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January 13, 2017

**VIA HAND DELIVERY**

Ruby Potter, Administrator
Maryland Health Care Commission
Center for Health Care Facilities
Planning & Development
4160 Patterson Avenue
Baltimore, MD 21215

Re: Amedisys Hospice of the Greater Chesapeake
General Hospice Program for Prince George's County
CON Matter No. 16-16-2382

Dear Ms. Potter:

Enclosed are an original and six copies of the Applicant's Response to Completeness Questions for filing in the above-referenced case.

Should you have any questions, please contact me. Thank you for your attention to this matter.

Sincerely,

Marta D. Harting

Marta D. Harting

MDH:rlh
Enclosures

CON Matter 16-16-2382
Amedisys Hospice of the Greater Chesapeake
General Hospice Program for Prince George's County

Project Description and Project Budget

1. The project budget shows no expense for equipment. Is that correct?

**APPLICANT RESPONSE: TABLE 1: Project Budget, as submitted, does not show expenses for equipment. We have REVISED TABLE 1: Project Budget to show the expenses for office equipment to be obtained for the proposed Amedisys Hospice of the Greater Chesapeake's ("Amedisys") office to be located in Prince George's County. (See Exhibit 19). These expenses include the cost of conventional office equipment such as telephones, copiers, computers, and printers.**

**No expenses for medical equipment are included in TABLE 1: Project Budget, as it is the policy of Amedisys to not carry an inventory of medical equipment. Expenses for medical equipment have been included in TABLE 4: REVENUES AND EXPENSES – PROPOSED PROJECT. The costs of medical equipment are expensed as equipment is purchased or otherwise acquired to meet a particular patient's needs. (See TABLE 4. "Other Patient Related Expenses, CON Application, which we have attached again here for reference as Exhibit 20).**

**Part I – General Information**

2. Will there be a local PG County office?

**APPLICANT RESPONSE:**

**Yes. Amedisys will establish a local office in Prince George's County.**

**Part III – Consistency with General Review Criteria at COMAR 10.24.01.08G(3)**

**A) State Health Plan:** COMAR 10.24.13.05 standards

**Minimum Services**

3. With whom has Amedysis been in contact with as potential providers of inpatient and respite care? Please document the nature of those contacts.

**APPLICANT RESPONSE:**

**Please refer to Exhibit 21 for the existing providers of inpatient and respite care in Prince George's County that Amedysis has contacted and a description of the contact and its status. As reflected in Exhibit 21, all are open to contracting with Amedisys but prefer to wait until Amedisys is authorized to enter into an agreement. Please refer to Exhibit 22 for the inpatient services agreement that Amedisys has with Upper Chesapeake Health System for its existing hospice program in Harford County as an example of the form of agreement that Amedisys uses for these kinds of relationships. In its existing authorized jurisdictions in Maryland and throughout the Country, Amedisys always establishes contractual relationships with existing providers of inpatient and respite care to ensure that these services are readily available to its patients, and Amedisys will do the same in Prince George's County. Amedisys continues to work closely with the staff of Amedisys Home Health Care in Prince George's County to identify additional potential providers there. Additionally, following approval of the CON, Amedisys will implement a formal marketing plan to inform all interested providers of the offerings of Amedisys for the full-range of hospice care services. Among those providers who will be contacted will be those with experience treating African-Americans in the community.**

4. Please explain how pharmacy services will be provided. The response speaks to a third party that will administer pharmacy contacts, and that "patient(s) can continue to use their own pharmacy and billing is routed through Optum (our third party payor)." Explain how this works; an example might be helpful.

**APPLICANT RESPONSE:**

**Amedisys is contracted with Optum Hospice Pharmacy Services to provide Amedisys patients with easy access to retail pharmacies, facility pharmacies, home delivery, infusion options and a discount drug program for medications not covered under an existing plan.**

**Through the Optum network of pharmacies Amedisys can:**

1) **Maximize medication discounts that helps reduce medication costs**
2) **The Optum pharmacy network allows for streamlined financial and administrative processes through consolidated billing**
3) **Amedisys receives one consolidated bill from Optum for all of their pharmacy claims every 30 days**

**Other valuable services Optum offers Amedisys:**

1) **24/7 customer service**
2) **Leading clinical consulting teams and resources that provide strong clinical support to the Amedisys team in their efforts to deliver high quality patient care while containing cost**
3) **Analytic tools for easy access to utilization trends/data**
4) **Technology solutions through electronic medical record interfaces which help manage patient's eligibility, medication information and medication plan of care**

**The Optum process for Amedisys is very simple and is as follows:**

1) **The patient is admitted to Amedisys's hospice service through their electronic medical record system, Home Care Home Base**

2) **The patient admission, demographics and medication coverage information is then transmitted from HCHB to Optum via the electronic integration portal**
3) **Once the patient information is received via integration, the patient is active in the Optum system**
4) **Once the patient is active, medications can adjudicate through the Optum claims processing system. *The Optum claims processing system has been coded/system supported to process claims with Amedisys's contracted rates, designated formulary and parameter guidelines. These customized guidelines will allow the medications to process correctly at the pharmacy level**
5) **The Amedisys nurse will then contact the contracted pharmacy to order medications for the patient**
6) **The pharmacy will then process those medications through Optum's claims processing system**
7) **The medications are ready to be picked up or delivered to the patient.**

**Information to Providers and the General Public**

5. Identify and provide the location of the visiting Senior Information and Assistance Offices that Amedysis has or intends to connect with information about its PG hospice service, if approved.

**APPLICANT RESPONSE:**

**The Prince George's County Department of Aging is the Senior Information and Assistance Office that Amedysis intends to contact with information about its Prince George's hospice service. Its website is shown below:**

**http://www.princegeorgescountymd.gov/2147/Department-of-Aging**

**Charity Care and Sliding Fee Scale**

12. The application states that: "Amedisys will make a determination of probable eligibility and communicate the determination of probable eligibility to the patient and/or responsible party within two days following a patient's request for charity care services," and refers to Exhibit 8. Staff does not find that commitment in the policy. Please point it out with a highlighted copy or revise the policy if necessary.

**APPLICANT RESPONSE: Please find the revised policy at Exhibit 23.**

13. Re: notice of the charity care policy, provide examples of: the annual notice, business office postings, and link to where charity care is addressed on the web site.

**APPLICANT RESPONSE:**

**As stated in the CON Application in response to this State Health Plan standard, Amedisys will publish an annual notice of the hospice's charity care polity in publications available to residents of Prince George's County. Please refer to Exhibit 24 for a draft form of notice; please note, however, that prior to utilizing any particular form of notice Amedisys will solicit input from local contacts and organizations, including representatives of the Prince George's County Health Department, on the form of notice, as well as the best method for communicating the Amedisys notice to Prince George's County residents.**

**Amedisys is very proud of its record with respect to providing charity care to its patients, including the provision of over 10,000 charity days of care. All questions concerning Amedisys charity care policy can be found on Amedisys' FAQ website at:**

**http://www.amedisys.com/patients-and-caregivers/hospice-care/hospice-faqs**

14. Amedisys claims to be "considering adding a sliding fee scale and time payment plans for low income residents who do not qualify for full charity care, but are unable to bear the full cost of service, as required by this standard." Meeting this standard is a necessary condition of acquiring a CON. Please document that it is in place and describe your plan for publicizing it should you be approved.

**APPLICANT RESPONSE:**

**The sliding fee scale is also included the revised charity care policy found at Exhibit 23.**

15. In discussing its track record for provision of charity care, Amedisys stated that FY 2015 it "provided 47,248 days of hospice care to 922 patients, and that 239 days of care were provided to three charity care patients during that same period, .51% and .33% respectively." Are these statistics for Amedysis Hospice of Greater Chesapeake? If not, to what do they refer?

**APPLICANT RESPONSE:**

**Yes, those statistics are for Amedisys Hospice of Greater Chesapeake.**

**Quality**

16. This standard asks for documentation of Amedisys Hospice of Greater Chesapeake's compliance with all federal and State quality of care standards. Please report on your participation in the Hospice Experience of Care Survey and/or CAHPS Hospice Survey Quality Measures, including scores received and any peer comparisons. References are provided below.

    https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/Hospice_Survey.html

    http://www.hospicecahpssurvey.org/globalassets/hospice-cahps3/home-page/cahps_hospice_survey_fact_sheet_october_2015.pdf

**APPLICANT RESPONSE: Please find the relevant reports at Exhibit 25.**

17. This standard also requires an applicant's quality assurance and improvement program to be consistent with the requirements of COMAR 10.07.21.09. Please document that the Office of Health Care Quality has reviewed and approved Amedisys' QAPI.

**APPLICANT RESPONSE:**

**QAPIs are not filed and approved with OHCQ. However, please refer to Exhibit 26 for the grid demonstrating that Amedisys' QAPI complies with COMAR 10.07.21.09.**

**Linkages with Other Service Providers.**

18. Inpatient and Respite Care:

a) Amedisys responded that it would develop contracts with "shall provide inpatient hospice care through a contract with an inpatient provider that ensures continuity of patient care." Please document which provider(s) have you contacted and report the current status.

b) Amedisys stated that it will maintain contractual arrangements for the provision of respite care with qualified facilities in Prince George's County. Please identify these potential sites and document that contact has been made with them.

**APPLICANT RESPONSE:**

**Please refer to Exhibit 21 and Amedisys' response to Question 3 above.**

**B) Need**

19. The applicant's response to this criterion references Amedisys' projections of serving approximately 250 hospice patients per year. Table 2B shows admissions of 168 and patients served at 197; please explain the relation between admissions and patients served as well as explaining how those projections tie to the aforementioned projection of 250.

**APPLICANT RESPONSE: With respect to the projections of need, Amedisys sought to make it projections consistent with both the State Health Plan need methodology, as well as its own business plan for a financially viable expansion into Prince George's County. While Amedisys is confident that it can ultimately address the needs of approximately 250 Prince George's County residents (as summarized in response to the Need Criterion), its own projections through FY 2020 are more conservative, and assume a reasonable "ramp up" to achieve its admissions and patient served targets of 168 and 197 patients respectively.**

**These more conservative projections are based on both Amedisys experience operating hospice programs in other States, as well as its own hospice experience in Maryland. As the operations of its expanded program in Prince George's become established, the "tie in" between its projections and actual utilization will be reported to the MHCC on an annual basis, as is the case for Amedysis current hospice operations serving residents of Baltimore City, Baltimore County, Cecil County and Harford County.**

**D) Viability of the Proposal**

20. Table 3 shows the revenues and expenses of the "total hospice program." What does that cover? Is it Amedysis Maryland, LLC, dba Amedysis Hospice of Greater Chesapeake, or Amedisys' hospice operations on a national scale? If the latter, submit a Table 3 for Amedysis Maryland, LLC.

**APPLICANT RESPONSE:**

**The revenues and expenses shown on TABLE 3 are for Amedisys Maryland, LLC, dba Amedisys Hospice of Greater Chesapeake.**

21. The audited financial statements show that Amedysis, Inc. and Subsidiaries lost money for two of the last three fiscal years, totaling about $140 million. Please address how this affects the operations and ongoing viability of Amedysis Hospice of Greater Chesapeake.

**APPLICANT RESPONSE:**

**The losses reported for FY 2013 and FY 2015 were onetime events that have no impact on future operations, cash flow, and the ongoing viability of Amedisys Hospice of the Greater Chesapeake, and its plan to expand services into Prince George's County.**

**See Exhibit 27 which shows: 1) the onetime events as described in our audited financials, and 2) Amedisys' most recent quarterly release for 2016 that shows a profit. Quarterly reports are reviewed by Amedisys' auditors prior to release, and the FY 2016 Audited Statements will become available in the Spring.**

**F) Impact on Existing Providers**

22. Amedisys only responded to the part of this criterion that involved staffing. Please respond to this component:
***For evaluation under this subsection, an applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.***

**Applicant Response: The proposed project will not have a negative impact on existing hospice providers in Prince George's County. The Commission-projected net need of 662 patients in 2019 indicates growth in hospice volume and unmet need Prince George's County for hospice services in Prince George's County, need beyond the levels being met by existing providers. This represents need for additional hospice care providers to serve additional patients, their families, and the communities in Prince George's County. The projected growth in volume is so significant, nearly 2 new hospice patients per day. Amedisys expects there to be no measurable negative impact on the census of existing authorized hospices as a result of the approval of this project. As explained in detail in response to Standard .05G (Impact), the Commission's approval of this project (projected to serve 168 hospice patients in 2020) would not have a negative impact on existing providers because it represents part of the projected level of unmet need for 2019. Indeed, the Commission could approve this project and up to two additional hospice providers in Prince George's County to serve at or below the current average of the existing authorized hospices without producing any negative impact to existing hospice providers through lowered utilization or occupancy of existing providers.**

**The proposed project will improve geographic and demographic access to hospice services in Prince George's County services because it will represent an additional resource for hospice care in the County that will contribute towards meeting the projected unmet need for hospice services in that jurisdiction, with a particular focus**

**on increasing utilization among the African American population that under-utilizes hospice services currently.**

**Approval of this project will have no impact on the existing occupancy or utilization of existing providers. As discussed above and in response to Standard .05G, this project will meet part of the projected *unmet* need for hospice services in Prince George's County.**

**Approval of this project will not increase costs to the health care delivery system. As explained in response to 10.24.01.08G(3)(c) (Availability of More Cost Effective Alternatives), hospice care is more less costly than inpatient care settings, so by preventing avoidable inpatient hospital or nursing home stays, the project can contribute to a reduction in costs to the health care delivery system. In addition, for the great majority of hospice patients, Medicare reimbursement is fixed consistent with national payment policies, and therefore costs of providing care do not vary by provider.**

**For these reasons, approval of this project is not projected to have any impact on costs and charges of other providers.**

The instructions elaborate on what an applicant should address, as follows: *Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.*

**Applicant Response: The proposed project will have a positive impact on the health care system as an additional resource to meet the projected growth in hospice volume in Prince George's County. The project would contribute to meeting the projected large level of unmet (net) need for hospice care in Prince George's County in the target year, with a focus on increasing utilization among populations that underutilize hospice services today. The project does not duplicate existing resources because the projected**

**level of unmet need that this project will contribute to meeting is net need, which takes into account the capacity of existing hospice providers. Specifically, the Commission's need projection methodology takes into account the capacity of existing providers (subject to a growth rate) in the target year, so there is no duplication of existing resources in meeting the net need in Prince George's County.**

**In addition, Amedisys submits that several factors distinguish its project and demonstrate why it is uniquely well suited to have a positive impact in Prince George's County. These factors include the wealth of experience that Amedisys and its corporate family have in providing hospice services throughout the country as well as in Maryland, including extensive experience in public education about the benefits of hospice. Additionally, Amedisys has experience and existing relationships in Prince George's County in providing home health care, which provides a foundation for establishing relationships for an effective hospice program there. Further, Amedisys has committed to providing resources to increase the utilization of hospice care services in Prince George's County, particularly among members of the African American community, as well as to providing charity care for those that are unable to pay for services.**

I also note that under the VIABILITY criterion, Amedisys stated...

> "Amedisys does not consider its plans to provide general hospice care services to have any significant impact on the cost and charges for similar services in Prince George's County. Its projection of patient volumes, approximately 168 admissions in FY 2020, represent only a portion of the net need projected in the State Health Plan. At this level, all of the eight existing hospice care programs authorized to operate in the County can be assured of an ability to maintain their current volume of patients and visits for the next four years, as well as their cost and charges."

...But you did not make this point under the Impact criterion. Please confirm that that statement is what you would like on the record under this criterion, and/or provide another response if you are inclined to.

**Amedisys Response: This statement should be recorded as part of Amedisys' response to this criterion as well.**

## AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in these Responses to MHCC Staff Questions on the Certificate of Need Application submitted by Amedisys Hospice of Greater Chesapeake are true and correct to the best of my knowledge, information, and belief.

RT Coughlin
Name and Title

1-4-17
Date

**AFFIRMATION**

I hereby declare and affirm under the penalties of perjury that the facts stated in these Responses to MHCC Staff Questions on the Certificate of Need Application submitted by Amedisys Hospice of Greater Chesapeake are true and correct to the best of my knowledge, information, and belief.

Laura Scripp, RN, AVP of Operations — Name and Title

01-06-2017 — Date

**AFFIRMATION**

I hereby declare and affirm under the penalties of perjury that the facts stated in these Responses to MHCC Staff Questions on the Certificate of Need Application submitted by Amedisys Hospice of Greater Chesapeake are true and correct to the best of my knowledge, information, and belief.

DSO

Name and Title

DAVID KWIATKOWSKI

1/5/17

Date

# EXHIBIT 19

## REVISED TABLE 1: PROJECT BUDGET

**INSTRUCTIONS: All estimates for 1.a.-d., 2.a.-j., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. (DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)**

**A. Use of Funds**

1. Capital Costs (if applicable):

| | | | |
|---|---|---|---|
| a. | New Construction | $_____ | |
| (1) | Building | _____ | |
| (2) | Fixed Equipment (not included in construction) | _____ | |
| (3) | Land Purchase | _____ | |
| (4) | Site Preparation | _____ | |
| (5) | Architect/Engineering Fees | _____ | |
| (6) | Permits, (Building, Utilities, Etc) | _____ | |
| **SUBTOTAL** | | | $ 0 |
| b. | Renovations | | |
| (1) | Building | $_____ | |
| (2) | Fixed Equipment (not included in construction) | _____ | |
| (3) | Architect/Engineering Fees | _____ | |
| (4) | Permits, (Building, Utilities, Etc.) | _____ | |
| **SUBTOTAL** | | | $ 0 |
| c. | Other Capital Costs | | |
| (1) | Major Movable Equipment | _____ | |
| (2) | Minor Movable Equipment | _____ | |
| (3) | Contingencies | _____ | |
| (4) | Other (Office Equipment) | | $50,000 |
| **TOTAL CURRENT CAPITAL COSTS** (a - c) | | | $ 0 |
| d. | Non Current Capital Cost | | |
| (1) | Interest (Gross) | $_____ | |
| (2) | Inflation (state all assumptions, Including time period and rate) | $_____ | |
| **TOTAL PROPOSED CAPITAL COSTS** (a - d) | | | $ $50,000 |

2. Financing Cost and Other Cash Requirements:

| | | |
|---|---|---|
| a. | Loan Placement Fees | $_____ |
| b. | Bond Discount | _____ |
| c. | Legal Fees (CON Related) | $18,000 |
| d. | Legal Fees (Other) | _____ |
| e. | Printing | _____ |

| | | | |
|---|---|---|---|
| f. | Consultant Fees | | |
| | CON Application Assistance | $20,000 | |
| | Other (Specify) | | |
| g. | Liquidation of Existing Debt | | |
| h. | Debt Service Reserve Fund | | |
| i. | Principal Amortization Reserve Fund | | |
| j. | Other (Specify) | | |
| | **TOTAL (a - j)** | $ 88,000 | |
| 3. | Working Capital Startup Costs | $ 0 | |
| | **TOTAL USES OF FUNDS (1 - 3)** | | $ 88,000 |

**B. Sources of Funds for Project:**

| | | |
|---|---|---|
| 1. | Cash (100% financed through current operations) | $88,000 |
| 2. | Pledges: Gross _____, less allowance for uncollectables _____ = Net | |
| 3. | Gifts, bequests | |
| 4. | Interest income (gross) | |
| 5. | Authorized Bonds | |
| 6. | Mortgage | |
| 7. | Working capital loans | |
| 8. | Grants or Appropriation | |
| | (a) Federal | |
| | (b) State | |
| | (c) Local | |
| 9. | Other (Specify) | |
| | **TOTAL SOURCES OF FUNDS (1-9)** | $ 88,000 |

Annual Lease Costs:

| | | | | |
|---|---|---|---|---|
| a. Land | $ _____ | x _____ | = $ | _____ |
| b. Building | $ 6,000 | x 12 mo | = $ | 72,000 |
| c. Major Movable Equipment | $ _____ | x _____ | = $ | _____ |
| d. Minor Movable Equipment | $ _____ | x _____ | = $ | _____ |
| e. Other (Specify) | $ _____ | x _____ | = $ | _____ |

# EXHIBIT 20

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

**(INSTRUCTIONS: Each applicant should complete this table for the proposed project only)**

| | Projected Years (ending with first full year at full utilization) | | | |
|---|---|---|---|---|
| CY or FY (Circle) (7/1-6/30) | 2017 | 2018 | 2019 | 2020 |
| **1. Revenue** | | | | |
| a. Inpatient services | | 7,307 | 38,131 | 56,949 |
| b. Hospice House services | | | | |
| c. Home care services | | 358,543 | 1,871,091 | 2,794,528 |
| d. Gross Patient Service Revenue | | 365,850 | 1,909,222 | 2,851,478 |
| e. Allowance for Bad Debt | | (10,468) | (54,628) | (81,588) |
| f. Contractual Allowance | | (82,050) | (23,953) | (42,705) |
| g. Charity Care | | 82,050 | 23,953 | 42,705 |
| h. Net Patient Services Revenue | | 355,382 | 1,854,594 | 2,769,890 |
| i. Other Operating Revenues (Specify) | | | | |
| j. Net Operating Revenue | | 355,382 | 1,854,594 | 2,769,890 |
| **2. Expenses** | | | | |
| a. Salaries, Wages, and Professional Fees, (including fringe benefits) | | 638,174 | 1,265,007 | 1,651,551 |
| b. Contractual Services | | | | |
| c. Interest on Current Debt | | | | |
| d. Interest on Project Debt | | | | |
| e. Current Depreciation | | 6,700 | 8,100 | 10,200 |
| f. Project Depreciation | | | | |
| g. Current Amortization | | | | |
| h. Project Amortization | | | | |
| i. Supplies (medical) | | 5,953 | 29,726 | 44,399 |
| j. Other Pt Related Expenses<br>- Pharmacy<br>- DME<br>- Ambulance<br>- Other (Chemo/Radiation/Labs, Xrays, | | <br>14,000<br>14,551<br>750<br>265 | <br>67,874<br>65,397<br>2,000<br>3,607 | <br>109,557<br>97,677<br>3,000<br>7,600 |

| | | | | |
|---|---|---|---|---|
| GIP, RSP,etc) | | | | |
| ** Other Admin Expenses:<br>- Rent/Facilities<br>- Advertising<br>- Travel<br>- Office Supplies<br>- Other (phones, IT work, etc) | | 109,000<br>2,600<br>7,000<br>1200<br>16400 | 8,400<br>6,900<br>22,800<br>1200<br>23700 | 84,000<br>7,200<br>26,400<br>1,200<br>2,400 |
| k. Total Operating Expenses | | 816,592 | 1,580,310 | 2,063,783 |
| **3. Income** | | | | |
| a. Income from Operation | | (461,210) | 274,284 | 706,107 |
| b. Non-Operating Income | | | | |
| c. Subtotal | | (461,210) | 274,284 | 706,107 |
| d. Income Taxes | | | | |
| e. Net Income (Loss) | | (461,210) | 274,284 | 706,107 |

# EXHIBIT 21

**PG County Follow up:**

**Hillhaven Nursing Center**, Adelphi MD- Joyce Malin-Admin. Spoke with Joyce in September and spoke to a SW in January. Facility is open to contracting. Current Status-On hold awaiting CON decision.

3210 Powder Mill Road

Adelphi, Md 20783

301-937-3939

Contact: Joyce Malin Admin

**Futurecare Pineview**, Clinton MD- Dir of SW-Shiretta Warner and Administrator Jody Dyer. Spoke with contacts in September and in January. Facility is open to contracting. Current Status-On hold awaiting CON decision.

9106 Pineview Lane

Clinton, MD 20735

301-856-2930

Contact: Shiretta Warner, Dir of SW

Contact: Jody Dyer, Admin

**Manorcare**- Glenarden and Hyattsville, MD-SW's Cheral and Jackie. Spoke to contacts in September and in January. Facilities are open to contracting. Current Status-On hold awaiting CON decision.

600 Largo Road

Largo, MD 20774

301-350-5555

Contact: Patrina, SW, Cheral SW, and Jackie SW

6500 Riggs Road

Hyattsville, MD 20783

301-559-0300

Contact: Jacqueline (Jackie) Stevens, SW

**(Magnolia Center – new name)**, Lanham, MD- Kathleen Triggs, Director. Spoke to contact in September and in January. Facility open to contracting. Current Status-On hold awaiting CON decision.

**Doctor's Community Rehab and Patient Care Center**

6710 Mallery Drive

Lanham, MD 20706

301-552-2000

Contact: Kathleen Triggs, Executive Director

**Bradford Oaks Center**, Clinton MD- Dir of SW-Audra Smith. Spoke to facility in September and in January. Facility open to contracting. Current Status-On hold awaiting CON decision.

7520 Surratts Road

Clinton, MD 20735

301-856-1660

Contact: Audra Smith, Director

**Prince George's Hospital**-CM's. Tiffany Flake and Gwen Miles. Spoke to facility in September and in January. Facility open to contracting. Current Status-On hold awaiting CON decision.

3001 Hospital Drive

Cheverly, MD 20785

301-618-2740

Contact: Case Manager

**Doctors Community Hospital**-Business Office. Spoke to facility in September and in January. Facility open to contracting. Current Status-On hold awaiting CON decision.

8111 Good Luck Road

Lanham, MD 20706

301-324-4968

Contact: Melissa Hurst, SW 301-552-8033

Contact: Kyley, secretary/co-ordinator 301-552-8628

**Laurel Regional Hospital**-Business Office/Karen Laurer Director of CM. Spoke to facility in September and in January. Facility open to contracting. Current Status-On hold awaiting CON decision.

7300 Van Dusen Road

Laurel, MD 20707

301-725-4300

# EXHIBIT 22

Amedisys
Home Health and Hospice

# INPATIENT SERVICES AGREEMENT

THIS INPATIENT SERVICES AGREEMENT ("Agreement") is made and entered into this **26th day of August, 2013** (the "Effective Date") by and between **Amedisys Maryland, L.L.C. d/b/a Amedisys Hospice of Greater Chesapeake** ("Hospice") and **Upper Chesapeake Health System, Inc.** ("UCHS").

## RECITALS

A. WHEREAS, Hospice operates a licensed hospice program.

B. WHEREAS, UCHS owns and operates two (2) acute care, not-for-profit hospitals, Upper Chesapeake Medical Center in Bel Air, Maryland ("Upper Chesapeake Medical") and Harford Memorial Hospital in Havre de Grace, Maryland ("Harford Memorial Hospital", and Upper Chesapeake Medical and Harford Memorial Hospital are collectively referred to as the "Facility"

C. WHEREAS, Facility is a duly licensed facility that is certified to participate in the Medicare program and is able to provide inpatient care for pain control and/or symptom management.

D. WHEREAS, Hospice desires to engage UCHS, and UCHS desires to be engaged, to provide Inpatient Services at the Facility to Hospice Patients (as such terms are defined below) in accordance with the terms and conditions of this Agreement.

## AGREEMENTS

In consideration of the Recitals and mutual agreements that follow, the parties agree to the following terms and conditions:

1. Definitions.

(a) "General Inpatient Care Day" means a day on which a Hospice Patient receives Inpatient Services for pain control or symptom management which cannot be managed in other settings. Any portion of a 24-hour period, if less than 24 hours, shall constitute a General Inpatient Care Day and shall be compensated pursuant to this Agreement, except the day on which the Hospice Patient is discharged unless such patient dies as an inpatient.

(b) "Hospice Patient" means an individual who has elected, directly or through such individual's legal representative, to receive Hospice Services and is accepted by Hospice to receive Hospice Services.

(c) "Hospice Physician" means a duly licensed doctor of medicine or osteopathy employed or contracted by Hospice who, along with the Hospice Patient's attending physician (if any), is responsible for the palliation and management of a Hospice Patient's terminal illness and related conditions.

(d) "Hospice Services" means those services provided to a Hospice Patient that are reasonable and necessary for the palliation and management of such Hospice Patient's terminal illness and are specified in a Hospice Patient's Plan of Care. Hospice Services include: (i) nursing care and services by or under the supervision of a registered nurse; (ii) medical social services provided by a qualified social worker under the direction of a physician; (iii) physician services to the extent that these services are not provided by the attending physician; (iv) counseling services, including bereavement, dietary and spiritual counseling; (v) physical, respiratory, occupational and speech therapy services; (vi) home health aide/homemaker services; (vii) medical supplies; (viii) drugs and biologicals; (ix) use of medical appliances; and (x) medical direction and management of the Hospice Patient.

(e) "Inpatient Services" means inpatient beds and related services that are available at, and provided by, Facility pursuant to and at all times in compliance with its, or its affiliates, policies and procedures, including services necessary for pain control, or for symptom management. Such services include, without limitation, nursing, dietary, housekeeping, therapies, emergency, laboratory, radiology, respiratory, pharmacy, oxygen services and related ancillary services.

(f) "Interdisciplinary Group" ("IDG") means a group of qualified individuals employed by or under contract with the Hospice, including, but not limited to: a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor.

(g) "Medicare and/or Medicaid Eligible Hospice Patient" means a Hospice Patient who is eligible for Medicare and/or Medicaid benefits and who has elected the Medicare or Medicaid hospice benefit.

(h) "Plan of Care" means a written care plan established, maintained, reviewed and modified, if necessary, at intervals identified by the IDG. The Plan of Care must reflect Hospice Patient and family goals and interventions based on the problems identified in the Hospice Patient assessments. The Plan of Care includes: (i) an identification of the Hospice Services, including interventions for pain management and symptom relief, needed to meet such Hospice Patient's needs and the related needs of the Hospice Patient's family; (ii) a detailed statement of the scope and frequency of such Hospice Services; (iii) measurable outcomes anticipated from implementing and coordinating the Plan of Care; (iv) drugs and treatment necessary to meet the needs of the Hospice Patient; (v) medical supplies and appliances necessary to meet the needs of the Hospice Patient; and (vi) the IDG's documentation of the Hospice Patient's or representative's level of understanding, involvement, and agreement with the Plan of Care.

(i) "Private Pay Hospice Patient" means a Hospice Patient who is not eligible for the Medicare Part A hospice benefit, or the Medicaid hospice benefit, or if eligible, has revoked or elected not to receive the Medicare Part A hospice benefit and/or the Medicaid hospice benefit.

2. Responsibilities of UCHS.

(a) Provision of Inpatient Services.

(i) Inpatient Services. Upon the request of an authorized Hospice staff member, and to the extent that a Facility has available beds, the Facility shall provide Inpatient Services to a Hospice Patient in accordance with each Hospice Patient's Plan of Care, and at all times pursuant to applicable laws, rules, regulations, Hospice's palliative care protocols, and the Facility's then current policies and procedures, including patient care policies consistent with those of Hospice.

(ii) Availability. Facility shall be available to provide Inpatient Services 24 hours per day, 7 days per week and shall maintain sufficient personnel as Facility deems appropriate, who have the requisite training, skills and experience to meet this obligation including, but not limited to, a registered nurse on each shift who provides direct care.

(iii) Twenty-Four Hour Nursing Services. Inpatient Services furnished by a Facility shall include 24-hour nursing services that meet the nursing needs of Hospice Patients and are furnished in accordance with each Hospice Patient's Plan of Care. Each Hospice Patient must receive all nursing services as prescribed.

(iv) Home-Like Atmosphere. Facility shall provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort and privacy of patients.

(b) Professional Standards and Credentials.

(i) Professional Standards. UCHS shall ensure that all Inpatient Services are provided competently and efficiently. Inpatient Services shall meet or exceed the standards of care for providers of such services and shall be in compliance with all applicable laws, rules, regulations, professional standards and licensure requirements.

(ii) Credentials.

[a] Licensure. UCHS represents and warrants that it has and will maintain in good standing during the term of this Agreement all federal, state and local licenses and certificates required by law to provide Inpatient Services. Upon Hospice's request, UCHS shall provide Hospice with evidence of such licenses and certifications.

[b] Medicare Certification. UCHS represents and warrants that each Facility is currently, and will at all times during the term of this Agreement remain, certified to participate in the Medicare program.

[c] Qualifications of Personnel. UCHS represents and warrants that personnel providing Inpatient Services: [i] are duly licensed, credentialed,

certified, and/or registered as required under applicable state laws and pursuant to UCHS's policies and procedures; and [ii] possess the education, skills, training and other qualifications as UCHS deems necessary to provide Inpatient Services. Based on criminal background checks conducted by UCHS, Facility personnel who have direct contact with Hospice Patients or have access to Hospice Patient records have not been found to have engaged in improper or illegal conduct relating to the elderly, children or vulnerable individuals. Upon Hospice's request, Facility shall provide Hospice with proof of an individual's qualifications to provide Inpatient Services. **UCHS currently obtains and throughout the term of this Agreement shall obtain criminal background checks on personnel hired after the effective date of this Agreement, who will have direct Hospice Patient contact or access to Hospice Patient records upon hire and in accordance with State requirements**

[d] Disciplinary Action. UCHS represents and warrants that to the best of its knowledge, neither it nor any of its clinical personnel are under suspension or subject to any disciplinary proceedings by any agency having jurisdiction over professional activities of Facility or its clinical personnel and is not under any formal or informal investigation or preliminary inquiry by such department or agency for possible disciplinary action.

[e] Exclusion from Medicare or Medicaid. UCHS represents and warrants that to the best of its knowledge, neither it nor its clinical personnel have been, at any time, excluded from participation in any federally funded health care program including, without limitation, Medicare or Medicaid, nor have been convicted or found to have violated any federal or state fraud and abuse law or illegal remuneration law.

(c) Authorization of Services. Facility shall provide Inpatient Services to Hospice Patients only with the authorization of designated Hospice personnel. Facility is authorized to provide all Inpatient Services identified in the Plan of Care. Facility shall seek authorization from designated Hospice personnel prior to providing services not identified in the Plan of Care.

(d) Quality Assessment and Performance Improvement Activities. UCHS shall cooperate with Hospice in its hospice-wide quality assessment and performance improvement activities. Components of the quality assessment and performance improvement program include (i) data collection; (ii) reporting adverse patient events; analyzing their causes, and implementing preventive actions and mechanisms; and (iii) taking actions to improve performance. Upon request, Hospice shall provide UCHS with a description of its quality assessment and performance improvement program and information on performance improvement projects. Third party payors may also impose their own utilization management or quality assurance requirements which UCHS must meet. Cooperating in such activities shall not constitute a waiver of any legal privileges or rights that may apply to the information that is shared. Hospice shall maintain the confidentiality of such information in whatever form it is provided.

(e) Coordination of Care. UCHS shall participate in any meetings, when requested, for the coordination, supervision and evaluation by Hospice of the provision of Inpatient Services. Hospice and UCHS shall communicate with one another regularly and as needed, via phone, fax, email and/or in person, for each particular Hospice Patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day.

(f) Notification of Change in Condition. Facility shall immediately inform Hospice of any change in the condition of a Hospice Patient. This includes, without limitation, a significant change in a Hospice Patient's physical, mental, social or emotional status, clinical complications that suggest a need to alter the Plan of Care, a need to transfer the Hospice Patient to another facility, or the death of a Hospice Patient.

(g) Discharge Summary. Facility shall provide Hospice with a copy of the discharge summary at the time of discharge.

(h) Policies and Procedures.

(i) Hospice Policies and Procedures. In providing Inpatient Services, Facility shall abide by Hospice's policies and procedures, palliative care protocols and Plans of Care.

(ii) Facility Policies and Procedures. Facility shall institute, maintain and implement administrative procedures and patient care protocols for the Hospice Patients that are: consistent with the procedures and protocols of Hospice including, but not limited to, Hospice protocols relating to resuscitation, nutrition and hydration; in accordance with recognized professional standards of care for terminally ill patients; and reasonably necessary to implement the provisions of this Agreement. Upon the execution of this Agreement, Facility shall provide Hospice with Facility's established policies and protocols and shall promptly provide Hospice with any amendments or modifications thereto.

(i) Assist with Surveys and Complaints. Facility shall be available during federal, state, local and other surveys to cooperate with Hospice in responding to surveyor questions and survey citations, attending exit conferences, drafting plans of correction for identified survey deficiencies and providing clinical expertise when necessary to appeal survey deficiencies. In the event of any complaint filed by or with respect to a Hospice Patient or any investigation initiated by any governmental agency or any litigation commenced against Hospice, Facility shall reasonably cooperate with Hospice in an effort to respond to and resolve the same in a timely and effective manner. Facility shall also reasonably cooperate with any insurance company providing protection to Hospice in connection with investigations. Facility shall notify Hospice promptly if Facility becomes aware of any inquiries, claims, and investigations relating to a Hospice Patient.

(j) Visiting and Access by Hospice.

(i) Visiting Privileges. Facility shall permit free access and unrestricted visiting privileges, including visits by children of any age, 24 hours per day, 7 days per week.

(ii) Visitor Accommodations. Facility shall provide adequate space, located conveniently to Hospice Patient, for private visiting among Hospice Patient, Hospice Patient's family members and any other visitors. Facility shall provide adequate accommodations for Hospice Patient's family members to remain with Hospice Patient up to 24 hours per day, and permit family members privacy following the death of a Hospice Patient.

(iii) Hospice Access to Facility. Facility shall permit employees, contractors, agents and volunteers of Hospice access to Facility 24 hours per day, as necessary, to permit Hospice to counsel, treat, attend and provide services to each Hospice Patient, provided that all such persons shall be subject to, at all times while on Facility's premises, Facility's policies and procedures, and that each individual shall meet and maintain the following minimum qualifications during the term of this Agreement if applicable:

i. Be currently licensed to practice in the State of Maryland;

ii. Satisfy the applicable professional association requirements in Maryland for qualification;

iii. Shall not be excluded, sanctioned or suspended from a federal or state health care program; and

Hospice shall notify Facility immediately, but in no event later than forty-eight (48) hours after Hospice becomes aware that any such individual no longer satisfies the minimum qualifications set forth above, and the individual shall no longer be permitted access to Hospice Patients at the Facility. Hospice shall ensure and upon request provide all necessary documentation to support the requirements listed above and additionally provide all applicable documentation related to The Joint Commission standards. These may include but are not limited to:

1. Proof of Primary Source Verification of Licensure and any required certifications (e.g., - state licensure)

2. Valid current signed job description which identifies the minimum qualifications for the specific position and the tasks required to perform the job.

3. Most recent Performance Evaluation

4. Completed annual skills/competency checklist demonstrating the individual is competent to perform the essential functions of the job.

5. Proof of TB, PPD, and influenza vaccines as required by UCHS policy.

(iv) Hospice Physician. Hospice Physicians are not permitted to treat or render care to Hospice Patients at the Facility unless he or she has been credentialed by the Facility and granted staff privileges.

(k) Patient Transfer. Except in the case of an emergency, Facility shall not transfer any Hospice Patient to another care setting without the prior approval of Hospice.

(l) Physician Orders. If there are physician orders that are inconsistent with the Plan of Care or Hospice protocols, an authorized representative of Hospice shall attempt to resolve the differences directly with the physician and secure the necessary orders.

(m) Implementation of Agreement. UCHS shall designate an individual within Facility who shall be responsible for the implementation of the provisions of this Agreement ("Responsible Facility Representative"). The current Responsible Facility Representative is identified at the end of this Agreement. UCHS shall notify Hospice if a new individual is designated as the Responsible Facility Representative.

3. Responsibilities of Hospice.

(a) Assessing Continued Eligibility. Hospice shall have sole authority for assessing a Hospice Patient's continued eligibility for Hospice Services and for discharging a Hospice Patient from Hospice.

(b) Professional Management Responsibility.

(i) Compliance with Law. Hospice shall retain responsibility as the care provider to all Hospice Patients and family units, pursuant to the Medicare Conditions of Participation for Hospice Care and state and local laws and regulations. This includes admission and/or discharge of patients, patient and family assessments, reassessments, establishment of the Plan of Care, authorization of all services and management of the care through IDG meetings.

(ii) Plan of Care.

[a] Management of Plan of Care. Hospice shall retain professional management responsibility to ensure that Inpatient Services are furnished in a safe and effective manner by qualified personnel in accordance with Hospice Patient's Plan of Care.

[b] Provision of Plan of Care to Facility. Upon a Hospice Patient's admission to Facility, Hospice shall furnish a copy of the current Plan of Care. Hospice shall specify the Inpatient Services to be furnished by Facility to such Hospice Patient.

(iii) Coordination and Evaluation. Hospice shall retain responsibility for coordinating, evaluating and administering the hospice program, as well as ensuring the continuity of care of Hospice Patients, which shall include coordination of Inpatient Services. Methods used to evaluate the care may include: [a] periodic supervisory visits; [b] review of the qualifications of personnel providing Inpatient Services; [c] review of documentation; [d] evaluation of the response of a Hospice Patient to the Plan of Care; [e] discussion with patient and patient's caregivers; [f] patient evaluation surveys; and [g] quality improvement data.

(iv) Assessment of Inpatient Services. Hospice shall develop, maintain and conduct an ongoing, comprehensive assessment of the quality and appropriateness of Facility and the provision of Inpatient Services. Such assessments shall be conducted at least annually.

(c) Hospice Care Training. Hospice shall provide orientation and ongoing hospice care training to Facility's personnel as necessary to facilitate the provision of safe and effective care to Hospice Patients.

(d) Designation of Hospice Representative. For each Hospice Patient, Hospice shall designate a registered nurse, who will be responsible for coordinating and supervising services provided to a Hospice Patient and available 24 hours per day, 7 days per week for consultation with Facility concerning a Hospice Patient's Plan of Care. The Hospice representative shall monitor Facility and be available to provide information to Facility regarding the provision of Inpatient Services and to coordinate the periodic evaluation of patient progress and outcomes of care upon request. Further, the Hospice representative shall be responsible for communicating with Facility representatives to ensure quality of care for Hospice Patients and their families.

(e) Provision of Information. Hospice shall promote open and frequent communication with Facility and shall provide Facility with sufficient information to ensure that the provision of Inpatient Services under this Agreement is in accordance with the Hospice Patient's Plan of Care, assessments, treatment planning and care coordination.

(f) Policies and Procedures. Hospice shall provide Facility with copies of Hospice's policies and procedures applicable to the provision of Inpatient Services and shall meet with Facility to review such policies and procedures, as necessary.

(g) Physician Orders. All physician orders communicated by Hospice under this Agreement shall be in writing and signed by the applicable attending physician or Hospice Physician; provided, however, that in the case of urgent or emergency

circumstances, such orders may be communicated orally by any such persons. Hospice shall maintain adequate records of all physician orders communicated in connection with the Plan of Care.

(h) Assist with Surveys and Complaints. Hospice shall be available during federal, state, local and other surveys to assist Facility in responding to surveyor questions and survey citations, attending exit conferences, drafting plans of correction for identified survey deficiencies and providing medical expertise when necessary to appeal survey deficiencies. In the event of any complaint filed by or with respect to a Hospice Patient or any investigation initiated by any governmental agency or any litigation commenced against Facility, Hospice shall fully cooperate with Facility in an effort to respond to and resolve the same in a timely and effective manner. Hospice shall also cooperate fully with any insurance company providing protection to Facility in connection with investigations. Hospice shall notify Facility promptly of any inquiries, claims and investigations.

(i) Notification of Hospice Services. Hospice shall fully inform Hospice Patient of the Hospice Services to be provided by Hospice.

4. Billing and Payment.

(a) Billing and Payment for Inpatient Services Provided to Medicare and/or Medicaid Eligible Hospice Patients.

(i) Rates. Hospice shall pay UCHS a fixed rate for each General Inpatient Care Day provided to a Medicaid and/or Medicare Eligible Hospice Patient, except the day on which such patient is discharged from Facility, unless such patient dies while residing at Facility. The fixed payment rate shall be 95% of the rate Hospice receives from Medicare or Medicaid for each General Inpatient Care Day. UCHS shall accept this rate as payment in full for each General Inpatient Care Day provided to Medicare and/or Medicaid Eligible Hospice Patients and shall not bill such patients, their family, representatives or any third party payor. The rate represents fair market value and does not take into account the volume or value of referrals. Hospice shall meet with UCHS at least 60 days prior to the end of the then current term of this Agreement to discuss the rate.

(ii) Billing and Payment. Within ten (10) calendar days of the end of the month and within at least 30 days of providing Inpatient Services, UCHS shall submit to Hospice an accurate and complete statement of Inpatient Services provided to Medicare and/or Medicaid Eligible Hospice Patients. The statement shall be in a form acceptable to Hospice and include information usually provided to third party payors to verify services and charges, which may include, but is not limited to: [a] the name of the Medicare and/or Medicaid Eligible Hospice Patient; [b] the dates for the General Inpatient Care Days; [c] the total charges to Hospice for each Medicare and/or Medicaid Eligible Hospice Patient; and [d] any other information requested by Hospice. Hospice shall pay UCHS within 60 days after receipt of a complete statement. All invoices shall be submitted to:

Amedisys, Inc
Accounts Payable Dept
P.O. Box 90002
Baton Rouge, LA 70879-0002
Or to: hospiceaccountspayable@amedisys.com

(b) Billing and Payment for Inpatient Services Provided to Private Pay Hospice Patients. UCHS may bill usual and customary charges for all Inpatient Services provided under this Agreement directly to Hospice Patients who are Private Pay Hospice Patients or their applicable third party payor. UCHS shall accept such payment as payment in full for Inpatient Services. Hospice will not be responsible for reimbursing UCHS for any portion of the cost of Inpatient Services provided to a Private Pay Hospice Patient. UCHS shall not seek payment from Hospice in the event of default of financial obligations on the part of a Private Pay Hospice Patient or third party payors. Hospice will, to the extent permitted by law, provide UCHS with any information it may reasonably require to obtain payment from any payor or other permissible payment source.

(c) Limitation on Hospice's Financial Responsibility. Hospice shall retain financial management responsibility for care furnished by Hospice, directly or under arrangement with other providers, which is related to a Hospice Patient's terminal illness, provided that such care is specified in the Plan of Care for the patient. Hospice shall bear no responsibility, obligation or other liability to reimburse Facility for any charges, costs, expenses or other fees for services: (i) provided to Hospice Patients who are not Medicare and/or Medicaid Eligible Hospice Patients; (ii) that are not in conformity with the Plan of Care for a given Medicare and/or Medicaid Eligible Hospice Patient; and/or (iii) that are provided without the prior authorization of Hospice.

5. Insurance and Hold Harmless.

(a) Insurance. Each party shall obtain and maintain appropriate professional liability, commercial general liability, worker's compensation and employer's liability insurance coverage in accordance with the minimum amounts required from time to time by applicable federal and state laws and regulations, but at no time shall the terms or coverage amounts of such professional liability, commercial general liability, and employer's liability insurance be less than $1 million per claim and $3 million in the aggregate. Each party shall provide evidence of such insurance to the other party prior to the effective date of this Agreement, and shall thereafter notify the other party not less than 30 days in writing in advance of any reduction, suspension or termination of any coverage required under this Section 5.

(b) Mutual Hold Harmless. Each party hereby agrees to indemnify and hold harmless and defend the other party, and its officer, directors, employees and or agents, from and against any and all claims, suits, damages, fines, penalties, liabilities, losses, damages, costs and expenses (including reasonable attorney's fees and court costs) resulting from or arising out of, any act or omission by the indemnifying party or

any of its directors, officers, employees, agents, or volunteers pertaining to this Agreement.

6. Records.

(a) Creation and Maintenance of Records. Each Facility shall prepare and maintain complete and detailed records concerning each Hospice Patient receiving Inpatient Services under this Agreement in accordance with prudent record-keeping procedures and as required by applicable federal and state laws and regulations and Medicare and Medicaid program guidelines. Facility shall retain such records pursuant to and in accordance with its policies and procedures then in effect and as required by applicable federal and state law. Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each Hospice Patient, including evaluations, treatments, progress notes, authorizations to admission to Hospice and/or Facility, physician orders entered pursuant to this Agreement and discharge summaries, and shall be signed and dated by the person providing Inpatient Services.

(b) Access by Hospice. Facility shall permit Hospice or its authorized representative, upon reasonable notice, to review and make photocopies of records maintained by Facility relating to the provision of Inpatient Services including, but not limited to, clinical records and billing and payment records. Not more than once per year, Hospice may, at its expense, retain an independent public accountant or other auditor to review the financial transactions related to this agreement and prepare a detailed statement showing the charges made to Hospice by Facility. This section shall survive the termination of this Agreement.

(c) Inspection by Government. In accordance with 42 U.S.C. § 1395x(v)(1)(i) and 42 C.F.R. § 420.300, et seq., UCHS shall make available, until the expiration of five years from the termination of this Agreement, upon written request, to the Secretary of Health and Human Services of the United States, and upon request, to the Comptroller General of the United States, or any of their duly authorized representatives, this Agreement and any of its books, documents and records that are necessary to certify the nature and costs of Medicare reimbursable services provided under this Agreement. If and to the extent UCHS carries out any of its duties under this Agreement through a subcontract with a related organization having a value or cost of $10,000 or more over a 12-month period, then UCHS shall ensure that the subcontract contains a clause comparable to the clause in the preceding sentence. Nothing contained in this section shall be construed as a waiver by either party of any legal rights of confidentiality with respect to patient records and proprietary information.

(d) Destruction of Records. UCHS shall take reasonable precautions to safeguard records against loss, destruction and unauthorized disclosure.

7. Confidentiality. Each party acknowledges that as part of its performance under this Agreement, it may be required to disclose to the other party certain information pertaining to Hospice Patients (collectively, "Patient Information") and may

be required to disclose certain business or financial information (collectively, with the Patient Information, the "Confidential Information"). Each party agrees that it shall treat Confidential Information with the same degree of care it affords its own similarly confidential information and shall not, except as specifically authorized in writing by the other party or as otherwise required by law, reproduce any Confidential Information or disclose or provide any Confidential Information to any person. A party that discloses Confidential Information shall be entitled to injunctive relief to prevent a breach or threatened breach of this section, in addition to all other remedies that may be available. This section shall survive termination of this Agreement.

8. Term and Termination.

(a) Term. This Agreement shall have an initial term of one year beginning on the Effective Date ("Initial Term") and shall automatically renew for successive one year terms, unless sooner terminated as provided below.

(b) Termination.

(i) Without Cause. This Agreement may be terminated by either party for any reason by providing at least 90 days' prior written notice to the other party. In the event of termination of this Agreement during the first year of the term, the parties shall not enter into a new agreement for the same or substantially the same arrangement for the duration of the year. This provision shall survive termination of this Agreement.

(ii) Mutual Written Agreement. This Agreement may terminate at any time after the Initial Term upon written agreement of the parties.

(iii) For Cause. Either party may terminate this Agreement upon 30 days' prior written notice to the other party, if the other party breaches this Agreement and fails to cure such breach within such 30-day period.

(iv) Change in Law. In the event there are substantial changes or clarifications to any applicable laws, rules or regulations that materially affect, in the opinion of either party's legal counsel, any party's right to reimbursement from third party payors or any other legal right of any party to this Agreement, the affected party may, by written notice to the other party, propose such modifications to this Agreement as may be necessary to comply with such change or clarification. Upon receipt of such notice, the parties shall engage in good faith negotiations regarding any appropriate modifications to this Agreement. If such notice is given and the parties are unable within 60 days thereafter to agree to appropriate modifications to this Agreement, either party may terminate this Agreement by providing at least 30 days' notice to the other party.

(v) Immediate Termination. Notwithstanding the above, either party may immediately terminate this Agreement if:

[a] Failure to Have Qualifications. A party or its personnel providing services hereunder are excluded from any federal health program or

no longer have the necessary qualifications, certifications and/or licenses required by federal, state and/or local laws to provide Inpatient Services.

[b] Liquidation. A party commences or has commenced against it proceedings to liquidate, wind up, reorganize or seek protection, relief or a consolidation of its debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

[c] Failure to Have Insurance. A party ceases to have any of the insurance required under this Agreement.

[d] Threats to Health, Safety or Welfare. A party fails to perform its duties under this Agreement and the other party determines in its full discretion that such failure threatens the health, safety or welfare of any patient.

[e] Commission of Misconduct. A party commits an act of misconduct, fraud, dishonesty, misrepresentation or moral turpitude involving the other party or a mutual patient of the parties.

(c) Effect of Termination on Availability of Inpatient Services. In the event this Agreement is terminated, UCHS shall work with Hospice in coordinating the continuation of Inpatient Services to existing Hospice Patients and shall continue to provide Inpatient Services to Hospice Patients after this Agreement is terminated, if the parties mutually agree that removing Inpatient Services would be detrimental to Hospice Patients. In such cases, Inpatient Services shall continue to be provided in accordance with the terms set forth in this Agreement and UCHS shall be paid for the provision of such services pursuant to this Agreement. This section shall survive termination of this Agreement.

9. Notification of Material Events. Either party shall immediately notify the other party of:

(a) Ownership Change. Any change in 10% or more of its ownership.

(b) Business Address Change. Any change in business address.

(c) Licensure Actions. Any sanctions, intermediate or otherwise, administrative or judicial fines, penalties, or action by federal or state officials against the party or its personnel providing services hereunder.

(d) Exclusion. Any threatened, proposed or actual exclusion of it or any of its subcontractors or personnel providing services hereunder, from any government program including, but not limited to, Medicare or Medicaid.

(e) Insurance. The cancellation or modification of any of the insurance coverage that the party is required to have under this Agreement.

(f) Liquidation. The commencement of any proceeding to liquidate, wind up, reorganize or seek protection, relief or a consolidation of UCHS's or Hospice's debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

(g) Incident Reporting. Any of the following alleged incidents involving a Hospice Patient:

(i) mistreatment or neglect;

(ii) verbal, mental, sexual or physical abuse;

(iii) injuries of an unknown source; or

(iv) misappropriation of patient property.

10. Nondiscrimination. The parties agree that in the performance of this Agreement they will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, sex, age, religion, national origin, or any other protected class in any manner prohibited by federal or state laws.

11. Independent Contractor. In performance of the services discussed herein, Hospice and UCHS shall each be, and at all times are, acting and performing as an independent contractor, and not as a partner, a co-venturer, an employee, an agent or a representative of the other. No employee or agent of one party to this Agreement shall be considered an employee or agent of the other party.

12. Use of Name or Marks. Neither Hospice nor UCHS shall have the right to use the name, symbols, trademarks or service marks of the other party in advertising or promotional materials or otherwise without receiving the prior written approval of such other party.

13. Verification of Regulatory Requirements. Hospice shall verify compliance with the following requirements established by the Medicare Conditions of Participation for Hospice Care.

(a) Copy of Plan of Care. Hospice shall document in the patient's record that the Plan of Care has been provided to Facility and specify the Inpatient Services that Facility will furnish. Hospice shall periodically review Hospice Patients' records to verify that these requirements are met.

(b) Patient Care Policies. Hospice shall verify that Facility has established patient care policies that are consistent with Hospice's policies and agrees to abide by the palliative care protocols and Plans of Care established by Hospice for its patients. Hospice shall review Facility's policies to determine their consistency with Hospice policies.

(c) Inpatient Clinical Records. Hospice shall periodically review Hospice Patients' inpatient clinical records to determine that they include a record of all Inpatient Services furnished and events regarding care that occurred at Facility. Facility shall make inpatient clinical records available to Hospice at all times, including after discharge.

(d) Copy of Discharge Summary. Hospice shall document in the patient's record that Facility provided a copy of the discharge summary at the time of discharge. Hospice shall periodically review Hospice Patients' records to verify that this requirement is met.

(e) Responsible Facility Representative. The Responsible Facility Representative is identified at the end of this Agreement. UCHS shall immediately notify Hospice if a new Responsible Facility Representative is appointed, and shall inform Hospice of the name and contact information of the new Responsible Facility Representative. Hospice shall maintain a record of Responsible Facility Representatives.

(f) Hospice Training. UCHS shall provide Hospice with a list of Facility personnel who will be providing care to Hospice Patients, indicating whether each person has already been provided with hospice training. For personnel who have already received training, Facility shall provide Hospice with the names of the individuals who gave the training and a description of the training. For personnel who have not received hospice training, Hospice shall provide training, and shall document the names of the individuals who gave the training and a description of the training. Upon hiring new personnel who will be providing care to Hospice Patients, Facility shall notify Hospice and indicate whether the personnel have received hospice training and, if so, the names of the individuals who gave the training and a description of the training.

14. Miscellaneous Provisions.

(a) Amendment. No amendment, modification or discharge of this Agreement, and no waiver hereunder, shall be valid or binding unless set forth in writing and duly executed by the parties hereto.

(b) Severability. This Agreement is severable, and in the event that any one or more of the provisions hereof shall be deemed invalid, illegal or unenforceable in any respect, the validity, legality and enforceability of the remaining provisions contained herein shall not in any way be affected or impaired thereby.

(c) Headings. The descriptive headings in this Agreement are for convenience only and shall not affect the construction of this Agreement.

(d) Governing Law. This Agreement, the rights and obligations of the parties hereto, and any claims or disputes relating thereto, shall be governed by and construed in accordance with the laws of the State of Maryland.

(e) Nonassignability. Neither party shall assign nor transfer, in whole or in part, this Agreement or any of its rights, duties or obligations under this Agreement

without the prior written consent of the other party, and any assignment or transfer without such consent shall be null and void. Notwithstanding the foregoing, this Agreement shall inure to the benefit of any successor in interest of either party.

(f) Waiver. The waiver by either party of a breach or violation of any provision in this Agreement shall not operate or be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any such provisions, rights, or privileges hereunder.

(g) Binding Effect. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns. There are no third party beneficiaries of or to this Agreement.

(h) No Third Party Beneficiaries. Except as expressly provided elsewhere herein, nothing in this Agreement is intended to be construed or be deemed to create any rights or remedies in any third party.

(i) Force Majeure. In the event that either party's business or operations are substantially interrupted by acts of war, fire, labor strike, insurrection, riots, earthquakes or other acts of nature of any cause that is not that party's fault or is beyond that party's reasonable control, then that party shall be relieved of its obligations only as to those affected operations and only as to those affected portions of this Agreement for the duration of such interruption.

(j) No Requirement to Refer. This Agreement is not intended to influence the judgment of any physician or provider in choosing medical specialists or medical facilities appropriate for the proper care and treatment of residents. Neither UCHS nor Hospice shall receive any compensation or remuneration for referrals.

(k) Nonexclusive Agreement. This Agreement is intended to be nonexclusive, and either party may use any provider for the same or similar services.

(l) Counterparts. This Agreement may be executed in any number of counterparts, all of which together shall constitute one and the same instrument.

(m) Responsible Facility Representative. UCHS has identified the following individual as the Responsible Facility Representative:_____

(n) Notices. All notices or other communications which may be or are required to be given, served or sent by any party to the other party pursuant to this Agreement shall be in writing, addressed as set forth below, and shall be mailed by first-class, registered or certified mail, return receipt requested, postage prepaid, or transmitted by hand delivery or facsimile. Such notice or other communication shall be deemed sufficiently given or received for all purposes at such time as it is delivered to the addressee (with the return receipt, the delivery receipt, the affidavit or messenger or the answer back being deemed conclusive evidence of such delivery) or at such time as delivery is refused by the addressee upon presentation. Each party may designate by

notice in writing a new address to which any notice or communication may thereafter be so given, served or sent.

**TO: HOSPICE**
**Amedisys Maryland, L.L.C. #5014**
**5959 South Sherwood Forest Blvd.**
**Baton Rouge, LA 70816**
**Attn: Contracting Department**

**TO: Upper Chesapeake Health System, Inc.**
**520 Upper Chesapeake Drive Suite 405**
**Bel Air, Maryland, 21014**
**Attn:**_____

(o) Entire Agreement. This instrument contains the entire agreement of the parties hereto and supersedes all prior oral or written agreements or understandings between them and any predecessors in ownership, with respect to the matters provided for herein. This Agreement may not be modified or amended except by mutual consent of the parties, and any such modification or amendment must be in writing duly executed by the parties hereto, and shall be attached to, and become a part of, this Agreement.

The parties have executed this Agreement as of the day, month and year first written above.

**Amedisys Maryland, L.L.C.**
**d/b/a Amedisys Hospice of Greater Chesapeake:**

By:_____
Name: David Forrest
Title: Sr. Sourcing Specialist - Hospice

**Upper Chesapeake Health System, Inc.:**

By:_____
Name: Joseph E. Hoffman III
Title: EVP/CFO

# EXHIBIT 23

| Policy: FM-006 | Date(s) Revised: | 12/2016 |
|---|---|---|
| **Subject:** ***Indigent and Charity*** | | |
| **Applicable Service(s):** Hospice | **Page:** | Page 1 of 5 |

## PURPOSE:

To provide guidelines for establishing patient eligibility for uncompensated services.

## PROCEDURE:

1. Requirements for Consideration of Indigent or Charity Services
   a. The indigent patient must meet the indigent income levels of 125% of the Federal Poverty Guidelines (for appropriate family size) as defined below for the year 2016, or subsequent years as those guidelines are updated by the Federal government.

   b. The charitable patient must have an income level greater than 125% of the Federal Poverty Guidelines, for his or her family size, but less than 400% of the Federal Poverty Guidelines.

   c. An indigent or charitable patient has no other source of governmental, insurance or other third-party reimbursement for all or the portion of his or her bill that is written-off or discounted pursuant to this policy. An income qualified indigent or charity patient may be so qualified, however, for services rendered in excess of (or excluded from) that patient's defined benefits under any governmental or insurance coverage.

   d. The patient and/or staff member working with the patient should document his or her income by the best available information in his/her possession, such as W-2 form, pay stub, tax return, Medicaid card, or other similar documentation of income level. Persons seeking a discount under this policy should fill out a form that attests to his or her income and family size and the social worker or intake personnel may make his or her own determination whether the income and family size information is accurate and correct, in the absence of documentation of income. The social worker should so indicate in the patient's file that this determination has been made. In the event that Amedisys is prohibited from obtaining detailed information concerning a particular patient, an appropriate staff member may make a determination of the patient's status as an indigent or charity case based on the totality of the patient's circumstances. As applicable, the indigent or charity patient's file shall also retain the income form filled out by the patient, including written documentation of the patient's income, if any.

   e. The home health agency should provide a copy of it to any patient upon request and to any patient the social worker or intake personnel deems may benefit from it.

**2016 Poverty Guidelines for the 48 Contiguous States and the District of Columbia are as follows:**

| PERCENT OF POVERTY GUIDELINE | |
|---|---|
| FAMILY SIZE | 100% |
| 1 | 11,880 |
| 2 | 16,020 |
| 3 | 20,160 |
| 4 | 24,300 |
| 5 | 28,440 |
| 6 | 32,580 |
| 7 | 36,730 |
| 8 | 40,890 |

For family units of more than 8 members, add $4,160 for each additional member.

**Alaska Only**

| PERCENT OF POVERTY GUIDELINE | |
|---|---|
| FAMILY SIZE | 100% |
| 1 | 14,840 |
| 2 | 20,020 |
| 3 | 25,200 |
| 4 | 30,380 |
| 5 | 35,560 |
| 6 | 40,740 |
| 7 | 45,920 |
| 8 | 51,120 |

For family units of more than 8 members, add $5,200 for each additional member.

**Hawaii Only**

| PERCENT OF POVERTY GUIDELINE | |
|---|---|
| FAMILY SIZE | 100% |
| 1 | 13,670 |
| 2 | 18,430 |
| 3 | 23,190 |
| 4 | 27,950 |
| 5 | 32,710 |
| 6 | 37,470 |
| 7 | 42,230 |
| 8 | 47,010 |

For family units of more than 8 members, add $4, 780 for each additional member.

2. Patients are required to disclose all circumstances surrounding insurance, third party coverage, assets, liabilities, guarantors, and any other factors. Guarantors may include immediate family, relatives, friends, significant others, individuals involved in accidents or liability coverage or the responsible party in the case of a pregnancy.

3. If the patient is eligible for any state or federal assistance and has not applied to the program, application should be made prior to consideration for uncompensated services. Indigent or charity status may be provisionally granted while eligibility for other governmental assistance programs is sought.

4. Patients who fail to cooperate fully in obtaining assistance will be ineligible for uncompensated services and efforts will ensue to collect payment for all services rendered until appropriate income information is obtained to demonstrate qualification for indigent or charity status.

5. Victims of assault must press charges or initiate legal action as appropriate against their assailant to be considered eligible for indigent services.

6. No patient or his or her charges shall be counted as indigent or charity if any legal action has been pursued against such patient, including garnishment, lawsuit, etc., or whose payment history has

been submitted to a credit reporting agency. However, collection activities may be pursued that do not involve legal action or credit agency reporting either by Amedisys or third party agents. A determination of income eligibility for indigent or charity status may be made at any time prior to such legal action being taken.

7. Changes in billing or payment practices by an insurer or governmental payor that render a patient ineligible for coverage by such payor may be considered in determining if a patient qualifies.

8. The approval levels for Indigent/Charity care are based upon job classifications - see MI-002 Indigent and Charity in the Miscellaneous Folder of Revenue Recovery policies and procedures for additional information.

## ***State Specific Requirements***

***Connecticut:***

19-13-D78. Patient's bill of rights and responsibilities

An agency shall have a written bill of rights and responsibilities governing agency services which shall be made available and explained to each patient or representative at the time of admission. Such explanation shall be documented in the patient's clinical record. The bill of rights shall include but not be limited to:

a) A description of available services, unit charges and billing mechanisms. Any changes in such must be given to the patient orally and in writing as soon as possible but no later than thirty (30) working days from the date the agency becomes aware of a change;
**b) Policy on uncompensated care;**
c) Criteria for admission to service and discharge from service;
d) Information regarding the right to participate in the planning of the care to be furnished, the disciplines that will furnish care, the frequency of visits proposed and any changes in the care to be furnished, the person supervising the patients' care and the manner in which that person may be contacted;
e) Patient responsibility for participation in the development and implementation of the home health care plan;
f) Right of the patient or designated representative to be fully informed of patients' health condition, unless contraindicated by a physician in the clinical record
g) Right of the patient to have his or her property treated with respect;
h) Explanation of confidential treatment of all patient information retained in the agency and the requirement for written consent for release of information to persons not otherwise authorized under law to receive it;
i) Policy regarding patient access to the clinical record;
j) Explanation of grievance procedure and right to file grievance without discrimination or reprisal from agency regarding treatment or care to be provided or regarding the lack of respect for property by anyone providing agency services;
k) Procedure for registering complaints with the commissioner and information regarding the availability of the Medicare toll-free hotline, including telephone number, hours of operation for receiving complaints or questions about local home health agencies;

Agency's responsibility to investigate complaints made by a patient, patient's family or guardian regarding treatment or care provided or that fails to be provided and lack of respect for the patient's property by anyone providing agency services. Agency complaint log shall include date, nature and resolution of the complaint. (Effective September 20, 1978; Am

***Georgia:***

1. Providing a written commitment that services for indigent and charity patients will be offered at a standard which meets or exceeds one percent of annual, adjusted gross revenues for the home health agency or, in the case of an applicant providing other health services, the applicant may request that the Division allow the commitment for services to indigent and charity patients to be applied to the entire facility;
2. Providing documentation of the demonstrated performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to Medicare, Medicaid, and indigent and charity patients;

***Maryland:***

**Maryland Sliding Fee Scale**

The charitable patient must have an income level greater than 125% of the Federal Poverty Guidelines, for his or her family size, but less than 400% of the Federal Poverty Guidelines to qualify for a discounted fee.

The discounted fee will be applied as follows:

| Poverty Level (at or below) | % Discount |
|---|---|
| 125% | 100% |
| 150% | 90% |
| 175% | 80% |
| 200% | 70% |
| 225% | 60% |
| 250% | 50% |
| 275% | 40% |
| 300% | 30% |
| 325% | 20% |
| 350% | 10% |
| 375% | 5% |
| 400% | 5% |

Amedisys will make a determination of probable eligibility for financial assistance and/or reduced fees within two business days after the request is made.

***New York:***

Indigent Care (Certified Home Health Agencies ONLY):

Charity Care is provided to patients who are un-eligible for covered health benefits under Title XVIII or XIX of the Social Security Act, and are unable to pay full charges, and are not covered by private insurance and their total household income is less than two-hundred percent (200%) of the federal poverty level at no or reduced charge for care from a certified home health agency.

Charity Care in each fiscal year:

*Non-Profit & For Profit Agencies*

- No less than two percent (2%) of agency total operating cost in that fiscal year.

*Public Agencies*

- Three and one third percent (3 1/3%) of agency total operating cost in that fiscal year.

The Health system agency may request the New York State Department of Health to adjust the charity care percentages based on significant variations between county and state averages in respect to proportion of indigent and medically uninsured persons to total population.

***Rhode Island:***

Agency shall endeavor to provide uncompensated care in an amount equal to one percent (1%) of net patient revenue earned on an annual basis. Uncompensated care shall be cost adjusted by applying ratio of costs to charges from the licensee's Medicare Cost Report. Licensees not filing Medicare Cost Reports shall submit an audited financial report or such other report as deemed acceptable to the Director.

**Tennessee:**

**1200-08-26-.04 ADMINISTRATION.**

(22) The facility shall develop a concise statement of its charity care policies and shall post such statement in a place accessible to the public.

# EXHIBIT 24

[AMEDISYS HOSPICE OF GREATER CHESAPEAKE LOGO]

# FINANCIAL ASSISTANCE POLICY

Amedisys Hospice of Greater Cheapeake ("Amedisys Hospice") provides hospice care to residents of Prince George's County. Amedisys Hospice is committed to providing accessible hospice care to its community. Hospice care is available to all patients regardless of their race, color, national origin, gender or ability to pay. Amedisys Hospice offers financial assistance to residents of Prince Georges County who are unable to pay for its services and who apply for financial assistance under the program. Eligibility to pay is determined on an individual basis based on income as explained in the financial assistance policy. If you have any questions about Amedisys Hospice's financial assistance policy, please contact us at _____ or visit our website for to review the financial assistance policy: **http://www.amedisys.com/patients-and-caregivers/hospice-care/hospice-faqs**

# EXHIBIT 25

# DEYTA

**Integrated HQRP Report**
**Hospice CAHPS & HIS Results**
***Amedisys Home Health Services***

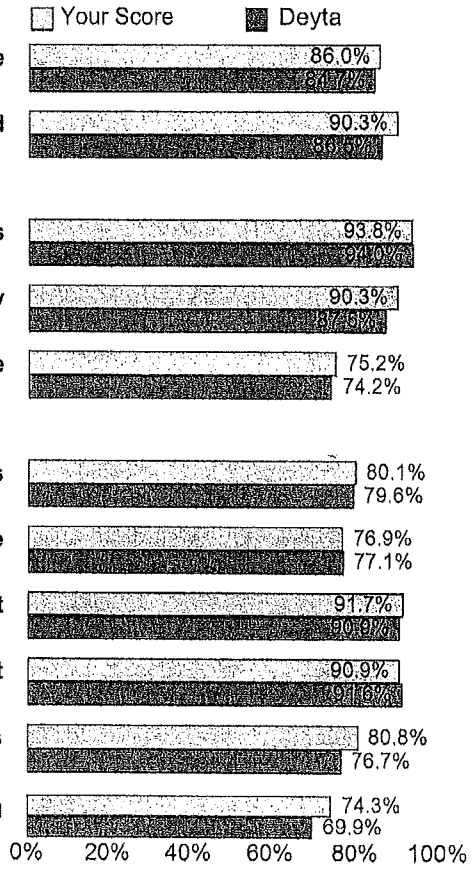
**Timeframe: 2016 (1/1/2016 - 8/31/2016)**
**CMS Complete Surveys: 186**

**Report Level: CCN# 211536**
**HIS Discharge Records: n/a**

## HOSPICE CAHPS QUALITY MEASURES

**Report by: Sample Month**

*Interim results. CMS-published reports are official results.*




| | Your Score | Deyta | Difference | |
|---|---|---|---|---|
| **Global Measures** | | | | |
| Rating of Patient Care | 86.0% | **84.7%** | 1.3% | ↑ |
| Would Recommend | 90.3% | **86.5%** | 3.8% | ↑ |
| **Single Item Measures** | | | | |
| Support for Spiritual Beliefs | 93.8% | **94.0%** | -0.2% | ↓ |
| Information Continuity | 90.3% | **87.5%** | 2.8% | ↑ |
| Side Effects of Pain Medicine | 75.2% | **74.2%** | 1.0% | ↑ |
| **Composite Measures** | | | | |
| Hospice Team Communications | 80.1% | **79.6%** | 0.5% | ↑ |
| Getting Timely Care | 76.9% | **77.1%** | -0.2% | ↓ |
| Treat Patient with Respect | 91.7% | **90.9%** | 0.8% | ↑ |
| Providing Emotional Support | 90.9% | **91.6%** | -0.7% | ↓ |
| Getting Help with Symptoms | 80.8% | **76.7%** | 4.1% | ↑ |
| Getting Hospice Care Training | 74.3% | **69.9%** | 4.4% | ↑ |

## HOSPICE ITEM SET NQF QUALITY MEASURES

HIS data is only available for hospices using Deyta's Quality Actionboards.

**Your Score is:** ↑ **Higher than Deyta** ◉ **Same as Deyta** ↓ **Lower than Deyta**

# DEYTA

## Quality Measure Dashboard
## Hospice CAHPS
***Amedisys Home Health Services***

**Timeframe:** Jan 2016 - Dec 2016 (1/1/2016 - 12/31/2016)
**Report by:** Survey Return Date

**Surveys Included:** Only CMS Complete
**Report Level:** 211536

## GLOBAL MEASURES

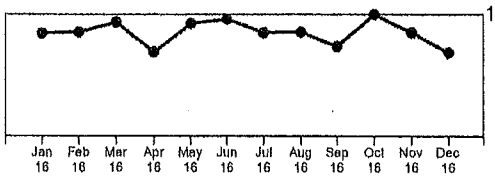
***Interim results. CMS-published reports are official results.***

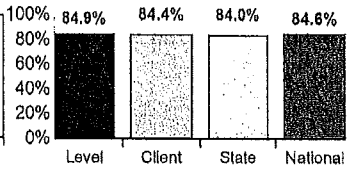
Report Level Results | Report Level Monthly Trends | Comparison Results

### Rating of Patient Care (Survey Question: 39)

% Favorable: **84.9%**

% Unfavorable: **15.1%**

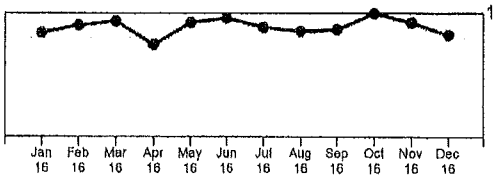


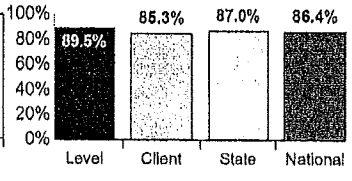




### Would Recommend This Hospice (Survey Question: 40)

% Favorable: **89.5%**

% Unfavorable: **10.5%**



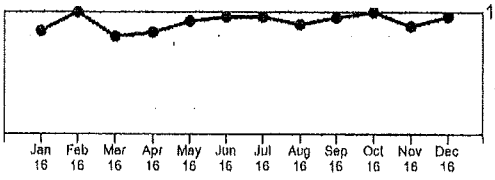



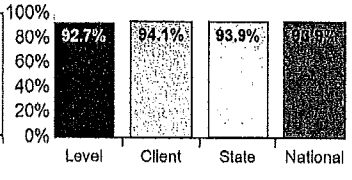

## SINGLE ITEM MEASURES

### Support for Religious and Spiritual Beliefs (Survey Question: 36)

% Favorable: **92.7%**

% Unfavorable: **7.3%**

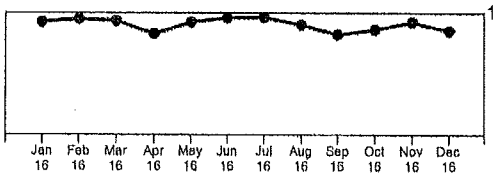


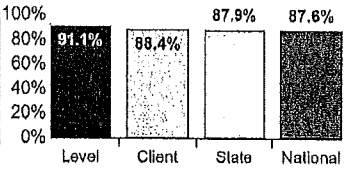




### Information Continuity (Survey Question: 10)

% Favorable: **91.1%**

% Unfavorable: **8.9%**

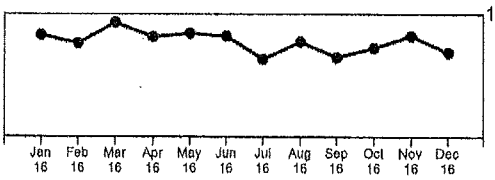


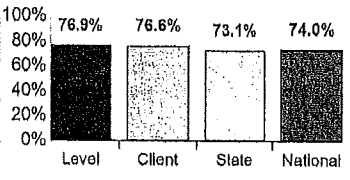




### Understanding Side Effects of Pain Medications (Survey Question: 18)

% Favorable: **76.9%**

% Unfavorable: **23.1%**




## SURVEY PARTICIPATION

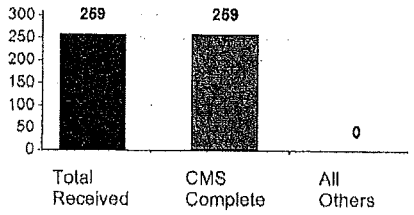
**Records Submitted to Deyta**

Not available by Survey Return Date

**Surveys Sampled**

Not available by Survey Return Date

**Surveys Received**



DEYTA

# Quality Measure Dashboard
# Hospice CAHPS
## *Amedisys Home Health Services*

**Timeframe:** Jan 2016 - Dec 2016 (1/1/2016 - 12/31/2016)
**Report by:** Survey Return Date

**Surveys Included:** Only CMS Complete
**Report Level:** 211536

**COMPOSITE MEASURES**

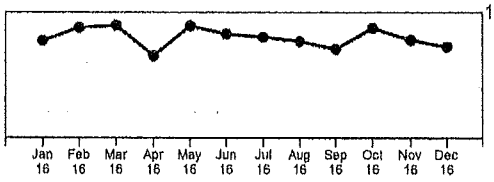
***Interim results. CMS-published reports are official results.***

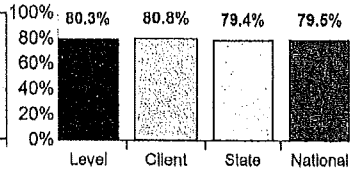
Report Level Results | Report Level Monthly Trends | Comparison Results

### Hospice Team Communications (Survey Questions: 6, 8, 9, 14, 35)

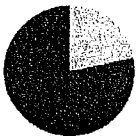
% Favorable: **80.3%**

% Unfavorable: **19.7%**



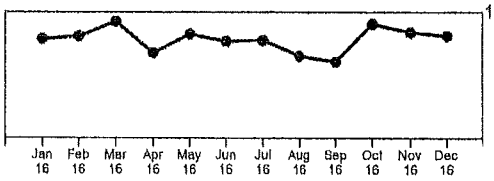



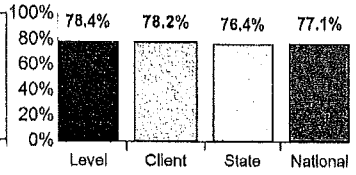

### Getting Timely Care (Survey Questions: 5, 7)



% Favorable: **78.4%**

% Unfavorable: **21.6%**

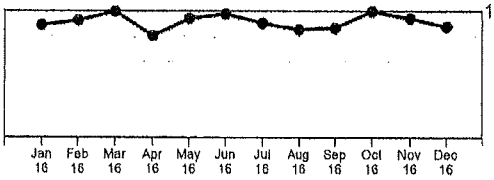


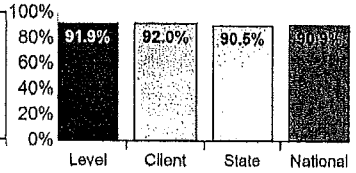




### Treating Family Member with Respect (Survey Questions: 11, 12)

% Favorable: **91.9%**

% Unfavorable: **8.1%**

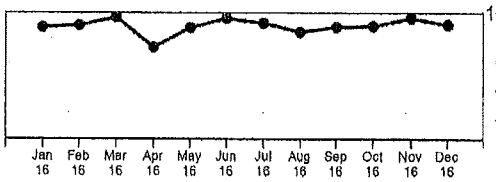


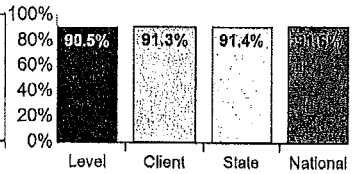




### Providing Emotional Support (Survey Questions: 37, 38)

% Favorable: **90.5%**

% Unfavorable: **9.5%**

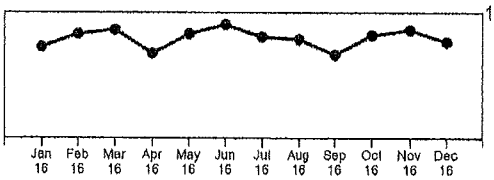


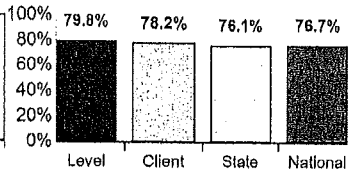




### Getting Help with Symptoms (Survey Questions: 16, 22, 25, 27)

% Favorable: **79.8%**

% Unfavorable: **20.2%**

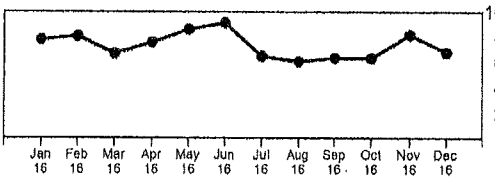


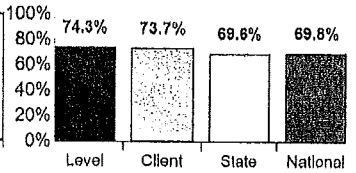




### Getting Hospice Care Training (Survey Questions: 19, 20, 23, 29)

% Favorable: **74.3%**

% Unfavorable: **25.7%**



DEYTA

**Date Range:** 2016 - 2017 (1/1/2016 - 1/6/2017)
**Report by:** Survey Return Date

*Interim results. CMS-published reports are official results.*

**Surveys to Include: Only CMS Complete**
*Determined by CMS criteria*

**Real time updates - Results may change**
*Results updated as surveys are received*

N

| | Deyta National | Deyta MD | Overall Total |
|---|---|---|---|
| HOSPICE TEAM COMMUNICATIONS | 79.5% | 79.4% | 80.2% |
| GETTING TIMELY CARE | 77.1% | 76.3% | 78.2% |
| TREATING FAMILY MEMBER WITH | 90.9% | 90.4% | 91.7% |
| PROVIDING EMOTIONAL SUPPORT | 91.6% | 91.4% | 90.5% |
| GETTING HELP WITH SYMPTOMS | 76.7% | 76.1% | 79.8% |
| SUPPORT FOR RELIGIOUS AND | 93.9% | 93.9% | 92.4% |
| INFORMATION CONTINUITY | 87.6% | 87.9% | 90.7% |
| UNDERSTANDING SIDE EFFECTS OF | 74.0% | 73.1% | 76.6% |
| GETTING HOSPICE CARE TRAINING | 69.8% | 69.6% | 74.0% ↑ |
| RATING OF CARE | | | |
| ADDITIONAL QUALITY INDICATORS | | | |
| DEYTA QUESTION SET | | | |

# Comparison Report
# Hospice CAHPS
## *Amedisys Home Health Services*

**Report Level:** 211536
**Compare by:** None

**Comparison Group:**
*Deyta National*

# EXHIBIT 26

| Documentation | State regulation reference | Location/citation in Applicant's QAPI |
|---|---|---|
| Develop, implement and maintain an effective, ongoing, hospice-wide data driven QAPI program | 10.07.21.09A & B | Page 4-5 (Quality Statement; Mission Statement; Objectives) |
| Maintain documentary evidence – able to demonstrate operation | 10.07.21.09D(2) | Page 6 (Methodology) , Page 10-11 (Adverse & Sentinel events; Near Misses); Page 12 (Patient Falls; Tracking & Trending Reports); Page 13 (Monitoring and Evaluating Activities; Clinical Record Review); Page 14 (Action Plans; Care Center Specific Outcomes) |
| Program capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services | 10.07.21.09C(2) | Page 14 (Action Plans; Care Center Specific Outcomes); Page 17 (Responsibilities of the QAPI Committee) |
| Must measure, analyze and track quality indicators including adverse patient events | 10.07.21.09C(3) | Pages 10-11 (Adverse & Sentinel events; Near Misses); Page 12 (Patient Falls; Tracking & Trending) |
| Must use quality indicator data in design of program to: monitor effectiveness and safety of services and quality of care; identify opportunities for improvement | 10.07.21.09D(3) | Page 12 (Patient Falls; Tracking & Trending; Data Sources and Collection); Page 13 (Monitoring and Evaluating Activities Experience of |

| | | |
|---|---|---|
| | | Care); Page 14 (Risk/Safety Management) |
| Frequency and detail of data collection must be approved by governing body | 10.07.21.09E | Page 15 (Governing Body); Page 19 (Evaluation of the QAPI Plan) |
| Must focus on high risk, high volume or problem prone areas | | Page 11 (Failure Mode Analysis) |
| PI activities must track adverse patient events, analyze their causes and implement preventive actions | 10.07.21.09D(3) | Pages 10-11 (Adverse & Sentinel events; Near Misses) |
| Must measure success and track performance to ensure improvements are sustained | | Page 14 (Action Plans; Care Center Specific Outcomes); Page16 (Director of Operations-Care Center; QAPI Committee; Clinical Manager; Clinical and Support Staff; Professional Advisory Committee (PAG); Quality Management Team) |
| Number and scope of PIP (performance improvement projects), conducted **annually** based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity and past performance of the hospice's services and operations | 10.07.21.09C(1-6) | Page 15 (Hospice Clinical operations Quality Team); Page 16 (Director of Operations - Care Center); Page 17 (Responsibilities of the QAPI Committee) |
| Governing Body- responsible for ensuring that one or more individual(s) who are responsible for operating the QAPI program are designated | 10.07.21.09D(4) | Page 15 (Governing Body); Page 17 (Responsibilities of the QAPI Committee); Page 19 (Evaluation of the QAPI plan) |
| | | |

# EXHIBIT 27

AMEDISYS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
(Amounts in thousands, except per share data)

| | For the Years Ended December 31, | | |
|---|---|---|---|
| | 2015 | 2014 | 2013 |
| Net service revenue | $1,280,541 | $1,204,554 | $1,249,344 |
| Cost of service, excluding depreciation and amortization | 725,915 | 691,061 | 717,996 |
| General and administrative expenses: | | | |
| Salaries and benefits | 279,425 | 292,497 | 302,564 |
| Non-cash compensation | 11,824 | 5,597 | 6,519 |
| Other | 161,186 | 143,644 | 164,991 |
| Provision for doubtful accounts | 14,053 | 16,294 | 15,882 |
| Depreciation and amortization | 20,036 | 28,307 | 36,871 |
| U.S. Department of Justice settlement | — | — | 150,000 |
| Asset impairment charge | 77,268 | 3,107 | 9,492 |
| Operating expenses | 1,289,707 | 1,180,507 | 1,404,315 |
| Operating (loss) income | (9,166) | 24,047 | (154,971) |
| Other income (expense): | | | |
| Interest income | 71 | 94 | 54 |
| Interest expense | (10,783) | (8,217) | (4,412) |
| Equity in earnings from equity method investments | 9,823 | 2,991 | 1,520 |
| Miscellaneous, net | 9,747 | 2,061 | 4,334 |
| Total other income (expense), net | 8,858 | (3,071) | 1,496 |
| (Loss) income before income taxes | (308) | 20,976 | (153,475) |
| Income tax (expense) benefit | (2,004) | (7,671) | 58,773 |
| (Loss) income from continuing operations | (2,312) | 13,305 | (94,702) |
| Discontinued operations, net of tax | — | (216) | (3,073) |
| Net (loss) income | (2,312) | 13,089 | (97,775) |
| Net (income) loss attributable to noncontrolling interests | (709) | (313) | 1,597 |
| Net (loss) income attributable to Amedisys, Inc. | $ (3,021) | $ 12,776 | $ (96,178) |

## 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, 2015, based on our continuing operations. The financial data for the years ended December 31, 2015, 2014 and 2013 should be read together with our consolidated financial statements and related notes included in 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.

| | 2015 (1) | 2014 (2) | 2013 (3) | 2012 (4) | 2011 (5) |
|---|---|---|---|---|---|
| | (Amounts in thousands, except per share data) | | | | |
| **Income Statement Data:** | | | | | |
| Net service revenue | $1,280,541 | $1,204,554 | $1,249,344 | $1,440,836 | $1,418,464 |
| Operating (loss) income from continuing operations | $ (9,166) | $ 24,047 | $ (154,971) | $ (108,855) | $ (469,190) |
| Net (loss) income from continuing operations attributable to Amedisys, Inc. | $ (3,021) | $ 12,992 | $ (93,105) | $ (80,262) | $ (374,430) |
| Net (loss) income from continuing operations attributable to Amedisys, Inc. per basic share | $ (0.09) | $ 0.40 | $ (2.98) | $ (2.68) | $ (13.05) |
| Net (loss) income from continuing operations attributable to Amedisys, Inc. per diluted share | $ (0.09) | $ 0.40 | $ (2.98) | $ (2.68) | $ (13.05) |

(1) 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).

(2) 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).

(3) During 2013, we recorded a charge for the accrual for the U.S. Department of Justice settlement, which amounted to $150.0 million ($93.9 million, net of tax) and recognized non-cash goodwill and other intangibles impairment charges of $9.5 million ($5.8 million, net of tax).

(4) During 2012, we recorded a $162.1 million ($110.2 million, net of tax and non-controlling interests) charge for the impairment of goodwill and other intangibles and incurred certain costs associated with our exit activities in the amount of $2.7 million ($1.6 million, net of tax).

(5) During 2011, we recorded a $579.9 million ($438.4 million, net of tax) charge for the impairment of goodwill and other intangibles and incurred certain costs associated with our exit activities in the amount of $6.6 million ($4.0 million, net of tax).

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

# FORM 10-Q

(Mark One)

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

**For the quarterly period ended September 30, 2016**

**or**

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

**For the transition period from _____ to _____**

**Commission File Number: 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)**

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted 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 and post such files). Yes ☒ No ☐

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

| | | | |
|---|---|---|---|
| Large accelerated filer | ☐ | Accelerated filer | ☒ |
| Non-accelerated filer | ☐ (Do not check if a smaller reporting company) | Smaller reporting company | ☐ |

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

The number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date, is as follows: Common stock, $0.001 par value, 33,569,601 shares outstanding as of November 1, 2016.

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## SPECIAL CAUTION CONCERNING FORWARD-LOOKING STATEMENTS

*When included in this Quarterly Report on Form 10-Q, 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 expressions are 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 Medicare and other medical payment levels, our ability to open care centers, acquire additional care centers and integrate and operate these care centers effectively, 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, competition in the home health 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 attract and retain qualified personnel, changes in payments and covered services due to the economic downturn and deficit spending by federal and state governments, future cost containment initiatives undertaken by third-party payors, our access to financing due to the volatility and disruption of the capital and credit markets, 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 and manage our information systems, our ability to comply with requirements stipulated in our corporate integrity agreement and 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.*

*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 our Annual Report on Form 10-K for the year ended December 31, 2015, filed with the SEC on March 10, 2016, particularly, Part I, Item 1A, Risk Factors therein, which are incorporated herein by reference and Part II, Item 1A, Risk Factors of subsequent Quarterly Reports on Form 10-Q. Additional risk factors may also be described in reports that we file from time to time with the SEC.*

### 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. We also use our website to expedite public access to time-critical information regarding our company in advance of or in lieu of distributing a press release or a filing with the SEC disclosing the same information. Therefore, investors should look to the Investor Relations subpage of our website for important and time-critical information. 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 practicable after we electronically file 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 "Corporate Governance").*

*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.*

**PART I. FINANCIAL INFORMATION**
**ITEM 1. FINANCIAL STATEMENTS**

**AMEDISYS, INC. AND SUBSIDIARIES**
**CONDENSED CONSOLIDATED BALANCE SHEETS**
**(Amounts in thousands, except share data)**

| | September 30, 2016 (Unaudited) | December 31, 2015 |
|---|---|---|
| **ASSETS** | | |
| Current assets: | | |
| Cash and cash equivalents | $ 8,915 | $ 27,502 |
| Patient accounts receivable, net of allowance for doubtful accounts of $16,710 and $16,526 | 162,500 | 125,010 |
| Prepaid expenses | 9,948 | 8,110 |
| Other current assets | 12,070 | 14,641 |
| Total current assets | 193,433 | 175,263 |
| Property and equipment, net of accumulated depreciation of $144,055 and $141,793 | 42,960 | 42,695 |
| Goodwill | 284,552 | 261,663 |
| Intangible assets, net of accumulated amortization of $27,180 and $25,386 | 47,249 | 44,047 |
| Deferred income taxes | 113,797 | 125,245 |
| Other assets, net | 39,741 | 32,802 |
| Total assets | $ 721,732 | $ 681,715 |
| **LIABILITIES AND EQUITY** | | |
| Current liabilities: | | |
| Accounts payable | $ 33,088 | $ 25,682 |
| Payroll and employee benefits | 78,754 | 72,546 |
| Accrued expenses | 65,112 | 71,965 |
| Current portion of long-term obligations | 5,220 | 5,000 |
| Total current liabilities | 182,174 | 175,193 |
| Long-term obligations, less current portion | 88,874 | 91,630 |
| Other long-term obligations | 4,306 | 4,456 |
| Total liabilities | 275,354 | 271,279 |
| Commitments and Contingencies - Note 5 | | |
| Equity: | | |
| Preferred stock, $0.001 par value, 5,000,000 shares authorized; none issued or outstanding | — | — |
| Common stock, $0.001 par value, 60,000,000 shares authorized; 35,195,655 and 34,786,966 shares issued; and 33,551,441 and 33,607,282 shares outstanding | 35 | 35 |
| Additional paid-in capital | 531,112 | 504,290 |
| Treasury stock at cost, 1,644,214 and 1,179,684 shares of common stock | (46,253) | (26,966) |
| Accumulated other comprehensive income | 15 | 15 |
| Retained earnings | (39,462) | (67,806) |
| Total Amedisys, Inc. stockholders' equity | 445,447 | 409,568 |
| Noncontrolling interests | 931 | 868 |
| Total equity | 446,378 | 410,436 |
| Total liabilities and equity | $ 721,732 | $ 681,715 |

The accompanying notes are an integral part of these condensed consolidated financial statements.

**AMEDISYS, INC. AND SUBSIDIARIES**
**CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS**
**(Amounts in thousands, except per share data)**
**(Unaudited)**

| | For the Three-Month Periods Ended September 30, | | For the Nine-Month Periods Ended September 30, | |
|---|---|---|---|---|
| | 2016 | 2015 | 2016 | 2015 |
| Net service revenue | $ 361,595 | $ 326,450 | $ 1,071,158 | $ 942,174 |
| Cost of service, excluding depreciation and amortization | 212,124 | 186,772 | 620,466 | 533,432 |
| General and administrative expenses: | | | | |
| Salaries and benefits | 77,019 | 69,993 | 231,079 | 209,797 |
| Non-cash compensation | 4,750 | 3,060 | 12,556 | 7,637 |
| Other | 42,658 | 39,551 | 134,951 | 114,734 |
| Provision for doubtful accounts | 5,471 | 3,638 | 13,664 | 9,370 |
| Depreciation and amortization | 5,214 | 4,646 | 14,662 | 15,798 |
| Asset impairment charge | — | 2,075 | — | 77,268 |
| Operating expenses | 347,236 | 309,735 | 1,027,378 | 968,036 |
| Operating income (loss) | 14,359 | 16,715 | 43,780 | (25,862) |
| Other income (expense): | | | | |
| Interest income | 14 | 7 | 45 | 33 |
| Interest expense | (1,136) | (4,936) | (3,551) | (9,778) |
| Equity in earnings from equity method investments | 3,244 | 1,924 | 3,602 | 8,701 |
| Miscellaneous, net | 1,713 | 1,330 | 3,106 | 3,962 |
| Total other income (expense), net | 3,835 | (1,675) | 3,202 | 2,918 |
| Income (loss) before income taxes | 18,194 | 15,040 | 46,982 | (22,944) |
| Income tax (expense) benefit | (6,693) | (6,465) | (18,323) | 7,560 |
| Net income (loss) | 11,501 | 8,575 | 28,659 | (15,384) |
| Net income attributable to noncontrolling interests | (66) | (135) | (315) | (548) |
| Net income (loss) attributable to Amedisys, Inc. | $ 11,435 | $ 8,440 | $ 28,344 | $ (15,932) |
| Basic earnings per common share: | | | | |
| Net income (loss) attributable to Amedisys, Inc. common stockholders | $ 0.34 | $ 0.25 | $ 0.86 | $ (0.48) |
| Weighted average shares outstanding | 33,309 | 33,128 | 33,142 | 32,957 |
| Diluted earnings per common share: | | | | |
| Net income (loss) attributable to Amedisys, Inc. common stockholders | $ 0.34 | $ 0.25 | $ 0.84 | $ (0.48) |
| Weighted average shares outstanding | 33,823 | 33,631 | 33,699 | 32,957 |

The accompanying notes are an integral part of these condensed consolidated financial statements.

AMEDISYS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(Amounts in thousands)
(Unaudited)

| | For the Nine-Month Periods Ended September 30, | |
|---|---|---|
| | 2016 | 2015 |
| **Cash Flows from Operating Activities:** | | |
| Net income (loss) | $ 28,659 | $ (15,384) |
| Adjustments to reconcile net income (loss) to net cash provided by operating activities: | | |
| Depreciation and amortization | 14,662 | 15,798 |
| Provision for doubtful accounts | 13,664 | 9,370 |
| Non-cash compensation | 12,556 | 7,637 |
| 401(k) employer match | 5,134 | 4,544 |
| Loss on disposal of property and equipment | 556 | 945 |
| Gain on sale of care centers | — | (184) |
| Deferred income taxes | 18,689 | (9,547) |
| Write off of deferred debt issuance costs | — | 2,513 |
| Equity in earnings from equity method investments | (3,602) | (8,701) |
| Amortization of deferred debt issuance costs/debt discount | 555 | 774 |
| Return on equity investment | 1,913 | 5,135 |
| Asset impairment charge | — | 77,268 |
| Changes in operating assets and liabilities, net of impact of acquisitions: | | |
| Patient accounts receivable | (46,107) | (31,788) |
| Other current assets | 870 | 12,701 |
| Other assets | (11,909) | (803) |
| Accounts payable | 7,308 | 8,597 |
| Accrued expenses | (9,100) | 9,152 |
| Other long-term obligations | (150) | (286) |
| Net cash provided by operating activities | 33,698 | 87,741 |
| **Cash Flows from Investing Activities:** | | |
| Proceeds from sale of deferred compensation plan assets | 230 | 1,077 |
| Purchases of deferred compensation plan assets | — | (19) |
| Purchases of property and equipment | (13,502) | (17,969) |
| Purchase of investment | (750) | (2,561) |
| Proceeds from sale of investment | — | 5,000 |
| Acquisitions of businesses, net of cash acquired | (31,378) | (5,800) |
| Proceeds from dispositions of care centers | — | 413 |
| Net cash used in investing activities | (45,400) | (19,859) |
| **Cash Flows from Financing Activities:** | | |
| Proceeds from issuance of stock upon exercise of stock options and warrants | — | 399 |
| Proceeds from issuance of stock to employee stock purchase plan | 1,818 | 1,591 |
| Tax benefit from stock options exercised and restricted stock vesting | 7,241 | — |
| Non-controlling interest distribution | (284) | (300) |
| Sale of non-controlling interest | 405 | — |
| Proceeds from revolving line of credit | 128,500 | 63,400 |
| Repayments of revolving line of credit | (128,500) | (78,400) |
| Proceeds from issuance of long-term obligations | — | 100,000 |
| Principal payments of long-term obligations | (3,750) | (103,000) |
| Debt issuance costs | — | (2,553) |
| Purchase of company stock | (12,315) | — |
| Net cash used in financing activities | (6,885) | (18,863) |
| Net (decrease) increase in cash and cash equivalents | (18,587) | 49,019 |
| Cash and cash equivalents at beginning of period | 27,502 | 8,032 |
| Cash and cash equivalents at end of period | $ 8,915 | $ 57,051 |
| **Supplemental Disclosures of Cash Flow Information:** | | |
| Cash paid for interest | $ 2,276 | $ 5,598 |
| Cash paid for income taxes, net of refunds received | $ 758 | $ (12,383) |

The accompanying notes are an integral part of these condensed consolidated financial statements.

**AMEDISYS, INC. AND SUBSIDIARIES**
**NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS**
**(Unaudited)**

## 1. NATURE OF OPERATIONS, CONSOLIDATION AND PRESENTATION OF FINANCIAL STATEMENTS

Amedisys, Inc., a Delaware corporation, and its consolidated subsidiaries ("Amedisys," "we," "us," or "our") are a multi-state provider of home health and hospice services with approximately 78% of our revenue derived from Medicare for the three and nine-month periods ended September 30, 2016 and approximately 79% and 80% of our revenue derived from Medicare for the three and nine-month periods ended September 30, 2015. As of September 30, 2016, we owned and operated 326 Medicare-certified home health care centers, 79 Medicare-certified hospice care centers and 14 personal-care care centers in 34 states within the United States and the District of Columbia.

### *Basis of Presentation*

In our opinion, the accompanying unaudited condensed consolidated financial statements contain all adjustments (consisting solely of normal recurring adjustments) necessary to present fairly our financial position, our results of operations and our cash flows in accordance with U.S. Generally Accepted Accounting Principles ("U.S. GAAP"). Our results of operations for the interim periods presented are not necessarily indicative of results of our operations for the entire year and have not been audited by our independent auditors.

Certain information and footnote disclosures normally included in financial statements prepared in accordance with U.S. GAAP have been condensed or omitted from the interim financial information presented. This report should be read in conjunction with our consolidated financial statements and related notes included in our Annual Report on Form 10-K for the year ended December 31, 2015, as filed with the Securities and Exchange Commission ("SEC") on March 10, 2016 (the "Form 10-K"), which includes information and disclosures not included herein.

### *Use of Estimates*

Our accounting and reporting policies conform with U.S. GAAP. In preparing the unaudited condensed consolidated financial statements, we are required to make estimates and assumptions that impact the amounts reported in the condensed consolidated financial statements and accompanying notes. Actual results could materially differ from those estimates.

### *Reclassifications and Comparability*

Certain reclassifications have been made to prior periods' financial statements in order to conform to the current period's presentation. In compliance with Accounting Standards Update ("ASU") 2015-03, *Interest – Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs,* we have reclassified 2015 amounts related to unamortized debt issuance costs from other assets, net to long-term obligations, less current portion.

### *Principles of Consolidation*

These unaudited condensed consolidated financial statements include the accounts of Amedisys, Inc., and our wholly owned subsidiaries. All significant intercompany accounts and transactions have been eliminated in our accompanying unaudited condensed consolidated financial statements, and business combinations accounted for as purchases have been included in our unaudited condensed consolidated financial statements from their respective dates of acquisition. In addition to our wholly owned subsidiaries, we also have certain equity investments that are accounted for as set forth below.

### *Equity Investments*

We consolidate investments when the entity is a variable interest entity and we are the primary beneficiary or if we have controlling interests in the entity, which is generally ownership in excess of 50%. Third party equity interests in our consolidated joint ventures are reflected as noncontrolling interests in our condensed consolidated financial statements. During the three-month period ended September 30, 2016, we sold a 30% interest in one of our care centers while maintaining controlling interest in the newly formed joint venture.

We account for investments in entities in which we have the ability to exercise significant influence under the equity method if we hold 50% or less of the voting stock and the entity is not a variable interest entity in which we are the primary beneficiary. The book value of investments that we accounted for under the equity method of accounting was $28.2 million as of September 30, 2016, and $25.7 million as of December 31, 2015. We account for investments in entities in which we have less than a 20% ownership interest under the cost method of accounting if we do not have the ability to exercise significant influence over the investee.

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## 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

***Revenue Recognition***

We earn net service revenue through our home health and hospice care centers by providing a variety of services almost exclusively in the homes of our patients. This net service revenue is earned and billed either on an episode of care basis, on a per visit basis or on a daily basis depending upon the payment terms and conditions established with each payor for services provided. We refer to home health revenue earned and billed on a 60-day episode of care as episodic-based revenue.

When we record our service revenue, we record it net of estimated revenue adjustments and contractual adjustments to reflect amounts we estimate to be realizable for services provided, as discussed below. We believe, based on information currently available to us and based on our judgment, that changes to one or more factors that impact the accounting estimates (such as our estimates related to revenue adjustments, contractual adjustments and episodes in progress) we make in determining net service revenue, which changes are likely to occur from period to period, will not materially impact our reported consolidated financial condition, results of operations, cash flows or our future financial results.

*Home Health Revenue Recognition*

Medicare Revenue

Net service revenue is recorded under the Medicare prospective payment system ("PPS") based on a 60-day episode payment rate that is subject to adjustment based on certain variables including, but not limited to: (a) an outlier payment if our 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 was fewer than five; (c) a partial payment if our patient transferred to another provider or we received a patient from another provider before completing the episode; (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) adjustments to payments if we are unable to perform periodic therapy assessments; (f) 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; (g) changes in the base episode payments established by the Medicare Program; (h) adjustments to the base episode payments for case mix and geographic wages; and (i) recoveries of overpayments. In addition, we make adjustments to Medicare revenue if we find that we are unable to produce appropriate documentation of a face to face encounter between the patient and physician.

We make adjustments to Medicare revenue to reflect differences between estimated and actual payment amounts, our discovered inability to obtain appropriate billing documentation or authorizations and other reasons unrelated to credit risk. We estimate the impact of such adjustments based on our historical experience, which primarily includes a historical collection rate of over 99% on Medicare claims, and record this estimate during the period in which services are rendered as an estimated revenue adjustment and a corresponding reduction to patient accounts receivable. Therefore, we believe that our reported net service revenue and patient accounts receivable will be the net amounts to be realized from Medicare for services rendered.

In addition to revenue recognized on completed episodes, we also recognize a portion of revenue associated with episodes in progress. Episodes in progress are 60-day episodes of care that begin during the reporting period, but were not completed as of the end of the period. We estimate this revenue on a monthly basis based upon historical trends. The primary factors underlying this estimate are the number of episodes in progress at the end of the reporting period, expected Medicare revenue per episode and our estimate of the average percentage complete based on visits performed. As of September 30, 2016 and 2015, the difference between the cash received from Medicare for a request for anticipated payment ("RAP") on episodes in progress and the associated estimated revenue was immaterial and, therefore, the resulting credits were recorded as a reduction to our outstanding patient accounts receivable in our condensed consolidated balance sheets for such periods.

Non-Medicare Revenue

*Episodic-based Revenue.* We recognize revenue in a similar manner as we recognize Medicare revenue for episodic-based rates that are paid by other insurance carriers, including Medicare Advantage programs; however, these rates can vary based upon the negotiated terms.

*Non-episodic based Revenue.* Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to our established or estimated per-visit rates, as applicable. Contractual adjustments are recorded for the difference between our standard rates and the contracted rates to be realized from patients, third parties and others for services provided and are deducted from gross

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revenue to determine net service revenue and are also recorded as a reduction to our outstanding patient accounts receivable. In addition, we receive a minimal amount of our net service revenue from patients who are either self-insured or are obligated for an insurance co-payment.

*Hospice Revenue Recognition*

Hospice Medicare Revenue

Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are daily or hourly rates for each of the four levels of care we deliver. The four levels of care are routine care, general inpatient care, continuous home care and respite care. Routine care accounts for 99% of our total net Medicare hospice service revenue for each of the three and nine-month periods ended September 30, 2016, and 98% of our total net Medicare hospice service revenue for each of the three and nine-month periods ended September 30, 2015. We make adjustments to Medicare revenue for an inability to obtain appropriate billing documentation or acceptable authorizations and other reasons unrelated to credit risk. We estimate the impact of these adjustments based on our historical experience, which primarily includes our historical collection rate on Medicare claims, and record it during the period services are rendered as an estimated revenue adjustment and as a reduction to our outstanding patient accounts receivable.

Additionally, as Medicare hospice revenue is subject to an inpatient cap limit and an overall payment cap for each provider number, we monitor these caps and estimate amounts due back to Medicare if we estimate a cap has been exceeded. We record these adjustments as a reduction to revenue and an increase in other accrued liabilities. Beginning for the cap year ending October 31, 2014, providers are required to self-report and pay their estimated cap liability by March 31st of the following year. As of September 30, 2016, we have settled our Medicare hospice reimbursements for all fiscal years through October 31, 2012. As of September 30, 2016 and December 31, 2015, we have recorded $1.0 million and $1.4 million, respectively, for estimated amounts due back to Medicare in other accrued liabilities for the Federal cap years ended October 31, 2013 through October 31, 2016.

Hospice Non-Medicare Revenue

We record gross revenue on an accrual basis based upon the date of service at amounts equal to our established rates or estimated per day rates, as applicable. Contractual adjustments are recorded for the difference between our established rates and the amounts estimated to be realizable from patients, third parties and others for services provided and are deducted from gross revenue to determine our net service revenue and patient accounts receivable.

*Personal Care Revenue Recognition*

Personal Care Non-Medicare Revenue

We generate net service revenues by providing our services directly to patients primarily on a per hour, visit or unit basis. We receive payment for providing such services from our payor clients, including state and local governmental agencies, managed care organizations, commercial insurers and private consumers. Net service revenues are principally provided based on authorized hours, visits or units determined by the relevant agency, at a rate that is either contractual or fixed by legislation which are recognized as net service revenue at the time services are rendered.

***Patient Accounts Receivable***

Our patient accounts receivable are uncollateralized and consist of amounts due from Medicare, Medicaid, other third-party payors and patients. As of September 30, 2016 there is no single payor, other than Medicare, that accounts for more than 10% of our total outstanding patient receivables. Thus we believe there are no other significant concentrations of receivables that would subject us to any significant credit risk in the collection of our patient accounts receivable. We fully reserve for accounts which are aged at 365 days or greater. We write off accounts on a monthly basis once we have exhausted our collection efforts and deem an account to be uncollectible.

We believe the credit risk associated with our Medicare accounts, which represent 58% and 64% of our net patient accounts receivable at September 30, 2016 and December 31, 2015, respectively, is limited due to our historical collection rate of over 99% from Medicare and the fact that Medicare is a U.S. government payor. Accordingly, we do not record an allowance for doubtful accounts for our Medicare patient accounts receivable, which are recorded at their net realizable value after recording estimated revenue adjustments as discussed above. During the three and nine-month periods ended September 30, 2016, we recorded $1.6 million and $5.9 million, respectively, in estimated revenue adjustments to Medicare revenue as compared to $1.5 million and $4.0 million during the three and nine-month periods ended September 30, 2015, respectively.

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We believe there is a certain level of credit risk associated with non-Medicare payors. To provide for our non-Medicare patient accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying amount to its estimated net realizable value.

*Medicare Home Health*

For our home health patients, our pre-billing process includes verifying that we are eligible for payment from Medicare for the services that we provide to our patients. Our Medicare billing begins with a process to ensure that our billings are accurate through the utilization of an electronic Medicare claim review. We submit a RAP for 60% of our estimated payment for the initial episode at the start of care or 50% of the estimated payment for any subsequent episodes of care contiguous with the first episode for a particular patient. The full amount of the episode is billed after the episode has been completed ("final billed"). The RAP received for that particular episode is then deducted from our final payment. If a final bill is not submitted within the greater of 120 days from the start of the episode, or 60 days from the date the RAP was paid, any RAPs received for that episode will be recouped by Medicare from any other claims in process for that particular provider number. The RAP and final claim must then be re-submitted.

*Medicare Hospice*

For our hospice patients, our pre-billing process includes verifying that we are eligible for payment from Medicare for the services that we provide to our patients. Our Medicare billing begins with a process to ensure that our billings are accurate through the utilization of an electronic Medicare claim review. Once each patient has been confirmed for eligibility, we will bill Medicare on a monthly basis for the services provided to the patient.

*Non-Medicare Home Health, Hospice and Personal Care*

For our non-Medicare patients, our pre-billing process primarily begins with verifying a patient's eligibility for services with the applicable payor. Once the patient has been confirmed for eligibility, we will provide services to the patient and bill the applicable payor. Our review and evaluation of non-Medicare accounts receivable includes a detailed review of outstanding balances and special consideration to concentrations of receivables from particular payors or groups of payors with similar characteristics that would subject us to any significant credit risk. We estimate an allowance for doubtful accounts based upon our assessment of historical and expected net collections, business and economic conditions, trends in payment and an evaluation of collectability based upon the date that the service was provided. Based upon our best judgment, we believe the allowance for doubtful accounts adequately provides for accounts that will not be collected due to credit risk.

***Property and Equipment***

Property and equipment is stated at cost and we depreciate it on a straight-line basis over the estimated useful lives of the assets. Additionally, we have internally developed computer software for our own use. Additions and improvements (including interest costs for construction of qualifying long-lived assets) are capitalized. Maintenance and repair expenses are charged to expense as incurred. The cost of property and equipment sold or disposed of and the related accumulated depreciation are eliminated from the property and related accumulated depreciation accounts, and any gain or loss is credited or charged to other general and administrative expenses.

As of December 31, 2014, we had $75.8 million of internally developed software costs related to the development of AMS3 Home Health and Hospice. Expanded beta testing to additional sites in February of 2015 demonstrated that AMS3 was disruptive to operations. Additional analysis of the system determined that the system was not ready to be fully implemented and would require significant time and investment to redesign. Therefore, during the three-month period ended March 31, 2015, we made the decision to discontinue AMS3 and recorded a non-cash asset impairment charge of $75.2 to write off the software costs incurred related to the development of AMS3 Home Health and Hospice.

During the three-month period ended September 30, 2015, we commenced an active program to sell our corporate headquarters located in Baton Rouge, Louisiana. In accordance with U.S. GAAP, we classified this asset as held for sale and reduced the carrying value of the asset to its estimated fair value less estimated costs to sell the asset. As a result, we recorded a non-cash asset impairment charge of $2.1 million during the three-month period ended September 30, 2015

The following table summarizes the balances related to our property and equipment for the periods indicated (amounts in millions):

| | September 30, 2016 | December 31, 2015 |
|---|---|---|
| Building and leasehold improvements | $ 6.6 | $ 2.3 |
| Equipment and furniture | 85.4 | 89.6 |
| Computer software | 95.0 | 92.6 |
| | 187.0 | 184.5 |
| Less: accumulated depreciation | (144.0) | (141.8) |
| | $ 43.0 | $ 42.7 |

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*Fair Value of Financial Instruments*

The fair value hierarchy is based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value. The three levels of inputs are as follows:

- Level 1 – Quoted prices in active markets for identical assets and liabilities.
- Level 2 – Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.
- Level 3 – Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities.

Our deferred compensation plan assets are recorded at fair value and are considered a level 2 measurement. The carrying amount of our other financial instruments, including cash and cash equivalents, patient accounts receivable, accounts payable, payroll and employee benefits and accrued expenses approximate fair value due to the short maturities of these instruments. As of September 30, 2016, the carrying value of our long-term debt is subject to a variable rate of interest based on current market rates, and as such, the carrying value approximates fair value.

*Weighted-Average Shares Outstanding*

Net income (loss) per share attributable to Amedisys, Inc. common stockholders, calculated on the treasury stock method, is based on the weighted average number of shares outstanding during the period. The following table sets forth, for the periods indicated, shares used in our computation of the weighted-average shares outstanding, which are used to calculate our basic and diluted net income (loss) attributable to Amedisys, Inc. common stockholders (amounts in thousands):

| | For the Three-Month Periods Ended September 30, | | For the Nine-Month Periods Ended September 30, | |
|---|---|---|---|---|
| | 2016 | 2015 | 2016 | 2015 |
| Weighted average number of shares outstanding - basic | 33,309 | 33,128 | 33,142 | 32,957 |
| Effect of dilutive securities: | | | | |
| Stock options | 207 | 57 | 156 | — |
| Non-vested stock and stock units | 307 | 446 | 401 | — |
| Weighted average number of shares outstanding - diluted | 33,823 | 33,631 | 33,699 | 32,957 |
| Anti-dilutive securities | 204 | 89 | 254 | 983 |

*Recently Issued Accounting Pronouncements*

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers (Topic 606)*, which requires an entity to recognize the amount of revenue for which it expects to be entitled for the transfer of promised goods or services to customers. The ASU will replace most existing revenue recognition guidance in U.S. GAAP. In August 2015, the FASB issued ASU 2015-14, *Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date*, to defer the effective date of the standard from January 1, 2017, to January 1, 2018, with an option that permits companies to adopt the standard as early as the original effective date. The new ASU reflects the decisions reached by the FASB at its meeting in July 2015. Early application prior to the original effective date is not permitted. The standard permits the use of either the retrospective or cumulative effect transition method. The Company is evaluating the effect that ASU 2014-09 and ASU 2015-14 will have on its consolidated financial statements and related disclosures, its transition method and the effect of the standard on its ongoing financial reporting.

In April 2015, the FASB issued ASU 2015-03, *Interest - Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs*. The amendments in this ASU require that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. The recognition and measurement guidance for debt issuance costs are not affected by the amendments in this ASU. ASU 2015-03 is effective for annual and interim periods beginning on or after December 15, 2015. We adopted this ASU during the three-month period ended March 31, 2016, and applied the change retrospectively for prior period balances of unamortized debt issuance costs, resulting in a $3.4 million reduction in other assets, net and long-term obligations, less current portion, on our condensed consolidated balance sheet as of December 31, 2015.

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)*, which will require lessees to recognize a lease liability and right-of-use asset for all leases (with the exception of short-term leases) at the commencement date. The ASU is effective for annual and interim periods beginning on or after December 15, 2018. Early adoption is permitted. The standard requires a modified

retrospective transition method which requires application of the new guidance for all periods presented. The Company is evaluating the effect that ASU 2016-02 will have on its consolidated financial statements and related disclosures and the effect of the standard on its ongoing financial reporting.

In March 2016, the FASB issued ASU 2016-09, *Compensation – Stock Compensation (Topic 718): Improvement to Employee Share-Based Payment Accounting*, which will simplify the accounting for share-based payment award transactions, including income tax consequences, classification of awards as either equity or liability, and classification on the statement of cash flows. The ASU is effective for annual and interim periods beginning after December 15, 2016. Early adoption is permitted. The Company is evaluating the effect that ASU 2016-09 will have on its consolidated financial statements and related disclosures and the effect of the standard on its ongoing financial reporting.

In August 2016, the FASB issued ASU 2016-15, *Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments*, which provides specific guidance on eight cash flow classification issues not specifically addressed by U.S. GAAP. The ASU is effective for annual and interim periods beginning after December 15, 2017. Early adoption is permitted. The standard should be applied using a retrospective transition method unless it is impractical to do so for some of the issues. In such case, the amendments for those issues would be applied prospectively as of the earliest date practicable. The Company is evaluating the effect that ASU 2016-15 will have on its consolidated financial statements and related disclosures and the effect of the standard on its ongoing financial reporting.

## 3. ACQUISITIONS

We complete acquisitions from time to time in order to pursue our strategy of increasing our market presence by expanding our service base and enhancing our position in certain geographic areas as a leading provider of home health and hospice services. The purchase price paid for acquisitions is negotiated through arm's length transactions, with consideration based on our analysis of, among other things, comparable acquisitions and expected cash flows. Acquisitions are accounted for as purchases and are included in our consolidated financial statements from their respective acquisition dates. Goodwill generated from acquisitions is recognized for the excess of the purchase price over tangible and identifiable intangible assets because of the expected contributions of the acquisitions to our overall corporate strategy. We typically engage outside appraisal firms to assist in the fair value determination of identifiable intangible assets. Preliminary purchase price allocation is adjusted, as necessary, up to one year after the acquisition closing date if management obtains more information regarding asset valuation and liabilities assumed.

On March 1, 2016, we acquired Associated Home Care which owns and operates 9 personal-care care centers servicing the state of Massachusetts for a total purchase price of $27.7 million, net of cash acquired (subject to certain adjustments), of which $0.5 million was placed in escrow for indemnification purposes and working capital price adjustments. The purchase price was paid with cash on hand on the date of the transaction. Based on our preliminary purchase price allocation, in connection with the acquisition, we recorded goodwill ($23.5 million) and other assets and liabilities, net ($4.2 million) during the three-month period ended March 31, 2016. During the three-month period ended June 30, 2016, we received the final report from our outside appraisal firm. As a result, we reduced our preliminary goodwill by $5.0 million and recorded corresponding increases in the fair value of assets acquired ($0.2 million), other intangibles - acquired names of business ($3.5 million) and other intangibles - non-compete agreements ($1.3 million). The non-compete agreements will be amortized over a weighted-average period of 2.1 years.

On September 1, 2016, we acquired the assets of Professional Profiles, Inc. which owns and operates 4 personal-care care centers servicing the state of Massachusetts for a total purchase price of $4.4 million, (subject to certain adjustments), of which $0.7 million was placed in a promissory note to be paid over 24 months, subject to any offsets or withholds for indemnification purposes. The purchase price was paid with cash on hand on the date of the transaction. During the three-month period ended September 30, 2016, we recorded goodwill ($4.2 million) and other intangibles – non-compete agreements ($0.2 million). The non-compete agreements will be amortized over a weighted-average period of 0.9 years.

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## 4. LONG-TERM OBLIGATIONS

Long-term debt consisted of the following for the periods indicated (amounts in millions):

| | September 30, 2016 | December 31, 2015 |
|---|---|---|
| $100.0 million Term Loan; principal payments plus accrued interest payable quarterly; interest rate at ABR Rate plus applicable percentage or Eurodollar Rate plus the applicable percentage (2.52% at September 30, 2016); due August 28, 2020 | $ 96.2 | $ 100.0 |
| $200.0 million Revolving Credit Facility; interest only payments; interest rate at ABR Rate plus applicable percentage or Eurodollar Rate plus the applicable percentage; due August 28, 2020 | — | — |
| Promissory notes | 0.7 | — |
| Deferred debt issuance costs | (2.8) | (3.4) |
| | 94.1 | 96.6 |
| Current portion of long-term obligations | (5.2) | (5.0) |
| Total | $ 88.9 | $ 91.6 |

Our weighted average interest rate for our $100.0 million Term Loan, under our Credit Agreement, was 2.5% for the three and nine-month periods ended September 30, 2016, respectively, and 2.2% for the period August 28, 2015 to September 30, 2015. Our weighted average interest rate for our $200.0 million Revolving Credit Facility was 4.5% and 3.5% for the three and nine-month periods ended September 30, 2016, respectively.

As of September 30, 2016, our consolidated leverage ratio was 1.0, our consolidated fixed charge coverage ratio was 3.9 and we are in compliance with our Credit Agreement. In the event we are not in compliance with our debt covenants in the future, we would pursue various alternatives in an attempt to successfully resolve the non-compliance, which might include, among other things, seeking debt covenant waivers or amendments.

As of September 30, 2016, our availability under our $200.0 million Revolving Credit Facility was $173.3 million as we had $26.7 million outstanding in letters of credit.

## 5. COMMITMENTS AND CONTINGENCIES

***Legal Proceedings - Ongoing***

We are involved in the following legal actions:

*Securities Class Action Lawsuits*

On June 10, 2010, a putative securities class action complaint was filed in the United States District Court for the Middle District of Louisiana (the "District Court") against the Company and certain of our current and former senior executives. Additional putative securities class actions were filed in the District Court on July 14, July 16, and July 28, 2010.

On January 18, 2011, the Co-Lead Plaintiffs filed an amended, consolidated class action complaint (the "Securities Complaint") which supersedes the earlier-filed securities class action complaints. The Securities Complaint alleges that the defendants made false and/or misleading statements and failed to disclose material facts about our business, financial condition, operations and prospects, particularly relating to our policies and practices regarding home therapy visits under the Medicare home health prospective payment system and the related alleged impact on our business, financial condition, operations and prospects. The Securities Complaint seeks a determination that the action may be maintained as a class action on behalf of all persons who purchased the Company's securities between August 2, 2005 and September 28, 2010 and an unspecified amount of damages.

All defendants moved to dismiss the Securities Complaint. On June 28, 2012, the District Court granted the defendants' motion to dismiss the Securities Complaint. On July 26, 2012, the Co-Lead Plaintiffs filed a motion for reconsideration, which the District Court denied on April 9, 2013.

On May 3, 2013, the Co-Lead Plaintiffs appealed the dismissal of the Securities Complaint to the United States Court of Appeals for the Fifth Circuit (the "Fifth Circuit"). On October 2, 2014, a three-judge panel of the Fifth Circuit issued a decision reversing the District Court's dismissal of the Securities Complaint. On October 16, 2014, all defendants filed a petition with the Fifth Circuit to review the three-judge panel's decision *en banc*, or as a whole court. On December 29, 2014, the Fifth Circuit denied the defendants' motion for *en banc* review of the Fifth Circuit panel's decision reversing the District Court's dismissal of the Securities Complaint.

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The case then returned to the District Court for further proceedings. On March 30, 2015, the defendants filed a Petition for Writ of Certiorari (the "Petition") with the United States Supreme Court asking the Supreme Court to consider whether the Fifth Circuit erred in reversing the District Court's dismissal of the Securities Complaint. The Supreme Court denied the Petition on June 29, 2015, which did not affect the ongoing proceedings before the District Court, including the District Court's consideration of a motion filed on April 3, 2015, by the Co-Lead Plaintiffs for leave to amend the Securities Complaint, which motion was granted by the District Court. On December 15, 2015, the defendants filed a motion to dismiss the Co-Lead Plaintiffs' First Amended Consolidated Complaint. All discovery in the case is currently stayed pursuant to federal law. The parties agreed to explore the possibility of a mediated settlement of this matter, and a mediation was held on June 21, 2016. The parties were unable to resolve this matter during the mediation. On August 19, 2016, the District Court denied the defendants motion to dismiss the Co-Lead Plantiffs' First Amended Consolidated Complaint. The Defendants filed an Answer to the Complaint on October 20, 2016.

We are unable to assess the probable outcome or reasonably estimate the potential liability, if any, arising from the securities litigation described above. The Company intends to continue to vigorously defend itself in the securities litigation matter but, if decided adverse to the Company, its impact could be material. No assurances can be given as to the timing or outcome of the securities matter described above or the impact of any of the inquiry or litigation matters on the Company, its consolidated financial condition, results of operations or cash flows, which could be material, individually or in the aggregate.

*Frontier Litigation*

On April 2, 2015, Frontier Home Health and Hospice, L.L.C. ("Frontier") filed a complaint against the Company in the United States District Court for the District of Connecticut alleging breach of contract, negligent misrepresentation and unfair and deceptive trade practices under Conn. Gen. Stat. §42-110b. Frontier acquired our interest in five home health and four hospice care centers in Wyoming and Idaho in April 2014. The complaint alleges that certain of the hospice patients on service at the time of the acquisition did not meet Medicare eligibility requirements and that we breached certain of the representations and warranties under the purchase agreement and therefore, the businesses were worth less than the purchase price. Under the complaint, Frontier seeks declaratory judgment from the District Court that, under the terms of the purchase agreement with Frontier, we are obligated to determine the amount of the alleged Medicare overpayments and reimburse the government for the same in a timely manner, as well as unspecified compensatory and punitive damages, attorneys' fees and pre- and post-judgment interest.

We are unable to assess the probable outcome arising from the Frontier litigation described above. The Company has engaged an independent auditing firm to perform a clinical audit of the hospice locations in question and intends to defend itself in the Frontier litigation matter. No assurances can be given as to the timing or outcome of the audit, the Frontier litigation matter described above or the impact of any of the audit or litigation matters on the Company, its consolidated financial condition, results of operations or cash flows, which could be material, individually or in the aggregate. In accordance with our corporate integrity agreement ("CIA") with the Office of Inspector General-HHS ("OIG") as discussed below under "Other Investigative Matters – Corporate Integrity Agreement", we have notified the OIG of this matter.

*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. The Subpoena generally covers the period from January 1, 2011, through the present. We are fully cooperating with the U.S. Department of Justice with respect to this investigation. Based on the information currently available to us, we cannot predict the timing or outcome of this investigation or reasonably estimate the amount or range of potential losses, if any, which may arise from this matter.

*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. The CID requests the delivery of information to the United States Attorney's Office for the Northern District of West Virginia regarding 66 identified hospice patients, as well as documents relating to our hospice clinical and business operations in the Morgantown area. The CID generally covers the period from January 1, 2009 through August 31, 2015. We are fully cooperating with the U.S. Department of Justice with respect to this investigation. Based on the information currently available to us, we cannot predict the timing or outcome of this investigation or reasonably estimate the amount or range of potential losses, if any, which may arise from this matter.

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. The CID requests the delivery of information to the United States Attorney's Office for the Southern District of West Virginia regarding 68 identified hospice patients, as well as documents relating to our hospice clinical and business operations in the

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Parkersburg area. The CID generally covers the period from January 1, 2011 through June 20, 2016. We are fully cooperating with the U.S. Department of Justice with respect to this investigation. Based on the information currently available to us, we cannot predict the timing or outcome of this investigation or reasonably estimate the amount or range of potential losses, if any, which may arise from this matter.

In addition to the matters referenced in this note, we are involved in legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages. We do not believe that these normal course actions, when finally concluded and determined, will have a material impact on our consolidated financial condition, results of operations or cash flows.

***Legal Proceedings – Settled***

*Wage and Hour Litigation*

On July 25, 2012, a putative collective and class action complaint was filed in the United States District Court for the District of Connecticut against us in which three former employees allege wage and hour law violations. The former employees claim that they were not paid overtime for all hours worked over 40 hours in violation of the FLSA, as well as the Pennsylvania Minimum Wage Act. More specifically, they allege they were paid on both a per-visit and an hourly basis, and that such a pay scheme resulted in their misclassification as exempt employees, thereby denying them overtime pay. Moreover, in response to a Company motion arguing that plaintiffs' complaint was deficient in that it was ambiguous and failed to provide fair notice of the claims asserted and plaintiffs' opposition thereto, the Court, on April 8, 2013, held that the complaint adequately raises general allegations that the plaintiffs were not paid overtime for all hours worked in a week over 40, which may include claims for unpaid overtime under other theories of liability, such as alleged off-the-clock work, in addition to plaintiffs' more clearly stated allegations based on misclassification. On behalf of themselves and a class of current and former employees they allege are similarly situated, plaintiffs seek attorneys' fees, back wages and liquidated damages going back three years under the FLSA and three years under the Pennsylvania statute. On October 8, 2013, the Court granted plaintiffs' motion for equitable tolling requesting that the statute of limitations for claims under the FLSA for plaintiffs who opt-in to the lawsuit be tolled from September 24, 2012, the date upon which plaintiffs filed their original motion for conditional certification, until 90 days after any notice of this lawsuit is issued following conditional certification. Following a motion for reconsideration filed by the Company, on December 3, 2013, the Court modified this order, holding that putative class members' FLSA claims are tolled from October 29, 2012 through the date of the Court's order on plaintiffs' motion for conditional certification. On January 13, 2014, the Court granted plaintiffs' July 10, 2013 motion for conditional certification of their FLSA claims and authorized issuance of notice to putative class members to provide them an opportunity to opt in to the action. On April 17, 2014, that notice was mailed to putative class members. The period within which putative class members were permitted to opt into the action expired on July 16, 2014.

On September 10, 2014, the plaintiffs in the Connecticut case filed a motion for leave to amend their complaint to add a new claim under the Kentucky Wage and Hour Act ("KWHA") alleging that the Company did not pay certain home health clinicians working in the Commonwealth of Kentucky all of the overtime wages they were owed, either because the Company misclassified them as exempt from overtime or, while treating them as overtime eligible, did not properly pay them overtime for all hours worked over 40 in a week. On behalf of themselves and a class of current and former employees they allege are similarly situated, plaintiffs seek attorneys' fees, back wages and liquidated damages going back five years before the filing of their original complaint under the KWHA. On October 1, 2014, the Company filed an opposition to the plaintiffs' motion to amend. On October 15, 2014, plaintiffs filed a reply brief in support of their motion. On December 12, 2014, the Court granted the plaintiffs' motion to amend the complaint to add the claims under the KWHA. The Company and the plaintiffs agreed to explore the possibility of a mediated settlement of the Connecticut case, and on February 23, 2015 filed a joint motion to stay proceedings for six months to pursue that process, which was granted by the Court on February 24, 2015.

On June 10, 2015, the Company and plaintiffs participated in a mediation whereby they agreed to fully resolve all of plaintiffs' claims in the lawsuit for $8.0 million, subject to approval by the Court. The settlement agreement was submitted to the Court for preliminary approval and plaintiffs requested certification of Pennsylvania and Kentucky classes for the sole purpose of this proposed settlement. The Court granted preliminary approval, notice was issued to members of the settlement classes to provide them with an opportunity to object to the settlement and, in the case of members of the Pennsylvania and Kentucky classes, opt out of the settlement. Following this notice period, the Court held a final fairness hearing for the purpose of considering objections and deciding whether to grant final approval of the settlement. As of September 30, 2015, we had an accrual of $8.0 million for this matter. On January 29, 2016, the Court approved the final settlement of this case. The settlement became effective on February 26, 2016. As a result of the final amount calculated by the settlement administrator based on claims timely submitted, we reduced our accrual to $5.3 million as of December 31, 2015; this amount was paid during the three-month period ended March 31, 2016.

On September 13, 2012, a putative collective and class action complaint was filed in the United States District Court for the Northern District of Illinois against us in which a former employee alleges wage and hour law violations. The former employee claims she was paid on both a per-visit and an hourly basis, and that such a pay scheme resulted in her misclassification as an exempt employee,

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thereby denying her overtime. The plaintiff alleges violations of federal and state law and seeks damages under the Federal Fair Labor Standards Act ("FLSA") and the Illinois Minimum Wage Law. Plaintiff seeks class certification of similar employees who were or are employed in Illinois and seeks attorneys' fees, back wages and liquidated damages going back three years under the FLSA and three years under the Illinois statute. On May 28, 2013, the Court granted the Company's motion to stay the case pending resolution of class certification issues and dispositive motions in the earlier-filed Connecticut case. On December 23, 2015, the parties agreed to explore the possibility of a mediated settlement of the Illinois case, and a mediation occurred on April 18, 2016. The parties agreed to settle the case for $0.8 million, subject to court approval, which the Company has accrued as of September 30, 2016. On August 4, 2016, the Court approved the final settlement of this case.

***Other Investigative Matters***

*Corporate Integrity Agreement*

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 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 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 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 corporate integrity agreement has a term of five years.

During the course of our compliance with the CIA we identified several such reportable events and notified the OIG as required. As of December 31, 2015, we had an accrual of $4.7 million for these matters. On May 5, 2016, the company entered into a settlement agreement with the OIG and the matters were fully resolved for $4.7 million; this amount was paid during the three-month period ended June 30, 2016.

*Computer Inventory and Data Security Reporting*

On March 1 and March 2, 2015, we provided official notice under federal and state data privacy laws concerning the outcome of an extensive risk management process to locate and verify our large computer inventory. The process identified approximately 142 encrypted computers and laptops for which reports were required under federal and state data privacy laws. The devices at issue were originally assigned to Company clinicians and other team members who left the Company between 2011 and 2014. We reported these devices to the U.S. Department of Health and Human Services, state agencies, and individuals whose information may be involved, as required under applicable law because we could not rule out unauthorized access to patient data on the devices. The Office of Civil Rights, U.S. Department of Health and Human Services ("OCR") is reviewing our compliance with applicable laws, as is typical for any data breach involving more than 500 individuals. We are cooperating with OCR in its review and if any other regulatory reviews are formally commenced, will cooperate with applicable regulatory authorities. In accordance with our CIA, we have notified the OIG of this matter.

***Third Party Audits - Ongoing***

From time to time, in the ordinary course of business, we are subject to audits under various governmental programs in which third party firms engaged by the Centers for Medicare and Medicaid Services ("CMS") conduct extensive review of claims data to identify potential improper payments under the Medicare program.

In July 2010, our subsidiary that provides hospice services in Florence, South Carolina received from a Zone Program Integrity Contractor ("ZPIC") a request for records regarding a sample of 30 beneficiaries who received services from the subsidiary during the period of January 1, 2008 through March 31, 2010 (the "Review Period") to determine whether the underlying services met pertinent Medicare payment requirements. We acquired the hospice operations subject to this review on August 1, 2009; the Review Period covers time periods both before and after our ownership of these hospice operations. Based on the ZPIC's findings for 16 beneficiaries, which were extrapolated to all claims for hospice services provided by the Florence subsidiary billed during the Review Period, on June 6, 2011, the MAC for the subsidiary issued a notice of overpayment seeking recovery from our subsidiary of an alleged overpayment. We dispute these findings, and our Florence subsidiary has filed appeals through the Original Medicare Standard Appeals Process, in which we are seeking to have those findings overturned. An ALJ hearing was held in early January 2015. On January 18, 2016 we received a letter dated January 6, 2016 referencing the ALJ hearing decision for the overpayment

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issued on June 6, 2011. The decision was partially favorable with a new overpayment amount of $3.7 million with a balance owed of $5.6 million including interest based on 9 disputed claims (originally 16). We filed an appeal to the Medicare Appeals Council on the remaining 9 disputed claims and also argued that the statistical method used to select the sample was not valid. No assurances can be given as to the timing or outcome of the Medicare Appeals Council decision. As of June 30, 2016, Medicare has withheld payments of $5.7 million (including additional interest) as part of their standard procedures once this level of the appeal process has been reached. In the event we are not able to recoup this alleged overpayment, we are indemnified by the prior owners of the hospice operations for amounts relating to the period prior to August 1, 2009. As of September 30, 2016, we have an indemnity receivable for the amount withheld related to the period prior to August 1, 2009.

***Third Party Audits – Settled***

In January 2010, our subsidiary that provides home health services in Dayton, Ohio received from a Medicare Program Safeguard Contractor ("PSC") a request for records regarding 137 claims submitted by the subsidiary paid from January 2, 2008 through November 10, 2009 (the "Claim Period") to determine whether the underlying services met pertinent Medicare payment requirements. Based on the PSC's findings for 114 of the claims, which were extrapolated to all claims for home health services provided by the Dayton subsidiary paid during the Claim Period, on March 9, 2011, the Medicare Administrative Contractor ("MAC") for the subsidiary issued a notice of overpayment seeking recovery from our subsidiary of an alleged overpayment of approximately $5.6 million. We disputed these findings, and our Dayton subsidiary filed appeals through the Original Medicare Standard Appeals Process, in which we were seeking to have those findings overturned. A consolidated administrative law judge ("ALJ") hearing was held in late March 2013. In January 2014, the ALJ found fully in favor of our Dayton subsidiary on 74 appeals and partially in favor of our Dayton subsidiary on eight appeals. Taking into account the ALJ's decision, certain determinations that our Dayton subsidiary decided not to appeal as well as certain determinations made by the MAC, of the 114 claims that were originally extrapolated by the MAC, 76 claims were decided in favor of our Dayton subsidiary in full, 10 claims were decided in favor of our Dayton subsidiary in part, and 28 claims were decided against or not appealed by our Dayton subsidiary. The ALJ ordered the MAC to recalculate the extrapolation amount based on the ALJ's decision. The Medicare Appeals Council could decide on its own motion to review the ALJ's decisions. As of July 13, 2016, we were notified that the PSC elected not to re-extrapolate the overpayment and instead issued a new calculated overpayment in the amount of $0.2 million. The overpayment has been paid in full and the matter is fully resolved.

***Insurance***

We are obligated for certain costs associated with our insurance programs, including employee health, workers' compensation and professional liability. While we maintain various insurance programs to cover these risks, we are self-insured for a substantial portion of our potential claims. We recognize our obligations associated with these costs, up to specified deductible limits in the period in which a claim is incurred, including with respect to both reported claims and claims incurred but not reported. These costs have generally been estimated based on historical data of our claims experience. Such estimates, and the resulting reserves, are reviewed and updated by us on a quarterly basis.

Our health insurance has a retention limit of $0.9 million, our workers' compensation insurance has a retention limit of $0.5 million and our professional liability insurance has a retention limit of $0.3 million.

**6. SEGMENT INFORMATION**

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 surgery, have a chronic disability or terminal illness or need assistance with completing important personal tasks. Our hospice segment provides palliative care and comfort to terminally ill patients and their families. Our personal care segment, which was established with the acquisition of Associated Home Care during the three-month period ended March 31, 2016, provides patients with assistance with the essential activities of daily living. The "other" column in the following tables consists of costs relating to executive management and administrative support functions, primarily information services, accounting, finance, billing and collections, legal, compliance, risk management, procurement, marketing, clinical administration, training, human resources and administration.

Management evaluates performance and allocates resources based on the operating income of the reportable segments, which includes an allocation of corporate expenses directly attributable to the specific segment and includes revenues and all other costs directly attributable to the specific segment. Segment assets are not reviewed by the company's chief operating decision maker and therefore are not disclosed below (amounts in millions).

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| | For the Three-Month Period Ended September 30, 2016 | | | | |
|---|---|---|---|---|---|
| | Home Health | Hospice | Personal Care | Other | Total |
| Net service revenue | $ 268.9 | $ 82.0 | $ 10.7 | $ — | $ 361.6 |
| Cost of service, excluding depreciation and amortization | 162.4 | 41.9 | 7.8 | — | 212.1 |
| General and administrative expenses | 71.8 | 17.6 | 2.3 | 32.7 | 124.4 |
| Provision for doubtful accounts | 4.0 | 1.4 | 0.1 | — | 5.5 |
| Depreciation and amortization | 1.6 | 0.3 | — | 3.3 | 5.2 |
| Operating expenses | 239.8 | 61.2 | 10.2 | 36.0 | 347.2 |
| Operating income (loss) | $ 29.1 | $ 20.8 | $ 0.5 | $ (36.0) | $ 14.4 |

| | For the Three-Month Period Ended September 30, 2015 | | | | |
|---|---|---|---|---|---|
| | Home Health | Hospice | Personal Care | Other | Total |
| Net service revenue | $ 253.4 | $ 73.0 | $ — | $ — | $ 326.4 |
| Cost of service, excluding depreciation and amortization | 150.0 | 36.8 | — | — | 186.8 |
| General and administrative expenses | 65.7 | 16.1 | — | 30.8 | 112.6 |
| Provision for doubtful accounts | 3.1 | 0.5 | — | — | 3.6 |
| Depreciation and amortization | 1.2 | 0.3 | — | 3.1 | 4.6 |
| Asset impairment charge | — | — | — | 2.1 | 2.1 |
| Operating expenses | 220.0 | 53.7 | — | 36.0 | 309.7 |
| Operating income (loss) | $ 33.4 | $ 19.3 | $ — | $ (36.0) | $ 16.7 |

| | For the Nine-Month Period Ended September 30, 2016 | | | | |
|---|---|---|---|---|---|
| | Home Health | Hospice | Personal Care | Other | Total |
| Net service revenue | $ 817.2 | $230.8 | $ 23.2 | $ — | $1,071.2 |
| Cost of service, excluding depreciation and amortization | 483.6 | 120.1 | 16.8 | — | 620.5 |
| General and administrative expenses | 215.3 | 51.8 | 5.0 | 106.4 | 378.5 |
| Provision for doubtful accounts | 10.8 | 2.8 | 0.1 | — | 13.7 |
| Depreciation and amortization | 4.4 | 1.0 | — | 9.3 | 14.7 |
| Operating expenses | 714.1 | 175.7 | 21.9 | 115.7 | 1,027.4 |
| Operating income (loss) | $ 103.1 | $ 55.1 | $ 1.3 | $(115.7) | $ 43.8 |

| | For the Nine-Month Period Ended September 30, 2015 | | | | |
|---|---|---|---|---|---|
| | Home Health | Hospice | Personal Care | Other | Total |
| Net service revenue | $ 742.6 | $199.6 | $ — | $ — | $ 942.2 |
| Cost of service, excluding depreciation and amortization | 431.0 | 102.4 | — | — | 533.4 |
| General and administrative expenses | 192.0 | 45.8 | — | 94.3 | 332.1 |
| Provision for doubtful accounts | 8.0 | 1.4 | — | — | 9.4 |
| Depreciation and amortization | 4.0 | 1.0 | — | 10.8 | 15.8 |
| Asset impairment charge | — | — | — | 77.3 | 77.3 |
| Operating expenses | 635.0 | 150.6 | — | 182.4 | 968.0 |
| Operating income (loss) | $ 107.6 | $ 49.0 | $ — | $(182.4) | $ (25.8) |

## 7. STOCK REPURCHASE PROGRAM

On September 9, 2015, we announced that our Board of Directors authorized a stock repurchase program, under which we may repurchase up to $75 million of our outstanding common stock on or before September 6, 2016.

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Under the terms of the program, we could repurchase shares from time to time in open market transactions, block purchases or in private transactions in accordance with applicable federal securities laws and other legal requirements. We could enter into Rule 10b5-1 plans to effect some or all of the repurchases. The timing and the amount of the repurchases, if any, were determined by management based on a number of factors, including but not limited to share price, trading volume and general market conditions, as well as on working capital requirements, general business conditions and other factors.

During the three-month period ended March 31, 2016, pursuant to this program, we repurchased 324,141 shares of our common stock at a weighted average price of $37.96 per share and a total cost of approximately $12.3 million. The repurchased shares are classified as treasury shares. We did not repurchase any shares pursuant to this stock repurchase program during the three-month periods ended June 30, 2016 or September 30, 2016. The stock repurchase program expired on September 6, 2016.

**8. RELATED PARTY TRANSACTIONS**

On November 20, 2015, we engaged KKR Consulting, LLC ("KKR Capstone"), a consulting company of operational professionals that works exclusively with portfolio companies of Kohlberg Kravis Roberts & Co. Nathaniel M. Zilkha, a member of our Board of Directors, is a member of KKR Management, LLC, which is an affiliate of KKR Asset Management LLC ("KAM"), a substantial stockholder of our Company, and an affiliate of Kohlberg Kravis Roberts & Co. KKR Capstone will receive a fee in connection with providing consulting services to the Company in the ordinary course of business. Mr. Zilkha will not receive any direct compensation or direct financial benefit from the engagement of KKR Capstone. During the three and nine-month periods ended September 30, 2016, we incurred costs of approximately $0.4 million and $1.6 million, respectively, related to this related party engagement.

Effective October 22, 2015, we entered into a contract for telemonitoring services with Care Innovations, LLC ("Care Innovations"). Paul Kusserow, our President and Chief Executive Officer, is a member of the Advisory Board to Care Innovations. Care Innovations will receive an annual fee of approximately $1.8 million in connection with our contract for telemonitoring services for the Company. Care Innovations has confirmed to us that Mr. Kusserow will not receive any direct compensation or direct financial benefit from the engagement of Care Innovations as our telemonitoring partner. During the three and nine-month period ended September 30, 2016, we incurred costs of approximately $0.3 million and $0.9 million, respectively, related to this related party engagement.

**9. SUBSEQUENT EVENT**

On October 20, 2016, we acquired the regulatory assets from a former nonprofit organization in New York for a purchase price of $4.6 million.

## ITEM 2. 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 the three and nine-month periods ended September 30, 2016. This discussion should be read in conjunction with the condensed consolidated financial statements and notes thereto included herein, and the consolidated financial statements and notes and the related Management's Discussion and Analysis of Financial Condition and Results of Operations in our Annual Report on Form 10-K for the year ended December 31, 2015 filed with the Securities and Exchange Commission ("SEC") on March 10, 2016 (the "Form 10-K"), which are incorporated herein by this reference.*

*Unless otherwise provided, "Amedisys," "we," "our," and the "Company" refer to Amedisys, Inc. and our consolidated subsidiaries.*

### Overview

We are a provider of high-quality, low-cost services to the chronic, co-morbid, aging American population, with approximately 78% of our revenue derived from Medicare for the three and nine-month periods ended September 30, 2016, and approximately 79% and 80% of our revenue derived from Medicare for the three and nine-month periods ended September 30, 2015, 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 September 30, 2016, we owned and operated 326 Medicare-certified home health care centers, 79 Medicare-certified hospice care centers and 14 personal-care care centers in 34 states within the United States and the District of Columbia.

***Owned and Operated Care Centers***

| | Home Health | Hospice | Personal Care |
|---|---|---|---|
| At December 31, 2015 | 329(1) | 79 | — |
| Acquisitions/Startups | — | — | 14 |
| Closed/Consolidated | (3) | — | — |
| At September 30, 2016 | 326 | 79 | 14 |

(1) Includes 15 home health care centers acquired from Infinity HomeCare on December 31, 2015.

### Recent Developments

***Governmental Inquiries and Investigations and Other Litigation***

See Note 5 – Commitments and Contingencies to our condensed consolidated financial statements for additional information regarding our corporate integrity agreement and for a discussion of and updates regarding class action litigation and other legal proceeding and investigations we are involved in. No assurances can be given as to the timing or outcome of these items.

***Payment***

In July 2016, the Centers for Medicare and Medicaid Services ("CMS") issued a final rule to update hospice payment rates and the wage index for fiscal year 2017. CMS estimates hospices serving Medicare beneficiaries would see an estimated 2.1% increase in payments, which reflects a market basket update of 2.7%, reduced to reflect the Patient Protection and Affordable Care Act ("PPACA") mandated reductions of 0.6%. CMS will reimburse hospice providers with two routine home care rates, to provide separate payment rates for the first 60 days of care and care beyond 60 days, a change that was instituted in 2016. These regulations are effective on October 1, 2016. As of September 30, 2016, we estimate our impact of the 2017 final rule to be approximately 1.5% - 2.0%.

In October 2016, CMS issued a final rule to update and revise Medicare home health reimbursement rates for the calendar year 2017. The final rule implements the final year of the four-year phase-in of the rebasing adjustments to the home health PPS payment rates as required by the PPACA. CMS also provides an update to the Home Health Quality Reporting Program. CMS estimates that the net impact of the payment provisions of the final rule will result in a decrease of 0.7% in reimbursement to home health providers. The decrease is the result of a 2.8% market basket increase minus 0.3% for productivity, a 2.3% decrease for the last year in the four-year rebasing cycle and a 0.97% decrease for the second year in a three-year series of cuts for nominal case mix growth. Our impact could differ depending on differences in the wage index and the impact of coding and outlier changes. We are currently evaluating the final rule's impact on our home health operations.

**Results of Operations**

***Three-Month Period Ended September 30, 2016 Compared to the Three-Month Period Ended September 30, 2015***

Consolidated

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

| | For the Three-Month Periods Ended September 30, | |
|---|---|---|
| | 2016 | 2015 |
| Net service revenue | $ 361.6 | $ 326.4 |
| Gross margin, excluding depreciation and amortization | 149.5 | 139.6 |
| *% of revenue* | *41.3%* | *42.8%* |
| Other operating expenses | 135.1 | 120.8 |
| *% of revenue* | *37.4%* | *37.0%* |
| Asset impairment charge | — | 2.1 |
| Operating income | 14.4 | 16.7 |
| Total other income (expense), net | 3.8 | (1.7) |
| Income tax expense | (6.7) | (6.5) |
| *Effective income tax rate* | *36.8%* | *43.0%* |
| Net income | 11.5 | 8.5 |
| Net income attributable to noncontrolling interests | (0.1) | (0.1) |
| Net income attributable to Amedisys, Inc. | $ 11.4 | $ 8.4 |

Our operating income decreased $2 million on a $35 million increase in revenue. Our results for the three-month period ended September 30, 2016, include the results of an acquisition of 15 home health care centers (Infinity HomeCare, ("Infinity")) on December 31, 2015, and the addition of a personal care segment on March 1, 2016 with the acquisition of Associated Home Care which was further expanded when we purchased the assets of Professional Profiles, Inc. on September 1, 2016. These three acquisitions accounted for $22 million of our $35 million increase in revenue and $9 million of our $14 million increase in other operating expenses. Our operating results were also impacted by an increase of approximately $5 million in costs associated with our move to our new operating platform, Homecare Homebase ("HCHB"). Approximately $2 million relates to implementation services provided by a third-party with the remaining $3 million related to disruption in care center operations as well as additional corporate resources needed to support multiple systems. While we anticipate these costs to continue as we complete the roll-out, our care centers generally return to normal operating results approximately 60 to 90 days after implementation. We do expect a reduction in the costs associated with running multiple systems; however, it will not occur until we are fully implemented and transitioned to one operating system. Additionally, our results were impacted by approximately $3 million as a result of the CMS rate cut.

Total other income (expense), net for the three-month period ended September 30, 2016, includes a $3 million gain from an equity method investment as compared to a $1 million gain from an equity method investment during the three-month period ended September 30, 2015. Additionally, interest expense decreased $4 million during the three-month period ended September 30, 2016 as the result of our August 28, 2015 Credit Agreement and the related payoff of our second Lien Credit Agreement.

Home Health Division

The following table summarizes our home health segment results:

| | For the Three-Month Periods Ended September 30, | |
|---|---|---|
| | 2016 | 2015 |
| **Financial Information *(in millions)*:** | | |
| Medicare | $ 203.9 | $ 190.2 |
| Non-Medicare | 65.0 | 63.2 |
| Net service revenue | 268.9 | 253.4 |
| Cost of service | 162.4 | 150.0 |
| Gross margin | 106.5 | 103.4 |
| Other operating expenses | 77.4 | 70.0 |
| Operating income | $ 29.1 | $ 33.4 |
| **Key Statistical Data:** | | |
| **Medicare:** | | |
| *Same Store Volume (1):* | | |
| Revenue | 1% | 3% |
| Admissions | 1% | 4% |
| Recertifications | (3%) | 0% |
| *Total (2):* | | |
| Admissions | 47,625 | 44,434 |
| Recertifications | 25,522 | 25,420 |
| Completed episodes | 71,948 | 67,288 |
| Visits | 1,266,780 | 1,208,853 |
| Average revenue per completed episode (3) | $ 2,841 | $ 2,821 |
| Visits per completed episode (4) | 17.5 | 17.5 |
| **Non-Medicare:** | | |
| *Same Store Volume (1):* | | |
| Revenue | 4% | 22% |
| Admissions | (1%) | 21% |
| Recertifications | 1% | 15% |
| *Total (2):* | | |
| Admissions | 24,335 | 24,792 |
| Recertifications | 9,479 | 9,447 |
| Visits | 506,729 | 504,441 |
| **Total (2):** | | |
| Cost per Visit | $ 91.58 | $ 87.54 |
| Visits | 1,773,509 | 1,713,294 |

(1) Same store Medicare and Non-Medicare revenue, admissions or recertifications growth (decline) is the percent increase (decrease) in our Medicare and Non-Medicare revenue, admissions or recertifications for the period as a percent of the Medicare and Non-Medicare revenue, admissions or recertifications of the prior period.

(2) Total includes acquisitions.

(3) Average Medicare revenue per completed episode is the average Medicare revenue earned for each Medicare completed episode of care which includes the impact of sequestration.

(4) 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.

Operating Results

Overall, our operating income declined $4 million on a $15 million increase in revenue offset by a $12 million increase in cost of service and a $7 million increase in other operating expenses. The Infinity acquisition accounted for $12 million of our total revenue increase and $5 million of other operating expenses. Our results have been negatively impacted by approximately $3 million as a result of the CMS rate cut which became effective January 1, 2016 and by approximately $2 million as the result of disruptions associated with the roll-out of HCHB.

Net Service Revenue

Our Medicare revenue increased approximately $14 million which includes approximately $12 million from our Infinity acquisition. Our same store revenue increased $2 million despite relatively flat admit and recertification volumes and the $3 million impact of the 2016 CMS rate cut. This increase was due to higher completed episodes which is reflective of a higher patient census at the beginning of the three-month period ended September 30, 2016 compared to prior year.

Our non-Medicare revenue increased approximately $2 million, with revenue from episodic payors increasing 15% while our revenue from per visit payors decreased 3%. We continue to focus on contract payors with significant concentrations in our markets and those that add incremental margin to our operations as we continue to evaluate our portfolio of managed care contracts.

Cost of Service, Excluding Depreciation and Amortization

Our cost of service increased $12 million primarily as a result of a 3% increase in visits and an increase in cost per visit. The increase in cost per visit is primarily due to higher health insurance expense, annual salary adjustments and additional costs related to our HCHB roll-out. We believe that the impact of the HCHB roll-out is temporary and will normalize once the roll-out is complete.

Other Operating Expenses

Other operating expenses increased $7 million, which includes $5 million related to Infinity HomeCare, as the result of increases in other care center related expenses, primarily salaries and benefits, travel and training expense and HCHB maintenance and hosting fees. In addition, our provision for doubtful accounts increased approximately $1 million. We are completing the consolidation of our legacy Florida operations with Infinity and the conversion of Infinity to our back office platform. We expect to completely realize the related synergies in the first quarter of 2017.

Hospice Division

The following table summarizes our hospice segment results:

| | For the Three-Month Periods Ended September 30, | |
|---|---|---|
| | 2016 | 2015 |
| **Financial Information *(in millions)*:** | | |
| Medicare | $ 77.0 | $ 68.6 |
| Non-Medicare | 5.0 | 4.4 |
| Net service revenue | 82.0 | 73.0 |
| Cost of service | 41.9 | 36.8 |
| Gross margin | 40.1 | 36.2 |
| Other operating expenses | 19.3 | 16.9 |
| Operating income | $ 20.8 | $ 19.3 |
| **Key Statistical Data:** | | |
| *Same Store Volume (1):* | | |
| Medicare revenue | 12% | 17% |
| Non-Medicare revenue | 14% | 14% |
| Hospice admissions | 16% | 26% |
| Average daily census | 14% | 17% |
| *Total (2):* | | |
| Hospice admissions | 5,751 | 4,962 |
| Average daily census | 6,087 | 5,346 |
| Revenue per day, net | $ 146.49 | $ 148.47 |
| Cost of service per day | $ 74.77 | $ 74.82 |
| Average length of stay | 92 | 92 |

(1) Same store Medicare and Non-Medicare revenue, Hospice admissions or average daily census growth (decline) is 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.

Operating Results

Overall, our operating income increased $2 million on a $9 million increase in revenue offset by a $5 million increase in cost of service and a $2 million increase in other operating expenses.

Net Service Revenue

Our hospice revenue increased $9 million, primarily due to an increase in our average daily census as a result of a 16% increase in hospice admissions. Beginning January 1, 2016, CMS has 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, beginning January 1, 2016, Medicare is also 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.

Cost of Service, Excluding Depreciation and Amortization

Our hospice cost of service increased $5 million as the result of a 14% increase in average daily census.

Other Operating Expenses

Other operating expenses increased $2 million due to increases in other care center related expenses, primarily salaries and benefits. We have experienced an increase in days revenue outstanding, net as we transitioned to the HCHB platform. As such, our provision for doubtful accounts increased $1 million, which is reflective of an increase in our accounts receivable aging. We do expect to return to normal days revenue outstanding, net levels once we are on one operating platform.

Personal Care Division

On March 1, 2016, we acquired Associated Home Care, a personal care home health care company with nine care centers. On September 1, 2016, we acquired the assets of Professional Profiles, Inc. which owns and operates 4 personal-care care centers. In addition, during the three-month period ended September 30, 2016, we opened a start-up personal-care care center. Operating income related to our new personal care segment for the three-month period ended September 30, 2016 was less than $1 million on net service revenue of $11 million and cost of service of $8 million; other operating expenses were approximately $2 million.

Corporate

The following table summarizes our corporate operating expenses:

| | For the Three-Month Periods Ended September 30, | |
|---|---|---|
| | 2016 | 2015 |
| **Financial Information** *(in millions):* | | |
| Other operating expenses | $ 32.7 | $ 30.8 |
| Depreciation and amortization | 3.3 | 3.1 |
| Total before impairment (1) | $ 36.0 | $ 33.9 |

(1) Total of $36.0 million on a GAAP basis for the three-month period ended September 30, 2015 (including $2.1 million asset impairment charge).

Corporate expenses consist of costs relating to our executive management and corporate and administrative support functions, primarily information services, accounting, finance, billing and collections, legal, compliance, risk management, procurement, marketing, clinical administration, training, human resources and administration. Excluding the asset impairment charge in 2015, corporate other operating expenses have increased approximately $2 million. This increase includes approximately $2 million in corporate support expenses related to acquisitions and $2 million related to HCHB implementation costs, offset by decreases of $2 million in various other costs.

***Nine-Month Period Ended September 30, 2016 Compared to the Nine-Month Period Ended September 30, 2015***

Consolidated

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

| | For the Nine-Month Periods Ended September 30, | |
|---|---|---|
| | 2016 | 2015 |
| Net service revenue | $ 1,071.2 | $ 942.2 |
| Gross margin, excluding depreciation and amortization | 450.7 | 408.8 |
| *% of revenue* | *42.1%* | *43.4%* |
| Other operating expenses | 406.9 | 357.3 |
| *% of revenue* | *38.0%* | *37.9%* |
| Asset impairment charge | — | 77.3 |
| Operating income (loss) | 43.8 | (25.8) |
| Total other income (expense), net | 3.2 | 2.9 |
| Income tax (expense) benefit | (18.3) | 7.5 |
| *Effective income tax rate* | *39.0%* | *(32.9%)* |
| Net income | 28.7 | (15.4) |
| Net income attributable to noncontrolling interests | (0.3) | (0.5) |
| Net income (loss) attributable to Amedisys, Inc. | $ 28.3 | $ (15.9) |

Our operating income, excluding the $77 million non-cash asset impairment charges recorded during the nine-month period ended September 30, 2015, decreased $8 million on a $129 million increase in revenue. Our results for the nine-month period September 30, 2016, include the results of Infinity HomeCare, Associated Home Care and Professional Profiles. These three acquisitions accounted for $61 million of our $129 million increase in revenue and $27 million of our $50 million increase in other operating expenses. Our operating results were also impacted by an increase of approximately $14 million in costs associated with our move to HCHB. Approximately $7 million relates to implementation services provided by a third party with the remaining $7 million related to disruption in care center operations as well as additional corporate resources to support multiple systems. While we anticipate these costs to continue as we complete the roll-out, our care centers generally return to normal operating results approximately 60 to 90 days after implementation. We do expect a reduction in the costs associated with running multiple systems; however, it will not occur until we are fully implemented and transitioned to one operating system. Additionally, our results were impacted by approximately $9 million as a result of the CMS rate cut.

Total other income (expense), net for the nine-month period ended September 30, 2016 includes a $2 million gain from an equity method investment as compared to a $7 million gain from an equity method investment during the nine-month period ended September 30, 2015, while interest expense decreased $6 million during the nine-month period ended September 30, 2016 as the result of our August 28, 2015 Credit Agreement and the related payoff of our prior Second Lien Credit Agreement.

Home Health Division

The following table summarizes our home health segment results:

| | For the Nine-Month Periods Ended September 30, | |
|---|---|---|
| | 2016 | 2015 |
| **Financial Information *(in millions)*:** | | |
| Medicare | $ 619.2 | $ 565.8 |
| Non-Medicare | 198.0 | 176.8 |
| Net service revenue | 817.2 | 742.6 |
| Cost of service | 483.6 | 431.0 |
| Gross margin | 333.6 | 311.6 |
| Other operating expenses | 230.5 | 204.0 |
| Operating income | $ 103.1 | $ 107.6 |
| **Key Statistical Data:** | | |
| **Medicare:** | | |
| *Same Store Volume (1):* | | |
| Revenue | 3% | 2% |
| Admissions | 3% | 2% |
| Recertifications | 1% | (2%) |
| *Total (2):* | | |
| Admissions | 147,025 | 133,973 |
| Recertifications | 77,565 | 74,386 |
| Completed episodes | 218,007 | 200,301 |
| Visits | 3,893,568 | 3,580,751 |
| Average revenue per completed episode (3) | $ 2,835 | $ 2,816 |
| Visits per completed episode (4) | 17.5 | 17.4 |
| **Non-Medicare:** | | |
| *Same Store Volume (1):* | | |
| Revenue | 12% | 19% |
| Admissions | 4% | 17% |
| Recertifications | 11% | 13% |
| *Total (2):* | | |
| Admissions | 74,139 | 71,733 |
| Recertifications | 28,945 | 26,072 |
| Visits | 1,549,760 | 1,424,595 |
| **Total (2):** | | |
| Cost per Visit | $ 88.83 | $ 86.10 |
| Visits | 5,443,328 | 5,005,346 |

(1) Same store Medicare and Non-Medicare revenue, admissions or recertifications growth (decline) is the percent increase (decrease) in our Medicare and Non-Medicare revenue, admissions or recertifications for the period as a percent of the Medicare and Non-Medicare revenue, admissions or recertifications of the prior period.

(2) Total includes acquisitions.

(3) Average Medicare revenue per completed episode is the average Medicare revenue earned for each Medicare completed episode of care which includes the impact of sequestration.

(4) 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.

Operating Results

Overall, our operating income declined $4 million on a revenue increase of $75 million offset by a $53 million increase in cost of service and a $26 million increase in other operating expenses. These results are inclusive of Infinity HomeCare which accounted for $38 million of our total revenue increase and $14 million of other operating expenses. Our results have been negatively impacted by approximately $9 million related to the CMS rate cut which became effective January 1, 2016 and approximately $5 million as the result of disruptions associated with the roll-out of HCHB.

Net Service Revenue

Our Medicare revenue increased approximately $53 million which is inclusive of $37 million from acquired care centers. The increase in same store revenue is due to higher admit and recertification volumes which were offset by the impact of the rate cut which was approximately $9 million.

Our non-Medicare revenue increased approximately $21 million, with revenue from episodic payors increasing 15% while our revenue from per visit payors grew 10%. We continue to focus on contract payors with significant concentrations in our markets and those that add incremental margin to our operations as we continue to evaluate our portfolio of managed care contracts.

Cost of Service, Excluding Depreciation and Amortization

Our cost of service increased $53 million primarily as a result of a 9% increase in visits. The increase in cost per visit is primarily due to contractor utilization due to higher volumes, higher health insurance expense and additional costs related to our HCHB roll-out. We believe that the impact of the HCHB roll-out is temporary and will normalize once the roll-out is complete.

Other Operating Expenses

Other operating expenses increased $26 million due to increases in other care center related expenses, primarily salaries and benefits and travel and training expense. In addition, our provision for doubtful accounts increased $3 million. Other operating expenses related to care centers acquired from Infinity HomeCare were approximately $14 million. As previously mentioned, we are completing the consolidation of our legacy Florida operations with Infinity and the conversion of Infinity to our back office platform; we expect to completely realize the related synergies during the first quarter of 2017.

Hospice Division

The following table summarizes our hospice segment results:

| | For the Nine-Month Periods Ended September 30, | |
|---|---|---|
| | 2016 | 2015 |
| **Financial Information *(in millions)*:** | | |
| Medicare | $ 217.0 | $ 187.6 |
| Non-Medicare | 13.8 | 12.0 |
| Net service revenue | 230.8 | 199.6 |
| Cost of service | 120.1 | 102.4 |
| Gross margin | 110.7 | 97.2 |
| Other operating expenses | 55.6 | 48.2 |
| Operating income | $ 55.1 | $ 49.0 |
| **Key Statistical Data:** | | |
| *Same Store Volume (1):* | | |
| Medicare revenue | 16% | 10% |
| Non-Medicare revenue | 15% | 11% |
| Hospice admissions | 18% | 14% |
| Average daily census | 17% | 8% |
| *Total (2):* | | |
| Hospice admissions | 16,757 | 14,239 |
| Average daily census | 5,776 | 4,947 |
| Revenue per day, net | $ 145.86 | $ 147.79 |
| Cost of service per day | $ 75.89 | $ 75.87 |
| Average length of stay | 94 | 90 |

(1) Same store Medicare and Non-Medicare revenue, Hospice admissions or average daily census growth (decline) is 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.

Operating Results

Overall, our operating income increased $6 million on a $31 million increase in revenue offset by a $18 million increase in cost of service and a $7 million increase in other operating expenses.

Net Service Revenue

Our hospice revenue increased $31 million primarily due to an increase in our average daily census as a result of an 18% increase in hospice admissions.

Cost of Service, Excluding Depreciation and Amortization

Our hospice cost of service increased $18 million as the result of a 17% increase in average daily census.

Other Operating Expenses

Other operating expenses increased $7 million due to increases in other care center related expenses, primarily salaries and benefits as resources were added to support the average daily census growth.

Personal Care Division

Operating income related to our new personal care segment for the nine-month period ended September 30, 2016 was $1 million on net service revenue of $23 million and cost of service of $17 million; other operating expenses were approximately $5 million.

Corporate

The following table summarizes our corporate operating expenses:

| | For the Nine-Month Periods Ended September 30, | |
|---|---|---|
| | 2016 | 2015 |
| **Financial Information *(in millions)*:** | | |
| Other operating expenses | $ 106.4 | $ 94.3 |
| Depreciation and amortization | 9.3 | 10.8 |
| Total before impairment (1) | $ 115.7 | $ 105.1 |

(1) Total of $182.4 million on a GAAP basis for the nine-month period ended September 30, 2015 (including $77.3 million asset impairment charge).

Excluding the asset impairment charge and the $8 million Wage and Hour Litigation settlement in 2015, corporate expenses increased $19 million which is inclusive of approximately $10 million related to our acquisition activity (including acquired corporate support and other acquisition costs), $7 million related to HCHB implementation and $2 million related to various legal matters.

**Liquidity and Capital Resources**

***Cash Flows***

The following table summarizes our cash flows for the periods indicated (amounts in millions):

| | For the Nine-Month Periods Ended September 30, | |
|---|---|---|
| | 2016 | 2015 |
| Cash provided by operating activities | $ 33.7 | $ 87.7 |
| Cash used in investing activities | (45.4) | (19.8) |
| Cash used in financing activities | (6.9) | (18.9) |
| Net (decrease) increase in cash and cash equivalents | (18.6) | 49.0 |
| Cash and cash equivalents at beginning of period | 27.5 | 8.0 |
| Cash and cash equivalents at end of period | $ 8.9 | $ 57.0 |

Cash provided by operating activities decreased $54.0 million during 2016 compared to 2015 primarily due to a decrease in our cash collections relative to our growth in accounts receivable as our days revenue outstanding, net increased eight days from December 31, 2015. For additional information regarding our operating performance, see "Results of Operations" and "Outstanding Patient Accounts Receivable". The recognition of the asset impairment charges of $77.3 million, which resulted in the net loss for the nine-month period ended September 30, 2015, is a non-cash item and therefore had no impact on our cash flow from operations.

Cash used in investing activities increased $25.6 million during 2016 compared to 2015 primarily due to our acquisition activity of $31.0 million. This increase was partially offset by a $4.5 million decrease in capital expenditures.

Cash used in financing activities decreased $12.0 million during 2016 compared to 2015 primarily due to tax benefits from stock compensation plans and a decrease in repayments of outstanding borrowings, offset by repurchases of company stock pursuant to our stock repurchase program.

***Liquidity***

Typically, our principal source of liquidity is the collection of our patient accounts receivable, primarily through the Medicare program. In addition to our collection of patient accounts receivable, from time to time, we can and do obtain additional sources of liquidity by the incurrence of additional indebtedness.

During the nine-month period ended September 30, 2016, we spent $13.5 million in capital expenditures as compared to $18.0 million during the nine-month period ended September 30, 2015. Our capital expenditures for 2016 are expected to be approximately $15.0 - $20.0 million.

As of September 30, 2016, we had $8.9 million in cash and cash equivalents and $173.3 million in availability under our $200.0 million Revolving Credit Facility. Based on our operating forecasts and our new debt service requirements, we believe we will have sufficient liquidity to fund our operations, capital requirements and debt service requirements.

***Outstanding Patient Accounts Receivable***

Our net patient accounts receivable increased $37.5 million ($7 million related to 2016 acquisitions) from December 31, 2015 to September 30, 2016. Our cash collection as a percentage of revenue was 98% and 99% for the nine-month periods ended September 30, 2016 and 2015, respectively. Our days revenue outstanding, net at September 30, 2016 was 40.0 days which is an increase of 8.1 days from December 31, 2015 and an increase of 2.8 days from June 30, 2016. We have experienced a slowdown in collections primarily as the result of our shift from our legacy platforms (AMS2 and AMS3) to HCHB. We anticipate further reductions in days revenue outstanding once we complete our HCHB implementation and are completely off our legacy system. Our days revenue outstanding, net at December 31, 2015 does not include the Infinity HomeCare acquisition.

Our patient accounts receivable includes unbilled receivables and are aged based upon our initial service date. We monitor unbilled receivables on a care center by care center basis to ensure that all efforts are made to bill claims within timely filing deadlines. Our unbilled patient accounts receivable can be impacted by acquisition activity, probe edits or regulatory changes which result in additional information or procedures needed prior to billing. The timely filing deadline for Medicare is one year from the date the episode was completed, varies by state for Medicaid-reimbursable services and varies among insurance companies and other private payors.

Our provision for estimated revenue adjustments (which is deducted from our service revenue to determine net service revenue) and provision for doubtful accounts were as follows for the periods indicated (amounts in millions). We fully reserve for both our Medicare and other patient accounts receivable that are aged over 365 days.

| | For the Three-Month Periods Ended September 30, | | For the Nine-Month Periods Ended September 30, | |
|---|---|---|---|---|
| | 2016 | 2015 | 2016 | 2015 |
| Provision for estimated revenue adjustments | $ 1.6 | $ 1.5 | $ 5.9 | $ 4.0 |
| Provision for doubtful accounts | 5.5 | 3.6 | 13.7 | 9.4 |
| Total | $ 7.1 | $ 5.1 | $ 19.6 | $ 13.4 |
| As a percent of revenue | 1.9% | 1.6% | 1.8% | 1.4% |

The following schedules detail our patient accounts receivable, net of estimated revenue adjustments, by payor class, aged based upon initial date of service (amounts in millions, except days revenue outstanding, net):

| | 0-90 | 91-180 | 181-365 | Over 365 | Total |
|---|---|---|---|---|---|
| **At September 30, 2016:** | | | | | |
| Medicare patient accounts receivable, net (1) | $82.6 | $ 12.8 | $ — | $ — | $ 95.4 |
| Other patient accounts receivable: | | | | | |
| Medicaid | 13.9 | 4.7 | 3.4 | — | 22.0 |
| Private | 40.6 | 10.3 | 7.9 | 3.0 | 61.8 |
| Total | $54.5 | $ 15.0 | $ 11.3 | $ 3.0 | $ 83.8 |
| Allowance for doubtful accounts (2) | | | | | (16.7) |
| Non-Medicare patient accounts receivable, net | | | | | $ 67.1 |
| Total patient accounts receivable, net | | | | | $162.5 |
| Days revenue outstanding, net (3) | | | | | 40.0 |

| | 0-90 | 91-180 | 181-365 | Over 365 | Total |
|---|---|---|---|---|---|
| **At December 31, 2015:** | | | | | |
| Medicare patient accounts receivable, net (1) | $73.5 | $ 7.0 | $ (0.4) | $ — | $ 80.1 |
| Other patient accounts receivable: | | | | | |
| Medicaid | 12.4 | 1.7 | 0.9 | — | 15.0 |
| Private | 31.2 | 8.1 | 5.1 | 2.0 | 46.4 |
| Total | $43.6 | $ 9.8 | $ 6.0 | $ 2.0 | $ 61.4 |
| Allowance for doubtful accounts (2) | | | | | (16.5) |
| Non-Medicare patient accounts receivable, net | | | | | $ 44.9 |
| Total patient accounts receivable, net | | | | | $125.0 |
| Days revenue outstanding, net (3) | | | | | 31.9 |

(1) The following table summarizes the activity and ending balances in our estimated revenue adjustments (amounts in millions), which is recorded to reduce our Medicare outstanding patient accounts receivable to their estimated net realizable value, as we do not estimate an allowance for doubtful accounts for our Medicare claims.

| | For the Three-Month Period Ended September 30, 2016 | For the Three-Month Period Ended December 31, 2015 | For the Nine-Month Period Ended September 30, 2016 | For the Nine-Month Period Ended December 31, 2015 |
|---|---|---|---|---|
| Balance at beginning of period | $ 4.0 | $ 3.8 | $ 4.0 | $ 3.6 |
| Provision for estimated revenue adjustments | 1.6 | 2.1 | 5.9 | 4.6 |
| Write offs | (1.8) | (1.9) | (6.1) | (4.2) |
| Balance at end of period | $ 3.8 | $ 4.0 | $ 3.8 | $ 4.0 |

Our estimated revenue adjustments were 3.8% and 4.8% of our outstanding Medicare patient accounts receivable at September 30, 2016 and December 31, 2015, respectively.

(2) The following table summarizes the activity and ending balances in our allowance for doubtful accounts (amounts in millions), which is recorded to reduce only our Medicaid and private payer outstanding patient accounts receivable to their estimated net realizable value.

| | For the Three-Month Period Ended September 30, 2016 | For the Three-Month Period Ended December 31, 2015 | For the Nine-Month Period Ended September 30, 2016 | For the Nine-Month Period Ended December 31, 2015 |
|---|---|---|---|---|
| Balance at beginning of period | $ 15.9 | $ 14.7 | $ 16.5 | 14.8 |
| Provision for doubtful accounts | 5.5 | 4.7 | 13.7 | 11.1 |
| Write offs | (4.7) | (2.9) | (13.5) | (9.4) |
| Balance at end of period | $ 16.7 | $ 16.5 | $ 16.7 | $ 16.5 |

Our allowance for doubtful accounts was 19.9% and 26.9% of our outstanding Medicaid and private patient accounts receivable at September 30, 2016 and December 31, 2015, respectively.

(3) Our calculation of days revenue outstanding, net is derived by dividing our ending net patient accounts receivable (i.e., net of estimated revenue adjustments and allowance for doubtful accounts ) at September 30, 2016 and December 31, 2015 by our average daily net patient revenue for the three-month periods ended September 30, 2016 and December 31, 2015, respectively.

***Indebtedness***

Our weighted average interest rate for our $100.0 million Term Loan under our Credit Agreement, was 2.5% for the three and nine-month periods ended September 30, 2016, respectively, and 2.2% for the period August 28, 2015 to September 30, 2015. Our weighted average interest rate for our $200.0 million Revolving Credit Facility was 4.5% and 3.5% for the three and nine-month periods ended September 30, 2016, respectively.

As of September 30, 2016, our consolidated leverage ratio was 1.0, our consolidated fixed charge coverage ratio was 3.9 and we are in compliance with our Credit Agreement.

As of September 30, 2016, our availability under our $200.0 million Revolving Credit Facility was $173.3 million as we had $26.7 million outstanding in letters of credit.

See Note 4 to our condensed consolidated financial statements and Note 7 of the financial statements included in our Form 10-K for additional details on our outstanding long-term obligations.

*Stock Repurchase Program*

During the three-month period ended March 31, 2016, pursuant to our stock repurchase program, we repurchased 324,141 shares of our common stock at a weighted average price of $37.96 per share and a total cost of approximately $12.3 million. The repurchased shares are classified as treasury shares. We did not repurchase any shares pursuant to this stock repurchase program during the three-month periods ended June 30, 2016 or September 30, 2016. The stock repurchase program expired on September 6, 2016.

**Inflation**

We do not believe inflation has significantly impacted our results of operations.

**Critical Accounting Estimates**

See Part II, Item 7 – Critical Accounting Estimates and our consolidated financial statements and related notes in Part II, Item 8 of our 2015 Annual Report on Form 10-K, for accounting policies and related estimates we believe are the most critical to understanding our condensed consolidated financial statements, financial condition and results of operations and which require complex management judgment and assumptions, or involve uncertainties. These critical accounting estimates include: revenue recognition, patient accounts receivable, insurance, goodwill and other intangible assets and income taxes. There have not been any changes to our significant accounting policies or their application since we filed our 2015 Annual Report on Form 10-K.

## ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We are exposed to market risk from fluctuations in interest rates. Our Revolving Credit Facility and Term Loan carry a floating interest rate which is tied to the Eurodollar rate (*i.e.* LIBOR) and the Prime Rate, and therefore, our condensed consolidated statements of operations and our condensed consolidated statements of cash flows will be exposed to changes in interest rates. As of September 30, 2016, the total amount of outstanding debt subject to interest rate fluctuations was $96.2 million. A 1.0% interest rate change would cause interest expense to change by approximately $1.0 million annually.

## ITEM 4. CONTROLS AND PROCEDURES

**Evaluation of Disclosure Controls and Procedures**

We have established disclosure controls and procedures which are designed to provide reasonable assurance of achieving their objectives and to ensure that information required to be disclosed in our reports filed under the Securities Exchange Act of 1934 as amended (the "Exchange Act") is recorded, processed, summarized, disclosed and reported within the time periods specified in the SEC's rules and forms. This information is also accumulated and communicated to our management and Board of Directors to allow timely decisions regarding required disclosure.

In connection with the preparation of this Quarterly Report on Form 10-Q, as of September 30, 2016, under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our disclosure controls and procedures, as such term is defined under Rules 13a-15(e) and 15d-15(e) promulgated under the Exchange Act.

Based on this evaluation, our principal executive officer and principal financial officer concluded that our disclosure controls and procedures were effective at a reasonable assurance level as of September 30, 2016, the end of the period covered by this Quarterly Report.

**Changes in Internal Controls**

During 2015, we began the implementation of Homecare Homebase ("HCHB") with a total of 380 care centers on HCHB as of September 30, 2016. The Company has included the changes to processes, information technology systems and other components of internal controls over financial reporting as part of its ongoing implementation activities as part of its review of internal controls over financial reporting.

There have been no changes in our internal control over financial reporting (as defined in Exchange Act Rule 13a-15(f)) that have occurred during the quarter ended September 30, 2016 that have materially impacted, or are reasonably likely to materially impact, our internal control over financial reporting.

*Inherent Limitations on Effectiveness of Controls*

Our management, including our principal executive officer and principal financial officer, does not expect that our disclosure controls or our internal controls over financial reporting will prevent or detect all errors and all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the control system's objectives will be met. The design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Further, because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that misstatements due to error or fraud will not occur or that all control issues and instances of fraud, if any, have

been detected. These inherent limitations include the realities that judgments in decision-making can be faulty and that breakdowns can occur because of simple error or mistake. Controls can also be circumvented by the individual acts of some persons, by collusion of two or more people, or by management override of the controls. The design of any system of controls is based in part on certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions. Projections of any evaluation of controls' effectiveness to future periods are subject to risks. Over time, controls may become inadequate because of changes in conditions or deterioration in the degree of compliance with policies and procedures. Our disclosure controls and procedures are designed to provide reasonable assurance of achieving their objectives and, based on an evaluation of our controls and procedures, our principal executive officer and our principal financial officer concluded our disclosure controls and procedures were effective at a reasonable assurance level as of September 30, 2016, the end of the period covered by this Quarterly Report.

## PART II. OTHER INFORMATION

### ITEM 1. LEGAL PROCEEDINGS

See Note 5 to the condensed consolidated financial statements for information concerning our legal proceedings.

### ITEM 1A. RISK FACTORS

In addition to other information set forth in this Quarterly Report on Form 10-Q, you should carefully consider the risk factors included in Part I, Item 1A. – Risk Factors of our Annual Report on Form 10-K. These risk factors could materially impact our business, financial condition and/or operating results. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely impact our business, financial condition and/or operating results.

### ITEM 2. UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

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 September 30, 2016:

| 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 |
|---|---|---|---|---|
| July 1, 2016 to July 31, 2016 | 7,910 | $ 53.54 | — | $ — |
| August 1, 2016 to August 31, 2016 | — | — | — | — |
| September 1, 2016 to September 30, 2016 | — | — | — | — |
| | 7,910(1) | $ 53.54 | — | $ — |

(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.

### ITEM 3. DEFAULTS UPON SENIOR SECURITIES

None.

### ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

### ITEM 5. OTHER INFORMATION

None.

## ITEM 6. EXHIBITS

The exhibits marked with the cross symbol (†) are filed and the exhibits marked with a double cross (††) are furnished with this Form 10-Q. Any exhibits marked with the asterisk symbol (*) are management contracts or compensatory plans or arrangements filed pursuant to Item 601(b)(10)(iii) of Regulation S-K.

| Exhibit Number | Document Description | Report or Registration Statement | SEC File or Registration Number | Exhibit or Other Reference |
|---|---|---|---|---|
| 3.1 | Composite of Certificate of Incorporation of the Company inclusive of all amendments through June 14, 2007 | The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007 | 0-24260 | 3.1 |
| 3.2 | Composite of By-Laws of the Company inclusive of all amendments through April 20, 2016 | The Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016 | 0-24260 | 3.2 |
| †31.1 | Certification of Paul B. Kusserow, President and Chief Executive Officer (principal executive officer), pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 | | | |
| †31.2 | Certification of Ronald A. LaBorde, Vice Chairman and Chief Financial Officer (principal financial officer), pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 | | | |
| ††32.1 | Certification of Paul B. Kusserow, President and Chief Executive Officer (principal executive officer), pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 | | | |
| ††32.2 | Certification of Ronald A LaBorde, Vice Chairman and Chief Financial Officer (principal financial officer), pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 | | | |
| †101.INS | XBRL Instance | | | |
| †101.SCH | XBRL Taxonomy Extension Schema Document | | | |
| †101.CAL | XBRL Taxonomy Extension Calculation Linkbase Document | | | |
| †101.DEF | XBRL Taxonomy Extension Definition Linkbase | | | |
| †101.LAB | XBRL Taxonomy Extension Labels Linkbase Document | | | |
| †101.PRE | XBRL Taxonomy Extension Presentation Linkbase Document | | | |

## SIGNATURES

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

AMEDISYS, INC.
(Registrant)

By: /s/ SCOTT G. GINN
**Scott G. Ginn,**
**Principal Accounting Officer and**
**Duly Authorized Officer**

Date: November 4, 2016

## EXHIBIT INDEX

The exhibits marked with the cross symbol (†) are filed and the exhibits marked with a double cross (††) are furnished with this Form 10-Q. Any exhibits marked with the asterisk symbol (*) are management contracts or compensatory plans or arrangements filed pursuant to Item 601(b)(10)(iii) of Regulation S-K.

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| †101.PRE | XBRL Taxonomy Extension Presentation Linkbase Document | | | |

Exhibit 31.1

**CERTIFICATION**

I, Paul B. Kusserow, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q for the quarter ended September 30, 2016, of Amedisys, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an Annual Report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's Board of Directors (or persons performing the equivalent functions):

a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: November 4, 2016

/S/ Paul B. Kusserow

**Paul B. Kusserow**
**President and Chief Executive Officer**
**(Principal Executive Officer)**

**Exhibit 31.2**

**CERTIFICATION**

I, Ronald A. LaBorde, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q for the quarter ended September 30, 2016, of Amedisys, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an Annual Report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's Board of Directors (or persons performing the equivalent functions):

a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: November 4, 2016

/S/ Ronald A. LaBorde

**Ronald A. LaBorde**
**Vice Chairman and Chief Financial Officer**
**(Principal Financial Officer)**

**Exhibit 32.1**

**CERTIFICATION OF PRINCIPAL EXECUTIVE OFFICER PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Quarterly Report of Amedisys, Inc. (the "Company") on Form 10-Q for the quarter ended September 30, 2016 (the "Report"), I, Paul B. Kusserow, President and Chief Executive Officer of the Company, hereby certify to my knowledge, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

Date: November 4, 2016

/S/ Paul B. Kusserow

**Paul B. Kusserow**
**President and Chief Executive Officer**
**(Principal Executive Officer)**

**Exhibit 32.2**

**CERTIFICATION OF PRINCIPAL FINANCIAL OFFICER PURSUANT TO 18 U.S.C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Quarterly Report of Amedisys, Inc. (the "Company") on Form 10-Q for the quarter ended September 30, 2016 (the "Report"), I, Ronald A. LaBorde, Vice Chairman and Chief Financial Officer of the Company, hereby certify to my knowledge, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and result of operations of the Company.

Date: November 4, 2016

/S/ Ronald A. LaBorde

**Ronald A. LaBorde**
**Vice Chairman and Chief Financial Officer**
**(Principal Financial Officer)**