AMEDISYS INC
Form 10-K
February 28, 2019

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

(Mark One)
x ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended: December 31, 2018
OR
o 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: 0-24260

AMEDISYS, INC.
(Exact Name of Registrant as Specified in its Charter)

Delaware	11-3131700
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

3854 American Way, Suite A, Baton Rouge, LA 70816
(Address of principal executive offices, including zip code)
(225) 292-2031 or (800) 467-2662
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, par value $0.001 per share	The NASDAQ Global Select Market

Securities registered pursuant to Section 12(g) of the 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 þ No o
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. Yes o No þ
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 þ No o
Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes þ No o

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) 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. o

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

Large accelerated filer þ	Accelerated filer o
Non-accelerated filer o	Smaller reporting company
	Emerging growth company

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. o

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

The aggregate market value of the voting and non-voting common stock held by non-affiliates of the registrant, based on the last sale price as quoted by the NASDAQ Global Select Market on June 29, 2018 (the last business day of the registrant's most recently completed second fiscal quarter) was $2.3 billion. For purposes of this determination shares beneficially owned by executive officers, directors and ten percent stockholders have been excluded, which does not constitute a determination that such persons are affiliates.

As of February 22, 2019, the registrant had 32,010,292 shares of Common Stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive Proxy Statement for its 2019 Annual Meeting of Stockholders (the "2019 Proxy Statement") to be filed pursuant to the Securities Exchange Act of 1934 with the Securities and Exchange Commission within 120 days of December 31, 2018 are incorporated herein by reference into Part III of this Annual Report on Form 10-K.

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SPECIAL CAUTION CONCERNING FORWARD-LOOKING STATEMENTS

When included in this Annual Report on Form 10-K, or in other documents that we file with the Securities and Exchange Commission ("SEC") or in statements made by or on behalf of the Company, words like "believes," "belief," "expects," "plans," "anticipates," "intends," "projects," "estimates," "may," "might," "would," "should" and similar expression intended to identify forward-looking statements as defined by the Private Securities Litigation Reform Act of 1995. These forward-looking statements involve a variety of risks and uncertainties that could cause actual results to differ materially from those described therein. These risks and uncertainties include, but are not limited to the following: changes in or our failure to comply with existing federal and state laws or regulations or the inability to comply with new government regulations on a timely basis, changes in Medicare and other medical payment levels, our ability to open care centers, acquire additional care centers and integrate and operate these care centers effectively, competition in the healthcare industry, changes in the case mix of patients and payment methodologies, changes in estimates and judgments associated with critical accounting policies, our ability to maintain or establish new patient referral sources, our ability to consistently provide high-quality care, our ability to attract and retain qualified personnel, changes in payments and covered services by federal and state governments, future cost containment initiatives undertaken by third-party payors, our access to financing, our ability to meet debt service requirements and comply with covenants in debt agreements, business disruptions due to natural disasters or acts of terrorism, our ability to integrate, manage and keep our information systems secure, our ability to comply with the requirements stipulated in our corporate integrity agreement, our ability to realize the anticipated benefits of the acquisition of Compassionate Care Hospice, changes in law or developments with respect to any litigation relating to the Company, including various other matters, many of which are beyond our control, and such other factors as discussed throughout Part I, Item 1A. "Risk Factors" of this Annual Report on Form 10-K.

Because forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified, you should not rely on any forward-looking statement as a prediction of future events. We expressly disclaim any obligation or undertaking and we do not intend to release publicly any updates or changes in our expectations concerning the forward-looking statements or any changes in events, conditions or circumstances upon which any forward-looking statement may be based, except as required by law. For a discussion of some of the factors discussed above as well as additional factors, see Part I, Item 1A, "Risk Factors" and Part II, Item 7, "Critical Accounting Estimates" within "Management's Discussion and Analysis of Financial Condition and Results of Operations."

Unless otherwise provided, "Amedisys," "we," "us," "our," and the "Company" refer to Amedisys, Inc. and our consolidated subsidiaries and when we refer to 2018, 2017 and 2016, we mean the twelve month period then ended December 31, unless otherwise provided.

A copy of this Annual Report on Form 10-K for the year ended December 31, 2018 as filed with the SEC, including all exhibits, is available on our internet website at http://www.amedisys.com on the "Investors" page under the "SEC Filings" link.

PART I

ITEM 1. BUSINESS

Overview

Amedisys, Inc. is a leading healthcare services company focused on providing care in the home. Our operations involve serving patients across the United States through our three operating divisions: home health, hospice and personal care. We deliver clinically distinct care that best suits our patients' needs, whether that is home-based recovery and rehabilitation after an operation or injury, care that empowers patients to manage a chronic disease, hospice care at the end of life, or providing assistance with daily activities through our personal care division.

We are among the largest, pure play providers of home health and hospice care in the United States, with 472 care centers in 38 states within the United States and the District of Columbia. Our 21,000 employees deliver the highest quality care making more than ten million visits to more than 376,000 patients annually. Over 3,000 hospitals and 65,000 physicians nationwide have chosen us as a partner in post-acute care.

Due to the age demographics of our patient base, our services are primarily paid for by Medicare which has represented approximately 73% to 79% of our net service revenue over the last three years. We also remain focused on maintaining a profitable and strategically important managed care contract portfolio.

Amedisys is headquartered in Baton Rouge, Louisiana, with an executive office in Nashville, Tennessee. Our common stock is currently traded on the NASDAQ Global Select Market under the trading symbol “AMED.” Founded and incorporated in Louisiana in 1982, Amedisys was reincorporated as a Delaware corporation prior to becoming a publicly traded company in August 1994.

Our strategy is to become the best choice for care wherever our patients call home. We accomplish this by providing clinically distinct care, being the employer of choice and delivering operational excellence and efficiency, which when combined, drive growth. Our mission is to provide best-in-class home health, hospice and personal care services allowing our patients to maintain a sense of independence, quality of life and dignity while delivering industry leading outcomes. We believe that our unwavering dedication to clinical quality and constant focus on both our patients and our employees differentiates us from our competitors.

Our Home Health Segment:

Amedisys Home Health provides compassionate healthcare to help our patients recover from surgery or illness, live with chronic diseases, and prevent avoidable hospital readmissions. Our home health footprint includes 323 care centers located in 34 states within the United States and the District of Columbia. Within these care centers, we deploy our care teams which include skilled nurses who are trained, licensed and certified to administer medications, care for wounds, monitor vital signs and provide a wide range of other nursing services; rehabilitation therapists specialized in physical, speech and occupational therapy; and social workers and aides who assist our patients with completing important personal tasks.

We take an empowering approach to helping our patients and their families understand their medical conditions, how to manage them and how to maximize the quality of their lives while living with a chronic disease or other health condition. Our clinicians are trained to understand the whole patient – not just their medical diagnosis.

This commitment to clinical distinction is most evident in our clinical quality measures such as Star Ratings. In the Center for Medicare and Medicaid Services (“CMS”) reports for the January 2019 release, the Quality of Patient Care star average across all Amedisys providers is 4.40 with 94% of our providers at 4+ stars and 69 care centers rated at 5+ stars. Our Patient Satisfaction average as of the last known release was 3.96, outperforming the industry average of 3.70. Our goal is to have all care centers achieve a 4.0 Quality Star Rating, and we are implementing targeted action plans to continue to improve the quality of care we deliver for our patients and further our culture of quality.

Our Hospice Segment:

Hospice care is designed to provide comfort and support for those who are dealing with a terminal illness. It is a benevolent form of care that promotes dignity and affirms quality of life for the patient, family members and other loved ones. Individuals with a terminal illness such as heart disease, pulmonary disease, Alzheimer’s, HIV/AIDS or cancer may be eligible for hospice care, if they have a life expectancy of six months or less.

We operate 84 hospice care centers in 22 states within the United States. Within these care centers, we deploy our care teams which include nurse practitioners and other skilled nurses, social workers, aides, bereavement counselors and

chaplains.

At Amedisys Hospice, our focus is on building and retaining an exceptional team, delivering the highest quality care and service to our patients and their families, and establishing Amedisys as the preferred and preeminent hospice provider in each community we serve. In order to realize these goals, we invest in tailored training, development, and recognition programs for our employees, including medical record training, employee skills training and leadership development. This has led to our team's consistent achievement at or above the national average in family satisfaction results and quality scores, as well as the trust of the healthcare community.

Another element of our approach is our outreach strategy to more fully engage the entire community of eligible patients. These outreach efforts have built our hospice patient population to more accurately represent the causes of death in the communities we serve, with a specific focus on heart disease, lung disease, and dementia in order to address the historical underrepresentation of non-cancer diagnoses.

By working to accept every eligible patient who seeks end-of-life care, we fulfill our hospice mission and strengthen our standing in the community.

On February 1, 2019, we acquired Compassionate Care Hospice ("CCH"), a hospice provider headquartered in Parsippany, New Jersey with 2,300 employees and 53 locations nationwide. With this acquisition, Amedisys now cares for more than 11,000 hospice patients daily with 137 hospice care centers in 33 states, making us the third largest hospice provider in America.

Our Personal Care Segment:

On March 1, 2016, Amedisys acquired its first personal care company – an important step in executing our strategy of improving the continuity of care our patients receive as their clinical needs change. We continued our strategy to expand our personal care segment in 2017 and 2018 as we completed four additional acquisitions and currently operate 10 personal-care care centers in Massachusetts and one personal-care care center in both Florida and Tennessee. We are continually looking to expand our personal care footprint to states where we have a strong home health and hospice presence.

Personal care provides assistance with the essential activities of daily living. We believe that personal care services are highly synergistic with our core skilled home health and hospice businesses, and that by acquiring these capabilities we will be able to provide our patients and payor partners with a true continuum of care.

Responding to the Changing Regulatory and Reimbursement Environment:

As the government continues to seek opportunities to refine payment models, we believe that our strategy of becoming a leader in providing a range of service across the at-home continuum positions us well for the future. Our ability to provide quality home health, hospice and personal care allows us to partner with health systems and managed care organizations to improve care coordination, reduce hospitalizations and lower costs.

Acquisitions:

On March 1, 2018, we acquired the assets of Christian Care at Home for a total purchase price of $2.3 million. Christian Care at Home provided home health services to the state of Kentucky.

On May 1, 2018, we acquired the assets of East Tennessee Personal Care Services for a total purchase price of $2.0 million. East Tennessee Personal Care Services owned and operated one personal-care care center servicing the state of Tennessee.

On October 1, 2018, we acquired the assets of Bring Care Home, a personal care provider which serviced the state of Massachusetts for a total purchase price of $5.7 million.

On February 1, 2019, we acquired 100% of the ownership interests in Compassionate Care Hospice, a nationwide hospice provider headquartered in Parsippany, New Jersey, for a purchase price of $340 million, which is inclusive of approximately $50 million in payments related to a tax asset and working capital.

Financial Information:

Financial information for our home health, hospice and personal care segments can be found in our consolidated financial statements included in this Annual Report on Form 10-K.

Our Employees

As of February 22, 2019, we employed approximately 21,000 employees, consisting of approximately 11,000 home health care employees, 6,000 hospice care employees, 3,000 personal care employees and 1,000 corporate and divisional support employees.

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Payment for Our Services

Home Health Medicare

The Medicare home health benefit is available both for patients who need home care following discharge from a hospital and patients who suffer from chronic conditions that require ongoing, but intermittent, care.

As a condition of participation under Medicare, beneficiaries must be homebound (meaning that the beneficiary is unable to leave his/her 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.

Medicare payment rates are based on the severity of the patient's condition, his or her service needs and other factors relating to the cost of providing services and supplies, bundled into 60-day episodes of care. An episode starts with the first day a billable visit is performed and ends 60 days later or upon discharge, if earlier. If a patient is still in treatment on the 60th day, a recertification assessment is undertaken to determine whether the patient needs additional care. If the patient's physician determines that further care is necessary, another episode begins on the 61st day (regardless of whether a billable visit is rendered on that day) and ends 60 days later. The first day of a consecutive episode, therefore, is not necessarily the new episode's first billable visit.

Annually, the Medicare program base episodic rates are set through federal legislation, as follows:

Period	Base Episode Payment
January 1, 2016 through December 31, 2016	$ 2,965
January 1, 2017 through December 31, 2017	$ 2,990
January 1, 2018 through December 31, 2018	$ 3,040
January 1, 2019 through December 31, 2019	$ 3,154

Medicare payments may be adjusted up or down as a result of one or more of the following: (a) an outlier payment if a patient's care was unusually costly (capped at 10% of total reimbursement per provider number); (b) a low utilization payment adjustment ("LUPA") if the number of visits during the episode was four or fewer; (c) a partial payment if a patient transferred to another provider or we admitted a patient transferring from another provider before an episode was complete; (d) a payment adjustment based upon the level of therapy services required (with various incremental adjustments made for additional visits, with larger payment increases associated with the sixth, fourteenth and twentieth visit thresholds); (e) the number of episodes of care provided to a patient, regardless of whether the same home health provider provided care for the entire series of episodes; (f) changes in the base episode payments established by the Medicare program and (g) adjustments to the base episode payments for case mix and geographic wages.

CMS issued a final rule that updates the Medicare Home Health Prospective Payment System ("HHPPS") rates and wage index for calendar year ("CY") 2019. The final rule results in a 2.2 percent increase ($420 million) in payments to Home Health agencies ("HHA") in CY 2019. In addition, the most recent regulation from CMS finalizes the implementation of an alternative case-mix adjustment methodology, the Patient Drive Groupings Model ("PDGM"). The PDGM will be implemented in a budget neutral manner on January 1, 2020. See "Home Health Payment Reform" below for additional information on the most recent regulation from CMS.

As a Medicare provider, we are subject to periodic audits by the Medicare program, and that program has various rights and remedies against us if they assert that we have overcharged the program or failed to comply with program requirements. Home Health providers are subject to pre- and post-payment reviews for compliance with Medicare coverage guidelines and medical necessity. Adjustments on this basis may include individual claims adjustments or overpayment determinations based on an extrapolated sample of claims. Medical necessity reviews evaluate whether services are clinically appropriate in terms of frequency, type, extent, site and duration. Technical billing and documentation reviews focus on documentation of services. Medicare and other payors may reject or deny claims for payment if the underlying paperwork does not support the medical necessity of services or fails to establish satisfaction of a coverage rule; such as if a provider is unable to perform periodic therapy assessments required by coverage criteria or cannot provide appropriate billing documentation, acceptable physician authorizations or face-to-face meeting documentation.

Medicare can reopen previously filed and reviewed claims and require us to repay any overcharges, as well as make deductions from future amounts due to us. In the ordinary course of business, we appeal the Medicare and Medicaid program's denial of costs claimed to seek recovery of those denied costs.

Home Health Non-Medicare

Payments from Medicaid and private insurance carriers are episodic-based rates (60-day episode of care) or per-visit rates depending upon the terms and conditions established with such payors. Episodic-based rates paid by our non-Medicare payors are paid in a similar manner and subject to the same adjustments as discussed above for Medicare; however, these rates can vary based upon negotiated terms which generally range from 90% to 100% of Medicare rates.

Hospice Medicare

The Medicare hospice benefit is available when a physician and specific clinical findings support a diagnosis of a terminal condition where the patient has a terminal timeline of six months or less. Hospice care is evaluated in benefit periods; two 90-day benefit periods followed by an unlimited number of 60-day benefit periods. Payments are based on daily rates for each day a beneficiary is enrolled in the hospice benefit. The daily payment rates are intended to cover costs that hospices incur in furnishing services identified in patients' care plans, based on specific levels of care. Payments are adjusted by a wage index to reflect health care labor costs across the country and are established annually through federal legislation. Payments are made according to a fee schedule that has four different levels of care: routine home care, continuous home care, inpatient respite care and general inpatient care.

Medicare payment is provided for 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, on January 1, 2016, Medicare also began reimbursing for a service intensity add-on (“SIA”). The SIA is based on visits made in the last seven days of life by a registered nurse (“RN”) or medical social worker (“MSW”) for patients in a routine level of care.

Adjustments for medical necessity and technical billing requirements may be made to Medicare revenue based on the same claims processing or medical necessity reviews described above for Home Health services when we find we are unable to obtain appropriate billing documentation, authorizations or face-to-face documentation and other reasons unrelated to credit risk.

Two caps limit the amount and cost of care that any individual hospice provider number provides in a single year. Generally, each hospice care center has its own provider number. However, where we have created branch care centers to help our parent care centers serve a geographic location, the parent and branch have the same provider number.

- Inpatient Cap - One cap limits the number of days of inpatient care an agency may provide to not more than 20 percent of its total patient care days. The daily Medicare payment rate for any inpatient days of service that exceed the cap is set at the routine home care rate, and the provider is required to reimburse Medicare for any amounts it receives in excess of the cap.
- Overall Payment Cap - The other cap is an absolute dollar limit on the average annual payment per beneficiary a hospice agency can receive. This cap is calculated by the Medicare fiscal intermediary at the end of each hospice cap period to determine the maximum allowable payments per provider number. We estimate our potential cap exposure using information available for both inpatient day limits as well as per beneficiary cap amounts. The total cap amount for each provider is calculated by multiplying the number of beneficiaries electing hospice care during the period by a statutory amount that is indexed for inflation.

Payment rates for hospice care, the hospice cap amount, and the hospice wage index are updated annually according to Section 1814(i)(1)(C)(ii)(VII) of the Social Security Act, which requires CMS to use the inpatient hospital market basket, adjusted for multifactor productivity (MFP) and other adjustments as specified in the Social Security Act, to determine the hospice payment update percentage. The caps are subject to annual and retroactive adjustments, which can cause providers to be required to reimburse the Medicare program if such caps are exceeded. Our ability to stay within these caps depends on a number of factors, each determined on a provider number basis, including the average length of stay and mix in level of care.

Our revenues are derived in large part from governmental third-party payors. There are budget pressures from government and other payors to control health care costs and to reduce or limit increases in reimbursement rates for health care services. Governmental payment programs are subject to statutory and regulatory changes, retroactive rate adjustments, administrative or executive orders and government funding restrictions, all of which may materially increase or decrease the rate of program payments to us for our services. It is possible that future budget cuts in

Medicare and Medicaid may be enacted by Congress and implemented by CMS. Therefore, we cannot assure you that payments from governmental or private payors will remain at levels comparable to present levels or will, in the future, be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to such programs.

Hospice Non-Medicare

Non-Medicare payors pay at rates that differ from established Medicare rates for hospice services, and are based on separate, negotiated agreements. We bill and are paid by these non-Medicare payors based on such negotiated agreements.

Personal Care Non-Medicare

Personal care payments are received from payor clients including state and local governmental agencies, managed care organizations, commercial insurers and private consumers, based on rates that are either contractual or fixed by legislation.

Controls over Our Business System Infrastructure

We establish and maintain processes and controls over coding, clinical operations, billing, patient recertifications and compliance to help monitor and promote adherence with Medicare requirements.

- Coding – Specified international classification of disease ("ICD") diagnosis codes are assigned to each of our patients based on their particular health conditions (such as diabetes, coronary artery disease or congestive heart failure). Because coding regulations are complex and are subject to frequent change, we maintain controls surrounding our coding process. To reduce associated risk of coding failures, we provide coding training and annual update training to clinical managers and provide training during orientation for new employees to ensure accurate information is gathered and provided to our coding team. For home health, we also provide monthly specialized coding education, obtain outside expert coding instruction, have certified clinician coders review all patient outcome and assessment information sets (“OASIS”) and assign the appropriate ICD code. Our electronic medical records system (Homecare Homebase) includes automated home health coding edits based on pre-defined compliance metrics.
- Clinical Operations – Regulatory requirements allow patients to be eligible for home health care benefits if they are considered homebound and require skilled nursing, physical therapy or speech therapy services. These clinical services may include: educating the patient about their disease, assessment and observation of disease status, delivery of clinical skills such as wound care, administration of injections or intravenous fluids, management and evaluation of a patient’s plan of care, physical therapy services to assist patients with functional limitations and speech therapy services for speech or swallowing disorders. Patients eligible for hospice care are terminally ill (with a life expectancy of six months or less if the illness runs its normal course). Our hospice program provides care and support to our patients and their families with services including physical care, counseling, medication management and needed equipment and supplies for the terminal illness and related condition. To help monitor and promote compliance with regulatory requirements, we provide education on Medicare Guidelines for Coverage and Conditions of Participation, hold recurrent homecare regulatory education, utilize outside expert regulatory services, and have a toll-free hotline to offer additional assistance.
- Billing – We maintain controls over our billing processes to help promote accurate and complete billing. To promote the accuracy and completeness of our billing, we have annual billing compliance testing; use formalized billing attestations; limit access to billing systems; use automated daily billing operational indicators; and take prompt corrective action with employees who knowingly fail to follow our billing policies and procedures in accordance with a well-publicized “Zero Tolerance Policy.”
- Patient Recertification – In order to be recertified for an additional episode of care, a patient must continue to meet qualifying criteria and have a continuing medical need. Changes in the patient’s condition may require changes to the patient’s medical regimen or modified care protocols within the episode of care. The patient’s progress towards established goals is evaluated prior to recertification. As with the initial episode of care, a recertification requires orders from the patient’s physician. Before any employee recommends recertification to a physician, we conduct a care center level, multidisciplinary care team conference. Specific tools are used to ensure that the patient continues to meet coverage criteria prior to recertifying.
- Compliance – We develop, implement and maintain ethics and compliance programs as a component of the centralized corporate services provided to our home health, hospice and personal-care care centers. Our ethics and compliance program includes a Code of Conduct for our employees, officers, directors, contractors and affiliates and a disclosure program for reporting regulatory or ethical concerns to our compliance team through a confidential hotline, which is augmented by exit interviews of departing employees. We promote a culture of compliance within our company

through educational presentations, regular newsletters and persistent messaging from our senior leadership to our employees stressing the importance of strict compliance with legal requirements and company policies and procedures. Additionally, we have mandatory compliance training and testing for all new employees upon hire and annually for all staff thereafter. We also maintain a robust compliance audit program focusing on key risk areas.

Our Regulatory Environment

We are highly regulated by federal, state and local authorities. Regulations and policies frequently change, and we monitor changes through trade and governmental publications and associations.

Our home health and hospice subsidiaries are certified by CMS and therefore are subject to the rules and regulations of the Medicare system. Additionally, all of our business lines are likewise subject to federal, state and local laws and regulations dealing with issues such as occupational safety, employment, medical leave, insurance, civil rights, discrimination, building codes, privacy, and recordkeeping. We have set forth below a discussion of the regulations that we believe most significantly affect our home health and hospice businesses.

Licensure, Certificates of Need (CON) and Permits of Approval (POA)

Home health and hospice care centers operate under licenses granted by the health authorities of their respective states. Some states require health care providers (including hospice and home health agencies) to obtain prior state approval for the purchase, construction or expansion of health care locations, capital expenditures exceeding a prescribed amount, or changes in services. For those states that require a CON or POA, the provider must also complete a separate application process establishing a location, and must receive required approvals.

Certain states, including a number in which we operate, carefully restrict new entrants into the market based on demographic and/or demonstrative usage of additional providers. These states limit the entry of new providers or services and the expansion of existing providers or services in their markets through a CON process, which is periodically evaluated and updated as required by applicable state law.

To the extent that we require a CON or other similar approvals to expand our operations, our expansion could be adversely affected by the inability to obtain the necessary approvals, changes in the standards applicable to those approvals, and possible delays and expenses associated with obtaining those approvals.

In every state where required, our care centers possess a license and/or CON or POA issued by the state health authority that determines the local service area for the home health or hospice care centers. Currently, state health authorities in 20 states and the District of Columbia require a CON or, in the State of Arkansas, a POA, in order to establish and operate a home health care center, and state health authorities in 16 states and the District of Columbia require a CON to operate a hospice care center.

We operate home health care centers in the following CON states: Arkansas (POA), California, Georgia, Kentucky, Maryland, Mississippi, Missouri, New Jersey, New York, North Carolina, Pennsylvania, South Carolina, Tennessee, Washington and West Virginia, as well as the District of Columbia. We provide hospice related services in the following CON states: Alabama, Maryland, North Carolina, Rhode Island, Tennessee and West Virginia.

Medicare Participation: Licensing, Certification and Accreditation

All providers are subject to compliance with various federal, state and local statues and regulations in the U.S. and receive periodic inspection by state licensing agencies to review standards of medical care, equipment and safety.

Our care centers must comply with regulations promulgated by the United States Department of Health and Human Services and CMS in order to participate in the Medicare program and receive Medicare payments. Section 1861(o) and 1891 of the SSA, 42 CFR 484.1. et seq., establish the conditions that an HHA must meet in order to participate in the Medicare program. Among other things, these regulations, known as “Conditions of Participation (“COPs”),” relate to the type of facility, its personnel and its standards of medical care, as well as its compliance with state and local laws and regulations.

New COPs, which went into effect on January 13, 2018, focus on the safe delivery of quality care provided to patients and the impact of that care on patient outcomes through the protection and promotion of patients' rights, care planning, delivery and coordination of services, and streamlining of regulatory requirements.

CMS has adopted alternative sanction enforcement options which allow CMS (i) to impose temporary management, direct plans of correction or direct training and (ii) to impose payment suspensions and civil monetary penalties in each case on providers out of compliance with the COPs. CMS has engaged a number of third party contractors, including Recovery Audit Contractors (“RACs”), Program Safeguard Contractors (“PSCs”), Zone Program Integrity Contractors (“ZPICs”), Uniform Program Integrity Contractors ("UPICs") and Medicaid Integrity Contributors (“MICs”), 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. In addition to identifying overpayments, audit contractors can refer suspected violations of law to government enforcement authorities.

If we fail to comply with applicable laws and regulations, we could be subjected to liabilities, including criminal penalties, civil penalties (including the loss of our licenses to operate one or more of our businesses) and exclusion of a facility from participation in the Medicare, Medicaid, and other federal and state health care programs. If any of our facilities were to lose its accreditation or otherwise lose its certification under the Medicare and Medicaid programs, the facility may be unable to receive reimbursement from the Medicare and Medicaid programs and other payors. We believe our facilities are in substantial compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, it may become necessary for us to make changes in our facilities, equipment, personnel and services in the future, which could have a material adverse impact on operations.

Regulations and Other Factors

The healthcare industry is subject to numerous laws, regulations and rules including, among others, those related to government healthcare participation requirements, various licensure and accreditations, reimbursement for patient services, health information privacy and security rules, and Medicare and Medicaid fraud and abuse provisions (including, but not limited to, federal statutes and regulations prohibiting kickbacks and other illegal inducements to potential referral sources, false claims submitted to federal health care programs and self-referrals by physicians). Providers that are found to have violated any of these laws and regulations may be excluded from participating in government healthcare programs, subjected to significant fines or penalties and/or required to repay amounts received from the government for previously billed patient services. Although we believe our policies, procedures and practices comply with governmental regulations, no assurance can be given that we will not be subjected to additional governmental inquiries or actions, or that we would not be faced with sanctions, fines or penalties if so subjected.

Federal and State Anti-Fraud and Anti-Kickback Laws

As a provider under the Medicare and Medicaid systems, we are subject to various anti-fraud and abuse laws, including the Federal health care programs' anti-kickback statute and, where applicable, its state law counterparts. Affected government health care programs include any health care plans or programs that are funded by the United States government (other than certain federal employee health insurance benefits/programs), including certain state health care programs that receive federal funds, such as Medicaid.

Subject to certain exceptions, these laws prohibit any offer, payment, solicitation or receipt of any form of remuneration to induce or reward the referral of business payable under a government health care program or in return for the purchase, lease, order, arranging for, or recommendation of items or services covered under a government health care program. A related law forbids the offer or transfer of anything of value, including certain waivers of co-payment obligations and deductible amounts, to a beneficiary of Medicare or Medicaid that is likely to influence the beneficiary's selection of health care providers, again, subject to certain exceptions. Violations of the anti-fraud and abuse laws can result in the imposition of substantial civil and criminal penalties and, potentially, exclusion from furnishing services under any government health care program. In addition, the states in which we operate generally have laws that prohibit certain direct or indirect payments or fee-splitting arrangements between health care providers where they are designed to obtain the referral of patients from a particular provider.

Stark Laws

The Social Security Act includes a provision commonly known as the "Stark Law." This law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship, unless an exception is met. These types of referrals are known as "self-referrals." Sanctions for violating the Stark Law include civil penalties up to $15,000 for each violation, up to $100,000 for sham arrangements, up to $10,000 for each day an entity fails to report required information and exclusion from the federal health care programs. There are a number of exceptions to the self-referral prohibition, including employment contracts, leases and recruitment agreements that adhere to certain enumerated requirements.

Violations of the Stark Law result in payment denials and may also trigger civil monetary penalties and program exclusion. Several of the states in which we conduct business have also enacted statutes similar in scope and purpose to the federal fraud and abuse laws and the Stark Laws. These state laws may mirror the Federal Stark Laws or may be different in scope. The available guidance and enforcement activity associated with such state laws varies considerably.

We monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. Nonetheless, because the law in this area is complex and

constantly evolving, there can be no assurance that federal regulatory authorities will not determine that any of our arrangements with physicians violate the Stark Law.

Federal and State Privacy and Security Laws

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, requires us to comply with standards for the exchange of health information within our company and with third parties, such as payors, business associates and patients. These include standards for common health care transactions, such as: claims information, plan eligibility, payment information and the use of electronic signatures; unique identifiers for providers, employers, health plans and individuals; and security, privacy and enforcement.

HIPAA transactions regulations establish form, format and data content requirements for most electronic health care transactions, such as health care claims that are submitted electronically. The HIPAA privacy regulations establish comprehensive requirements relating to the use and disclosure of protected health information. The HIPAA security regulations establish minimum standards for the protection of protected health information that is stored or transmitted electronically. Violations of the privacy and security regulations are punishable by civil and criminal penalties.

The American Recovery and Economic Reinvestment Act of 2009 (“ARRA”) increased the amount of civil monetary penalties that can be imposed for violations of HIPAA. ARRA also authorized state attorneys general to bring civil enforcement actions under HIPAA. ARRA also requires that the Department of Health and Human Services ("HHS") promulgate regulations requiring that certain notifications be made to individuals, to HHS and potentially to the media in the event of breaches of the privacy of protected health information.

The Health Information Technology for Economic and Clinical Health (“HITECH”) Act was enacted in conjunction with ARRA. Among other things, the HITECH Act makes business associates of covered entities directly liable for compliance with certain HIPAA requirements, strengthens the limitations on the use and disclosure of protected health information without individual authorizations, and adopts the additional HITECH Act enhancements, including enforcement of noncompliance with HIPAA due to willful neglect. The changes to HIPAA enacted as part of ARRA reflect a Congressional intent that HIPAA’s privacy and security provisions be more strictly enforced. These changes have stimulated increased enforcement activity and enhanced the potential that health care providers will be subject to financial penalties for violations of HIPAA.

In addition to the federal HIPAA regulations, most states also have laws that protect the confidentiality of health information. Also, in response to concerns about identity theft, many states have adopted so-called “security breach” notification laws that may impose requirements regarding the safeguarding of personal information, such as social security numbers and bank and credit card account numbers, and that impose an obligation to notify persons when their personal information has or may have been accessed by an unauthorized person. Some state security breach notification laws may also impose physical and electronic security requirements. Violation of state security breach notification laws can trigger significant monetary penalties.

The False Claims Act

The Federal False Claims Act ("FCA") prohibits false claims or requests for payment for health care services. Under the FCA, the government may penalize any person who knowingly submits, or participates in submitting, claims for payment to the Federal Government which are false or fraudulent, or which contain false or misleading information. Any person who knowingly makes or uses a false record or statement to avoid paying the Federal Government, or knowingly conceals or avoids an obligation to pay money to the Federal Government, may also be subject to fines under the FCA. Under the FCA, the term “person” means an individual, company, or corporation.

The Federal Government has used the FCA to prosecute Medicare and other governmental program fraud in areas such as violations of the Federal anti-kickback statute or the Stark Laws, coding errors, billing for services not provided, and submitting false cost reports. The FCA has also been used to prosecute people or entities that bill services at a higher reimbursement rate than is allowed and that bill for care that is not medically necessary. In addition to government enforcement, the FCA authorizes private citizens to bring qui tam or “whistleblower” lawsuits, greatly extending the practical reach of the FCA. In 2018, the Department of Justice ("DOJ") announced that the FCA penalties would once again be increasing. The minimum per-claim penalty will be set for 2019 at $11,181 to $22,363.

The Fraud Enforcement and Recovery Act of 2009 (“FERA”) amended the False Claims Act with the intent of enhancing the powers of government enforcement authorities and whistleblowers to bring False Claims Act cases. In

particular, FERA attempts to clarify that liability may be established not only for false claims submitted directly to the government, but also for claims submitted to government contractors and grantees. FERA also seeks to clarify that liability exists for attempts to avoid repayment of overpayments, including improper retention of federal funds. FERA also included amendments to False Claims Act procedures,

expanding the government's ability to use the Civil Investigative Demand process to investigate defendants, and permitting government complaints in intervention to relate back to the filing of the whistleblower's original complaint. FERA is likely to increase both the volume and liability exposure of False Claims Act cases brought against health care providers.

In the Patient Protection and Affordable Care Act (discussed in more detail below), Congress enacted requirements related to identifying and returning overpayments made under Medicare and Medicaid. CMS finalized regulations regarding this so-called "60-day rule," which requires providers to report and return Medicare and Medicaid overpayments within 60 days of identifying the same. A provider who retains identified overpayments beyond 60 days may be liable under the False Claims Act. "Identification" occurs when a person "has, or should have through the exercise of reasonable diligence," identified and quantified the amount of an overpayment. The final rule also established a six year lookback period, meaning overpayments must be reported and returned if a person identifies the overpayment within six years of the date the overpayment was received. Providers must report and return overpayments even if they did not cause the overpayment.

In addition to the False Claims Act, the Federal Government may use several criminal statutes to prosecute the submission of false or fraudulent claims for payment to the Federal Government. Many states have similar false claims statutes that impose liability for the types of acts prohibited by the False Claims Act. As part of the Deficit Reduction Act of 2005 (the "DRA"), Congress provided states an incentive to adopt state false claims acts consistent with the Federal False Claims Act. Additionally, the DRA required providers who receive $5 million or more annually from Medicaid to include information on Federal and state false claims acts, whistleblower protections and the providers' own policies on detecting and preventing fraud in their written employee policies.

Civil Monetary Penalties

The United States Department of Health and Human Services may impose civil monetary penalties ("CMP") for a variety of civil offenses related to federal health care programs. They may be imposed upon any person or entity who presents, or causes to be presented, certain ineligible claims for medical items or services, for providing improper inducements to beneficiaries to obtain services, for payments to limit services to patients, and for offenses related to relationships with excluded individuals, among other things.

Maximum CMP amounts have been increased significantly as a result of the Bipartisan Budget Act of 2018, which was signed into law on February 9, 2018. The maximum CMP has increased from $55,262 to $100,000 for: (1) knowingly making or causing to be made a false statement, omission or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider or supplier (42 CFR 1003.210(a)(6)), and (2) making or using a false record or statement that is material to a false or fraudulent claim (42 CFR 1003.210(a)(7)).

FDA Regulation

The U.S. Food and Drug Administration ("FDA") regulates medical device user facilities, which include home health care providers. FDA regulations require user facilities to report patient deaths and serious injuries to the FDA and/or the manufacturer of a device used by the facility if the device may have caused or contributed to the death or serious injury of any patient. FDA regulations also require user facilities to maintain files related to adverse events and to establish and implement appropriate procedures to ensure compliance with the above reporting and recordkeeping requirements. User facilities are subject to FDA inspection, and noncompliance with applicable requirements may result in warning letters or sanctions including civil monetary penalties, injunction, product seizure, criminal fines and/or imprisonment.

Patient Protection and Affordable Care Act

In March 2010, comprehensive health care reform legislation was signed into law in the United States through the passage of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, "PPACA"). Since the 2016 election, it has been widely discussed that the PPACA will be "repealed and replaced." PPACA calls for a number of changes to HHA reimbursement, many of which were outlined in the 2019 regulations. These changes are discussed in greater detail below.

The Improving Medicare Post-Acute Care Transformation Act

In October 2014, the Improving Medicare Post-Acute Care Transformation Act (“IMPACT Act”) was signed into law requiring the reporting of standardized patient assessment data for quality improvement, payment and discharge planning purposes across the spectrum of post-acute care providers (“PACs”), including skilled nursing facilities and home health agencies. The IMPACT Act requires PACs to begin reporting: (1) standardized patient assessment data at admission and discharge by October 1, 2018 for post-acute care providers, including skilled nursing facilities and by January 1, 2019 for home health agencies; (2) new quality measures, including functional status, skin integrity, medication reconciliation, incidence of major falls, and patient preference regarding treatment and discharge at various intervals between October 1, 2016 and January 1, 2019; and (3) resource use measures, including Medicare spending per beneficiary, discharge to community, and hospitalization rates of potentially preventable readmissions by October 1, 2016 for post-acute care providers, including skilled nursing facilities and by October 1, 2017 for home health agencies. Failure to report such data when required would subject a facility to a two percent reduction in market basket prices then in effect.

The IMPACT Act further requires HHS and the Medicare Payment Advisory Commission (“MedPAC”), a commission chartered by Congress to advise it on Medicare payment issues, to study alternative PAC payment models, including payment based upon individual patient characteristics and not care setting, with corresponding Congressional reports required based on such analysis. The IMPACT Act also included provisions impacting Medicare-certified hospices, including: (1) increasing survey frequency for Medicare-certified hospices to once every 36 months; (2) imposing a medical review process for facilities with a high percentage of stays in excess of 180 days; and (3) updating the annual aggregate Medicare payment cap.

See discussion of the effects of this law on our operations below.

Pre-Claim Review Demonstration for Home Health Services

On June 8, 2016, CMS announced the implementation of a three year Medicare pre-claim review ("PCR") demonstration for home health services provided to beneficiaries in the states of Illinois, Florida, Texas, Michigan and Massachusetts. The pre-claim review is a process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment. On April 1, 2017, CMS paused the PCR Demonstration for Home Health Services while CMS considered a number of changes. CMS revised the demonstration to incorporate more flexibility and choices for providers, as well as risk-based changes to reward providers who show compliance with Medicare home health policies.

On May 31, 2018, CMS issued a notice indicating its intention to re-launch an HHA pre-claim review demonstration project. The original program had drawn criticism that it created significant administrative burdens and reduced access to care. Now called the Review Choice Demonstration for Home Health Services, the revised demonstration will give HHAs in the demonstration states 3 options: pre-claim review of all claims, post-payment review of all claims, or minimal post-payment review with a 25% payment reduction for all home health services. The demonstration initially will apply to HHA 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). As of December 2018, CMS is continuing the process for Paperwork Reduction Act (PRA) approval for the restarted program. After PRA approval is received, CMS will provide a start date for home health agencies in Illinois and instructions on the choice selection process. CMS will later provide notice before phasing in the other demonstration states: Ohio, North Carolina, Florida, and Texas.

Home Health Value-Based Purchasing

On January 1, 2016, CMS implemented Home Health Value-Based Purchasing ("HHVBP"). The HHVBP model was designed to give Medicare-certified home health agencies incentives or penalties, through payment bonuses, to give higher quality and more efficient care. HHVBP was rolled out to nine pilot states: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington, seven of which Amedisys currently has home health operations. Bonuses and penalties began in 2018 with the maximum of plus or minus 3% growing to plus or minus 8% by 2022. Payment adjustments are calculated based on performance in 20 measures which include current Quality of Patient Care and Patient Satisfaction star measures, as well as measures based on submission of data to a CMS web portal. The measures used may be subject to modification or change by CMS.

Under the demonstration, agencies with higher performance receive bonuses, while those with lower scores receive lower payments relative to current levels. Agency performance is evaluated against separate improvement and attainment scores, with payment tied to the higher of these two scores. CMS used 2015 as the baseline year for performance, with 2016 as the first year for performance measurement. The first payment adjustment began January 1, 2018, based on 2016 performance data. Between 2018 and 2022, the payment adjustment increases from 3 percent to 8 percent. Based on the CMS published Total Performance Score results, we received a net positive adjustment in 2018 and are anticipating a net positive adjustment in 2019 as well.

Home Health Payment Reform

On February 9, 2018, Congress passed the Bipartisan Budget Act of 2018 ("BBA of 2018"), which funded government operations, set two-year government spending limits and enacted a variety of healthcare related policies. Specific to home health, the BBA of 2018 provides for a targeted extension of the home health rural add-on payment, a reduction of the 2020 market basket update, modification of eligibility documentation requirements and reform to the HHPPS. The HHPPS reform included the following parameters: for home health units of service beginning on January 1, 2020, a 30-day payment system will apply; the transition to the 30-day payment system must be budget neutral; and CMS must conduct at least one Technical Expert Panel during 2018, prior to any notice and comment rulemaking process, related to the design of any new case-mix adjustment model.

The final HHA regulations introduced by CMS (CMS-1689-FC) that updates the Medicare HHPPS and finalizes the implementation of an alternative case-mix adjustment methodology, PDGM, will be implemented on January 1, 2020. The PDGM will adjust payments to home health agencies providing home health services under Medicare Fee-For-Service based on patient characteristics for 30-day periods of care and will also eliminate the use of therapy visits in the determination of payments. While the changes are 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 assumptions about behavioral changes which have not yet been finalized.

Our Competitors

There are few barriers to entry in the home health and hospice jurisdictions that do not require certificates of need or permits of approval. Our primary competition in these jurisdictions comes from local privately and publicly-owned and hospital-owned health care providers. We compete based on the availability of personnel, the quality of services, expertise of visiting staff, and, in certain instances, on the price of our services. In addition, we compete with a number of non-profit organizations that finance acquisitions and capital expenditures on a tax-exempt basis or receive charitable contributions that are unavailable to us.

Available Information

Our company website address is www.amedisys.com. We use our website as a channel of distribution for important company information. Important information, including press releases, analyst presentations and financial information regarding our company, is routinely posted on and accessible on the Investor Relations subpage of our website, which is accessible by clicking on the tab labeled “Investors” on our website home page. Visitors to our website can also register to receive automatic e-mail and other notifications alerting them when new information is made available on the Investor Relations subpage of our website. In addition, we make available on the Investor Relations subpage of our website (under the link “SEC Filings”), free of charge, our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, ownership reports on Forms 3, 4 and 5 and any amendments to those reports as soon as reasonably practicable after we electronically file or furnish such reports with the SEC. Further, copies of our Certificate of Incorporation and Bylaws, our Code of Ethical Business Conduct, our Corporate Governance Guidelines and the charters for the Audit, Compensation, Quality of Care, Compliance and Ethics and Nominating and Corporate Governance Committees of our Board are also available on the Investor Relations subpage of our website (under the link “Governance”). Reference to our website does not constitute incorporation by reference of the information contained on the website and should not be considered part of this document.

Additionally, the public may read and copy any of the materials we file with the SEC at the SEC’s Public Reference Room at 100 F Street, NE, Room 1580, Washington, D.C. 20549. Information on the operation of the Public Reference Room may be obtained by calling the SEC at (800) SEC-0330. Our electronically filed reports can also be obtained on the SEC’s internet site at http://www.sec.gov.

ITEM 1A. RISK FACTORS

The risks described below, and risks described elsewhere in this Form 10-K, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows and the actual outcome of matters as to which forward-looking statements are made in this Form 10-K. The risk factors described below and elsewhere in this Form 10-K are not the only risks faced by Amedisys. Our business and consolidated financial

condition, results of operations and cash flows may also be materially adversely affected by factors that are not currently known to us, by factors that we currently consider immaterial or by factors that are not specific to us, such as general economic conditions.

If any of the following risks are actually realized, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected. In that case, the trading price of our common stock could decline.

You should refer to the explanation of the qualifications and limitations on forward-looking statements under “Special Caution Concerning Forward-Looking Statements.” All forward-looking statements made by us are qualified by the risk factors described below.

Risks Related to Reimbursement

Federal and state changes to reimbursement and other aspects of Medicare and Medicaid could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our net service revenue is primarily derived from Medicare, which accounted for 73%, 76% and 79% of our revenue during 2018, 2017 and 2016, respectively. Payments received from Medicare are subject to changes made through federal legislation. When such changes are implemented, we must also modify our internal billing processes and procedures accordingly, which can require significant time and expense. These changes, as further detailed in Part I, Item 1, “Business: Payment for Our Services,” can include changes to base episode payments and adjustments for home health services, changes to cap limits and per diem rates for hospice services and changes to Medicare eligibility and documentation requirements or changes designed to restrict utilization. Any such changes, including retroactive adjustments, adopted in the future by the Center for Medicare and Medicaid Services (“CMS”) could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

In April of 2015, Congress passed and President Obama signed the so-called “doc fix” in the form of the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”). This law replaces a long-standing physician reimbursement formula with statutorily prescribed physician payment updates and provisions. MACRA provides for an increase of 3% of the payment amount otherwise made for home health services furnished in rural areas and sets Medicare reimbursements for post-acute care providers to increase by 1.0% in fiscal year 2018.

On February 2, 2016, CMS published a final rule, which is currently in effect, adding new requirements for Medicaid home health services. Among other things, the final rule requires that for the initial ordering of home health services, the physician must document that a face-to-face encounter that is related to the primary reason the beneficiary requires home health services occurred no more than 90 days before or 30 days after the start of services. The final rule also requires that for the initial ordering of certain medical equipment, the physician or authorized non-physician practitioner must document that a face-to-face encounter that is related to the primary reason the beneficiary requires medical equipment occurred no more than six months prior to the start of services. The requirements for face-to-face encounters continue to be one of the most complex issues in the industry and can be the source of claims denials if not fulfilled.

On August 6, 2018, CMS published annual changes in Medicare hospice payment rates. As finalized, CMS estimates hospices will see a 1.8% increase in Medicare payments for fiscal year 2019. This increase is the result of a 2.9% market basket adjustment less a 0.8% productivity adjustment, less 0.3% as required under the Patient Protection and Affordable Health Care Act and the Heath Care and Education Reconciliation Act (collectively, "PPACA"). CMS also increased the aggregate cap amount by 1.8% to $29,205.44. As of December 31, 2018, we expect the impact of the 2019 final rule on us to be in line with that of the hospice industry.

On November 1, 2018, CMS issued a final rule to update and revise Medicare home health reimbursement rates for calendar year 2019. CMS estimated that the net impact of the payment provisions of the final rule will result in an increase of 2.2% in reimbursement to home health providers. This increase is the result of a 3.0% market basket increase less a 0.8% productivity adjustment. As of December 31, 2018, we expect the impact of the 2019 final rule on us to be an increase of 1.2%.

Additionally, CMS proposed changes to the Home Health Prospective Payment System (“HHPPS”) case-mix adjustment methodology through the use of a new Patient-Driven Groupings Model ("PDGM") for home health payments. This change is proposed to be implemented 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 proposed changes are 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 assumptions about behavioral changes which have not been finalized. The finalization of these assumptions could negatively impact our 2020 rate of reimbursement and have a material adverse effect on our business and consolidated financial condition,

results of operations and cash flows.

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 centers. Though we cannot predict what, if any, reform proposals will be adopted, health

care 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.

We could be affected adversely by the continuing efforts of governmental payors to contain health care costs. We cannot assure you that reimbursement payments under governmental payor programs, including Medicare supplemental insurance policies, 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.

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. 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%.

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.

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.

Any economic downturn, deepening of an economic downturn, continued deficit spending by the Federal Government or state budget pressures may result in a reduction in payments and covered services.

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. As an example, the failure of the 2011 Joint Select Committee to meet its Deficit Reduction goal resulted in an automatic reduction in Medicare home health and hospice payments of 2% beginning April 1, 2013.

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.

In addition, sustained unfavorable economic conditions may affect the number of patients enrolled in managed care programs and the profitability of managed care companies, which could result in reduced payment rates and could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Future cost containment initiatives undertaken by private third party payors may limit our future revenue and profitability.

Our non-Medicare revenue and profitability are affected by continuing efforts of third party payors to maintain or reduce costs of health care by lowering payment rates, narrowing the scope of covered services, increasing case management review of services

and negotiating pricing. There can be no assurance that third party payors will make timely payments for our services, and there is no assurance that we will continue to maintain our current payor or revenue mix. We are continuing our efforts to develop our non-Medicare sources of revenue and any changes in payment levels from current or future third party payors could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Risks Related to Laws and Government Regulations

We are operating under a Corporate Integrity Agreement. Violations of this agreement could result in substantial penalties or exclusion from participation in the Medicare program.

On April 23, 2014, with no admissions of liability on our part, we entered into a settlement agreement with the U.S. Department of Justice relating to certain of our clinical and business operations. Concurrently with our entry into this agreement, we entered into a Corporate Integrity Agreement ("CIA") with the Office of Inspector General-HHS ("OIG"). The CIA, which has a term of five years, formalizes various aspects of our already existing ethics and compliance programs and contains other requirements designed to help ensure our ongoing compliance with federal health care program requirements. Among other things, the CIA requires us to maintain our existing compliance program, executive compliance committee and compliance committee of the Board of Directors; provide certain compliance training; continue screening new and current employees to ensure they are eligible to participate in federal health care programs; engage an independent review organization ("IRO") to perform certain auditing and reviews and prepare certain reports regarding our compliance with federal health care programs, our billing submissions to federal health care programs and our compliance and risk mitigation programs; and provide certain reports and management certifications to the OIG. Additionally, the CIA specifically requires that we report substantial overpayments that we discover we have received from the federal health care programs, as well as probable violations of federal health care laws. Upon breach of the CIA, we could become liable for payment of certain stipulated penalties, or could be excluded from participation in federal health care programs. Although we believe that we are currently in compliance with the CIA, any violations of the agreement could 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 to the laws and regulations governing our business, or to the interpretation and enforcement of those laws or regulations, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our industry is subject to extensive federal and state laws and regulations. See Part I, Item 1, "Our Regulatory Environment" for additional information on such laws and regulations. Federal and state laws and regulations impact how we conduct our business, the services we offer and our interactions with patients, our employees and the public and impose certain requirements on us such as:

- 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;
- billing for services;
- requirements for utilization of services;
- documentation required for billing and patient care; and
- reporting and maintaining records regarding adverse events.

These laws and regulations, and their interpretations, are subject to change. Changes in existing laws and regulations, or their interpretations, or the enactment of new laws or regulations could have a material adverse effect on our

business and consolidated financial condition, results of operations and cash flows by:

- increasing our administrative and other costs;
- increasing or decreasing mandated services;
- causing us to abandon business opportunities we might have otherwise pursued;
- decreasing utilization of services;
- forcing us to restructure our relationships with referral sources and providers; or
- requiring us to implement additional or different programs and systems.

Additionally, we are subject to various routine and non-routine reviews, audits and investigations by the Medicare and Medicaid programs and other federal and state governmental agencies, which have various rights and remedies against us if they establish that we have overcharged the programs or failed to comply with program requirements. Violation of the laws governing our operations, or changes in interpretations 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 and/or the suspension or revocation of our licenses. If we become subject to material fines, or if other sanctions or other corrective actions are imposed on us, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

We face periodic and routine 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.

As a result of our participation in the Medicare and Medicaid programs, we are subject to various governmental reviews, audits and investigations to verify our compliance with these programs and applicable laws and regulations. We also are subject to audits under various government programs, including the RAC, ZPIC, UPIC, PSC and MIC programs as well as in accordance with the requirements of our CIA, in which third party firms engaged by CMS or by the Company conduct extensive reviews of claims data and medical and other records to identify potential improper payments under the Medicare program. Private pay sources also reserve the right to conduct audits. If billing errors are identified in the sample of reviewed claims, the billing error can be extrapolated to all claims filed which could result in a larger overpayment than originally identified in the sample of reviewed claims. 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.

If a care center fails to comply with the conditions of participation in the Medicare program, that care center could be subjected to sanctions or terminated from the Medicare program.

Each of our care centers must comply with required conditions of participation in the Medicare program. If we fail to meet the conditions of participation at a care center, we may receive a notice of deficiency from the applicable state surveyor. If that care center then fails to institute an acceptable plan of correction to remediate the deficiency within the correction period provided by the state surveyor, that care center could be terminated from the Medicare program or subjected to alternative sanctions. CMS outlined its alternative sanction enforcement options for home health care centers through a regulation published in 2012; under the regulation, CMS may impose temporary management, direct a plan of correction, direct training or impose payment suspensions and civil monetary penalties, in each case, upon providers who fail to comply with the conditions of participation. Termination of one or more of our care centers from the Medicare program for failure to satisfy the program’s conditions of participation, or the imposition of alternative sanctions, could disrupt operations, require significant attention by management, or have a material adverse effect on our business and reputation and consolidated financial condition, results of operations and cash flows.

We are subject to federal and state laws that govern our financial relationships with physicians and other health care providers, including potential or current referral sources.

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We are required to comply with federal and state laws, generally referred to as "anti-kickback laws," that prohibit certain direct and indirect payments or other financial arrangements between health care providers that are designed to encourage the referral of patients to a particular provider for medical services. In addition to these anti-kickback laws, the Federal Government has enacted specific legislation, commonly known as the "Stark Law," that prohibits certain financial relationships, specifically including ownership interests and compensation arrangements, between physicians (and the immediate family members of physicians) and providers of designated health services, such as home health care centers, to whom the physicians refer patients. Some of these same financial relationships are also subject to additional regulation by states. Although we believe we have structured our relationships with physicians and other potential referral sources to comply with these laws where applicable, we cannot assure you that courts or regulatory agencies will not interpret state and federal anti-kickback laws and/or the Stark Law and similar state laws regulating relationships between health care providers and physicians in ways that will adversely implicate our practices or that isolated instances of noncompliance will not occur. Violations of federal or state Stark or anti-kickback laws could lead to criminal or civil fines or other sanctions, including denials of government program reimbursement or even exclusion from participation in governmental health care programs, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

We may face significant uncertainty in the industry due to government health care reform.

The health care industry in the United States is subject to fundamental changes due to ongoing health care reform efforts and related political, economic and regulatory influences. In March 2010, comprehensive health care reform legislation was signed into law in the United States through the passage of PPACA. However, it is difficult to predict the full impact of PPACA due to the law's complexity and phased-in effective dates, as well as our inability to foresee how CMS and other participants in the health care industry will respond to the choices available to them under the law.

PPACA makes a number of changes to Medicare payment rates and also calls for a rebasing of the home health payment system. These reimbursement changes are described in detail in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations: Overview – Economic and Industry Factors."

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.

PPACA also calls for a number of other changes to be made over time that will likely have a significant impact upon the health care delivery system. For example, PPACA mandates creation of a home health value-based purchasing program, the development of quality measures, and decreases in home health reimbursement rates, including rebasing, as further described in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations: Overview – Economic and Industry Factors."

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. At this time, it is not possible to estimate what impact PPACA may have on our non-Medicare businesses.

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.

Risks Related to our Growth Strategies

Our growth strategy depends on our ability to acquire additional care centers and integrate and operate these care centers effectively. If our growth strategy is unsuccessful or we are not able to successfully integrate newly acquired care centers into our existing operations, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

We may not be able to fully integrate the operations of our acquired businesses with our current business structure in an efficient and cost-effective manner. Acquisitions involve significant risks and uncertainties, including difficulties in recouping partial episode payments and other types of misdirected payments for services from the previous owners; difficulties integrating acquired personnel and business practices into our business; the potential loss of key employees, referral sources or patients of acquired care centers; the delay in payments associated with change in ownership, control and the internal process of the Medicare fiscal intermediary; and the assumption of liabilities and exposure to unforeseen liabilities of acquired care centers. 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, improve the reputation of the acquired business in the community and control costs. The failure to accomplish any of these objectives or to effectively integrate any of these businesses could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

State efforts to regulate the establishment or expansion of health care providers could impair our ability to expand our operations.

Some states require health care providers (including skilled nursing facilities, hospice care centers, home health care centers and assisted living facilities) to obtain prior approval, known as a CON or POA, in order to commence operations. See Part I, Item 1, “Our Regulatory Environment” for additional information on CONs and POAs. If we are not able to obtain such approvals, our ability to expand our operations could be impaired, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

Changes in federal laws or regulations may materially adversely impact our ability to acquire care centers or open new start-up care centers. For example, the Social Security Act provides the Secretary with the authority to impose temporary moratoria on the enrollment of new Medicare providers, if deemed necessary to combat fraud, waste or abuse under government programs. While there are no active Medicare moratoria as of January 30, 2019, there can be no assurance that CMS will not adopt a moratorium on new providers in the future. Additionally, in 2010, CMS implemented and amended a regulation known as the “36 Month Rule” that is applicable to home health care center acquisitions. Subject to certain exceptions, the 36 Month Rule prohibits buyers of certain home health care centers - those that either enrolled in Medicare or underwent a change in majority ownership fewer than 36 months prior to the acquisition - from assuming the Medicare billing privileges of the acquired care center. The 36 Month Rule may restrict bona fide transactions and potentially block new investments in home health agencies. These changes in federal laws and regulations, and similar future changes, may further increase competition for acquisition targets and could have a material detrimental impact on our acquisition strategy.

Risks Related to our Operations

Because we are limited in our ability to control rates received for our services, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected if we are not able to maintain or reduce our costs to provide such services.

As Medicare is our primary payor and rates are established through federal legislation, we have to manage our costs of providing care to achieve a desired level of profitability. Additionally, non-Medicare rates are difficult for us to negotiate as such payors are under pressure to reduce their own costs. As a result, we manage our costs in order to achieve a desired level of profitability including, but not limited to, centralization of various processes, the use of technology and management of the number of employees utilized. If we are not able to continue to streamline our processes and reduce our costs, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

Our industry is highly competitive, with few barriers to entry in certain states.

There are few barriers to entry in home health markets that do not require a CON or POA. Our primary competition comes from local privately-owned and hospital-owned health care providers. We compete based on the availability of personnel; the quality of services; expertise of visiting staff; and in certain instances, on the price of our services. Increased competition in the future may limit our ability to maintain or increase our market share.

Further, the introduction of new and enhanced service offerings by others, in combination with industry consolidation and the development of strategic relationships by our competitors (including mergers of competitors with each other

and with insurers), could cause a decline in revenue or loss of market acceptance of our services or make our services less attractive. 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.

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. 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 terminate us as a provider and/or engage our competitors as a preferred or exclusive provider. 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. For example, New Hampshire repealed its CON laws in 2015, and legislation was recently introduced in South Carolina that would have limited the application of its CON program. There can be no assurances that other 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 cannot assure you that we will 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.

If we are unable to maintain relationships with existing patient referral sources, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

Our success depends on referrals from physicians, hospitals and other sources in the communities we serve and on our ability to maintain good relationships with existing referral sources. Our referral sources are not contractually obligated to refer patients to us and may refer their patients to other providers. Our growth and profitability depends, in part, on our ability to establish and maintain close working relationships with these patient referral sources and to increase awareness and acceptance of the benefits of home health and hospice care by our referral sources and their patients. Our loss of, or failure to maintain, existing relationships or our failure to develop new referral relationships could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

If we are unable to provide consistently high quality of care, our business will be adversely impacted.

Providing quality patient care is the cornerstone of our business. We believe that hospitals, physicians and other referral sources refer patients to us in large part because of our reputation for delivering quality care. Clinical quality is becoming increasingly important within our industry. Effective October 2012, Medicare began to impose a financial penalty upon hospitals that have excessive rates of patient readmissions within 30 days from hospital discharge. We believe this new regulation provides a competitive advantage to home health providers who can differentiate themselves based upon quality, particularly by achieving low patient acute care hospitalization readmission rates and by implementing disease management programs designed to be responsive to the needs of patients served by referring hospitals. We are focused intently upon improving our patient outcomes, particularly our patient acute care hospitalization readmission rates. If we should fail to attain our goals regarding acute care hospitalization readmission rates and other quality metrics, we expect our ability to generate referrals would be adversely impacted, which could have a material adverse effect upon our business and consolidated financial condition, results of operations and cash flows.

Additionally, Medicare has established consumer-facing websites, Home Health Compare and Hospice Compare, that present data regarding our performance on certain quality measures compared to state and national averages. If we should fail to achieve or exceed these averages, it may affect our ability to generate referrals, which could have a material adverse effect upon our business and consolidated financial condition, results of operations and cash flows.

Our business depends on our information systems. Our inability to effectively integrate, manage and keep our information systems secure and operational could disrupt our operations.

Our business depends on effective, secure and operational information systems which include systems provided by external contractors and other service providers. Problems with, or the failure of, our technology and systems or any

system upgrades or programming changes associated with such technology and systems could have a material adverse effect on data capture, medical documentation, billing, collections, assessment of internal controls and management and reporting capabilities. Any such problems or failures and the costs incurred in correcting any such problems or failures, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Further, to the extent our external information technology contractors or other service providers become insolvent or fail to support the software or systems we have licensed from them, our operations could be materially adversely affected.

Our care centers also depend upon our information systems for accounting, billing, collections, risk management, quality assurance, human resources, payroll and other information. If we experience a reduction in the performance, reliability, or availability of our information systems, our operations and ability to produce timely and accurate reports could be materially adversely affected.

Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs. Our acquisition activity requires transitions and integration of various information systems. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition and integration of information systems or are unable to implement, maintain, or expand our systems properly, we could suffer from, among other things, operational disruptions, regulatory problems and increases in administrative expenses.

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. Our security measures may be inadequate to prevent security breaches and our business operations could be materially adversely affected by federal and state fines and penalties, legal claims or proceedings, cancellation of contracts and loss of patients if security breaches are not prevented.

We have installed privacy protection systems and devices on our network and point of care tablets in an attempt to prevent unauthorized access to information in our database. However, our technology may fail to adequately secure the confidential health information and personally identifiable information we maintain in our databases. In such circumstances, we may be held liable to our patients and regulators, which could result in fines, litigation or adverse publicity that could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Even if we are not held liable, any resulting negative publicity could harm our business and distract the attention of management.

Further, our information systems are vulnerable to damage or interruption from fire, flood, power loss, telecommunications failure, break-ins and similar events. A failure to restore our information systems after the occurrence of any of these events could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Because of the confidential health information we store and transmit, loss of electronically stored information for any reason could expose us to a risk of regulatory action and litigation and possible liability and loss.

We believe we have all the necessary licenses from third parties to use technology and software that we do not own. A third party could, however, allege that we are infringing its rights, which may deter our ability to obtain licenses on commercially reasonable terms from the third party, if at all, or cause the third party to commence litigation against us. In addition, we may find it necessary to initiate litigation to protect our trade secrets, to enforce our intellectual property rights and to determine the scope and validity of any proprietary rights of others. Any such litigation, or the failure to obtain any necessary licenses or other rights, could materially and adversely affect our business.

Possible changes in the case mix of patients, as well as payor mix and payment methodologies, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our revenue is determined by a number of factors, including our mix of patients and the rates of payment among payors. Changes in the case mix of our patients, payment methodologies or the payor mix among Medicare, Medicaid and private payors could have a material adverse effect on our business and consolidated financial condition, 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 put in place favorable contracts with managed care payors. However, we may not be successful in these efforts. Additionally, there is a risk that the favorable managed care contracts that we put in place may be terminated. Managed care contracts typically permit the payor to terminate the contract without cause, on very short notice, typically 60 days, which can provide payors leverage to reduce volume or obtain favorable pricing. Our failure

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

A write off of a significant amount of intangible assets or long-lived assets could have a material adverse effect on our consolidated financial condition and results of operations.

A significant and sustained decline in our stock price and market capitalization, a significant decline in our expected future cash flows, a significant adverse change in the business climate, or slower growth rates could result in the need to perform an impairment

analysis under Accounting Standard Codification ("ASC") Topic 350 "Intangibles – Goodwill and Other" in future periods in addition to our annual impairment test. If we were to conclude that a write down of goodwill is necessary, then we would record the appropriate charge, which could result in material charges that are adverse to our consolidated financial condition and results of operations. See Part II, Item 8, Note 4 – Goodwill and Other Intangible Assets, Net to our consolidated financial statements for additional information.

Because we have grown in part through acquisitions, goodwill and other acquired intangible assets represent a substantial portion of our assets. Goodwill was approximately $329.5 million as of December 31, 2018 and if we make additional acquisitions, it is likely that we will record additional goodwill and intangible assets in our consolidated financial statements. We also have long-lived assets consisting of property and equipment and other identifiable intangible assets of $73.6 million as of December 31, 2018, which we review on a periodic basis as well as when events or circumstances indicate that the carrying amount of an asset may not be recoverable. If a determination that a significant impairment in value of our unamortized intangible assets or long-lived assets occurs, such determination could require us to write off a substantial portion of our assets. A write off of these assets could have a material adverse effect on our consolidated financial condition and results of operations.

A shortage of qualified registered nursing staff and other clinicians, such as therapists and nurse practitioners, could materially impact our ability to attract, train and retain qualified personnel and could increase operating costs.

We compete for qualified personnel with other healthcare providers. Our ability to attract and retain clinicians depends on several factors, including our ability to provide these personnel with attractive assignments and competitive salaries and benefits. We cannot be assured we will succeed in any of these areas. In addition, there are shortages of qualified health care personnel in some of our markets. As a result, we may face higher costs of attracting clinicians and providing them with attractive benefit packages than we originally anticipated which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. 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. Generally, if we are unable to attract and retain clinicians, the quality of our services may decline and we could lose patients and referral sources, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our insurance liability coverage may not be sufficient for our business needs.

As a result of operating in the home health industry, our business entails an inherent risk of claims, losses and potential lawsuits alleging incidents involving our employees that are likely to occur in a patient's home. We maintain professional liability insurance to provide coverage to us and our subsidiaries against these risks. However, we cannot assure you claims will not be made in the future in excess of the limits of our insurance, nor can we assure you that any such claims, if successful and in excess of such limits, will not have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Our insurance coverage also includes fire, property damage and general liability with varying limits. We cannot assure you that the insurance we maintain will satisfy claims made against us or that insurance coverage will continue to be available to us at commercially reasonable rates, in adequate amounts or on satisfactory terms. Any claims made against us, regardless of their merit or eventual outcome, could damage our reputation and business.

We may be subject to substantial malpractice or other similar claims.

The services we offer involve an inherent risk of professional liability and related substantial damage awards. As of February 22, 2019, we have approximately 21,000 employees (11,000 home health, 6,000 hospice, 3,000 personal care and 1,000 corporate employees). In addition, we employ direct care workers on a contractual basis to support our existing workforce. Due to the nature of our business, we, through our employees and caregivers who provide services on our behalf, may be the subject of medical malpractice claims. A court could find these individuals should be considered our agents, and, as a result, we could be held liable for their acts or omissions. 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. While we maintain malpractice liability coverage that we believe is appropriate given the nature and breadth of our operations, any claims against us in excess of insurance limits, or

multiple claims requiring us to pay deductibles, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

If we are unable to maintain our corporate reputation, our business may suffer.

Our success depends on our ability to maintain our corporate reputation, including our reputation for providing quality patient care and for compliance with Medicare requirements and the other laws to which we are subject. Adverse publicity surrounding

any aspect of our business, including the death or disability of any of our patients due to our failure to provide proper care, or due to any failure on our part to comply with Medicare requirements or other laws to which we are subject, could negatively affect our Company's overall reputation and the willingness of referral sources to refer patients to us.

We depend on the services of our executive officers and other key employees.

We depend greatly on the efforts of our executive officers and other key employees to manage our operations. The loss or departure of any one of these executives or other key employees could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our operations could be impacted by natural disasters.

The occurrence of natural disasters in the markets in which we operate could not only impact the day-to-day operations of our care centers, but could also disrupt our relationships with patients, employees and referral sources located in the affected areas and, in the case of our corporate office, our ability to provide administrative support services, including billing and collection services. In addition, any episode of care that is not completed due to the impact of a natural disaster will generally result in lower revenue for the episode. For example, our corporate office and a number of our care centers are located in the southeastern United States and the Gulf Coast Region, increasing our exposure to hurricanes and flooding. Future hurricanes or other natural disasters may have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Risks Related to Liquidity

Delays in payment may cause liquidity problems.

Our business is characterized by delays from the time we provide services to the time we receive payment for these services. If we have difficulty in obtaining documentation, such as physician orders, experience information system problems or experience other issues that arise with Medicare or other payors, we may encounter additional delays in our payment cycle.

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 or other 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. 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 ("HHA") pre-claim review demonstration project. Now called the Review Choice Demonstration for Home Health Services, the revised demonstration will give HHAs in the demonstration states 3 options: pre-claim review of all claims, post-payment review of all claims, or minimal post-payment review with a 25% payment reduction for all home health services. The demonstration initially will apply to HHA 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). As of December 2018, CMS is continuing the process for Paperwork Reduction Act ("PRA") approval for the restarted program. After PRA approval is received, CMS will provide a start date for home health agencies in Illinois and instructions on the choice selection process. CMS will later provide notice before phasing in the other demonstration states: Ohio, North Carolina, Florida, and Texas. Compliance with this process could result in increased administrative costs or delays in reimbursement for home health services in states subject to the demonstration.

Additionally, our hospice operations may experience payment delays. We have experienced payment delays when attempting to collect funds from state Medicaid programs in certain instances. Delays in receiving payments from these programs may also materially adversely affect our working capital.

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 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 is proposed to be implemented January 1, 2020 in a budget neutral manner. Thus, 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, for example that home health agencies will change their documentation and coding practices and would put the highest

paying diagnosis code as the principal diagnosis code in order to have a 30-day period be placed into a higher-paying clinical group. 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 2020 rate of reimbursement and have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. See Part I, Item 1, "Our Regulatory Environment - Home Health Payment Reform" for additional information on the PDGM.

The volatility and disruption of the capital and credit markets and adverse changes in the United States and global economies could impact our ability to access both available and affordable financing, and without such financing, we may be unable to achieve our objectives for strategic acquisitions and internal growth.

While we intend to finance strategic acquisitions and internal growth with cash flows from operations and borrowings under our revolving credit facility, we may require sources of capital in addition to those presently available to us. Uncertainty in the capital and credit markets may impact our ability to access capital on terms acceptable to us (i.e. at attractive/affordable rates) or at all, and this may result in our inability to achieve present objectives for strategic acquisitions and internal growth. Further, in the event we need additional funds, and we are unable to raise the necessary funds on acceptable terms, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

Our indebtedness could impact our financial condition and impair our ability to fulfill other obligations.

As of December 31, 2018, we had total outstanding indebtedness of approximately $8.6 million. Our level of indebtedness could have a material adverse effect on our business and consolidated financial position, results of operations and cash flows and could impair our ability to fulfill other obligations in several ways, including:

- it could require us to dedicate a portion of our cash flow from operations to payments on our indebtedness, which could reduce the availability of cash flow to fund acquisitions, start-ups, working capital, capital expenditures and other general corporate purposes;
- it could limit our ability to borrow money or sell stock for working capital, capital expenditures, debt service requirements and other purposes;
- it could limit our flexibility in planning for, and reacting to, changes in our industry or business;
- it could make us more vulnerable to unfavorable economic or business conditions; and
- it could limit our ability to make acquisitions or take advantage of other business opportunities.

In the event we incur additional indebtedness, the risks described above could increase.

The agreements governing our indebtedness contain various covenants that limit our discretion in the operation of our business and our failure to satisfy requirements in these agreements could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

The agreements governing our indebtedness (the "Debt Agreements") contain certain obligations, including restrictive covenants that require us to comply with or maintain certain financial covenants and ratios and restrict our ability to:

- incur additional debt;
- redeem or repurchase stock, pay dividends or make other distributions;
- make certain investments;
- create liens;
- enter into transactions with affiliates;
- make acquisitions;
- enter into joint ventures;
- merge or consolidate;
- invest in foreign subsidiaries;
- amend acquisition documents;
- enter into certain swap agreements;
- make certain restricted payments;

- transfer, sell or leaseback assets; and
- make fundamental changes in our corporate existence and principal business.

Our Debt Agreements also limit our ability to reinvest the net cash proceeds from asset sales or subordinated debt issuances in certain circumstances. For example, in the event we or any of our subsidiaries receive more than $5 million in net cash proceeds from an asset sale, disposition or involuntary disposition, our Debt Agreements require us to prepay our term loan facility and revolving credit facility with all of such net cash proceeds, unless we elect to reinvest the net cash proceeds in fixed or capital assets related to our business.

In addition, events beyond our control could affect our ability to comply with the Debt Agreements. Any failure by us to comply with or maintain all applicable financial covenants and ratios and to comply with all other applicable covenants could result in an event of default with respect to the Debt Agreements. If we are unable to obtain a waiver from our lenders in the event of any non-compliance, our lenders could accelerate the maturity of any outstanding indebtedness and terminate the commitments to make further extensions of credit (including our ability to borrow under our revolving credit facility). Any failure to comply with these covenants could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Risks Related to Ownership of Our Common Stock

The price of our common stock may be volatile.

The price at which our common stock trades may be volatile. The stock market from time to time experiences significant price and volume fluctuations that impact the market prices of securities, particularly those of health care companies. The market price of our common stock may be influenced by many factors, including:

- our operating and financial performance;
- variances in our quarterly financial results compared to research analyst expectations;
- the depth and liquidity of the market for our common stock;
- future purchases or sales of common stock by the Company or large stockholders or the perception that such purchases or sales could occur;
- investor, analyst and media perception of our business and our prospects;
- developments relating to litigation or governmental investigations;
- changes or proposed changes in health care laws or regulations or enforcement of these laws and regulations, or announcements relating to these matters;
- departure of key personnel;
- changes in the Medicare, Medicaid and private insurance payment rates for home health and hospice;
- announcements by us or our competitors of significant contracts, acquisitions, strategic partnerships, joint ventures or capital commitments; or
- general economic and stock market conditions.

In addition, the stock market in general, and the NASDAQ Global Select Market (“NASDAQ”) in particular, has experienced price and volume fluctuations that we believe have often been unrelated or disproportionate to the operating performance of health care provider companies. These broad market and industry factors may materially reduce the market price of our common stock, regardless of our operating performance. Securities class-action cases have often been brought against companies following periods of volatility in the market price of their securities.

The activities of short sellers could reduce the price or prevent increases in the price of our common stock. “Short sale” is defined as the sale of stock by an investor that the investor does not own. Typically, investors who sell short believe the price of the stock will fall, and anticipate selling shares at a higher price than the purchase price at which they will buy the stock. As of December 31, 2018, investors held a short position of approximately 1.9 million shares of our common stock which represented 6.1% of our outstanding common stock. The anticipated downward pressure on our stock price due to actual or anticipated sales of our stock by some institutions or individuals who engage in short sales of our common stock could cause our stock price to decline.

Sales of substantial amounts of our common stock or the availability of those shares for future sale, could materially impact our stock price and limit our ability to raise capital.

The following table presents information about our outstanding common and preferred stock and our outstanding securities exercisable for or convertible into shares of common stock:

	As of December 31, 2018
Common stock outstanding	31,973,505
Preferred stock outstanding	—
Common stock available under 2018 Omnibus Incentive Compensation Plan	2,350,831
Stock options outstanding	833,315
Stock options exercisable	462,845
Non-vested stock outstanding	14,904
Non-vested stock units outstanding	467,077

If we were to sell substantial amounts of our common stock in the public market or if there was a public perception that substantial sales could occur, the market price of our common stock could decline. These sales or the perception of substantial future sales may also make it difficult for us to sell common stock in the future to raise capital.

Our Board of Directors may use anti-takeover provisions or issue stock to discourage a change of control.

Our certificate of incorporation currently authorizes us to issue up to 60,000,000 shares of common stock and 5,000,000 shares of undesignated preferred stock. Our Board of Directors may cause us to issue additional stock to discourage an attempt to obtain control of our company. For example, shares of stock could be sold to purchasers who might support our Board of Directors in a control contest or to dilute the voting or other rights of a person seeking to obtain control. In addition, our Board of Directors could cause us to issue preferred stock entitling holders to vote separately on any proposed transaction, convert preferred stock into common stock, demand redemption at a specified price in connection with a change in control, or exercise other rights designed to impede a takeover.

The issuance of additional shares may, among other things, dilute the earnings and equity per share of our common stock and the voting rights of common stockholders.

We have implemented other anti-takeover provisions or provisions that could have an anti-takeover effect, including advance notice requirements for director nominations and stockholder proposals, no cumulative voting for directors, director vacancies are filled by remaining directors (including vacancies resulting from removal), and the number of directors is fixed by the Board of Directors, and the Board of Directors can increase or decrease the size of the Board of Directors without stockholder approval (within the range set forth in our Certificate of Incorporation and Bylaws). These provisions, and others that our Board of Directors may adopt hereafter, may discourage offers to acquire us and may permit our Board of Directors to choose not to entertain offers to purchase us, even if such offers include a substantial premium to the market price of our stock. Therefore, our stockholders may be deprived of opportunities to profit from a sale of control.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

Our executive office is located in Nashville, Tennessee in a leased property consisting of 25,097 square feet; our corporate headquarters is located in Baton Rouge, Louisiana in a leased property consisting of 85,955 square feet. We believe we have adequate space to accommodate our corporate staff located in these locations for the foreseeable future.

In addition to our executive office and corporate headquarters, we also lease facilities for our home health, hospice and personal-care care centers. Generally, these leases have an initial term of five years with a three year early termination option, but range from one to seven years. Most of these leases also contain an option to extend the lease period. The following table shows the location of our 323 Medicare-certified home health care centers, 84 Medicare-certified hospice care centers and 12 personal-care care centers at December 31, 2018:

State	Home Health	Hospice	Personal Care	State	Home Health	Hospice	Personal Care
Alabama	30	7	—	New Jersey	2	1	—
Arkansas	5	—	—	New York	5	—	—
Arizona	3	1	—	New Hampshire	3	3	—
California	4	—	—	North Carolina	8	6	—
Connecticut	4	1	—	Ohio	1	2	—
Delaware	2	—	—	Oklahoma	6	—	—
Florida	20	—	1	Oregon	3	1	—
Georgia	62	6	—	Pennsylvania	7	6	—
Illinois	3	—	—	Rhode Island	1	2	—
Indiana	5	1	—	South Carolina	20	7	—
Kansas	1	1	—	Tennessee	43	11	1
Kentucky	17	—	—	Texas	1	1	—
Louisiana	10	4	—	Virginia	13	2	—
Massachusetts	5	9	10	Washington	1	—	—
Maine	2	4	—	West Virginia	11	6	—
Maryland	8	2	—	Wisconsin	1	—	—
Mississippi	9	—	—	Washington, D.C.	1	—	—
Missouri	6	—	—	Total	323	84	12

ITEM 3. LEGAL PROCEEDINGS

See Part II, Item 8, Note 9 – Commitments and Contingencies for information concerning our legal proceedings.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Information and Holders

Our common stock trades on the NASDAQ Global Select Market under the trading symbol "AMED." As of February 22, 2019, there were approximately 510 holders of record of our common stock.

Dividend Policy

We have not declared or paid any cash dividends on our common stock or any other of our securities and do not expect to pay cash dividends for the foreseeable future. We currently intend to retain our future earnings, if any, to fund the development and growth of our business. Future decisions concerning the payment of dividends will depend upon our results of operations, financial condition, capital expenditure plans and debt service requirements, as well as such other factors as our Board of Directors, in its sole discretion, may consider relevant. In addition, our outstanding indebtedness restricts, and we anticipate any additional future indebtedness may restrict, our ability to pay cash dividends; provided, however, that we may pay (i) dividends payable solely in our equity securities and (ii) dividends if (1) no default or event of default under the Credit Agreement shall have occurred and be continuing at the time of such dividend or would result therefrom, (2) we demonstrate that, upon giving pro forma effect to such dividend, our consolidated leverage ratio (as defined in the Credit Agreement) is less than 2.0 to 1.0 and (3) we demonstrate a minimum liquidity of $50 million upon giving effect to such dividend.

Purchases of Equity Securities

The following table provides the information with respect to purchases made by us of shares of our common stock during each of the months during the three-month period ended December 31, 2018:

Period	(a) Total Number of Shares (or Units) Purchased	(b) Average Price Paid per Share (or Unit)	(c) Total Number of Shares (or Units) Purchased as Part of Publicly Announced Plans or Programs	(d) Maximum Number (or Approximate Dollar Value) of Shares (or Units) That May Yet Be Purchased Under the Plans or Programs
October 1, 2018 to October 31, 2018	2,025	$ 115.10	—	$ —
November 1, 2018 to November 30, 2018	—	—	—	—
December 1, 2018 to December 31, 2018	7,379	124.24	—	—
	9,404 (1)	$ 122.27	—	$ —

(1) Includes shares of common stock surrendered to us by certain employees to satisfy tax withholding obligations in connection with the vesting of non-vested stock previously awarded to such employees under our 2008 Omnibus

Incentive Compensation Plan.

Stock Performance Graph

The Performance Graph below compares the cumulative total stockholder return on our common stock, $0.001 par value per share, for the five-year period ended December 31, 2018, with the cumulative total return on the NASDAQ composite index and an industry peer group over the same period (assuming the investment of $100 in our common stock, the NASDAQ composite index and the industry peer group on December 31, 2013 and the reinvestment of dividends). The peer group we selected for 2018 is comprised of: Adus Homecare ("ADUS"), Chemed ("CHE"), Encompass Health ("EHC"), LHC Group, Inc. (“LHCG”) and National Healthcare (“NHC”). The peer group we selected for 2017 is comprised of: LHC Group, Inc. ("LHCG") and Almost Family, Inc. ("AFAM"). The cumulative total stockholder return on the following graph is historical and is not necessarily indicative of future stock price performance. No cash dividends have been paid on our common stock.

	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
Amedisys, Inc.	$ 100.00	$ 200.62	$ 268.76	$ 291.39	$ 360.29	$ 800.48
NASDAQ Composite	$ 100.00	$ 114.62	$ 122.81	$ 133.19	$ 172.11	$ 165.84
2018 Peer Group	$ 100.00	$ 123.58	$ 137.25	$ 159.62	$ 201.35	$ 259.78
2017 Peer Group	$ 100.00	$ 129.70	$ 188.39	$ 190.10	$ 254.78	$ 390.52

This stock performance information is “furnished” and shall not be deemed to be “soliciting material” or subject to Regulation 14A under the Securities Exchange Act of 1934 (the “Exchange Act”), shall not be deemed “filed” for purposes of Section 18 of the Exchange Act or otherwise subject to the liabilities of that section, and shall not be deemed incorporated by reference in any filing under the Securities Act of 1933, as amended, or the Exchange Act, whether made before or after the date of this report and irrespective of any general incorporation by reference language in any such filing, except to the extent we specifically incorporate the information by reference.

ITEM 6. SELECTED FINANCIAL DATA

The selected consolidated financial data presented below is derived from our audited consolidated financial statements for the five-year period ended December 31, 2018, based on our continuing operations. The financial data for the years ended December 31, 2018, 2017 and 2016 should be read together with our consolidated financial statements and related notes included in Item 8, “Financial Statements and Supplementary Data” and the information included in Item 7, “Management’s Discussion and Analysis of Financial Condition and Results of Operations” herein.

	2018	2017 (2)	2016 (3)	2015 (4)	2014 (5)
	(Amounts in thousands, except per share data)				
Income Statement Data:					
Net service revenue from continuing operations (1)	$1,662,578	$1,511,272	$1,419,261	$1,266,489	$1,188,111
Operating income (loss) from continuing operations	$155,148	$78,524	$57,340	$(9,166)	$24,047
Net income (loss) from continuing operations attributable to Amedisys, Inc.	$119,346	$30,301	$37,261	$(3,021)	$12,992
Net income (loss) from continuing operations attributable to Amedisys, Inc. per basic share	$3.64	$0.90	$1.12	$(0.09)	$0.40
Net income (loss) from continuing operations attributable to Amedisys, Inc. per diluted share	$3.55	$0.88	$1.10	$(0.09)	$0.40

(1) Net service revenue has been recast to present our retrospective adoption of 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.

(2) During 2017, we recorded charges related to the Securities Class Action Lawsuit settlement, net and related legal fees in the amount of $29.8 million ($18.1 million, net of tax). Additionally, we recorded a charge in the amount of $21.4 million as the result of H.R. 1 (Tax Cuts and Jobs Act) enacted on December 22, 2017.

(3) During 2016, we recorded charges related to Homecare Homebase (“HCHB”) implementation costs in the amount of $8.4 million ($5.1 million, net of tax) and recognized a non-cash charge to write off assets as a result of our conversion to the HCHB platform in the amount of $4.4 million ($2.7 million, net of tax).

(4) During 2015, we recorded non-cash charges to write off the software costs incurred related to the development of AMS3 Home Health and Hospice in the amount of $75.2 million ($45.5 million, net of tax) and to reduce the carrying value of our corporate headquarters in the amount of $2.1 million ($1.2 million, net of tax).

(5) During 2014, we recorded charges for relators’ fees and exit and restructuring activity in the amount of $13.9 million ($8.5 million, net of tax) and recognized non-cash other intangibles impairment charges of $3.1 million ($2.0 million, net of tax).

	2018	2017	2016	2015	2014
	(Amounts in thousands)				
Balance Sheet Data:					
Total assets (1)	$717,118	$813,482	$734,029	$681,715	$666,956
Total debt, including current portion (1)	$7,387	$88,841	$93,029	$96,630	$113,586
Total Amedisys, Inc. stockholders’ equity	$481,582	$515,321	$460,203	$409,568	$397,167
Cash dividends declared per common share	$—	$—	$—	$—	$—

(1) Total assets and Total debt, including current portion have been recast to present our retrospective adoption of Accounting Standards Update 2015-03, Interest – Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs.

ITEM 7. MANAGEMENT’S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion and analysis provides information we believe is relevant to an assessment and understanding of our results of operations and financial condition for 2018, 2017 and 2016. This discussion should be read in conjunction with our audited financial statements included in Item 8, “Financial Statements and Supplementary Data” and Part I, Item 1, “Business” of this Annual Report on Form 10-K. The following analysis contains forward-looking statements about our future revenues,

operating results and expectations. See “Special Caution Concerning Forward-Looking Statements” for a discussion of the risks, assumptions and uncertainties affecting these statements as well as Part I, Item 1A, “Risk Factors.”

Overview

We are a provider of high-quality in-home healthcare and related services to the chronic, co-morbid, aging American population, with approximately 73%, 76% and 79% of our revenue derived from Medicare for 2018, 2017 and 2016, respectively.

Our operations involve servicing patients through our three reportable business segments: home health, hospice and personal care. Our home health segment delivers a wide range of services in the homes of individuals who may be recovering from an illness, injury or surgery. Our hospice segment provides care that is designed to provide comfort and support for those who are facing a terminal illness. Our personal care segment provides patients assistance with the essential activities of daily living. As of December 31, 2018, we owned and operated 323 Medicare-certified home health care centers, 84 Medicare-certified hospice care centers and 12 personal-care care centers, including unconsolidated joint ventures, in 34 states within the United States and the District of Columbia.

Care Centers Summary (Includes Unconsolidated Joint Ventures)

	Home Health	Hospice	Personal Care
At December 31, 2015	332	81	—
Acquisitions/Start-Ups	1	—	14
Closed/Consolidated	(3)	—	—
At December 31, 2016	330	81	14
Acquisitions/Start-Ups	3	2	7
Closed/Consolidated	(10)	—	(6)
At December 31, 2017	323	83	15
Acquisitions/Start-Ups	1	1	1
Closed/Consolidated	(1)	—	(4)
At December 31, 2018	323	84	12

When we refer to “same store business,” we mean home health, hospice and personal-care care centers that we have operated for at least the last twelve months; when we refer to “acquisitions,” we mean home health, hospice and personal-care care centers that we acquired within the last twelve months; and when we refer to “start-ups,” we mean home health, hospice and personal-care care centers opened by us in the last twelve months. Once a care center has been in operation for a twelve month period, the results for that particular care center are included as part of our same store business from that date forward.

2018 Developments

- Continued to deliver on our goal of clinical distinction with 94% of our care centers at 4+ Stars in the January 2019 Home Health Compare ("HHC") release.
- Lowered company voluntary turnover rate to 20%.
- Expanded home health gross margin as a percentage of revenue by 40 basis points.
- Signed a definitive agreement to acquire Compassionate Care Hospice, the 8th largest hospice provider in the United States (subsequently closed on February 1, 2019).
- Invested in Medalogix, a predictive data and analytics company, helping to further optimize our current business and enabling us to work more closely with Medicare Advantage payors.
- Acquired the assets of Bring Care Home and East Tennessee Personal Care Services, further solidifying our position as the largest personal care provider in Massachusetts and establishing our presence in Tennessee.
- Increased total revenue 10% and operating income 98%.
- Exceeded 7,800 in hospice average daily census.

2019 Strategy

- Continue our commitment to clinical distinction with a goal of all care centers achieving a 4.0 Quality Star Rating.

- Focus on recruitment and retention of world class employees while fostering a culture of engagement to become the employer of choice in the industry.
- Continue to reduce voluntary turnover, specifically within our registered nurse ("RN") cohort.
- Implement pay practice changes and staffing model efficiencies to further drive operational excellence.
- Invest in the business to prepare ourselves for the Patient-Driven Groupings Model ("PDGM").
- Continue to build on our industry-leading hospice platform by exploring various growth opportunities including small and large acquisitions and denovos.
- Partner with innovative companies to drive new payment arrangements and new product offerings for Medicare Advantage payors.
- Continue to focus on organic growth (denovos) and inorganic expansion in all three segments.

Financial Performance

Results for the year ended December 31, 2018 reflect the results of our focused efforts on operational improvements that began during 2014.

Our home health care centers experienced growth in volumes and increases in clinician productivity which positively impacted our gross margin as a percentage of revenue and led to the segment delivering a $43 million increase in operating income (see "Results of Operations") despite the impact of the 2018 Centers for Medicare and Medicaid Services ("CMS") rate cut.

Our hospice segment achieved significant growth in admissions and average daily census which helped deliver a $10 million improvement in our operating income over the year ended December 31, 2017 (see "Results of Operations").

Our personal care segment completed two acquisitions in 2018. These acquisitions contributed less than $1 million in personal care operating income.

Economic and Industry Factors

Our home health, hospice and personal care segments operate in a highly fragmented and highly competitive industry. The degree of competitiveness varies based upon whether our care centers operate in states that require a certificate of need (CON) or permit of approval (POA). In such states, expansion by existing providers or entry into the market by new providers is permitted only where determination is made by state health authorities that a given amount of unmet healthcare need exists. Currently, 65% and 40% of our home health and hospice care centers, respectively, operate in CON/POA states.

As the Federal government continues to debate a reduction in expenditures and a reform of the Medicare system, our industry continues to face reimbursement pressures. These reform efforts 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 centers.

The CMS Calendar Year 2019 Home Health Final Rule, released in November 2018, provides for the first payment rate increase for home health providers since 2010. Additionally, CMS proposed changes to the Home Health Prospective Payment System ("HHPPS") case-mix adjustment methodology through the use of a new PDGM for home health payments. This change is proposed to be implemented 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 proposed changes are 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 assumptions about behavioral changes which have not been finalized.

The following payment adjustments are effective for each of the years indicated based on CMS's final rules:

	Home Health			Hospice		
	2019 (1)	2018 (2)	2017	2019 (3)	2018	2017
Market Basket Update	3.0 %	1.0 %	2.8 %	2.9 %	1.0%	2.7 %
Rebasing	—	—	(2.3)	—	—	—
50/50 Blend of Wage Index	—	—	—	—	—	—
Nominal Case Mix Adjustment	—	(0.9)	(0.9)	—	—	—
PPACA Adjustment	—	—	—	(0.3)	—	(0.3)
Budget Neutrality Adjustment Factor	—	—	—	—	—	—
Productivity Adjustment	(0.8)	—	(0.3)	(0.8)	—	(0.3)
Estimated Industry Impact	2.2 %	0.1 %	(0.7)%	1.8 %	1.0%	2.1 %
Estimated Company-Specific Impact (4)	1.2 %	(0.7)%	(2.0)%	1.6 %	1.0%	2.0 %

(1) Effective for episodes scheduled to be completed on or after January 1, 2019.

(2) Includes the targeted extension of the home health rural add-on payment from the Bipartisan Budget Act of 2018.

(3) Effective for services provided from October 1, 2018 to September 30, 2019.

(4) Our company-specific impact of the final rules differs depending on differences in the wage index and the impact of coding and outlier changes.

As part of the 2016 final rule issued in October 2015, CMS finalized their proposal to implement a Home Health Value-Based Purchasing ("HHVBP") model in nine states that seeks to test whether incentives for better care can improve outcomes in the delivery of home health services. Financial impacts from this change, either positive or negative, began January 1, 2018, and are based on 2016 performance data. Benchmarks for future years are detailed below.

Performance Year	Year Reward/ Penalty Imposed	Maximum Reward/ Penalty
2016	2018	3%
2017	2019	5%
2018	2020	6%
2019	2021	7%
2020	2022	8%

Based on our performance to date, we received approximately $1 million in 2018 and anticipate that we will receive approximately $2 million in 2019 related to HHVBP.

Governmental Inquiries and Investigations and Other Litigation

Corporate Integrity Agreement

In connection with a settlement agreement with the U.S. Department of Justice, on April 23, 2014, we entered into a corporate integrity agreement ("CIA") with the Office of Inspector General-HHS ("OIG"). The CIA formalizes various aspects of our already existing ethics and compliance programs and contains other requirements designed to help ensure our ongoing compliance with federal health care program requirements. Among other things, the CIA requires us to maintain our existing compliance program, executive compliance committee and compliance committee of the Board of Directors; provide certain compliance training; continue screening new and current employees to ensure they are eligible to participate in federal health care programs; engage an independent review organization to perform certain audits and reviews and prepare certain reports regarding our compliance with federal health care programs, our billing submissions to federal health care programs and our compliance and risk mitigation programs; and provide certain reports and management certifications to the OIG. Additionally, the CIA specifically requires that we report substantial overpayments that we discover we have received from federal health care programs, as well as probable violations of federal health care laws. Upon breach of the CIA, we could become liable for payment of certain stipulated penalties, or could be excluded from participation in federal health care programs. The CIA has a term of five years. We expect the CIA to impact operating expenses by approximately $1 million annually.

Subpoena Duces Tecum Issued by the U.S. Department of Justice

On May 21, 2015, we received a Subpoena Duces Tecum (“Subpoena”) issued by the U.S. Department of Justice. The Subpoena requests the delivery of information regarding 53 identified hospice patients to the United States Attorney’s Office for the District of Massachusetts. It also requests the delivery of documents relating to our hospice clinical and business operations and related compliance activities.

Civil Investigative Demands Issued by the U.S. Department of Justice

On November 3, 2015, we received a civil investigative demand ("CID") issued by the U.S. Department of Justice pursuant to the federal False Claims Act relating to claims submitted to Medicare and/or Medicaid for hospice services provided through designated facilities in the Morgantown, West Virginia area.

On June 27, 2016, we received a CID issued by the U.S. Department of Justice pursuant to the federal False Claims Act relating to claims submitted to Medicare and/or Medicaid for hospice services provided through designated facilities in the Parkersburg, West Virginia area.

Florida Zone Program Integrity Contractor Audit

During the three-month period ended September 30, 2017, we received a request for medical records from SafeGuard Services, L.L.C. ("SafeGuard"), a Zone Program Integrity Contractor ("ZPIC") related to services provided by some of the Florida care centers that the Company acquired from Infinity Home Care, L.L.C. The review period covers time periods both before and after our ownership of the care centers which were acquired on December 31, 2015. Subsequent to the request for medical records, we received Requests for Repayment from Palmetto GBA, L.L.C. ("Palmetto") regarding two of these care centers. As a result we recorded a reduction in revenue in our consolidated statement of operations of approximately $7 million during the three-month period ended September 30, 2017.

See Item 8, Note 9 – Commitments and Contingencies to our consolidated financial statements for additional information regarding our CIA, the Subpoena issued by the U.S. Department of Justice, the CIDs issued by the U.S. Department of Justice and the Florida ZPIC audit. No assurances can be given as to the timing or outcome of these items.

Results of Operations

Consolidated

The following table summarizes our consolidated results of operations (amounts in millions):

	For the Years Ended December 31,		
	2018	2017	2016
Net service revenue	$1,662.6	$1,511.3	$1,419.3
Gross margin, excluding depreciation and amortization	669.7	607.9	584.8
% of revenue	40.3 %	40.2 %	41.2 %
Other operating expenses	514.6	499.4	523.1
% of revenue	30.9 %	33.0 %	36.9 %
Securities Class Action Lawsuit settlement, net	—	28.7	—
Asset impairment charge	—	1.3	4.4
Operating income	155.1	78.5	57.3
Total other income, net	3.8	2.3	4.2
Income tax expense	(38.8)	(50.1)	(23.9)
Effective income tax rate	24.4 %	62.0 %	38.9 %
Net income	120.1	30.7	37.6
Net income attributable to noncontrolling interests	(0.8)	(0.4)	(0.4)
Net income attributable to Amedisys, Inc.	$119.3	$30.3	$37.3

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

Overall, our operating income increased $77 million on a revenue increase of $151 million. Our 2017 operating results were negatively impacted $40 million; these impacts include a $30 million charge for the Securities Class Action Lawsuit settlement and related legal fees, a $7 million reduction in revenue as a result of the Florida ZPIC audit and charges of approximately $3 million related to our home health closures and restructuring plan. Excluding these 2017 impacts, operating income increased $37 million, driven by continued growth in our home health and hospice segments, increases in clinical productivity in our home health segment and a continued focus on maintaining cost discipline, as our other operating expenses increased only 3% on a 10% increase in net service revenue. In addition, our gross margin as a percentage of revenue was relatively flat despite a net reduction of $3 million in net service revenue and gross margin resulting from the 2018 changes in reimbursement and planned wage increases that became effective during the three-month period ended September 30, 2018.

Our 2018 operating results include the results of our acquisition of Christian Care at Home which provided home health services to the state of Kentucky, East Tennessee Personal Care Services which owned and operated one personal-care care center servicing the state of Tennessee and certain personal care operations from Bring Care Home in Massachusetts. These three acquisitions accounted for approximately $5 million of our $151 million increase in revenue and $1 million of our $15 million increase in other operating expenses.

Total other income, net includes the following items (amounts in millions):

	For the Years Ended December 31,	
	2018	2017
Interest income	$ 0.3	$ 0.1
Interest expense	(7.4)	(5.0)
Equity in earnings from equity method investments	7.7	3.4
Miscellaneous, net	3.2	3.8
	$ 3.8	$ 2.3

Interest expense includes interest expense related to the Florida ZPIC audit of $2 million for 2018. Equity in earnings from equity method investments includes gains of $5 million and $1 million for 2018 and 2017, respectively, related to one of our equity method investments. Miscellaneous, net includes proceeds from legal settlements of $1 million and $2 million for 2018 and 2017, respectively. Excluding these items, total other income, net increased $1 million in 2018 from 2017.

Our 2017 income tax expense includes a $21 million charge related to the remeasurement of our deferred tax assets and liabilities to the enacted corporate income tax rate of 21% as required by the enactment of H.R. 1 (Tax Cuts and Jobs Act), on December 22, 2017 (see Item 8, Note 7 - Income Taxes to our consolidated financial statements).

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

Overall, our operating income increased $21 million on a revenue increase of $92 million. Our decline in gross margin as a percentage of revenue was the result of the 2017 and 2018 changes to home health and hospice reimbursement which reduced revenue and gross margin by approximately $14 million, net. Our 2017 results are inclusive of a $30 million charge for the Securities Class Action Lawsuit settlement and related legal fees, a $7 million reduction in revenue as a result of the Florida ZPIC audit and charges of approximately $3 million related to our home health closures and restructuring plan. Our 37% increase in operating income despite the cumulative impact of $40 million from the items noted above was driven by the continued growth of our hospice division and continued reductions in operating expenses across the organization.

Our 2017 operating results include the results of our acquisition of three home health and two hospice care centers on May 1, 2017 and our personal care acquisitions of Home Staff, L.L.C and Intercity Home Care. These three acquisitions accounted for approximately $22 million of our $92 million increase in revenue and $5 million of our $499 million in other operating expenses.

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Total other income, net includes the impact of the following items (amounts in millions):

	For the Years Ended December 31,	
	2017	2016
Interest income	$ 0.1	$ 0.1
Interest expense	(5.0)	(5.2)
Equity in earnings from equity method investments	3.4	5.6
Miscellaneous, net	3.8	3.7
	$ 2.3	$ 4.2

Equity in earnings from equity method investments includes gains of $1 million and $4 million for 2017 and 2016, respectively, related to one of our equity method investments. Miscellaneous, net includes proceeds from legal settlements of $2 million for each 2017 and 2016. Excluding these items, total other income, net increased $1 million in 2017 from 2016.

Our 2017 income tax expense includes a $21 million charge related to the remeasurement of our deferred tax assets and liabilities to the enacted corporate income tax rate of 21% as required by the enactment of H.R. 1 (Tax Cuts and Jobs Act), on December 22, 2017 (see Item 8, Note 7 - Income Taxes to our consolidated financial statements).

Home Health Division

The following table summarizes our home health segment results of operations:

	For the Years Ended December 31,		
	2018	2017	2016
Financial Information (in millions):			
Medicare	$830.8	$793.3	$822.4
Non-Medicare	343.7	290.6	249.3
Net service revenue	1,174.5	1,083.9	1,071.7
Cost of service	722.1	670.9	643.7
Gross margin	452.4	413.0	428.0
Asset impairment charge	—	1.3	—
Other operating expenses	279.8	281.9	289.4
Operating income	$172.6	$129.8	$138.6
Same Store Growth (1):			
Medicare revenue	6 %	(4 %)	2 %
Non-Medicare revenue	18 %	17 %	3 %
Total admissions	5 %	2 %	2 %
Total volume (2)	7 %	4 %	2 %
Total Episodic admissions (3)	4 %	1 %	4 %
Total Episodic volume (4)	5 %	3 %	3 %
Key Statistical Data - Total (5):			
Medicare:			
Admissions	190,748	190,132	194,662
Recertifications	112,773	106,774	103,193
Total volume	303,521	296,906	297,855
Completed episodes	296,223	290,227	289,862
Visits	5,261,315	5,067,436	5,124,002
Average revenue per completed episode (6)	$2,854	$2,823	$2,839
Visits per completed episode (7)	17.6	17.3	17.5
Non-Medicare:			
Admissions	118,577	107,665	98,448
Recertifications	55,736	46,364	38,618
Total volume	174,313	154,029	137,066
Visits	2,772,339	2,347,363	2,050,975
Total (5):			
Visiting Clinician Cost per Visit	$81.88	$82.04	$81.18
Clinical Manager Cost per Visit	$8.01	$8.44	$8.53
Total Cost per Visit	$89.89	$90.48	$89.71
Visits	8,033,654	7,414,799	7,174,977

(1) Same store information represents the percent increase (decrease) in our Medicare, Non-Medicare, Total and Episodic revenue, admissions or volume for the period as a percent of the Medicare, Non-Medicare, Total and Episodic revenue, admissions or volume of the prior period.

(2) Total volume includes all admissions and recertifications.

(3) Total Episodic admissions includes admissions for Medicare and Non-Medicare payors that bill on a 60-day episode of care basis.

(4) Total Episodic volume includes admissions and recertifications for Medicare and Non-Medicare payors that bill on a 60-day episode of care basis.

(5) Total includes acquisitions.

(6) Average Medicare revenue per completed episode is the average Medicare revenue earned for each Medicare completed episode of care.

(7) Medicare visits per completed episode are the home health Medicare visits on completed episodes divided by the home health Medicare episodes completed during the period.

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

Operating Results

Overall, our operating income increased $43 million on a $91 million increase in net service revenue. The $43 million increase includes a $7 million reduction in revenue related to the Florida ZPIC audit in 2017. Our growth in volumes and increases in clinician productivity positively impacted our gross margin as a percentage of revenue, which increased despite the 2018 changes in reimbursement and planned wage increases that became effective during the three-month period ended September 30, 2018. The impact of the 2018 changes in reimbursement was a reduction in net service revenue and gross margin of approximately $7 million.

Net Service Revenue

Our revenue increased $91 million on a 7% increase in total volume which is inclusive of a 5% increase in episodic volume. The volume growth was driven by a 5% increase in admissions and a 130 basis point increase in our Medicare recertification rate. In addition to the increase in volume, our revenue per episode is up $31 per episode as a result of an increase in the acuity level of our patients which enabled us to overcome the 70 basis point reimbursement reduction effective January 1, 2018.

Cost of Service, Excluding Depreciation and Amortization

Our cost of service consists of costs associated with direct clinician care in the homes of our patients as well as the cost of clinical managers who monitor the overall delivery of care. Our cost of service increased 8% on an 8% increase in total visits. Our increase in total visits was driven by growth in volumes as well as an increase in visits per completed episode which is the result of an increase in the acuity level of our patients. Our cost per visit decreased 1% as an increase in clinician productivity offset planned wage increases.

Other Operating Expenses

Other operating expenses decreased approximately $2 million on an 8% increase in net service revenue primarily due to a decrease in salaries and benefits expense as 2017 operating expenses included approximately $3 million in costs related to our home health restructuring plan. Additionally, we experienced decreases in rent expense, professional fees and telecommunications expense which were offset by increases in information technology expense and travel and training expense.

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

Operating Results

Overall, our operating income decreased $9 million on a $12 million increase in revenue. Our decrease in gross margin as a percentage of revenue was the result of the 2017 and 2018 changes in reimbursement which reduced revenue and gross margin by $17 million. Additionally, our results include a $7 million reduction in revenue and gross margin related to a reserve recorded as the result of a ZPIC audit in four care centers in Florida. Growth in episodic volumes and reductions in operating expenses helped to mitigate the impacts of the items noted above.

Net Service Revenue

Our Medicare revenue decreased approximately $29 million which includes a $7 million reduction in revenue related to the Florida ZPIC audit. Our total Medicare volumes (admissions plus recertifications) decreased by approximately 1,000 from 2016, and our revenue per episode decreased by 60 basis points which resulted in a reduction in revenue of approximately $5 million. The decrease in revenue per episode is the result of the combined impact of the 2017 and 2018 CMS rate cuts on our episodes in progress which reduced our revenue by approximately $17 million; this reduction was offset by a $12 million increase related to the acuity level of our patients.

Our non-Medicare revenue increased approximately $41 million. Admissions from episodic payors increased 27% while our per visit payors increased 2% as a result of our focus on contract payors with significant concentrations in our markets and those that add incremental margin to our operations.

Cost of Service, Excluding Depreciation and Amortization

Our cost of service increased 4% on a 3% increase in total visits. Our cost per visit increased 1% as the result of annual wage increases and increases in health insurance costs. These increases were partially mitigated by improvements in clinician productivity.

Other Operating Expenses

Other operating expenses decreased $8 million despite incurring approximately $3 million in costs related to our home health restructuring plan. These charges were offset by decreases in other care center related expenses, primarily salaries and benefits as the result of planned decreases post our Homecare Homebase ("HCHB") rollout. Other operating expenses included approximately $3 million related to acquisitions during 2017.

Hospice Division

The following table summarizes our hospice segment results of operations:

	For the Years Ended December 31,		
	2018	2017	2016
Financial Information (in millions):			
Medicare	$390.2	$350.7	$297.7
Non-Medicare	20.7	17.1	14.2
Net service revenue	410.9	367.8	311.9
Cost of service	212.0	187.5	164.5
Gross margin	198.9	180.3	147.4
Other operating expenses	85.7	77.5	71.5
Operating income	$113.2	$102.8	$75.9
Same Store Growth (1):			
Medicare revenue	11 %	17 %	15 %
Non-Medicare revenue	21 %	20 %	(16 %)
Hospice admissions	8 %	11 %	17 %
Average daily census	11 %	15 %	16 %
Key Statistical Data - Total (2):			
Hospice admissions	27,596	25,381	22,526
Average daily census	7,588	6,820	5,912
Revenue per day, net	$148.36	$147.75	$144.11
Cost of service per day	$76.53	$75.31	$75.97
Average discharge length of stay	100	93	96

(1) Same store information represents the percent increase (decrease) in our Medicare and Non-Medicare revenue, Hospice admissions or average daily census for the period as a percent of the Medicare and Non-Medicare revenue, Hospice admissions or average daily census of the prior period.

(2) Total includes acquisitions.

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

Operating Results

Overall, our operating income increased $10 million on a $43 million increase in net service revenue. The 12% increase in net service revenue was partially offset by a lower gross margin as a percentage of revenue primarily related to planned wage increases that became effective during the three-month period ended September 30, 2018, an increase in revenue price concessions and amounts due back to Medicare for hospice caps and an increase in other operating expenses.

Net Service Revenue

Our hospice revenue increased $43 million on an 11% increase in our average daily census and a 1.0% and 1.6% increase in reimbursement effective for services provided from each October 1, 2017 and October 1, 2018, respectively. We experienced a $2 million increase in our revenue price concessions and cap which partially offset the revenue increase for the year ended December 31, 2018.

Cost of Service, Excluding Depreciation and Amortization

Our hospice cost of service increased $25 million (13%) as the result of an 11% increase in average daily census. Our cost of service per day increased 2% primarily due to an increase in salary cost per day as a result of planned wage

increases.

Other Operating Expenses

Other operating expenses increased $8 million on a 12% increase in net service revenue. The increase was related to other care center related expenses, primarily salaries and benefits expense, advertising expense, information technology expense, professional fees and travel and training expense as a result of the addition of resources to support census growth.

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

Operating Results

Overall, our operating income increased $27 million on a $33 million increase in gross margin offset by a $6 million increase in other operating expenses. Our significant growth in volumes and decrease in cost of service per day resulted in a 22% increase in gross margin.

Net Service Revenue

Our hospice revenue increased approximately $56 million due to an increase in our average daily census as a result of an 11% increase in hospice admissions and an increase in reimbursement effective for services provided from each October 1, 2016 and 2017.

Cost of Service, Excluding Depreciation and Amortization

Our hospice cost of service increased $23 million as the result of a 15% increase in average daily census. Our cost of service per day decreased $0.66 primarily due to significant improvements in salary and pharmacy cost per day driven by cost controls and census growth.

Other Operating Expenses

Other operating expenses increased $6 million due to increases in other care center related expenses, primarily salaries and benefits, medical director fees and HCHB-related IT fees, driven by our census growth.

Personal Care Division

During 2018, management revised its measurement of the personal care segment's operating income (loss) to exclude certain expenses that were not directly attributable to the support of the segment, but rather a corporate support function. Prior periods have been restated to conform to the current presentation. The following table summarizes our personal care segment results of operations:

	For the Years Ended December 31,		
	2018	2017	2016
Financial Information (in millions):			
Medicare	$ —	$ —	$ —
Non-Medicare	77.2	59.6	