.9 million for the same period in 2017. The Company adjusted its deferred state income tax rate taking into consideration the federal income tax adjustments signed into law on December 22, 2017. Deferred tax assets and liabilities were revalued as of December 31, 2017, which resulted in a credit to income tax expense of $14.0 million.

Year Ended December 31, 2017 Compared to Year Ended December 31, 2016

Net Service Revenue

Consolidated net service revenue for the year ended December 31, 2017 was $1,062.6 million compared to $900.0 million for the same period in 2016, an increase of $162.5 million, or 18.1%. Consolidated net service revenue growth in 2017 was primarily due to both our acquisitions of 77 agencies during 2017 and an increase in same store growth in our home health services segment. Consolidated net service revenue was comprised of the following for the periods ending December 31:

Segment	2017	2016
Home health	73.1 %	72.8 %
Hospice	14.8	14.8
Home and community-based services	4.4	4.8
Facility-based	7.7	7.6
	100.0%	100.0%

Revenue derived from Medicare represented 71.7% and 75.5% of our consolidated net service revenue for the years ended December 31, 2017 and 2016, 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, 2017 and the related change for the same period in 2016 (amounts are in thousands, except statistical data, and revenue excludes implicit price concessions):

	Same Store (1)	De Novo (2)	Organic (3)	Organic Growth (Loss)%	Acquired (4)	Total	Total Growth (Loss) %
Home health							
Revenue	$732,436	$ 68	$732,504	10.0 %	$51,003	$783,507	17.7 %
Revenue Medicare	$529,618	$ 68	$529,686	4.7	$32,697	$562,383	11.1

New admissions	177,028	1	177,029	10.7	15,087	192,116	20.1
New Medicare admissions	111,266	1	111,267	5.4	8,910	120,177	13.8
Average census	40,211	3	40,214	4.2	2,893	43,107	11.7
Average Medicare census	27,779	2	27,781	(1.3)	1,733	29,514	4.9
Episodes	201,420	—	201,420	1.1	11,835	213,255	7.0
Hospice							
Revenue	$133,637	$412	$134,049	(0.7)	$25,148	$159,197	18.0
Revenue Medicare	$125,249	$367	$125,616	(0.2)	$21,427	$147,043	16.8
New admissions	10,222	18	10,240	2.5	3,129	13,369	33.9
New Medicare admissions	8,853	12	8,865	1.2	2,693	11,558	31.9
Average census	2,529	7	2,536	(3.2)	500	3,036	15.9
Average Medicare census	2,342	7	2,349	(3.5)	468	2,817	15.7
Patient days	963,591	2,676	966,267	0.8	142,056	1,108,323	15.6
Home and community-based							
Revenue	$43,560	$—	$43,560	(0.8)	$3,349	$46,909	6.9
Billable hours	1,527,255	—	1,527,255	2.9	117,117	1,644,372	10.8
Facility-based							
LTACHs							
Revenue	$61,085	$—	$61,085	(6.2)	$11,688	$72,773	11.7
Patient days	53,916	—	53,916	(4.1)	9,252	63,168	12.4

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

Total home health organic revenue and patient metrics increased due to market share growth in service areas where we have quality scores greater than 4 stars. Total organic revenue and patient days decreased in our facility-based services segment due to the negative impact from the reduction of 18 beds in one LTACH location. In addition, patient criteria changes went into effect for two of our LTACH locations on June 1, 2016 and six of our LTACH locations on September 1, 2016. The criteria changes are reflective in our decrease of revenue per patient day.

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

The following table sets forth the reconciliation of total revenue disclosed above, which excludes implicit price concessions, to net service revenue recognized for the twelve months ended December 31, 2017 and 2016 (amounts in thousands):

	2017	% of Net Service Revenue	2016	% of Net Service Revenue
Revenue	$1,072,086		$914,823	
Less: Implicit price concessions	9,484	0.9 %	14,790	1.6 %
Net service revenue	$1,062,602		$900,033	

Cost of Service Revenue

Consolidated cost of service revenue for the year ended December 31, 2017 was $675.8 million compared to $557.7 million for the same period in 2016, an increase of $118.2 million, or 21.2%.

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

	2017		2016	
Home health				
Salaries, wages and benefits	$438,856	56.4%	$360,378	54.9%
Transportation	24,550	3.2	22,252	3.4
Supplies and services	18,773	2.4	15,820	2.4
Total	$482,179	62.0%	$398,450	60.7%
Hospice				
Salaries, wages and benefits	$73,621	46.8%	$58,094	44.2%
Transportation	6,146	3.9	5,384	4.1
Supplies and services	24,202	15.4	19,881	15.1
Total	$103,969	66.1%	$83,359	63.4%
Home and community-based				
Salaries, wages and benefits	$34,642	75.0%	32,086	74.5%
Transportation	335	0.7	263	0.6
Supplies and services	267	0.6	254	0.6
Total	$35,244	76.3%	$32,603	75.7%
Facility-based				
Salaries, wages and benefits	$38,303	47.0%	$28,802	41.7%
Transportation	267	0.3	233	0.3
Supplies and services	15,848	19.4	14,203	20.6
Total	$54,418	66.7%	$43,238	62.6%

Consolidated cost of service revenue variances were as follows:

- Home Health Segment -- Cost of service increased as a percentage of net service revenue due in part to 2.0% Medicare reimbursement cuts recognized in 2017. Additionally, acquisitions accounted for $44.9 million of the $83.7 million increase, with the remaining difference caused by the growth in our same store agencies.

- Hospice Segment -- Acquisitions accounted for $19.1 million of the $20.6 million increase. Cost of service revenue increased as a percentage of net service revenue due to the decline in same store census during the twelve months ended December 31, 2017.

- Home and Community-Based Services Segment -- Acquisitions accounted for the $2.6 million increase.

- Facility-Based Services Segment -- Acquisitions accounted for the $11.8 million in cost of service revenue for the year. This amount was offset by a decrease in cost of service revenue for on LTACH location that had a reduction of beds during 2016. Cost of service revenue increased as a percentage of net service revenue due to lower revenue per patient day for the period caused by patient criteria changes that went into effect in June 2016 and September 2016.

General and Administrative Expenses

Consolidated general and administrative expenses for the year ended December 31, 2017 was $310.5 million compared to $270.6 million for the same period in 2016, an increase of $39.9 million, or 14.8%; however, as a percentage of net service revenue, it is a decrease of 0.8%. Of the $39.9 million increase, acquisitions accounted for $32.2 million, with the remainder of the increase attributable to growth in our same store agencies.

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

	2017		2016	
Home health				
General and administrative	$220,509	28.4%	$195,591	29.8%
Depreciation and amortization	8,755	1.1	7,827	1.2

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Total	$229,264	29.5%	$203,418	31.0%
Hospice				
General and administrative	$43,102	27.4%	$35,046	26.6%
Depreciation and amortization	2,414	1.5	2,161	1.6
Total	$45,516	28.9%	$37,207	28.3%
Home and community-based				
General and administrative	$9,491	20.6%	$8,380	19.4%
Depreciation and amortization	455	1.0	405	0.9
Total	$9,946	21.6%	$8,785	20.3%
Facility-based				
General and administrative	$24,015	29.4%	$19,445	28.1%
Depreciation and amortization	1,798	2.2	1,767	2.6
Total	$25,813	31.6%	$21,212	30.7%

Income Tax Expense

Consolidated income tax expense for the year ended December 31, 2017 was $10.9 million compared to $22.2 million for the same period in 2016. The Company adjusted its deferred state income tax rate taking into consideration the federal income tax adjustments signed into law on December 22, 2017. Deferred tax assets and liabilities were revalued as of December 31, 2017, which resulted in a credit to income tax expense of $14.0 million.

Liquidity and Capital Resources

Cash at December 31, 2018 was $49.4 million, compared to $2.8 million at December 31, 2017. 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 $500 million. As of December 31, 2018, we had $234.6 million available for borrowing under our credit facility.

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 – Some of our employees are paid bi-weekly on Fridays, while others are paid weekly on Fridays. Operating cash outflows increase in reporting periods that end on a Friday.

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

Cash used in investing activities primarily relates to acquisitions of home nursing, hospice agencies, and LTACHs, while cash used by financing activities primarily relates to borrowings or 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,	
	2018	2017
Net cash provided by (used in):		
Operating activities	$ 108,585	$ 32,326
Investing activities	(25,291)	(74,774)
Financing activities	(36,780)	42,033

During 2018, the change in operating activities was attributable to:

- Increased net income related to the Merger.
- Increased cash from lower federal tax payments related to the Tax Cuts and Job's Act of 2017 and deferred taxes largely related to acquired deductible goodwill and intangibles
- A decline in the use of cash for prepaid expenses and other assets as the prior year due to the Merger.

Cash used in investing activities and financing activities changed due to the difference in volume of acquisition activity occurring between 2018 and 2017.

Credit Facility

During the period from January 1, 2018 through April 1, 2018, we maintained our revolving line of credit through a revolving credit facility with Capital One, National Association (the "Prior Credit Facility"). The Prior Credit Facility was unsecured and provided for a maximum aggregate principal borrowing of $225 million (with a letter of credit sub-limit equal to $15 million), and was scheduled to expire on June 18, 2019. We were 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.

On March 30, 2018, we entered into a Credit Agreement with JPMorgan Chase Bank, N.A., which was effective on April 2, 2018 (the "New Credit Agreement"). The New Credit Agreement provides a senior, secured revolving line of credit commitment with a maximum principal borrowing limit of $500.0 million, which includes an additional $200.0 million accordion expansion feature, and a letter of credit sub-limit equal to $50.0 million. The expiration date of the New Credit Agreement is March 30, 2023. Our obligations under the New Credit Agreement are secured by substantially all of the assets of the Company and its wholly-owned subsidiaries, which assets include the Company's equity ownership of its wholly-owned subsidiaries and its equity ownership in joint venture entities. Our wholly-owned subsidiaries also guarantee the obligations of the Company under the New Credit Agreement. Debt issuance costs of $1.9 million were capitalized with the New Credit Agreement and will be amortized through March 30, 2023, the termination date for the New Credit Agreement.

Revolving loans under the New Credit Agreement bear interest at, as selected by us, either in (a) Base Rate, which is defined as a fluctuating rate per annum equal to the highest of (1) the Federal Funds Rate in effect on such day plus 0.5%, (2) the Prime Rate in effect on such day, and (3) the Eurodollar Rate for one month interest period on such day plus 1.5%, plus a margin ranging from 0.50% to 1.25% per annum or (b) Eurodollar Rate plus a margin ranging from 1.50% to 2.25% per annum. Swing line loans bear interest at the Base Rate. We are limited to 15 Eurodollar borrowings outstanding at the same time. We are required to pay a commitment fee for the unused commitments at rates ranging from 0.20% to 0.35% per annum depending upon our consolidated Leverage Ratio, as defined in the New Credit Agreement. The effective interest rates on our borrowings under the New Credit Agreement were 4.19% as of December 31, 2018.

On April 2, 2018, in connection with the consummation of the Merger, we borrowed approximately $247.4 million under the New Credit Agreement to (i) repay the approximately $107.3 million of outstanding borrowings under Almost Family's prior credit facility with JPMorgan Chase Bank, N.A., which was terminated in connection with the Merger, (ii) repay the approximately $125.1 million of outstanding borrowings under the Prior Credit Facility, which was also terminated in connection with the Merger, and (iii) pay certain debt issuance and repayment costs and Merger related fees and expenses.

At December 31, 2017, we had $144.0 million drawn and letters of credit outstanding in the amount of $9.6 million under our Prior Credit Facility. At December 31, 2018, we had $235.0 million drawn and letters of credit outstanding in the amount of $30.4 million under the New Credit Agreement, and had approximately $234.6 million of remaining borrowing capacity available under the New Credit Agreement.

Under the New Credit Agreement with JPMorgan Chase Bank, N.A., a letter of credit fee shall be equal to the applicable Eurodollar Rate on the average daily amount of the letter of credit exposure. The agent's standard up-front fee and other customary administrative charges will also be due upon issuance of the letter of credit along with a renewal fee on each anniversary date of such issuance while the letter of credit is outstanding.

Borrowings accrue interest under the New 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	1.50 %	0.50 %	0.200 %
>1.00:1.00 ≤ 2.00:100	1.75 %	0.75 %	0.250 %
>2.00:1.00 ≤ 3.00:1.00	2.00 %	1.00 %	0.300 %
>3.00:1.00	2.25 %	1.25 %	0.350 %

Our New Credit Agreement contains customary affirmative, negative and financial covenants, which are subject to customary carve-outs, thresholds, and materiality qualifiers. The New Credit Facility allows us to make certain restricted payments within certain parameters provided we maintain compliance with those financial ratios and covenants after giving effect to such restricted payments or, in the case of repurchasing shares of its stock, so long as such repurchases are within certain specified baskets.

Our New Credit Agreement also contains customary events of default, which are subject to customary carve-outs, thresholds, and materiality qualifiers. These include 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, 2018, we were in compliance with all debt covenants contained in the New 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, 2018 (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	$243,703	$ 7,773	$235,256	$ 674	$ —
Operating leases	107,931	35,473	42,478	17,097	12,883
Total contractual cash obligations	$351,634	$ 43,246	$277,734	$ 17,771	$ 12,883

Off-Balance Sheet Arrangements

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

Recently Issued Accounting Pronouncements

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

Critical Accounting Policies

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

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

We base our estimates on past

experience and other assumptions that we believe are reasonable under the circumstances and we evaluate these estimates on an ongoing basis.

Principles of Consolidation

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

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

Ownership type	2018	2017	2016
Wholly owned subsidiaries	59.2 %	51.1 %	57.1 %
Equity joint ventures	40.0	46.8	41.2
Managed or licensed	0.8	2.1	1.7
	100.0%	100.0%	100.0%

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

We consolidate equity joint venture entities as we have controlling interests, have voting control over these entities, or have the ability to exercise significant influence in these entities. The members of our equity joint ventures participate in profits and losses in proportion to their equity interest.

We have management service agreements under which we manage certain operations of agencies. We do not consolidate these managed agencies because we do not have an ownership interest in, nor do we have an obligation to absorb losses of, or right to receive benefits from the entities that own the agencies.

We, through wholly owned subsidiaries, lease home health licenses necessary to operate certain of our home nursing and hospice agencies. As with wholly owned subsidiaries, we consolidate these entities in which have license leasing arrangements as we own 100% of the equity of these subsidiaries.

Revenue Recognition

For a detailed discussion of revenue recognition, see Part I, Item 1. Reimbursement in this Annual Report on Form 10-K which is incorporated here by reference.

We report net service revenue at the amount that reflects the consideration we expect to receive from Medicare, Medicaid, commercial insurance, managed care payors, patients and others for services rendered.

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

Payor	2018	2017	2016
Medicare	65.4 %	71.7 %	75.5 %
Medicaid	3.2	1.7	1.6
Other	31.4	26.6	22.9
	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 base payment adjustments for case-mix and geographic wage differences and 2% sequestration reduction for episodes beginning after March 31, 2013. In addition, final payments 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 or transferred from another provider before completing the episode; or (d) a payment adjustment based upon the level of therapy services required. Adjustments outlined above are automatically recognized in net service revenue when changes occur during the period in which the services are provided to the patient. Net service revenue and related patient accounts receivable are recorded at amounts estimated to be realized from Medicare for services rendered.

Hospice Services

Hospice services provided by us are paid by Medicare under a per diem payment system. We receive one of four predetermined daily rates based upon the level of care we furnish. We record net service revenue from hospice services based on the daily rate and recognize revenue as hospice services are provided.

Hospice payments are subject to an inpatient cap and an overall Medicare payment cap. The inpatient cap relates to individual programs receiving more than 20% of its total Medicare reimbursement from inpatient care services and the overall Medicare payment cap relates to individual programs receiving reimbursements in excess of a "cap amount," calculated by multiplying the number of beneficiaries during the period by a statutory amount that is indexed for inflation. The determination for each cap is made annually based on the 12 -month period ending on October 31 of each year. We monitor its limits on a provider-by-provider basis and record an estimate of its liability for reimbursements received in excess of the cap amount. Beginning with cap year ended October 1, 2014, Center for Medicare and Medicaid Services ("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 long-term acute care hospital ("LTACH") prospective payment system. 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

Other sources of net service revenue for all our segments fall into Medicaid, managed care or other payers of our services. 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 and other payors reimburse us based upon a predetermined fee schedule or an episodic basis, depending on the terms of the applicable contract. Accordingly, we recognize revenue from managed care and other payors as services are provided, such costs are incurred, and estimates of expected payments are known for each different payer.

Healthcare Innovations Services

The Company's Healthcare Innovations segment provides strategic health management services to Accountable Care Organizations ("ACOs") that have been approved to participate in the Medicare Shared Savings Program ("MSSP"). The HCI segment has service agreements with ACOs that provide for sharing of MSSP payments received by the ACO, if any. ACOs are legal entities that contract with Centers for Medicare and Medicaid Services ("CMS") to provide services to the Medicare fee-for-service population for a specified annual period with the goal of providing better care for individuals, improving health for populations and lowering costs. ACOs share savings with CMS to the extent that

the actual costs of serving assigned beneficiaries are below certain trended benchmarks of such beneficiaries and certain quality performance measures are achieved. The generation of shared savings is the performance obligation of each ACO, which only become certain upon the final issuance of unembargoed calculations by CMS, generally in the third quarter of each year. During the year ended December 31, 2018, the HCI segment recorded net service revenue of $3.7 million related to the 2017 ACO

service periods, as certain ACO's served by the HCI segment received unembargoed calculations from CMS confirming the performance obligation had been met. As of December 31, 2018, no net service revenue was recognized related to potential MSSP payments for savings generated for the program periods then ended, if any, as it remains unclear as to if performance obligation has been met by any ACO's served by the HCI segment.

Accounts Receivable

We report accounts receivable net of estimates of variable consideration and implicit price concessions. 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 explicit price concession to reduce the carrying amount of such receivables to their estimated net realizable value 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 approximately 50% of our patient accounts receivable at December 31, 2018 and 2017, 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 recouped 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% 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 explicit price concessions, similar to a contractual adjustment, when reporting the majority of our net service revenue for each reporting period.

Insurance Programs

We bear significant risk under our large-deductible workers’ compensation insurance program and our self-insured employee health program. Under the workers’ compensation insurance program, we bear risk up to $0.5 million per incident. We purchase stop-loss insurance for the employee health plan and bear risk up to $0.3 million per incident. Malpractice and general patient liability claims for incidents which may give rise to litigation have been asserted against us by various claimants. The claims are in various stages of processing and some may ultimately be brought to trial. We are aware of incidents that have occurred through year-end that may result in the assertion of additional claims. We currently carry professional liability insurance coverage on claims made basis and general liability insurance coverage on an occurrence basis for this exposure with a $0.1 million deductible. We also carry D&O coverage (also on a claims made basis) for potential claims against our directors and officers, including securities actions, with deductibles ranging from $0.5 million to $1.0 million per claim.

We record estimated liabilities for our insurance programs based on information provided by the third-party plan administrators, historical claims experience, the life cycle of claims, expected costs of claims incurred but not paid, and expected costs to settle unpaid claims. We monitor our estimated insurance-related liabilities and recoveries, if any, on a monthly basis and as required by ASU 2010-24, Health Care Entities (Topic 954): Presentation of Insurance

Claims and Related Insurance Recoveries, record amounts due under insurance policies in other current assets, while recording the estimated carrier liability in self-insurance reserves in the consolidated balance sheets. As facts change, it may become necessary to make adjustments that could be material to our results of operations and financial condition.

Goodwill and Intangible Assets

We have a significant amount of goodwill on our balance sheet that resulted from the numerous business acquisitions we have made in prior years. We review goodwill and other intangible assets with indefinite lives annually for impairment or more frequently if circumstances indicate impairment may have occurred. We evaluate goodwill for impairment by comparing the current fair value of each of our reporting units to their carrying value, including goodwill. Our business is comprised of five reporting units: home health, hospice, home and community-based, LTACH, and healthcare innovations. 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 their carrying values. 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 2018, 2017 or 2016 related to the annual impairment testing.

Components of our reporting units are collections of markets of similar service offerings that operate collaboratively under a house of brands, i.e. multiple brands are used across markets, states, and segments. During the years ended December 31, 2018 and 2017, we recognized a disposal of $0.6 million and $1.5 million related to goodwill associated with the closure of underperforming locations. The impairment was calculated using a market approach.

Included in intangible assets are definite-lived assets subject to amortization such as software licenses, non-compete agreements, customer relationships, and defensive assets, which are defined as trade names that are not actively used. Amortization of the definite-lived intangible assets is calculated on a straight-line basis over the estimated useful lives of the related assets. Non-compete agreements are amortized over the life of the agreement, usually ranging from one to three years. Customer relationships are amortized over 20 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 lives 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. Based on the results of the qualitative assessment, we may perform a quantitative test. The quantitative impairment test on trade names uses the relief-from-royalty method. Under this method, the fair value of the trade name is determined by calculating the present value of the after-tax cost savings associated with owning the trade names and, therefore, not having to pay royalties for use over its estimated useful life. The quantitative impairment test for certificates of need and licenses applies the cost approach. Under this method, assumptions are made about the cost to replace the certificates of need and licenses. Based on our analysis, there were no indicators that any intangible assets were impaired and no impairment charge was recorded for the year ended December 31, 2018 and 2017; however, during the year ended December 31, 2018, we recognized a disposal of $3.7 million related to certificates of need, license, and customer relationships due to the closure of underperforming locations and the loss of a contract in the HCI reporting unit.

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 $2.2 million and $1.0 million for the years ended December 31, 2018 and 2017, respectively.

Item 8. Financial Statements and Supplementary Data.

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

Item 9. Changes In and Disagreements with Accountants on Accounting and Financial Disclosure.
None.

Item 9A. Disclosure Controls and Procedures.
Evaluation of Disclosure Control and Procedures
The Company maintains disclosure controls and procedures that are designed to ensure that information required to be disclosed by the Company in the reports we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms, and that such information is accumulated and communicated to the Company's management, including its Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosure.
Under the supervision and with the participation of the Company's Chief Executive Officer and Chief Financial Officer, the Company's management evaluated the effectiveness of the Company's disclosure controls and procedures as of December 31, 2018. 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, 2018.
Management's Annual Report on Internal Control Over Financial Reporting
The Company's management is responsible for establishing and maintaining adequate internal control over financial reporting, as that term is defined in Rule 13a-15(f) of the Exchange Act. Under the supervision and with the participation of the Company's Chief Executive Officer and Chief Financial Officer, the Company's management conducted an evaluation of its internal control over financial reporting based on the framework in Internal Control – Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.
Based on management's testing and evaluation under the framework in Internal Control – Integrated Framework (2013), management concluded that our internal control over financial reporting was effective as of December 31, 2018.
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 our merger with Almost Family, Inc. completed April 1, 2018. Operations from these acquisitions represented approximately 8% of total assets and 33% of total revenue as of and for the year ended December 31, 2018.
The attestation report of KPMG LLP, the independent registered public accounting firm that audited the financial statements included in this Annual Report on Form 10-K, is included herein.
Changes in Internal Control Over Financial Reporting
There have not been any changes in the Company's internal control over financial reporting, as such term is defined in Rule 13a-15(f) of the Exchange Act, during the Company's fiscal quarter ended December 31, 2018 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

To the Stockholders and Board of Directors
LHC Group, Inc.:

Opinion on Internal Control Over Financial Reporting
We have audited LHC Group, Inc. and subsidiaries' (the Company) internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2018 and 2017, 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, 2018, and the related notes (collectively, the consolidated financial statements), and our report dated February 28, 2019 expressed an unqualified opinion on those consolidated financial statements.

The Company completed its "merger of equals" with Almost Family, Inc. on April 1, 2018, and management excluded from its assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2018, Almost Family, Inc.'s internal control over financial reporting associated with approximately 8 percent of total assets and 33 percent of total revenue included in the consolidated financial statements of the Company as of and for the year ended December 31, 2018. Our audit of internal control over financial reporting of the Company also excluded an evaluation of the internal control over financial reporting of Almost Family, Inc.

Basis for Opinion

The Company'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 are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. 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 of internal control over financial reporting 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.

Definition and Limitations of Internal Control Over Financial Reporting

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.

/s/ KPMG LLP
KPMG LLP
Baton Rouge, Louisiana
February 28, 2019

Item 9B. Other Information.
None noted.

PART
III

Item 10. Directors, Executive Officers and Corporate Governance.
The information required by this Item 10 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 2019 Annual Meeting of Stockholders.
The information required by this Item 10 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 2019 Annual Meeting of Stockholders.
The information required by this Item 10 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 2019 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 11 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 2019 Annual Meeting of Stockholders.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.
The information required by this Item 12 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 2019 Annual Meeting of Stockholders.
Equity Compensation Plan Information

The following table provides information as of December 31, 2018, regarding shares of common stock that may be issued under the Company's existing equity compensation plans:

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

Equity compensation plans approved by Stockholders:	~~$~~	~~2~~,346,418
Equity compensation plans not approved by Stockholders:	———	
Total	~~$~~	~~2~~,346,418

(1) Includes 2,194,074 shares remaining available for issuance under the LHC Group, Inc. 2018 Long-Term Incentive Plan (all of which are available for issuance pursuant to grants of full-value stock awards) and 152,344 shares remaining available for issuance under the Amended and Restated LHC Group, Inc.'s 2006 Employee Stock Purchase Plan.

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

The information required by this Item 13 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 2019 Annual Meeting of Stockholders.

Item 14. Principal Accountant Fees and Services.

The information required by this Item 14 regarding accounting and audit fees is incorporated by reference from the information contained under the heading “Principal Accountant Fees and Services” in the definitive Proxy Statement relating to the Company’s 2019 Annual Meeting of Stockholders.

PART
IV

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

Report of Independent Registered Public Accounting Firm	F-1
Consolidated Balance Sheets as of December 31, 2018 and 2017	F-2
For each of the years in the three-year period ended December 31, 2018	
Consolidated Statements of Income	F-3
Consolidated Statements of Changes in Equity	F-4
Consolidated Statements of Cash Flows	F-5
Notes to the Consolidated Financial Statements	F-6

(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
To the Stockholders and Board of Directors
LHC Group, Inc.:

Opinion on the Consolidated Financial Statements

We have audited the accompanying consolidated balance sheets of LHC Group, Inc. and subsidiaries (the Company) as of December 31, 2018 and 2017, 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, 2018, and the related notes (collectively, the consolidated financial statements). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2018, 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) (PCAOB), the Company’s internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 28, 2019 expressed an unqualified opinion on the effectiveness of the Company’s internal control over financial reporting.

Change in Accounting Principle

As discussed in Note 2 to the consolidated financial statements, the Company has changed its method of accounting for revenue recognition in 2018, 2017 and 2016 due to the adoption of ASU No. 2014-09, Revenue from Contracts with Customers.

Basis for Opinion

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 are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ KPMG LLP
KPMG LLP
We have served as the Company's auditor since 2008.
Baton Rouge, Louisiana

February 28, 2019

F-1

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

	As of December 31,	
	2018	2017
ASSETS		
Current assets:		
Cash	$49,363	$2,849
Receivables:		
Patient accounts receivable	252,592	161,898
Other receivables	6,658	3,163
Amounts due from governmental entities	830	830
Total receivables, net	260,080	165,891
Prepaid income taxes	11,788	7,006
Prepaid expenses	24,775	13,042
Other current assets	20,899	12,177
Total current assets	366,905	200,965
Property, building and equipment, net of accumulated depreciation of $55,253 and $43,565, respectively	79,563	46,453
Goodwill	1,161,717	392,601
Intangible assets, net of accumulated amortization of $15,176 and $13,041, respectively	297,379	134,610
Assets held for sale	2,850	—
Other assets	20,301	19,073
Total assets	$1,928,715	$793,702
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and other accrued liabilities	$77,135	$39,750
Salaries, wages and benefits payable	84,254	44,747
Self insurance reserves	32,776	12,450
Current portion of long-term notes payable	7,773	286
Amounts due to governmental entities	4,174	5,019
Total current liabilities	206,112	102,252
Deferred income taxes	43,306	27,466
Income taxes payable	4,297	—
Revolving credit facility	235,000	144,000
Long-term notes payable	930	—
Total liabilities	489,645	273,718
Noncontrolling interest-redeemable	14,596	13,393
Stockholders' equity:		
LHC Group, Inc. stockholders' equity:		
Preferred stock – $0.01 par value: 5,000,000 shares authorized; none issued or outstanding	—	—
Common stock – $0.01 par value: 60,000,000 and 40,000,000 shares authorized in 2018 and 2017, respectively; 35,636,414 and 22,640,046 shares issued in 2018 and 2017, respectively	356	226
Treasury stock – 4,958,721 and 4,890,504 shares at cost, respectively	(49,374)	(42,249)
Additional paid-in capital	937,968	126,490
Retained earnings	427,975	364,401
Total LHC Group, Inc. stockholders' equity	1,316,925	448,868
Noncontrolling interest – non-redeemable	107,549	57,723

Total stockholders' equity	1,424,474	506,591

Total liabilities and stockholders' equity	$1,928,715	$793,702

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,		
	2018	2017	2016
Net service revenue	$1,809,963	$1,062,602	$900,033
Cost of service revenue	1,156,357	675,810	557,650
Gross margin	653,606	386,792	342,383
General and administrative expenses	537,916	310,539	270,622
Impairment of intangibles and other	4,689	1,571	1,199
Operating income	111,001	74,682	70,562
Interest expense	(9,679)	(3,352)	(2,444)
Income before income taxes and noncontrolling interests	101,322	71,330	68,118
Income tax expense	22,399	10,944	22,176
Net income	78,923	60,386	45,942
Less net income attributable to noncontrolling interests	15,349	10,274	9,359
Net income attributable to LHC Group, Inc.’s common stockholders	$63,574	$50,112	$36,583
Earnings per share - basic:			
Net income attributable to LHC Group, Inc.’s common stockholders	$2.31	$2.83	$2.08
Earnings per share - diluted:			
Net income attributable to LHC Group, Inc.’s common stockholders	$2.29	$2.79	$2.07
Weighted average shares outstanding:			
Basic	27,498,351	17,715,992	17,559,477
Diluted	27,773,396	17,961,018	17,682,820

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 - non-redeemable	Total equity	Non controlling interest - redeemable	Net income
Balances at December 31, 2015	$222	22,224,423	(37,139)	4,776,560	$113,793	$277,706	$3,211	$357,793	$12,408	
Net income	—	—	—	—	—	36,583	1,373	37,956	7,986	45,942
Acquired noncontrolling interest	—	—	—	—	—	—	1,783	1,783	—	
Sale of noncontrolling interest	—	—	—	—	(931)	—	1,400	469		
Noncontrolling interest distributions	—	—	—	—	—	—	(1,341)	(1,341)	(7,827)	
Stock options exercised	—	5,500	—	—	109	—	—	109	—	
Nonvested stock compensation	—	—	—	—	4,872	—	—	4,872	—	
Issuance of vested stock	2	174,969	—	—	(2)	—	—	—	—	
Treasury shares redeemed to pay income tax	—	—	(1,996)	52,119	—	—	—	(1,996)	—	
Excess tax benefits-vesting nonvested stock	—	—	—	—	995	—	—	995	—	
Issuance of common stock under Employee Stock Purchase Plan	—	24,149	—	—	912	—	—	912	—	
Balances at December 31, 2016	$224	22,429,041	$(39,135)	4,828,679	$119,748	$314,289	$6,426	$401,552	$12,567	
Net income	—	—	—	—	—	50,112	(595)	49,517	10,869	60,386
Acquired noncontrolling interest	—	—	—	—	—	—	53,657	53,657	—	
Purchase of additional controlling interest	—	—	—	—	(368)	—	—	(368)	(1,120)	

Sale of noncontrolling interest	—	—	—	—	122	—	282	404	412	
Noncontrolling interest distributions	—	—	—	—	—	—	(2,047)	(2,047)	(9,335)	
Nonvested stock compensation	—	—	—	—	5,964	—	—	5,964	—	
Issuance of vested stock	2	192,463	—	—	(2)	—	—	—	—	
Treasury shares redeemed to pay income tax	—	—	(3,114)	61,825	—	—	—	(3,114)	—	
Issuance of common stock under Employee Stock Purchase Plan	—	18,542	—	—	1,026	—	—	1,026	—	
Balances at December 31, 2017	$226	22,640,046	$(42,249)	4,890,504	$126,490	$364,401	$57,723	$506,591	$13,393	
Net Income	—	—	—	—	—	63,574	5,672	69,246	9,677	78,923
Acquired noncontrolling interest	—	—	—	—	—	—	41,055	41,055	8,230	
Purchase of additional controlling interest	—	—	—	—	7,661	—	(371)	7,290	(7,706)	
Sale of noncontrolling interest	—	—	—	—	(2,161)	—	6,016	3,855	590	
Noncontrolling interest distributions	—	—	—	—	—	—	(2,546)	(2,546)	(9,588)	
Nonvested stock compensation	—	—	—	—	9,358	—	—	9,358	—	
Issuance of vested stock	3	212,355	—	—	—	—	—	3	—	
Treasury shares redeemed to pay income tax	—	—	(7,125)	68,217		—	—	(7,125)	—	
Merger consideration	127	12,765,288	—	—	795,278	—	—	795,405		
Issuance of common stock under Employee Stock Purchase Plan	—	18,725	—	—	1,342	—	—	1,342	—	
Balances at December 31,	$356	35,636,414	$(49,374)	4,958,721	$937,968	$427,975	$107,549	$1,424,474	$14,596	

2018

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,		
	2018	2017	2016
Operating activities			
Net income	$78,923	$60,386	$45,942
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization expense	16,362	13,422	12,160
Stock-based compensation expense	9,358	5,964	4,872
Deferred income taxes	19,453	(4,475)	7,402
Loss on disposal of assets	319	60	1,199
Impairment of goodwill and intangibles	4,370	1,511	—
Changes in operating assets and liabilities, net of acquisitions:			
Receivables	(362)	(26,906)	(14,083)
Prepaid expenses and other assets	(10,257)	(26,973)	1,034
Prepaid income taxes	(2,519)	(7,006)	1,641
Accounts payable and accrued expenses	(6,577)	19,666	9,182
Income tax payable	511	(3,499)	84
Net amounts due to/from governmental entities	(996)	176	(1,961)
Net cash provided by operating activities	108,585	32,326	67,472
Investing activities			
Cash acquired from business combination, net of cash paid	7,702	(64,598)	(23,156)
Purchases of property, building and equipment	(32,993)	(10,176)	(16,009)
Advanced payments on acquisitions	—	—	(11,215)
Net cash used in investing activities	(25,291)	(74,774)	(50,380)
Financing activities			
Proceeds from line of credit	303,943	96,000	38,000
Payments on line of credit	(319,743)	(39,000)	(49,000)
Proceeds from employee stock purchase plan	1,342	1,026	912
Payments on debt	(4,975)	(260)	(238)
Payments on deferred financing fees	(1,884)	—	—
Noncontrolling interest distributions	(12,134)	(11,382)	(9,413)
Purchase of additional controlling interest	(412)	(1,488)	—
Sale of noncontrolling interest	4,208	251	356
Withholding taxes paid on stock-based compensation	(7,125)	(3,114)	(584)
Net cash (used in) provided by financing activities	(36,780)	42,033	(19,967)
Change in cash	46,514	(415)	(2,875)
Cash at beginning of period	2,849	3,264	6,139
Cash at end of period	$49,363	$2,849	$3,264
Supplemental disclosures of cash flow information			
Interest paid	$9,067	$3,853	$3,123
Income taxes paid	$5,703	$25,199	$11,533
Non-cash financing and investing activity:			
Accrued capital expenditures	$3,449	$—	$—
Consideration transferred for a business combination	$795,412	$—	$—
Purchase of additional controlling interests	$7,705	$—	$—

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. The Company provides services through five segments: home health, hospice, home and community-based, facility-based, the latter primarily through long-term acute care hospitals ("LTACHs"), and healthcare innovations ("HCI").

On April 1, 2018, the Company completed its previously announced "merger of equals" business combination (the "Merger") with Almost Family, Inc. ("Almost Family"). Almost Family's operating results are included in the Company's operating results from the date of acquisition. See Note 3 of the Notes to the Consolidated Financial Statements.

As of December 31, 2018, the Company, through its wholly and majority-owned subsidiaries, equity joint ventures, controlled affiliates, and management agreements, operated 757 service providers in 36 states within the continental United States.

2. Summary of Significant Accounting Policies

Use of Estimates

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

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

Principles of Consolidation

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

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

Ownership type	2018	2017	2016
Wholly owned subsidiaries	59.2 %	51.1 %	57.1 %
Equity joint ventures	40.0	46.8	41.2
Managed or licensed	0.8	2.1	1.7
	100.0%	100.0%	100.0%

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

The Company consolidates equity joint venture entities as the Company has controlling interests, has voting control over these entities, or has ability to exercise significant influence in these entities. The members of the Company's equity joint ventures participate in profits and losses in proportion to their equity interests.

The Company has management services agreements under which the Company manages certain operations of agencies. The Company does not consolidate managed agencies that the Company does not have an ownership interest in, nor does it have an obligation to absorb losses of, or right to receive benefits from the entities that own the agencies.

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.

Revenue Recognition

Basis of Presentation

The Company adopted ASU No. 2014-09, Revenue from Contracts with Customers, ("ASU 2014-09") on January 1, 2018 on a full retrospective basis, which required the Company to present the prior comparable periods as adjusted. The adoption of the standard did not have a material impact on the Company's financial statements. The Company did not adjust the opening balance of retained earnings to account for the implementation of the requirements of this standard as there are no timing differences related to the recognition of implicit price concessions as part of net service revenue. All amounts previously classified as provision for bad debts were reclassified within the Company's net service revenue. For the year ending December 31, 2018, the Company recorded $25.5 million of implicit price concessions as a direct reduction of net service revenue that would have been recorded as provision for bad debts prior to the adoption of ASU 2014-09.

Adoption of the standard impacted the Company's previously reported results as follows (amounts in thousands):

	As previously reported	Adjustment for ASU 2014-09	As adjusted
	As of December 31, 2017		
Consolidated Balance Sheets:			
Patients accounts receivable	$161,898	$—	$161,898
Allowance for uncollectible accounts	23,556	(23,556)	—
	For the year ended December 31, 2017		
Consolidated Statements of Income:			
Net service revenue	$1,072,086	$(9,484)	$1,062,602
Provision for bad debts	(9,484)	9,484	—
Net income attributable to LHC Group, Inc.'s common stockholders	50,112	—	50,112
Consolidated Statements of Cash Flows:			
Provision for bad debts	9,484	(9,484)	—
Changes in operating assets and liabilities, net of acquisitions: Receivables	(36,390)	9,484	(26,906)
	For the year ended December 31, 2016		
Consolidated Statements of Income:			
Net service revenue	$914,823	$(14,790)	$900,033
Provision for bad debts	(14,790)	14,790	—
Net income attributable to LHC Group, Inc.'s common stockholders	36,583	—	36,583
Consolidated Statements of Cash Flows:			
Provision for bad debts	14,790	(14,790)	—
Changes in operating assets and liabilities, net of acquisitions: Receivables	(28,873)	14,790	(14,083)

Net service revenue is reported at the amount that reflects the consideration the Company expects to receive in exchange for providing services. Receipts are from Medicare, Medicaid, Managed Care, Commercial and others for services rendered, and they include implicit price concessions for retroactive revenue adjustments due to actual receipts from third-party payors, settlements of audits, and reviews. The estimated uncollectible amounts due from these payors are considered implicit price concessions that are a direct reduction to net service revenue. 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. Medicare contributes to the net service revenue of the Company's home health services, hospice services, facility-based services, and healthcare innovations services. Medicaid and other payors contribute to the net service revenue of all of the Company's segments.

Performance obligations are determined based on the nature of the services provided by the Company. The majority of the Company's performance obligations is to provide services to each patient based on medical necessity and identifies

the bundle of services to be provided to achieve the goals established in the contract, while the healthcare innovations segment's performance obligation is largely to provide services under customer contracts. Revenue for performance obligations is

satisfied over time and recognized based on actual charges incurred in relation to total expected charges over the measurement period of the performance obligation, which depicts the transfer of services and related benefits received by the patient and customers over the term of the contract to satisfy the obligations. The Company measures the satisfaction of the performance obligation as services are provided.

The Company's performance obligations relate to contracts with a duration of less than one year; therefore, the Company has elected to apply the option exemption provided by ASC 606 - Revenue Recognition, and is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations are generally completed when the patients are discharged.

The Company determines the transaction price for the majority of its performance obligations based on gross charges for services provided, reduced by explicit price concessions provided to third-party payors and implicit price concessions. The Company determines estimates of explicit price concessions, principally contractual adjustments based on established agreements with payors, and implicit price concessions based on historical collection experience. Estimates of explicit and implicit price concessions are periodically reviewed to ensure they encompass the Company's current contract terms, are reflective of the Company's current patient mix, and are indicative of the Company's historic collections to ensure net service revenue is recognized at the expected transaction price. As such, net service revenue is recorded equal to expected cash receipts for services when rendered.

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

	2018	2017	2016
Home health:			
Medicare	71.8 %	72.6 %	76.8 %
Medicaid	1.3	1.1	1.0
Managed Care, Commercial, and Other	26.9	26.3	22.2
	100.0%	100.0%	100.0%
Hospice:			
Medicare	90.7 %	92.9 %	94.8 %
Medicaid	0.4	0.3	0.9
Managed Care, Commercial, and Other	8.9	6.8	4.3
	100.0%	100.0%	100.0%
Home and Community-Based:			
Medicaid	23.9 %	18.9 %	15.2 %
Managed Care, Commercial, and Other	76.1	81.1	84.8
	100.0%	100.0%	100.0%
Facility-Based:			
Medicare	59.7 %	63.7 %	72.5 %
Managed Care, Commercial, and Other	40.3	36.3	27.5
	100.0%	100.0%	100.0%
Healthcare Innovations:			
Medicare	22.8 %	— %	— %
Medicaid	0.3	—	—
Managed Care, Commercial, and Other	76.9	—	—
	100.0%	— %	— %

Medicare

Home Health Services

The home health segment's Medicare patients, including certain Medicare Advantage patients, are classified into one of 153 home health resource groups prior to receiving services. Based on the patient's 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 elects to use the same 60-day length of episode that Medicare recognized as standard but accelerates

revenue upon discharge to align with a patient's episode length, if less than the expected 60 days, which depicts the transfer of services and related benefits received by the patient over the term necessary to satisfy the obligations. The Company recognizes revenue based on the number of days elapsed during an episode of care within the reporting period.

Final payments from Medicare will reflect base payment adjustments for case-mix and geographic wage differences and 2% sequestration reduction. In addition, final payments may reflect one of four retroactive adjustments to the total reimbursement: (a) an outlier payment if the patient's care was unusually costly; (b) a low utilization adjustment if the number of visits was fewer than five; (c) a partial payment if the patient transferred to another provider or transferred from another provider before completing the episode; or (d) a payment adjustment based upon the level of therapy services required. The retroactive adjustments outlined above are recognized in net service revenue when the event causing the adjustment occurs and during the period in which the services are provided to the patient. The Company reviews these adjustments to ensure it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustments is subsequently resolved. Net service revenue and related patient accounts receivable are recorded at amounts estimated to be realized from Medicare for services rendered.

Hospice Services

The Company's hospice services segment is reimbursed by Medicare under a per diem payment system based on the determined need for the patient on a daily basis. The hospice segment receives one of four predetermined daily rates based upon the level of care the Company furnishes. Each level of care is contingent upon the patient's medical necessity and is a distinct performance obligation, which depicts the transfer of services and related benefits received by the patient over the term to satisfy the obligations. The Company records net service revenue for hospice services based on the promulgated per diem rate over time as services are provided, satisfying the performance obligation. Hospice payments are subject to variable consideration through 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," determined by Medicare to be payment equal to six months of hospice care for the aggregate base of hospice patients, 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, if any, in the reporting period. The Company reviews these estimates to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustments is subsequently resolved.

Facility-Based Services

The Company's facility-based services segment is reimbursed primarily 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 LTACH patient classified in that particular long-term care diagnosis-related group. For selected LTACH 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 LTACH claims paid. Similar to other Medicare prospective payment systems, the rate is also adjusted for geographic wage differences. Net service revenue adjustments resulting from reviews and audits of Medicare cost report settlements are considered implicit price concessions for LTACHs and are measured at expected value. The Company reviews these estimates to ensure that it is probable that a significant reversal in the amount of LTACH services cumulative revenue recognized will not occur when the uncertainty associated with retroactive adjustments is subsequently resolved. Net service revenue for the Company's LTACH services are satisfied over time and recognized based on actual charges incurred in relation to total expected charges, which depicts the transfer of services and related benefits received by the customer over the service period to satisfy the obligations.

Non-Medicare Revenues

Substantially all remaining revenues are derived from services provided under a per visit, per hour or unit basis, per assessment or per member per month basis for which revenues are calculated and recorded using payor-specific or patient-specific fee schedules based on the contracted rates in each underlying third party payor or services agreement or out of network rates, as applicable. Net service revenue is recognized as such services are provided and costs for delivery of such services are incurred.

Contingent Service Revenues

The Company's Healthcare Innovations segment provides strategic health management services to Affordable Care Organizations ("ACOs") that have been approved to participate in the Medicare Shared Savings Program ("MSSP"). The HCI segment has service agreements with ACOs that provide for sharing of MSSP payments received by the ACO, if any. ACOs are legal entities that contract with Centers for Medicare and Medicaid Services ("CMS") to provide services to the Medicare fee-for-service population for a specified annual period with the goal of providing better care for the individual, improving health for populations and lowering costs. ACOs share savings with CMS to the extent that the actual costs of serving assigned beneficiaries are below certain trended benchmarks of such beneficiaries and certain quality performance measures are achieved. The generation of shared savings is the performance obligation of each ACO, which only become certain upon the final issuance of unembargoed calculations by CMS, generally in the third quarter of each year. During the year ended December 31, 2018, the HCI segment recorded net service revenue of $3.7 million related to the 2017 ACO service periods, as certain ACOs served by the HCI segment received a MSSP payment from CMS confirming the performance obligation had been met. As of December 31, 2018, no net service revenue was recognized related to potential MSSP payments for savings generated for the program periods ended December 31, 2018, if any, as it remains unclear as to if performance obligation has been met by any ACOs served by the HCI segment.

Accounts Receivable

The Company reports accounts receivable net of estimates of variable consideration and implicit price concessions. Accounts receivable are uncollateralized and primarily consist of amounts due from Medicare, Medicaid, other third-party payors, and to a lesser degree patients. The Company establishes an allowances for explicit and implicit price concessions to reduce the carrying amount of such receivables to their estimated net realizable value. The credit risk associated with receivables from other payors is limited due to the significance of Medicare as the primary payor. The Company believes the credit risk associated with its Medicare accounts, which have historically exceeded 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 implicit price concessions 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 recouped prior to receiving final payment in full. 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 RAP 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% of the estimated reimbursement.

The Company’s services to the Medicare population are paid at prospectively set amounts 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 it provides. The Company’s managed care contracts and other in or out of network payors provide for payments based upon a predetermined fee schedule or an episodic basis. 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 explicit price concessions when reporting net service revenue for each reporting period.

The following table sets forth the percentage of patient accounts receivable by payor for the years ended December 31:

	2018	2017
Medicare	51.3 %	60.8 %

Medicaid	8.6	5.8
Managed Care, Commercial, and Other	40.1	33.4
Total patient accounts receivable	100.0%	100.0%

Business Combination

The Company accounts for its acquisitions in accordance with ASC 805, "Business Combinations" ("ASC 805") using the acquisition method of accounting. Assets typically acquired consist primarily of Medicare licenses, trade names, certificates of need, and/or non-compete agreements. 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. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. The operations of the acquisitions are included in the consolidated financial statements from their respective dates of acquisition. Acquisition transactions that occurred in 2018 are further described in Notes 3 and 4 and goodwill and intangible assets are discussed in Note 5.

Insurance Programs

The Company bears significant risk under its large-deductible workers' compensation insurance program and its self-insured employee health program. Under the workers' compensation insurance program, the Company bears risk up to $0.5 million per incident, after which stop-loss coverage is maintained. The Company purchases stop-loss insurance for the employee health plan and bear risk up to $0.3 million per incident.

Malpractice and general patient liability claims for incidents which may give rise to litigation have been asserted against the Company by various claimants. The claims are in various stages of processing and some may ultimately be brought to trial. The Company currently carries professional liability insurance coverage on a claims made basis and general liability insurance coverage on an occurrence basis for this exposure with a $0.1 million. The Company also carries D&O coverage (also on a claims made basis) for potential claims against the Company's directors and officers, including securities actions, with deductibles ranging from $0.5 million to $1.0 million per claim.

The Company records estimated liabilities for its insurance programs based on information provided by the third-party plan administrators, historical claims experience, the life cycle of claims, expected costs of claims incurred but not paid, and expected costs to settle unpaid claims. The Company monitors its estimated insurance-related liabilities and recoveries, if any, on a monthly basis and records amounts due under insurance policies in other current assets, while recording the estimated carrier liability in self-insurance reserves. As facts change, it may become necessary to make adjustments that could be material to the Company's results of operations and financial condition.

Goodwill and Intangible Assets

In accordance with ASC 350, "Intangibles - Goodwill and Other" ("ASC 350") goodwill and intangible assets with indefinite lives are reviewed by the Company at least annually for impairment. The Company performs its annual impairment review of goodwill at November 30, and when a triggering event occurs between annual impairment tests. For 2018 and 2017, 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 2018, 2017 or 2016 related to the annual impairment testing. Components of the Company's reporting units are collections of markets of similar service offerings that operate collaboratively under a house of brands, i.e. multiple brands are used across markets, states, and segments. During the years ended December 31, 2018 and 2017, the Company recognized a disposal of $0.6 million and $1.5 million, respectively related to goodwill associated with the closure of underperforming locations. The impairments were calculated using a market approach.

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 ten years. Amortization expense for the Company's definite-lived intangible assets for the years ended December 31, 2018, 2017 and 2016 was $2.1 million, $2.1 million and $2.5 million, respectively, which was recorded in general and administrative expenses.

The Company also has indefinite-lived assets that are not subject to amortization expense such as trade names, certificates of need, and Medicare 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 lives of these intangible assets and the Company intends to renew and operate the certificates of need and licenses and use the trade names indefinitely. In some cases, the value of licenses and certificates of need is increased by moratoriums in effect. 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, 2018 and 2017, the Company did not record an impairment charge related to indefinite-lived intangible assets. During the year ended December 31, 2018, the Company recognized a disposal of $3.7 million related to intangible assets associated with closures 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, if any.

Property, Building and Equipment

Property, building and equipment are recorded at cost. Property and equipment acquired in connection with business combinations are recorded at estimated fair value in accordance with the acquisition method of accounting in accordance with ASC 805. Expenditures that increase capacities or extend useful lives are capitalized to the appropriate property, building and equipment accounts. Costs and related accumulated depreciation associated with assets that are sold or retired are written off and any gain or losses are recorded in operating income. Routine repairs and maintenance costs are expensed as incurred.

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.

In accordance with ASC 360, "Property, Plant, and Equipment", the Company evaluates its long-lived assets for possible impairment whenever events or changes in circumstances occur that indicate that the carrying amount of the asset may not be recoverable. There were no impairment charges recognized during the periods ended December 31, 2018, 2017 and 2016.

The following table describes the Company’s components of property, building and equipment for the years ended December 31, 2018 and 2017 (amounts in thousands):

	2018	2017
Land	$6,750	$2,033
Building and improvements	35,474	14,166
Transportation equipment	13,503	11,363
Fixed equipment	745	780
Office furniture and medical equipment	78,344	61,676
	134,816	90,018
Less accumulated depreciation	55,253	43,565
Property, building and equipment, net	$79,563	$46,453

Depreciation expense for the years ended December 31, 2018, 2017 and 2016 was $14.1 million, $11.3 million and $9.7 million, respectively, which was recorded in general and administrative expenses.

Noncontrolling Interest

The Company classifies noncontrolling interests of its joint ventures based upon a review of the legal provisions governing the redemption of such interests. In each of the Company's joint ventures, those provisions are embodied within the joint

venture's operating agreement. For joint ventures with operating agreement provisions that establish an obligation for the Company to purchase the third party partners' noncontrolling interests other than as a result of events that lead to a liquidation of the joint venture, such noncontrolling interests are classified as redeemable noncontrolling interests in temporary equity. For joint ventures with operating agreement provisions that establish an obligation that the Company purchase the third party partners' noncontrolling interests, but which obligation is triggered by events that lead to a liquidation of the joint venture, such noncontrolling interests are classified as nonredeemable noncontrolling interests in permanent equity. Additionally, for joint ventures with operating agreement provisions that do not establish an obligation for the Company to purchase the third party partners' noncontrolling interests (e.g., where the Company has the option, but not the obligation, to purchase the third party partners' noncontrolling interests), such noncontrolling interests are classified as nonredeemable noncontrolling interests in permanent equity.

The Company's equity joint ventures that are classified as redeemable noncontrolling interests are subject to operating agreement provisions that require the Company to purchase the noncontrolling partner's interest upon the occurrence of certain triggering events, which are defined as the bankruptcy of the partner or the partner's exclusion from the Medicare or Medicaid programs. These triggering events and the related repurchase provisions are specific to each redeemable equity joint venture, since the triggering of a repurchase obligation for any one redeemable noncontrolling interest in an equity joint venture does not necessarily impact any of the other redeemable noncontrolling interests in other equity joint ventures. Upon the occurrence of a triggering event requiring the purchase of a redeemable noncontrolling interest, the Company would be required to purchase the noncontrolling partner's interest based upon a valuation methodology set forth in the applicable joint venture agreement.

Redeemable noncontrolling interests and nonredeemable noncontrolling interests are initially recorded at their fair value as of the closing date of the transaction establishing the joint venture. Such fair values are determined using various accepted valuation methods, including the income approach, the market approach, the cost approach, and a combination of one or more of these approaches. A number of facts and circumstances concerning the operation of the joint venture are evaluated for each transaction, including (but not limited to) the ability to choose management, control over acquiring or liquidating assets, and control over the joint venture's strategy and direction, in order to determine the fair value of the noncontrolling interest.

Subsequent to the closing date of the transaction establishing the joint venture, recorded values for both redeemable and nonredeemable noncontrolling interests are adjusted at the end of each reporting period for (a) comprehensive income (loss) that is attributed to the noncontrolling interest, which is calculated by multiplying the noncontrolling interest percentage by the comprehensive income (loss) of the joint venture's operations during the reporting period, (b) dividends paid to the noncontrolling interest partner during the reporting period, and (c) any other transactions that increase or decrease the Company's ownership interest in the joint venture, as a result of which the Company retains its controlling interest. If the Company determines based upon its analysis as of the end of each reporting period in accordance with authoritative accounting guidance, that it is not probable that an event would occur to otherwise require the redemption of a redeemable noncontrolling interest (i.e., the date for such event is not set or such event is not certain to occur), then the Company does not adjust the recorded amount of such redeemable noncontrolling interest.

The carrying amount of each redeemable equity instrument presented in temporary equity for the twelve months ended December 31, 2018 is not less than the initial amount reported for each instrument. The activity of noncontrolling interest-redeemable for the twelve months ended December 31, 2018 is summarized in the Company's Statements of Changes in Equity.

Based upon the Company's evaluation of the redemption provisions concerning redeemable noncontrolling interests as of December 31, 2018, the Company determined in accordance with authoritative accounting guidance that it was not probable that an event otherwise requiring redemption of any redeemable noncontrolling interest would occur (i.e., the

date for such event was not set or such event is not certain to occur). Therefore, none of the redeemable noncontrolling interests were identified as mandatorily redeemable interests at such times, and the Company did not record any values in respect of any mandatorily redeemable interests.

Stock-Based Compensation

The Company accounts for its stock-based awards in accordance with provisions of ASC 718, "Compensation - Stock Compensation" ("ASC 718"). The Company grants restricted stock or restricted stock units to employees and members of its Board of Directors as a form of compensation. In accordance with ASC 718, 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 8 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, 2018, 2017 and 2016:

	2018	2017	2016
Weighted average number of shares outstanding for basic per share calculation	27,498,351	17,715,992	17,559,477
Effect of dilutive potential shares:			
Options	—	—	863
Nonvested restricted stock	275,045	245,026	122,480
Adjusted weighted average shares for diluted per share calculation	27,773,396	17,961,018	17,682,820
Antidilutive shares	46,002	—	219,855

Effective April 1, 2018, in conjunction with the Merger, the Company increased the authorized number of common shares to 60.0 million.

Assets Held for Sale

As of December 31, 2018, assets held for sale includes the land and building and all related equipment and fixtures of one closed hospice facility, which was acquired in the Merger and that the Company is actively marketing and intends to sell.

Other Recently Adopted Accounting Pronouncements

In August 2016, the FASB issued ASU No. 2016-15, Statement of Cash Flows: Classification of Certain Cash Receipts and Cash Payments, ("ASU 2016-15"), which addresses eight classification issues related to the statement of cash flows. This ASU is effective for annual and interim periods in fiscal years beginning after December 15, 2017. Entities should apply this ASU using a retrospective transition method to each period presented. There is no material impact to the Company's consolidated financial statements upon adoption of ASU 2016-15.

In January 2017, the FASB issued ASU No. 2017-01, Business Combinations: Clarifying the Definition of a Business, ("ASU 2017-01"), which assist entities with evaluating whether a set of transferred assets and activities is a business. This ASU is effective for annual and interim periods in fiscal years beginning after December 15, 2017. There is no material impact on the Company's consolidated financial statements upon adoption of ASU 2017-0l.

Recently Issued Accounting Pronouncements

In February 2016, the FASB issued ASU No. 2016-02, Leases, ("ASU 2016-02"), as modified by ASUs 2018-01, 2018-10, 2018-11 and 2018-20 (collectively, ASU 2016-02), which requires lessees to recognize leases with terms exceeding 12 months on the Company's Consolidated Balance Sheet. Qualifying leases will be classified as finance or operating right-of-use ("ROU") assets and lease liabilities. The new standard was effective on January 1, 2019. Early adoption is permitted. ASU 2016-02 provides a number of optional practical expedients in transition. The Company: i) elected the 'package of practical expedients', which permitted the Company not to reassess under the new standard the Company's prior conclusions about lease identification, lease classification and initial direct costs, ii) elected all the use-of-hindsight or the practical expedient pertaining to land easements; the latter not being applicable to the Company, iii) to elect all the new standard's available transition practical expedients. Adoption of this standard increased total assets and total liabilities by $90.0 million for the Company's operating leased office space and copiers for locations in each segment. The adoption did not change the Company's leasing activities. ASU 2016-02 also provides practical expedients for an entity's ongoing accounting. The Company elected the short-term recognition exemption for certain medical devices and storage space leases that qualify, which means it will not recognize ROU assets or lease liabilities, including not recognizing ROU assets or lease liabilities for existing short-term leases of these assets in transition.

In January 2017, the FASB issued ASU No. 2017-04, Intangibles - Goodwill and Other: Simplifying the Test for Goodwill Impairment, which requires an entity to no longer perform a hypothetical purchase price allocation to measure goodwill impairment. Instead, impairment will be measured using the difference between the carrying value and fair value of the

reporting unit. This ASU is effective for the annual and interim periods in fiscal years beginning after December 15, 2019. Early adoption is permitted for goodwill impairment tests with measurement dates on or after January 1, 2017.

3. Almost Family Merger

On November 15, 2017, the Company announced the execution of an Agreement and Plan of Merger (the “Merger Agreement”) entered into among the Company, Almost Family, Inc. (“Almost Family”), and Hammer Merger Sub, Inc. (“Merger Sub”), a wholly owned subsidiary of the Company, providing for a “merger of equals” business combination of the Company and Almost Family (the "Merger"). On April 1, 2018, the Company completed the Merger as contemplated by that certain Agreement and Plan of Merger. At the effective time of the Merger on April 1, 2018, each outstanding share of Almost Family, other than certain canceled shares, was converted into the right to receive 0.9150 shares of the Company's common stock and cash in lieu of any fractional shares of any Company common stock that Almost Family shareholders would otherwise have been entitled to receive. As a result, the Company issued approximately 12.8 million shares of its common stock to former stockholders of Almost Family. The Company was determined to be the accounting acquirer in the Merger.

The following table summarizes the consideration transferred in connection with the Merger (amounts in thousands, except share data):

Outstanding shares of Almost Family common stock as of April 1, 2018	13,951,134
Exchange ratio	0.9150
Shares of the Company issued	12,765,288
Price per share as of April 1, 2018	$ 61.56
Fair value of the Company common stock issued	$ 785,831
Fair value of vested Almost Family equity awards exchanged for equity awards in the Company	$ 9,581
Preliminary merger consideration	$ 795,412

The Company's preliminary valuation analysis of identifiable assets and liabilities assumed for the Merger is in accordance with the requirements of ASC Topic 805, Business Combinations, the preliminary estimates of which are presented in the table below (amounts in thousands). The final determination of the fair value of assets acquired and liabilities assumed will be completed in accordance with the applicable accounting guidance. Due to the significance of the Merger, the Company may use all of the measurement period to adequately analyze and assess the fair value of assets acquired and liabilities assumed.

Preliminary merger consideration	
Stock	$ 795,412
Preliminary fair value of total consideration transferred	
Recognized amounts of identifiable assets acquired and liabilities assumed:	
Cash and cash equivalents	16,547
Patient accounts receivable	91,095
Prepaid income taxes	2,262
Prepaid expenses and other current assets	11,490
Property and equipment	11,144
Trade name	76,090
Certificates of need/licenses	76,505
Customer relationships	13,970
Assets held for sale	2,850
Deferred income taxes	3,613
Accounts payable	(43,731)
Accrued other liabilities	(56,100)
Seller notes payable	(13,555)
NCI - Redeemable	(8,034)

Long term income taxes payable	(3,786)
Line of credit	(106,800)
NCI - Nonredeemable	(36,609)
Other assets and (liabilities), net	(2)
Total identifiable assets and liabilities	36,949
Preliminary goodwill	$758,463

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 need 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 the 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 customer relationships that are amortized over 20 years. Customer relationships were valued using the multi period excess earnings method. Noncontrolling interest is valued at fair value.

The following unaudited pro forma financial information reflects the consolidated results of operations of the Company had the Merger occurred on January 1, 2017. Almost Family's financial information has been compiled in a manner consistent with the accounting policies adopted by LHC Group. The unaudited pro forma financial information has been prepared for comparative purposes and does not purport to be indicative of what would have occurred had the Merger occurred on January 1, 2017, nor are they indicative of any future results (amounts in thousands, except per share amount).

	Pro forma (unaudited)	
	2018	2017
Net service revenue	$2,002,420	$1,845,041
Net income attributable to the Company	79,434	70,526
Diluted earnings per share	$2.55	$2.26

The pro forma financial information contained in this report, including the above, is based on the Company's preliminary assignment of consideration given and therefore subject to adjustment. These proforma amounts were calculated after applying the Company's accounting policies and adjusting Almost Family's and LHC Group's results to reflect adjustments that are directly attributable to the Merger. These adjustments mainly exclude transaction costs incurred by Almost Family and LHC Group in the fiscal quarter preceding the consummation of the Merger, together with the consequential tax effects at the statutory rate.

The unaudited pro forma financial information contained in this report, including the above, has been prepared for informational purposes only and does not include any anticipated synergies or other potential benefits of the Merger. Pro forma information is not present for any other acquisitions or joint venture transactions, as the aggregate operations of the acquired businesses were not significant to the overall operations of the Company. It also does not give effect to certain future charges that the Company expects to incur in connection with the Merger, including, but not limited to, additional professional fees, legal expenses, severance, retention and other employee-related costs, contract breakage costs, and costs related to consolidation of technology systems and corporate facilities.

Transaction costs associated with the Merger that were incurred by the Company during the year ended December 31, 2018 are being expensed as incurred and are presented in the consolidated statements of income as general and administrative expenses. These expenses include investment banking, legal, accounting, and other third-party transaction costs associated with the Merger, including preparation for regulatory filings and shareholder approvals. During the year ended December 31, 2018, the Company incurred $33.0 million of transaction, transition and integration costs related to the Merger.

4. Other Acquisitions and Joint Ventures

2018 Acquisitions

The Company acquired the majority-ownership of seven home health agencies and one hospice agency during the year ended December 31, 2018. The total aggregate purchase price for these transactions was $9.4 million, of which $8.8 million was paid in cash. The purchase prices were determined based on the Company's analysis of comparable acquisitions and the target market's potential future cash flows. Substantially all of the preliminary allocation of the purchase price for the

acquisitions were allocated to goodwill of $11.0 million, indefinite lived intangibles trade names of $1.5 million and certificates of need/licenses of $1.4 million. Acquired noncontrolling interest was $5.0 million.
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.
During the year ended December 31, 2018, the Company sold ownership interests in five of its wholly-owned subsidiaries. The total sales prices of such ownership interests were $4.2 million, all of which were accounted for as equity transactions, resulting in the Company reducing additional paid in capital by $2.2 million.
During the year ended December 31, 2018, the Company purchased additional ownership interests in two of its equity joint venture subsidiaries. The total consideration of such ownership was $8.1 million, of which $7.7 million was paid in shares of the Company's common stock. These transactions were accounted for as equity transactions, resulting in the Company increasing additional paid in capital by $7.7 million.
The Company conducted preliminary assessments and recognized provisional amounts in its initial accounting for these acquisitions for all identified assets in accordance with the requirements of ASC 805. The Company is continuing its review of these matters during the measurement period. If new information about facts and circumstances that existed at the acquisition date is obtained and indicates adjustments are necessary, the acquisition accounting will be revised to adjust to the provisional amounts initially recognized.

2017 Acquisitions

On January 1, 2017, the Company formed a joint venture with LifePoint Health, Inc. ("LifePoint"). LifePoint contributed 28 home health agencies, 12 hospice agencies, and one inpatient hospice unit to the joint venture during the twelve months ended December 31, 2017. The Company acquired majority ownership of the membership interests of these agencies. These providers conduct home health operations in Arizona, Colorado, Louisiana, Michigan, North Carolina, Pennsylvania, Tennessee, Texas, and Virginia; and conduct hospice operations in Michigan, North Carolina, Pennsylvania, Tennessee, and Virginia, and conduct inpatient hospice operations in North Carolina.

On June 1, 2017, the Company formed a joint venture with Baptist Memorial Health Care ("Baptist"). Baptist contributed three home health agencies, six hospice agencies, and one inpatient hospice unit to the joint venture during the twelve months ended December 31, 2017. The Company acquired majority ownership of the membership interests of these agencies. These providers conduct home health and hospice operations in Mississippi and Tennessee, and conduct inpatient hospice operations in Tennessee.

On September 1, 2017, the Company formed a joint venture with CHRISTUS Continuing Care (“CHRISTUS”). CHRISTUS contributed seven home health agencies, five hospice agencies, one inpatient hospice unit, one home and community-based agency, and six LTACH agencies to the joint venture during the twelve months ended December 31, 2017. The Company acquired majority ownership of the membership interests of these agencies. These providers conduct home health and hospice operations in Louisiana and Texas, conduct inpatient hospice operations in Texas, conduct home and community-based operations in Texas; and conduct LTACH operations in Arkansas, Louisiana, and Texas.

In separate transactions, the Company acquired five home health agencies, two hospice agencies, and one pharmacy during the twelve months ended December 31, 2017.

The total aggregate purchase price for these transactions was $80.2 million, of which $10.4 million was paid in December 2016 and $64.6 million was paid in cash during the twelve months ended December 31, 2017. The difference between the total aggregate purchase price and cash payments relates to acquired liabilities for each business combination.

5. Goodwill and Other Intangibles, Net

The following table summarizes changes in goodwill by reporting unit during the twelve months ended December 31, 2018 and 2017 (amounts in thousands):

	Home health	Hospice	Home and community-based	Facility-based	Healthcare Innovations	Total
Balance as of December 31, 2016	$210,839	$64,234	$ 18,820	$ 13,424	—	$307,317
Acquisitions	30,623	15,000	6,220	160	—	52,003
Noncontrolling interests	21,469	9,580	3,501	(141)	—	34,409
Adjustments and disposals	(1,475)	—	—	347	—	(1,128)
Balance as of December 31, 2017	$261,456	$88,814	$ 28,541	$ 13,790	$ —	$392,601
Acquisitions	558,628	29,263	137,042	—	40,755	765,688
Noncontrolling interests	3,297	506	—	—	—	3,803
Adjustments and disposals	(779)	—	—	404	—	(375)
Balance as of December 31, 2018	$822,602	$118,583	$ 165,583	$ 14,194	$ 40,755	$1,161,717

The Company determined that there was no impairment for the goodwill of any reporting units as of December 31, 2018, 2017 and 2016 based on the Company's annual impairment testing. The Company did record $0.6 million and $1.5 million of disposal of goodwill during the years ended December 31, 2018 and 2017 due to the closure of underperforming locations. The amount of disposal of goodwill was determined using prices of comparable business in the market. This was recorded in impairment of intangibles and other on the Company's consolidated statements of income.

The Company performed an impairment analysis on its indefinite-lived intangible assets related to the Company's trade names, licenses and certificates of need and determined that it is not more likely than not that the fair values of the indefinite-lived intangible assets are less than its carrying amount as of November 30, 2018; however, the Company did record $3.7 million of disposals of licenses, certificates of needs, and customer relationship intangible assets due to the closure of underperforming locations. This was recorded in impairment of intangibles and other on the Company's consolidated statements of income.

The following tables summarize the changes in intangible assets during the twelve months ended December 31, 2018 and 2017 (amounts in thousands):

	2018	2017
Indefinite-lived intangible assets:		
Trade Names	$156,049	$78,299
Certificates of Need/Licenses	128,577	53,493
Net total	284,626	131,792
Definite-lived intangible assets:		
Trade Names		
Gross carrying amount	10,127	10,127
Accumulated amortization	(8,817)	(7,547)
Net total	1,310	2,580
Non-compete agreements		
Gross carrying amount	5,980	5,732
Accumulated amortization	(5,729)	(5,494)
Net total	251	238
Customer relationships		
Gross carrying amount	11,822	—
Accumulated amortization	(630)	—
Net total	11,192	—
Total definite-lived intangible assets		

Gross carrying amount	27,929	15,859
Accumulated amortization	(15,176)	(13,041)

Net total	12,753	2,818
Total intangible assets:		
Gross carrying amount	312,555	147,651
Accumulated amortization	(15,176)	(13,041)
Net total	$297,379	$134,610

Remaining useful lives of trade names, customer relationships, and non-compete agreements were 8.8, 19.3, and 2.8 years, respectively. Similar amounts at December 31, 2017 were 10.3 and 2.1 years for trade names and non-compete agreements, respectively.

Amortization expense for the Company's intangible assets was $2.1 million for the years ended December 31, 2018 and 2017 and $2.5 million for the year ended December 31, 2016, which was recorded in general and administrative expenses.

The estimated intangible asset amortization expense for each of the five years subsequent to December 31, 2018 is as follows (amounts in thousands):

Year	Amortization amount
2019	$ 1,112
2020	899
2021	732
2022	682
2023	682
Total	$ 4,107

6. 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, 2018 and 2017 were as follows (amounts in thousands):

	2018	2017
Deferred tax assets:		
Allowance for uncollectible accounts	$8,645	$5,224
Accrued employee benefits	6,038	4,147
Stock compensation	2,322	663
Accrued self-insurance	8,656	2,157
Acquisition costs	1,413	2,064
Net operating loss carry forward	9,147	1,299
Intangible asset impairment	18	21
Other	1,021	91
Capital loss carryforward	—	12
Valuation allowance	(3,574)	(44)
Deferred tax assets	$33,686	$15,634
Deferred tax liabilities:		
Amortization of intangible assets	(64,001)	(35,955)
Tax depreciation in excess of book depreciation	(7,693)	(5,988)

Prepaid expenses	(1,134)	(623)
Non-accrual experience accounting method	(602)	(534)

Other	(3,562)	—
Deferred tax liabilities	(76,992)	(43,100)
Net deferred tax liability	$(43,306)	$(27,466)

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

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

	2018	2017	2016
Current:			
Federal	$892	$12,798	$12,563
State	3,382	2,621	2,371
	4,274	15,419	14,934
Deferred:			
Federal	15,383	(6,273)	6,223
State	2,742	1,798	1,019
	18,125	(4,475)	7,242
Total income tax expense	$22,399	$10,944	$22,176

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

	2018	2017	2016
Federal statutory tax rate	21.0 %	35.0 %	35.0 %
State income taxes, net of federal benefit	5.7	4.4	3.8
Nondeductible expenses	2.6	3.2	2.6
Uncertain tax position	(1.3)	—	(3.3)
TCJA Enactment	—	(22.9)	—
Excess Tax Benefit	(2.6)	(1.6)	—
Credits and other	0.7	(0.1)	(0.4)
Effective tax rate	26.1 %	18.0 %	37.7 %

The Company is subject to both federal tax and state income tax for jurisdictions within which it operates. Within these jurisdictions, the Company is open to examination for tax years ended after December 31, 2013.

As of December 31, 2018, the Company has U.S. operating loss carry forwards of $15.5 million that are available to reduce future taxable income. If not used to offset taxable income, a portion of these losses will expire between 2032 and 2034. Losses generated in years ending after December 31, 2017 have an unlimited carryforward under the Tax Cut and Jobs Act. Due to U.S. limitations on acquired operating losses, a valuation allowance has been established on $0.8 million of these losses.

State operating loss carryforwards totaling $92.3 million at December 31, 2018 are being carried forward in jurisdictions where the Company is permitted to use tax losses from prior periods to reduce future taxable income. If not used to offset future taxable income, these losses will expire between 2019 and 2038. Due to uncertainty regarding the Company's ability to use some of the carryforwards, a valuation allowance has been established on $49.4 million of state net operating loss carryforwards. Based on the Company's historical record of producing taxable income and expectations for the future, the Company has concluded that future operating income will be sufficient to give rise to taxable income sufficient to utilize the remaining state net operating loss carryforwards.

US GAAP prescribes a recognition threshold and measurement attribute for the accounting and financial statement disclosure of tax positions taken or expected to be taken in a tax return. The evaluation of a tax position is a two-step process. The first step requires the Company to determine whether it is more likely than not that a tax position will be sustained upon examination based on the technical merits of the position. The second step requires the Company to recognize in the financial statements each tax position that meets the more likely than not criteria, measured at the amount of benefit that has a greater than 50% likelihood of being realized. The Company's unrecognized tax benefits would affect the tax rate, if recognized. The Company includes the full amount of unrecognized tax benefits in other noncurrent liabilities in the consolidated balance sheets. The Company anticipates it is reasonably possible an increase or decrease in the amount of unrecognized tax benefits could be made in the next twelve months. However, the Company does not presently anticipate that any increase or decrease in unrecognized tax benefits will be material to the consolidated financial statements. The amount recognized as of December 31, 2018 was $4.3 million.

A reconciliation of the total amounts of unrecognized tax benefits follows:

Acquired unrecognized tax position	$3,786
Increased (decreases) in unrecognized tax benefits as a result of:	
Tax positions taken in the current year	1,835
Lapse of statute of limitations	(1,324)
Total unrecognized tax benefits as of December 31, 2018	$4,297

7. Debt

Credit Facility

During the period from January 1, 2018 through April 1, 2018, the Company maintained its revolving line of credit through a credit facility with Capital One, National Association (the "Prior Credit Facility"), which provided a senior, secured revolving line of credit commitment with a maximum principal borrowing limit of $225.0 million and a letter of credit sub-limit equal to $15.0 million. The expiration date of the Credit Agreement was June 18, 2019.

On March 30, 2018, the Company entered into a Credit Agreement with JPMorgan Chase Bank, N.A., which was effective on April 2, 2018 following the Merger (the "New Credit Agreement"). The New Credit Agreement provides a senior, secured revolving line of credit commitment with a maximum principal borrowing limit of $500.0 million, which includes an additional $200.0 million accordion expansion feature, and a letter of credit sub-limit equal to $50.0 million. The expiration date of the New Credit Agreement is March 20, 2023. The New Credit Agreement replaced the Prior Credit Facility with Capital One, National Association, which was set to mature on June 18, 2019. The Company's obligations under the New Credit Agreement were secured by substantially all of the assets of the Company and its wholly-owned subsidiaries (subject to customary exclusions), which assets include the Company's equity ownership of its wholly-owned subsidiaries and its equity ownership in joint venture entities. The Company's wholly-owned subsidiaries also guarantee the obligations of the Company under the New Credit Agreement. Debt issuance costs of $1.9 million were capitalized with the New Credit Agreement and will be amortized through March 30, 2023, the termination date for the New Credit Agreement.

Revolving loans under the New Credit Agreement with JPMorgan Chase Bank, N.A. bear interest at, as selected by the Company, either a (a) Base Rate which is defined as a fluctuating rate per annum equal to the highest of (1) the Federal Funds Rate in effect on such day plus 0.5%, (2) the Prime Rate in effect on such day and (3) the Eurodollar Rate for a one month interest period on such day plus 1.50%, plus a margin ranging from 0.5% to 1.25% per annum or (b) Eurodollar Rate plus a margin ranging from 1.50%% to 2.25% per annum, with pricing varying based on the Company's quarterly consolidated Leverage Ratio (as defined in the New Credit Agreement). Swing line loans bear interest at the Base Rate. The Company is limited to 15 Eurodollar borrowings outstanding at any time. The Company is required to pay a commitment fee for the unused commitments at rates ranging from 0.20% to 0.35% per annum depending upon the Company's quarterly consolidated Leverage Ratio. The Base Rate at December 31, 2018 was 5.50% and the Eurodollar Rate was 4.19%. As of December 31, 2018, the effective interest rate on outstanding borrowings under the New Credit Agreement was 4.19%.

On April 2, 2018, in connection with the consummation of the Merger, the Company borrowed approximately $247.4 million under the New Credit Agreement to (i) repay the approximately $107.3 million of outstanding borrowings

under Almost Family' $350.0 million credit facility, which was terminated in connection with the Merger (ii) repay the approximately $125.1 million of outstanding borrowings under the Prior Credit Facility, which was also terminated in connection with the Merger, and (iii) pay certain debt issuance and repayment costs and Merger related fees and expenses.

As of December 31, 2018 the Company had $235.0 million drawn and letters of credit in the amount of $30.4 million outstanding under the credit facility. At December 31, 2017, the Company had $144.0 million drawn and letters of credit in the amount of $9.6 million outstanding under the Prior Credit Facility.

Under the terms of the New Credit Agreement, the Company is required to maintain certain financial ratios and comply with certain financial covenants. The New Credit Agreement permits the Company to make certain restricted payments, such as purchasing shares of its stock, within certain parameters, provided the Company maintains compliance with those financial ratios and covenants after giving effect to such restricted payments. The Company was in compliance with debt covenants at December 31, 2018.

The scheduled principal payments on long-term debt for each of the five years subsequent to December 31, 2018 is as follows (amounts in thousands):

Year	Principal payment amount
2019	$7,773
2020	235,123
2021	133
2022	143
2023	531
Total	$243,703

8. Stockholders’ Equity

Equity Based Awards

At the Company’s 2018 Annual Meeting of Stockholders held on June 7, 2018, the stockholders of the Company approved the Company’s 2018 Long Term Incentive Plan (the “2018 Incentive Plan”) to replace the Company's 2010 Long Term Incentive Plan (the "Prior Plan"). The 2018 Incentive Plan is administered by the Compensation Committee of the Company’s Board of Directors (the “Compensation Committee”). The total number of shares of the Company's common stock originally reserved and available for issuance pursuant to awards granted under the 2018 Incentive Plan was 2,000,000, plus an additional number of shares (not to exceed 300,000) underlying stock awards granted under the Company's Prior Plan that terminated, expired, or forfeited. As of June 7, 2018, there were 2,210,544 shares of our common stock reserved for future awards, under the 2018 Incentive Plan. A total of 2,194,074 shares are available for issuance as of December 31, 2018. A variety of discretionary awards for employees, officers, directors and consultants are authorized under the 2018 Incentive Plan, including incentive or non-qualified statutory stock options and restricted stock, restricted stock units and performance-based awards. All awards must be evidenced by a written award certificate which will include the provisions specified by the Compensation Committee. The Compensation Committee determines the exercise price for stock options, which cannot be less than the fair market value of the Company's common stock as of the date of grant.

Almost Family had Stock and Incentive Compensation Plans that provided for stock awards of the Company's common stock to employees, non-employee directors, or independent contractors. Almost Family issued restricted shares and/or option awards to employees and non-employee directors. Under the change of control provisions of the Almost Family plans, all outstanding restricted stock, performance restricted stock, and options became non-forfeitable in conjunction with the Merger.

Each unvested restricted share award issued by Almost Family that was outstanding immediately prior to the Merger converted into a restricted stock award to acquire shares of the Company on the same terms and conditions rounded up or down to the nearest whole share, determined by multiplying the number of shares of Almost Family's common stock subject to such restricted stock award by the exchange ratio. Each stock option to purchase shares of Almost Family that was outstanding immediately prior to the Merger converted into an option to purchase shares of the Company on the same terms and conditions, (A) the number of shares of LHC's common stock, rounded down to the nearest whole share, determined by multiplying (I) the total number of shares of Almost Family's common stock by

(II) the exchange ratio, and (B) at a per-share exercise price, rounded up to the nearest whole cent, equal to the quotient determined by dividing (I) the exercise price per share of Almost Family's common stock by (II) the exchange ratio.

Share Based Compensation

Nonvested Stock

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

During 2018, 2017 and 2016, respectively, 213,105, 139,310 and 220,800 nonvested shares were granted to employees pursuant to the 2010 Incentive Plan. In addition, 16,470 nonvested shares were granted to employees pursuant to the 2018 Incentive Plan.

The Company also issues nonvested stock to its independent directors of the Company's Board of Directors. During 2018, 2017 and 2016, respectively, 13,600, 11,700 and 15,300 nonvested shares of stock were granted to the independent directors under the 2005 Director Compensation Plan. The shares issued under the 2005 Director Compensation Plan were drawn from the 1,500,000 shares reserved for issuance under the 2010 Incentive Plan. The shares fully vest one year from the date of the grant. During the twelve months ended December 31, 2018, four new directors were granted 14,000 nonvested shares of common stock under the Second Amended and Restated 2005 Non-Employee Directors Compensation Plan. The shares vest 33% at the grant date, then 33% each year on the anniversary date until the third year.

The fair value of nonvested shares is determined based on the closing trading price of the Company's shares on the grant date. The weighted average grant date fair values of nonvested shares granted during the years ended December 31, 2018, 2017 and 2016 were $64.11, $48.52 and $37.99, respectively.

The following table represents the share grants stock activity for the year ended December 31, 2018:

	Restricted stock		Options	
	Number of Shares	Weighted average grant date fair value	Number of Shares	Weighted average grant date fair value
Share grants outstanding at December 31, 2017	529,465	$ 37.34	—	$ —
Granted	257,175	64.11	—	—
Acquired	—	—	270,710	36.48
Vested or exercised	(212,355)	37.77	(108,903)	34.11
Share grants outstanding at December 31, 2018	574,285	$ 49.68	161,807	$ 38.08

As of December 31, 2018, there was $19.4 million of total unrecognized compensation cost related to nonvested shares granted. That cost is expected to be recognized over the weighted average period of 3.10 years. The total fair value of shares vested in the year ended December 31, 2018 was $8.0 million and the total fair value of shares vested in the years December 31, 2017 and 2016 was $5.6 million and $4.5 million, respectively. The Company records compensation expense related to nonvested share awards at the grant date for shares that are awarded fully vested and over the vesting term on a straight line basis for shares that vest over time. Compensation expense is reduced for estimated forfeitures. The Company estimates forfeitures at the time of grant and revises the estimate in subsequent periods if actual forfeitures differ. The Company has recorded $9.4 million, $6.0 million and $4.9 million in compensation expense related to non-vested stock grants in the years ended December 31, 2018, 2017 and 2016, respectively. Options acquired in connection with the Merger are fully vested and non-forfeitable.

Aggregate intrinsic value for options represents the estimated value of the Company's common stock at the end of the period in excess of the weighted average exercise price multiplied by the number of options exercisable. The aggregate intrinsic value of options outstanding at December 31, 2018 was $9.0 million. The total intrinsic value of options exercised during the year ended December 31, 2018 was $6.8 million. The following table summarizes information about stock options outstanding and exercisable at December 31, 2018:

Range of Exercise Price	Shares	Wtd. Avg. Remaining Contractual Life	Wtd. Avg. Exercise

		Price
$0.00 - 30.00	47,579	4.47
$30.01 - 40.00	71,684	6.23
Over $40.00	42,544	7.73

161,807 6.46 $38.08

Employee Stock Purchase Plan

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

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

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

The following table represents the shares issued during 2018, 2017 and 2016 under the Employee Stock Purchase Plan:

	Number of Shares	Weighted Average Per Share Price
Shares available as of December 31, 2015	213,760	
Shares issued in 2016	24,149	$ 37.79
Shares issued in 2017	18,542	$ 55.40
Shares issued in 2018	18,725	$ 71.12
Shares available as of December 31, 2018	152,344	

Treasury Stock

In conjunction with the vesting of the nonvested shares of stock or exercise of options, recipients incur personal income tax obligations. The Company allows the recipients to turn in shares of common stock to satisfy those personal tax obligations. The Company redeemed 68,217, 61,825 and 52,119 shares of common stock related to these tax obligations during the years ended December 31, 2018, 2017 and 2016, respectively. In addition, the Company redeemed 68,070 shares of common stock valued at $2.5 million, related to the exercise of Almost Family options. Such shares are held as treasury stock and are available for reissuance by the Company. Additionally, shares were submitted by employees in lieu of paying the stock option exercise price that would have otherwise been due on exercise. Such shares are held in treasury stock and are available for reissuance by the Company.

9. Leases

The Company leases office space and equipment at its various locations. Many of the leases contain renewal options with varying terms and conditions. Management expects that in the normal course of business, expiring leases will be renewed or, upon making a decision to relocate, replaced by leases for new locations. Operating lease terms range from three to ten years. Rent expense includes insurance, maintenance, and other costs as required by the lease. Total rental expense was $47.6 million, $25.1 million and $20.8 million for the years ended December 31, 2018, 2017 and 2016, respectively.

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

Year	Total
2019	$35,473
2020	24,663
2021	17,815
2022	10,795
2023	6,302
Thereafter	12,883
	$107,931

10. Employee Benefit Plan

Defined Contribution Plan

The Company sponsors a 401(k) plan for all eligible employees. The plan allows participants to contribute up to $18,500 in 2018, tax deferred (subject to IRS guidelines). The plan also allows discretionary Company contributions as determined by the Company's Board of Directors. Effective January 1, 2006, the Company implemented a discretionary match of up to two percent of participating employee contributions. The employer contribution will vest 25% in an employee's account for each year of service with the Company and 25% each additional year until it is fully vested in year four. Contribution expense to the Company was $10.1 million, $7.9 million and $6.3 million in the years ended December 31, 2018, 2017 and 2016, respectively.

11. Commitments and Contingencies

Contingencies

The Company provides services in a highly regulated industry and is a party to various proceedings and regulatory and other governmental and internal audits and investigations in the ordinary course of business (including audits by Zone Program Integrity Contractors ("ZPICs") and Recovery Audit Contractors ("RACs") and investigations resulting from the Company's obligation to self-report suspected violations of law). Management cannot predict the ultimate outcome of any regulatory and other governmental and internal audits and investigations. While such audits and investigations are the subject of administrative appeals, the appeals process, even if successful, may take several years to resolve. The Department of Justice, CMS, or other federal and state enforcement and regulatory agencies may conduct additional investigations related to the Company's businesses in the future. These audits and investigations have caused and could potentially continue to cause delays in collections, recoupments from governmental payors. Currently, the Company has recorded $16.9 million in other assets, which are from government payors related to the disputed finding of pending ZPIC audits. Additionally, these audits may subject the Company to sanctions, damages, extrapolation of damage findings, additional recoupments, fines, and other penalties (some of which may not be covered by insurance), which may, either individually or in the aggregate, have a material adverse effect on the Company's business and financial condition.

On January 18, 2018, Jordan Rosenblatt, a purported shareholder of Almost Family, Inc. (“Almost Family”) filed a Complaint for Violations of the Securities Exchange Act of 1934 (the "1934 Act") in the United States District Court for the Western District of Kentucky, styled Rosenblatt v. Almost Family, Inc., et al., Case No. 3:18-cv-40-TBR (the “Rosenblatt Action”). The Rosenblatt Action was filed against the Company, Almost Family, Almost Family’s board of directors, and Hammer Merger Sub, Inc. ("Merger Sub"). The complaint in the Rosenblatt Action (“Complaint”) asserts that the Form S-4 Registration Statement (“Registration Statement”) filed on December 21, 2017 contains false and misleading statements with respect to the Merger. The Complaint asserts claims against Almost Family and its board of directors for violations of Section 14(a) of the 1934 Act in connection with the dissemination of the Registration Statement, and asserted claims against the Almost Family board of directors and the Company for violations of Section 20(a) of the 1934 Act as controlling persons of Almost Family. The Rosenblatt Action seeks, among other things, an injunction enjoining the Merger from closing and an award of attorneys’ fees and costs.

In addition to the Rosenblatt Action, two additional complaints were filed against Almost Family in the United States District Court for the District of Delaware ("the Delaware Actions") alleging similar violations as the Rosenblatt Action. These Delaware Actions also sought, among other things, an injunction to enjoin both the vote of the Almost Family stockholders with respect to the Merger and the closing of the Merger, monetary damages and an award of attorneys’ fees and costs from Almost Family.

On February 22, 2018, one of the plaintiffs in the Delaware Actions moved for a preliminary injunction to enjoin the merger of Almost Family and Merger Sub. Then, on March 2, 2018 the Delaware Actions were transferred to the United States District Court for the Western District of Kentucky. Shortly thereafter, on March 12, 2018, Almost Family, LHC and Merger Sub opposed the plaintiffs' motion for a preliminary injunction, and the court heard oral argument on the plaintiffs' motion for a preliminary injunction on March 19, 2018. On March 22, 2018, the court denied the plaintiffs' motion for preliminary injunction. The next day, on March 23, 2018, one of the plaintiffs in the Delaware Actions moved to consolidate the Delaware Actions with the Rosenblatt Action and for the appointment of a lead plaintiff and that motion is pending before the court.

The Company believes that the claims asserted in these lawsuits are entirely without merit and intend to defend these lawsuits vigorously.

The Company is involved in various legal proceedings arising in the ordinary course of business. Although the results of litigation cannot be predicted with certainty, management believes the outcome of pending litigation will not have a material adverse effect, after considering the effect of the Company's insurance coverage, on the Company's consolidated financial information.

During 2018, the Company purchased the home office building, land and adjacent land parcels in Lafayette for approximately $19.3 million. The purchase was part of plans for an approximate $70.0 million home office expansion. The expansion is structured into multiple phases. The early phase commitment which was active at December 31, 2018 was approximately $4.0 million.

Joint Venture Buy/Sell Provisions

Most of the Company's joint ventures include a buy/sell option that grants to the Company and its joint venture partners the right to require the other joint venture party to either purchase all of the exercising member's membership interests or sell to the exercising member all of the non-exercising member's membership interest, at the non-exercising member's option, within 30 days of the receipt of notice of the exercise of the buy/sell option. In some instances, the purchase price is based on a multiple of the historical or future earnings before income taxes and depreciation and amortization of the equity joint venture at the time the buy/sell option is exercised. In other instances, the buy/sell purchase price will be negotiated by the partners and subject to a fair market valuation process. The Company has not received notice from any joint venture partners of their intent to exercise the terms of the buy/sell agreement nor has the Company notified any joint venture partners of its intent to exercise the terms of the buy/sell agreement.

Compliance

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

The Company is subject to various routine and non-routine governmental reviews, audits and investigations. In recent years, federal and state civil and criminal enforcement agencies have heightened and coordinated their oversight efforts related to the health care industry, including referral practices, cost reporting, billing practices, joint ventures and other financial relationships among health care providers. Violation of the laws governing the Company's operations, or changes in the interpretation of those laws, could result in the imposition of fines, civil or criminal penalties, and/or termination of the Company's rights to participate in federal and state-sponsored programs and suspension or revocation of the Company's licenses. The Company believes that it is in material compliance with all applicable laws and regulations.

12. Segment Information

In the second quarter of 2018, in recognition of the changes to the Company's business segments resulting from the addition of Almost Family and its subsidiaries through the Merger, the Company redefined its reporting segments to include (1) home health services, (2) hospice services, (3) home and community-based services, formerly referred to by the Company as community-based services, (4) facility-based services, and (5) healthcare innovations ("HCI"). In management's opinion, this approach provides investors clarity and best aligns with the Company's internal decision-making processes as viewed by the chief operating decision maker. Reportable segments have been identified based upon how management has organized the business by services provided to customers and how the chief operating decision maker manages the business and allocates resources, consistent with the criteria in ASC 280, Segment Reporting.

The accounting policies of the segments are the same as those described in the summary of significant accounting policies, as described in Note 2 of the Notes to Condensed Consolidated Financial Statements, including the adoption of ASU 2014-09.

The following tables summarize the Company's segment information for the twelve months ended December 31, 2018, 2017 and 2016 (amounts in thousands):

	Year Ended December 31, 2018					
	Home health	Hospice	Home and community-based	Facility-based	Healthcare innovations	Total
Net service revenue	$1,291,457	$199,118	$ 172,501	$ 113,784	$ 33,103	$1,809,963
Cost of service revenue	802,006	130,991	130,660	76,899	15,801	1,156,357
General and administrative expenses	378,124	60,933	40,467	39,638	18,754	537,916
Impairment of intangibles and other	1,816	186	(6)	554	2,139	4,689
Operating income (loss)	109,511	7,008	1,380	(3,307)	(3,591)	111,001
Interest expense	(7,060)	(1,529)	(76)	(545)	(469)	(9,679)
Income (loss) before income taxes and noncontrolling interests	102,451	5,479	1,304	(3,852)	(4,060)	101,322
Income tax expense (benefit)	22,711	1,227	420	(1,136)	(823)	22,399
Net income (loss)	79,740	4,252	884	(2,716)	(3,237)	78,923
Less net income (loss) attributable to noncontrolling interests	13,361	1,764	(275)	589	(90)	15,349
Net income (loss) attributable to LHC Group, Inc.'s common stockholders	$66,379	$2,488	$ 1,159	$ (3,305)	$ (3,147)	$63,574
Total assets	$1,336,988	$209,680	$ 236,072	$ 70,261	$ 75,714	$1,928,715

	Year Ended December 31, 2017					
	Home health	Hospice	Home and community-based	Facility-based	Healthcare innovations	Total
Net service revenue	$777,583	$157,287	$ 46,159	$ 81,573	$ —	$1,062,602
Cost of service revenue	482,179	103,969	35,244	54,418	—	675,810
General and administrative expenses	229,264	45,516	9,946	25,813	—	310,539
Impairment of intangibles and other	1,612	22	—	(63)	—	1,571
Operating income	64,528	7,780	969	1,405	—	74,682
Interest expense	(2,546)	(511)	(191)	(104)	—	(3,352)
Income before income taxes and noncontrolling interests	61,982	7,269	778	1,301	—	71,330
Income tax expense	9,509	1,057	156	222	—	10,944
Net income	52,473	6,212	622	1,079	—	60,386
Less net income (loss) attributable to noncontrolling interests	9,102	1,248	(111)	35	—	10,274
Net income attributable to LHC Group, Inc.'s common stockholders	$43,371	$4,964	$ 733	$ 1,044	$ —	$50,112
Total assets	$534,385	$155,230	$ 48,216	$ 55,871	$ —	$793,702

	Year Ended December 31, 2016					
	Home health	Hospice	Home and community-based	Facility-based	Healthcare innovations	Total
Net service revenue	$656,287	$131,547	$ 43,094	$ 69,105	$ —	$900,033
Cost of service revenue	398,450	83,359	32,603	43,238	—	557,650

General and administrative expenses	203,418	37,207	8,785	21,212	—	270,622
Impairment of intangibles and other	857	338	49	(45)	—	1,199

Operating income	53,562	10,643	1,657	4,700	—70,562
Interest expense	(1,794)	(292)	(130)	(228)	—(2,444)
Income before income taxes and noncontrolling interests	51,768	10,351	1,527	4,472	—68,118
Income tax expense	16,505	3,485	651	1,535	—22,176
Net income	35,263	6,866	876	2,937	—45,942
Less net income attributable to noncontrolling interests	6,876	1,867	(58)	674	—9,359
Net income attributable to LHC Group, Inc.’s common stockholders	$28,387	$4,999	$934	$2,263	$—$36,583
Total assets	$427,782	$116,090	$33,520	$36,679	$—$614,071

13. Fair Value of Financial Instruments

The carrying amounts of the Company’s cash, receivables, accounts payable and accrued liabilities approximate their fair values. The estimated fair value of intangible assets was calculated using level 3 inputs based on the present value of anticipated future benefits. For the year ended December 31, 2018, the carrying value of the Company’s long-term debt approximates fair value as the interest rates approximates current rates.

14. Concentration of Risk

The Company operates in 36 states within the continental United States. The Company's facilities in Louisiana, Tennessee, Arkansas, Mississippi, Kentucky, Florida, and Alabama accounted for approximately 54.2%, 63.0% and 66.6% of net service revenue during the years ended December 31, 2018, 2017 and 2016, respectively. Any material change in the current economic or competitive conditions in these states could have a disproportionate effect on the Company’s overall business results.

15. Unaudited Summarized Quarterly Financial Information

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

	First Quarter 2018	Second Quarter 2018	Third Quarter 2018	Fourth Quarter 2018
Net service revenue	$ 291,054	$ 502,024	$ 507,043	$ 509,842
Gross margin	102,436	181,020	184,847	185,303
Net income attributable to LHC Group, Inc.’s common stockholders	4,995	16,797	21,230	20,552
Net income attributable to LHC Group' Inc.'s common stockholders				
Basic earnings per share:	$ 0.28	$ 0.55	$ 0.69	$ 0.67
Diluted earnings per share:	$ 0.28	$ 0.55	$ 0.68	$ 0.66
Weighted average shares outstanding:				
Basic	17,789,863	30,497,501	30,750,227	30,777,556
Diluted	18,039,345	30,742,293	31,083,815	31,142,061

	First Quarter 2017	Second Quarter 2017	Third Quarter 2017	Fourth Quarter 2017
Net service revenue	$ 244,249	$ 257,535	$ 269,678	$ 291,140
Gross margin	89,879	96,377	96,822	103,714
Net income attributable to LHC Group, Inc.’s common stockholders	9,467	11,304	10,906	18,435
Net income attributable to LHC Group' Inc.'s common stockholders				

Basic earnings per share:	$ 0.54	$ 0.64	$ 0.61	$ 1.04
Diluted earnings per share:	$ 0.53	$ 0.63	$ 0.61	$ 1.02
Weighted average shares outstanding:				
Basic	17,643,463	17,728,567	17,740,818	17,749,872
Diluted	17,817,880	17,964,387	18,010,522	18,043,297

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

16. Subsequent Event

On February 26, 2019, the Company announced an anticipated definitive agreement with Geisinger Home Health and Hospice for a joint venture partnership in Pennsylvania and New Jersey. The expected completion date is April 1, 2019 for the Pennsylvania locations and June 1, 2019 for the New Jersey locations, subject to customary closing conditions. The Company will purchase the majority ownership of these home health and hospice locations and assume management responsibility.

SIGNATURES

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

LHC GROUP, INC.

February 28, 2019 /s/ KEITH G. MYERS
Keith G. Myers
Chief Executive Officer

POWER OF ATTORNEY

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

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

Signature	Title	Date
/s/ KEITH G. MYERS Keith G. Myers	Chief Executive Officer and Chairman of the Board of Directors	February 28, 2019
/s/ JOSHUA L. PROFFITT Joshua L. Proffitt	Executive Vice President, Chief Financial Officer, Principal Accounting Officer	February 28, 2019
/s/ JEFFREY T. REIBEL Jeffrey T. Reibel	Senior Vice President, Chief Accounting Officer	February 28, 2019
/s/ MONICA F. AZARE Monica F. Azare	Director	February 28, 2019
/s/ JONATHAN D. GOLDBERG Jonathan D. Goldberg	Director	February 28, 2019
/s/ CLIFFORD S. HOLTZ Clifford S. Holtz	Director	February 28, 2019
/s/ JOHN L. INDEST John L. Indest	Director	February 28, 2019
/s/ RONALD T. NIXON Ronald T. Nixon	Director	February 28, 2019
/s/ W. EARL REED III W. Earl Reed III	Director	February 28, 2019
/s/ W.J. “BILLY” TAUZIN W.J. “Billy” Tauzin	Director	February 28, 2019
/s/ BRENT TURNER Brent Turner	Director	February 28, 2019
/s/ TYREE G. WILBURN	Director	February 28, 2019

Tyree G. Wilburn

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EXHIBIT INDEX

Exhibit Number	Description of Exhibits
2.1	Agreement and Plan of Merger, dated as of November 15, 2017, by and among LHC Group, Inc., Hammer Merger Sub, Inc., and Almost Family, Inc. (incorporated by reference to Exhibit 2.1 to LHC Group's Form 8-K filed on November 16, 2017).
3.1	Certificate of Incorporation of LHC Group, Inc. (previously filed as Exhibit 3.1 to LHC Group's Form S-1/A (File No. 333-120792) filed on February 14, 2005).
3.2	Bylaws of LHC Group, Inc., as amended on December 3, 2007 (previously filed as Exhibit 3.2 to LHC Group's Form 10-Q for the quarterly period ended March 31, 2008, filed on May 9, 2008).
4.1	Specimen Stock Certificate of LHC Group's Common Stock, par value $0.01 per share (previously filed as Exhibit 4.1 to LHC Group's Form S-1/A (File No. 333-120792) filed on February 14, 2005).
10.1+	LHC 2003 Key Employee Equity Participation Plan (previously filed as Exhibit 10.3 to LHC Group's Form S-1 (File No. 333-120792) filed on November 26, 2004).
10.2+	LHC Group, Inc. 2005 Long-Term Incentive Plan (previously filed as Exhibit 10.4 to the Form S-1/A (File No. 333-120792) filed on February 14, 2005).
10.3+	LHC Group, Inc. 2010 Long-Term Incentive Plan (previously filed as Exhibit 10.1 to LHC Group's Form 10-Q for the quarterly period ended June 30, 2010, filed on August 6, 2010).
10.4+	LHC Group, Inc. Second Amended and Restated 2005 Non-Employee Directors Compensation Plan (previously filed as Exhibit 10.4 to LHC Group's Form 10-K for the year ended December 31, 2014, filed on March 11, 2015).
10.5+	Form of Indemnity Agreement between LHC Group and directors and certain officers (previously filed as Exhibit 10.10 to the Form S-1/A (File No. 333-120792) filed on February 14, 2005).
10.6+	LHC Group, Inc. 2006 Employee Stock Purchase Plan (previously filed as Exhibit 99.2 to LHC Group's Form 8-K filed on June 16, 2006).
10.7	Credit Agreement, dated as of June 18, 2014, among LHC Group, Inc., Capital One, National Association, as administrative agent, sole bookrunner, sole lead arranger, and a lender, JPMorgan Chase Bank, N.A., Regions Bank and Compass Bank, as co-syndication agents and lenders, and Whitney Bank, as a lender (previously filed as Exhibit 10.1 to LHC Group's Form 8-K filed on June 23, 2014).
10.8+	Amended and Restated Employment Agreement between Keith G. Myers and LHC Group, Inc. dated April 1, 2017 (previously filed as Exhibit 10.1 to the Form 8-K filed April 5, 2017).
10.9+	Amended and Restated Employment Agreement between Donald D. Stelly and LHC Group, Inc. dated June 1, 2016 (previously filed as Exhibit 10.1 to the Form 8-K filed June 3, 2016).

10.10+	Amended and Restated Employment Agreement between Joshua L. Proffitt and LHC Group, Inc. dated September 12, 2016 (previously filed as Exhibit 10.2 to the Form 10-Q filed November 3, 2016).

10.11+	Employment Agreement between Bruce D. Greenstein and LHC Group, Inc. dated June 25, 2018.
10.12+	Employment Agreement between Nicholas Gachassin, III and LHC Group, Inc. dated January 2, 2019.
10.13+	Amendment to LHC Group, Inc. Second Amended and Restated 2005 Non-Employee Directors Compensation Plan, effective January 20, 2015. (previously filed as Exhibit 10.1 to LHC Group's Form 10-Q filed on May 7, 2015).
21.1	Subsidiaries of the Registrant.
23.1	Consent of KPMG LLP.
31.1	Certification of Keith G. Myers, Chief Executive Officer pursuant to Rule 13a- 14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Joshua L. Proffitt, Chief Financial Officer pursuant to Rule 13a-14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1*	Certification of the Chief Executive Officer and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Instance Document
101.SCH	XBRL Schema Document
101.CAL	XBRL Calculation Linkbase Document
101.DEF	XBRL Definition Linkbase Document
101.LAB	XBRL Label Linkbase Document
101.PRE	XBRL Presentation Linkbase Document

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

+ Indicates a management contract or compensatory plan.

* This exhibit is furnished to the SEC as an accompanying document and is not deemed to be "filed" for purposes of Section 18 of the Securities Exchange Act of 1934 or otherwise subject to the liabilities of that Section, and the document will not be deemed incorporated by reference into any filing under the Securities Act of 1933.