LHC GROUP

2019 ANNUAL REPORT

LHC GROUP

Our Culture

With an unwavering commitment to integrity, quality, professionalism, and compassion, we make healthcare work better for the patients, families, and communities we are privileged to serve.

It's all about helping people.

A REPUTATION FOR QUALITY AND SERVICE

Driven by a culture of commitment, compassion, and community.

Keith G. Myers
Chairman and
Chief Executive Officer

To Our Valued Stakeholders:

As I write this letter, our nation and our industry are confronting unprecedented times. The situation around the COVID-19 outbreak continues to change rapidly, on a daily basis. It's important to understand that many of the things we discuss in this report may well have changed significantly by the time we publish.

It is equally important to understand that our LHC Group family – at every level of our organization – has not hesitated in stepping into the breach and onto the front lines.

At the outset, we established an internal multi-disciplinary COVID-19 Task Force to organize resources and coordinate efforts. And we joined our local, state, and federal leaders, as well as our healthcare industry colleagues, in a much larger unified effort to contain and minimize the effects of this virus.

We may be facing a difficult time, but LHC Group maintains our focus on the things we always do – no matter what: providing quality, compassionate, and personalized care and service to as many people as possible. The things that are true about LHC Group – what we do and what we stand for – will always direct our path, as expressed in our foundational mission statement: "It's all about helping people."

Looking back at 2019, I am amazed by the remarkable achievements of the diverse and talented team we have assembled here at LHC Group. At every level of our organization – culturally and operationally – our unyielding pursuit of excellence, dedication, and hard work has produced a level of success unmatched in our industry.

Today the in-home healthcare industry is the preferred and most appropriate setting for lower total cost of care and higher quality. And with monumental advances in care coordination, technology, and key data utilization, more patients than ever can and are being cared for in the comfort of their home.

LHC Group is well-positioned to benefit from this trend. Thanks to the performance, forethought, and preparation of our team, our experience and national scale, our unique assets and positioning, and a proven track record as a value creator for our more than 350 joint venture hospital and health system partners, we will continue improving in-home healthcare in America.

I'd like to begin by touching on a just few of our high points from 2019:

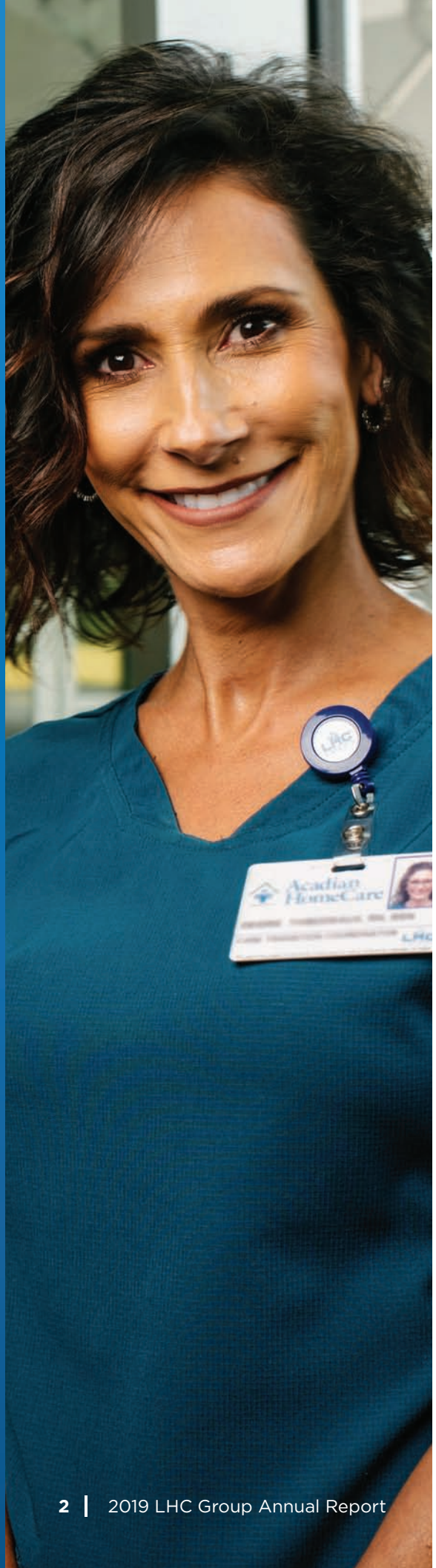
- In September, LHC Group achieved a major milestone when we reached a daily average census of 100,000 on-service patients.
- We formed new partnerships with great healthcare leaders like Norton Healthcare, Geisinger Home Health and Hospice, AtlantiCare Home Health and Hospice, Unity Health, and Atmore Community Hospital.
- We successfully – and significantly – expanded our existing joint ventures with outstanding healthcare partners like LifePoint Health, Ochsner Health System, Texas Health Resources, Methodist Health System, Capital Region Medical Center, and others.
- We began significant expansions of our Home Office operations to provide better and more efficient service to our colleagues in the field.
- We continued leading our industry in virtually every independent measurement of clinical quality, patient satisfaction, and overall performance, and actually increased the distance between ourselves and our nearest competitors.

Perhaps our most impactful accomplishment was the teamwork demonstrated by so many people – across virtually every professional discipline represented at our company – in strategically planning and positioning LHC Group for success in the face of the new Patient Driven Groupings Model (PDGM).

Mandated by the Centers for Medicare and Medicaid Services (CMS) for implementation on January 1, 2020, PDGM represents the most significant regulatory change in reimbursement models our industry has seen in two decades.

I must acknowledge our team's courage and innovative thinking as we prepared our company to weather these changes. Thanks to their strategic planning efforts in advance of PDGM implementation, we saw no significant disruptions or surprises in our business operations.

We fulfilled our obligation to our patients and partners to remain healthy, viable, and flexible – and we did so without compromising our focus on clinical quality or our commitment to excellent service. LHC Group remains poised to seize opportunities – with scale, positioning, and assets, as well as a proven reputation for continually improving efficacy, outcomes, efficiency, and adding value.



Our LHC Group family is further distinguished by what we believe is our most significant business differentiator – a unique and thriving company culture. It drives success across our organization, creating an atmosphere of camaraderie, enthusiasm, inspiration, and teamwork that produces the numerous accomplishments and successes you'll learn about in this report.

Wherever we serve, our culture revolves around prioritizing service to individuals, neighborhoods, and communities, and around a sense of accountability to each other. This is fertile ground for growth, as more partners, potential acquisitions, and industry talent are eager to join us and find out what truly drives our forward momentum.

As we look to the future, we seek to enhance our culture by embracing greater responsibility. To that end, we are actively furthering our involvement in what are commonly called the "social" aspects of corporate conduct and governance – through our "Environment-Social-Governance (ESG) and Sustainability" initiative.

Our ESG/Sustainability initiative is another great example of our culture in action. LHC Group has a responsibility to be a good citizen and neighbor – for the cities, towns, and communities we serve, and for our nation and our planet. There are many more details about this initiative that we will share in the coming months.

More than two decades ago, our foundational values were established in small-town America. We maintain an unwavering commitment to those values, as embodied in our six pillars of excellence – PEOPLE, SERVICE, QUALITY, EFFICIENCY, GROWTH, and ETHICS.

Our mission is to be an indispensable asset for every community we serve. Not a day goes by where I am not reminded, at least in some small way, that these values are as strong as ever, and that the passion we have for our work still burns bright in the hearts and minds of our LHC Group family.

PEOPLE

Here at LHC Group, it all starts with people – with the people we serve, and with the people who provide that service as part of our team.

Our company culture of family, empowerment, and service at a local and individual level continued to flourish in 2019. Our leadership team is dedicated to a true open-door policy, where each and every member of our organization is empowered to share their thoughts, ideas, and experiences at every level.

We are proud to be a company with a purpose and culture that has remained steadfast for 25 years. Today, in cities and towns around the nation, we continue doing what we first set out to do for four elderly neighbors in one small community – ensure access to quality healthcare and provide assurance, peace, and comfort in the midst of difficult circumstances.

As commonly and broadly defined, culture is "the customary beliefs, social forms, and material traits of a racial, religious, or social group" (Merriam-Webster). And when we look closer, we learn that culture can be a force that binds an otherwise diverse group as a unit – in pursuit of a common goal and committed to supporting and helping each other.

Research shows that most employees don't leave an organization because of pay or benefits. The number one reason they leave is because of a poor relationship with their leaders. Companies with a strong cultural foundation, which take the initiative to recognize hard work and achievement, experience lower turnover.

As in recent years, staffing and retention are still among the biggest daily challenges – and opportunities – faced by in-home healthcare providers. I am happy to report that because of our focus on nurturing a culture that champions family and support for the

people we work with, LHC Group's vacancy rate, as measured by our number of open positions compared to our headcount, currently stands at less than 5 percent – which is among the best in our industry.

I can say with confidence that we have assembled one of the finest teams in the in-home healthcare industry. And as we continue our commitment to strong orientation and integration programs, employee voice, and transparency, we are confident in our ability to attract, onboard, train, and retain the best talent in our industry.

In June, LHC Group was named to the inaugural *Forbes* list of "America's Best-in-State Employers 2019" for employers from the state of Louisiana. The list was based on a survey conducted from October 2018 to February 2019, and included approximately 80,000 part- and full-time workers at companies with at least 500 employees in their U.S. operations.

This achievement affirms our commitment to being the "employer of choice" in every market we serve, and our focus on attracting and retention of our workforce will be front and center. It all starts with effective communication. We will clearly and convincingly present our "employee value proposition" – in other words, that which makes us different than our competitors.

As we remain true to who we are, our ability to cope with changes and challenges will not waver. We will continue to make a positive difference in the lives of the many people we are blessed and privileged to serve – and for the people with whom we work and live.

Service is both a responsibility and a journey. We have a profound responsibility to the patients and families entrusted to our care, and to being a productive and honest partner for the Medicare program and the many health plans and hospital partners with which we collaborate.

Together we are all on a journey toward creating greater value in our healthcare system. It's not an easy path. Despite the changes that have taken place, the old system still dominates the healthcare landscape in many ways.

The good news is that more healthcare leaders, regulators, and payors are realizing that in-home care is not only the past, it is the future – the setting where the newest, most innovative, and most effective care will be delivered. And LHC Group's relentless pursuit to enhance our value proposition makes us an increasingly important partner for the organizations and companies that finance our nation's healthcare system.

We elevate our value proposition in two fundamental ways:

First, in contracting for services, we de-emphasize increased visits and assume more responsibility for outcomes (avoiding readmissions, reducing total cost-of-care, etc.). Next, when clinically appropriate, we follow patients' preferences and deliver high-quality care in the lowest-cost and most-preferred setting – their home or place of residence.

With our long and established track record of outstanding service, and a strong industry reputation for sustained success with partner hospitals and health systems across the nation, LHC Group continues to demonstrate that value proposition to providers and payors.

Providing outstanding service at a community level – in every community we serve – is part of our core mission. We approach each day with the sincere mindset and desire to treat others as we would like to be treated, and to exceed the expectations of those we are privileged to serve.

Our home health teams help patients recover from a procedure, manage a chronic illness or condition, and improve their overall quality of life. Our hospice professionals are there for patients and their families, helping guide them through the final stages of their diagnosis and make the most of life. And our growing team of palliative care clinicians and nurse practitioners (NPs) manage patients with chronic conditions and serve as a care continuum bridge if and when they qualify for hospice services.

At our home and community based services locations, trained professionals help families and their loved ones with the tasks of daily living – helping improve their quality of life and maintain independence. And facility based care teams at our long-term acute care hospitals work every day to meet the needs of individuals with medically complex conditions who require intense, specialized treatment for an extended period of time.

Going the extra mile means going above and beyond our job descriptions at times. Our record of consistently rising to this challenge is a byproduct of team members who truly care about those entrusted to our care and believe in what we do.

We do not achieve success singlehandedly. Each individual member of our LHC Group family is a co-author in the success we have achieved – and will continue to achieve through a firm commitment to a culture of collaboration, continuous learning, and improvement in all that we do at every level of our organization.

Excellence in service requires us to step up and consistently create value and positive outcomes for the people, partners, and communities we serve. Excellence is a prevailing attitude and a way of life here at LHC Group. We are inspired and driven by a desire to be better.

At LHC Group, we are on a constant journey in pursuit of our full potential, consistently and persistently infusing a spirit of excellence into everything we do. We will never settle for the ordinary. We will always strive for the extraordinary.

QUALITY

LHC Group's success, particularly our remarkable growth which has outpaced the industry, goes hand-in-hand with our outstanding quality performance. Our accomplishments would not be possible without a record of providing industry-leading quality service to the patients and families we are privileged to care for every day.

Our reputation for quality, patient satisfaction, and overall excellence is one of our most precious assets. Along with the exemplary performance of our growth team members and strong operational leadership at the agency level, our high quality and patient satisfaction scores are a major reason why referral sources are confident in choosing LHC Group.

Quality is an important part of our organic growth strategy. As we continue to expand our services in communities across the country, we also reaffirm our commitment to ensuring that we maintain our position and reputation as the industry's leader in quality and patient satisfaction measures.

As a healthcare organization that embraces responsibility and accountability, our local teams hold themselves to high expectations. Their performance in the face of everyday challenges is nothing short of remarkable.

For several consecutive years, it has been my pleasure to report that LHC Group's quality and patient satisfaction ratings continue to lead the home health industry and outperform national averages. This year is no different. Here are a few of the highlights:

LHC Group's scores led the Centers for Medicare and Medicaid Services (CMS) Five-Star Quality Rating System results as reported for each quarter in 2019. LHC Group's results are separated based on "standalone" performance (excluding the 2018 Almost Family and other recent acquisitions), and on "combined" ratings (including Almost Family and other recent acquisitions).

According to the January 2020 results, LHC Group (standalone) achieved an average score of 4.66 stars in the quality category. Our combined average was 4.28 – significantly outperforming the national average of 3.27. In the patient satisfaction category, LHC Group (standalone) earned an average of 4.10 stars. Our combined average was 3.89 – also ahead of the national average of 3.50.

LHC Group's January 2020 achievements for standalone locations also included:

- 97 percent of LHC Group same-store locations had a quality rating of four stars or better.
- 90 percent of LHC Group same-store locations had a patient satisfaction rating of four stars or better.

In the 2019 HomeCare Elite results released in October 2019, LHC Group landed an industry best total of 211 home health providers, representing 321 branch locations around the nation, among the top 25 percent of all home health agencies in the country – with 11 providers achieving a spot in the "Top 100."

Our focus on overall quality and superior performance for our patients has not waivered since our founding. As Medicare and other reimbursement requirements continue placing greater value on quality and patient outcomes, we believe our strong performance in these leading performance evaluations will position us to earn an increased market share in the cities, towns, and communities we serve across the nation.

EFFICIENCY

Here at LHC Group, our focus on efficiency requires us to wisely and responsibly use our resources to achieve the greatest possible value for our patients, partners, stakeholders, and others. In doing so, we ensure our company's financial health – now and in the future – and our ability to continue fulfilling our overall mission of service.

LHC Group has consistently lived up to our goals and responsibilities regarding efficiency, and 2019 was no different. We achieved another strong year of growth in revenues and earnings, while maintaining our balance sheet in excellent shape.

In 2019, we grew adjusted earnings per share by 25.9 percent to $4.47 – with net service revenue increasing 14.9 percent to $2.08 billion.

These 2019 financial highlights further demonstrate our commitment to responsible and strategic financial planning:

- LHC Group's balance sheet contains little debt. As of December 31, 2019, our total debt to EBITDA leverage ratio was 1.19x – compared to the average leverage ratio of the S&P 500 companies at 4.10x.
- On December 31, 2019, the current ratio for LHC Group, which is a measure of short-term liquidity, was 1.65x – compared to an average of 0.66x for S&P 500 companies.
- On December 31, 2019, return on asset for LHC Group was 6.51 percent when using adjusted net income – compared to the average of 2.83 percent for S&P 500 companies.
- We continue to leverage our general and administrative expenses and reduce them as a percentage of revenue. For 2019, these expenses were 27.1 percent of revenue – our lowest percentage reported since becoming a public company in 2005.

GROWTH

Part of our ongoing mission is to reach as many people as possible with high-quality care. One way we achieve this is by increasing our capabilities through strategic growth – organically, in cooperation with our new and current JV partners, and stand-alone acquisitions. In doing so, we continue to clearly demonstrate our value proposition and ability to reduce costs and avoidable re-hospitalizations.

As I mentioned in the introduction, 2019 was an outstanding year for growth at LHC Group. We formed new JV partnerships, expanded our service areas with existing partners, and completed several strategic acquisitions.

In 2019 and to date in 2020, LHC Group acquired 27 home health, 11 hospice, three home and community based services locations, and one LTAC hospital in 13 states and the District of Columbia, the majority of which are hospital joint ventures. These acquisitions represent approximately $114.3 million in annualized revenue.

We believe we have an historic opportunity to benefit from accelerated consolidation within the highly fragmented home health market. This consolidation is naturally increasing our focus on additional home health acquisitions, and we are also ramping up an equal emphasis on growing our hospice footprint. And we are also ramping up an equal focus on growing our hospice footprint. Here, our growth strategy is to enter a market with home health services, establish a strong presence, and then introduce hospice and co-locate the service lines in the same market. And in states with favorable reimbursement for personal care services, we intend to include that as well. We call this the "tri-level of care" – it's the optimum condition for our model.

Our goal, over the next five years, is to have home health co-located with hospice in at least 75 percent of our locations. To put this growth potential in perspective, we currently have a total of 553 home health locations nationwide with only 74 co-locations of home health and hospice.

The preceding data points are much more than just facts and figures, with each representing an opportunity to reach out and touch more lives. It's both a great accomplishment and a tremendous responsibility. Each patient on our census is an individual life – a beloved wife, husband, father, mother, grandparent, brother, or sister – entrusted to our care. And each is surrounded by a family who cares deeply about how they are cared for.

Our consistent growth is an outstanding accomplishment, and the credit goes to each one of our 32,000 employees around the nation. It is a testament to their hard work and dedication, and to the consistency with which this team lives up to and exceeds our guiding principles.

ETHICS

We've worked hard to build a culture of ethics, integrity, and compliance across all levels of our organization. Adherence to these directives is vital to our success. Compliance is the responsibility of every LHC Group employee, and we take pride in our record.

Poor ethics and a lack of integrity cannot be hidden, and will cause irreparable damage to an organization's reputation. When people conduct business with integrity, it allows success to follow across each of our other five pillars of excellence.

LHC Group has specific policies and procedures in place – for example, our "Integrity Line" and the way we structure our new hire and exit interviews – which are intentionally designed to provide a place for employees' voices to be heard. Our agencies and team members across the nation must know that they can come to leadership with issues or concerns that could negatively affect our reputation.

Each one of us – at all levels and across each department and service line – must be guided by a high level of moral and social responsibility in our practices and decision-making.

In 2019, we successfully completed integration of our Almost Family locations into our robust compliance program. Full implementation of our compliance processes at these locations included:

- Introduction of our annual mandatory compliance training courses.
- Implementation of our sales compliance education and procedures for tracking of expenses related to referral sources.
- Incorporation into our data monitoring and clinical billing compliance audit processes.
- Replacement of the former Almost Family hotline with the LHC Group "Integrity Line" and our web-based issue submission option.

Since the beginning, our LHC Group family has been guided by a culture that consistently emphasizes the importance of ethics and integrity in our business practices. The future of our company is dependent upon our continued commitment to honesty and a refusal to compromise on our long-term goal of sustainable success instead of a quick return achieved by employing questionable tactics.

We will continue to be guided by our high standards of moral and social responsibility. This is true of both our personal and professional lives. Embracing these high standards has allowed our team to achieve a level that others in our industry seek to emulate.

The processes by which we succeed are as important as the end result. Our future success hinges upon our continued focus on discipline, work ethic, and reputation as a dependable provider of consistently superior quality and service to those entrusted to our care in communities throughout our country.

We will remain steadfast in our commitment to our six pillars of excellence. That firm commitment will be our guiding light.

With a focus on our foundational mission – It's all about helping people – and a culture that empowers each one of us to achieve our best, we will continue moving forward, helping our nation overcome and emerge stronger, wiser, and even more resilient!

Sincerely,

Keith G. Myers
Chairman & CEO

UNITED STATES SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2019

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 ☒

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 ☒

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 ☒ 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 ☒ 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. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer," and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒ Accelerated filer ☐ 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 ☒

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, 2019, the aggregate market value of the registrant's common stock held by non-affiliates of the registrant was $3.6 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 31,525,608 shares of common stock, $0.01 par value, issued and outstanding as of February 25, 2020.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's Annual Report to Stockholders for the fiscal year ended December 31, 2019 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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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," and similar 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, 2019;
- 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, including changes in reimbursement resulting from regulatory changes;
- 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; and
- the impact of changes in or future interpretations of fraud, anti-kickback or other laws.

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

We qualify all of our forward-looking statements by this cautionary statement. In addition, with respect to all of our forward-looking statements, we claim the protection of the safe harbor for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995.

You should read this Annual Report on Form 10-K, the information incorporated by reference into this Annual Report on Form 10-K and the documents filed as exhibits to this Annual Report on Form 10-K completely and with the understanding that our actual future results or achievements may differ materially from what we expect or anticipate.
Unless otherwise indicated, "LHC Group," "we," "us," "our," and "the Company," refer to LHC Group, Inc. and its consolidated subsidiaries.

Item 1. Business.

Overview

We provide quality, cost-effective post-acute health care services to our patients. As of December 31, 2019, we have 811 service providers in 35 states within the continental United States and the District of Columbia. Our services are classified into five segments: (1) home health services, (2) hospice services, (3) home and community-based services ("HCBS"), (4) facility-based services, primarily offered through our long-term acute care hospitals ("LTACHs"), and (5) healthcare innovations ("HCI").

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, 2019, we operated 553 home health service locations, of which 350 are wholly-owned by us, 199 are majority-owned by us through equity joint ventures, two are under license lease arrangements, and the operations of the remaining two locations are managed by us.

Our hospices provide end-of-life care to patients with terminal illnesses through interdisciplinary teams of physicians, nurses, home health aides, counselors, and volunteers. We offer a wide range of services, including pain and symptom management, emotional and spiritual support, inpatient and respite care, homemaker services, and counseling. As of December 31, 2019, we operated 110 hospice locations, of which 53 are wholly-owned by us, 55 are majority-owned by us through equity joint ventures, and two are under license lease arrangements.

Our HCBS 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, 2019, we operated 107 locations, of which 97 are wholly-owned by us and 10 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, 2019, our LTACHs had 341 licensed beds. We operated 11 LTACHs with 13 locations, of which all but three are located within host hospitals. As part of our facility-based services segment, we also own and operate one skilled nursing facility, two pharmacies, a family health center, a rural health clinic, and 13 physical therapy clinics. Of these 31 facility-based services locations, 20 are wholly-owned by us and 11 are majority-owned 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 Accountable Care Organization ("ACO") enablement and management company, (b) Long Term Solutions, Inc., an in-home assessment company serving the long-term care insurance industry, and (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. 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 10 HCI locations, nine of which are wholly-owned and one is controlled by us through an equity joint venture.

Our net service revenue by segment for the years ended December 31, 2019, 2018 and 2017 was as follows (amounts in thousands):

	Year Ended December 31,		
	2019	2018	2017
Home Health	$ 1,503,393	$ 1,291,457	$ 777,583
Hospice	226,922	199,118	157,287
Home and Community-Based	208,455	172,501	46,159
Facility-Based	111,809	113,784	81,573
Healthcare Innovations	29,662	33,103	—
Consolidated Net Service Revenue	$ 2,080,241	$ 1,809,963	$ 1,062,602

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

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

Merger with Almost Family

On April 1, 2018, we completed a "merger of equals" business combination ("the Merger") with Almost Family, Inc. ("Almost Family"). As a result, our financial results for the twelve months period in 2019 include the operating results of Almost Family, while our financial results with the addition of Almost Family start to be reflected during our second quarter of 2018. See Note 3 to the Consolidated Financial Statements included in this Annual Report on Form 10-K.

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. In 2019, the majority of our net service revenue was generated under the Medicare prospective payment systems (“PPS”) through which we were paid pre-determined rates based upon the clinical condition and severity of the patients in our care. In 2020, net service revenue generated from Medicare will be under the Patient Driven Groupings Model ("PDGM"), which is also paid at pre-determined rates based upon the patient's clinical condition. 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 segments: (1) home health services, (2) hospice services, (3) HCBS, (4) facility-based services offered through our LTACHs, and (5) HCI.

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 HCBS 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 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 skilled nursing facility, family health center, a rural health clinic, 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, and (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. 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, HCBS, facility-based, and HCI 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, 2019, 2018 and 2017, respectively, is found in Note 11 to the Consolidated Financial Statements included in this Annual Report on Form 10-K.

Our home health agencies are operated in one segment that is separated into 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 HCBS agencies are operated in one segment separated into multiple geographic regions. Each of our home health and hospice 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 HCBS agencies are licensed and certified by the state and federal governments. As of December 31, 2019, 466 of our 553 home health service locations, 85 of our 110 hospice service locations, and five of our 13 LTACH 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 to allow for them to provide the highest quality care possible.

Patient care is coordinated on-site at the agency level of each home health service, hospice service, and HCBS 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, information technology, and general clinical oversight accomplished by periodic on-site surveys are provided from our home offices.

Our HCI 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, 2019, we had 85 equity joint ventures including 77 with hospital and health systems, which are comprised of 283 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.

Competition

The markets supporting post-acute care are highly fragmented. According to the Medicare Payment Advisory Commission ("MedPac"), an independent agency that advises Congress on various Medicare issues, there were approximately 11,566 Medicare-certified home nursing agencies in the United States in 2018. MedPac estimated that in 2017 approximately 17% of Medicare-certified home health agencies provided a majority of their services in rural areas, and 88% of agencies were proprietary. MedPac also disclosed that 4,488 hospice agencies were participating in the Medicare Program in 2017. 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 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 home 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, Centers for Medicare & Medicaid Services ("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, 2019, 97% of our same store home health agencies were rated 4 stars or greater when excluding recent acquisitions and legacy Almost Family locations.

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 and Quality 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

Technology plays a key role in the day-to-day operation of our business, our ability to grow our business organically and through acquisitions, and in maintaining effective managerial oversight and controls. The technology solutions we use are highly scalable. We believe that our ability to implement, maintain, and leverage our technology solutions provides us with a competitive advantage that allows us to grow our business in a cost-efficient manner and provide better patient care.

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

providing that care, on both a patient-specific and agency-specific basis. In 2019, we updated our Service Value Point system for the new PDGM payment system adopted by CMS, and other payors.

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. HomeCare HomeBase is our solution of choice for home health and hospice operations. Currently, all of our home health and hospice locations are on a single instance of HomeCare HomeBase. During 2019, all of our home and community-based locations transitioned to a single instance of Continulink. Our advance practice services utilize eMD's Aprima solution and our long term acute care hospitals and skilled nursing facility services utilize WellSky's HCS solution.

Each of these applications support their respective lines of business and locations with administrative, office, clinical, and operating information system needs, including assisting with the compliance of our operating systems with HIPAA requirements. Each application also assists our staff in gathering information to improve the quality of consumer care, optimizing financial performance, promoting regulatory compliance, and enhancing staff efficiency. Each application (with the exception of WellSky's HCS solution) is hosted by the vendor in a secure data center, with multiple redundancies for storage, power, bandwidth, and security. The WellSky's HCS solution is hosted at a co-located data center that is managed by the Company.

We have built an enterprise data warehouse that aggregates data from our ERP solution, and various health record/billing systems in use. We use various third-party solutions and several LHC-developed applications to provide historical, current, and forward-looking operational performance analysis. Our dashboards and reports provide high-level and detailed, historical and current, views to measure performance against budget and deliver insights into factors that drive our execution against our financial, operational, and compliance goals. These dashboards and reports are available in summary and detailed views to accommodate user needs from senior management down to the operators in the field.

We utilize a variety of third-party solutions for human resource management and use their services and products to manage our payroll processing, leave of absence ("LOA") processes, flexible spending account ("FSA") administration, and time and attendance. We also utilize third-party solutions for financial management, including budgeting, forecasting, financial reporting (general ledger, accounts payable, and fixed assets).

We are also deploying solutions across all of our home and community-based service locations to comply with the requirements for electronic visit verification ("EVV") to collect and submit home visit data through our delivery of home and community-based services, such as visit start and end times. In order to comply with current and future state and federal regulations for EVV, we utilize several different solutions. In states with an "open" model, we are able to choose our EVV vendor, and we use ContinuLink as our preferred EVV solution provider. In "closed" systems where states mandate the EVV vendor, we utilize the state-mandated EVV solution provider. In all cases, we have built interfaces between the EVV solution providers and our ContinuLink home and community-based electronic health record and billing system.

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 CMS. Medicare payments accounted for 63.5%, 65.4%, and 71.7% of our net service revenue for the years ended December 31, 2019, 2018 and 2017, 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.

Prior to January 1, 2020, under the PPS model, we received 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. The base payment rate for Medicare home nursing was $3,039.64 per 60-day episode for the year ended December 31, 2019. The base payment rate does not take into consideration the 2% sequestration payment reduction mandated by the Budget Control Act of 2011.

In addition, as mandated by the Bipartisan Budget Act of 2018 (the "BBA 2018") the following provisions impact our home health business:

- 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.
- A specific market basket update percentage of 1.5% for fiscal year 2020, leaving intact the full market basket update of 2.2% for fiscal year 2019. Suspends the productivity adjustment in 2020.

Effective January 1, 2020, CMS implemented the PDGM prospective payment system. Under PDGM, the initial certification of Medicare patient eligibility, plan of care, and comprehensive assessment remains valid for 60-day episodes of care but payments for Medicare home health services are made based upon 30-day payment periods. The national, standardized 30-day Medicare payment amount will be $1,864.03, resulting in a 1.3% increase in payments. The rule implements the 1.5% Medicare home health payment update mandated by the Bipartisan Budget Act of 2018, offset by a 0.2% decrease due to the

rural add-on. The final rule also adjusts PDGM case-mix weights, which implements the removal of therapy thresholds for payments. For Medicare payments associated with low utilization payment adjustments ("LUPAs") under PDGM, the threshold varies for a 30-day period depending on the PDGM payment group. The 30-day payment amounts are for 30-day periods of care beginning on and after January 1, 2020. There will be a transition period for home health episodes that span the implementation date of January 1, 2020, whereby payments for those services rendered during those episodes will be made under the national, standardized 60-day episode payments. CMS will also reduce a request for anticipated payment ("RAP") payments to 20% for existing home health providers. CMS finalized its proposal to eliminate RAP payments for calendar year 2021, and will require home health providers to submit "no pay" RAPs during that year. Beginning January 1, 2021, home health providers will be required to submit a Notice of Admission ("NOA") within five calendar days of the first 30-day period and within five calendar days of the day 31 for the second, subsequent 30-day period. CMS also finalized a policy allowing therapy assistants to provide maintenance therapy services in the home and modified certain requirements relating to the home health plan of care.

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.

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

Hospice

In order for a Medicare beneficiary to qualify for the Medicare hospice benefit, two physicians must certify that, in their clinical judgment, the beneficiary has less than six months to live, assuming the beneficiary's disease runs its normal course. In addition, the Medicare beneficiary must affirmatively elect hospice care and waive any rights to other Medicare curative benefits related to his or her terminal illness. At the end of each benefit period (described below), a physician must recertify that the Medicare beneficiary's life expectancy is six months or less in order for the beneficiary to continue to qualify for and to receive the Medicare hospice benefit. The first two benefit periods are 90 days and subsequent benefit periods are 60 days. A Medicare beneficiary may revoke his or her election at any time and resume receiving traditional Medicare benefits. There is no limit on how long a Medicare beneficiary can receive hospice benefits and services, provided that the beneficiary continues to meet Medicare hospice eligibility criteria.

Medicare reimburses for hospice care using one of four predetermined daily 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.

Effective October 1, 2018, hospices were 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.

On August 6, 2019, CMS published the Final Rule setting hospice payment rates and policies for fiscal year 2020. Effective October 1, 2020, CMS finalized its proposal to rebase reimbursement rates for general inpatient care, respite care, and continuous home care which resulted in increased reimbursement for these service lines. To maintain budget neutrality, CMS reduced reimbursement for routine home care by -2.72%. The hospice payment update percentage for fiscal year 2020 is equal to 2.6% for hospices that submit the required quality data and 0.6% (fiscal year 2020 hospice payment update of 2.6% minus 2 percentage points) for hospices that do not submit the required data. The hospice cap amount for the fiscal year 2020 cap year will be $29,964.78, which is equal to the fiscal year 2019 cap amount ($29,205.44) updated by the fiscal year 2020 hospice payment update percentage of 2.6%. CMS finalized the removal of the 1 year wage index lag and will use the current year's wage index to geographically wage adjust hospice payments. CMS also finalized its proposal to call the hospice assessment tool the Hospice Outcomes & Patient Evaluation instead of Hospice Evaluation Assessment Reporting Tool (HEART). CMS also made some minor changes to the measures used in the hospice quality reporting program. CMS delayed implementation of a new hospice election statement policy for one year until fiscal year 2021.

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, 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, 2019, we had a total of 13 LTACH facilities, with 310 licensed beds. Eleven of our LTACH facilities were classified as HwHs and two were classified as freestanding. Of the 13 facilities, eight were located in Metropolitan Statistical Area ("MSA") or urban areas and five were located in non-MSA or rural areas. Two of our HwH facilities was a satellite location of a parent hospital located in an MSA. Both of our freestanding locations are in MSAs, with one being 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.

On August 16, 2019, CMS published the Final Rule for LTACH reimbursement for fiscal year 2020. CMS established the LTACH PPS standard Federal payment rate of $42,677.64. This was the result of a 2.5% annual update to the standard federal rate, an incremental change in the one-time budget neutrality adjustment factor of 0.999858 for eliminating the 25-percent threshold policy in fiscal year 2020, and the area wage budget neutrality factor of 1.0020203. CMS estimates that overall LTACH PPS payments in fiscal year 2020 will increase by approximately 1.0% percent.

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, 2019, our managed care contracts included over 393 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

Certain provisions of the Social Security Act, 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 and results of operations.

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, 2019, 2018 and 2017, 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

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

The 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, could have a material adverse effect on the Company's business and financial condition and results of operations.

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.

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 2019.

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, 2019.

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 2020.

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, 2019, the Joint Commission had accredited 466 of our 553 home health locations, 85 of our 110 hospice locations, and five of our 13 LTACH locations. 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, 2019, we had 30,399 employees, of which 15,170 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 Washington. Coverage for workers' compensation matters within the State of Washington is procured from the State's respective mandated program. Under our workers' compensation insurance policies, the Company maintains a deductible of the first $1.0 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 http://investor.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 mandated time periods. If we fail to identify and return overpayments within the required time periods we could be subject to suits under the False Claims Act by the government or relators (whistleblowers).

Regulations implementing the provisions of the PPACA and related initiatives may similarly increase our costs, decrease our revenues, expose us to expanded liability or require us to revise the ways in which we conduct our business.

In addition, various health care reform proposals similar to the federal reforms described above have also emerged at the state level, including in several states in which we operate. We cannot predict with certainty what health care initiatives, if any, will be implemented at the state level, or what the ultimate effect of federal health care reform or any future legislation or regulation may have on us or on our business and consolidated financial condition, results of operations and cash flows.

In addition to impacting our Medicare businesses, PPACA may also significantly affect our non-Medicare businesses. PPACA makes many changes to the underwriting and marketing practices of private payors. The resulting economic pressures could prompt these payors to seek to lower their rates of reimbursement for the services we provide.

Finally, efforts to repeal or substantially modify provisions of the PPACA continue in Congress. The ultimate outcomes of legislative efforts to repeal, substantially amend, eliminate or reduce funding for the PPACA is unknown. In addition to the prospect for legislative repeal or revision, the President and members of his administration hostile to the PPACA could seek to impose substantial changes upon the PPACA through administrative action, including revised regulation and other Executive Branch action. The effect of any major modification or repeal of the PPACA on our business, operations, or financial condition cannot be predicted, but could be materially adverse.

There are continuing efforts to reform governmental health care programs that could result in major changes in the health care delivery and reimbursement system on a national and state level, including changes directly impacting the reimbursement systems for our home health and hospice care services. Though we cannot predict what, if any, reform proposals will be adopted, healthcare reform and legislation may have a material adverse effect on our business and our financial condition, results of operations, and cash flows through decreasing payments made for our services.

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, required that federal agencies 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, home and community-based services, or facility-based services. Additionally, the Executive Order also prohibits the issuance of any new regulations not approved by the Director of the Office of Management and Budget and included in the Unified Regulatory Agenda. 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.

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, 2019 and 2018, we received 63.5% and 65.4%, 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. We cannot be assured that reimbursement payments under governmental payor programs, including Medicare, will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to these programs. Any such changes could have a material adverse effect on our business and consolidated financial condition, results of operations, and cash flows. 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.

Additionally, CMS proposed changes to the Home Health Prospective Payment System case-mix adjustment methodology through the use of a new PDGM for home health payments. This change was implemented on January 1, 2020, and also includes a change in the unit of payment from a 60-day payment period to a 30-day payment period and eliminates the use of therapy visits in the determination of payments. While the changes are intended to be implemented in a budget-neutral manner to the industry, the ultimate impact will vary by provider based on factors including patient mix and admission source. Additionally, in arriving at the calculation of a rate that is budget-neutral, CMS has made numerous assumptions about behavioral changes. The application of these assumptions could negatively impact our rates of reimbursement and have a material adverse effect on our business and consolidated financial condition, results of operations, and cash flows.

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 certification,
- adequacy and quality of health care services,
- qualifications of health care and support personnel,
- quality and safety of medical equipment,
- confidentiality, maintenance, and security issues associated with medical records and claims processing,
- relationships with physicians and other referral sources,
- operating policies and procedures,
- emergency preparedness risk assessments and policies and procedures,
- policies and procedures regarding employee relations,
- addition of facilities and services,
- coding and Billing for services,
- requirements for utilization of services,
- documentation required for billing and patient care, and
- reporting and maintaining records regarding adverse events.

The laws and regulations governing our operations, along with the terms of participation in various government programs, regulate how we conduct 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 1 to 5 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, failing to maintain satisfactory star rating scores could affect our rates of reimbursement and have a material adverse effect on our business and consolidated financial condition, results of operations, and cash flows.

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 ADR and other third party firms, including ZPICs and 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, and the termination of our rights to participate in federal and state-sponsored programs or the suspension or revocation of our licenses to operate. Our costs to respond to and defend reviews, audits, and investigations may be significant and could have a material adverse effect on our business and consolidated financial condition, results of operations, and cash flows. Moreover, an adverse review, audit, or investigation could result in:

- required refunding or retroactive adjustment of amounts we have been paid pursuant to the federal or state programs or from private payors,
- state or federal agencies imposing fines, penalties, and other sanctions on us,
- loss of our right to participate in the Medicare program, state programs, or one or more private payor networks, or
- damage to our business and reputation in various markets.

These results could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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.

While our services are not typically sensitive to general declines in the federal and state economies, the erosion in the tax base caused by a general economic downturn has caused, and will likely 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.

Adverse developments in the United States could lead to a reduction in federal government expenditures, including governmentally funded programs in which we participate, such as Medicare and Medicaid. In addition, if at any time the

federal government is not able to meet its debt payments unless the federal debt ceiling is raised, and legislation increasing the debt ceiling is not enacted, the federal government may stop or delay making payments on its obligations, including funding for government programs in which we participate, such as Medicare and Medicaid. Failure of the government to make payments under these programs could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Further, any failure by the United States Congress to complete the federal budget process and fund government operations may result in a federal government shutdown, potentially causing us to incur substantial costs without reimbursement under the Medicare program, which could have a material adverse effect on our business and consolidated financial condition, results of operations, and cash flows. Historically, state budget pressures have resulted in reductions in state spending. Given that Medicaid outlays are a significant component of state budgets, we can expect continuing cost containment pressures on Medicaid outlays for our services.

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 is not applied to LTACH discharges occurring on or before September 30, 2018.

The implementation of 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 created new Medicare criteria and payment rules for our LTACHs. Under these 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 was 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. We estimate that approximately 40% of our LTACH patients will be paid at the site-neutral rate once the new criteria is fully phased-in. The site-neutral payment rates are 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 the business, financial position, and the results of operations of our LTACHs.

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.
- 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, 2019, we operated in 16 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.

Quality reporting requirements may negatively impact Medicare reimbursement.

Hospice quality reporting was mandated by PPACA, which directs the Secretary to establish quality reporting requirements for hospice programs. Failure to submit required quality data will result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year. This quality reporting program is currently “pay-for-reporting,” meaning it is the act of submitting data that determines compliance with program requirements.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (the "IMPACT Act") requires the submission of standardized data by home health agencies and other providers. Specifically, the IMPACT Act requires, among other significant activities, the reporting of standardized patient assessment data with regard to quality measures, resource use, and other measures. Failure to report data as required will subject providers to a 2% reduction in market basket prices then in effect. Additionally, reporting activities associated with the IMPACT Act are anticipated to be quite burdensome.

Similarly, in the Calendar Year 2015 Home Health Final Rule, CMS proposed to establish a new "Pay-for-Reporting Performance Requirement" with which provider compliance with quality reporting program requirements can be measured. Home health agencies that do not submit quality measure data to CMS are subject to a 2.0% reduction in their annual home health payment update percentage. Home health agencies are required to report prescribed quality assessment data for a minimum of 70.0% of all patients with episodes of care that occur on or after July 1, 2015. This compliance threshold increased by 10.0% in each of two subsequent periods - i.e., for episodes beginning on or after July 1, 2016 and before June 30, 2017, home health agencies must score at least 80%, and for episodes beginning on or after July 1, 2017 and thereafter, the required performance level is at least 90%.

There can be no assurance that all of our agencies will continue to meet quality reporting requirements in the future which may result in one or more of our agencies seeing a reduction in its Medicare reimbursements. Regardless, we, like other healthcare providers, are likely to incur additional expenses in an effort to comply with additional and changing quality reporting requirements.

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. While we have not experienced any individual lender limitations to extend credit under our revolving credit facility, the obligations of each of the lending institutions in our revolving credit facility are independent 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 seek consent or comply with or maintain certain financial tests and ratios in order 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,
- enter into joint ventures,
- 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. Adverse weather events could disrupt our business and results of operations, result in damage to our properties, and negatively affect the local economies in which we operate. 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. Beginning in 2020, a portion of our estimated reimbursement (20% for existing home health providers) 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.

In addition, timing delays in billings and collections 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, Medicare, state Medicaid, or other payor

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. CMS's inability to have its systems ready to properly reimburse home health providers under the new PDGM could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

On May 31, 2018, CMS issued a notice indicating its intention to re-launch a home health agency pre-claim review demonstration project. Now called the Review Choice Demonstration for Home Health Services, the revised demonstration will give home health agencies in the demonstration states 3 options: (1) pre-claim review of all claims, (2) post-payment review of all claims, or (3) minimal post-payment review with a 25% payment reduction for all home health services. The demonstration initially will apply to home health providers in Florida, Illinois, North Carolina, Ohio, and Texas, with the option to expand after 5 years to other states in the Medicare Administrative Contractor Jurisdiction M (Palmetto). Compliance with this process could result in increased administrative costs or delays in reimbursement for home health services in states subject to the demonstration.

Changes in units of payment for home health agencies could reduce our Medicare home health reimbursement levels.

As required by the Bipartisan Budget Act of 2018, the new PDGM will change the unit of payment for home health agencies from a 60-day episode of care to 30-day periods of care. This change was implemented January 1, 2020, and is stated to be effectuated in a budget-neutral manner, whereby the move to the PDGM is not supposed to result in lower net reimbursement. However, CMS has made assumptions about behavioral changes which have not been finalized or proven, for example that home health agencies will change their documentation and coding practices. CMS may take into account expected behavioral effects of policy changes related to the implementation of the proposed rule, resulting in lower reimbursement levels in some cases. Accordingly, the implementation of the PDGM could negatively impact our rates of reimbursement beginning January 1, 2020, and have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. See Part I, Item 1, “Risk Factors Related to Reimbursement and Government Regulation” included in this Annual Report on Form 10-K for additional information on the PDGM.

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. In addition, if we expand our operations into geographic areas where health care providers historically have been unionized, or if any of our care center employees become unionized, being subject to a collective bargaining agreement may have a negative impact on our ability to timely and successfully recruit qualified personnel and may increase our operating costs.

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 joint ventures 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 national, regional, and local 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. 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 strategic relationships by our competitors, could cause a decline in our 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. Additionally, we compete with a number of non-profit organizations that can finance acquisitions and capital expenditures on a tax-exempt basis or receive charitable contributions that are unavailable to us. 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.

Managed care organizations and other third party payors continue to consolidate, which enhances their ability to influence the delivery of health care services. Consequently, the health care needs of patients in the United States are increasingly served by a smaller number of managed care organizations, and these organizations generally enter into service agreements with a limited number of providers. Our business and consolidated financial condition, results of operations, and cash flows could be materially adversely affected if these organizations do not contract with us as a provider and/or engage our competitors as a preferred or exclusive providers. In addition, should private payors, including managed care payors, seek to negotiate additional discounted fee structures or the assumption by health care providers of all or a portion of the financial risk through prepaid capitation arrangements, our business and consolidated financial condition, results of operations, and cash flows could be materially adversely affected.

If we are unable to react competitively to new developments, our operating results may suffer. State CON or POA laws often limit the ability of competitors to enter into a given market, are not uniform throughout the United States and are frequently the subject of efforts to limit or repeal such laws. If states remove existing CONs or POAs, we could face increased competition in these states. There can be no assurances that states will not seek to eliminate or limit their existing CON or POA programs, which could lead to increased competition in these states. Further, we may not be able to compete successfully against current or future competitors, which could have a material adverse effect on our business and consolidated financial condition, results of operations, and cash flows.

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, the delay in payments

associated with change in ownership, control, and the internal process of the Medicare fiscal intermediary, and the exposure to unforeseen liabilities of acquired agencies. Further, the financial benefits we expect to realize from many of our acquisitions are largely dependent upon our ability to improve clinical performance, overcome regulatory deficiencies, and improve the reputation of the acquired business in the community and control costs. 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, having 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.

The company may fail to realize all of the anticipated benefits of the Merger with Almost Family 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.

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.

Portions of our 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, HCBS, 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, and (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. 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 Accountable Care Organization ("ACO") enablement and management company, (b) Long Term Solutions, Inc., a provider of in-home nursing assessments for the long-term care insurance industry, and (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. 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 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.

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. At December 31, 2019, we have approximately 30,400 employees. In addition, we employ direct care workers on a contractual basis to support our existing workforce. 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, provide services, and bill and collect for our services. In addition to our Service Value Point system, our business is also substantially dependent on non-proprietary software provided by third-party vendors. For example, we utilize third-party software information systems for billing and maintaining patient claim receivables. Our business also depends on a comprehensive payroll and human resources system for basic payroll functions and reporting, payroll tax reporting, managing wage assignments and garnishments. Our business also supports the use of Electronic Visit Verification ("EVV") to collect visit submission information through our delivery of HCBS, and we rely on third-party software vendors to provide continual maintenance, enhancements, as well as security of collected data. To the extent that our EVV vendors fail to support these processes, our internal operations could be negatively affected.

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.

Our systems require constant maintenance, upgrades, and enhancements to preserve system capabilities and security and to meet our operational needs. Our information systems require an ongoing commitment of significant resources to maintain, protect, and enhance existing systems and develop new systems to keep pace with continuing changes in technology, evolving industry and regulatory standards, and changing customer preferences. Problems with, or the failure of, our information systems or software could negatively impact our clinical performance and our management and reporting capabilities. To the extent third-party software vendors fail to support our licensed software or systems, or if we lose our licenses, our operations could be materially and negatively affected. 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 and collect from Medicare or other payors for our services, or impair our data capture, medical documentation, or 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.

Additionally, 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 built redundancy into our networks and installed privacy protection systems on our network and point-of- care devices to prevent unauthorized access to proprietary, sensitive, and legally protected information. However, our technology may fail to adequately secure the confidential health information and personally identifiable information we maintain in our databases. Additionally, 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 information 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 fines and penalties associated with the breach of security or be required to take other action in response to judicial or regulatory actions arising out of the incident, including under HIPAA or other judicial acts.

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.

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

We develop and maintain proprietary software systems to collect assessment data, log patient visits, generate medical orders, and monitor treatments and outcomes in accordance with established medical standards. These systems integrate 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, such technologies 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.

Our ability to maintain the security of patient, employee, third-party, or company information could have an impact on our reputation, our financial position, and the results of our operations.

We have been, and likely will continue to be, subject to attempts of computer hacking, vandalism and theft, malware, computer viruses, ransomware, and other malicious codes, phishing, employee error and 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. The proliferation of ever-evolving threats mean that 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 operations 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.

A cybersecurity or ransomware attack or other incident that affects our information systems security could cause a security breach that may lead to a material disruption to our information systems infrastructure or business and may involve a significant loss of business or patient health information. If a cybersecurity attack or other unauthorized attempt to access our systems or facilities were to be successful, it could result in the theft, destruction, loss, misappropriation, or release of confidential information or intellectual property, and could cause operational or business delays that may materially impact our ability to provide various healthcare services. Any successful cybersecurity attack or other unauthorized attempt to access our systems or facilities also could result in negative publicity which could damage our reputation or brand with our patients, referral sources, payors, or other third parties and could subject us to substantial sanctions, fines, and damages and other additional civil and criminal penalties under HIPAA, HITECH, the Omnibus Rule and other federal and state privacy laws, in addition to litigation with those affected.

We provide our employees with training and regular reminders on important measures they can take to prevent breaches or phishing schemes. However, given the rapidly evolving nature and proliferation of cyber threats, there can be no assurance our training and network security measures or other controls will detect, prevent, or remediate security or data breaches in a timely manner or otherwise prevent unauthorized access to, damage to, or interruption of our systems and operations.

We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches, including unauthorized access to patient data and personally identifiable information stored in our information systems, and the introduction of computer viruses or other malicious software programs to our systems, and cyber-attacks, email phishing schemes, malware, and ransomware. Moreover, a security breach, or threat thereof, could require that we expend significant resources to repair or improve our information systems and infrastructure and could distract management and other key personnel from performing their primary operational duties. In the case of a material breach or cyber-attack, the associated expenses and losses may exceed our current insurance coverage for such events. Some adverse consequences are not insurable, such as reputational harm and third-party business interruption. Failure to maintain proper function, security, or availability of our information systems or protect our data against

unauthorized access could have a material adverse effect on our business, financial position, results of operations, and cash flows.

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 5.13% of our outstanding shares of common stock as of December 31, 2019. 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,

- no cumulative voting for directors,
- director vacancies are filled by remaining directors (including vacancies resulting from removal), 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 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 stock. Therefore, our stockholders may be deprived of opportunities to profit from a sale of control. 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 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.

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 step in the total $70.0 million home office campus expansion project expected to be completed in the first half of 2021.

In addition, the Company leases two off-campus office buildings in Lafayette, Louisiana, where we occupy 22,571 and 24,416 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, five 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.

Eleven 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.

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 ZPICs, 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 and results of operations.

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 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 in connection with the Merger contained false and misleading statements with respect to the Merger. 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 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 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, 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, the Company 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. On April 12, 2019, we moved to dismiss the Consolidated Complaint and filed a motion on May 28, 2019, and we submitted reply briefs in support of its motions on June 19, 2019. On February 11, 2020, the court granted our motion to dismiss and our motion to strike and dismissed Lead Plaintiff's federal claims with prejudice and state law claims without prejudice. The deadline for Lead Plaintiff to appeal the court's dismissal of his claims is March 12, 2020.

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.

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

Sales of Unregistered Common Stock

None.

Market Information and Holders

Our common stock trades on the NASDAQ Global Select Market ("NASDAQ") under the symbol "LHCG." As of February 24, 2020, there were approximately 409 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 2019 and 2018 as quoted by NASDAQ:

	High	Low
2019		
Fourth Quarter	$ 137.76	$ 107.94
Third Quarter	126.58	112.96
Second Quarter	120.55	99.63
First Quarter	113.79	88.98
	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

The closing price of our common stock as reported by NASDAQ on February 25, 2020 was $148.40.

Performance Graph

This item is incorporated by reference from our Annual Report to Stockholders for the fiscal year ended December 31, 2019.

Issuer Purchases of Equity Securities

None.

Item 6. Selected Financial Data.

The selected consolidated financial data presented below is derived from our audited consolidated financial statements for each of the years in the five year period ended December 31, 2019. The financial data for the years ended December 31, 2019, 2018 and 2017 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. Financial Statements and Supplementary Data included herein (amounts in thousands, except share and per share data).

Year Ended December 31,	2019	2018	2017	2016	2015
Consolidated Statements of Operations Data:					
Net service revenue	$ 2,080,241	$ 1,809,963	$ 1,062,602	$ 900,033	$ 797,123
Gross margin	755,354	653,606	386,792	342,383	316,245
Operating income	151,614	111,001	74,682	70,562	66,343
Net income	113,852	78,923	60,386	45,942	41,650
Net income attributable to LHC Group, Inc.'s common stockholders	95,726	63,574	50,112	36,583	32,335
Net income attributable to LHC Group, Inc.'s common stockholders:					
Basic	$ 3.09	$ 2.31	$ 2.83	$ 2.08	$ 1.86
Diluted	$ 3.07	$ 2.29	$ 2.79	$ 2.07	$ 1.84
Weighted average shares outstanding:					
Basic	30,932,607	27,498,351	17,715,992	17,559,477	17,405,379
Diluted	31,209,824	27,773,396	17,961,018	17,682,820	17,547,531

As of December 31,	2019	2018	2017	2016	2015
Consolidated Balance Sheet Data:					
Cash	$ 31,672	$ 49,363	$ 2,849	$ 3,264	$ 6,139
Total assets (1)	2,140,295	1,928,715	793,702	614,071	566,054
Total debt	253,000	243,703	144,286	87,796	98,784
Total LHC Group, Inc. stockholders' equity	1,413,323	1,316,925	448,868	395,126	354,582

Footnote 1: The Company adopted Accounting Standards Update ("ASU") 2016-02 on January 1, 2019, resulting in the recognition of $89.7 million of operating right-of-use assets. See Note 2 to the Consolidated Financial Statements included in this Annual Report on Form 10-K for additional information.

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, HCBS, long-term acute care hospitals, and HCI. Our net service revenue increased $270.3 million to $2.1 billion for the year ending December 31, 2019 from $1.8 billion for the year ending December 31, 2018 largely as a result of the merger with Almost Family, Inc. that occurred on April 1, 2018. During 2019, we acquired 27 agencies, such that, as of December 31, 2019, we operated 811 locations in 35 states within the continental United States and the District of Columbia.

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, 2019 includes the results of Almost Family for the twelve month period and 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. See Note 3 to the Consolidated Financial Statement included in this Annual Report on Form 10-K for additional information about the Merger.

Segments

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

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, 2019, we operated 553 home health service locations, of which 350 are wholly-owned by us, 199 are majority-owned or controlled by us through equity joint ventures, two are controlled by us through license lease arrangements, and the remaining two 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, 2019, we operated 110 hospice locations, of which 53 are wholly-owned by us, 55 are majority-owned by us through equity joint ventures and two, are controlled by us through license lease arrangements.

Through our HCBS, 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, 2019, we operated 107 community-based services locations, of which 97 are wholly-owned and 10 are majority-owned through an equity joint venture.

We provide facility-based services principally through our LTACHs. As of December 31, 2019, we operated 11 LTACHs with 13 locations, of which all but two are located within host hospitals. We also operate one skilled nursing facility, two pharmacies, a family health center, a rural health clinic, and 13 physical therapy clinics. Of these 31 facility-based services locations as of December 31, 2019, 20 are wholly-owned by us and 11 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, and (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. 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 10 HCI locations, with nine being wholly-owned and one controlled by us through an equity joint venture.

The percentage of net service revenue contributed from each reporting segment for the each of the periods ended December 31, 2019, 2018 and 2017 was as follows:

Type of Segment	2019	2018	2017
Home Health	72.3%	71.4%	73.1%
Hospice	10.9	11.0	14.8
Home and Community-Based	10.0	9.5	4.4
Facility-Based	5.4	6.3	7.7
Healthcare Innovations	1.4	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, 2018 through December 31, 2019. This table does not include our skilled nursing facility, pharmacies, family health center, rural health clinic, and physical therapy clinics through our facility-based services segment.

	Home Health Agencies	Hospice Agencies	Home and Community - Based Agencies	Long-Term Acute Care Hospitals	HCI
Total at January 1, 2018	315	91	12	14	—
Developed	—	1	4	—	—
Acquired (1)	278	22	65	—	12
Divested/Merged	(38)	(6)	—	(2)	—
Total at December 31, 2018	555	108	81	12	12
Developed	4	—	24	—	
Acquired	16	8	2	1	—
Divested/Merged	(22)	(6)	—	—	(2)
Total at December 31, 2019	553	110	107	13	10

(1) 2018 acquired locations for home health and hospice were updated to reflect location counts identified upon completing the integration of Almost Family locations into our single instance of HomeCare HomeBase.

Recent Developments

Home Health Services

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 increased to $3,154.27 in 2019. The rule estimated an impact of 2.2% increase in payments due to the rate and policy changes proposed in the rule. The rule implemented 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 established 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.

On October 31, 2019, CMS issued its final rule regarding Medicare reimbursements for the calendar year 2020. Beginning on January 1, 2020, CMS implemented the PDGM prospective payment system, as mandated by the Bipartisan Budget Act of 2018. Under PDGM, the initial certification of Medicare patient eligibility, plan of care, and comprehensive assessment will remain valid for 60-day episodes of care, but payments for Medicare home health services will be made based upon 30-day payment periods. The national, standardized 30-day Medicare payment amount will be $1,864.03, resulting in a 1.3% increase in payments. The rule implements the 1.5% Medicare home health payment update mandated by the Bipartisan Budget Act of 2018, offset by a 0.2% decrease due to the rural add-on. The final rule also adjusts PDGM case-mix weights,

which implements the removal of therapy thresholds for payments. For Medicare payments associated with LUPAs under PDGM, the threshold will vary for a 30-day period depending on the PDGM payment group. The 30-day payment amounts will be for 30-day periods of care beginning on and after January 1, 2020. There will be a transition period for home health episodes that span the implementation date of January 1, 2020, whereby payments for those services rendered during those episodes will be made under the national, standardized 60-day episode payments. CMS will also reduce a request for RAP payments to 20% for existing home health providers. CMS finalized its proposal to eliminate RAP payments for calendar year 2021, and will require home health providers to submit "no pay" RAPs during that year. Beginning January 1, 2021, home health providers will be required to submit a Notice of Admission ("NOA") within five calendar days of the first 30-day period and within five calendar days of the day 31 for the second, subsequent 30-day period. CMS also finalized a policy allowing therapy assistants to provide maintenance therapy services in the home and modified certain requirements relating to the home health plan of care.

The final rule also includes the public reporting of Total Performance Score ("TPS") and TPS percentile ranking for each home health agency in the nine model states that qualifies for a payment adjustment under the Home Health Value-Based Purchasing model for fiscal year 2020. CMS also made some changes to the Home Health Quality Reporting Program.

Hospice

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 received 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 was $29,205.44 (2018 cap amount of $28,689.04 increased by 1.8%). Additionally, this rule finalized 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 ended 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

On July 31, 2019, CMS issued a final rule, which would update the hospice wage index, payment rates, and cap amount for fiscal year 2020. CMS finalized a net 2.6% market basket update, which is calculated from the 2020 hospital market basket update of 3.0%, reduced by multifactor productivity adjustment, as mandated by the Affordable Care Act, of 0.4 percentage points. CMS is also rebasing payments for Continuous Home Care, Inpatient Respite Care, and General Inpatient Care to approximate costs in a budget neutral manner, which will result in a 2.7% decrease in rates for Routine Home Care to achieve budget neutrality. Also, 2020 hospice cap amount will be $29,964.98. CMS finalized the removal of the one year wage index lag and will use the current year's wage index to geographically wage adjust hospice payments, and changes to the Hospice Election Statement.

The following table shows the hospice Medicare payment rates for fiscal year 2020, which will began on October 1, 2019 and will end September 30, 2020:

Description		Rate per patient day
Routine Home Care days 1-60	$	194.50
Routine Home Care days 61+	$	153.72
Continuous Home Care	$	1,395.63
Full Rate = 24 hours of care		
$58.15 = hourly rate		
Inpatient Respite Care	$	450.10
General Inpatient Care	$	1,021.25

Home and Community-Based Services

HCBS 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 STCH intensive care unit 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 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. 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 also proposed 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.

On August 2, 2019, CMS issued a final rule for the fiscal year 2020 LTACH-PPS. Overall, CMS expects LTACH-PPS payments to increase by approximately 1.0%, which reflects the continued statutory implementation of the revised LTACH-PPS payments. LTACH-PPS payments for fiscal year 2020 for discharges paid using the standard LTACH payment rate are expected to increase by 2.7% after accounting for the proposed annual standard Federal rate update for fiscal year 2020 of 2.5%, an estimated decrease in outlier payments of 0.2%, and other factors.

LTACH-PPS payments for cases continuing to transition to the site neutral payment rates are expected to decrease by approximately 5.9%. This accounts for the LTACH site neutral payment rate cases that will continue to be paid a blended payment rate as the rolling statutory transition period ends for LTACH discharges occurring in cost reporting periods beginning in fiscal year 2020, and other changes.

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

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 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.

Operational Data

This section of this Form 10-K generally discusses 2019 and 2018 items and year-to-year comparisons between 2019 and 2018. Discussions of 2017 items and year-to-year comparisons between 2018 and 2017 that are not included in this Form 10-K can be found in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 of the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018 filed on February 28, 2019.

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, 2019	Three Months Ended June 30, 2019	Three Months Ended September 30, 2019	Three Months Ended December 31, 2019
Home Health:				
Average census	75,675	77,138	76,905	78,380
Average Medicare census	49,411	49,827	49,016	49,108
Admissions	93,674	95,198	97,647	102,940
Medicare admissions	57,456	57,391	57,496	59,664
Hospice:				
Average census	3,752	4,070	4,187	4,238
Average Medicare census	3,447	3,760	3,883	3,914
Admissions	4,587	4,637	4,522	4,768
Medicare admissions	4,089	4,131	3,987	4,213
Patient days	337,649	370,407	385,164	389,926
Home and Community-Based:				
Billable hours	2,271,894	2,292,719	2,276,984	2,111,816
LTACHs:				
Patient days	19,636	19,970	18,918	20,313
	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

Consolidated Results of Operations

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

	Year Ended December 31,	
	2019	2018
Consolidated Services Data:		
Net service revenue	$ 2,080,241	$ 1,809,963
Cost of service revenue	1,324,887	1,156,357
Gross margin	755,354	653,606
General and administrative expenses	596,006	537,916
Impairment of intangibles and other	7,734	4,689
Operating income	151,614	111,001
Interest expense	(11,155)	(9,679)
Income tax expense	26,607	22,399
Income attributable to noncontrolling interests	18,126	15,349
Net income available to LHC Group, Inc.'s common stockholders	$ 95,726	$ 63,574

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,	
	2019	2018
Consolidated Services Data:		
Cost of service revenue	63.7%	63.9%
Gross margin	36.3	36.1
General and administrative expenses	28.7	29.7
Impairment of intangibles and other	0.4	0.3
Operating income	7.3	6.1
Interest expense	(0.5)	(0.5)
Income tax expense	21.7	26.1
Income attributable to noncontrolling interests	0.9	0.8
Net income attributable to LHC Group, Inc.'s common stockholders	4.6	3.5

Consolidated net service revenue for the year ended December 31, 2019 was $2.1 billion compared to $1.8 billion for the same period in 2018, an increase of $270.3 million, or 14.9%. Consolidated net service revenue growth in 2019 was primarily due to both our acquisitions during 2019 and 2018, and an increase in same store growth. Consolidated net service revenue was comprised of the following for the periods ending December 31:

Segment	2019	2018
Home Health	72.3%	71.4%
Hospice	10.9	11.0
Home and Community-Based	10.0	9.5
Facility-Based	5.4	6.3
Healthcare Innovations	1.4	1.8
	100.0%	100.0%

Revenue derived from Medicare represented 64.1% and 65.4% of our consolidated net service revenue for the years ended December 31, 2019 and 2018, 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, 2019 and the related change from the same period in 2018 (amounts in thousands, except statistical data, and revenue excludes implicit price concessions):

	Organic (1)	Organic Growth (Loss)%	Acquired (2)	Total	Total Growth (Loss) %
Home Health					
Revenue	$ 909,439	6.5 %	$ 607,226	$ 1,516,665	15.9 %
Revenue Medicare	$ 605,974	3.4	$ 451,754	$ 1,057,728	13.9
New admissions	230,477	9.1	158,982	$ 389,459	17.4
New Medicare admissions	132,727	2.9	99,280	$ 232,007	12.6
Average census	47,116	5.1	29,909	$ 77,025	1.4
Average Medicare census	29,576	—	19,764	$ 49,340	(2.3)
Home health episodes	219,970	1.3	152,846	$ 372,816	10.2
Hospice					
Revenue	$ 184,531	6.6	$ 42,164	$ 226,695	12.2
Revenue Medicare	$ 170,421	9.2	$ 37,610	$ 208,031	14.5
New admissions	15,007	5.6	3,508	$ 18,515	4.6
New Medicare admissions	13,288	6.4	3,140	$ 16,428	6.6
Average census	3,425	8.9	637	$ 4,062	12.8
Average Medicare census	3,165	9.2	588	$ 3,753	13.2
Patient days	1,254,443	9.3	228,522	$ 1,482,965	12.8
Home and Community-Based					
Revenue	$ 60,989	4.8	$ 153,304	$ 214,293	22.1
Billable hours	2,476,567	29.4	6,430,893	$ 8,907,460	22.7
Facility-Based					
LTACHs					
Revenue	$ 101,194	(1.9)	$ 1,641	$ 102,835	(3.4)
Patient days	77,572	(5.1)	1,265	$ 78,837	(6.0)
Other facility-based					
Revenue	$ 11,501	17.1	$ —	$ 11,501	17.1
Healthcare Innovations					
Revenue	$ —	—	$ 29,919	$ 29,919	(10.3)
Consolidated					
Revenue	$ 1,267,654	33.1 %	$ 834,254	$ 2,101,908	53.6 %

(1) Organic - combination of same store, a location that has been in service with us for greater than 12 months, and de novo, an internally developed location that has been in service for 12 months or less.
(2) 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. Almost Family locations remained counted as acquired locations due to system integrations, which were completed at the end of 2019.

Revenue and patient days decreased in our LTACHs during the twelve months ended December 31, 2019 due to the closures of two LTACHs during 2018.

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, 2019 and 2018 (amounts in thousands):

	2019	% of Net Service Revenue	2018	% of Net Service Revenue
Revenue	$ 2,101,908		$ 1,835,478	
Less: Implicit price concessions	21,667	1.0%	25,515	1.4%
Net service revenue	$ 2,080,241		$ 1,809,963	

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):

	2019		2018	
Home Health				
Salaries, wages, and benefits	$ 860,184	57.2%	$ 733,432	56.8%
Transportation	44,046	2.9	40,760	3.2
Supplies and services	34,805	2.3	27,814	2.2
Total	$ 939,035	62.4%	$ 802,006	62.1%
Hospice				
Salaries, wages, and benefits	$ 101,927	44.9%	$ 94,966	47.7%
Transportation	7,733	3.4	7,330	3.7
Supplies and services	30,517	13.4	28,695	14.4
Total	$ 140,177	61.7%	$ 130,991	65.8%
Home and Community-Based				
Salaries, wages, and benefits	$ 154,665	74.2%	$ 128,124	74.3%
Transportation	2,164	1.0	1,797	1.0
Supplies and services	988	0.5	739	0.4
Total	$ 157,817	75.7%	$ 130,660	75.7%
Facility-Based				
Salaries, wages, and benefits	$ 51,941	46.5%	$ 53,920	47.4%
Transportation	280	0.3	310	0.3
Supplies and services	21,053	18.8	22,669	19.9
Total	$ 73,274	65.4%	$ 76,899	67.6%
Healthcare Innovations				
Salaries, wages, and benefits	$ 13,707	46.2%	$ 15,101	45.6%
Transportation	444	1.5	551	1.7
Supplies and services	433	1.5	149	0.5
Total	$ 14,584	49.2%	$ 15,801	47.8%
Consolidated				
Total	$ 1,324,887	63.7%	$ 1,156,357	63.9%

Consolidated cost of service revenue for the year ended December 31, 2019 was $1,324.9 million compared to $1,156.4 million for the same period in 2018, an increase of approximately $168.5 million, or 14.6%. The improvement from 2018 to 2019 as a percentage of net service revenue was the result of our ability to continue to experience synergies and improved operational efficiencies associated with the integration of the AFAM locations. The dollar increase was the result of the Merger and the exclusion of expenses until April 1, 2018, when the Merger was completed, and 2019 acquisitions. The reduction of total costs in the facility-based services segment was due to the closure of two LTACH locations.

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):

	2019		2018	
Home Health				
General and administrative	$ 426,775	28.4%	$ 368,761	28.6%
Depreciation and amortization	10,501	0.7	9,363	0.7
Total	$ 437,276	29.1%	$ 378,124	29.3%
Hospice				
General and administrative	$ 59,341	26.2%	$ 58,655	29.5%
Depreciation and amortization	1,849	0.8	2,278	1.1
Total	$ 61,190	27.0%	$ 60,933	30.6%
Home and Community-Based				
General and administrative	$ 42,647	20.5%	$ 39,847	23.1%
Depreciation	1,378	0.7	620	0.4
Total	$ 44,025	21.2%	$ 40,467	23.5%
Facility-Based				
General and administrative	$ 34,991	31.3%	$ 36,732	32.3%
Depreciation and amortization	3,367	3.0	2,906	2.6
Total	$ 38,358	34.3%	$ 39,638	34.9%
Healthcare Innovations				
General and administrative	$ 13,998	47.2%	$ 17,559	53.0%
Depreciation	1,159	3.9	1,195	3.6
Total	$ 15,157	51.1%	$ 18,754	56.6%
Consolidated				
Total	$ 596,006	28.7%	$ 537,916	29.7%

Consolidated general and administrative expenses for the year ended December 31, 2019 were $596.0 million compared to $537.9 million for the same period in 2018, an increase of approximately $58.1 million, or 10.8%. Substantially all of the change in consolidated general and administrative expenses was a result of the Merger and other acquisitions completed during the latter part of 2018 and 2019. The improvement from 2018 to 2019 as a percentage of net service revenue was the result of our ability to continue to experience synergies and improved operational efficiencies associated with the integration of the AFAM locations.

Income Tax Expense

Consolidated income tax expense for the year ended December 31, 2019 was $26.6 million compared to $22.4 million for the same period in 2018. The increase in income tax expense was primarily attributable to the increase in our results of operations in 2019 as compared to 2018.

Liquidity and Capital Resources

Cash at December 31, 2019 was $31.7 million, compared to $49.4 million at December 31, 2018. 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, 2019, we had $218.6 million available for borrowing under our credit facility. We believe our operating cash flow, credit facility, and any potential future borrowings will be sufficient to fund our long-term initiatives.

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,	
	2019	2018
Net cash provided by (used in):		
Operating activities	$ 130,462	$ 108,585
Investing activities	(107,902)	(25,291)
Financing activities	(40,251)	(36,780)
Change in cash	$ (17,691)	$ 46,514
Cash at beginning of period	49,363	2,849
Cash at end of period	$ 31,672	$ 49,363

From 2018 to 2019, our use of cash decreased by $64.2 million. The primary reason for the increase in use of cash was the result of cash used in investing activities with our 2019 acquisitions and payments of acquisitions effective January 1, 2020 of $74.3 million and $15.1 million for the home office expansion project, which was slightly offset by an increase in cash provided by operating activities as our overall working capital improved from 2018 to 2019.

Credit Facility

On March 30, 2018, we entered into a Credit Agreement with JPMorgan Chase Bank, N.A., which was effective on April 2, 2018. The 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 Credit Agreement is March 30, 2023. Our obligations under the 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 Credit Agreement.

Revolving loans under the 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 Credit Agreement. The effective interest rates on our borrowings under the Credit Agreement were 3.71% and 4.19% as of December 31, 2019 and 2018, respectively.

At December 31, 2019, we had $253.0 million drawn, letters of credit in the amount of $28.4 million outstanding under the credit facility, and $218.6 million remaining borrowing capacity available under the Credit Agreement. At December 31, 2018, we had $235.0 million drawn and letters of credit outstanding in the amount of $30.4 million under our Credit Facility.

Under the Credit Agreement, 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 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 Credit Agreement contains customary affirmative, negative and financial covenants, 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. The 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.

At December 31, 2019, we were in compliance with all debt covenants contained in the Credit Agreement governing our credit facility.

Contractual Obligations

The following table discloses aggregate information about our contractual obligations and the periods in which payments are due as of December 31, 2019 (amounts in thousands):

	Payment Due by Period				
Recorded Liabilities:	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
Long-term debt	$ 253,000	$ —	$ 253,000	$ —	$ —
Operating leases	109,537	34,457	43,994	18,120	12,966
Uncertain tax position (1)	3,867	3,867	—	—	—
Other:					
Purchase obligations (2)	43,664	43,664	—	—	—
Total contractual cash obligations	$ 410,068	$ 81,988	$ 296,994	$ 18,120	$ 12,966

(1) As of December 31, 2019, we recorded a liability for uncertain tax positions of $3.9 million. Due to the high degree of uncertainty regarding the timing of future cash outflows of liabilities for uncertain tax positions beyond one year, a reasonable estimate of the period of cash settlement beyond twelve months from the balance sheet date of December 31, 2019, cannot be made.

(2) Primarily reflects future payments under various contractual arrangements related to the purchase of fixed assets.

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 included in this Annual Report on Form 10-K, which is incorporated herein by reference.

Critical Accounting Policies

The following discussion describes our critical accounting policy, which we believe requires 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.

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.

Net service revenue from contracts with customers is recognized in the period the performance obligations are satisfied under our contracts by transferring the requested services to our patients in amounts that reflect the consideration to which is expected to be received in exchange for providing patient care, which is the transaction price allocated to the services provided in accordance with ASU 2014-09, *Revenue from Contracts with Customers ("Topic 606")* and ASU 2015-14, *Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date* (collectively, "ASC 606").

Net service revenue is recognized as performance obligations are satisfied, which can vary depending on the type of services provided. The performance obligation is the delivery of patient care in accordance with the requested services outlined in physicians' orders, which are based on specific goals for each patient.

The performance obligations are associated with contracts in duration of less than one year; therefore, the optional exemption provided by ASC 606 was elected resulting in us not being required to disclose the aggregate amount of the transaction price allocated to the performance obligations that are unsatisfied or partially unsatisfied as of the end of the reporting period. Our

unsatisfied or partially unsatisfied performance obligations are primarily completed when the patients are discharged and typically occur within days or weeks of the end of the period.

We determine the transaction price based on gross charges for services provided, reduced by estimates for explicit and implicit price concessions. Explicit price concessions include contractual adjustments provided to patients and third-party payors. Implicit price concessions include discounts provided to self-pay, uninsured patients or other payors, adjustments resulting from regulatory reviews, audits, billing reviews and other matters. Subsequent changes to the estimate of the transaction price are recorded as adjustments to net service revenue in the period of change. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay (i.e. change in credit risk) are recorded as a provision for doubtful accounts.

Explicit price concessions are recorded for the difference between our standard rates and the contracted rates to be realized from patients, third party payors and others for services provided.

Implicit price concessions are recorded for self-pay, uninsured patients and other payors by major payor class based on historical collection experience and current economic conditions. The implicit price concession represents the difference between amounts billed and amounts expected to be collected based on collection history with similar payors. We assess our ability to collect for the healthcare services provided at the time of patient admission based on the verification of the patient's insurance coverage under Medicare, Medicaid, and other commercial or managed care insurance programs.

Amounts due from third-party payors, primarily commercial health insurers and government programs (Medicare and Medicaid), include variable consideration for retroactive revenue adjustments due to settlements of audits and reviews. We have determined estimates for price concessions related to regulatory reviews based on our historical experience and success rates in the claim appeals and adjudication process. Revenue is recorded at amounts estimated to be realizable for services provided.

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

Payor	2019	2018	2017
Medicare	64.1%	65.4%	71.7%
Medicaid	2.9	3.2	1.7
Other	33.0	31.4	26.6
	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 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 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

We record gross revenue on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are predetermined daily or hourly rates for each of the four levels of care delivered. We receive one of four predetermined daily rates based upon the level of care provided. The four levels of care are routine care, general inpatient care, continuous home care and respite care. There are two separate payment rates for routine care: payments for the first 60 days of care and care beyond 60 days. In addition to the two routine rates, we may also receive a service intensity add-on ("SIA"). The SIA is based on visits made in the last seven days of life by a registered nurse or medical social worker for patients in a routine level of care.

The performance obligation is the delivery of hospice services to the patient, as determined by a physician, each day the patient is on hospice care.

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. We estimate the impact of these adjustments based on our historical experience.

Additionally, hospice service revenue is subject to certain limitations on payments from Medicare which are considered variable consideration. We are subject to an inpatient cap limit and an overall Medicare payment cap for each provider number. These caps are monitored on a provider-by-provider basis and estimated amounts due back to Medicare, if we estimate a cap has been exceeded. These adjustments are recorded as a reduction to revenue and an increase in accrued expenses within our consolidated balance sheet. Beginning for the cap year ending October 31, 2017, providers are required to self-report and pay their estimated cap liability by February 28th of the following year. Net service revenue and related patient accounts receivable are recorded at amounts estimated to be realized from Medicare for services rendered.

Facility-Based Services

Long-Term Acute Care Services

Gross revenue is recorded as services are provided under the LTACH prospective payment system. Each patient is assigned a long-term care diagnosis-related group. Payments are made at 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. Adjustments to revenue are based on historical averages of these types of adjustments for claims paid. Similar to other Medicare prospective payment systems, the rate is also adjusted for geographic wage differences. All adjustments are reflected in net service revenue such that the recorded amounts reflect the estimated transaction price for services provided. Net service revenue and related patient accounts receivable are recorded at amounts estimated to be realized from Medicare for services rendered.

Medicaid, managed care and other payors

Other sources of net service revenue for all our segments fall into Medicaid, managed care or other payors 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 payor, thus our revenue is recorded at the estimated transaction price.

Healthcare Innovations Services

The Company's HCI segment provides strategic health management services to ACOs that have been approved to participate in the 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 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, 2019 and 2018, the HCI segment recorded net service revenue of $2.9 million and $3.7 million, respectively, related to the 2018 and 2017 ACO respective 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, 2019 and 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.

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 $2.4 million and $2.2 million for the years ended December 31, 2019 and 2018, 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 filed or submitted 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, 2019. The term "disclosure controls and procedures," as defined in Rules 13a-15(e) under the Exchange Act, means controls and other procedures of an issuer that are designed to ensure that information required to be disclosed by an issuer in the reports that it files or submits under the Exchange Act, is recorded, processed, summarized, and reported, within the time periods specified in the Securities and Exchange Commission's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by an issuer in the

reports that it files or submits under the Exchange Act is accumulated and communicated to the issuer's management, including its principal executive and principal financial officers, or persons performing similar functions, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on that evaluation, the Company's Chief Executive Officer and its Chief Financial Officer concluded that the Company's disclosure controls and procedures were effective as of December 31, 2019.

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 our management, including the Company's Chief Executive Officer and Chief Financial Officer, we 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,* management concluded that our internal control over financial reporting was effective as of December 31, 2019.

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, 2019 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, 2019, 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, 2019, 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, 2019 and 2018, 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, 2019, and the related notes (collectively, the consolidated financial statements), and our report dated February 27, 2020 expressed an unqualified opinion on those consolidated financial statements.

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 27, 2020

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 2020 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 2020 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 2020 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 2020 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 2020 Annual Meeting of Stockholders.

Equity Compensation Plan Information

The following table provides information as of December 31, 2019, 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:	—	$ —	2,141,893
Equity compensation plans not approved by Stockholders:	—	—	—
Total	—	$ —	2,141,893

(1) Includes 2,009,444 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 132,449 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 and the independence of our Directors 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 2020 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 2020 Annual Meeting of Stockholders.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

(a) Documents to be filed with Form 10-K:

(1) Financial Statements

(2) Financial Statement Schedules

There are no financial statement schedules included in this report.

(3) Exhibits

The Exhibits are listed in the Index of Exhibits required by Item 601 of Regulation S-K included herewith, which is incorporated by reference.

Report of Independent Registered Public Accounting Firm

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, 2019 and 2018, 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, 2019, and 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, 2019 and 2018, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2019, 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, 2019, 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 27, 2020 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 leases in 2019 due to the adoption of Accounting Standards Update (ASU) No. 2016-02, *Leases* (Topic 842); as modified by ASUs 2018-01, 2018-10, 2018-11, and 2018-20.

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.

Critical Audit Matter

The critical audit matter communicated below is a matter arising from the current period audit of the consolidated financial statements that was communicated or required to be communicated to the audit committee and that: (1) relates to accounts or disclosures that are material to the consolidated financial statements and (2) involved our especially challenging, subjective, or complex judgment. The communication of a critical audit matter does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the accounts or disclosures to which it relates.

Evaluation of implicit price concessions for the Home Health segment

As discussed in Note 2 to the consolidated financial statements, net service revenue from contracts with customers is recognized in the period the performance obligations are satisfied under the contracts by transferring the requested services to patients in amounts that reflect the consideration which is expected to be received in exchange for providing patient care. Implicit price concessions include discounts provided to self-pay, uninsured patients or other payors, adjustments resulting from regulatory reviews, audits, billing reviews and other matters. The Company estimates implicit price concessions based on historical collection experience by payor class. Estimates of implicit price concessions are periodically reviewed to ensure they are reflective of current business and economic conditions and trends and indicative of the Company's historical collections. As a result, net service revenue is recorded in amounts equal to expected cash receipts for services when rendered. The Company's net service revenue for the year ended December 31, 2019 was $2,080 million, of which $22 million related to implicit price concessions.

We identified the evaluation of implicit price concessions for the Home Health segment as a critical audit matter. A high degree of subjective auditor judgment was required to evaluate the implicit price concessions as they were based on estimated collection rates by payor class. Specifically, the estimated transaction prices required knowledge of the payor mix and current business and economic conditions and trends.

The primary procedures we performed to address this critical audit matter included the following. We tested certain internal controls over the Company's net service revenue process, including controls over the data used to support the estimated transaction prices. We assessed the outcome of the estimation of the implicit price concessions for the Home Health segment in the prior period financial statements to identify any circumstances or conditions that are relevant to the determination of the current year estimate. This included testing historical accounts receivable that were written off in the current year. To assess the relevance and reliability of the current year estimated transaction prices, we evaluated the Company's collections on Home Health revenue recorded by payor class.

/s/ KPMG LLP
KPMG LLP

We have served as the Company's auditor since 2008.

Baton Rouge, Louisiana
February 27, 2020

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

	As of December 31,	
	2019	**2018**
ASSETS		
Current assets:		
Cash	$ 31,672	$ 49,363
Receivables:		
Patient accounts receivable	284,962	252,592
Other receivables	10,832	6,658
Amounts due from governmental entities	—	830
Total receivables, net	295,794	260,080
Prepaid income taxes	9,652	11,788
Prepaid expenses	21,304	24,775
Other current assets	21,852	20,899
Total current assets	380,274	366,905
Property, building and equipment, net of accumulated depreciation of $69,441 and $55,253, respectively	97,908	79,563
Goodwill	1,219,972	1,161,717
Intangible assets, net of accumulated amortization of $16,431 and $15,176, respectively	305,556	297,379
Assets held for sale	2,500	2,850
Operating lease right of use asset	95,452	—
Other assets	38,633	20,301
Total assets	$ 2,140,295	$ 1,928,715
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and other accrued liabilities	$ 83,572	$ 77,135
Salaries, wages and benefits payable	85,631	84,254
Self insurance reserves	31,188	32,776
Current operating lease payable	28,701	—
Current portion of long-term notes payable	—	7,773
Amounts due to governmental entities	1,880	4,174
Total current liabilities	230,972	206,112
Deferred income taxes	60,498	43,306
Income taxes payable	3,867	4,297
Revolving credit facility	253,000	235,000
Long-term notes payable	—	930
Operating lease payable	69,556	—
Total liabilities	617,893	489,645
Noncontrolling interest-redeemable	15,151	14,596
Commitments and contingencies		
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 shares authorized; 36,129,280 and 35,835,348 shares issued, and 30,992,390 and 30,805,919 shares outstanding, respectively	361	358
Treasury stock – 5,136,890 and 5,029,429 shares at cost, respectively	(60,060)	(49,373)
Additional paid-in capital	949,321	937,965
Retained earnings	523,701	427,975
Total LHC Group, Inc. stockholders' equity	1,413,323	1,316,925
Noncontrolling interest – non-redeemable	93,928	107,549
Total stockholders' equity	1,507,251	1,424,474
Total liabilities and stockholders' equity	$ 2,140,295	$ 1,928,715

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,		
	2019	2018	2017
Net service revenue	$ 2,080,241	$ 1,809,963	$ 1,062,602
Cost of service revenue (excluding depreciation and amortization)	1,324,887	1,156,357	675,810
Gross margin	755,354	653,606	386,792
General and administrative expenses	596,006	537,916	310,539
Impairment of intangibles and other	7,734	4,689	1,571
Operating income	151,614	111,001	74,682
Interest expense	(11,155)	(9,679)	(3,352)
Income before income taxes and noncontrolling interests	140,459	101,322	71,330
Income tax expense	26,607	22,399	10,944
Net income	113,852	78,923	60,386
Less net income attributable to noncontrolling interests	18,126	15,349	10,274
Net income attributable to LHC Group, Inc.'s common stockholders	$ 95,726	$ 63,574	$ 50,112
Earnings per share - basic:			
Net income attributable to LHC Group, Inc.'s common stockholders	$ 3.09	$ 2.31	$ 2.83
Earnings per share - diluted:			
Net income attributable to LHC Group, Inc.'s common stockholders	$ 3.07	$ 2.29	$ 2.79
Weighted average shares outstanding:			
Basic	30,932,607	27,498,351	17,715,992
Diluted	31,209,824	27,773,396	17,961,018

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		Treasury		Additional paid-in capital	Retained earnings	Noncontrolling interest -non-redeemable	Total equity	Non controlling interest - redeemable	Net income
	Amount	Shares	Amount	Shares						
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	1	90,031	—	—	7,658	—	(371)	7,288	(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	—	—	(7,124)	138,925	—	—	—	(7,124)	—	
Merger consideration	127	12,765,288	—	—	795,278	—	—	795,405	—	
Exercise of stock options	1	108,903	—	—	—	—	—	1	—	
Issuance of common stock under Employee Stock Purchase Plan	—	18,725	—	—	1,342	—	—	1,342	—	
Balances at December 31, 2018	$ 358	35,835,348	$ (49,373)	5,029,429	$ 937,965	$ 427,975	$ 107,549	$ 1,424,474	$ 14,596	
Net Income	—	—	—	—	—	95,726	6,855	102,581	11,271	113,852
Acquired noncontrolling interest	—	—	—	—	—	—	10,478	10,478	—	
Purchase of additional controlling interest	—	—	—	—	(2,183)	—	(18,382)	(20,565)	—	
Sale of noncontrolling interest	—	—	—	—	819	—	794	1,613	—	
Noncontrolling interest distributions	—	—	—	—	—	—	(13,366)	(13,366)	(10,716)	
Nonvested stock compensation	—	—	—	—	9,646	—	—	9,646	—	
Issuance of vested stock	2	210,986	—	—	—	—	—	2	—	
Treasury shares redeemed to pay income tax	—	—	(10,687)	107,461	1,008	—	—	(9,679)	—	
Exercise of stock options	1	63,051	—	—	—	—	—	1	—	
Issuance of common stock under Employee Stock Purchase Plan	—	19,895	—	—	2,066	—	—	2,066	—	
Balances at December 31, 2019	$ 361	36,129,280	$ (60,060)	5,136,890	$ 949,321	$ 523,701	$ 93,928	$ 1,507,251	$ 15,151	

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,		
	2019	**2018**	**2017**
Operating activities:			
Net income	$ 113,852	$ 78,923	$ 60,386
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization expense	18,254	16,362	13,422
Amortization and impairment of operating lease right of use asset	33,368	—	—
Stock-based compensation expense	9,646	9,358	5,964
Deferred income taxes	18,400	19,453	(4,475)
Loss on disposal of assets	802	319	60
Impairment of intangibles and other	7,734	4,370	1,511
Changes in operating assets and liabilities, net of acquisitions:			
Receivables	(38,907)	(362)	(26,906)
Prepaid expenses and other assets	607	(10,257)	(26,973)
Prepaid income taxes	(78)	(2,519)	(7,006)
Accounts payable and accrued expenses	(3,082)	(6,577)	19,666
Operating lease payable	(28,062)	—	—
Income tax payable	(431)	511	(3,499)
Net amounts due to/from governmental entities	(1,641)	(996)	176
Net cash provided by operating activities	130,462	108,585	32,326
Investing activities:			
Cash paid for acquisitions, net of cash acquired	(74,293)	7,702	(64,598)
Purchases of property, building and equipment	(33,609)	(32,993)	(10,176)
Net cash used in investing activities	(107,902)	(25,291)	(74,774)
Financing activities:			
Proceeds from line of credit	267,000	303,943	96,000
Payments on line of credit	(249,000)	(319,743)	(39,000)
Proceeds from employee stock purchase plan	2,066	1,342	1,026
Payments on debt	(7,650)	(4,975)	(260)
Payments on deferred financing fees	—	(1,884)	—
Noncontrolling interest distributions	(24,082)	(12,134)	(11,382)
Purchase of additional controlling interest	(19,663)	(412)	(1,488)
Sale of noncontrolling interest	756	4,208	251
Withholding taxes paid on stock-based compensation	(10,687)	(7,125)	(3,114)
Exercise of options	1,009	—	—
Net cash (used in) provided by financing activities	(40,251)	(36,780)	42,033
Change in cash	(17,691)	46,514	(415)
Cash at beginning of period	49,363	2,849	3,264
Cash at end of period	$ 31,672	$ 49,363	$ 2,849
Supplemental disclosures of cash flow information			
Interest paid	$ 11,015	$ 9,067	$ 3,853
Income taxes paid	$ 10,109	$ 5,703	$ 25,199
Non-Cash Operating activity:			
Operating right of use assets in exchange for lease obligations	129,290	—	—
Non-Cash Investing activity:			
Accrued capital expenditures	2,729	3,449	—
Consideration transferred for a business combination	—	795,412	—
Non-Cash Financing activity:			
Purchase of additional controlling interest	—	7,705	—

See accompanying Notes to the 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 services, facility-based services, the latter primarily through long-term acute care hospitals ("LTACHs"), and healthcare innovations ("HCI").

On April 1, 2018, the Company completed its "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 included in this Annual Report on Form 10-K for additional information.

As of December 31, 2019, the Company, through its wholly and majority-owned subsidiaries, equity joint ventures, controlled affiliates, and management agreements, operated 811 service providers in 35 states within the continental United States and the District of Columbia.

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.

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.

All significant intercompany 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, 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.

Reclassification and Immaterial Correction of an Error

The Company has reclassified certain amounts relating to its prior year results to conform to its current period presentation. These reclassifications have not changed the results of operations of prior years.

During the year ended December 31, 2019, the Company increased the reported balance of common stock by $2,000, increased the reported number of common shares issued by 198,934 shares, decreased the reported balance of treasury stock by $1,000, increased the reported number of treasury shares by 70,708, and decreased the reported balances of Additional paid-in-capital by $3,000 for the year ended December 31, 2018 due to (1) the exclusion of reporting the number of common shares issued in conjunction with the Company's purchase of an additional controlling interest in a joint venture and (2) the

exclusion of reporting the number of common shares issued as a result of the exercise of certain outstanding stock options and the number of treasury shares redeemed to pay income tax associated with such stock option exercises.

The Company has evaluated the effects both qualitatively and quantitatively, and concluded that they did not have a material impact on previously issued financial statements for the year ended December 31, 2018.

Revenue Recognition

Basis of Presentation

Net service revenue from contracts with customers is recognized in the period the performance obligations are satisfied under the Company's contracts by transferring the requested services to patients in amounts that reflect the consideration to which is expected to be received in exchange for providing patient care, which is the transaction price allocated to the services provided in accordance with Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers (Topic 606)* and ASU 2015-14*, Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date* (collectively, "ASC 606").

Net service revenue is recognized as performance obligations are satisfied, which can vary depending on the type of services provided. The performance obligation is the delivery of patient care in accordance with the requested services outlined in physicians' orders, which are based on specific goals for each patient.

The performance obligations are associated with contracts in duration of less than one year; therefore, the optional exemption provided by ASC 606 was elected resulting in the Company not being required to disclose the aggregate amount of the transaction price allocated to the performance obligations that are unsatisfied or partially unsatisfied as of the end of the reporting period. The Company's unsatisfied or partially unsatisfied performance obligations are primarily completed when the patients are discharged and typically occur within days or weeks of the end of the period.

The Company determines the transaction price based on gross charges for services provided, reduced by estimates for explicit and implicit price concessions. Explicit price concessions include contractual adjustments provided to patients and third-party payors. Implicit price concessions include discounts provided to self-pay, uninsured patients or other payors, adjustments resulting from regulatory reviews, audits, billing reviews and other matters. Subsequent changes to the estimate of the transaction price are recorded as adjustments to net service revenue in the period of change. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay (i.e. change in credit risk) are recorded as a provision for doubtful accounts within general and administrative expenses.

Explicit price concessions are recorded for the difference between our standard rates and the contracted rates to be realized from patients, third party payors and others for services provided.

Implicit price concessions are recorded for self-pay, uninsured patients and other payors by major payor class based on historical collection experience, aged accounts receivable by payor, and current economic conditions. The implicit price concession represents the difference between amounts billed and amounts expected to be collected based on collection history with similar payors. The Company assesses the ability to collect for the healthcare services provided at the time of patient admission based on the verification of the patient's insurance coverage under Medicare, Medicaid, and other commercial or managed care insurance programs.

Amounts due from third-party payors, primarily commercial health insurers and government programs (Medicare and Medicaid), include variable consideration for retroactive revenue adjustments due to settlements of audits and reviews. The Company has determined estimates for price concessions related to regulatory reviews based on historical experience and success rates in the claim appeals and adjudication process. Revenue is recorded at amounts estimated to be realizable for services provided.

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

	2019	2018	2017
Home Health:			
Medicare	70.2%	71.8%	72.6%
Managed Care, Commercial, and Other	29.8	28.2	27.4
	100.0%	100.0%	100.0%
Hospice:			
Medicare	92.0%	90.7%	92.9%
Managed Care, Commercial, and Other	8.0	9.3	7.1
	100.0%	100.0%	100.0%
Home and Community-Based:			
Medicaid	23.2%	23.9%	18.9%
Managed Care, Commercial, and Other	76.8	76.1	81.1
	100.0%	100.0%	100.0%
Facility-Based:			
Medicare	56.2%	59.7%	63.7%
Managed Care, Commercial, and Other	43.8	40.3	36.3
	100.0%	100.0%	100.0%
Healthcare Innovations:			
Medicare	21.6%	22.8%	—%
Managed Care, Commercial, and Other	78.4	77.2	—
	100.0%	100.0%	—%

Medicare

Home Health Services

The home nursing Medicare 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. Revenue is recognized 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 also reflect, but are not limited to, 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. Medicare rates are based on the severity of the patient's condition, service needs and goals, and other factors relating to the cost of providing services and supplies, bundled into an episode of care, not to exceed 60 days. An episode starts the first day a billable visit is performed and ends 60 days later or upon discharge, if earlier, with multiple continuous episodes allowed.

The Medicare home health benefit requires that beneficiaries be homebound (meaning that the beneficiary is unable to leave their home without a considerable and taxing effort), require intermittent skilled nursing, physical therapy or speech therapy services, and receive treatment under a plan of care established and periodically reviewed by a physician. All Medicare contracts are required to have a signed plan of care which represents a single performance obligation, comprising of the delivery of a series of distinct services that are substantially similar and have a similar pattern of transfer to the customer. Accordingly, the Company accounts for the series of services ("episode") as a single performance obligation satisfied over time, as the customer simultaneously receives and consumes the benefits of the goods and services provided. Expected

Medicare revenue per episode is recognized based on the number of days elapsed during an episode of care within the reporting period.

The base episode payment can be adjusted based on each patient's health including clinical condition, functional abilities, and service needs, as well as for the applicable geographic wage index, low utilization, patient transfers and other factors. The services covered by the episode payment include all disciplines of care in addition to medical supplies. Medicare can also make various adjustments to payments received resulting from regulatory reviews, audits, billing reviews and other matters. The Company estimates the impact of such adjustments based our historical experience, and records this estimate during the period in which services are rendered as an estimated price concession and a corresponding reduction to patient accounts receivable.

A portion of reimbursement from each Medicare episode is billed near the start of each episode, and cash is typically received before all services are rendered. The amount of revenue recognized for episodes of care which are incomplete at period end is based on the number of days elapsed during the episode of care within the reporting period. As of December 31, 2019 and 2018, the difference between the cash received from Medicare for a request for anticipated payment (“RAP”) on episodes in progress and the associated estimated revenue was immaterial and, therefore, the resulting credits were recorded as a reduction to our outstanding patient accounts receivable in our consolidated balance sheets for such periods.

Hospice Services

The Company records revenue on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are predetermined daily or hourly rates for each of the four levels of care delivered. The Company receives one of four predetermined daily rates based upon the level of care the Company furnishes. The four levels of care are routine care, general inpatient care, continuous home care, and respite care. There are two separate payment rates for routine care: payment for the first 60 days of care and care beyond 60 days. In addition to the two routine rates, the Company may also receive a service intensity add-on ("SIA"). The SIA is based on visits made in the last seven days of life by a registered nurse or medical social worker for patients in a routine level of care.

The performance obligation is the delivery of hospice services to the patient, as determined by a physician, each day the patient is on hospice care.

Adjustments to Medicare revenue are made from regulatory reviews, audits, billing reviews and other matters. The Company estimates the impact of these adjustments based on our historical experience.

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.

Facility-Based Services

Gross revenue is recorded as services are 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.

Non-Medicare Revenue

Other sources of net service revenue for all segments fall into Medicaid, managed care or other payers of the Company's services. 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. The Company's managed care and other payors reimburse the Company based upon a predetermined fee schedule or an episodic basis, depending on the terms of the applicable contract. Accordingly, the Company recognizes 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, thus the Company's revenue is recorded at the estimated transaction price.

Contingent Service Revenues

The Company's Healthcare Innovations ("HCI") 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 years ended December 31, 2019 and 2018, the HCI segment recorded net service revenue of $2.9 million and $3.7 million, respectively, related to the 2018 and 2017 ACO respective service periods, as certain ACOs served by the HCI segment received a MSSP payment from CMS confirming the performance obligation has been met.

Patient Accounts Receivable

The Company reports patient accounts receivable from services rendered at their estimated transaction price, which includes price concessions based on the amounts expected to be due from payors. The Company's patient accounts receivable is uncollateralized and primarily consist of amounts due from Medicare, Medicaid, other third-party payors, and to a lesser degree patients. The credit risk 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 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 from any particular payor that would subject it to any significant credit risk in the collection of patient 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”). 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 following table sets forth the percentage of patient accounts receivable by payor for the years ended December 31:

	2019	2018
Medicare	48.3%	51.3%
Medicaid	9.4	8.6
Managed Care, Commercial, and Other	42.3	40.1
Total patient accounts receivable	100.0%	100.0%

Business Combinations

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 2019 and 2018 are further described in Note 3 and Note 4 to the Consolidated Financial Statements included in this Annual Report on Form 10-K.

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 $1.0 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 Directors and Officers 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 2019 and 2018, 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 2019, 2018 or 2017 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, 2019, 2018, and 2017, the Company recognized an impairment of $0.6 million, $0.6 million, and $1.5 million 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, customer relationships, 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 nineteen years. Amortization expense for the Company's definite-lived intangible assets for the year ended December 31, 2019, was $1.3 million, and for each of the years ended December 31, 2018 and 2017 was $2.1 million, 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, 2019, 2018 or 2017, the Company did not record an impairment charge related to indefinite-lived intangible assets in the annual impairment testing.

During the year ended December 31, 2019, the Company did record $7.1 million related to impairments, of which $6.1 million was related to impairment due to changes in moratorium regulations and $1.0 million was related to the closure of underperforming locations. During 2019, CMS removed all federal moratoria with regard to Medicare provider enrollments in four states. The Medicare licenses were deemed impaired upon the notice of removal. 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. The Company did not recognize any such costs during the year ended December 31, 2017.

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, building 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, fixed equipment, and office furniture and 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, 2019, 2018 and 2017.

The following table describes the Company's components of property, building and equipment for the years ended December 31, 2019 and 2018 (amounts in thousands):

	2019	2018
Land	$ 7,339	$ 6,750
Building and leasehold improvements	36,142	35,474
Transportation equipment	12,470	13,503
Fixed equipment	376	745
Office furniture and medical equipment	94,993	78,344
Construction in progress	16,029	—
	167,349	134,816
Less accumulated depreciation	69,441	55,253
Property, building and equipment, net	$ 97,908	$ 79,563

Depreciation expense for the years ended December 31, 2019, 2018 and 2017 was $17.0 million, $14.1 million and $11.3 million, respectively, which was recorded in general and administrative expenses. In addition, the Company capitalized $0.2 million in interest costs related to the construction of its home office expansion project.

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 as of December 31, 2019 is not less than the initial amount reported for each instrument. The activity of noncontrolling interest-redeemable for the twelve months ended December 31, 2019, 2018 and 2017 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, 2019, 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 7 to the Consolidated Financial Statements included in this Annual Report on Form 10-K for additional information.

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, 2019, 2018 and 2017:

	2019	2018	2017
Weighted average number of shares outstanding for basic per share calculation	30,932,607	27,498,351	17,715,992
Effect of dilutive potential shares:			
Nonvested restricted stock	277,217	275,045	245,026
Adjusted weighted average shares for diluted per share calculation	31,209,824	27,773,396	17,961,018
Antidilutive shares	157,608	46,002	—

Recently Adopted 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 were classified as finance or operating right-of-use ("ROU") operating assets and lease payables. The Company adopted this new standard on January 1, 2019 using the modified retrospective transition approach, which required the new standard to be applied to all leases existing at the date of initial application. ASU 2016-02 provides a number of optional practical expedients in transition and the Company (a) 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, (b) elected all the use-of-hindsight or the practical expedient pertaining to land easements; the latter not being applicable to the Company, and (c) elected all the new standard's available transition practical expedients.

The adoption had a material impact to the Company's consolidated balance sheets but did not materially impact the Consolidated statements of income. Adoption of this standard increased total assets and total payables by $89.7 million on January 1, 2019, primarily for the Company's operating leased office space 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 has elected the practical expedient that allows us not to separate lease and non-lease components for all leases. The Company elected the short-term recognition exemption for certain medical devices and storage space leases that qualify, which means it did not recognize ROU assets or lease payables, including not recognizing ROU assets or lease liabilities for existing short-term leases of these assets in transition. See Note 8 of the Notes to Consolidated Financial Statements included in this Annual Report on Form 10-K for additional information.

Recently Issued Accounting Pronouncements

In January 2017, the FASB issued ASU 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 amount and the fair value of the reporting unit. This ASU is effective for annual and interim periods in fiscal years beginning after December 15, 2019, and is not expected to significantly impact the Company.

In June 2016, the FASB issued ASU 2016-13, *Measurement of Credit Losses on Financial Instruments* which amends *Financial Instruments - Credit Losses* ("Topic 326"). ASU 2016-13 provides guidance for measuring credit losses on financial instruments. Early adoption is permitted. The amendments in this ASU should be applied retrospectively. This ASU is effective for annual and interim periods in fiscal years beginning after December 15, 2019, and is not expected to significantly impact the Company.

3. Acquisitions and Joint Venture Activities

The Merger

On April 1, 2018, the Company completed the Merger with Almost Family. At the effective time of the Merger on April 1, 2018, each outstanding share of common stock 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, while also converting outstanding employee share awards, which resulted in total merger consideration of approximately $795.4 million.

The Company was determined to be the accounting acquirer in the Merger. The Company's final valuation analysis of identifiable assets and liabilities assumed for the Merger in accordance with the requirements of ASC Topic 805, Business Combinations, are presented in the table below (amounts in thousands):

Merger consideration	
Stock	$ 795,412
Fair value of total consideration transferred	
Recognized amounts of identifiable assets acquired and liabilities assumed:	
Cash and cash equivalents	16,547
Patient accounts receivable	88,234
Prepaid income taxes	47
Prepaid expenses and other current assets	11,490
Property and equipment	11,144
Trade names	76,090
Certificates of need/licenses	76,505
Customer relationships	13,970
Assets held for sale	2,500
Deferred income taxes	4,821
Accounts payable	(43,027)
Accrued other liabilities	(57,243)
Seller notes payable	(12,145)
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	(178)
Total identifiable assets and liabilities	33,526
Goodwill	$ 761,886

2019 Acquisitions

The Company acquired the majority-ownership of 16 home health agencies, eight hospice agencies, two home and community-based agencies, and one LTACH location during the twelve months ended December 31, 2019. The total aggregate purchase price for these transactions was $61.8 million, of which $57.9 million was paid in cash. In addition, the Company paid $16.4 million for acquisitions effective January 1, 2020, which was included in other assets. The purchase prices were determined based on the Company's analysis of comparable acquisitions and the target market's potential future cash flows.

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. Accordingly, the accompanying financial information includes the results of operations of the acquired entities from the date of acquisition.

The following table summarizes the aggregate consideration paid for the acquisitions and the amounts of the assets acquired and liabilities assumed at the acquisition dates, as well as their provisional fair value at the acquisition dates and the noncontrolling interest acquired during the twelve months ended December 31, 2019:

Consideration	
Cash	$ 57,930
Fair value of total consideration transferred	
Recognized amounts of identifiable assets acquired and liabilities assumed	
Trade name	7,403
Certificates of need/licenses	7,998
Other assets and (liabilities), net	(2,835)
Total identifiable assets	12,566
Noncontrolling interest	10,478
Goodwill, including noncontrolling interest of $7,390	$ 55,842

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.

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 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.

Joint Venture Activities

During the twelve months ended December 31, 2019, the Company acquired the minority ownership interests associated with certain agencies previously operated within four of its equity joint ventures. The total consideration for the purchase of such ownership interests was $19.7 million, which was paid in cash. These transactions were accounted for as equity transactions.

During the twelve months ended December 31, 2019, the Company sold minority ownership interests associated with three home health agencies. The total consideration for the sale of such ownership interests was $4.2 million. The transaction was accounted for as an equity transaction.

Other 2018 Acquisitions and Joint Venture Activities

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 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.

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.

4. Goodwill and Other Intangibles, Net

The following table summarizes changes in goodwill and other intangibles assets by segment during the twelve months ended December 31, 2019 and 2018 (amounts in thousands):

	Home Health	Hospice	Home and community-based	Facility-based	Healthcare Innovations	Total
Goodwill						
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
Acquisitions	40,237	6,726	551	938	—	48,452
Noncontrolling interests	4,489	2,351	—	550	—	7,390
Adjustments and disposals	596	1,215	495	—	107	2,413
Balance as of December 31, 2019	$ 867,924	$ 128,875	$ 166,629	$ 15,682	$ 40,862	$ 1,219,972
Intangibles Assets						
Balance as of December 31, 2017	$ 88,078	$ 31,955	$ 9,533	$ 5,045	$ —	$ 134,611
Acquisitions	130,055	5,453	14,420	—	16,892	166,820
Amortization	(1,636)	(398)	(5)	(97)	—	(2,136)
Adjustments and disposals	(1,115)	—	—	(801)	—	(1,916)
Balance as of December 31, 2018	$ 215,382	$ 37,010	$ 23,948	$ 4,147	$ 16,892	$ 297,379
Acquisitions	12,537	2,452	154	1,202	—	16,345
Amortization	(436)	(154)	(4)	(32)	(629)	(1,255)
Adjustments and disposals	(7,611)	1,282	(2)	—	(582)	(6,913)
Balance as of December 31, 2019	$ 219,872	$ 40,590	$ 24,096	$ 5,317	$ 15,681	$ 305,556

The Company determined that there was no impairment for the goodwill of any reporting units as of December 31, 2019, 2018 and 2017 based on the Company's annual impairment testing. The Company did record $0.6 million, $0.6 million and $1.5 million of impairment of goodwill during the years ended December 31, 2019, 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 and disclosed in adjustments and disposals.

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, 2019; however, the Company did record $7.1 million related to impairments of other intangibles related to the lifting of a moratoria and closure of underperforming locations. The Medicare license impairment was a result of CMS action to remove all federal moratoria with regard to Medicare provider enrollment in four states. This was recorded in impairment of intangibles and other on the Company's consolidated statements of income and disclosed in adjustments and disposals.

The following tables summarize the changes in intangible assets during the twelve months ended December 31, 2019 and 2018 (amounts in thousands):

	2019	2018
Indefinite-lived intangible assets:		
Trade Names	$ 163,499	$ 156,049
Certificates of Need/Licenses	129,689	128,577
Net total	$ 293,188	$ 284,626
Definite-lived intangible assets:		
Trade Names		
Gross carrying amount	$ 10,182	$ 10,127
Accumulated amortization	(9,229)	(8,817)
Net total	$ 953	$ 1,310
Non-compete agreements		
Gross carrying amount	$ 6,795	$ 5,980
Accumulated amortization	(5,991)	(5,729)
Net total	$ 804	$ 251
Customer relationships		
Gross carrying amount	$ 11,822	$ 11,822
Accumulated amortization	(1,211)	(630)
Net total	$ 10,611	$ 11,192
Total definite-lived intangible assets		
Gross carrying amount	$ 28,799	$ 27,929
Accumulated amortization	(16,431)	(15,176)
Net total	$ 12,368	$ 12,753
Total intangible assets:		
Gross carrying amount	$ 321,987	$ 312,555
Accumulated amortization	(16,431)	(15,176)
Net total	$ 305,556	$ 297,379

Remaining useful lives of trade names, customer relationships, and non-compete agreements were 9.8, 18.2, and 2.8 years, respectively at December 31, 2019. Similar amounts at December 31, 2018 were 8.8 and 19.3 and 2.8 years, respectively.

Amortization expense for the Company's intangible assets was $1.3 million for the year ended December 31, 2019 and $2.1 million for the years ended December 31, 2018 and 2017, which was recorded in general and administrative expenses.

The estimated intangible asset amortization expense for each of the five years subsequent to December 31, 2019 is as follows (amounts in thousands):

Year	Amortization amount
2020	$ 1,179
2021	1,012
2022	819
2023	687
2024	687
Total	$ 4,384

5. Income Taxes

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

Significant components of the Company's deferred tax assets and liabilities as of December 31, 2019 and 2018 were as follows (amounts in thousands):

	2019	2018
Deferred tax assets:		
Allowance for uncollectible accounts	$ 8,181	$ 8,645
Accrued employee benefits	7,404	6,038
Stock compensation	2,037	2,322
Accrued self-insurance	6,688	8,656
Acquisition costs	1,569	1,413
Net operating loss carry forward	6,661	9,147
Intangible asset impairment	14	18
Lease payable	24,751	—
Other	332	1,021
Gross deferred tax assets	57,637	37,260
Less: valuation allowance	(3,850)	(3,574)
Net deferred tax assets	$ 53,787	$ 33,686
Deferred tax liabilities:		
Amortization of intangible assets	(73,512)	(64,001)
Tax depreciation in excess of book depreciation	(9,247)	(7,693)
Prepaid expenses	(1,287)	(1,134)
Non-accrual experience accounting method	(1,468)	(602)
Right of use asset	(24,044)	—
Other	(4,727)	(3,562)
Deferred tax liabilities	(114,285)	(76,992)
Net deferred tax liability	$ (60,498)	$ (43,306)

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):

	2019	2018	2017
Current:			
Federal	$ 4,678	$ 892	$ 12,798
State	3,528	3,382	2,621
	8,206	4,274	15,419
Deferred:			
Federal	14,549	15,383	(6,273)
State	3,852	2,742	1,798
	18,401	18,125	(4,475)
Total income tax expense	$ 26,607	$ 22,399	$ 10,944

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:

	2019	2018	2017
Federal statutory tax rate	21.0%	21.0%	35.0%
State income taxes, net of federal benefit	4.8	5.7	4.4
Nondeductible expenses	1.8	2.6	3.2
Uncertain tax position	(0.9)	(1.3)	—
Tax Cut and Jobs Act Enactment	—	—	(22.9)
Excess tax benefit	(2.5)	(2.6)	(1.6)
Credits and other	(2.5)	0.7	(0.1)
Effective tax rate	21.7%	26.1%	18.0%

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, 2014.

As of December 31, 2019, the Company has U.S. operating loss carry forwards of $6.2 million that are available to reduce future taxable income. If not used to offset taxable income, a portion of these losses will expire between 2031 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 $1.6 million of these losses.

State operating loss carryforwards totaling $102.0 million at December 31, 2019 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 2020 and 2039. Due to uncertainty regarding the Company's ability to use some of the carryforwards, a valuation allowance has been established on $58.6 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, 2019 was $3.9 million.

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

	Unrecognized tax benefits
As of January 1, 2018	$ —
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)
As of December 31, 2018	$ 4,297
Increased (decreases) in unrecognized tax benefits as a result of:	
Tax positions taken in the current year	873
Lapse of statute of limitations	(1,303)
As of December 31, 2019	$ 3,867

6. Debt

Credit Facility

On March 30, 2018, the Company entered into a Credit Agreement with JPMorgan Chase Bank, N.A., which was effective on April 2, 2018 (the "Credit Agreement"). The 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 Credit Agreement is March 20, 2023. The Company's obligations under the 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 Credit Agreement.

Revolving loans under the Credit Agreement 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. 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, 2019 was 5.50% and the Eurodollar Rate was 3.56%. As of December 31, 2019, the effective interest rate on outstanding borrowings under the Credit Agreement was 3.71%.

As of December 31, 2019 the Company had $253.0 million drawn and letters of credit in the amount of $28.4 million outstanding under the credit facility. At 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.

Under the terms of the Credit Agreement, the Company is required to maintain certain financial ratios and comply with certain financial covenants. The 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 its debt covenants under the Credit Agreement at December 31, 2019.

The scheduled principal payments on long-term debt for each of the five years subsequent to December 31, 2019 is as follows (amounts in thousands):

Year	Principal payment amount
2020	$ —
2021	—
2022	—
2023	253,000
2024	—
Total	$ 253,000

7. Stockholders' Equity

Equity Based Awards

The 2018 Incentive Plan is administered by the Compensation Committee of the Company's Board of Directors. The total number of shares of the Company's common stock originally reserved were 2,210,544 shares of our common stock and a total of 2,009,444 shares are currently available for issuance. A variety of discretionary awards for employees, officers, directors, and consultants are authorized under the 2018 Incentive Plan, including incentive or non-qualified 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 of the Board of Directors. 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.

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 years 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. The Company estimates forfeitures at the time of grant and revises the estimate in subsequent periods if actual forfeitures differ to ensure that total compensation expense recognized is at least equal to the value of vested awards.

During 2019, 2018, and 2017, respectively, 163,250, 213,105, and 139,310 nonvested shares were granted to employees, which will vest over a five year period. The Company also issues nonvested stock to its independent directors of the Company's Board of Directors. During 2019, 2018 and 2017, respectively, 17,880, 13,600 and 11,700 nonvested shares of stock were granted to the independent directors. The shares fully vest one year from the date of the grant.

During the twelve months ended December 31, 2019, one new director was granted 3,500 nonvested shares of common stock. 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, 2019, 2018 and 2017 were $110.56, $64.11 and $48.52, respectively.

The following table represents the share grants stock activity for the year ended December 31, 2019:

	Nonvested 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, 2018	574,285	$ 49.68	161,807	$ 38.08
Granted	184,630	110.56	—	—
Vested or exercised	(224,584)	45.76	(63,051)	35.41
Share grants outstanding at December 31, 2019	534,331	$ 71.01	98,756	$ 40.71

As of December 31, 2019, there was $26.5 million of total unrecognized compensation cost related to nonvested shares granted. That cost is expected to be recognized over the weighted average period of 3.07 years. The total fair value of shares vested in the year ended December 31, 2019, 2018, and 2017 were $9.4 million, $8.0 million, and $5.6 million, respectively. The Company recorded $9.6 million, $9.4 million and $6.0 million in compensation expense related to non-vested stock grants in the years ended December 31, 2019, 2018 and 2017, 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, 2019 was $5.5 million. The total intrinsic value of options exercised during the year ended December 31, 2019 was $1.5 million. The following table summarizes information about stock options outstanding and exercisable at December 31, 2019:

Range of Exercise Price	Shares	Wtd. Avg. Remaining Contractual Life	Wtd. Avg. Exercise Price
$0.00 - 30.00	25,619	4.55	$ 26.23
$30.01 - 40.00	20,609	3.65	$ 39.38
Over $40.00	52,528	5.69	$ 47.33
	98,756	6.54	$ 40.71

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 2019, 2018, and 2017, under the Employee Stock Purchase Plan:

	Number of Shares	Weighted Average Per Share Price
Shares available as of December 31, 2016	189,611	
Shares issued in 2017	18,542	$ 55.40
Shares issued in 2018	18,725	$ 71.12
Shares issued in 2019	19,895	$ 103.84
Shares available as of December 31, 2019	132,449	

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 107,461, 138,925 and 61,825 shares of common stock related to these tax obligations during the years ended December 31, 2019, 2018 and 2017, respectively. 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.

8. Leases

The Company determines if a contract contains a lease at inception date. The Company's leases are operating leases, primarily for office and office equipment, that expire at various dates over the next nine years. The office leases have renewal options for periods ranging from one to five years. As it is not reasonably certain these renewal options will be exercised, the options were not considered in the lease term, and payments associated with the option years are excluded from lease payments. The office leases also generally have termination options, which allow for early termination of the lease; however, as the exercise of such options is not reasonably certain, the options were not considered in determining the lease term; payments for the full lease term are included in the lease payments. Additionally, the leases do not contain any material residual value guarantees.

Payments due under operating leases include fixed and variable payments. These variable payments for the Company's office leases can include operating expenses, utilities, property taxes, insurance, common area maintenance, and other facility-related expense. Additionally, any leases with terms less than one year were not recognized as operating lease right of use assets or payables for short term leases in accordance with the election of 'package of practical expedient' under ASU 2016-02 and recognizes operating lease right of use assets and operating lease payable based on the present value of the future minimum lease payments at the lease commencement date. The Company's leases do not provide implicit rates. Therefore, the Company used an incremental borrowing rate based on the information available at the lease commencement date in determining the present value of future payments.

During the year ended December 31, 2019, the Company incurred $44.0 million associated with operating lease costs, $0.7 million associated with impairments of operating lease right of use assets, and $4.2 million for abandonments for a total of $48.9 million. Abandonment expenses were recorded in general and administrative expenses. Expenses associated with lease expense was $47.6 million, and $25.1 million for the years ended December 31, 2018 and 2017 respectively.

Information related to the Company's operating lease right of use assets and related lease payables for the office and office equipment leases were as follows (amounts in thousands):

		December 31, 2019
Cash paid for operating lease payables	$	32,511
Right-of-use assets obtained in exchange for new operating lease payables	$	129,290
Weighted-average remaining lease term		4.59 years
Weighted-average discount rate		4.77%

Maturities of operating lease payables as of December 31, 2019 were as follows (amounts in thousands):

Year	Total
2020	$ 34,457
2021	26,197
2022	17,797
2023	11,780
2024	6,340
Thereafter	12,966
Total future minimum lease payments	109,537
Less: Imputed interest	(11,280)
Total	$ 98,257

9. Employee Benefit Plan

Defined Contribution Plan

The Company sponsors a 401(k) plan for all eligible employees. The plan allows participants to contribute up to $19,000 in 2019, 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 $12.2 million, $10.1 million and $7.9 million in the years ended December 31, 2019, 2018 and 2017, respectively.

10. Commitments and Contingencies

Contingencies

The Company provides services in a highly regulated industry and is a party to various proceedings and regulatory and other governmental and internal audits and investigations in the ordinary course of business (including audits by Zone Program Integrity Contractors ("ZPICs") and Recovery Audit Contractors ("RACs") and investigations resulting from the Company's obligation to self-report suspected violations of law). Management cannot predict the ultimate outcome of any regulatory and other governmental and internal audits and investigations. 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 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 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 filed a complaint for violations of the Securities Exchange Act of 1934 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 Merger Sub, Inc. The complaint in the Rosenblatt Action ("Rosenblatt Complaint") asserts, among other things, that the Form S-4 Registration Statement ("Registration Statement") filed on December 21, 2017 in connection with the Merger contained false and misleading statements with respect to the Merger. 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, 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, the Company, 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. On December 19, 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, Lead Plaintiff filed his Consolidated Amended Class Action Complaint (the "Consolidated Complaint"). The Consolidated Complaint asserts claims against Almost Family, the Company and Almost Family's board of directors for violations of Section 14(a) of the 1934 Act in connection with the dissemination of the Company's and Almost Family's Proxy Statement concerning the Merger, and asserts breach of fiduciary duty claims and claims for violations of Section 20(a) of the 1934 Act against Almost Family's former board of directors. The Consolidated Complaint seeks, among other things, monetary damages and an award of attorneys' fees and costs. On April 12, 2019, the Company moved to dismiss the Consolidated Complaint and filed a motion to strike an affidavit attached to the Consolidated Complaint. Lead Plaintiff opposed the Company's motions on May 28, 2019, and the Company submitted reply briefs in support of its motions on June 19, 2019. On February 11, 2020, the court granted the Company's motion to dismiss and the Company's motion to strike and dismissed Lead Plaintiff's federal claims with prejudice and state law claims without prejudice. The deadline for Lead Plaintiff to appeal the court's dismissal of his claims is March 12, 2020.

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.

Legal fees related to all legal matters are expensed as incurred.

Joint Venture Buy/Sell Provisions

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

Compliance

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

or their interpretations, or the enactment of new laws or regulations could materially and adversely affect the Company's operations and financial condition.

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

11. Segment Information

The Company's reporting segments include (1) home health services, (2) hospice services, (3) home and community-based services, (4) facility-based services and (5) healthcare innovations ("HCI"). The accounting policies of the segments are the same as those described in the summary of significant accounting policies, as described in Note 2 to the Consolidated Financial Statements included in this Annual Report on Form 10-K.

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 following tables summarize the Company's segment information for the twelve months ended December 31, 2019, 2018 and 2017 (amounts in thousands):

	Year Ended December 31, 2019					
	Home Health	Hospice	Home and Community -Based	Facility-Based	HCI	Total
Net service revenue	$ 1,503,393	$ 226,922	$ 208,455	$ 111,809	$ 29,662	$ 2,080,241
Cost of service revenue (excluding depreciation and amortization)	939,035	140,177	157,817	73,274	14,584	1,324,887
General and administrative expenses	437,276	61,190	44,025	38,358	15,157	596,006
Impairment of intangibles and other	7,443	291	—	—	—	7,734
Operating income (loss)	119,639	25,264	6,613	177	(79)	151,614
Interest expense	(7,762)	(1,269)	(1,112)	(678)	(334)	(11,155)
Income (loss) before income taxes and noncontrolling interests	111,877	23,995	5,501	(501)	(413)	140,459
Income tax expense (benefit)	21,147	4,353	1,394	(204)	(83)	26,607
Net income (loss)	90,730	19,642	4,107	(297)	(330)	113,852
Less net income (loss) attributable to noncontrolling interests	14,651	3,979	(906)	435	(33)	18,126
Net income (loss) attributable to LHC Group, Inc.'s common stockholders	$ 76,079	$ 15,663	$ 5,013	$ (732)	$ (297)	$ 95,726
Total assets	$ 1,486,012	$ 244,105	$ 249,524	$ 91,337	$ 69,317	$ 2,140,295

	Year Ended December 31, 2018					
	Home Health	Hospice	Home and Community -Based	Facility-Based	HCI	Total
Net service revenue	$ 1,291,457	$ 199,118	$ 172,501	$ 113,784	$ 33,103	$ 1,809,963
Cost of service revenue (excluding depreciation and amortization)	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	HCI	Total
Net service revenue	$ 777,583	$ 157,287	$ 46,159	$ 81,573	$ —	$ 1,062,602
Cost of service revenue (excluding depreciation and amortization)	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 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

12. Fair Value of Financial Instruments

The carrying amounts of the Company's cash, receivables, accounts payable, accrued liabilities, and operating lease right of use assets and liabilities approximate their fair values. The estimated fair value of intangible assets acquired was calculated using level 3 inputs based on the present value of anticipated future benefits. For the year ended December 31, 2019, the carrying value of the Company's long-term debt approximates fair value as the interest rates approximates current rates.

13. Concentration of Risk

The Company operates in 35 states within the continental United States and the District of Columbia. The Company's facilities in Louisiana, Tennessee, Arkansas, Mississippi, Kentucky, Florida, and Alabama accounted for approximately 53.0%, 54.2% and 63.0% of net service revenue during the years ended December 31, 2019, 2018 and 2017, 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.

14. 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 2019	Second Quarter 2019	Third Quarter 2019	Fourth Quarter 2019
Net service revenue	$ 502,585	$ 517,842	$ 528,499	$ 531,315
Gross margin	181,593	191,982	193,731	188,048
Net income attributable to LHC Group, Inc.'s common stockholders	18,856	25,000	30,067	21,803
Net income attributable to LHC Group' Inc.'s common stockholders				
Basic earnings per share:	$ 0.61	$ 0.81	$ 0.97	$ 0.70
Diluted earnings per share:	$ 0.60	$ 0.80	$ 0.96	$ 0.70
Weighted average shares outstanding:				
Basic	30,837,290	30,960,468	30,970,589	30,977,812
Diluted	31,187,098	31,200,930	31,247,196	31,270,149

	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

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.

15. Subsequent Event

Effective January 1, 2020, the Company purchased a portion of the noncontrolling membership interest in one of our equity joint venture partnerships, which prior to the purchase was classified as a nonredeemable noncontrolling interest in permanent equity. As a result of the purchase, the Company retained its controlling financial interests in the joint venture partnership and the noncontrolling interest of our partner will continue to be classified as a nonredeemable noncontrolling interest in permanent equity. Total consideration for this noncontrolling interest purchase was $23.6 million.

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 27, 2020

/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 27, 2020
/s/ JOSHUA L. PROFFITT **Joshua L. Proffitt**	Chief Financial Officer, Principal Accounting Officer	February 27, 2020
/s/ COLLIN MCQUIDDY **Collin McQuiddy**	Senior Vice President of Accounting, Chief Accounting Officer	February 27, 2020
/s/ MONICA F. AZARE **Monica F. Azare**	Director	February 27, 2020
/s/ TERI G. FONTENOT **Teri G. Fontenot**	Director	February 27, 2020
/s/ JONATHAN D. GOLDBERG **Jonathan D. Goldberg**	Director	February 27, 2020
/s/ CLIFFORD S. HOLTZ **Clifford S. Holtz**	Director	February 27, 2020
/s/ JOHN L. INDEST **John L. Indest**	Director	February 27, 2020
/s/ RONALD T. NIXON **Ronald T. Nixon**	Director	February 27, 2020
/s/ W. EARL REED III **W. Earl Reed III**	Director	February 27, 2020
/s/ W.J. "BILLY" TAUZIN **W.J. "Billy" Tauzin**	Director	February 27, 2020
/s/ BRENT TURNER **Brent Turner**	Director	February 27, 2020

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	Amended and Restated Certificate of Incorporation of LHC Group, Inc. (previously filed as Exhibit 3.3 to LHC Group's Form S-4/A (File No. 333-222209) filed on February 5, 2018).
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).
4.2	Description of Securities Registered Pursuant to Section 12 of the Exchange Act.
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 Joshua L. Proffitt and LHC Group, Inc. dated October 7, 2019 (previously filed as Exhibit 10.1 to the Form 10-Q filed November 7, 2019).

10.10+	Employment Agreement between Bruce D. Greenstein and LHC Group, Inc. dated January 2, 2019 (previously filed as Exhibit 10.11 to the Form 10-K filed February 28, 2019).
10.11+	Employment Agreement between Nicholas Gachassin, III and LHC Group, Inc. dated June 25, 2018 (previously filed as Exhibit 10.12 to the Form 10-K filed February 28, 2019).
10.12+	Separation Agreement by and between Donald D. Stelly and LHC Group, Inc. (previously filed as Exhibit 10.1 to Form 8-K filed November 29, 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.

CORPORATE INFORMATION

Independent Registered Public Accounting Firm

KPMG LLP
301 Main Street, Suite 2150 • Baton Rouge, LA 70801
kpmg.com

Transfer Agent and Registrar

American Stock Transfer & Trust Company LLC
6201 15th Avenue • Brooklyn, NY 11219
800.937.5449

Corporate Headquarters

LHC Group, Inc.
901 Hugh Wallis Road South • Lafayette, LA 70508
Phone: 866.LHC.GROUP • Fax: 337.235.8037
LHCgroup.com

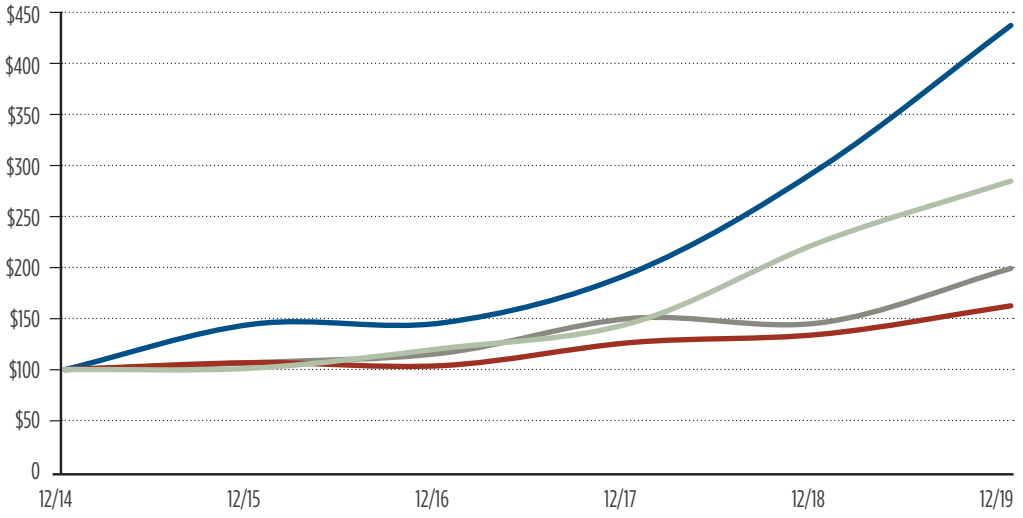
Common Stock

LHC Group's common stock is traded on the NASDAQ Global Select Market under the symbol "LHCG." As of February 24, 2020, there were approximately 409 registered holders of our common stock.

Performance Graph

The graph below matches the cumulative 5-Year total return of holders of LHC Group, Inc.'s common stock with the cumulative total returns of the NASDAQ Composite index, the S&P Health Care index and a customized peer group of three companies that includes: Addus Homecare Corp, Amedisys, Inc. and Encompass Health Corp. The graph assumes that the value of the investment in our common stock, in each index, and in the peer group (including reinvestment of dividends) was $100 on 12/31/2014 and tracks it through 12/31/2019.

PERFORMANCE GRAPH



	12/14	12/15	12/16	12/17	12/18	12/19
LHC Group Inc.	$100.00	$145.25	$146.57	$196.44	$301.09	$441.82
NASDAQ Composite	$100.00	$106.96	$116.45	$150.96	$146.67	$200.49
S&P Health Care	$100.00	$106.89	$104.01	$126.98	$135.19	$163.34
Peer Group	$100.00	$101.49	$121.10	$146.54	$227.09	$287.27

$100 invested on 12/31/14 in stock or index, including reinvestment of dividends. Fiscal year ending December 31.
The stock price performance included in this graph is not necessarily indicative of future stock price performance.

LEADERSHIP

Executive Officers

Keith G. Myers
Chief Executive Officer

Joshua L. Proffitt
Chief Financial Officer

Directors

Keith G. Myers
Chairman

W. J. "Billy" Tauzin
Lead Independent Director
- Chair - Nominating and Corporate Governance Committee
- Compensation Committee

Monica F. Azare
- Chair - Compensation Committee
- Clinical Quality Committee

Teri G. Fontenot
- Audit Committee
- Clinical Quality Committee

Jonathan D. Goldberg
- Compensation Committee
- Nominating and Corporate Governance Committee

Clifford S. Holtz
- Clinical Quality Committee
- Corporate Development Committee

John L. Indest
- Chair - Clinical Quality Committee
- Corporate Development Committee

Ronald T. Nixon
- Chair - Corporate Development Committee
- Audit Committee
- Nominating and Corporate Governance Committee

W. Earl Reed III
- Audit Committee
- Corporate Development Committee

William Brent Turner
- Chair - Audit Committee
- Corporate Development Committee

901 HUGH WALLIS ROAD SOUTH
LAFAYETTE, LA 70508
1.866.LHC.GROUP
LHCgroup.com